UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

TRUST BOARD

MEETING TO BE HELD ON THURSDAY 30 JANUARY 2014 FROM 9.30AM IN SEMINAR ROOMS 2 AND 3, CLINICAL EDUCATION CENTRE, GLENFIELD HOSPITAL

Public meeting commences at 12.30pm

AGENDA

Please take papers as read

Item no.	Item	Paper ref:	Lead	Discussion time
1.	**EXCLUSION OF THE PRESS AND PUBLIC** It is recommended that, pursuant to the Public Bodies (Admission to Meetings) Act 1960, the press and members of the public be excluded from the following items of business, having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest (items 1-16).			-
2.	**APOLOGIES AND WELCOME** To receive apologies for absence from Mr A Seddon, Director of Finance and Business Services, Ms J Wilson, Non-Executive Director and Professor D Wynford-Thomas, Non-Executive Director. To welcome Mr P Hollinshead, Interim Director of Financial Strategy to the meeting.	**-**	**Acting Chairman**	9.30am – 9.35am
3.	**DECLARATIONS OF INTERESTS** Members of the Trust Board and other persons attending are asked to declare any interests they may have in the business on the agenda (Standing Order 7 refers). Unless the Trust Board agrees otherwise in the case of a non-prejudicial interest, the person concerned shall withdraw from the meeting room and play no part in the relevant discussion or decision.			-
4.	**ACTING CHAIRMAN'S AND CHIEF EXECUTIVE'S OPENING COMMENTS**	**-**	**Acting Chairman and Chief Executive**	9.35am – 9.40am
5.	**CONFIDENTIAL MINUTES** Confidential Minutes of the meetings held on 13 and 20 December 2013. *For approval* To note that the confidential Minutes of the 16 January 2014 Trust Board development session will be presented to the 27 February 2014 Trust Board meeting.	**A & A1**	**Acting Chairman**	9.40am – 9.45am
6.	**MATTERS ARISING** Confidential action logs from the 13 and 20 December 2013 Trust Board meetings and the 21 November 2013 Trust Board development session. *For approval*	**B & B1**	**Acting Chairman**	9.45am – 9.50am
7.	**REPORTS BY THE MEDICAL DIRECTOR** *Prejudicial to the conduct of public affairs*	**C & C1**	**Medical Director**	9.50am – 10.20am
8.	**REPORTS BY THE CHIEF NURSE** *Commercial interests and prejudicial to the conduct of*	**D – D2**	**Chief Nurse**	10.20am – 10.50am

	public affairs	**(D2 to follow)**		
9.	**REPORTS BY THE DIRECTOR OF STRATEGY** *Commercial interests and prejudicial to the conduct of public affairs*	**E & E1**	**Director of Strategy**	10.50am – 11.10am
10.	**REPORTS BY THE INTERIM DIRECTOR OF FINANCIAL STRATEGY** *Prejudicial to the conduct of public affairs*	**verbal**	**Interim Director of Financial Strategy**	11.10am – 11.30am
11.	**REPORTS BY THE DIRECTOR OF HUMAN RESOURCES** *Personal information and prejudicial to the conduct of public affairs*	**F & F1**	**Director of Human Resources**	11.30am – 11.35am
12.	**REPORT BY THE ACTING CHAIRMAN AND DIRECTOR OF CORPORATE AND LEGAL AFFAIRS** *Commercial interests and prejudicial to the conduct of public affairs*	**G**	**Acting Chairman/ Director of Corporate and Legal Affairs**	11.35am – 11.40am
13.	**REPORT BY THE DIRECTOR OF CORPORATE AND LEGAL AFFAIRS** *Personal information and prejudicial to the conduct of public affairs*	**H**	**Director of Corporate and Legal Affairs**	11.40am – 11.45am
14.	**REPORTS FROM BOARD COMMITTEES**			11.45am – 11.50am
14.1	**FINANCE AND PERFORMANCE COMMITTEE** Confidential Minutes of the 18 December 2013 meeting for noting. *Commercial interests and prejudicial to the conduct of public affairs*	**I**	**Acting Chairman**	
14.2	**QUALITY ASSURANCE COMMITTEE** Confidential Minutes of the 17 December 2013 meeting for noting. *Prejudicial to the conduct of public affairs*	**J**	**Acting Quality Assurance Committee Chair**	
14.3	**REMUNERATION COMMITTEE** Confidential Minutes of the 10 January 2014 meeting for noting. *Personal information and prejudicial to the conduct of public affairs* To note that the Minutes of the meeting to be held on 30 January 2014 will be presented to the 27 February 2014 Trust Board.	**K**	**Acting Chairman**	
15.	**PRIVATE TRUST BOARD BULLETIN JANUARY 2014**	**L**	**-**	-
16.	**ANY OTHER BUSINESS**	**-**	**Acting Chairman**	11.50am – 11.55am
Lunch break from 12noon to 12.30pm prior to commencing the public section of the meeting				
17.	**DECLARATION OF INTERESTS**	**-**	**Acting Chairman**	-
	Members of the Trust Board and other persons attending are asked to declare any interests they may have in the business on the public agenda (Standing Order 7 refers). Unless the Trust Board agrees otherwise in the case of a non-prejudicial interest, the person concerned shall withdraw from the meeting room and play no part in the relevant discussion or decision.			
18.	**ACTING CHAIRMAN'S AND CHIEF EXECUTIVE'S OPENING COMMENTS**		**Acting Chairman/ Chief Executive**	12.30pm – 12.35pm

19.	**MINUTES**			
	Minutes of the 20 December 2013 Trust Board meeting. *For approval*	**M**	**Acting Chairman**	12.35pm – 12.40pm
20.	**MATTERS ARISING**			
	Action log from the 20 December 2013 meeting. *For approval*	**N**	**Acting Chairman**	12.40pm – 12.45pm
21.	**REPORTS BY THE CHIEF EXECUTIVE**			12.45pm – 12.55pm
21.1	**MONTHLY UPDATE REPORT – JANUARY 2014** *For discussion and assurance*	**O**	**Chief Executive**	
21.2	**CHILDREN'S SERVICES – BOARD LEVEL LEADERSHIP** *For discussion and assurance*	**P**	**Chief Executive**	
22.	**CLINICAL QUALITY AND SAFETY**			12.55pm – 1.15pm
22.1	**PATIENT EXPERIENCE** *For discussion and assurance*	**Q**	**Chief Nurse**	
22.2	**SUPPORTING CARERS OF PEOPLE WITH DEMENTIA** *For discussion and assurance*	**R**	**Chief Nurse**	
23.	**HUMAN RESOURCES**			1.15pm – 1.25pm
23.1	**LOCAL CLINICAL EXCELLENCE AWARDS** *For discussion and approval*	**S**	**Director of Human Resources**	
24.	**QUALITY AND PERFORMANCE** *For assurance*			
24.1	**MONTH 9 QUALITY, FINANCE AND PERFORMANCE REPORT** *For assurance* ***Consideration of this item will be structured as follows:-*** **<u>Quality</u>** (a) The **Acting Non-Executive Director Chair** of the **Quality Assurance Committee** will be invited to comment verbally on the month 9 position, as considered at the meeting held on 29 January 2014 (the Minutes of which will be presented to the 27 February 2014 Trust Board); (b) **Lead Executive Directors** will then be invited to comment on their respective sections of the month 9 report, specifically:- • **Chief Nurse** – patient safety and quality, quality commitment, patient experience and facilities management performance; • **Medical Director** – mortality rates; **<u>Finance and Performance</u>** (c) **Acting Chair** to comment verbally on the month 9 position, as considered at the **Finance and Performance Committee** meeting held on 29 January 2014 (the Minutes of which will be	**T**	**Acting Quality Assurance Committee Chair** **Chief Nurse** **Medical Director** **Acting Chair**	1.25pm – 2.10pm

	presented to the 30 January 2014 Trust Board). (d) **Lead Executive Directors** will then be invited to comment on their respective sections of the month 9 report, specifically:- • **Chief Operating Officer** – operational performance and exception reports, • **Chief Executive** – information management and technology performance, • **Director of Human Resources** – staff appraisal, sickness absence and statutory and mandatory training compliance, and • **Interim Director of Financial Strategy** – month 9 financial position.		**Chief Operating Officer** **Chief Executive** **Director of Human Resources** **Interim Director of Financial Strategy**	
24.2	**EMERGENCY CARE PERFORMANCE AND RECOVERY PLAN** *For discussion and assurance*	**U**	**Chief Operating Officer**	2.10pm – 2.25pm
24.3	**NHS TRUST OVER-SIGHT SELF CERTIFICATION** *For discussion and approval*	**V**	**Director of Corporate and Legal Affairs**	2.25pm – 2.30pm
25.	**STRATEGY AND FORWARD PLANNING**			
25.1	**ANNUAL OPERATIONAL PLAN 2013-14 QUARTER 3 PROGRESS REPORT** *For assurance*	**W**	**Director of Strategy**	2.30pm – 2.40pm
25.2	**UPDATE ON DRAFT ANNUAL OPERATIONAL PLANS 2014-15 AND 2015-16** *For discussion and ratification*	**X**	**Director of Strategy**	2.40pm – 2.50pm
25.3	**QUARTERLY REVIEW OF THE IMPROVEMENT AND INNOVATION FRAMEWORK**	**withdrawn**	**Director of Strategy**	-
26.	**RISK**			
26.1	**BOARD ASSURANCE FRAMEWORK – UPDATE** *For discussion and assurance*	**Y**	**Chief Nurse**	2.50pm – 3pm
27.	**MEDICAL EDUCATION**			
27.1	**QUARTERLY UPDATE ON MEDICAL EDUCATION** *For discussion and assurance*	**Z**	**Medical Director**	3pm – 3.10pm
28.	**RESEARCH AND DEVELOPMENT**			
28.1	**QUARTERLY UPDATE ON RESEARCH AND DEVELOPMENT** *For discussion and assurance*	**AA**	**Medical Director**	3.10pm – 3.20pm
29.	**REPORTS FROM BOARD COMMITTEES**			
29.1	**FINANCE AND PERFORMANCE COMMITTEE** Minutes of the 18 December 2013 meeting for noting and endorsement of any recommendations.	**BB**	**Acting Chairman**	-
29.2	**QUALITY ASSURANCE COMMITTEE** Minutes of the 17 December 2013 meeting for noting and endorsement of any recommendations.	**CC**	**Acting Quality Assurance Committee Chair**	-
30.	**CORPORATE TRUSTEE BUSINESS**			
30.1	**FINAL ACCOUNTS AND ANNUAL REPORT 2012-13 FOR LEICESTER HOSPITAL CHARITY**	**DD**	**Interim Director of Financial Strategy /Charitable Funds**	3.20pm – 3.30pm

	For approval.		**Committee Chairman**	
31.	**TRUST BOARD BULLETIN – JANUARY 2014**	**EE**	**-**	-
32.	**QUESTIONS FROM THE PUBLIC RELATING TO BUSINESS TRANSACTED AT THIS MEETING**	**-**	**Acting Chairman**	3.30pm – 3.50pm
33.	**ANY OTHER BUSINESS**	**-**	**Acting Chairman**	3.50pm – 3.55pm
34.	**DATE OF NEXT MEETING**			
	The next Trust Board meeting will be held on **Thursday 27 February 2014** from 9.00am in the C J Bond rooms, Clinical Education Centre, Leicester Royal Infirmary.	**-**		

Kate Rayns
Trust Administrator

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF A MEETING OF THE TRUST BOARD, HELD ON FRIDAY 20 DECEMBER 2013 AT 10AM IN SEMINAR ROOMS 2 AND 3, CLINICAL EDUCATION CENTRE, GLENFIELD HOSPITAL

Present:
Mr R Kilner – Acting Trust Chairman
Mr J Adler – Chief Executive
Colonel (Retired) I Crowe – Non-Executive Director
Dr K Harris – Medical Director (excluding part of Minute 332/13/2)
Ms K Jenkins – Non-Executive Director
Mr R Mitchell – Chief Operating Officer
Ms R Overfield – Chief Nurse
Mr A Seddon – Director of Finance and Business Services
Ms J Wilson – Non-Executive Director
Professor D Wynford-Thomas – Non-Executive Director

In attendance:
Ms D Baker – Service Equality Manager (for Minute 344/13/1)
Dr T Bentley – Leicester City CCG
Mr N Bond – Capital Projects Manager, NHS Horizons (for Minute 342/13/3)
Ms K Bradley – Director of Human Resources
Mr E Charlesworth – Healthwatch Representative (from Minute 334/13)
Ms H Leatham – Head of Nursing (for Minute 339/13/1)
Mrs K Rayns – Trust Administrator
Ms K Shields – Director of Strategy
Mr S Ward – Director of Corporate and Legal Affairs
Mr M Wightman – Director of Marketing and Communications

ACTION

322/13 EXCLUSION OF THE PRESS AND PUBLIC

Resolved – that, pursuant to the Public Bodies (Admission to Meetings) Act 1960, the press and members of the public be excluded during consideration of the following items of business (Minutes 322/13 – 333/13), having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.

323/13 APOLOGIES

Apologies for absence were received from Mr P Panchal, Non-Executive Director and Mr I Sadd, Non-Executive Director.

324/13 DECLARATIONS OF INTERESTS IN THE CONFIDENTIAL BUSINESS

The Medical Director declared an interest in the business discussed under Minute 332/13/2 below and it was agreed that he would absent himself from the meeting for this discussion.

325/13 ACTING CHAIRMAN'S AND CHIEF EXECUTIVE'S OPENING COMMENTS

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

326/13 CONFIDENTIAL MINUTES

Resolved – that (A) subject to a correction to Minute 297/13/1, the confidential Minutes of the 28 November 2013 Trust Board meeting be confirmed as a correct record;

(B) the notes of the 21 November 2013 Trust Board Development Session be confirmed as a correct record, and

(C) the confidential Minutes of the 13 December 2013 Trust Board meeting be submitted to the 30 January 2014 meeting for approval. **DCLA/ TA**

327/13 CONFIDENTIAL MATTERS ARISING REPORT

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

328/13 REPORT BY THE DIRECTOR OF FINANCE AND BUSINESS SERVICES

Resolved – 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.

329/13 REPORT BY THE DIRECTOR OF STRATEGY

Resolved – 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.

330/13 REPORTS BY THE DIRECTOR OF HUMAN RESOURCES

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

331/13 REPORT BY THE CHIEF OPERATING OFFICER

Resolved – 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.

332/13 REPORT BY THE MEDICAL DIRECTOR

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

333/13 REPORTS FROM BOARD COMMITTEES

333/13/1 Finance and Performance Committee

Resolved – 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.

333/13/2 Quality Assurance Committee

Resolved – that the confidential Minutes of the Quality Assurance Committee meeting

held on 27 November 2013 (paper I refers) be received and noted.

333/13/3 Remuneration Committee

Resolved – that the confidential Minutes of the Remuneration Committee meeting held on 28 November 2013 (paper J refers) be received and noted.

334/13 DECLARATIONS OF INTERESTS IN THE PUBLIC BUSINESS

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

335/13 ACTING CHAIRMAN'S AND CHIEF EXECUTIVE'S OPENING COMMENTS

The Acting Chairman welcomed Mr E Charlesworth, Healthwatch Representative to the meeting following his recent illness and he drew members' attention to the following issues:-

(a) UHL's projected year end deficit was likely to reach £39.8m by 31 March 2014, as a result of the Trust spending more on patient care than it received in income. The drivers for this would be discussed later in the meeting, but stakeholders had recognised that staff were doing the best job possible under difficult circumstances;
(b) feedback relating to how effectively the NHS (including primary, secondary and intermediate care and social services) was working together in the wider health economy. Joint discussions between UHL and CCG Non-Executive Directors and Lay Members were planned in the New Year to support an increased focus on outputs from the LLR wide Better Care Together Programme, and
(c) the Board had endorsed the decision that Ms K Shields, Director of Strategy would assume the role of NHS Horizons Board Chair following the January 2014 meeting.

Resolved – that the verbal information provided by the Acting Chairman be received and noted.

336/13 MINUTES

Resolved – that the Minutes of the Trust Board meeting held on 28 November 2013 (paper K) be confirmed as a correct record.

337/13 MATTERS ARISING FROM THE MINUTES

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

(a) item 1 – Minute 303 of 28 November 2013 – the Chief Executive advised that the business case for UHL's emergency floor had been endorsed by the 3 CCGs. He highlighted ongoing discussions surrounding affordability and the strategy for the local health economy strategy and noted that a report on the required enabling works was due to be presented to the TDA Capital Committee. In parallel, further design work was progressing to provide a modular ward block as this was one of the key enabling schemes;
(b) item 7 – Minute 306/13/1 of 28 November 2013 – a summary of UHL's Quality and Safety supporting structure was provided in the Assurance and Escalation Framework report (which featured later in the agenda as paper Z). In addition, it was agreed that the Trust Administrator would circulate copies of a report on the structure which had recently been endorsed by the Executive Team; **TA**
(c) item 10 – Minute 308/13/2 of 28 November 2013 – the Director of Marketing and Communications confirmed that further analysis was taking place to differentiate between feedback provided by healthcare professionals and the wider stakeholder

group. This information would be circulated outside the Trust Board meeting once available; **DMC**

(d) item 11 – Minute 309/13/1 of 28 November 2013 – Ms K Jenkins, Non-Executive Director sought an update on progress with improving the tracking of outstanding internal audit recommendations, noting in response that a refreshed position would be considered by the Executive Performance Board on 28 January 2014 and an updated report would be provided to the February 2014 Audit Committee. The Director of Finance and Business Services added that the functionality of the TrAction monitoring tool had improved significantly and email reminders had now been issued to the accountable officers in respect of their outstanding actions; **DFBS**

(e) item 12 – Minute 311/13(1) of 28 November 2013 – the Director of Strategy had commenced discussions with the wider health economy regarding the potential impact of increased immigration from Romania and Bulgaria. A further update would be provided to the 30 January 2014 meeting; **DoS**

(f) item 13 – Minute 311/13/2 of 28 November 2013 – the Director of Corporate and Legal Affairs confirmed that he had contacted Mr M Woods regarding progress of the outstanding responses to queries raised at the 28 September 2013 Trust Board meeting. Since then, Mr Woods had raised some additional concerns regarding a particular incident of patient care. These concerns had already been shared with all Trust Board members and the Director of Corporate and Legal Affairs undertook to circulate copies of the Trust's response letter (once available); **DCLA**

(g) item 14 – Minute 312/13/1 of 28 November 2013 – the Acting Chairman had briefly referred to the arrangements for improving governance of the Better Care Together Programme in his earlier announcements, but he suggested that an update on this matter be provided to the 27 February 2014 Trust Board; **Chairman**

(h) item 15 – Minute 312/13/2 of 28 November 2013 – details of the Quality and Safety walkabouts would be circulated to Trust Board members to supplement the briefing packs in preparation for the forthcoming CQC inspection; **CN**

(i) item 17 – Minute 277/13/5 of 31 October 2013 – the Director of Human Resources reported on the arrangements to establish an Executive-level Workforce Board with similar terms of reference to the previous Board-level Workforce and Organisational Development Committee which had been disbanded in March 2013. Draft terms of reference and membership would be submitted to the Executive Team in January 2014; **DHR**

(j) item 18 – Minute 249/13/1 of 26 September 2013 – the Medical Director confirmed that letters requesting information to evidence expenditure against SIFT funding had been re-provided to the new CMG education leads and they were now positively engaged in this process. It was agreed to remove this item from the progress log of matters arising; **TA**

(k) item 19 – Minute 252/13/1 of 26 September 2013 – the Chief Nurse apologised for not having spoken to Ms K Jenkins, Non-Executive Director regarding the monitoring arrangements for risk 4 on the Board Assurance Framework and she undertook to complete this action outside the meeting, and **CN**

(l) item 20 – Minute 227/13(1) of 29 August 2013 – members noted that the organisational structure chart provided in the December 2013 Trust Board Bulletin (paper BB refers) now detailed the names of the CMG Patient and Public Involvement leads and agreed that this item would now be removed from the progress log. **TA**

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

338/13 REPORT BY THE CHIEF EXECUTIVE

338/13/1 <u>Monthly Update Report – December 2013</u>

The Chief Executive introduced paper M, the Chief Executive's monthly summary of key issues. Noting that separate reports featured elsewhere on the Trust Board agenda in respect of financial sustainability and emergency care performance, he drew members' attention to the following issues:-

(a) the forthcoming CQC inspection due to commence on Monday 13 January 2014. A range of staff focus groups and public listening events were planned and a letter would be circulated to staff inviting them to share any specific concerns with the CQC. The logistical arrangements for the visit were due to be finalised on 23 January 2014. The Trust had already held its own listening event which had been well-attended and had provided a range of positive and negative observations relating to care at UHL which would now be followed up appropriately, and

(b) opportunities highlighted by Sir Bruce Keogh to develop 7 day working in key services – UHL and the wider health economy were planning to hold 2 super weekends during January 2014 with the aim of maintaining the mid-week patient flows and discharge rates throughout the weekend periods to support ED performance during the early part of the week.

Resolved – that the Chief Executive's monthly update report for December 2013 be received and noted.

339/13 CLINICAL QUALITY AND SAFETY

339/13/1 Patient Experience – Patient Relative's Story relating to care in the Emergency Department

The Chief Nurse introduced paper N, providing the Board with an example of negative feedback received from a patient's relative regarding the care of his father who had received treatment in the Minor Injuries section of the Emergency Department in May 2013 and had been subsequently admitted to ward 15 at the LRI. She introduced Ms H Leatham, Head of Nursing who attended the meeting to present this item. A short video was shown, providing highlights from an interview with the relative (who was also in attendance for this section of the meeting).

Following the video, the Board held a constructive discussion on the range of issues highlighted and the developments implemented within the Emergency Department to improve patient experience. These were noted to include greater awareness of disposal arrangements for used vomit bowels, availability of tissues in all cubicles, more transparency of caring behaviours by staff, professional communications between staff, intentional rounding (whereby patients were checked every hour to see if they needed any assistance or something to eat or drink), improved frequency of refuse collections, soft closing (quieter) waste bins and customer service training for portering staff.

Particular discussion took place regarding the following points:-

(a) contextual information provided in relation to the high levels of ED attendances and 4 hour breaches experienced during the relevant period during May 2013;
(b) a detailed review of complaints themes which would take place at the February 2014 Trust Board development session;
(c) arrangements for patients attending ED without a friend or relative accompanying them – the Director of Marketing and Communications suggested that the Trust might like to consider an offer received from the Chief Executive of Age UK to develop arrangements for patient advocates within the ED. Members supported this idea, but noted a potential concern raised by the Head of Nursing regarding limited availability of volunteers during unsociable hours;
(d) opportunities for UHL staff to trial the patient experience for themselves, such as sampling the patient meals whilst lying down in bed and wearing a special suit designed to simulate the effects of arthritis – the Director of Nursing provided assurance that such observational audits were regularly undertaken at UHL;
(e) opportunities to provide individual feedback to Interserve staff regarding any poor communications skills, rather than implementing a service wide training programme. The Healthwatch Representative also recorded his personal observations relating to

portering staff behaviours and use of bad language in front of patients. In response, the Head of Nursing advised that staff tracking systems at the time had not supported an individual feedback approach, but electronic tracking had since been implemented which would enable this approach to be used, and

(f) weekly audits of the intentional rounding in ED were undertaken and these were incorporated into the quality dashboard. Should any issues emerge within a particular shift then this would be highlighted by the audit process and escalated accordingly.

The Board thanked the Head of Nursing and the patient's relative for attending the meeting and raising these important issues for Trust Board consideration.

Resolved – that (A) the presentation on patient experience within the Emergency Department be received and noted, and

(B) a review of the key themes arising from the complaints process be considered in depth at the February 2014 Trust Board development session. **CN**

340/13 HUMAN RESOURCES

340/13/1 Quarterly Update on Workforce and Organisational Development

Further to Minute 248/13/2 of 26 September 2013, the Director of Human Resources introduced paper O, providing the Quarter 3 (October to December 2013) update on progress of the Trust's Organisational Development Plan, performance against key HR metrics, workforce profile and pay bill and setting out key developments in relation to the HR service model. She particularly drew members' attention to the following elements of the report:-

- Divisional staff development sessions which aimed at "putting people first" had been well-evaluated and would be rolled out within the CMGs as part of the next phase of development;
- progress with implementation of the medical engagement strategy priorities – including the first UHL Consultant/GP Conference, a Clinical Senate event and implementation of the UHL Doctors in Training Committee. Dr T Bentley, CCG Representative commented that he had attended the Consultant/GP Conference and he confirmed that primary care partners were very keen to work with UHL on improving patient pathways, and
- the revised Corporate Induction programme which would provide on-site access to induction training for new staff within the first week of commencement.

Ms J Wilson, Non-Executive Director noted that this was a comprehensive and useful report. She raised a query on the arrangements for consistent adherence to staff values and behaviours and monitoring of staff appraisals going forwards. In response, the Director of Human Resources confirmed that one of the main workstreams for the (soon to be established) Executive Workforce Board would be to focus upon ensuring that staff were actively managed through the appraisals process and that managers who were not conducting appraisals in a timely manner were performance managed (where appropriate).

The Director of Corporate and Legal Affairs commented upon opportunities to strengthen UHL's leadership through talent management and development, noting in response that Mr N Dingley would be facilitating a medical leadership development programme to support managers who had demonstrated potential leadership skills and that coaching arrangements were available for any "rising stars". A further update on this workstream would be provided in the March 2014 quarterly update. **DHR**

Resolved – that (A) the Quarter 3 update on Workforce and Organisational Development be received and noted, and

(B) an update on the Trust's arrangements for talent management and leadership development be provided in the Quarter 4 update report. **DHR**

340/13/2 Reward and Recognition Strategy 2013-16

Paper P provided a copy of UHL's draft Reward and Recognition Strategy and the detailed action plan for 2013-14 was provided at appendix 1. Following a query raised by Colonel (Retired) I Crowe, Non-Executive Director, a short discussion took place regarding use of the national honours systems and local and national awards to motivate staff appropriately. The Trust Board endorsed the strategy as presented in paper P.

Resolved – that the draft Reward and Recognition Strategy 2013-16 (paper P refers) be endorsed for implementation. **DHR**

340/13/3 Listening into Action (LiA) Update

The Chief Executive presented the LiA progress report (paper Q refers), particularly highlighting the success of the Pioneering Teams, Enabling our People schemes and the LiA team led by Ms M Cloney in embedding LiA as part of the management of change process for major transformational projects (such as the managed print service). The graph on the final page illustrated the positive improvement between UHL staff survey scores in March 2013 and the LiA Pulse Check survey undertaken in October 2013. Members noted that the score for question 8 had deteriorated, although this question was noted to have changed from "I am proud to work in this work area/team/department" to "I would recommend our Trust to my family and friends".

Discussion took place regarding the Doctors in Training Committee and an event held on 19 December 2013 to support the leaders of each of the Enabling our People schemes. The Director of Human Resources noted the need to consider the level of support required from Optimise for year 2 of the LiA approach. Ms K Jenkins, Non-Executive Director requested that future LiA reports focus upon real achievements in the workplace, for example what difference had the regular Duty Manager meetings really made to the workplace. Board members suggested that the following developments provided 2 relevant examples of actual LiA-enabled achievements:-

- overnight stay facilities for parents in the children's high dependency unit, and
- food vending machines within the Emergency Department.

Resolved – that the quarterly update on progress with Listening into Action be received and noted.

341/13 QUALITY AND PERFORMANCE

341/13/1 Month 8 Quality and Performance Report

Paper R, the quality and performance report for month 8 (month ending 30 November 2013) advised of red/amber/green (RAG) performance ratings for the Trust, and set out performance exception reports in the accompanying appendices. Ms J Wilson, Non-Executive Director and Quality Assurance Committee (QAC) Chair briefed Trust Board members on the following issues, as considered at the 17 December 2013 QAC meeting:-

- neonatal and paediatric 10 x medication errors;
- nurse staffing levels and vacancy rates – assurance had been provided that no wards were running below the minimum staffing levels and permanent recruitment plans were progressing well;
- a downward trend in complaints which would be considered in more detail at the

February 2014 Trust Board development session;

- a steady improvement in safety thermometer data relating to pressure ulcers;
- a new ward performance monitoring process which had highlighted 4 particular wards for additional support;
- a breach of the same sex accommodation standard affecting 2 patients in November 2013, and
- a follow up report due to be presented to the QAC in January 2014 in response to a narrative verdict provided by the Coroner during an inquest.

Papers R1 and R2 provided the Minutes of the QAC and Finance and Performance Committee meetings held on 27 November 2013 for noting.

The Medical Director reported verbally on VTE risk assessment, mortality rates and the process for the annual rebasing of the Dr Foster Intelligence clinical benchmarking tool (as set out in section 3.2 of paper R).

The Chief Nurse summarised progress with the Trust's overseas nursing recruitment plans and the arrangements for their preceptorship, retention and socialisation once they arrived in Leicester. A summary of ward staffing levels was due to be incorporated into future iterations of the Quality and Performance report. Accountability arrangements for prevalence of pressure ulcers and patient falls were being strengthened through performance management meetings with the Chief Nurse. Appendix 3 to paper R provided the new monthly clinical measures performance dashboard and appendix 4 provided a Trust level summary of the new ward performance tool.

The Chief Operating Officer reported on operational performance, updating the Trust Board in respect of the action plan being developed to address non-compliant RTT performance and noting that treating the backlog of patients within the Ophthalmology service would be central to the overall recovery plan. Cancelled operations on the day performance stood at 1.8% (above the threshold of no more than 0.8%). Urgent discussions were being held with the ITAPS CMG to improve elective surgery throughput and mitigate the impact of emergency activity. Cancer performance targets continued to be met in full for November and December 2013. Choose and Book slot unavailability stood at 17% and was RAG-rated red against the threshold of 4%. Delayed transfers of care (which had been reducing during September and October 2013) had deteriorated in November 2013.

Ms J Wilson, Non-Executive Director reported on the operational performance issues considered by the Finance and Performance Committee on 18 December 2013, noting the scope for organisational learning opportunities arising from the cancer improvement plan led by Mr M Metcalfe, Cancer Centre Lead Clinician; and the capacity issues surrounding Ophthalmology improvement plans. Ms K Jenkins, Non-Executive Director sought additional information to evidence whether any patients had come to any harm as a result of their operation being cancelled, noting in response that the CQRG had requested a look-back exercise be conducted to confirm this. The Chief Operating Officer advised that adjustments were being made to theatre scheduling which would increase availability for emergency lists by reducing 1 elective list per day.

The Director of Human Resources presented section 6 of the Quality and Performance report covering appraisal and sickness rates, staff turnover, statutory and mandatory training performance and corporate induction attendance. The Chief Executive noted improved progress in respect of statutory and mandatory training performance since these courses had been made more accessible to staff and the system of email reminders had commenced to advise staff whose training had lapsed. Responding to a query raised by Ms K Jenkins, Non-Executive Director, the Director of Human Resources advised that whilst copies of the email reminders weren't yet provided to managers of the staff whose training had lapsed, information on training compliance was available by training type for all CMGs and Corporate Directorates. In addition, a focus was being maintained on the creation of a

training passport for trainee doctors rotating between various Trusts within the East Midlands region.

The Chief Nurse introduced section 8 of paper R, providing a report on facilities management delivery and Ms K Jenkins, Non-Executive Director queried the absence of any performance targets. It was agreed that these would be re-introduced for the next iteration of the report and Professor D Wynford-Thomas, Non-Executive Director requested that consideration be given to including some qualitative performance metrics in respect of portering services.

There were no questions or comments raised in respect of the IM&T service delivery report (section 9 of paper R refers).

Paper R3 provided an overview of the Trust's full year financial reforecast. This report had been considered in depth by the Executive Performance Board and the Finance and Performance Committee on 17 and 18 December 2013, respectively. The Director of Finance and Business Services provided verbal feedback from the CMG Performance Management meetings held between 16 and 19 December 2013 and he reiterated the background and context leading up to the Trust's declaration of the forecast year-end deficit of £39.8m. Whilst acknowledging opportunities for UHL to improve efficiency and control of costs, he advised that the Trust had continued to invest in improving patient quality, even where funding was not available.

The Director of Finance and Business Services highlighted comments received recently to the effect that UHL's cost control could have been better and he advised that the Trust's Reference Cost Index (RFI) stood at 97 which indicated that the cost of providing UHL's services was 3% below the national average. The report highlighted the need for UHL to apply to the Department of Health for short term Public Dividend Capital (PDC) to fund the projected deficit and advised that 2014-15 was also expected to be a deficit year. The first cut submission for 2014-15 was due to be submitted to the TDA on 13 January 2014.

In further discussion on paper R4, the following comments were raised:-

(i) Ms K Jenkins, Non-Executive Director sought and received additional information on the arrangements for implementing centralised cost controls and opportunities to monitor the authorisation process for bank and agency expenditure without compromising operational performance and patient safety;
(ii) a comment on the importance of improving the governance arrangements for the Better Care Together Programme in order to translate the strong sense of commitment within the local health economy into a unified strategy to develop robust arrangements to protect and enhance good quality services for patients, and
(iii) the Healthwatch Representative confirmed that Healthwatch had endorsed a no blame culture and would be closely monitoring developments to ensure that the health economy worked together to resolve the underlying financial deficit.

Paper R4 provided an update report on the Trust's Capital Programme for 2013-14 and sought Trust Board approval of the revised capital plan submission (appendix B refers) to re-align funding with key developments (including the enabling works for the new emergency floor). The Trust Board endorsed the revised Capital Programme for 2013-14 as presented in appendix B to paper R4.

<u>Resolved</u> – that (A) the quality and performance report for month 8 (month ending 30 November 2013) be noted;

(B) the report on UHL's financial year-end forecast (paper R3) be noted;

(C) the revised 2013-14 Capital Programme (paper R4) be endorsed; **DFBS**

(D) a detailed report on UHL's month 8 financial performance be circulated following the meeting for information; **DFBS**

(E) the Minutes of the 27 November 2013 Quality Assurance Committee meeting (paper R1) be received and noted, and

(F) the Minutes of the 27 November 2013 Finance and Performance Committee meeting (paper R2) be received and noted.

341/13/2 Emergency Care Performance and Recovery Plan

The Chief Operating Officer introduced paper S, briefing members on recent performance against the 4 hour emergency care target and advising of the key actions underway to deliver an improved position. For the month of November 2013, performance was 88.5% against the 95% target. A copy of the Emergency Care Hub action plan was appended to the report for information (appendix 1 refers).

The Chief Operating Officer particularly highlighted the following aspects of the report:-

(1) UHL staff visits to the University Hospitals of Coventry and Warwickshire NHS Trust on 10 and 16 December 2013 to gain knowledge and understanding of the bronze level command cells implemented there – arrangements were being made to implement these command cells at UHL on a trial basis, and
(2) 2 super weekends had been planned for early January 2014, with the aim of increasing weekend discharge rates to improve patient flows and create additional midweek capacity. Key messages had been provided through BBC Radio Leicester and East Midlands television to explain the purpose of this exercise and he thanked the Director of Marketing and Communications and the CCGs for their support with this work. **COO**

Board members requested that additional information be provided in future iterations of this report in respect of progress with improving discharge and outcomes from ward round audits.

Resolved – that (A) the presentation and report on Emergency Care Performance be received and noted, and

(B) additional information on improving discharge rates and ward round audit data be provided within future reports on Emergency Care Performance. **COO**

341/13/3 NHS Trust Over-Sight Self Certifications

The Director of Corporate and Legal Affairs introduced UHL's self certification returns for December 2013 (paper T refers), inviting any comments or questions on this report. He sought and received the Board's delegated authority to agree a form of words with the Chief Executive in respect of the Trust's RTT compliance, financial performance and ED performance. Subject to the above amendments, the December 2013 self certification against Monitor Licensing Requirements (appendix A), and Trust Board Statements (appendix B) were endorsed for signature by the Chief Executive and submission to the TDA accordingly. **DCLA/ CE**

Resolved – that, subject to the inclusion of additional wording in respect of operational and financial performance, the NHS Trust Over-Sight Self Certification returns for December 2013 be approved for signature by the Chief Executive, and submitted to the TDA as required. **CE**

342/13 STRATGEGY AND FORWARD PLANNING

342/13/1 Securing Sustainable Services

Trust Board members noted the content of paper U, outlining proposed changes to the process for assessing Trusts on their journey towards Foundation Trust Status.

Resolved – that the briefing on proposed changes to the process for Foundation Trust Assessment (paper U refers) be received and noted.

342/13/2 Draft Annual Operational Plans 2014-15 and 2015-16

The Director of Strategy introduced paper V, providing an overview of the national and local landscape within which the Trust was developing 2-year operational plans, a high level overview of the first draft CMG plans and outlining the next steps to development of a single framework for the Trust's business plan and clear trajectories for its delivery. She advised that the NHS Planning Framework was expected to be published within the next week and commented on the positive engagement with the CMG teams. It was agreed that a set of presentation slides on the LLR Health and Social Care 5 year strategy would be circulated for information outside the meeting and a further report would be presented to the January 2014 Trust Board meeting.

Resolved – that (A) presentation slides on the LLR Health and Social Care 5 year strategy be circulated to Trust Board members for information, and **DoS**

(B) a further progress report on the Annual Operational Planning Process be presented to the 30 January 2014 Trust Board meeting. **DoS**

342/13/3 UHL Travel Plan

Paper W provided an executive summary of the UHL Travel Plan for and advised that copies of the full document were available for review upon request. Mr N Bond, Capital Projects Manager, NHS Horizons attended the meeting to present this item, noting that under the National Planning Policy Framework, travel plans were required for any developments that generated significant amounts of movement and that all Trusts should have an active Board approved Travel Plan as part of their Sustainable Development Management Plan.

During a detailed discussion on this item, the Board considered the arrangements for the Listening into Action car parking workstream, patient and public involvement implications and the Equality Impact Assessment process. The Chief Executive noted that he was the Executive Sponsor for the LiA Car Parking Scheme and that some important policy decisions would be required in respect of differential targets between staff and patients who travelled to the hospital sites by car. Ms J Wilson, Non-Executive Director offered her support with this workstream (if required). It was agreed that some time would be allocated at a future Trust Board development session to consider these issues in more depth. **DCLA/ DoS**

Board members endorsed the UHL Travel Plan as presented in paper W, noting that it supported the required direction of travel for the Trust.

Resolved – that (A) the UHL Travel Plan (paper W refers) be endorsed , and

(B) the Director of Corporate and Legal Affairs be requested to arrange for specific time to be allocated within the Trust Board development programme for discussion on the policy decisions required to support the Trust's Travel Plan. **DCLA/ DoS**

343/13 RISK

343/13/1 Board Assurance Framework (BAF) Update

The Chief Nurse presented the latest iteration of UHL's BAF (paper X) and the report was taken as read, noting that all Executive Leads and risk owners would be providing progress reports on any follow-up actions to the Risk and Assurance Manager outside the meeting. Members noted that a new high risk had been opened during November 2013 relating to availability of robust training records to comply with the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER).

In respect of the 3 risks selected for detailed consideration, the Trust Board noted the following information:-

- risk 5 (*ineffective strategic planning and response to external influences*) the risk score had increased from 12 to 16 following advice that the previous risk score had not reflected the importance of this issue, prior to the appointment of the Director of Strategy;
- risk 6 *(failure to achieve Foundation Trust status)* the Board supported the proposal to remove this risk from the BAF, noting that this risk reflected a consequence of the failure to control other risks relating to operational performance and financial sustainability, and
- risk 7 *(failure to maintain productive and effective relationships)* the Director of Marketing and Communications advised that he would be updating this section in the New Year to reflect feedback from the recent reputation audit (once the Internal Audit review had been completed) and some 1 to 1 interviews held with key stakeholders.

Resolved – that (A) the Board Assurance Framework (presented as paper X) and the subsequent discussion on this item be noted, and

(B) the proposal to remove risk 6 from the BAF be endorsed. **CN**

344/13 GOVERNANCE

344/13/1 Workforce and Service Equality and Diversity Update

Further to Minute 199/13/1 of 25 July 2013, the Director of Human Resources introduced paper Y, providing an update on the equality work programme for 2013-14 and summarising changes to the internal assurance process and the national Equality Delivery System. The Service Equality Manager attended the meeting for this item. The qualitative audit of practice (which had been delayed due to adjustments to the clinical management structure) had now been completed and had revealed that whilst all areas responded positively to reasonable adjustments to manage patients with additional needs, some areas responded on a reactive rather than a proactive basis. In discussion on this report, Trust Board members:-

(i) sought additional information on the process for rolling out pockets of good practice through the new Equality, Engagement and Patient Experience Committee, noting that the terms of reference were provided at appendix 3;
(ii) expressed disappointment that this item had featured towards the end of the agenda and not been allocated more time for discussion. It was agreed that future iterations of this report would be prioritised to facilitate discussion on any emerging themes and examples of good practice in respecting individuals' needs and treating them equally, and
(iii) suggested that consideration be given to including equality and diversity matters within the Trust Board development programme.

Resolved – that (A) the update report on Workforce and Service Equality and Diversity be received and noted, and

(B) the Director of Corporate and Legal Affairs be requested to consider prioritising discussion on equality and diversity within the Trust Board agenda and explore the scope to include this theme within the Trust Board development programme. **DCLA**

344/13/2 Assurance and Escalation Framework

The Director of Corporate and Legal Affairs presented paper Z, the draft UHL Assurance and Escalation Framework for the Board's consideration, noting the intention to further develop this framework as the new CMG arrangements became embedded and the approach to service line management was developed. The draft framework was due to be reviewed in March 2014 and then the finalised document would be reviewed on an annual basis by the Trust Board thereafter. **DCLA**

The Chief Nurse commended the draft framework but noted the scope to strengthen the section on response (eg what does the Trust need to do?). The Chief Executive concurred with this view and suggested that the title of the framework be amended to read "Assurance, Escalation and Response Framework". He encouraged the Director of Corporate and Legal Affairs to issue the framework and modify it as a "live" work in progress through appropriate version control mechanisms. **DCLA**

Resolved – that (A) subject to the above amendments, the draft Assurance, Escalation and Response Framework be approved for implementation as a "live" work in progress, and **DCLA**

(B) the framework be reviewed by the Trust Board in March 2014 and then annually thereafter. **DCLA**

344/13/3 Trust Board Calendar of Business

Further to Minute 143/13/2 of 30 May 2013, paper AA highlighted a range of developments implemented during the course of 2013 which, together, had made it necessary to update the Trust Board calendar of business. The updated calendar of business was provided at appendix A for consideration. In discussion on this item, Trust Board members raised the following comments and suggested amendments:-

(1) the Chief Executive queried the scope to spread out the annual reports on complaints, infection prevention, safeguarding and emergency preparedness (instead of submitting them all annually in June);
(2) additional reports on strategic planning and financial strategy would require building into the calendar of business;
(3) Colonel (Retired) I Crowe, Non-Executive Director queried the arrangements for embedding security governance and noted in response that this was covered in the annual work programme of the Audit Committee (as required by a NHS directive);
(4) the Director of Finance and Business Services suggested that additional agenda items on Empath, Interserve and IM&T be included in the calendar of business; **DCLA**
(5) the Acting Chairman queried whether any additional headings would be helpful, such as a separate line for agenda items relating to "Our People";
(6) Ms J Wilson, Non-Executive Director commented that this document was very internally focused, and
(7) the Acting Chairman requested that an updated version of the calendar of business be presented to the Board in February 2014.

Resolved – that (A) the draft Trust Board calendar of business be updated to reflect comments provided under points (1) to (7) above; **DCLA**

(B) a further iteration of the Trust Board calendar of business be presented to the Board on 27 February 2014, and **DCLA**

345/13 TRUST BOARD BULLETIN – DECEMBER 2013

Resolved – that the Trust Board Bulletin report containing the updated Clinical Management Structure (paper BB) be received for information.

346/13 QUESTIONS AND COMMENTS FROM THE PUBLIC RELATING TO BUSINESS TRANSACTED AT THIS MEETING

No formal comments and questions were received regarding items of business on the Trust Board meeting agenda. However, the Director of Marketing and Communications read out a nativity-themed query relating to potential non-availability of maternity services at Leicester Royal Infirmary on Christmas Eve, to which the response was that any maternity patients not able to be accommodated in the Leicester Royal Infirmary maternity unit would be transferred to the Trust's other maternity unit on the Leicester General Hospital site.

The Acting Chairman thanked everyone for attending the meeting and provided his best wishes for Christmas and the New Year.

Resolved – that the comments above be noted.

347/13 ANY OTHER BUSINESS

347/13/1 Report by the Chief Nurse

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

347/13/2 NHS Fraud

The Director of Finance and Business Services briefed Board members on the outcome of a Crown Court case relating to a former Trust manager who had been found guilty of stealing a number of iPads from the Trust. He confirmed that a custodial sentence had been issued and that arrangements were being made to repatriate the stolen devices.

Resolved – that the information be noted.

348/13 DATE OF NEXT MEETING

Resolved – that the next Trust Board meeting be held on Thursday 30 January 2014 in Seminar Rooms 2 and 3, Clinical Education Centre, Glenfield Hospital.

The meeting closed at 4.15pm

Kate Rayns,
Trust Administrator

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

Name	Possible	Actual	% attendance	Name	Possible	Actual	% attendance
R Kilner (Acting Chair from 26.9.13)	11	11	100	R Overfield	5	4	80
J Adler	11	10	91	P Panchal	11	9	82
T Bentley*	9	5	56	I Reid	4	4	100
K Bradley*	11	9	82	C Ribbins	4	4	100
I Crowe	7	6	86	I Sadd	4	2	50
S Dauncey	1	1	100	A Seddon	11	11	100
K Harris	11	11	100	K Shields*	3	3	100
S Hinchliffe	2	2	100	J Tozer*	3	2	66
M Hindle (Chair up to 26.9.13)	7	7	100	S Ward*	11	11	100
K Jenkins	11	10	91	M Wightman*	11	10	91
R Mitchell	7	7	100	J Wilson	11	10	91
				D Wynford-Thomas	11	5	45

* non-voting members

N

University Hospitals of Leicester NHS Trust

Trust Board Paper N

Progress of actions arising from the Trust Board meeting held on Friday 20 December 2013

Item No	Minute Reference	Action	Lead	By When	Progress Update	RAG status*
1	337/13 (g)	Acting Chairman to provide feedback on proposals to strengthen the governance arrangements for the Better Care Together Programme.	Acting Chair	27.2.14	Update to be provided by 27 February 2014 Trust Board.	4
2	340/13/1	Update on talent management and leadership development to be incorporated into the Quarter 4 update on workforce and OD.	DHR	27.3.14	To be included in the report scheduled for the 27 March 2014 Board meeting.	4
3	341/13/2	Additional information on discharge and ward rounds to be included in the next report on emergency care.	COO	30.1.14	To be included in the monthly emergency care report.	4
4	342/13/2	Further progress report on the Annual Operational Planning Process to be presented to the January 2014 Trust Board.	DoS	30.1.14	Provisionally scheduled on the 30 January 2014 Trust Board agenda.	4
5	342/13/3	Trust Board development time to be allocated for discussion of issues relating to the UHL Travel Plan.	DCLA	31.3.14	Under discussion between the Acting Chairman and the Director of Corporate and Legal Affairs.	4
6	344/13/1	Equality and Diversity report to feature earlier in the agenda in July 2014 and consideration be given to holding a Board development session on equality and diversity.	DCLA	31.7.14	Under discussion between the Acting Chairman and the Director of Corporate and Legal Affairs.	4
7	344/13/2	Assurance, Escalation and Response Framework to be updated, implemented as a “live” document and further reviewed in March 2014.	DCLA	27.3.14	Provisionally scheduled on the 27 March 2014 Trust Board agenda.	4
8	344/13/3	Trust Board calendar of business to be refreshed and presented to the February 2014 Board meeting for approval.	DCLA	27.2.14	Provisionally scheduled on the 27 February 2014 Trust Board agenda.	4

Matters arising from previous Trust Board meetings

Item No	Minute Reference	Action	Lead	By When	Progress Update	RAG Status*
28 November 2013						
9	303/13/2	Full Business Case to be developed for the Emergency Floor and Chief Executive to determine the pace at which enabling works could proceed in consultation with the Acting Chair and the TDA.	CE	February 2014	Update received on 20 December 2013. **Verbal report to be provided at 30 January 2014 Trust Board.**	
10	304/13/1	Arrangements to be made to roll out the Information packs on	CN	31.3.14	**Verbal update to be provided at the 30**	

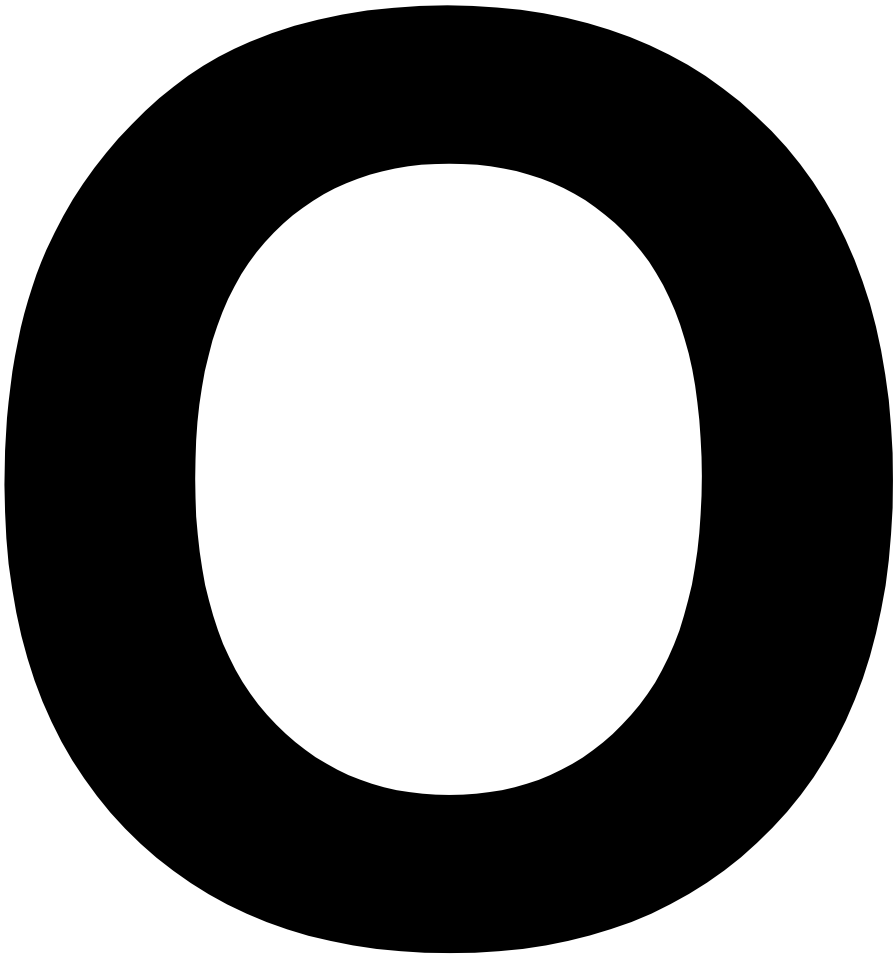
** Both numerical and colour keys are to be used in the RAG rating. If target dates are changed this must be shown using ~~strikethrough~~ so that the original date is still visible.*

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

Item No	Minute Reference	Action	Lead	By When	Progress Update	RAG Status*
		community based rehabilitation facilities to other wards.			**January 2014 Trust Board.**	
11	308/13/1	Executive Team to review and monitor progress relating to the emergency preparedness, resilience and response self-assessment and determine whether an additional entry on the Risk Register would be appropriate.	COO/ET	31.1.14	Report deferred to 18 February 2014 Executive Team meeting.	4
12	308/13/2	Director of Marketing and Communications to undertake a further analysis of the results of the reputation audit and consider the Board's recommendation for annual audits to be conducted.	DMC	31.12.13	Differential analysis of the reputation audit feedback to be circulated outside the meeting when available.	4
13	309/13/1	Progress against Internal Audit actions to be monitored through the Executive Performance Board.	DCLA	31.1.14	Updates scheduled for the Executive Performance Board on 28 January 2014 and Audit Committee in February 2014.	4
14	311/13(1)	Director of Strategy to raise the potential impact of large scale immigration from Romania and Bulgaria with the whole health community through the Better Care Together Programme Board.	DoS	31.1.14	Update received on 20 December 2013. **Verbal report to be provided at 30 January 2014 Trust Board.**	
15	311/13(2)	Director of Corporate and Legal Affairs to remind the relevant Board members of any outstanding responses to queries raised by Mr M Woods on 28 September 2013.	DCLA	20.12.13	Status of outstanding queries reviewed and reminders issued where appropriate. **Further concerns raised by Mr Woods on 17 December 2013 circulated to Board members on 18 December 2013 – issues under investigation.**	4
31 October 2013						
16	277/13/1	Meaningful Activities initiative for dementia patients to be highlighted to the National Lead for Dementia Care and the LLR Workforce Group.	CN/DHR	~~28.11.13~~ 31.1.13	To be highlighted at the first 2014 meeting of the LLR Workforce Group.	4
17	277/13/5	Acting Chairman and Chief Executive to consider the governance arrangements for monitoring the Trust's workforce.	Acting Chair/CE	~~28.11.13~~ 20.12.13	Executive Workforce Board to be established. Membership and terms of reference considered by the Executive Team on 21 January 2014.	4
26 September 2013						
18	252/13/1	Chief Nurse to respond to Ms K Jenkins outside the meeting regarding the monitoring arrangements for risk 4.	CN	~~31.10.13~~ ~~28.11.13~~ 20.12.13	**Verbal report to be provided on 30 January 2014.**	

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

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



Trust Board Paper O

To:	**Trust Board**
From:	**CHIEF EXECUTIVE**
Date:	**30 January 2014**
CQC regulation:	N/A

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

Author/Responsible Director: Director of Corporate and Legal Affairs

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

The Report is provided to the Committee for:

Decision		Discussion	√
Assurance	√	Endorsement	

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

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

Previously considered at another corporate UHL Committee? No

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

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

Assurance Implications: N/A

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

Stakeholder Engagement Implications: N/A

Equality Impact: N/A

Information exempt from Disclosure: None

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **30 JANUARY 2014**

REPORT BY: **CHIEF EXECUTIVE**

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

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

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

(a) the Trust's financial position as at month 9 2013/14;

(b) emergency care performance;

(c) Referral Time to Treatment performance;

(d) the recent Care Quality Commission (CQC) inspection which took place between 13th and 16th January 2014;

(e) the development of an LLR 5 year Health and Social Care Strategy.

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

John Adler
Chief Executive

22nd January 2014

P

Trust Board Paper P

To:	**Trust Board**
From:	**CHIEF EXECUTIVE**
Date:	**30 January 2014**
CQC regulation:	N/A

Title:	**BOARD LEVEL LEAD : CHILDREN'S SERVICES**

Author/Responsible Director: Director of Corporate and Legal Affairs

Purpose of the Report: To brief the Board on the appointment of a lead for Children's Services at Trust Board level.

The Report is provided to the Committee for:

Decision		Discussion	√
Assurance	√	Endorsement	

Summary / Key Points: The National Service Framework (NSF) for Children's Services identifies as good practice the appointment of a lead for Children's Services at Trust Board level.

Recommendations: The Trust Board is invited to confirm the designation of the Director of Strategy as the Trust Board lead for Children's Services.

Previously considered at another corporate UHL Committee? No

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

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

Assurance Implications: N/A

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

Stakeholder Engagement Implications: N/A

Equality Impact: N/A

Information exempt from Disclosure: None

Requirement for further review? N/A

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **30 JANUARY 2014**

REPORT BY: **CHIEF EXECUTIVE**

SUBJECT: **BOARD LEVEL LEAD : CHILDREN'S SERVICES**

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1. The National Service Framework (NSF) for Children's Services identifies as good practice the appointment of a lead for children's services at Trust Board level.

2. Since taking up her appointment at the Trust in November 2013, the Director of Strategy has assumed this role and is involved in a range of children's services issues, including chairing the new Children's Board which is to have its first meeting shortly.

3. To formalise the position, the Trust Board is invited to confirm the appointment of the Director of Strategy as the designated Trust Board lead for Children's Services.

John Adler
Chief Executive

22nd January 2014

Trust Board Paper Q

To:	**Trust Board**
From:	Rachel Overfield, Chief Nurse
Date:	**30th January 2014**
CQC regulation:	Outcome 1,2,4,11,14,17

Title:	Patient Stories – Experience of Acupuncture Treatment within the Trust

Author/Responsible Director:
Lorraine Stevens, Clinical Nurse Specialist
Heather Leatham, Head of Nursing

Purpose of the Report:
To describe patients experience of Acupuncture within the pain service

The Report is provided to the Board for:

Decision		Discussion	X
Assurance		Endorsement	

Summary / Key Points:

Introduction

- The purpose of this paper is to share with Trust Board a number of patients stories that highlight the experiences of Acupuncture within Leicester's Hospitals.
- The Acupuncture Service receives a great deal of positive feedback from patients and the four patients within the accompanying DVD share how the access to Acupuncture has changed their lives allowing them all to experience life without pain.

Patient Experiences

- All four patients whose stories are shared have prior to Acupuncture felt isolated, depressed, in constant pain. All the patients required large dosages of pain killers with the possibility of extensive surgery.
- Following treatment with Acupuncture all the patients expressed an ability to conduct a 'normal life', and a better quality of life. The patients did not require the large numbers of pain killers and had avoided surgery. Patients were able to exercise and felt free to do activities that they had not undertaken for a long period due to the severe pain they were experiencing.
- One patient states "*I have come in today in pain, and I am going home smiling!*"

The Acupuncture Service

- Acupuncture is a treatment modality that has been provided as part of the chronic pain service since 1997.
- Over the years the service has collected robust evidence of its effectiveness with audit and research projects. This is also substantiated by a large body of positive evidence world wide.

- Currently in Leicester's Hospitals there are three Clinical Nurse Specialists providing acupuncture and they treat 4,500 patients per year and generate an income of £135k per annum.

- Acupuncture is an efficient, effective, safe and pain free treatment with no side effects. It is used for all types of painful conditions including: musclo-skeletal pain, joint pain, headache, nerve pain and abdominal pain. Not only does it provide pain relief but improves sleep, reduces depression, increases mobility and their quality of life far better.

- It has been shown to reduce the need for analgesics and patients have even avoided surgery so has an important cost saving aspect. General Practitioners understand the value of Acupuncture and UHL take multiple referrals from across Leicestershire.

- In order to cope with the large number of referrals the nurses have taught seven hundred patients to do their own self acupuncture and this has been very successful.

<u>The Future</u>

- The Acupuncture Service is very pleased that they continue to be commissioned as many other Acupuncture Services throughout Britain have been reduced or stopped. If the Acupuncture Service was expanded it may provide cost savings in other areas.

- The future plans include taking this valuable service into primary care.

Recommendations: Trust Board to continue to support this important service.

Previously considered at another corporate UHL Committee? No

Strategic Risk Register: N/A	**Performance KPIs year to date:** 4,500 patients seen per annum £135k income per annum

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

Assurance Implications: N/A

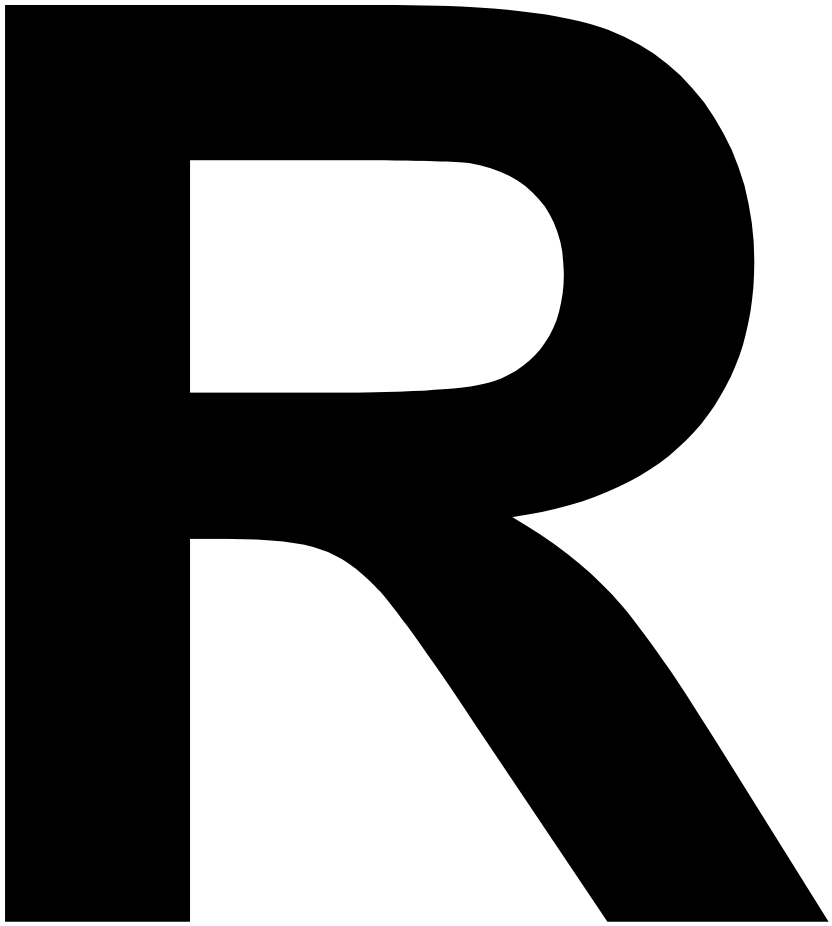
Patient and Public Involvement (PPI) Implications: N/A

Stakeholder Engagement Implications: N/A

Equality Impact: N/A

Information exempt from Disclosure: None

Requirement for further review? None



Trust Board Paper R

To:	**Trust Board**
From:	Rachel Overfield, chief Nurse
Date:	**30 January 2014**
CQC regulation:	Outcome 1, 4, 16

Title:	National CQUIN requirements: Support and Information for Carers of Patients with Dementia

Author/Responsible Director:
Lesley Hale, Dementia Screening CQUIN, Education and Practice Development Sister

Purpose of the Report: To brief Trust Board on the results of the survey to establish if the carers of people with dementia feel supported by UHL.

The Report is provided to the Board for:

Decision		Discussion	X
Assurance	X	Endorsement	

Summary / Key Points: The carer's survey is conducted to establish if the carers of people with dementia feel supported by UHL. The baseline survey results highlighted the areas that require improvement and identified the appropriate actions. The re-audited data shows significant progress but also highlights that further improvements can be made.

Recommendations: Trust Board is asked to support the on-going achievement of the National CQUIN requirements focused upon carers of patients with dementia.

Previously considered at another corporate UHL Committee? Executive Quality Board.

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

Resource Implications (eg Financial, HR): Requires on-going CQUIN funded support

Assurance Implications: N/A

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

Stakeholder Engagement Implications: N/A

Equality Impact: N/A

Information exempt from Disclosure: N/A

Requirement for further review? Will form part of the Trust level Dementia Implementation Plan 2014

University Hospitals of Leicester NHS Trust Report

REPORT TO: Trust Board

REPORT FROM: Lesley Hale, Dementia Screening CQUIN, Education and Practice Development Sister

SUBJECT: CQUIN Pre-Requisite Criteria 2013/14
National 3.3 Dementia Supporting Carers and PR 1.3 Carers Information Report

DATE: 30 January 2014

1.0 Introduction

1.1 National CQUINs in the NHS Standard Contract 2013/14 to ensure that the carers of our patients with dementia feel supported by the trust.

This includes a carer's survey, feedback and results from the audits should be actioned to ensure improvements.

Ref	Title in Brief	Indicator Title and Detail	Threshold	QS RAG / CQUIN Payment Mech	Reporting Frequency
National 3.3a	Dementia - Carers	3.3. Ensuring carers of people with dementia feel adequately supported	3.3a Monthly audit of carers of patients with dementia 3.3b Reporting of survey findings to the Board	Q1 & Q3 100% Monthly audit undertaken Q2 & Q4 100% Monthly audit undertaken and report biannually to the Board	Quarterly / Narrative Report

2.0 Commentary on Performance

The carer's survey has now been conducted in all CMG's and all baseline data collected. We are now in the re-audit process to assess how we have improved on the support that we offer carers of people with dementia in UHL. The re-audit has also been conducted in Medicine and respiratory wards and the data collated. The baseline and re-audit survey was conducted on a monthly rotational basis. The ward dementia link nurse/champion completes the surveys with the carer or relative of a patient with a confirmed dementia diagnosis.

The baseline data showed many examples of excellent support and dementia care but also highlighted areas for improvement. The majority of the carers of a person with dementia felt supported by UHL. The data collected shows that carers feel that staff in clinical areas have a good understanding of dementia and they are encouraged to have input into their relatives care whilst they are in hospital.

The key themes identified to improve the support we offer to carers are mainly based around communication. Actions to improve these results will be raising the profile of the patient profile, improving the information we give to carers and relatives about

dementia and about the patient's medical condition and by involving and informing carers and families in discharge planning arrangements.

Since the collection of the baseline data each ward that has been involved in the carer's survey has been asked to ensure that they have a process in place to ensure that the carer or relative has access to a patient profile. Examples of these processes are identifying those patients who would benefit from a profile at the board round, part of the dementia champions role, ward display and some admission areas include the profile in the admission pack.

Wards involved in the survey are also ensuring that the UHL dementia leaflet is available in their area. Each ward currently has leaflets available on their wards and has a nominated staff member responsible to order more stock.

November 2013 was the first of the re-audits and was completed in medical wards including wards that specialise in care of the elderly wards. The results of this audit show some excellent improvements. 100% of carers surveys felt supported by UHL. In these areas the use of the patient profile has improved greatly. The only low figure is about the UHL dementia leaflet. It is available in all of these areas but consideration to the location of the leaflets may lead to improvements in this area.

The patient profile has recently had a lot of publicity and one avenue for this is in the dementia category B awareness training. Two of the wards surveyed also have a Meaningful Activity Coordinator which from the additional comments made by the carers has improved dementia care in those areas considerably.

December 2013 was the second month of re-audit and was conducted on respiratory wards. These results showed improvements in the majority of all areas. Overall the carers on these wards felt supported by the carers of people with dementia felt supported in these areas. The use of the patient profile and UHL dementia leaflet has also improved.

The carer's survey re-audit is currently being conducted in Cardiology and Renal wards for January 2014.

Audit Plan 1st April 2013 – 31st March 2014

Baseline Audit	
April 13	**Ward 36 LRI – Trial**
May 13	**Older Peoples wards – Speciality Medicine**
June 13	**Speciality Medicine**
July 13	**Respiratory**
August 13	**Cardiology and Renal**
September 13	**Trauma**
October 13	**Surgery**
Re-Audit	
November 13	**Speciality Medicine (including Care of the Elderly)**
December 13	**Respiratory**
January 13	**Cardiology and Renal**
February	**Trauma**
March 13	**Surgery**

3.0 Quarter 3 performance

Carers Survey 2013/14 Data.

	Quarter 1			Quarter 2			Quarter 3		
% of carers that	**Ward 36**	**Older peoples wards**	**Medicine**	**Respiratory**	**Cardiology and Renal**	**Trauma Orthopaedics**	**Surgery**	**Medicine**	**Respiratory**
Felt supported	50%	60%	60%	33%	50%	80%	50%	100%	100%
Were asked for their input	100%	87%	100%	83%	50%	80%	50%	82%	100%
Were asked to complete a patient profile	0%	40%	40%	33%	50%	80%	50%	82%	33.3%
Were permitted to visit outside of set visiting times	100%	100%	100%	83%	50%	60%	100%	82%	100%
Were updated on medical treatment	50%	28%	50%	33%	50%	40%	100%	100%	33.3%
Were involved in discharge planning	0%	60%	60%	50%	50%	80%	50%	100%	66.6%
Were given a UHL dementia leaflet	0%	33%	30%	33%	100%	20%	50%	36.5%	33.3%
Could find someone is discuss their worries and fears with	100%	80%	90%	83%	50%	80%	100%	100%	66.6%
Felt that staff had a good understanding of dementia	75%	60%	70%	83%	100%	100%	75%	82%	66.6%
Month of re-audit	November 13	November 13	November 13	December 13	January 14	February 14	March 14		

Carers Support Action Plan - Supporting the Carers of People with Dementia **Updated January 2014**

Ref	Area for Improvement	Action to be taken	Lead for Action	Action Completion Deadline	Progress RAG	Progress update/comment
1a	Provide the carers of people with dementia with a UHL information leaflet	Ensure leaflets are available on all areas	Sue Mason	April 2013	5	Action complete
1b		Identify a ward specific process to ensure that relatives and carers have access to the UHL dementia leaflet	Lesley Hale	August 2013	5	Action complete Processes include • Ward display • Identification at board round
1c		Identify a member of staff responsible for re-ordering leaflets	Lesley Hale	August 2013	5	Action completed
2a	Improve the use of the patient profile for all patients with dementia	Each ward to identify a process to identify the patient who require the patient profile and ensure that the carer has the opportunity to complete	Lesley Hale	August 2013	5	Action complete. Discussed with each ward sister and dementia link nurse where available
2b		Ensure patient profile and guidance is available on all wards	Lesley Hale	August 2013	5	Action complete. Displayed on ward or in dementia recourse folder/drawer[i]
2c		Provide education on the patient profile on dementia awareness and dementia champion training	Martyn Deighton DATAG	June 2015	5	Training plan ensures all relevant staff groups will be trained by June 2015
2d		Re-audit of the patient profile. Actions to be set to re-launch the profile	Patient Experience team	January 2014	4	

Status key:	5	Complete	4	On track	3	**Some delay-expect to complete as planned or implemented but not consistently delivering**	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Objective Revised

Ref	Area for Improvement	Action to be taken	Lead for Action	Action Completion Deadline	Progress RAG	Progress update/comment
3a	Ensure that the relatives of patients with dementia are involved in discharge planning	Care coordinator for all areas to communicate with carers to involve and inform them of discharge plans	Lesley Hale	August 2013	5	Discussed with Ward Sisters and Matrons to encompass this as part of care coordinator role
4a	Improve dementia awareness, knowledge and understanding in clinical practice	Ensure that all staff within the relevant areas attend dementia awareness training category A and B	Martyn Deighton	June 2015	4	Training plan ensures all relevant staff groups will be trained by June 2015
4b		Promote the Dementia Champions network. Becoming a Dementia Champion is voluntary and the training to become a champion complements category A and B dementia awareness training	Patient Experience Team Dementia champions network	At all times	4	Ward Sisters to encourage staff with a dementia interest to sign up to the Dementia Champions network. Promoted at category B awareness training
4c		Introduce a communication symbol to identify patients with dementia in order to promote appropriate communication	Quality Commitment	June 2013	4	Pilot complete. Currently introducing on sample of wards

DATAG = Dementia awareness training action group (Cascade trainers of dementia awareness category A and B training and working group to ensure training is appropriate to audience and fit for purpose)

Status key:	5	Complete	4	On track	3	**Some delay-expect to complete as planned or implemented but not consistently delivering**	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Objective Revised

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Trust Board Paper S

To:	**Trust Board**
From:	**Director of Human Resources**
Date:	**30 January 2014**

Title:	**LOCAL CLINICAL EXCELLENCE AWARDS**

Author/Responsible Director: Kevin Harris – Medical Director, Kate Bradley – Director of Human Resources

Purpose of the Report: To inform the Trust about the outcome of the Clinical Excellence Awards (CEA) Scheme for 2013 and to summarise the outcomes from the CEA Scheme in relation to the equality and diversity background of applicants and to outline the CMG spread of awards.

The Report is provided to the Board for:

Decision		Discussion	
Assurance	√	Endorsement	

Summary / Key Points: The CEA Scheme is a National Scheme which forms part of the national consultant contract. It rewards consultants for excellence in service delivery, service development, teaching and training, research and development and/or their contribution to management and clinical leadership roles. The Trust is required to report to the National Advisory Committee on Clinical Excellence Awards (ACCEA) on the outcomes of this annual process including the breakdown of awards made by gender, ethnic background and consultants in academic posts.

**Local CEA 2013 Round - There were 451 eligible consultants for this year, 131 consultants submitted applications this round (compared to 138 submitted for the previous year). A total of 92 single value unitary awards were made this year to 76 awardees. (Some applicants at the top of the ranking outcomes received more than one point).

Diversity Analysis
The number of 'Women' and consultants from a 'Black or Minority' ethnic background (BME – all other groupings with the exception of White-British) who were awarded in 2013 continues to show a year on year slight increase when set against previous yearly figures. The results for the awards can be considered to be representative of gender and ethnic background for the consultant staff group when comparing to percentage numbers eligible and those awarded.

CMG Breakdown
The CEA awards can be seen to be split across Specialities and CMGs.

Recommendations: The Trust Broad is asked to note the contents of this report and support the recommendations outlined.

Strategic Risk Register	**Performance KPIs year to date** Links to appraisal and job planning requirements as a pre-requisite for an award to be granted.
Resource Implications (e.g. Financial, HR) **Financial** – For the 2013 round a minimum investment of the number of eligible consultants 451 x £2,957 x 0.2 = £266,721 was allocated into this year's local process. This is in line with the national guidance.	
Assurance Implications N/A	
Patient and Public Involvement (PPI) Implications Process subject to public scrutiny.	
Equality Impact: An analysis of the awards is undertaken by gender and ethnic group.	
Information exempt from Disclosure N/A	
Requirement for further review? An annual report is produced yearly, once the CEA process is completed and is reviewed by TB before sending to ACCEA.	

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

REPORT BY: **DIRECTOR OF HUMAN RESOURCES / MEDICAL DIRECTOR**

DATE: **30th January 2013**

SUBJECT: **LOCAL CLINICAL EXCELLENCE AWARDS – 2013 Round**

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1. INTRODUCTION

1.1 The Clinical Excellence Awards Scheme

The Clinical Excellence Awards (CEA) Scheme recognises and rewards NHS consultants and academic GPs who perform 'over and above' the standard expected from them in their role. Awards are given for quality and excellence, acknowledging exceptional personal contributions.

The Scheme forms part of the national consultant contract and is open to any consultant who has been in a substantive consultant post for at least 12 months on the 1st April 2013. Individual consultants apply for an award by completing a nationally constructed application form which requires the provision of evidence regarding their contribution across 5 domains:-

- Delivering a high quality service.
- Developing high quality service.
- Leadership and managing a high quality service.
- Research and innovation.
- Teaching and training.

1.2 How does the Scheme work?

There are 12 levels of award. Levels 1-8 are awarded locally and Levels 9-12 (Bronze, Silver, Gold and Platinum) are awarded nationally. Level 9 can be awarded locally or nationally, depending on the type of contribution made.

Level 1	Level 2	Level 3	Level 4	Level 5	Level 6	Level 7	Level 8	Level 9 Bronze	Level 10 Silver	Level 11 Gold	Level 12 Platinum
£2,957	£5,914	£8,871	£11,828	£14,785	£17,742	£23,656	£29,570	£34,484	£46,644	£58,305	£75,796

N.B. Current Values at 1st April 2013

ACCEA and its Regional Sub-Committees recommend individuals for Bronze, Silver, Gold and Platinum awards. Applicants for Levels 1-9 are recommended by employer-based Committees. ACCEA monitors the employer-based scheme and publishes an annual report on the awards that includes information on their distribution.

1.3 About the ACCEA and Supporting Committees

National guidance is used when recommending applicants for every level, and all awards are assessed against the same criteria. The employer-based committees measure achievements within the parameters of an individual's employment and recognise excellent service and contribution.

Consultants who have already achieved at least a CEA level 4/5 locally may choose to apply on-line for a centrally funded, national award. The Trust is required to assess and rank those

consultants who apply for a national award and annually there are usually c40 candidates across UHL who do so.

The Trust convenes a panel to score and evaluate each of these applications and then submits a citation and a ranked list of consultants for consideration by the ACCEA. This information goes to one of the 13 Regional Sub-Committees. Similarly, the Royal Colleges and Societies produce a ranked list of the candidates and their own recommendations for the ACCEA Committee.

1.4 National Nominating Bodies

The National Committee (ACCEA) also consider the applications of all those consultants and academic GPs who have been nominated by accredited national bodies, such as the Medical Royal Colleges, the British Medical Association, Medical Women's Federation and the British International Doctors Association. Those bodies are invited to submit a ranked shortlist in a similar way to those produced by the Regional Committees.

1.5 Employer-Based Committees

Every year, each NHS organisation employing consultants eligible for an award, appoint an employer-based awards Committee. Within UHL this year the committee structure is a Higher (Levels 6 and above) and Lower (Levels 1-5) Awarding Committee panel chaired by the Medical Director, both comprised of approx 15 members each including management representatives, lay members and at least 50% of its membership from the consultant body representing different speciality areas. Members of each Committee need to evidence that they have undertaken equalities training within the last three years. The panels constituted were made up with the specific aim of reflecting different specialities and gender and ethnic backgrounds of the consultant body appropriately.

2.1 Annual Report - 2013 Round

The policy framework for the CEA scheme makes clear that it must be transparent, fair and based on clear evidence – and that the public and those within the profession perceive it to be so. Each employer-based awards committee must produce an annual report containing its outcomes for awards payable from 1 April 2013.

It is good practice to publish the report on the Trust's website and to submit a copy of the report to UHL Trust Board. Regional Sub-Committees monitor the quality of awards procedures and the distribution of awards made by employer-based awards Committees, through the receipt of the annual report.

The annual report lists members of the employer-based Committees, with personal details, to demonstrate their selection complies with membership guidelines. The annual report demonstrates that the process has been completed fairly, according to ACCEA guidelines and is a separate report submitted to ACCEA.

3. ANNUAL INVESTMENT FOR EMPLOYER-BASED AWARDS

3.1 Guidelines for Calculating Investment

The Department of Health, which advises ACCEA on finance, provides guidance on how employers should calculate the investment they need to make in the employer-based awards each year. NHS organisations should spend no less than the minimum investment each year when granting awards, in line with this guidance (i.e. number of eligible consultants x 0.2 x £2,957 = £266, 721). In addition any carryover from the previous year is included in the number of points available.

4. EMPLOYER-BASED 'LOCAL' AWARDS - 2013 ROUND

4.1 There are 376 award holders in total (both national and local) within UHL in 2013. (Of these 376, approx. 70 are either national award or level 9 award holders).

4.2 Consultants submit a completed application for consideration for local awards which are considered by either the higher or lower committee depending on their current award status. It should be noted that locally the inclusion on a 'fallow' year affects the numbers of applications received. A 'fallow' year means that a consultant who is awarded in one year is not expected to apply the following year to allow a greater spread of awards.

4.3 The Higher and Lower Committee panels considered the applications by scoring the 5 domains (as detailed in 1.1) utilising a common objective assessment form comprising a scoring matrix developed for this purpose. After due consideration through a process of review of evidence of achievement, there was agreement to make the recommendations which subsequently received final agreement.

4.4 This year, where overall scores were tied, and the rank order was the same near to the awarding line the committee used a process of 'weighting' domains one and two specifically around delivering and developing a high quality service to distinguish between applications.

4.5 Following informed debate regarding comparisons of scores, appropriateness of above/below line cut-off and under-pinning rationale and chairmen's statements, the outcomes were communicated to the applicants, totalling 92 points awarded this year to consultants in both the higher and lower panels. In the Higher Committee panel an award has the value of 2 unitary levels, there were 8 awards available that were all made. In the Lower committee, some awardees received more than 1 point, depending on discussion and to reflect performance that could be considered as 'exceptional'. This was also done to ensure progression through the scheme and to enable exceptional performance to compete within the national awarding arena.

5 STATISTICAL ANALYSIS

Diversity Analysis – National and Local Awards

5.1 Appendix 1 – Shows the numbers of academic consultants, women consultants and those from a black or minority ethnic background that are UHL award holders at local or national level from 2006/07 to April 2013.

5.2 In summary the last 3 years are detailed below:-.

	Apr-11	**Apr-12**	**Apr-13**
Overall number of consultants eligible for 'Local' consideration	**426**	**444**	**451**
a) the percentage of:			
i) consultants in academic posts	6.10%	5.63%	5.53%
ii) women consultants	29.13%	29.50%	29.20%
iii) ethnic minority consultants	41.38%	42.79%	42.48%
Overall number of award holders both Natl. & Local	**361**	**355**	**376**
a) the percentage of:			
i) consultants in academic posts	13.30%	13.24%	12.77%
ii) women consultants	21.33%	21.41%	21.81%
iii) ethnic minority consultants	30.75%	32.11%	32.98%

5.3 Each year the percentages can be seen to be broadly similar or show a slight increase in line with total eligible numbers with the exception of academic post holders this year which is thought to be due to a larger number of national award holding retirees/leavers.

5.4 The gender and ethnicity breakdown of applications and awards, for the 2013 local process, is detailed below. Over 50% of each consultant staff grouping (as defined by gender and ethnicity below) applying for awards this year received at least one point in this year's process.

Local CEA process 2013 Higher and lower panel

Gender	Applied	Awarded	%
Male	86	49	56.98%
Female	45	27	60.00%
Totals	131	76	

Local CEA Process 2013 Higher and lower panel

Ethnicity	Applied	Awarded	%
White British	70	45	64.29%
BME (all other groups)	61	31	50.82%
Totals	131	76	

6 CEA Award Holders 2013 – Speciality/CMG Analysis

The process of those applying for local awards in 2013 as split by CMG is detailed below. Comparison of those applying and awarded is broken down by higher and lower panels in the grid below. A spread of applications can be seen across all CMG areas. The highest numbers of awards was made in CHUGGS this year. However, it should be noted that this was also the area to make the highest number of applications.

Lower CEA Panel 2013 process

CMG	Applied	Awarded	%
ITAPS	17	13	76.47%
CHUGGS	16	14	87.50%
Renal, Resp & Cardiac	14	7	50.00%
Women's and Children's	18	8	44.44%
Emergency & Spec ialty Medicine	17	8	47.06%
Clinical Support and Imaging	11	4	36.36%
HR & Training	1	0	0.00%
MSK and Specialist	18	14	77.78%
Totals	112	68	60.71%

***NB** some applicants received more than 1 point*

Higher CEA panel 2013 process (Levels 6 -9)

CMG	Applied	Awarded	%
ITAPS	5	2	40.00%
CHUGGS	6	3	50.00%
Renal, Resp & Cardiac	0	0	0.00%
Women's and Children's	1	0	0.00%
Emergency & Spec ialty Medicine	2	1	50.00%
Clinical Support and Imaging	0	0	0.00%
HR & Training	0	0	0.00%
MSK and Specialist	5	2	40.00%
Totals	19	8	42.11%

6.1 The below table shows the speciality CMG split and number of award holders across the Trust compared to none award holders which includes prior awards. There are awards in each specialty area showing spread across each CMG within the Trust. It can be noted that W&C's have a proportionally lower number of awards overall compared to other areas.

6.2 UHL CEA award holders both national and local compared to none award holders.

Speciality/CMG	No CEA Award	National or local award holder	Total number of consultants	% Award Holders
ITAPS	26	58	84	69.05%
CHUGGS	17	50	67	74.63%
Renal, Respiratory & Cardiac	8	46	54	85.19%
Women's & Children's	39	50	89	56.18%
Emergency & Specialist Medicine	19	52	71	73.24%
Clinical Support & Imaging Services	21	60	81	74.07%
Human Resources & Training		2	2	100.00%
MSK & Specialist Surgery	20	58	78	74.36%
Grand Total	**150**	**376**	**526**	**71.48%**

7 Conclusion

7.1 The process is considered to have run successfully this year with a spread of awards across the various specialty areas noting a slightly lower representation within Women's and Children's CMG. The gender and diversity mix of the eligible consultant workforce is considered to be represented in the results of the local awards process demonstrated by the year on year figures. (Appendix 1)

8. Recommendations

8.1 UHL to continue to manage the process in line with any revised national guidance.

8.2 To undertake further analysis as to why Women's and Children's have proportionality a lower number of awards.

8.3 The Trust Board is asked to note the contents of this report and support the recommendation.

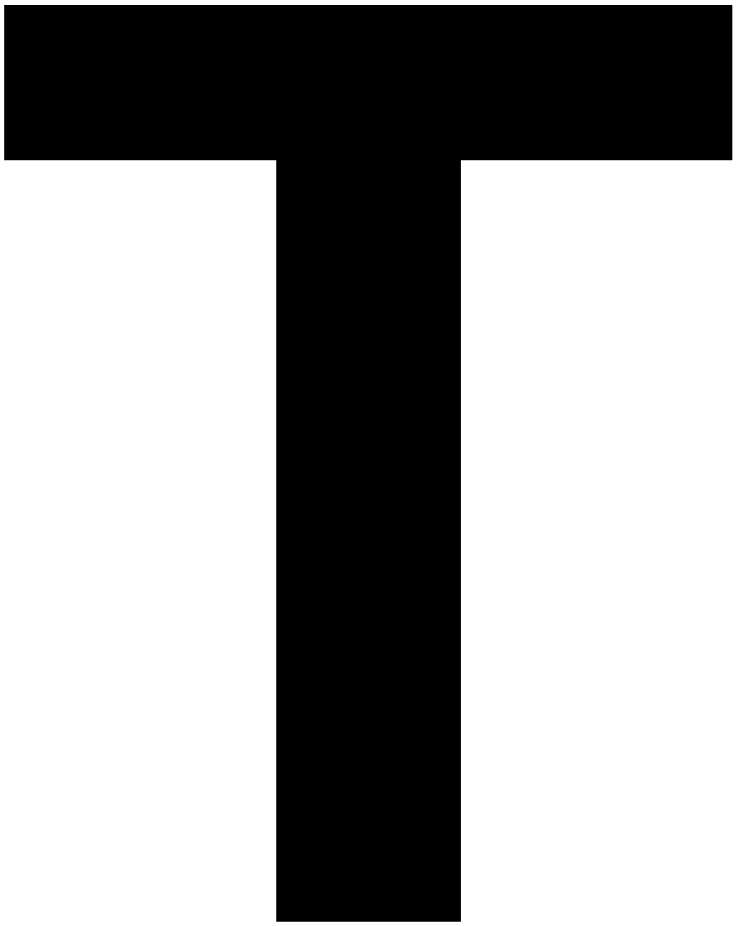
9 Appendix

Appendix 1 – ACCEA mandatory annual report extract – year on year analysis

Appendix 1 – Academic, Women and Ethnic Minority % 2006 - 2013

***NB**: It should be noted that in appendix 1 - the overall number of consultants eligible for 'local' consideration from a BME background in 2008/9 can be seen to have increased from 27.34% in 2008/9 to 40.58% in 2010/11 which is attributable to a change in the reporting of categories which is impacting on figures available. This was a broadening of the BME category to include all with the exception of White- British.*

	2006/07	2007/08	2008/09	2009/10	2010/11	Apr-11	Apr-12	Apr-13
Overall number of consultants eligible for 'Local' consideration	**358**	**373**	**384**	**383**	**414**	**426**	**444**	**451**
a) the percentage of:								
i) consultants in academic posts	8.38%	6.97%	6.77%	7.05%	7.25%	6.10%	5.63%	5.53%
ii) women consultants	24.30%	26.01%	26.82%	27.68%	30.19%	29.13%	29.50%	29.20%
iii) ethnic minority consultants	31.84%	33.51%	27.34%	36.55%	40.58%	41.38%	42.79%	42.48%
Overall number of award holders both Natl. & Local	**287**	**309**	**324**	**335**	**349**	**361**	**355**	**376**
a) the percentage of:								
i) consultants in academic posts	18.12%	16.18%	15.74%	15.22%	14.33%	13.30%	13.24%	12.77%
ii) women consultants	16.72%	17.48%	17.90%	18.51%	20.92%	21.33%	21.41%	21.81%
iii) ethnic minority consultants	24.04%	26.21%	27.16%	29.25%	29.51%	30.75%	32.11%	32.98%



Trust Board Paper T

	TRUST BOARD
From:	Rachel Overfield, Kevin Harris, Richard Mitchell Kate Bradley Peter Hollinshead
Date:	**30th January 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, operational performance against national and local indicators and Finance for the month of December.

The Report is provided to the Board for:

Decision		Discussion	√
Assurance	√	Endorsement	

Summary / Key Points:

Successes

- Theatres – 100% WHO compliant for the last 12 months.
- 62 day cancer – performance for November was 85.7%and year to date performance now delivering 85%,
- VTE - The 95% threshold for VTE risk assessment within 24 hours of admission has been achieved for the last 6 months
- The percentage of stoke patients spending 90% of their stay on a stroke ward year to date position is 82.5%.
- Friends and Family Test - performance for December is 68.7.

Areas to watch:-

- C Difficile – on trajectory to date with 52 reported against cumulative target of 52.
- Diagnostic waiting times– the 1% threshold was missed in December
- C&B – performance similar to this time last year and target is still not delivered.

Exceptions/Contractual Queries:-

- Pressure Ulcers – recovery action plan signed off and revised trajectory agreed
- ED 4hr target - Performance for emergency care 4hr wait in December was 90.1%. Actions relating to the emergency care performance are included in the ED exception report.
- Cancelled Operations – contract query has been raised by the commissioners due to consistent failure of the threshold. Remedial action plan updated.

- RTT admitted and non-admitted – this remains a contractual failure to agree. Ongoing discussions with commissioners about the capacity gap and financial impact of resolving current backlogs over 18 weeks.

Finance:-

- The Trust is reporting a deficit at the end of December of £28.5m, which is £31.5m adverse to the planned surplus of £3.0m.
- Patient care income £12.2m (2.6%) favourable against Plan.
- Pay costs are £16.7m over budget, almost £20m more than the same period in 2012/13 (5.9%). When viewed by staff group, the most significant increases year on year are seen across agency and medical locums, nursing spend and consultants' costs.
- CIP - £2.5m adverse to Plan

Recommendations: Members to note and receive the report	
Strategic Risk Register	**Performance KPIs year to date** CQC/NTDA
Resource Implications (eg Financial, HR) N/A	
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 – December 2013

Trust Board

Thursday 30th January 2014

One team shared values

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **30TH JANUARY 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: **DECEMBER 2014 QUALITY & PERFORMANCE SUMMARY REPORT**

1.0 INTRODUCTION

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

2.0 2013/14 NTDA Oversight and Escalation Level

2.1 NTDA 2013/14 Indicators

Performance for the 2013/14 indicators in Delivering *High Quality Care for Patients: The Accountability Framework for NHS Trust Boards* was published by the NTDA early April.

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

- Outcome Measures
- Quality Governance Measures
- Access Measures – see Section 5

Outcome Measures	Target	2012/13	Apr-13	May-13	Jun-13	Qtr1	Jul-13	Aug-13	Sep-13	Qtr2	Oct-13	Nov-13	Dec-13	Qtr 3	YTD
30 day emergency readmissions	7.0%	7.8%	7.5%	7.8%	7.7%	7.7%	7.5%	7.6%	7.8%	7.6%	7.9%	7.8%		7.9%	7.7%
Avoidable Incidence of MRSA	0	2	0	0	0	0	0	0	1	1	0	0	0	0	1
Incidence of C. Difficile	67	94	6	7	2	15	6	5	9	20	6	6	5	17	52
Incidence of MSSA		46	5	2	5	12	1	4	3	8	1	1	1	3	23
Safety Thermometer Harm free care		94.1%*	92.1%	93.7%	93.6%		93.8%	93.5%	93.1%		94.7%	93.9%	94.0%		
Never events	0	6	1	0	0	1	0	0	1	1	0	0	0	0	2
C-sections rates*	25%	23.9%	23.8%	26.1%	26.1%	25.3%	25.0%	25.2%	24.6%	24.9%	25.6%	27.5%	25.2%	26.1%	25.5%
Maternal deaths	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Avoidable Pressure Ulcers (Grade 3 and 4)	0	98	11	4	8	23	8	8	5	21	4	4	4	12	56
VTE risk assessment	95%	94.5%	94.1%	94.5%	93.1%	93.9%	95.9%	95.2%	95.4%	95.3%	95.5%	96.7%	96.1%	96.1%	95.2%
Open Central Alert System (CAS) Alerts		13	14	9	15		36	10	10		14	15	12		
WHO surgical checklist compliance	100%	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

* target revised to 25%

Quality Governance Indicators	Target	2012/13	Apr-13	May-13	Jun-13	Qtr1	Jul-13	Aug-13	Sep-13	Qtr2	Oct-13	Nov-13	Dec-13	Qtr 3	YTD
Patient satisfaction (friends and family)		64.5	66.4	73.9	64.9		66.0	69.6	67.6		66.2	70.3	68.7		68.1
Sickness/absence rate	3.0%	3.4%	3.3%	3.1%	3.0%	3.2%	3.2%	3.1%	3.1%	3.1%	3.4%	3.7%	4.7%*	3.6%	3.4%
Proportion temporary staff – clinical and non-clinical (WTE for Bank, Overtime and Agency)			5.6%	5.9%	5.6%		5.6%	5.5%	5.3%		6.0%	6.1%	6.0%		
Staff turnover (excluding Junior Doctors and Facilities)	10.0%	9.0%	8.8%	8.9%	9.2%		9.5%	9.3%	9.7%		9.6%	9.7%	10.2%		
Mixed sex accommodation breaches	0	7	0	0	0	0	0	0	0	0	0	2	0	2	2
% staff appraised	95%	90.1%	90.9%	90.2%	90.7%		92.4%	92.7%	91.9%		91.0%	91.8%	92.4%		
Statutory and Mandatory Training	75%		45%	46%	46%		48%	49%	55%		58%	60%	65%		
% Corporate Induction attendance rate	95%		87%	82%	95%		90%	94%	94%		91%	87%	89%		

*provisional data

2.2 UHL NTDA Escalation Level

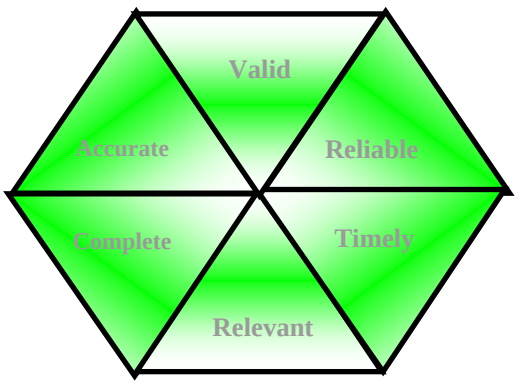
The Accountability Framework sets out five different categories by which Trust's are defined, depending on key quality, delivery and finance standards.

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?

It is proposed the data quality diamond assessment will be included in the January Quality and Performance report against indicators that have been assessed.

4.0 QUALITY AND PATIENT SAFETY – KEVIN HARRIS/RACHEL OVERFIELD

4.1 Quality Commitment

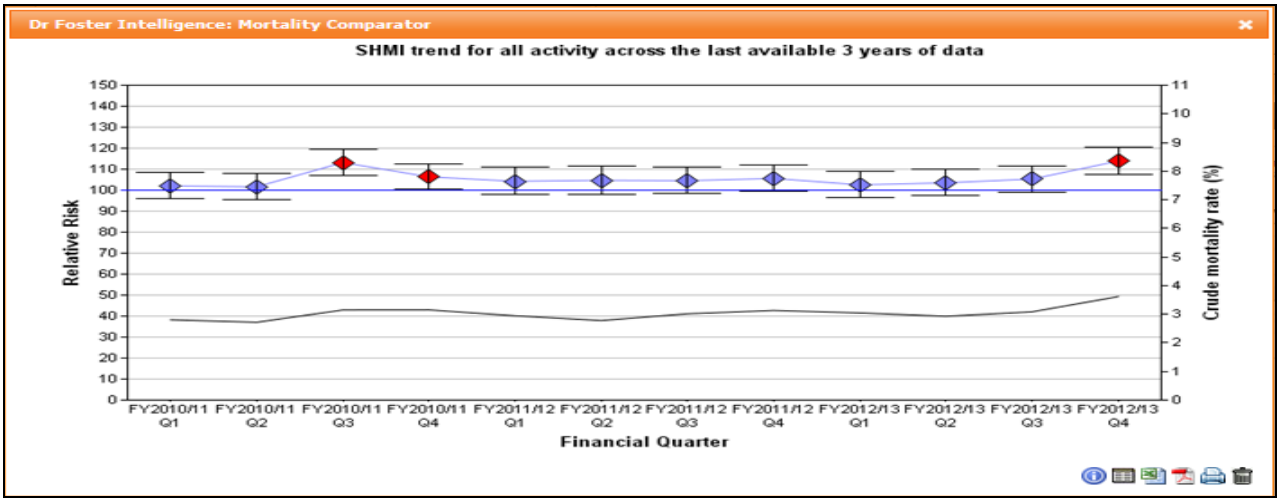
There is no update on the Quality Commitment programme this month. An end of year closure report will be presented to the Quality Assurance Committee at its meeting on the 29th January and they will be asked to advise what is taken forward to the Trust Board.

4.2 Mortality Rates

Mth | Qtr 1 | Qtr2 | Qtr3 | YTD

The latest published SHMI by the Health and Social Care Information Centre (HSCIC) covers the financial year 12/13 and UHL's SHMI is 106 and is in Band 2 (ie within expected).

The SHMI for July 12 to June 13 is due to be published at the end of January. The new SHMI is anticipated to either remain at 106 or possibly increase to 107 as this time period includes April 13 where we saw an increase in both the crude and risk adjusted mortality. As can be seen from the Quarterly SHMI chart below, Jul 12 to Jun 13 will also include the increased SHMI period for January to March 13 whilst losing the lower SHMI of April to June 2012.



UHL now subscribes to the Hospital Evaluation Dataset (HED) which is similar to the Dr Foster Intelligence clinical benchmarking system but also includes a 'SHMI analysis tool'. UHL's SHMI for the months May to October 2013 is predicted to be closer to 100. However, due to the published SHMI being based on a '12 month rolling figure', the trust's SHMI is likely to remain above 100 for some time. Further analysis of the HED data is currently being undertaken and will be reported to the next Mortality Review Committee.

Reassuringly UHL's HSMR for 13/14 (Apr to Oct) is 90 (using the Dr Foster Intelligence clinical benchmarking tool). Our current HSMR is compared with the England average of 100 for 2012/13. Following Dr Foster's annual rebasing at the end of the financial year it is likely to be higher than 92 (the number of in-hospital deaths falls nationally year on year). Currently UHL's rebased HSMR for 13/14 is predicted to be 100 (i.e. the same as the England average).

UHL's monthly HSMR for the past 12 months is presented below.

Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13		YTD	Target
98.5	101.4	98.7	102.9	97	89.8	92.4	92.6	94.4	85	84.4		90.7	100

4.3 Patient Safety

Mth | Qtr 1 | Qtr2 | Qtr3 | YTD

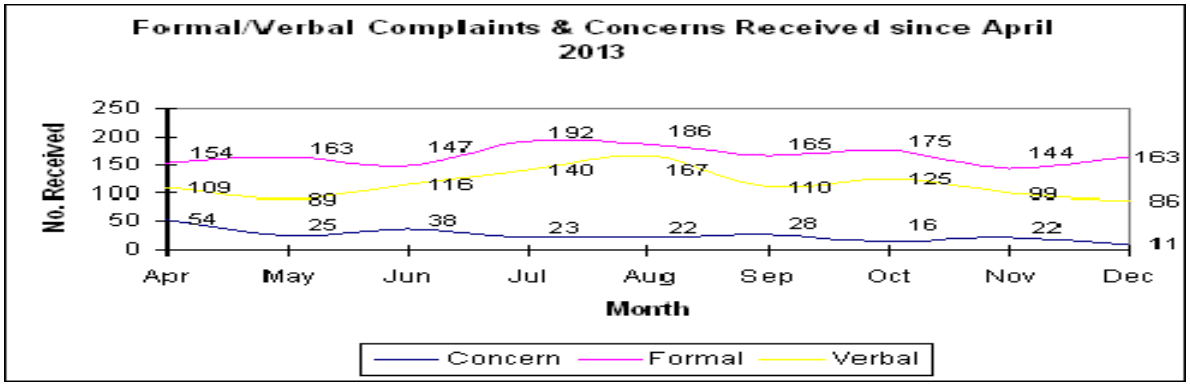
In December a total of 7 new Serious Untoward Incidents (SUIs) were escalated within the Trust (a reduction of 9 compared to November), 4 of which were patient safety incidents, 2 were Hospital Acquired Pressure Ulcers and 1 was a Healthcare Acquired Infection. 2 of the SUIs related to Children's Services and 2 related to delayed diagnosis. No Never Events were reported in the Trust in December. Six patient safety root causes analysis (RCA) 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 December 7 calls were made to the 3636 Staff Concerns Reporting Line, all of which have been followed up by a Director. A high level of compliance with deadlines for external CAS (Central Alerting System) alerts has been maintained - 100% for quarter three and 99% over a rolling 12 months.

Overall complaint activity remains high with the top 5 themes of written complaints being:-

- Medical Care
- Waiting Times
- Communication
- Cancellations
- Discharge issues

Pleasingly, complaints relating to nursing care have reduced and complaints regarding staff attitude have dropped to the lowest level for over twelve months.



4.4 5 Critical Safety Actions

Mth | Qtr 1 | Qtr2 | Qtr3 | YTD

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:-

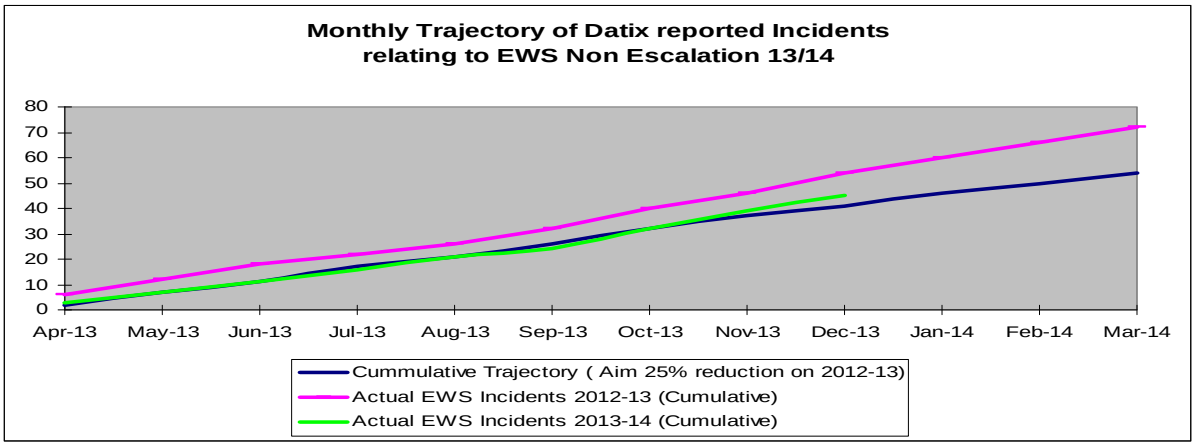
- The first meeting of the Nerve Centre handover project steering group took place this month to agree implementation plan. Plan to commence roll out as soon as 24/7 server upgraded and handover module added which is planned for January 2014.
- Almost all specialities have now responded to request for documentation of current handover practice following chase email from the Medical Director.

2. Relentless attention to Early Warning Score triggers and actions

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

Actions:-

- EWS Datix reported incidents related to non escalation are still being monitored this year. The internal aim is to reduce these by 25% against 2012-13 figures.



- Monthly data for response times to red calls which includes EWS>4 calls is captured from 24/7 system. As per EWS pathway, these should be responded to within 30 minutes.

% of red calls within response time <30 minutes

Site	September 13	October 13	November 13
GH	100%	100%	100%
LGH	100%	98%	97%
LRI	100%	97%	98%

The EWS response times < 30 mins **Green 95% and above, Amber 85%- 94% Red > 84%**

- A case note review to validate data with for the medical documentation of for the review of patients with escalated EWS via 24/7 system took place for the LRI and GH sites in early December with one site per week. The LGH site will be undertaken the week commencing 13th January 2014. Collated results will be reported next month.

3. Acting upon 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 60% of specialities. More are still in draft version and require CMG approval.
- CMG deputy directors have been communicated with to ensure that those specialities without agreed processes are supported to undertake these in adherence with the CSA plan. Have received good response from most.

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.

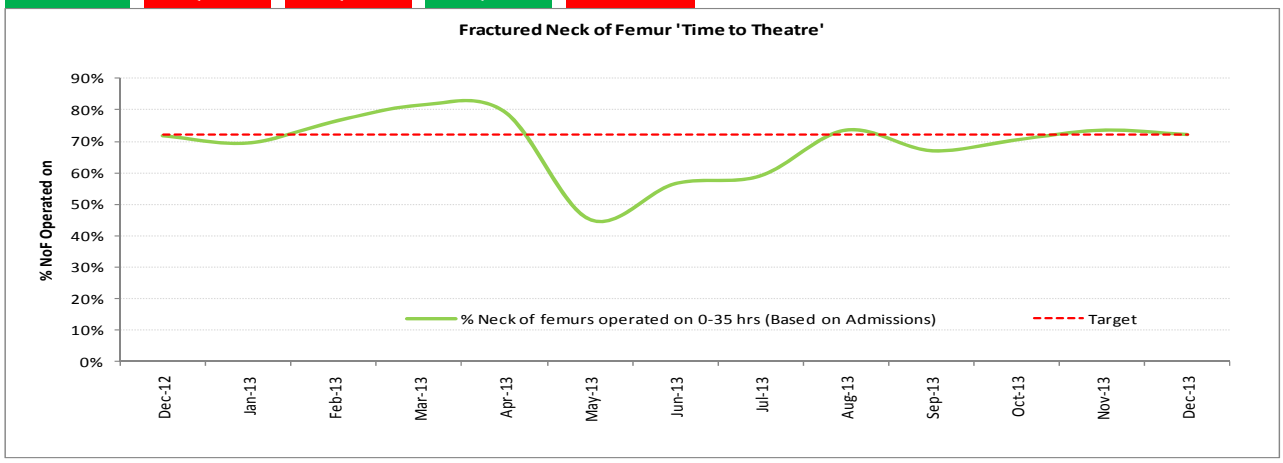
Actions:-

- Ward round audit results collated by the CASE team. This is now to be used as a pilot audit due to lack of forms returned and lack of junior doctor auditors. Report to be written for next month.
- Spend breakdown for current continuation paper from supplies received. Savings will be made but it is difficult to establish actual amount due to the variety of order routes at present. Work is currently being undertaken on the changeover process as old codes will need to be replaced with the new coded paper and stops put on ordering the old paper.
- Ward round education session undertaken to FY1 doctors at LRI this month.
- Plan for January implementation delayed until ward round safety checklist and revised continuation paper for Children's and Obstetrics finalised. This is due to print changeover processes inability to implement separately. All documentation should be finalised by end of January for revised February implementation.

There is a risk to Q3 CQUIN full compliance from the delay in implementing the ward round documentation for the Senior Clinical Review, Ward Rounds and Notation action. All the other actions have achieved full compliance for Q3 against agreed action plans.

4.5 Fractured Neck of Femur 'Time to Theatre'

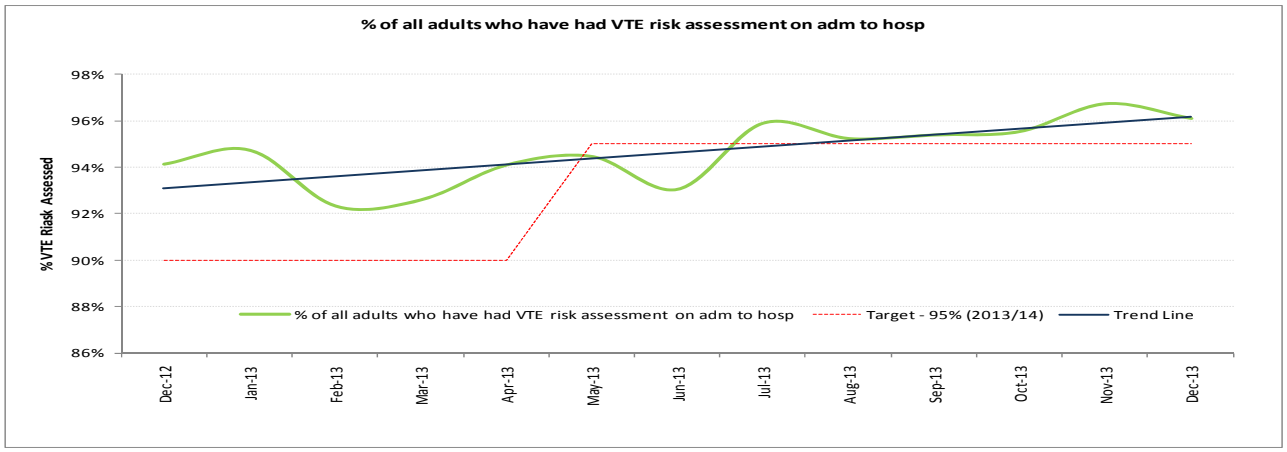
Mth | Qtr 1 | Qtr2 | Qtr3 | YTD



The percentage of patients admitted with fractured neck of femur during December who were operated on within 36hrs was 72.2% (52 out of 72 #NOF patients admitted during December).

4.6 Venous Thrombo-embolism (VTE) Risk Assessment

Mth | Qtr 1 | Qtr2 | Qtr3 | YTD



The 95% threshold for VTE risk assessment within 24 hours of admission has been achieved for December at 96.1%. The year to date performance is also being achieved at 95.2%.

4.7 Quality Schedule and CQUIN Schemes – Quarter 3

The table below summarises the anticipated RAG ratings for the Quality Schedule and CQUIN indicators in respect Quarter 3's performance.

Good progress has been made against the Quarter 3 thresholds for each of the CQUIN indicators and it is anticipated that all CQUIN schemes will be given a Green RAG rating.

There are two "Red" Quality Schedule indicators – Never Events and Same Sex. There was one Never Event in October and one 'non clinically justified' Same Sex Accommodation breach in November and therefore the RAG has been made Red for the full Quarter.

There are several Amber Quality Schedule indicators at risk of being RAG'd Amber because thresholds have not been fully met for one of the indicators for part or all of the Quarter.

Communication (Discharge, Out-patient and ED Letters) - There have been delays with implementation of ED action plan and backlogs remain with outpatient letters for some specialities. An audit has been carried out by GPs from East and Leicester City GPs and the results should be available in February.

Medicines Management – Whilst improvements have been made with compliance for both Controlled Drugs in respect of storage and the Medicines Code for prescribing and administration, performance is still below the threshold. Spot check audits continue for those areas non compliant.

Complaints Response Times – performance below threshold for 'responses within 25 days' for November.

Pressure Ulcers – The revised Trajectory was achieved for both Nov and December and Action Plan timescales met for all but one action - establishing a Pressure Ulcer database. Commissioner have advised that the Contract Query is to remain in place until the end of the financial year and possibly longer.

Children's Dashboard – potentially will remain at Amber if training figures have not improved.

PROMs – Participation has improved for both Groin Hernia and Varicose Vein PROMs but there has been a deterioration in number of patients reporting a health gain following their Groin Hernia Surgery. An audit is currently underway to confirm whether these patients had any post op complications or were readmitted to hospital following surgery.

Mortality – Whilst UHL's SHMI remains 'within expected' UHL has RAG'd itself as Amber for this indicator due to the SHMI being above 100.

All LLR indicators will be reviewed at the CQRG meeting on 20th February and the RAGs confirmed. Conformation of the RAG for the Specialised Service CQUINs is due after their review meeting on 28th February.

Contract negotiation discussions are currently underway with the Commissioning Quality Leads with respect of the Quality Schedule and CQUIN schemes for 14/15 and a final draft of both is due to be completed by 14th February.

The contract guidance suggests there should be a small number of local quality schedule indicators. Early discussions have been held with Commissioners about the idea of having 'baskets' of indicators which would reflect the work programme associated with that basket (i.e. Infection Prevention, Medicines Optimisation) and have one thresholds and RAG rating set accordingly.

The national guidance recommends a maximum of 10 local CQUIN schemes, currently there are 7 that have been put forward by UHL, most of which are a continuation of previous schemes with the addition of 'reducing avoidable weight loss' and 'earlier recognition of sepsis'.

Proposed indicators have been discussed with the Executive Quality Board and Executive Team. Each of the Clinical Commissioning Group Boards are also considering which indicators should be in both the Quality Schedule and CQUIN schemes for 14/15 and the expectation is that the first formal draft will be available for circulation and consultation week commencing 27th January.

Schedule	Ref	Indicator Title and Detail	Q3 Predicted RAG
QS	IP1 IP2 IP3	IP1: MRSA bacteraemias C Diff MRSA Screens (EI & Em) MSSA bacteraemias E Coli bacteraemias MRSA and C Diff Reduction Plan IP2: C Section Surveillance IP3: HII Audits	G
QS	PS1	Patient Safety Dashboard to include: SUIs Never Events Duty of Candour	R
QS	PS2	Safety Assurance Dashboard to include: Compliance with Duty of Candour Risk Register Central Alerting System	G
QS	PS4	Ward Health Check To include: Staffing / establishment, use of agency, Nursing Metrics F&FT etc	G
QS	PS5	Compliance with letter content: ED and Discharge Letters: GP Actions; Follow up; Patient Information, Medication Changes and Consultant Outpatient Letters: GP Actions; Follow up; Patient Information, Medication Changes Absence of requests for GP to initiate treatment	A
QS	PS6	Eliminating "avoidable" Grade 2, 3 and 4 Hospital Acquired Pressure Ulcers	A
QS	MM1	Medicines Management Dashboard to include: Compliance with - Leicester Medicines Code - Controlled Drugs Regs - Medicines Reconcilliation - Antipsychotics Prescribing - 'Traffic Lights' Policy - LLR Formulary Medication errors causing harm	A
QS	PE1	Same Sex Accommodation	R
QS	PE2	PE2c – Reopened Complaints – improving response times PE2e – Actions being taken to reduce complaints relating to staff attitude, medical and nursing care	A
QS	PE3a	Pt Exp – Quality Commitment PE3aii Discharge Experience	A
QS	PE4	Patient Experience in ED	A
QS	CE2	Children's Services Dashboard	A
QS	CE3	PROMS - Hip or Knee Replacement - Groin Hernia Surgery - Varicose Vein Repair a) Participation in PROMs b) Outcome PROMS - utilising HES pre and post outcome data	A

Schedule	Ref	Indicator Title and Detail	Q3 Predicted RAG
QS	CE4	#NOF scorecard to include Time to theatre (36 hrs & 48 hrs) and Orthogeriatric / MDT related indicators	A
QS	CE5	Stroke & TIA Clinic Indictors to include: 90% stay, Swallow Assessment, TIA referral within 24 hrs	A
QS	CE6	Mortality Dashboard: SHMI, HSMR Perinatal Mortality Amenable Mortality (linked to Everyone counts) LTC Mortality - Alcoholic Liver Disease (linked to Everyone Counts')	A
QS	CE7	Quality Assurance Dashboard to include: Compliance with NICE TAGs and other guidance Clinical Audit Programme progress External Visits Schedule	tbc
QS	CE10	Consultant level survival rates as stated on the 'Everyone Counts' document	tbc
QS	PR1	Digital First IOFM Advice for Carers of Pts with Dementia	tbc
		CQUIN SCHEMES	
Nat CQUIN	Nat 1	Implementation of Friends and Family Test: 1.1 Phased Expansion 1.2 Increased Response Rate 1.3 Improved Performance on Staff Test	G
Nat CQUIN	Nat 2	2.1. To collect data on the following three elements of the NHS Safety Thermometer: pressure ulcers, falls UTI in patients with a catheter 2.2a Reduction in CAUTIs 2.2b Reduction in Falls	tbc
Nat CQUIN	Nat 3	3.1 .Patients aged 75 and over admitted as an emergency are screened for dementia, where screening is positive they are appropriately assessed and where appropriate referred on to specialist services/GP. 3.2. Ensuring sufficient clinical leadership of dementia within providers and appropriate training of staff. 3.3. Ensuring carers of people with dementia feel adequately supported	G tbc G
Nat CQUIN	Nat 4	Reduce avoidable death, disability and chronic ill health from Venous thromboembolism(VTE) 1. VTE risk assessment 2. VTE RCAs	G
LLR CQUIN	Loc 1	Making Every Contact Count Increased advice and referral to STOP and ALW	G
LLR CQUIN	Loc 2	Implementation of the AMBER care bundle to ensure patients and carers will receive the highest possible standards of end of life care	G
LLR CQUIN	Loc 3	Improve care pathway and discharge for patients with Pneumonia a) Admission directly to respiratory ward and piloting of 'pneumonia virtual clinic for patients admitted to LRI') b) Improving care pathway and discharge for patients with Pneumonia - Implementation of Pneumonia Care Bundle	G
LLR CQUIN	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
LLR CQUIN	Loc 5	Critical Safety Actions – Clinical Handover Acting on Results Senior Review/Ward Round Standards Early Warning Score	tbc
LLR CQUIN	Loc 7	Implementation of DoH Quality Mark with specific focus on Dignity Aspects	G

Schedule	Ref	Indicator Title and Detail	Q3 Predicted RAG
EMSCG CQUIN	SS1	Implementation of Specialised Service Quality Dashboards	G
EMSCG CQUIN	SS2	Bone Marrow Transplant (BMT) – Donor acquisition measures	G
EMSCG CQUIN	SS3	Fetal Medicine – Rapidity of obtaining a tertiary level fetal medicine opinion – within 3 working days.	G
EMSCG CQUIN	SS4	Joint Pain Scores for Moderate/Severe Haemophilia Patients	G
EMSCG CQUIN	SS5	Discharge planning is important in improving the efficiency of units and engaging parents in the care of their infants thereby improving carer satisfaction of NICU services.	G
EMSCG CQUIN	SS6	Radiotherapy – Improving the proportion of radical Intensity modulated radiotherapy (excluding breast and brain) with level 2 imaging – image guided radiotherapy (IGRT)	G
EMSCG CQUIN	SS7	Acute Kidney Injury	tbc
EMSCG CQUIN	SS8	PICU - . To prevent and reduce unplanned readmissions to PICU within 48 hours	G

4.8 Theatres – 100% WHO compliance

Mth | Qtr 1 | Qtr2 | Qtr3 | YTD

The National Patient Safety Agency endorsed WHO checklist consists of four stages and is monitored and reported every month to commissioners. For December the checklist compliance stands at 100% and has been fully compliant for the last 12 months.

4.9 C-sections rate

Mth | Qtr 1 | Qtr2 | Qtr3 | YTD

The C-section rates for the 3rd quarter is 26.1%, this was mainly due to a higher rate in November. The Perinatal risk group have reviewed this rate early in January and are reviewing case notes in relation to November's rates. On the positive side the low risk birth unit at LGH has seen a rise in women using it through December by almost 50%, which proves the midwives are working hard to promote low risk care.

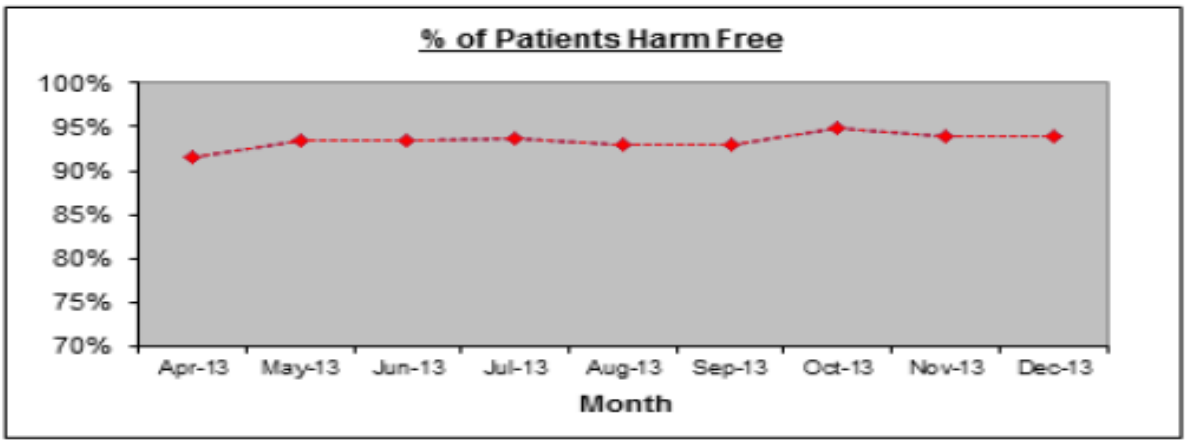
4.10 Safety Thermometer

Table one below confirms the December 2013 Safety Thermometer Data for UHL. It is noted that the UHL percentage of Harm Free Care for December was 94%. There are no areas of concern in relation to the prevalence of New Harms.

Table One – December 2013 Safety Thermometer Data

		Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13
	Number of patients on ward	1672	1686	1650	1514	1496	1579	1596	1662	1558
All Harms	Total No of Harms - Old (Community) and Newly Acquired (UHL)	150	117	113	100	108	121	85	102	102
	No of patients with no Harms	1531	1577	1540	1417	1392	1466	1512	1560	1464
	% Harm Free	91.57%	93.53%	93.33%	93.59%	93.05%	92.84%	94.74%	93.86%	93.97%
Newly Acquired Harms	Total No of Newly Acquired (UHL) Harms	73	58	56	49	59	46	42	40	41
	No of Patients with no Newly Acquired Harms	1600	1631	1596	1466	1438	1535	1555	1622	1519
	% of UHL Patients with No Newly Acquired Harms	95.69%	96.74%	96.73%	96.83%	96.12%	97.21%	97.43%	97.59%	97.50%
Harm One	No of Patients with either an OLD or NEWLY Acquired Grade 2, 3 or 4 Pressure Ulcers (PUs)	92	75	73	66	67	87	54	74	62
	No of Newly Acquired Grade 2, 3 or 4 PUs	26	27	26	19	25	16	19	17	13
Harm Two	No of Patients having fallen in hospital in previous 72 hrs	14	8	8	5	3	3	2	3	3
Harm Three	No of Patients with Urinary Catheter and Urine Infection (prior to or post admission)	36	27	27	25	31	25	22	15	24
	Newly Acquired UTIs with Catheter	25	16	17	21	24	21	14	10	12
Harm Four	Newly Acquired VTE (DVT, PE or Other)	8	7	5	4	7	6	7	10	13

Chart One – UHL Percentage of Harm Free Care April to December 2013



Pressure Ulcer Prevalence

As part of the recent CQC inspection, the CQC data pack highlighted that the UHL New pressure ulcer prevalence rate for all grades of pressure ulcers, for all patients (including those over 70 years of age) has been above the England average from March 2013 to November 2013. Although this is factually correct, the CQC compared UHL data to the national average that does not take account for trust-to-trust variation in the demographic make-up of the population. The two charts below provide a more accurate comparison of organisations and illustrate the mean percentage of all new pressure ulcers for acute hospitals or similar size trusts to UHL. The data provides assurance that UHL is not an outlier in terms of new pressure ulcers for all patients (including patients over 70 years of age).

Chart Two – New Pressure Ulcers (all Patients) from Nov 2012 to Dec 2013

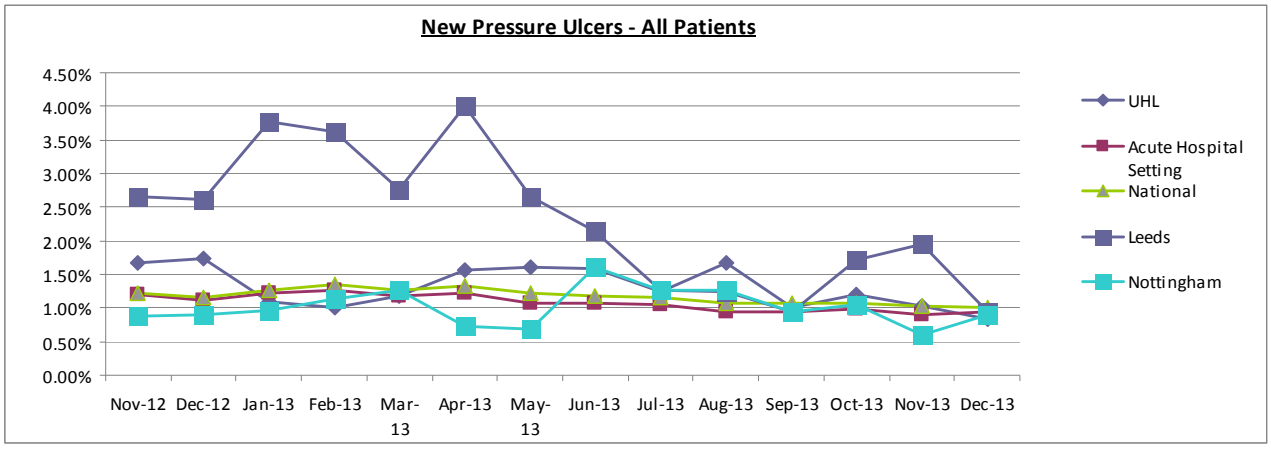
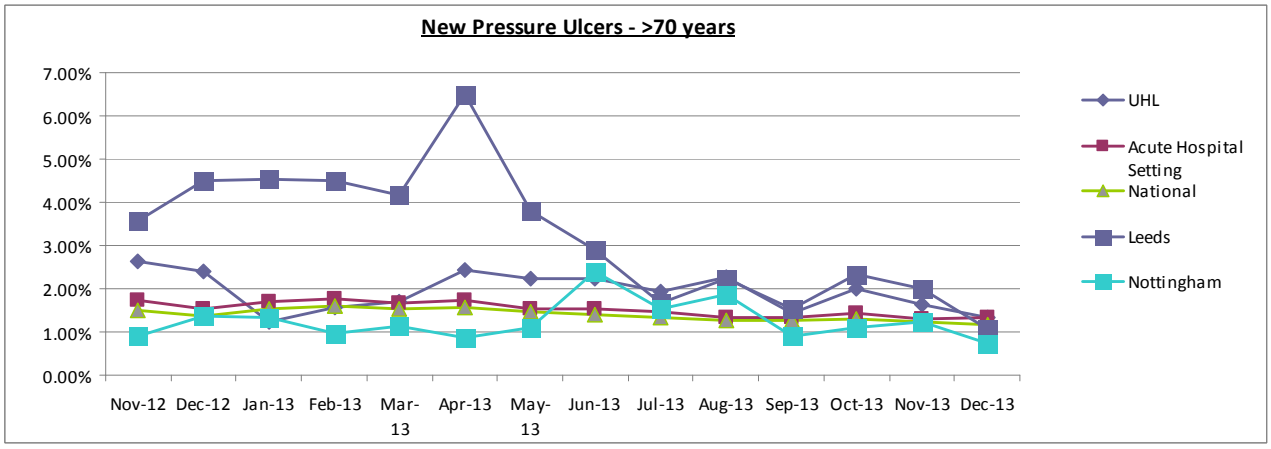


Chart Three – New Pressure Ulcers (Patients over 70 years) from Nov 2012 to Dec 2013



The Leicestershire and Lincolnshire Area Team have provided UHL with the Midlands and East Pressure Ulcer Ambition Programme Dashboard that compares Safety Thermometer prevalence data for pressure ulcers in different organisations across the patch. The data in table two below again confirms that UHL are not an outlier when comparing the mean percentage of new pressure ulcers across Leicestershire and Lincolnshire (data only available for November 2013). It is anticipated that UHL will now receive this data on a monthly basis as from February 2014.

Table Two – UHL Mean Percentage Prevalence for New Pressure Ulcers November 2013 and Comparisons with other Organisations across Leicester / Leicestershire

November 2013	Mean % PU prevalence for New PU	Mean % prevalence for all PU
UHL	1.0	4.5
Same Setting of Care (i.e. Acute Trust)	1.0	4.6
Leicestershire and Lincolnshire Area Team	0.8	4.1
Midlands and East	1.0	4.8
National	1.1	4.9

Falls Prevalence

The UHL prevalence of falls with harm in all patients and those over seventy years of age measured by the Safety Thermometer was also compared to the national average as part of the CQC review. The two charts below highlight that UHL has a significantly lower prevalence of falls with harm compared to other acute hospital settings or similar sized Trusts during the period from November 2012 to December 2103. This data confirms the success of recent falls initiatives implemented across the Trust over the last 12 months.

Chart Four – Falls Rate (all Patients) from Nov 2012 to Dec 2013

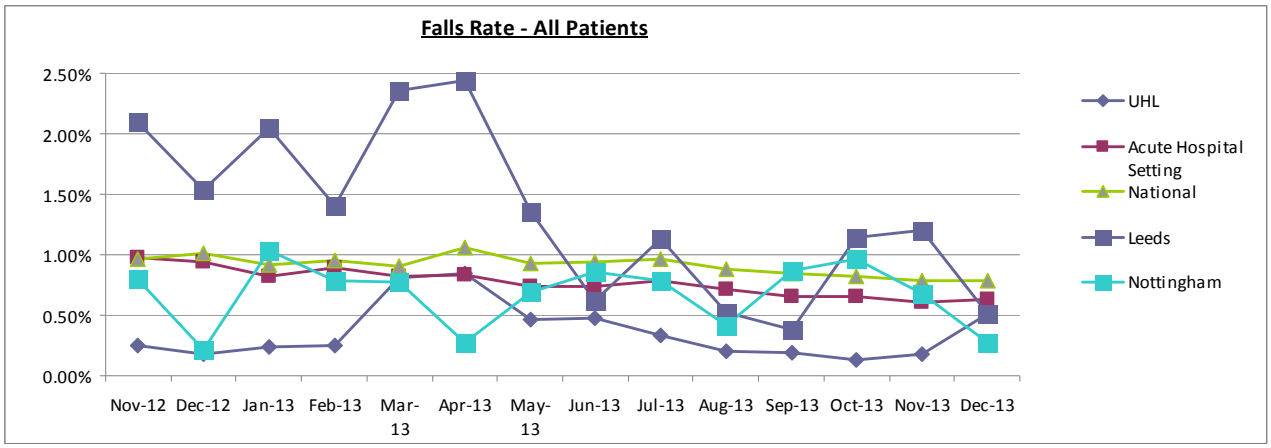
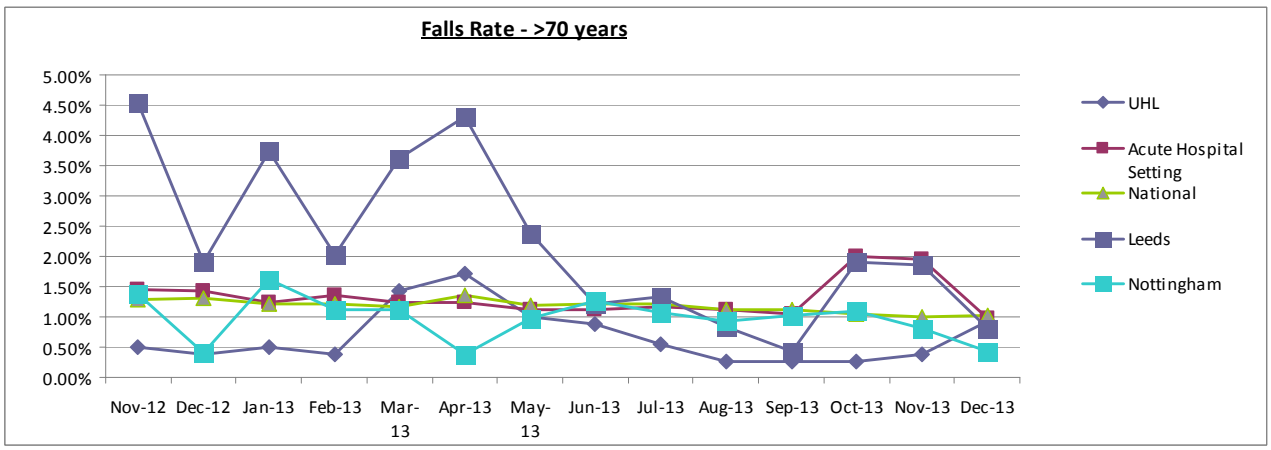


Chart Five – Falls Rate (Patients over 70 years) Nov 2012 – Dec 2013



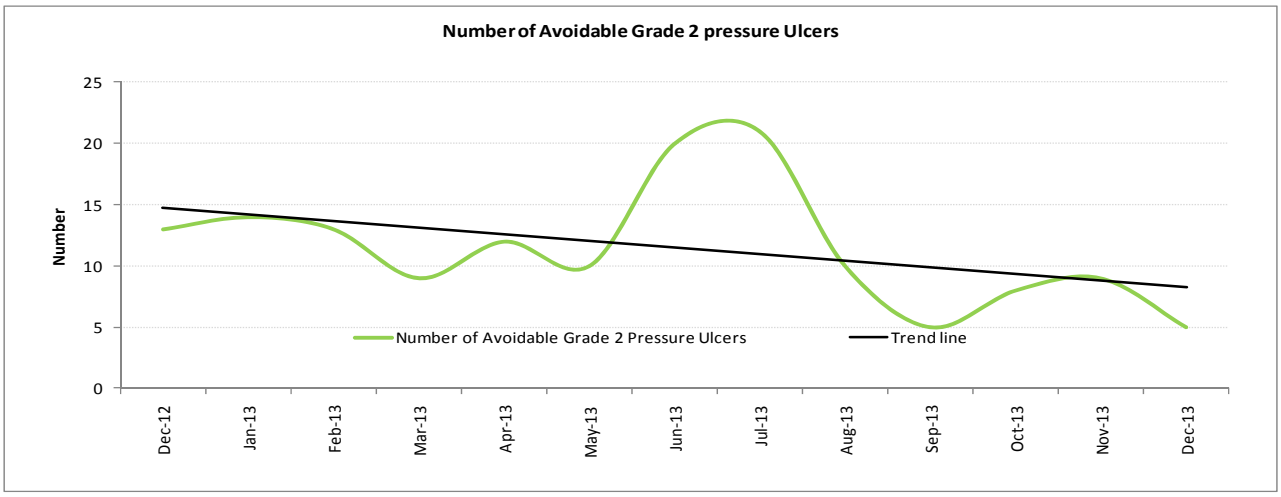
CAUTI and VTE Prevalence

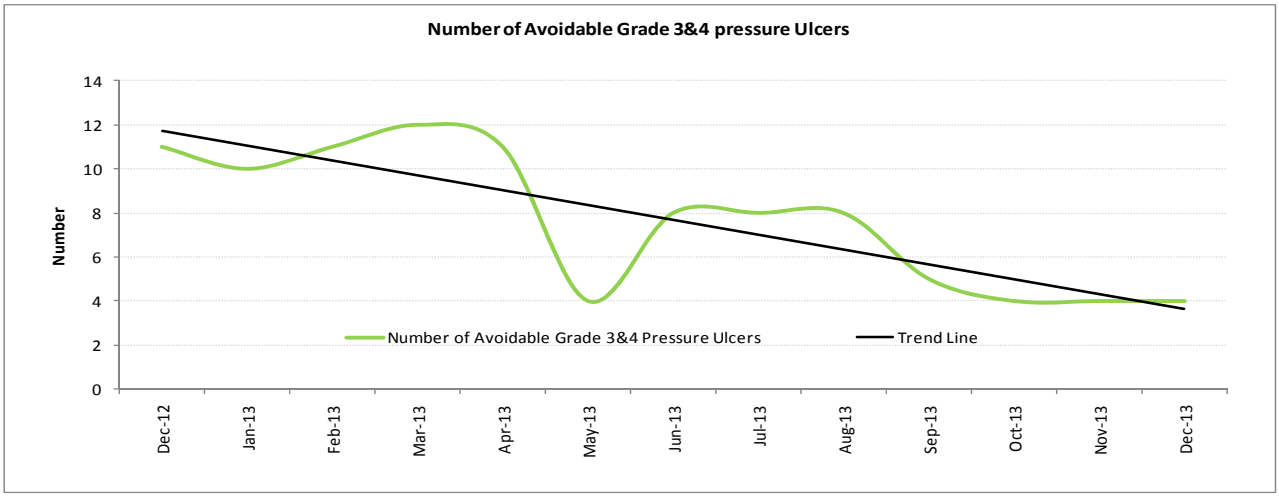
The Nurse Specialists for these harms have not reported any concerns with the December prevalence data for CAUTIs or VTEs

Pressure Ulcer Incidence

Mth | Qtr 1 | Qtr2 | Qtr3 | YTD

The number of avoidable grade 3 pressure ulcers for December 2013 was four Grade 3 ulcers and five grade 2 ulcers.

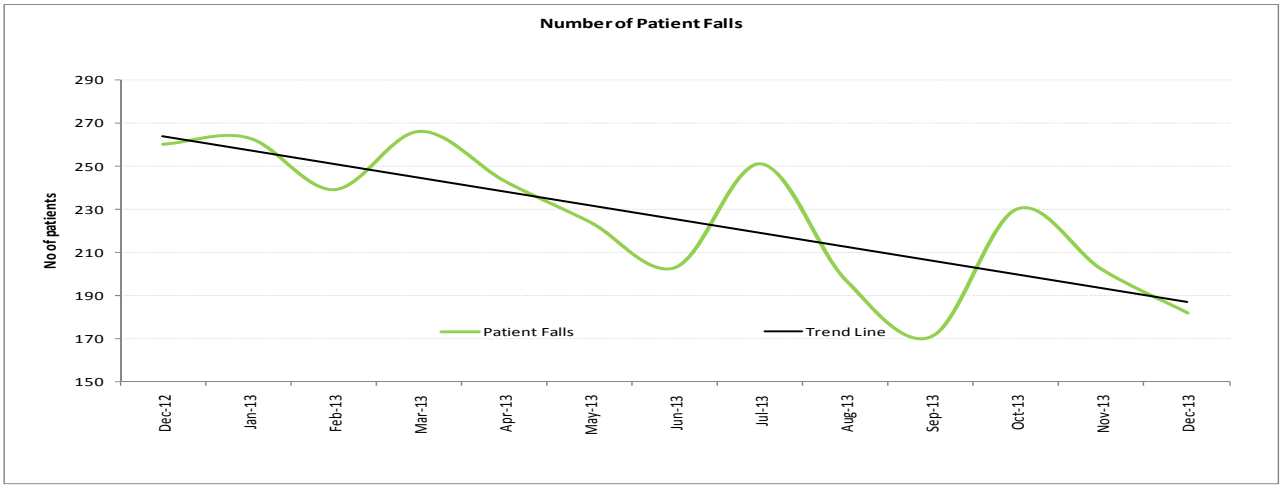




It should be noted that the incidence of avoidable Grade 3 pressure ulcers for the month of November 2013 was actually four and not five (which was the number reported in the Q&P report). The change was because additional evidence was presented to the Tissue Viability team in relation to one of the avoidable ulcers proving that the ulcer was actually unavoidable. This has been agreed with commissioners.

For the month of December 2103, UHL has maintained the reduction thresholds for avoidable pressure ulcers.

Patient Falls



Falls incidence for December 2013 reported on Datix has seen a further decrease in the number of falls compared to November resulting in a further reduction in the number falls for Q3 across UHL.

5.0 PATIENT EXPERIENCE – RACHEL OVERFIELD

5.1 Infection Prevention

a) MRSA

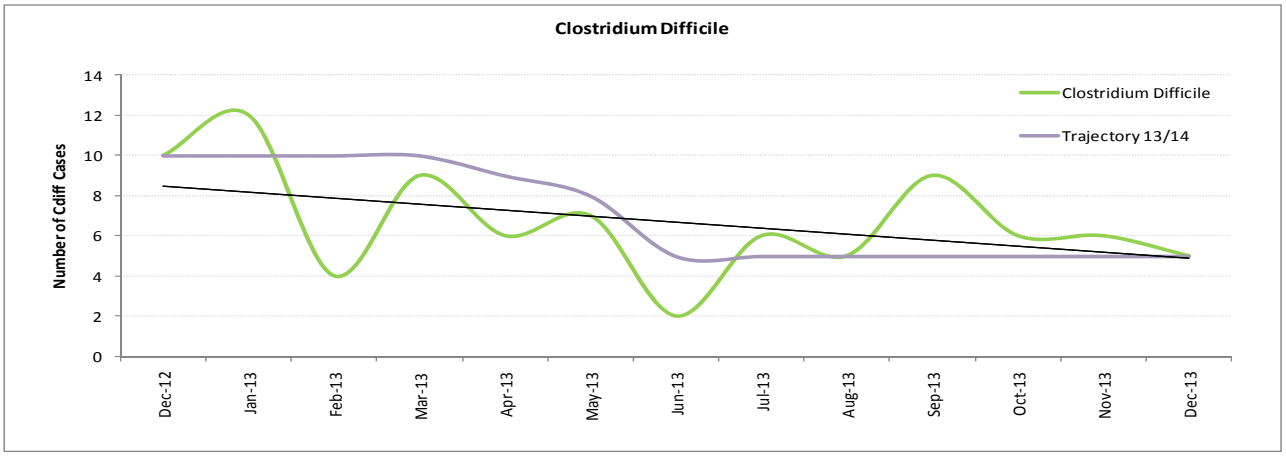
Mth	Qtr 1	Qtr2	Qtr3	YTD

There were no avoidable MRSA cases reported in December.

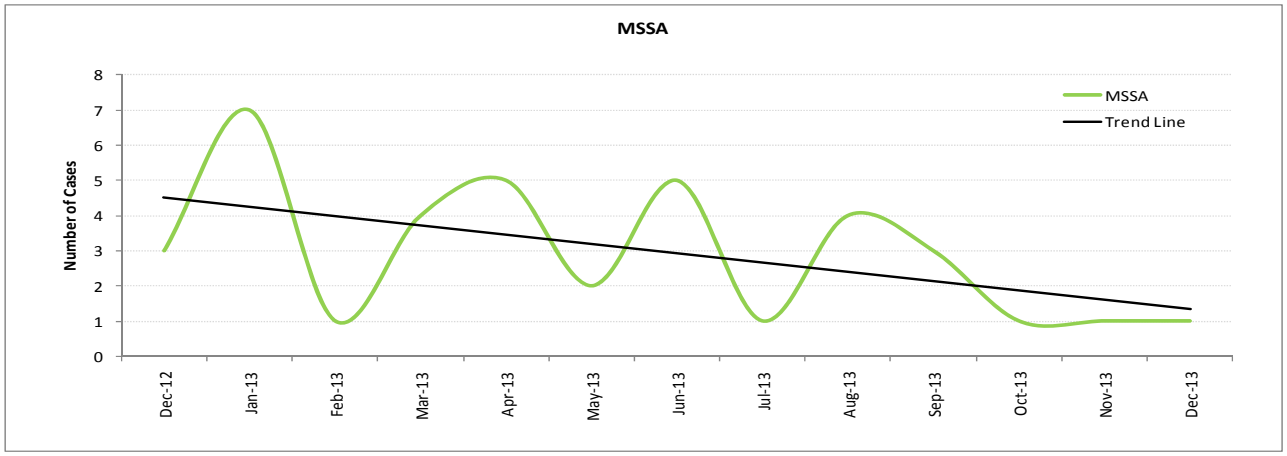
b) CDT

Mth	Qtr 1	Qtr2	Qtr3	YTD

On trajectory to date with 52 reported against cumulative target of 52. All 5 cases of CDT reported in December have been fully investigated and there are no links between any of the cases.



c) The number of MSSA cases reported in December was 1, with a year to date figure of 23.



5.2 Patient Experience

Patient Experience Surveys continue across 94 clinical areas and have 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 December 2013, 3,760 Patient Experience Surveys were returned this is broken down to:

- 2,044 paper inpatient/day case surveys
- 978 electronic surveys
- 533 ED paper surveys
- 205 maternity paper surveys

Share Your Experience – Electronic Feedback Platform

In December 2013, a total of 978 electronic surveys were completed via email, touch screen, our Leicester's Hospitals web site or handheld devices.

A total of 183 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	Hand Held	Web		Total Surveys		Emails sent
Carers Survey	0	0	0	0		0		0
Children's Urgent & ED Care	0	22	0	0		22		2
A&E Department	0	87	6	3		96		2
Eye Casualty	0	278	0	0		278		0
Glenfield CDU	0	73	0	0		73		0
Glenfield Radiology	24	0	0	0		24		61
IP and Childrens IP	0	0	0	10		10		0
Maternity Survey	0	0	348	1		349		1
Neonatal Unit	0	0	0	17		17		1
Outpatient Survey	22	19	50	7		98		116
Windsor Eye Clinic	0	11	0	0		11		0
Total	**46**	**490**	**404**	**38**		**978**		**183**

Treated with Respect and Dignity

Mth	Qtr 1	Qtr2	Qtr3	YTD

The Trust has maintained a GREEN rating for the question 'Overall do you think you were you treated with dignity and respect while in hospital' based on the scoring methodology used in the national survey.

Friends and Family Test

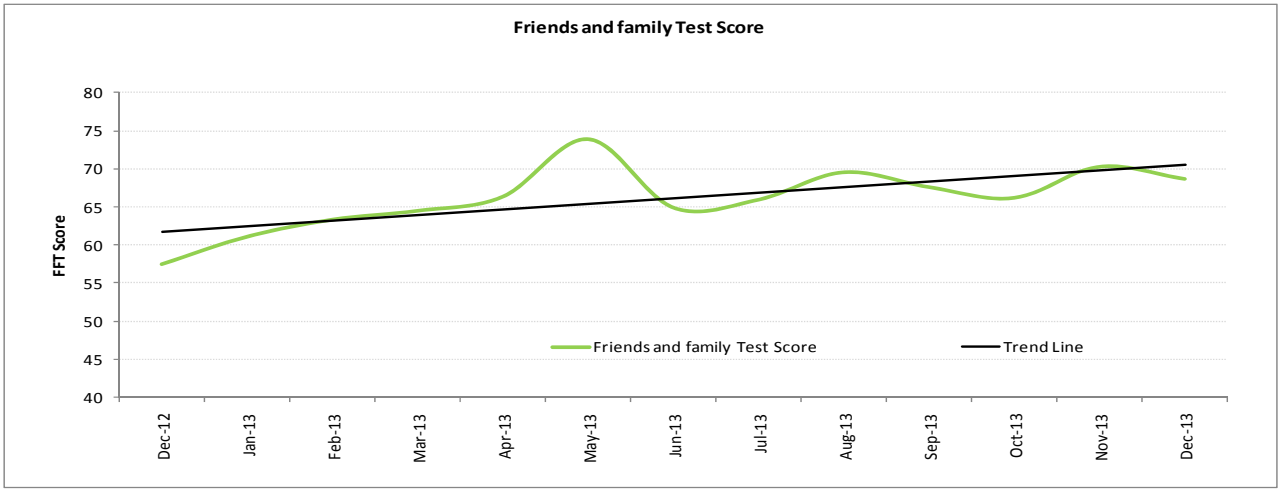
Inpatient

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 December, 1,517 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 6,514 patients in the relevant areas within the month of December 2013. The Trust easily met the 15% target achieving coverage of **23.3%.**

The Friends & Family Test responses broken down to:

Extremely likely:	1,108
Likely:	328
Neither likely nor unlikely:	52
Unlikely	12
Extremely unlikely	8
Don't know:	9
Overall Friends & Family Test Score	**68.7**



November 2013 Data Published Nationally

NHS England has begun publishing all trust's Friends and Family Test scores. November data was published at the end of December and the average Friend and Family Test score for England (excluding independent sector providers) was **72**.

With private, single speciality and Trusts that achieved less than a 20% footfall excluded, the UHL Friends and Family Test score of **70** for November ranks the Trust 82nd out of the remaining 129 Trusts.

Friends and Family Test Scores by CMG

Emergency and Specialist Medicine was the only CMG to improve their FFT score this month, and show a rise in the number of promoters.

Renal, Respiratory and Cardiac, and Musculoskeletal and Specialist Surgery, both showed declines in their FFT score compared to November performance. For Renal, Respiratory and Cardiac this was caused by an increase in detractors, whereas Musculoskeletal and Specialist Surgery respondents chose to be 'passive' more frequently this month.

CHUGS also showed a small decline in their FFT score, as respondents switched to being 'passive' rather than 'promoters' in December.

Women's and Children's had fewer responses this month, but their FFT performance in December was consistent with November performance.

The FFT score for the Emergency Department showed a large improvement this month, with their score rising from 59 in November to 67 in December. There was a 7 percentage point improvement in the number of promoters, as respondents moved away from being 'passive' in favour of recommending the service to friends and family in December.

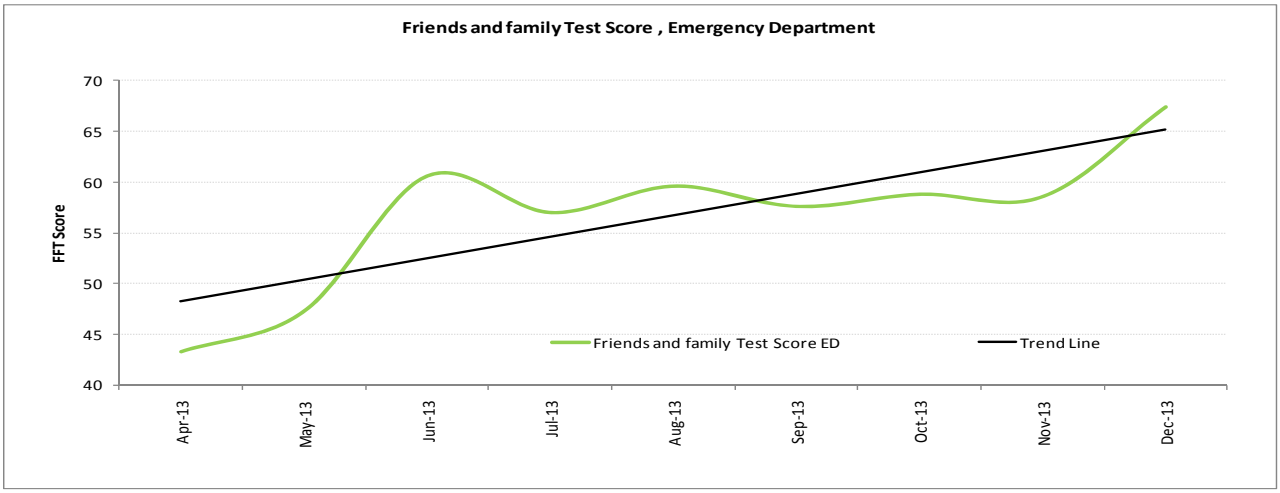
	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Point Change in FFT Score (Nov - Dec 13)
UHL Trust Level Totals	**66.4**	**73.9**	**64.9**	**66.0**	**69.6**	**67.6**	**66.2**	**70.3**	**68.7**	**-1.6**
Renal, Respiratory and Cardiac	70	76	73	80	80	79	70	78	74	-3.9
Emergency and Specialist Medicine	64	72	57	62	63	68	63	68	73	+5.0
CHUGS	59	70	57	53	61	53	58	59	56	-2.5
Musculoskeletal and Specialist Surgery	72	75	73	66	68	69	69	70	66	-3.7
Women's and Children's	78	80	74	68	76	77	70	76	76	-0.2
Emergency Department	43	47	61	57	60	58	59	59	67	+8.9

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 5,604 patients who were seen in A&E and then discharged home within the month of December 2013. The Trust surveyed 919 eligible patients meeting **16.4%** of the footfall. The Friends & Family test responses break down to:

Extremely likely:	657
Likely:	206
Neither likely nor unlikely:	20
Unlikely	12
Extremely unlikely	13
Don't know:	11
Overall Friends & Family Test Score	**67.4**



Breakdown by department	No. of responses	FFT Score	Total no. of patients eligible to respond
Emergency Dept Majors	182	63.5	1379
Emergency Dept Minors	316	69.0	2264
Emergency Dept – not stated	62	68.9	
Emergency Decisions Unit	95	65.2	791
Eye Casualty	264	68.6	1170

November 2013 Data Published Nationally

NHS England also published all trust's A&E Friends & Family Test scores. November data was published at the end of December and the average Friends and Family Test score for A&E in England was **56** including data from 143 Trusts.

If we filter out the Trusts that achieved less than 20% footfall, then we are left with 36 Trusts. However our UHL score of **59** does not feature among these as the 20% footfall was not achieved.

Maternity Services

December was the third month that Maternity Services have reported the Friends and Family Test scores externally. 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 3,168 patients in total who were eligible within the month of December 2013. The Trust surveyed 787 eligible patients meeting **24.8%** of the footfall. The Friends & Family test responses break down to:

Extremely likely:	524
Likely:	227
Neither likely nor unlikely:	20
Unlikely	6
Extremely unlikely	2
Don't know:	8

Overall Maternity Friends & Family Test Score 63.7

Breakdown by maternity journey stage	No. of responses	FFT Score	Total no. of patients eligible to respond
Antenatal following 36 week appointment	145	60.6	853
Labour Ward/Birthing centre following delivery	290	65.6	808
Postnatal Ward at discharge	245	62.8	605
Postnatal community – 10 days after birth	107	64.5	902

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

5.3 Nurse to Bed Ratios

Nurse to Bed Ratio by ward for December are reported in Appendix 2. This is based on a 60% qualified and 40% unqualified skill mix split, with 1 x Band 7 and 2 x Band 6s in the funded establishment:

- General base ward range = 1.1-1.3 WTE
- Specialist ward range = 1.4-1.6 WTE
- HDU area range = 3.0-4.0 WTE
- ITU areas = 5.5-6.0 WTE

5.4 Real Time Staffing

The Trust now has a system in place for monitoring staffing levels on a shift by shift basis. The system captures variance from plan plus a safety statement regarding how gaps are risk rated and being managed.

In December (NB system not fully embedded), there were an average 30 shifts per week left with unmanaged staffing levels i.e. the CMG had exhausted all possible options and therefore resorted to re-prioritising ward work and seeking corporate assistance.

For the same time period, approximately 20 shifts per week were overstaffed.

200 shifts per week on average required wider CMG intervention to make wards safe.

We are continuing to refine the use of this tool, especially around the 'unmanaged' shifts and our corporate response in these situations.

5.5 Ward Performance and Ward Alerting Concerns

The dashboard (Appendix 3) represents November data. We are unable currently to make this more current. Wards that previously alerted as concern areas:

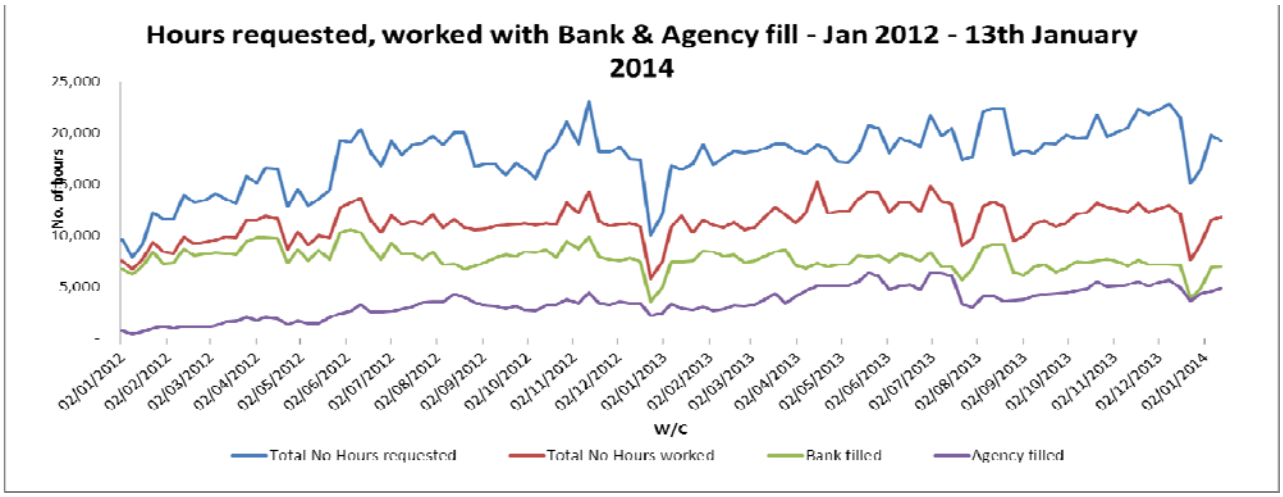
Ward 19 – December data suggests the ward is improving following some targeted support and the implementation of key actions. Substantively appointed staff is essential for improvement to sustain.

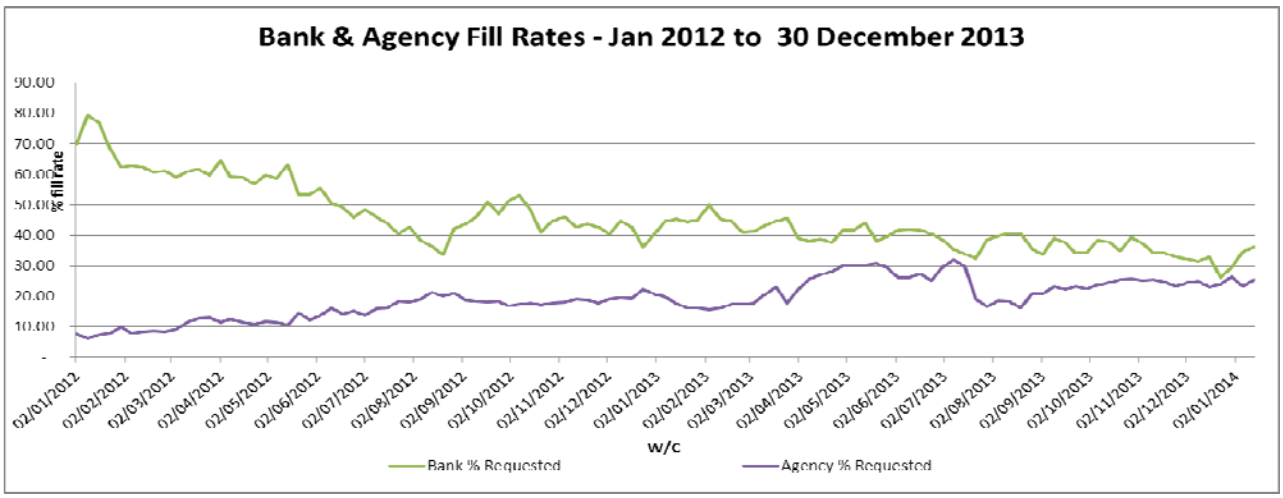
Wards 29, 30 and 41 – Review of each of these wards showed that the CMG should continue with their own targeted support. The appointment of substantive staff will provide the sustained improvement required.

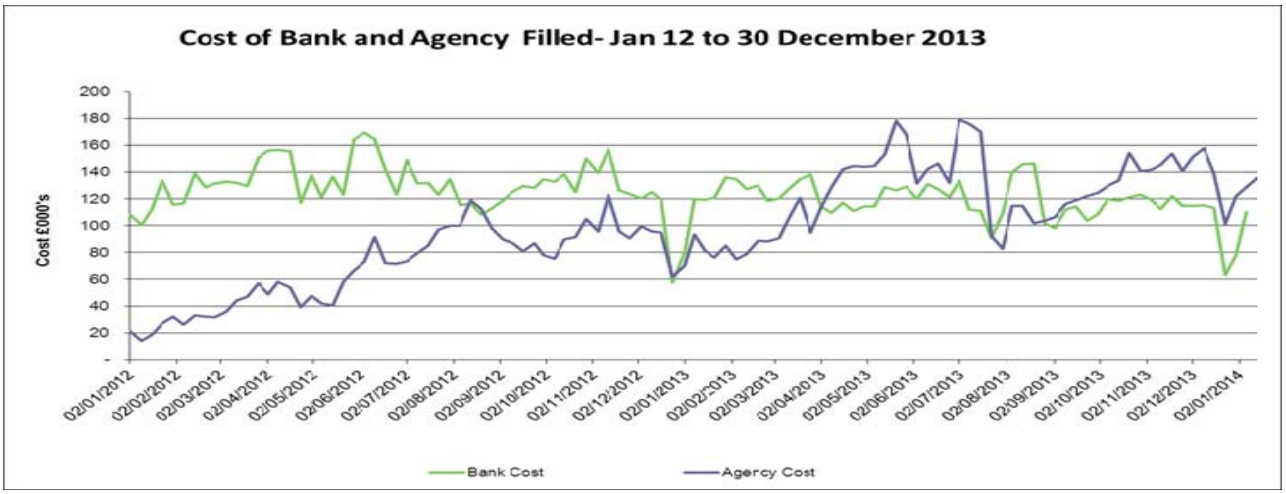
Wards 26 and 28 at Leicester General Hospital are for discussion at Nursing Executive Team on 23 January 2014 as are beginning to flag. Other wards that have adverse indicators have been considered and currently we are not concerned.

5.6 Bank and Agency

Bank and agency information is shown in the following graphs.



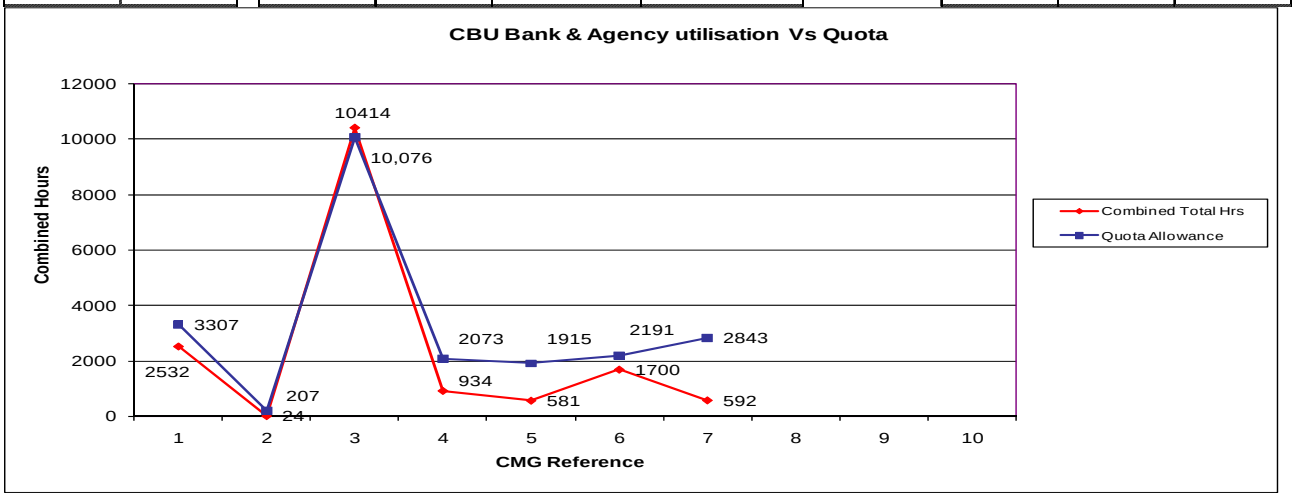




COMPARISON OF BANK AND AGENCY ACTUAL USAGE *versus* QUOTA ALLOWANCE

FOR PERIOD w/c - 13th January 2014

CBU	Ref Nr for Graph	Bank Staff	Agency Total	Total All	Quota Allowance	(For Back Up Reference) Agency Staff	Factor x Nr	Agency Total
CHUGS	1	1748	784	2532	3307	392	2	784
CSI	2	24	0	24	207	0	2	0
EM&SM	3	2822	7592	10414	10,076	3796	2	7592
ITAPS	4	168	766	934	2073	383	2	766
MS &SS	5	455	126	581	1915	63	2	126
CRR	6	1574	126	1700	2191	63	2	126
W&C	7	166	426	592	2843	213	2	426



5.7 Same Sex Accommodation

Mth | Qtr 1 | Qtr2 | Qtr3 | YTD

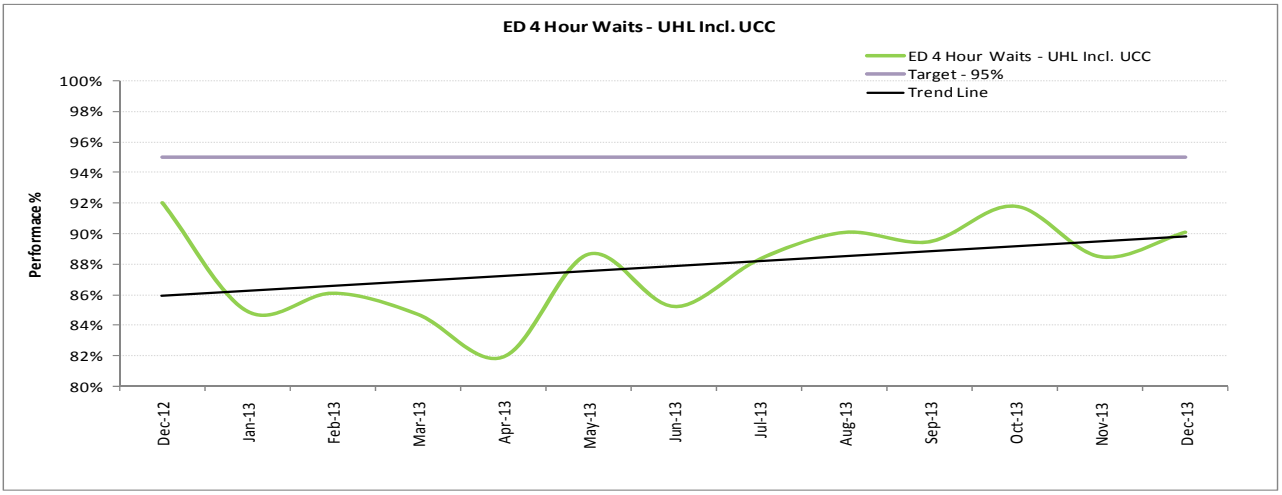
All UHL wards and intensivist areas continue to offer Same Sex Accommodation (SSA) during December in line with the UHL SSA Matrix guidance and delivered 100%.

6.0 OPERATIONAL PERFORMANCE – RICHARD MITCHELL

Performance Indicator	Target	2012/13	Q2	Oct-12	Nov-12	Dec-12	Q3	Jan-13	Feb-13	Mar-13	Q4	Apr-13	May-13	Jun-13	Q1 2013	Jul-13	Aug-13	Sep-13	Q2 2013	Oct-13	Nov-13	Dec-13	Q3 2013	YTD
A&E - Total Time in A&E (UHL+UCC)	95%	91.9%	97.0%	94.2%	92.0%	92.0%	92.7%	84.9%	86.1%	84.7%	85.2%	82.0%	88.7%	85.3%	85.3%	88.3%	90.1%	89.5%	89.3%	91.8%	88.5%	90.1%	90.2%	88.2%
RTT waiting times - admitted	90%	91.3%		91.2%	91.7%	91.9%		92.2%	91.9%	91.3%		88.2%	91.3%	85.6%	88.4%	89.1%	85.7%	81.8%	85.6%	83.5%	83.2%	82.0%		
RTT waiting times - non-admitted	95%	97.0%		97.1%	96.7%	97.3%		97.3%	97.0%	97.0%		97.0%	95.9%	96.0%	96.3%	96.4%	95.5%	92.0%	94.6%	92.8%	91.9%	92.8%		
RTT - incomplete 92% in 18 weeks	92%	92.6%		94.6%	93.9%	93.3%		93.4%	93.5%	93.6%		92.9%	93.4%	93.8%	93.8%	93.1%	92.9%	93.8%	93.8%	92.8%	92.4%	91.8%		
RTT - 52+ week waits	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	1
Diagnostic Test Waiting Times	<1%	0.5%		0.4%	0.6%	1.1%		0.7%	1.0%	0.5%		1.6%	0.8%	0.6%		0.6%	0.8%	0.7%		1.0%	0.8%	1.4%		
Cancelled operations re-booked within 28 days	100%	92.9%	93.6%	91.0%	97.3%	89.0%	93.1%	97.1%	92.3%	94.2%	94.6%	90.4%	91.0%	86.4%	89.8%	99.1%	96.0%	98.6%	98.0%	94.2%	97.7%	94.3%	95.3%	95.2%
Cancelled operations on the day (%)	0.8%	1.2%	0.8%	1.1%	1.6%	1.2%	1.3%	1.6%	1.6%	1.6%	1.6%	1.5%	1.5%	1.0%	1.3%	1.2%	1.4%	2.3%	1.6%	1.7%	1.8%	1.7%	1.8%	1.7%
Cancelled operations on the day (vol)		1247	202	100	149	91	340	137	130	137	404	125	135	81	341	117	124	212	453	171	172	141	343	1137
Urgent operation being cancelled for the second time	0	1	0	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2 week wait - all cancers	93%	93.4%	94.1%	93.0%	90.6%	95.1%	92.8%	89.8%	95.9%	95.2%	93.7%	93.0%	95.2%	94.8%	94.4%	94.2%	94.6%	93.0%	94.0%	94.9%	95.7%			94.4%
2 week wait - for symptomatic breast patients	93%	94.5%	95.3%	93.4%	93.9%	94.6%	93.9%	93.6%	93.1%	95.4%	94.0%	94.0%	94.8%	93.2%	94.1%	93.6%	92.0%	95.2%	93.8%	93.0%	91.3%			93.5%
31-day for first treatment	96%	97.4%	98.3%	98.3%	97.5%	97.4%	97.8%	96.6%	97.6%	98.8%	97.6%	97.5%	97.0%	99.0%	97.8%	98.3%	99.7%	99.1%	99.0%	98.9%	96.2%			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%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%			100.0%
31-day wait for subsequent treatment - surgery	94%	95.8%	96.6%	98.1%	97.4%	94.6%	97.1%	94.6%	94.1%	93.7%	94.0%	97.2%	94.4%	97.5%	96.4%	100.0%	98.4%	88.6%	95.9%	96.4%	97.1%			96.3%
31-day wait subsequent treatment - radiotherapy	94%	98.5%	98.8%	99.3%	98.9%	100.0%	99.4%	99.1%	98.9%	99.1%	99.0%	100.0%	97.8%	99.1%	98.8%	100.0%	100.0%	97.7%	99.4%	97.5%	98.5%			98.8%
62-day wait for treatment	85%	83.5%	86.5%	85.6%	85.8%	84.6%	85.3%	79.5%	75.4%	81.5%	78.8%	80.9%	80.3%	85.9%	82.3%	85.8%	88.2%	87.4%	87.1%	86.4%	85.7%			85.0%
62-day wait for screening	90%	94.5%	94.6%	96.8%	98.7%	92.3%	96.3%	91.7%	95.7%	95.8%	94.4%	98.6%	94.3%	95.0%	95.9%	90.6%	97.2%	96.2%	94.1%	100.0%	97.0%			96.0%
Stroke - 90% of Stay on a Stroke Unit	80%	79.8%	82.2%	83.7%	79.5%	71.3%	77.9%	77.8%	81.4%	82.3%	80.6%	77.4%	80.7%	78.7%	78.5%	87.1%	88.6%	89.1%	88.3%	83.5%	78.0%			82.5%
Stroke - TIA Clinic within 24 Hours (Suspected TIA)	60%	68.4%	63.9%	68.7%	72.5%	68.7%	70.0%	60.8%	85.1%	77.0%	73.1%	51.1%	69.2%	72.0%	63.9%	60.5%	73.6%	64.6%	66.0%	62.4%	76.8%	65.7%	68.4%	66.0%
Choose and Book Slot Unavailability	4%			10%	13%	8%		5%	10%	9%		7%	9%	13%		15%	14%	11%		16%	17%	13%		
Delayed transfers of care	3.5%	3.1%	3.4%	3.4%	3.6%	2.7%	3.3%	2.8%	2.7%	3.7%	3.0%	3.7%	3.9%	3.1%	3.6%	3.6%	3.1%	3.9%	3.5%	3.1%	4.6%	2.8%	3.5%	3.5%

6.1 Emergency Care 4hr Wait Performance

Mth | Qtr 1 | Qtr2 | Qtr3 | YTD



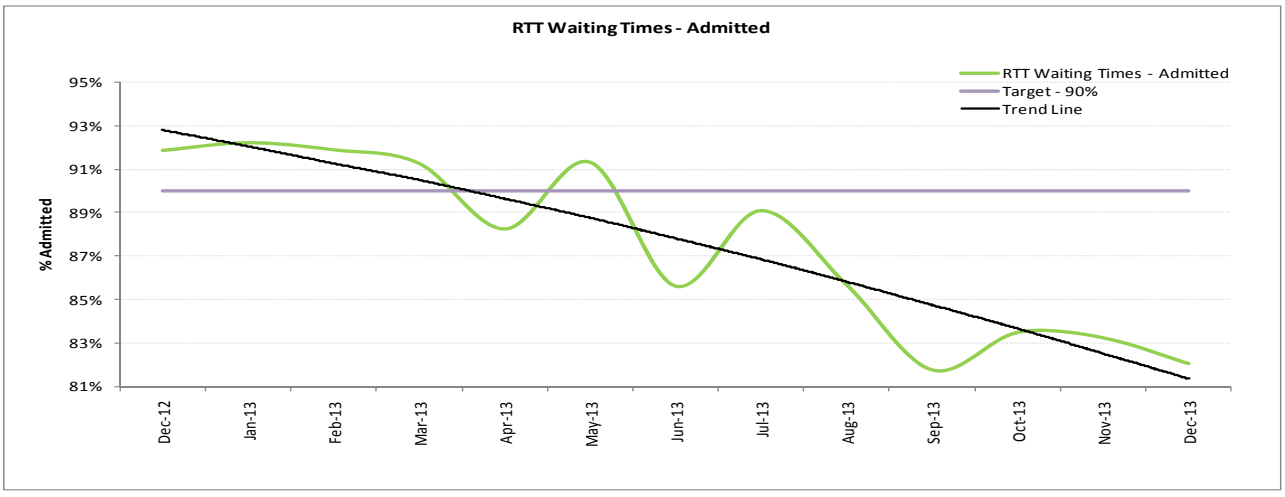
Performance for emergency care 4hr wait in December was 90.1%. Actions relating to the emergency care performance are included in the ED exception report.

UHL was ranked 107 out of 144 Trusts with Type 1 Emergency Departments in England for the four weeks up to 1st December 2013. Over the same period 62 out of 144 Acute Trusts delivered the 95% target. For the week ending the 12th January the Trust was ranked 55 out of 144.

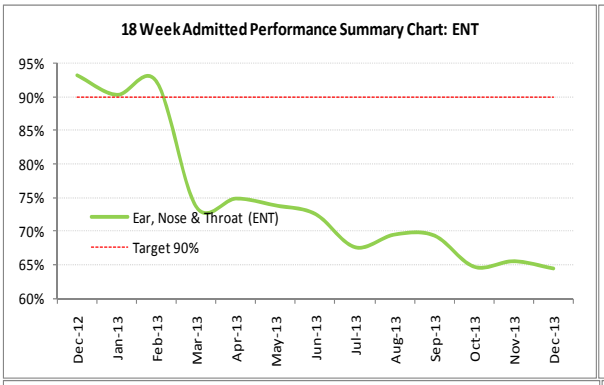
6.2 RTT – 18 week performance

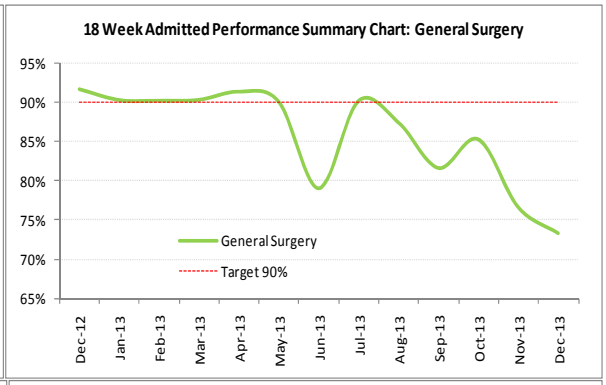
a) RTT Admitted performance

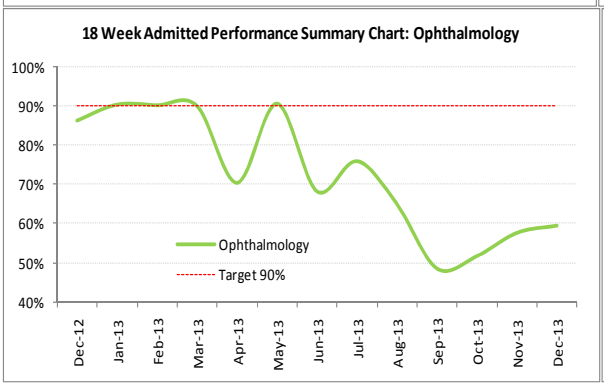
Mth | Qtr 1 | Qtr2 | Qtr3 | YTD

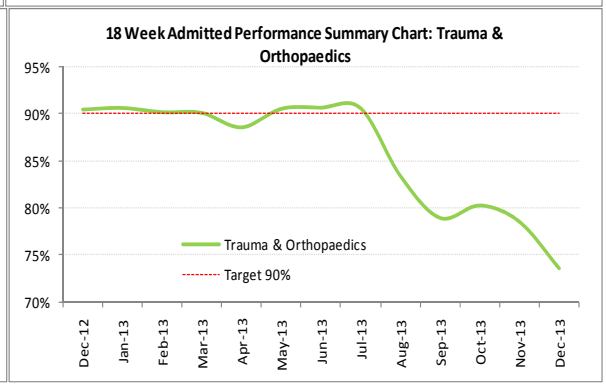


RTT admitted performance for December was 82.0% with significant speciality level failures in ENT, General Surgery, Ophthalmology and Orthopaedics. Further details are included in the RTT 18 week exception report – Appendix 4.

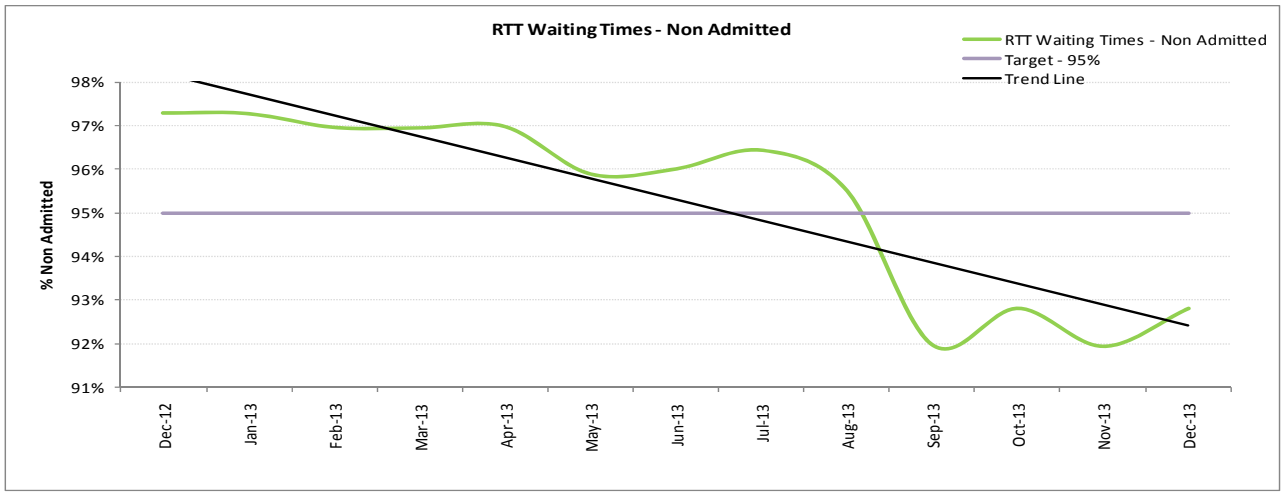




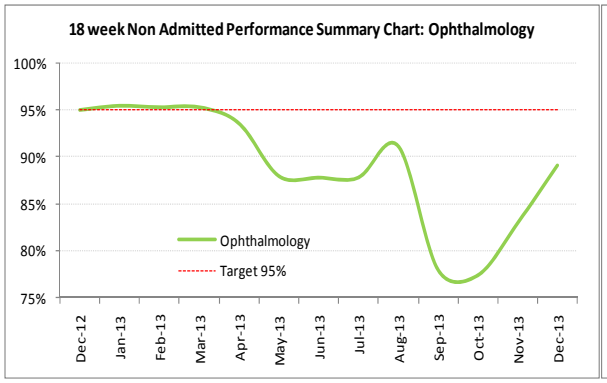


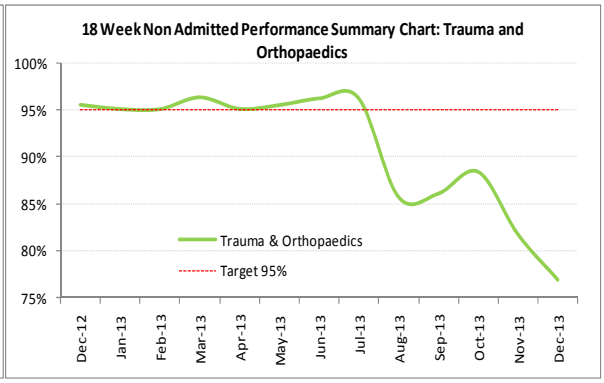


b) RTT Non Admitted performance



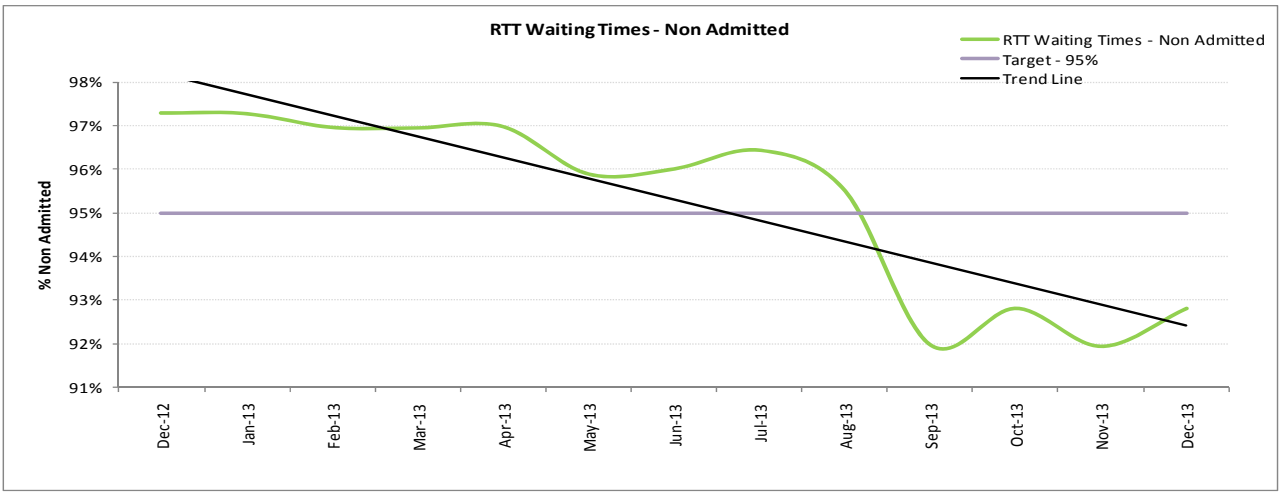
Non-admitted performance during December was 92.8%, with the significant specialty level failures in Orthopaedics and Ophthalmology. Further details are included in the RTT 18 week exception report – Appendix 4.





c) RTT Incomplete Pathways

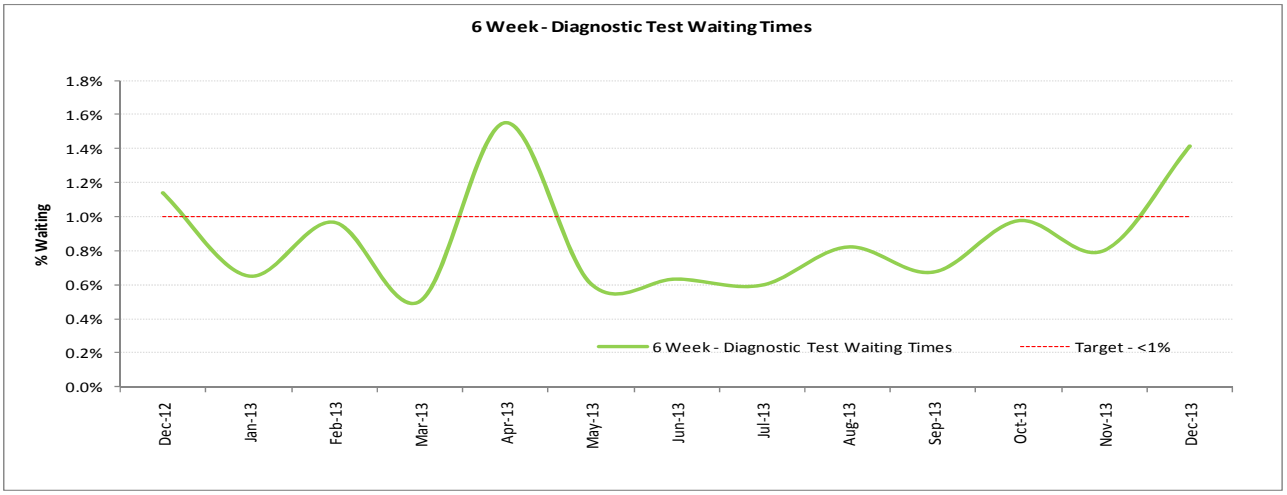
Mth | Qtr 1 | Qtr2 | Qtr3 | YTD



RTT incomplete (i.e. 18+ week backlog) performance was 91.8% against a target of 92.0%. In numerical terms the total number of patients waiting 18+ weeks for treatment (admitted and non-admitted) at the end of December was 3,290.

6.3 Diagnostic Waiting Times

Mth | Qtr 1 | Qtr2 | Qtr3 | YTD



At the end of December 1.4% of patients were waiting for diagnostic tests longer than 6 weeks. Further details are included in the diagnostic exception report – Appendix 5.

National performance for November shows that 0.8% of patients were waiting for diagnostic tests longer than 6 weeks.

6.4 Cancer Targets

a) Two Week Wait

Mth | Qtr 1 | Qtr2 | Qtr3 | YTD

November performance for the 2 week to be seen for an urgent GP referral for suspected cancer was achieved at 95.7% (national performance 95.5%).

Mth | Qtr 1 | Qtr2 | Qtr3 | YTD

Performance for the 2 week symptomatic breast patients (cancer not initially suspected) was not achieved at 91.3% (national performance 94.9%), predominantly due to patient choice.

Performance for December has improved and both these indicators will be delivered.

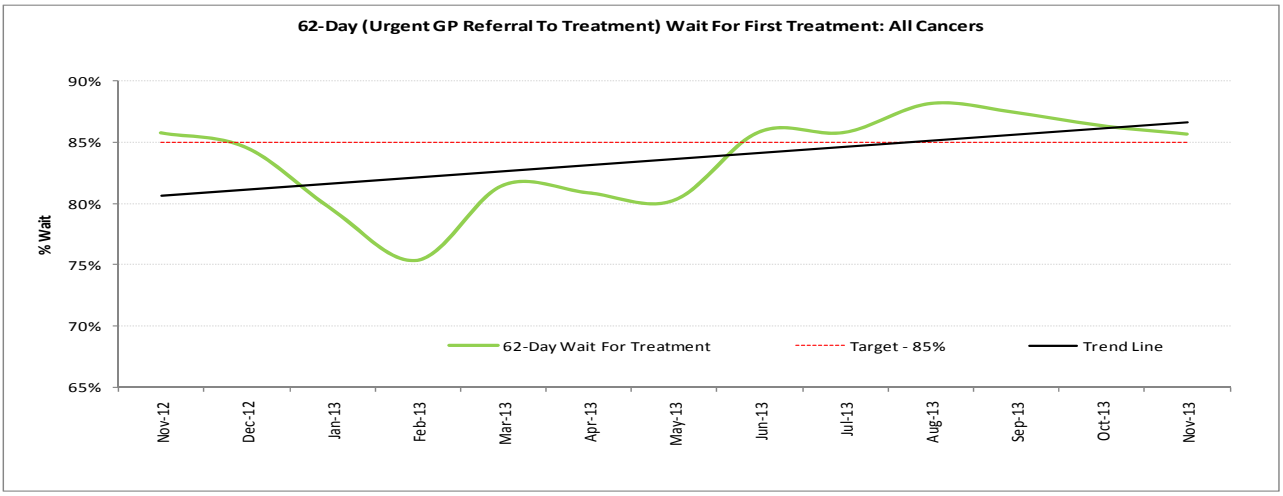
b) 31 Day Target

Mth | Qtr 1 | Qtr2 | Qtr3 | YTD

Al four of the 31 day cancer targets have been achieved in November (latest reported month).

c) 62 Day Target

Mth | Qtr 1 | Qtr2 | Qtr3 | YTD



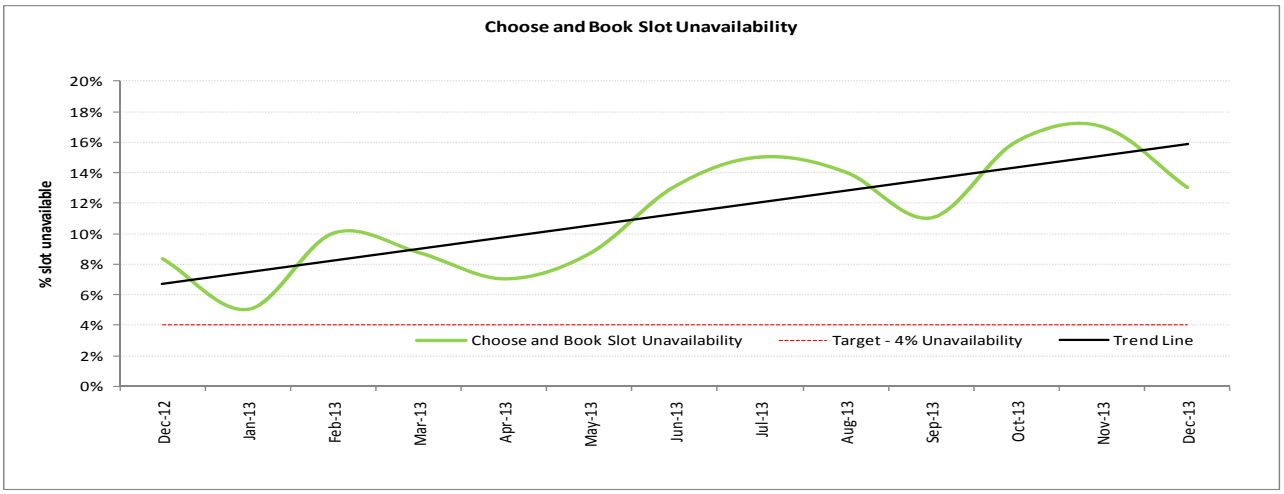
The 62 day urgent referral to treatment cancer performance in November was 85.7% (national performance close to 85%) against a target of 85%. The year to date position is now also being delivered at 85.0%.

The Cancer Action Board continues to meet weekly, it is responsible for monitoring the Trusts Cancer Action Plan to ensure that actions are being delivered and there is representation from all the key tumour sites including Radiology and theatres. This meeting is chaired by the Cancer Centre Clinical Lead.

The key points to note this month are:-

- Performance for December is on track to deliver trajectory
- 62 day backlog is 24 (threshold is 30)
- There are 3 patients waiting 100+ days 2 in Urology one Skin– one patient was a late referral from another Trust, one was cancelled due to ill health, but has since been dated for treatment. The third patient has only recently decided on their treatment plan.

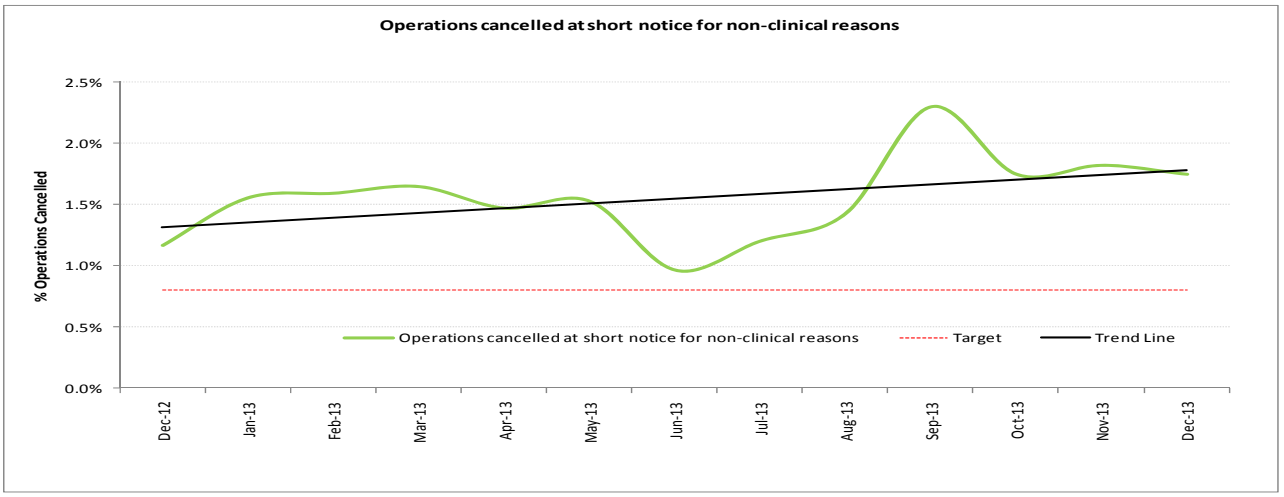
6.5 Choose and Book slot availability



Choose and book slot availability performance for December is 13% with the national average at 9%. Resolution of slot unavailability requires a reduction in waiting times for 1st outpatient appointments in key specialties and prospectively. For ENT and Orthopaedics, this will form part of the 18 week remedial action plan. Neurology is in the process of recruiting additional Clinical staff to increase capacity.

6.6 Short Notice Cancelled Operations

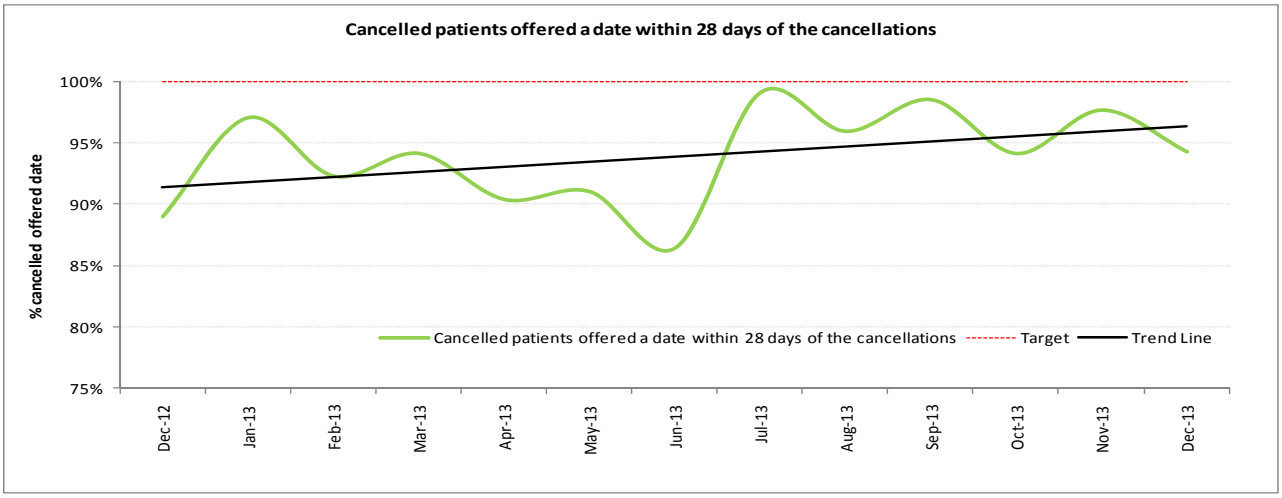
Mth | Qtr 1 | Qtr2 | Qtr3 | YTD



The percentage of operations cancelled on/after the day activity for non-clinical reasons during December is 1.7% against a target of 0.8%. The year to date performance is 1.7%. Further details can be found in the cancelled operations exception report – Appendix 6.

Cancelled patients offered a date within 28 days

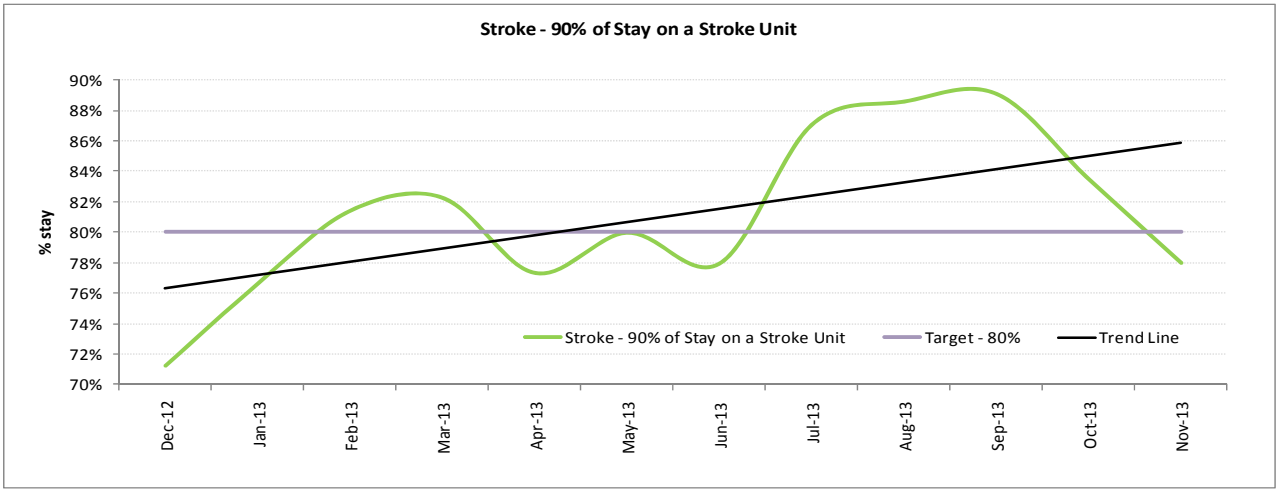
Mth | Qtr 1 | Qtr2 | Qtr3 | YTD



The threshold has been amended from 95% to 100% to reflect that every breach of this standard is subject to a financial penalty. The number of patients breaching this standard in December was 8 with 94.3% offered a date within 28 days of the cancellation.

6.7 Stroke % stay on stroke ward

Mth | Qtr 1 | Qtr2 | Qtr3 | YTD

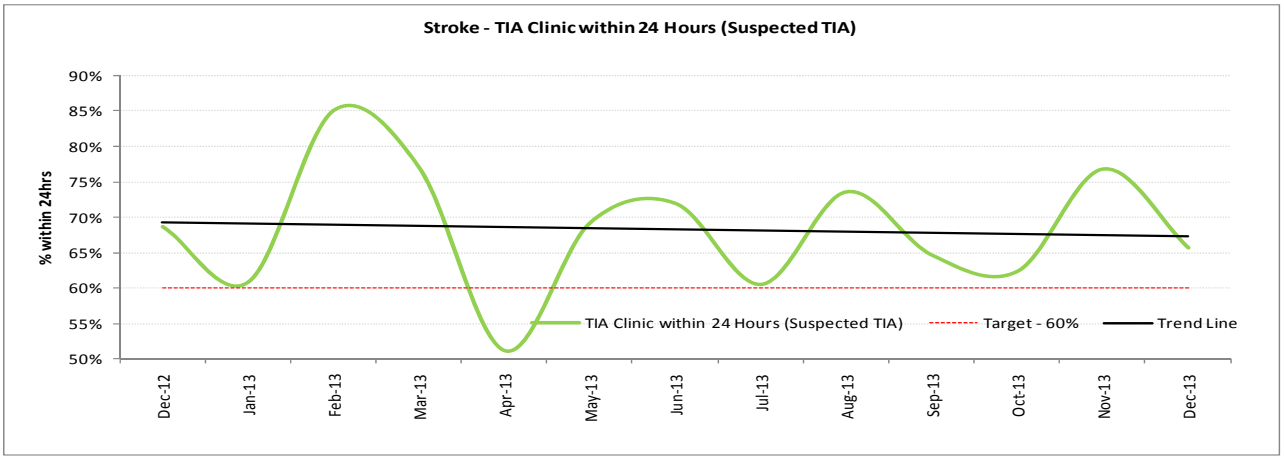


The percentage of stoke patients spending 90% of their stay on a stroke ward in November (reported one month in arrears) is 78% against a target of 80%. The year to date position is 82.5%.

Commissioners have confirmed that due to the improved performance for stroke patients, the Contract Query has been formally closed.

6.8 Stroke TIA

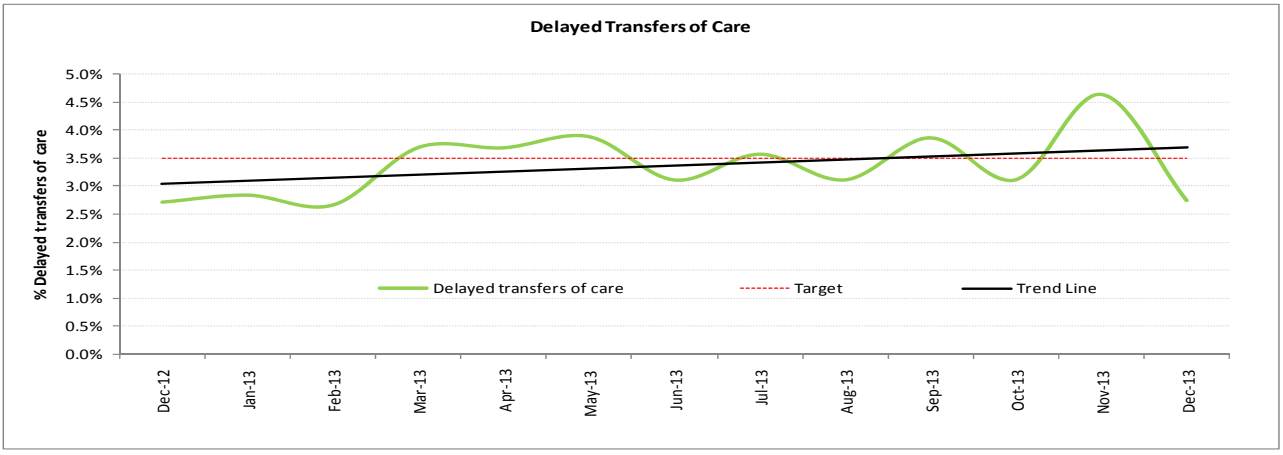
Mth | Qtr 1 | Qtr2 | Qtr3 | YTD



The percentage of high risk suspected TIAs receiving relevant investigations and treatment within 24 hours of referral receipt is 65.7% against a national target of 60.0%. The year to date performance is 66.0%.

6.9 Delayed Transfers of Care

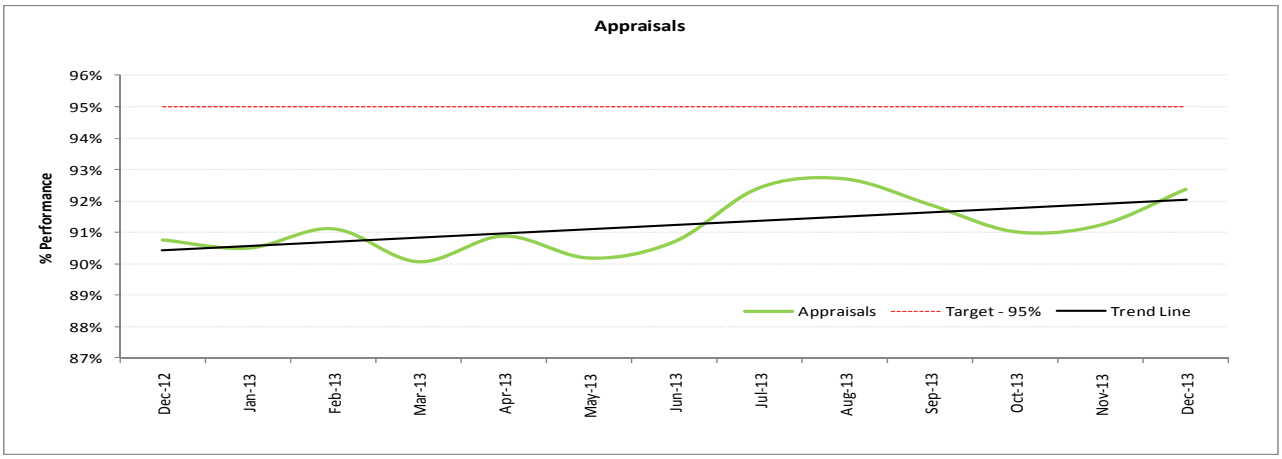
The December delayed transfer of care position was 2.8% with a year to date position of 3.5% against a threshold of 3.5%. A work stream of the HUB work plan is focussing on reducing DTOCs.



7.0 HUMAN RESOURCES – KATE BRADLEY

7.1 Appraisal

Mth | Qtr 1 | Qtr2 | Qtr3 | YTD

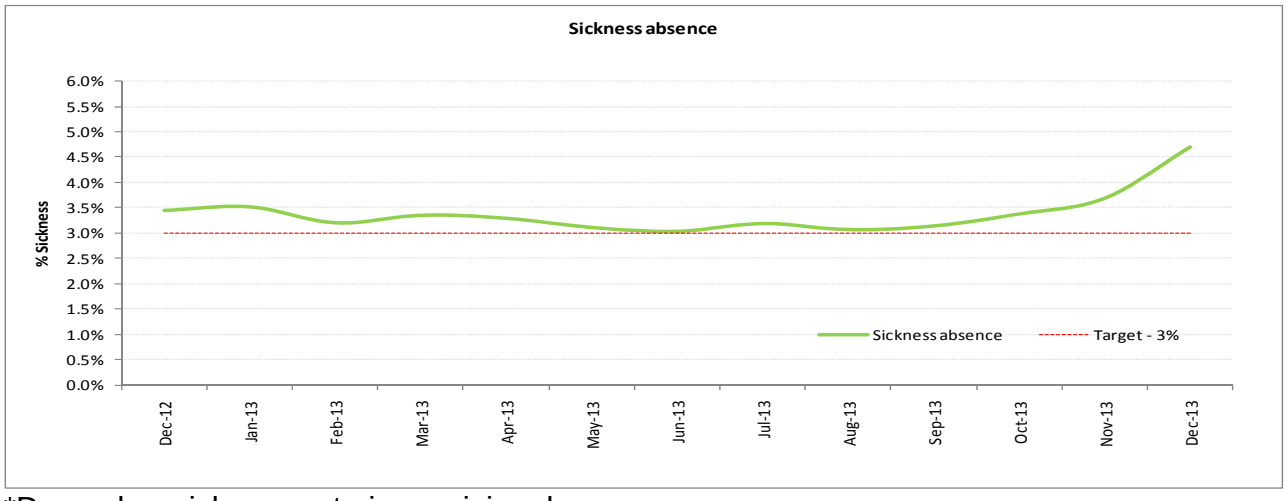


There continues to be considerable appraisal activity over the last month, between November and December the Appraisal rate has increased to 92.4% at the end of December. There are increasing numbers of Clinical and Corporate areas meeting the 95% target

Appraisal performance continues to feature on CMG Board Meetings in monitoring the implementation of agreed actions. HR CMG Leads continue to work closely with CMGs to implement targeted 'recovery plans'.

7.2 Sickness

Mth | Qtr 1 | Qtr2 | Qtr3 | YTD



*December sickness rate is provisional.

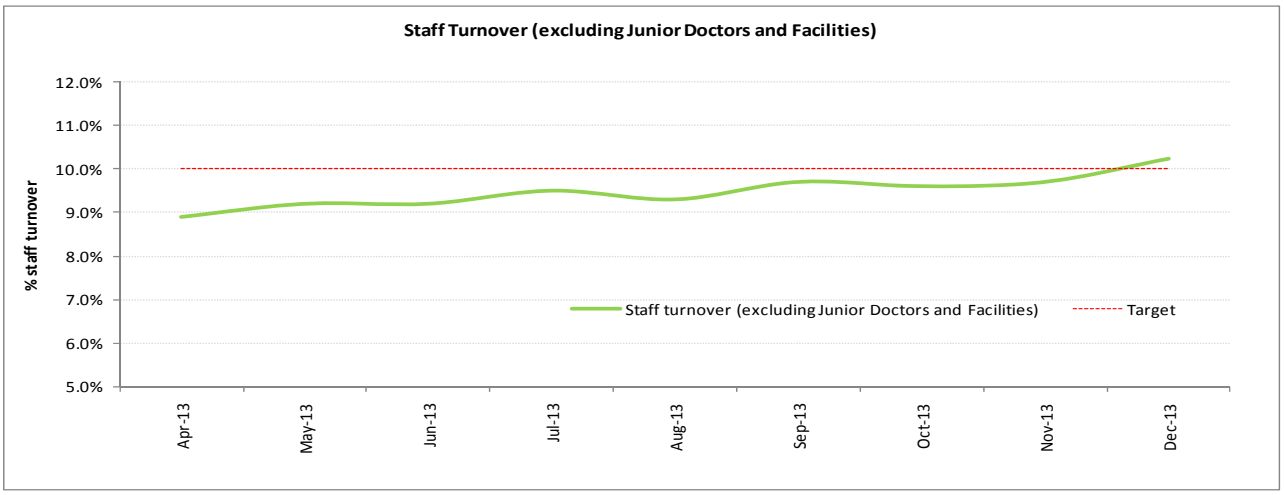
The sickness rate for December is 4.7% and the November figure has now adjusted to 3.7% to reflect closure of absences. The overall cumulative sickness figure is now 3.4% which is an increase of 0.1% on last month. This is equal to the previous SHA's target of 3.4% but slightly above the Trust stretch target of 3%. As a result of Christmas and New Year annual leave, the impact of closure of late absences in December is likely to be greater than the 0.5% adjustment in previous months.

We continue to provide training in a range of areas including emotional resilience, self-care at work, sickness absence management and 20 exercise classes as part of staff well being. In recognition of the demand, and positive health and wellbeing benefits, emotional

resilience workshops will continue in 2014, and the format of the workshops will be reviewed to meet high levels of demand.

7.3 Staff Turnover

Mth | Qtr 1 | Qtr2 | Qtr3 | YTD



The cumulative Trust turnover figure (excluding junior doctors and facilities staff who have Tupe'd from the Trust) has increased slightly from 9.7% to 10.2%. 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

Mth | Qtr 1 | Qtr2 | Qtr3 | YTD

As a Trust we are now report against nine core subjects in relation to Statutory and Mandatory Training. These are Fire Safety Training, Moving & Handling, Hand Hygiene, Equality & Diversity, Information Governance, Safeguarding Children, Conflict Resolution, Safeguarding Adults and Resuscitation (BLS Equivalent).

Division	Fire Training %age	Moving & Handling %age	Hand Hygiene %age	Equality & Diversity %age	Info. Gover'ce %age	Safeguard Children ONLY %age	Conflict Resolution %age	Safeguard Adults ONLY %age	Resus - BLS Equivalent %age	Average %age Compliance
Refresher period Months	**12**	**24**	**12**	**36**	**12**	**36**	**36**	**36**	**12**	
(E = eLearning, F = Face to Face)	**E&F**	**E&F**	**E**	**E**	**E**	**E**	**F**	**E**	**F**	
Acute Care	70%	75%	72%	68%	68%	78%	54%	65%	55%	67%
Planned Care	68%	74%	69%	62%	71%	78%	48%	69%	66%	67%
UHL Corporate Areas	57%	62%	55%	56%	57%	64%	35%	50%	44%	53%
Women's & Children's	73%	75%	69%	61%	63%	89%	43%	39%	75%	65%
Trust wide Compliance	68%	72%	68%	63%	66%	77%	47%	60%	59%	
UHL staff are this compliant with their mandatory & statutory training from the key 9 subjects										65%

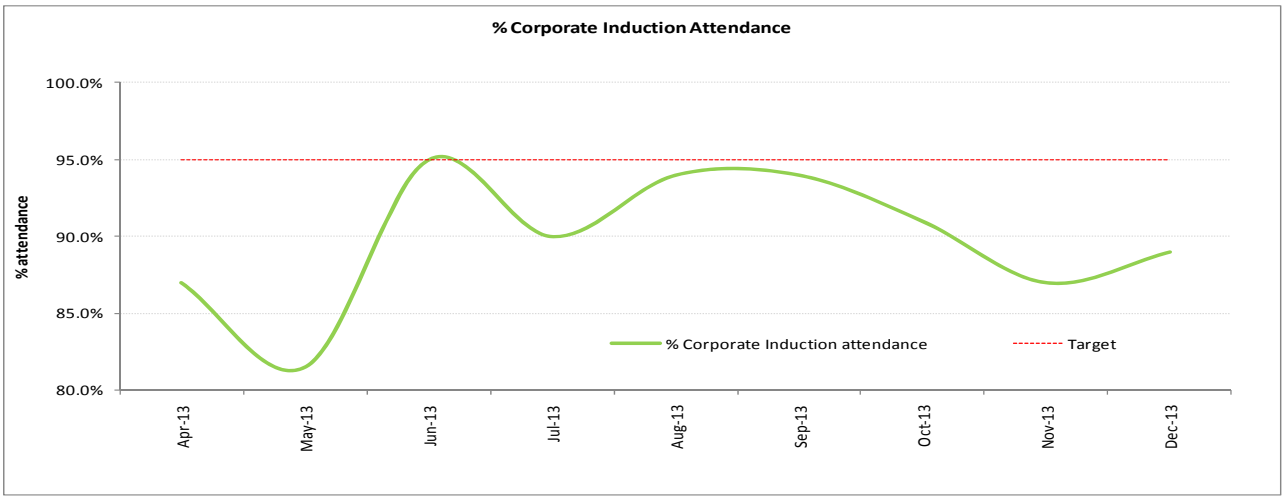
In the period between December 16th and January 8th staff compliance against Statutory and Mandatory Training has increased from 62% to 65% across these nine core areas, despite the seasonal pressures. A plan to restructure eUHL, has been submitted to IM&T to capture performance by Clinical Management Group and Corporate Directorates, this will be completed by the end of January 2014.

There are a total of 7 new eLearning packages live on eUHL, the remaining 3 will be live by the end of Jan 2014, and this slight delay was to avoid any confusion with core staff training requirements in the weeks preceding the CQC visit.

We continue to communicate progress, essential training requirements and follow up on non-compliance at an individual level. This has been supported by the distribution of the 'UHL Mandatory and Statutory Training Guide – Dec 2013', targeted email campaigns to non-compliant individuals, drop in support sessions and Team Builder training sessions. During January the CE Special Feature focused on Statutory and Mandatory Training and was communicated to all staff.

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

7.5 Corporate Induction



Performance has improved marginally at the end of December. The figures continue to reflect numbers booked onto Corporate Induction against actual attendance. The process for following-up non-attendees continues to be implemented at a local level in line with the Induction Policy.

A new weekly Corporate Induction Programme has been devised (to commence on the 1 April 2014) and will be communicated across the organisation over coming weeks. It is expected that where possible, all new starters will attend Corporate Induction on their first day of employment with UHL and all core Statutory and Mandatory Training will be completed within a maximum of four weeks.

Working in collaboration with the Assistant Director of Nursing, a venue is being identified to better support the clinical elements of induction delivery. This venue will be fit for purpose and be beneficial to supporting multi-professional education and training.

8.0 2013/14 CONTRACTUAL QUERY STATUS

Commissioner Notices	Subject	Action/Update	Associated Penalty	Status
Contract Query	Cancer 62 Day	Remedial Action Plan (RAP) has been signed off. Monthly progress reports against the agreed RAP	£50,000 Qtr1 fine has been repaid.	Contract query to be formally closed.
Second Exception report.	ED Performance	Remedial Action Plan & Trajectory Agreed. Due to the failure of meeting the improvement trajectory a Second Exception report has been issued.	2% Overall Contract penalty from August to November Automatic Contract Penalty (non refundable)	Failing to meet improvement trajectory.
Contract Query	18 Wk RTT	The revised RAP to be submitted to the commissioners by the 14th February.	2% overall contract value commencing August. Automatic Individual specialty penalties	On-going
First Exception report for 30+ minute ambulance handover and Second Exception report for 60+minute ambulance handover	Ambulance Handover	Remedial Action Plan has been signed off. Due to the failure of meeting the improvement trajectory a First and Second Exception report has been issued	Automatic Contract Penalty	Failing to meet improvement trajectory.
Contract Query	Pressure Ulcers	RAP has been signed off and revised trajectory agree. CCG's to work with UHL to see a significant sustained improvement.	Revised trajectory and finacial penalties confirmed by CCG's. Automatic penalties applied.	On-going
Contract Query	Short notice cancelled operations and rebooking in 28 days	Revised remedial Action Plan to be submitted by the 31st January.	Automatic Contract Penalty	On-going
Activity Query Notice	Emergency over performance	Emergency analysis provide by commissioners and UHL have responded. Financial agreement has been reached.	Financial agreement has been reached.	Activity query has been formally closed.

9.0 UHL - FACILITIES MANAGEMENT– RACHEL OVERFIELD

9.1 Introduction

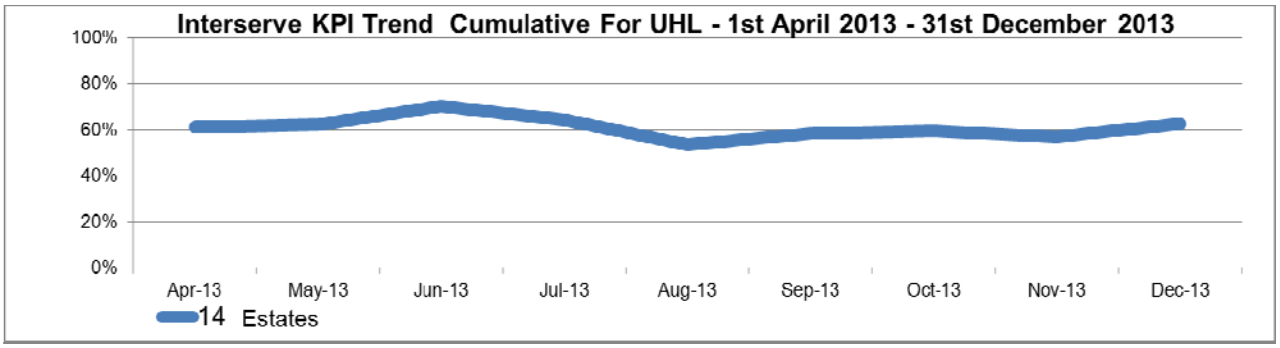
This report covers a review of overall performance on the Facilities Management (FM) delivery provided by Interserve FM (IFM) and contract managed by NHS Horizons up to month 10 of the contract.

The FM contract supplying 14 different services to the Trust is underpinned by 83 Key Performance Indicators (KPI's) and the summary information and trend analysis below is a snapshot of 6 key Indicators over the past nine months.

9.2 Key Performance Indicators

KPI 14 – Estates

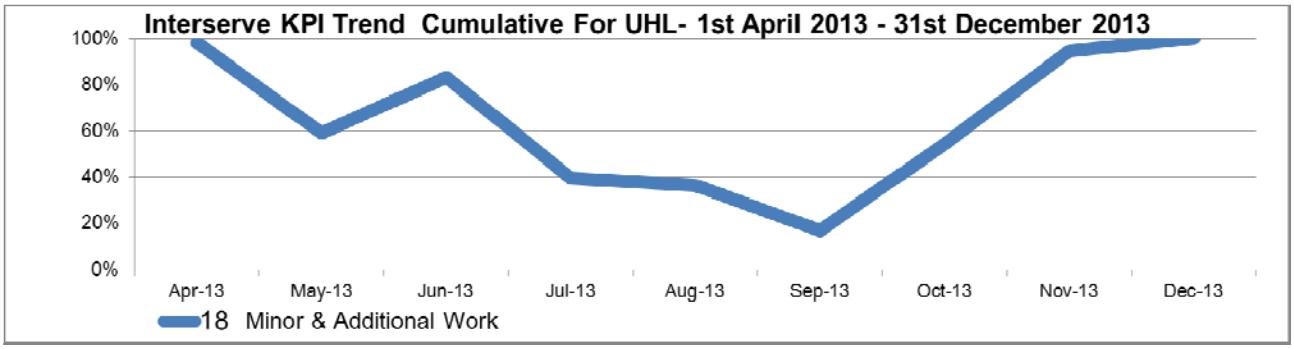
Percentage of routine requests achieving response time



KPI 14 This service measures the response by estates for routine requests and continues to have an inconsistent level of performance. This is in part due initially to reduced resources and limited electronic works management support. With regard resources recent recruitment initiatives are reported to have been successful and as such the service has moved to 24hr 7 day shift coverage on all 3 sites with effect from December.

KPI 18 – Minor & Additional Work

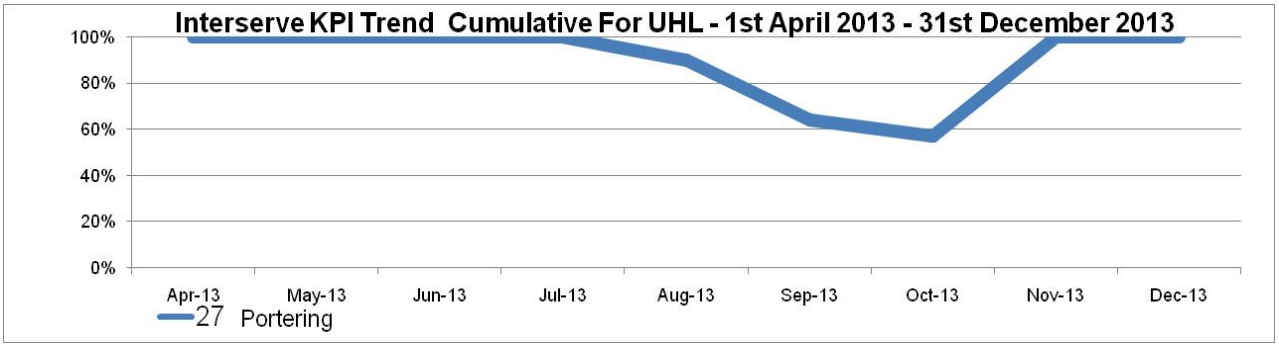
Percentage of Minor works quoted and priced within 10 working days



KPI 18 has now reached 100% with the introduction of new dedicated management of the service and new processes being implemented to ensure work is quoted and priced within the 10 day SLA. Interserve Construction are now carrying out approved requests within acceptable timescale. Additional UHL protocols have also been introduced to reduce the numbers of abortive requests.

KPI 27 – Portering

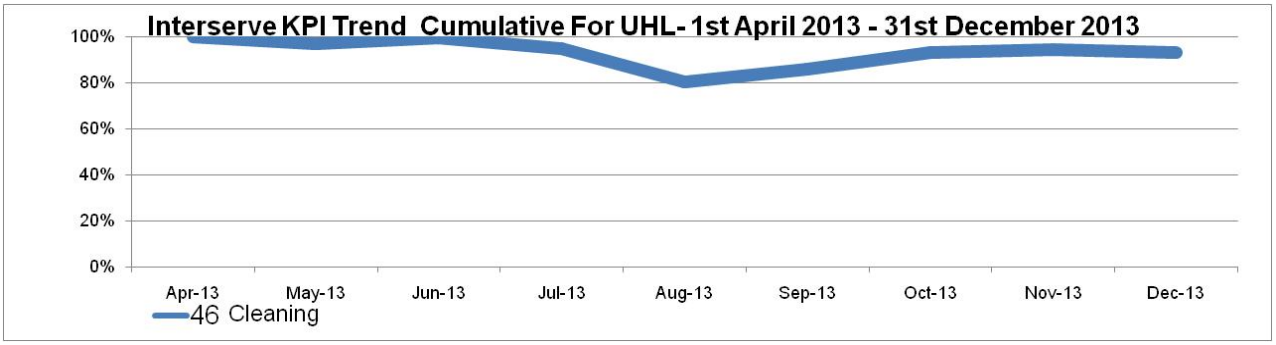
Percentage of emergency portering tasks achieving response time



KPI 27 has seen improvements to 100% for November and December with all recorded emergency portering requests achieving the required response time.

KPI 46 – Cleaning

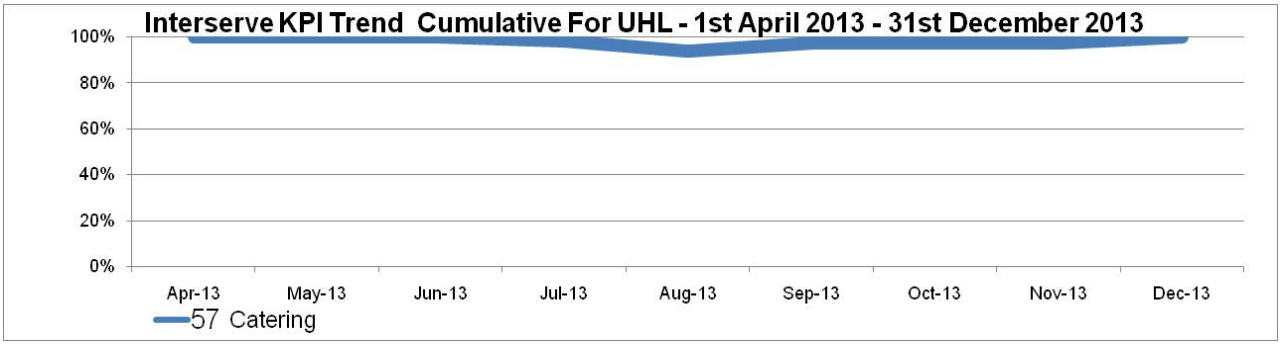
Percentage of audits in clinical areas achieving National Specification for cleaning audit scores for cleaning above 90%



KPI 46 has shown consistent performance over the last few months with December's percentage at 93% with a levelling off of performance over the past two months. Additional resources have been employed to support the improvement plans for this service.

KPI 57 – Catering

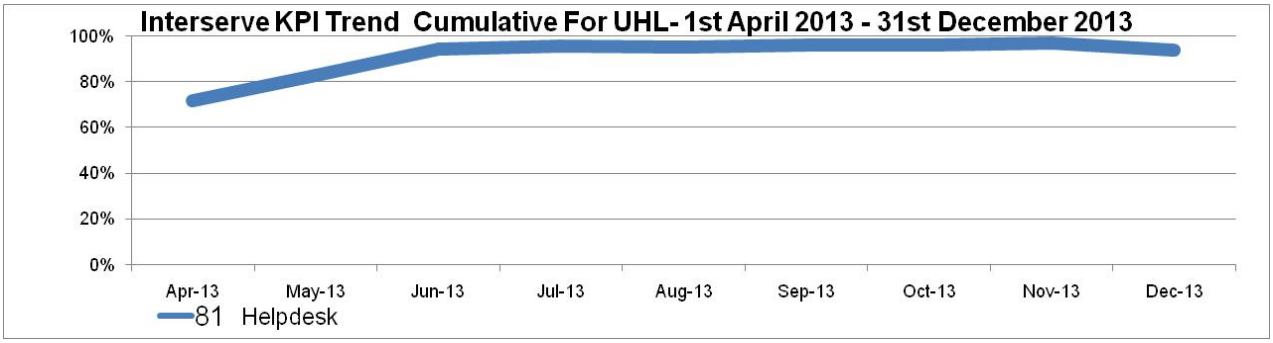
Percentage of meals delivered to wards in time for the designated meal service as per agreed schedules



KPI 57 now shows improved performance across the Trust, however whilst it is recognised that there a significant number of meals served to each ward over the month, there has continued to be reported on-going late deliveries particularly focussed at the LRI.

KPI 81 –Helpdesk

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



KPI 81 started at a low percentage due to the change in how helpdesk calls across the services were handled at the start of the contract. Over recent months performance has improved supported by further staff recruitment and training plus more robust protocols being established and implemented for this service.

9.3 General Summary

December's recorded performance when measured against the 14 services and 83 KPI's shows a consistent levelling out of services with some small improvements in specific areas when compared to previous months. Interserve have confirmed that additional recruitment specifically focussed on cleaning and estates is in progress and should lead to further improvements within those services.

Electronic works and management systems are still yet to be fully established across the UHL and once these are fully operational should lead to improved performance as regards response and rectification times.

10.0 December IM&T Service Delivery Review

10.1 Highlights

Successful go live for the Philips Xcelera solution (replacement for Heartlab)
Pre transition work for the transfer of sexual health services to SSOTP
Successful JAC system server upgrade
No Emergency changes during Festive period IT change freeze

10.2 IT Service Review

There were 6795 (7498 previous month) incidents were logged during December, out of which 4823 (5198 previous month) were resolved. Incidents logged via X8000, email and self-service.

There were 5578 telephone calls to X8000 - 1208 (1558 previous month) incidents were closed on first contact
Performance against service level agreements is as expected and follows the flight path for service level agreements.

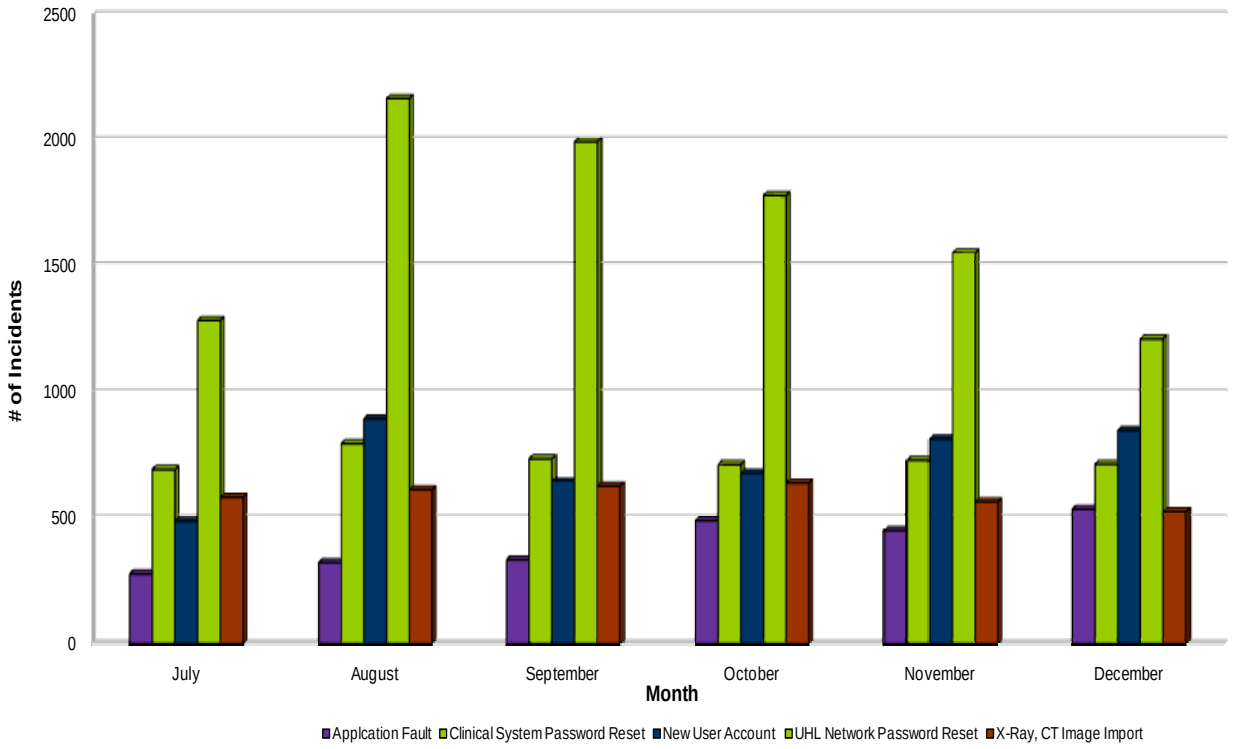
Number of complaints relating to service has dropped to 3 in month (5 in previous month)
There were 636 (635 previous month) incidents logged out of hours via the 24/7 service desk function

10.3 Future Action

Continuation of engagement with CMG's on the future of Programmes and Projects processes and capturing requirements for 2014/2015:-

- ❖ Managed Print service
- ❖ Continue communication session, start training from next week
- ❖ Conclude audit activity at LGH

10.4 IM&T Service Desk top 5 issues



10.5 IM&T December Heatmap

Incidents Closed on first contact	1208	
All Incidents Resolved in October	5507	
Incidents Resolved on Day Logged	2220	
Incidents Escalated / Total Escalations	250	336
Incidents Unresolved / Total Unresolved	92	92

Service Level Agreements

Red : <90% of calls resolved within SLA

Amber : 90-94.99% of calls resolved within SLA

Green : >95% of calls resolved within SLA

Affected System	Incidents	
	Logged	Resolved
CRIS	241	172
EDIS	84	58
Euroking/E3	8	1
HISS/Clinicom	453	493
iLab/Apex	518	526
JAC	20	17
ORMIS	85	79
PACS/IMPAX	231	192
Sunquest ICE	256	289
Total:	**1896**	**1827**

Incidents Outstanding at end of November*	401
New Incidents Logged in December	6795
Incidents Logged & Resolved in December	4823
Outstanding Incidents**	1427

		Priority 1 *4hrs 45mins*		Priority 2 *1 working day*		Priority 3 *2 working days*		Priority 4 *4 working days*		Priority 5 *10 working days*			Totals for This Month *(December)*		Totals for Last Month *(November)*	
Application Management	Calls resolved in SLA (%)	75%		100%		92.19%		96.02%		87.5%			95.81%		97.18%	
	Resolved in SLA/Total Resolved	3	4	2	2	59	64	1665	1734	7	8		1736	1812	1690	1739
Clinical Systems	Calls resolved in SLA (%)	N/A		N/A		N/A		N/A		N/A			N/A		N/A	
	Resolved in SLA/Total Resolved	0	0	0	0	0	0	0	0	0	0		0	0	0	0
Data Centre Service	Calls resolved in SLA (%)	100%		N/A		100%		99.03%		100%			99.13%		96.23%	
	Resolved in SLA/Total Resolved	1	1	0	0	33	33	306	309	3	3		343	346	332	345
Desktop & AMC	Calls resolved in SLA (%)	N/A		N/A		96.38%		96.49%		93.1%			96.39%		95.81%	
	Resolved in SLA/Total Resolved	0	0	0	0	133	138	989	1025	27	29		1149	1192	1302	1359
Imaging	Calls resolved in SLA (%)	100%		N/A		96.11%		94.62%		97.5%			95.24%		89.59%	
	Resolved in SLA/Total Resolved	2	2	0	0	420	437	739	781	39	40		1200	1260	1153	1287
IMT RA Services	Calls resolved in SLA (%)	N/A		N/A		N/A		100%		N/A			100%		100%	
	Resolved in SLA/Total Resolved	0	0	0	0	0	0	1	1	0	0		1	1	3	3
IT Security	Calls resolved in SLA (%)	N/A		N/A		N/A		100%		N/A			100%		N/A	
	Resolved in SLA/Total Resolved	0	0	0	0	0	0	1	1	0	0		1	1	0	0
Network Services	Calls resolved in SLA (%)	100%		N/A		100%		98.4%		100%			98.67%		98.17%	
	Resolved in SLA/Total Resolved	1	1	0	0	12	12	123	125	12	12		148	150	215	219
NTT	Calls resolved in SLA (%)	N/A		N/A		N/A		100%		N/A			100%		N/A	
	Resolved in SLA/Total Resolved	0	0	0	0	0	0	1	1	0	0		1	1	0	0
Pathology	Calls resolved in SLA (%)	N/A		N/A		N/A		N/A		N/A			N/A		0%	
	Resolved in SLA/Total Resolved	0	0	0	0	0	0	0	0	0	0		0	0	0	1
Pharmacy	Calls resolved in SLA (%)	N/A		N/A		100%		100%		N/A			100%		100%	
	Resolved in SLA/Total Resolved	0	0	0	0	4	4	15	15	0	0		19	19	6	6
Service Desk	Calls resolved in SLA (%)	100%		100%		93.33%		99.15%		92.31%			98.81%		96.69%	
	Resolved in SLA/Total Resolved	4	4	1	1	14	15	466	470	12	13		497	503	585	605
Telecoms	Calls resolved in SLA (%)	N/A		N/A		100%		95.77%		100%			96.3%		92.24%	
	Resolved in SLA/Total Resolved	0	0	0	0	4	4	68	71	6	6		78	81	107	116
Theatre Support	Calls resolved in SLA (%)	N/A		N/A		100%		92.54%		100%			92.86%		64.77%	
	Resolved in SLA/Total Resolved	0	0	0	0	2	2	62	67	1	1		65	70	57	88
UHL Business Intelligence	Calls resolved in SLA (%)	N/A		N/A		N/A		50%		N/A			50%		N/A	
	Resolved in SLA/Total Resolved	0	0	0	0	0	0	1	2	0	0		1	2	0	0
UHL Data Integration	Calls resolved in SLA (%)	N/A		N/A		N/A		100%		N/A			100%		N/A	
	Resolved in SLA/Total Resolved	0	0	0	0	0	0	8	8	0	0		8	8	0	0
UHL I&D Team	Calls resolved in SLA (%)	N/A		100%		N/A		88.46%		N/A			88.89%		80.65%	
	Resolved in SLA/Total Resolved	0	0	1	1	0	0	23	26	0	0		24	27	25	31
UHL Management	Calls resolved in SLA (%)	N/A		N/A		N/A		66.67%		N/A			66.67%		0%	
	Resolved in SLA/Total Resolved	0	0	0	0	0	0	2	3	0	0		2	3	0	9
UHL Service Delivery	Calls resolved in SLA (%)	N/A		100%		100%		87.5%		100%			90.48%		100%	
	Resolved in SLA/Total Resolved	0	0	1	1	2	2	14	16	2	2		19	21	17	17
UHL Team Leaders	Calls resolved in SLA (%)	N/A		N/A		N/A		66.67%		N/A			66.67%		85.71%	
	Resolved in SLA/Total Resolved	0	0	0	0	0	0	2	3	0	0		2	3	6	7
Workforce Planning & Information	Calls resolved in SLA (%)	N/A		N/A		N/A		100%		N/A			100%		N/A	
	Resolved in SLA/Total Resolved	0	0	0	0	0	0	1	1	0	0		1	1	0	0
	Calls resolved in SLA (%)	N/A		N/A		N/A		66.67%		N/A			66.67%		50%	
	Resolved in SLA/Total Resolved	0	0	0	0	0	0	2	3	0	0		2	3	1	2

11.0 FINANCE – PETER HOLLINSHEAD

11.1 INTRODUCTION

11.1.1 This section summarises the Month 9 financial position. As well as the following commentary, this report contains a number of key financial statements included at the end of this section:

- Income and Expenditure
- Balance Sheet
- Cash Flow
- Capital Programme
- Financial Performance by CMG
- December Actuals against December Forecast by CMG

11.1.2 We have also attached the Trust-wide summary pack which accompanies the monthly performance meetings.

11.2 FINANCIAL POSITION AS AT END OF DECEMBER 2013

11.2.1 The Trust is reporting:

- A deficit at the end of December 2013 of £28.5m, which is £31.5m adverse to the planned surplus of £3.0m
- In month position is a £8.2m deficit, £8.3m adverse to the Plan
- The forecast for December was a deficit of £6.2m; therefore the December actuals reflect a £2.0m adverse position to forecast

Table 1: Income & Expenditure Position

	December 2013			April -December 2013		
	Plan £m	Actual £m	Var (Adv) / Fav £m	Plan £m	Actual £m	Var (Adv) / Fav £m
Income						
Patient income	49.9	51.9	2.0	480.5	491.3	10.8
Teaching, R&D	5.3	5.3	0.0	56.4	55.9	(0.6)
Service Income	**55.2**	**57.2**	**2.0**	**537.0**	**547.2**	**10.2**
Other operating Income	3.0	3.6	0.6	28.7	29.3	0.6
Total Income	**58.2**	**60.9**	**2.6**	**565.7**	**576.5**	**10.9**
Operating expenditure						
Pay	37.3	40.6	(3.3)	336.1	352.9	(16.7)
Non-pay	23.0	24.7	(1.7)	207.1	219.6	(12.4)
Reserves	(6.0)	-	(6.0)	(13.6)	-	(13.6)
Total Operating Expenditure	**54.3**	**65.4**	**(11.0)**	**529.7**	**572.4**	**(42.8)**
EBITDA	**3.9**	**(4.5)**	**(8.4)**	**36.0**	**4.1**	**(31.9)**
Net interest	0.0	0.0	(0.0)	0.0	(0.0)	0.0
Depreciation	(2.7)	(2.7)	0.0	(24.4)	(24.3)	0.1
PDC dividend payable	(1.0)	(1.0)	0.0	(8.7)	(8.4)	0.3
Net deficit	**0.2**	**(8.2)**	**(8.3)**	**3.0**	**(28.5)**	**(31.5)**
EBITDA %		**-7.4%**			**0.7%**	

11.2.2 The **key points** to highlight in the YTD position are:

- **Patient care income £10.8m (2.2%)** favourable against Plan
- **Pay costs, £16.7m (5.0%) adverse to Plan**
- **Non pay costs, £12.4m (6.0%)** adverse to Plan
- **Adverse variances to Plan in all CMGs, with the exception of Women's & Children's**

11.2.3The **Month 9 YTD position** may be analysed as follows.

11.3 INCOME

11.3.1 Within patient income, NHS income (excluding non-NHS patient care income) is £12.2m (2.6%) above Plan year to date. The key areas are shown in the following table:

- Elective IP activity is 3.0% down on Plan
- Emergency IP activity 3.7% up on Plan, but income is £107k (0.2%) adverse
- Over-performance in outpatients, £4.9m (4.1%)
- Other income:
  - Critical care, £2.3m, 7% over performing
  - Direct access – Imaging and Pathology, £0.2m, 2%
  - End Stage Renal Failure, £0.9m, 5%
  - Excluded drugs and devices, £3.1m, 6.7%
  - Contractual penalties, £1.5m, offsetting the above favourable variances

Table 2: Patient Care Activity

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	60,452	63,436	2,984	4.94	37,051	38,077	1,026	2.77
Elective Inpatient	17,008	16,502	(506)	(2.97)	52,546	52,440	(107)	(0.20)
Emergency / Non-elective Inpatient	70,761	73,394	2,633	3.72	132,781	133,349	569	0.43
Marginal Rate Emergency Threshold (MRET)	0	0	0	0.00	(2,563)	(4,444)	(1,881)	73.38
Outpatient	550,139	572,576	22,437	4.08	62,310	65,377	3,067	4.92
Emergency Department	118,875	115,206	(3,669)	(3.09)	12,760	12,642	(118)	(0.92)
Winter Monies	0	0	0	0.00	0	4,649	4,649	
Other	5,798,886	5,954,181	155,295	2.68	180,182	185,139	4,957	2.75
Grand Total	**6,616,120**	**6,795,295**	**179,175**	**2.71**	**475,066**	**487,229**	**12,163**	**2.56**

11.3.2 Table 3 below highlights the impact of price and volume changes in activity across the major “points of delivery”. Overall, excluding the winter monies, this shows that the £7.5m Trust level over-performance is as a consequence of a volume (activity) related £12.3m favourable impact, lessened by a £4.8m adverse shift in average tariff prices.

Table 3: Price and Volume Impact on Patient Care Activity

Average tariff	Price Variance YTD %	Volume Variance YTD %	Price / Mix Variance (£000)	Volume Variance (£000)	Variance YTD (£000)
Day Case	(2.1)	4.9	(803)	1,829	1,026
Elective Inpatient	2.9	(3.0)	1,456	(1,563)	(107)
Emergency / Non-elective Inpatient	(3.2)	3.7	(4,373)	4,941	569
Marginal Rate Emergency Threshold (MRET)			(1,881)	0	(1,881)
Outpatient	0.8	4.1	526	2,541	3,067
Emergency Department	2.2	(3.1)	276	(394)	(118)
Winter Monies			0	4,649	4,649
Other			0	4,957	4,957
Grand Total	**(0.1)**	**2.7**	**(4,798)**	**16,961**	**12,163**

11.3.3 Whilst the volume increase in emergency activity reflects the patient activity, the price variance of £4.4m (3.2%) needs greater analysis. The CMGs are investigating the reasons at a specialty and sub-specialty level and we will orally update the Finance & Performance Committee. At this time, the income for Month 9 is still based on the early cut information.

11.3.4 Within the year to date income position, we have made provision for the following **penalties**. Year to date, this amounts to just over £4.9m, £1.5m if we exclude re-admissions.

Table 4: Penalties & Fines

	Month 9 £000s
Emergency Readmissions	(3,443)
RTT	(958)
ED Wait Times (Automatic)	(252)
Contract Penalties Provision	(60)
Cancelled Ops	(67)
Cancer 62 Day Target (Automatic)	(50)
Pressure Ulcers	(64)
Diagnosic Imaging	(16)
Never Events	(6)
ED 12 Hour Trolley Breaches	(5)
Total	**(4,921)**

11.3.5 The key RTT penalties relate to General Surgery, ENT, Ophthalmology and Orthopaedics. Other includes pressure ulcers, cancelled operations and ED 12 hour trolley breaches. As can be seen from the table, at the moment, we are not assuming any penalties around ambulance turnaround times, and the ED and RTT rapid action plans.

11.4 EXPENDITURE

11.4.1 Operating expenditure is £42.8m above Plan as at the end of December (8.1%).

11.4.2 The CMGs and Corporate Directorates have identified that a total of £26.0m CIP savings have been delivered year to date, representing a £0.6m adverse variance to the £26.6m CIP Plan. The 2013/14 CIP paper provides further details on the CIP performance to date, yearend forecasts, remedial action plans and RAG ratings for the remaining schemes.

11.4.3 **PAY –** as at Month 9, pay costs are £16.7m over budget, almost £20m more than the same period in 2012/13 (5.9%). When viewed by staff group, the most significant increases year on year are seen across agency and medical locums, nursing spend and consultants' costs (see below).

Table 5

Staff Type	2013/14 £'000s	2012/13 £'000s	Change £'000s	Change %
A&C / Managers	44,266	44,905	639	1.4
Agency / Medical Locums	16,928	12,560	(4,368)	(34.8)
Allied Health Prof's	14,117	14,116	(1)	(0.0)
Medical - Non Consultant	47,274	45,581	(1,692)	(3.7)
Consultant	67,206	61,218	(5,988)	(9.8)
Nursing & Midwifery	130,811	123,502	(7,309)	(5.9)
Other	32,254	31,193	(1,060)	(3.4)
TOTAL	**352,855**	**333,076**	**(19,779)**	**(5.9)**

11.4.4 Analysis of the year to date £16.7m variance to Plan, and year on year movement highlights the following key factors, and split by CMG (the table below excludes Corporate Directorates and Research & Development):

	Pay					
CMG's	YTD Budget £000s	YTD Actual £000s	'Variance £000s	M1-9 2012/13 Actual £000s	Year on Year Change £000s	Year on Year Change %
C.H.U.G.S	34,123	34,804	(682)	33,109	(1,695)	(5.1)
Clinical Support & Imaging	50,422	52,163	(1,741)	50,668	(1,495)	(3.0)
Divisional Management Code	2,959	2,841	118	2,812	(30)	(1.1)
Emergency & Specialist Med	47,700	55,321	(7,621)	46,731	(8,590)	(18.4)
I.T.A.P.S	37,398	41,048	(3,650)	38,177	(2,871)	(7.5)
Musculo & Specialist Surgery	32,680	33,894	(1,215)	33,117	(778)	(2.3)
Renal, Respiratory & Cardiac	42,077	43,783	(1,706)	42,626	(1,157)	(2.7)
Womens & Childrens	55,846	56,025	(178)	52,991	(3,034)	(5.7)
TOTAL	**303,205**	**319,880**	**(16,675)**	**300,230**	**(19,650)**	**(6.5)**

- Estimated pay over-spend due to patient care activity over-performance **- £6.0m,** assuming that pay stepped/marginal cost is c50% of relevant patient care income volume variance and staffed at non-premium rates
- Declared under-delivery on pay CIP schemes **£2.5m**
- Continued use of extra capacity wards (Fielding Johnson, Ward 1 LRI, Ward 2 LGH, Ward 19 LRI and Odames LRI) to meet the emergency activity levels. Premium spend has covered a significant amount of the staff costs in these areas. Nursing incentives are also being paid to bank and agency to increase the "fill rates", although these are now restricted to the Emergency Care CMG
- Increased doctors and nurses in Medicine and ED to ensure the flow of patients from ED to support the 4 hour target. The CMG is now £7.6m adverse to the pay plan and spending almost £8.6m (18%) above the same level in 2012/13
- A continued reliance on premium payments as per Chart 1 below. Increases have continued into this financial year, climbing to almost £4m in May and June, falling to £3.5m in July, and remaining around this level during August and September. Table 6 illustrates the relative percentages of total pay spend of each type. It can be seen that there has been a significant rise in the total percentage to almost 10% in Quarter 1 of this financial year, and 9.5% in Month 9.

Chart 1: Non-Contracted/Premium Pay Spend

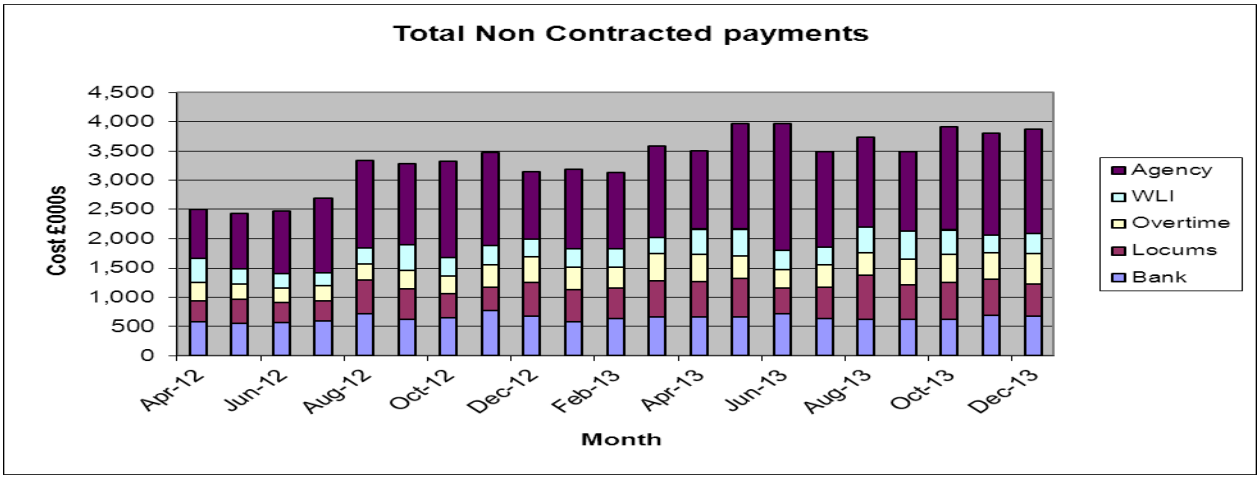


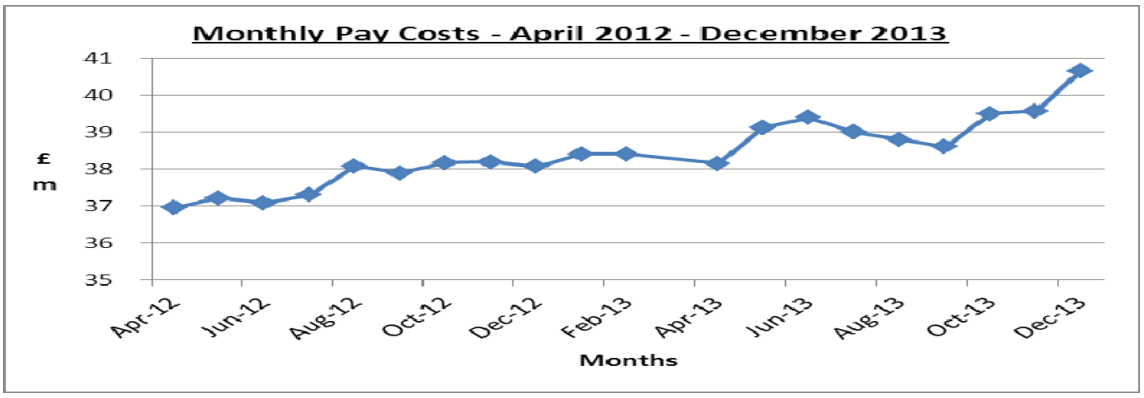
Table 6: Non-Contracted Pay Costs as %age of Total Pay Bill

Type	12/13 Q1	12/13 Q2	12/13 Q3	12/13 Q4	13/14 Q1	13/14 M7	13/14 M8	13/14 M9
Bank	1.5%	1.7%	1.8%	1.6%	1.7%	1.6%	1.7%	1.6%
Locums	1.0%	1.3%	1.2%	1.5%	1.5%	1.6%	1.6%	1.4%
Overtime	0.8%	0.8%	1.0%	1.1%	1.0%	1.2%	1.1%	1.3%
WLI	0.8%	0.8%	0.8%	0.8%	1.0%	1.1%	0.8%	0.9%
Agency	2.5%	3.7%	3.8%	3.6%	4.5%	4.4%	4.4%	4.4%
Total	**6.6%**	**8.2%**	**8.7%**	**8.5%**	**9.8%**	**9.9%**	**9.6%**	**9.5%**

11.4.5 Pay costs rose steadily from April 2012 to June 2013, hitting an initial peak of £39.4m in June; July saw a reduction to £39.0m with August (£38.8m) and September continuing this trend down at £38.6m. However, since the September position, we have seen 3 consecutive monthly increases; October (£39.5m), November (£39.6m) and December £40.6m.

11.4.6 Nursing and related agency costs make up the largest part of the adverse pay variance. Some of the overspend, as described above, is volume related (extra capacity opened) and the impact of agency rates is clear. Increase in nurse:bed ratios have also pushed up costs.

Chart 2: Monthly Pay Costs



11.4.7 The continued reliance on premium staff comes at the same time as our contracted staff numbers in medical and nursing professions have increased by 6.1%, equivalent to an increase of 383 WTE since March 2012 (Table 7).

Table 7: Contracted WTE

Staff Type	Movement Dec 13 - March 12		Contracted Staff	
	WTE	(%)	Dec 13 WTE	March 12 WTE
ADMIN & CLERICAL	(44)	(2.5)	1,743	1,787
ALLIED HEALTH PROFESSIONALS	12	2.6	470	458
CAREER GRADES	9	13.3	79	70
CONSULTANT	47	8.8	580	533
HEALTHCARE ASSISTANTS	30	13.7	247	217
HEALTHCARE SCIENTISTS	(15)	(2.0)	726	741
MAINTENANCE & WORKS	1	10.6	7	6
NURSING QUALIFIED	78	2.3	3,427	3,348
NURSING UNQUALIFIED	181	15.2	1,376	1,195
OTHER MEDICAL & DENTAL STAFF	37	4.1	936	899
OTHER SCIEN, THERAP & TECH	71	25.7	345	274
SENIOR MANAGERS	(40)	(23.1)	132	171
TOTAL	**368**	**3.8**	**10,067**	**9,699**
MEDICAL & NURSING	383	6.1	6,645	6,262
OTHER STAFF GROUPS	(15)	(0.4)	3,422	3,437
TOTAL	**368**	**3.8**	**10,067**	**9,699**

11.4.8 **NON PAY** – operating non pay spend, excluding reserves, is now showing a YTD adverse position to Plan of £12.7m (6%).

11.4.9 This is as a result of three main factors:

- Activity related marginal costs e.g. keeping Ward 19 open - **£3.2m** (assuming that non pay marginal cost is c25% of patient care income variance)
- Patient care income backed costs such as NICE/HCT costs - **£3.0m** e.g. haemophilia patients, high cost devices in Renal, Respiratory & Cardiac CMG and Women's & Children's CMG
- Other cost pressures/over-stated non-pay CIP delivery - **£6.5m.** This includes:
  - £1.1m Imaging and laboratory non pay consumables
  - £1.7m Use of independent sector and contracted clinical services
  - £0.4m Blood products
  - £0.8m Printing, stationery and postage
  - £0.3m Security
  - £0.6m Maintenance and MES costs
  - £1.2m Consultancy
  - £0.6m Furniture, office equipment and IT

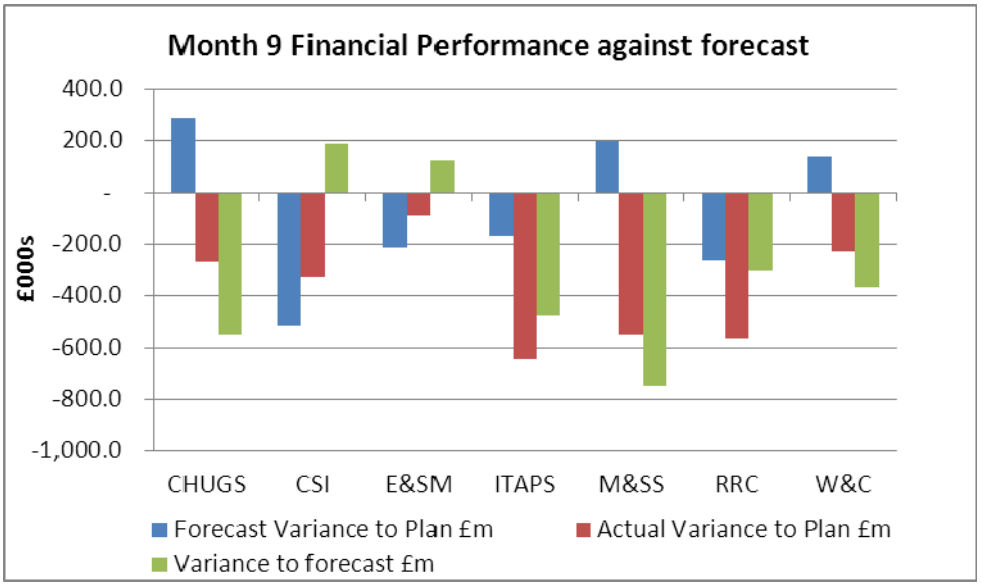
11.4.10 As well as the operating non pay deficit of £10.7m, there is an in month adverse variance of £13.6m against reserves. This is as a consequence of the contingency created through the annual planning cycle being over-committed due to in year pressures and agreed changes. These include the investment in the nursing budgets, the re-basing of the initial £40.4m CIP target for "over heating" issues, and additional cost pressures supported post AOP submission e.g. CQUIN posts.

11.5 CMG AND CORPORATE DIRECTORATE

11.5.1 The table below shows the in month variance from the Month 9 forecast by CMG and Corporate Directorate. The detailed breakdown by pay, non-pay and income is shown within the appendices.

CMG/Directorate	Income £'000	Pay £'000	Non Pay £'000	TOTAL £'000
C.H.U.G.S	(87)	(81)	(383)	(551)
Clinical Support & Imaging	49	115	27	191
Emergency & Specialist Med	41	120	(34)	127
I.T.A.P.S	(110)	(336)	(29)	(475)
Musculo & Specialist Surgery	(409)	(165)	(176)	(750)
Renal, Respiratory & Cardiac	(315)	(11)	23	(304)
Womens & Childrens	(268)	(117)	18	(368)
Total CMGs	**(1,100)**	**(475)**	**(556)**	**(2,131)**
Total Corporate Directorates	**0**	**82**	**61**	**143**
Total Central & R&D	**(167)**	**(96)**	**216**	**(47)**
Grand Total	**(1,266)**	**(489)**	**(279)**	**(2,035)**

11.5.2 The chart below shows graphically December performance by CMG against the forecast. Detailed charts by CMG and across pay, non-pay and income are included within the appendices.



11.5.3 The month 9 results have been very disappointing against the forecast position, £2m adverse in total with £2.1m adverse within the CMGs. The material movements in month are:

- CHUGS (£551k adverse)
  - £68k adverse against patient care income – day cases down £16k, elective activity adverse by £151k, and emergency activity adverse by £170k. All of these movements are in General Surgery. These movements have been offset by £247k over performance against excluded drugs – offset in non pay
  - Pay costs, £81k adverse to forecast, mainly due to a £65k backdated local discretionary points awards to Consultants
  - Non pay is £383k adverse – £247k on excluded drugs and Haemophilia, higher use of TPN on the Gastro wards, and recharges for out-of-hours theatres

- ITAPS (£475k adverse)
  - Patient care income - £103k less income than forecast in month. Analysis by PoD as follows:
    - Critical Care - the under performance of £15k relates to lower than forecast activity (£109k) within ITU at the LRI and LGH PACU (£12k). There was an increase in activity within CICU (£45k). See above for detail on activity levels
    - Outpatient - £14k additional income against plan due to increased activity with the Sleep Service
    - Emergency - the CMG was down on activity compared to forecast £11k on Emergency activity
    - Excluded Drugs and Devices - the reduction in income predominantly relates to the Sleep Service, this is being addressed as it appears to relate to recording of device usage
  - Pay - £336k adverse against forecast.
    - There was £21k spent on speciality doctor introductory fees. There is only one more speciality doctor of whom the start date is yet to be confirmed of which an introductory fee will be attached

        - There was £51k paid for clinical excellence award arrears and £11k on APA arrears which were not known about. Internal locum payments were £45k higher than forecast, there may be backdated claims
        - Nursing costs were £87k higher than forecast due to new posts coming in and a big increase in overtime and enhancements
    - Non pay - £100k adverse against forecast. There was £35k expended on 10 theatre trollies not forecast; Flotrac sensors were purchased which amounted to £20k and there was additional drugs expenditure of £31k than forecast; speciality doctor expenses amounted to £9k above forecast. Unexpected theatre repairs resulted in costs of £7k

- Musculo-Skeletal & Specialist Surgery (£750k adverse)
    - Patient care income - £387k adverse variance compared to the December forecast:
        - Daycases - under performance of £81k relates to most specialties but primarily Plastic Surgery (£23k) and MaxFax (£13k)
        - Elective IP - under performance of £259k mainly within Orthopaedics (£190k), Vascular Surgery (£32k) and ENT (£18k) which is partially offset by over performance within MaxFax (£21k)
        - Emergencies - under performance relates to Trauma (£81k, 36 patients)
        - Excluded Drugs & Devices - over performance relates to stents and ARMD (£46k)
    - Pay - £165k adverse:
        - Medical and dental overspend of £88k relates primarily to Clinical Excell Awards arrears paid in month of £70k
        - The agency overspend of £66k relates to the use of NISE nursing due to patient acuity and A&C staff needed to clear the backlog within Ophthalmology, this is an interim arrangement
    - Non pay - £176k overspend:
        - The Drugs (£40k) and Clinical Supplies and Services (£30k) overspends relate to NICE/HCT spend within Ophthalmology and Vascular Surgery
        - Recharges consist of the Theatres Trading recharge (£39k)
        - Other costs (£69k) overspend is linked to Independent Sector, this is backed by additional patient care income within ENT, Ophthalmology and Orthopaedics

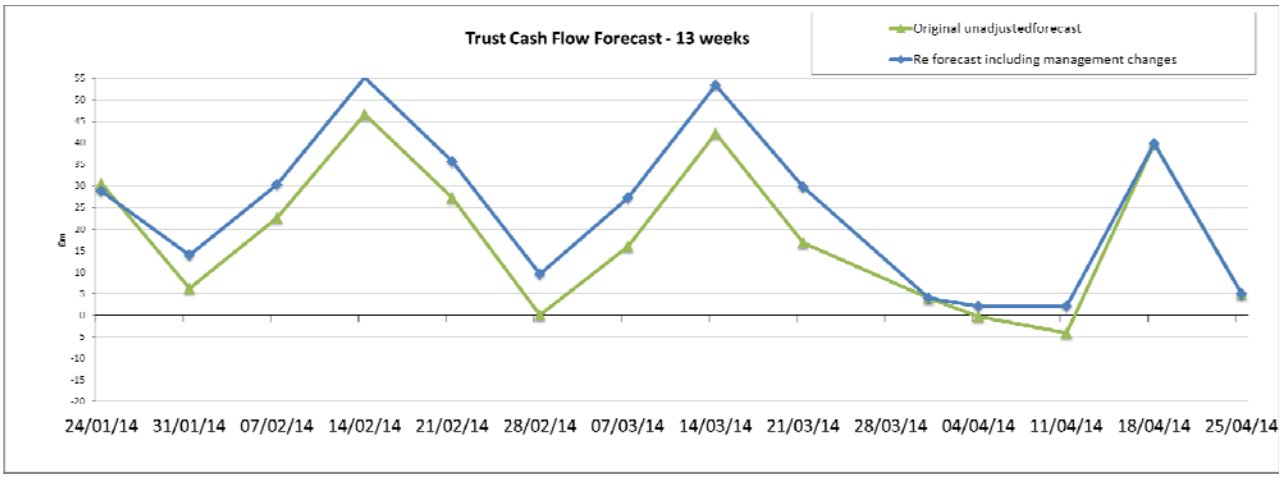
- RRC (£304k adverse)
    - Patient care income - (£282k) worse than forecast. This is mainly due to under performance of HDU income (£99k) for Thoracic Surgery and Nephrology. Excluded drugs and devices income down by (£61k) offset by underspend in non-Pay. ESRF income lower than forecast by (£61k), Inpatient income across all points of delivery is (£62k) lower than forecast
    - Pay (£11k) worse than forecast. Main reason being CEA arrears
    - Non pay - £23k favourable than forecast contributed by an underspend on excluded drugs and devices and a reduction in renal activity

- W&C (£368k adverse)
    - £265k adverse of patient care income across all points of delivery with the exception of emergencies
    - Pay costs, £117k adverse due to medical and agency costs
    - £18k favourable on non pay

11.5.4 The year-end forecast position is shown in detail within the 2013/14 Year End and 2014/15 Financial Plan paper.

11.6 CASH

11.6.1 The Trust's cash balance was £6.9m at the end of December 2013. The year-end cash balance is forecast to be £3.9m as shown in the following graph:



11.6.2 We are taking a number of actions to ensure the above year end cash balance is achieved. These actions include:

- Managing the timing of expenditure within the capital programme to ensure that cash payments are slipped to the following financial year
- Maintaining a year-end balance of creditor invoices which are authorised for payment but which are overdue beyond their 30 day payment terms

11.6.3 To manage any in-month cash shortfalls, local CCGs are continuing to pay us £21m of the monthly SLA payments to the start of each month instead of the 15th of the month.

11.6.4 The Trust is required to meet its External Financing Limit (EFL) at the end of each financial year. This is a performance target which controls our cash expenditure and against which we are not allowed to overspend.

11.6.5 To achieve our EFL for 2013/14, our year-end cash balance will need to increase by a further £13m from £3.9m to £16.9m. We are unlikely to achieve this by internal measures alone and therefore we are likely to require loan financing from the NTDA, particularly to minimise the impact on our supplier payments. We are seeking advice from the NTDA on the process and timescale for securing a short term loan. This process will be orally updated to the Finance & Performance Committee

11.6.6 Any decisions made in relation to financing will also need to take into account any financing requirements for 2014/15 and the impact of the Trust's reconfiguration programme. We will be holding discussions with the NTDA and completing the necessary loan documentation in sufficient time to secure any loan funding before the year end.

11.7 CAPITAL

11.7.1 At the end of December, the Trust had spent £17.7m which is just under 45% of the annual plan of £39.8m. The year-end forecast has dropped to £34.8m and is likely to drop further as we approach year end.

11.7.2 Expenditure is now being monitored to support the Trust's cash position. Where possible, new schemes will be delayed until next year if they are not already in the forecast.

11.8 CONCLUSION

11.8.1 The Trust has reported to the NTDA that we are £31.5m adverse to our planned £3.0m surplus.

FINANCIAL APPENDICES

	December 2013			April 2013 - December 2013		
	Plan £ 000	Actual £ 000	Variance (Adv) / Fav £ 000	Plan £ 000	Actual £ 000	Variance (Adv) / Fav £ 000
Elective	5,277	**4,792**	(485)	52,546	**52,440**	(107)
Day Case	3,744	**3,588**	(156)	37,051	**38,077**	1,026
Emergency	17,273	**18,688**	1,415	132,781	**133,349**	569
Outpatient	6,409	**6,769**	361	62,310	**65,377**	3,067
Non NHS Patient Care	611	**253**	(358)	5,454	**4,087**	(1,367)
Winter funding	0	**1,558**	1,558	0	**4,649**	4,649
Other	16,642	**16,274**	(368)	190,379	**193,338**	2,959
Patient Care Income	**49,956**	**51,922**	**1,966**	**480,520**	**491,316**	**10,796**
Teaching, R&D income	5,298	**5,332**	34	56,449	**55,881**	(568)
Other operating Income	3,008	**3,603**	595	28,700	**29,348**	648
Total Income	**58,262**	**60,857**	**2,595**	**565,669**	**576,545**	**10,876**
Pay Expenditure	**37,320**	**40,648**	**(3,328)**	**336,126**	**352,855**	**(16,729)**
Non Pay Expenditure	**23,030**	**24,704**	**(1,674)**	**207,145**	**219,552**	**(12,407)**
Central Reserves	**(6,015)**	**0**	**(6,015)**	**(13,619)**	**0**	**(13,619)**
Total Operating Expenditure	**54,335**	**65,352**	**(11,017)**	**529,652**	**572,407**	**(42,755)**
EBITDA	**3,927**	**(4,495)**	**(8,422)**	**36,017**	**4,138**	**(31,879)**
Interest Receivable	7	**6**	(1)	62	**134**	72
Interest Payable	(5)	**(4)**	1	(45)	**(141)**	(96)
Depreciation & Amortisation	(2,707)	**(2,749)**	(42)	(24,361)	**(24,250)**	111
Surplus / (Deficit) Before Dividend and Disposal of Fixed Assets	**1,222**	**(7,242)**	**(8,464)**	**11,673**	**(20,119)**	**(31,792)**
Dividend Payable on PDC	(964)	**(980)**	(16)	**(8,676)**	**(8,381)**	295
Net Surplus / (Deficit)	**258**	**(8,222)**	**(8,480)**	**2,997**	**(28,500)**	**(31,497)**
EBITDA MARGIN		**-7.39%**			**0.72%**	

Balance Sheet

BALANCE SHEET	Mar-13 £000's Actual	Apr-13 £000's Actual	May-13 £000's Actual	Jun-13 £000's Actual	Jul-13 £000's Actual	Aug-13 £000's Actual	Sep-13 £000's Actual	Oct-13 £000's Actual	Nov-13 £000's Actual	Dec-13 £000's Actual
Non Current Assets										
Property, plant and equipment	354,680	353,855	353,723	352,327	352,803	353,255	352,521	352,993	353,114	352,703
Intangible assets	5,318	5,160	5,012	4,940	4,795	4,650	4,627	4,419	4,273	4,328
Trade and other receivables	3,125	3,183	3,181	3,252	3,302	3,291	3,331	3,268	3,191	3,218
TOTAL NON CURRENT ASSETS	**363,123**	**362,198**	**361,916**	**360,519**	**360,900**	**361,196**	**360,479**	**360,680**	**360,578**	**360,249**
Current Assets										
Inventories	13,064	13,869	13,257	13,778	13,861	13,776	14,499	14,176	14,155	14,558
Trade and other receivables	44,616	42,408	42,628	35,756	40,713	44,182	46,674	42,210	49,634	50,922
Other Assets	40	40	40	40	40	40	40	40	40	40
Cash and cash equivalents	19,986	19,957	14,257	19,129	15,343	7,203	4,484	5,335	2,933	6,876
TOTAL CURRENT ASSETS	**77,706**	**76,274**	**70,182**	**68,703**	**69,957**	**65,201**	**65,697**	**61,761**	**66,762**	**72,396**
Current Liabilities										
Trade and other payables	(75,559)	(73,056)	(67,971)	(68,079)	(71,026)	(69,123)	(77,327)	(81,916)	(88,794)	(93,069)
Dividend payable	0	(964)	(1,928)	(2,892)	(3,856)	(4,820)	0	(964)	(1,928)	(2,892)
Borrowings	(2,726)	(2,800)	(2,800)	(2,800)	(2,800)	(2,800)	(2,800)	(2,800)	(2,800)	(2,727)
Provisions for liabilities and charges	(1,906)	(1,906)	(1,906)	(1,906)	(1,906)	(1,906)	(1,342)	(1,342)	(1,342)	(2,244)
TOTAL CURRENT LIABILITIES	**(80,191)**	**(78,726)**	**(74,605)**	**(75,677)**	**(79,588)**	**(78,649)**	**(81,469)**	**(87,022)**	**(94,864)**	**(100,932)**
NET CURRENT ASSETS (LIABILITIES)	**(2,485)**	**(2,452)**	**(4,423)**	**(6,974)**	**(9,631)**	**(13,448)**	**(15,772)**	**(25,261)**	**(28,102)**	**(28,536)**
TOTAL ASSETS LESS CURRENT LIABILITIES	**360,638**	**359,746**	**357,493**	**353,545**	**351,269**	**347,748**	**344,707**	**335,419**	**332,476**	**331,713**
Non Current Liabilities										
Borrowings	(10,906)	(10,958)	(11,190)	(10,809)	(11,522)	(11,484)	(11,159)	(10,797)	(10,410)	(10,887)
Other Liabilities	0	0	0	0	0	0	0	0	0	0
Provisions for liabilities and charges	(2,407)	(2,454)	(2,488)	(2,404)	(2,315)	(2,312)	(2,986)	(2,910)	(2,870)	(2,004)
TOTAL NON CURRENT LIABILITIES	**(13,313)**	**(13,412)**	**(13,678)**	**(13,213)**	**(13,837)**	**(13,796)**	**(14,145)**	**(13,707)**	**(13,280)**	**(12,891)**
TOTAL ASSETS EMPLOYED	**347,325**	**346,334**	**343,815**	**340,332**	**337,432**	**333,952**	**330,562**	**321,712**	**319,196**	**318,822**
Public dividend capital	277,733	277,733	277,733	277,733	277,733	277,733	277,733	277,733	277,733	277,733
Revaluation reserve	64,628	64,626	64,628	64,632	64,632	64,628	64,628	64,628	64,628	64,628
Retained earnings	4,960	3,975	1,454	(2,033)	(4,933)	(8,409)	(11,799)	(20,649)	(23,165)	(23,539)
TOTAL TAXPAYERS EQUITY	**347,325**	**346,334**	**343,815**	**340,332**	**337,432**	**333,952**	**330,562**	**321,712**	**319,196**	**318,822**

Cash Flow Forecast

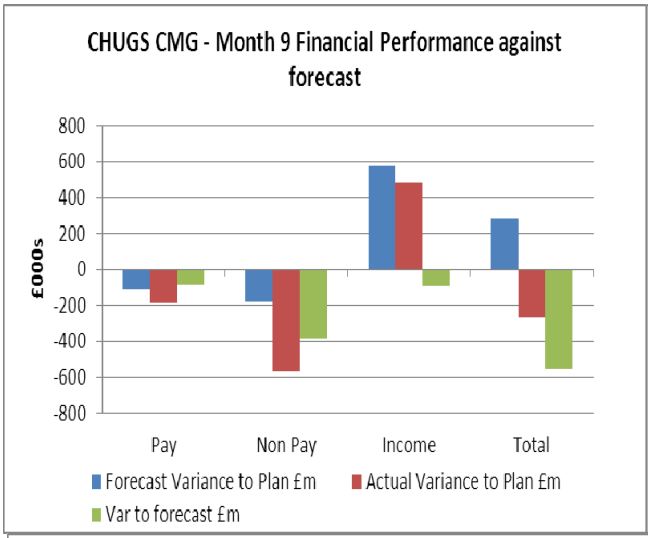
Cash Flow for the period ended 31st December 2013				Rolling 12 month cashflow forecast - January 2014 to December 2014											
	2013/14 Apr - Dec Plan £ 000	2013/14 Apr - Dec Actual £ 000	2013/14 Apr - Dec Variance £ 000	2013/14 January Forecast £ 000	2013/14 February Forecast £ 000	2013/14 March Forecast £ 000	2014-15 April Forecast £ 000	2014-15 May Forecast £ 000	2014-15 June Forecast £ 000	2014-15 July Forecast £ 000	2014/15 August Forecast £ 000	2014/15 September Forecast £ 000	2014/15 October Forecast £ 000	2014/15 November Forecast £ 001	2013/14 December Forecast £ 000
CASH FLOWS FROM OPERATING ACTIVITIES															
Operating surplus before Depreciation and Amortisation	36,314	4,138	(32,176)	5,321	1,279	3,366	2,098	5,468	2,098	5,468	5,468	2,971	6,341	4,719	3,658
Donated assets received credited to revenue and non cash	(225)	(271)	(46)	(25)	(25)	(26)	(26)	(26)	(26)	(26)	(26)	(26)	(26)	(26)	(25)
Interest paid	(634)	(635)	(1)	(77)	(79)	(78)	(82)	(82)	(81)	(81)	(80)	(80)	(79)	(78)	(77)
Movements in Working Capital:														-	
- Inventories (Inc)/Dec	-	(1,494)	(1,494)											-	
- Trade and Other Receivables (Inc)/Dec	-	(5,180)	(5,180)	3,000	1,654	3,150	(2,869)	(10)	41	9	8	41	(11)	24	2,000
- Trade and Other Payables Inc/(Dec)	-	21,464	21,464	(2,500)	(2,500)	(2,000)	(83)	(83)	(83)	(83)	(83)	(83)	(83)	(83)	(2,500)
- Provisions Inc/(Dec)	(1,602)	(65)	1,537	(8)	(8)	(8)	(8)	(8)	(8)	(8)	(8)	(8)	(8)	(8)	(8)
PDC Dividends paid	(5,500)	(5,454)	46	-	-	(5,454)	-	-	-	-	-	(5,615)	-	-	-
Other non-cash movements	(273)	101	374	-	-	-	-	-	-	(21)	-	-	-	-	-
Net Cash Inflow / (Outflow) from Operating Activities	**28,080**	**12,604**	**(15,476)**	**5,711**	**321**	**(1,050)**	**(970)**	**5,259**	**1,941**	**5,258**	**5,279**	**(2,800)**	**6,134**	**4,548**	**3,047**
CASH FLOWS FROM INVESTING ACTIVITIES															
Interest Received	72	493	421	8	8	8	6	6	6	6	7	7	7	7	8
Payments for Property, Plant and Equipment	(22,282)	(22,419)	(137)	(2,252)	(2,251)	(4,409)	(2,294)	(2,295)	(2,294)	(2,295)	(2,294)	(2,295)	(2,294)	(2,295)	(2,251)
Capital element of finance leases	(3,465)	(3,788)	(323)	(400)	(400)	(400)	(391)	(391)	(391)	(391)	(391)	(391)	(391)	(391)	(400)
Net Cash Inflow / (Outflow) from Investing Activities	**(25,675)**	**(25,714)**	**(39)**	**(2,644)**	**(2,643)**	**(4,801)**	**(2,679)**	**(2,680)**	**(2,679)**	**(2,680)**	**(2,678)**	**(2,679)**	**(2,678)**	**(2,679)**	**(2,644)**
CASH FLOWS FROM FINANCING ACTIVITIES															
New PDC	-	-	-	-	2,147	-	-	-	-	-	-	-	-	-	-
Other Capital Receipts	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Net Cash Inflow / (Outflow) from Financing	**-**	**-**	**-**	**-**	**2,147**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Opening cash	19,986	19,986	-	**6,876**	**9,943**	**9,768**	**3,917**	**268**	**2,847**	**2,109**	**4,687**	**7,288**	**1,809**	**5,265**	**6,876**
Increase / (Decrease) in Cash	2,405	(13,110)	**(15,515)**	3,067	(175)	(5,851)	(3,649)	2,579	(738)	2,578	2,601	(5,479)	3,456	1,869	404
Closing cash	**22,391**	**6,876**	**(15,515)**	**9,943**	**9,768**	**3,917**	**268**	**2,847**	**2,109**	**4,687**	**7,288**	**1,809**	**5,265**	**7,134**	**7,280**

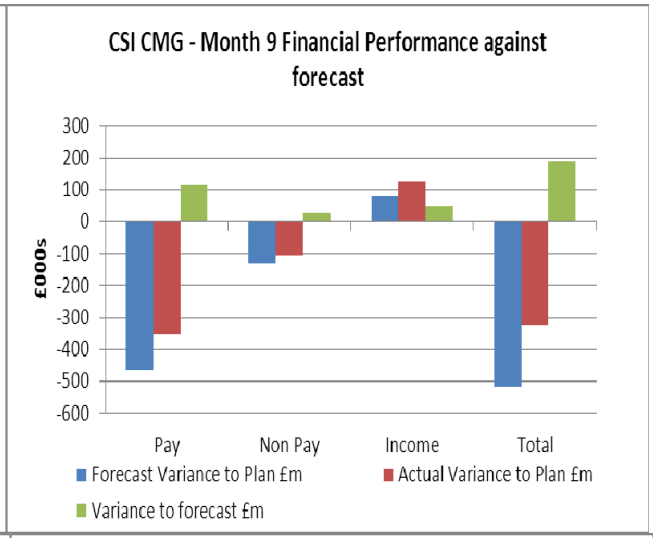
Capital Programme

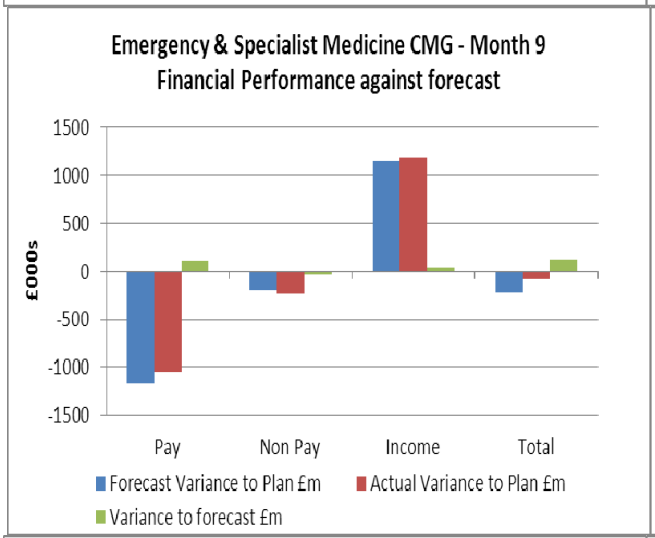
	Capital Plan 2013/14	YTD Spend 13/14	Expenditure Profile												Forecast Out Turn	Variance
			Actual									Forecast				
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar		
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£'000's
Recurrent Budgets																
IM&T	3,375	2,867	69	226	290	203	688	311	1,031	12	38	500	500	558	4,425	(1,050)
Medical Equipment	4,187	2,770	264	7	209	119	386	347	904	431	103	0	518	900	4,187	0
Facilities Sub Group	6,000	2,125	286	204	193	388	261	143	78	334	238	1,000	1,250	1,625	6,000	0
Divisional Discretionary Capital	406	338	150	65	9	10	16	12	56	4	16	68	0	0	406	0
MES Installation Costs	1,750	1,825	38	178	343	455	40	403	32	92	243	200	250	225	2,500	(750)
Total Recurrent Budgets	**15,718**	**9,924**	**807**	**680**	**1,045**	**1,174**	**1,392**	**1,215**	**2,102**	**872**	**637**	**1,768**	**2,518**	**3,308**	**17,518**	**(1,800)**
Reconfiguration Schemes																
Emergency Floor	4,000	1,231	2	7	14	79	79	130	312	575	34	500	750	919	3,400	600
Theatres Assessment Area (TAA)	1,549	1,169	4	10	27	30	491	172	75	171	188	191	208	12	1,580	(31)
Advanced Recovery LRI & LGH	625	154	63	(7)	55	11	7	(6)	18	8	5	15	200	231	600	25
GGH Vascular Surgery	1,156	53	0	0	0	0	0	0	24	4	25	0	100	680	833	323
Hybrid Theatre (Vascular)	500	0	0	0	0	0	0	0	0	0	0	0	0	0	0	500
Daycase / OPD Hub	350	0	0	0	0	0	0	0	0	0	0	0	0	0	0	350
GH Imaging	500	0	0	0	0	0	0	0	0	0	0	0	0	0	0	500
Ward 4 LGH / H Block Isolation	283	1	0	0	0	0	0	0	1	0	0	50	100	132	283	0
Modular Wards	4,050	0	0	0	0	0	0	0	0	0	0	43	0	0	43	4,007
Brandon Unit Refurb: OPD 1-4	2,000	106	0	0	0	0	5	4	1	95	0	0	0	16	122	1,878
ITU	140	0	0	0	0	0	0	0	0	0	0	0	0	55	55	85
Poppies Conversion	250	28	0	0	0	0	0	0	0	28	0	100	100	72	300	(50)
Feasibility Studies	100	24	0	0	0	0	0	0	35	(2)	(9)	5	5	13	47	53
Total Reconfiguration	**15,503**	**2,766**	**70**	**10**	**96**	**121**	**582**	**300**	**465**	**880**	**243**	**904**	**1,463**	**2,130**	**7,263**	**8,240**
Corporate / Other Schemes																
Osborne Ventilation	566	381	0	0	0	0	13	(1)	18	199	151	110	110	49	650	(84)
Endoscopy Redesign	250	152	0	80	(1)	24	5	28	16	1	0	0	0	4	156	94
Maternity Interim Development	2,800	1,871	3	18	9	273	388	332	190	334	324	362	354	413	3,000	(200)
Aseptic Suite	650	17	7	0	1	0	0	2	5	1	0	150	150	153	470	180
Diabetes BRU	600	740	0	62	125	128	141	37	105	121	21	0	0	235	975	(375)
Respiratory BRU	500	807	3	809	(245)	190	9	(46)	10	1	75	0	0	0	807	(307)
Stock Management System	3,000	201	0	0	0	0	0	0	3	185	13	600	600	599	2,000	1,000
LIA Schemes		0	0	0	0	0	0	0	0	0	0	100	200	200	500	(500)
CMG Contingency	194	0	0	0	0	0	0	0	0	0	0	50	50	94	194	0
Other Developments	0	843	163	123	91	36	69	(9)	104	163	102	100	100	177	1,220	(1,220)
	8,560	**5,011**	**177**	**1,093**	**(20)**	**650**	**625**	**343**	**450**	**1,006**	**687**	**1,472**	**1,564**	**1,925**	**9,972**	**(1,412)**
Total Capital Programme	**39,781**	**17,701**	**1,054**	**1,783**	**1,121**	**1,945**	**2,598**	**1,858**	**3,017**	**2,759**	**1,567**	**4,144**	**5,545**	**7,362**	**34,753**	**5,028**

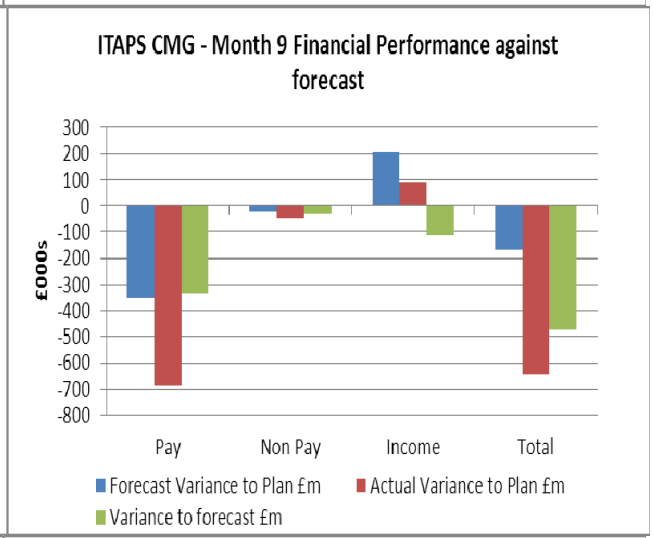
YTD Position as at 31st December - Month 9

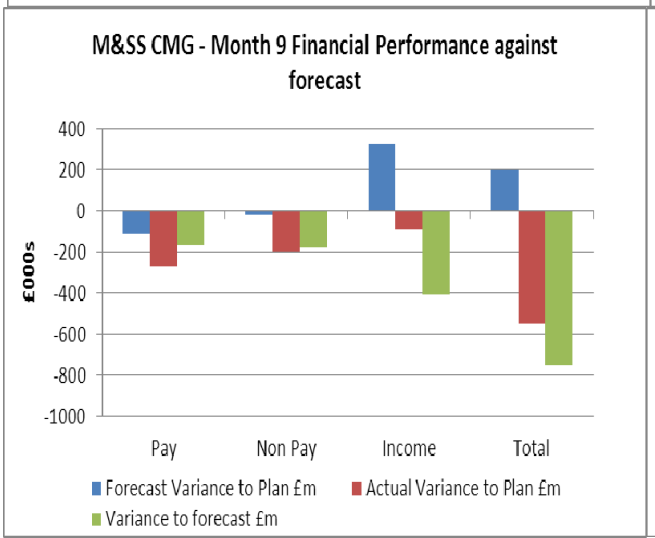
		Income			Pay			Non Pay			TOTAL		
Division	CMG's	YTD Budget £000s	YTD Actual £000s	'Variance £000s	YTD Budget £000s	YTD Actual £000s	'Variance £000s	YTD Budget £000s	YTD Actual £000s	'Variance £000s	YTD Budget £000s	YTD Actual £000s	'Variance £000s
Clinical Cmg'S	C.H.U.G.S	90,270	92,172	1,902	34,123	34,804	(682)	26,760	30,211	(3,451)	29,387	27,156	(2,231)
	Clinical Support & Imaging	23,318	24,066	748	50,422	52,163	(1,741)	1,571	3,923	(2,352)	(28,675)	(32,020)	(3,345)
	Divisional Management Codes	469	14	(455)	2,959	2,841	118	508	151	357	(2,998)	(2,978)	20
	Emergency & Specialist Med	79,201	87,284	8,083	47,700	55,321	(7,621)	22,666	24,120	(1,454)	8,834	7,842	(992)
	I.T.A.P.S	20,991	21,178	187	37,398	41,048	(3,650)	14,675	15,622	(947)	(31,081)	(35,492)	(4,411)
	Musculo & Specialist Surgery	71,932	72,043	111	32,680	33,894	(1,215)	13,768	14,349	(581)	25,485	23,800	(1,685)
	Renal, Respiratory & Cardiac	97,313	97,717	405	42,077	43,783	(1,706)	31,563	34,213	(2,650)	23,673	19,722	(3,951)
	Womens & Childrens	105,590	106,783	1,192	55,846	56,025	(178)	22,118	22,903	(784)	27,626	27,855	230
Clinical Cmg'S Total		**489,085**	**501,257**	**12,172**	**303,205**	**319,880**	**(16,675)**	**133,629**	**145,491**	**(11,862)**	**52,252**	**35,887**	**(16,365)**
Corporate	Communications & Ext Relations	25	17	(8)	577	647	(70)	91	97	(6)	(643)	(727)	(84)
	Corporate & Legal	0	72	72	728	721	7	876	982	(107)	(1,604)	(1,632)	(28)
	Corporate Medical	1,092	1,143	51	2,849	2,811	37	548	600	(53)	(2,304)	(2,269)	35
	Facilities	8,817	8,945	128	956	913	43	40,911	39,639	1,271	(33,050)	(31,607)	1,442
	Finance & Procurement	38	48	10	3,225	3,149	76	2,019	1,879	140	(5,206)	(4,980)	226
	Human Resources	2,144	2,449	306	4,098	4,049	49	1,354	1,597	(242)	(3,308)	(3,197)	112
	Im&T	150	135	(15)	2,251	2,120	131	4,352	4,664	(312)	(6,453)	(6,649)	(196)
	Nursing	206	243	37	4,333	3,899	434	9,941	10,128	(188)	(14,067)	(13,783)	284
	Operations	278	534	257	2,232	2,682	(450)	161	407	(247)	(2,115)	(2,555)	(440)
	Strategic Devt	0	67	67	2,071	2,236	(165)	110	355	(245)	(2,181)	(2,524)	(343)
Corporate Total		**12,749**	**13,654**	**905**	**23,319**	**23,227**	**92**	**60,362**	**60,350**	**12**	**(70,933)**	**(69,923)**	**1,009**
Research & Development Total		**23,215**	**23,192**	**(23)**	**9,602**	**9,556**	**46**	**12,614**	**12,284**	**330**	**1,000**	**1,353**	**353**
Central Division Total		**40,621**	**38,444**	**(2,177)**	**0**	**193**	**(193)**	**19,942**	**34,067**	**(14,125)**	**20,679**	**4,184**	**(16,495)**
Grand Total		**565,670**	**576,547**	**10,878**	**336,126**	**352,855**	**(16,730)**	**226,547**	**252,192**	**(25,645)**	**2,997**	**(28,500)**	**(31,498)**

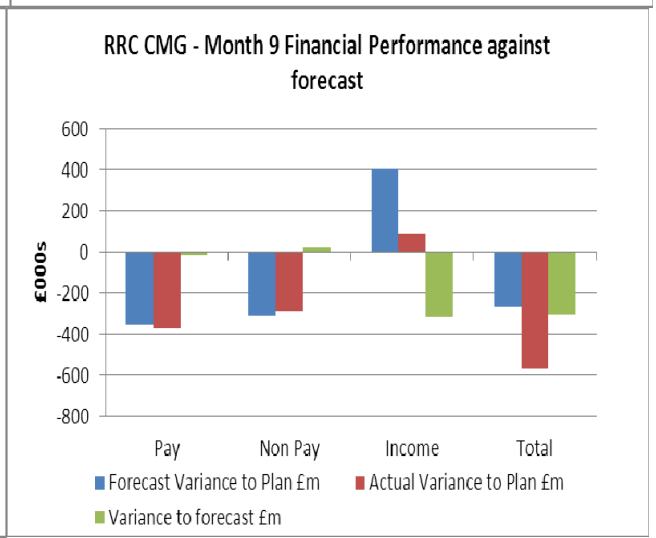

CHUGS CMG - Month 9 Financial Performance against forecast
£000s
800
600
400
200
0
-200
-400
-600
-800
Pay
Non Pay
Income
Total
Forecast Variance to Plan £m
Actual Variance to Plan £m
Var to forecast £m

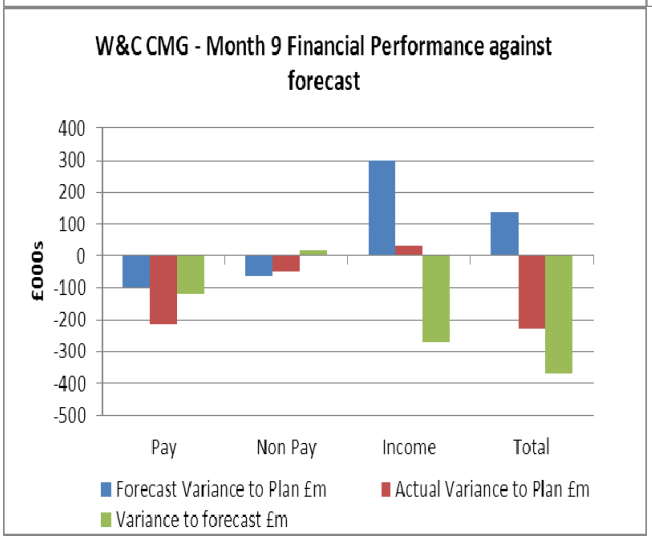

CSI CMG - Month 9 Financial Performance against forecast
£000s
300
200
100
0
-100
-200
-300
-400
-500
-600
Pay
Non Pay
Income
Total
Forecast Variance to Plan £m
Actual Variance to Plan £m
Variance to forecast £m


Emergency & Specialist Medicine CMG - Month 9 Financial Performance against forecast
£000s
1500
1000
500
0
-500
-1000
-1500
Pay
Non Pay
Income
Total
Forecast Variance to Plan £m
Actual Variance to Plan £m
Variance to forecast £m


ITAPS CMG - Month 9 Financial Performance against forecast
£000s
300
200
100
0
-100
-200
-300
-400
-500
-600
-700
-800
Pay
Non Pay
Income
Total
Forecast Variance to Plan £m
Actual Variance to Plan £m
Variance to forecast £m


M&SS CMG - Month 9 Financial Performance against forecast
£000s
400
200
0
-200
-400
-600
-800
-1000
Pay
Non Pay
Income
Total
Forecast Variance to Plan £m
Actual Variance to Plan £m
Variance to forecast £m


RRC CMG - Month 9 Financial Performance against forecast
£000s
600
400
200
0
-200
-400
-600
-800
Pay
Non Pay
Income
Total
Forecast Variance to Plan £m
Actual Variance to Plan £m
Variance to forecast £m


W&C CMG - Month 9 Financial Performance against forecast
£000s
400
300
200
100
0
-100
-200
-300
-400
-500
Pay
Non Pay
Income
Total
Forecast Variance to Plan £m
Actual Variance to Plan £m
Variance to forecast £m

University Hospitals of Leicester NHS
NHS Trust

Financial performance report for the period ending 31st December 2013

Page

Author: Lorraine Bentley & Simon Sheppard
Month - Year: December 2013

YTD Position as at 31st December - Month 9

		Income			Pay			Non Pay			TOTAL		
Division	CMG's	YTD Budget £000s	YTD Actual £000s	'Variance £000s	YTD Budget £000s	YTD Actual £000s	'Variance £000s	YTD Budget £000s	YTD Actual £000s	'Variance £000s	YTD Budget £000s	YTD Actual £000s	'Variance £000s
Clinical Cmg'S	C.H.U.G.S	90,270	92,172	1,902	34,123	34,804	(682)	26,760	30,211	(3,451)	29,387	27,156	(2,231)
	Clinical Support & Imaging	23,318	24,066	748	50,422	52,163	(1,741)	1,571	3,923	(2,352)	(28,675)	(32,020)	(3,345)
	Divisional Management Codes	469	14	(455)	2,959	2,841	118	508	151	357	(2,998)	(2,978)	20
	Emergency & Specialist Med	79,201	87,284	8,083	47,700	55,321	(7,621)	22,666	24,120	(1,454)	8,834	7,842	(992)
	I.T.A.P.S	20,991	21,178	187	37,398	41,048	(3,650)	14,675	15,622	(947)	(31,081)	(35,492)	(4,411)
	Musculo & Specialist Surgery	71,932	72,043	111	32,680	33,894	(1,215)	13,768	14,349	(581)	25,485	23,800	(1,685)
	Renal, Respiratory & Cardiac	97,313	97,717	405	42,077	43,783	(1,706)	31,563	34,213	(2,650)	23,673	19,722	(3,951)
	Womens & Childrens	105,590	106,783	1,192	55,846	56,025	(178)	22,118	22,903	(784)	27,626	27,855	230
Clinical Cmg'S Total		**489,085**	**501,257**	**12,172**	**303,205**	**319,880**	**(16,675)**	**133,629**	**145,491**	**(11,862)**	**52,252**	**35,887**	**(16,365)**
Corporate	Communications & Ext Relations	25	17	(8)	577	647	(70)	91	97	(6)	(643)	(727)	(84)
	Corporate & Legal	0	72	72	728	721	7	876	982	(107)	(1,604)	(1,632)	(28)
	Corporate Medical	1,092	1,143	51	2,849	2,811	37	548	600	(53)	(2,304)	(2,269)	35
	Facilities	8,817	8,945	128	956	913	43	40,911	39,639	1,271	(33,050)	(31,607)	1,442
	Finance & Procurement	38	48	10	3,225	3,149	76	2,019	1,879	140	(5,206)	(4,980)	226
	Human Resources	2,144	2,449	306	4,098	4,049	49	1,354	1,597	(242)	(3,308)	(3,197)	112
	Im&T	150	135	(15)	2,251	2,120	131	4,352	4,664	(312)	(6,453)	(6,649)	(196)
	Nursing	206	243	37	4,333	3,899	434	9,941	10,128	(188)	(14,067)	(13,783)	284
	Operations	278	534	257	2,232	2,682	(450)	161	407	(247)	(2,115)	(2,555)	(440)
	Strategic Devt	0	67	67	2,071	2,236	(165)	110	355	(245)	(2,181)	(2,524)	(343)
Corporate Total		**12,749**	**13,654**	**905**	**23,319**	**23,227**	**92**	**60,362**	**60,350**	**12**	**(70,933)**	**(69,923)**	**1,009**
Research & Development Total		**23,215**	**23,192**	**(23)**	**9,602**	**9,556**	**46**	**12,614**	**12,284**	**330**	**1,000**	**1,353**	**353**
Central Division Total		**40,621**	**38,444**	**(2,177)**	**0**	**193**	**(193)**	**19,942**	**34,067**	**(14,125)**	**20,679**	**4,184**	**(16,495)**
Grand Total		**565,670**	**576,547**	**10,878**	**336,126**	**352,855**	**(16,730)**	**226,547**	**252,192**	**(25,645)**	**2,997**	**(28,500)**	**(31,498)**

Pay Actuals and forecast by month 2013/14

	CMG's	Actuals Apr 2013 £'000's	Actuals May 2013 £'000's	Actuals June 2013 £'000's	Actuals July 2013 £'000's	Actuals Aug 2013 £'000's	Actuals Sept 2013 £'000's	Actuals Oct 2013 £'000's	Actuals Nov 2013 £'000's	Actual Dec 2013 £'000's	Forecast Jan 2014 £'000's	Forecast Feb 2014 £'000's	Forecast Mar 2014 £'000's	Total
Clinical Cmg'S	C.H.U.G.S	3,823	3,862	3,910	3,866	3,882	3,887	3,907	3,879	3,980	3,926	3,934	3,941	46,798
	Clinical Support & Imaging	5,718	5,744	5,717	5,760	5,733	5,828	5,852	5,906	5,906	5,943	5,916	5,900	69,922
	Divisional Management Codes	285	324	355	326	309	300	312	322	309	239	239	243	3,563
	Emergency & Specialist Med	5,692	6,191	6,495	6,149	6,023	5,972	6,180	6,169	6,449	6,353	6,282	6,219	74,174
	I.T.A.P.S	4,442	4,607	4,491	4,596	4,588	4,440	4,642	4,514	4,728	4,582	4,608	4,621	54,859
	Musculo & Specialist Surgery	3,770	3,801	3,700	3,652	3,665	3,722	3,790	3,891	3,903	3,750	3,716	3,722	45,083
	Renal, Respiratory & Cardiac	4,836	4,862	4,945	4,813	4,787	4,684	4,949	4,870	5,037	4,945	5,012	5,023	58,762
	Womens & Childrens	6,158	6,188	6,159	6,151	6,138	6,161	6,277	6,331	6,461	6,200	6,178	6,162	74,565
Clinical Cmg'S Total		**34,724**	**35,580**	**35,772**	**35,313**	**35,124**	**34,994**	**35,909**	**35,882**	**36,773**	**35,937**	**35,886**	**35,832**	**427,727**
Corporate	Communications & Ext Relations	74	75	76	72	71	69	69	71	69	67	67	61	842
	Corporate & Legal	82	78	89	80	76	81	80	75	82	81	85	85	972
	Corporate Medical	295	304	333	350	332	278	317	316	285	313	306	308	3,738
	Facilities	94	98	97	104	100	106	106	105	104	105	105	105	1,229
	Finance & Procurement	343	331	340	351	353	354	353	363	361	371	381	381	4,282
	Human Resources	418	456	449	450	452	458	452	456	458	467	465	467	5,448
	Im&T	315	296	328	312	230	225	157	168	90	87	87	87	2,381
	Nursing	428	405	397	410	406	494	435	457	467	532	541	531	5,504
	Operations	352	357	329	344	340	338	337	353	559	642	642	646	5,239
	Strategic Devt	121	122	96	150	141	134	112	290	252	283	309	319	2,326
Corporate Total		**2,523**	**2,522**	**2,533**	**2,623**	**2,501**	**2,538**	**2,417**	**2,651**	**2,727**	**2,948**	**2,988**	**2,991**	**31,961**
Research & Development	Chugs Cmg R&D	16	93	91	86	82	155	64	89	101	90	91	100	1,058
	Clinical Supp & Imag Cmg R&D	57	56	48	42	47	44	86	49	55	51	51	51	638
	Emerg & Spec Med Cmg R&D	286	328	330	243	310	333	300	268	309	291	291	323	3,610
	Itaps Cmg R&D	16	8	11	23	16	14	11	12	9	12	10	10	151
	Musc & Spec Surgery Cmg R&D	9	25	17	19	19	19	21	17	22	19	19	19	225
	Renal, Resp & Cardiac Cmg R&D	308	287	346	241	271	279	292	284	352	302	285	324	3,571
	Research & Development	173	173	200	362	246	244	298	279	268	310	305	300	3,157
	Womens & Childrens Cmg R&D	35	49	53	42	68	43	38	36	35	35	35	35	502
Research & Development Total		**900**	**1,018**	**1,096**	**1,059**	**1,059**	**1,131**	**1,109**	**1,033**	**1,151**	**1,109**	**1,086**	**1,161**	**12,912**
Central Division	Central Income	-	-	-	-	-	-	-		-	-	-	-	-
	Central Other	-	0	- 3	- 4	127	- 53	98	32	- 2	-	-	-	193
	Reserves	-	-	-	-	-	-	-		-	-	-	-	-
Central Division Total		**-**	**0**	**- 3**	**- 4**	**127**	**- 53**	**98**	**32**	**- 2**	**-**	**-**	**-**	**193**
Grand Total		**38,147**	**39,121**	**39,397**	**38,990**	**38,811**	**38,609**	**39,532**	**39,599**	**40,648**	**39,995**	**39,960**	**39,983**	**472,793**

Q1	Q2	Q3	Q4	H1	H2	Decrease / (increase) H1 H2
11,595	11,634	11,767	11,802	23,230	23,569	(339)
17,179	17,321	17,663	17,759	34,500	35,422	(922)
964	935	942	722	1,900	1,664	236
18,378	18,144	18,799	18,853	36,522	37,652	(1,130)
13,540	13,624	13,884	13,811	27,164	27,695	(531)
11,272	11,038	11,584	11,188	22,310	22,772	(462)
14,643	14,284	14,856	14,980	28,927	29,835	(908)
18,505	18,450	19,070	18,540	36,955	37,610	(654)
106,076	**105,431**	**108,564**	**107,655**	**211,508**	**216,219**	**(4,711)**
226	212	208	195	438	404	35
249	237	236	251	485	487	(2)
932	961	918	927	1,894	1,845	49
288	309	315	316	597	631	(34)
1,014	1,058	1,076	1,133	2,073	2,209	(137)
1,323	1,361	1,366	1,399	2,683	2,765	(82)
939	767	414	261	1,706	675	1,032
1,230	1,310	1,359	1,605	2,540	2,964	(424)
1,038	1,022	1,249	1,929	2,060	3,178	(1,118)
338	425	653	910	763	1,563	(800)
7,578	**7,662**	**7,795**	**8,927**	**15,240**	**16,722**	**(1,482)**
200	323	254	281	523	535	(12)
161	133	190	153	295	343	(48)
944	885	876	905	1,829	1,781	48
34	53	32	31	88	63	25
51	57	60	57	108	117	(9)
941	792	928	910	1,733	1,838	(105)
546	852	845	915	1,397	1,760	(363)
137	153	108	104	290	212	78
3,014	**3,249**	**3,293**	**3,356**	**6,263**	**6,649**	**(386)**
-	-	-	-	-	-	0
- 3	69	127	-	66	127	(61)
-	-	-	-	-	-	0
- 3	**69**	**127**	**-**	**66**	**127**	**(61)**
116,665	**116,411**	**119,779**	**119,938**	**233,076**	**239,717**	**(6,641)**

Pay WTE Actuals and forecast by month 2013/14

Division	CMG's	Sum of Actuals Apr 2013 WTE	Sum of Actuals May 2013 WTE	Sum of Actuals June 2013 WTE	Sum of Actuals July 2013 WTE	Sum of Actuals Aug 2013 WTE	Sum of Actuals Sept 2013 WTE	Sum of Forecast Oct 2013 WTE	Sum of Forecast Nov 2013 WTE	Sum of Actual Dec 2013 WTE	Sum of Forecast Jan 2014 WTE	Sum of Forecast Feb 2014 WTE	Sum of Forecast Mar 2014 WTE	Total	Q1	Q2	Q3	Q4	H1	H2	Decrease / (increase) H1 H2
Clinical Cmg'S	C.H.U.G.S	1,034.5	1,028.8	1,033.5	1,035.5	1,037.5	1,023.2	1,052.2	1,040.9	1,065.3	1,061.5	1,064.5	1,067.5	12,545.0	1,032.3	1,032.1	1,052.8	1,064.5	1,032.2	1,058.7	(26.5)
	Clinical Support & Imaging	1,681.9	1,676.8	1,667.6	1,664.7	1,683.1	1,692.3	1,707.1	1,724.0	1,733.5	1,773.2	1,757.5	1,754.8	20,516.6	1,675.5	1,680.0	1,721.6	1,761.8	1,677.7	1,741.7	(64.0)
	Divisional Management Codes	65.9	70.0	77.9	73.0	72.4	74.6	76.9	77.9	75.5	78.7	78.7	79.9	901.2	71.3	73.3	76.8	79.1	72.3	77.9	(5.6)
	Emergency & Specialist Med	1,478.0	1,543.0	1,558.9	1,550.6	1,533.3	1,494.2	1,530.0	1,644.2	1,622.5	1,580.9	1,584.0	1,570.3	18,690.0	1,526.7	1,526.1	1,598.9	1,578.4	1,526.4	1,588.6	(62.3)
	I.T.A.P.S	1,050.9	1,056.4	1,045.0	1,058.7	1,069.1	1,056.1	1,090.1	1,080.7	1,091.6	1,084.4	1,092.0	1,097.0	12,872.0	1,050.8	1,061.3	1,087.5	1,091.2	1,056.0	1,089.3	(33.3)
	Musculo & Specialist Surgery	948.0	961.7	939.1	934.6	941.2	933.5	946.0	954.4	961.0	961.8	962.8	964.8	11,408.7	949.6	936.4	953.8	963.1	943.0	958.5	(15.5)
	Renal, Respiratory & Cardiac	1,377.5	1,371.7	1,378.4	1,352.4	1,346.8	1,356.1	1,403.0	1,422.2	1,421.0	1,411.6	1,437.3	1,437.3	16,715.3	1,375.9	1,351.8	1,415.4	1,428.8	1,363.8	1,422.1	(58.3)
	Womens & Childrens	1,617.7	1,605.2	1,571.6	1,569.4	1,586.4	1,582.2	1,605.5	1,631.6	1,633.2	1,572.1	1,564.7	1,561.8	19,101.4	1,598.1	1,579.3	1,623.4	1,566.2	1,588.7	1,594.8	(6.1)
Clinical Cmg'S Total		**9,254.3**	**9,313.6**	**9,272.0**	**9,238.9**	**9,269.8**	**9,212.2**	**9,410.8**	**9,575.9**	**9,603.7**	**9,524.1**	**9,541.5**	**9,533.5**	**112,750.1**	**9,279.9**	**9,240.3**	**9,530.1**	**9,533.0**	**9,260.1**	**9,531.6**	**(271.5)**
Corporate	Communications & Ext Relations	18.7	18.9	18.2	17.1	17.8	17.2	17.7	17.7	17.7	16.2	16.2	15.2	208.5	18.6	17.3	17.7	15.9	18.0	16.8	1.2
	Corporate & Legal	20.3	20.3	21.3	21.5	20.3	20.3	20.3	20.3	21.8	21.3	22.3	23.3	253.4	20.7	20.7	20.8	22.3	20.7	21.6	(0.9)
	Corporate Medical	67.1	69.9	71.9	68.3	71.3	70.2	70.7	68.3	67.2	67.7	65.7	65.7	824.0	69.6	69.9	68.7	66.4	69.8	67.5	2.2
	Facilities	19.2	21.9	22.4	24.0	21.5	22.2	24.5	24.5	24.6	24.6	24.6	24.6	278.5	21.2	22.6	24.5	24.6	21.9	24.5	(2.7)
	Finance & Procurement	113.5	113.7	113.6	115.2	117.9	119.5	117.7	120.7	122.0	123.3	126.6	126.6	1,430.3	113.6	117.5	120.1	125.5	115.6	122.8	(7.3)
	Human Resources	135.1	140.2	139.4	140.6	144.4	145.8	144.7	144.4	146.1	150.3	149.9	150.7	1,731.6	138.2	143.6	145.1	150.3	140.9	147.7	(6.8)
	Im&T	86.9	89.7	95.2	91.6	63.3	62.2	42.5	42.6	20.1	22.0	22.0	22.0	660.0	90.6	72.4	35.1	22.0	81.5	28.5	53.0
	Nursing	127.2	123.7	121.5	124.0	125.6	135.4	133.9	139.1	141.6	147.4	147.4	147.4	1,614.2	124.1	128.4	138.2	147.4	126.2	142.8	(16.6)
	Operations	69.0	69.0	69.3	72.4	72.2	73.2	72.9	76.8	81.3	94.0	94.0	96.0	939.8	69.1	72.6	77.0	94.6	70.8	85.8	(15.0)
	Strategic Devt	59.8	61.9	61.8	62.1	62.4	62.6	59.3	58.9	58.7	68.5	71.5	73.5	760.9	61.1	62.4	59.0	71.2	61.8	65.1	(3.3)
Corporate Total		**716.8**	**729.0**	**734.6**	**736.9**	**716.6**	**728.6**	**704.2**	**704.2**	**701.1**	**735.2**	**740.1**	**744.9**	**8,692.0**	**726.8**	**727.4**	**703.2**	**740.1**	**727.1**	**721.6**	**5.5**
Research & Development Total		**294.7**	**295.4**	**303.6**	**297.8**	**304.9**	**298.3**	**301.7**	**303.4**	**307.3**	**292.4**	**292.4**	**294.4**	**3,586.2**	**297.9**	**300.4**	**304.1**	**293.0**	**299.1**	**298.6**	**0.5**
Grand Total		**10,265.8**	**10,337.9**	**10,310.1**	**10,273.6**	**10,291.4**	**10,239.1**	**10,416.6**	**10,592.5**	**10,612.1**	**10,551.7**	**10,574.0**	**10,572.7**	**125,037.4**	**10,304.6**	**10,268.0**	**10,540.4**	**10,566.1**	**10,286.3**	**10,553.3**	**(267.0)**

Non Pay Actuals and forecast by month 2013/14

Division	CMG's	Actuals Apr 2013 £'000's	Actuals May 2013 £'000's	Actuals June 2013 £'000's	Actuals July 2013 £'000's	Actuals Aug 2013 £'000's	Actuals Sept 2013 £'000's	Actuals Oct 2013 £'000's	Actuals Nov 2013 £'000's	Actuals Dec 2013 £'000's	Forecast Jan 2014 £'000's	Forecast Feb 2014 £'000's	Forecast Mar 2014 £'000's	Total £'000's	Q1	Q2	Q3	Q4	H1	H2	Decrease / (increase) H1 H2
Clinical Cmg'S	C.H.U.G.S	3,034	3,271	3,107	3,485	3,425	3,483	3,406	3,466	3,553	3,247	3,233	3,222	39,931	9,413	10,393	10,424	9,702	19,805	20,126	- 321
	Clinical Support & Imaging	251	441	349	442	425	709	450	430	426	296	443	305	4,967	1,041	1,576	1,306	1,044	2,617	2,350	267
	Divisional Management Codes	11	14	16	17	28	9	13	16	26	29	29	29	237	41	54	55	86	96	142	- 46
	Emergency & Specialist Med	2,442	2,641	2,692	2,709	2,570	2,719	2,728	2,887	2,734	2,814	2,728	2,761	32,425	7,775	7,997	8,349	8,304	15,772	16,653	- 881
	I.T.A.P.S	1,627	1,754	1,790	1,999	1,848	1,435	1,795	1,702	1,673	734	1,632	1,804	19,792	5,170	5,282	5,171	4,170	10,452	9,340	1,111
	Musculo & Specialist Surgery	1,572	1,622	1,512	1,486	1,586	1,445	1,811	1,643	1,673	1,576	1,500	1,536	18,961	4,705	4,517	5,127	4,613	9,222	9,739	- 517
	Renal, Respiratory & Cardiac	3,566	3,770	3,576	4,040	3,884	3,635	3,910	4,086	3,748	3,674	3,642	3,645	45,176	10,912	11,559	11,744	10,961	22,471	22,705	- 234
	Womens & Childrens	2,555	2,681	2,380	2,779	2,386	2,452	2,543	2,617	2,501	2,429	2,450	2,438	30,210	7,616	7,616	7,661	7,317	15,232	14,978	254
Clinical Cmg'S Total		**15,057**	**16,194**	**15,421**	**16,957**	**16,151**	**15,886**	**16,656**	**16,847**	**16,333**	**14,799**	**15,657**	**15,741**	**191,699**	46,673	48,993	49,837	46,196	95,666	96,033	- **367**
Corporate	Communications & Ext Relations	13	10	11	5	11	13	8	15	13	16	9	28	151	33	29	35	54	62	89	- 28
	Corporate & Legal	157	98	149	100	94	100	97	85	103	108	104	120	1,315	404	294	285	332	698	617	81
	Corporate Medical	60	83	63	66	62	29	67	115	56	97	79	141	918	207	157	237	318	363	555	- 191
	Facilities	4,605	4,556	4,457	4,465	4,176	4,110	4,166	4,637	4,468	4,826	4,738	4,344	53,548	13,618	12,751	13,270	13,908	26,369	27,178	- 809
	Finance & Procurement	248	219	194	204	197	216	223	169	210	239	216	216	2,551	661	616	602	672	1,277	1,274	3
	Human Resources	143	164	189	158	167	189	197	200	190	173	199	191	2,160	496	514	587	564	1,010	1,150	- 140
	Im&T	574	511	561	536	453	529	481	480	540	490	491	868	6,514	1,646	1,518	1,501	1,849	3,163	3,350	- 187
	Nursing	1,223	1,097	1,135	1,104	1,117	995	1,134	1,163	1,160	1,158	1,215	1,185	13,685	3,455	3,217	3,457	3,557	6,671	7,014	- 342
	Operations	17	15	24	35	45	54	140	34	62	112	154	118	810	55	134	236	385	189	621	- 432
	Strategic Devt	128	44	17	11	7	8	17	25	61	65	60	258	702	189	26	103	383	216	486	- 271
Corporate Total		**7,167**	**6,797**	**6,799**	**6,685**	**6,328**	**6,243**	**6,529**	**6,923**	**6,861**	**7,285**	**7,267**	**7,471**	**82,354**	20,763	19,256	20,313	22,022	40,019	42,335	- **2,316**
Research & Development Total		**1,021**	**1,861**	**1,244**	**1,626**	**1,385**	**1,190**	**1,559**	**1,310**	**1,094**	**1,129**	**992**	**988**	**15,401**	4,125	4,202	3,963	3,110	8,327	7,074	**1,253**
Central Division Total		**3,179**	**3,722**	**3,767**	**3,980**	**3,739**	**3,782**	**3,772**	**3,981**	**4,143**	**4,169**	**4,169**	**4,169**	**46,571**	10,669	11,501	11,896	12,506	22,169	24,402	- **2,232**
Grand Total		**26,425**	**28,574**	**27,232**	**29,247**	**27,604**	**27,101**	**28,516**	**29,062**	**28,431**	**27,382**	**28,084**	**28,368**	**336,025**	82,230	83,951	86,009	83,835	166,181	169,843	- 3,662

Patient Care Income by month - Excluding Penalties and contract deductions - 2013/14

	2	3	4	5	6	7	8	9	10	11	12	13	
Clinical Management Group	Actuals Apr 2013 £'000's	Actuals May 2013 £'000's	Actuals June 2013 £'000's	Actuals July 2013 £'000's	Actuals Aug 2013 £'000's	Actuals Sept 2013 £'000's	Actuals Oct 2013 £'000's	Actual Nov 2013 £'000's	Actual Dec 2013 £'000's	Forecast Jan 2014 £'000's	Forecast Feb 2014 £'000's	Forecast Mar 2014 £'000's	Total
CHUGS	9,150	9,657	9,713	10,686	10,143	9,935	10,488	10,426	9,838	10,274	9,556	10,124	119,989
CSI	2,208	1,925	1,931	2,050	1,915	2,351	2,299	2,086	2,022	2,403	2,296	2,479	25,963
Emergency and Specialist Medicine	8,505	8,573	8,301	9,281	9,784	8,604	9,568	11,707	9,681	10,013	9,568	10,034	113,620
Facilities	-	-	-	-	-	216	-	-	-	-	-	-	216
ITAPS	2,234	2,148	2,056	2,159	2,527	2,192	2,751	2,262	2,328	2,500	2,419	2,526	28,104
Musculoskeletal and Specialist Surgery	7,557	7,625	7,805	8,436	7,462	7,642	8,407	8,733	7,319	8,431	8,002	8,466	95,883
Operations	-	-	-	-	-	-	150	253	77	353	353	353	1,538
Renal Respiratory and Cardiac	10,382	10,763	9,851	10,363	11,086	10,381	11,292	10,917	10,749	11,463	10,619	11,134	129,000
Women's and Children's	11,142	11,869	11,045	11,749	11,272	11,413	11,935	12,215	11,504	11,754	10,948	11,528	138,374
Central	25	(275)	(206)	(624)	329	90	(850)	(1,059)	1,030	(1,741)	(253)	(215)	(3,749)
Grand Total	**51,204**	**52,284**	**50,497**	**54,100**	**54,518**	**52,823**	**56,039**	**57,539**	**54,548**	**55,450**	**53,507**	**56,429**	**648,937**

Q1	Q2	Q3	Q4	H1	H2	Increase / (decrease)
28,520	30,764	30,752	29,954	59,284	60,706	1,422
6,064	6,316	6,407	7,177	12,379	13,584	1,205
25,380	27,669	30,956	29,615	53,049	60,571	7,522
-	216	-	-	216	-	(216)
6,438	6,878	7,341	7,446	13,317	14,787	1,470
22,987	23,540	24,458	24,898	46,527	49,356	2,828
-	-	480	1,058	-	1,538	1,538
30,996	31,830	32,958	33,216	62,826	66,174	3,349
34,056	34,434	35,654	34,230	68,490	69,884	1,393
(456)	(205)	(879)	(2,209)	(661)	(3,089)	(2,428)
153,985	**161,442**	**168,125**	**165,385**	**315,427**	**333,510**	**18,083**

12/13 & 13/14 M1-9 Pay Spend Comparisons

		£'000s			
Division	**CMG's**	**M1-9 1213**	**M1-9 1314**	**Decrease / (increase)**	**Decrease / (increase) %**
Clinical Cmg'S	C.H.U.G.S	33,109	34,804	(1,695)	(5.1)
	Clinical Support & Imaging	50,668	52,163	(1,495)	(3.0)
	Divisional Management Codes	2,812	2,841	(30)	(1.1)
	Emergency & Specialist Med	46,731	55,321	(8,590)	(18.4)
	I.T.A.P.S	38,177	41,048	(2,871)	(7.5)
	Musculo & Specialist Surgery	33,117	33,894	(778)	(2.3)
	Renal, Respiratory & Cardiac	42,626	43,783	(1,157)	(2.7)
	Womens & Childrens	52,991	56,025	(3,034)	(5.7)
Clinical Cmg'S Total		300,230	319,880	(19,650)	(6.5)
Corporate	Communications & Ext Relations	658	647	11	1.6
	Corporate & Legal	970	721	248	25.6
	Corporate Medical	2,710	2,811	(102)	(3.8)
	* Facilities	861	913	(52)	(6.0)
	Finance & Procurement	3,458	3,149	309	8.9
	Human Resources	3,867	4,049	(182)	(4.7)
	Im&T	3,379	2,120	1,259	37.3
	Nursing	3,526	3,899	(373)	(10.6)
	Operations	2,020	2,682	(662)	(32.8)
	Strategic Devt	2,179	2,236	(57)	(2.6)
Corporate Total		23,627	23,227	400	1.7
Research & Development Total		8,380	9,556	(1,176)	(14.0)
Central Division Total		840	193	646	77
Grand Total		333,076	352,855	(19,779)	(5.9)

12/13 & 13/14 M1-9 Non Pay Spend Comparisons

		£'000s			
Division	CMG's	M1-9 1213	M1-9 1314	Decrease / (increase)	Decrease / (increase) %
Clinical Cmg'S	C.H.U.G.S	26,612	30,211	(3,600)	(13.5)
	Clinical Support & Imaging	2,364	3,923	(1,559)	(65.9)
	Divisional Management Codes	(96)	151	(247)	257.1
	Emergency & Specialist Med	22,167	24,120	(1,953)	(8.8)
	I.T.A.P.S	15,289	15,622	(333)	(2.2)
	Musculo & Specialist Surgery	13,832	14,349	(517)	(3.7)
	Renal, Respiratory & Cardiac	31,816	34,213	(2,397)	(7.5)
	Womens & Childrens	23,867	22,903	965	4.0
Clinical Cmg'S Total		135,850	145,491	(9,641)	(7.1)
Corporate	Communications & Ext Relations	89	97	(8)	(8.9)
	Corporate & Legal	906	982	(76)	(8.4)
	Corporate Medical	550	600	(51)	(9.2)
	Facilities	30,705	39,639	(8,935)	(29.1)
	Finance & Procurement	2,026	1,879	147	7.3
	Human Resources	1,574	1,597	(23)	(1.5)
	Im&T	1,945	4,664	(2,720)	(139.9)
	Nursing	7,009	10,128	(3,119)	(44.5)
	Operations	157	407	(251)	(159.7)
	Strategic Devt	50	355	(306)	(615.3)
Corporate Total		45,010	60,350	(15,341)	(34.1)
Research & Development Total		7,855	12,284	(4,429)	(56.4)
Central Division Total		32,982	34,065	(1,083)	(3.3)
Grand Total		221,697	252,190	(30,493)	(13.8)

APPENDIX 1

University Hospitals of Leicester NHS
NHS Trust
Caring at its best

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 : July - December'13

									DECEMBER SCORE BREAKDOWN				
			Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Total Responses	Promoters	Passives	Detractors	Score
GLENFIELD HOSPITAL	GH WD 15	F15	91	100	82	91	73	70	20	14	6	0	70
	GH WD 16 Respiratory Unit	F16	80	68	80	80	87	100	30	30	0	0	100
	GH WD 20	F20	77	79	-	59	56	79	24	19	5	0	79
	GH WD 23A	F23A	83	-	80	55	82	0	0	0	0	0	0
	GH WD 24	F24	100	-	95	96	100	88	16	14	2	0	88
	GH WD 24	F24	100	-	95	96	100	88	16	14	2	0	88
	GH WD 26	F26	0	94	93	87	80	94	36	34	2	0	94
	GH WD 27	F27	45	90	67	54	74	25	20	6	13	1	25
	GH WD 28	F28	90	96	76	89	80	87	23	20	3	0	87
	GH WD 29	F29	96	75	68	74	90	88	24	22	1	1	88
	GH WD 30	F30	91	94	0	95	94	0	0	0	0	0	0
	GH WD 31	F31	87	94	88	90	95	87	23	20	3	0	87
	GH WD 32	F32	81	87	81	74	79	84	19	16	3	0	84
	GH WD 33	F33	81	73	76	77	79	76	38	29	9	0	76
	GH WD 33A	F33A	80	84	67	80	87	95	20	19	1	0	95
	GH WD Clinical Decisions Unit	FCDU	49	58	50	44	65	28	69	36	14	17	28
	GH WD Coronary Care Unit	FCCU	98	90	91	100	89	79	70	59	7	4	79

University Hospitals of Leicester NHS
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FRIENDS AND FAMILY TEST : July - December'13

									DECEMBER SCORE BREAKDOWN				
			Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Total Responses	Promoters	Passives	Detractors	Score
LEICESTER GENERAL HOSPITAL	LGH WD 1	G1	-	-	-	78	84	0	0	0	0	0	0
	LGH WD 10	G10	80	70	50	56	70	100	10	10	0	0	100
	LGH WD 14	G14	70	85	61	78	46	74	19	15	3	1	74
	LGH WD 15N Nephrology	G15N	-	-	38	60	86	0	0	0	0	0	0
	LGH WD 16	G16	75	71	50	94	70	74	27	22	3	2	74
	LGH WD 17 Transplant	G17	81	84	88	86	79	82	27	22	5	0	82
	LGH WD 18	G18	75	93	71	81	85	81	37	30	7	0	81
	LGH WD 18	G18	75	93	71	81	85	81	37	30	7	0	81
	LGH WD 2	G2	25	-	87	57	46	63	8	5	3	0	63
	LGH WD 22	G22	42	50	79	46	42	52	21	13	6	2	52
	LGH WD 26 SAU	G26	65	48	46	52	60	67	36	25	10	1	67
	LGH WD 27	G27	0	64	55	58	60	33	12	5	6	1	33
	LGH WD 28 Urology	G28	31	100	24	51	60	68	19	14	4	1	68
	LGH WD 3	G3	67	70	43	100	80	40	5	2	3	0	40
	LGH WD 31	G31	84	73	83	89	79	76	46	36	7	2	76
	LGH WD Brain Injury Unit	GBIU	100	-	100	100	50	0	0	0	0	0	0
	LGH WD Crit Care Med	GDCM	64	90	56	70	89	81	21	18	2	1	81
	LGH WD Surg Acute Care	GSAC	-	100	79	100	100	0	0	0	0	0	0
	LGH WD Young Disabled	GYDU	-	100	100	50	0	67	3	2	1	0	67

University Hospitals of Leicester NHS
NHS Trust

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FRIENDS AND FAMILY TEST : July - December'13

									DECEMBER SCORE BREAKDOWN				
			Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Total Responses	Promoters	Passives	Detractors	Score
LEICESTER ROYAL INFIRMARY	LRI WD 10 Bal L4	R10	74	77	62	83	68	0	0	0	0	0	0
	LRI WD 11 Bal L4	R11	69	68	74	77	48	0	0	0	0	0	0
	LRI WD 14 Bal L4	R14	100	95	0	100	96	0	0	0	0	0	0
	LRI WD 15 AMU Bal L5	R15	43	65	56	53	67	73	87	65	19	2	73
	LRI WD 17 Bal L5	R17	0	48	74	44	0	50	26	13	13	0	50
	LRI WD 18 Bal L5	R18	47	-100	57	48	0	65	46	32	12	2	65
	LRI WD 19 Bal L6	R19	43	35	59	44	63	53	17	11	4	2	53
	LRI WD 21 Bal L6	R21	-	89	100	91	82	64	22	15	6	1	64
	LRI WD 22 Bal 6	R22	64	44	38	63	58	42	39	22	10	6	42
	LRI WD 24 Win L3	R24	29	52	38	25	18	28	19	8	7	3	28
	LRI WD 25 Win L3	R25	75	69	88	73	85	80	20	17	2	1	80
	LRI WD 26 Win L3	R26	80	65	0	69	86	71	14	10	4	0	71
	LRI WD 27 Win L4	R27	75	100	75	100	100	0	0	0	0	0	0
	LRI WD 28 Windsor Level 4	R28	50	-	0	82	62	0	0	0	0	0	0
	LRI WD 29 Win L4	R29	55	70	65	75	67	75	20	15	5	0	75
	LRI WD 31 Win L5	R31	64	48	23	72	40	65	23	15	8	0	65
	LRI WD 32 Win L5	R32	23	48	58	54	69	64	14	10	3	1	64
	LRI WD 33 Win L5	R33	77	75	58	81	77	81	37	30	5	1	81
	LRI WD 34 Windsor Level 5	R34	80	58	55	55	70	68	19	15	2	2	68
	LRI WD 36 Win L6	R36	50	50	60	57	63	95	19	18	1	0	95
	LRI WD 37 Win L6	R37	86	71	81	52	100	0	0	0	0	0	0
	LRI WD 38 Win L6	R38	87	85	100	82	92	86	21	18	3	0	86
	LRI WD 39 Osb L1	R39	87	72	88	81	76	44	23	12	9	2	44
	LRI WD 40 Osb L1	R40	77	-	71	56	61	72	25	18	7	0	72
	LRI WD 41 Osb L2	R41	55	73	50	75	86	83	19	16	1	1	83
	LRI WD 7 Bal L3	R07	71	64	61	75	61	59	58	37	18	3	59
	LRI WD 8 SAU Bal L3	RSAU	49	52	56	14	40	44	43	22	18	3	44
	LRI WD Bone Marrow	RBMT	100	67	33	25	86	100	4	4	0	0	100
	LRI WD Chemo Suite Osb L1	RCHM	86	86	88	92	72	83	23	19	4	0	83
	LRI WD Childrens Admissions	RCAU	17	-	-	53	61	0	0	0	0	0	0
	LRI WD Endoscopy Win L2	REND	100	64	100	81	70	85	13	11	2	0	85
	LRI WD Fielding John Vic L1	RFJW	71	67	86	81	82	83	30	25	5	0	83
	LRI WD GAU Ken L1	RGAU	46	82	65	53	71	0	0	0	0	0	0
	LRI WD Hambleton Suite	RHAM	95	94	100	100	100	92	12	11	1	0	92
	LRI WD IDU Infectious Diseases	RIDU	80	68	48	67	25	73	15	11	4	0	73
	LRI WD ITU Bal L2	RITU	90	95	87	80	78	82	22	18	4	0	82
	LRI WD Kinmonth Unit Bal L3	RKIN	70	57	89	74	76	73	22	18	2	2	73
	LRI WD Ophthalmic Suite Bal L6	ROPS	76	79	0	80	87	0	0	0	0	0	0
	LRI WD Osborne Assess Unit	ROND	68	84	88	73	76	85	20	17	3	0	85
	LRI WD Osborne Day Care Unit	RHAD	89	79	68	80	90	78	18	14	4	0	78
	LRI WD Paed ITU	RCIC	100	100	100	100	100	100	5	5	0	0	100

University Hospitals of Leicester NHS
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FRIENDS AND FAMILY TEST : July - December'13

			Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13

DECEMBER SCORE BREAKDOWN				
Total Responses	Promoters	Passives	Detractors	Score

University Hospitals of Leicester NHS
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FRIENDS AND FAMILY TEST : July - December'13

								DECEMBER SCORE BREAKDOWN				
		Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Total Responses	Promoters	Passives	Detractors	Score
EMERGENCY DEPARTMENT	ED - Majors	50	47	23	48	59	64	182	125	41	12	64
	ED - Minors	60	65	31	66	62	69	316	229	71	13	69
	ED - (not stated)	63	72	65	69	69	69	62	46	11	4	69
	Eye Casualty	55	54	44	50	51	69	264	191	63	10	69
	Emergency Decisions Unit	-	69	81	57	61	65	95	66	20	6	65

Appendix 2 - December Nurse to Bed Ratios

		Per finance ledger							
Cost centre description	No. of beds	Actual worked WTEs(per finance ledger)	Including bank wtes	Including agency wtes	Budgeted Nurse to bed ratio	Actual Nurse to bed ratio	Accuity ward type	Budgeted Qualified %age	Budgeted Unqualified %age
Ward 15	30	37.78	1.14	0.00	1.31	1.26	Base	60.4%	39.6%
Ward 16	30	34.68	3.85	0.41	1.21	1.16	Base	63.4%	36.6%
Ward 17 - Respiratory	30	37.12	5.87	0.72	1.35	1.24	Base	75.0%	25.0%
Ward 27	27	29.80	1.75	0.41	1.16	1.10	Base	61.9%	38.1%
Coronary Care Unit - Ggh	19	52.00	0.88	0.00	2.77	2.74	Specialist	75.8%	24.2%
Clin Dec. Unit - Ward 19 Ggh	25	90.03	2.28	1.35	3.84	3.60	Specialist	62.9%	37.1%
Ward 28 - Cardio	31	34.17	2.49	0.00	1.11	1.10	Base	60.0%	40.0%
Ward 33	29	31.85	0.83	0.00	1.17	1.10	Base	70.2%	29.8%
Ward 32	17	18.65	1.59	0.00	1.19	1.10	Base	74.7%	25.3%
Ward 33a	20	28.33	3.89	0.00	1.32	1.42	Base	64.2%	35.8%
Ward 31	34	44.79	3.06	0.00	1.29	1.32	Base	76.9%	23.1%
Ward 26	15	30.14	3.09	0.00	2.05	2.01	Specialist	76.5%	23.5%
Ward 23a	17	24.20	2.28	0.00	0.89	1.42	Base	45.2%	54.8%
Ward 29 - Resp	25	32.82	6.45	0.24	1.22	1.31	Base	61.3%	38.7%
Ward 15 High Dependency	9	25.25	1.95	0.00	3.07	2.81	Specialist	85.9%	14.1%
Ward 15 Nephrology	18	29.57	1.26	0.00	1.78	1.64	Specialist	63.1%	36.9%
Ward 10 Capd	18	37.23	0.06	0.00	2.15	2.07	Specialist	60.9%	39.1%
Ward 17 - Capd	14	20.60	0.91	0.00	1.43	1.47	Specialist	70.3%	29.7%
Admissions Unit (15/16) Lri	52	126.50	7.74	11.79	2.23	2.43	Specialist	60.0%	40.0%
Ward 33 Lri	23	49.82	4.93	6.81	2.09	2.17	Specialist	57.0%	43.0%
Emergency Decisions Unit Lri	16	21.53	0.00	-0.30	1.76	1.35	Specialist	66.8%	33.2%
Ward 24 Lri	27	41.65	3.01	6.11	1.43	1.54	Base	60.0%	40.0%
Ward 36 Lri	28	40.05	4.96	6.10	1.41	1.43	Base	60.0%	40.0%
Ward 31 Lri - Med	30	41.74	3.84	2.35	1.41	1.39	Base	60.0%	40.0%
Ward 37 Lri	24	38.35	7.49	3.17	1.53	1.60	Base	60.0%	40.0%
Ward 23 Lri	28	38.27	6.88	3.22	1.41	1.37	Base	60.0%	40.0%
Ward 38 Lri	28	35.75	5.37	2.91	1.30	1.28	Base	60.0%	40.0%
Infectious Diseases Unit	18	24.42	3.30	0.93	1.31	1.36	Specialist	60.0%	40.0%
Ward 19 Lri	30	36.70	2.05	6.60	1.41	1.22	Specialist	60.0%	40.0%
Ward 2 Lgh	21	23.73	16.33	0.15	1.32	1.13	Specialist	60.0%	40.0%
Ward 8 Lgh	15	32.24	8.75	0.00	1.84	2.15	Specialist	60.0%	40.0%
Stroke Unit - Ward 25 & 26 Lri	36	61.65	2.64	9.18	1.59	1.71	Specialist	69.5%	30.5%
Ydu Wakerley Lodge Lgh	8	17.50	2.14	0.00	2.40	2.19	Specialist	60.0%	40.0%
Brain Injury Unit Lgh	7	23.32	5.43	0.00	3.06	3.33	Specialist	70.0%	30.0%
Fielding Johnson - Medicine	20	36.54	13.73	3.77	1.60	1.83	Base	60.0%	40.0%
Ward 34 Lri	26	39.94	2.65	7.61	1.27	1.54	Base	60.0%	40.0%
Onc Ward East	19	23.89	1.98	1.00	1.28	1.26	Base	65.8%	34.2%
Osbourne Assessment Unit	6	10.93	0.87	0.00	2.04	1.82	Specialist	67.0%	33.0%
Onc Ward West	19	21.74	0.55	1.20	1.28	1.14	Specialist	72.5%	27.5%
Haem Ward	22	27.17	1.48	2.64	1.52	1.24	Specialist	71.5%	28.5%
Bmtu	5	14.79	0.30	0.00	3.02	2.96	Specilaist	96.7%	3.3%
Ward 29 Lri	30	32.89	1.85	4.00	1.23	1.10	Base	60.0%	40.0%
Ward 30 Lri	28	33.30	0.48	1.21	1.41	1.19	Specialist	60.0%	40.0%

Appendix 2 - December Nurse to Bed Ratios

		Per finance ledger							
Cost centre description	No. of beds	Actual worked WTEs(per finance ledger)	Including bank wtes	Including agency wtes	Budgeted Nurse to bed ratio	Actual Nurse to bed ratio	Accuity ward type	Budgeted Qualified %age	Budgeted Unqualified %age
Ward 26 Lgh	25	32.39	3.21	0.18	1.12	1.30	Base	65.7%	34.3%
Sau - Lri	30	36.98	1.64	1.85	1.51	1.23	Specialist	58.1%	41.9%
Ward 22 - Lri	30	33.38	2.41	0.00	1.21	1.11	Base	63.8%	36.2%
Ward 29 - Lgh	27	35.21	0.30	0.92	1.42	1.30	Base	58.1%	41.9%
Ward 22 - Lgh	20	27.37	0.14	0.00	1.32	1.37	Base	61.8%	38.2%
Ward 28 - Lgh	25	31.06	1.57	1.60	1.41	1.24	Base	62.4%	37.6%
Ward 20 - Lgh	20	23.91	1.58	0.27	1.22	1.20	Base	60.8%	39.2%
Sacu - Lgh	6	17.55	0.36	0.00	2.78	2.93	Specialist	68.4%	31.6%
Itu Gh	19	112.27	0.00	0.00	6.60	5.91	ITU	92.3%	7.7%
Itu Lri	17	101.26	0.39	0.23	5.95	5.96	ITU	89.0%	11.0%
Itu Lgh	9	56.67	0.00	0.00	6.63	6.30	ITU	95.2%	4.8%
Ward 17 Lri	30	43.89	1.91	0.00	1.43	1.46	Base	57.5%	42.5%
Ward 18 Lri	30	36.71	0.68	0.00	1.41	1.22	Base	55.2%	44.8%
Ward 32 Lri	24	39.13	0.69	0.00	1.62	1.63	Specialist	56.3%	43.7%
Ward 16 Lgh	20	22.25	1.30	0.70	1.12	1.11	Base	65.0%	35.0%
Ward 18 Lgh	17	17.49	6.21	0.00	0.78	1.03	Base	76.8%	23.2%
Ward 7 - Lri	29	31.82	1.35	1.00	1.19	1.10	Base	57.6%	42.4%
Kinmouth Unit	14	22.96	0.15	0.00	1.81	1.64	Specialist	65.1%	34.9%
Ward 21 - Lri	28	30.51	3.80	1.00	1.20	1.10	Base	60.9%	39.1%
Childrens Ward 30	13	20.23	0.35	0.00	1.45	1.56	Specialist	86.0%	14.0%
Paediatric Itu	6	38.56	0.23	0.00	7.60	6.43	ITU	94.5%	5.5%
Ward 11	12	32.53	0.53	0.00	2.97	2.71	Specialist	70.4%	29.6%
Ward 12	5	24.40	0.44	0.00	5.72	4.88	Specialist	83.1%	16.9%
Children'S Intensive Care Unit	6	36.58	0.00	0.00	6.70	6.10	ITU	94.7%	5.3%
Children'S Admissions Unit	9	25.28	0.00	0.00	2.89	2.81	Specialist	68.6%	31.4%
Ward 28 - Childrens	14	21.83	0.91	0.00	1.86	1.56	Specialist	73.6%	26.4%
Ward 10	14	23.46	0.00	0.00	1.97	1.68	Specialist	69.2%	30.8%
Ward 14	19	24.16	0.00	0.00	1.42	1.27	Specialist	69.7%	30.3%
Neo-Natal Unit (Lri)	24	71.41	0.00	0.00	3.76	2.98	Specialist	89.8%	10.2%
N.I.C.U. (Lgh)	12	24.44	0.00	0.00	2.40	2.04	HDU	65.3%	34.7%
Ward 5 Obstetrics (Lri)	26	36.25	0.00	0.00	1.54	1.39	Specialist	59.9%	40.1%
Ward 6 Obstetrics (Lri)	26	42.99	0.00	0.00	1.65	1.65	Specialist	63.4%	36.6%
Lgh Delivery Suite & Ward 30	32	106.50	0.07	0.00	3.61	3.33	HDU	76.3%	23.7%
Gau	20	22.97	0.08	0.00	1.39	1.15	Base	68.9%	31.1%
Lgh Ward 31 Gynae	21	25.00	0.54	0.00	1.38	1.19	Base	61.3%	38.7%

APPENDIX 3 - MONTHLY CLINICAL MEASURES DASHBOARD: November '13

																							NURSING METRICS											
		Budgeted Qualified %	Total vacancies (WTE)	Current appraisal Rate % (rolling 12 months)	Sickness Absence %	Friends & Family score	No. of complaints	No. of compliments	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 falls per 1000 beds	No. of patient safety SUI's (severe)	No. Patient safety incidents (moderate)	No. Patient safety incidents (low)	Number of never events	No. of medication errors	Continence	Controlled Medicines	Discharge	Falls Assessment	Infection Prevention & Control	Medicine Prescribing & Administration	Nutritional Assessment	Pain Management	Patient Dignity	Patient Observations	Pressure Area Care	Resuscitation Equipment
		> = 60%	< = 5	> = 95%	< = 3%	> = 75.0	< 2		> = 95%	> = 90%	0	0	0	0	100%	100%	0	0	<= 7.5	0	0	0	0	0	RED: < 80 AMBER: 80 - 90 GREEN: >90										
GLENFIELD HOSPITAL	F15	↔ 60%	↔ 4.10	↑ 84%	↑ 9.2%	↓ 73.3	↔ 0	↓ 5	↓ 93%	↑ 100%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↓ 3	↓ 3.5	↔ 0	↔ 0	↓ 0	↔ 0	↓ 0	↓ 93	↔ 100	↑ 86	↓ 90	↓ 96	↑ 97	↓ 94	↓ 78	↑ 98	↓ 83	↓ 73	↔ 100
	F16	↔ 63%	↔ 7.00	↑ 79%	↑ 1.6%	↑ 86.7	↔ 0	6	↑ 97%	↑ 100%	↑ 1	↔ 0	↔ 0	↔ 0	-	-	↑ 1	↔ 2	↑ 2.3	↔ 0	↔ 0	↑ 9	↔ 0	↑ 3	↑ 100	↔ 100	↑ 36	↑ 83	↑ 100	↑ 94	↓ 92	↑ 100	↑ 89	↑ 75	↑ 80	↔ 100
	F17	↔ 75%	↓ 7.50	↓ 64%	↑ 9.8%	↑ 57.7	↑ 2	↓ 28	↔ 96%	↓ 0%	↑ 3	↔ 0	↔ 0	↔ 0	-	-	↑ 2	↑ 3	↑ 4.4	↔ 0	↑ 1	↑ 5	↔ 0	↔ 0	↓ 87	↔ 100	↓ 62	↑ 100	↓ 90	↑ 92	↓ 92	↓ 81	↓ 94	↓ 81	↓ 83	↓ 0
	F17H	↔ 75%	↓ 7.50	↓ 64%	↑ 9.8%	-	↔ 0	-	-	↔ 0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0.0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	-	-	-	-	-	-	-	-	-	-	-	-
	F20	-	-	-	-	↓ 56.0	↓ 0	-	↑ 90%	↔ 100%	↑ 1	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↓ 1	↑ 3.1	↔ 0	↑ 1	↓ 1	↔ 0	↑ 1	↔ 100	↔ 100	↓ 76	↔ 100	↓ 83	↔ 100	↓ 94	↓ 94	↓ 97	↔ 100	↔ 100	↔ 100
	F23A	↔ 45%	↑ -6.94	↑ 96%	↓ 5.3%	↑ 81.5	↔ 0	-	↔ 100%	↔ 100%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↑ 5	↑ 11.3	↔ 0	↔ 0	↓ 0	↔ 0	↑ 2	↑ 100	↔ 100	↑ 95	↑ 87	↑ 88	↑ 83	↑ 100	↑ 94	↑ 97	↓ 78	↑ 100	↓ 0
	F24	↓ 0%	↓ 0.00	↓ 75%	↑ 2.8%	↓ 84.6	↔ 0	-	100%	↔ 0%	↔ 0	↔ 0	↔ 0	↔ 0	-	↔ 100%	↔ 0	↓ 0	↓ 0.0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	100	100	86	20	100	100	0	100	91	100	100	100
	F26	↔ 77%	↑ 3.77	↓ 97%	↑ 3.7%	↓ 80.0	↑ 1	↓ 9	↔ 100%	↓ 0%	↔ 0	↔ 0	↔ 0	↔ 0	↔ 100%	↑ 100%	↔ 0	↑ 1	↑ 2.2	↔ 0	↔ 0	↓ 0	↔ 0	↔ 0	↔ 100	↔ 100	↔ 100	↔ 100	↓ 93	↔ 100	↔ 100	↔ 100	↔ 100	↔ 100	↔ 100	↔ 100
	F26H	↔ 77%	↑ 3.77	↓ 97%	↑ 3.7%	-	↔ 0	-	-	-	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0.0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	-	-	-	-	-	-	-	-	-	-	-	-
	F27	↔ 62%	↑ 1.72	↑ 100%	↑ 8.1%	↑ 74.2	↔ 0	-	↔ 100%	↔ 80%	↔ 0	↔ 0	↔ 0	↔ 0	100%	-	↔ 0	↓ 1	↓ 1.3	↔ 0	↔ 0	↔ 4	↔ 0	↔ 0	↔ 100	↔ 100	↑ 100	↔ 100	↑ 85	↑ 100	↔ 100	↑ 94	↑ 97	↓ 94	↑ 97	↑ 100
	F28	↔ 60%	↑ 4.25	↓ 97%	↓ 1.5%	↓ 80.0	↔ 0	↓ 22	↑ 100%	↔ 100%	↔ 0	↔ 0	↔ 0	↔ 0	↔ 100%	-	↔ 0	↔ 2	↑ 2.5	↔ 0	↓ 0	↓ 1	↔ 0	↔ 0	↔ 100	↔ 100	↑ 100	↓ 87	↑ 100	↑ 100	↓ 92	↔ 100	↑ 100	↑ 100	↔ 100	↔ 100
	F29	↔ 61%	↓ 1.56	↓ 81%	↑ 4.0%	↑ 90.0	↔ 0	↑ 23	↑ 100%	↔ 100%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↑ 6	↑ 8.8	↔ 0	↔ 0	↑ 5	↔ 0	↓ 0	↔ 100	↔ 100	↑ 86	↑ 95	↑ 88	↔ 100	↔ 100	↔ 100	↑ 95	↑ 92	↔ 100	↔ 100
	F30	↑ 86%	↓ -0.40	↓ 75%	↓ 1.7%	↓ 0.0	↔ 0	↓ 3	↔ 100%	↔ 0%	↔ 0	↔ 0	↔ 0	↔ 0	-	↔ 100%	↔ 0	↔ 0	↔ 0.0	↑ 1	↔ 0	↔ 1	↔ 0	↑ 6	100	100	100	100	100	96	100	100	89	100	100	100
	F31	↔ 77%	↓ 3.02	↑ 96%	↑ 6.7%	↑ 95.0	↓ 0	↓ 20	↔ 100%	-	↔ 0	↔ 0	↔ 0	↔ 0	↔ 100%	↔ 100%	↔ 0	↔ 2	↑ 3.3	↔ 0	↔ 0	↓ 0	↔ 0	↔ 0	↔ 100	↔ 100	↑ 96	↔ 100	↑ 75	↓ 83	↔ 100	↔ 100	↑ 93	↑ 83	↑ 100	↔ 100
	F31H	↔ 77%	↓ 3.02	↑ 96%	↑ 6.7%	-	↔ 0	-	-	↔ 0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0.0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	-	-	-	-	-	-	-	-	-	-	-	-
	F32	↔ 75%	↑ 3.77	↑ 100%	↓ 3.7%	↑ 78.9	↔ 0	↑ 6	↔ 100%	↔ 100%	↔ 0	↔ 0	↔ 0	↔ 0	-	↔ 100%	↔ 0	↓ 0	↓ 0.0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	↓ 87	↔ 100	↑ 95	↓ 60	↑ 79	↓ 78	↔ 100	↔ 100	↑ 100	↑ 83	↑ 100	↔ 100
	F33	↔ 70%	↓ 0.13	↓ 95%	↓ 5.3%	↑ 78.8	↓ 0	↔ 13	↔ 100%	↑ 62%	↔ 0	↔ 0	↔ 0	↔ 0	100%	-	↓ 0	↑ 5	↑ 6.5	↔ 0	↔ 0	↑ 4	↔ 0	↔ 0	↔ 100	↔ 100	↑ 86	↑ 100	↑ 100	↑ 100	↔ 100	↑ 100	↑ 89	↔ 100	↔ 100	↔ 100
	F33A	↔ 64%	↔ 1.47	↑ 100%	↑ 14.2%	↑ 87.0	↑ 2	↑ 9	↔ 100%	↓ 0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↓ 1	↑ 1.8	↔ 0	↔ 0	↔ 1	↔ 0	↔ 0	↔ 100	↔ 100	↑ 71	↔ 100	↑ 94	↔ 100	↑ 100	↑ 100	↑ 84	↓ 88	↔ 100	↔ 100
	F34	-	-	-	-	↔ 0.0	↔ 0	-	↔ 100%	-	↔ 0	↔ 0	↔ 0	↔ 0	100%	↔ 100%	↔ 0	↔ 0	↔ 0.0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	-	-	-	-	-	-	-	-	-	-	-	-
	FCCU	↑ 76%	↑ 0.49	↓ 93%	↑ 10.5%	↓ 89.4	↔ 0	↓ 18	↑ 100%	↔ 100%	↔ 0	↔ 0	↔ 0	↔ 0	↔ 100%	-	↔ 0	↑ 4	↑ 8.9	↔ 0	↓ 0	↑ 2	↔ 0	↑ 2	↔ 100	↔ 100	↔ 100	↔ 100	↔ 100	↔ 100	↔ 100	↔ 100	↔ 100	↔ 100	↔ 100	↔ 100
	FCDU	↔ 63%	↓ 8.57	↑ 93%	↑ 5.8%	↑ 64.9	↑ 2	↔ 1	↔ 100%	↔ 100%	↑ 1	↔ 0	↔ 0	↔ 0	↔ 100%	-	↔ 0	↓ 2	↑ 3.0	↔ 0	↓ 0	↑ 7	↔ 0	↓ 1	↓ 87	↔ 100	↑ 76	↓ 93	↑ 96	↔ 100	↔ 100	↑ 94	↓ 58	↑ 100	↔ 100	↔ 100
	FCHD	↔ 70%	↓ 0.13	↓ 95%	↓ 5.3%	-	↔ 0	-	-	↔ 0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0.0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	-	-	-	-	-	-	-	-	-	-	-	-
	FCIC	-	-	-	-	-	↔ 0	-	-	↑ 91%	↔ 0	↔ 0	↔ 0	↔ 0	100%	-	↔ 0	↔ 0	↔ 0.0	↔ 0	↑ 2	↑ 3	↔ 0	↔ 0	-	-	-	-	-	-	-	-	-	-	-	-
	FCID	-	-	↑ 94%	↓ 4.7%	-	↔ 0	-	-	↔ 0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↓ 0	↔ 0.0	↔ 0	↔ 0	↓ 0	↔ 0	↔ 0	-	-	-	-	-	-	-	-	-	-	-	-
	FDIS	↔ 50%	↓ -0.97	↑ 100%	↓ 0.0%	-	↔ 0	-	-	↔ 0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0.0	↔ 0	↔ 0	↑ 1	↔ 0	↔ 0	-	-	-	-	-	-	-	-	-	-	-	-
	FITU	↔ 92%	↔ 0.17	↓ 99%	↑ 7.6%	-	↔ 0	↑ 23	-	↓ 0%	↓ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↓ 0	↓ 0.0	↔ 0	↓ 0	↓ 0	↔ 0	↔ 0	-	-	-	-	-	-	-	-	-	-	-	-
	FPIC	↓ 95%	↑ 4.81	↓ 98%	↑ 2.9%	-	↔ 0	↓ 3	100%	-	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0.0	↔ 0	↑ 1	↓ 1	↔ 0	↑ 5	100	100	100	93	100	100	100	78	96	100	100	100
	FREC	↔ 92%	↑ 1.89	↑ 100%	↑ 8.6%	-	↔ 0	-	-	-	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0.0	↔ 0	↔ 0	↓ 0	↔ 0	↔ 0	-	-	-	-	-	-	-	-	-	-	-	-
LEICESTER GENERAL HOSPITAL	G10	↔ 61%	↑ -0.61	↓ 90%	↑ 10.7%	↑ 70.0	↓ 0	10	↑ 94%	↓ 0%	↔ 0	↔ 0	↔ 0	↔ 0	↔ 100%	-	↔ 0	↓ 0	↓ 0.0	↔ 0	↔ 0	↓ 2	↔ 0	↑ 1	↑ 92	↑ 100	↑ 69	↑ 100	↑ 93	↑ 100	↑ 100	↑ 87	↑ 85	↑ 83	↑ 100	↑ 100
	G14	↔ 67%	↑ 0.54	↔ 100%	↑ 1.3%	↓ 46.2	↓ 0	27	↓ 94%	↔ 0%	↔ 0	↔ 0	↔ 0	↔ 0	-	↔ 100%	↔ 0	↑ 3	↑ 6.3	↔ 0	↔ 0	↑ 3	↔ 0	↔ 0	↔ 100	↔ 100	↑ 89	↓ 92	↔ 100	↔ 100	↓ 93	↑ 100	↑ 100	↓ 90	↔ 100	↔ 100
	G15A	↔ 86%	↑ 3.31	↓ 90%	↑ 9.3%	↑ 75.0	↔ 0	13	↔ 100%	↓ 0%	↔ 0	↔ 0	↔ 0	↔ 0	↔ 100%	-	↔ 0	↑ 2	↑ 9.3	↔ 0	↔ 0	↑ 1	↔ 0	↔ 0	↔ 100	↔ 100	↓ 71	↑ 100	↓ 83	↔ 100	↔ 100	↓ 83	↑ 91	↓ 83	↑ 100	↔ 100
	G15N	↔ 63%	↑ 3.83	↓ 90%	↓ 0.0%	↑ 85.7	↔ 0	↑ 4	↑ 100%	↓ 0%	↔ 0	↔ 0	↔ 0	↔ 0	↔ 100%	-	↔ 0	↔ 0	↔ 0.0	↔ 0	↔ 0	↑ 1	↔ 0	↔ 1	↓ 83	↔ 100	↓ 55	↓ 80	↓ 85	↑ 100	↑ 100	↑ 83	↑ 95	↓ 75	↓ 97	↓ 0
	G16	↔ 65%	↔ 2.11	↔ 100%	↑ 6.6%	↓ 70.0	↔ 0	-	↔ 100%	↔ 0%	↔ 0	↔ 0	↔ 0	↔ 0	-	↔ 100%	↔ 0	↑ 1	↑ 3.0	↔ 0	↔ 0	↑ 1	↔ 0	↓ 0	↔ 100	↔ 100	↑ 83	↑ 96	↔ 100	↔ 100	↑ 97	↑ 100	↑ 100	↑ 97	↔ 100	↔ 100
	G17	↔ 70%	↑ 1.78	↔ 95%	↑ 10.1%	↓ 79.3	↔ 0	-	↑ 100%	↓ 0%	↔ 0	↔ 0	↔ 0	↔ 0	↔ 100%	↔ 100%	↔ 0	↔ 0	↔ 0.0	↔ 0	↔ 0	↓ 0	↔ 0	↔ 0	75	100	71	90	63	100	100	63	91	71	100	100
	G18	↔ 59%	↔ 3.71	↔ 100%	↓ 1.8%	↑ 85.1	↓ 0	-	↔ 100%	↔ 0%	↔ 0	↔ 0	↔ 0	↔ 0	-	↔ 100%	↔ 0	↔ 1	↑ 2.4	↔ 0	↔ 0	↔ 0	↔ 0	↓ 0	↔ 100	↔ 100	↑ 91	↓ 92	↔ 100	↑ 100	↓ 93	↔ 100	↑ 100	↓ 90	↑ 100	↔ 100
	G19	↔ 77%	↔ 5.04	↓ 91%	↓ 0.0%	↔ 0.0	↔ 1	14	↔ 100%	↔ 0%	↔ 0	↔ 0	↔ 0	↔ 0	-	↔ 100%	↔ 0	↔ 0	↔ 0.0	↔ 0	↔ 0	↑ 3	↔ 0	↔ 0	↔ 100	↔ 100	↑ 94	↔ 100	↔ 100	↔ 100	↓ 97	↔ 100	↑ 100	↓ 97	↓ 96	↔ 100
	G2	↔ 60%	↓ 7.70	↑ 33%	↓ 0.0%	↓ 46.2	↑ 1	-	↑ 100%	↔ 0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↑ 5	↑ 9.7	↔ 0	↔ 0	↓ 0	↔ 0	↔ 0	100	100	75	95	81	96	100	83	93	83	100	100
	G20	↔ 62%	↔ 5.47	↔ 100%	↓ 0.0%	↔ 0.0	↓ 1	-	-	↔ 0%	↔ 0	↔ 0	↔ 0	↔ 0	-	↔ 100%	↔ 0	↔ 0	↔ 0.0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 100	↓ 0	↔ 100	↔ 100	↑ 100	↔ 100	↔ 100	↔ 100	↔ 100	↔ 100	↔ 100	↔ 100
	G22	↔ 62%	↓ -0.08	↔ 84%	↓ 2.2%	↓ 41.7	↑ 2	-	↑ 100%	↔ 0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↓ 1	↑ 1.7	↔ 0	↔ 0	↓ 0	↔ 0	↔ 1	↔ 100	↔ 100	↓ 91	↔ 100	↔ 100	↑ 100	↔ 100	↔ 100	↓ 91	↔ 100	↑ 100	↔ 100
	G26	↔ 66%	↓ 2.01	↓ 78%	↑ 9.8%	↑ 59.5	↓ 0	↑ 7	↓ 71%	↓ 0%	↑ 1	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↓ 0	↓ 0.0	↔ 0	↔ 0	↓ 0	↔ 0	↓ 0	↔ 100	↑ 100	↓ 60	↔ 100	↔ 100	↔ 100	↔ 100	↔ 100	↓ 91	↔ 100	↑ 96	↔ 0
	G27	↔ 61%	↓ 1.51	↓ 62%	↑ 5.2%	↑ 60.0	↔ 1	-	↓ 95%	↔ 0%	↔ 0	↑ 1	↔ 0	↔ 0	-	-	↔ 0	↓ 1	↓ 1.7	↔ 0	↔ 0	↑ 2	↔ 0	↑ 1	↔ 100	↔ 100	↑ 100	↔ 100	↑ 100	↔ 100	↑ 100	↓ 90	↓ 91	↔ 100	↑ 84	↔ 100
	G28	↔ 62%	↓ 5.68	↑ 91%	↑ 12.3%	↑ 59.5	↔ 1	↓ 15	↔ 100%	-	↔ 0	↔ 0	↔ 0	↔ 0	↔ 100%	100%	↓ 0	↑ 1	↑ 1.6	↔ 0	↔ 0	↔ 4	↔ 0	↔ 0	↔ 100	↔ 100	↑ 90	↑ 100	↓ 80	↔ 100	↑ 100	↑ 100	↓ 91	↔ 100	↓ 77	↔ 100
	G3	↔ 60%	↓ 0.58	↑ 88%	↑ 19.1%	↓ 80.0	↓ 0	-	↓ 86%	↑ 92%	↓ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↑ 3	↑ 6.7	↔ 0	↔ 0	↑ 4	↔ 0	↔ 0	-	-	-	-	-	-	-	-	-	-	-	-
	G30	-	-	-	-	-	↑ 7	↑ 21	↔ 100%	↓ 0%	↔ 0	↔ 0	↔ 0	↔ 0	↔ 100%	↑ 100%	↔ 0	↔ 0	↔ 0.0	↔ 0	↔ 0	↔ 2	↔ 0	↑ 1	↔ 100	↔ 100	-	-	↑ 100	↔ 100	↔ 100	↔ 100	↔ 100	-	↔ 100	↔ 100
	G31	↔ 61%	↑ 4.34	↑ 94%	↑ 5.5%	↓ 79.2	↔ 0	↑ 17	↓ 95%	↔ 0%	↔ 0	↔ 0	↔ 0	↔ 0	-	100%	↔ 0	↓ 0	↓ 0.0	↔ 0	↔ 0	↔ 1	↔ 0	↑ 1	↔ 100	↔ 100	↔ 100	↔ 100	↔ 100	↔ 100	↔ 100	↔ 100	↔ 100	↔ 100	↔ 100	↔ 100
	GBIU	↔ 70%	↓ 1.16	↓ 86%	↓ 11.4%	↓ 50.0	↔ 0	↓ 6	↔ 100%	↔ 0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 1	↑ 5.6	↔ 0	↔ 0	↓ 0	↔ 0	↔ 0	100	100	86	100	100	100	100	94	88	89	93	100
	GDCM	↔ 95%	↓ 0.56	↑ 100%	↑ 7.0%	-	↔ 0	↓ 6	-	↑ 75%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↓ 0	↔ 0	↔ 0.0	↔ 0	↔ 0	↓ 0	↔ 0	↓ 0	100	100	100	100	100	100	92	96	89	100	100	0
	GSAC	↔ 68%	↓ -1.67	↔ 100%	↑ 0.4%	↓ 0.0	↔ 0	-	100%	↔ 100%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0.0	↔ 0	↓ 0	↓ 0	↔ 0	↑ 1	↔ 100	↔ 100	↑ 100	↔ 100	↑ 100	↔ 100	↔ 100	↔ 100	↑ 100	↔ 100	↔ 100	↔ 100
	GSM	↔ 0%	↔ 0.00	↔ 100%	↔ 0.0%	-	↔ 0	-	-	-	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0.0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	-	-	-	-	-	-	-	-	-	-	-	-
	GUEA	↔ 58%	↓ 6.15	↓ 85%	↓ 2.8%	↑ 33.3	↑ 1	↓ 10	-	↔ 0%	↔ 0	↔ 0	↔ 0	↔ 0	↔ 100%	↔ 100%	↔ 0	↓ 0	↓ 0.0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	↑ 100	↔ 100	↑ 90	↓ 57	↔ 100	↓ 97	↑ 100	↓ 77	↓ 89	↑ 100	↔ 96	↑ 100
	GYDU	↔ 60%	↓ 0.87	↓ 79%	↑ 13.7%	↓ 0.0	↔ 0	-	↔ 100%	↓ 0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↓ 3	↑ 11.5	↔ 0	↑ 1	↔ 1	↔ 0	↔ 0	100	100	100	100	88	100	100	96	93	96	80	100

APPENDIX 3 - MONTHLY CLINICAL MEASURES DASHBOARD: November '13

																						NURSING METRICS											
		Budgeted Qualified %	Total vacancies (WTE)	Current appraisal Rate % (rolling 12 months)	Sickness Absence %	Friends & Family score	No. of complaints	No. of compliments	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 falls per 1000 beds	No. of patient safety SUI's (severe)	No. Patient safety incidents (moderate)	No. Patient safety incidents (low)	Number of never events	No. of medication errors	Continence	Controlled Medicines	Discharge	Falls Assessment	Infection Prevention & Control	Medicine Prescribing & Administration	Nutritional Assessment	Pain Management	Patient Dignity	Patient Observations	Pressure Area Care	Resuscitation Equipment
		> = 60%	< = 5	> = 95%	< = 3%	> = 75.0	< 2		> = 95%	> = 90%	0	0	0	0	100%	100%	0	0	< = 7.5	0	0	0	0	0	RED: < 80 AMBER: 80 - 90 GREEN: >90										
LEICESTER ROYAL INFIRMARY	R01	-	-	↑ 80%	↑ 5.9%	-	↔ 0	-	-	↔ 0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0.0	↔ 0	↔ 0	↔ 0	↔ 0	↑ 1	-	-	-	-	-	-	-	-	-	-	-
	R05	↔ 60%	↓ -1.72	↓ 73%	↓ 6.9%	-	↑ 1	10	-	↔ 0%	↔ 0	↔ 0	↔ 0	↔ 0	↔ 100%	-	↑ 1	↔ 0	↔ 0.0	↔ 0	↔ 0	↔ 1	↔ 0	↑ 5	↓ 92	↓ 50	-	-	↓ 88	↓ 95	↔ 100	↑ 100	↔ 100	-	↓ 67	↔ 100
	R06	↔ 63%	↓ -0.97	↑ 91%	↓ 5.5%	-	↓ 0	↑ 24	-	↓ 0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0.0	↔ 0	↔ 0	↓ 0	↔ 0	↑ 1	↔ 100	↔ 100	-	-	↔ 100	↔ 100	↔ 100	↑ 100	↔ 100	-	↔ 100	↔ 100
	R07	↔ 58%	↓ 4.27	↓ 94%	↓ 3.7%	↓ 60.7	↑ 2	-	-	↓ 0%	↔ 0	↔ 0	↔ 0	↔ 0	↔ 100%	↔ 100%	↔ 0	↓ 2	↑ 3.0	↔ 0	↔ 0	↑ 1	↔ 0	↓ 0	↔ 100	↔ 100	↑ 100	↑ 100	↑ 100	↔ 100	↑ 100	↑ 100	↑ 100	↑ 100	↔ 100	↔ 100
	R10	↔ 69%	↓ 5.85	↔ 96%	↑ 2.8%	↓ 0.0	↓ 0	10	↔ 100%	↓ 0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0.0	↔ 0	↓ 0	↔ 0	↔ 0	↓ 1	↓ 97	↔ 100	↓ 25	↔ 100	↑ 89	↓ 92	↔ 100	↔ 100	↑ 100	↓ 83	↔ 100	↔ 100
	R11	↔ 67%	↓ 10.19	↓ 93%	↓ 5.8%	↓ 0.0	↑ 1	↓ 22	↔ 100%	-	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0.0	↔ 0	↑ 2	↓ 1	↔ 0	↓ 0	↔ 100	↔ 100	↓ 17	↔ 100	↓ 92	↓ 91	↔ 100	↔ 100	↑ 100	↓ 90	↔ 100	↔ 100
	R12	↔ 83%	↓ 4.03	↑ 100%	↓ 2.9%	↓ 0.0	↑ 1	↓ 5	↓ 91%	↓ 0%	↑ 1	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0.0	↔ 0	↑ 1	↑ 3	↔ 0	↓ 1	-	-	-	-	-	-	-	-	-	-	-	-
	R12A	↔ 83%	↓ 4.03	↑ 100%	↓ 2.9%	-	↔ 0	-	-	-	↔ 0	↑ 2	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0.0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	-	-	-	-	-	-	-	-	-	-	-	-
	R14	↔ 70%	↑ 2.46	↔ 100%	↑ 4.9%	↓ 0.0	↔ 1	-	↔ 100%	↓ 0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↑ 2	↑ 5.3	↔ 0	↔ 0	↔ 2	↔ 0	↓ 0	↔ 100	↔ 100	↓ 58	↔ 100	↑ 96	↓ 92	↓ 64	↔ 100	↓ 91	↓ 93	↓ 87	↔ 100
	R15	↔ 60%	↓ 15.59	↑ 95%	↓ 1.4%	66.67	↔ 2	-	↑ 100%	↔ 0%	↑ 2	↔ 0	↔ 0	↔ 0	↔ 100%	-	↔ 0	↓ 2	↓ 2.5	↔ 0	↑ 1	↓ 5	↔ 0	↔ 0	↑ 100	↔ 100	↑ 86	↓ 67	↓ 88	↔ 100	↓ 92	↓ 81	↑ 100	↑ 89	↑ 100	↔ 100
	R16	↔ 60%	↓ 15.59	↑ 95%	↓ 1.4%	-	↓ 1	-	↑ 96%	↔ 0%	↔ 0	↓ 0	↔ 0	↔ 0	100%	-	↔ 0	↔ 2	↑ 4.9	↔ 0	↑ 3	↑ 5	↔ 0	↓ 2	-	-	-	-	-	-	-	-	-	-	-	-
	R17	↔ 57%	↑ 2.39	↑ 100%	↑ 6.4%	↓ 0.0	↑ 1	-	↓ 90%	↑ 100%	↔ 0	↑ 1	↔ 0	↔ 0	↔ 100%	-	↔ 0	↔ 3	↑ 3.4	↔ 0	↑ 1	↓ 1	↔ 0	↓ 1	↔ 100	↔ 100	↓ 69	↑ 100	↔ 100	↔ 100	↔ 100	↓ 90	↔ 96	↔ 97	↔ 100	↔ 100
	R18	↔ 55%	↓ 1.43	↔ 100%	↓ 7.1%	↓ 0.0	↔ 1	-	↔ 100%	↓ 90%	↔ 0	↔ 0	↔ 0	↔ 0	↔ 100%	-	↔ 0	↓ 5	↑ 6.6	↔ 0	↔ 0	↓ 2	↔ 0	↓ 0	↔ 100	↔ 100	↓ 74	↔ 100	↔ 100	↔ 100	↔ 100	↓ 83	↔ 100	↓ 97	↔ 100	↔ 100
	R19	↔ 60%	↓ 1.45	↑ 100%	↑ 6.0%	↑ 62.5	↓ 2	↔ 11	↓ 93%	↓ 0%	↔ 0	↔ 1	↓ 0	↔ 0	-	-	↔ 0	↓ 3	↓ 3.7	↓ 0	↔ 0	↑ 7	↔ 0	↓ 0	-	-	-	-	-	-	-	-	-	-	-	-
	R21	↔ 61%	↓ 0.14	↓ 80%	↓ 2.5%	↓ 81.8	↔ 0	-	↑ 100%	↔ 0%	↑ 1	↔ 0	↔ 0	↔ 0	-	↔ 100%	↔ 0	↔ 3	↑ 4.8	↑ 1	↑ 1	↓ 5	↔ 0	↔ 0	↔ 100	↔ 100	↑ 100	↔ 100	↔ 100	↔ 100	↔ 100	↔ 100	↑ 100	↑ 100	↔ 100	↔ 100
	R22	↔ 63%	↓ -1.01	↔ 100%	↑ 10.3%	↓ 57.6	↑ 1	11	↓ 93%	↔ 0%	↔ 0	↔ 0	↔ 0	↔ 0	-	↔ 100%	↓ 0	↓ 3	↑ 3.6	↔ 0	↔ 0	↑ 2	↔ 0	↓ 1	↑ 100	↔ 100	↓ 64	↑ 100	↓ 90	↔ 100	↔ 100	↑ 100	↑ 100	↑ 100	↔ 100	↔ 100
	R23	↔ 60%	↑ 6.95	↑ 94%	↓ 5.9%	↑ 89.5	↑ 1	↓ 5	↔ 100%	↓ 90%	↔ 0	↓ 0	↔ 0	↔ 0	-	-	↓ 0	↓ 3	↓ 3.7	↔ 0	↓ 0	↑ 3	↔ 0	↑ 1	↔ 100	↑ 100	↑ 80	↔ 100	↔ 100	↔ 100	↓ 90	↑ 90	↓ 96	↑ 87	↔ 100	↑ 100
	R24	↔ 60%	↓ 9.20	↓ 79%	↑ 8.0%	↓ 17.6	↑ 2	-	↑ 100%	↔ 100%	↑ 1	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↓ 5	↑ 6.7	↔ 0	↔ 0	↓ 3	↔ 0	↑ 1	-	-	-	-	-	-	-	-	-	-	-	-
	R25	↓ 69%	↑ -0.95	↑ 93%	↓ 5.7%	↑ 85.0	↑ 1	-	↓ 94%	↔ 0%	↑ 1	↑ 1	↔ 0	↔ 0	↔ 100%	-	↔ 0	↑ 7	↑ 14.8	↔ 0	↑ 1	↔ 8	↔ 0	↓ 1	↔ 100	↑ 100	↑ 79	↑ 97	↔ 100	↔ 100	↑ 97	↓ 92	↔ 100	↓ 94	↔ 100	↔ 0
	R26	↓ 69%	↑ -0.95	↑ 93%	↓ 5.7%	↑ 85.7	↓ 1	-	↔ 94%	↓ 80%	↓ 0	↑ 1	↔ 0	↔ 0	-	-	↔ 0	↑ 5	↑ 9.7	↔ 0	↑ 1	↓ 1	↔ 0	↔ 0	↑ 100	↑ 100	↑ 91	↑ 88	↑ 100	↑ 100	↑ 100	↑ 97	↑ 100	↑ 100	↑ 100	↑ 100
	R27	↔ 80%	↔ 6.63	↑ 97%	↑ 1.6%	↑ 100.0	↔ 0	-	↔ 100%	↓ 0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0.0	↔ 0	↔ 0	↓ 0	↔ 0	↓ 0	↔ 100	↔ 100	↑ 100	↔ 100	↑ 96	↑ 100	↑ 98	↔ 100	↑ 98	↔ 100	↓ 97	↔ 100
	R27A	↔ 80%	↔ 6.63	↑ 97%	↑ 1.6%	-	↔ 0	-	-	-	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0.0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	-	-	-	-	-	-	-	-	-	-	-	-
	R28	↔ 74%	↓ 4.32	↓ 57%	↑ 7.4%	↓ 0.0	↔ 0	-	↔ 100%	↓ 0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↓ 0	↓ 0.0	↔ 0	↔ 0	↓ 0	↔ 0	↓ 0	↔ 100	↔ 100	↓ 25	↓ 90	↓ 83	↔ 88	↑ 77	↓ 94	↓ 82	↓ 73	↑ 85	↔ 100
	R29	↔ 60%	↓ 5.00	↓ 97%	↑ 11.3%	↓ 66.7	↑ 1	↑ 4	↑ 100%	↔ 0%	↑ 1	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↑ 4	↑ 4.6	↔ 0	↑ 5	↔ 4	↔ 0	↑ 1	0	100	0	0	100	0	0	0	100	0	0	0
	R30	↔ 60%	↓ 6.28	↔ 94%	↑ 8.3%	↑ 100.0	↔ 0	-	↔ 100%	↔ 0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↑ 5	↑ 7.2	↔ 0	↑ 2	↓ 1	↔ 0	↔ 0	0	100	0	0	75	0	0	0	100	0	0	100
	R30H	↔ 60%	↓ 6.28	↔ 94%	↑ 8.3%	-	↔ 0	-	-	-	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0.0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	-	-	-	-	-	-	-	-	-	-	-	-
	R31	↔ 60%	↓ 5.71	↔ 100%	↑ 10.1%	↓ 40.0	↓ 1	-	↑ 100%	↓ 0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 3	↑ 3.6	↔ 0	↑ 3	↑ 4	↔ 0	↓ 0	-	-	-	-	-	-	-	-	-	-	-	-
	R32	↔ 56%	↓ 0.99	↑ 98%	↓ 2.3%	↑ 69.2	↑ 1	-	↑ 96%	↑ 100%	↔ 0	↔ 0	↔ 0	↔ 0	↓ 98%	-	↔ 0	↑ 11	↑ 16.8	↔ 0	↔ 0	↑ 7	↔ 0	↔ 0	↔ 100	↔ 100	↓ 74	↑ 100	↔ 100	↔ 100	↔ 100	↔ 90	↓ 96	↓ 90	↔ 100	↔ 100
	R33	↔ 57%	↓ 7.29	↓ 84%	↑ 4.6%	↓ 76.7	↓ 2	-	↔ 100%	↔ 0%	↑ 2	↑ 3	↔ 0	↔ 0	↔ 100%	-	↓ 0	↓ 6	↓ 7.1	↑ 1	↓ 0	↓ 5	↔ 0	↑ 3	↔ 100	↔ 100	↔ 0	↔ 100	↔ 100	↓ 96	↔ 100	↑ 100	↓ 98	↓ 83	↔ 100	↔ 100
	R34	↑ 60%	↓ 0.72	↑ 94%	↑ 10.5%	↑ 70.0	↑ 4	↑ 13	↔ 100%	↑ 86%	↑ 2	↑ 1	↔ 0	↔ 0	-	-	↔ 0	↓ 0	↓ 0.0	↔ 0	↔ 0	↓ 1	↔ 0	↑ 3	↔ 100	↑ 100	↑ 97	↓ 76	↑ 88	↔ 100	↓ 70	↓ 97	↓ 98	↓ 97	↔ 100	↔ 0
	R36	↔ 60%	↓ 7.44	↑ 96%	↓ 1.6%	↑ 63.2	↑ 2	-	↔ 96%	↓ 94%	↔ 1	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↓ 5	↑ 6.2	↑ 1	↓ 0	↑ 6	↔ 0	↔ 1	-	-	-	-	-	-	-	-	-	-	-	-
	R37	↓ 0%	↑ 22.10	↑ 97%	↑ 4.8%	↑ 100.0	↑ 1	↓ 15	↓ 91%	↓ 90%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↑ 3	↑ 4.4	↔ 0	↔ 0	↑ 4	↔ 0	↔ 0	↔ 100	↑ 50	↑ 86	↑ 96	↓ 85	↓ 97	↓ 83	↑ 97	↑ 96	↑ 77	↔ 100	↔ 0
	R38	↔ 60%	↑ 4.27	↑ 97%	↑ 12.3%	↑ 92.0	↑ 1	↑ 7	↔ 100%	↓ 94%	↔ 0	↓ 0	↔ 0	↔ 0	-	-	↔ 0	↑ 10	↑ 12.1	↔ 0	↔ 1	↓ 3	↔ 0	↔ 1	100	100	81	100	96	100	78	100	94	94	100	100
	R39	↔ 66%	↓ 1.86	↓ 96%	↓ 2.8%	↓ 76.0	↔ 0	↑ 12	↔ 100%	↓ 80%	↓ 0	↔ 0	↔ 0	↔ 0	-	-	↑ 1	↓ 5	↑ 9.3	↔ 0	↔ 0	↔ 3	↔ 0	↑ 1	↔ 100	↔ 100	↓ 34	↓ 96	↓ 85	↑ 100	↔ 100	↓ 80	↑ 89	↑ 100	↔ 100	↔ 100
	R40	↔ 72%	↓ 0.43	↑ 90%	↓ 1.6%	↑ 60.7	↔ 0	↑ 6	↑ 100%	↑ 95%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↓ 0	↓ 0.0	↔ 0	↑ 3	↓ 1	↔ 0	↓ 0	↓ 0	↔ 100	↓ 0	↓ 0	↓ 75	↓ 0	↓ 0	↓ 0	↓ 75	↓ 0	↓ 0	↔ 100
	RACB	↔ 57%	↓ 7.29	↓ 84%	↑ 4.6%	-	↔ 0	-	-	-	↔ 0	↔ 0	↔ 0	↔ 0	↔ 100%	-	↔ 0	↔ 0	↔ 0.0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	-	-	-	-	-	-	-	-	-	-	-	-
	RAMB	↔ 100%	↔ 0.00	↔ 100%	↔ 0.0%	-	↔ 0	-	-	-	↔ 0	↔ 0	↔ 0	↔ 0	↔ 100%	-	↔ 0	↔ 0	↔ 0.0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	-	-	-	-	-	-	-	-	-	-	-	-
	RBMT	↔ 97%	↓ 0.30	↑ 94%	↓ 0.0%	↑ 85.7	↔ 0	11	100%	↔ 100%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0.0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	-	-	-	-	-	-	-	-	-	-	-	-
	RCAU	↔ 69%	↓ 4.33	↑ 100%	↑ 8.0%	-	↑ 1	-	-	↔ 0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0.0	↔ 0	↔ 0	↑ 1	↔ 0	↓ 0	-	-	-	-	-	-	-	-	-	-	-	-
	RCIC	↓ 95%	↑ 4.81	↓ 98%	↑ 2.9%	-	↔ 0	-	100%	↓ 0%	↑ 1	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0.0	↔ 0	↑ 1	↑ 1	↔ 0	↑ 2	-	-	-	-	-	-	-	-	-	-	-	-
	REDU	↔ 67%	↓ 5.27	↔ 100%	↓ 5.9%	-	↔ 7	↑ 4	↑ 83%	-	↑ 1	↔ 0	↔ 0	↔ 0	↔ 100%	-	↑ 1	↓ 1	↑ 4.7	↔ 0	↔ 0	↓ 1	↔ 0	↓ 1	↔ 100	↔ 100	↔ 0	↓ 75	↓ 94	↔ 100	↑ 100	↓ 83	↑ 100	↑ 96	↔ 100	↔ 100
	REFU	-	-	-	-	-	↓ 0	-	-	-	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↑ 2	↑ 35.1	↔ 0	↔ 0	↑ 1	↔ 0	↔ 0	-	-	-	-	-	-	-	-	-	-	-	-
	RFJW	↔ 60%	↓ 3.00	↔ 100%	↑ 2.1%	↑ 81.8	↓ 0	↔ 4	↓ 90%	↑ 100%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↑ 6	↑ 12.0	↔ 0	↔ 0	↑ 4	↔ 0	↓ 0	↑ 100	↑ 100	↑ 89	↓ 92	↔ 100	↔ 100	↔ 100	↑ 100	↓ 89	↓ 77	↓ 76	↑ 100
	RGAU	↑ 69%	↓ 3.71	↑ 97%	↑ 3.9%	↑ 70.7	↓ 0	↑ 11	↔ 100%	-	↔ 0	↔ 0	↔ 0	↔ 0	↔ 100%	↔ 100%	↔ 0	↔ 0	↔ 0.0	↔ 0	↓ 0	↓ 0	↔ 0	↔ 0	↔ 100	↔ 100	↔ 100	↔ 100	↑ 100	↔ 100	↔ 100	↔ 100	↔ 100	↔ 100	↔ 100	↔ 100
	RIDU	↔ 60%	↓ -2.13	↔ 100%	↑ 3.2%	↓ 25.0	↔ 0	-	↓ 94%	↓ 94%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↓ 3	↑ 6.0	↔ 0	↔ 0	↑ 3	↔ 0	↓ 0	↓ 0	↑ 100	↓ 0	↓ 0	↑ 100	↓ 0	↓ 0	↓ 0	↑ 100	↓ 0	↓ 0	↑ 100
	RITU	↔ 89%	↑ -9.24	↑ 95%	↓ 5.9%	-	↔ 0	↓ 8	↑ 100%	↓ 84%	↑ 1	↔ 0	↔ 0	↔ 0	↔ 100%	-	↔ 0	↔ 0	↔ 0.0	↔ 0	↓ 0	↓ 1	↔ 0	↑ 1	100	100	100	73	88	100	89	100	59	100	100	100
	RKIN	↓ 0%	↓ 0.00	↓ 89%	↑ 4.6%	↑ 76.0	↑ 1	↓ 23	92%	↔ 0%	↔ 0	↔ 0	↔ 0	↔ 0	↑ 100%	-	↔ 0	↓ 1	↑ 2.6	↔ 0	↑ 1	↓ 2	↔ 0	↔ 0	↑ 97	↔ 100	↑ 100	↑ 100	↑ 96	↑ 100	↑ 100	↔ 100	↑ 88	↑ 94	↓ 97	↓ 0
	RODA	↔ 72%	↓ 4.30	↑ 91%	↑ 5.5%	-	↑ 2	-	-	↔ 0%	↑ 2	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0.0	↔ 0	↔ 0	↑ 4	↔ 0	↑ 1	-	-	-	-	-	-	-	-	-	-	-	-
	ROMO	↓ 0%	↓ 0.00	↓ 75%	↓ 2.3%	-	↔ 0	-	-	↔ 0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0.0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	-	-	-	-	-	-	-	-	-	-	-	-
	ROND	↔ 67%	↔ 1.63	↔ 100%	↑ 0.3%	↑ 76.0	↔ 0	-	-	-	↔ 0	↔ 0	↔ 0	↔ 0	↔ 100%	-	↔ 0	↓ 0	↓ 0.0	↔ 0	↔ 0	↔ 0	↔ 0	↓ 0	-	-	-	-	-	-	-	-	-	-	-	-
	RPAC	↔ 83%	↓ 3.83	↑ 86%	↑ 4.3%	-	↔ 0	-	-	↔ 0%	↔ 0	↑ 1	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0.0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	-	-	-	-	-	-	-	-	-	-	-	-
	RPSS	-	-	-	-	-	↔ 0	-	-	-	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0.0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	-	-	-	-	-	-	-	-	-	-	-	-
	RSAU	↔ 56%	↓ 4.73	↔ 97%	↓ 2.4%	↑ 40.0	↔ 1	↑ 3	100%	-	↓ 0	↔ 0	↔ 0	↔ 0	↔ 100%	-	↔ 0	↓ 0	↓ 0.0	↔ 0	↓ 0	↓ 1	↔ 0	↓ 0	↔ 100	↔ 100	↓ 83	↓ 83	↑ 96	↔ 100	↔ 100	↔ 100	↑ 100	↔ 97	↔ 100	↔ 100
	RSCB	↔ 90%	↑ 19.76	↓ 92%	↓ 1.9%	-	↔ 0	↓ 13	-	↔ 0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0.0	↔ 1	↔ 0	↔ 0	↔ 0	↓ 5	-	-	-	-	-	-	-	-	-	-	-	-

Appendix 4

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

OPERATIONAL PERFORMANCE EXCEPTION REPORT

REPORT TO: **Trust Board**

DATE: **January 2014**

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

AUTHOR: **Charlie Carr, Head of Performance Improvement**

SUBJECT: **Referral to Treatment**

Introduction

In December the Trust failed the referral to treatment targets against the admitted , non admitted and the incomplete targets. There continue to be significant failures at specilaity level in the following areas:
General surgery, Orthopaedics, ENT and Ophthalmology.
In addition there was a breach of the 52 week target on an incomplete pathway, in Ophthalmology. A breach report identified inadequate administrative processes as the key point of failure. Corrective action has been taken in the department with a specific focus on staff training and use of appropriate data quality reports. The patient has an agreed treatment date in early February. The specifics have been shared with commissioners.

During January the Trust reached agreement with Commissioners on the principles of backlog reduction to agreed waiting times in the problem specialties for 1st outpatients (6 weeks) and elective waiting times (11 weeks). In addition, to ensure a sustainable position going forward agreement has been reached on target waiting list sizes for the key specialties.
Funding for this activity will be paid at tariff.

Current position

Recovery action plans are being finalised for submission to Commissioners by 31st January.

These plans include the requirement for the following :

- Additional sessions in outpatients and electives in UHL
- The appointment of Locum and Substantive Consultant and Fellow posts
- Continued outsourcing to independed sector providers for ENT, Ophthalmology and Orthopaedics

The key dependencies for the additional activity in UHL are theatre and bed capacity and outpatient facilities. A weekly RTT performance meeting has been initiated (January 20th) Chaired by The Chief Operating Officer with representation from all key teams.

Date when recovery of target or standard is expected

It is anticipated that Trust level recovery of the:

-Incomplete standard will be February 2014

- Non admitted standard will be in Q2 2014-15

- Admitted standard will be in Q3 2014-15

Speciality level compliance with the standards are to be finalised as part of the Recovery action plans that will be submitted to Commissioners by 31st January

Details of senior responsible officer Charlie Carr, Head of Performance Improvement

Appendix 5

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

OPERATIONAL PERFORMANCE EXCEPTION REPORT

REPORT TO: **TRUST BOARD**

DATE: **January 2014**

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

AUTHOR: **Carl Ratcliff, Manager, Imaging & Medical Physics**

CMG GENERAL MANAGER: **Nigel Kee**

SUBJECT: **Diagnostic Imaging 6 week waits**

Introduction

Imaging failed to meet the diagnostic 6 week target for December 2013 with performance exceeding 1% of breaches (1.6%). The impact on the Trust performance is that it failed the threshold, with performance of 1.4%

Investigation

Virtually all of the breaches were in the MRI modality and whilst this is not the normal trend of performance, there were, and are, issues with the equipment replacement programme and the loss of 3 working days in December that has led to a downturn in performance. This has also impacted on January's performance which is also likely to fail the 1% threshold.

In the last year there have also been two other months of failure against target again due to MRI demand/ capacity issues with the replacement programme.

Conclusion and Resolution

In December 2013, Imaging had diagnostic breaches in MRI totalling 1.6%. This is above the required target due to a number of factors but predominately the effects of the equipment replacement programme.

In January at present we are forecasting a risk of breaching the target for MRI only with other modalities comfortably delivering the target

Actions are being undertaken to reduce the risk of failure from February onwards and these include additional external capacity being sourced, limiting requests to consultants only, and extending the working day to 2200 hours across all 7 days of the week (currently its until 2000 hours).

Looking ahead, there is a high level of confidence that performance will be consistently delivered once the replacement programme is concluded in April.

Details of senior responsible officer

CMG SRO: Nigel Kee

Appendix 6

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

OPERATIONAL PERFORMANCE EXCEPTION REPORT

REPORT TO: **TRUST BOARD**

DATE: **January 2014**

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

AUTHOR: **Charlie Carr , Head of Performance Improvement**

CMG GENERAL MANAGER: **Monica Harris**

SUBJECT: **Cancelled Operations and rebooking within 28 days**

Introduction

Operations cancelled on the day, standard 0.8%

All patients who have had their operations cancelled on the day to be rebooked within 28 days, standard 100%

Current position

December performance shows that the percentage of operations cancelled on/after the day of admissions of all elective activity for non-clinical reasons was 1.7%
The % rebooked within 28 days was 94.3% which equates to 8 patients. Each breach of this standard is subject to a financial penalty**.**
Commissioners have issued a contract performance notice against these standards with a deadline of 31st January. In response the Trust has developed a recovery action plan. this specifically targets the cancellation reasons as below:

		December 2013
Capacity Pressures	HOSP CANCEL WARD CLOSED	1
	HOSPITAL CANCEL - HDU BED UNAVAILABLE	5
	HOSPITAL CANCEL - ITU BED UNAVAILABLE	2
	HOSPITAL CANCEL - PT DELAYED TO ADM HIGH PRIORITY PATIENT	13
	HOSPITAL CANCEL - WARD BED UNAVAILABLE	66
Capacity Pressures	Sum:	87

Other	HOSPITAL CANCEL - CASENOTES MISSING	4
	HOSPITAL CANCEL - LACK ANAESTHETIC STAFF	2
	HOSPITAL CANCEL - LACK SURGEON	6
	HOSPITAL CANCEL - LACK THEATRE EQUIPMENT	5
	HOSPITAL CANCEL - LACK THEATRE TIME / LIST OVERRUN	37
Other	Sum:	54

	TOTAL	141

Additional elements of the plan are:

- The reiteration and re issuing of the existing Trust policy on cancelled operations
- The institution of a 21 day Trust standard for re booking of patients cancelled on the day to addres the 28 day national target.
- Daily patient level reports to all CMG's to target the re booking of previously cancelled patients.

Date when recovery of target or standard is expected

Operations cancelled on the day (standard 0.8%) - August 2014

All patients who have had their operations cancelled on the day to be rebooked within 28 days - March 2014

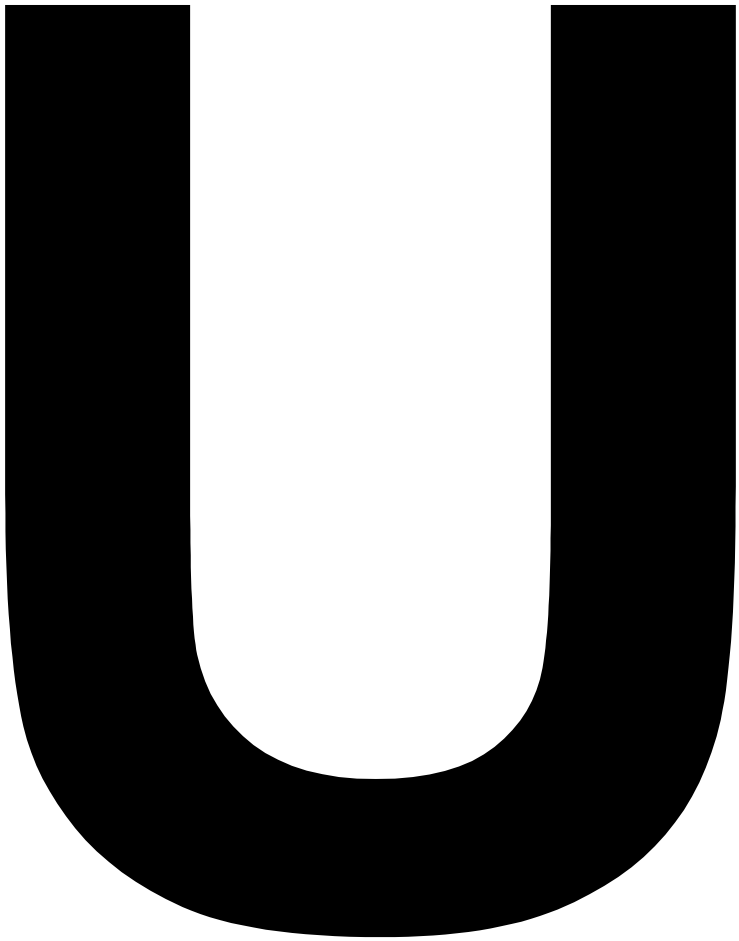
Details of senior responsible officer

CMG SRO: Monica Harris

Date: January 2014
Clinical Lead: Paul Spiers
General Manager: Monica Harris
Operations Cancelled On the Day – Recovery / Improvement

5	Complete	4	On track	3	Some delay, expected to be completed as planned	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Objective revised

	Issue	Priority 1= High	Actions	Responsible Officer(s)	Due Date	New or pre-existing action	Status	RAG
1	**Lack of theatre time / List over run**	3	a) Establish a project team to look at reasons for late starts - develop an action plan in response to findings	DT	13.1.14	New	Group being formed	1
		3	b) Review of overrun policy commenced and will be rolled out across all 3 sites (trans)	DT	16.2.14	Refreshed	Complex agenda – resolution relies on many other things Changed reporting to increase awareness	1
		3	c) Monitoring of any late starts and agreed escalation in place (transformational)	MT	16.2.14	Refreshed	Monitoring in place	4
		2	d) Confirm and challenge with each speciality to manage late starts – these will involve all specialities on a monthly basis. (transformational)	MH	30.11.13	New	Already started – these are ongoing and are repeated every 6 weeks approx	5
		1	e) Weekly reporting of activity (transformational)	AM	23.11.13	New	completed , reports go to each speciality	5
		2	f) Internal theatre escalation to authorise a cancellation on the day	MH	23.11.13	New	in place but reinforcing process	5
		3	g) Establish a system to respond within 24 hrs to the CMG to issues and problems on lists for that day(transformational)	KD/ DT	2.12.13	In progress	floor walker daily feedback set up – to establish daily reporting	5
		1	h) Develop a robust escalation process to prevent on the day cancellations – corporate	MH / PW	31.1.14	New	Re instate , re enforce cancellation policy	4
		1	i) Develop a team leader score card to performance manage system to hold teams to account(transformational)	DT	25.1.14	New	work initiated, further development required	4
2	**Patient delayed due to admission of a higher priority patient**	3	a) Review of emergency list policy to ensure it supports effective running of the session b) Review the advantages of combining of all emergency lists as a means to improve access(transformational) c) Review the advantages of combining of all emergency lists as a means to improve access(transformational)	DT/MH/PR	15.12.13	Pre-existing	Review of emergency sessions on Monday and Friday to prevent backlog of emergencies building up – discussions with specialities with regards to loading these lists pre weekend	4
3	**Lack of Theatre equipment**	3	a) Issue escalated to Synergy and equipment lead	PV	On-going	Pre-existing	Good performance from synergy	5
		3	b) 2 weeks pre-plan to ensure equipment available – to ensure all lists are loaded onto ORMIS >2 weeks	DT/KD	13-Jan	New	Progress been made - Score card being developed to monitor performance.	4
		3	c) 48hour requests for equipment so synergy can manage expectations	KD	13.1.13	New		4
		3	d) Evaluate upgrade of Ormis	MH	14.2.14	New	Meeting with Ormis planned	1
4	**Lack of Anaesthetic staff/Lack of theatre staff (non-medical)**	1	a) New scheduling system (CLW) to be rolled out which will enable increased viability of Clinical Pa's	DT	28.11.13	New	CLW rolled out better transparency of where PAs are being allocated	4
		3	b) Six week planning of capacity	MT	14.1.13	New	Progressing to 6week booking slowly.	4
		2	c) Review ILS payments	PS	ongoing	New	Daily monitoring of WLI	5
		3	d) Matrons to undertake Floor Control to release Band 7 to clinical team if possible	Matrons/Floor Control	On-going	New	Floor walker daily update complete	5
		2	e) Cancel any non-critical management duties.	Matrons/Floor Control	On-going	New	Daily review	5
		1	f) Active recruitment program nationally	JH	On-going	New	Recruitment underway and progressing well	4
		1	g) Retention review – to encourage staff to stay	JH	13.1.13	New	Working with HR to establish recruitment and retention strategy	4
5	**Ward bed unavailable**	1	a) Review of urology day-case to transfer where possible patients to an OPD with procedure out of Daycase	CMG team	November	New	Discussions undertaken and action being taken to transfer cases to OPD with procedure	4
		1	b) Review the ability to establish a 23 hour facility are the LGH site (transformational)	MH	31.12.13	New	23hr – surgery – estates solution investigated– paper being prepared for executive	4
		1	c) Confirm arrangements for outsourcing	RM	31.12.13	New	Cases being transferred – further work underway to increase numbers. ENT . Ophthalmology. Orthopaedics. General surgery	5
		2	d) Previous day, review of capacity to allow earlier cancellations	PW	16.12.13	New	Embedding practice via daily bed meetings	5
		2	e) Data accuracy to ensure reasons are correct	MT	30.11.13	New	daily report to floor coordinators of any incomplete data	5
		2	f) Review number of day case beds	MH	16.12.13	New	Ongoing , linked to 23 hr unit	4
		1	g) Clinical lead for day surgery	PS	31.1.14	New	Advertised role	4
		1	h) Develop a robust escalation process to prevent on the day cancellations – corporate	MH / PW	31.1.14	New	Re instate , re enforce cancellation policy	4
7	**Lack of surgeon**	1	a) Aligning job plans with theatre sessions (transformational)	CMG team	13.2.14	New	Work underway	4
		2	b) Review principles and policy for emergency scheduling	CMG team	13.2.14	New	Work underway	4
		2	c) Review surgeon availability for emergency lists (transformational)	CMG team	13.2.14	New	Work underway	4
8	**HDU / critical care bed unavailable**	1	a) Flexible staffing across all three sites	JH	Dec-13	completed	Flexible staffing established	5
		1	b) Service requirements for CC beds to be reviewed on the Thursday capacity meeting	DT	Nov-13	New	Being included as part of the agenda – need to embed process to 6-4-2	5
		2	c) Electronic planner reflecting elective demand	PV	Nov-13	New	In place	5
		1	d) PACU on LRI site to be completed in 2014 increasing capacity	PV	Sep-14	New	On track with project plan	4
		1	e) Daily review of level one beds in CC to prioritise their moves	PW / DM	Nov-13	on-going	In place	5
10	**Lack of theatre staff**	2	a. The theatre transformation programme. Particular emphasis on pre-assessment and scheduling are considered to be the top two priorities that would have greatest immediate benefit (transformational)	SK/DT	Dec-13	Pre-existing	To be discussed at theatre project board meeting	4
			b. International recruitment underway	JH	ongoing	new	See section 4	4
11	**Other**	2	a). Forum to review cancellation – to learn from experience and patterns	DT	December	New	Added to weekly activity meeting, weekly reporting being generated	4
12	**Cancellation and Re booking within 28 days (max) of cancellation**	1	a) Institute new Trust standard of requirement to contact patient within 48 hrs of cancellation and rebook TCI date within 21 days, and associated escallation process	CC / SP	31.1.14	New	Cancelled ops flow chart revised, includes local standard and process to rebook within 21 days.	5
		1	b) daily cancelled opeartions patient level report to be e mailed via automated route to service and operational managers , highlighting 21 day re book date	CC/ SL	31.1.14	New		4
		1	c) Weekly monitoring of performance against Trust 21 day / national 28 day standard, capturing of reasons for failure against the standard	CC / SP	31.1.14	New		4



To:	**Trust Board**
From:	**Richard Mitchell, Chief Operating Officer**
Date:	**January 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 December was 90.5%
- Performance year to date is 88.56%
- There have been six consecutive weeks above 90%
- Three super weekends were effective and key actions taken are now being normalised during the working week
- Non admitted breaches continue to reduce
- Site meetings continue to improve

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

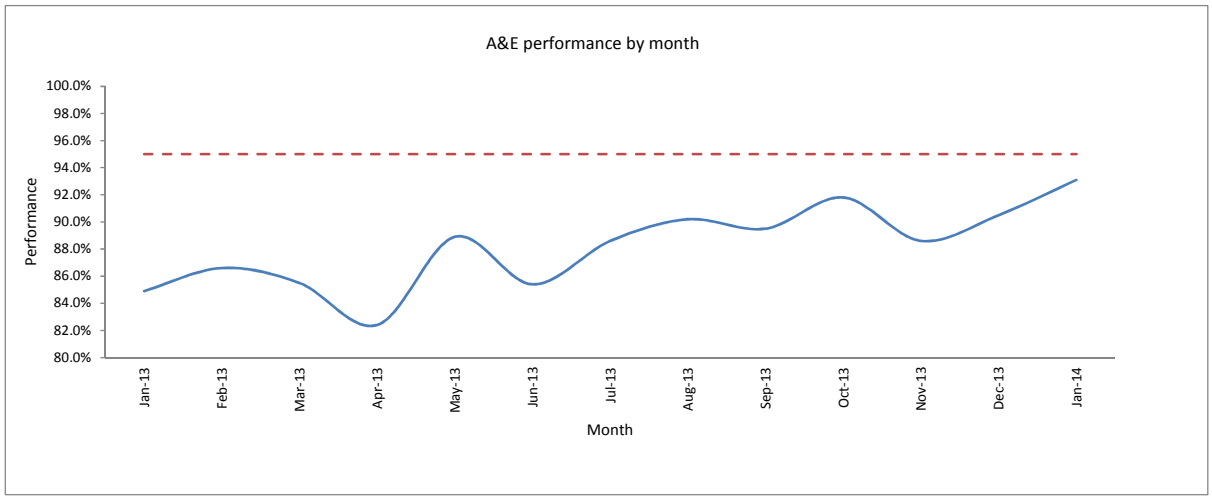
REPORT TO:	**Trust Board**
REPORT FROM:	**Richard Mitchell, Chief Operating Officer**
REPORT SUBJECT:	**Emergency Care Performance Report**
REPORT DATE:	**30 January 2014**

Introduction

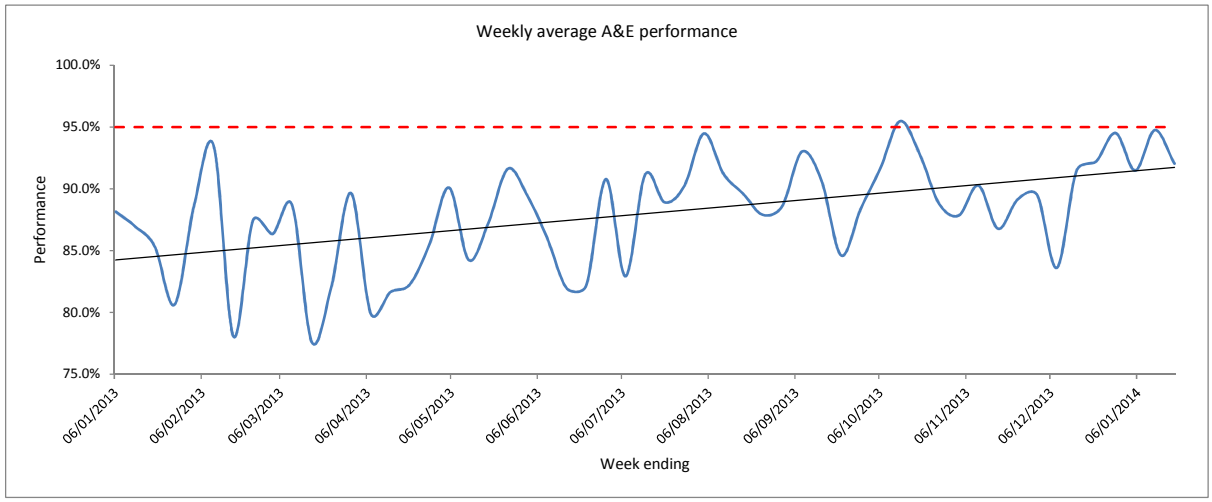
UHL's performance is improving against the four hour emergency care measure. January is set to be the best performing month for the last 15 months (93.12%). Performance improvementactions continue to embed,including twice daily discharge meetings, command and control leadership through the site meetings, the focus on non-admitted breaches and 'super weekends' (attachment one).This report provides an overview of performance for December 2013 and January 2014.

Performance overview

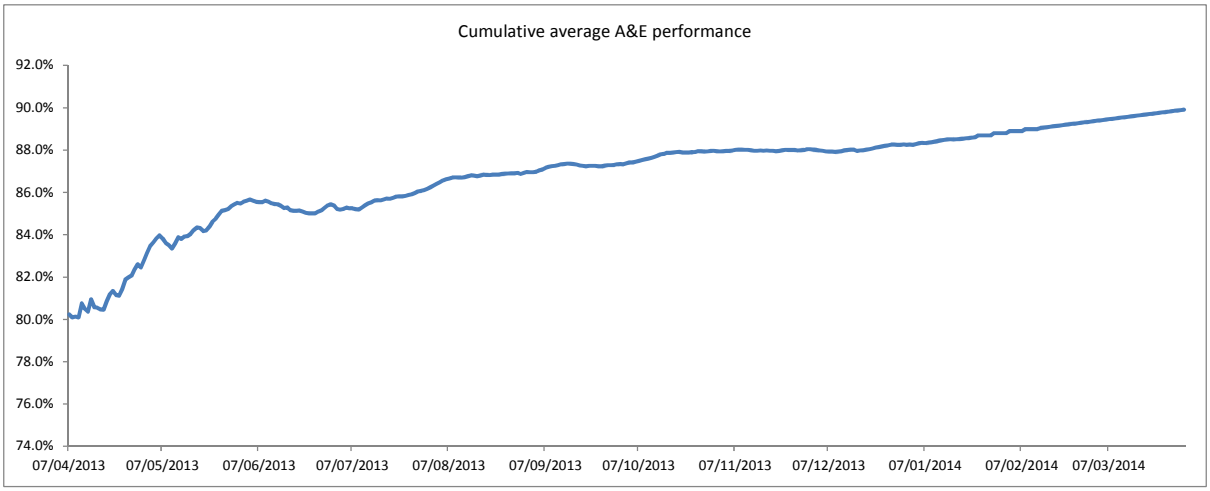
In December 2013,90.50% of patients were treated, admitted or discharged within four hours (graph one). In the first week of the month 84.4% patients were treated within four hours and this rose to 92.6% in the remainder of the month (graph two). As of 24 January 2014, there have been six weeks of performance greater than 90.0%. Year to date performance is 88.56% and if performance continues to improve at the same rate as the last four weeks, year-end performance will be 88.91% (graph three). Every effort will be taken to get year-end performance above 90.0%.



(graph one)

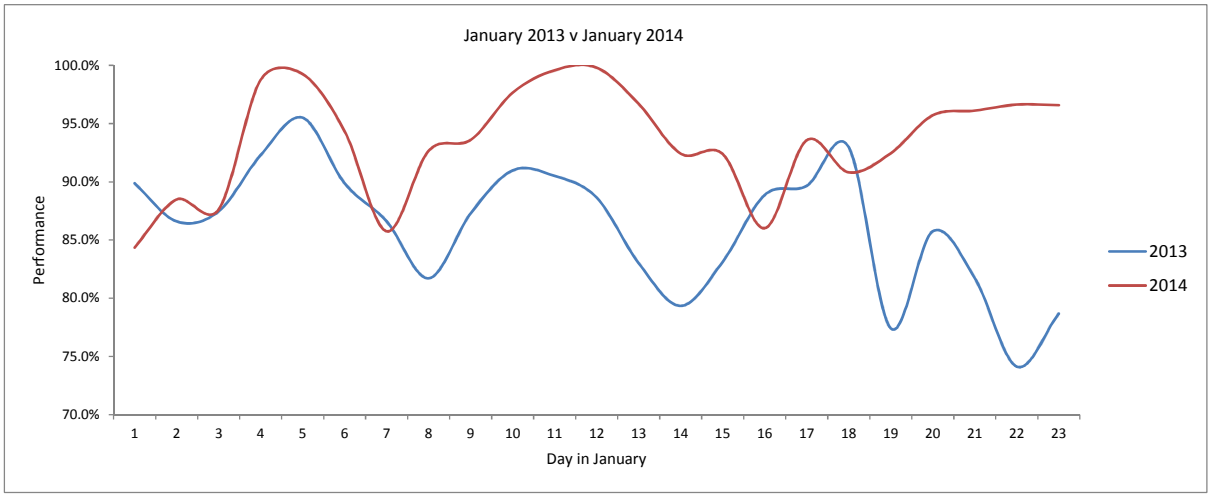


(graph two)

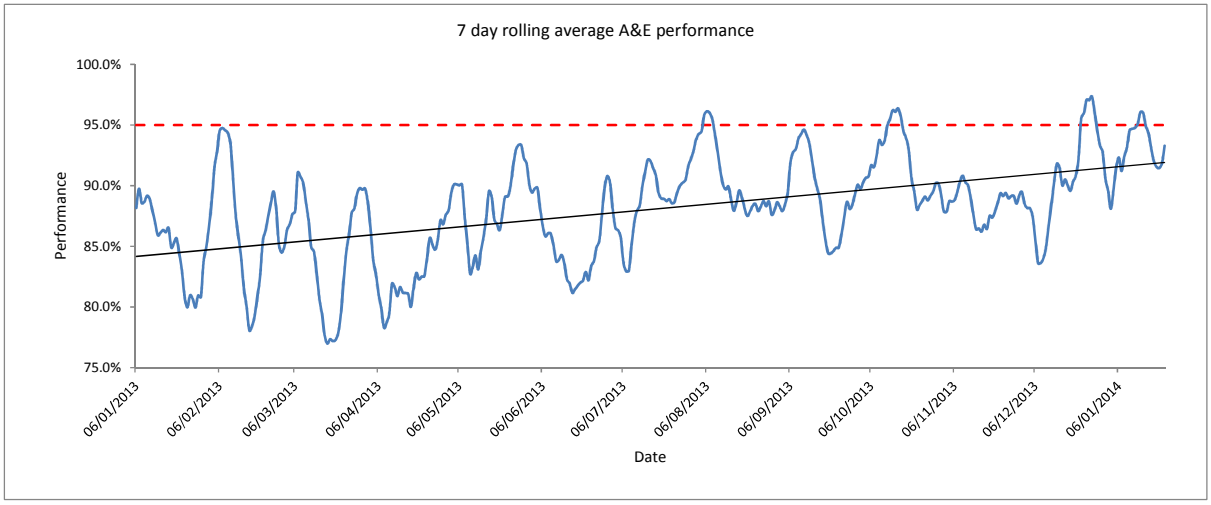


(graphthree)

The month of January is often the most challenged month of the year which makes the continual progress through the month pleasing. Performance is significantly better than 12 months ago (graph four) and variation continues to reduce (graph five).



(graph four)



(graphfive)

Performance is still not at the level it needs be, but UHL has continued to improve whilst many of our neighbouring trusts have struggled. Support from the many collaborating organisations is appreciated and Jeff Worrall, Portfolio Director TDA, Rachel Bilsborough, Divisional Director LPT and Dave Briggs MD East Leicestershire and Rutland CCGhave in particular been incredibly helpful.

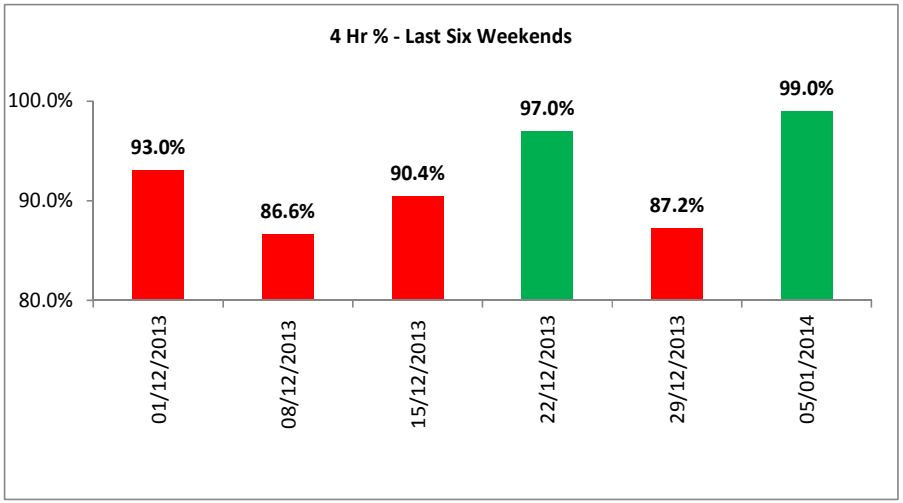
We believe we are taking the right actions and progress will continue. Q1 2014-15 compliance is a realistic target but improvement will not be linear.

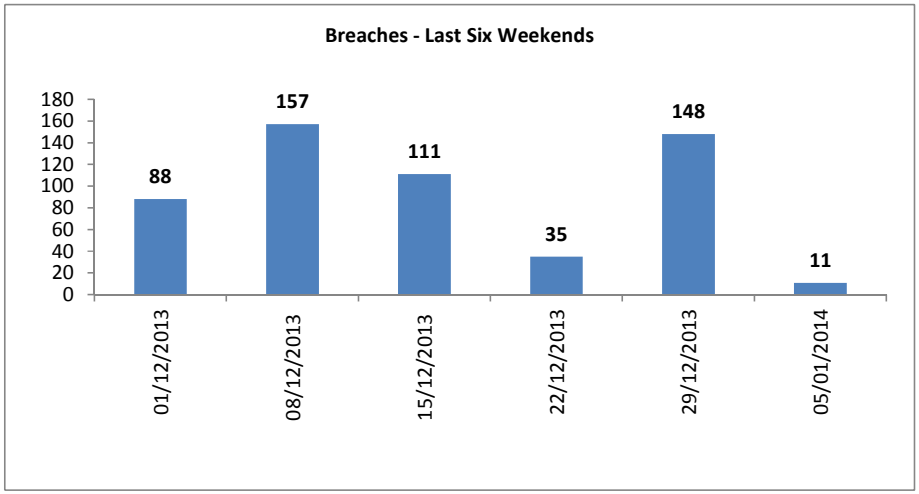
Recommendations
The board are asked to:

- Note the contents of the report
- Acknowledge the continuing focus on sustainably improving emergency care performance.

Super Weekend I – 4/5 January 2014 - Results

ED, Emergency CCU & Eye Casualty									Urgent Care Centre				Total % All Hospital Campus <4 Hrs
Day	Arrival Date	Total	>4 Hrs	>4 Hrs Admitted	>4 Hrs Non Admitted	<4 Hrs	% <4 Hrs	Average Last 6 weeks % <4 Hrs	Total	>4 Hrs	<4 Hrs	% <4 Hrs	
Thursday	02/01/2014	397	65	50	15	332	83.63%	89.96%	176	1	175	99.43%	88.48%
Friday	03/01/2014	374	64	56	8	310	82.89%	88.88%	151	1	150	99.34%	87.62%
Saturday	04/01/2014	365	7	6	1	358	98.08%	87.14%	197	0	197	100.00%	98.75%
Sunday	05/01/2014	337	3	3	0	334	99.11%	83.90%	199	1	198	99.50%	99.25%
Monday	06/01/2014	387	31	29	2	356	91.99%	79.45%	160	0	160	100.00%	94.33%
Tuesday	07/01/2014	359	70	65	5	289	80.50%	86.99%	136	0	136	100.00%	85.86%
Wednesday	08/01/2014	370	37	32	5	333	90.00%	85.22%	133	0	133	100.00%	92.64%
Cumulative	Mon-Sun	**1116**	**138**	**126**	**12**	**978**	87.63%		**429**	**0**	**429**	100.00%	91.07%
Last 7 Days	*recent data*	**2589**	**277**	**241**	**36**	**2312**	89.30%		**1152**	**3**	**1149**	99.74%	92.52%
Month to Date	*January*	**2957**	**359**	**313**	**46**	**2598**	87.86%		**1308**	**3**	**1305**	99.77%	91.51%
Year to Date	*all data*	**118368**	**19069**	**14144**	**4925**	**99299**	83.89%		**44864**	**46**	**44818**	99.90%	88.29%





Adults Discharges (Emergencies)

	GH	LGH	LRI	Sum:
16/11/2013 (Sat)	37	27	82	146
17/11/2013 (Sun)	32	24	84	140
Total	69	51	166	286
23/11/2013 (Sat)	27	21	93	141
24/11/2013 (Sun)	15	19	67	101
Total	42	40	160	242
30/11/2013 (Sat)	37	24	80	141
01/12/2013 (Sun)	27	24	68	119
Total	64	48	148	260
07/12/2013 (Sat)	29	33	107	169
08/12/2013 (Sun)	20	22	63	105
Total	49	55	170	274
14/12/2013 (Sat)	26	16	86	128
15/12/2013 (Sun)	24	34	65	123
Total	50	50	151	251
21/12/2013 (Sat)	40	29	96	165
22/12/2013 (Sun)	34	24	76	134
Total	74	53	172	299
04/01/2014 (Sat)	36	30	106	172
05/01/2014 (Sun)	27	16	98	141
Total	63	46	204	313
Sat 4/1 compared to av	110%	120%	117%	116%
Sun 5/1 compared to av	107%	65%	139%	117%

Six Week Averages

	GH	LGH	LRI	Sum:
Saturday	33	25	91	148
Sunday	25	25	71	120
Weekend	58	50	161	269

Admissions and Discharges : UHL

Equivalent Time Two Years Ago

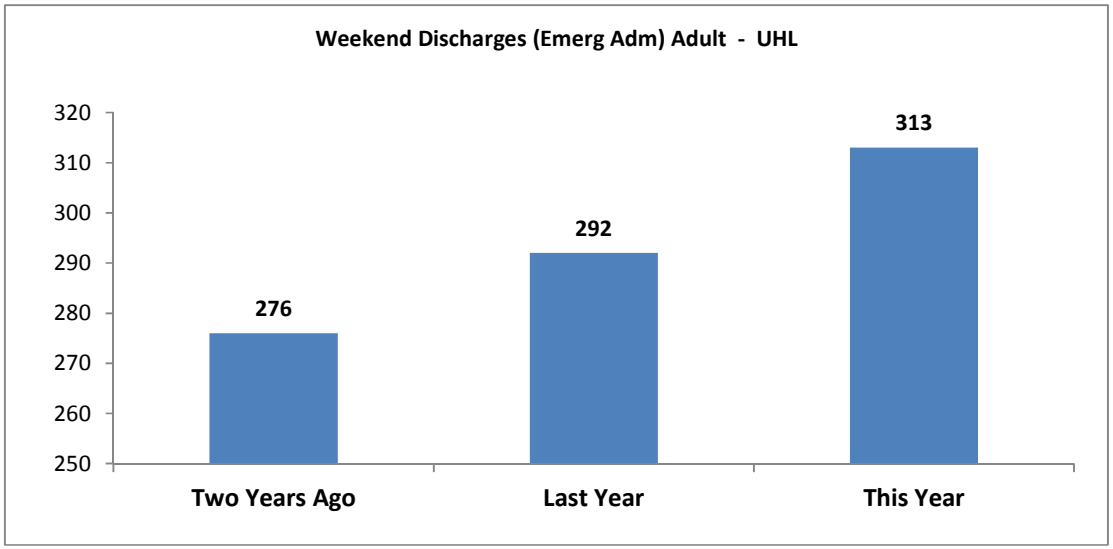
Date	Emergency Admissions	Emergency Admissions (Adults)	Discharges (Emerg Adm)	Discharges (Emerg Adm) Adult
07/01/2012 (Sat)	174	161	158	147
08/01/2012 (Sun)	146	134	139	129
Total	320	295	297	276

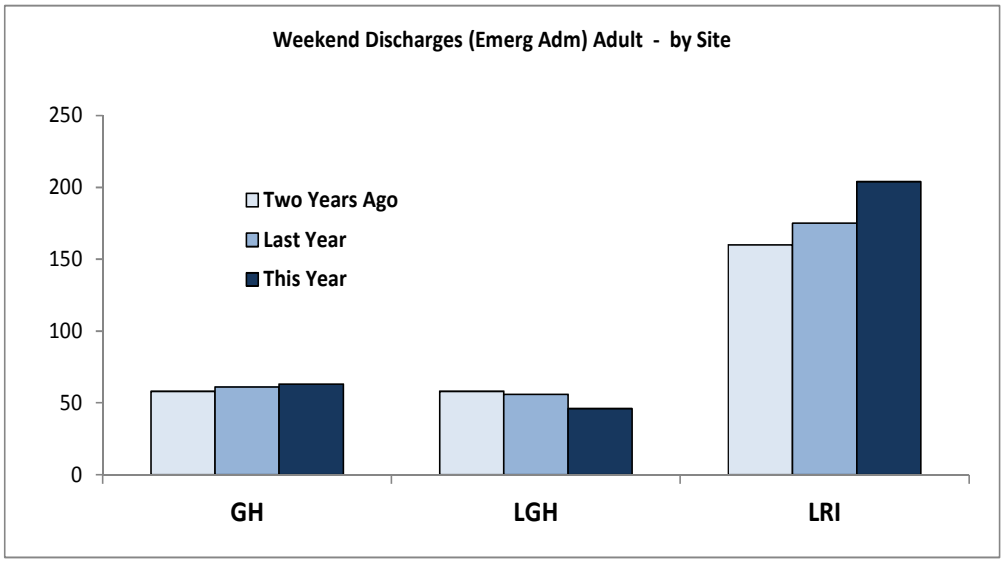
Last Year

05/01/2013 (Sat)	195	179	193	174
06/01/2013 (Sun)	182	172	132	118
Total	377	351	325	292

This Year : Super Weekend

04/01/2014 (Sat)	161	146	187	172
05/01/2014 (Sun)	184	166	156	141
Total	345	312	343	313





Discharges (Emerg Adm) Adult - by Site

Two Years Ago	GH	LGH	LRI	Total
07/01/2012 (Sat)	33	39	75	147
08/01/2012 (Sun)	25	19	85	129
Total	58	58	160	276
Last Year				
05/01/2013 (Sat)	39	35	100	174
06/01/2013 (Sun)	22	21	75	118
Total	61	56	175	292
This Year				
04/01/2014 (Sat)	36	30	106	172
05/01/2014 (Sun)	27	16	98	141
Total	63	46	204	313

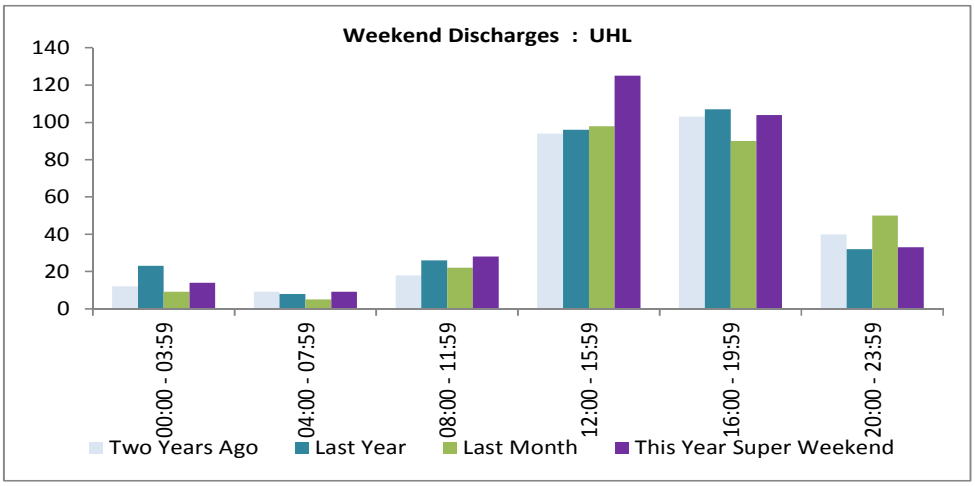
LRI Discharge Wards : Adults Discharged Following and Emergency Admission

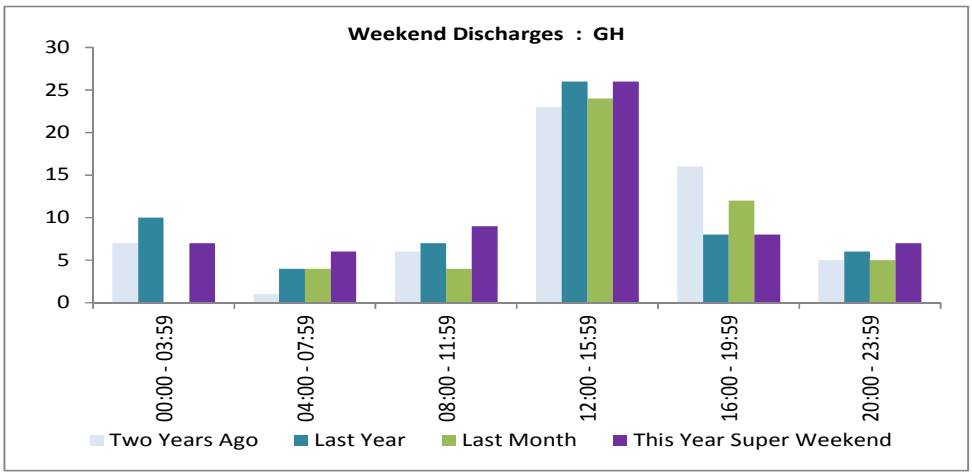
The "Top 20" in terms of discharge volumes

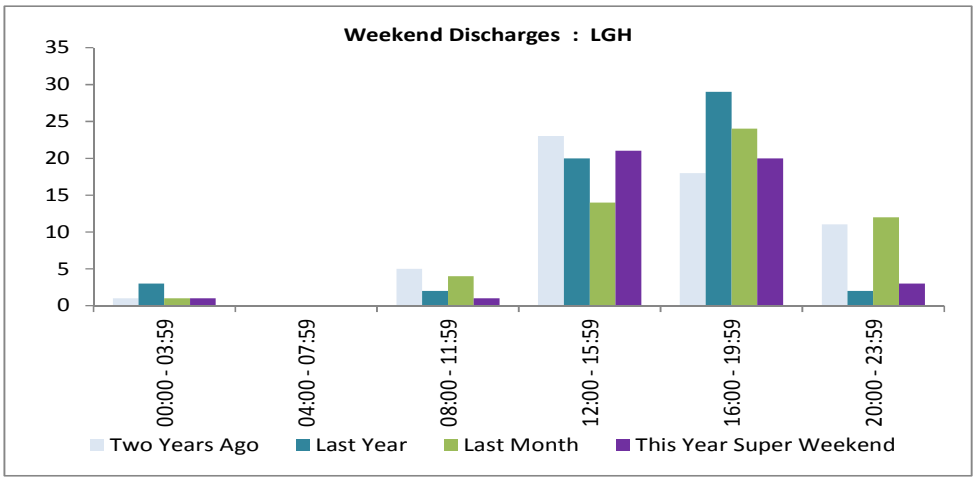
	Two Years Ago			Last Year			Last Month			This Year : Super Weekend		
	07/01/2012	08/01/2012		05/01/2013	06/01/2013		07/12/2013	08/12/2013		04/01/2014	05/01/2014	
Discharge Ward	(Sat)	(Sun)	**Sum**	(Sat)	(Sun)	**Sum**	(Sat)	(Sun)	**Sum**	(Sat)	(Sun)	**Sum**
RDIS			**0**	17	9	**26**	14	7	**21**	20	16	**36**
R15	5	9	**14**	6	11	**17**	5	13	**18**	13	14	**27**
RGAU			**0**	10	11	**21**	11	5	**16**	11	11	**22**
R16	3	13	**16**	7	5	**12**	3	3	**6**	5	3	**8**
RSAU	2	4	**6**	6	2	**8**	10	4	**14**	7	6	**13**
R07	6	7	**13**	5	5	**10**	4	3	**7**	3	4	**7**
R33	2	1	**3**	3	3	**6**	5	4	**9**	2	5	**7**
R17	2	1	**3**	4	3	**7**	2	4	**6**	4	2	**6**
RAFM	1	4	**5**	3		**3**	7		**7**	3	4	**7**
RAMB			**0**	3	4	**7**	6	2	**8**	3	3	**6**
ROND	4	5	**9**	2	3	**5**	2		**2**	3	1	**4**
R34	2	3	**5**	3		**3**	4	2	**6**	1	4	**5**
R18	2	2	**4**	3		**3**	6	1	**7**	1	1	**2**
R25	6	1	**7**	1	2	**3**	1	2	**3**	1	1	**2**
R01	5	7	**12**	1	1	**2**			**0**			**0**
R39			**0**		2	**2**	3	1	**4**	5	3	**8**
R22	4	3	**7**		3	**3**			**0**	1	2	**3**
R26	2	2	**4**	2	1	**3**		1	**1**	2	2	**4**
R19	2	1	**3**	1		**1**	3	1	**4**	1	2	**3**
R29	3		**3**	1		**1**	1	1	**2**	1	4	**5**
R38	1	3	**4**	1		**1**	2	1	**3**	3		**3**
RAMU	2	2	**4**	3	4	**7**			**0**			**0**
Total "Top 20" Only	54	68	**122**	82	69	**151**	89	55	**144**	90	88	**178**

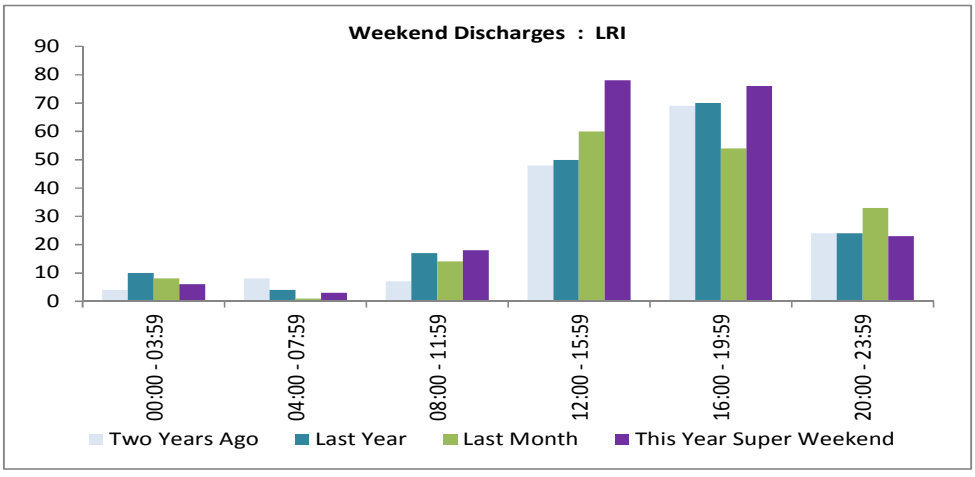
Wards Prior to Transfer to the Discharge Lounge

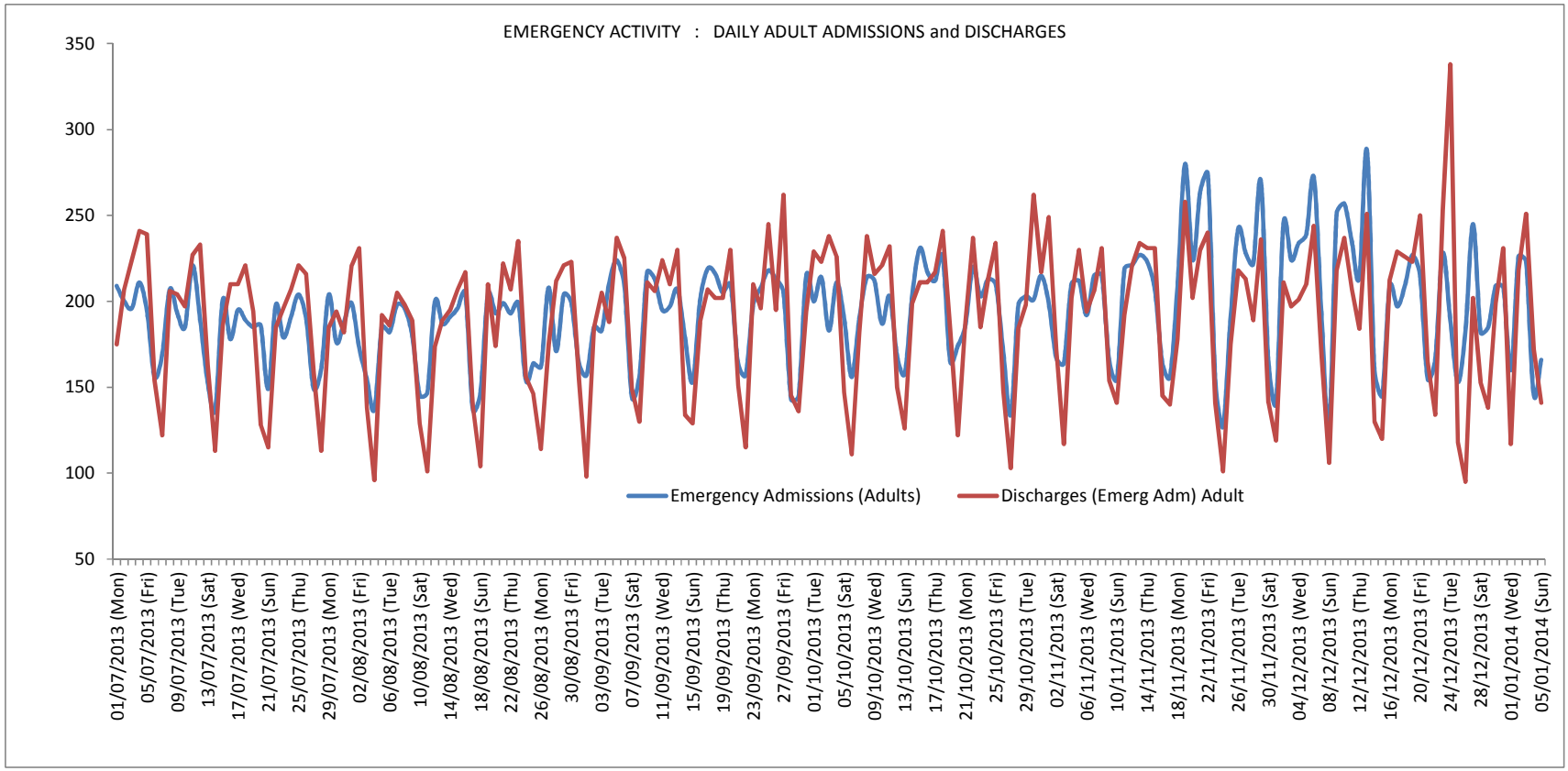
	Two Years Ago			Last Year			Last Month			This Year : Super Weekend		
	07/01/2012	08/01/2012		05/01/2013	06/01/2013		07/12/2013	08/12/2013		04/01/2014	05/01/2014	
Discharge Ward	(Sat)	(Sun)	Sum	(Sat)	(Sun)	**Sum**	(Sat)	(Sun)	**Sum**	(Sat)	(Sun)	**Sum**
R33			0	1	2	**3**	4	3	**7**	4		**4**
R34			0	1		**1**	1		**1**	3	4	**7**
R19			0	1	2	**3**	1		**1**		2	**2**
R24			0	3		**3**	1	1	**2**		1	**1**
R15			0	1		**1**	1		**1**	1	2	**3**
R26			0	1		**1**	1		**1**	3		**3**
RFJW			0	2	2	**4**		1	**1**			**0**
REDU			0	1	1	**2**		1	**1**		1	**1**
R18			0			**0**			**0**	2	1	**3**
R29			0		1	**1**	1		**1**	1		**1**
R30			0	1		**1**	2		**2**			**0**
R38			0			**0**			**0**	2	1	**3**
R16			0	2		**2**			**0**			**0**
R17			0			**0**			**0**	1	1	**2**
R23			0	1		**1**			**0**	1		**1**
R31			0		1	**1**	1		**1**			**0**
R37			0			**0**	1		**1**		1	**1**
R07			0			**0**			**0**		1	**1**
R22			0	1		**1**			**0**			**0**
R32			0			**0**			**0**		1	**1**
R36			0			**0**			**0**	1		**1**
RAMB			0			**0**		1	**1**			**0**
RKIN			0			**0**			**0**	1		**1**
RODA			0	1		**1**			**0**			**0**
Total	0	0	0	17	9	**26**	14	7	**21**	20	16	**36**


Weekend Discharges : UHL
140
120
100
80
60
40
20
0
00:00 - 03:59
04:00 - 07:59
08:00 - 11:59
12:00 - 15:59
16:00 - 19:59
20:00 - 23:59
Two Years Ago
Last Year
Last Month
This Year Super Weekend


Weekend Discharges : GH
30
25
20
15
10
5
0
00:00 - 03:59
04:00 - 07:59
08:00 - 11:59
12:00 - 15:59
16:00 - 19:59
20:00 - 23:59
Two Years Ago
Last Year
Last Month
This Year Super Weekend


Weekend Discharges : LGH
35
30
25
20
15
10
5
0
00:00 - 03:59
04:00 - 07:59
08:00 - 11:59
12:00 - 15:59
16:00 - 19:59
20:00 - 23:59
Two Years Ago
Last Year
Last Month
This Year Super Weekend


Weekend Discharges : LRI
90
80
70
60
50
40
30
20
10
0
00:00 - 03:59
04:00 - 07:59
08:00 - 11:59
12:00 - 15:59
16:00 - 19:59
20:00 - 23:59
Two Years Ago
Last Year
Last Month
This Year Super Weekend


EMERGENCY ACTIVITY : DAILY ADULT ADMISSIONS and DISCHARGES
350
300
250
200
150
100
50
Emergency Admissions (Adults)
Discharges (Emerg Adm) Adult
01/07/2013 (Mon)
05/07/2013 (Fri)
09/07/2013 (Tue)
13/07/2013 (Sat)
17/07/2013 (Wed)
21/07/2013 (Sun)
25/07/2013 (Thu)
29/07/2013 (Mon)
02/08/2013 (Fri)
06/08/2013 (Tue)
10/08/2013 (Sat)
14/08/2013 (Wed)
18/08/2013 (Sun)
22/08/2013 (Thu)
26/08/2013 (Mon)
30/08/2013 (Fri)
03/09/2013 (Tue)
07/09/2013 (Sat)
11/09/2013 (Wed)
15/09/2013 (Sun)
19/09/2013 (Thu)
23/09/2013 (Mon)
27/09/2013 (Fri)
01/10/2013 (Tue)
05/10/2013 (Sat)
09/10/2013 (Wed)
13/10/2013 (Sun)
17/10/2013 (Thu)
21/10/2013 (Mon)
25/10/2013 (Fri)
29/10/2013 (Tue)
02/11/2013 (Sat)
06/11/2013 (Wed)
10/11/2013 (Sun)
14/11/2013 (Thu)
18/11/2013 (Mon)
22/11/2013 (Fri)
26/11/2013 (Tue)
30/11/2013 (Sat)
04/12/2013 (Wed)
08/12/2013 (Sun)
12/12/2013 (Thu)
16/12/2013 (Mon)
20/12/2013 (Fri)
24/12/2013 (Tue)
28/12/2013 (Sat)
01/01/2014 (Wed)
05/01/2014 (Sun)

Date	Emergency Admissions (Adults)	Discharges (Emerg Adm) Adult	Net Change (Adult)
13/12/2013 (Fri)	288	251	37
22/11/2013 (Fri)	274	240	34
06/12/2013 (Fri)	272	244	28
29/11/2013 (Fri)	270	236	34
27/12/2013 (Fri)	245	202	43
18/10/2013 (Fri)	226	241	-15
03/01/2014 (Fri)	223	251	-28
08/11/2013 (Fri)	215	231	-16
20/12/2013 (Fri)	215	250	-35
04/10/2013 (Fri)	211	226	-15
20/09/2013 (Fri)	210	230	-20
25/10/2013 (Fri)	210	234	-24
06/09/2013 (Fri)	209	225	-16
13/09/2013 (Fri)	207	230	-23
15/11/2013 (Fri)	207	231	-24
16/08/2013 (Fri)	205	217	-12
27/09/2013 (Fri)	205	262	-57
11/10/2013 (Fri)	203	232	-29
23/08/2013 (Fri)	199	235	-36
30/08/2013 (Fri)	199	223	-24
01/11/2013 (Fri)	199	249	-50
07/12/2013 (Sat)	192	169	23
05/10/2013 (Sat)	190	147	43
29/12/2013 (Sun)	185	138	47
28/12/2013 (Sat)	182	153	29
14/09/2013 (Sat)	179	134	45
20/10/2013 (Sun)	174	122	52
26/10/2013 (Sat)	171	148	23
12/10/2013 (Sat)	168	150	18
02/11/2013 (Sat)	167	172	-5
22/12/2013 (Sun)	166	134	32
05/01/2014 (Sun)	166	141	25
19/10/2013 (Sat)	165	183	-18
09/11/2013 (Sat)	165	154	11
30/11/2013 (Sat)	165	141	24
25/08/2013 (Sun)	164	146	18
31/08/2013 (Sat)	164	155	9
21/09/2013 (Sat)	164	151	13
03/11/2013 (Sun)	164	117	47
16/11/2013 (Sat)	164	145	19
14/12/2013 (Sat)	160	130	30
13/10/2013 (Sun)	158	126	32
01/09/2013 (Sun)	157	98	59
08/09/2013 (Sun)	157	130	27
22/09/2013 (Sun)	157	115	42
06/10/2013 (Sun)	156	111	45
17/11/2013 (Sun)	156	140	16
10/11/2013 (Sun)	155	141	14
21/12/2013 (Sat)	155	165	-10
24/08/2013 (Sat)	154	156	-2
23/11/2013 (Sat)	154	141	13
15/09/2013 (Sun)	153	129	24
04/01/2014 (Sat)	146	172	-26
29/09/2013 (Sun)	145	136	9
15/12/2013 (Sun)	145	120	25
07/09/2013 (Sat)	144	149	-5
28/09/2013 (Sat)	143	145	-2
01/12/2013 (Sun)	141	119	22
17/08/2013 (Sat)	137	139	-2
27/10/2013 (Sun)	134	103	31
08/12/2013 (Sun)	128	106	22
24/11/2013 (Sun)	127	101	26

		Type 1 +2	Type 3	Total	>4hrs	%
01/01/2013	Tuesday	427	185	612	62	89.87%
02/01/2013	Wednesday	507	142	649	87	86.59%
03/01/2013	Thursday	439	151	590	74	87.46%
04/01/2013	Friday	485	138	623	48	92.30%
05/01/2013	Saturday	449	173	622	28	95.50%
06/01/2013	Sunday	459	172	631	63	89.86%
07/01/2013	Monday	468	144	612	82	86.60%
08/01/2013	Tuesday	433	141	574	105	81.71%
09/01/2013	Wednesday	406	121	527	67	87.29%
10/01/2013	Thursday	424	119	543	48	90.98%
11/01/2013	Friday	477	102	579	55	90.50%
12/01/2013	Saturday	414	149	563	64	88.63%
13/01/2013	Sunday	464	142	606	103	83.00%
14/01/2013	Monday	428	119	547	113	79.34%
15/01/2013	Tuesday	392	112	504	85	83.13%
16/01/2013	Wednesday	420	101	521	58	88.87%
17/01/2013	Thursday	430	92	522	54	89.66%
18/01/2013	Friday	386	69	455	32	92.97%
19/01/2013	Saturday	449	131	580	131	77.41%
20/01/2013	Sunday	400	105	505	72	85.74%
21/01/2013	Monday	409	100	509	93	81.73%
22/01/2013	Tuesday	461	107	568	147	74.12%
23/01/2013	Wednesday	429	101	530	113	78.68%
24/01/2013	Thursday	456	122	578	146	74.74%
25/01/2013	Friday	443	110	553	70	87.34%
26/01/2013	Saturday	450	144	594	92	84.34%
27/01/2013	Sunday	451	171	622	103	83.44%
28/01/2013	Monday	493	128	621	143	76.97%
29/01/2013	Tuesday	482	132	614	116	81.11%
30/01/2013	Wednesday	490	130	620	138	77.74%
31/01/2013	Thursday	430	134	564	28	95.04%

Super weekend 2

ED, Emergency CCU & Eye Casualty								Urgent Care Centre				Total %
Day	Arrival Date	Total	>4 Hrs	>4 Hrs Admitted	>4 Hrs Non Admitted	<4 Hrs	% <4 Hrs	Total	>4 Hrs	<4 Hrs	% <4 Hrs	
Saturday	28/12/2013	359	70	64	6	289	80.50%	235	0	235	100.00%	88.22%
Sunday	29/12/2013	366	78	73	5	288	78.69%	193	0	193	100.00%	86.05%

Day	Arrival Date	Total	>4 Hrs	>4 Hrs Admitted	>4 Hrs Non Admitted	<4 Hrs	% <4 Hrs	Total	>4 Hrs	<4 Hrs	% <4 Hrs	
Saturday	04/01/2014	365	7	6	1	358	98.08%	197	0	197	100.00%	98.75%
Sunday	05/01/2014	337	3	3	0	334	99.11%	199	1	198	99.50%	99.25%

Day	Arrival Date	Total	>4 Hrs	>4 Hrs Admitted	>4 Hrs Non Admitted	<4 Hrs	% <4 Hrs	Total	>4 Hrs	<4 Hrs	% <4 Hrs	
Monday	06/01/2014	387	31	29	2	356	91.99%	160	0	160	100.00%	94.33%
Tuesday	07/01/2014	359	70	65	5	289	80.50%	136	0	136	100.00%	85.86%
Wednesday	08/01/2014	371	37	32	5	334	90.03%	133	0	133	100.00%	92.66%
Thursday	09/01/2014	354	33	30	3	321	90.68%	162	0	162	100.00%	93.60%
Friday	10/01/2014	325	11	7	4	314	96.62%	144	0	144	100.00%	97.65%
Saturday	11/01/2014	298	2	2	0	296	99.33%	190	0	190	100.00%	99.59%
Sunday	12/01/2014	313	1	1	0	312	99.68%	196	0	196	100.00%	99.80%
Cumulative	Mon-Sun	2407	185	166	19	2222	92.31%	1121	0	1121	100.00%	94.76%

Monday	13/01/2014	382	18	18	0	364	95.29%	161	0	161	100.00%	96.69%
Tuesday	14/01/2014	372	38	38	0	334	89.78%	129	0	129	100.00%	92.42%
Wednesday	15/01/2014	359	39	33	6	320	89.14%	153	0	153	100.00%	92.38%
Cumulative	Mon-Sun	731	77	71	6	654	89.47%	282	0	282	100.00%	92.40%
Last 7 Days	recent data	2408	142	129	13	2266	94.10%	1135	0	1135	100.00%	95.99%
Month to Date	January	5366	501	442	59	4865	90.66%	2382	3	2379	99.87%	93.50%

Aims

1. **Increase number of discharges**

	GH	LGH	LRI	Total
First Super Weekend				
04/01/2014 (Sat)	36	30	106	172
	110%	120%	117%	116%
05/01/2014 (Sun)	27	16	98	141
	107%	65%	139%	117%
Total	63	46	204	313
	109%	93%	127%	117%
Second Super Weekend				
11/01/2014 (Sat)	42	29	104	175
	129%	116%	115%	118%
12/01/2014 (Sun)	22	19	93	134
	87%	78%	132%	111%
Total	64	48	197	309
	110%	97%	122%	115%

2. **Improveav time of discharge –** 52% (153 and 145) of patients discharged before 1600 compared to 46% (120) average
3. **Reduction in breaches –** 3 v 11 v 148
4. **NABs –** zero and zero
5. **Patients waiting for beds on Monday morning-** no, but admissions are lower at the weekend

Meeting structure

	Time	Meeting	Attendees	Output
1	06:30	Site meeting	Night site manager	Capacity report
2	08:00	Senior Clinical Command	CoO, four clinical leaders, HoO, key managers	Key actions for SCC
3	08:30	Site meeting	CoO, site managers, HoO, key representation from CMGs	Plan for flow and capacity report
4	10:00	Discharge conference call	HoO, JT, kep representation from CMGs and LPT etc	Identification of patients suitable for discharge and plan
5	11:00	Site meeting	CoO, site managers, HoO, key representation from CMGs	Plan for flow and capacity report
6	13:00	Senior Clinical Command	CoO, four clinical leaders, HoO, key managers	Key actions for SCC
7	14:00	Site meeting	CoO, site managers, HoO, key representation from CMGs	Plan for flow, capacity report and plan for night
8	15:00	Discharge conference call	HoO, kep representation from CMGs and LPT etc	Confirmation of patients suitable for discharge and plan
9	16:30	Site meeting	CoO, site managers, HoO, key representation from CMGs	Plan for flow, capacity report and confirmation of plan for night
10	17:00	Senior Clinical Command	CoO, four clinical leaders, HoO, key managers	Key actions for SCC
11	20:00	Handover to night team	CoO, SMOC, site manager and night manager	Confirmation of plan for night
12	21:00	Site meeting	Night site manager	Capacity report

Comparative performance 2013 v 2014

01/01/2013	89.87%	01/01/2014	84.35%
02/01/2013	86.59%	02/01/2014	88.48%
03/01/2013	87.46%	03/01/2014	87.62%
04/01/2013	92.30%	04/01/2014	98.75%
05/01/2013	95.50%	05/01/2014	99.25%
06/01/2013	89.86%	06/01/2014	94.33%
07/01/2013	86.60%	07/01/2014	85.86%
08/01/2013	81.71%	08/01/2014	92.66%
09/01/2013	87.29%	09/01/2014	93.60%
10/01/2013	90.98%	10/01/2014	97.66%
11/01/2013	90.50%	11/01/2014	99.59%
12/01/2013	88.63%	12/01/2014	99.80%
13/01/2013	83.00%	13/01/2014	96.69%
14/01/2013	79.34%	14/01/2014	92.42%
15/01/2013	83.13%	15/01/2014	92.38%
Av	87.52%		93.56%

- High admissions last five days
- Five – ten patients have been waiting for beds last three mornings in ED
- Therefore five – ten patients already breached
- Flow has been slow all day with one bed identified, one patient moving – three patients breached yesterday because beds available on 239 minutes
- All wards have had strong clinical input
- Process in meetings has been positive with clear actions taken and delivered
- Good representation from all CMGs
- Command cells have identified and resolved key issues, but need more work
- Capacity each night has been 92 Monday, 95 Tuesday and 102 Wednesday- stretch target is 89 beds
- Position has not deteriorated overnight
- Key challenges to flow are well known

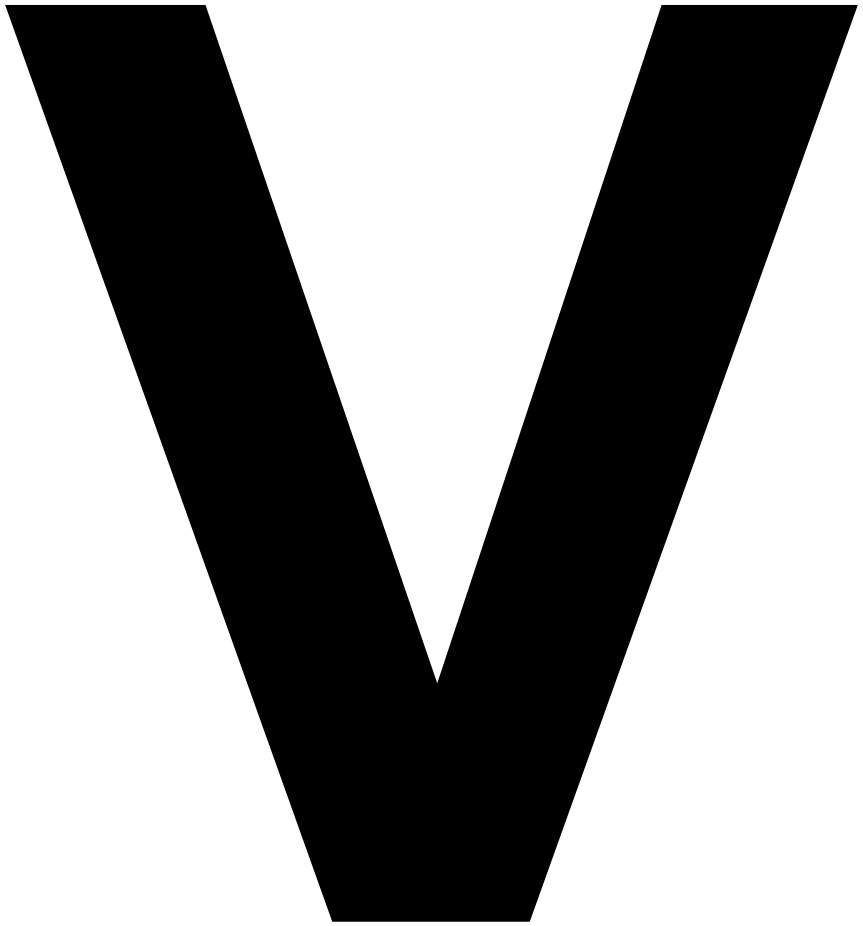
This weekend and subsequent weekends - UHL

- Wash up yesterday
- Commitment to try to replicate weekends going forwards- benefits to quality are obvious to see

- **ED-**Ensure department is staffed to required (normal) levels of nursing and medics and additional consultant on late shift – same as SW
- **Assessment units**-staffing was not increased for the SW and different teams were on both days- same as SW
- **Medical base wards** -remove Medical consultant locums from ED on Saturday and Sunday nights and utilise money to fund sessions for internal consultants 900 - 1300 on base wards – agreed with ED and increased junior doctor support – will be similar to SW
- **Emergency surgery** -continuing with second emergency list every weekday at LRI – working well- same as SW
- **Gastro** -will do a morning ward round- same as SW
- **Portering**- increased to SW levels- same as SW
- **Imaging** - have been asked to run second CT- same as SW
- **Pharmacy, physio, OT etc**-have been asked to staff up to levels to support 17% more discharges- same as SW
- **Site management and bed coordinator -** two of each at LRI- same as SW
- **Senior manager oncall and exec on call -**on site in the morning at least
- **Paediatrics -** no change as yet, but note requirement for change depending on the weather
- **Discharge lounge –** open at 0800 - 1800- same as SW

Plan for tomorrow

- Maximise discharges and clear plan of patients for discharge on Saturday
- Minimise patients waiting for emergency surgery
- Two site managers and two bed coordinators
- Capacity for 95 – 105 at 2000



Trust Board Paper V

To:	Trust Board
From:	Stephen Ward, Director of Corporate & Legal Affairs
Date:	30th January 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 December 2013 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 January 2014 Trust Board meeting on matters relating to operational and financial performance, it is proposed that the January 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 January 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: 24/12/2013 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: 24/12/2013 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:

28/02/2013

RESPONSE:

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

The trust is forecasting a deficit of £39.8m for 2013/14 and therefore there is a risk of a lack of liquidity from April 2014. Accordingly the Trust is making applications for short term loan and medium term PDC funding to the DoH with support from the regional office of the NHS TDA. We expect to be clear on the funding sources in February 2014 and on that basis we consider the Trust to be a going concern.

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:

28/02/2013

RESPONSE:

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

Following independent review the Trust has formally forecast a year-end deficit of £39.8m. This follows a series of meetings with CCG/LAT/NTDA and review of the draft reports by NTDA. A financial recovery strategy is now be developed with partners.

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:

01/04/2014

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.
The formal agreement of a RTT plan by commissioners remains outstanding. An initial RTT action plan was submitted to commissioners on 14th August 2013 and a revised plan was subsequently submitted on 11th September 2013. As requested, we have submitted a further recovery plan to commissioners on 28th November 2013. Recovery of the RTT admitted and non-admitted targets is expected by 2014/15. Previous reported performance appears to have been enhanced by not taking patients in chronological order. This is being investigated

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	

W

University Hospitals of Leicester NHS
NHS Trust

Trust Board Paper W

To:	**Trust Board**
From:	**Kate Shields, Director of Strategy**
Date:	**30 January 2014**
CQC regulation:	**All**

Title:	**QUARTER 3 REVIEW 2013/14 ANNUAL OPERATING PLAN (AOP)**

Author/Responsible Director: Helen Seth/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 October – December 2013/14 (quarter three – Q3).

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. 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 (TDA).

Our Q3 report captures a high level overview of what is working well and what could be better.

What is working well?

Prevention of Falls: Falls incidence for December 2013 reported on Datix has seen a further decrease in the number of falls compared to November resulting in a further reduction in the number falls for Q3 across UHL.

Discharge: Multidisciplinary board rounds are being under taken daily in all medical wards at LRI and Ward 2 at LGH monitored through daily conference calls including members of the integrated discharge team, social care and pharmacy.

"Leaving Hospital" and "Now You Are Getting Better" leaflets are being given to all patients on discharge to improve communication.

Outdoor Clothes are now available for patients to go to discharge lounge (if they do not have their own in hospital) to ensure privacy and dignity standards met.

Older People and Dementia Care: The implementation of the Meaningful Activities Facilitators is showing early benefits in supporting Nursing, MDT and Medical Teams for example: increasing nutritional support, increasing well-being of patients with dementia and strengthening carer support.

UHL and Alzheimer's Society implemented three 'Carers Support Programmes' for new carers of people with dementia. Further funding has been secured for four more programmes to continue in 2014-15.

325 additional members of staff, including student nurses have attended Older People Champions workshops – in line with trajectory.

Medical Education: A development day for the Doctors in Training Committee members was held

in September in UHL and a Listening in Action Event for doctors in training took place on 9 December 2013 with positive feedback received. UHL has been launched, with the support of the Head of Service Improvement and LNR Foundation School. 'Enhancing Quality Improvement Programme'

What needs to be better?

Financial Performance: There is continuing financial pressure and an underlying deficit which needs to be addressed.

Emergency process: There are early indications that recent changes are starting to have a positive on performance which is encouraging; however there is still a significant challenge ahead.

Mandatory Training: Current overall performance is at 60% (against a target of 75%) – an increase of 20% since the initiation of the dashboard during early July 2013.

The lowest level of performance is across medical staff (currently at 36% overall). The Deputy Medical Director is currently working through a number of key actions in addressing this including reviewing data at individual level and corresponding with medical colleagues.

Scale and pace of change: When we consider the scale and pace of improvement that is required to address current performance challenges, it is apparent that a significant amount of time is taken in addressing the early, technical aspects of change (for example designing and agreeing a standardised templates). Whilst it is essential that parties are given opportunity to engage and design the solution there is a need to accelerate the pace with which this stage is completed so we can seek early implementation and benefit for the patients we care for.

Recommendations: The Trust Board are asked to:

RECEIVE this report

NOTE the progress against Q3 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?
Finance and Performance
Trust Board

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

Resource Implications (e.g. Financial, HR): Set out in the AOP 2013**/**14**.**

Assurance Implications: N/A

Patient and Public Involvement (PPI) Implications:

Stakeholder Engagement Implications:

Equality Impact: The AOP is subject to the Trust's equality impact processes.

Information exempt from Disclosure: None
Requirement for further review? Q4 report on the AOP 2013/14 will be submitted to the Board in April 2014.

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: Trust Board

REPORT FROM: Kate Shields, Director of Strategy

AUTHOR: Jo Bee/Helen Seth

RE: Executive Summary – Q3 Review Annual Operational Plan 2013/14

DATE: 30 January 2013

1. PURPOSE

The purpose of this paper is to:

i. Provide an executive summary of the Q3 review of the 2013/2014 Annual Operational Plan (AOP). It should be considered alongside the detailed quarterly and monthly reports presented to Trust Board in December 2013 and January 2014.

ii. Summarise Q3 performance against the key improvement and development priorities for 2013/14 (Appendix 1).

iii. Highlight key areas of variance and the action being taken to bring performance in line with plan.

2. ACCOUNTABILITY FRAMEWORK FOR 2013/2014

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 year-to-date, the Trust has been graded at Level 4 (material issues) by the NTDA, which we understand is reserved for those trusts that have submitted a deficit AOP or are reporting material adverse deficits year-to-date.

3. HIGH LEVEL OVERVIEW

The AOP 2013/14 was based on four common themes that we know must be addressed through our planning and delivery processes if UHL is going to be safe and sustainable.

The themes are:

- clinical and financial sustainability
- the emergency process
- delivering quality
- securing clinical reconfiguration.

Using these themes, a high level overview of performance in Q3 against our AOP is summarised below:

3.1 Financial performance

At the end of month 9 (December 2013) UHL's deficit sat at £28.5m, £31.5m adverse to the planned surplus of £3.0m.

Finance have worked closely with the CMG's and corporate directorates on bottom-up forecasts which arrive at the projected deficit of £39.8m; these forecasts have been looked at independently by our auditors who have confirmed their robustness.

CMG's and corporate directorate have been advised to concentrate on the revised budgets for the rest of the financial year and are commencing work on a 3-5 year financial recovery plan.

On a more positive note the CMG's and corporate directorates have achieved 97.5% of the cost improvement plan (up to end of December) with 98.3% of the plan projected by year end. It is important that this is maintained to the year end, as it is effectively part of the forecast above.

3.2 Emergency process

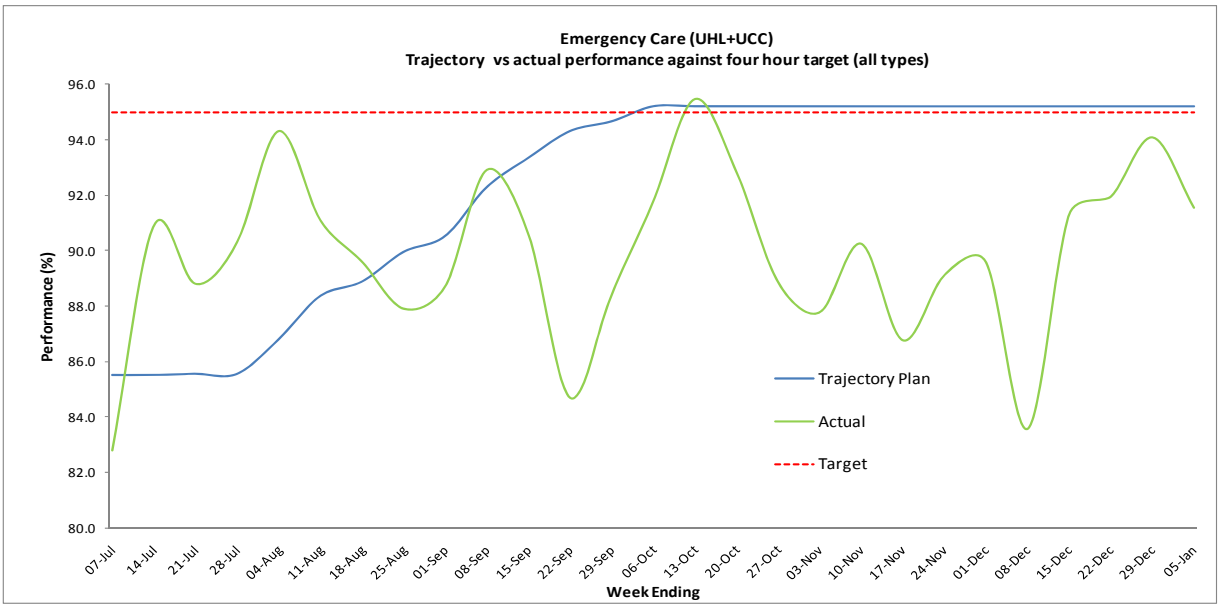
ED 4hr target - Performance for emergency care 4hr wait in December was 90.1%. The performance for Q3 was 88.2%.

Emergency admissions have continued to increase creating significant capacity problems. A resilience checklist has been developed for use in the site meetings and a senior site manager and deputy site manager have been externally appointed. During Q3 there has been an increased emphasis on eliminating non-admitted breaches. Whilst improvement has been seen it is still too dependent on key individuals and it is recognised that more consistent and sustainable solutions are required.

In early January the Trust has undertaken two 'Super Weekends' to improve consistent weekend support. The impact on performance was significant and will be reviewed in more detail in the Q4 report

.

UHL was ranked 107 out of 144 Trusts with Type 1 Emergency Departments in England for the four weeks up to 1st December 2013. Over the same period 62 out of 144 Acute Trusts delivered the 95% target. For the week ending the 12th January the Trust was ranked 55 out of 144.



3.3 62 day cancer target

For Q3 the cancer targets have shown sustained performance.

November performance for the 2 week to be seen for an urgent GP referral for suspected cancer was achieved at 95.7% (national performance 95.5%).

Performance for the 2 week symptomatic breast patients (cancer not initially suspected) was not achieved at 92.0% (national performance 94.9%). This was predominantly due to patient choice.

The 62 day urgent referral to treatment cancer performance in November was 85.7% (national performance close to 85%) against a target of 85%. The year to date position is now also being delivered at 85.0%. This represents a significant achievement.

3.4 Referral to Treatment Time

RTT admitted performance for December was 82.0% with significant speciality level failures in ENT, General Surgery, Ophthalmology and Orthopaedics.

The capacity and demand modelling work completed by the UHL team in conjunction with the Intensive Support Team in October is the most detailed estimate of the core capacity requirements (recurrent) and backlog (non-recurrent) to date and was shared with commissioners on 7 November 2013. A further meeting has been arranged with commissioners to agree capacity requirements and financial affordability.

Non-admitted performance during December was 92.8%, with the significant specialty level failures in Orthopaedics and Ophthalmology. Remedial action plans are in place.

3.5 Delivering our Quality Commitment

A Quality Commitment dashboard has been developed to present updates on the 3 core metrics that track performance against our 3 goals (reduce mortality, avoid harm and patient centred care). These will be tracked throughout the programme up to 2015.

Good progress has been made in at least one of the work streams supporting each of the goals and there have been some early positive results in respect of the Respiratory Pathway. Dramatic reductions have been achieved through the Falls Reduction work-streams.

The CQC visited the Trust in January. The inspection team (peer review) made up of doctors, nurses, allied health professionals, managers and members of the public visited UHL to understand whether our services are safe, effective, caring, and responsive to people's needs and well led.

The team visited eight key areas: ED, acute medical pathways including the frail elderly, acute surgical pathways, critical care, maternity, paediatrics, End of Life Care and outpatients.

Initial feedback reflected a positive description of our staff as a whole, as well as observing that staff were caring. There was acknowledgment of the good work that has been carried out in respect of staff engagement with LiA programme.

Clearly the Trust is tackling long standing challenges that will require on-going action in the short, medium and long term for example responding to the continued pressure from emergency activity and securing substantial development of our IT systems. A full CQC report will be provided in February the implications of which will be reflected in our Q4 report.

3.6 Clinical configuration

The development of our critical estate reconfiguration projects is progressing through the steps of business case development including the development of our Strategic Outline Case for service and estate transformation.

In summary, despite the enormous amount the hard work has been undertaken the Trust is not where it needs, or wants to be. The financial 2013/14 year to date results have worsened. It reflects anticipated (nurse to bed ratio investment) and unanticipated changes. There has been sustained pressure created by emergency demand, and the failure to manage this effectively, has led to unfavourable operational and financial results. Although there has been external support, changes in clinical management structures, operational processes and commissioner support, ED and RTT performance remains challenging.

4. FINANCIAL POSITION AS AT THE END OF NOVEMBER 2013

2013/14 year to date results have been poor. To cope with the additional emergency demand, and to ensure safe staffing levels, the Trust has had to resort to substantial use of bank and agency staffing. Nursing ratios were

reviewed in the summer and enhanced in the light of the Francis report recommendations and existing local acuity reviews. Partly as a result, the Trust has averaged almost £4million per month in non-contractual payments, despite an increase in permanent headcount. The enhanced nursing levels add a recurrent £5.8 million to budget baselines (and therefore to the deficit), but in reality the expenditure has been greater as many of those posts have been filled this year at premium rates. A successful nursing recruitment campaign is underway in Mediterranean Europe (with around 500 vacancies to fill) remains a fundamental challenge for the Trust. We have had 49 nurses start in the last week.

As a consequence of the poor financial and emergency performance year-to-date, the trust has been graded at Level 4 by the NTDA. Cost controls have been stretched and revised procedures implemented over the last two months. Enhanced controls of non-pay have been announced more recently, with a theme of stronger compliance with existing processes.

The month 9 results and year-to-date performance may be summarised:

	December 2013			April -December 2013		
	Plan £m	Actual £m	Var (Adv) / Fav £m	Plan £m	Actual £m	Var (Adv) / Fav £m
Income						
Patient income	49.9	51.9	2.0	480.5	491.3	10.8
Teaching, R&D	5.3	5.3	0.0	56.4	55.9	(0.6)
Service Income	55.2	57.2	2.0	537.0	547.2	10.2
Other operating Income	3.0	3.6	0.6	28.7	29.3	0.6
Total Income	58.2	60.9	2.6	565.7	576.5	10.9
Operating expenditure						
Pay	37.3	40.6	(3.3)	336.1	352.9	(16.7)
Non-pay	23.0	24.7	(1.7)	207.1	219.6	(12.4)
Reserves	(6.0)	-	(6.0)	(13.6)	-	(13.6)
Total Operating Expenditure	54.3	65.4	(11.0)	529.7	572.4	(42.8)
EBITDA	3.9	(4.5)	(8.4)	36.0	4.1	(31.9)
Net interest	0.0	0.0	(0.0)	0.0	(0.0)	0.0
Depreciation	(2.7)	(2.7)	0.0	(24.4)	(24.3)	0.1
PDC dividend pr, ible	(1.0)	(1.0)	0.0	(8.7)	(8.4)	0.3
Net deficit	0.2	(8.2)	(8.3)	3.0	(28.5)	(31.5)
EBITDA %		-7.4%			0.7%	

The Trust is reporting:

- A deficit at the end of December 2013 of £28.5m, which is £31.5m adverse to the planned surplus of £3.0m.

4.1 Year End Forecast

The revised year end forecast, taking account of the month 9 results is **£39.8m deficit**.

This is summarised in the following table:

	Year End Forecast		
	Plan £m	Forecast £m	Var (Adv) / Fav £m
Income			
Patient income	634.0	654.3	20.3
Teaching, R&D	75.0	72.5	(2.4)
Other operating Income	38.2	38.8	0.6
Total Income	**747.1**	**765.7**	**18.5**
Operating expenditure			
Pay	447.6	472.8	(25.2)
Non-pay	275.7	289.0	(13.2)
Reserves	(24.0)	-	(24.0)
Total Operating Expenditure	**699.4**	**761.8**	**(62.4)**
EBITDA	**47.8**	**3.9**	**(43.9)**
Net interest			0.0
Depreciation	(32.5)	(32.5)	-
PDC dividend payable	(11.6)	(11.2)	**0.4**
Net deficit	**3.7**	**(39.8)**	**(43.5)**
EBITDA %		**0.5%**	

The principal drivers for the forecast deficit result are:

- Non-receipt of strategic transitional support (£15m) to fund the underlying deficit.
- Less than expected non-recurrent funding from commissioners to support the transformation project costs incurred (£5.3m).
- In year operating cost pressures and a conscious investment in nurse staffing to sustain quality of care and patient safety standards (£14.3m).
- Contractual penalties and deductions of £5.2m including a £3.4m increase in MRET deductions (taking the total MRET deduction to £7.1m).

Within this forecast there are the following potential risks and opportunities

- Activity, and the associated income, necessary to fully recover and deliver all **RTT targets** are not included in the forecast.
- **Activity and income assumptions** have been aligned with our commissioners, both CCGs and NHS England.
- **Winter severity** – the current forecast assumes an average winter in terms of emergency activity, and elective activity assumed to be the same as 2012/13.
- The forecast assumes that **contractual penalties are reinvested**, specifically ED performance fines, ambulance handover and RTT penalties. MRET deductions, readmission penalties and service line penalties will continue to be transacted and retained by commissioners.

- Note that **enhanced expenditure controls**, with greater centralisation over discretionary spend, both pay and non-pay, have just been introduced. This has been reinforced through rigorous performance management of the CMG forecasts and operational performance in the remaining months of this year.

5. QUALITY AND PERFORMANCE

The Quarter 3 Quality and Performance (Q&P) paper was not available at the time of preparing this report. An overview is provided which should be read in conjunction with the Q&P report. Comments will be added verbally where necessary.

5.1 Quality Commitment

Our AOP outlined the activity we would undertake during 2013/14 to secure and maintain sustainable performance against the above. To deliver our vision of 'Caring at its best' we laid out an ambitious Quality Commitment. Our priorities are led through three over-arching strategic goals, each with a target to be delivered over the next 3 years. By 2016 we will aim to deliver a programme of quality improvements which will:

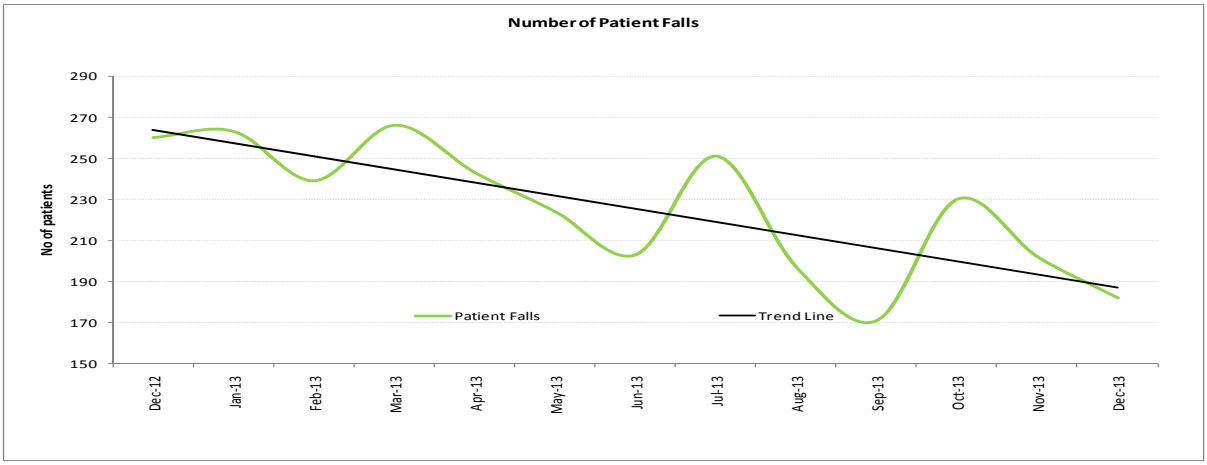
i. Save 1000 extra lives
ii. Avoid 5000 harm events
iii. Provide patient centred care so that 75% of our patients would recommend us

A detailed review of progress against Quality Commitment objectives in Q3 is outlined at Appendix 1. At a high level key points to note include:

What is working well?

a) <u>Prevention of Falls</u>

Falls incidence for December 2013 reported on Datix has seen a further decrease in the number of falls compared to November resulting in a further reduction in the number falls for Q3 across UHL. This downward trend is consistent with the yearly performance to date. This has been achieved by targeted support, strong leadership and simple solutions for example implementing dedicated fall-risk bays. Opportunities to apply these principles across the board will be applied.



b) Discharge

Daily multidisciplinary conference calls have been implemented to proactively manage discharge, anticipating needs in collaboration with community partners. This is currently focussed in medicine but the direction of travel is to roll this out to other areas. UHL is hoping in the near future to be able to hold a collaborative conference call for the improved management of capacity for stroke rehabilitation. UHL has continued to build on this collaborative work with health and social care partners to strengthen discharge and rehabilitation processes improving access to community resources thereby creating creative solutions to discharge.

Internally, through the investment in nursing budgets there are plans to roll out and strengthen the role of the discharge coordinator.

Clinical teams continue to strengthen board and ward rounds further and optimise the use of the estimated date of discharge, planning for discharge from the point of admission.

It is anticipated that there will be investment in other disciplines to streamline discharge processes further and to create a no delays process eg: investment in Pharmacy support to improve the TTO process so that we increase the numbers of patients discharged earlier in the day (before 11am and 1pm) in partnership with ambulance providers.

There is continued work across the community focusing on the cohort of patients who are frequently admitted with the purpose of developing care plans to promote early discharge and admission prevention.

c) Older People and Dementia Care

Meaningful Activity Facilitators have recently been appointed (funded through CQUIN and Charitable Funds) forming part of the Patient Experience Team. They attend the 'board round', along with the multidisciplinary team where patients with dementia or suspected dementia are referred for meaningful activity support. The role focuses on those patients who are exhibiting agitation or distress or requiring additional support at mealtimes or are prone to wandering. They support people with dementia and their carers in hospital with: cognitive stimulation, support for sensory and psychological wellbeing, as well as reducing vulnerability.

The implementation of the Meaningful Activities Facilitators is showing early benefits by supporting Nursing, MDT and Medical Teams in increasing nutritional support, increasing well-being of patients with dementia and strengthening carer support.

UHL and Alzheimer's Society implemented three 'Carers Support Programmes' for new carers of people with dementia. Further funding has been secured for four more programmes to continue in 2014-15. Also a Carers Support & Advice post has been recruited to with the post holder

due to commence in January to work on the wards to advise and support carers in the UHL.

In complement, 325 additional members of staff, including student nurses have attended Older People Champions workshop (in line with 2013/14 trajectory).

d) Medical Education

A development day for the Doctors in Training Committee (DiTC) members was held in September in UHL. In addition, a Listening in Action Event took place for doctors in training on 9 December 2013. A UHL 'Enhancing Quality Improvement Programme' has been launched, with the support of the Head of Service Improvement and LNR Foundation School.

The UHL DiTC meet on a bi-monthly basis with representation from all specialties and grades. Priority work streams for the committee have been identified as:-

1) Maximising Training and Learning Opportunities;
2) Patient Safety; and
3) Communication.

The focus for next 3 months will include work on the DiTC work streams.

What could be better?

Delivering change

As we think about the scale and pace of improvements required to address current performance challenges, it is apparent that a disproportionate amount of time is taken in addressing the early, technical aspects of change (for example designing and agreeing a standardised ward round template). Whilst it is essential that parties are given opportunity to engage and design the solution there is a need to accelerate the pace with which this stage is completed so we can seek early implementation and benefit for the patients we care for.

To do this we need to build greater confidence and strong leadership in front line services. Moving forward the Trust will need to ensure that there is sufficient capacity and capability to support and facilitate change at scale and pace whilst adopting a style and approach that will ensure change is embedded in everyday practice and sustained improvement secured.

6. ORGANISATIONAL DEVELOPMENT

A Q3 Organisational Development Report was provided to the Trust Board in December 2013 and therefore is not covered in detail in this report. Key headlines include:

What is going well?

All Q3 actions have progressed in line with plan and have been assigned a green RAG rating. Illustrative progress includes:

- Training delivered in 'Improving Experience for Patients and Staff' incorporating nationally endorsed 'Putting People First' tools and techniques;

- Training has been delivered to Consultant Recruitment Panels and UHL is working on strengthening future Consultant recruitment practices including the use of Assessment Centres;

- During December we have presented exceptional staff and teams with 'Caring at its best' quarterly awards in the workplace;

- A LiA 'Pass it on' Event was held during November and the Trust has moved into Phase 4 of our LiA journey: 'embedding LiA as the way we do things at UHL';

- Work is progressing in improving medical engagement across the Trust, through a range of activities including medical leadership and financial skills development and the first meeting of the 'UHL Clinical Senate' was held in December along with UHL's first Consultant / GP Conference focusing on 'improving quality and understanding commissioning';

- Workforce plans continue to be implemented supported by rigorous marketing and recruitment activity including international nurse recruitment;

- The Trust's Chief Nurse held a Public Engagement Listening Event during December exploring the recent experience of patients and their families. Emerging themes will form the basis of a work programme monitored by the assurance committee;

What could be better?

Mandatory Training:

Current overall performance is at 60% (against a target of 75%). This has increased by 20% since the initiation of the dashboard during early July 2013 showing an upward trend but still off the trajectory expected.

The lowest level of performance is across medical staff (currently at 36% overall). The Deputy Medical Director is currently working through a number of key actions in addressing this including reviewing data at individual level and corresponding with medical colleagues.

The Trust has entered into a contract with OCB Media to redesign training material in e-learning format to improve programme access.

Based on our agreed delivery model, face to face training is essentially required for four subjects. Work is underway in increasing capacity to deliver against these four areas.

7. IMPROVEMENT AND DEVELOPMENT PRIORITIES

The 2013/14 AOP set out a range of priorities which were designed to take forward the key themes identified in Section 3 and those of our Strategic Direction published in autumn 2012. The actions reflect the breadth of the Trust's portfolio and are summarised below. The RAG rating applied indicates an assessment of

the overall performance in Q3 of the portfolio of activities supporting each priority. The activities themselves are explained in more detail in Appendix 1.

PRIORITY	WHICH MEANS	THEME	STRATEGIC OBJECTIVE
Delivering our Quality Commitment	Save more lives, reduce avoidable harm, improve patient experience	Quality and Performance	Action to provide safe, high quality, patient-centred healthcare
Improving the emergency care process including the Emergency Department (ED)	Consistently deliver timely, safe care and a good patient experience	Emergency Care	Provide joined up emergency care
Improving theatre productivity (clinical service transformation)	Fewer cancelled operations, fewer delays for patients.	Quality and performance standards	Earn the right to be the provider of choice
Improving outpatients (clinical service transformation)	Fewer cancellations, fewer patients who do not attend (DNAs)	Quality and performance standards	Earn the right to be the provider of choice
Improving the estate (estate improvement)	A series of schemes to bring immediate benefits as well as well as to take forward medium term reconfiguration	Financial sustainability and quality and performance standards	Sustainable high performing NHS Foundation Trust
Improving IM&T (support service transformation)	Priority schemes to support clinical service delivery	Reconfiguration; Financial sustainability; quality and performance standards	Sustainable high performing NHS Foundation Trust
Developing Listening into Action as part of our Organisational Development Plan	Better engagement with staff, leading to better support for colleagues and clear leadership standards.	Quality and performance standards	Professional passionate and valued workforce
Developing our specialised services	For example, vascular, adult cardiac, children's cardiac, renal	Quality and performance standards. Financial sustainability	Sustainable high performing NHS Foundation Trust. Provider of choice. Enhanced reputation in Research, Innovation and Education
Developing medical education	Clinical Education Centre improvements at The Royal, better engagement with trainees, considering the shape of future medical workforce	Quality and performance standards Financial sustainability	Sustainable high performing NHS Foundation Trust. Enhanced reputation in Research, Innovation and Education
Developing research and development	Strengthening our three Biomedical Research Units, playing a leading role in the creation of the Academic Health Sciences Network, and securing funding from the National Institute for Health Research. (NIHR)	Quality and performance standards Financial sustainability	Enhanced reputation in Research, Innovation and Education

Developing as a Foundation Trust	Strengthening our membership and making progress towards our Strategic Direction	Quality and performance standards Financial sustainability	Sustainable high performing NHS Foundation Trust

8. RECOMMENDATIONS

The Trust Board is asked to:

RECEIVE this report

NOTE the progress against Q3 delivery of our Annual Operational Plan and the high level RAG rating of key aspects.

NOTE the key areas of variance and the outline action proposed to rectify the position.

APPENDIX 1

IMPROVEMENT AND DEVELOPMENT PRIORITIES - PROGRESS AGAINST 2013/14 AOP – Q3

The Trust identified a range of priorities which are designed to take forward the key themes identified above and those of our Strategic Direction published last autumn. The actions reflect the breadth of the Trust's portfolio. Key progress against our AOP in quarter 3 (Q3) is outlined below:

PRIORITY	WHICH MEANS	ACTION PLANNED	PROGRESS Q3	KPIs	TRUST BOARD ASSURANCE AND SCRUTINY	ACTION RAG
IMPROVEMENT PRIORITY - DELIVERING OUR QUALITY COMMITMENT						
Save Lives	Reinforce Hospital 24/7 programme	Cultural changes - Identify key interventions to improve communications.	It is anticipated that Hospital 24/7 will be fully operational at GH, LGH and LRI by January 2014. Hospital 24/7 is also supporting improvements to discharges at the weekend using NerveCentre. Connectivity issues have caused early problems but these were fixed ahead of the LRI launch. Early response time metrics have been very promising and further opportunities have been identified in medical handover processes, phlebotomy cover & culture around calling consultants	Response times	Monthly Quality and Performance Reports to Trust Board	**4**
Saving more lives	Respiratory Care Pathway	Redirect all respiratory pathway patients to Glenfield (either direct, or via LRI)	The Respiratory pathway has led to an increase in pneumonia patients with, co-morbidity and frailty being admitted to the LRI. There is still a cohort of patients that meet the criteria being admitted to the LRI that should be admitted to Glenfield Hospital. An audit of why this is the case is being undertaken and will be reported on Q4. However, early results seem to suggest there has been a reduction in mortality for patients admitted with pneumonia, both at the LRI and Glenfield site.	Percentage compliance to COST and COPD protocols	Monthly Quality and Performance Reports to Trust Board	**3**

PRIORITY	WHICH MEANS	ACTION PLANNED	PROGRESS Q3	KPIs	TRUST BOARD ASSURANCE AND SCRUTINY	ACTION RAG
			Overall mortality for UHL has fallen for both crude and risk adjusted mortality between Q1 and Q2 in 13/14			
Saving more lives	Respiratory Care Pathway	Utilise findings from care bundle audit (January 2013) to reinforce best practice May 2013	In Sept 13, two dedicated pneumonia nurses started in post. Their main role, supported by the Respiratory Pathway consultant lead, is to support implementation of the pneumonia care bundle across both the LRI and GH sites. They have reviewed over 300 patients with pneumonia to date (at the LRI and Glenfield). Pneumonia admissions and care bundle delivery are tracked using an online database tool. An audit of this will be fed back to the clinical teams for further action in Q4. A *4 hour integrated community acquired pneumonia care pathway* has been designed and will be field tested in January 2014. An ICM referral document for the 'Respiratory Virtual Clinic' was designed and is awaiting release by IM&T. As well supporting junior doctors teaching, the nurses are also working with the clinical skills centre to look at including teaching about the pneumonia care bundle into a 'simulation package'.	Percentage compliance to COST and COPD protocols	Monthly Quality and Performance Reports to Trust Board	**4**
Avoiding 5000 harm events by 2016	Falls	Establish older people's team to coach under-performing wards Review of all falls for every ward with the Education Sister for falls leading a falls validation process with each Head of Nursing and implementing falls prevention strategies	The aim to reduce the incidence of falls in patients who are 65 years or over to less than 7.5 per 1000 bed days has been achieved in Q3. Falls incidence for all patients recorded on Datix and the Safety Thermometer has also reduced with Q3 maintaining the reduction seen in Q2.	Fall reports/1000 bed days aged > 65 years	Monthly Quality and Performance Reports to Trust Board	**5**

PRIORITY	WHICH MEANS	ACTION PLANNED	PROGRESS Q3	KPIs	TRUST BOARD ASSURANCE AND SCRUTINY	ACTION RAG
Avoiding 5000 harm events by 2016 [1 i]	Acting on results in ED	Agree standards for checking blood results and reporting imaging • DFR process in ED agreed May 2013 (attached) • Pathology process agreed with lab & POCT • Standards for Radiology in ED: • CT scans 2 hours • X-rays 48 hours- completed in April 2013 • X-rays 24 hours not currently possible Requires development of a full radiographer "hot" reporting rota after recruitment and 3-year training package	Dynamic Film Review - a process where ED review the patients that have been discharged following radiographs to identify positive results and recall any missed diagnoses. This would allow identification of missed fractures and lung cancer to be recalled for earlier treatment. This scheme is progressing. CT is request to report within 2 hours (ED) is being met X-ray is request to formal report within 48 hours (ED) is being met The shorter the time between performance and report the less time for management delay or mismanagement. Immediate reporting of plain film reporting may also save up to £30 per patient when radiographer reporting is fully established through admission avoidance and appropriate referral. There is at least an 18 month lead to achieving this once recruitment and training is commenced Pathology achieved- altered process with lab in ED	Percentage of results authorised (through ICE) (100% target) before patient discharge / transfer ED X-rays reported in < 24 & 48 hrs (Business Objects)	Monthly Quality and Performance Reports to Trust Board	**3**
Avoiding 5000 harm events by 2016	Senior clinical review, ward rounds and no	Ward rounds/Notation - Pilot and audit two key approaches on selected wards. Review pilot and select most impactful approach for roll-out. Monitor compliance (including spot checks)	Pilot of template undertaken with feedback form clinicians involved. Pilot audit undertaken to assess adherence to template and frequency of senior review of patients in selected area (medicine), this showed considerable variation and lack of uptake of form. Decision made to revise current continuation paper as preference to use of specific ward round template.	Adherence to ward round safety checklist and completion of ward round tick box on revised continuation paper.	Monthly Quality and Performance Reports to Trust Board	3

PRIORITY	WHICH MEANS	ACTION PLANNED	PROGRESS Q3	KPIs	TRUST BOARD ASSURANCE AND SCRUTINY	ACTION RAG
			Planned implementation for Q4.			
Avoiding 5000 harm events by 2016	Senior clinical review, ward rounds and notation	Senior Review - Agree standard minimum for senior clinician ward round frequency. Monitor compliance of standards by audit.	Finalising and planning of implementation of ward round safety checklist for Q4. Identification for need of specific ward round safety checklist each for children's and obstetrics'. Discussion with specialities re: senior review standards.	Adherence to agreed standards for senior review.	Monthly Quality and Performance Reports to Trust Board	**3**
Providing patient centred care so that 75 of our patients would recommend us	Older People and Dementia Care	Multidisciplinary working - Offer opportunity for all to be Older People's Champions. Set up resource centre. Facilitate stronger utilisation of carers, volunteers and charities	325 members of staff, including student nurses have attended Older People Champions workshop. Meeting held 18th December with Older Peoples Champions and key specialist healthcare professionals to identify key themes of what services we currently provide for older people, gaps in service, and training needs of staff. Key themes are being collated and will link to the Older Peoples Strategy for 2014	Increase to a further 400 Older Peoples Champions over next year - 25% increase	Monthly reporting to Trust Board via the Quality & Performance Paper. Monthly meeting of the Quality Action Groups chaired by Director Lead and Director 0f Quality	**4**

PRIORITY	WHICH MEANS	ACTION PLANNED	PROGRESS Q3	KPIs	TRUST BOARD ASSURANCE AND SCRUTINY	ACTION RAG
Providing patient centred care so that 75 of our patients would recommend us	Older People and Dementia Care	Communicate effectively - Ensure completion of personal profile for all patients with dementia Utilise White board for communication with patients and carers). Increase patient / carer involvement in care	Patient Profile Audit Sept 2013. Results show low level of compliance. Specific actions tasked to the CMGs by Nov 2013. Re audit planned for Jan 2014 The implementation of Meaningful Activities Facilitators is showing early indicators of support for Nursing, MDT and Medical Teams in; increasing nutritional support, increasing well-being of patients with dementia and strengthening carer support UHL and Alzheimer's Society implemented three 'Carers Support Programmes' for new carers of people with dementia. Further funding has been secured for four more programmes to continue in 2014-15 A Carers Support & Advice post has been recruited. Due to start in January, to work on the wards to advise and support carers in the UHL.	Improvement in the Friends and family Test scores. To achieve a Friends and family test score of 75 by 2015	Monthly reporting to Trust Board via the Quality & Performance Paper. Monthly meeting of the Quality Action Groups chaired by Director Lead and Director 0f Quality	**4**
Providing patient centred care so that 75 of our patients would recommend us	Older People and Dementia Care	Track and hold to account - Agree metrics and track against them. Identify suitable method for increasing transparency (e.g. Ward Friends and family Score).	Wards are displaying Public Facing Dashboards that have been designed by patients that illustrate the quality metrics of that particular ward such as all the patient feedback survey results, number of complaints, number of falls, infections etc. FFT scores available nationally via NHS England and via the trusts Public website at ward level. 8 wards MDT completed baseline stage 1 of the National Quality Mark Scheme for Older People and identified key areas for improvement – including improving ward environments for older people e.g. installing handrails, improved signage, improved food and nutrition, age	Improvement in the Friends and family Test scores. To achieve a Friends and family test score of 75 by 2015 Improvement in three key Patient Experience Survey questions	Monthly reporting to Trust Board via the Quality & Performance Paper. Monthly meeting of the Quality Action Groups chaired by Director Lead and Director 0f Quality	**4**

PRIORITY	WHICH MEANS	ACTION PLANNED	PROGRESS Q3	KPIs	TRUST BOARD ASSURANCE AND SCRUTINY	ACTION RAG
			appropriate equipment to improve safety e.g. low beds, raised toilet seats, better training for staff around the needs of older people and easier access to services whilst in hospital, this area is being taken forward as a Listening into Action project			
Providing patient centred care:	Discharge experience	Deliver discharge plans standard - involve multi-disciplinary team and patient / carer. Co-ordinate discharge plan and communicate with patient / carer. Implement across all priority wards	Multi–disciplinary board rounds under taken daily in all medical wards at LRI and Ward 2 LGH-monitored through daily conference calls which includes members of integrated discharge team present, social care and pharmacy.	Net Promoter Score Discharge survey	Monthly reporting to Trust Board via the Quality & Performance Paper. Monthly meeting of the Quality Action Groups chaired by Director Lead and Director 0f Quality	**4**
Providing patient centred care:	Discharge experience	Communication tools - Design and roll-out 'Ticket Home' tool including key information for every patient. Roll-out for every patient.	Leaving Hospital and Now You Are Getting Better leaflets given to all patients on discharge. (key Information re discharge) Outdoor Clothes now available for patients to go to discharge lounge (if do not have their own in hospital) to ensure privacy and dignity standards met.	Net Promoter Score Discharge survey	Monthly reporting to Trust Board via the Quality & Performance Paper. Monthly meeting of the Quality Action Groups chaired by Director Lead and Director 0f Quality	**4**
IMPROVEMENT PRIORITY - EMERGENCY CARE INCLUDING THE EMERGENCY DEPARTMENT (ED)						
Emergency Care	**Achievement of the ED 4 Hour standard**	Delivery of HUB action plan with particular focus on: NABs, discharge and super weekends	January is on course to be best month in 14 months. Six weeks of performance +90%	ED 4 hour standard Length of stay reduction	Monthly Quality and Performance Report ED Exception Report	**3**
Emergency care	**Ambulance turnarounds times**	Ambulance turnarounds times within contracted agreement Current performance 19mins	Achieving the turnaround times remain difficult due to peaks of activity and a small ED footprint. Discussions are taking place with commissioners regarding the contract position. UHL's times remain some of the best for a large trust in the east midlands	Within contracted agreement (15mins for clinical handover time). Reduction in contractual penalties	Monthly Quality and Performance Report ED Exception Report	**3**

PRIORITY	WHICH MEANS	ACTION PLANNED	PROGRESS Q3	KPIs	TRUST BOARD ASSURANCE AND SCRUTINY	ACTION RAG
IMPROVEMENT PRIORITY - CLINICAL SERVICE TRANSFORMATION						
Theatre Productivity	Fewer cancelled operations, fewer delays for patients.	**Capacity and Demand and theatre info** - Review current capacity / demand; Define Future state; Develop Key Performance indicators and implementation plan ; Explore viability of further use of patient bar coding for real time information	Capacity and demand model developed by specialty – used in check and challenge sessions as data sharing and scenarios presented for evaluation. KPI s as per trust documents for utilisation and patient throughput, cancellations etc Master schedule developed	Improved theatre throughput; Reduced cancellations Reduced backlog; Reduced WLIs	Theatre Transformation Board; Improvement and Innovation Board; Exec leadership; Regular reports to Trust Board	4
Theatre Productivity	Fewer cancelled operations, fewer delays for patients.	**Scheduling -** Define processes for scheduling; Review use of IT systems for theatre information and scheduling; Model patient selection for optimum use of theatre lists	Scheduling tool pilot in ophthalmology SIEVE tool for appropriate pre assessment developed and piloted in ophthalmology. Will roll out to other specialties. Scheduling meeting under review	Improved theatre throughput; Reduced cancellations, Reduced backlog; Reduced WLIs	Theatre Transformation Board; Improvement and Innovation Board; Exec leadership; Regular reports to Trust Board	4
Theatre Productivity	Fewer cancelled operations, fewer delays for patients.	**Workforce Review** - Ensure Job planning matches scheduling and theatre list allocation; Review skill mix required for future state	Recruitment of staffing to fill substantial gaps continues in theatre. LIA approach at ;GH to increase staff involvement and engagement	Improved workforce productivity	Theatre Transformation Board; Improvement and Innovation Board; Exec leadership; Regular reports to Trust Board	4
Theatre Productivity	Fewer cancelled operations, fewer delays for patients.	**Pre-operative assessment -** Standardise processes and systems; IT solution to record pre- operative assessment and booking of appointments; Review workforce and capabilities;	Work stream project plan produced and some action i areas.	Improved theatre throughput; Reduced cancellations	Theatre Transformation Board; Improvement and Innovation Board; Exec leadership; Regular reports to Trust Board	2
Theatre Productivity	Fewer cancelled operations, fewer delays for patients.	Implement Theatre arrivals (all sites)	Due to open Jan 2014	Improved theatre throughput; Reduced cancellations	Theatre Transformation Board; Improvement and Innovation Board; Regular reports to Trust Board	4
Outpatient Transformation	Improving clinic slot booking utilisation	Detailed analysis of top 25 specialties that result in 80% of outpatient income to identify opportunities for	Approach modified. Top 40 specialities asked to provide baseline data by end July 13. Wave 1 of specialities (x10) reviews	Target 95% utilisation	Reports to the Improvement and Innovation Framework Board chaired by the CE.	3

PRIORITY	WHICH MEANS	ACTION PLANNED	PROGRESS Q3	KPIs	TRUST BOARD ASSURANCE AND SCRUTINY	ACTION RAG
		improvement	completed in by Nov 13. Reports completed for 5 of 10 specialties. 2nd wave started in Dec 13 – 7 specialties confirmed for Wave 2. Programme for 2014 identified showing how top 40 specialties review will be completed.			
Outpatient Transformation	Reducing the number of patients who do not attend (DNA)	SMS text message reminders. Pilot commenced January 2013 in 4 specialties to call top 10% of patients identified as high risk of DNA utilising bespoke software – "patient call optimiser". On-going pilot.	UHL has had over 3000 less DNA's in 2013/14 than for the 1st 9 months of 2012/13. SMS coverage continues to steadily increase from ~ 42% of all appointments in March 2013 to ~ 53% in December 2013. Trust DNA rate has dropped from 7.2% for the 1st 9 months of 2012/13 to 6.6% for the 1st 9 months of 2013/14 'Patient Call Optimiser' has gone live as per plan in October 13. With the exception of Ophthalmology, the roll out is now complete for all specialties. A timeline will be agreed with ophthalmology as to when this will be complete. Benefits will be seen in Q4	SMS - Target 70% of patients by end of 2013/14.	Reports to the Improvement and Innovation Framework Board chaired by the CE.	**5**
Outpatient Transformation	Building capacity and capability - service improvement	Outpatient Improvement Team – Establish team to ensure common approach and sharing of best practice	Recruited one individual to band 5 posts. Individual has now been seconded to support Ophthalmology in August 13. No further recruitment has taken place and is unlikely to take place in light of current financial position. Future project management arrangements are under assessment as part of the IIF review.	Increased staff morale and staff productivity	Reports to the Improvement and Innovation Framework Board chaired by the CE.	**2**

PRIORITY	WHICH MEANS	ACTION PLANNED	PROGRESS Q3	KPIs	TRUST BOARD ASSURANCE AND SCRUTINY	ACTION RAG
IMPROVEMENT PRIORITY - SUPPORT SERVICE TRANSFORMATION						
Estates & Facilities Service Delivery	Implementation of LLR Facilities Management Consortium to act on behalf of all LLR Trusts to actively manage the Estates/FM Contract	In working with private sector partners it is essential that their style and approach reflects the values and culture of the Trust. The relationship and partnering values will be managed by Interserve and the Health partners forming a joint board to drive the values and direction of the framework and services provided under it. This body is called the LLR FMC. The Trust's interests will be served by an intelligent client management team – who will manage the performance of the private sector partner and uphold the interests of the health partners.	NHS Horizons is now well established and operational.	Year on year cost improvement from Lot1 without detriment to quality	Governance through Trust Board representation by DoF and NED representation of the NHS Horizons Programme Board	**5**
Estates & Facilities Service Delivery	Progress against lot 1 LLR EFM contract	Responsibility for the day to day operational management and delivery of core FM services would be undertaken by Interserve on 1 March 2013.	As a result of transforming services a number of challenges have been experienced by Interserve in maintaining the quality of services delivered. These relate to the areas of cleaning catering and estates management. Interserve has implemented a remedial plan and this has resulted in gradual but continuing improvements in performance. Horizons continue to manage the contract to ensure that improvements continue to be driven upwards and that the actions taken by Interserve are appropriate to achieve this.	Year on year cost improvement from Lot1 without detriment to quality Moving into 2014 results in a saving of in excess of £4m	Governance through Trust Board representation by DoF and NED representation of the NHS Horizons Programme Board	**3**
Reconfiguration and Estate	Day Case / Outpatient Hub	A Day Case / Outpatient Hub Feasibility study will be completed prior to the development of an Outline Business	The project will fall within the frameworks of the Strategic Outline Case (SOC) and therefore constrained by the timeline of	Reduced cancellations	Governance through Commercial Executive, Executive Team, Trust	**3**

PRIORITY	WHICH MEANS	ACTION PLANNED	PROGRESS Q3	KPIs	TRUST BOARD ASSURANCE AND SCRUTINY	ACTION RAG
Improvement Progress against lot 2 A series of schemes to bring immediate benefits as well as well as to take forward medium term reconfiguration		Case for a dedicated Day Case and Outpatient Hub. This would support the segmentation of ambulatory planned care flows from inpatient hospital care and will also be a critical enabler for the emergency floor development.	the SOC. This has yet to progress to the development of the FBC The activity assumptions in relation to the Hub and left shift into it have been identified at a high level however further challenge will be required following the SOC outcome (the location of the hub would have an impact on the quantum and nature of activity being undertaken in that setting)	Improved ratio between income per m2 and occupancy per m2	Board and NTDA. Public Consultation will be required on the development of the Hub.	
Reconfiguration and Estate Improvement	Emergency model of care	Emergency model of care – early feasibility studies	The Outline business case for the emergency floor was approved by the Trust Board in October and has been forwarded to the NTDA for comments. Works are progressing with the enabling schemes – the NTDA have supported the first work package – replacement of the ward and outpatient space. Discussions have commenced with the planners and stakeholders ! 500 block designs are approved, 1 200 detailed design has commenced.	Sustainable achievement of ED standard	Governance through Commercial Executive, Executive Team, Trust Board and NTDA.	**2**
Reconfiguration and Estate Improvement	Theatres Arrival Area and Advanced Recovery	Completion of construction at the LRI	The TAA was handed over to the Trust on 16th January. Advanced recovery Full business case delayed slightly owing to time taken to get full costs for the project.	Reducing theatre delays -Reducing idle capacity (cost)	Governance through Theatres Programme Board, Executive Strategy Board and financial approval through the Commercial Executive	**4** **3**
Reconfiguration and Estate Improvement	Maternity interim development	Construction of additional delivery rooms at the LGH and LRI to safely accommodate the increase in births	Construction work is on-going and running to plan. Work is planned to run through until the end of June 2014	TBC	Governance through Project Board, Reconfiguration Board and Commercial Executive	**4**

PRIORITY	WHICH MEANS	ACTION PLANNED	PROGRESS Q3	KPIs	TRUST BOARD ASSURANCE AND SCRUTINY	ACTION RAG
Reconfiguration and Estate Improvement	Vascular	Move vascular services from the LRI to the GH thereby realising the development of a cardio-vascular centre and a pre-SOC enabler to future service change on the LRI site. The scheme includes the relocation of vascular inpatients, admissions; VSU; angiography and the provision of a hybrid theatre	Draft OBC in production - Capital costs, scope and programme to be finalised to conclude estates annexe. Equipment choice to be concluded	Increased utilisation of lower cost facilities without detriment to clinical quality	Governance through Vascular Programme Board, Executive Strategy Board and financial approval through the Commercial Executive	3
Reconfiguration and Estate Improvement	As care moves closer to home our hospitals will become smaller and more specialised. To optimise clinical outcomes and safety, sites will need to be consolidated. Renal & Transplant Services	Relocation of Renal & Transplant Services from the LGH to the GGH. Approval given to complete a feasibility study	Estate feasibility undertaken to identify whether the renal and transplant services could be relocated into part new build and part retained estate. Output confirmed that this would be possible. Discussions on-going with the University of Leicester to ensure the potential Donor is aware of the feasibility output. Opportunity to develop a charitable appeal to support the capital funding of the relocation - initial discussions have been undertaken, detail to be developed further.	TBC	Governance through Commercial Executive, Executive Team, Trust Board and NTDA.	4
Reconfiguration and Estate Improvement	Welcome Centre LRI	New main entrance located in the Windsor Building. Approved to progress to detailed design and delivery of an Outline Business Case	The Welcome Centre forms part of the "enterprise schemes" initiative through the Interserve Framework. Discussions are progressing with this to provide Interserve with functional brief for the Trust required operational content of this facility.	Patient experience	Governance through Trust Board representation by DoF and NED representation of the NHS Horizons P. Board	4
Reconfiguration and Estate Improvement	Balmoral Access for the Emergency Department	Review of highways, traffic plans, pedestrian access, car parking, levels, gradients and Blue Light access. Approval given develop detailed designs and tender	Work proceeding in light of the revised design for the new emergency floor. Discussions with Highways have commenced and will be considered as part of the Planning Application.	TBC	Governance through Trust Board representation by DoF and NED representation of the NHS Horizons P. Board	4
Reconfiguration and Estate Improvement	Refurbishment of Poppies Nursery	Approval given to proceed to detailed design and tender. Contract award subject to future review by Exec Team.	Construction work has commenced in January 2014.	TBC	Governance through Trust Board DoF and NED representation of the NHS Horizons P. Board	4

PRIORITY	WHICH MEANS	ACTION PLANNED	PROGRESS Q3	KPIs	TRUST BOARD ASSURANCE AND SCRUTINY	ACTION RAG
Reconfiguration and Estate Improvement	Clinical Education Centre at the LRI	Initial designs for the conversion of Odames Ward into a CEC have been reviewed. Approval has been given to develop an OBC	Design team has been commissioned to commence construction in April	TBC	Governance through Trust Board representation by DoF and NED representation of the NHS Horizons P. Board	4
Reconfiguration and Estate Improvement	Energy Centre	Removal of existing life expired combined heat and power units (CHP) at LRI and GH. Installation of new gas CHP units on all 3 acute sites. Lighting and building energy management upgrades across UHL	The Energy Centre forms part of the "enterprise schemes" initiative through the Interserve Framework. Procurement currently under way	TBC	Governance through Trust Board representation by DoF and NED representation of the NHS Horizons P. Board	4
Information Management and Information	Managed Business Partner	Implementation of the contract with our preferred Managed Business Partner: IBM. The Trust will work with IBM to progress the early stages of the Trust's IM&T Transformation Plan throughout 2013/14	Contract is in place and the third of 4 tranches of TUPE to IBM has been undertaken.	All transferred services have a suit of KPIS in place.	The board receives a monthly update paper and a fuller quarterly review through the Director of Finance. Joint Governance Board in place.	4
Information Management and Information	Electronic Document Record Management (EDRM) - project to deliver Electronic versions of our clinical notes	Develop the business case for EDRM and progress procurement options.	Business case developed and presented to the Trust Board in November. Some refinement in the process has been requested and we will be undertaking a pilot to prove the benefits in q4 2013/14 for 16 weeks within a defined area	NA	Papers for the transformation projects have been taken through the Trust Board. Joint Governance Board in place.	3
Information Management and Information	Managed print solution	Develop the business case for Managed Print. Progress procurement options.	Project is approved and is due to go-live Q4 2013/14	Project milestone dates Savings profile	Papers for the transformation projects have been taken through the Trust Board. Joint Governance Board in place. Project board established	4
Information Management and Information	Clinical portal and Electronic Patient Record (EPR)	Develop the business case for Clinical Portal and EPR. Progress each project including consideration of procurement options.	Paper to TB in November 2013 further paper due Feb 2014	TBC in business case	Papers for the transformation projects have been taken through the Trust Board. Joint Governance Board in place.	3
DEVELOPMENT PRIORITY - IMPLEMENTING OUR ORGANISATIONAL DEVELOPMENT PLAN						
Professional, passionate and	Live our values	Implement the "Putting People First"	During September each Division hosted a staff development day funded through the	Reduced complaints	Organisational Development Plan Priorities (2013/15) - Quarterly	4

PRIORITY	WHICH MEANS	ACTION PLANNED	PROGRESS Q3	KPIs	TRUST BOARD ASSURANCE AND SCRUTINY	ACTION RAG
valued workforce		cultural shift programme	Trust's Charitable Funds Committee. These days were titled: 'Improving the Experience for Patients and Staff' and led by the Patient Experience Team. Each day was structured around the needs of the specific Division and aimed at medical, nursing and administrative staff. The objectives of each development day were:- To provide the leaders with top tips to help them manage more effectively; To help leaders engage and communicate more effectively using simple, pragmatic and relevant tools; and To understand how we can improve our patients' experience in our day to day work. All days were positively evaluated with Friends and Family Test Scores. We are consulting with Clinical Management Groups (CMGs) in progressing the next phase of development.	Patient Satisfaction (friends and family)	Update Report (Quarter 3 October to December 2013) presented to Trust Board 20.12.14	
Professional, passionate and valued workforce	Live our values	Fundamentals – Implement Values Based Recruitment Embed Values within Systems and Processes Continue 'Caring at its best' Awards	Values based recruitment continues to feature in our recruitment and selection training and will be expanded further in the current redesign plan for consultant recruitment. The Trust has signed up as a partner site for the values based recruitment project facilitated by NHS Employers	Increase in compliments Staff and Patient Satisfaction (friends and family)	Organisational Development Plan Priorities (2013/15) - Quarterly Update Report (Quarter 3 October to December 2013) presented to Trust Board 20.12.14	**4**
Professional, passionate and valued workforce	Improve two way engagement	Driving accelerated improvement through the adoption of Listening into Action (LiA).	During Q3, a further 11 Pioneering teams volunteered to adopt the LiA approach to improve patient outcomes, staff engagement and service quality. The	Increased engagement and staff morale	Progress report on Enabling Our people Schemes presented to Improvement and Innovation	**4**

PRIORITY	WHICH MEANS	ACTION PLANNED	PROGRESS Q3	KPIs	TRUST BOARD ASSURANCE AND SCRUTINY	ACTION RAG
-			existing 12 Pioneering teams continued to be supported around Step 7 LiA – maintaining momentum. A further 1 Enabling Our People Schemes commenced adopting LiA and the existing 10 EoP schemes continued working on corporate themes to address the issues raised by staff at the listening events. A Pass it On event was held on 6 November 2013 with 155 staff attending. In October 2013, 10 of the first wave Pioneering teams repeated the Team Pulse Check Survey. The results were an improvement from the ones that were completed at the start of their LiA journeys back in June 2013. Additional Thematic LiA events have taken place including 3 Meals and Cleaning event across the 3 hospital sites and an event for Junior Doctors.		Board per month. Quarterly OD Update Report (Quarter 2 – July – September 2013) presented to Trust Board LiA Update report presented to Trust Board – December 2013	
Professional, passionate and valued workforce -	Improve two way engagement	Build our model employer approach by implementing medical engagement priorities identified through the Medical Engagement Strategy (2013/14) Change Management Achieve and maintain 'Excellent Employer' status	The Medical Leadership Programme was delivered to the October cohort. A new consultant's development event took place on 01.11.13. The Director of Strategy hosted UHL's first Consultant/GP conference event on 05.12.13 focussing on developing consultants on skills related to commissioning and influencing networks. A mentoring development event took place on 12.12.13. The UHL Drs in training committee continue to meet bi monthly to address targeted areas for action which has been underpinned by a Listening into Action event	Increased engagement and staff morale	Organisational Development Plan Priorities (2013/15) - Quarterly Update Report (Quarter 3 October to December 2013) presented to Trust Board 20.12.13	**4**
Professional, passionate and valued workforce	Strengthen Leadership	Devise and implement Leadership Qualities and Behaviours	Work is progressing the development of a 360 degree feedback tool with OCB media Review and comparison of the NHS Healthcare Leadership Model with the UHL	Increased recruitment, retention and succession planning	Organisational Development Plan Priorities (2013/15) - Quarterly Update Report (Quarter 3 October to December 2013) presented to Trust Board	**4**

PRIORITY	WHICH MEANS	ACTION PLANNED	PROGRESS Q3	KPIs	TRUST BOARD ASSURANCE AND SCRUTINY	ACTION RAG
			Leadership Qualities and Behaviours		20.12.13	
Professional, passionate and valued workforce	Strengthen Leadership	Agree Senior Leadership Development plans. Agree skills development in Finance and Business Acumen	Project Team to attend Leading Across Boundaries Programme to support improvement in cancer care Talent Management report presented to Trust remuneration Committee outlining the senior management team talent profile	Increased recruitment, retention and succession planning	Organisational Development Plan Priorities (2013/15) - Quarterly Update Report (Quarter 3 October to December 2013) presented to Trust Board 20.12.13	**4**
Professional, passionate and valued workforce	Strengthen Leadership	Agree Board and Executive Leadership Development plans.	Continued programme of Board Development sessions Board agreed to commission independent Board effectiveness review		Organisational Development Plan Priorities (2013/15) - Quarterly Update Report (Quarter 3 October to December 2013) presented to Trust Board 20.12.13	**4**
Professional, passionate and valued workforce	Enhance workplace learning	Enhance Statutory and Mandatory Training	Improvements in the reporting dashboard Demonstrable improvements in performance Launch of 7 new OCB e learning products to improve compliance	Compliance with statutory and mandatory training standards	Organisational Development Plan Priorities (2013/15) - Quarterly Update Report (Quarter 3 October to December 2013) presented to Trust Board 20.12.13	**4**
Professional, passionate and valued workforce	Implement workforce plans	Each Division developed a Workforce Plan for 2013/14 which was based on predicted activity levels and Cost Improvement Schemes.	Workforce plans have remained fluid in year to reflect increased capacity requirements. Workforce CiP Schemes continue to be performance managed through the Improvement and Innovation Framework. Nursing agency expenditure has fallen in the last quarter reflecting increased substantive staffing numbers and increased use of Bank staff. A high level workforce plan for the Emergency Floor is being developed and work is underway to develop a fully costed workforce plan for the full business case in June 2014.	Increased recruitment, retention and succession planning	Organisational Development Plan Priorities (2013/15) - Quarterly Update Report (Quarter 3 October to December 2013) presented to Trust Board 20.12.13	**4**

PRIORITY	WHICH MEANS	ACTION PLANNED	PROGRESS Q3	KPIs	TRUST BOARD ASSURANCE AND SCRUTINY	ACTION RAG
			Following the review of the nursing establishment, rigorous recruitment campaigns are underway including a successful programme of international recruitment. !7 apprentice Healthcare Assistants have been appointed to develop a career pathway for potential future nursing staff			
Professional, passionate and valued workforce -	Improve External Relationships and Workplace Partnerships	Develop Patient and Public Involvement Strategy	Each CMG has a named PPi Lead to develop and encourage PPI activity. An assurance committee has been established to scrutinise the Trust's equality, engagement and patient experience agendas. A new reputation audit was conducted. The Chief Nurse held a public engagement event in December to explore the experience of recent patients and their families. Members of Healthwatch are increasingly engaged in our reconfiguration work	Evidence of increased engagement	Organisational Development Plan Priorities (2013/15) - Quarterly Update Report (Quarter 3 October to December 2013) presented to Trust Board 20.12.13	**4**
Professional, passionate and valued workforce	Encourage creativity and Innovation	Produce Service Improvement Strategy / Skills Development to drive forward service improvement	During this quarter, we have developed and implemented a new way of managing projects and programmes being delivered within the IIF. This includes: 1. A standardised approach to project documentation including templates, reports and e-filing system. 2. An IT project tracking and reporting system. 3. Resource and training centre accessible through the IIF website on INsite • A strategy for building capability for improvement has been agreed by the IIF board this quarter. This comprises of a	Increased evidence of project management training and service improvement tools and techniques	IIF Board chaired by CEO Reports to Trust Board Organisational Development Plan Priorities (2013/15) - Quarterly Update Report (Quarter 2 – July to Sept 2013) presented to Trust Board 27/9/13	**4**

PRIORITY	WHICH MEANS	ACTION PLANNED	PROGRESS Q3	KPIs	TRUST BOARD ASSURANCE AND SCRUTINY	ACTION RAG
			mixed approach to learning based on the individual's role and improvement skills required. The programme will align with and form a key component of the Trust's Leadership into Action Strategy as there is a strong overlay with team behaviours and attitude in order to achieve successful improvement. The programme includes e-learning modules, train the trainer programme and classroom based, multi-professional learning, aimed at operational leaders and clinical leaders. Preparation of the training material for this are underway and will be supported by our future Quality Improvement Academy (to be launched in the next quarter)			
Professional, passionate and valued workforce	Encourage creativity and Innovation	Embedding Releasing Time to Care Build on Research and Development	**Embedding Releasing Time to Care** Releasing Time To Care (RT2C) – the Productive Ward continues to be rolled out to all inpatient wards, aiming for all wards to complete implementation by May 2014 using the "Fast Track" implementation programme. Modular based, it focuses on improving nursing processes carried out in ward areas to maximise on time for delivering high quality patient care. **Build on Research and Development** We host the East Midlands Clinical Research Network with a contract value of £23 million per annum over a five year period. At the end of this quarter we have seen a sustained increase in recruitment to NIHR-adopted research studies: UHL is currently 42% above target and 85% above recruitment for the same time point last year.	Increased staff morale, retention, staff satisfaction	Organisational Development Plan Priorities (2013/15) - Quarterly Update Report (Quarter 2 – July to Sept 2013) presented to Trust Board 27/9/13	**4**

PRIORITY	WHICH MEANS	ACTION PLANNED	PROGRESS Q3	KPIs	TRUST BOARD ASSURANCE AND SCRUTINY	ACTION RAG
DEVELOPMENT PRIORITY – SPECIALISED SERVICES						
Developing our specialised services	For example, vascular surgery	Plans are to be progressed to relocate Vascular Surgery from the LRI to the GGH thereby consolidating Cardio-Vascular Services onto one site. Enhance minimally invasive vascular and renal Interventional Radiology at GGH - Supporting the shift from inpatient to day case	An Outline Business case is currently being written and due for submission to Trust Board in January. The projected completion date of the Project is Nov 2015. The provision of vascular surgical procedures is a core element of the Trust's clinical strategy – and the co-location of vascular services with cardiology/cardiothoracic services is essential to the delivery of an enhanced service to patients in line with the national drivers for vascular services.	Patient experience Patient outcome	Governance through Single Site Take Programme Board, Executive Strategy Board and financial approval through the Commercial Executive	3
Developing our specialised services	For example, Children's Cardiac Services	The outcome of the national Safe and Sustainable Review into Children's Cardiac Surgery was referred by the Secretary of State for Health to the Independent Reconfiguration Review Panel following challenge from various sources including our own local Health Overview and Scrutiny Committee. The outcome of the panel consideration was unknown at the time of the approval of our AOP. The Trust (with commissioner support) will implement the action required in response.	East Midlands Congenital Heart Centre Programme Board established. Latest meeting held in January 2014. The programme board is the vehicle by which the EM Congenital Heart Centre will engage with the national process for specialised services and the internal planning process (to address the derogations previously submitted as part of the specialised specification process)	Retention of paediatric cardiac surgery	Reports to Executive Strategy Board	**4**
Developing our specialised services	For example, Adult Cardiac Surgery Services	The Trust is engaging in early discussions with Nottingham University Hospitals (NUH) to explore the benefits of an East Midlands network approach towards adult cardiac surgery allowing	Discussions have taken place and there is commitment on both sides of the memorandum of commitment and an understanding that this will provide the framework within which future discussions	Market share (value and volume)	Reports to Executive Strategy Board	**4**

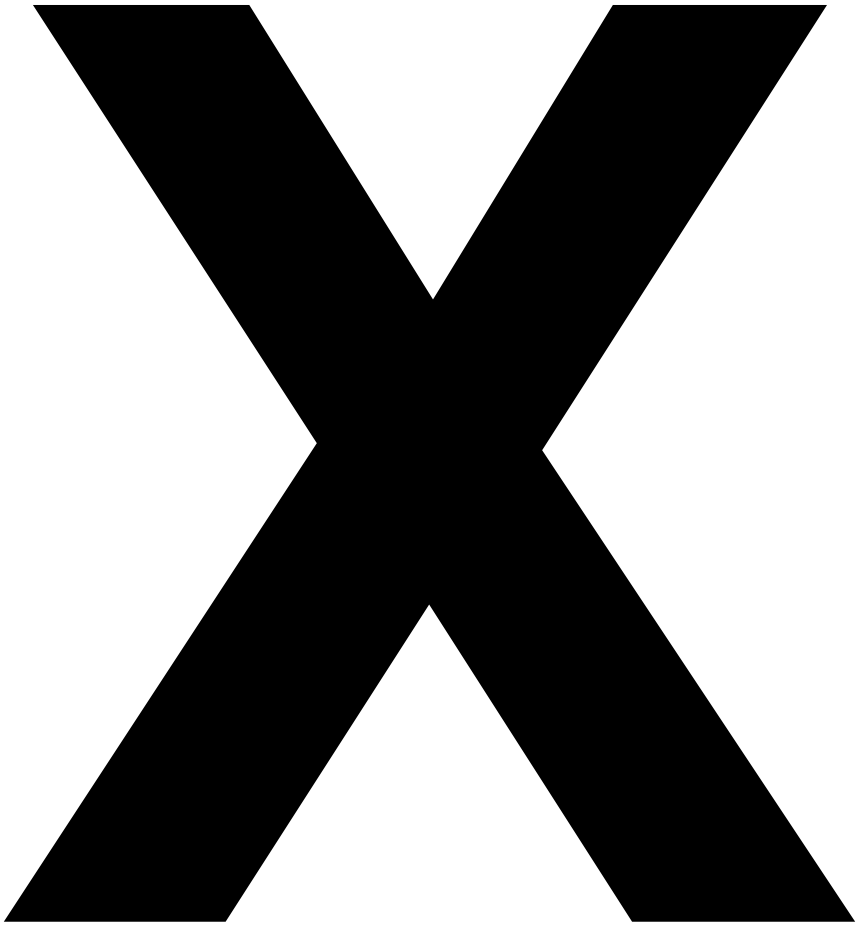
PRIORITY	WHICH MEANS	ACTION PLANNED	PROGRESS Q3	KPIs	TRUST BOARD ASSURANCE AND SCRUTINY	ACTION RAG
		opportunity to share and benefit from, best practice.	take place.			
DEVELOPMENT PRIORITY – MEDICAL EDUCATION						
Medical Education	Improved infrastructure for clinical education at LRI	Conversion of Odames Ward to a library/learning centre and an option appraisal of other solutions to resolve lack of education and training space generally across LRI. Initial designs for conversion of Odames Ward into a Clinical Education Centre have been reviewed and approval given to develop an Outline Business Case for delivery in 2013/14.	Odames Library project group is up and running. Plan for delivery progressing with a target of April 2014.		Quarterly review considered by Trust Board (last report June 2013). Need new non-executive director to work with Clinical Education department to represent education and training issues to the Board since the Chairman left the trust	**4**
Medical Education	Accountability for education and training resources	Increase accountability for education and training resources and map resources to quality of education and training delivery	Improved understanding of SIFT funding in UHL via PLICs however further work has temporarily paused due to structural changes (previous discussions with people now not in post). Supporting documents prepared for future meetings. Little progress with improving transparency of funding for education and training within trust and CMGs		Quarterly review considered by Trust Board (last report June 2013)	**3**
Medical Education	Educational Governance	Develop a funded (SPA) CMG Medical Education Lead role to improve links between clinical service and training, to deliver quality measures and respond to the challenges of increased accountability for education funding	New terms of reference for Medical education committee have been agreed. The job description agreed for CMG medical Education lead role has been	Education dashboard as part of the Quality and Performance report is under discussion and	Quarterly review considered by Trust Board (last report June 2013)	**3**

PRIORITY	WHICH MEANS	ACTION PLANNED	PROGRESS Q3	KPIs	TRUST BOARD ASSURANCE AND SCRUTINY	ACTION RAG
			developed and agreed. And 4 appointed The education quality dashboard has been developed. Meetings are planned to discuss this with CMGs in Q3/4. Training of appraisers to appraise SPA education roles is ongoing.	development.		
Medical Education	Medical workforce planning (Medical Workforce group)	Agree the shape of the future medical workforce in UHL and the associated training implications	Department of clinical education continues to support this work The TPD for Respiratory medicine is working with HR to develop a link with Malta to send a small number of trainees to UHL Trust doctor posts – Education department has supported an SAS Tutor this year after funds were withdrawn from the Deanery. This is a valuable post to the trust as this group of doctors grows – The Education Department will not be able to sustain in longer term. In addition, the number of junior doctors in trust funded posts is growing as the medical workforce changes. Workforce manager is very involved with this. The medical education lead supporting a plan to offer this group supervision and support so that they are a valued and more stable workforce	Education dashboard as part of the Quality and Performance report is under discussion and development.	Quarterly review considered by Trust Board (last report June 2013)	**3**
Medical Education	Enhance trainee experience	Enhance trainee experience and engagement with UHL through processes including Listening into Action (LiA) and UHL doctors in training committee	The UHL Doctors in Training Committee (DiTC) meet on a bi-monthly basis with representation from all specialties and grades. Priority work streams for the committee have been identified as:- 1) Maximising Training and Learning Opportunities; 2) Patient Safety; and 3) Communication.	Education dashboard as part of the Quality and Performance report	Quarterly review considered by Trust Board - Quarterly Update Report (Quarter 3 October to December 2013) presented to Trust Board 20.12.14	**4**

PRIORITY	WHICH MEANS	ACTION PLANNED	PROGRESS Q3	KPIs	TRUST BOARD ASSURANCE AND SCRUTINY	ACTION RAG
			A development day for the DiTC members was held in September in UHL. In addition a Listening in Action Event took place for doctors in training on 9 December 2013 and a UHL 'Enhancing Quality Improvement Programme' has been launched, with the support of the Head of Service Improvement and LNR Foundation School. The focus for next 3 months will include work on the DiTC work streams identified above. Outputs from the LiA event and Quality Improvement Programme will lead to further work streams that doctors in training will undertake.			
DEVELOPMENT PRIORITY – RESEARCH AND DEVELOPMENT						
Research and Development	Optimising the value added by our Biomedical Research Units (BRU)	To ensure the BRUs operate efficiently, effectively and are delivering on their objectives for example, developing new and effective treatments for severe asthma and chronic obstructive pulmonary disease (COPD) (LLR have a high incidence of COPD)	The BRUs are performing in line with Q3 plan.	Staff appointed Volume of clinical trials Value of grant income Accommodation complete and occupied	Performance monitored through the joint BRU Board UHL Research and Development Executive reports to Executive Strategy Board and by exception to Trust Board	**4**
Research and Development	Engaging with NIHR portfolio studies	Improving UHL's engagement with NIHR portfolio studies, thereby making significant progression towards every service taking part in this activity	Engagement in terms of patient recruitment to NIHR trials continues to improve; figures available up to mid-October 2013 show the Trust to be ~50% ahead of target to date	Number of patients recruited to NIHR trials	UHL Research and Development Executive reports to Executive Strategy Board and by exception to Trust Board	**4**
Research and Development	Enhancing Leadership	Being a leading, influential partner in the development of the East Midlands Academic Health and Science Network (AHSN)	Interactions with the AHSN structure have been slow to develop although we are now feeding into AHSN priority areas. Plans in place for interaction at senior level	Membership of substantive AHSN Board	UHL Research and Development Executive reports to Executive Strategy Board and by exception to Trust Board	**3**

PRIORITY	WHICH MEANS	ACTION PLANNED	PROGRESS Q3	KPIs	TRUST BOARD ASSURANCE AND SCRUTINY	ACTION RAG
Research and Development	Improving Communication	Developing and delivering a comprehensive communication strategy for R&D within the Trust	Research Communication Manager post agreed; job description and person spec have been agreed; post awaiting grading – then go immediately to advert.	Staff awareness of R&D and how it fits with the Trust's overall strategy	UHL Research and Development Executive reports to Executive Strategy Board and by exception to Trust Board	3
DEVELOPMENT PRIORITY – FOUNDATION TRUST STATUS						
Foundation Trust Status	Board Development	Develop and agree Trust Board Development programme for 2013/14.	Topics covered in Board development sessions throughout October to December 2013 include: • The new CQC inspection regime • Internal and external stakeholder engagement • The Assurance, Escalation and Response Framework • Mortality • Strategy development • The reconfiguration programme	Delivery of programme for 2013/14	Actions arising from the Trust Board development sessions reported at subsequent Board development sessions	4
Foundation Trust Status	Integrated Business Plan (IBP) and Long Term Financial Model (LTFM)	UHL is in stage 1 (diagnosis and due diligence) of the approvals model set out in the NTDA Accountability Framework. The next iteration of the IBP/LTFM is under development for completion of a first draft to be approved by the April 2014 Trust Board	The review will fall within the framework of LLR Strategy under the umbrella of Better Care Together. UHL and LLR are working together to compile a 5 year strategy.	Milestone plan and associated products delivered on time to quality standards	Updates as and when required to the Trust Board; and the Executive Strategy Board	4
Foundation Trust Status	Integrated Development Plan (IDP)	Develop and implement an Integrated Development Plan incorporating required developments in Quality Governance, Board Governance and Development and external assurance processes		Integrated Development Plan actions completed on time to quality standards	Updates reported by exception to the Executive Strategy Board	4
Foundation Trust Status	Service Line Management	Develop a Service Line Management (SLM) programme incorporating the key elements of business strategy, performance management, information and organisational structure	Agreed at the last SLM Programme team meeting (November 2013) that a workshop would take place in early 2014 at which: • CMGs would be brought up to speed on SLM • A programme plan for implementation	SLM KPI's to be developed during next stage of SLM implementation	Monthly SLM updates presented to the Executive Strategy Board	4

PRIORITY	WHICH MEANS	ACTION PLANNED	PROGRESS Q3	KPIs	TRUST BOARD ASSURANCE AND SCRUTINY	ACTION RAG
			of SLM across UHL would be agreed			
Foundation Trust Status	Blueprint	Further develop the Trust's Strategic Direction so that there is clarity about site configuration and annual priorities for the organisation in pursuit of that Direction	Weekly meetings taking place with CMG's. A workshop called 'delivering our strategic direction' was held in November, hosted by Kate Shields, and provided opportunity to set the scene and define the context within which 2 year operational plans are to be delivered. Further workshops are planned for Jan/Feb with each individual CMG to develop their 5 year service strategies.		Updates as and when required to the Trust Board and the Executive Strategy Board	**4**



Trust Board Paper X

To:	Trust Board
From:	Kate Shield
Date:	30 January 2014
CQC regulation:	All

Title:	2014/ 2016 OPERATIONAL PLAN – 1ST DRAFT

Author/Responsible Director: Kate Shields/Helen Seth

Purpose of the Report:

i. Provide a brief synopsis of the national planning guidance for NHS Trusts "Securing Sustainability" 2014/2015 – 2018/2019.

ii. Identify the key messages which will ultimately inform our final operational plan submission to the Trust Development Authority (TDA) on 4 April, 2014.

iii. Note and seek ratification of the 1st cut operational plan submitted to the TDA on 13 January, 2014.

iv. Confirm next steps and timescales.

The Report is provided to the Board for:

Decision		Discussion	X
Assurance		Endorsement	

Summary / Key Points:

The TDA published the planning guidance for NHS Trusts on the 23 December, 2013 and required a first cut submission on 13 January, 2014 (Annex A - Annex E). The plan submitted on 13 January was at a very early stage of development. It is not therefore the intention to share the detailed documents (Annex A – Annex E) although these can be made available to Trust Board members.

The planning guidance is focused on improving quality, patient safety, clinical and financial sustainability and covers the planning requirements for our 2 - year operational plan which will ultimately be set within a Leicester, Leicestershire and Rutland (LLR) 5 – year strategy (to be completed by June 2014). The process by which the LLR strategy will be completed will be launched at event on 29 January which will be attended by Trust Board and clinical leaders.

Key points to note include:

Finance – There is a national expectation that no Trust will be in deficit by 2016/17. Our current plans are predicated on a 3 – 5 year financial recovery plan and the requirement for strategic transformation funding to effectively manage transition. In developing granular plans the Trust will need to carefully consider how it can meet its statutory duties and the requirements of the planning guidance.

System wide response – The guidance outlines a clear expectation around whole system solutions delivered in partnership, across health and social care. The 'burning platform' created by our financial position creates the ideal impetus for LLR to adopt the principles of a collaborative alliance. Based on mutualism and subsidiarity, this would call for a shift from

traditional, technical, transactional relationships to behaviours built on joint solutions, delivered in partnership, facilitated (rather than prescribed) through appropriate use of contractual levers. How this might be achieved is the currently the subject of discussion.

Patient and Public Involvement - The planning guidance lays out clear expectations in respect to patient and public involvement. The Trust and it's partners are carefully considering how best to do this in the 5 – year strategy work. Within the Trust we will utilise established forums to share and seek feedback on our early plans.

Operational and strategic 'grip' (finance, operations and quality) - The guidance outlines a clear expectation in respect of operational and strategic 'grip' on planning, performance and delivery. Plans to date have focused on delivery of immediate, operational imperatives. Significantly more work is required on 7 day working, the next stage of our quality commitment, granular CMG plans, addressing derogation plans, the future configuration of specialised services, the capital plan and the implementation of account management.

Workforce Plans - Underpinning all of the above is the requirement for robust workforce plans. A workforce planning process and plan is in place however during this next phase it is essential that this is reviewed and where appropriate enhanced to reflect the implications of the forthcoming changes without detriment to safe staffing ratios. The requirements of the workforce template (Annex D) are far reaching and require data that isn't currently available from electronic data sources. Discussions are ongoing with the TDA.

Development Plan – The planning guidance calls for careful consideration of development plans. A critical gap has been identified in capacity planning. Future iterations will consider how this might be addressed across the Trust and the wider community.

Planning Checklist – As in previous years the guidance requires the submission of a detailed planning checklist and a statement of compliance or non compliance across multiple parameters (Annex E). For the next iteration considerable effort will be required to enhance the supporting evidence for the compliance statements made. Responsibility for this task will be via the Executive Team.

Recommendations:
The Trust Board are asked to:
RECEIVE this report
NOTE the progress to date
PROVIDE comment as necessary

Previously considered at another corporate UHL Committee? Trust Board December 2013

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

Resource Implications (eg Financial, HR):

Assurance Implications: Yes

Patient and Public Involvement (PPI) Implications: Yes

Stakeholder Engagement Implications: Yes

Equality Impact:

Information exempt from Disclosure:

Requirement for further review? Yes February 2014

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: Trust Board

REPORT FROM: Kate Shields, Director of Strategy

AUTHOR: Helen Seth, Head of Planning and Business Development

RE: Overview - Draft 1 Operational Plan 2014-2016

DATE: 30 January, 2014

1. PURPOSE

The purpose of this paper is to:

i. Provide a brief synopsis of the national planning guidance for NHS Trusts "Securing Sustainability" 2014/2015 – 2018/2019.

ii. Identify the key messages which will ultimately inform our final operational plan submission to the Trust Development Authority (TDA) on 4 April, 2014.

iii. Note and seek ratification of the 1st cut operational plan submitted to the TDA on 13 January, 2014. Due to the timing of the submission this was signed off by the Chairman and Chief Executive on the basis of delegated authority.

iv. Confirm next steps and timescales.

The plan submitted on 13 January was at a very early stage of development. It is not therefore the intention to share the detailed documents (Annex A – Annex E) themselves at this stage although these can be made available to Trust Board members.

2. CONTEXT

The TDA published the planning guidance for NHS Trusts on the 23 December, 2013.

It is set against the backdrop of an acute sector experiencing a dramatic reduction in planned income leading to a pronounced increase in the number of planned and forecast deficits. Trust income is expected to reduce further in real terms.

A traditional response based on incremental productivity and efficiency improvement will not address the anticipated gap and there is therefore the need to move away from incremental annual planning focusing instead on the development of longer term integrated plans in partnership with the wider health and care community.

Moving forward our 2 – year operational plan will fall within the framework of a Leicester, Leicestershire and Rutland (LLR) Integrated health and care 5 – year strategy. This will be subject to iterative development, future consideration and ratification by Trust Board prior to submission on 20 June, 2014. The process to jointly develop the 5 – year strategy will be formally launched at an event on 29 January which Trust Board members and clinical leaders will be attending.

The Trust remains committed to achieving Foundation Trust status in accordance with the revised FT application process set out in the "Securing sustainable services for patients" letter to all aspirant foundation trusts. It is our intention to pursue a

standalone FT application and we will not be pursuing an alternative organisational form (reference Annex E).

3. PLANNING GUIDANCE - KEY MESSAGES

The guidance focuses on improving quality, patient safety, clinical and financial sustainability. It covers the planning requirements for our 2 - year operational plan set within a 5 – year strategy and is predicated on system wide transformation delivered in partnership.

Key messages include:

Finance – There is a national expectation that no Trust will be in deficit by 2016/17 however locally, the Trust is working on the basis of a 3 – 5 year financial recovery plan to address our underlying deficit. On face value this would suggest a timing issue. Currently the Trust does not have a granular level of detail in its plans for quality, innovation, productivity and prevention (QIPP) or where, how and from whom, strategic transformation funding with be forthcoming. Potential sources of non-recurrent funding might include a joint application for non-recurrent Better Care Funding where proposed changes will ultimately support service integration but where double running costs will be incurred during transition. It is essential that the Trust exploits all avenues if it is to meet the national expectation laid out in the planning guidance, its statutory duties and our declared position on the planning checklist (Annex E – Planning Checklists).

System wide response – The guidance outlines a clear expectation around whole system solutions delivered in partnership, across health and social care. Locally, it is clear that the Trust will not achieve clinical and financial sustainability in isolation and is therefore a committed partner to the Better Care Together programme. As such, it is LLR that is facing shared risks and opportunities. The 'burning platform' created by our financial position creates the ideal impetus to adopt the principles of a collaborative alliance (as proposed for the LLR Community Elective Care Bundle). Based on mutualism and subsidiarity, it calls for a shift from traditional, technical, transactional relationships to behaviours built on joint solutions, delivered in partnership, facilitated (rather than prescribed) through appropriate use of contractual levers. This is not the approach typically adopted but is an area of focus for our 2nd draft submission on 14 February, 2014 and the forthcoming contractual round. It is essential that subject to agreement these principles are documented in a Memorandum of Understanding (MOU) which can be used to hold all parties to account in delivery (acknowledging it is not legally binding). Trust Board will explore this issue further at a development session on the 13 February.

The planning guidance lays out clear expectations in respect to patient and public involvement including the need for meaningful and timely engagement and the creation of opportunities to capture real time feedback. The Trust and it's partners are carefully considering how best to do this as we take forward the 5 – year strategy work. Within the Trust we will utilise established forums to share and seek feedback on our early plans. There is clearly significant scope for improvement in this regard.

Operational and strategic 'grip' (finance, operations and quality) - The guidance outlines a clear expectation in respect of operational and strategic 'grip' on planning, performance and delivery. Our plans to date have focused on delivery of immediate,

operational imperatives and are not sufficient for the purposes of a 2 – year operational plan (e.g. ED, RTT). Moving forward we need to utilise our clinical community more effectively in generating plans for clinical transformation, empower our front line staff to deliver change and make best use of diagnostic analysis already undertaken. Our plans must demonstrate a granular level of detail of how we intend to deliver 7 day working, maintain safe and effective core and specialised services (particularly cancer, cardiac, vascular and children's) whilst nurturing relationships with our commissioners and Local Authority partners.

Significantly more work is required on 7 day working, the next stage of our quality commitment, granular CMG plans, addressing derogation plans, the future configuration of specialised services and the implementation of account management to strategically manage relationships within and external to the Trust.

The delivery of a credible financial plan is clearly essential including a robust capital programme. Based on current planning assumptions, the funds required to facilitate the delivery of proposed estate reconfiguration over the next 5 years significantly exceeds current source of funds. How we source additional funds to support estate transformation will form an essential part of the work outlined above. How the capital programme is then actively performance managed in line with plan is another area for improvement.

Underpinning all of the above is the requirement for robust workforce plans. A workforce planning process and plan is in place however during this next phase it is essential that this is reviewed and where appropriate enhanced to reflect the implications of the forthcoming changes e.g. 7 day working, CMG plans, technological transformation. In complement, it is essential that an appropriate level of assurance can be given that QIPP activities will not have an adverse impact on multidisciplinary safe staffing ratios. It is important to note that the planning guidance requires a detailed working planning template to be completed as part of our submission (Annex D). This requires far more detail than ever before and requests certain data that cannot automatically be provided from electronic data sources (e.g. all staff directly or indirectly supporting ED). Discussions have been held with the TDA to highlight our concerns (scale, detail, time and data availability) and agreement reached as to the level of detail that we can submit in the early drafts and the caveats that we might wish to put on the data submitted. Trust Board are asked to note this point.

Development Plan – It is to be expected that the delivery of our 2 – year operational plan will be supported and facilitated through the appropriate application of capacity and capability. The Trust has a robust Organisational Development Plan which as demonstrated by the quarterly reports to Trust Board, is progressing well, enhancing the culture of the organisation. A key component of this plan is the implementation of the Listening into Action methodology. Empowering our staff to effect change will be central to our operational plan. As such, there will be a need to demonstrate how the benefits of this approach can be embedded to achieve improvement at scale and with increasing pace.

Our early draft plans have highlighted a critical gap in the discipline of capacity planning – across the Trust and the wider community. As such our final submission will need to reflect how we intend to address and thereby inform our integrated short, medium and long term plans. This issue will explored internally through a capacity

planning workshop with CMG's in late February and in parallel through the modelling sub-group of Better Care Together programme.

Planning Checklist – As in previous years the guidance requires the submission of a detailed planning checklist and a statement of compliance or non compliance across multiple parameters (Annex E). This includes specific statements around organisational form. The checklists were completed and signed off by appropriate executive directors however given the time constraints there was limited opportunity to link our response to supporting evidence. This represents a key task for the 2nd submission which will be coordinated and actioned via Executive Team.

4. TIMELINE AND NEXT STEPS

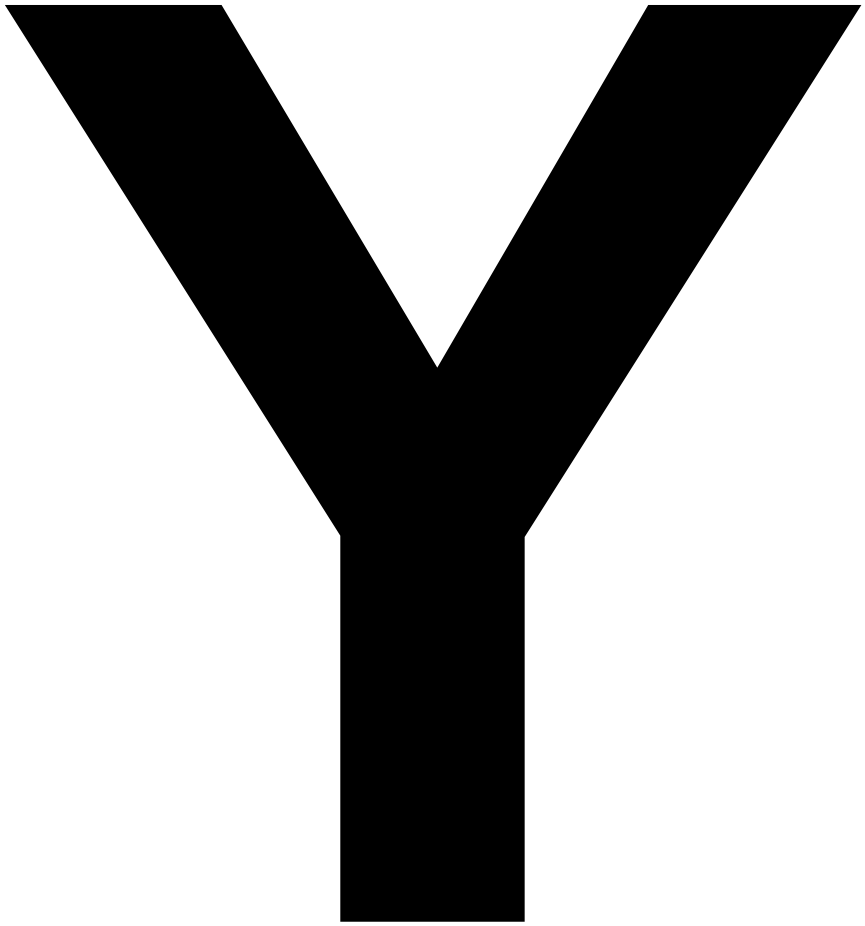
The Trust was informally advised on 23 January by the TDA that a general request was going to be made for a further interim submission on the 14 February. The Trust had already been working on the basis that for internal purposes only, we would develop a 2nd draft for internal review in mid February. With this in mind the immediate timeline is as follows:

TRUST TIMELINE	TDA SUBMISSIONS
2nd draft - Board Development Session 13 February 2014	2nd draft – 14 February 2014
2nd draft – Trust Board note and ratify 27 February 2014	Final draft – 5 March 2014
Clinical Service Contract agreed 28 February 2014	
2 – year submission - Board Development Session 13 March 2014	
2 year submission – Trust Board note and ratify 27 March 2014	2 – year submission – 4 April 2014
Programme to be agreed WB 27 January	5-year strategy submission – 20 June 2014

5. RECOMMENDATIONS

Trust Board are asked to:

RECEIVE this report
NOTE the key messages
RATIFY the 1st draft of our 2 – year operational plan 2014-2016
PROVIDE comment



University Hospitals of Leicester NHS
NHS Trust

To:	**Trust Board**
From:	**Rachel Overfield - Chief Nurse**
Date:	**30 January 2014**
CQC regulation:	Outcome 16 – Assessing and Monitoring the Quality of Service Provision

Trust Board Paper Y

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

Author/Responsible Director: Chief Nurse

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

a) A copy of the BAF as of 31 December 2013.
b) An action tracker to monitor progress of BAF actions
c) A summary diagram of BAF risk score movements from the previous month.
d) New extreme and/ or high risks opened during the reporting period.
e) Excerpt from the organisational risk register showing all current UHL extreme and high risks.

The Report is provided to the Board for:

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

Summary :

- There have been no changes to BAF risk scores during the reporting period.
- Risk number six has been removed from the BAF.
- Action 6.11 will be removed from future iterations of the action tracker.
- Action 8.11 is no longer relevant and has been removed from the BAF and will be removed from future iterations of the tracker.
- Action 10.1 has been integrated within action 10.5 and has been removed from the BAF and will be removed from future iterations of the action tracker.
- The lack of progress with actions 11.8 and 11.11 due to poor engagement from Interserve has been escalated to *'NHS Horizons'* for resolution.
- Action 13.8 has moved from a red RAG rating to green (on track).
- Seven new high risks have opened during December 2013 as described below.
- The Board is asked to note a moderate risk in relation to the NIHR Clinical Research Network: East Midlands transition plan. As the appointed host organisation, UHL is now leading and facilitating the transition process. The associated risk is reported as an exception to normal reporting due to the contractual obligation with the NIHR and Department of Health to report associated risks to the host Trust Board.

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

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

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

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

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

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

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **30 JANUARY 2014**

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

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

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1. INTRODUCTION

1.1 This report provides the Board with:-

a) A copy of the BAF as of 31 December 2013.
b) An action tracker to monitor progress of BAF actions.
c) A summary diagram of BAF scores to show any changes from the previous month.
d) Notification of any new extreme or high risks opened during the reporting period.
e) Excerpt from the organisational risk register showing all open extreme and high risks.

2. BAF POSITION AS OF 31 DECEMBER 2013

2.1 A copy of the BAF is attached at appendix one with changes to narrative since the previous version shown in red text.

2.2 The progress of actions associated with the BAF is monitored by reference to the action tracker attached at appendix two. Actions completed prior to December 2013 have been removed from the tracker however a full audit trail of these is available by reference to previous documents.

2.3 Appendix three provides a summary of changes to BAF scores and the Board is asked to note that there have been no changes to BAF risk scores since the previous report.

2.4 The Board is asked to note the following points:

- Following discussion and agreement at the December 2013 Board meeting, risk number six has been removed from the BAF.
- As a consequence of the above, action 6.11 will be removed from future iterations of the action tracker.
- Action 8.11 is no longer relevant and has been removed from the BAF and will be removed from future iterations of the tracker.
- Action 10.1 has been integrated within action 10.5 and has been removed from the BAF and will be removed from future iterations of the action tracker.
- The lack of progress with actions 11.8 and 11.11 due to poor engagement from Interserve has been escalated to *'NHS Horizons'* for resolution.
- Action 13.8 has moved from a red RAG rating to green (on track) following confirmation that Odames ward will be handed over to

Clinical Education on 1st February 2014 for work to begin in conversion to a library /learning centre.

2.5 In order to provide an opportunity for more detailed scrutiny the following three BAF entries are presented for Board members to review against the parameters listed in appendix four.

- Risk 8 – Failure to achieve and sustain quality standards (risk owners; Chief Nurse and Medical Director).
- Risk 9 – Failure to achieve and sustain high standards of operational performance (risk owner Chief Operating Officer).
- Risk 10 – Inadequate reconfiguration of buildings and services (risk owner Director of Strategy)

3 QUARTER THREE EXTREME AND HIGH RISK REPORT.

3.1 In line with the UHL Risk Management Policy, the Board is provided with a quarterly summary of all currently open extreme and high risks. As of 31 December 2013 there are 31 high risks (including those listed in section 3.2) and one extreme risk on the UHL organisational risk register. These are detailed at appendix five.

3.2 The Board is asked to note that seven new high risks were opened during December 2013 as detailed below.

Risk ID	Risk Title	Risk Score	CMG/Corporate Directorate
2267	Risk of reduced compliance with DoH requirements in relation to adherence to antimicrobial prescribing policy	20	Corporate Nursing
2271	Failure to achieve compliance of 75% attendance at Safeguarding training may have adverse impact on UHL safeguarding processes	16	Corporate Nursing
2278	Risk that the Leicester Fertility Centre could have its licence for the provision of treatment and services withdrawn	15	Women's & Children's
2270	Failure to achieve compliance of 75% attendance at Fire Safety training may cause UHL to fail to meet its statutory obligation	15	Corporate Nursing
2268	Failure to meet targets for training compliance for moving & handling training may adversely affect patient care /staff safety	15	Corporate Nursing
2272	Failing to meet internal and external targets in relation to undertaking IG training may adversely affect UHL compliance with IP	15	Corporate Nursing
2269	Failure to meet UHL target of a minimum of 75% of clinical staff undertaking IP/Hand hygiene training	15	Corporate Nursing

3.3 Finally, the Board is asked to note a moderate risk in relation to the National Institute for Health Research (NIHR) Clinical Research Network: East Midlands transition plan. This plan sets out progress, further actions and risks with respect to the local transition process from existing NIHR research network structures to the NIHR CRN: East Midlands structure by April 1, 2014. As the appointed host organisation, UHL is now leading and facilitating the transition process. The associated risk is reported as an exception to normal reporting due to the contractual obligation with the NIHR and Department of Health to report associated risks to the host Trust Board. Details of the risk are attached at appendix six.

4. RECOMMENDATIONS

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

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

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

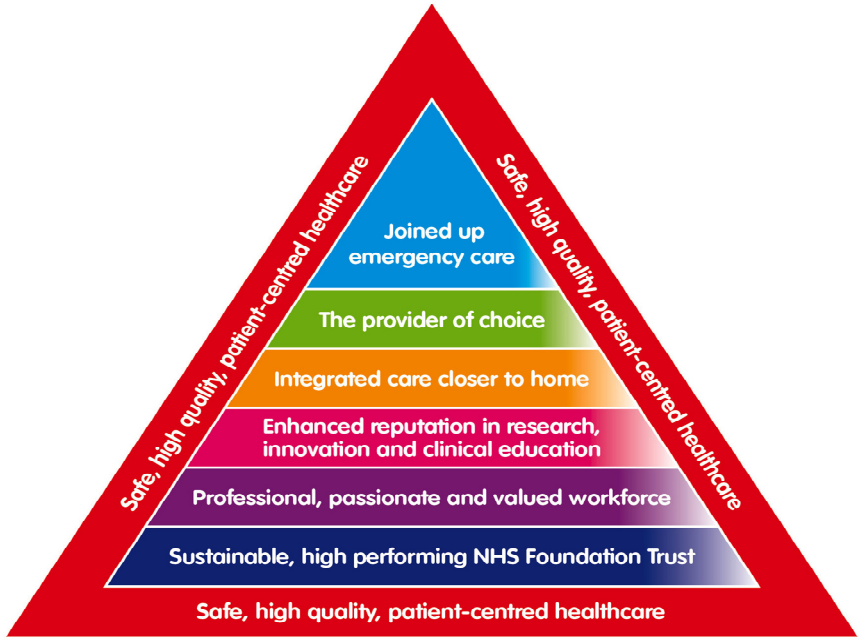
(c) identify any areas which it feels that the Trust's controls are inadequate and do not, therefore, effectively manage the principal risks to the organisation achieving its objectives;

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

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

Peter Cleaver,
Risk and Assurance Manager,
21 January 2014.

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK DECEMBER 2013



PERIOD: DECEMBER 2013

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

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK DECEMBER 2013

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to achieve financial sustainability including:	Overarching financial governance processes including PLICS process and expenditure controls. Revised variance analysis and reporting metrics especially for the ETPB Self-assessment and SLM baseline exercise completed and project manager identified Finalised SLM Action plan Full information has now been received on UHL allocations from all the no-recurrent funding streams including transformation monies. This information is being incorporated into the financial forecasts.	5X5=25	Monthly /weekly financial reporting to Exec Team Performance Board, F&P Committee and Board. Cost centre reporting and monthly PLICS reporting. Monthly confirm and challenge processes at specialty and CMG level. Annual internal and external audit programmes. Monthly meetings with the NTDA and the CCG Contract Performance Meeting	(c) SLM programme not fully implemented	ESB will continue to meet every 6 weeks to ensure implementation of SLM across the Trust (expected Mar 2014) (1.19)	4x3=12	Mar 2014 DFBS
Failure to achieve CIP.	Strengthened CIP governance structure including appt of Head of CIP programme		Progress in delivery of CIPs is monitored by CIP Programme Board (meeting fortnightly) and reported to ET and Board.	(c) Under-delivery of CIP programme (£0.8m adverse to plan M8)			

Locum expenditure.	Workforce plan to identify effective methods to recruit to 'difficult to fill' areas Reinstatement of weekly workforce panel to approve all new posts. STAFFflow for medical locums saving £130k of every £1m expenditure Financial Recovery plans developed Non Contractual Payments are discussed at monthly CMG meetings Confirm and Challenge Meetings All CMGs (by specialty) have produced premium spend trajectories and associated plans until March 2014 Weekly Staff Bank data reports are issued for medical and nursing (qualified and unqualified) staff Action plan to increase bank staff capacity and drive down agency nurse expenditure.		The use of locum staff in 'difficult to fill' areas reported monthly to the Board via the Q&P report. A reduction in the use of locums would be an assurance of success in recruiting substantive staff to 'difficult to fill' areas. Increase in contracted staff numbers of medical and nursing professions of 252wte since Mar 12. Saving in excess of £0.6m 5 weeks after 'go live' date Monthly Q&P report to TB Monthly confirm and challenge meetings Non contractual payments (premium spend) are reported monthly to the Finance and Performance Committee A weekly report is presented to ET. Weekly meetings with HoNs and DHR to monitor progress.	(c) Further investigation required as to the increase in Consultant numbers by 41wte (7.7%)			
Loss of income due to tariff/tariff changes (including referral rate for emergency admissions – MRET)	Contract meetings with Commissioners Negotiations with Commissioners concluded at a transactional level. Ongoing discussions with commissioners about planned re-investment of the MRET deductions.		Monthly /weekly financial reporting to Finance and Performance (F&P) Committee and Board.	(c) Failing to manage marginal activity efficiently and effectively. This is being addressed via ongoing discussions with Commissioners			

Ineffective processes for Counting and Coding.	Clinical coding project. Clinical coding to be included as a 2nd wave LIA pioneering team to involve clinicians.		Ad-Hoc reports on annual counting and coding process. PbR clinical coding audit Jan 2013 (final report received 29 May 2013). IG toolkit audit (sample of 200 General Surgery episodes).	(c) Error rates in audit sample could be indicative of underlying process issues (c) Error rates identified as: Primary diagnoses incorrect 8.0% › Secondary diagnoses incorrect 3.6%. › Primary procedure incorrect 6.4% › Secondary procedure incorrect 4.5%.			
Loss of liquidity.	Liquidity Plan.		Monthly /weekly financial reporting to F&P Committee and Board. Detailed cash management plans presented at August 2013 F&P committee				
Lack of robust control over pay and non-pay expenditure.	Pay and Non-pay recovery action plan in place and monitored monthly Catalogue control project.		Monthly /weekly financial reporting to F&P Committee and Board. Non-pay management plan presented at July F&P committee Ongoing Monitoring via F&P Committee.				
Commissioner fines against performance targets.	Contract meetings with Commissioners and negotiations with Commissioners concluded at a transactional level. Plans and trajectories developed to reduce admission rates that are monitored at monthly C&C meetings.		Monthly /weekly monitoring of action plans, key performance target, and financial reporting to F&P Committee and Board.				
Use of readmission monies.	Contract meetings with Commissioners Negotiations with Commissioners concluded at a transactional level Ownership of readmissions work streams in divisions clarified		Monthly /weekly financial reporting to F&P Committee and Board.				
Ineffective organisational transformation.	See risk 4		See risk 4.	See risk 4.	See risk 4.		See risk 4

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK DECEMBER 2013

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

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

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK DECEMBER 2013

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Inability to recruit, retain, develop and motivate suitably qualified staff leading to inadequate organisational capacity and development.	Leadership and talent management programmes to identify and develop 'leaders' within UHL.	4x5=20	Development of UHL talent profiles.	No gaps identified.	No actions required.	4x3=12	
			Talent profile update reports to Remuneration Committee.	No gaps identified.	No actions required.		
	Substantial work program to strengthen leadership contained within OD Plan.			No gaps identified.	No actions required.		
	Organisational Development (OD) plan.		A central enabler of delivering against the OD Plan work streams will be adopting, 'Listening into Action' (LiA) and progress reports on the LiA will be presented to the Trust Board on a quarterly basis.	No gaps identified.	No actions required.		
	A central enabler of delivering against the OD Plan work streams will be adopting, 'Listening into Action (LiA). A Sponsor Group personally led by our Chief Executive and including, Executive Leads and other key clinical influencers has been established.		Progress reports on the LiA will be presented to the Trust Board on a quarterly basis.	No gaps identified. No gaps identified.	No actions required. No actions required.		
	Staff engagement action plan encompassing six integrated elements that shape and enable successful and measurable staff engagement		Results of National staff survey and local patient polling reported to Board on a six monthly basis. Improving staff satisfaction position.	No gaps identified.	No actions required.		
			Staff sickness levels may also provide an indicator of staff satisfaction and performance. Staff sickness rate is 4.1% for M8.	No gaps identified	No actions required.		

	Appraisal and objective setting in line with UHL strategic direction. Local actions and appraisal performance trajectories agreed with CMGs and Directorates Boards		Appraisal rates reported monthly to Board via Quality and Performance report. Month 8 appraisal rate = 91.8%	(C) Appraisal rate consistently below target (target =95%)	Implement targeted recovery plans and trajectories for each cost centre (3.11).		Review Jan 2014 DHR
	Summary of quality findings communicated across the Trust; to identify how to improve the quality of the appraisal experience for the individual and the quality of appraisal meeting recording.		Results of quality audits to ensure adequacy of appraisals reported to the Board via the quarterly workforce and OD report.	No gaps identified.	No actions required.		
			Appraisal Quality Assurance Findings reported to Trust Board via OD Update Report June 2013 Quality Assurance Framework to monitor appraisals on an annual cycle (next due March 2014).	No gaps identified.	No actions required.		
	Workforce plans to identify effective methods to recruit to 'difficult to fill areas). CMG and Directorates 2013/14 Workforce Plans. Active recruitment strategy including implementation of a dedicated nursing recruitment team		Nursing Workforce Plan reported to the Board in September 2013 highlighting demand and initiatives to reduce gap between supply and demand. The use of locum staff in 'difficult to fill' areas is reported to the Board on a monthly basis via the Q&P report. Reduction in the use of such staff would be an assurance of our success in recruiting substantive staff.	((c) Risks with employing high number from an International Pool in terms of ensuring competence	Develop an employer brand and maximise use of social media (3.9) Programme of induction and adaptation in development with Nursing education leads, timetabled to ensure capacity to support programme. (3.10)		April 2014 DHR April 2014 DHR
	Reward /recognition strategy and programmes (e.g. salary sacrifice, staff awards, etc). Recruitment and Retention Premia for ED medical and nursing staff			(a) Reward and recognition strategy requires revision to include how we will provide assurance that reward and recognition programmes are making a difference to staffing recruitment/ retention/ motivation.	Revise and launch reward and recognition strategy. (3.1) Development of Pay Progression Policy for Agenda for Change staff (3.3)		Jan 2014 DHR Feb 2014 DHR

	UHL Branding – to attract a wider and more capable workforce. Includes development of recruitment literature and website, recruitment events, international recruitment. Recruitment progress is measured now there is a structured plan for bulk recruitment. Leads have been identified to develop and encourage the production of fresh and up to date recruitment material. Reporting and monitoring of posts with 5 or less applicants.		Evaluate recruitment events and numbers of applicants. Reports issued to Nursing Workforce Group (last report 4 Feb). Reporting will be to the Board via the quarterly workforce an OD report. Quarterly report to senior HR team and to Board via quarterly workforce and OD report	(a) Better baselining of information to be able to measure improvement. (c) Lack of engagement in production of website material.			
	Statutory and mandatory training programme for 9 key subject areas in line with National Core Skills Framework		Monthly monitoring of statutory and mandatory training uptake via reports to TB and ESB against 9 key subject areas (currently showing month on month improvements (58% at M7)	(c) Compliance against the 9 key subject areas is 62% (December 2013) (a) Potentially there may be inaccuracies of training data within the e-UHL system	Ensure Statutory and Mandatory training is easy to access and complete with 75% compliance by reviewing delivery mode, access and increasing capacity to deliver against specific subject areas (3.5) Update e-UHL records to ensure accuracy of reporting on a real time basis (3.7)		Mar 2014 DHR Mar 2014 DHR

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK DECEMBER 2013

RISK NUMBER/ TITLE:	**RISK 4 – INEFFECTIVE ORGANISATIONAL TRANSFORMATION**
LINK TO STRATEGIC OBJECTIVE(S)	**a. - To provide safe, high quality patient-centred health care.** **c. - To be the provider of choice.** **d. - To enable integrated care closer to home**
EXECUTIVE LEAD:	Director of Strategy

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to put in place a robust approach to organisational transformation, adequately linked to related initiatives and financial planning/outputs	Development of Improvement and Innovation Framework (IIF) Outputs from this transformation programme will drive the implementation of the clinical strategy.	4x4=16	Monthly progress reports to Exec Strategy Board and F&P Committee. Approval of framework and operational arrangements due at Trust Board June 2013. Monitoring of overall Framework will be via IIF Board and F&P Ctte and monitoring of financial outputs (CIPs) will be via CIP Delivery Board, Exec Performance Board and F&P Committee. Delivery of whole hospital change programmes requires alignment with the whole local Health Economy change programme – currently described through the Better Care Together programme	(c) Gaps are evident in the alignment of transformational process between UHL and principle partners – this is being raised through the Better Care Together Programme structures	Review outputs from Chief Officers Group and strategic Planning Group to ensure gaps in current processes are being addressed (4.1)	4x3=12	Review Feb 2014 DS

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK DECEMBER 2013

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to put in place appropriate systems to horizon scan and respond appropriately to external drivers. Failure to proactively develop whole organisation and service line clinical strategies	Appointment of Strategy Director	4x4=16	Plan agreed by Remuneration Committee	None identified	Not applicable	4x3=12	N/A
	Allocation of market intelligence responsibility to Director of Marketing and Communications		Agreed by Remuneration Committee	None identified	Not applicable		N/A
	Co-ordinated approach to business intelligence gathering and response via Clinical Management Groups Workshop 'hosted by the Director of Strategy 'delivering our strategic direction' held in November with all CMGs to set the external context within which we will need to develop a LLR Integrated 5-yaer plan, within which our 2-yaer operational plans will sit. CMG Strategy Leads now engaged in the BSST meetings to improve engagement, alignment and teamwork. ESB forward plan reflecting a 12 month programme aligned with: • the development of the IBP/LTFM • the reconfiguration programme • the development of the next AOP • The TB Development Programme The TB formal agenda		Weekly strategic planning meetings in place – cross CMG and corporate team attendance with delivery led through the Strategy Directorate Development of a clear, clinically based 5 year strategic will provide assurance that strategic planning is taking place Reports to ESB Regular reports to TB reflecting progress of 12 month programme	None identified None identified	Not applicable Not applicable		

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK DECEMBER 2013

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to maintain productive relationships with external partners/ stakeholders leading to potential loss of activity and income, poor reputation and failure to retain/ reconfigure clinical services.	Stakeholder Engagement Strategy. Regular meetings with external stakeholders and Director of Communications and member of Executive Team to identify and resolve concerns. Regular stakeholder briefing provided by an e-newsletter to inform stakeholders of UHL news. Leicester, Leicestershire and Rutland (LLR) health and social care partners have committed to a collaborative programme of change ('Better Care Together')	5X3=15	Twice yearly GP surveys with results reported to UHL Executive Team. Latest survey results discussed at the April 2013 Board and showed increasing levels of satisfaction… a trend which has now continued for 18 months. Annual Reputation / Relationship survey to key professional and public stakeholders Nov 13.	(c) No external and 'dispassionate' professional view of stakeholder / relationship management activity	Invite PWC (Trust's Auditors) to offer opinion on the plan / talk to a selection of stakeholders. (7.3)	5X2=10	Jan 2014 DCM

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK DECEMBER 2013

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to achieve and sustain quality standards leading to failure to reduce patient harm with subsequent deterioration in patient experience/ satisfaction/ outcomes, loss of reputation and deterioration of 'friends and family test' score.	Standardised M&M meetings in each speciality.	4x4=16	Routine analysis and monitoring of out of hours/weekend mortality at CMG Boards.	No gaps.	No action needed.	4x3=12	
	Systematic speciality review of "alerts" of deterioration to address cause and agree remedial action by Mortality Review Committee. Reports to Executive Quality Board, QAC, and by exception to ET and TB. All deaths in low risk groups identified. Working with DFI to ensure data has been recorded accurately		Quality and Performance Report and National Quality dashboard presented to ET and TB. Currently SMHI "within expected" (i.e. 106).	(a) UHL risk adjusted perinatal mortality rate above regional and national average.	Women's CMG to work with Dr Foster and other trusts to better understand risk adjustment model (8.2).		Jan 2014 MD
	Robust implementation of actions to achieve Quality Commitment (save 1000 extra lives in 3 years).		SHMI remains "within expected" (i.e. 106). Independent analysis of mortality review performed by Public Health. Results reported at November 2013 TB meeting.	No gaps identified.	No action needed.		
	Agreed patient centred care priorities for 2013-14: - Older people's care - Dementia care - Discharge Planning		Quality Action Group meets monthly. Achievement against key objectives and milestones report to Trust board on a monthly basis. A moderate improvement in the older people survey scores has been recorded.	No gaps identified.	No action needed.		
	Multi-professional training in older peoples care and dementia care in line with LLR dementia strategy.		Quality Action Group monitoring of training numbers and location.	No gaps identified.	No action needed.		

	Protected time for matrons and ward sisters to lead on key outcomes.		CMG/ specialty reporting on matron activity and implementation or supervisory practice.	(c) Present vacancy levels prevent adoption of supervisory practice.	Active recruitment to ward nursing establishment so releasing ward sister –for supervisory practice (8.5).		Sep 2014 CN
	To promote and support older peoples champions network and new dementia champions network.		Monthly monitoring of numbers and activity.	No gaps identified.	No action needed.		
	Targeted development activities for key performance indicators - answering call bells - assistance to toilet - involved in care - discharge information		Monthly monitoring and tracking of patient feedback results. Monthly monitoring of Friends and Family Test reported to the TB (70.3% at M8). England average 71% Older Peoples Quality Outcomes: all scores increased from M7 to M8 Discharge: All scores except for the question on being informed of problems/dangers signals increased from M7 to M8				
	Quality Commitment 2013 – 2016: • Save 1000 extra lives • Avoid 5000 harm events • Provide patient centred care so that we consistently achieve a 75 point patient recommendation score		Quality Action Groups monitoring action plans and progress against annual priority improvements. A Quality Commitment dashboard has been developed to present updates to the TB on the 3 core metrics for tracking performance against our 3 goals. These metrics will be tracked up to 2015. Impressive drops in fall numbers have been observed in Datix reports and in the Safety Thermometer audit.				
	Relentless attention to 5 Critical Safety Actions (CSA) initiatives to lower mortality.		Q&P report to TB showing outcomes for 5 CSAs. 4CSAs form part of local CQUIN monitoring. RAG rated green at end of quarter 2. M&M CSA removed from CQUIN monitoring due to full implementation 100%CQUIN funding for CAS programme for quarter two of 2013/14.	(c) Lack of a unified IT system in relation to ordering and receiving results means that many differing processes are being used to acknowledge/respond to results. Potential risk of results not being acted upon in a timely fashion.	Implementation of Electronic Patient Record (EPR). (8.10)		2015 CIO

	NHS Safety thermometer utilised to measure the prevalence of harm and how many patients remain 'harm free' (Monthly point prevalence for '4 Harms'). Monthly meetings with operational/clinical and managerial leads for each harm in place.		Monthly outcome report of '4 Harms' is reported to Trust board via Q&P report. The percentage of Harm Free Care for M8 was 93.86% reflecting a reduction in the number of patients with newly acquired harms.	(a) There is some concern that the revised DH monitoring tool is still not an effective measure to produce accurate information. Local actions to resolve this are not practicable.			

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to achieve and sustain operational targets leading to contractual penalties, patient dissatisfaction and poor reputation.	Referral to treatment (RTT) backlog plans (patients over 18 weeks) and operational performance of 90% (for admitted) and 95 % (for non-admitted). Further recovery plans submitted to Commissioners for external assurance	4x5=20	Key specialities will go onto weekly performance meetings with COO Weekly patient level reporting meeting for all key specialties Monthly Q&P report to Trust Board showing 18 week RTT performance Daily RTT performance and prospective reports to inform decision making	(c) 83.2% admitted RTT performance (M8). Backlog plans require further development in line with review of demand and capacity in key specialties. Recovery of the admitted and non admitted standards at Trust and speciality level is not anticipated until the new financial year. (c) Capacity issues created by emergency demand causes cancellations of operations. (c) ongoing discussions with commissioners have failed to agree a clear recovery plan at this stage	Re-configuration of surgical beds to create a 'protected area' for surgical patients or by use of independent sector. (9.2) Agree recovery action plan with commissioners to recover Referral to Treatment Performance within required operational standards	4x3=12	Review Jan 2014 COO Feb 2014 COO

	Transformational theatre project to improve theatre efficiency to 80 -90%.		Monthly theatre utilisation rates. Theatre Transformation monthly meeting. Transformation update to Board.	No gaps identified.	No actions required.		
	Emergency Care process redesign (phase 1) implemented 18 February 2013 to improve and sustain ED performance.		Monthly report to Trust Board in relation to Emergency Dept (ED) flow (including 4 hour breaches).	See risk number 2.	See risk number 2.		
	Cancer 62 day performance - Tumour site improvement trajectory agreed and each tumour site has developed action plans to achieve targets. Senior Cancer Manager appointed Lead Cancer Clinician appointed Action plan to resolve Imaging issues implemented.		Cancer action board established and weekly meetings with all tumour sites represented Monthly trajectory agreed and Cancer action plan agreed with CCGs in June 2013 and reported and monitored at Executive Performance board. Chief Operating Officer receives reports from Cancer Manager and 62 day performance included within Monthly Q&P report to Trust Board. Performance against 62 day standard has been above national average and exceeded 85% for the past 3 months.				

RISK NUMBER/ TITLE:		**RISK 10 – INADEQUATE RECONFIGURATION OF BUILDINGS AND SERVICES**					
LINK TO STRATEGIC OBJECTIVE(S)		**a. - To provide safe, high quality patient-centred health care**					
EXECUTIVE LEAD:		Director of Strategy					
Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Inadequate reconfiguration of buildings and services leading to less effective use of estate and services.	Clinical Strategy.	3x5=15	Trust Board development session on development of approach to strategic planning and development of SOC. This outlined the methodology being used to ensure any changes in configuration is specifically designed to deliver optimum quality of care Ongoing monitoring of service outcomes by MRC to ensure outcomes improve. Improvement in health outcomes and effective Infection Prevention and Control practices monitored by Executive Quality Board (Q+P report) with escalation to ET, QAC and TB as required.	(a) Service specific KPIs not yet identified for all services	Iterative development of strategic plans with specialities. This is monitored by CMG and Executive Boards. Work continues with DS and CMGS to prioritise key areas for delivery within the clinical strategy. Further workshops planned for Jan/Feb 2014. (10.5)	3X3=9	March 2014 MD

	Estates Strategy including award of FM contract to private sector partner to deliver an Estates solution that will be a key enabler for our clinical strategy in relation to clinical adjacencies. Reconfiguration Programme working with clinicians to develop a 'preferred' way forwards' with regards to the alignment of the future estate with clinical strategy		Facilities Management Collaborative (FMC) will monitor against agreed KPIs to provide assurance of successful outsourced service.	(c) Estates plans not fully developed to achieve the strategy. (c) The success of the plans will be dependent upon capital funding and successful approval by the NTDA.	Reconfiguration programme to develop a strategic outline case which will inform the future estate strategy (10.6) Secure capital funding. (10.3)		Jan 2014 DS Mar 2014 DFBS
	CMG service development strategies and plans to deliver key developments.		Progress of divisional development plans reported to Service Reconfiguration Board.	No gaps identified.	No actions required.		
	Service Reconfiguration Board.		Monthly ET Strategy session to provide oversight of reconfiguration.	No gaps identified.	No actions required.		
	Capital expenditure programme to fund developments.		Capital expenditure reports reported to the Board via F&P Committee.	No gaps identified.	No actions required.		
	Managed Business Partner for IM&T services to deliver IT that will be a key enabler for our clinical strategy. IM&T incorporated into Improvement and Innovation Framework.		IM&T Board in place.	No gaps identified.	No actions required.		

RISK NUMBER/ TITLE:			**RISK 11 – LOSS OF BUSINESS CONTINUITY**				
LINK TO STRATEGIC OBJECTIVE(S))			**g. - To be a sustainable, high performing NHS Foundation Trust.**				
EXECUTIVE LEAD:			Chief Operating Officer				
Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?

Inability to react /recover from events that threaten business continuity leading to sustained downtime and inability to provide full range of services.	Major incident/business continuity/ disaster recovery and Pandemic plans developed and tested for UHL/ wider health community. This includes UHL staff training in major incident planning/ coordination and multi agency involvement across Leicestershire to effectively manage and recover from any event threatening business continuity. Tailored training packages for service area based staff. Contingency plans developed to manage loss of critical supplier and how we will monitor and respond to incidents affecting delivery of critical supplies.	3x4=12	Annual Emergency planning Report identifying good practice presented to the GRMC July 2012. Training Needs Analysis developed to identify training requirements for staff supported by appropriate training packages for Senior Managers on Call External auditing and assurances to SHA, Business Continuity Self-Assessment, June 2010, completed by Richard Jarvis Completion of the National Capabilities Survey, November 2013 completed by Aaron Vogel. Results included in the annual report on Emergency Planning and Business Continuity to the QAC. Audit by PwC Jan 2013. Results being compiled and will be reported to Trust Board (date to be agreed). Documented evidence from key critical suppliers has been collected to ensure that contracts include business continuity arrangements.	(c) On-going continual training of staff to deal with an incident. (a) Do not consider realistic testing of different failure modes for critical IT systems to ensure IT Disaster Recovery arrangements will be effective during invocation. c) not all the critical suppliers questioned provided responses (c) contracts aren't assessed for their potential BC risk on the Trust.	Training and Exercising events to involve multiple specialties/CMGs to validate plans to ensure consistency and coordination (11.13). Determine an approach to delivering a physical testing of the IT Disaster Recovery arrangements which have been identified as a dependency for critical services. Include assessment of the benefits of realistic testing of arrangements against the potential disruption of testing to operations. (11.2) Finance and procurement staff to be trained how to assess the BC risk to a contract and utilise the tools developed. (11.14)	2x3=6	Aug 2014 COO Review Jan 2014 CIO Mar 2014 COO
	Emergency Planning Officer appointed to oversee the development of business continuity within the Trust.		Outcomes from PwC LLP audit identified that there is a programme management system in place through the Emergency Planning Officer to oversee. A year plan for Emergency Planning developed. Production/updates of documents/plans relating to Emergency Planning and Business Continuity aligned with national guidance have begun. Including Business Impact Assessments for all specialties. Plan templates for specialties now include details/input from Interserve	((c) Local plans for loss of critical services not completed due to change over of facilities provider (c) Plans have not been provided by Interserve as to how they would respond or escalate issues to the Trust.	Further work required to develop escalation plans and response plans for Interserve. (11.11)		Feb 2014 COO

	New policy to identify key roles within the Trust of those responsible for ensuring business continuity planning /learning lessons is undertaken.		Minutes/action plans from Emergency Planning and Business Continuity Committee. Any outstanding risks/issues will be raised through the COO.	No gaps identified.	No actions required.		
			New Policy on InSite Emergency Planning and Business Continuity Committee ensures that processes outlined in the Policy are followed, including the production of documents relating to business continuity within the service areas. 3 incidents within the Trust have been investigated and debrief reports written, which include recommendations and actions to consider. Issues/lessons feed into the development of local plans and training and exercising events.				
			Head of Operations and Emergency Planning Officer are consulted on the implementation of new IM&T projects that will disrupt users access to IM&T systems	(c) Do not always consider the impact on business continuity and resilience when implementing new systems and processes.	Further processes require development, particularly with the new Facilities and IM&T providers to ensure resilience is considered/ developed when implementing new systems, infrastructure and processes. (11.8)		Review Feb 2014 COO
				(a) Lack of coordination of plans between different service areas and across the specialties.	Training and Exercising events to involve multiple specialties/CMGs to validate plans to ensure consistency and coordination. (11.10)		Aug 2014 COO

RISK NUMBER/ TITLE:	RISK 12 FAILURE TO EXPLOIT THE POTENTIAL OF IM&T						
LINK TO STRATEGIC OBJECTIVE(S))	**a. - To provide safe, high quality patient-centred health care.** **d. - To enable integrated care closer to home**						
EXECUTIVE LEAD:	Director of Finance and Business services						
Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?

Failure to integrate the IM&T programme into mainstream activities	Managed Business Partner for IM&T services to deliver IT that will be a key enabler for our clinical strategy. IM&T now incorporated into Improvement and Innovation Framework	3x3=9	IM&T Board in place. Quarterly reports to Trust Board	No gaps identified	No actions required	3x2=6	
	Engagement with the wider clinical communities (internal) including formal meetings of the newly created advisory groups/ clinical IT. Improved communications plan incorporating process for feedback of information		CMIO(s) now in place, and active members of the IM&T meetings The joint governance board monitors the level of communications with the organisation	No gaps identified	No actions required		
	Engagement with the wider clinical communities (External). UHL CMIOs are added as invitees to the meetings, as are the clinical (IM&T) leads from each of the CCGs		UHL membership of the wider LLR IM&B board	No gaps identified	No actions required		
Benefits are not well defined or delivered	Appointment of IBM to assist in the development of an incentivised, benefits driven, programme of activities to get the most out of our existing and future IM&T investments Initial engagement with key members of the TDA to ensure there is sufficient understanding of technology roadmap and their involvement. The development of a strategy to ensure we have a consistent approach to delivering benefits Increased engagement and communications with departments to ensure that we capture requirements and communicate benefits Standard benefits reporting methodology in line with trust expectations		Minutes of the joint governance board, the transformation board and the service delivery board Benefits are part of all the projects that are signed off by the relevant groups	(c) the delivery programme is dependent on TDA approvals for some elements (c) ensure that all CMGs/ specialties have the approach to IM&T benefits as part of delivery projects (a) production of a standard report on the delivery of benefits	TDA approvals documentation to be completed (12.8)		Review Jan 2014 CIO

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to implement and embed an effective medical training and education culture with subsequent critical reports from commissioners, loss of medical students and junior doctors, impact on reputation and potential loss of teaching status.	Medical Education Strategy and Action Plan	4x3 = 12	Strategy approved by the Trust Board Strategy monitored by Operations Manager and reviewed monthly in Full team Meetings. Favourable Deanery visit in relation to ED Drs training	(c) Lack of engagement/awareness of the Strategy with CMGs.	Meetings to discuss strategy with CMGs (13.1)	3x2 = 6	Feb 2014 MD

	UHL Education Committee 'Doctors in Training' Committee established Education and Patient Safety		Professor Carr reports to the Trust Board Reports submitted to the Education Committee Terms of reference and minutes of meetings	(c) Attendance at the Committee could be improved. (c) Improved trainee representation on Trust wide committees (c) Improve engagement with other patient safety activities/groups	Relevance of the committee to be discussed at specialty/ CMG meetings (13.2) 'Build relationships with CMG Quality Leads. Establish links with LEG/QAC and QPMG. (13.4)		Feb 2014 MD Feb 2014 MD
	Quality Monitoring		Quality dashboard for education and training (including feedback from GMC and LETB visits) monitored monthly by Operations Manager, Quality Manager and Education Committee. Education Quality Visits to specialties Exit surveys for trainees Monitor progress against the Education Strategy and GMC Training Survey results	(a) Lack of engagement with specialties to share findings from the dashboards (a) Do not currently ensure progress against strategic and national benchmarks (c) Inadequate educational resources	Attend CMG management meetings and liaise with specialties. (13.6) Monitor UHL position against other trusts nationally. (13.7) New Library/learning facilities to be developed at the LRI .(13.8)		Feb 2014 MD Review Feb 2014 MD Apr 2014 MD
	Educational project teams to lead on education transformation projects		Project team meets monthly Favourable outcome from Deanery visit in relation to ED Drs training	(c) Implementation of the project within Acute Medicine needs to be improved.	Dr Hooper in post for Acute Medicine to implement project. (13.9)		Feb 2014 MD
	Financial Monitoring		SIFT monitoring plan in place	(c) Poor engagement with specialties in relation to implication of SIFT	Need to engage with the specialties to help them understand the implication of SIFT and their funding streams. (13.10)		Feb 2014 MD

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

ACTION TRACKER FOR THE 2013/14 BOARD ASSURANCE FRAMEWORK (BAF)

Monitoring body (Internal and/or External):	Executive Team
Reason for action plan:	Board Assurance Framework
Date of this review	**December 2013**
Frequency of review:	Monthly
Date of last review:	November 2013

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
1	**Failure to achieve financial sustainability**					
1.19	ESB will continue to meet every 6 weeks to ensure implementation of SLM across the Trust (expected Mar 2014)	DFBS		March 2014	On track.	4
1.20	Submit application for clinical coding to be included as a 2nd wave LIA pioneering team to involve clinicians.	DS	ADI	Review January 2014	**Complete.** Successful with LIA application and upgraded to a 2nd wave LIA Enabling our People project with a focus on improving coding at the LRI.	5
2	**Failure to transform the emergency care system**					
2.7	Continue with substantive appts until funded establishment within ED is achieved.	COO	HO	Review ~~Sept Nov 2013~~ Jan 2014	Remains on track. Further review of progress Jan 2014.	4
2.9	CCG/LPT to increase capacity by use of Intermediate Care Services.	COO	HO	~~August~~ Review ~~October November 2013~~ January 2014	**Complete.** 24 additional beds now open. Rehab capacity increased significantly.	5
3	**Inability to recruit, retain, develop and motivate staff**					
3.1	Revise and re-launch UHL reward and recognition strategy.	DHR	DDHR	~~October 2013~~ January 2014	The Reward and Recognition Strategy was ratified by the Board on December 20th 2013 and the launch of the strategy is anticipated in January 2014.	4

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

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
3.2	Take baseline from January and measure progress in relation to the success of recruitment events now that there is a structured plan for bulk recruitment. Identify a lead from each professional group to develop and encourage the production of fresh and up to date material.	DHR	DDHR	December 2013	**Complete.** Programme of Trust wide recruitment campaigns for Registered nurses and HCA's during 2013 leading to the appointment of 47 nurses and 234 HCAs. Key actions have included Development and implementation of a Band 5 registered nurse and Band 2 HCA job swap to limit the number of internal moves from full recruitment processes. Attendance at 3 Registered Nurse jobs fairs in Manchester, London and Glasgow (leading to 36 appointments) Development to a Nursing recruitment web page. Adverts have appeared on train platforms between Leicester, London and surrounding areas and use of social media as an advertising source has been utilised. LiA will support further development of all of the above for Nursing and other staff groups in UHL. International Recruitment campaigns are continuing to progress. A comprehensive rolling programme of advertising has been proposed for 2014.	5

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

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
3.3	Development of Pay Progression Policy for Agenda for Change staff.	DHR	DDHR	~~October~~ ~~November~~ ~~December 2013~~ February 2014	Initial staff side comments acquired and specific meeting to discuss on 16 December 13. A number of points of agreement were made at this meeting. The Policy has been amended to reflect these and further discussions will take place at the JSCNC on 15 January 2014 with a view to reaching agreement on remaining points of difference. The proposal for Agenda for Change staff in Band 8C, D and 9 was agreed in principle and a listening event will be held with affected staff at the beginning of February 2014. Timescales have been amended to reflect these changes.	3
3.5	Ensure Statutory and Mandatory training is easy to access and complete with 75% compliance by reviewing delivery mode, access and increasing capacity to deliver against specific subject areas.	DHR	ADLOD	March 2014	Performance improved to 62%. First seven newly designed e-learning packages have been completed:- All other e-learning packages will be available from the end of December 2013.	4

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

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
3.7	Update e-UHL records to ensure accuracy of reporting on a real time basis	DHR		March 2014	Work in progress with designing new system and completion of Project Documentation for review by IMT Project Board on 4 November 2013. Data from other systems has been migrated across to the e-UHL System to support accurate reporting. A Project Brief has been completed to reflect e-UHL System upgrade requirements and a Project Board has been established in taking forward this work.	4
3.8	Active recruitment strategy to recruit to current nurse vacancies including implementation of a dedicated nursing recruitment team	CN/ DHR		December 2013	**Complete.**	5
3.9	Develop an employer brand and maximise use of social media to describe benefits of working at UHL	DHR		April 2014	First meeting of task and finish group taken place. Use of Linked-In and staff good news stories to describe benefits of working at UHL. Group has expanded membership to broader range of staff groups. Action Plan in development, focused on three elements of employment cycle – attraction, retaining existing staff and understanding why individuals exit.	4
3.10	Programme of induction and adaptation in development with Nursing education leads, timetabled to ensure capacity to support recruitment programme.	DHR		April 2014	Programme in development which covers induction, interim development and long term development. Includes dedicated older person's training course	4

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

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
3.11	Implement targeted appraisal recovery plans for each cost centre	DHR		~~Dec 2013~~ Review Jan 2014	Appraisal recovery plans in place, and appraisal performance improved slightly to 91.8% (increase by 0.8%) at the end of November 2013 however the target of 95% has still not been achieved. All areas have been asked to further review appraisal recovery action plans by 6 January 2014 and confirm when the appraisal 95% target will be met.	3
4	**Ineffective organisational transformation**					
4.1	Review outputs from Chief Officers Group and strategic Planning Group to ensure gaps in current processes are being addressed	DS		Review Feb 2014	On track	4
5	**Ineffective strategic planning and response to external influences**					
6	**Failure to achieve FT status**					
6.11	Action plans to be developed to address recommendations from independent reviews	CEO		Dec 2013	**Action no longer relevant following deletion of risk number six from the BAF.** This entry will be removed in the next iteration of the action tracker	**N/A**
7	**Failure to maintain productive and effective relationships**					
7.3	Invite PWC (Trust's Auditors) to offer opinion on the plan / talk to a selection of stakeholders.	DMC		January 2014	On track	4
8	**Failure to achieve and sustain quality standards**					
8.2	Women's CMG to work with Dr Foster and other trusts to better understand risk adjustment model related to the national quality dashboard.	MD		January 2014	On track	4
8.5	Active recruitment to ward nursing establishment so releasing ward sister for supervisory practice.	CN		September 2014	On going recruitment process in place and is likely to take 12 -18months. Deadline extended to reflect this.	4

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

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
8.10	Implementation of Electronic Patient Record (EPR)	CIO		2015	Currently developing the procurement strategy for the EPR solution	4
8.11	UHL to be involved in the DH review in to the use of the Safety Thermometer tool	CN		**N/A**	Although the DH had expressed a desire to work with UHL to review the existing tool UHL has not received any further invitation. A revised tool has already been produced by DH and it is felt that this action is no longer relevant and will be removed the BAF and from future iterations of the tracker	0
8.12	Review of all deaths identified in low risk groups. Working with DFI to ensure data has been recorded accurately.	MD		Dec 2013	**Complete.**	5
9	**Failure to achieve and sustain high standards of operational performance**					
9.2	Re-configuration of surgical beds to create a 'protected area' for surgical patients or by use of independent sector.	COO	HO/CMGM Planned	~~November 2013~~ January 2014	Discussions with independent sector regarding sending elective surgical work to them. Paper written and presented to QAC and F&P. RAG rating changed to reflect delays to original completion date. Review progress in January 2014	3
9.11	Agree recovery action plan with commissioners to recover Referral to Treatment Performance within required operational standards	COO	Head of Performance Improvement	Feb 2014	Intensive Support Team model used to determine capacity gap. Continued failure to agree on a recovery plan that is deliverable and affordable. Met with CCGs 12 December, CCG to review UHL / IST modelling. Agreed to meet in early new year with intention to agree plan by end January 14	4
10	**Inadequate reconfiguration of buildings and services**					

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

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
10.1	Prioritisation of key areas within the clinical strategy for delivery *(Action reworded Nov 2013)* *(action now integrated into action 10.5 – December 2013)*	MD		n/a	This action is now integrated with action 10.5 and has been removed from the BAF. Action will be removed from tracker for future iterations	4
10.3	Secure capital funding to implement Estates Strategy.	DFBS		~~May 2013~~ ~~December 2013~~ March 2014	Work underway on capital planning around reconfiguration – SOC due for completion in March 2014 which will be the key vehicle to agree availability of capital funding.	3
10.5	Iterative development of strategic plans with specialities. This is monitored by CMG and Executive Boards. Work continues with DS and CMGS to prioritise key areas for delivery within the clinical strategy. Further workshops planned for Jan/Feb 2014. *(Action reworded December 2013 to incorporate action 10.1)* .	MD		March 2014	On track	4
10.6	Reconfiguration programme to develop a strategic outline case which will inform the future estate strategy	DS		January 2014	On track	4
11	**Loss of business continuity**					

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

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
11.2	Determine an approach to delivering a physical testing of the IT Disaster Recovery arrangements which have been identified as a dependency for critical services. Include assessment of the benefits of realistic testing of arrangements against the potential disruption of testing to operations.	COO	CIO	~~September~~ Further review ~~December 2013~~ January 2014	Testing programme hasn't been developed but it is part of the work that IBM are doing to achieve ISO 27001. Further review in December 2013 by an external audit as part of ISO 27001 accreditation. We are awaiting the final written report. initial views are that the new approach is acceptable	3
11.8	Further processes require development, particularly with the new Facilities and IM&T providers to ensure resilience is considered/ developed when implementing new systems, infrastructure and processes.	COO	EPO	~~July~~ ~~August~~ Review ~~October~~ ~~November 2013~~ ~~December 2013~~ February 2014	Work with IM&T has been completed. Delays are being encountered in developing agreed processes with Interserve. Briefed by NHS Horizons in terms of large capital projects. No progress with Interserve in terms of planned maintenance works. Lack of progress with Interserve escalated via NHS Horizons.	3
11.10	Training and Exercising events to involve multiple CMGs/specialties to validate plans to ensure consistency and coordination.	COO	EPO	August 2014	BCM training and exercising programme has been developed.	4
11.11	Further work required to develop escalation plans and response plans for Interserve.	COO	EPO	~~October~~ ~~December 2013~~ February 2014	Draft escalation plan received and discussions held on 9.12.13. Was due to be implemented w/c 16th Dec. No update received from Interserve. Lack of response from Interserve escalated via NHS Horizons.	3
11.12	Develop a plan and a better understanding of how a loss of critical suppliers will affect the Trust	COO	EPO	~~October~~ ~~November 2013~~ December 2013	**Complete.**	5

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

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
11.13	Training and Exercising events to involve multiple CMGs/ specialties to validate plans to ensure consistency and coordination	COO	EPO	August 2014	On track	4
11.14	Finance and procurement staff to be trained how to assess the BC risk to a contract and utilise the tools developed.	COO	EPO	March 2014	On track	4
12	**Failure to exploit the potential of IM&T**					
12.8	TDA approvals documentation to be completed	CIO		~~October 2013~~ Review Jan 2014	How we procure the EPR solution has a material effect on how or if we proceed with TDA approval. This will be decided in the next two months	2
13	**Failure to enhance education and training culture**					
13.1	To improve CMG engagement facilitate meetings to discuss Medical Education Strategy and Action Plans with CMGs.	MD	AMD	~~December 2013/January 2014~~ February 2014	Meetings now arranged for December13 /January 14/ February 14	3
13.2	Relevance of the UHL Education Committee to be discussed at CMG Meetings in an effort to improve attendance.	MD	AMD	~~December 2013/January 2014~~ February 2014	Meetings now arranged for December13 /January 14/ February 14	3
13.4	Build relationships with CBU Quality Leads and establish links with LEG/QAC and QPMG in an effort to improve engagement with other patient safety activities/groups.	MD	AMD	~~December 2013/January 2014~~ February 2014	Meetings now arranged for December13 /January 14/ February 14	3
13.5	Introduce exit surveys for trainees and communicate feedback from the GMC training survey and LETB visits via the Dashboard.	MD	AMD	December 2013	**Complete.**	5

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REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
13.6	Attend CMG management meetings and liaise with CMGs in an effort to improve engagement of CMGs.	MD	AMD	~~December 2013/January 2014~~ February 14	Meetings now arranged for December13 /January 14/ February 14	3
13.7	Monitor UHL position against other trusts nationally to ensure progress against strategic and national benchmarks.	MD	AMD	Review ~~October 2013~~ February 2014	Following further discussions with the LETB this data is not readily available. LETB to investigate how we can acquire this data.	2
13.8	New Library/learning facilities to be developed at the LRI to help resolve inadequate educational resources.	MD	AMD	~~October 2013~~ April 2014	A Project Manager is now in place. Odames Ward will be handed over on 1st February for work to start on 1st April 2014.	4
13.9	Dr Hooper in post for Acute Medicine to implement project and improve Acute Medicine progress.	MD	AMD	February 2014	On track.	4
13.10	Need to engage with the CMGs to help them understand the implication of SIFT and their funding streams.	MD	AMD	~~December 2013/January 2014~~ February 2014	Meetings now arranged for December13 /January 14/ February 14	3

Key

CEO	Chief Executive Officer
DFBS	Director of Finance and Business Services
MD	Medical Director
AMD	Assistant Medical Director
COO	Chief Operating Officer
DHR	Director of Human Resources
DDHR	Deputy Director of Human Resources
DS	Director of Strategy
ADLOD	Asst Director of Learning and Organisational Development
DMC	Director of Marketing and Communications
CIO	Chief Information Officer

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

CMIO	Chief Medical Information Officer
EPO	Emergency Planning Officer
HPO	Head of Performance Improvement
HO	Head of Operations
CD	Clinical Director
CMGM	Clinical Management Group Manager
DDF&P	Deputy Director Finance and Procurement
FTPM	Foundation Trust Programme Manager
HTCIP	Head of Trust Cost Improvement Programme
ADI	Assistant Director of Information
FC	Financial Controller
ADP&S	Assistant Director of Procurement and Supplies
HoN	Head of Nursing
TT	Transformation Team
CN	Chief Nurse

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

Appendix Three

BAF RISK SCORE MAP – DECEMBER 2013

Likelihood ↓	Consequence				
	1	2	3	4	5
	Insignificant	Minor	Moderate	Major	Extreme
5 Almost Certain			10. Reconfiguration of buildings and services ●	3. Recruit, retain, develop and motivate staff ● 9. Operational performance ●	1. Financial sustainability ● 2. Emergency care system ●
4 Likely			11. Business continuity ●	5. Strategic planning and response to external influences ● 8. Achieve and sustain quality standards ● 4. Organisational transformation ●	
3 Possible			12. IM&T ●	13. Education and training culture ●	7. Productive and effective relationships ●
2 Unlikely					
1 Rare					

Key

● - No change in score from previous month.

⇧ - Risk score increased from previous month

⇩ - Risk score decreased from previous month

◈ - New risk

BAF RISK SCORE MAP – DECEMBER 2013

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

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

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

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

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

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

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

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

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

8) Are the assigned risk scores realistic?

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

OPERATIONAL RISKS SCORING 15 OR ABOVE FOR THE PERIOD ENDING 31/12/13

REPORT PRODUCED BY: UHL CORPORATE RISK MANAGEMENT TEAM

Key

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

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Strategic risk No.
2236	Emergency and Specialist Medicine	ED	There is a risk of overcrowding due to the design and size of the ED footprint	31/01/2014	04/10/2013	Design and size of footprint in paediatrics causes delay in being seen by clinician. Risk of deterioration. Risk of four hour target and local CQUINS. Lack of patient confidentiality. Increased violence and aggression. Design and size of footprint in resus causes delay in definitive treatment, delay in obtaining critical care, risk of serious incidents, increased crowding in majors, risk to four hour target. Poorer quality care. Risk of rule 43. Lack of privacy and dignity. Increased staff stress. Design and size of majors causes delay in definitive treatment and medical care. Poor quality care. Lack of privacy and dignity. High number of patient complaints. Risk of deterioration. Difficulty in responding to unwell patient in majors. Risk of adverse media interest. Staff stress. Risk of serious incident. Inability to meet four hour target resulting in patient safety and financial consequences. High number of incidents. Increased staff stress. Infection control risk. Risk of rule 43. Design and size of assessment bay causes delay in time to assessment. Paramedics unable to reach turnaround tar Design and size of minors results in delay in receiving med Design and size footprint in streaming rooms causes threat	Patient safety	The Emergency Care Action Team, which was established in spring 2013 aims to improve emergency flow and therefore reduce the ED crowding. The Emergencey department is actively engaging in plans to increase the ED footprint via the 'hot floor' initiaitve, but in the shorter term to increase the capacity of assessment bay and resus.	Extreme	Almost certain	25	New ED plus associated hot floor rebuild approved by the trust and OBC (Outline Business Case) submitted and first phase of construction of new ED to completed by December 2015 . Bays to be allocated and staffed appropriately in majors to act as resus step-down bays for when space in resus is at a premium and some patients are well enough to be moved to majors with the appropriate level of observation - 16/06/14. The resus viewing room is to be made into a fully equipped resus bay - 31/03/14. Resus space to be increased to 8 bays - 15/02/14.	16	JE	2

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Strategic risk No.
2234	Emergency and Specialist Medicine	ED	There is a medical staffing shortfall resulting in a risk of an understaffed Emergency Department	31/01/2014	04/10/2013	Consultant vacancies. Poor quality care, continued lack of retention. Stress and burnout. Increased incidents and complaints. Inability to do the general work of the department. 4 hour target. Increased sickness. Middle grade vacancies. Poor quality care, reputation. Risk of losing trainees due to incorrect service/training balance. Trainee attrition. Stress, poor morale. Trainees not wanting to apply for consultant positions. Reduced cohesiveness as a trainee group. Risk to four hour target. Increased sickeness Junior grade vacancies. Poorer quality care. 4 hour target. Stress. Juniors defecting to other specialities. Increased sickness. Poorer quality of training resulting in poor deanery reports. Non ED medical consultants. Increased incidents. Serious incidents. Stress. Locums.Financial. Poor quality care. Increased complaints, incidents, claims, serious incidents. Increased consultant workload. Lack of uniformity. Risk to 4 hour target. Paediatric medical staffing. Poorer quality care for paediatric population. Increased number of incidents, complaints and claims. Reduced ability to maintain CPD co	Patient safety	The chief executive and medical director have met with senior trainees in Leicester ED to invite them to apply for consultant positions. The East Midlands Local Education and training board has recognised middle grade shortages as a workforce issues and has set up several projects aiming to attract and retain emergency medicine trainees and consultants. Advanced nurse practitioners and non-training CT1 grades have been employed in order to backfill the shortage of SHO grade junior doctors. There has been shared teaching sessions in which non ED consultants and ED consultants have shared skills, (i.e. ED consultants learning about collapse in the elderly and elderly medicine consultants doing ALS). The non ED consultants have been set up on a specific mailing list so that new developments and departmental 'mini-teaches' (= learning cases from incidents) can be shared. Only approved locum agencies are used for ED internal locums and their CVs are checked for suitability prior to appointing them. Locums receive a brief shop floor induction on arrival and also must s Locum doctors are only placed in paeds ED in excep The grid paediatric trainees shift pattern has change ED employs medical registrars to work night shifts in ED consultants have extended their shop-floor hours	Extreme	Likely	20	Review of shift vs rota and the required number of juniors per shift - 01/03/14	6	BTD	3

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Strategic risk No.
2244	Musculoskeletal and Specialist Surgery	Ophthalmology	Medium-term staffing shortages/ lack of equipment/poor processes in Ophthalmology causing deterioration in service	29/10/2013	31/12/2013	**Causes** Admin staffing shortages following a previous MoC exercise. This is exacerbated by a slow recruitment process following successful interview and unavailability of temporary workforce with necessary skill set and access to hospital systems. Poor management processes and inadequate assurance mechanisms Staffing vacancies in ophthalmology Medical records. Lack of assurance mechanisms. Use of ICE for outpatient letters (taking existing staff approximately 30% longer to type and process). Lack of computers and printers. A-Scanner (biometry) is broken and replacement not yet delivered. Lack of clinical space in OPD. **Consequences** Transcription: There is a considerable typing backlog in the department which is not maintaining a steady state in relation to patient letters. Currently there is a backlog of 14,500 patient letters. These include letters to GPs and interdepartmental referrals. This leads to ineffective communication with GPs and other eye centres and may impact adversely on the patient's underlying condition e.g. GPs may not prescribe new treatments if patients fail to att Filing: There is a significant backlog in relation to filing of typed let Referrals Management: Delays to registering and booking of referrals	Quality	Executive Director leadership/ engagement with current issues. Letter to referrers indicating current situation. ICE no longer used and all letters typed using Microsoft 'word'. Additional audio typists recruited supported by agency staffing. Clinic process in place to ensure all clinics are cashed up on the day and outcomes dealt with All referrals to go to consultants for triage before booking. Route for urgent cases made explicit. Clinicians asked to keep outcome sheet on discharged patients for subsequent handover to clerk at the end of a clinic. Continual monitoring and reporting of the backlog of typed letters and filing of typed letters. Transfer of some cataract (x67) / oculoplastics (x87) cases to independent sector. Weekly monitoring of waiting list and RTT position. Two new Fellows recruited for diabetic oedema retinal injections (backlog expected to be cleared by end of October 2013. Nursing staff and A&C staff available until 8pm (however no technicians available) Use of WHO surgical safety checklist in theatres Ongoing monitoring of incidents and complaints data Weekly senior team meeting to ensure controls are e Agency staff supporting clinic and notes preparation Skilled staff moved to appropriate areas e.g. waiting	Maior	Almost certain	20	Begin monitoring the backlog and ensure real progress in achieving a steady state (9 - 12 weeks to catch-up with backlog and 20 weeks to achieve steady state (i.e. backlog at a maximum of 1000) - 31/3/14. Identify suitable workstations for additional staff and install computers and printers. - 31 12 13. Monitor the progress in reducing the number of typed letters waiting to be filed and agree a point at which the previous process can be reinstated. - 31/3/14. Improve theatre utilisation by the effective management of operating lists and Implement processes to enable theatre list booking up to 6 weeks in advance. - (4 weeks in advance by) 31/03/14 Organise 'clean room' sessions for Mon, Tues and Thurs am. - 31 12 13. Develop clinical pathways (referral to follow-up). 31/12/13. Training of clinic clerks to be reinforced and data quality checking initiated. - 31 03 14. Close liaison with HR team to expedite the recruitment process for successful interviewees - 31 03 14 Development and 'sign-off' of new protocols for independent operating - 31 03 14. Ensure robust assurance / monitoring mechanisms	9	DTR	3

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Strategic risk No.
698	Clinical Support and Imaging	Pharmacy	Risk to the production of aseptic pharmaceutical products	03/05/2007	31/01/2014	**Causes** Provision of aseptically prepared chemotherapy is being undertaken from a temporary rental unit. Temporary nature and age of facility indicates high probability of failure. Arrangements for segregation of in-process and completed items is inadequate leading to high possibility of error. Current temporary unit is outside the range of the department's temperature monitoring system. Failure of refrigerated storage will remain undetected outside working hours, and has already occurred. Planning permission for temporary unit only valid until August 2012 Contingency arrangements are insufficient and could only provide for the very short term. Project is already 6 months behind schedule Storage, receipts and dispensing facility for dose-banded chemotherapy and other outsourced items purchased. Alternative arrangements will need to be found when unit is refurbished **Consequences** Failure of Current Temporary Facility; Inability to provide 50% of current chemotherapy products for adult services. Inability to provide chemotherapy for paediatric services. Substantial delay in re-establishing service provision from alternative supplier Limitations of treatments that can be sourced from an alternative supplier. Inability to support research where aseptic compounding required. High cost of sourcing required products from alternative supplier at short notice. Increase in datix incidents pertaining to the Aseptic Unit.	Target	Planned servicing & maintenance of temporary facility being undertaken. Constant environmental monitoring of facility in place. Contingency arrangement for supply from external source currently being pursued. Business Case for new unit (refurbishment of facility within the Windsor building) has been presented and approved by the commercial exec board in 2011. Facilities are working with Pharmacy and commercial architects in order to finalise plans and get refurbishment started. Project to refurbish the aspetic unit has now started - nov 2013	Extreme	Likely	20	New unit in operation - due 12/05/2014	3	GH	**10**

Risk ID	CMG	Specialty	Risk Title	Review Date	Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Strategic risk No.
847	Women's and Children's	Maternity	Lack of Capacity in maternity services	28/09/2007	18/01/2014	**Causes** Continuing increase to the birth-rate in Leicester . The number of maternity beds has decreased. Consultant cover for Delivery Suite is 60 hours a week with long term business plans to increase the hours in accordance with Safer Childbirth Recommendations **Consequences** Midwifery staffing levels are not in accordance with national guidance however are in line with regional averages Transfer of activity between the LGH and LRI occurs on a frequent basis with Leicestershire having to close to maternity admissions on a number of occasions Increase in incidents reported where there has been a delay in elective CS, IOL and augmentation due to lack of beds Staff frequently go without meal breaks Increased waiting time in MAC and therefore increased risk of a clinical adverse outcome to both mother and baby	Patient safety	Length of postnatal stay in hospital as short as possible. Community staff prepare women for early discharge home if straightforward delivery. Extra triage room on Delivery Suite, LRI completed July 2012 Triage and admission areas in acute units to ensure no category x women sitting on delivery suite Use of Escalation Plan to inform staff on actions required if capacity is high Capacity is managed between the two acute units by temporarily transferring care if one site is busy Liaison with neighbouring maternity hospitals if high risk of closure of Leicestershire Maternity Hospitals Prioritisation of both elective and 'emergency' work according to clinical urgency and need On call Manager On call SOM Funded midwife places increased to 1:32 Escalation and contingency plans in place Relocation of all elective gynaecology beds to LGH	Extreme	Likely	20	Increase ward capacity on LRI site by having EL CS women on level 1 - due 31/1/2014 Gynae theatres to be refurbished to accommodate EL CS at LRI - due 28/02/2014	12	JPORT	3
2031	Medical Directorate	R&D	Commercial Research Partner withdrawal	29/06/2012	31/03/2014	Failure to install replacement system for ICESPY. Failure to undertake work to assure commercial partners of commitment to fulfil obligations as a research organisation.	Quality	Currently manual temperature monitoring Libero device at LRI & GH but not with alarms.	Extreme	Likely	20	Replacement for IceSpy - revised due date 31/03/2014	4	CMAL	13

Risk ID	CMG	Specialty	Risk Title	Review Date	Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Strategic risk No.
2267	Corporate Nursing	Infection Prevention	Risk of reduced compliance with DoH requirements in relation to adherence to antimicrobial prescribing policy	09/12/2013	31/01/2014	**Causes:** Change over from paper prescription chart which contains a dedicated section for prescribing antimicrobials, with a prompt for only a 5 days duration, extended duration verification code requirements, and dedicated boxes for documentation of the indication and duration. The current EPMA system does not allow antimicrobials to be differentiated from any other drug and hence duration cannot be mandated, and there is no section to record indication - the lack of this information leads to poor compliance with the duration policy. **Consequences:** On the EPMA wards there has been a reduced compliance with the antimicrobial duration policy and antimicrobial documentation requirements compared to non EPMA wards. Increased risk of C. difficile infection. Increased resistance to anti-microbials. Potential financial penalty via CQUINS in relation to C difficile cases (£50k per patient above C Diff. target). Poor Trust reputation with Commissioners in relation to quality of care.	Patient safety	Education and training of prescribers (including educating prescribers to record duration for antimicrobials). Monitoring of progress (including weekly telecommunications) in relation to including an antimicrobial section within EPMA and exception reports to TIPAC if there is a failure to progress. Attendance on EPMA board to review progress.	Maior	Almost certain	20	Mandate use of indication and duration fields in EPMA - 30/04/14 Create second microbial tab within EPMA - to be advised	4	KDA	**8**

Risk ID	CMG	Specialty	Risk Title	Review Date Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Strategic risk No.
2193	ITAPS	Theatres	Risk of unplanned loss of theatre and/or recovery capacity at the LRI	28/06/2013	13/01/2014	**Causes:** 1. The Theatre and Recovery estate and supporting plant(s) are old, unsupported from a maintenance perspective and not fit for purpose. There is recent history of unplanned loss of surgical functionality at the LRI site due to plant failure, problems with sluice plumbing and ventilation. 2. In addition, the poor quality of the floors, walls, doors, fittings and ceilings mean an unfit working environment from a working life, infection prevention and patient experience perspectives. 3. There is insufficient electricity and medical gas outlets per bed. 4. Aged electrical sockets resulting in actual and potential electrical faults - fire in theatres at LRI (Theatre 4) in July 2013. **Consequences:** 1. Periodic failure of the theatre estate (ventilation etc) so elective operating has to stop 2. Risk of complete failure of the theatre estate so elective and emergency operating has to stop 3. Increase risk of patient infections 4. Poor staff morale working in an aged and difficult working environment 5. Difficulty in recruiting and retaining specialised staff (the 6. Poor patient experience - our most vulnerable patients a 7. May impair delivery of life support technologies	HR	1. Regular contact with plant manufacturers to ensure any possible maintenance is carried out 2. Use of limited charitable funds available to purchase improvements such as new staff room chairs and anaesthetic stools 3. TAA building work has started 4. Plan to develop full business case for new recovery build 2013 - start 2014 5. 5S'ing events taking place within the theatre transformation project frame work 6. Compliance with all IP&C recommendations where estate allows 7. Purchase of new disposable curtains for recovery area, reducing infection risk and improving look of environment	Maior	Likely	16	1. TAA Build - due 28/02/14 2. Recovery re-build - due 01/12/14 3. Replacement of all theatre corridor floors and doors - due 31/12/14 (Will not be implemented as no funding for works) 4. Completion of ITAPS nursing recruitment plan - regular monitoring 5. Capital investment and refurbishment of LRI theatres - plan in place and commenced - due 01/12/15	4	PV	**10**

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Strategic risk No.
2194	ITAPS	Theatres	Risk of unplanned loss of theatre, recovery or Critical Care capacity across UHL due to insufficient nursing staffing	28/06/2013	13/01/2014	**Causes:** Locally, ITU and theatre nursing staff have been historically difficult to recruit and retain. Turnover regularly negates recruitment efforts and the effects of a poor working environment in a high stress and risk area has meant difficulties in resolving the issue previously. **Consequences:** 1. Increased overtime and waiting list payments required to run the core service 2. Tired and unmotivated staff in post 3. Poor staff morale working in an aged and difficult working environment 4. Difficulty in recruiting and retaining specialised staff (theatre and Critical care) due to poor working environment and low staff morale in general 5. Reduction in critical care capacity across UHL 6. Inability to respond to increases in demand in theatre, recovery and critical care capacity 7. Elective patient cancellations including cancer patients 8. Critical Care alternatives becoming the norm for high level of care patients e.g. Kinmonth, overnight PACU and specialty "HDU's". 9. Poor patient and carer experience for some of our sickest patients	HR	1. Use of Bank and Agency staff with block contracts for consistency and cost effectiveness. 2. Regular team and leadership meetings/training events 3. Rolling adverts in place 4. International recruitment with HRSS and relevant agencies commenced 5. Exit interviews used regularly and in line with trust policy to understand issues exacerbating higher than wanted turnover of staff	Maior	Likely	16	1. Continuation of monthly rolling adverts - monthly monitoring 2. Introduction of electronic rostering to standardise shift patterns and maximise efficient use of theatre, recovery and ITU staff - due 30/04/14 (slippage on action due to roll out plans and implementation of theatre off duty into current system)	4	JHOL	**10**

Risk ID	CMG	Specialty	Risk Title	Review Date Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Strategic risk No.
2191	Musculoskeletal and Specialist Surgery	Ophthalmology	Follow up backlogs and capacity issues in Ophthalmology	31/01/2014 12/06/2013	**Causes:** Lack of capacity within services Junior Doctor decision makers resulting in increased follow ups Follow-ups not protocol led No partial booking Non adherence to 6/52 leave policy Clinic cancellation process unclear, inadequate communication and escalation **Consequences:** Backlog of patients to be seen Risk of high risk patients not being seen/delayed Poor patient outcome Increased complaints	Patient safety	Outpatient efficiency work ongoing Full recovery plan for ophthalmology in process	Maior	Likely	16	Agree management plan with clinicians to address backlogs - 31 01 14. Clinical care, joint commissioning groups to support backlog clearance - 31 01 14. Develop condition specific follow up protocols - 31 03 14.	8	DTR	**3**

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Strategic risk No.
607	Clinical Support and Imaging	Blood Transfusion	Failure of UHL BT to fully comply with BCSH guidance and BSRs may adversely impact on patient safety and service delivery	22/12/2006	01/02/2014	**Causes:** Failure to implement electronic tracking for blood and blood products to provide full traceability from donor to recipient At UHL blood is tracked electronically up to the point of transfer of blood from local fridge to patient with a manual system thereafter which is not 100% effective (currently approximately 1 - 2% (approx 1200 units) of all transfusion recording is non-compliant = 98% compliance). Non-compliance with blood transfusion policies resulting in incorrect identification processes resulting in sample identification and labeling error resulting in wrong blood cross-matched and / or provided for patient (last incident of ABO incompatibility by wrong transfusion approx. 4 years ago (yr 2008); approximately 6 near misses per year). New British Committee for Standards in Haematology (BCSH) guidelines require 2 samples from a patient where manual pre-transfusion compatibility testing is performed. An electronic system would require only 1 sample. Critical report received from MHRA in relation to UHL having no credible strategy for compliance with Blood Safe **Consequences:** Potential loss of blood bank licence (via MHRA) with severe Financial penalty for non-compliance. Delay in timely supply of blood and blood components for n Increased potential for 'Never event' (i.e. wrong transfusion Potential loss of Trust's good reputation via publication of c Inefficiencies in service delivery.	Quality	Policies and procedures in place for correct patient identification and blood/ blood product identification to reduce risk of wrong transfusion. Paper system provides a degree of compliance with the regulations. Training and competency assessment for UHL staff involved in the transfusion process including e-learning and induction training with competency assessment for key staff groups. Fortnightly monitoring and reporting system to CBU Managers in relation to blood/ blood product traceability performance.	Maior	Likely	16	Submit briefing paper to UHL Executive Team and EMPATH. 31/01/14 IM&T project approval. 31/1/14 Obtain Board approval for funding. 31/01/14 Develop implementation plan for electronic tracking system. 31/01/14 Complete SOP's and quality documentation. 31/1/14 Training within clinical areas. 31/1/14 Implement system start date - tba	4	KJON	8

Risk ID	CMG	Specialty	Risk Title	Review Date	Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Strategic risk No.
2248	Clinical Support and Imaging	Medical Physics	Lack of IR(ME)R training records held across the Trust	14/11/2013	28/02/2014	Although the Trust Radiation Protection Policy states that "IRMER training records must be managed and maintained by individual Directorates (to be changed to Clinical Business Units in the current review) involved in the use of radiation" audits carried out routinely find that these training records are not sufficient, particularly for medical staff. Audits therefore suggest the policy is not being followed. **Causes** Current training records are poorly designed and / or incomplete / do not exist Inadequate or missing training records for IR(ME)R defined roles due to lack of compliance with the Trust policy in some areas. Staff working independently without reaching full competency No central records are kept of which staff have responsibilities under IRMER **Consequences** Lack of suitable training records may result in a failure to comply with standards set by regulatory and healthcare agencies (e.g. HSE / CQC). Failure at assessment might result in financial penalty and / or warning notices being issued. Non-compliance with national standards leading to enforcement action taken on the Trust following a routine in Increased patient radiation doses due to lack of training. Increased staff doses due to lack of awareness of the poter Potential damage to expensive equipment if training on hov Management unable to easily identify which staff are traine Breach of statutory duty Negative effect on the reputation of the Trust	Quality	There is a defined method of recording training across the Trust in the Trust Radiation Safety policy. Although this is working in some areas it is not working consistently in all areas. The issue has been raised at the Trust Radiation Protection Committee numerous times where representatives of each Division have been in attendance. This has not so far led to a an increase in compliance. Radiation Protection produced a specific plan of what is required to demonstrate compliance. Mock audit completed 2/12/13.	Maior	Likely	16	1. Identify Trust staff with responsibilities under IRMER - due 28/2/2014 3. Investigate potential of using e-UHL to deliver a centralised record of IRMER training - due 31/3/2014 4. Introduce centralised training records for IRMER compliance - due 31/03/2014 5. Review training in the policy. due 01/04/2014 6. Ongoing monitoring of the effectiveness of the determined method of recording training will be detailed in the new policy. due 01/04/2014 7. CMG and service to manage and maintain records for the staff groups identified due 31/03/2014	4	MNO	**12**

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Strategic risk No.
2153	Women's and Children's	Paediatrics	Children's Hospital including ECMO staffing and Capacity	01/02/2014	05/03/2013	**Causes** The Children's Hospital is currently experiencing a shortfall in the number of appropriately qualified Children's nurses. This is in part due to the increased numbers of staff on maternity leave and the issues with recruiting Children's trained nurses. The demand for PICU beds currently outweighs capacity. There is an establishment of 6.5 beds but due to vacancies and long-term sickness/maternity leave the unit is currently only able to run at maximum capacity of 6 beds and on specific days only 5 beds (depending on the overall ECMO activity across adults and children). In addition to NHS activity the Trust has contracted to provide cardiac surgery for a cohort of Libyan children. At the time that the contract was developed (Nov-December 2012) it was assessed that there would be sufficient capacity to operate on one child per week without impacting on NHS Activity. However, the current staffing and long-term profile of patients on PICU has resulted in pressures on both NHS work and the delivery of the Libyan contract. Currently there are vacancies for 5.82 wte qualified and 1 w **Consequences** There is a short fall in the number of appropriately qualified Balancing the demand for PICU beds between NHS contra Unsafe staffing levels, therefore unable to provide the reco Staff from PICU are moved to cover ward shifts to ensure n Elective surgery cases have to be cancelled on the day of t Nurses without the key ITU or paediatric skills may be usec Children's medication can be delayed. Communication with parents is not optimum. Staff miss breaks in order to facilitate care. There has been an increase in staff sickness levels and mo There are an increased number of complaints being receiv	HR	The bed base in Leicester Royal infirmary has been reduced. There is an active campaign being undertaken to recruit new nurses from around the country. Additional health care assistance have been employed to support the shortfall of qualified nurses. No further Libyan patients are being operated on until agency staff can be recruited to support their PICU stay or until the patient flow changes on PICU to allow week-end operating which does not compromise week-day operating or access to PICU. Active Recruitment in progress Educational team cover clinical shifts Cardiac Liaison Team cover Outpatient clinics Overtime, bank & agency staff requested Lead Nurse, Matron and ECMO Co-ordinator cover clinical shifts Children's Hospital & Adult ICU staff cover shifts The beds on Ward 30 have been reduced from 13 to 10 PICU beds are closed where necessary	Maior	Likely	16	Income from the Libyan Ministry of Health programmer will be used to fund agency nursing staff to open an additional PICU bed - 30/04/2014. Recruitment of suitably trained/experienced agency PICU nurses - 30/04/2014.	8	LBLA	3

Risk ID	CMG	Specialty	Risk Title	Review Date	Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Strategic risk No.
697	Communications	Communications	Failure to achieve Foundation Trust (FT) status	31/03/2014	30/04/2007	Public opinion does not support our FT application; Failure of the Trust to persuade the public about the benefits and importance of FT status. Failure to engage staff / public re: FT / Strategic Direction; Disengagement of members / public from the process. Disengagement of staff from the process. Public perception may be of a ""failing"" Trust. We will be required by Monitor to show that staff and the public / stakeholders are aware of and support the Trust's Strategic Direction and FT Trust application. The consultation fails to generate sufficient responses / poor demographic representation among responders; Consultation document / communications do not reach sufficient numbers of people / organisations. Responses do not reflect the diversity of the population.	Public	FT programme Board meets regularly to drive and monitor progress on FT application. FT programme leads meet weekly to keep application on track. Dedicated FT Programme Manager in post, supported by the Trust's strategy team. Consultation Document and supporting communication clearly sets out aspirations and benefits. Communications and Engagement strategy established for FT consultation and strategic direction. FT consultation will be supported and monitored by Membership Engagement Services (MES) Regular briefings to members of staff/ public/ members/ stakeholders. Bi - monthly Prospective Governor meetings established Consultation Strategy specifically targets a wide demographic range of groups / organisations Risk monitored at Board level in Board Assurance Framework.	Maior	Likely	16	Consultation and Engagement actions - 31/03/14	12	KMAY	6

Risk ID	CMG	Specialty	Risk Title	Review Date Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Strategic risk No.
1312	Communications	Communications	Poor quality of information on UHL document management system (DMS)	31/03/2014 17/12/2009	Documents are not managed properly by UHL owners (staff) ie. Have an owner, are version controlled, are managed appropriately through their lifecycle then they become worthless to the user trying to access them because the user cannot be sure the document is timely or accurate. The further development of standards in a UHL records management programme is currently on hold (Jan 2013) due to organisational restructure and removal of records manager post. UPDATE March 2012: Records Management Policy approved Feb 2012. DMS migration to Sharepoint in progress but completion delayed pending upgrade to 2010 version. Expected May 2012. UPDATE Dec 2012: IM&T committed to supporting SP2010. Ascribe consultancy working with KM team to implement SP2010 by end Dec 2012. UPDATE Mar 2013: SP2010 installed and formally supported by IM&T. Migration of docs from 2007 to 2010 in progress, expected Jun 2013. UPDATE Jun 2013: migration and testing in progress. Further development work required for completion. Agreed with Ascribe consulting - cost £7k. UPDATE Sep 2013: migration of data complete for informa	Quality	Internal documented procedures at http://insite.uhl.nhs.uk/document management. Asst Knowledge Manager provides all training. Discussion with HR Training to take on user training due May 2013. System supported by IM&T via an Operating Level Agreement April 2013. Update Sep 2013: IM&T will take on the duties of the project lead for sharepoint.	Maior	Likely	16	User support is limited with only one corporate administrator. Improve user support processes. DMS to be replaced with Sharepoint: review support and document management processes - 31/03/14	6	SAN	**12**

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Strategic risk No.
2237	Medical Directorate	Medical Directorate	Risk of results of outpatient diagnostic tests not being reviewed or acted upon resulting in patient harm.	07/10/2013	28/02/2014	**Causes** Outpatients use paper based requesting system and results come back on paper and electronically. Results not being reviewed acknowledged on IT results systems due to; Volume of tests Lack of consistent agreed process IT systems too slow and 'lock up' Results reviewed not being acted upon due to; No consistent agreed processes for management of diagnostic test results Actions taken not being documented in medical notes due to; Volume of work and lack of capacity in relation to medical staff Lack of agreed consistent process Referrals for some tests still being made on paper with no method of tracking for receipt of referral, test booked or results. Poor communication process for communicating abnormal results back to referring clinician; Abnormal pathology results- cannot always contact clinician that requested test and paper copies of results not being sent to correct clinicians or being turned off to some areas. Suspicious imaging findings- referred to MDT but not always also communicated back to clinician that referred for test. Lack of standards or meeting standards for diagnostic tests **Consequences** Potential for mismanagement of patients to include: Severe harm or death to patient Suboptimal treatment Delayed diagnosis Increased potential for incidents, complaints, inquests and Risk of adverse publicity to UHL leading to loss of good rep Financial consequences to include: Potential increase in NHSLA contributions	Patient safety	Abnormal pathology results escalation process Suspicious imaging findings escalated to MDTs	Maior	Likely	16	Implementation of Diagnostic testing policy across Trust - to ensure agreed speciality processes for outpatient management of diagnostic tests results. March 14 Development IT work with IBM to improve results system for clinicians and Trust to develop EPR with fit for purpose results management system. - Jan 16	8	CER	12

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Strategic risk No.
2271	Corporate Nursing	Nursing	Failure to achieve compliance of 75% attendance at Safeguarding training may have adverse impact on UHL safeguarding processes	11/01/2014	11/12/2013	**Causes:** Adult Safeguarding e-learning modules have only been available for the last 4/5 months as previous programme was not SCORN compliant and due to length of development had to then be further reviewed to ensure accuracy of content. Safeguarding Childrens e-learning modules have also only been available since early 2013. Poor uptake for medical staff training. Difficulties in releasing staff to undertake training. Lack of staff awareness in relation to the availability of an e-learning module. Current accuracy of e-UHL data is questionable. e-UHL does not show the individual the training that is required to be undertaken. **Consequences:** Delays in Safeguarding referrals and / or referrals to wrong agency leading to: Potential for loss of evidence. Greater risk of harm. Patient discharged prior to alert being raised. Additional staff time required to retrospectively resolve issues. Non-compliance with CQC outcomes. Potential for critical reports from OFSTED/ CCGs etc. Loss of good reputation as specific safeguarding cases are publicly reportable. Potential for 'Rule 43' to be applied. Staff may be vulnerable and under additional stress if they	Quality	Safeguarding team and Safeguarding web pages to provide guidance in relation to Safeguarding issues. New SCORN compliant e-learning package developed and live on e-UHL. Face to face training carried out by Divisional education teams in clinical Divisions (now CMGs) since April 2012 to cover gaps in safeguarding training programme.	Major	Likely	16	Incentivise medical staff attendance for safeguarding training - 31/03/14. Continue to develop -eUHL to ensure that individuals are aware of their mandatory training requirements - 31/03/14. Implement protected learning time for clinical staff - 31/03/14. Validate e-UHL attendance data - 31/03/14. Implement more effective management control in relation to non-attendance - 31/03/14. CMG education leads to raise awareness of Safeguarding training at local level - 31/01/14. Advertise Safeguarding training on InSite - 31/01/14.	6	MCLA	**3**

Risk ID	CMG	Specialty	Risk Title	Review Date Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Strategic risk No.
2247	Corporate Nursing	Nursing	There are 500 Registered Nurse vacancies in UHL leading to a deterioration in service and adverse effect on financial position	31/01/2014 30/10/2013	**Causes** Shortage of available Registered Nurses in Leicestershire. Nursing establishment review undertaken resulting in significant vacancies due to investment. Insufficient HRSS Capacity leading to delays in recruitment. **Consequences** Potential increased clinical risk in areas Increase in occurrence of pressure damage and patient falls Increase in patient complaints Reduced morale of staff, affecting retention of new starters Risk to Trust reputation Impact on Trust financial position due to premium rate staffing being utilised to maintain safety. Increased vacancies across UHL Increased paybill in terms of cover for establishment rotas prior to permanent appointments HRSS capacity has not increased to coincide and support the increase in vacancies across the Trust Delays in processing of pre employment checks due to increased recruitment activity Delayed start dates for business critical posts Benefits of bulk and other recruitment campaigns not being realised as effectively as anticipated and expected Service areas outside of nursing being impacted upon due to emphasis on nursing roles.	Patient safety	HRSS structure review. A temporary Band 5 HRSS Team Leader appointed. A Nursing lead identified. Recruitment plan developed with fortnightly meetings to review progress. Vacancy monitoring. Bank/agency utilisation. Shift moves of staff. Ward Manager/Matron return to wards full time.	Maior	Likely	16	Ward dashboards - 31/01/14 Ward performance process - 31/01/14 Over recruit HCAs. - 31/01/14 Utilise other roles to liberate nursing time - 31/01/14	12	CRIB	3

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Strategic risk No.
1693	Strategy	Strategy	Risk of inaccuracies in clinical coding	02/08/2011	31/12/2013	**Causes** Casenote availability HISS constraints (HRG codes not generated) High workload (coding per person above national average) Inaccuracies / omissions in source documentation (e.g. case notes may not include co-morbidities, high cost drugs may not be listed) Inability to provide training to large groups of coders due to lack of time and financial constraints **Consequences** Loss of income (PbR) Outlier for CHKS/HSMR data Non- optimisation of HRG Loss of Trust reputation	Economic	Coding improvement project initiated April 2011. Project Board commenced September 2011 (PID, project plan and highlight report agreed). Electronic coding implemented February 2012 and to be upgraded November 2012 - HRG code generated. Will aid with audit, implementation of local policies and performance management. Task and finish groups completed in Divisions review improvements in coding using PeRL, PLICs, CHKS and medicode (encoder). New process for medical records retrieving notes. Due to changes in recording and payment of EDU and CAU episodes number of episodes coded has reduced. Shifts from day case to outpatient will reduce workload. Lead clinicians identified and Trust wide communication to move coding closer to the clinician. Tick lists introduced in both the ward area and discharge letter. Bank staff and overtime authorised to meet deadline. Scorecard developed to demonstrate improvements and benchmark against other Trusts. 3 year refresher programme completed November 2011. Quarterly updates/briefings to be led by Asst Director of Information - commenced April 2012. Team restructure Annual External Audit Internal Audit - commences November 2013 Audit Committee updates	Maior	Likely	16	Succession Planning for Coding Manager - 31/12/13 Coding Improvement Board - 31/12/13 2013/14 PbR Audit - 22/01/14 CIP - to increase income for Trust by £1.5m - 31/03/14 Review the priority of this risk after go live with the encoder as all actions will have been taken - 31/03/14	8	JRO	**12**

Risk ID	CMG	Specialty	Risk Title	Review Date	Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Strategic risk No.
1737	Renal, Respiratory and Cardiac (RRC)	Renal Transplant	Inappropriate environment and infection prevention Renal Transplant	31/03/2014	25/10/2011	**Causes** Insufficient side room capacity Inadequate space in existing side room for haemodialysis and line procedures. Insufficient en suite facilities in side rooms Vascular access and % of patients with dialysis catheters Procedure room on ward 10 not fit for purpose Inappropriate areas used for renal biopsy on ward 17 Inadequate drug preparation areas Inadequate domestic storage areas No separate facility for isolating patients in ward 10/17 DCU Movement of patients to accommodate admissions or haemodialysis in another area **Consequences** Poor compliance with cannula care Challenges in maintaining integrity of commode lids using Chlorclean Infection prevention risk Transportation of contamination through patient occupied areas (15N/A)	Patient safety	Preventing Transmission of Infection including Isolation Guidelines (DMS 47699) MRSA Screening policy Weekly MRSA audits undertaken by IP Team Local Infection Prevention Group Communication of IP issues regular agenda item on local meetings Link Nurse Network Daily side room list Monthly Nursing Metrics audits Monthly HII audits Monthly Environment audits Recent refurbishment and upgrade of ward 15N/A accommodation Steam cleaning post CDT patients Vascular access being monitored by CQUIN & EMRN Medically led Vascular Access coordination Expert specialty trained competent staff Use 'cohort facility' as required Ongoing competency based programme for the training and implementation of ANTT	Extreme	Possible	15	Development of renal relocation plan - 31/01/2017	15	JPR	**10**
2070	Renal, Respiratory and Cardiac (RRC)	Satellite Units	Harborough Lodge environment stops staff safely delivering haemodialysis	31/03/2014	16/08/2012	**Causes:** Insufficient space to: Safely carry out dialysis procedures Safely carry out manual handling procedures Safely carry out emergency procedures Maintain patient privacy & dignity Poor state of repair of within clinical areas **Consequences:** Cross contamination/infection Manual handling injury to staff/patient/visitor Poor patient experience Negative reputation of Trust Complaints	Patient safety	Specialist haemodialysis trained and competency assessed staff Haemodialysis/other clinical policies Annual manual handling training Annual infection prevention training Infection prevention policy Infection prevention audits Environment audits Curtains at each bed space Minimum cleaning standards	Extreme	Possible	15	UHL undertake Duty of Care review and produce recommendations - 31/03/2014	5	JPR	**10**

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Strategic risk No.
1196	Clinical Support and Imaging		No comprehensive out of hours on call rota for consultant Paediatric radiologists	29/06/2009	31/03/2014	**Causes** There are Consultant Radiologists on call however there are not sufficient numbers to provide an on call service. Registrars are available but they have variable experience. **Consequences** Delays for patients requiring Paediatric radiological investigations. Sub-optimal treatment. Paediatric patients may have to be sent outside Leicester for treatment. Potential for patient dissatisfaction / complaints. Consultants are called in when they are not officially on call and they take lieu time back for this, resulting in loss of expertise during the normal working day.	Patient safety	There are Consultant Radiologists on call however there are not sufficient numbers to provide an on call service. Registrars are available but they have variable experience. Non Paediatric radiology consultants are not able to perform or interpret Paediatric radiological interventions.	Moderate	Almost certain	15	Review Paediatric service to determine the employment of further Consultants - due 31/03/14	2	RG	3

Risk ID	CMG	Specialty	Risk Title	Review Date	Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Strategic risk No.
1157	Clinical Support and Imaging	Medical Physics	Lack of planned maintenance for medical equipment maintained by Medical Physics	14/05/2009	28/02/2014	**Causes:** Lack of Medical Physics technical staff No mechanism to ensure that the revenue consequences of maintenance are identified and funding given to Medical Physics to perform this maintenance. **Consequences:** Potential for equipment to perform out of specification leading to increased risk of patient/ staff harm. Equipment failure due to non-replacement / maintenance of limited life parts Failure to meet statutory requirements for electrical safety testing of medical equipment. Increased risk of patient complaints / claims Potential for adverse media attention and risk to the reputation of the Trust May impact upon successful outcome of future NHSLA assessments Possibility of non-compliance with CQC Outcome 11 May attract attention of Medicines and Healthcare products Regulatory Agency (MHRA) Low morale / unreasonable pressure on Medical Physics technical staff.	Statutory	Some critical equipment is being maintained under service agreements set up with supplier. Medical Physics team are targeting "High" risk equipment as a first priority. Trust wide project team has been assembled to categorise the risk rating of equipment categories for both Maintenance and training needs - work from this team will eventually lead to many of the recommended actions being possible Identified all critical equipment and maintenance needs through the risk assessment process Reviewed the Medical Devices policy Site wide audit of medical devices Standardise medical equipment wherever possible Trust wide communication about future of medical device management issued. Develop robust mechanism to ensure the revenue consequences of maintenance for medical equipment purchases are identified - 30/9/13 - completed Develop process to allow appropriate funding for Medical Physics to ensure programmed maintenance can be performed - completed 2/12/13	Moderate	Almost certain	15	Secure funding to increase current staff base for Medical Physics technical staff or outsource maintenance contracts - 01/04/14 Quantify the shortfall in maintenance provision from existing resources and identify to the Trust (to enable Trust decision on corrective to be made) - 28/2/14 Establish infusion pump libraries at LGH and LRI - 1/4/14	6	MNO	**8**

Risk ID	CMG	Specialty	Risk Title	Review Date Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Strategic risk No.
2278	Women's and Children's		Risk that the Leicester Fertility Centre could have its licence for the provision of treatment and services withdrawn	17/01/2014 17/12/2013	**Causes:** Inadequate staffing levels and inappropriate quality systems in place. ISO 15189 accreditation would be an outcome if the service was adequately staffed with appropriate quality systems in place. **Consequences:** Patient safety and quality issues if unable to deliver service. Financial impact if patients choose to move elsewhere or NHS contracts not obtained. Risk to Trust reputation. Challenging external recommendations/improvement notice from HFEA - critical report received Feb 2013.	Statutory	1 fulltime trained Embryologist to a national recognised level 3 part time trained Embryologist to a national recognised level 1 0.8wte Band 6 BMS	Moderate	Almost certain	15	Recruit to Band 4 associate laboratory practitioner for embryology post - due 28/2/2014 Complete application for ISO accreditation - due 31/3/14 Review of protocols to ensure meet ISO 15189 standards - due 31/3/2014 Improve information for patient and service users - due 31/3/2014 Completion of internal risk assessments with regards to privacy and infection control when delivering samples to reception - due 31/12/13 Formulation of business plan for Quality Manager post - due 31/3/2014 Recruit to Band 4 associate laboratory practitioner for andrology post - due 28/2/2014 Overhaul of specimen request, collection and delivery procedures - due 31/3/2014 IQA system to be improved in order to meet accreditation requirements - due 31/3/2014 review of the need for a automated semen analyser - due 31/3/2014 Introduction of an appointment system for andrology samples - due 31/3/2014	6	DMARS	8

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Strategic risk No.
2200	Women's and Children's	Maternity	Failure to achieve compliance with level 3 of the NHSLA CNST Maternity Risk Management Standards (CNST)	13/01/2014	05/08/2013	In February 2013, the Women's CBU successfully attained CNST Level 2. The plan is now to attain Level 3 in February 2014. Possible barriers to successfully attaining Level 3 include: Competing priorities within the Trust (e.g. NHSLA acute risk management assessment 2013/14, CQC registration, CIP schemes, etc) Policy/procedural documents do not reflect recent organisational changes (including reporting frameworks) Failure to implement and embed processes described within polices and procedural documents Failure to monitor effectiveness of policies/ procedural documents Limited understanding of CNST requirements throughout the CBU, Division and the organisation Lack of capacity within divisions for evidence collection / collation Inappropriate quality and / or quantity of evidence at time of assessment (evidence required to cover 12 months preceding assessment across all care settings and sites). Difficulty in monitoring compliance with maternity related policies outside the CBU but within the Trust **Consequences:** Severe financial impact with NHSLA contributions. Failure of assessment would result in an immediate downg Adverse publicity and potential to impact reputation.	Economic	1.Dedicated full-time Project Manager identified. 2.CNST project team identified. 3.Project Specialist Midwife Co-ordinator identified (Quality & Safety Team). 4.Project Obstetric Lead Clinician identified. 5.CNST Facilitator identified (Quality & Safety Team). 6.x2 midwives seconded to assist in the implementation of CNST requirements in the clinical settings. 7.Project action plan and timetable in place. 8.Specific Lead Officers appointed to co-ordinate actions for CNST criterion where required. 9.Regular Lead Officer meetings to assess progress / resolve issues. 10.Regular progress reports to CBU, Divisional and Senior Trust committees. 11.Regular liaison with CNST Local Assessor (including x4 informal visits) 12.Monthly monitoring of evidence to identify areas of non-compliance to enable early resolution.	Extreme	Possible	15	Appointment of Admin & Clerical member of staff (specific to CNST) - due 31/01/14	4	STA	8
2167	Communications	Communications	Loss of charity funder	31/07/2014	01/10/2011	Loss of (up to) £300k income to Charity from WRVS as a result of single FM supplier contract award. The Charity currently has no recovery plan for such a loss of income. The WRVS funding covers a number of posts within the Trust which would be put at risk.	Economic	The Charitable Funds Committee monitors income and expenditure at bi-monthly meetings. A reduction or cessation of funding is manageable if necessary. Currently awaiting outcome of discussions between WRVS and Interserve.	Moderate	Almost certain	15	Implement the new five year plan, beginning with better location for Charity and recruitment of additional staff in first half of 2014 - 31/07/14	8	TDI	1

Risk ID	CMG	Specialty	Risk Title	Review Date Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Strategic risk No.
1310	Medical Directorate	Medical Directorate	Risk of user error associated with non-standardisation of manual and automated external defibrillators	28/02/2014 16/12/2009	**Causes:** Medical staff using the defibrillator will rotate to other sites within the Trust Different make / model of defibrillator used at LGH site (Zoll defibrillators as opposed to Medtronic LifePak 20) Defibrillator training at LRI/ Glenfield hospital uses Lifepak defibrillators for practical element of training but purely illustrates the differences between Zoll and Lifepak. This includes how to turn on, how to activate manual mode (2-stage activation), and location of 'shock' button. Defibrillator training at LGH hospital uses Zoll defibrillator for practical element of training but purely illustrates the differences between Zoll and Lifepak. This includes how to turn on, how to activate manual mode (finding release button and opening manual door), and location of 'shock' button. **Consequences:** Potential for unsuccessful defibrillation attempt Potential for injury to the patient (death) Potential to disrupt the advanced life support universal algorithm Non-compliance with recommendations of the CPR Standards for Clinical Practice and Training	Patient safety	Defibrillation training Defibrillator will give automated instructions (depending on clinical setting)	Extreme	Possible	15	Training and educating staff to use new defibs - due 28/02/14	5	LR	**8**

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Strategic risk No.
2270	Corporate Nursing		Failure to achieve compliance of 75% attendance at Fire Safety training may cause UHL to fail to meet its statutory obligation	31/01/2014	11/12/2013	**Causes:** CMG mandatory training study days may not be capturing the specific Fire Safety training as an individual component of the day therefore bringing into question the accuracy of e-UHL data. Difficulty in releasing staff to attend Fire Safety training (10 - 15% rate of non-attendance following booking). Lack of venues for additional sessions. Lack of managerial action re repeat non-attendees. **Consequences:** Non-compliance with statutory obligation. Potential non-compliance with CQC outcomes. Potential for staff / patient safety to be adversely affected in the event of a fire (it must be noted that no incidents recorded are attributable to lack of staff training). Loss of good reputation.	HR	Existing training developed to ensure that refresher training on alternate years can be via a e-learning module for non-clinical staff. Face to face training run at differing times in an attempt to satisfy everyone's needs.	Moderate	Almost certain	15	Increase the number of fire safety training sessions to two per month at each site (if venues are available) - 31/01/14. Education leads to be made aware that mandatory training days must be broken into their specific components on e-UHL in order to ensure attendance is accurately recorded - 31/01/14. Raise awareness of fire safety training via utilisation of Intranet and PC desktop messages - 31/01/14. Incentivise medical staff attendance - 31/01/14.	9	GBRO	3
2268	Corporate Nursing		Failure to meet targets for training compliance for M and H training may adversely affect patient care /staff safety	31/01/2014	11/12/2013	**Causes** Lack of dedicated training space Possible inaccuracies in e-UHL data (M&H records held by M&H team identify approx. 11,000 staff trained) Some areas have reduced training opportunities for staff from every year to 2 yearly against the advise of the MH service **Consequences** Increased risk of patient and/ or staff injury during moving and handling Risk to reputation of the Trust if an outlier against national targets	Quality	Cascade training utilised within UHL (approx 160 trainers available) Direct input from UHL M&H team in relation to MH processes/ equipment etc e-learning package available from October 2013	Extreme	Possible	15	Submit business case for additional M&H trainer Redesign of induction training to ensure appropriate level of M&H training - 31/3/14. Implement weekly M&H training to smaller groups - 28/2/14	9	NH	3

Risk ID	CMG	Specialty	Risk Title	Review Date Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Strategic risk No.
2272	Corporate Nursing		Failing to meet internal and external targets in relation to undertaking IG training may adversely affect UHL compliance	31/01/2014 11/12/2013	**Causes:** Lack of availability of face to face IG training sessions Previous on-line e-learning facility increasingly unreliable **Consequences:** Potential for an increase in IG incidents leading to: Adverse media attention and loss of good reputation. Fines from the Information Commissioner. Critical reports from external regulators.	HR	Blended learning using work books and e-learning. New IG e-learning package has been developed(live since mid October 2013). Already seeing an improvement in compliance rates.	Moderate	Almost certain	15	Market new on-line session - 31/1/14. Re-issue workbook and FIT training - 31/01/14	6	RSMI	**3**
2269	Corporate Nursing	Infection Prevention	Failure to meet UHL target of a minimum of 75% of clinical staff undertaking IP/Hand hygiene training	31/01/2014 11/12/2013	**Causes** Poor attendance rates for all staff groups (UHL compliance 58%). Staff not released to undertake IP face-face training. e-UHL has not signposted Infection Prevention training for Clinical Staff UHL is unable to demonstrate that all clinical staff within the trust has received Infection Prevention Training (including Hand Hygiene **Consequences** Poor attendance may be a contributory factor to patients acquiring Healthcare Associated Infections Financial impact of CDT infections in relation to CCG fines. Potential risk of staff acquiring infections through lack of basic hand hygiene. Non-compliance with national standards (CQC, Health and Social care Act 2010)	Patient safety	High risk areas (e.g. with increased infection rates, SI) targeted for focused training Active liaison with Clinical Skills Unit and UHL Education and Training team to resolve issues	Extreme	Possible	15	e-learning package to be re-developed to meet core skills framework and UHL requirements. 30/1/14. Hold discussions with Medical Director to incentivise medical staff attendance for hand hygiene 31/1/2014. Ensure e-UHL accurately signposts relevant staff to their role specific Infection Prevention training requirements. 1/4/14. Ensure e-UHL accurately signposts relevant staff to their mandatory Infection Prevention training requirements 1/4/14. Develop more robust links with medical staff training team. 31/3/14. Refine job role of link staff network to support ward managers in raising IP awareness at a local level. 31/3/14. Ward Managers to use observed assessment of ANTT for nurses and discuss the process for assessment of medical staff with medical staff training team. 31/3/14.	10	LCOL	**3**

Risk ID	CMG	Specialty	Risk Title	Review Date	Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Strategic risk No.
1551	Corporate Nursing	QS	Failure to manage Category C documents on UHL Document Management system (DMS)	31/03/2014	14/03/2011	**Causes** Lack of resource at Divisional/ directorate level Lack of resource in CASE team Delays in the development of 'SharePoint' that would enable automatic reminders for expired documents to be generated for the document authors. **Consequences** DMS does not contain the most recent versions of all category C documents Staff may be following incorrect guidance (clinical or non-clinical) May not be able to demonstrate compliance with NHSLA ARMS	Quality	Acting Head of Outcomes has discussed the problems with Clinical Business Units (CBUs) to identify which documents can be managed by the CBUs Reminders to be manually generated by the CASE team (one day a week only)	Moderate	Almost certain	15	Use of bank staff or redeployed staff for 3 - 6 months to update information on DMS and migrate to 'SharePoint' - 31/03/2014	9	SH	**8**

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

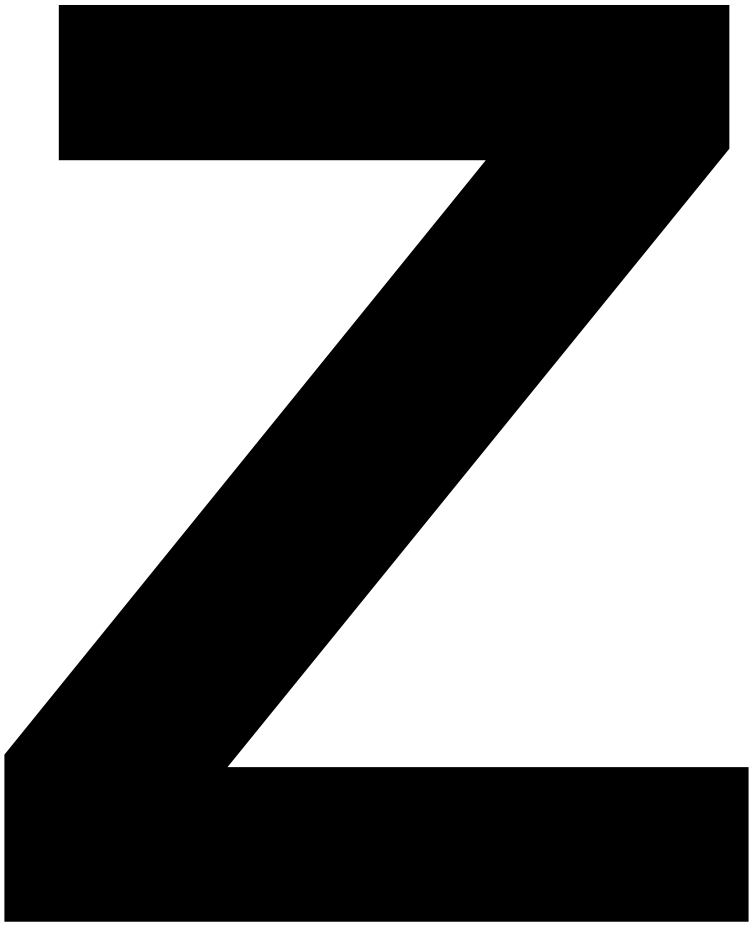
EXCEPTION RISK REPORT FOR CLINICAL RESEARCH NETWORK

REPORT PRODUCED BY: UHL CORPORATE RISK MANAGEMENT TEAM

Key

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

Risk ID	CMG	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2287	Medical Directorate	NIHR Clinical Research Network: East Midlands local transition plan may not be delivered by April 2014.	08/01/2014	08/04/2014	**Causes:** Difficulties in timely appointment of LCRN Leadership Team and in particular the COO and other senior managerial staff. Complex workforce change which will take account of local organisational policy and procedures. Loss of key staff during transition of research delivery functions. Duplication of effort in relation to patient, carer and public involvement and engagement. Delayed transition to LCRN governance arrangements Proposed workforce structure within the East Midlands may not be accepted causing delays. Host's new accommodation to house CRN may not be available by April 2014. **Consequences:** Delay and potential failure to realise significant improvements in supporting and facilitating increased recruitment of patients into high quality clinical research studies. Delayed opportunity to further drive clinical research delivery and enhance patient experience and outcome. CRN fails to function correctly and subsequent reduction in realisation of financial benefits for UHL. Risk of poor reputation of UHL as a 'host' for CRN.	Business	Clinical Director designate in post and taking a more active role and operational role in network management and transition Nominated Executive Director and Interim Partnership group established to operate as active partners in developing and scrutinising the CRN financial plan; driving network performance and challenging underperformance etc. Scheme of delegation and host board controls and assurances in place with clear routes for escalation Pooling of expertise in region to avoid any duplication of effort in relation patient, carer and public involvement. Interim Executive Group and Interim Operational group now established (Sept/Nov 2013) Letter of reassurance to Chief Execs of employing organisations in East Mids from the host to allay staff concerns and reduce the number of key staff likely to be lost during transition. Temporary office accommodation identified.	Major	Possible	12	Recruitment of temporary project management and other expertise - Complete Ensure effective leadership and communications throughout the management structure with people transition being a key objective. - 1/2/14 Convene a regional HR subgroup - Complete	6	DR



Trust Board Paper Z

To:	**Trust Board**
From:	**Professor Sue Carr**
Date:	**December 2013**
CQC regulation:	**As applicable**

Title:	**Update on Education & Training issues in UHL**

Author/Responsible Director: Professor Sue Carr, Associate Medical Director (Clinical Education)

Purpose of the Report: Update the board on educational issues in UHL

The Report is provided to the Board for:

Decision		Discussion	√
Assurance	√	Endorsement	

Key Priorities

1. Improve infrastructure for education and training at LRI
2. Improve links between service and training – CMG Education Leads
3. Increase accountability for UG and PG education and training resources and outcomes
4. Launch UHL E&T quality dashboard
5. Facilitate process for GMC recognition of UHL trainers
6. Contribute to innovation and patient safety improvement by E&T
7. Continue to improve trainee engagement

Recommendations:
Members to note and receive report

Previously considered at another corporate UHL Committee? N/A

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

Resource Implications (eg Financial, HR): N/A

Assurance Implications: N/A

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

Stakeholder Engagement Implications: N/A

Equality Impact: N/A

Information exempt from Disclosure: N/A

Requirement for further review? N/A

Education and training issues in UHL December 2013:- Update

Key Achievements since last meeting:

1. Odames Library project group established and plan progressing for work to start April 2014
2. Appointment of CMG Education Leads in progress
3. Planned discussion with new CMG's regarding education and training priorities
4. Commenced work with finance on HEE mandated reference cost development for education and training
5. Develop system of accountability for SIFT resources in CMG's (not progressed since CBU's changed to CMG's)

Odames project update

The Odames library project is on course to start structural surveys as soon as the Osborne patients have moved from the ward. The project board has been meeting for several months and has developed an overall plan and room data sheets. We have engaged a project manager with the help of Richard Kinnersley and have representatives from finance, IT and staff groups on the library project board. The current timeline anticipates building work starting in April with a projected completion date in September/October. Dr Powell has met with the capital projects manager for UHL and the newly appointed project manager and there is a timeline and project plan in place. A user survey has been circulated to ensure the building is fit for purpose and we have a link with the Undergraduate capital project in the Robert Kilpatrick Building to ensure compatibility of design.
During the next phase we will be approaching corporate donors outside UHL for additional funding but the current allocated capital monies are currently considered an adequate amount for the build, further detailed financial analysis is expected mid January when the engagement of a design team and contractors will commence

CMG Medical Education Leads:

We have had an excellent response from the CMG's regarding appointment of CMG Medical Education Leads. The position at present.

- CHUGS – Fiona Miall
- Renal, Respiratory & Cardiac – Chandra Ohri
- Emergency & Specialist Medicine - awaiting confirmation
- ITPAS – 2 candidates
- CSI - awaiting confirmation
- Musculoskeletal & Specialist Medicine – two candidates awaiting interview
- Women's & Children – (Childrens - Nahin Hussein, Womens tbc ?)

Key Changes and Challenges in Education and Training

Health Education England – have mandated a cost collection exercise to introduce a reference cost for education and training. This is a significant piece of work and requires the trust to deliver half and full year cost plan next year

LETB - Implementation of tariffs for postgraduate medical education will commence in April 2014 (50% salary costs and placement fee £12,400) and it is estimated UHL will lose a further £2.2 million as a consequence.

Medical School Placement agreement framework similar to the LDA for medical student teaching now received and we are formulating UHL response by October. The funding now specifically associated with delivery of student weeks and defined activities e.g. exams, preparing for professional practice etc

Changes in Medical workforce LETB plan a review of all medical training posts across East Midlands (emphasis on quality of training and training support provided) – no further update at present

Accreditation visits - This LETB team visited numerous areas of the Trust in August – and have since conducted additional special visits in Renal, Ophthalmology and Emergency medicine. There have been other areas of educational concern identified in colorectal surgery at LGH and anaesthetics. The Deanery have amended several areas of report from red/amber to green but outstanding red areas include – F1 doctors on F2 rotas, stretches of 12 working days, phlebotomy services

GMC recognition of trainers – framework needs to be in place and data collection began in August 2013 but database needs to be populated by July 2014.

Key Priorities and Board support requested with:

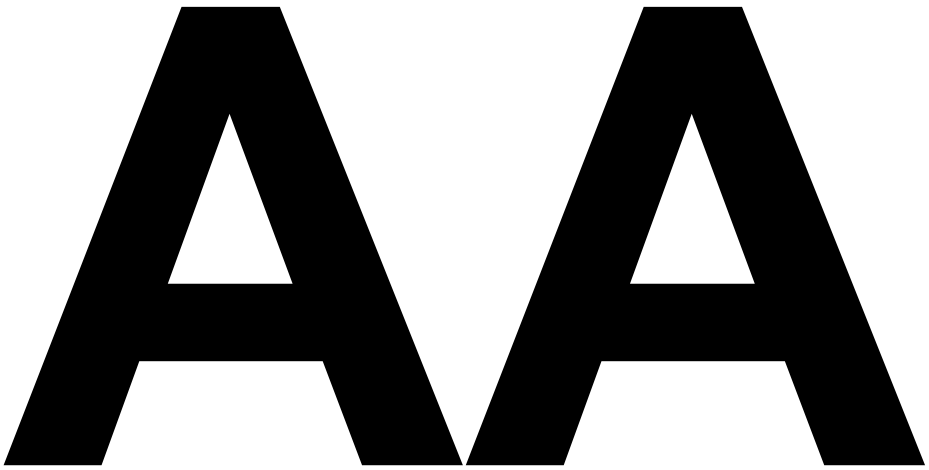
1. Need to identify non-executive Director to support education and training issues since Martin Hindle left the Trust

2. Support the ongoing Odames library plan and ensure ward is vacated in time frame

3. Increase accountability for UG and PG education and training resources and map resources to quality throughout UHL – in new financial year SIFT accountability needs to be transparent in CMG budgets and progressed urgently

4. Support appointment of CMG Medical Education Leads for all CMG's

5. Launch UHL E&T quality dashboard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Trust Board Paper AA

To:	Trust Board
From:	Medical Director
Date:	30 January 2014
CQC Regulation:	

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

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

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

The Report is provided to the Board for:

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

Summary / Key points:
UHL has an extensive R&D portfolio and is recognised nationally and international for excellence in many of its areas. This report is a high level summary of R&D activities in UHL and considers current challenges

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

Previously considered at another corporate UHL Committee?
No

Board Assured Framework:	**Performance KPIs year to date:**

Resource Implications (eg Financial, HR);

Assurance Implications:

Patent and Public Involvement (PPI) Implications:

Stakeholder Engagement Implications:
Equality Impact:
Information exempt from Disclosure:
Requirement for further review: Quarterly

1. Introduction

1.1. The R&D Committee is an executive committee and the Board receives formal quarterly R&D reports.

1.2. This is the third report since the R&D Committee became an executive committee and this report comprises a summary of the current situation and any present challenges.

2. Changes to R&D Reporting Structure in UHL

2.1. With the recent development of the UHL Clinical Management Group (CMG) structure each CMG now has an R&D Lead and is in the process of appointing a Deputy R&D Lead from an allied health professional group.

2.2. The Terms of Reference for the R&D Executive Committee have been adjusted to allow the new CMG Leads to be members

2.3. Research activity can now be reported at the CMG level (see Figure 1)

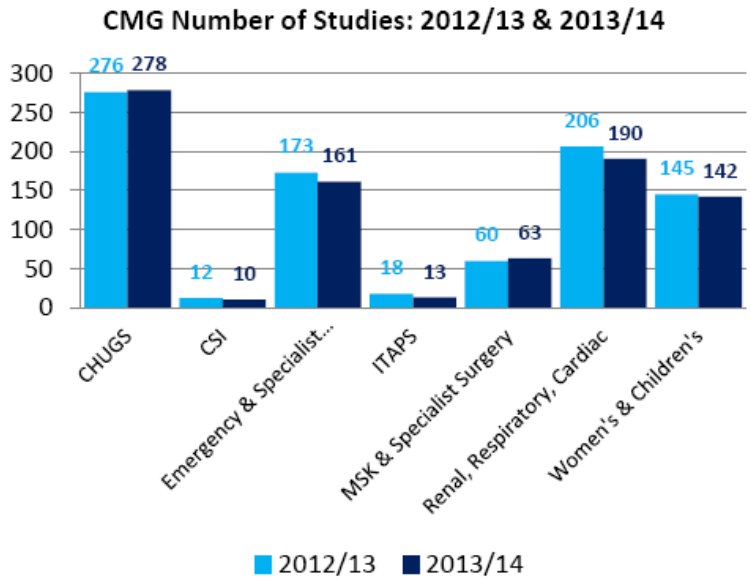


Figure 1. Numbers of research studies in UHL broken down per CMG

3. Major Strengths

3.1. Significant output of high-class clinical research activity. NIHR Central Commissioning Facility continues to rank UHL in the first division (out of four) for the numbers of new clinical trials (125) reported in Q2 2013/14. Currently UHL has 857 active trials with a target of 961 for the year (89%). In relation to portfolio trials UHL is exceeding its target recruitment rate, having currently recruited 5560 patients against a year-end target of 8380 (see Figure 2). The latest CLRN activity report has been circulated for information.

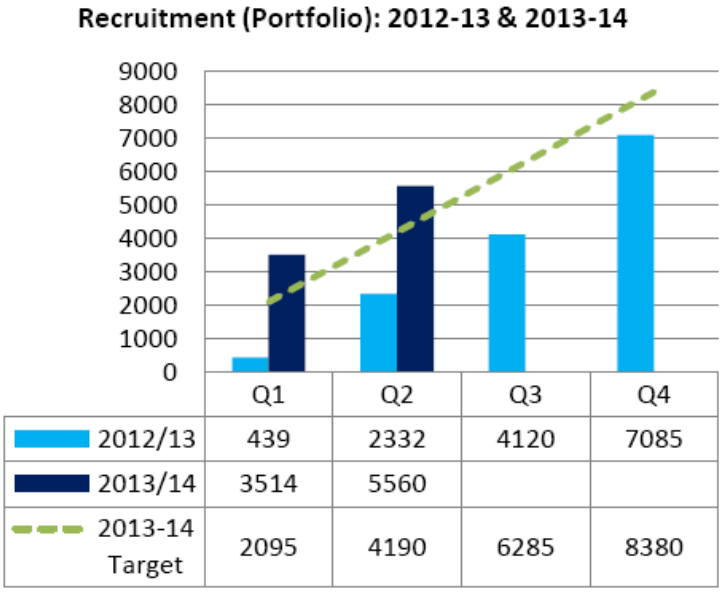


Figure 2. UHL recruitment against target into portfolio studies.

3.2. Excellent R&D approvals systems. Study approval times continue to be amongst the best in the UK (Figure 3 – from latest CLRN activity report), in Q1 2013/14 the median number of calendar days for Trusts approval was 1 day (national target 30 days). Our research management team are frequently asked to share best practice with other Trusts.

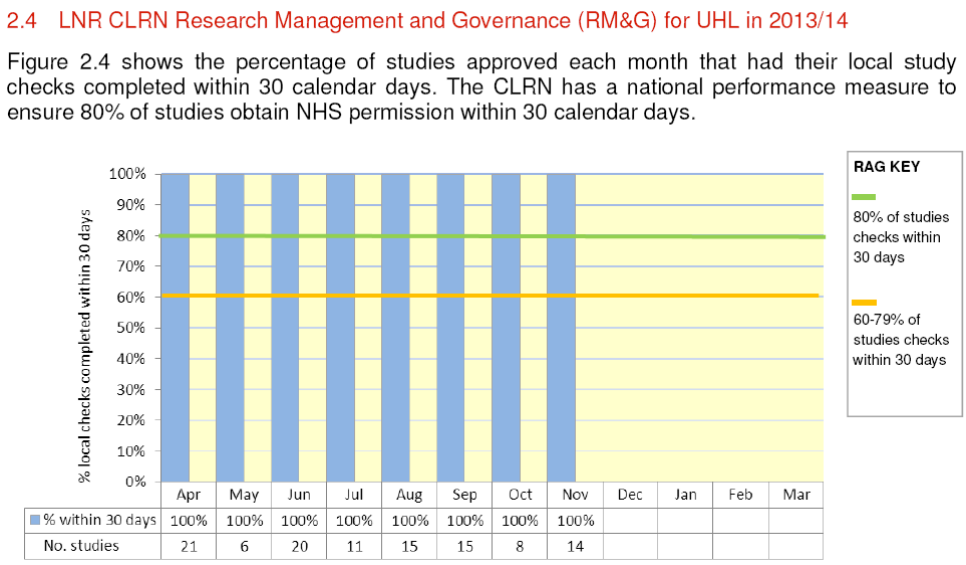


Figure 3. Percentage of studies in UHL with local study checks performed within 30 day target.

3.3 All CMGs contribute innovative R&D activity of direct relevance to patient care, outcomes and service delivery. Research addresses detection, prevention and management of common long-term conditions: (i) cardiovascular disease e.g. genetics, hypertension , novel interventions, arrhythmias, stroke, vascular surgery; (ii) respiratory disease e.g. asthma, chronic obstructive pulmonary disease, pulmonary rehabilitation; (iii) diabetes, e.g. prevention, early detection, management; (iv) cancer e.g. early phase trials, biomarkers, prevention, novel treatments; (v) influence of nutrition, exercise and lifestyle on long-term conditions.

Other CMG researchers include those from neonatal medicine, renal disease, infectious disease; child heath; care of the elderly; intensive care medicine;

medical genetics, gastroenterology; dermatology; ophthalmology; medical genetics; emergency medicine; health services research; endocrinology, orthopaedics, musculoskeletal medicine; pain medicine.

3.5 Trust hosted research institutions:

3.5.1. UHL continues to host or support:

Three Biomedical Research Units (BRU):
- Cardiovascular BRU (with University of Leicester)
- Respiratory Disease (with University of Leicester)
- Nutrition, Diet and Lifestyle (with Loughborough University & University of Leicester).

Experimental Cancer Medicine Centre

East Midlands Clinical Research Network.

NIHR Clinical Trials Unit

Clinical Research Facilities (CRF):
- Cardiovascular BRU CRF (Glenfield)
- Oncology CRF (Hope Unit, LRI)
- CRF and diabetes centre (LGH)
- Respiratory CRF (Glenfield).

3.5.2. Since the last report UHL and University of Leicester, with the support of the locally based charity Hope Against Cancer have been chosen as a Cancer Research UK Centre.

4. Current challenges

4.1. We need to support the BRUs in achieving their stated objectives. Also, we must ensure that they develop in a way that enables a credible application for NIHR Biomedical Research Centre status in the next round.

4.2. To protect posts which provide essential support to R&D activity.

4.3. To play a major role in the development of the AHSN.

4.4. To develop and maintain working relationship with new LCRN.

4.5. To maintain and develop relationships with academic and industry partners. New joint posts with Loughborough University contribute to this.

4.6. The numbers of patients recruited to NIHR portfolio clinical trials is a high profile target. Need to maintain constant vigilance is required to ensure these targets are met.

4.7. Presently, there are some support services within UHL which may limit our ability to delivery UHL's R&D potential. We are working constructively with colleagues and new working groups have been established to support this.

5. Report from the Leicestershire, Northamptonshire and Rutland CLRN

5.1. The CLRN provides quarterly reports to partner trusts on NIHR portfolio clinical trials performance. The latest report is included with this paper. This report is been considered by the R&D Executive Committee and will be presented with our quarterly reports to the Board (a requirement in order to qualify for NIHR funding).

6. Conclusion

6.1. This report is a high level summary of the present situation. We welcome suggestions from the Board on the content and format of future R&D reports.

Leicestershire, Northamptonshire and Rutland
Comprehensive Local Research Network

NHS
National Institute for Health Research

University Hospitals of Leicester NHS Trust

Monthly Activity Report

Report Date: **13 December 2013** Data Sourced: 2 December 2013

Welcome to the monthly NIHR portfolio activity report for your trust. This report contains information on 2013/14 recruitment and performance measures.

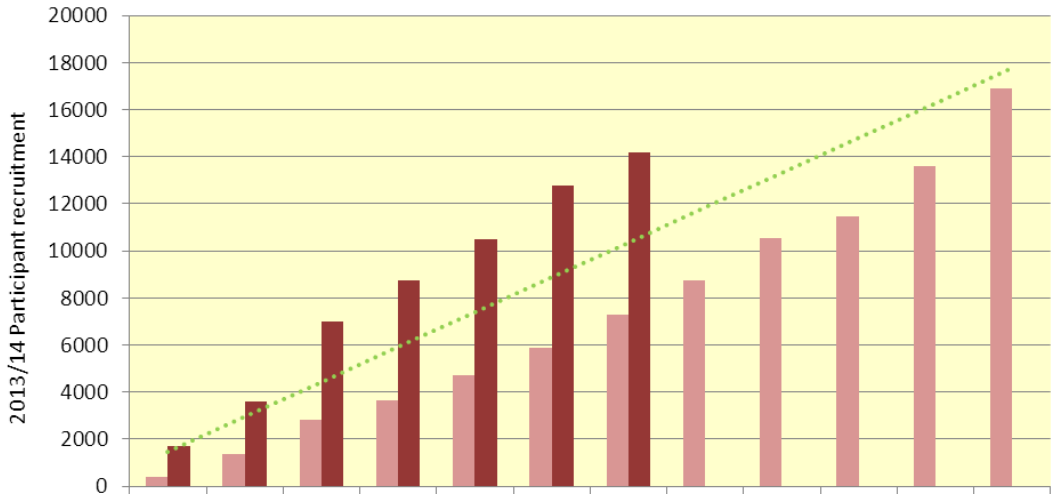
The table below is a snapshot of LNR CLRN member trusts and stakeholder organisations, progress measured against National and Local Performance Measures (N/LPMs). The table also states the corresponding chart within the report.

Recruitment Criteria						
13/14 YTD RAG %	Trust	YTD Recruitment	Annual Target	NPM/LPM	Description	Chart
127.21%	**UHL**	**6,561**	**8,381**	**NPM 1a.1**	**Progress towards 13/14 recruitment target**	**1.2 2.1**
94.31%	KGH	639	1,101	NPM 1a.2	Progress towards 13/14 recruitment target	1.2
143.18%	LPT	467	530	NPM 1a.4	Progress towards 13/14 recruitment target	1.2
114.57%	NGH	902	1,268	NPM 1a.3	Progress towards 13/14 recruitment target	1.2
83.06%	NHfT	276	540	NPM 1a.5	Progress towards 13/14 recruitment target	1.2
191.37%	LRPC	4,496	3,819	NPM 1a.6a	Progress towards 13/14 recruitment target	1.2
65.02%	NPC	849	2,122	NPM 1a.6b	Progress towards 13/14 recruitment target	1.2
129.75%	LNR CLRN	14,190	17,761	NPM 1a	5% increase in recruitment (2012/13 to 2013/14)	1.1
Time and Target Criteria - Network-wide						
62%	LNR	N/A	80%	NPM 2b	% of Non-Commercial Studies (Closed) recruiting to Time and Target in LNR	1.3
58%	LNR	N/A	80%	NPM 2a.1	% of Commercial Studies (CCRN-Closed) recruiting to Time and Target in LNR	1.3
56%	LNR	N/A	80%	NPM 2a.2	% of Commercial Studies (CCRN-Open) recruiting to Time and Target in LNR	1.3
63%	LNR	N/A	80%	LPM 8.3	% of Non-Commercial Studies (Open) recruiting to Time and Target in LNR	1.3
First Patient First Visit (FPFV) - Network-wide						
13/14 YTD RAG %	Area	2013/14 National Target	NPM/ LPM	Description		Table
15%	LNR	80%	NPM 4c	NHS Permission to first patient recruited in a commercial trial (<=30 days) in median calendar days for >=80% for all studies		1.4
18%				NHS Permission to first patient recruited in a commercial trial (<=30 days) in median calendar days for >=80% for CCRN-led studies		
22%	LNR	80%	NPM 4c	NHS Permission to first patient recruited in a non-commercial trial (<=30 days) in median calendar days for >=80% for all studies		1.4
34%				NHS Permission to first patient recruited in a non-commercial trial (<=30 days) in median calendar days for >=80% for CCRN-led studies		
Research Management and Governance Criteria - Network-wide						
Percent	Area	2013/14 National Target	NPM	Description		Chart
95%	LNR	80%	NPM 4a	Study-wide checks completed within 30 calendar days		1.5
100%	LNR	80%	NPM 4b	Local checks completed within 30 calendar days		1.5

Section 1—Research Network Overview

1.1 LNR CLRN recruitment against recruitment target (NPM 1a)

Figure 1.1 provides a monthly breakdown of reported participant recruitment in portfolio studies by financial year. This includes data from 2012/13 and 2013/14 year to date (YTD). The chart also shows how well LNR CLRN is recruiting towards the overall 2013/14 recruitment target of 17,761 participants.



	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2012/13 Recruitment	408	1382	2809	3670	4699	5891	7306	8740	10563	11453	13577	16915
2013/14 Recruitment	1710	3589	7010	8768	10491	12755	14190					
2013/14 Target	1480	2960	4440	5920	7400	8881	10361	11841	13321	14801	16281	17761

Figure 1.1: LNR CLRN recruitment by month and financial year (2012/13 and 2013/14)

1.2 LNR CLRN progress towards recruitment target by member organisation (NPM 1a.1-6b and 5a)

Figure 1.2 illustrates how well LNR CLRN and member organisations are recruiting towards their 2013/14 YTD recruitment targets.

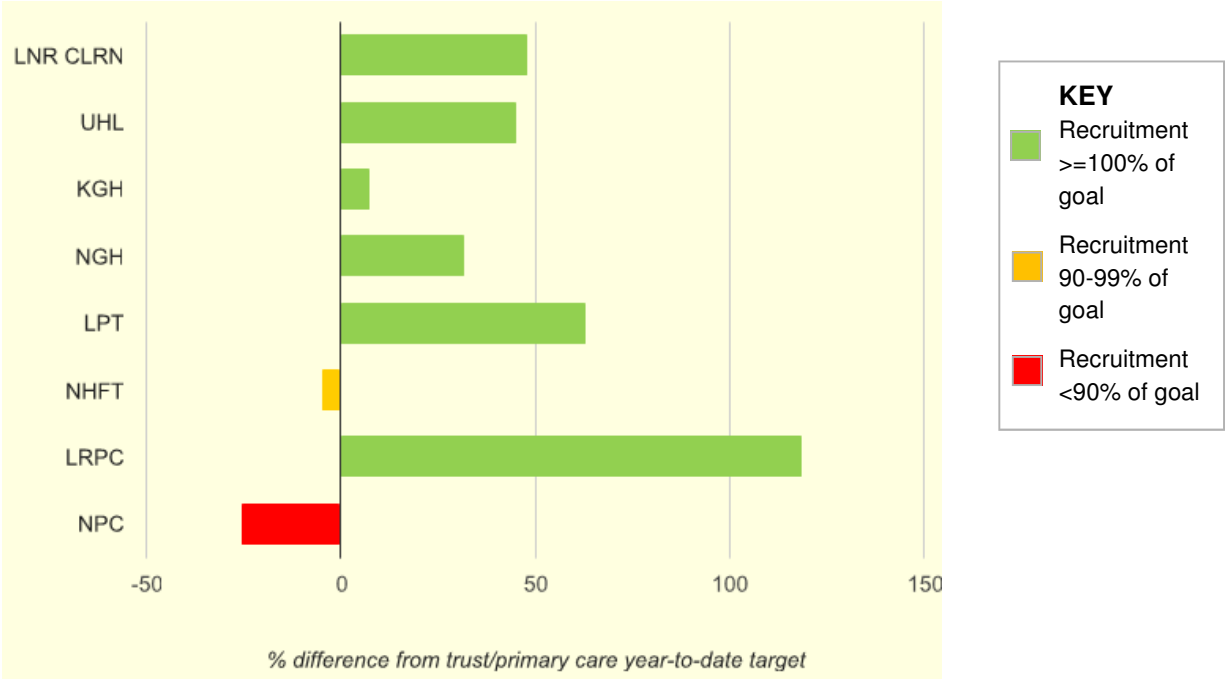
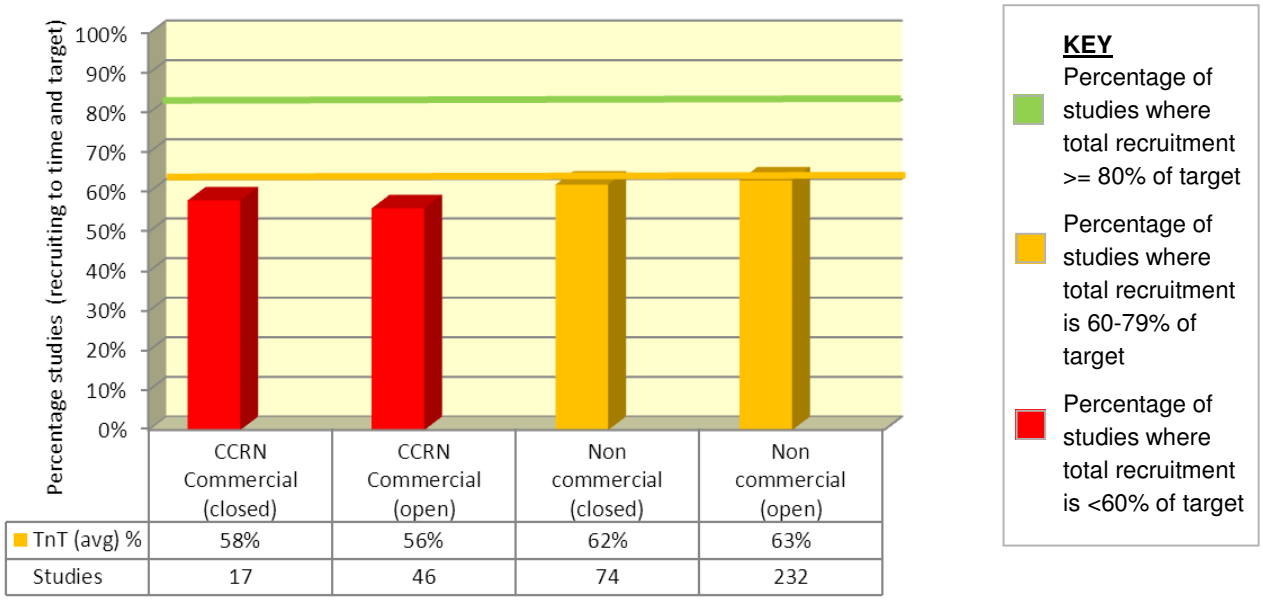


Figure 1.2: Percentage difference between 2013/14 YTD recruitment and YTD recruitment target by Member Organisation

1.3 LNR CLRN recruiting to time and target (NPM 2a.1, 2a.2, 2b and LPM 8.3)

LNR CLRN are performance managed on delivering all portfolio studies to time and target. We have three national performance measures (NPM) and one local performance measure (LPM) to monitor our progress. There are NPMs for open and closed studies for 80% of CCRN commercial portfolio studies to achieve their recruitment targets. The third NPM is for non-commercial studies and is measured at study closure. Open non-commercial studies are monitored locally and have an LPM also set at 80%, to ensure that they are recruiting to time and target throughout the study. Figure 1.3 shows data for all open study sites and those that have closed since 1 April 2013.



	CCRN Commercial (closed)	CCRN Commercial (open)	Non commercial (closed)	Non commercial (open)
TnT (avg) %	58%	56%	62%	63%
Studies	17	46	74	232

Figure 1.3: Percentage of LNR CLRN studies recruiting to time and target 2013/14 YTD

1.4 First Patient First Visit (FPFV) (NPM 4c)

LNR CLRN collects data on the number of days a study site takes to recruit a participant once a site has been authorised to do so. CLRNs are performance managed (NPM 4c) on ensuring that study sites recruit their first patients within 30 days of NHS permission, site initiation or site activation date. When calculating the first patient first visit data locally, the latest date is used.

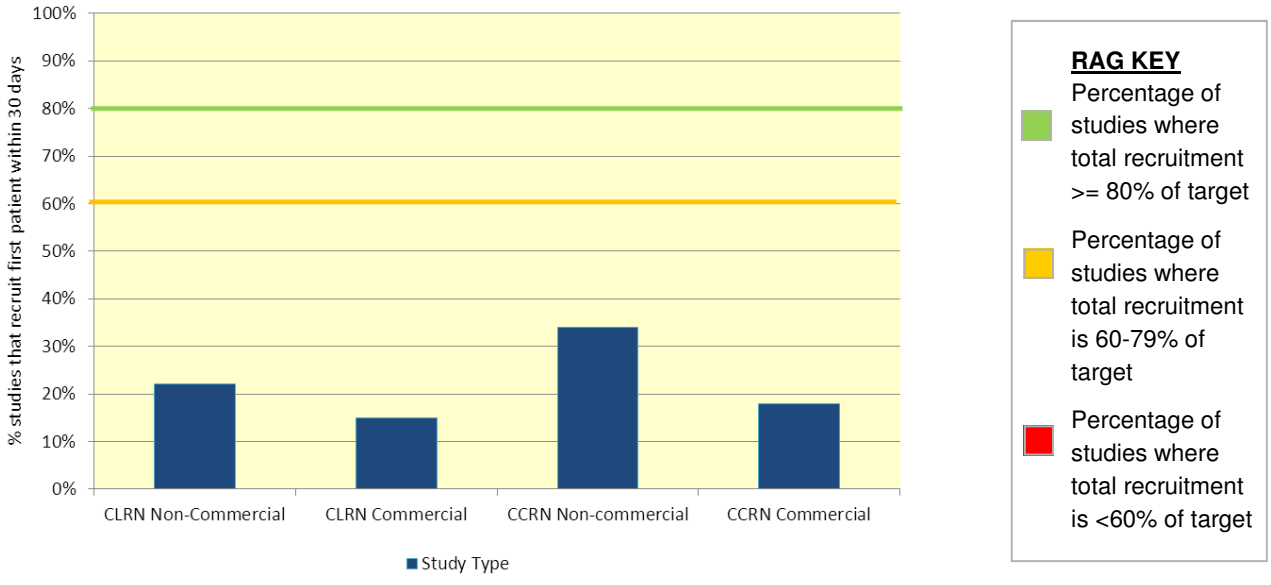


Figure 1.4: LNR CLRN performance against First Patient First Visit metrics 2013/14

1.5 Research Management and Governance (RM&G) (NPM 4a and 4b)

All CLRNs are performance measured on the time taken to complete study-wide and local site checks. This is to ensure that studies receive NHS permission as quickly as possible. The measure is for 80% of studies to have all checks completed within 30 calendar days. Figure 1.5 shows the percentage of studies approved each month that have had their study checks completed within 30 calendar days.

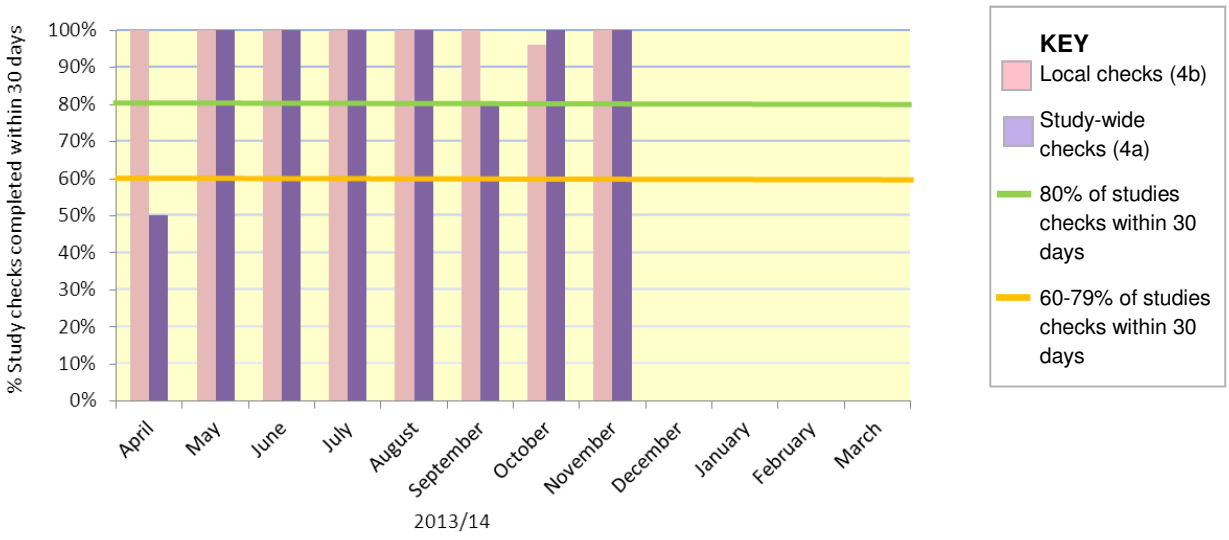


Figure 1.5: LNR CLRN RM&G performance against national metrics 2013/14

1.6 LNR CLRN funding

Figure 1.6a shows the percentage of funding allocated to member trusts and primary care (PC) in 2013/14. Figure 1.6b shows 2013/14 trust/primary care recruitment as a percentage of total LNR CLRN recruitment.

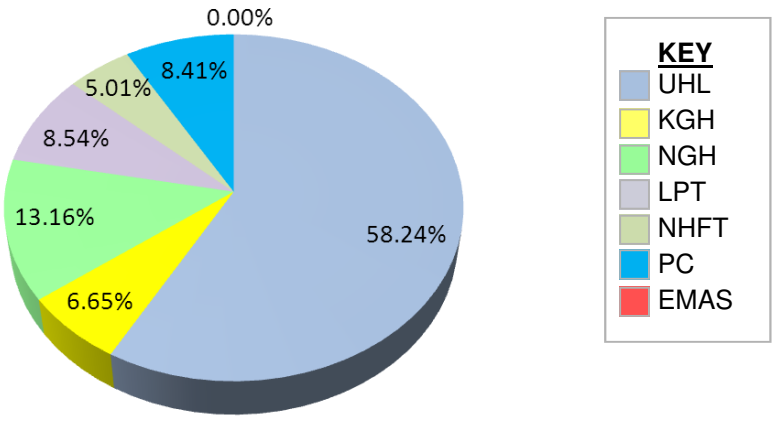


Figure 1.6a: LNR CLRN 2013/14 funding by trust

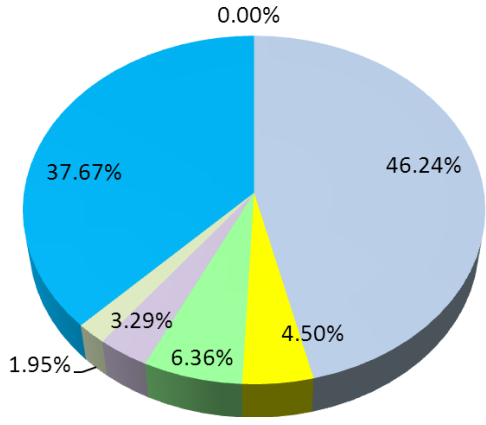


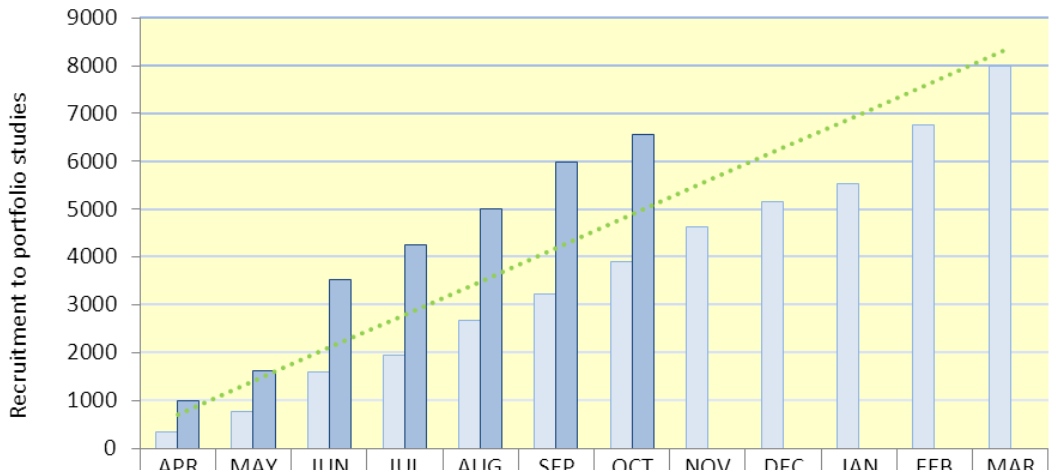
Figure 1.6b: LNR CLRN 2013/14 recruitment by trust

Note: The funding percentage for UHL is skewed as they host three research networks which provide support across a range of other NHS trusts in the region. Some of the funding shown for UHL is utilised in cross network coordinating functions of the South East Midlands Diabetes Research Network, LNR Cancer Research Network and Trent Stroke Network. At present, funding for primary care is considered as a total allocation, rather than by county, in line with the way recruitment is currently reported to us by the NIHR. Primary care funding also includes funding provided to the East Midlands and South Yorkshire Primary Care Research Network (EMSY PCRN). Please note that these figures do not take account of referrals from participant identification centres (PICs) to other sites where the recruitment actually takes place.

Section 2—Trust level information

2.1 2013/14 UHL recruitment against target (NPM 1a.2)

Figure 2.1 provides a cumulative monthly breakdown of reported participant recruitment in portfolio studies by financial year for 2012/13 and 2013/14 year to date (YTD). The chart also shows how well UHL is recruiting towards the 2013/14 recruitment target.



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

Figure 2.1: UHL recruitment by month and financial year (2012/13 and 2013/14)

2.2 UHL 2013/14 recruitment by Topic Network and CCRN Specialty Group

Figure 2.2 looks at UHL recruitment by topic network and specialty group. For studies that have been formally co-adopted, recruitment has been counted for all relevant topic networks and specialty groups. Therefore, recruitment may have been counted more than once.

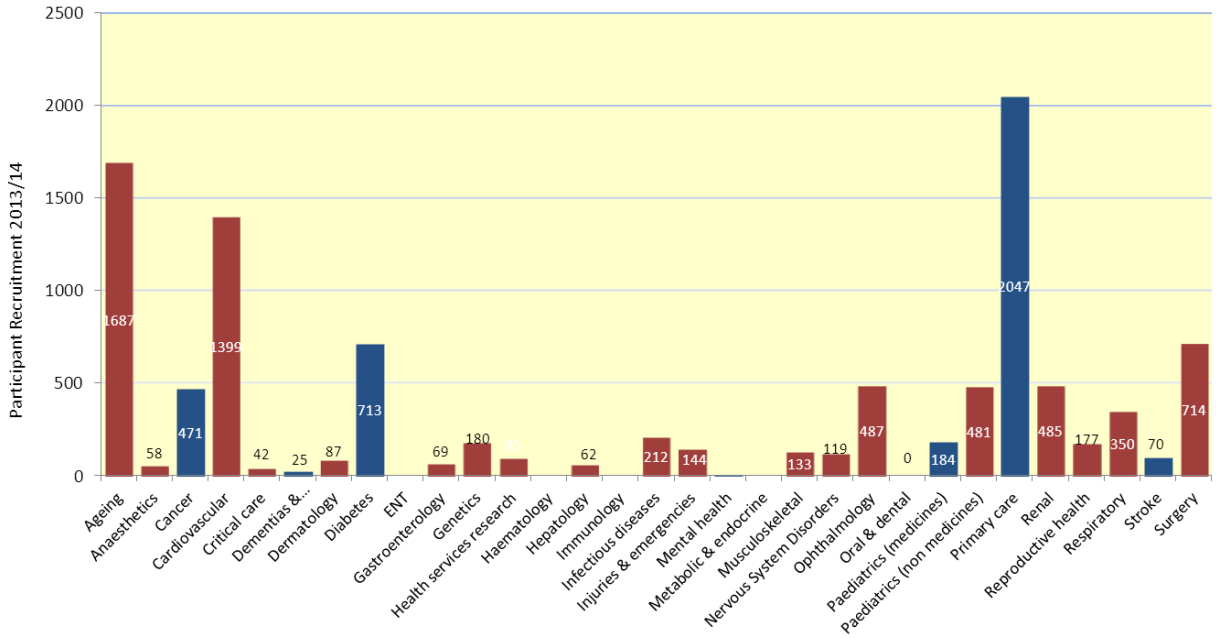
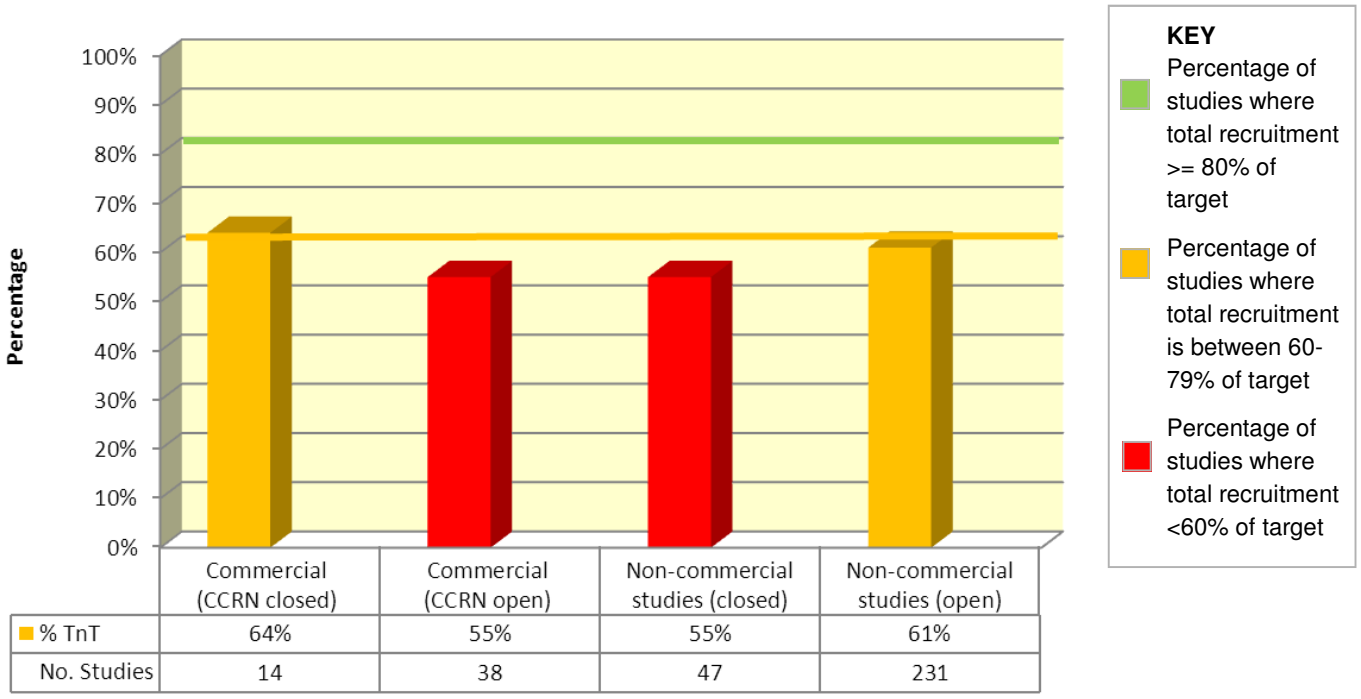


Figure 2.2: UHL 2013/14 recruitment in by Topic Network and CCRN Specialty Group

2.3 Percentage of UHL studies recruiting to time and target

Figure 2.3 shows recruitment to time and target data for open studies at UHL, and those that have closed since 1 April 2013. The data is displayed as an average across all studies that match the criteria, and shows commercial (CCRN only) and non-commercial (all studies) separately.

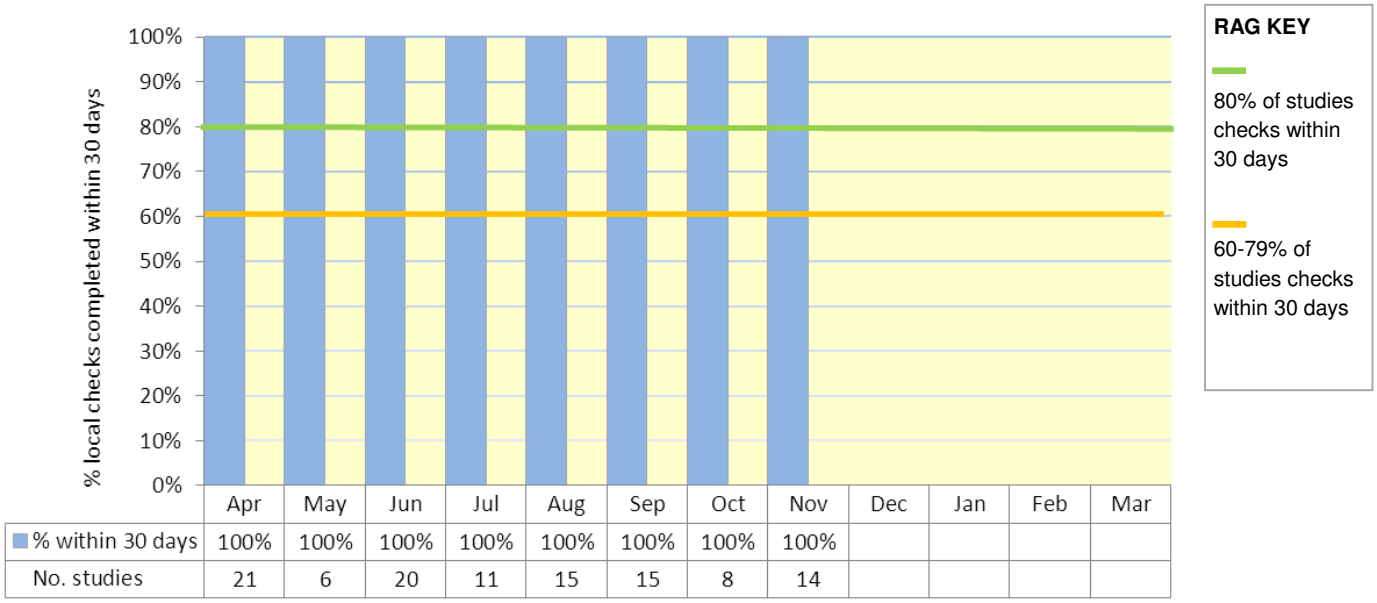


	Commercial (CCRN closed)	Commercial (CCRN open)	Non-commercial studies (closed)	Non-commercial studies (open)
% TnT	64%	55%	55%	61%
No. Studies	14	38	47	231

Figure 2.3: Percentage of UHL studies recruiting to time and target 2013/14 YTD

2.4 LNR CLRN Research Management and Governance (RM&G) for UHL in 2013/14

Figure 2.4 shows the percentage of studies approved each month that had their local study checks completed within 30 calendar days. The CLRN has a national performance measure to ensure 80% of studies obtain NHS permission within 30 calendar days.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
% within 30 days	100%	100%	100%	100%	100%	100%	100%	100%				
No. studies	21	6	20	11	15	15	8	14				

Figure 2.4: LNR CLRN RM&G performance for UHL in 2013/14

Section 3—Study Information

Recruitment information for open and closed studies at UHL has been generated using the Time and Target (TnT) database. These reports are published to the NIHR UHL-shared Portal site and compare local study recruitment with local site recruitment targets.

Time and Target (TnT) reports

3.1 UHL open studies

This portal site captures all portfolio studies open at UHL. This includes studies that have recruited participants as well as those that are yet to report recruitment. This information can be filtered by column heading and exported.

https://portal.nihr.ac.uk/sites/ccrn/lnrclrn/recruitment/uhlshared/Lists/uhlopenstudies/byacronym.aspx

3.2 UHL closed studies

This report includes all studies that have closed for recruitment within UHL during the current financial year (2013/14). This information can be filtered by column and exported.

https://portal.nihr.ac.uk/sites/ccrn/lnrclrn/recruitment/uhlshared/Lists/uhlclosedstudies/byacronym.aspx

If you experience any technical difficulties with the NIHR Portal please contact Paul Maslowski (LNR CLRN Information Manager) or Angel Christian (LNR CLRN TnT Administrator) for advice.

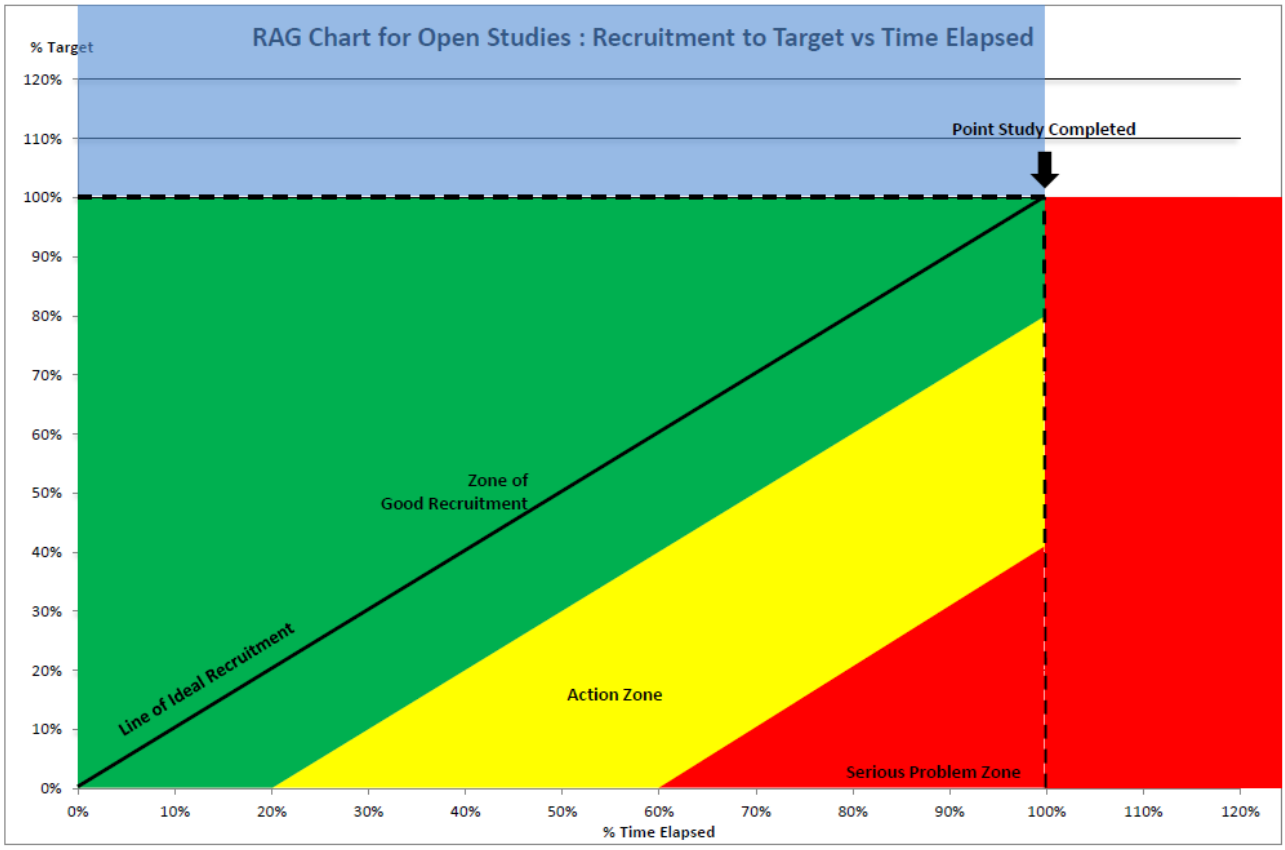
Glossary

Activity Based Funding (ABF)	Funding that is allocated to Comprehensive Research Networks which is based on recruitment and study complexity.
Awaiting response status (CSP report)	RM&G team are awaiting response from a member of the study team before the governance review can commence.
Closed study	A portfolio study that has closed to recruitment (across all study sites).
Commercial study	A commercial study is defined as one that is both industry-funded and industry-sponsored.
Commercial time and target data	There may be discrepancy between the time and target data presented in item 2.3 and the time and target reports. This is due to the delay in reporting commercial recruitment data nationally. We maintain local recruitment records for commercial studies which are accurate and these are used to calculate the data presented in item 2.3, while the national data is presented in the time and target reports.
CSP	The NIHR Coordinated System for gaining NHS Permission. CSP must be used for all new portfolio studies to gain NHS Trust permission and R&D approval.
Data sourced date	The date the national portfolio performance data is published by the NIHR CRN CC. This data is incorporated into our local TnT database and used to create this report. At present there is a four week lag from when a participant is recruited into a study and when this data will be reported by the NIHR CRN CC.
First Patient First Visit (FPFV)	This National Performance Measure looks at the time taken from NHS permission date (since 1 April 2013) **or** Site Initiation (which ever is later) to first patient recruited in a trial (<=30 days) for 80% of LNR CLRN studies.
Governance checks assigned (CSP report)	A LNR CLRN RM&G Facilitator has been assigned to the study for governance review.
Interventional study	A study where the participants' exposure to a particular intervention (e.g. treatment or lifestyle) is influenced by participating in the study (e.g. whether or not a participant receives a particular treatment will be determined by the research protocol). Clinical trials are the most common type of interventional study.
Lead CLRN—Trust R&D permission granted (CSP report)	The Chief Investigator is based at a trust within LNR. Trust R&D permission is granted at a research site once all governance checks have been undertaken by the CLRN.
LNR CLRN	The Leicestershire, Northamptonshire and Rutland Comprehensive Local Research Network (LNR CLRN) is one of 25 CLRNs across England. It coordinates and facilitates the conduct of clinical research and provides a wide range of support to the local research community. There are nine NHS Trusts and four Higher Education Institutions within the LNR CLRN constituency.
Local Performance Measure (LPM)	An objective decided by the LNR CLRN as a priority area for the financial year. Our progress towards achieving this measure is monitored locally and fed back to our local stakeholders and the NIHR CRN CC.

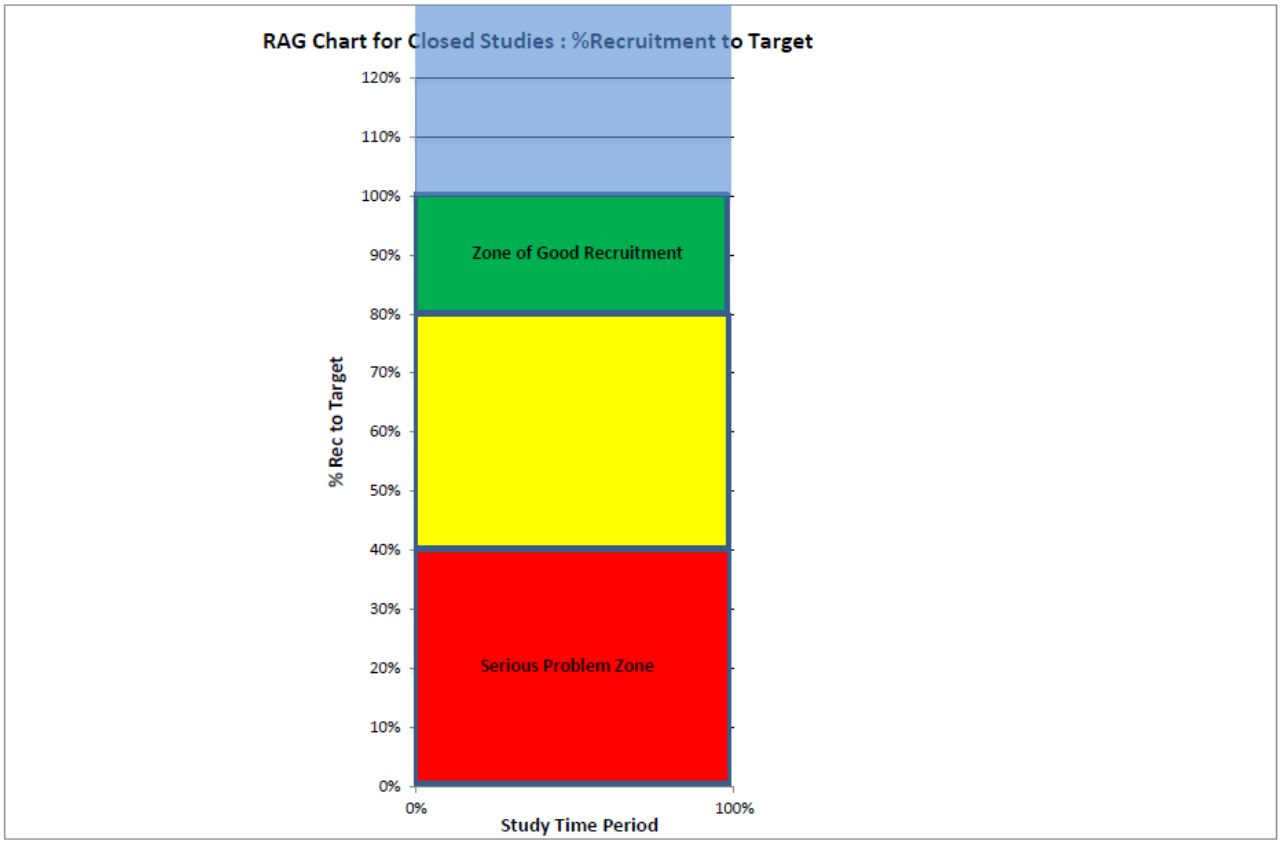
NHS Permission	Research cannot commence within the NHS without first gaining permission. This is granted as part of a study's research governance process, also referred to as R&D approval.
National Performance Measure (NPM)	An objective decided by the NIHR CRN CC as a priority area for all CLRNs. Our progress towards achieving this measure is monitored locally and fed back to our local stakeholders and the NIHR CRN CC.
NIHR CRN	National Institute of Health Research Clinical Research Network
NIHR CRN CC	National Institute of Health Research Clinical Research Network Coordinating Centre
Non-commercial study	A non-commercial study is one that has some of their research funded by the NIHR, other areas of central Government or NIHR non-commercial partners. However non-commercial studies can also be investigator initiated trials (i.e. commercial collaborative research) or funded by an overseas Government or overseas charity.
Observational study	A study in which the participants' lifestyle or care pathway is not affected by being part of the study i.e. the investigator does not determine whether or not the participants receive or do not receive a particular treatment. The investigator observes the outcome of participants following their exposure (or non-exposure) to a particular interventional or lifestyle.
Open Study	A portfolio study that has received NHS permission and is open to recruit patients. Open dates can vary across multi-centre studies as NHS permission has to be obtained at each study site.
Participant	A patient or individual who is recruited to a study.
Portfolio	A national database of research studies that meet specific eligibility criteria. Portfolio studies have access to infrastructure support via the NIHR Comprehensive Clinical Research Networks and swift R&D permissions through CSP.
QA (CSP report)	Once the governance review is complete, the study undergoes a final quality assurance process by a RM&G manager.
RAG criteria charts	RAG (red, amber, green) provides a key that help measures how well studies are recruiting to time and target. There are different charts for open and closed studies, and are included with this report.
Recruitment	The number of participants consented to a study.

Recruitment target	An agreed target in participant recruitment into portfolio studies in 2013/14.
Report date	The date the report is issued.
Reported recruitment	The sum total of participants consented to a study that is uploaded to the NIHR CRN CC database by a study's recruitment data contact (RDC).
Research Governance	The regulations, principles and standards of good practice that exist to achieve, and continuously improve, research quality across all aspects of healthcare.
Specialty Group	Within the Comprehensive Clinical Research Network (CCRN), there are 23 national Specialty Groups that provide research expertise in their field. They are designed to increase opportunities for researchers to contribute to national and international NIHR portfolio studies.
Study Complexity	Study complexity (also referred to as study design) is considered along with recruitment when allocating activity based funding. Studies are either categorised as simple, observational or interventional.
Time and Target (TnT)	TnT is a project which monitors how well a study progresses towards their recruitment target before the study recruitment close date. TnT can be applied to an entire study (across several sites) or used for local site analysis.
Study review abandoned (CSP report)	A study review may be abandoned for a number of reasons including problems with the funding, non adoption onto the portfolio or site unsuitability.
Topic Network	There are six topic research networks (Cancer, Diabetes, Dementias and Neurodegenerative Diseases, Medicines for Children, Mental Health and Stroke) and a Primary Care research network within the NIHR CRN. Each research network coordinates and facilitates the conduct of clinical research for their local research community.
Trust R&D permission granted (CSP report)	Trust R&D authorise the study to be undertaken within their trust based on the CLRN RM&G governance review.
Unable to commence local research governance checks (CSP report)	The governance review process is unable to start as not all the relevant documents, authorisations or information has been received by the CLRN RM&G reviewer.
Undergoing research governance review using CSP (CSP report)	The governance review process for a study has commenced using CSP.
YTD	Year to date.

RAG criteria for open studies



RAG criteria for closed studies



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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: 30 January 2014

COMMITTEE: Finance and Performance Committee

CHAIRMAN: Mr R Kilner, Acting Chairman

DATE OF COMMITTEE MEETING: 18 December 2013

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:

- **Improvements in Cancer Performance and Opportunities for Organisational Learning (Minute 137/13/1);**
- **Operational Performance and RTT compliance (Minute 138/13/4), and**
- **The Trust's forecast financial deficit and assurance provided regarding CMG delivery of the planned year-end position.**

DATE OF NEXT COMMITTEE MEETING: 29 January 2014

Mr R Kilner
24 January 2014

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF A MEETING OF THE FINANCE AND PERFORMANCE COMMITTEE, HELD ON WEDNESDAY 18 DECEMBER 2013 AT 8.30AM IN TEACHING ROOM 2, CLINICAL EDUCATION CENTRE, LEICESTER ROYAL INFIRMARY

Present:
Mr R Kilner – Acting Chairman (Committee Chair)
Colonel (Retired) I Crowe – Non-Executive Director
Mr R Mitchell – Chief Operating Officer (up to and including Minute 141/13)
Mr I Sadd – Non-Executive Director
Mr A Seddon – Director of Finance and Business Services (from part of Minute 139/13/1)
Mr G Smith – Patient Adviser (non-voting member)
Ms J Wilson – Non-Executive Director

In Attendance:
Mr J Deane – Consultant Ophthalmologist (for Minute 137/13/2)
Mr P Gowdridge – Finance Lead, ITAPS (for Minute 137/13/3)
Mr N Kee – General Manager, Clinical Supporting and Imaging (for Minute 138/13/2)
Ms S Khalid – Clinical Director, Clinical Supporting and Imaging (for Minute 138/13/2)
Mr C Lyon – Deputy General Manager, Musculoskeletal and Specialist Surgery (for Minute 137/13/2)
Mr M Metcalfe – Cancer Centre Lead Clinician (for Minute 137/13/1)
Ms D Mitchell – Head of Improvement and Innovation (for Minutes 139/13/2 and 139/13/3)
Mrs K Rayns – Trust Administrator
Ms H Seth – Head of Planning and Business Development (for Minutes 137/13/3 and 138/13/3)
Mr S Sheppard – Deputy Director of Finance
Ms K Shields – Director of Strategy (from Minute 134/13 to Minute 137/13/3 inclusive)

ACTION

RESOLVED ITEMS

134/13 APOLOGIES

There were no apologies for absence. It was noted that the Director of Finance and Business Services would be arriving late due to some media interviews taking place that morning in relation to the Trust's financial re-forecast.

135/13 MINUTES

Resolved – that the Minutes of the 27 November 2013 Finance and Performance Committee meeting (papers A and A1) be confirmed as a correct record.

136/13 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. Particular discussion took place in respect of the following items:-

(a) Minute 126/13/1 of 27 November 2013 – the Deputy Director of Finance confirmed that an Executive Director lead was in place to support the implementation of the level 2 financial and business awareness workshops. Three further workshop sessions had been held since the presentation to the Committee in November 2013 and a waiting list was now being held for further sessions. Appropriate dates would be provided to Colonel (Retired) I Crowe for him to attend one of these sessions; **DDF**

(b) Minute 126/13/2 of 27 November 2013 – the Committee Chairman had met with the Director of Strategy regarding the Trust's overarching programme for strategic change which was likely to supersede the Improvement and Innovation Framework (IIF). An update on progress would be provided to the Finance and Performance

Committee on 29 January 2014. Responding to a query raised by Ms J Wilson, Non-Executive Director, the Director of Strategy advised that some elements of the Improvement and Innovation Framework structure would be retained, but generally the IIF branding was not felt to be helpful going forwards; **DoS**

(c) Minute 128/13/1(c) of 27 November 2013 – the Deputy Director of Finance confirmed that the formal CIP reporting process had now been established through the Executive Performance Board (EPB) and that Ms D Mitchell, Head of Improvement and Innovation had attended the EPB meeting on 17 December 2013 for this discussion;

(d) Minute 115/13/1(f) of 27 November 2013 – the Committee Chairman advised that a new Executive Workforce Board was being convened in order to strengthen the governance arrangements relating to UHL's workforce, and

(e) Minute 28/13/3 of 27 March 2013 – in the absence of the Director of Finance and Business Services at this point in the meeting, an update on the 6 facet survey in respect of University occupied UHL premises would be provided to a future meeting. **DFBS**

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

137/13 STRATEGIC MATTERS

137/13/1 Improvements in Cancer Performance

The Chief Operating Officer introduced Mr M Metcalfe, Cancer Centre Lead Clinician, and invited him to brief the Committee on the approach adopted to deliver recent improvements in UHL's cancer performance. Mr Metcalfe presented a series of slides illustrating the patient experience and performance achievements delivered through the virtual entity of the Cancer Centre which aimed to put patients at the centre and establish clear overarching accountability for their care, through interaction with all relevant Clinical Management Groups. During the presentation, the Finance and Performance Committee particularly noted that:-

(a) the governance arrangements included weekly Cancer Action Board meetings, monthly Cancer Board meetings and monthly Clinical Nurse Specialist meetings;

(b) the level of support provided by the Executive Team and Corporate Directors had been a significant factor in the success of this initiative;

(c) some remaining gaps in UHL's performance had been identified and a tumour site dashboard was being developed in order to monitor progress and address any challenges appropriately;

(d) plans were being progressed to strengthen the relationships between the core Cancer Centre teams by co-locating them within the same building;

(e) recent progress had been made in building relationships with GPs by alleviating the need for "ghost" appointments to comply with the 2 week wait pathways – patients were now able to leave the GP surgery upon receiving their cancer diagnosis with a confirmed appointment and this was seen as a significant step in the right direction by GPs;

(f) during the last quarter, UHL's cancer performance had exceeded national targets and the improvement trajectory set by Commissioners;

(g) 1 to 1 focus groups were being held to address clinical engagement within the worst performing 2 or 3 tumour sites where progress was causing concern;

(h) a new process was being launched in January 2014 which would manage referrals to the Oncology service;

(i) Cancer Centre teams were still spending too much time correcting individual patient pathways which had fallen off track and work continued to ensure that the improvements achieved were sustainable in the longer term, and

(j) UHL aspired to be in the top quartile of high performing cancer services by the end of 2014. Regional solutions would be explored if it became apparent that any of

UHL's in-house systems were not capable of supporting this aspiration.

Following the presentation the following questions and comments were raised:-

- Ms J Wilson, Non-Executive Director thanked Mr Metcalfe for his presentation and commended the achievements delivered to date. She queried what would be required to sustain the improved performance already demonstrated. In response, it was noted that key factors would include less time being spent chasing imaging requests, a fully embedded Oncology referrals system and improved clinical engagement with all tumour site leads;
- Mr G Smith, Patient Adviser welcomed the patient centred approach and the commitment demonstrated by the Cancer Centre teams. Noting the specific focus on the imaging sections of patient pathways, he sought and received confirmation that all patients were being treated equally according to their clinical priority;
- the Chief Executive queried the extent to which the CCGs' approach to clinical problem solving had contributed to the improved position, noting in response that it had been helpful for UHL to have champions on the commissioning side and that a mutual understanding of the issues faced had supported an iterative approach to refining processes through clinical dialogue, and
- Mr I Sadd, Non-Executive Director queried the organisational learning points arising from cancer improvements. These were noted to include the sharing of good quality dashboard data with clinicians and gradually increasing the level of accountability for improving the data. The Chief Operating Officer noted the relevance of this work in respect of improving RTT and ED performance, suggesting that a high calibre manager, good clinical engagement and holding clinicians to account for their data were all crucial elements to improving performance in these areas.

Resolved – that the presentation on the Cancer Improvement Plan be received and noted.

137/13/2 Update on Ophthalmology Performance

Further to Minute 114/13/2 of 30 October 2013, Mr C Lyon, Deputy CMG Manager, Musculoskeletal and Specialist Surgery and Mr J Deane, Head of Services, Ophthalmology attended the meeting to present paper C, providing an update on the challenges associated with Ophthalmology performance and a review of the actions undertaken to address issues relating to RTT compliance, typing backlog reductions, financial performance and patient experience/complaints performance. During this discussion, Finance and Performance Committee members particularly noted that:-

(i) Mr M Watts had been appointed as the substantive Ophthalmology Service Manager with effect from 6 January 2014 and a case of need for phased expansion of the administrative and clerical resources had been approved by the CMG Board for submission to the Commercial Executive;
(ii) UHL's trajectory for achieving RTT compliance was in the process of being agreed with Commissioners;
(iii) the previously reported typing backlog of c12,500 letters had been under-estimated and subsequent validation work had identified a backlog of 14,979 letters as at 1 November 2013. Outsourced typing services were being utilised in order to generate in excess of 2,000 letters per week and whilst this was reducing the backlog in a consistent manner, it was still expected to take approximately 17 weeks to achieve an acceptable level (eg 1,200 letters), and
(iv) capacity and demand modelling had been undertaken with support from the Intensive Support Team and recommendations had been made to build additional capacity to improve patient access by expanding the physical clinic space, increasing efficiency and patient throughput, recruiting additional substantive staff and increasing evening and weekend activity through changes to Consultant job plans.

Resolved – that (A) the progress report on actions underway within Ophthalmology to improve financial and operational performance issues be received and noted, and

(B) a further report be provided to the Finance and Performance Committee in March 2014. **COO**

137/13/3 Report by the Director of Strategy

Resolved – 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.

137/13/4 Winter Plan 2013-14 Performance

In the absence of a written report on UHL's winter plan performance (paper E), the Committee Chairman had withdrawn this item from the agenda on 17 December 2013.

Resolved – that the briefing on Winter Plan 2013-14 performance be deferred to the 29 January 2014 meeting. **COO**

138/13 PERFORMANCE

138/13/1 Emergency and Specialist Medicine CMG

Ms J Edyvean, CMG General Manager and Ms G Staton, CMG Head of Nursing had been scheduled to attend the meeting to present paper F, a summary of the Emergency and Specialist Medicine CMG's financial and operational performance. This report had been circulated late on 17 December 2013, but the Committee noted that the CMG had not followed the reporting template and the resulting report appeared to represent a download of performance data instead of a meaningful report. Consequently, the report was withdrawn and the CMG representatives were stood down.

The Trust Administrator was requested to re-provide the Committee Chairman with a copy of the reporting template agreed by the Committee on 30 October 2013 for his further review. It was agreed that appropriate guidance would be developed to support a more focused approach to CMG presentations at future meetings.

Resolved – that (A) the Emergency and Specialist Medicine CMG presentation be deferred to the 29 January 2014 meeting; **TA/ ESM CMG**

(B) the Trust Administrator be requested to re-provide the Committee Chairman with a copy of the reporting template previously agreed by the Committee for his further review, and **TA**

(C) appropriate guidance be developed to support a more focused approach to CMG presentations at future meetings. **CHAIR MAN/ DFBS**

138/13/2 Imaging Services – Improving Financial and Operational Performance

The Clinical Director and the General Manager from the Clinical Supporting and Imaging CMG attended the meeting to present paper G, providing a progress report on the actions underway to improve imaging productivity, reduce waiting times and deliver key performance metrics. Following a demand and capacity review completed in September 2013 and further work by NHS England's Intensive Support Team to review imaging processes, a range of actions had been highlighted to improve productivity within a number of Imaging's modalities (including CT, ultrasound, plain film, nuclear medicine and fluoroscopy). A cohesive improvement programme action plan was being developed

which would require a transformational approach and include the targeted application of LEAN principles, use of the Improvement and Innovation Framework software and restructuring of Consultant job plans.

Ms J Wilson, Non-Executive Director recognised that the project plan was still work in progress but she requested an indication of the scale of potential savings, noting in response that the CMG hoped to save approximately £1m per year for the first 2 years of the project and that the balance of CIP savings were expected to be delivered by reducing the cost of outsourcing. The Committee Chairman suggested that the scope for workforce savings might be greater than the original assumption of 5%. The CMG Director confirmed that more ambitious targets would be considered when scoping the final assumptions for the project plan. She noted the importance of good quality medical engagement and reported on the recruitment process to appoint 3 new Heads of Service within Imaging.

The Committee also discussed opportunities for imaging demand management, national benchmarking of activity, and the development of a demand and capacity tool for diagnostic imaging for which the Trust had expressed an interest in becoming a pilot site. The General Manager noted a potential "quick win" to reduce the number of duplicate tests ordered for patients.

The Chief Executive summarised the major areas of variable performance and requested that a copy of the basic performance metrics data be provided to him outside the meeting. He also requested a summary of any patient backlogs be provided alongside the metrics report. The Finance and Performance Committee requested a further progress report on imaging improvements be provided to the 26 March 2014 meeting. **GM, CSI** **CD/GM, CSI**

<u>Resolved</u> – that (A) the report outlining progress with the Imaging Improvement Programme be received and noted;

(B) the General Manager, CSI be requested to provide the Chief Executive with a copy of the basic imaging performance metrics and a summary of any patient backlogs, and **GM, CSI**

(C) a further update on the Imaging Improvement Programme be presented to the 26 March 2014 Finance and Performance Committee meeting. **CD/GM, CSI**

138/13/3 <u>Imaging Services – Managed Equipment Service (MES) Control Mechanisms</u>

Ms H Seth, Head of Planning and Business Development attended the meeting to provide a verbal overview of developments relating to governance arrangements in respect of the MES II contract with Asteral and the new working arrangements with Interserve. The Committee noted that the rolling replacement programme was running behind schedule and that there was some lack of clarity surrounding roles and responsibilities. Work was taking place to align the outputs from the review of imaging capacity and demand with strategic estate development plans.

The Head of Planning and Business Development voiced her concerns regarding the level of imaging equipment damage and queried whether such incidents were caused by design faults or lack of due care. She also highlighted concerns relating to the joint working arrangements with Interserve where delays had been experienced within most project phases between the initial design stage to final snagging of the completed works.

The Committee Chairman queried whether delays in the Interserve processes had been documented and appropriately escalated. Assurance was provided that appropriate liaison was taking place with Interserve and Horizons representatives (including Mr N Bond, Mr A Chatten and Mr S Bull) to improve the joint working relationship. It was also noted that some of the delays were user generated and reflected a lack of awareness of

Interserve's processes. The Committee Chairman requested that Mr N Bond, Capital Projects Manager be invited to brief the Committee on Interserve's contributions to the MES programme at the 29 January 2014 meeting. A further update on the MES project would then be required at the 26 February 2014 meeting.

In response to a query raised by Colonel (Retired) I Crowe, Non-Executive Director it was noted that of the 2 CT scanners due to be installed in the Emergency Department, 1 of these would be dedicated to ED activity and the other would be used more flexibly.

Resolved – that (A) the verbal update on MES governance and controls mechanisms be received and noted,

(B) Mr N Bond, Capital Projects Manager be invited to attend the 29 January 2014 meeting to brief the Committee on Interserve's contributions to the MES programme, and **TA**

(C) a further update on the governance arrangements relating to the MES Contract be provided to the 26 February 2014 meeting. **HPBD**

138/13/4 Month 8 Quality and Performance Report

Paper H provided an overview of UHL's quality, patient experience, operational targets and HR performance against national, regional and local indicators for the month ending 30 November 2013 and a high level overview of the Divisional Heatmap report. The Chief Operating Officer reported on the following aspects of UHL's operational performance, using the table on page 21 as his central point of reference:-

ED Performance – stood at 88.5% against the 4 hour target with150 breaches on 16 December 2013. The level of breaches had reduced to 29 and nil respectively on the subsequent 2 days, but the pattern indicated a lack of resistance to high ED attendance levels. Dr B Teasdale and Ms L Lane had recently visited the ED at University Hospitals Coventry and Warwickshire NHS Trust where robust escalation measures had been implemented in the form of "Command Cells". A further visit had been arranged for UHL's ED Consultants to see the impact of these "Command Cells" in practice and, subject to positive feedback from this visit, it was intended to implement them at UHL on 6 January 2014.

In addition, a Senior Site Manager and a Deputy Site Manager had recently been appointed from Sherwood Forest Hospitals NHS Foundation Trust and they were expected to join UHL's ED within the next 2 months. The Chief Executive suggested that a discussion on ED medical staffing and medical ward processes for 8 key wards would be appropriate for the Trust Board meeting on 20 December 2013;

RTT 18 Week Performance – stood at 83.2% for admitted and 91.9% for non-admitted patients. A detailed report on improving RTT performance was due to be considered at the 20 December 2013 Trust Board meeting. Meanwhile, discussions continued with Commissioners regarding the improvement trajectory and the level of additional activity required to clear the backlogs.

Cancer Performance – compliant performance had been delivered against all cancer targets for October and November 2013. Indications were that the December 2013 performance would also be compliant, subject to validation.

Choose and Book Slot Unavailability and Cancelled Operations – both of these performance indicators were non-compliant due to their links to RTT performance.

In discussion on the Trust's operational performance, Ms J Wilson, Non-Executive Director requested that exception reports for choose and book and cancelled operations **COO**

be provided to future meetings. She also sought assurance that any impact upon patients was appropriately reviewed and that the same patient was not cancelled more than once. The Chief Operating Officer confirmed that the metric for measuring the number of patients cancelled 2 or more times remained at zero. He also reported on arrangements to improve cancellation rates by reducing elective surgery throughput and increasing emergency flows, supported by an increase in the Trust's bed base and recalibrated theatre allocations.

The Committee Chairman queried the timescale for improving choose and book slot availability and requested evidence of the actions underway to achieve this. In response, the Chief Operating Officer highlighted capacity issues to cope with the increase in referrals (particularly within Ophthalmology). Mr A Dennison had been appointed as the improvement lead for RTT and an additional management resource was being recruited to support him in this role. The Committee Chairman suggested that the challenges associated with choose and book compliance were more than clinic capacity and further discussion took place regarding DNA rates, increased referral rates, negotiations with Commissioners to deliver substantive increases in capacity and opportunities for UHL to use clinic capacity more effectively.

The Chief Executive noted that only 97.6% of cancelled operations had been re-booked within 28 days during November 2013 and he queried the impact of this for the patients involved. The Chief Operating Officer advised that no urgent operations were being cancelled but an additional focus was being developed to re-book cancelled operations in a more timely manner.

<u>Resolved</u> – that (A) the month 8 Quality and Performance report (paper H) and the subsequent discussion be received and noted, and

(B) the Chief Operating Officer be requested to provide exception reports on choose and book slot unavailability and cancelled operations performance to future meetings. **COO**

139/13 FINANCE

139/13/1 <u>Month 8 Financial Performance Report</u>

In the absence of the Director of Finance and Business Services at this point in the meeting, the Deputy Director of Finance introduced paper I, summarising the Trust's financial performance as at month 8 (November 2013) and providing key financial statements within appendix 1. Also accompanying paper I was the Trust level summary pack which was used to inform the monthly CMG Performance Management meetings. During the discussion on this item, Finance and Performance Committee members particularly noted:-

(a) an in-month income and expenditure deficit of £3.0m and a year-to-date deficit of £20.3m which was £23.0m adverse to the planned surplus of £2.7m;
(b) the revised year-end forecast deficit of £39.8m, reflecting continued high levels of pay expenditure for additional staffing and an adverse trend in non-pay expenditure some of which was backed by additional income;
(c) new financial controls agreed by the Executive Performance Board on 17 December 2013 in relation to recruitment, non-clinical non-pay expenditure and minor works requisitions;
(d) progress with implementation of temporary staffing controls where an appropriate focus was being made on maintaining safe staffing levels;
(e) that recruitment controls would not impact upon the existing recruitment plans for nursing staff as recruitment to these posts would deliver an overall financial saving to the Trust;
(f) a verbal clarification provided in relation to the central adverse variance of

£607,000 against forecast. It was noted that the 3 main elements of this variance reflected the difference between first cut coded activity and final activity, winter funding allocations (which had now been allocated to the appropriate CMGs) and a range of urgent and disputed invoices not yet allocated to budget holders – the latter practice had now ceased. None of these elements were expected to impact upon the Trust's year-end position and it was agreed that such variances would be presented in separate reporting lines within future iterations of this report, and

(g) a query raised by Mr I Sadd, Non-Executive Director regarding the monitoring arrangements for price and volume variances reported in table 3 on page 2 of paper I. It was noted in response that progress on the development of Service Line Management (SLM) data was reported regularly to the Audit Committee and the Trust Board and that this was a standing item in the monthly Quality, Finance and Performance reporting template.

The Director of Finance and Business Services arrived at this point in the meeting and discussion took place regarding the CMG and Corporate Directorate financial forecasts including the level of available assurance that they could deliver the planned year-end position. The Chief Operating Officer briefed the Committee on the outputs from the CMG Performance Management meetings held on 16 and 18 December 2013, noting the need to hold the CMG leadership teams to account and provide additional support where appropriate. He highlighted a requirement to improve the alignment of income and expenditure within the ITAPS CMG and to deliver a comprehensive cross-cutting efficiency programme for 2014-15. The Director of Finance and Business Services had emphasised the importance for each of the CMGs to develop suitable reporting metrics for weekly review.

Resolved – that the report on UHL's month 8 (November 2013) financial performance be received and noted.

139/13/2 Delivery of Cost Improvement Programme (CIP) 2013-14 Update

The Head of Improvement and Innovation attended the meeting to introduce paper J, providing the November 2013 status report on the Cost Improvement Programme for 2013-14, consisting of 332 schemes with a total forecast delivery value of £36.7m against the £37.7m target, representing an in-month deterioration of £538k. The RAG ratings for each scheme were presented in a table within section 1 of paper J. Members noted that the University Reimbursement scheme (£1.2m) had been removed from the forecast on the advice of the Director of Finance and Business Services, pending the outcome of a meeting with the University due to be held on 19 December 2013. Confirmation was provided that this deterioration had been allowed for within the Trust's financial re-forecast.

Discussion took place regarding the following particular schemes:-

(1) ***Theatres Programme*** – the impact of RTT and recruitment challenges had led to changes in the timescale for delivery and the project was being re-focused to maximise efficiencies in the 2014-15 financial year. A report would be presented to the Theatre Board in January 2014, but key changes were noted to include improved pre-operative assessment facilities, increases in day case capacity and centralised theatre scheduling;
(2) ***Medical Productivity*** – Dr P Rabey, Deputy Medical Director was now leading this programme which would focus upon job planning, Consultant metrics and additional payments made to medical staff;
(3) ***Outpatients*** – members were disappointed to learn that Mr O Sudar, OPD Project Lead would be leaving the Trust during January 2014 to take up a position with the Greater East Midlands Commissioning Unit. Assurance was provided that staff had been working closely with Mr Sudar on the 2014-15 CIP schedule and this would help to mitigate the risks relating to CIP delivery. However, the process for generating new

ideas for subsequent CIP schemes was likely to be less robust.

Mr I Sadd, Non-Executive Director sought additional information regarding the demand and capacity review within theatres and whether progress was on track. In response, the Head of Improvement and Innovation noted that the lowest areas of theatre utilisation were being progressed as the top priority, although the RTT backlog activity had prevented theatre sessions from being closed. The Committee Chairman noted that the last Theatre Board meeting he had attended was poorly attended and an issue had arisen relating to scheduling of daycase laparoscopic cholecystectomy prior to 2pm to prevent the need for daycase patients to stay in hospital overnight. He also reminded members that Ms S Khalid (in her role as Head of Improvement and Innovation) had previously shared the outputs of a medical productivity review with the Finance and Performance Committee indicating that the scope for savings was in the region of £20m. He requested that Dr P Rabey, Deputy Medical Director be requested to provide the Committee with an update on this workstream on 29 January 2014.

Resolved – that (A) the 2013-14 CIP update (paper H) be received and noted, and

(B) Dr P Rabey, Deputy Medical Director be invited to provide an update on medical productivity to the 29 January 2013 meeting. **TA/ DMD**

139/13/3 Progress Report on the Development of 5 Year CIP Plans

The Head of Improvement and Innovation introduced paper K, providing an update on the development of 2014-15 CIP plans and arrangements to deliver a stepped change for 2015-16 and beyond through detailed 2 year and outline 3 year planning processes in line with the draft strategic and operational planning guidance received from NHS England. Finance and Performance Committee members noted that a review of the IIF Programme was being undertaken and that the outputs were due to be considered by the Executive Strategy Board in January 2014. It was agreed that these proposals would also be presented to the Finance and Performance Committee on 29 January 2014.

The Committee Chairman referred to the table in appendix 1 providing a summary of identified 2014-15 CIP schemes for each CMG and queried whether the Head of Improvement and Innovation was comfortable with progress. In response, it was confirmed that progress was further advanced than in previous years and that the returns due to be submitted by 31 December 2013 were expected to improve the overall position significantly. The Head of Improvement and Innovation noted the need for further discussion with the Director of Finance and Business Services and the Deputy Director of Finance to clarify an outstanding issue relating to gain sharing.

Resolved – that (A) the 5 year CIP update (paper K) be received and noted;

(B) the outputs from the review of the Improvement and Innovation Framework Programme be presented to the Executive Strategy Board and the Finance and Performance Committee in January 2014, and **DoS**

(C) the Head of Improvement and Innovation be requested to liaise with the Director of Finance and Business Services and the Deputy Director of Finance regarding the arrangements for gain sharing within the context of CIP planning. **HII/ DFBS**

140/13 SCRUTINY AND INFORMATION

140/13/1 Clinical Management Group (CMG) Performance Management Meetings

Resolved – that the action notes arising from the November 2013 CMG Performance management meetings (papers L1, L2 and L3) be received and noted.

140/13/2 Executive Performance Board

Resolved – that the notes of the 26 November 2013 Executive Performance Board meeting (paper M) be received and noted.

140/13/3 Improvement and Innovation Framework Board

Resolved – that the notes of the 12 December 2013 Improvement and Innovation Framework Board meeting be presented to the January 2014 meeting.

140/13/4 Quality Assurance Committee (QAC)

Resolved – that the Minutes of the 27 November 2013 QAC meeting (paper N) be received and noted.

140/13/5 Quality and Performance Management Group (QPMG)

Resolved – that the notes of the 13 November 2013 QPMG meeting (paper O) be received and noted.

141/13 ITEMS FOR DISCUSSION AT THE NEXT FINANCE AND PERFORMANCE COMMITTEE

Paper P provided a draft agenda for the 29 January 2014 meeting. In discussion, the following amendments were considered and agreed:-

TA

(a) the update on improving medical productivity (as requested in Minute 139/13/2 above) would be incorporated into agenda item 2.6 relating to the benchmarking of medical staffing costs;
(b) agenda item 2.4 – the Improvement and Innovation Framework update would also include the Trust's strategy for financial recovery and any applications for additional funding;
(c) agenda item 3.1 – the CMG presentation by Clinical Supporting and Imaging would be deferred to February 2014 in order to accommodate the Emergency and Specialist Medicine CMG presentation in January 2014, and
(d) agenda item 4.2 – the scope to combine the update on Corporate Directorate Financial Recovery Plans within the Improvement and Innovation Framework update was considered, but the Chief Executive expressed his preference to retain this as a separate agenda item in the short term.

Resolved – that (A) the items for consideration at the Finance and Performance Committee meeting on 18 December 2013 (paper O) be noted, and

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

142/13 ITEMS TO BE HIGHLIGHTED TO THE TRUST BOARD

Resolved – that the following issues be highlighted verbally to the Trust Board meeting on 20 December 2013:- **JW, NED**

- Minute 137/13/1 – improvements in cancer performance and opportunities for organisational learning;
- Minute 137/13/3 – confidential report by the Director of Strategy;
- Minute 138/13/4 – operational performance and RTT compliance, and
- Minute 139/13/1 – the Trust's forecast financial deficit and assurance provided regarding CMG delivery of the planned year-end position.

143/13 ANY OTHER BUSINESS

143/13/1 Report by Ms J Wilson – Non-Executive Director

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

143/13/2 UHL's Year End Financial Forecast

The Director of Finance and Business Services briefed the Committee on the content of the radio and television interviews he had provided that morning, noting that there had been no CCG representatives available to comment for the radio interview.

Resolved – that the information be noted.

144/13 DATE OF NEXT MEETING

Resolved – that the next Finance and Performance Committee be held on Wednesday 29 January 2014 from 8.30am – 11.30am in Seminar Rooms A & B, Clinical Education Centre, Leicester General Hospital.

The meeting closed at 11.33am

Kate Rayns,
Trust Administrator

Attendance Record

Name	Possible	Actual	% attendance	Name	Possible	Actual	% attendance
R Kilner (Chair from 1.7.13)	9	9	100%	I Reid (Chair until 30.6.13)	3	3	100%
J Adler	9	7	78%	I Sadd	2	1	50%
I Crowe	6	6	100%	A Seddon	9	9	100%
R Mitchell	6	5	83%	G Smith *	9	8	89%
P Panchal	4	2	50%	J Tozer *	2	2	100%
				J Wilson	9	8	89%

* non-voting members

CC

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: 30 January 2014

COMMITTEE: Quality Assurance Committee

CHAIRMAN: Professor D Wynford-Thomas, Acting QAC Chairman and Non-Executive Director

DATE OF COMMITTEE MEETING: 17 December 2013

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: 29 January 2014.

Professor D Wynford-Thomas
24 January 2014

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF A MEETING OF THE QUALITY ASSURANCE COMMITTEE HELD ON TUESDAY 17 DECEMBER 2013 AT 9:30 AM IN THE LARGE COMMITTEE ROOM, MAIN BUILDING, LEICESTER GENERAL HOSPITAL

Present:
Ms J Wilson – Non-Executive Director (Chair)
Mr J Adler – Chief Executive
Mr M Caple – Patient Adviser (non-voting member)
Dr K Harris – Medical Director
Ms K Jenkins – Non-Executive Director
Mr P Panchal – Non-Executive Director
Professor D Wynford-Thomas – Non-Executive Director and Dean of the University of Leicester Medical School

In Attendance:
Dr B Collett – Associate Medical Director, Clinical Effectiveness
Dr J Cusack – Head of Service, Neonatal Service (for Minute 118/13/1)
Mr M Duthie – Consultant Paediatric Intensivist (for Minute 118/13/1)
Miss M Durbridge – Director of Safety and Risk
Mrs S Hotson – Director of Clinical Quality
Ms C Ribbins – Director of Nursing

RESOLVED ITEMS **ACTION**

116/13 APOLOGIES

Apologies for absence were received from Ms C O'Brien, Chief Nurse and Quality Officer, East Leicestershire and Rutland CCG (non-voting member) and Ms R Overfield, Chief Nurse.

117/13 MINUTES

Resolved – that the Minutes of the meeting held on 27 November 2013 (papers A & A1 refer) be confirmed as a correct record.

118/13 MATTERS ARISING REPORT

Members reported on progress in respect of the following actions:-

(a) Minute 110/13/2 of 27 November 2013 – a Trust Board Development session had been scheduled in February 2014 to discuss the 'Review of the NHS Hospitals Complaints System – Clywd-Hart Report'. This item could therefore be removed from the log. **TA**

(b) Minute 100/13/7 (i) of 29 October 2013 – a report on EPMA had been presented to the Improvement and Innovation Framework Board on 16 December 2013. The Trust Administrator undertook to circulate this report to QAC members, for information. The Associate Medical Director agreed to take a view on whether a report on EPMA needed to be presented to the QAC. **TA** **AMD**

Resolved – that the matters arising report (paper B) and the actions above, be noted. **TA/AMD**

118/13/1 Prescribing Errors within the Neonatal and Children's Service including ten times errors

Further to Minute 87/13/4 (i) of 25 September 2013, Dr J Cusack, Head of Service,

Neonatal Service and Mr M Duthie, Consultant Paediatric Intensivist attended the meeting to present papers C and C1, an update on prescribing errors within the Neonatal and Children's service respectively. Members noted that following two medication errors within the neonatal service, the prescribing practice was audited and a number of interventions had been implemented to minimise the risk. Dr J Cusack provided a comprehensive update on the following actions that had been put in place:-

(a) nursing education – enhancing the quality of the 'independent check' and preparing drugs away from the clinical area;
(b) medical staff training – bespoke online induction and education package in place;
(c) multidisciplinary simulation training had been well established;
(d) changes to prescription writing, documentation and formulations for emergency medications, and
(e) ongoing monitoring and audit.

Following the medication error in the Children's Service in July 2013, Mr M Duthie briefed members on the actions that had been implemented – as listed on pages 3 and 4 of paper C1. The lessons learned would be shared with the other clinical teams in the Children's service through a variety of forums.

Mr M Duthie suggested that a mechanism of credits needed to be developed which would be put on record in respect of staff members who had assisted in preventing a prescribing or administering a medication error. Members supported this innovative approach.

In discussion on the current staffing issues in Paediatric pharmacy, it was suggested that Mr D Harris, Principal Pharmacist, Women's and Children's Division be invited to attend the QAC in March 2014 to provide an update on staffing matters. The Committee Chair requested Dr J Cusack and Mr M Duthie to also attend the March 2014 QAC meeting to provide an update on the action plan. **PP, W&C** **HoS, Neonatal Service/ CPI**

<u>Resolved</u> – that (A) the contents of papers C and C1 be received and noted;

(B) Mr D Harris, Principal Pharmacist, Women's and Children's Division be invited to attend the QAC in March 2014 to provide an update on the current staffing issues in Paediatric pharmacy, and **PP, W&C**

(C) Dr J Cusack, Head of Service, Neonatal Service and Mr M Duthie, Consultant Paediatric Intensivist to attend the QAC in March 2014 to provide an update on the action plan. **HoS, Neonatal Service/ CPI**

118/13/2 <u>Education Programme for Nurses in ED</u>

<u>Resolved</u> – that the Director of Nursing undertook to circulate a briefing report on this matter. **DN**

119/13 QUALITY

119/13/1 <u>Month 8 – Quality and Performance Update</u>

Paper D provided an overview of the November 2013 quality and performance report highlighting key metrics and areas of escalation or further development where required.

The following issues were highlighted in particular:-

(a) 95% threshold for VTE risk assessment within 24 hours of admission had been achieved for October 2013;

(b) UHL's HSMR for 2013-14 (April – September 2013) was 92 (however this had not been rebased). UHL's HSMR for September 2013 was 83.0;
(c) 5 Critical Safety Actions – a pilot (snap shot) audit had been undertaken in medical wards in respect of senior clinical review, ward round and notation – the results of this audit had not been very positive. Further work would be undertaken to improve the procedures and re-audit would be undertaken and procedures in the base wards would also be audited. A comprehensive report of the CSA programme would be submitted to the QAC in January 2014; **AMD**
(d) an update on clinical coding improvement project had been presented to the Improvement and Innovation Framework Board in December 2013. A LiA Enabling Our People Scheme coding project was being established;
(e) pressure ulcer (PU) incidence – UHL ranked 6th best performing Trust for quarter 2 out of the 14 comparable Trusts. It had been agreed with Commissioners that UHL would need to maintain a threshold of nine or less grade 2 and seven or less grade 3 avoidable pressure ulcers a month;
(f) Friends and Family Test score for November 2013 was 70.3. The Medical Director advised that some Consultants had requested the FFT score of particular wards. The Director of Nursing agreed to email this information, as required;
(g) a new system of measuring ward performance had been introduced that sought to look at wards via the monthly clinical measures dashboard and also over time via the ward performance review process. Ward 19 had been put on targeted corporate support. Wards 29, 30 and 41 had been on targeted CMG support via monthly ward performance review. In discussion, members requested that a simple system of tracking ward performance would prove useful for QAC. The Committee Chair and the Director of Nursing agreed to discuss the best way of achieving this; **Chair/DN**
(h) same sex accommodation – a breach of this standard affecting 2 patients had been reported in November 2013;
(i) patient falls – November 2013 had seen a decrease in the number of falls reported, and
(j) a brief update on Interserve performance was provided and a detailed update would be provided at the December 2013 Trust Board.

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

(B) a comprehensive report of the 5 CSA programme be submitted to QAC in January 2014, and **AMD**

(C) the Committee Chair and Director of Nursing to discuss the best way of tracking ward performance in future QAC reports. **Chair/DN**

119/13/2 Executive Quality Board Work Plan

It was noted that the Assurance and Escalation Framework scheduled to be discussed at the Trust Board in December 2013 would inform the QAC workplan. The Committee Chair and Trust Administrator would have a discussion in early January 2014 and draft an initial workplan for QAC. **Chair/TA**

Resolved – that the Committee Chair and Trust Administrator discuss and draft the first version of the QAC workplan for further discussion at the QAC in January 2014. **Chair/TA**

119/13/3 Forthcoming CQC Inspection

The Director of Clinical Quality provided a detailed update on the practicalities for the CQC visit which would be held week commencing 13 January 2014 (paper E also refers).

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

119/13/4 Draft CQC Report – Unannounced Inspection of the Peterborough Renal Satellite Unit

The QAC noted the contents of paper F, a report following the unannounced CQC inspection of the Peterborough Renal Satellite Unit (managed by UHL) on 22 November 2013. The QAC recorded an appreciation of the efforts of the Matron of the Peterborough Renal Satellite Unit for ensuring that the information and the issues raised by the CQC were appropriately dealt with.

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

119/13/5 Quality Commitment

Resolved – that this item had been deferred by the Chief Nurse in consultation with the QAC Chair. **DCQ**

120/13 SAFETY

120/13/1 Patient Safety Report

The Director of Safety and Risk presented paper G, the patient safety report. The following points were highlighted in particular:-

(i) NHS England response to Francis report;
(ii) MHRA consultation;
(iii) Complaints analysis and end to end complaints, and
(iv) 45 day RCA update for November 2013.

Responding to a query from Ms K Jenkins, Non-Executive Director, the Director of Safety and Risk provided an update on categorising 10 days, 25 days and 45 days complaint responses, reopened complaints and learning from complaints.

During discussion of ten times medication errors, the need for particular focus on omission of drugs was noted. The Director of Safety and Risk advised that if omission of drugs was classed in the SUI category, then it would be recorded and reported as a medication error. The Associate Medical Director agreed to liaise with Dr J Cusack, Head of Service, Neonatal Service to check if any data existed in the Children's Service in respect of omission of drugs, further to this she agreed to liaise with the Medicines Management Board. **AMD**

Members noted that the Trust Board Development session in February 2014 would focus on complaints and the Director of Safety and Risk agreed to ensure that CMG complaints trend data (from October 2013) was available for this meeting including an update on complaints particularly related to maternity (as the proportion of SUIs were higher in the Women's Service). **DSR**

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

(B) the Associate Medical Director liaise with Dr J Cusack, Head of Service, Neonatal Service to check if any data existed in the Children's Service in respect of omission of drugs, further to this a discussion to take place with the Medicines Management Board, and **AMD**

(C) the Director of Safety and Risk be requested to ensure that CMG complaints trend data (from October 2013) and an update on complaints particularly related to maternity were available for the Trust Board Development session in February 2014. **DSR**

120/13/2 Quarter 2 (2013-14) Health and Safety Report

Paper H detailed the health and safety report for quarter 2 (July-September 2013) of 2013-14. In discussion, the Chief Executive suggested that IRMER incidents were included in future quarterly health and safety reports. **DSR**

Ms K Jenkins, Non-Executive Director queried the implications of the figures provided relating to training re. stress management and emotional resilience for managers – in response, the Director of Safety and Risk noted that this was a workforce related issue and the Committee Chair suggested that this issue be raised at the Trust Board in December 2013. **KJ, NED**

Mr P Panchal, Non-Executive Director noted that the paper detailed the training undertaken by the UHL health and safety team and sought assurance on the statutory and mandatory training requirement for non-UHL staff (i.e. Interserve staff/temporary/ agency staff) who worked on UHL premises – in response, it was noted that Interserve provided training to their own staff.

In discussion on reporting RIDDORs within the deadline, it was noted that this was monitored by the CMGs.

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

(B) future versions of the quarterly health and safety reports to include an update on IRMER incidents, and **DSR**

(C) Ms K Jenkins, Non-Executive Director to introduce a discussion on stress related absence at the Trust Board in December 2013. **KJ, NED**

120/13/3 Risk Assessment for Statutory and Mandatory Training Compliance

The Director of Safety and Risk advised that further to discussion at the Executive Team meeting (action note 5.3 of 8 October 2013 refers), the Risk and Assurance Manager had met with colleagues to review the position around mandatory training risks and nurse staffing risks that were not reflected in the UHL organisational risk register at that time. Risk assessments (paper I – appendix 1 refers) had been undertaken to identify the risks to the organisation in relation to the gaps in compliance with the target of 75% of staff attending mandatory training and the high number of nursing staff vacancies. The Chief Executive noted that the 75% target set for staff attending mandatory training was only a staging post and the actual target was 100%.

As the risks were corporate in nature, once they had been formally signed off by the relevant Corporate Director, the risks would be entered onto the organisational risk register. Members noted that as the risk assessments in respect of risks relating to personal safety awareness and nurse staffing vacancies had previously been assessed and approved and were already listed on the organisational risk register, these had not been included in appendix 1of paper I.

In response to a query in relation to Information Governance training, it was noted that an online e-learning training package was in place. Members were advised that statutory and mandatory compliance rates were monitored at Executive Performance Board meetings. The Committee Chair suggested that an update on progress with statutory and mandatory compliance be scheduled for the QAC in six months time (i.e. June 2014). **DHR**

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

(B) an update on progress with statutory and mandatory compliance be scheduled on the agenda for the QAC in six months time (i.e. June 2014). **DHR/TA**

120/13/4 Update on data reported in the NHS Safety Thermometer regarding 'harms'

Paper J provided the NHS Safety Thermometer prevalence results for November 2013 and remedial action plan for pressure ulcers. The percentage of harm free care for November 2013 was 93.86%. UHL was not an outlier in terms of hospital acquired, avoidable pressure ulcers together with the revised pressure ulcer reduction trajectories for the remainder of 2013-14. VTE prevalence increased from seven in October 2013 to ten in November 2013 – four of the patients were admitted with a pulmonary embolus (although this might not be the reason for the increase in numbers).

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

120/13/5 Nursing Workforce Report

Paper K provided an overview of the nursing workforce position for UHL. Vacancies for nursing and midwifery posts across UHL ran currently running at 544 WTE for October 2013. The Chief Executive requested that the actual number of nurses in the Trust be included in future versions of this report. **DN**

A brief update on bank and agency staffing and international recruitments was provided to the Committee. The staffing data was reviewed twice on a daily basis including weekends and this information would be published on wards by the end of January 2-14.

Members noted that the recruitment trajectory (vacancies, recruitment and turnover) was currently in place until March 2014 and sought assurance about sustainability beyond this period. The Committee Chair requested that although monthly reports on the nursing workforce were presented to the QAC, it was important that a discussion on this matter was scheduled for the Trust Board, as appropriate. **CN**

In response to a query in respect of monitoring the medical workforce, the Chief Executive advised that this matter had also been raised at a recent meeting with the Non-Executive Directors and the Trust's Acting Chairman would be pursuing the way forward.

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

(B) future versions of the nursing workforce report to include the actual number of nurses employed by UHL, and **DN**

(C) a discussion on nursing workforce be scheduled on the agenda for Trust Board meetings, as appropriate. **CN**

120/13/6 Update on NHS Trust Development Authority (NTDA) Visit on 2 and 3 December 2013 to review Infection Prevention procedures

Paper L provided an update on the feedback and suggested actions following a visit from the NTDA to review infection prevention arrangements within UHL. This report would be discussed at the re-established Infection Prevention Assurance Committee and an action plan would be developed. The Committee Chair requested that a verbal update on the actions that had been put in place following the suggestions from the NTDA be presented to the QAC in January 2014. **CN**

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

(B) the Chief Nurse be requested to provide a verbal update on the actions that had been put in place following the suggestions from the NTDA visit to the QAC **CN/TA**

in January 2014.

120/13/7 Report from the Director of Nursing

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

120/13/8 Detailed Report on 5 Critical Safety Actions

Resolved – that this item had been deferred by the Chief Nurse in consultation with the QAC Chair. **AMD**

121/13 ITEMS FOR INFORMATION

121/13/1 DOH Response to Francis Inquiry

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

121/13/2 Accreditation Visits Update

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

121/13/3 Gap Analysis of key recommendations from Francis, Keogh and Berwick Reviews – assurance on the implementation of the action plan further to discussion at Executive Quality Board on 4 December 2013

The Chief Executive noted that some actions in the action plan did not have deadline dates or Committees which would monitor the actions and requested that these be completed. He sought assurance that the various Committees listed in the action plan ensured that the actions were included on the action trackers in order that it would be appropriately monitored. He requested the Trust Administrator to provide the template for the action tracker to the Director of Clinical Quality. The Director of Clinical Quality agreed to ensure that the action plan was complete and the actions were monitored by the various Committees, as appropriate. She also agreed to build in the actions on the work plan for the newly established Executive Quality Board. **TA** **DCQ**

The Chief Executive queried whether the action plan had incorporated the relevant recommendations arising from the second Francis report – in response, the Director of Clinical Quality agreed to liaise with the Chief Nurse in respect of taking it forward.

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

(B) the Trust Administrator to provide the template for the action tracker to the Director of Clinical Quality; **TA**

(C) the Director of Clinical Quality to ensure that:- **DCQ**

- **the action plan key following recommendations from Francis, Keogh and Berwick reviews was complete (with specific dates);**
- **actions were monitored by the various Committees and included on the action trackers;**
- **actions (as appropriate) were included on the work plan for the newly established Executive Quality Board;**
- **a discussion was held with the Chief Nurse in respect of ensuring the action plan included the relevant recommendations from the second Francis report.**

(D) an updated version of the action plan incorporating the actions in point (C) above be presented to the QAC, when available. **DCQ**

121/13/4 Emergency Preparedness, Resilience and Response(EPRR) Self-Assessment Assurance Report

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

121/13/5 Update on Ophthalmology Performance

Resolved – that the report scheduled to be presented to the Finance and Performance Committee on 18 December 2013 had been circulated to QAC members.

122/13 MINUTES FOR INFORMATION

122/13/1 Finance and Performance Committee

Resolved – that the public Minutes of the Finance and Performance Committee meeting held on 27 November 2013 (paper R refers) be received and noted.

122/13/2 Executive Performance Board

Resolved – that the action notes of the Executive Performance Board meeting held on 26 November 2013 (paper S refers) be received and noted.

123/13 ANY OTHER BUSINESS

123/13/1 Report from the Associate Medical Director

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

124/13 IDENTIFICATION OF ANY KEY ISSUES FOR THE ATTENTION OF THE TRUST BOARD

Resolved – that there were no items to be brought to the attention of the Trust Board.

125/13 DATE OF NEXT MEETING

Resolved – that the next meeting be held on Wednesday, 29 January 2013 at 12:30pm in the Large Committee Room, Main Building, LGH.

The meeting closed at 12:41pm.

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

Name	*Possible*	*Actual*	*% attendance*	*Name*	*Possible*	*Actual*	*% attendance*
J Adler	*9*	*5*	*55*	*R Overfield*	*4*	*3*	*75*
*M Caple**	*9*	*8*	*88*	*R Palin**	*4*	*3*	*75*
S Dauncey	*1*	*1*	*100*	*P Panchal*	*9*	*6*	*66*
K Harris	*9*	*7*	*77*	*C Ribbins **	*4*	*3*	*75*
S Hinchliffe	*1*	*1*	*100*	*J Wilson (Chair)*	*9*	*9*	*100*
K Jenkins	*2*	*1*	*50*	*D Wynford-Thomas*	*9*	*6*	*66*
*C O'Brien – East Leicestershire/Rutland CCG**	*9*	*5*	*55*				

- *non-voting members*

- *** records attendance whilst Acting Chief Nurse*

Hina Majeed, **Trust Administrator**

DD

To:	**Trust Board**
From:	**Interim Director of Financial Strategy**
Date:	**30 January 2014**
CQC regulation:	**All applicable**

Trust Board Paper DD

Title:	LHC Final Accounts and Annual Report 2012-13

Author/Responsible Director: Interim Director of Financial Strategy

Purpose of the Report:
The report presents the audited annual accounts (Appendix 1), Trustee's Annual Report (Appendix 2) and letter of representation (Appendix 3) for the Leicester Hospitals Charity for the year ending 31st March 2013.

The Report is provided to the Board for:

Decision		Discussion	
Assurance		Endorsement	✓

Summary / Key Points:
The report details the summary financial performance of the Charity for the year ending 31st March 2013.

On receipt of the final Audit Opinion, the Final Accounts and Annual Return will be submitted to the Charity Commission. The deadline for submission is the 31 January 2014.

Following audit by the Charity's auditors, KPMG, we made a number of presentational adjustments to the accounts. There were no significant issues raised.

Recommendations:

The Trust Board is invited to:

- note the contents of the report and the Letter of Representation;
- approve the Charitable Funds Annual Accounts and Annual Report for the year 2012-13, and
- approve the signing of the relevant certificates by members of the Trust Board (as detailed in the report).

Previously considered at another corporate UHL Committee ? Yes – reported to members of the Charitable Funds Committee on 22nd January 2014.	
Strategic Risk Register N/A	**Performance KPIs year to date** N/A
Resource Implications (eg Financial, HR) N/A	
Assurance Implications N/A	
Patient and Public Involvement (PPI) Implications N/A	
Equality Impact N/A	
Information exempt from Disclosure N/A	
Requirement for further review ? N/A	

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **30th JANUARY 2014**

REPORT FROM: **PETER HOLLINSHEAD**
INTERIM DIRECTOR OF FINANCIAL STRATEGY

SUBJECT: **FINAL ACCOUNTS AND ANNUAL REPORT 2012-13 FOR THE LEICESTER HOSPITALS CHARITY**

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1. INTRODUCTION

1.1 The report presents the audited annual accounts (Appendix 1), Trustee's annual report (Appendix 2) and letter of representation (Appendix 3) for the Leicester Hospitals Charity for the year ending 31st March 2013.

1.2 The accounts and annual report were submitted to members of the Charitable Funds Committee on the 21st January.

1.3 This paper will summarise the headline financial figures and outline the process for finalising and submitting the annual accounts.

2. SUMMARY FINANCIAL PERFORMANCE

Balance Sheet

2.1 The net assets of the Charity have decreased by £342k to £5,171k during the 12 months ending 31 March 2013 (the Income and Expenditure section of this report gives further details).

2.2 The balance sheet shows a movement in net current assets of (£47k) due to a decrease in debtors (£2k), a decrease in creditors £109k and a decrease in cash (£154k) held at year end. This means that the Charity now has net current assets of £238k.

2.3 The balance sheet shows a reduction in the value of fixed asset investments of £295k.

Income & Expenditure

2.4 The Charity has a deficit of £342k on the Statement of Financial Activities. This reflects investment gains of £432k and a net outflow of (£774k) of expenditure compared to income.

Income

2.5 Total incoming resources have decreased from £2,126k in 2011-12 to £2,120k in 2012-13:

- Donated income has decreased from £647k to £563k.
- Legacy income has decreased from £705k to £385k.
- Income from fundraising initiatives has increased from £606k to £978k.

Expenditure

2.6 Total Charity expenditure has increased from £2,395k in 2011-12 to £2,895k in 2012-13:

- Grant expenditure has increased from £2,050k to £2,555k as shown in the following table.

Table 1 – Summary of Grant Expenditure 2011-12 and 2012-13

Grant Category	**2011-12 (£'000)**	**2012-13 (£'000)**	**Change (£'000)**
Patient Benefits	1,005	678	(327)
Staff Benefits	262	225	(37)
Research	68	101	32
Capital Contributions	715	1,551	837
Total	**2,050**	**2,555**	505

3. AUDIT OUTCOME

3.1 Following audit by the Charity's auditors, KPMG, we made a number of minor presentational adjustments to the accounts. KPMG's ISA 260 audit report is included in Appendix 4.

- KPMG expect to issue an unqualified audit opinion on receipt of our signed certificates.
- There are no unadjusted audit differences which need to be reported. All of the adjustments were presentational in nature and were corrected.
- No high or medium level recommendations have been made in KPMG's ISA 260 report.

4. FINAL ACCOUNTS PROCESS

4.1 The Final Accounts are being presented to the Trust Board for adoption.

4.2 On receipt of the final audit opinion, the final accounts and annual return will be submitted to the Charity Commission. The deadline for submission is the 31 January 2014. As in previous financial years, there is an additional requirement to submit a summary information return to the Charity Commission outlining key aspects of the Charity. The information provided in this return reflects particular items within the annual accounts and annual report.

5. LETTER OF REPRESENTATION

5.1 Appendix 3 contains the proposed Letter of Representation from KPMG and they do not require any specific representations.

5.2 Copies of the Certificates will be circulated separately.

6. RECOMMENDATION

6.1 The Trust Board is invited to:

- **note the contents of the above report, and the Letter of Representation;**
- **approve the Charitable Funds Annual Accounts and Annual Report for the year 2012-13, and**
- **approve the signing** *(in non-black ink)* **of the relevant certificates by members of the Trust Board, as follows** *(signatories are shown in brackets)***:**
  - **Charitable Funds – Statement of Trustee's responsibilities in respect of the Trustee's annual report and the financial statements** *(Chairman, and the Interim Director of Financial Strategy acting on behalf of the corporate trustee)***;**
  - **Balance Sheet** *(a member of the Trust Board acting on behalf of the corporate trustee)***, and**
  - **Management Letter of Representation** *(Chairman)*.

PETER HOLLINSHEAD
INTERIM DIRECTOR OF FINANCIAL STRATEGY

Statement of Trustees Responsibilities

Audit opinion

LEICESTER HOSPITALS CHARITY

TRUSTEE'S ANNUAL REPORT
FOR THE YEAR ENDED 31 MARCH 2013

Chairman's Foreword

Every year, the University Hospitals of Leicester NHS Trust holds its Caring at Its Best Awards, to recognise the excellent work carried out by individuals, teams and volunteers working for us. The event is funded by Leicester Hospitals Charity, and sponsored by some of our key corporate partners. It is a recognition in part of how much we achieve through collaboration between staff, business partners, our own charity and other voluntary organisations committed to caring at its best.

It is clear when travelling around our hospitals as I have done for the past six years, what added value we derive from Leicester Hospitals Charity and the other charitable organisations and volunteers who support us in many different ways.

During the past year we saw the successful opening of the new children and young people's cancer unit at the Leicester Royal Infirmary. It cost £1.4 million to build, and was a successful collaboration between the Teenage Cancer Trust, the Robbie Anderson Cancer Trust, Leicester Hospitals Charity and many others, including the Kay Kendall Leukaemia Fund, the Garfield Weston Foundation, Leicestershire and Rutland Community Foundation, and many hundreds of families, community groups and individuals who all made such an ambitious project a reality. The new unit has surpassed all expectations; the young people being treated there treat the unit as their own space, and the feedback from the staff is very positive.

We also were fortunate to receive many other gifts, which enabled us to make other smaller but equally important improvements to our hospitals. We provided £400 to fund clocks which show the day, time and date and for brain injury unit. Brain injured patients can "lose" gaps of time, and clocks like these make it much easier to keep track.

We continued to fund additional training for staff [example?] Better trained staff are in a position to enrich the service and care they offer to patients, which benefits everyone.

Finally, after nearly seven years as Chairman of both the Trust and Leicester Hospitals Charity, it is time to say farewell as I move on to another role. I have been constantly impressed with the commitment and passion shown by staff, and the unceasing generosity I have witnessed at first hand of people who have given so much to us through Leicester Hospitals Charity. I wish the Charity and the staff at our hospitals every success in the future.

The Charity's annual report and accounts for the year ended 31 March 2012 have been prepared by the Corporate Trustee in accordance with Part VI of the Charities Act 1993 and the Charities (Accounts & Reports) Regulations 2008. The Charity's report and accounts include all the separately established funds which benefit the staff, patients, their carers and the communities served by the Leicester Hospitals Charity.

I finish this foreword with a huge thank you to all those who have supported Leicester Hospitals Charity over the past year, and who continue to support us. We are deeply grateful for all that you help us to achieve.

Our Mission Statement

Leicester Hospitals Charity (the Charity) exists to provide support to patients, their carers and the NHS staff who look after them in Leicester, Leicestershire, Rutland and beyond.

It does this through targeted fundraising campaigns and effective management of donations, to provide additional resources, assets and skills which link closely with the strategic aims of UHL and the broader strategic aims of NHS healthcare in the East Midlands.

Our objectives for achieving the public benefit

The Charity aims to achieve benefit for the public in all of its activities.

UHL's Trust Board reviews the Charity Commission's general guidance on public benefit when setting the terms of reference for the Charitable Funds Committee.

The Charitable Funds Committee takes account of the Charity Commission's guidance on public benefit in planning the budget for each year and in setting or reviewing the guidelines for Fund Advisers, who are authorised to spend charitable funds.

The funds of the Charity comprise primarily of donations and legacies from members of the public and private organisations. The Charity's overall objective is to use these funds to benefit the public.

The Charity achieves this by ensuring that its funds are used for the following purposes:

- to purchase medical, surgical and other equipment and services;
- to purchase or construct assets for donation to the Trust; and
- to fund research projects.

These activities benefit the public are not covered or are not fully supported by core NHS funds. The Charity defines the public as patients, their carers and the NHS staff who look after them in Leicester, Leicestershire, Rutland and beyond.

All grant applications from the Trust for charitable expenditure are subject to review and challenge before they are approved. All applications are reported to the Charitable Funds Committee and this includes confirmation that the expenditure is for the public benefit and cannot be met through core NHS funds.

Leicester Hospitals Charity is at its most effective when it combines the expertise and commitment of highly skilled NHS staff, with the generous

support of the Leicester, Leicestershire and Rutland communities, to bring about better quality care and support for patients.

The Corporate Trustee confirms that it has referred to the guidance contained in the Charity Commission's general guidance on public benefit when reviewing the Trust's aims and objectives and in planning future activities and setting the grant making policy for the year

Our Achievements in 2013

Throughout 2012-13 the Charity has continued to support a wide range of charitable and health related activities for the benefit of patients, their carers, and staff.

The Charity's funds are used to purchase goods and services that provide additional benefits to patients and staff over and above that provided by the Trust itself.

In 2012-13 we received the following income:

- £563k of donations;
- £385k of legacies;
- £978k of fundraising income; and
- £194k of investment income.

We contributed £2,556k to the Trust for the benefit of its patients and staff.

OurSpace Appeal

The Charity has undertaken a number of fundraising initiatives in the year, including of the most ambitious campaign in the Charity's history, the OurSpace appeal, which successfully raised £1.2 million in just under two years.

Together with Teenage Cancer Trust (which contributed £500k) and with support from the Robbie Anderson Cancer Trust, we embarked on a project to transform our children and young people's cancer unit on ward 27 at Leicester Royal Infirmary.

In February 2013, the unit was opened and has totally transformed the environment in which children, teenagers and young adults are treated. The careful use of design, lighting and colour has turned an ordinary hospital ward into a space that children and young people will find stimulating, whatever their age.

Features of the new unit include:

- Dedicated medical and play facilities for children, including games and televisions.

- A Teenage Cancer Trust unit that provides separate medical and recreational facilities for teenagers and young people aged 13 to 24, including games, televisions and internet access.
- A Teenage Cancer Trust youth support coordinator to ensure that teenagers and young adults receive the emotional, social and practical support that they need.
- Dedicated outpatient and day case treatment areas within the children and young people's cancer unit.
- An integrated team of specialist nurses, doctors and healthcare professionals from adult and children's medicine.
- Specially trained staff to assist with social and educational activities; and to provide emotional support.
- Support for families with a child or young person on the unit.

Dr Fiona Miall, one of our consultant haematologists said:

"The hospital environment can be an intimidating and confusing place for anyone, but especially for children and young adults. The new unit will be a place for children just to be themselves - for younger children that could mean playing games or reading. For teenagers the space will allow them to socialise or study, listen to music or surf the internet. We want to improve the quality of the accommodation and the services we offer to young cancer patients and their families to make a positive impact on their experience with us."

Tim Diggle, our head of fundraising at Leicester Hospitals Charity, said:

"Raising the funds needed in the current economic climate is going to be a challenge, but anyone who has had experience of a young child with cancer knows how important this new unit is. We really hope that families and communities across Leicester, Leicestershire and Rutland can support this campaign and help provide the best possible facilities for all children and young people living with cancer."

Making a difference to the public

Charitable funds have also been used to purchase a number of vital items of equipment for use within the Trust, including:

- a Thulium laser, used in prostate surgery;
- a Fibroscan machine, used in the treatment of liver disease; and
- a Liquichip workstation used in the delivery of laboratory services to prospective renal patients.

In addition to contributing to the Trust's building works and equipment purchases, the Charity funds a number of initiatives to benefit staff and patients. The following posts have been funded by the Charity:

- a Time for a Treat Co-ordinator;
- a Meaningful Activities Co-ordinator; and

- a Volunteer Services Placement & Project Officer.

The following activities were funded by the Charity in 2012-13:

- the 2012 festive meal;
- the staff awards ceremony; and
- the ongoing funding of retirement gifts.

The Charity has also funded training and research projects during the year.

How we have raised the funds

As well as the vast number of individual donations into the appeal, we raised £19k at the OurSpace Celebration Ball in November 2012. This was held at the Kingpower Football Stadium and included live music; a fashion show featuring John Lewis; a charity draw and auction; and a disco.

We had great support from Leicester City Football Club for the OurSpace Appeal which was chosen as one of the charities for the Foxes Foundation and Alan Birchenall's 'One in a Million Campaign'. Radio Leicester's Ian Stringer joined a number of UHL fundraisers in running the London Marathon and the Charity was presented with £18k on the pitch in August 2012. – thanks to the Blue Army!.

Brown Dog cancer charity supported us again this year by raising £30k from their 2012 Peaks Challenge in which several doctors and nurses from UHL took part. The money, raised for the OurSpace Appeal, was used for one of the side rooms on ward 27. We are extremely grateful to all the members of Brown Dog for their continued support for cancer patients at UHL.

We had vast numbers of fundraisers who contributed to the OurSpace Appeal. A particularly noteworthy contribution was in connection with young cancer patient who asked her doctor at UHL, Professor Martin Dyer, if there was any problem with her having a tattoo. To raise money for OurSpace, Professor Dyer decided to join her in having the same image of a toucan tattooed on his bottom!. He raised an amazing £8k for the OurSpace Appeal by undertaking this one off venture through sponsorship from family, friends, patients and colleagues.

We held the biennial Kidney Care Appeal sponsored walk at Ratcliffe College on Sunday 17th June 2012. Donations sent in prior to the walk and on the day; and sponsorship money raised from the 111 walkers made just over £25k. We also held a Kidney Care Appeal spring raffle which was drawn on 21st March 2013 and raised a further £9k.

Donations and legacies

Wards continue to receive donations specifically given to thank the staff who care for the patients, and these are used for charitable activities that benefit staff. The charitable funds also enable consultants and other medical staff to

attend courses, not funded by the NHS, which will update them on the new ideas and modern techniques in their specialties.

The Charity has also received a number of large legacies in the year. Further information in respect of donations and legacies is given in the Governance and Finance section of this report.

Ongoing Appeals

We continue to work with the renal team in managing the Kidney Care Appeal and the orthopaedic team in managing the Foxtrot sponsored walk.

The Lord Mayor's stroke appeal is due to reach its conclusion in 2013. We are confident of exceeding our target of £60k. We are working closely with the Stroke team to ensure the funds raised are invested as widely as possible across the stroke pathway.

Staff Lottery and wellbeing at work

We continue to manage the UHL staff lottery, and assist in its marketing and promotion to new and existing staff. The staff lottery has a recurrent turnover of more than £185k per year. Consideration will be given to creating a separate public lottery to increase available funds. The Lottery funds the Wellbeing at Work programme which offers discounted and free activities and therapies to members of staff to help them achieve a healthier lifestyle.

Innovation Awards

The two rounds of Innovation Awards run in the last four years have shown there are members of staff with really good ideas who just need support to develop them further. We continue to support the Innovation Awards, and will develop our approach to work more effectively in partnership with, among others, our key corporate supporter, Next PLC.

Parent accommodation

We have worked with CICU to renovate the three parent accommodation rooms at the LRI, adjacent to the CICU. A number of parents gave support and made donations to fund this work. We are working with the Women and Children's Division to establish an interim solution for improved parent accommodation whilst plans for the Children's Hospital are worked through.

The Charity's Future Plans

Over the next five years Leicester Hospitals Charity will support UHL's plans to become internationally recognised for placing quality, safety and innovation at the centre of its service provision. We will seek to enhance the funding available for specialised services, research, teaching, and high quality patient

care. We will support staff development and an improved patient experience. Our aim is to support UHL in providing “Caring at its best”.

Our fundraising targets will be based around the identified need of each project. Working closely with clinical colleagues and senior UHL management, we will identify priority capital projects.

We will support the production of compelling cases of need to maximise our success in securing the necessary funds for each project. Most of the projects are still in the feasibility stage, but the early indications are that the Charity will need to increase its average annual fundraising income from £1.5 million to more than £2.2 million. The growth in income will come primarily from capital appeals.

The success of the OurSpace appeal has given us the confidence to consider other, more ambitious fundraising campaigns. Other than the £500k received from the Teenage Cancer Trust, the largest single donation was £90k, and the top twelve donors provided 50% of the funds needed for the appeal. Five of the significant gifts came from grant-making trusts, two were legacies and two corporate gifts.

Experience from across the charity sector suggests that in order to succeed, capital appeals need to secure gifts at this level as a proportion of the total amount raised.

The success of the appeal has also raised awareness amongst staff of the potential to use external funds to support new projects and enhance existing services.

In order to achieve the step-change in income that the OurSpace appeal required, the fundraising team dedicated resources and time into identifying and cultivating donors who could give significant gifts to the appeal.

Three possible major capital campaigns are currently being considered in the Trust, including:

- **Hybrid Theatre - £1.5 million**
  As part of the business plan for the Acute Division, a need has arisen for a hybrid theatre to be created at the Glenfield General Hospital. The Fundraising team are currently working with the clinicians to develop the business case and case of need.

- **Renal transplant and research project - £18 million**
  The University of Leicester have identified a potential major gift to support renal transplant and research. The fundraising team are looking at whether there is scope to collaborate and create a joint fundraising campaign to enable this project to go ahead.

- **Children’s Hospital – cost to be determined**
  The concept of a children’s hospital has long been a desire for the Women’s and Children’s Division. Under the new strategic direction, all paediatric services are to be managed by the Women’s and Childrens

Division. The Fundraising team will work with the Division to establish whether there is a viable project for a capital appeal.

We are also are looking at fundraising for a series of improvements to Children's Services through an overarching appeal.

Fundraising Strategy

In order to strengthen the fundraising function of the Charity we plan to refine our fundraising strategy. There are three elements to the strategy:

- Use of existing funds (leverage)
- Building and maintaining relationships with funding partners
- Creating and managing our own fundraising appeals; using those appeals to strengthen, develop and increase the size and scope of the fundraising team and the donor pool

There is a need to significantly increase the value of funds raised in order to fund the planned spend. This significantly increases the risk of shortfall in existing available funds should insufficient new funds be raised.

To mitigate this risk, each new major project needs to be viable on its own merits, as well as fitting in to the broader strategic direction of the Trust. In addition, the Charity plans to broaden its fundraising scope to increase the level of unrestricted funds coming in to the Charity.

We plan to identify and secure lead gifts early on in each campaign. Conducting the process of gift solicitation in the private, or silent, phase of the campaign also provides for a way to stop the campaign at an early stage, should the required gifts not be forthcoming.

This approach also means that the resources needed for each campaign can be outlined and agreed in advance, but only deployed should the campaign gather momentum and move to completion.

Each new project will start with:

- a planning template;
- a business case, supported by the relevant division(s) and approved by Commercial Executive; and
- a case of need, or support, to test the fundraising viability.

Each project will have a dedicated fundraising campaign lead (from the Charity), and a project leader (from the division) as a minimum. These two people will need to be given sufficient capacity to undertake full project evaluation and planning, and the ability to call on further support during the implementation phase.

Marketing and Communications

Communications runs through everything we do. The Charity has to continually make the case to secure funding and to encourage staff to make use of the funds

available. We will continue to work closely with our colleagues in communications, graphics and knowledge management to ensure our communications messages are as well-defined and accurate as they can be.

An identity for each fundraising appeal

The method of creating a separate appeal identity has been successful so far. We intend to continue to create separate brand identities for large-scale fundraising appeals, particularly where the beneficiaries can be clearly defined (e.g. the OurSpace appeal was for children and young people with cancer; the Forget-me-not appeal was for patients with dementia).

At the same time we will continue to refine the Leicester Hospitals Charity brand, with the Dr Fox logo, to try and improve recognition amongst staff, patients, visitors and the general public.

This year we will also be creating a booklet aimed specifically at staff, explaining in detail what the Charity does to benefit them and how they can apply for funds for their area of work. We also plan to promote the Charity to groups of staff through attendance at meetings such as the corporate induction programme.

All marketing and communications materials will be created to work in hard copy and online formats.

Governance and Finance

Trustees

The Charity has a Corporate Trustee, the University Hospitals of Leicester NHS Trust. The members of the NHS Trust's Board who served during the financial year were as follows:

Name	Title
M Hindle	Chairman
M Lowe-Lauri	Chief Executive
A Seddon	Director of Finance and Procurement
S Hinchliffe	Chief Operating Officer / Director of Nursing
K Harris	Acting Medical Director
K Bradley	Director of Human Resources
Professor D Wynford-Thomas	Non Executive Director
I Reid	Non Executive Director
D Tracy	Non Executive Director
R Kilner	Non Executive Director
J E Wilson	Non Executive Director
K Jenkins	Non Executive Director
P Panchal	Non Executive Director

The above members of the Trust Board have complied with the duty in section 4 of the Charities Act 2006 to have due regard to public benefit guidance published by the Commission.

Structure

The Leicester Hospitals Charity (the Charity) was formed in April 2000. This followed the merger of three separate NHS Trusts, the Leicester Royal Infirmary, Leicester General Hospital and Glenfield General Hospital Trusts, as the University Hospitals of Leicester NHS Trust (the NHS Trust). This resulted in the creation of one overall umbrella Charity, then known as the University Hospitals of Leicester NHS Trust Charitable Funds.

The Charity was renamed as the Leicester Hospitals Charity in 2007 to give it its own separate identity. The Charity's governing document is a Declaration of Trust dated 19th June 1996 and amended by supplemental deeds dated 28th March 2002 and 1st March 2007.

The Charity holds restricted, unrestricted and endowment funds. Separate funds are held for each of the Trust's operational areas.

Governance

The NHS Trust's Board (the Board) acts as Corporate Trustee and has overall responsibility for the management and activities of the Charity. Non-Executive members of the Board are appointed by the NHS Appointments Commission and Executive members are subject to recruitment by the Board. Members of the Board are not individual Trustees under Charity Law but act as agents on behalf of the Corporate Trustee.

The Corporate Trustee fulfils its legal duty by ensuring that funds are spent in accordance with the donor's wishes and the objects of each fund. By designating funds the Trustee respects the wishes of our generous donors to benefit patient care and advance the good health and welfare of patients, their carers and the staff who look after them.

New members of the Trust Board who sit on the Charitable Funds Committee are provided with an introduction to the Charity as part of their induction programmes within the NHS.

The Charitable Funds Committee (the Committee) acts for the Corporate Trustee and is responsible for the overall management of the funds, and for ensuring that Trustees are regularly apprised of changes in legislation and other important issues relating to Charities. The Committee meets every two months and its core membership includes Executive and Non-Executive Directors. The Chairman of the Committee is also the Chairman of the NHS Trust. Additional attendees are also invited, including senior Finance staff, the Trust Administrator and a representative from the Fundraising Team. Investment managers and other NHS staff are also invited to attend on an ad-hoc basis.

The Committee is responsible for:

- controlling, managing and monitoring the use of the Charity's resources for the public benefit, having regard for the guidance issued by the Charity Commission;

- providing support and guidance for its income raising activities whilst ensuring that the receipt of all income is effectively managed;
- ensuring that 'best practice' is followed in the conduct of all its affairs fulfilling all of its legal responsibilities;
- ensuring that the Investment Policy approved by the Trust Board as Corporate Trustee is adhered to and that performance is continually reviewed, whilst being aware of ethical considerations; and
- keeping the Trust Board fully informed on the Charity's activity, performance and risks.

Management

There is a designated Charitable Funds Finance Team within the NHS Trust's Finance directorate which comprises of three members of staff including the Charity Finance Manager. This team is primarily responsible for the maintenance of accounting records and administration of the funds. Their salaries are recharged back to the Charity along with associated accommodation costs. A service level agreement is in place between the Charity and the Trust covering the provision of the service.

The Charity also has a Fundraising Team which comprises of four members of staff, including the Head of Fundraising. This team is responsible for the coordination, management and reporting of appeals as well as providing support and advice to the Trust's wards and departments about their own specific income generation activities.

The Charity's Fundraising Team provides a point of contact for donors and fundraisers and coordinates the publicity aspects of fundraising events. The Fundraising Team also has an integral role to play in the wider promotion and marketing of the Charity in order to encourage additional voluntary income over and above that generated from specific appeals. All fundraising staff are employed by the Trust and the costs are recharged to the Charity.

Maintaining a healthy balance sheet

The assets and liabilities of the Charity as at 31 March 2013 are stated below, compared with the position at 31 March 2012.

	Total Funds 2012-13	Total Funds 2011-12
	£000	£000
Fixed Asset Investments	4,933	5,228
Net Current Assets	238	285
Total Net Assets	**5,171**	**5,513**
Funds of the Charity		
Endowment Funds	1,095	1,005
Restricted Funds	673	540
Unrestricted Funds	3,403	3,968

Total Funds of the Charity	**5,171**	**5,513**

Useful definitions:

Fixed Asset Investments are investments in quoted stocks and shares.

Net Current Assets represent cash held on deposit plus debtors less the value of outstanding liabilities.

Endowment Funds represents endowments which are held in perpetuity so that only the income is available for distribution.

Restricted Funds represents money which is held by the Trustees which can only legally be used for specified purposes.

Unrestricted Funds are funds available to be spent within the objects of the Charity which can legally be spent wholly in accordance with the discretion of the Trustees.

Sources of funds

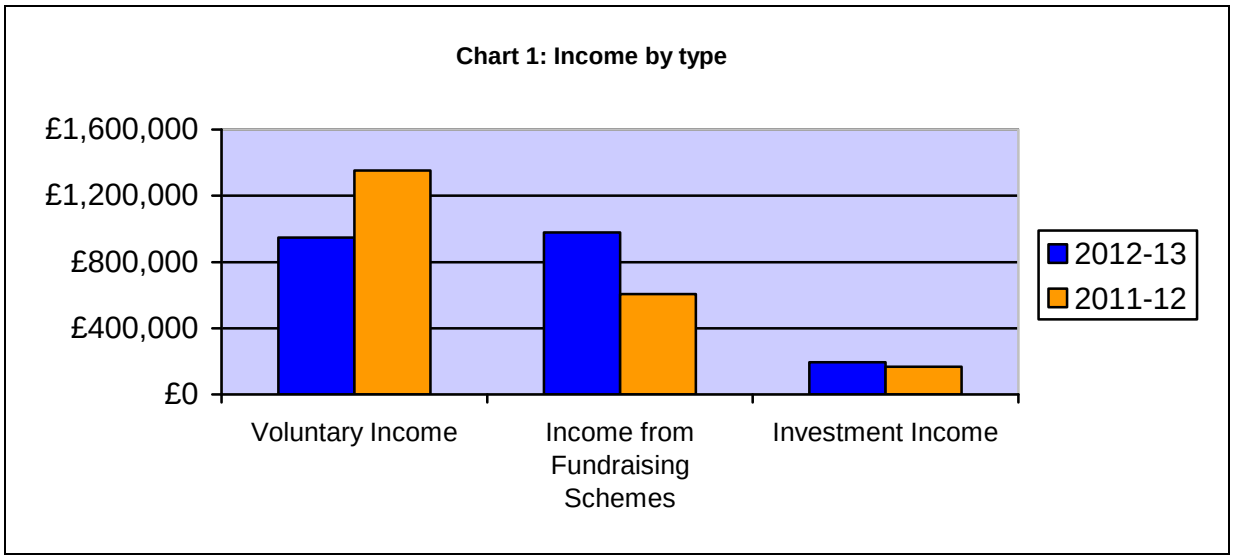
Incoming resources decreased slightly from £2,126k in 2011-12 to £2,120k in 2012-13. Fundraising income increased by £372k and legacies decreased by £320k.

Total resources expended have increased from £2,395k in 2011-12 to £2,896k in 2012-13 mainly due to an increase in charitable activities of £506k a large element of which is due to the OurSpace scheme.

The Charity generated a £342k deficit on the Statement of Financial Activities, with an excess of expenditure compared to income of (£774k) and an investment gain of £432k.

Although the Charity understands the importance of maintaining a healthy balance sheet and an adequate level of funds it does not plan to generate a surplus each year. The Charity's view is that where there is an excess of available funds over the minimum required level then these funds should be utilised. In some years it is appropriate for spending to exceed income, as was planned in 2012-13, and particularly where a large scheme is being funded following a fundraising campaign.

Income performance was as follows:



- **Voluntary Income (Donations and Legacies)**
  The level of income from donations and legacies decreased from £1,352k in 2011/12 to £948k in 2012-13.

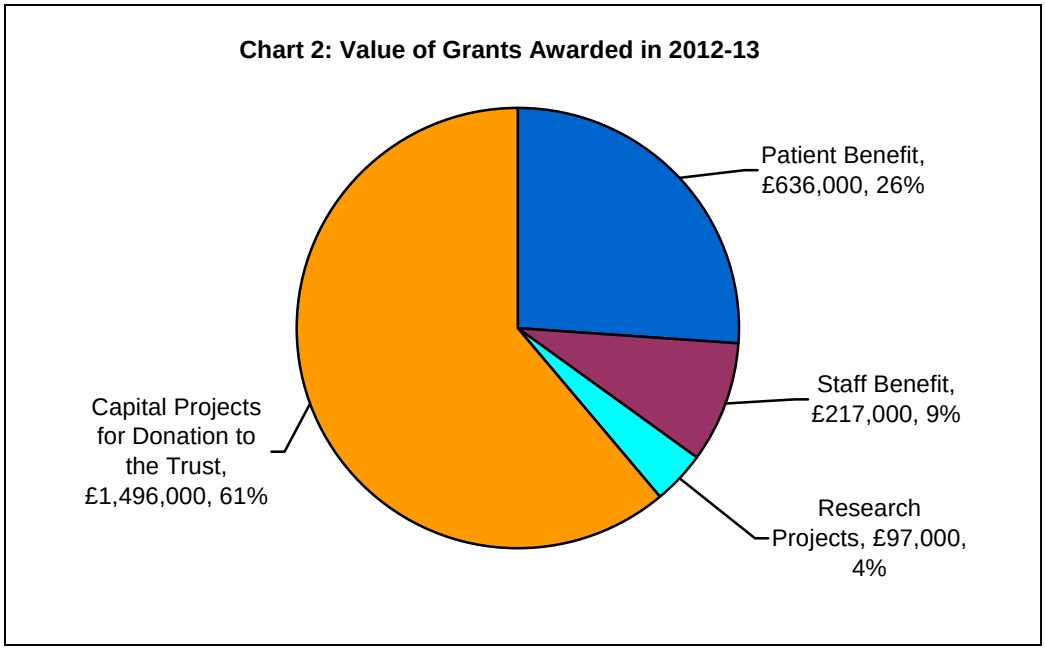
  Voluntary income most notably included legacies of £65k and £68k. Donations from the WRVS totalled £89k in the year. A further £43k was raised through the gift aid scheme.

- **Income from Fundraising Activities**
  A total of £792k was raised through fundraising schemes, including £688k for the OurSpace appeal.

- **Investment Income**
  During the year, the total return, including dividends and interest, was £194k. The Charity also benefited from investment gains of £432k (loss of £80k in 2011-12) reflecting the performance of the stock market over the last twelve months.

Where we spent the money

The awarding of grants represents the main activity for the Charity. During the 2012-13 financial year, the Charity expended approximately £k in grants as shown below:



Grants to provide benefits to patients
The Charity spent £636 on grants to benefit the Trust's patients, including:

- Purchases of Equipment to Supplement Wards and Departments £229k
- Furnishings of Patient Areas £294k

Grants to provide benefits to staff
The Charity spent £217k on grants with a purpose to provide benefits to the Trust's staff, including:

- UK and Overseas Course Fees, Study Leave and Travel £23k
- Social Activities £55k
- Furnishing Improvements to Staff Areas £30k
- Prize giving £22k
- Wellbeing at work (including other miscellaneous expenditure) £71k

Capital projects for donation to the NHS Trust
The Charity spent £1,496k on grants with a purpose to provide benefits to the Trust's patients and staff through capital expenditure, including:

- OurSpace construction works £1,060k
- Medical and dental equipment £272k
- Computer and other equipment £50k

Grants awarded for research projects
The Charity has a number of research funds and during the year £97k was spent on research related activities. The majority of this expense (£69k) related to the purchase of equipment for use in research activities.

Risk Management

The Charity has identified no new material risks during 2012-13, with the main risk being the potential loss from a fall in the market value of investments.

The Charity has established an investment strategy to mitigate this risk, which requires an investment portfolio which balances risk and return, and includes investments which can be converted to meet short term cash requirements. New investment managers have been appointed in the year and they act in accordance with the Charity's investment strategy.

Financial reports are presented to the Charitable Funds Committee and any significant trends and risks are highlighted in the commentaries supporting the reports. Other low priority operational risks relate to the grant application process and the financial system risks around the receiving of donations, ordering of goods and services and payment of invoices.

Appropriate controls and systems have been established to mitigate these risks, including the Charity adopting UHL's standing orders and standing financial instructions. Assurances are obtained from internal audit that these controls are operating effectively and for 2010-11, Internal Audit gave the Charity significant assurance that there is a generally sound system of control designed to meet the system's objectives.

The Trust's Audit Committee routinely receives updates on the Charity's performance and is responsible for the controls over the financial probity and management of the Charity and for overseeing the work of the auditors.

Grant Making Policy

The use of our funds is restricted by the governing document which established the Charity to purposes connected with the NHS. When approving grant expenditure consideration is first given to the public benefit that will be generated from the expenditure, as this is a core value in our activities.

The main activity for the Charity is the awarding of grants to UHL. Grants are awarded through the scheme of delegation, and authorisation is dependant on the fund's purpose and the value of the application. The grant application process ensures that individual funds are not able to commit expenditure in the absence of available funds.

Grant applications are subject to robust review and challenge before they are approved, including a review as to whether the expenditure is for the public benefit and cannot be met through core NHS funds.

Where expenditure relates to the purchase of medical equipment there is an expectation that the NHS Trust Medical Equipment Panel approves these before any application is submitted for consideration. This ensures that there remains consistency between the capital expenditure plans of the NHS Trust and the Charity in terms of capital planning, and compatibility with existing resources.

The Committee approves grants up to £25,000 in relation to the use of the Charity's funds The Charity Finance Manager is empowered by the Committee to consider and approve all grant applications of up to £10,000 from restricted or designated funds within the criteria set by the Committee. A report is presented to the next meeting of the Committee which details these approvals.

Applications involving proposed expenditure of £25,000 or more are referred to the NHS Trust Board, as Corporate Trustee, with the Committee's recommendation as to whether or not they should be approved or rejected.

Reserves

The Charity has a reserves policy as part of its overall plan to provide long term support to the NHS Trust. The Corporate Trustee has held the view that income donated to charitable funds should be expended in a timely way in accordance with the donor's wishes. This does not prevent any individual departments building up fund balances in order to purchase larger items in the future. Fund Managers submit annual plans to the Charitable Funds Committee. These are regularly monitored to ensure that funds are spent in a timely manner and in accordance with the donors' wishes.

The Corporate Trustee's intent is that designated funds are spent within a reasonable period of receipt and therefore foresee a need to only maintain reserves at a sufficient level to provide certainty of funding for the ongoing costs of the Charity.

The Charity has calculated that it needs to maintain total freely available reserves of at least £80k to meet its ongoing running costs and to meet expected future commitments. This level of funds represents the amount that would be required to wind the Charity down should the need ever arise. The Charity Commission defines reserves as the part of the Charity's funds which are "freely available" and excludes endowment, restricted and committed funds. The level of reserves available for general use as at 1st April 2013 is as follows:

Breakdown of reserves	£'000
Total funds	4,933
less restricted funds	(609)
less endowments	(1,096)
less committed funds	(761)
Freely available reserves	2,467

The Charity has a sufficient level of freely available reserves, although these are significantly higher than the required level. The Corporate Trustee recognises the need to identify plans to utilise these reserves and continues to work with the Trust's divisions to coordinate the Charity's expenditure plans with broader divisional plans.

As well as the £1,096k commitments shown above, we are also anticipating further expenditure of £500k within the year based on the historic level of ad-hoc applications.

Our Investments

The investments of the Charity are managed by Cazenove Capital Management (Cazenove) with the emphasis on maintaining a high level of liquidity and a low to moderate investment risk.

As part of the investment policy, Cazenove has the delegated authority to invest funds into equity, property and bond markets as well as maintain cash holdings. The investment firm are expected to work within the agreed portfolio mix shown below.

Investment Class	Permissible Range (%)	Proportion as at 31/03/13 (%)	Proportion as at 31/03/12 (%)
Equities (UK/Overseas)	35 to 65	61.8	55.4
Bonds	No restriction	25.3	25.6
Portfolio funds	No restriction	8.7	0
Hedge funds	0 to 10	0	4.9
Property	0 to 10	3.8	8.2
Cash	No restriction	0.4	6.0

The following restrictions also apply to the Charity's investment portfolio:

- investments that are not readily realisable must not exceed 10% of the total portfolio;
- investment in any one issuer's securities should not exceed 10%; and
- payment must be made on demand to the Charity in line with agreed procedures and approved signatories.

The Charity's governing document imposes two further restrictions on the Charity's power to invest funds:

- The Charity must not make any speculative or hazardous investment (and for the avoidance of doubt, this power to invest does not extend to the laying out of money on the acquisition of futures or traded options); and
- The Charity must not engage in trading ventures

The Charity does not wish to invest in companies whose principal activities are tobacco related. The Charity accepts that the investment in common investment funds (and similar products) may give the Charity indirect exposure to tobacco related investments.

The Charitable Funds Committee reviews investment management performance at each meeting. The investment managers provide the Charity with monthly performance reports highlighting performance against key indices such as the FTSE All Share Index. The investment managers also provide the Charity with a commentary in relation to the portfolio and market outlook. The Charity receives

regular advice from its investment managers and reviews opportunities to amend the Investment Strategy.

The Charity does not apportion unrealised investment gains or losses across funds unless they are in excess of £250k.

Reference & Administrative Details

Charity Name	Leicester Hospitals Charity	
Charity Address	Trust Headquarters Level 3, Balmoral Building Leicester Royal Infirmary Infirmary Square, LE1 5WW	
Registered Number	1056804	
Charity Staff	Tim Diggle	(Head of Fundraising)
	Debbie Adlerstein	(Community and Events Fundraising Manager)
	Marie Hough	(Fundraising Administrator)
	Maxine Walmsley	(Fundraising Events Assistant)
	Nick Sone	(Charity Finance Lead)
	Julie Woolley	(Charity Finance Manager)
	Mandy Tuddenham	(Charitable Funds Assistant)
Internal Auditors	PricewaterhouseCoopers LLP Cornwall Court, 19 Cornwall Street Birmingham B3 2DT	
External Auditors	KPMG LLP One Snowhill Snow Hill Queensway Birmingham B4 6GH	
Solicitors	Eversheds 1 Royal Standard Place Nottingham NG1 6FZ	
Bankers	The Royal Bank of Scotland St Johns House East Street Leicester LE1 9NB	

Investment Managers	Cazenove Capital Management Limited 12 Moorgate London EC2R 6DA
Corporate Trustee	University Hospitals of Leicester NHS Trust Trust Headquarters Level 3, Balmoral Building Leicester Royal Infirmary Infirmary Square, LE1 5WW

Thank You

On behalf of all the patients who continue to benefit from improved services due to donations and legacies, Leicester Hospitals Charity would like to thank all patients, relatives, staff and partners for their support.

If you want to know more about how to become involved in the work of the Trust, or take part in fundraising activities, or simply make a donation, contact the Leicester Hospitals Charity Fundraising team on 0116 258 8709, or email fundraising@uhl-tr.nhs.uk.

KPMG LLP
One Snowhill
Snow Hill Queensway
Birmingham
B4 6GH

30th January 2014

Dear Sirs

This representation letter is provided in connection with your audit of the financial statements of Leicester Hospitals Charity ("the Charity"), for the purpose of expressing an opinion as to whether these financial statements give a true and fair view of the financial position of Leicester Hospitals Charity and of its financial performance in accordance with UK Generally Accepted Accounting Practice. These financial statements comprise the balance sheet as at 31 March 2012, and the statement of financial activities for the year then ended, and a summary of significant accounting policies and other explanatory notes.

We acknowledge as Corporate Trustee ("the Trustee") our responsibilities under the Charities Act 1993 for preparing financial statements which give a true and fair view of the Charity.

We also acknowledge as Trustee our responsibilities under the Charities Act 1993, for making accurate representations to you and for ensuring that there is no relevant audit information that you are unaware of.

The Trust Board approves the financial statements.

The Board understands that auditing standards require you to obtain representations from the Trustee on matters that are material to your opinion. The Board understands that omissions or misstatements of items are material if they could, individually or collectively, influence the economic decisions of users taken on the basis of the financial statements. Materiality depends on the size and nature of the omission or misstatement judged in the surrounding circumstances. The size and nature of the item, or a combination of both, could be the determining factor.

The Board has made appropriate inquiries of the Trustee and officers of the Charity with the relevant knowledge and experience. Accordingly, the Board confirms, to the best of its knowledge and belief, the following representations:

1. The financial statements referred to above, which have been prepared on a going concern basis, give a true and fair view in accordance with UK Generally Accepted Accounting Practice.

2. All the accounting records have been made available to you for the purpose of your audit and the full effect of all the transactions undertaken by the Charity have been adequately reflected and recorded in the accounting records in accordance with agreements, including side agreements, amendments and oral agreements. All other records and related information, including minutes of all management, committee Board and Trustee's meetings and, where applicable, summaries of actions of meetings held after period end for which minutes have not yet been prepared, have been made available to you.

3. The Board is not aware of any known actual or possible non-compliance with laws and regulations that could have a material effect on the ability of the Charity to conduct its business and therefore on the results and financial position to be disclosed in the financial statements for the year ended 31 March 2011.

4. The Board:

(a) understands that the term "fraud" includes misstatements resulting from fraudulent financial reporting and misstatements resulting from misappropriation of assets. Misstatements resulting from fraudulent financial reporting involve intentional misstatements including omissions of amounts or disclosures in financial statements to deceive financial statement users. Misstatements resulting from misappropriation of assets involve the theft of an entity's assets, often accompanied by false or misleading records or documents in order to conceal the fact that the assets are missing or have been pledged without proper authorisation.

(b) acknowledges responsibility for the design and implementation of internal control to prevent and detect fraud and error.

(c) has disclosed to you our knowledge of fraud or suspected fraud affecting the Charity involving:

- management and those charged with governance;

- employees who have significant roles in internal control; or

- others where the fraud could have a material effect on the financial statements.

(d) has disclosed to you its knowledge of any allegations of fraud, or suspected fraud, affecting the financial statements communicated by employees, former employees, analysts, regulators or others.

(e) has disclosed to you the results of its assessment of the risk that the financial statements may be materially misstated as a result of fraud.

6. The Board confirms the completeness of the information provided to you regarding the identification of related parties and regarding transactions with such parties that are material to the financial statements. The identity of, and balances and transactions with, related parties have been properly recorded and when appropriate, adequately disclosed in the notes to the financial statements. The Board is not aware of any other such matters required to be disclosed in the financial statements, whether under FRS 8 *Related Party Disclosures* or other requirements. Included in Appendix A to this letter are the definitions of both a related party and a related party transaction as the Trustee understands them and as defined in FRS 8.

7. Presentation and disclosure of the fair value measurements of material assets, liabilities and components of equity are in accordance with UK Generally Accepted Accounting Practice. The amounts disclosed represent the Trustee's best estimate of fair value of assets and liabilities required to be disclosed by these standards. The measurement methods and significant assumptions used in determining fair value have been applied on a consistent

basis, are reasonable and they appropriately reflect the Trustee's intent and ability to carry out specific courses of action on behalf of the Charity where relevant to the fair value measurements or disclosures.

8. The Board has recorded or disclosed, as appropriate in the financial statements, all liabilities, both actual and contingent, including all guarantees that they have given to third parties.

9. The estimated financial effect of pending or threatened litigation and claims against the Charity has been properly recorded and/or disclosed in the financial statements. Except as disclosed in the notes to the financial statements, the Board is not aware of any additional claims that have been or are expected to be received.

10. Except as disclosed in the financial statements or notes thereto, there are no:

(a) other gain or loss contingencies or other liabilities that are required to be recognised or disclosed in the financial statements, including liabilities or contingencies arising from environmental matters resulting from illegal or possibly illegal acts, or possible violations of human rights legislation; or

(b) other environmental matters that may have a material impact on the financial statements.

This letter was agreed at the meeting of the Trust Board on 30th January 2014.

Yours truly,

Chairman

Appendix A to the Management Representation Letter of Leicester Hospitals Charity

Definitions

A. Two or more parties are related when at any time during the financial period:

i. one party has direct or indirect control over the other party; or

ii. the parties are subject to common control from the same source; or

iii. one party has influence over the financial and operating policies of the other party to the extent that that other party might be inhibited from pursuing at all times its own separate interests; or

iv. the parties, in entering a transaction, are subject to influence from the same source to such an extent that one of the parties to the transaction has subordinated its own separate interest

B. For the avoidance of doubt, the following are related parties of the reporting entity:

i. its ultimate and intermediate parent undertakings, subsidiary undertakings and fellow subsidiary undertakings;

ii. its associates and joint ventures;

iii. the investors or venturers in respect of which the reporting entity is an associate or joint venture;

iv. Trustees of the reporting entity and the Trustee of its ultimate and intermediate parent undertakings; and

v. pension funds for the benefit of employees of the reporting entity or of any entity that is a related party of the reporting entity.

C. The following are presumed to be related parties of the reporting entity unless it can be demonstrated that neither party has influenced the financial and operating policies of the other in such a way as to inhibit the pursuit of separate interests:

i. the key management of the reporting entity and key management of its parent undertaking(s);

ii. a person owning or able to exercise control over 20% or more of the voting rights of the reporting entity, whether directly or through nominees;

iii. each person acting ‘in concert’ in such a way as to be able to exercise control or influence over the reporting entity; and

iv. an entity managing or managed by the reporting entity under a management contract.

D. Additionally, because of their relationship with certain parties that are, or not, presumed to be, related parties of the reporting entity, the following are presumed to be related parties of the reporting entity:

i. members of the close family of any individual falling under the parties mentioned in points i to iii of para C above; and

ii. partnerships, companies, trusts or other entities in which any individual or member of the close family in points i to iii of para C above has a controlling interest.

KPMG

cutting through complexity™

Leicester Hospitals Charity

Audit highlights memorandum and management letter for the year ended 31 March 2013

January 2014

Contents

The contacts at KPMG in connection with this report are:

Andrew Bostock
Engagement Partner
(Charity Accredited)

Tel: 0121 232 3215
Andrew.bostock@kpmg.co.uk

Daniel Hayward
Manager
(Charity Accredited)

Tel: 0121 232 3280
Daniel.Hayward@kpmg.co.uk

This report is addressed to University Hospitals of Leicester NHS Trust as the corporate Trustee of Leicester Hospitals Charity, and has been prepared for the use of the Trustee only. We accept no responsibility towards any member of staff acting on their own, or to any third parties.

External auditors do not act as a substitute for the Trustee own responsibility for putting in place proper arrangements to ensure that public business is conducted in accordance with the law and proper standards, and that charitable money is safeguarded and properly accounted for, and used in line with the intentions of the donors.

If you have any concerns or are dissatisfied with any part of KPMG's work, in the first instance you should contact Andrew Bostock who is the engagement partner to the Charity, telephone 0121 232 3215 or email andrew.bostock@kpmg.co.uk who will try to resolve your complaint.

Please note that that this report is confidential between the Trustees and this firm. Any disclosure of this report beyond what is permitted above will prejudice this firm's commercial interests. A request for our consent to any such wider disclosure may result in our agreement to these disclosure restrictions being lifted in part. If the Trustees receive a request for disclosure of this report under the Freedom of Information Act 2000, having regard to these actionable disclosure restrictions you must let us know and you must not make a disclosure in response to any such request without our prior written consent.

Executive summary

Audit conclusions		
✓	■ An unqualified audit opinion is proposed on the financial statements.	
Accounting matters		
✓	■ No material audit differences were identified during the course of the audit. ■ We identified a small number of presentational issues during our audit and we understand that Management have adjusted for all of these matters.	Appendix 1
✓	■ Accounting policies appropriate for the annual report and the financial statements are in accordance with disclosure requirements of relevant charities legislation, UK GAAP and the Statement of Recommended Practice.	
Auditing matters		
✓	■ We have completed the audit subject to receipt of the signed management representations letter.	Page 3 and 4
✓	■ No significant audit issues arose during the course of our audit of the Charity. ■ The total charitable funds fell by £342k in the year from £5,513k to £5,171k.	
Systems and controls		
✓	■ No major weaknesses in the financial systems were identified.	
Regulatory and tax matters		
✓	■ No significant regulatory or tax matters came to our attention during the course of our normal audit work.	

Audit status and observations

The purpose of this document is to set out certain matters which came to our attention during the course of our audit of the accounts of **Leicester Hospitals Charity** *(the Charity) for the year ended 31 March 2013.*

The purpose of our audit

The main purpose of our audit, carried out in accordance with the Clarified International Auditing Standards issued by the Auditing Practices Board, is to issue a report to the Trustee of Leicester Hospitals Charity. This expresses in our opinion, whether the Charity financial statements:

- **give a true and fair view**, in accordance with UK Generally Accepted Accounting Practice, of the state of the Charity's affairs as at 31 March 2013 and of its incoming resources and application of resources for the year then ended; and
- **have been properly prepared** in accordance with the SORP 2005.

Our audit objectives

Our audit objectives go beyond the delivery of the statutory requirements of audit (the provision of an opinion) and reflect our desire to meet and exceed the Charity's expectations. Our audit objectives are to:

- deliver a high quality, efficient audit, focusing on key issues and risks, with an appreciation of operational sensitivities and of the overall environment in which the Charity operates;
- provide added value commentary on current issues, control recommendations and accounting and regulatory developments in our management reporting;
- report effectively within agreed timescales.

In delivering these objectives, we worked closely with finance staff to ensure that our work was undertaken with the minimum of disruption to the Trust.

Acknowledgements

- We would like to take this opportunity to thank the Charitable Funds accountant and finance team for their co-operation and assistance with our audit.

We set out below details of the required communications to the Trustee:

Disagreement with management	There have been no disagreements with management on financial accounting and reporting matters that, if not satisfactorily resolved, would have caused a modification of our auditors' report on the financial statements.
Consultation with other accountants	To the best of our knowledge, management has not consulted with or obtained opinions, written or oral, from other independent accountants during the past year that were subject to the requirements of Statement 1.213 of the Institute of Chartered Accountants in England and Wales Guide of Professional Ethics.
Difficulties encountered in performing the audit	We encountered no fundamental difficulties in dealing with management in performing the audit.
Material written communications	In accordance with the communication requirements of Clarified International Standard on Auditing (UK and Ireland) 260, we provide the following material written communications to the Trustee: ▪ Report to the Charitable Fund Committee – this is the main body of this report; and ▪ KPMG Independence communication (appendix 3).

Audit status and observations

Management Representations	In accordance with Clarified ISA 580 *Written representations,* we will request written representations from those charged with governance.
Audit misstatements	Under the requirements of Clarified ISA 260 *Communication of audit matters with those charged with governance*, we are required to report any adjusted audit misstatements arising from our work. There are no material unadjusted misstatements (see Appendix 1)

Audit of the Leicester Hospitals Charity

Our audit work on the financial statements is now substantially complete and we plan to issue an unqualified audit opinion for the year ended 31 March 2013 (based on our position at the date of this report), following our receipt of the management representations letter.

There were no significant issues identified during our audit as reported in this document in appendix 1.

Management Report

Our objective is to use our knowledge of the Charity gained during our routine audit work to make useful comments and suggestions for you to consider. However, you will appreciate that our routine audit work is designed to enable us to form the above audit opinion on the annual financial statements of the Leicester Hospitals Charity. It should not be relied upon to disclose errors or irregularities which are not material in relation to those financial statements.

Appendix 1
Summary of audit differences

Summary of audit differences

We are required by ISA (UK and Ireland) 260 Communication of Audit Matters to Those Charged with Governance to communicate all uncorrected misstatements, other than those that we believe are clearly trivial, to the Charitable Funds Committee. We are also required to report all material misstatements that management has corrected but that we believe should be communicated to the Charitable Funds Committee to assist it in fulfilling its governance responsibilities.

Audit differences

We identified no material audit difference during the course of our audit for the year ended 31 March 2013.

We identified a small number of presentational adjustments which have again been adjusted by management.

Accounting developments

New UK GAAP

In March 2013, the Financial Report Council (FRC) issued FRS102, the Financial Reporting Standard applicable in the UK and Republic of Ireland. This is the main part of the new UK GAAP regime and follows the issue in November 2012 of FRS 100 (overview of the framework) and FRS 101 (reduced disclosure framework that is not applicable to charities).

Charities will apply FRS 102, or, if eligible the FRSSE. They are not allowed to apply EU-IFRS or FRS 101. FRS 102 is based on the IFRS for Small and Medium Sized Enterprises (IFRS for SMEs) although amendments were made specifically for the UK market. There is a reduced disclosure framework under FRS 102 which, if certain criteria are met, exempts a charity's subsidiaries from preparing a cash flow statement, and certain other disclosures.

New UK GAAP is applicable for accounting periods beginning on or after 1 January 2015. This will require a transition balance sheet to be prepared as at 1 April 2014. Early adoption is permitted for periods ending on or after 31 December 2012 once the Charities SORP has been issued.

Accounting regime	Applicable to:	Example:
FRS 102	■ Large and medium sized entities	■ Large and medium private companies ■ **Larger charities**
FRS 102 with reduced disclosures	■ Individual accounts of qualifying parent and subsidiary entities*	■ Parent company and subsidiaries in a group ■ **Company subsidiaries in a charitable group**
FRSSE	■ Eligible small entities	■ Small** private companies ■ **Small** charities**

* A qualifying parent or subsidiary is a member of a group that prepares publicly available financial statements intended to give a true and fair view, in which it is consolidated. Fewer exemptions are available for financial institutions.

** As defined by company law

Accounting developments (continued)

Statement Of Recommended Practice (SORP) 2005

The SORP applies to all UK charities that prepare accruals-based accounts to give a true and fair view of a charity's financial activities and financial position. The SORP provides guidance on the application of accounting standards by charities.

The SORP Committee is now drafting the next SORP to reflect the new UK accounting framework. The new SORP is likely to take the form of online modules rather than be a single published book to provide guidance on the application of FRS 102 including the PBE specific requirements. A draft SORP in modular form will be made available for public consultation in due course and it is anticipated the consultation will commence in summer 2013, aiming to launch the SORP mid-2014.

FRS 102 GAAP differences

Differences between FRS 102 and current UK GAAP that may impact charities are set out in the table below. As you can see, the charity is not likely to be significantly affected by these changes.

Selected GAAP differences			
	Current UK GAAP	**FRS 102**	**EU-IFRS***
Defined benefit pension plans	▪ Multi-employer plans (including group) off balance sheet in individual accounts ▪ Expected return on assets reflects returns expected on assets held	▪ Group plans must be on at least one balance sheet. For non-group multi-employer plans, provision is made for agreed deficit funding ▪ One net interest charge/credit based on net balance sheet asset/liability i.e., return on asset element calculated using liability discount rate	▪ Group plans must be on at least one balance sheet. For non-group multi-employer plans, provision is made for agreed deficit funding ▪ One net interest charge/credit based on net balance sheet asset/liability i.e., return on asset element calculated using liability discount rate (for periods commencing 1 January 2013)
Goodwill	▪ Rebuttable presumption that amortised over maximum life of 20 years ▪ Intangibles generally subsumed within goodwill	▪ Amortised over a presumed life of five years unless has longer life ▪ Intangibles recognised separately	▪ No amortisation, but reviewed annually for impairment ▪ Intangibles recognised separately
Derivatives	▪ Generally off balance sheet (non-FRS 26)	▪ On balance sheet	▪ On balance sheet
Intercompany payables and receivables	▪ Recognised at face value (non-FRS 26)	▪ Recognised at fair value ▪ If the loan is for a fixed term and not at a commercial rate then fair value will not equal face value.	▪ Recognised at fair value ▪ If the loan is for a fixed term and not at a commercial rate then fair value will not equal face value.
Borrowing / Development costs	▪ May capitalise when criteria met	▪ May capitalise when criteria met	▪ Must capitalise when criteria met

* Under company and charity law a charity cannot apply EU-IFRS. The accounting treatment is given here for completeness.

Accounting developments (continued)

From 2013-14 the Charitable Funds may have to be included in the Trust's consolidated accounts, as the previous HM Treasury exemption for NHS bodies in relation to IAS 27 is no longer available.

Consolidation of the NHS Charitable Funds

From 2013-14, the previous HM Treasury exemption for NHS bodies in relation to IAS 27, Consolidated and Separate Financial Statements, is no longer available.

As this is a change in national accounting policy, IAS 8 requires the restatement of comparators for 2012-13, with accounts presenting the Statement Of Financial Position at 1 April 2012, 31 March 2013 and 31 March 2014 as if the charitable fund had always been consolidated. Both local accounts and summarisation schedules will need be presented so as to identify the NHS body's own transactions and the consolidated position in separate columns.

As of December 2013, the Trust is currently assessing whether its Charitable Fund is material and therefore needs to be consolidated. If it concludes that the Charitable Fund is material it will need to consider the following:

1. Amendment of closedown timetable for sign off of the Charitable Funds accounts; incorporating the preparation of financial statements, and related working papers ready for audit in April/May, rather than later in the year;
2. Preparing entries for restated comparatives; and
3. Preparation of consolidation journals.

Note that preparing entries for restated comparatives early in the year would facilitate an early audit and reduce the work load on the finance team during the year end Trust accounts timetable.

Gift Aid – Charities Online

Charities Online is a new service through which HMRC will administer electronic repayment claims for Gift Aid, the Gift Aid Small Donations Scheme and repayment of tax on other income. Charities Online went live on 22 April 2013. HMRC guidance regarding the new system can be found at:
http://www.hmrc.gov.uk/charities/online/index.htm

The new system is intended to make it quicker and easier for charities to submit repayment claims and it is expected that claims should be processed and paid within 15 workings days under the new system. In addition built-in checks are designed to help reduce errors and limit the risk of claims being rejected by HMRC. There are three options for charities to make their repayment claims under the new system:

1) Use HMRC online form – for a claim with up to 1,000 donors (there is no limit to the number of online forms that can be submitted);
2) Use own internal database – for a claim with up to 500,000 donors (one claim can be submitted per day);
3) Use a new paper form ChR1 – for those charities that do not have internet access.

In addition there are transitional provisions which will allow charities to make claims using the old paper form R68(i) until 30 September 2013.

Gift Aid Small Donations Scheme (GADS)

GADS became effective on 6 April 2013 and is intended for small cash donations received in collection boxes/bucket collections. GADS enables eligible charities to receive a Gift Aid style repayment on small (up to £20) cash donations without the need to obtain Gift Aid declarations from donors for those donations.

A charity is eligible under the GADS if it has been in existence for at least three years and made two valid Gift Aid claims in the previous four years. A matching rule applies so that for every £10 of donations claimed in a tax year under GADS an eligible charity must also claim £1 of donations under Gift Aid. The scheme is subject to an overall cap of £5,000 of small donations per year, although this cap may be increased in certain circumstances.

Gift Aid – Audits

HMRC are increasingly carrying out audits on Gift Aid reclaims made by charities to ensure that the correct amount of Gift Aid is being claimed. If in the course of an audit HMRC are unable validate the basis of a Gift Aid claim then the charity will be considered to have been overpaid in relation to its Gift Aid repayment. HMRC will therefore seek to recover overpaid tax for all relevant years plus interest and possibly penalties. The charity will also be required to undertake remedial action, during which period Gift Aid claims could be suspended.

The charity should review its systems, procedures and documentation surrounding Gift Aid reclaims to ensure that the correct amount of Gift Aid is being claimed and thereby reduce the risk of repayment, penalties or a possible suspension.

Appendix 4

Audit independence

Professional ethical standards require us to communicate to you in writing at least annually all significant facts and matters, including those related to the provision of non-audit services and the safeguards put in place that, in our professional judgment, may reasonably be thought to bear on KPMG LLP's independence and the objectivity of Andrew Bostock and the audit team. This letter is intended to comply with this requirement. We have summarised below the fees paid to us by the charity for significant professional services provided by us during the reporting period.

We are satisfied that our general procedures support our independence and objectivity.

KPMG LLP is committed to being and being seen to be independent. As part of our ethics and independence policies, all KPMG LLP Audit Partners, Directors and staff annually confirm their compliance with our Ethics and Independence Manual including in particular that they have no prohibited shareholdings. Our Ethics and Independence Manual is fully consistent with the requirements of the APB Ethical Standards. As a result we have underlying safeguards in place to maintain independence through:

- Instilling professional values.
- Communications.
- Internal accountability.
- Risk management.
- Independent review.

Please inform us if you would like to discuss any of these aspects of our procedures in more detail.

There are no other matters that, in our professional judgement, bear on our independence which need to be disclosed to the Charitable Funds Committee or the Trust Board.

We confirm that as of 6 January 2014, in our professional judgment, KPMG LLP is independent within the meaning of regulatory and professional requirements and the objectivity of the Audit Director and audit staff is not impaired.

This report is intended solely for the information of the Charitable Funds Committee of the Trust Board and should not be used for any other purposes.

Any additional services provided by KPMG to you are approved by management under delegated authority from the Corporate Trustee to ensure transparency. In addition to the audit of the financial statements, during 2012/13 KPMG has also undertaken no other work for the Corporate Trustee in respect of the Charity.

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UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

Trust Board Bulletin – 30 January 2014

The following report is attached to this Bulletin as an item for noting, and is circulated to UHL Trust Board members and recipients of public Trust Board papers accordingly:-

- **Sealing of Documents** – Lead contact point Mr S Ward, Director of Corporate and Legal Affairs (0116 258 8615) – **paper 1**.

It is intended that this paper will not be discussed at the formal Trust Board meeting on 30 January 2014, unless members wish to raise specific points on the report.

This approach was agreed by the Trust Board on 10 June 2004 (point 7 of paper Q). Any queries should be directed to the specified lead contact point in the first instance. In the event of any further outstanding issues, these may be raised at the Trust Board meeting with the prior agreement of the Chairman.

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **30 JANUARY 2014**

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

SUBJECT: **SEALING OF DOCUMENTS**

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1. The Trust's Standing Orders (Standing Order 12) set out the approved arrangements for custody of the Trust's seal and the sealing of documents.

2. Appended to this report is a table setting out details of the Trust sealings for Q3 of the 2013-14 financial year.

3. The Trust Board is invited to receive and note this information.

4. Reports on Trust sealings will continue to be submitted to the Trust Board on a quarterly basis.

Stephen Ward
Director of Corporate and Legal Affairs

List of Trust Sealings for Quarter 3, 2013/14

Date of Sealing	Nature of Document	Date of Authority and Minute Reference	Sealed by	Remarks
25/11/13	Deed of Gift for Scalp Cooling Equipment between UHL and 'Walk the Walk' Worldwide. Company No: SC201169	Trust Board – 31/10/13 Minute 277/13/6	Acting Chairman/ Assistant Director – Head of Legal Services	1 original to 'Walk the Walk', the other stored in deeds safe, Belgrave House.
25/11/13	Deed of Indemnity between (1) UHL and (2) The Royal College of Surgeons of England and (3) The Society of Cardiothoracic Surgery in Great Britain and (4) Mr Peter Bradley FRCS and (5) Mr Alan Wood FRCS and (6) Ms Jane Corfield.	Trust Board – 31/10/13 Minute 267/13/1	Acting Chairman/ Assistant Director – Head of Legal Services	All returned to Medical Director.