UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

TRUST BOARD

MEETING TO BE HELD ON THURSDAY 30 OCTOBER 2014 FROM 10AM IN SEMINAR ROOMS A & B, CLINICAL EDUCATION CENTRE, LEICESTER GENERAL HOSPITAL

Please note the new time for the public meeting and the new running order

Public meeting commences at 10am

AGENDA

Please take papers as read

Item no.	Item	Paper ref:	Lead	Discussion time
1.	**APOLOGIES AND WELCOME**	**-**	**Chairman**	
	To receive apologies for absence, and to welcome Mr K Singh, Trust Chairman, and Mr M Traynor, Non-Executive Director to their first formal Trust Board meeting.			
2.	**DECLARATIONS OF INTERESTS**	**-**	**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.			
3.	**MINUTES**			
	Minutes of the 25 September 2014 Trust Board meeting. *For approval*	**A**	**Chairman**	
4.	**MATTERS ARISING**			10am – 10.05am
	Action log from the 25 September 2014 meeting. *For approval*	**B**	**Chairman**	
5.	**CHAIRMAN'S MONTHLY REPORT – OCTOBER 2014** *For noting*	**C**	**Chairman**	10.05am – 10.10am
6.	**CHIEF EXECUTIVE'S MONTHLY UPDATE REPORT – OCTOBER 2014** *For noting*	**D**	**Chief Executive**	10.10am – 10.15am
7.	**KEY ISSUES FOR DECISION/DISCUSSION**			
7.1	**PRESENTATION ON LLR EMERGENCY CARE SYSTEM IMPROVEMENTS** *For discussion*	**E (to follow)**	**Dr D Briggs, LLR Emergency Care Lead**	10.15am – 10.30am
7.2	**LLR LEARNING LESSONS TO IMPROVE CARE REVIEW – 3-MONTH PROGRESS REPORT ON ACTIONS** *For assurance*	**F**	**Medical Director**	10.30am – 10.40am

7.3	**UHL CANCER PERFORMANCE** *For discussion and assurance*	**G**	**Chief Operating Officer/Cancer Centre Lead Clinician**	10.40am – 10.55am
7.4	**UHL DEVELOPMENT SUPPORT PLAN** *For approval*	**H (to follow)**	**Chief Executive/ Director of Strategy**	10.55am – 11.10am
7.5	**EBOLA PREPAREDNESS** *For assurance*	**verbal**	**Chief Nurse**	11.10am – 11.20am
8.	**STRATEGY, FORWARD PLANNING AND RISK**			
8.1	**BOARD ASSURANCE FRAMEWORK** *For discussion and assurance*	**I**	**Chief Nurse**	11.20m – 11.30am
9.	**CLINICAL QUALITY AND SAFETY**			
9.1	**PATIENT STORY** *For discussion*	**J**	**Chief Nurse**	11.30am – 11.45am
9.2	**MAKING EVERY CONTACT COUNT – ANNUAL PLAN** *For approval*	**K**	**Director of Marketing and Communications**	11.45am – 11.50am
9.3	**DESIGNATION OF UHL SENIOR RESPONSIBLE OFFICER (MEDICAL APPRAISAL/REVALIDATION)** *For approval*	**L**	**Medical Director**	11.50am – 11.55am
10.	**RESEARCH, EDUCATION AND TRAINING**			
10.1	**NATIONAL INSTITUTE FOR HEALTH RESEARCH COMPREHENSIVE LOCAL RESEARCH NETWORK EAST MIDLANDS – QUARTERLY UPDATE** *For discussion*	**M**	**Medical Director/ EM CLRN Clinical Director**	11.55am – 12.05pm
11.	**QUALITY AND PERFORMANCE** *For assurance*			
11.1	**QUALITY AND PERFORMANCE REPORT – MONTH 6** *For assurance* The Non-Executive Director Chairs of the Quality Assurance Committee and the Finance and Performance Committee will be invited to highlight any month 6 issues from their most recent meetings (29 October 2014). Minutes of the 24 September 2014 Finance and Performance Committee and the 27 August 2014 and 24 September 2014 Quality Assurance Committee meetings are attached. At each meeting, the Trust Chairman will then invite the Chief Executive to identify key priority issues from within the month 6 report, for wider Trust Board consideration.	**N** **N1 – N3**	**QAC Chair/ FPC Chair** **QAC Chair/ FPC Chair** **Chair/Chief Executive**	12.05pm – 12.20pm
11.2	**2014-15 MONTH 6 FINANCIAL POSITION** *For discussion and assurance*	**O**	**Acting Director of Finance**	12.20pm – 12.35pm
11.3	**EMERGENCY CARE PERFORMANCE AND RECOVERY PLAN** *For discussion and assurance*	**P**	**Chief Operating Officer**	12.35pm – 12.45pm
12.	**GOVERNANCE**			

12.1	**NHS TRUST OVER-SIGHT SELF CERTIFICATION** *For approval*	**Q**	**Director of Corporate and Legal Affairs**	12.45pm – 12.50pm
13.	**CORPORATE TRUSTEE BUSINESS**			
13.1	**CHARITABLE FUNDS COMMITTEE** Minutes of the 15 September 2014 meeting for noting and endorsement of any recommendations. *For Trust Board approval as Corporate Trustee*	**R**	**Charitable Funds Committee Chair**	12.50pm – 12.55pm
13.2	**URGENT CHARITABLE FUNDS APPLICATION** *For approval as Corporate Trustee*	**S**	**Chief Nurse**	12.55pm – 1pm
14.	**TRUST BOARD BULLETIN – OCTOBER 2014**	**T**	**-**	-
15.	**QUESTIONS FROM THE PUBLIC RELATING TO BUSINESS TRANSACTED AT THIS MEETING**		**Chair**	1pm – 1.15pm
16.	**ANY OTHER BUSINESS**		**Chair**	1.15pm – 1.20pm
17.	**DATE OF NEXT MEETING**			
	The next Trust Board meeting will be held on **Thursday 27 November 2014** from **10am** in **Seminar Rooms 2 and 3, Clinical Education Centre, Glenfield Hospital.**			
18.	**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 19-24).			-
Comfort break prior to the private session 1.20pm – 2pm				
19.	**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.			
20.	**CONFIDENTIAL MINUTES** Confidential Minutes of the 25 September 2014 Trust Board meetings. *For approval*	**U**	**Chairman**	
21.	**MATTERS ARISING** Confidential action log from the 25 September 2014 Trust Board. *For approval*	**V**	**Chairman**	2pm – 2.05pm
22.	**REPORT FROM THE VICE CHAIR AND THE DIRECTOR OF CORPORATE AND LEGAL AFFAIRS** *Personal information*	**W**	**Vice Chair/ Director of Corporate and Legal Affairs**	2.05pm – 2.20pm

23.	**REPORT FROM THE CHIEF EXECUTIVE** *Commercial in confidence*	**X**	**Chief Executive**	2.20pm 2.40pm
24.	**REPORTS FROM BOARD COMMITTEES**			
24.1	**FINANCE AND PERFORMANCE COMMITTEE** Confidential Minutes of the 24 September 2014 meeting for noting and endorsement of any recommendations. *Prejudicial to the conduct of public affairs*	**Y**	**Finance and Performance Committee Chair**	2.40pm – 2.45pm
24.2	**QUALITY ASSURANCE COMMITTEE** Confidential Minutes of the 27 August 2014 and 24 September 2014 meetings for noting and endorsement of any recommendations. *Commercial in confidence, personal information and prejudicial to the conduct of public affairs*	**Z & Z1**	**QAC Chair**	2.45pm – 2.50pm
24.3	**REMUNERATION COMMITTEE** Confidential Minutes of the 25 September 2014 meeting for noting and endorsement of any recommendations. *Personal information and prejudicial to the conduct of public affairs*	**AA**	**Chairman**	2.50pm – 2.55pm

Helen Stokes
Senior Trust Administrator

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF A MEETING OF THE TRUST BOARD, HELD ON THURSDAY 25 SEPTEMBER 2014 AT 11.00AM IN THE C J BOND ROOM, CLINICAL EDUCATION CENTRE, LEICESTER ROYAL INFIRMARY

Present:
Mr R Kilner – Acting Trust Chairman
Mr J Adler – Chief Executive
Col. (Ret'd) I Crowe – Non-Executive Director
Dr K Harris – Medical Director
Mr R Mitchell – Chief Operating Officer
Ms R Overfield – Chief Nurse
Mr S Sheppard – Acting Director of Finance
Ms J Wilson – Non-Executive Director
Professor D Wynford-Thomas – Non-Executive Director

In attendance:
Dr A Bentley – Leicester City CCG (from Minute 252/14)
Ms K Bradley – Director of Human Resources
Mr M Caple – Patient Advisor (for Minute 259/14/2)
Mr J Clarke – Chief Information Officer (for Minute 250/14)
Mr D Henson – LLR Healthwatch Representative (from Minute 252/14)
Dr R S Patel, NIHR Academic Clinical Lecturer in Medical Education at the University of Leicester and Honorary Specialist Registrar (for Minute 259/14/1)
Ms A Randle – Senior Patient Safety Manager (for Minute 259/14/2)
Ms S Remington – IBM (for Minute 250/14)
Ms K Shields – Director of Strategy
Mr M Smith – Healthwatch (for Minute 259/14/2)
Ms H Stokes – Senior Trust Administrator (up to and including Minute 251/14)
Ms M Thompson – Patient Experience Team (for Minute 259/14/1)
Mr J Visser – Paediatric Oncologist (for Minute 250/14)
Mr S Ward – Director of Corporate and Legal Affairs
Mr M Wightman – Director of Marketing and Communications

ACTION

244/14 EXCLUSION OF THE PRESS AND PUBLIC

Resolved – that, pursuant to the Public Bodies (Admission to Meetings) Act 1960, the press and members of the public be excluded during consideration of the following items of business (Minutes 244/14 – 251/14), having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.

245/14 APOLOGIES

Apologies for absence were received from Mr P Panchal, Non-Executive Director and Dr S Dauncey, Non-Executive Director.

246/14 DECLARATIONS OF INTERESTS IN THE CONFIDENTIAL BUSINESS

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

247/14 ACTING CHAIRMAN'S AND CHIEF EXECUTIVE'S OPENING COMMENTS

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

accordingly, on the grounds of commercial interests.

248/14 CONFIDENTIAL MINUTES

Resolved – that the confidential Minutes of the 28 August 2014 Trust Board be confirmed as a correct record and signed accordingly by the Acting Trust Chairman. **CHAIR**

249/14 CONFIDENTIAL MATTERS ARISING REPORT

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

250/14 REPORT BY THE CHIEF EXECUTIVE

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

251/14 REPORTS FROM BOARD COMMITTEES

251/14/1 Audit Committee

Resolved – that the confidential Minutes of the 2 September 2014 Audit Committee be received, and the recommendations and decisions therein endorsed and noted respectively.

251/14/2 Finance and Performance Committee

Resolved – that the confidential Minutes of the 27 August 2014 Finance and Performance Committee be received, and the recommendations and decisions therein endorsed and noted respectively.

252/14 DECLARATIONS OF INTERESTS IN THE PUBLIC BUSINESS

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

253/14 ACTING CHAIRMAN'S OPENING COMMENTS

The Acting Chairman:-

(a) noted that impending Non-Executive Director appointments would soon be confirmed by the NHS Trust Development Authority and announced formally shortly thereafter; **CHAIR**

(b) commended the ongoing recent improvement in the Trust's performance against the emergency care 4 hour standard;

(c) recorded the Trust Board's thanks to the Leicester City Council Officers and Councillors for granting planning permission on 24th September 2014 for the Trust's emergency floor development;

(d) commended the partnership working with key stakeholders which had underpinned the work on complaints management, featured under Minute 259/14/2 below.

Resolved – that the position be noted.

254/14 MINUTES

In respect of Minute 235/14/1 of 28th August 2014 (Blood Transfusion Laboratory Information System), in response to a point raised by Dr T Bentley, CCG representative the Trust Board agreed that the assurance given at the Trust Board meeting on 28th August 2014 regarding the availability of the ICE requesting systems for use by primary care once the Electronic Patient Record System went live be recorded in the Minutes.

Resolved – that the Minutes of the meeting of the Trust Board held on 28th August 2014 be confirmed as a correct record and signed by the Trust Chairman accordingly, subject to it being noted in respect of Minute 235/14/1 that the assurance given at that Board meeting regarding the availability of the ICE requesting system for use by primary care once the Electronic Patient Record System went live being recorded. **STA / CHAIR**

255/14 MATTERS ARISING FROM THE MINUTES

The Trust Board reviewed paper G setting out the current status of outstanding actions arising from the Board meeting held on 28th August 2014 and earlier Board meetings.

The following points were discussed and agreed by the Trust Board:-

(a) **item 2a** (Minute 232/14 of 28th August 2014) – Trust Board to be advised at its January 2015 meeting on the outcome of the Medical Director's/Executive Team's consideration of whether additional resource is to be deployed to enable the Trust to meet its medical revalidation and appraisal responsibilities; **MD/STA**

(b) **item 2d** (Minute 232/14 of 28th August 2014) – the Director of Human Resources to confirm the date for production of the next iteration of the Medical Workforce Strategy – date to be incorporated in the October 2014 Trust Board action log; **DHR**

(c) **item 4b** (Minute 232/14/2 of 28th August 2014) – Trust Board to be advised at its November 2014 meeting on the decision of the LLR CCGs on retendering the provision of urgent care services (NB decision expected to be taken by the end of October 2014); **COO**

(d) **item 5** (Minute 233/14/3 of 28th August 2014) – Trust Board to receive nursing workforce updates bi-annually, timing to be synchronised with the outcome of the bi-annual UHL nursing acuity review; **CN**

(e) **item 6c** (Minute 233/14/4 of 28th August 2014) – Trust Board to be updated on the issue of monitoring patient sexual orientation via the equality governance update report to be submitted to the January 2015 Trust Board meeting; **DHR**

(f) **item 6e** (Minute 233/14/4 of 28th August 2014) – Director of Human Resources to confirm the timescales for completion of the analysis of two critical incidents and patient outcome review – timescale to be incorporated in the October 2014 Trust Board action log; **DHR**

(g) **item 10a** (Minute 236/14/1 of 28th August 2014) – Trust Board to be advised at its January 2015 meeting on the outcome of the work to explore an increase in the number of available choose and book slots; **COO**

(h) **item 12** (Minute 236/14/3 of 28th August 2014) – the item on an update from the Local Education and Training Board on discussions concerning changes to the national Consultant contract be removed from the Trust Board action log; **STA**

(i) **item 2c** (Minute 232/14) – Director of Marketing and Communications to submit a report to the January 2015 Trust Board meeting recommending the consideration and adoption of an updated UHL patient and public involvement and engagement strategy; **DMC**

(j) **item 20** (Minute 180/14/2 of 26th June 2014) – Director of Marketing and

Communications to submit a report to the October 2014 Trust Board meeting on the plans for patient and stakeholder engagement, following consideration of this subject at the Better Care Together Programme Board on 2nd October 2014. **DMC**

Resolved – that the update on outstanding matters arising, and the associated actions above, be noted and agreed.

256/14 KEY ISSUES FOR DECISION/DISCUSSION

256/14/1 Better Care Together – Programme Update

The Chief Executive introduced paper H, commenting on the Better Care Together Programme update report dated September 2014 prepared by the Interim Programme Director which was appended to the report.

The Chief Executive also reported on the recent meetings of the Better Care Together Delivery Board and Clinical Reference Group, respectively.

The Trust Board noted that, with support from Ernst Young, work continued to calculate the anticipated transitional and transformational costs associated with implementation of the Better Care Together Programme. The costs would be significant and, as there was no provision to meet the costs from within the resources of the local health economy, a bid would need to be made to Government for support.

The updated LLR 5-year health and social care plan would be submitted to the Trust Board on 27th November 2014 for consideration and approval. **DS**

The Chief Executive noted in conclusion that Ms Kaye Burnett had been appointed as Independent Chair of the Better Care Together Programme and would take up her post on 6th October 2014.

Resolved – that the report be received and noted.

256/14/2 Congenital Heart Disease Review

Further to Minute 233/14/1 of 28th August 2014, the Director of Strategy introduced paper I and explained that NHS England had recently launched a 12 week consultation on the proposed congenital heart disease standards and service specifications. As anticipated, the revised draft standards for paediatric congenital cardiac surgical units stated that co-location with other paediatric services was essential: consequently, this would require the Trust's paediatric congenital heart service to move from Glenfield Hospital to join the rest of paediatric services on the Leicester Royal Infirmary site.

The paper set out a three stage approach to bringing children's services together on one site, co-located: at this point, it was anticipated that the achievement of an integrated women's and children's hospital at the Leicester Royal Infirmary would take up to five years.

It was noted that Commissioners might require the co-location of all paediatric services before the Trust had developed and implemented its proposals for co-location at the Leicester Royal Infirmary. Discussions would consequently now take place with Commissioners to enable an assessment to be made of whether a single move of services, or a staged move of services, would be required.

Paper I identified the intention to establish a charitable fundraising programme to complement the intended establishment of an integrated Women's and Children's Hospital at the Leicester Royal Infirmary.

The Director of Strategy confirmed that a report would be submitted to the October 2014 meeting of the Executive Strategy Board on this matter and that the draft Strategic Outline Case to give effect to the Trust's plans would be developed thereafter in line with the Trust's five year strategy and in alignment with the Better Care Together Programme.

In discussion, the Director of Strategy concurred with the views expressed by Ms J Wilson, Non-Executive Director that, at the appropriate juncture, it would be necessary for the Trust Board to be sighted to the risks associated with moving the services to the Leicester Royal Infirmary and to obtain assurance on the measures to be put in place to mitigate those risks.

Resolved – that the report be received and noted and approval be given to the action plan attached at appendix A to paper I to bring about the co-location of children's services at Leicester Royal Infirmary. **DS**

257/14 CHIEF EXECUTIVE'S MONTHLY UPDATE REPORT (SEPTEMBER 2014)

The Chief Executive introduced his monthly update report for September 2014 and highlighted the following issues:-

(a) improving emergency care performance;

(b) the Trust's financial position as at month 5 2014/15: the Trust continued to forecast that it would deliver its financial plan for 2014/15 (a deficit of £40.7M);

(c) the Trust expected to learn by the end of September 2014 if its bid to be part of the 'Mutuals in Health: Pathfinder Programme' had been successful;

(d) ongoing work with local Commissioners to agree a 'Memorandum of Understanding' to provide a framework within which issues concerning the in-year healthcare contract would be resolved;

(e) the intention, subject to the successful outcome of the Trust's bid to the Independent Trust Financing Facility for long term borrowing, and approval by the NHS Trust Development Authority (decisions anticipated mid October 2014) to proceed with the remainder of the emergency floor enabling works (estimated at £3.5M), subject to the approval of the Trust Board;

(f) work to finalise the Trust's Development Support Plan which it had been agreed with the NHS Trust Development Authority would be submitted to the Trust Development Authority by 31st October 2014: the Director of Strategy outlined the anticipated content of the Development Support Plan and it was noted that the final draft Plan would come before the Trust Board on 30th October 2014 for consideration and approval.

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

(B) subject to the successful outcome of the Trust's bid to the Independent Trust Financing Facility for long-term borrowing, and approval by the NHS Trust Development Authority (decisions anticipated mid October 2014), approval be given to proceeding with the remainder of the emergency floor enabling works at an estimated cost of £3.5M, **CE**

(C) consequent upon the decision at (B) above, measures to mitigate the over-commitment of the 2014/15 capital programme be discussed at the October 2014 Finance and Performance Committee meeting, **ADF**

(D) the draft UHL Development Support Plan be discussed at the Trust Board Development session on 16th October 2014, ahead of submission to the public Trust **DS**

Board meeting on 30th October 2014, for approval and onward submission to the NHS Trust Development Authority.

258/14 STRATEGY, FORWARD PLANNING AND RISK

258/14/1 Draft 2015/16 and 2016/17 Integrated Business Planning Guidance

The Acting Director of Finance introduced paper K which set out guidance for the development of the Trust's Integrated Business Plan for 2015/16 and 2016/17.

The draft guidance had been reviewed and endorsed by the Executive Workforce Board at its meeting on 16th September 2014 (Minute 8.2 refers) and the Finance and Performance Committee at its meeting on 24th September 2014 (Minute 106/14/1 refers).

The Acting Director of Finance recommended the guidance for approval, subject to the inclusion of additional wording to describe the Trust's approach to patient and public involvement in the development of the Trust's annual plan for 2015/16.

Resolved – that (A) the draft 2015/16 and 2016/17 Integrated Business Planning guidance appended to paper K be approved and implemented, subject to (B) below, and **ADF**

(B) additional wording be included within the draft 2015/16 and 2016/17 Integrated Business Planning guidance referred to at (A) above to describe the Trust's approach to patient and public involvement in the development of the Trust's Annual Plan 2015/16. **ADF/ DMC**

258/14/2 Board Assurance Framework (BAF)

Paper L detailed UHL's Board Assurance Framework as at 31st August 2014 and notified the Board of five new high risks which had been opened during August 2014, a full description of which was included at Appendix 3 to the paper.

The Board concurred with the view expressed by the Acting Chair that review of the scoring of risk 4 (delay in the approval of the Emergency Floor Business Case) should take into account the outcome of the Trust's bid to the Independent Trust Financing Facility for long term borrowing (also subject to approval by the NHS Trust Development Authority), referenced at Minute 257/14(e) above.

Further to Minute 235/14/3 of 28th August 2014, the Board proceeded to review each of the risks (namely, risks 5, 6, 7 and 8) linked to the strategic objective, "Responsive services which people choose to use (secondary, specialised and tertiary care).

In the course of this review, the Board:-

(a) concurred with the recommendation of the Chief Operating Officer that the current score of 9 for risk 5 remain unaltered at present;

(b) concurred with the view expressed by the Director of Marketing and Communications in relation to risk 6 that it would be appropriate to review the scoring of this risk once the Board had considered and approved a revised UHL patient and public involvement and engagement strategy at its meeting in January 2015 (Minute 255/14(i) above refers);

(c) concurred with the view expressed by the Director of Strategy that it would be appropriate to review the scoring for risk 7 at the November Trust Board meeting at which the Board would be asked to consider approving the updated LLR health and social care 5 year plan and the updated Trust 5 year plan, respectively;

(d) noted that the Director of Strategy would review the scoring of risk 8 in the light of revised guidance soon to be published by NHS England on specialised commissioning. **DS**

Resolved – that (A) the revised UHL Board Assurance Framework as at 31st August 2014 appended to paper L, now submitted, be received and noted,

(B) the new operational risks scoring 15 or above opened on the organisational risk register during August 2014 as detailed at Appendix 3 to paper L, now submitted, be noted,

(C) the risk scoring systems in place for the organisational risk register and the Board Assurance Framework, as described in paper L, now submitted (and se out at Appendix 4 to paper L) be noted.

259/14 CLINICAL QUALITY AND SAFETY

259/14/1 Patient Story: Effective Prescribing Insight for the Future (ePIFFany)

Dr R S Patel, NIHR Academic Clinical Lecturer in Medical Education at the University of Leicester and Honorary Specialist Registrar in renal medicine attended the Board with a colleague and introduced Paper M which described a new educational approach for junior doctors conducted between April and December 2013.

A video providing further information about the project was exhibited at the meeting. The Board noted that the aim of ePIFFany was to improve the prescribing performance and safety behaviours of junior doctors, while also creating a strong ethic for learning within the workplace.

The ePIFFany project contained four educational components:-

- clinical simulations (a simulated 'ward round'),
- face to face teaching in a dedicated 'feedback clinic' from pharmacists and clinicians,
- clinical-decision support,
- computer-based instruction (e-learning).

The rate of prescribing errors amongst junior doctors who had participated in the ePIFFany project had reduced by 50%, an improvement equivalent to an extra 12 months of clinical experience. There had been considerable reductions in prescribing errors across all grades of error severity. Moreover, junior doctors had reported that their confidence, well-being and enthusiasm in the workplace had improved as a result of the education.

The Board expressed its support for the use of patient stories within this project and, recognising that the approach might have wider applicability at UHL not only for junior doctors but for all staff, asked that consideration be given adapting and replicating the approach more widely at UHL.

Resolved – that (A) the ePIFFany project be commended, especially its emphasis on patient stories,

(B) the Medical Director, Chief Nurse and Director of Human Resources be requested to consider and determine how best to harness the new approach to staff education and training exemplified by the ePIFFany project, **MD/CN/ DHR**

(C) the Chief Executive be requested to invite Dr R S Patel, NIHR Academic Clinical Lecturer in Medical Education, University of Leicester and Honorary Specialist Registrar in renal medicine to the Executive Team Improvement Workshop to be held **CE**

on 30th September 2014.

259/14/2 Update on Complaints Process Review

The Chief Nurse introduced paper N which summarised the outcomes arising from a complaints engagement event held in 2014. The event had been supported by Healthwatch, POhWER, recent users of the complaints/PILS Service, Patient Advisers, carers and representatives of the Leicester Mercury Patients' Panel.

The primary focus of the event had been to listen to the experiences of the users of the service, including patients, carers and staff, learn from the feedback and to take action subsequently to ensure that the Trust operated a best practice complaints service.

Mr M Caple, Chair of the Trust's Patient Advisers, Mr M Smith, Healthwatch and the Trust's Senior Patient Safety Manager attended the meeting and, at the invitation of the Acting Chair, addressed the Board on the feedback arising from the engagement event and next steps, details of which were set out in an action log appended to paper N.

The Board discussed:-

(a) resourcing the action plan now submitted, noting that it might be necessary to consider additional, pump priming resource,

(b) noted that, at its meeting held on 24th September 2014, the Quality Assurance Committee had expressed its strong support for the improvement work set out in the action log, now submitted and expressed concurrence with the view of the Acting Chair that it was appropriate to review progress against the action log in 6 months time,

(c) discussed the contribution that the PILS Service could make to resolving concerns and, thereby, reducing the number of formal complaints,

(d) noted the comments made by Ms J Wilson, Non-Executive Director and Chair, Quality Assurance Committee on the opportunity to review ways in which patients and the public could raise concerns about patient care and other issues of concern afforded by the current review of the Trust's whistleblowing policy. In this regard, it was agreed that the Director of Human Resources should consider the point raised taking into account also the independent review of whistleblowing in the NHS which was due to complete its work by November 2014.

Resolved – that (A) Trust Board support for the organisational improvements and recommendations identified in the report now submitted (paper N) and accompanying action log be recorded,

(B) it be noted that both the Executive Quality Board and Quality Assurance Committee shall receive regular updates on the implementation of the complaints engagement event action log, now submitted,

(C) the Chief Nurse be requested to consider and determine the most effective way of deploying existing resources in the implementation of the complaints engagement event action plan, now submitted, **CN**

(D) taking into account the independent review of whistleblowing in the NHS ('Freedom to speak up?') due to complete its work by November 2014, the Director of Human Resources be requested to confirm the timescale for completing the review of the Trust's Whistleblowing Policy – for incorporation in the October 2014 Board action log, **DHR**

(E) the Chief Nurse be requested to give consideration to a means of strengthening **CN**

the ways in which patients and the public can raise concerns about patient care and other issues of concern; and to publicising such arrangements: with the outcome to be incorporated in the October 2014 Board action log.

259/14/3 Leicester Improvement, Innovation and Patient Safety Unit (LIIPS)

Paper O from the Medical Director updated the Trust Board on a new local NHS – academia collaborative initiative in the shape of the Leicester Improvement Innovation and Patient Safety Unit (LIIPS). Work was at a relatively embryonic stage, with governance issues to be discussed further on 29th September 2014. LIIPS had received a 'soft launch' to date, with a pilot year planned from September 2014, followed by full launch of the Unit (subject to a successful pilot) in September 2015.

Noting that, at its meeting held on 15th September 2014 (Minute 43/14 refers) the Charitable Funds Committee had agreed to fund the provision of a part-time post for a period of 1 year of Unit Lead, the Medical Director concurred with the view expressed by the Acting Chair that it would be necessary to give consideration to establishing permanent funding for such a post well in advance of that 'pump-priming' funding coming to an end.

Resolved – that (A) the Leicester Improvement, Innovation and Patient Safety Unit (LIIPS) be supported and

(B) an update on the progress of the LIIPS initiative be submitted to the Trust Board in March 2015. **MD**

260/14 EDUCATION AND TRAINING

260/14/1 Medical Education and Training – Quarterly Update

The Medical Director introduced paper P, the latest quarterly update on medical education and training issues.

The Trust Board:-

(a) noted the summary of the 2014 GMC training survey as set out in the report and, in particular, noted that the Trust had a number of "triple red" rated areas;

(b) noted the work in hand as described in the report regarding management of the 'MADEL' funding;

(c) noted the concerns expressed by external parties regarding the Trust's education facilities, and undergraduate medical examinations, as summarised in the report;

(d) noted the work underway to implement key performance indicators and education quality dashboards, summarised in the paper;

(e) noted the key priorities as set out in paper P and now commented upon by the Medical Director;

(f) noted with satisfaction the reduction in the number of patient safety comments raised by UHL GMC trainees in the 2014 survey, as compared to the position in 2013;

(g) discussed and agreed upon the need to dedicate some time at a forthcoming Trust Board development session on medical education at which it was agreed the Director of Clinical Education should be invited to attend; and that consideration should also be given to inviting the CMG Clinical Education Leads to join this session.

Resolved – that (A) the latest quarterly update on medical education and training issues at UHL as set out at paper P, now submitted, be received and noted,

(B) the presentation on medical education (to accompany paper P now submitted) be circulated to Trust Board members, **STA**

(C) discussion take place at the December 2014 Trust Board development session on medical education, to include the Director of Clinical Education and consideration be given to also inviting the CMG Clinical Education Leads to join the Trust Board for this session. **MD**

260/14/2 Workforce and Organisational Development – Quarterly Update

The Director of Human Resources introduced paper Q, updating the Trust Board on the implementation of the Trust's Organisational Development plan, specifically focussing on 'Strengthening Leadership' and 'Enhancing Workplace Learning'.

The Trust Board noted:-

(a) that the Trust has recently been awarded the 'Skills for Health Quality Mark', details of which were set out at Appendix 1 to the paper;

(b) the key components of the Trust's 'Leadership into Action Strategy 2014/16', summarised at Appendix 2 of paper Q;

(c) that work continued to develop the Trust's workforce indicator dashboard, as now explained by the Director of Human Resources.

Resolved – that the report be received and noted.

261/14 QUALITY AND PERFORMANCE

261/14/1 Month 5 Quality and Performance Report

The month 5 quality and performance report (paper R – month ending 31st August 2014) highlighted the Trust's performance against key internal and NHS Trust Development Authority metrics, with exception reports appended.

In terms of the 24th September 2014 Quality Assurance Committee meeting, Ms J Wilson, Non-Executive Director and Committee Chair highlighted the following issues:-

(a) consideration of the monthly patient safety report and annual patient safety report, respectively;

(b) the Committee's discussion on the subject of a shortage of junior doctors, and the intention of the Committee to review this matter again later in the year;

(c) the Committee's receipt of a presentation on stroke services, which had assured the Committee on the Trust's position on this matter;

(d) the Committee's review of fractured neck of femur performance, a subject upon which there would be a presentation to a future meeting;

(e) the Committee's receipt of a report on SHMI;

(f) the Committee's discussion of cancer waiting times performance – it was noted that it was proposed to receive a report on this subject at the October 2014 Trust Board meeting.

At the suggestion of the LLR Healthwatch representative, it was agreed that the report to be submitted to the October 2014 Board meeting on cancer waiting times performance should set out the local and national factors felt to be influencing the Trust's current performance. Furthermore, the Board agreed with the suggestion of the Chief Nurse that the report should also review the results of the national cancer patient survey 2014.

The Medical Director reported orally on recent improvements in the Trust's SHMI performance and it was agreed that, at its November 2014 Development Session, the Trust Board should examine mortality indicators in greater depth, together with the other key performance indicators featured in the new version quality and performance report.

The Acting Trust Chair and Finance and Performance Committee Chair then outlined key issues discussed by the 24th September 2014 Finance and Performance Committee, namely:-

(i) the challenges around ambulance waiting times, the need to ensure a realistic recording system with Commissioners and the importance of resolving this issue as a matter of high priority;

(ii) clinic letter performance: this matter was felt to need additional resource and prioritisation and, ideally, the implementation of a standardised technology model;

(iii) good progress in terms of Cost Improvement Programme Delivery 2014/15, although noting a key current risk in terms of job planning and associated productivity opportunities.

The Chief Nurse updated the Trust Board on a recent MRSA bacteraemia case.

Dr A Bentley, CCG representative noted the importance of reviewing the cancer detection rate in the context of the recent rise in cancer two week wait referrals; noted the Choose and Book recovery plan details of which were appended to the Quality and Performance report, implementation of which was being supported in primary care with progress scrutinised at the monthly LLR E-Communications Project Board. Dr Bentley also flagged performance against indicator E12 (Communication – ED, Discharge and Outpatient Letters), noting that it was important to be clear about whether the indicator referred to timeliness or electronic letter coverage and that achievement of 100% performance would help the Trust to work with primary care in switching off the circulation of paper letters to GP practices.

Finally, the Chief Operating Officer drew attention to performance in respect of operations cancelled on the day and their rebooking within 28 days.

Resolved – that (A) the month 5 quality and performance report for the period ending 31st August 2014 be received and noted,

(B) a comprehensive report on cancer waiting times performance be submitted to the October 2014 Board meeting and address:- **COO/ CN**

(1) how clinical risk is being mitigated in light of current performance,
(2) cancer detection rates,
(3) the local and national factors felt to be influencing the Trust's performance,
(4) the results of the national cancer patient survey 2014,

(C) discussion take place at the November 2014 Trust Board Development Session on mortality indicators and other key performance indicators featured in the new version UHL quality and performance report. **MD/CN**

261/14/2 Month 5 Financial Position

Paper S advised the Board of the Trust's financial position as at month 5 (ending 31st August 2014), noting a worsened year to date adverse variance to plan of £1.7M. Delivery of the year end £40.7M deficit was still being forecast, and paper S outlined mitigating actions in respect of key risks as set out in section 5 of the paper.

Resolved – that the month 5 financial update be received and noted.

261/14/3 Emergency Care Performance

Paper T provided an overview of ED performance, noting that performance in August 2014 had been 91.26%, compared to 90.1% in August 2013 and 92.52% in July 2014.

The Chief Operating Officer observed that, in general, performance was more stable than it had been over the last 18 months and drew Board members' attention to graph 3 of paper T, setting out the rolling 30 day average of performance.

The Chief Operating Officer:-

(a) highlighted the key actions taken since the Trust Board meeting on 28th August 2014, as set out in the report;

(b) amplified the key reasons why performance was not yet in line with the trajectory set out in the Trust's recovery plan, also summarised in the report;

(c) exchanged views with Dr T Bentley, CCG representative on the importance of integrated working with the Urgent Care Centre; and noted Dr Bentley's praise for the improved support provided by specialties to ED, especially out of hours;

(d) responded to questions posed by Professor Wynford-Thomas, Non-Executive Director on the sustainability of recent performance improvements;

(e) concurred with the views expressed by the Chief Executive on the need for the Trust to ensure that its improvement efforts on emergency care were appropriately resourced: the Chief Executive noted that this matter was being prioritised and that, in parallel, focus also needed to be applied to improvements in the emergency care system outwith UHL.

Resolved – that paper T, now submitted, updating the Trust Board on Emergency Department performance be received and noted and support be expressed for the actions being taken to improve performance. **COO**

262/14 GOVERNANCE

262/14/1 NHS Trust Over-Sight Self Certification

The Director of Corporate and Legal Affairs introduced the Trust's over-sight self certification return for August 2014. Following due consideration, and taking appropriate account of any further information needing to be included from today's discussions (including the month 5 exception reports, as appropriate), the Board authorised the Director of Corporate and Legal Affairs to finalise and submit the return to the NHS Trust Development Authority in consultation with the Chief Executive.

Resolved – that (A) paper U, now submitted, be received and noted,

(B) the Director of Corporate and Legal Affairs be authorised to agree a form of words with the Chief Executive in respect of the NHS Trust Over-sight self certification statements to be submitted to the NHS Trust Development Authority by **DCLA/ CE**

30th September 2014.

263/14 REPORTS FROM BOARD COMMITTEES

263/14/1 Audit Committee

Resolved – that the 2nd September 2014 Audit Committee Minutes be received and the recommendations and decisions therein be endorsed and noted, respectively (including adoption of the 2013/14 Annual Audit Letter as appended to those Minutes). **ADF**

263/14/2 Finance and Performance Committee

Resolved – that the 27th August 2014 Finance and Performance Committee Minutes be received and the recommendations and decisions therein be endorsed and noted, respectively. **ADF**

263/14/3 Quality Assurance Committee

Resolved – that it be noted that the Minutes of the August and September 2014 Quality Assurance Committee meetings shall be submitted to the Trust Board meeting to be held on 30th October 2014.

264/14 CORPORATE TRUSTEE BUSINESS

264/14/1 Applications for Charitable Funding

The Board received paper X, outlining the grant applications presented to an inquorate meeting of the Charitable Funds Committee held on 15th September 2014.

Ten applications were detailed in the report, all of which had been supported by the Charitable Funds Committee and which now came before the Board (as Corporate Trustee) for approval.

Also set out in paper X were details of the request for funding of the 2014 staff Christmas meal.

Prompted by a query raised by the Chief Nurse in respect of application 5158 (Appendix 7), the Board agreed with the proposal put forward by the Chief Executive that the Director of Marketing and Communications and Acting Director of Finance be requested to report to the Trust Board (as Corporate Trustee) on a framework to guide decision-making by the Charitable Funds Committee and Trust Board (as Corporate Trustee) on the expenditure of charitable funds.

The Board (as Corporate Trustee) approved each of the applications, now submitted, together with the charitable funding of the 2014 staff Christmas meal.

Resolved – that (A) paper X, now submitted, be received and each of the ten charitable funds application set out therein, together with the charitable funding of the 2014 staff Christmas meal, be approved, **ADF**

(B) the Director of Marketing and Communications and Acting Director of Finance be requested to report to the Trust Board as Corporate Trustee on a framework to guide decision-making by the Charitable Funds Committee and Trust Board (as Corporate Trustee) on the expenditure of charitable funds, such framework to recommend matters which are/are not suitable for charitable funds expenditure. **DMC/ ADF**

265/14 TRUST BOARD BULLETIN

Resolved – that the following Trust Board Bulletin items be noted:-

(A) Board effectiveness action plan;
(B) Listening into Action update.

266/14 QUESTIONS FROM THE PUBLIC RELATING TO BUSINESS TRANSACTED AT THIS MEETING

A member of the public commended the Acting Chair for the way in which he had carried out his duties as both Acting Chair and as a Non-Executive Director more generally. Noting that there were three Non-Executive Directors present today, a question was asked about the timescale for the recruitment of new Non-Executive Directors. In response, it was noted that the NHS Trust Development Authority had recently held interviews to recruit new UHL Non-Executive Directors and that an announcement was expected shortly.

A further comment was made by a Patient Advisor who was present at the meeting encouraging the Trust to ensure that the views of patients and the public were taken into account in the development of the Leicester Innovation and Improvement Patient Safety Unit and more generally.

Resolved – that the comments and questions, noted above, be recorded in the Minutes.

267/14 ANY OTHER BUSINESS

No other business was raised at the meeting.

Resolved – that the position be noted.

268/14 DATE OF NEXT MEETING

Resolved – that the next Trust Board meeting be held on Thursday, 30th October 2014 from 10am in Seminar Rooms A & B, Clinical Education Centre, Leicester General Hospital.

The meeting closed at 3.25pm

Stephen Ward
Director of Corporate and Legal Affairs

19th October 2014

University Hospitals of Leicester NHS Trust

Progress of actions arising from the Trust Board meeting held on Thursday, 25 September 2014

Item No	Minute Ref:	Action	Lead	By When	Progress Update	RAG status*
1	254/14	***Minute 235/14/1 of 28 August 2014*** The assurance given at the Trust Board meeting on 28.8.14 regarding the availability of the ICE requesting system for use by Primary Care once the EPR System goes live be recorded in the Minutes.	DCLA	Immediate	Actioned.	5
2	255/14(a)	***Matters Arising*** Trust Board to be advised at its January 2015 meeting on the outcome of the Medical Director's/Executive Team's consideration of whether additional resource is to be deployed to enable the Trust to meet its medical revalidation and appraisal responsibilities.	MD	TB 8.1.15	Update scheduled for the January 2015 Trust Board meeting.	4
2a	255/14(b)	***Medical Workforce Strategy*** Director of Human Resources to confirm the date for production of the next iteration of the Medical Workforce Strategy – date to be incorporated in the October 2014 Trust Board action log.	DHR	For TB action log 30.10.14	The Medical Strategy will be updated following discussions at the Clinical Senate and the New Roles Group. The next iteration will be produced by December 2014.	5
2b	255/14(c)	***Future provision of urgent care services*** Trust Board to be advised at its November 2014 meeting on the decision of the LLR CCGs on retendering the provision of urgent care services (NB decision expected to be taken by the end of October 2014)	CE	For TB action log 27.11.14	Update scheduled for the November 2014 Trust Board meeting.	4
2c	255/14(d)	***Nursing Workforce Report*** Trust Board to receive nursing workforce updates bi-annually, timing to be synchronised with the outcome of the bi-annual UHL nursing acuity review.	CN	Reports to be submitted to the TB at its meetings in January and July	Updates scheduled for the Trust Board meetings in January and July 2015.	4
2d	255/14(e)	***Monitoring of Patient Sexual Orientation*** Trust Board to be updated on this subject via the equality governance update report to be submitted to the January 2015 Trust Board meeting.	DHR	TB 8.1.15	Updates scheduled for the January 2015 Trust Board meeting. Considered by the Executive Team on 21.10.14 and agreed an alternative focus on capturing disability data to improve patient care and availability of support.	4

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

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

2e	255/14(f)	***Learning Disability: Critical Incidents and Patients Outcome Review*** Director of Human Resources to confirm timescales for completion of the analysis of two critical incidents and patient outcome review – timescale to be incorporated in October 2014 Trust Board action log.	DHR	For TB action log 30.10.14	Meeting to discuss outcome review methodology scheduled for 7.10.14. Completion date of the review to be agreed at that meeting.	4
2f	255/14(g)	***Choose and Book*** Trust Board to be advised at its January 2015 meeting on the outcome of the work to explore an increase in the number of available slots.	COO	TB 8.1.15	Update scheduled for the January 2015 Trust Board meeting.	4
2g	255/14(h)	Update on LETB discussions re: changes to the national Consultant contract: remove from Trust Board action log.	DCLA	Immediate	Actioned.	5
2h	255/14(i)	***UHL Patient and Public Involvement and Engagement Strategy*** Director of Marketing and Communications to submit a report to the January 2015 Trust Board meeting recommending the consideration and adoption of an updated UHL patient and public involvement and engagement strategy.	DMC	TB 8.1.15	Scheduled for January 2015 Trust Board meeting.	4
2i	255/14(j)	***UHL and LLR 5 Year Plans – Patient and Stakeholder Engagement*** Director of Marketing and Communications to submit a report to the October 2014 Trust Board meeting on the plans for patient and stakeholder engagement, following consideration of this subject at the Better Care Together Programme Board on 2nd October 2014.	DMC	TB 30.10.14	Rescheduled for November 2014 Trust Board meeting.	3
3	257/14(b)	***Emergency Floor Development*** Subject to the successful outcome of the Trust's bid to the Independent Trust Financing Facility for long-term borrowing, and approval by the NHS Trust Development Authority (decisions anticipated mid-October 2014), approval be given to proceeding with the remainder of the Emergency Floor enabling works.	CE	Contingent on decisions of Independent Trust Financing Facility & NHS TDA anticipated October 2014	Approval confirmed on 17.10.14 and approval to proceed with works confirmed.	5
3a	257/14(c)	Measures to mitigate the over-commitment of the 2014/15 capital programme to be discussed at the October 2014 Finance and Performance meeting.	ADF	Finance and Performance Committee October 2014	Recommendation arising from discussion at the 25.9.14 Finance and Performance Committee meeting to be considered for Trust Board approval on 20.10.14 (via the F&P Minutes).	4
4	257/14(d)	***UHL Development Support Plan*** Draft UHL development support plan to be discussed at the Trust Board development session on 16 October 2014, ahead of submission to the public Trust Board meeting on 30 October 2014, for approval and onward submission to the NHS Trust Development Authority.	CE/DS	TBDS 16.10.14 and TB 30.10.14	Scheduled for TBDS 16.10.14 and TB 30.10.14	5

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

5	258/14/1	***Draft 2015/16 and 2016/17 Integrated Business Planning Guidance*** Guidance approved for implementation, subject to the inclusion of the additional wording to describe the Trust's approach to patient and public involvement in the development of the Trust's Annual Plan 2015/16.	ADF/DMC	Immediate	Actioned.	5
6	260/14/1 (b)	***Medical Education*** Presentation on medical education (to accompany the paper submitted to the Trust Board on 25.9.14) to be circulated to Trust Board members.	STA	Immediate	Actioned.	5
6a	260/14/1 (c)	Discussion to take place at the December 2014 Trust Board development session on medical education, to include the Director of Clinical Education and consideration to be given to also inviting the CMG Clinical Education Leads to join the Trust Board for this session.	MD	TBDS December 2014	Scheduled for TBDS December 2014.	4
7	261/14/1 (b)	***Cancer Waiting Times Performance*** Comprehensive report on cancer waiting times performance to be submitted to the October 2014 Trust Board meeting: report to address (a) how clinical risk is being mitigated in light of current performance; (b) cancer detection rates; (c) the local and national factors felt to be influencing the Trust's performance; (d) the results of the national cancer patient survey 2014.	COO/CN	TB October 2014	Scheduled for Trust Board October 2014	4
8	261/14/1 (c)	***Mortality Indicators and other Key Performance Indicators*** Discussion to take place at the November 2014 Trust Board Development Session on the mortality indicators and other key performance indicators featured in the new version UHL Quality and Performance report.	MD/CN	TBDS November 2014	Scheduled for TBDS November 2014.	4
9	259/14/3 (a)	***ePIFFany*** Medical Director,Chief Nurse and Director of Human Resources to consider and determine how best to harness the new approach to staff education and training exemplified by the ePIFFany project.	MD/CN/DHR	Immediate	ECLIPSE (modelled on ePIFFany) is being trialled at LRI in order to improve functioning of MDT and improve patient safety. This will inform potential for future scalability which will then be discussed by the Executive Team.	5
9a	259/14/3 (b)	Chief Executive to invite Dr R Patel , NIHR Academic Clinical Lecturer in Medical Education, University of Leicester and Honorary Specialist Registrar in Renal Medicine to the Executive Team Improvement Workshop to be held on 30 September 2014.	CE	Immediate	Actioned.	5
10	259/14/2 (c)	***Complaints Engagement Event: Action Plan*** The Chief Nurse to consider and determine the most effective way of deploying existing resources in the implementation of the complaints	CN	Immediate	In progress. Update to be provided to the 27 November 2014 Trust Board.	4

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

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

		engagement event action plan.				
10a	259/14/2 (d)	***Whistleblowing Policy*** Taking in to account the independent review of whistleblowing in the NHS ('Freedom to speak up?') due to complete its work by November 2014,the Director of Human Resources to confirm the timescale for completing the review of the Trust's Whistleblowing Policy – for incorporation in the October 2014 action log.	DHR	For Trust Board action log 30.10.14	The Trust's Solicitors have advised on the revised content of this policy, along with HR and Staff Side colleague input. The revised policy has now been finalised and submitted for ratification to the Policy and Guideline Committee.	5
10b	259/14 (e)	Consideration be given to means of strengthening the ways in which patients and the public can raise concerns about patient care and other issues of concern; and to publicising such arrangements: outcome to be incorporated in the October 2014 Trust Board action log.	CN	For Trust Board action log 30.10.14	In progress. Update to be provided to the 27 November 2014 Trust Board.	4
11	264/14/1 (a)	***Applications for Charitable Funding*** Each of the 10 Charitable Funds applications, together with the charitable funding of the 2014 staff Christmas meal, be progressed consequent upon their approval by the Trust Board (as Corporate Trustee).	ADF	Immediate	Actioned	5
11a	261/14/1 (b)	Director of Marketing and Communications and Acting Director of Finance to report to the Trust Board as Corporate Trustee on a framework to guide decision-making by the Charitable Funds Committee and Trust Board (as Corporate Trustee) on the expenditure of charitable funds, such framework to recommend matters which are/are not suitable for charitable funds expenditure.	DMC/ADF	Trust Board 27.11.14	On track.	4

Matters arising from previous Trust Board meetings

Item No	Minute Ref:	Action	Lead	By When	Progress Update	RAG status *
28 August 2014						
7a	235/14/1	Empath Full Business Case to be presented to the September 2014 Trust Board.	ADF	TB ~~25.9.14~~ ~~30.10.14~~ 27.11.14	Rescheduled to November 2014 Trust Board.	4
9.	235/14/3	***Board Assurance Framework (BAF)*** Risk 1 to be divided into 'UHL' and 'LLR system-wide' components.	CN	Immediate	Plans in place to divide this risk in the next iteration of the BAF.	4

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

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

9b	235/14/3	Dr D Briggs, LLR emergency care plan lead, to be advised of UHL's concerns over the LLR emergency care plan and invited to clarify the position of that plan to the September 2014 Trust Board. **See also action 10 below**	COO	TB ~~25.9.14~~ 30.10.14	Dr Briggs contacted and as he is unavailable to attend the September 2014 Trust Board meeting, this item has been scheduled for the October 2014 Trust Board agenda.	4
10.	236/14/1	***Month 4 quality and performance report*** In his presentation to the September 2014 Trust Board **(see action 9b above)**, Dr D Briggs also to be asked for an action plan to reduce DToCs.	COO	TB ~~25.9.14~~ 30.10.14	Dr Briggs contacted and as he is unavailable to attend the September 2014 Trust Board meeting, this item has been scheduled for the October 2014 Trust Board agenda.	4
13b	237/14	Measures to raise the Board-level profile of R&D to be considered by Executive Directors and fed into the Board effectiveness action plan as appropriate.	DCLA/ EDs	Immediate	Director of Corporate and Legal Affairs to discuss with the newly appointed Trust Chair when he takes up his appointment on 1st October 2014.	4
31 July 2014						
17.	210/14/1	***Vascular Services Outline Business Case*** Full Business Case to include assurance on the impact on mortality, funding requirements, operational efficiencies (as per 30 July 2014 Finance and Performance Committee discussions).	DS	For FBC October 2014	A paper is due to go to the 24 September Quality Assurance Committee that includes a service move assessment framework, the paper is to then go to the October ESB. **Report deferred to October 2014 QAC to enable prior discussion by the Executive Quality Board.**	4
26 June 2014						
19.	180/14/1	Finalised LLR 5-year health and social care plan to be presented to the September 2014 Trust Board.	DS	~~TB~~ ~~25.9.14~~ 27.11.14	Scheduled accordingly. **Deferred to the November 2014 Trust Board. Update on the Better care Together Programme scheduled for September 2014 Trust Board.**	3
20.	180/14/2	***Draft UHL 5-year plan – executive summary*** Final versions of the UHL (and LLR) 5-year plan to be presented to the Trust Board for formal approval in September 2014.	DS/CE	~~TB~~ ~~Sept/Oct 2014~~ 27.11.14	Being worked through and on track to be presented to the Trust Board in September 2014. **Deferred to the November 2014 Trust Board.**	3
21.	180/14/2	Monitoring of progress against the 5-year plan to be included in the detailed Delivering Caring at its Best update being provided to the October 2014 Trust Board.	CE	TB ~~20.10.14~~ 27.11.14	Scheduled accordingly for report to 30 October 2014 Board meeting. **Deferred to the November 2014 Trust Board.**	3

** 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***

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **30 OCTOBER 2014**

REPORT BY: **CHAIRMAN**

SUBJECT: **CHAIRMAN'S OPENING COMMENTS**

Introductory Comments

This is my first Trust Board meeting. I look forward to working with my Board colleagues, staff, our partners in the local health and social care economy, patient and community groups, and other stakeholders. I believe that we should all have a common focus on how we can deliver safe, high quality health services to patients in the most efficient manner. In order to do this we have to demonstrate that we are receptive to emerging issues after considering the experience of our patients and responsive in terms of changing how we do things if that is necessary.

Immediate Priorities

My immediate priorities will be to focus on three areas:

The first is to ensure that current and emerging vacancies on the Trust Board are filled. It is important that we have Non-Executive and Executive Board members with the necessary skills and experience if we are to make the most out of creating opportunities from the many challenges which we face. This means that the Trust Board (which contains a majority of lay members including myself together with the Chief Executive and his team) has to work together in order to utilise these different perspectives effectively.

The second is that as a Board we need to have a clear sense of our strategy, vision and purpose and ensure that everyone within the Trust (and outside) understands it. We will have to ask ourselves whether any part of the strategy needs to be changed in the light of experience or assumptions which may no longer be valid. In addition to steering the organisation and thinking about the future, the Board is also responsible for holding to account (or supervising) the delivery of the strategy or performance of the Executive Team whilst ensuring value for money. This means that we will have to ask ourselves as a Board how the flow of information to us and decisions we take can be most efficient and effective. We also need to ensure that everyone understands that we will have a continued focus or eye on the ball.

The third is that we seek to understand the perspectives and experience of staff and patients within the Trust and others beyond. Executive members of the Board will inevitably have insights about what is happening within the Trust because of their interaction with staff and operational issues. My objective is to ensure that within the constraints of being part time

appointments, both myself and other Non-Executive members of the Board are able to interact as much as possible with patients and staff as well as stakeholders.

First Impressions

I have now had the opportunity to visit a number of clinical areas within the Trust and have been struck by the passion and pride with which some doctors and nurses talk about their service. I believe that innovation (or changes that lead to improvements) will come from ideas which they will have. I want to see how we can not only encourage fresh ideas and thinking but actually see them being put into practice.

I have also had an opportunity to talk to patients or groups representing their interests. Many of these discussions have made favourable references to the care that has been provided but some have been less positive. We need to ensure that we draw the appropriate learning and analysis from patient experiences and then act on it.

Concluding Comments

The Trust is an extremely large organisation operating within the communities of Leicester City, Leicestershire and Rutland (and patients coming from beyond for some services). Whilst the core business is delivering services in the health economy the Trust Board also needs to have a sense of how the organisation is contributing positively to the economic and social wellbeing of these communities. Finally we need to have the ambition and ability to make ourselves an exemplar and to be recognised as such.

Karamjit Singh CBE
Chairman, UHL Trust

University Hospitals of Leicester NHS
NHS Trust

Agenda Item: Trust Board paper D

TRUST BOARD – 30TH OCTOBER 2014

MONTHLY UPDATE REPORT – OCTOBER 2014

DIRECTOR:	CHIEF EXECUTIVE
AUTHOR:	DIRECTOR OF CORPORATE AND LEGAL AFFAIRS
DATE:	20TH OCTOBER 2014
PURPOSE:	**(concise description of the purpose, including any recommendations)** To brief the Trust Board on key issues and identify changes or issues in the external environment.
PREVIOUSLY CONSIDERED BY:	**(name of Committee)** N/A
Objective(s) to which issue relates *	[√] 1. Safe, high quality, patient-centred healthcare [√] 2. An effective, joined up emergency care system [ ] 3. Responsive services which people choose to use (secondary, specialised and tertiary care) [ ] 4. Integrated care in partnership with others (secondary, specialised and tertiary care) [ ] 5. Enhanced reputation in research, innovation and clinical education [√] 6. Delivering services through a caring, professional, passionate and valued workforce [√] 7. A clinically and financially sustainable NHS Foundation Trust [ ] 8. Enabled by excellent IM&T
Please explain any Patient and Public Involvement actions taken or to be taken in relation to this matter:	N/A
Please explain the results of any Equality Impact assessment undertaken in relation to this matter:	N/A
Organisational Risk Register/ Board Assurance Framework *	[ ] **Organisational Risk Register** [√] **Board Assurance Framework** [ ] **Not Featured**
ACTION REQUIRED *	For decision [ ] For assurance [ ] For information [√]

♦ We treat people how we would like to be treated ♦ We do what we say we are going to do
♦ We focus on what matters most ♦ We are one team and we are best when we work together
♦ We are passionate and creative in our work

* tick applicable box

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **30 OCTOBER 2014**

REPORT BY: **CHIEF EXECUTIVE**

SUBJECT: **MONTHLY UPDATE REPORT – OCTOBER 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 Caring at its Best Awards 25th September 2014;

(b) the Trust's success in being selected for the 'Mutuals in Health Pathfinder Programme';

(c) the successful outcome of the Trust's recent bid for loan funding;

(d) the Trust's recent Board to Board meeting (held on 10th October 2014) with the NHS Trust Development Authority;

(e) plans to implement changes to staff car parking arrangements;

(f) emergency care performance; and

(g) the Trust's Month 6 financial position.

John Adler
Chief Executive

20th October 2014

Trust Board paper E

LLR emergency care system developments/improvements

Dave Briggs

MD East Leicestershire and Rutland CCG

Inflow

Care planning

- Care plan access
- Care plan use – snap shot audit undertaken recently on cardiac arrest calls to nursing homes and DNAR / EOL plans in place.

Admission Avoidance

- Back office GP numbers for Care Homes and EMAS
- OOH direct line for Care Homes
- Falls – EMAS training and dedicated SPA line – expected non conveyance rate of 70%
- Older Persons Unit - Loughborough
- Community Response Team – City – non admission rate of 73%
- ECP's – West
- Nursing Home training – focus on high attendance/admission homes
- Night Nursing Service

Ambulatory Care

- Update of the Cellulitis pathway – re launch at the beginning of November
- UTI pathway - tasks and finish group meeting next week – will include UTI, urine retention and catheter changes.
- East have completed a review of GP use of existing ambulatory pathways – this will be rolled out in City and West
- More work to be undertaken in partnership to maximise opportunities

Discharge Oversight

- Discharge Steering Group – oversees the work stream :
- Activity monitoring – KPI's – over the last year whilst numbers haven't reduces the daily turnover has reducing bed days delayed from 500 to 300-250
- Oversight of Individual Service actions including providers, social care and CHC – specific actions being taken by county social care to support domiciliary care demand and although care packages have increase by 100% on the previous year demand is still outstripping supply in some areas. The Social Care team have introduced a number of actions to maximise availability of service including 2 week review processes.
- Identifying blocks to system delivery and agreeing actions and resources to address issues. The 3 key areas are described on the following slides

Discharge

Streamlining of the pathway with redesign of 2 key pathways

- Pathway 2 - Home with Support/reablement

Pathway is already underway within the County and links to the work on community service care at home

- Pathway 3 - Bed base reablement

Pilot is due to start at the beginning of November within the City . Locations have been identified in the County and are progressing to pilot stage

Benefits

Avoiding CHC assessments within the acute environment

Optimising a patients potential – home earlier and reducing long term care demand

Supporting Discharge

Minimum Data Set

- There are currently 23 different discharge documents.
- There is no trust assessment process in place which means there are delays whilst care homes come in to assess each patient

Advantages of MDS

- Minimum data requirements agreed by all services to identify patient need
- Needs based assessment enables services to identified support required rather than a prescription for care
- Electronic data transfer is being pursued and currently at option appraisal phase. This will enable data to be shared electronically partners adding to the assessment rather than duplication of effort. This will also be shared with care homes to build towards trusted assessment. Interim solutions are in place to support the discharge pathway 3 pilot.

Continuing Health Care

Fast Track – LLR had the highest fast track numbers within the country

•It was used as a quick discharge route rather than a focus on patients who where moving towards end of life and required rapid support to go home or preferred place of death.

•This caused the process to be slow and delays occurring in setting up support packages.

•As a result many patients were on Fast track pathway for months / years which was exacerbated by a back log in the review process.

•Actions

- Peer review of process
- Revision of process and implementation of review findings
- Education of care teams
- Assurances processes put in place
- Ensuring consent obtained for all patients
- Reducing the 3 month review back log
- Reallocation of patients to appropriate funding streams following review.
- Data cleansing

The result of which has been a reduction in numbers of Fast track referrals by 30-50%

More rapid response for patients who need the fast track support

The movement of a forecast outturn of £25m to £15m (some of which has been transferred to mainstream funding.

Work is now moving forward to apply the review process to mainstream CHC funding.

University Hospitals of Leicester NHS
NHS Trust

Agenda Item: Trust Board paper F

TRUST BOARD – 30th OCTOBER 2014

LEARNING LESSONS TO IMPROVE CARE

DIRECTOR:	Medical Director ~ Dr Kevin Harris
AUTHOR:	Caroline Trevithick ~ Chief Nurse & Quality Lead, WLCCG
DATE:	30th October 2014
PURPOSE:	To provide update to the Board on the progress made to implement the recommendations arising out of the learning lessons to improve care review
PREVIOUSLY CONSIDERED BY:	QAC
Objective(s) to which issue relates *	[Y] 1. Safe, high quality, patient-centred healthcare [Y] 2. An effective, joined up emergency care system [ ] 3. Responsive services which people choose to use (secondary, specialised and tertiary care) [Y] 4. Integrated care in partnership with others (secondary, specialised and tertiary care) [ ] 5. Enhanced reputation in research, innovation and clinical education [Y] 6. Delivering services through a caring, professional, passionate and valued workforce [ ] 7. A clinically and financially sustainable NHS Foundation Trust [Y] 8. Enabled by excellent IM&T
Please explain any Patient and Public Involvement actions taken or to be taken in relation to this matter:	All next of kin of patients in the review have been contacted. Meetings with next of kin have been offered and when taken up undertaken to explain the outcome of the review. There is "Healthwatch" representation on implementation Task Force overseeing the required actions. Public engagement events to explore themes from the review are planned for later in the year.
Please explain the results of any Equality Impact assessment undertaken in relation to this matter:	-
Organisational Risk Register/ Board Assurance Framework *	[ ] **Organisational Risk Register** [x] **Board Assurance Framework** [ ] **Not Featured**

ACTION REQUIRED *

For decision [ ] For assurance [x] For information [x]

♦ We treat people how we would like to be treated ♦ We do what we say we are going to do
♦ We focus on what matters most ♦ We are one team and we are best when we work together
♦ We are passionate and creative in our work

* tick applicable box

East Leicestershire and Rutland Clinical Commissioning Group
Leicester City Clinical Commissioning Group
Leicestershire Partnership NHS Trust
University Hospitals of Leicester NHS Trust
West Leicestershire Clinical Commissioning Group

Learning Lessons to Improve Care

Quarterly update to boards

1. INTRODUCTION

The following paper reports the actions taken following publication of the Learning Lessons to Improve Care review in July 2014.

The review was commissioned by health organisations in Leicester, Leicestershire and Rutland and examined the quality care patients received. It identified that of the 381 case notes audited, 208 (55%) were identified as having significant lessons to learn. Of these 89 (23%) were found to be below an acceptable standard. Thematic analysis of the findings identified 47 themes, the 'Top 12' being:

- DNAR orders
- Clinical reasoning
- Palliative care
- Clinical management
- Discharge summary
- Fluid management
- Unexpected deterioration
- Discharge
- Severity of illness
- Early Warning Score
- Antibiotics
- Medication

Many of the issues described by the review were already recognised locally and nationally as key areas for improvement and as such in many instances action is already being taken. Nonetheless the review has shown where, as a whole local health system, effort should be focused.

The local health organisations involved in the review have expressed regret over the findings and made a shared and public commitment to address the issues raised by the review and to do all in our power together and individually, to improve the quality and experience of care in Leicester, Leicestershire and Rutland.

2. PROGRESS TO DATE

2.1 Development of the Clinical Task Force

In order to address the themes that were either cross-organisational or common across

NHS organisations, a Clinical Task Force was established. The task force includes senior clinical representatives from University Hospitals of Leicester NHS Trust (UHL), Leicestershire Partnership NHS Trust (LPT), and the three local Clinical Commissioning Groups. All members have the authority of their governing bodies/board to take forward the work to make the necessary improvements in patient care. In addition Public Health England, Healthwatch and the Local Medical Committee are also represented on the task force.

The aims of the task force are to develop a granular plan that has the specific detail of what needs to be done by who (based on the LLR Learning Lessons to Improve Care Five point plan) and has clear timelines and outcomes. The task force are also responsible for facilitating the delivery of the plan and for evaluating the impact of the plan.

The plan is focused in five work streams – public involvement, clinical leadership, end of life care, urgent care and integration of quality and safety.

In order to ensure that the learning from the review results in sustainable change it is necessary to direct resources into the plan. It is suggested that the implementation of the plan will be a three-year project and therefore will need resourcing accordingly. A business case has been developed and shared with constituent organisations to ensure that the appropriate level of resource is identified to enable to actions to be implemented fully. All organisations have been requested to support the recommendations in the Business Case.

2.2 Workstream – Public Involvement

Contact with families
Prior to publication of the review, the local NHS made contact with the 381 families of the patients whose case notes had been reviewed in the audit. Letters were sent to each of the families explaining the review and its findings and indicating whether the reviewers had identified acceptable or unacceptable care in the case of their loved one. Relatives were offered the opportunity to call a dedicated phone number to find out more and to access support. The phone lines were staffed by senior nursing staff and patient experience leads from across Leicester, Leicestershire and Rutland.

76 families called the call centre and meetings were offered to discuss the care their relatives had received. 33 relatives took the opportunity to meet with clinical teams, from UHL, primary care or NHS England.

The full analysis of the call logs and the outcomes from the meetings is currently underway. Early indications indicate that most families welcomed the opportunity to discuss the care that their relatives had received. It is interesting to note that anecdotal evidence from these calls suggests that often families whose loved one had received ‘unacceptable care’ had a different view. This means there could be a disconnect between relatives’ understanding of acceptable care and that of clinicians. Once the information has been fully analysed the findings and recommendations will be incorporated into the action plan.

Public listening events
All local health organisations are committed to listening to, and acting on the views of patients and their relatives and significant work already takes place to enable this. Following the contact with the relatives of the patients involved in the audit, it has become

clear that there is more we can do collectively to understand about how our patients, relatives and carers experience care in LLR and to take shared action to address this.

To start this process, three public events are being held in venues across LLR in October and November so that we can better understand this aspect of care quality.

In line with the clinical events we will be undertaking a full thematic analysis of the findings to further shape the actions required.

A full communications and engagement plan is also being developed to support further work with the public.

2.3 Workstream – Clinical Leadership

Clinical leadership plays a very important part of the work to act on the findings of the audit and make improvements for patients. The task force has facilitated the first of a number of events where clinical staff from all disciplines and from all organisations across LLR can come together to co-produce the solutions to the problems.

The first of these events was held on 9th October using Listening into Action methodology. A total of 67 clinicians attended the event from UHL, LPT and the three CCGs.

Early feedback from the event is included as Appendix 1. The task force is working in partnership with De Montfort University to analyse the output from the event and identify themes and actions.

2.4 Workstream – End of Life Care

In recognition of issues relating to end of life care, a group was established to take forward the actions necessary to improve end of life care. Whilst there are still some ongoing actions for the end of life group the following achievements have been realised:

- Unified approach to Do Not Attempt Cardio Pulmonary Rehabilitation (DNR CPR)
- A singe DNACPR form in use across Leicester, Leicestershire and Rutland and available electronically for GPs and EMAS
- Unified Advance Care planning
- Green bags and wallets in place to ensure all staff are aware of care plans
- Anticipatory drugs
- Location agreed to ensure all staff are aware of preferred location
- Community access identified
- Timely access to wheelchair provision for end of life patients
- Standardising leaflets and terminology

2.5 Workstream – Urgent Care

The task force is planning to review the full report from Ian Sturgess on the Urgent Care pathway and review the findings and recommendations in conjunction with the learning from the clinical and patient listening events. The aim is to take these to a joint primary/secondary care clinical event in December.

2.6 Workstream – integration of quality and safety

The task force has been working to ensure appropriate governance arrangements are in place. It has been deemed essential that the learning from the audit be incorporated into the workstreams for Better Care Together (BCT). To this end the task force will be working closely with the BCT Clinical Reference Group to ensure that the objectives for the two groups are closely aligned in the aim to better develop clinical leadership. In addition the actions identified from the report have been shared with the BCT Clinical Leads to ensure that they are included in the planning for the individual workstreams.

3. FUTURE PLANNING

The clinical task force is determined to see tangible outcomes from their work every month and have developed a planning grid to identify actions. The planning grid is included as appendix 2, but it should be noted that this is an iterative document that will change over time.

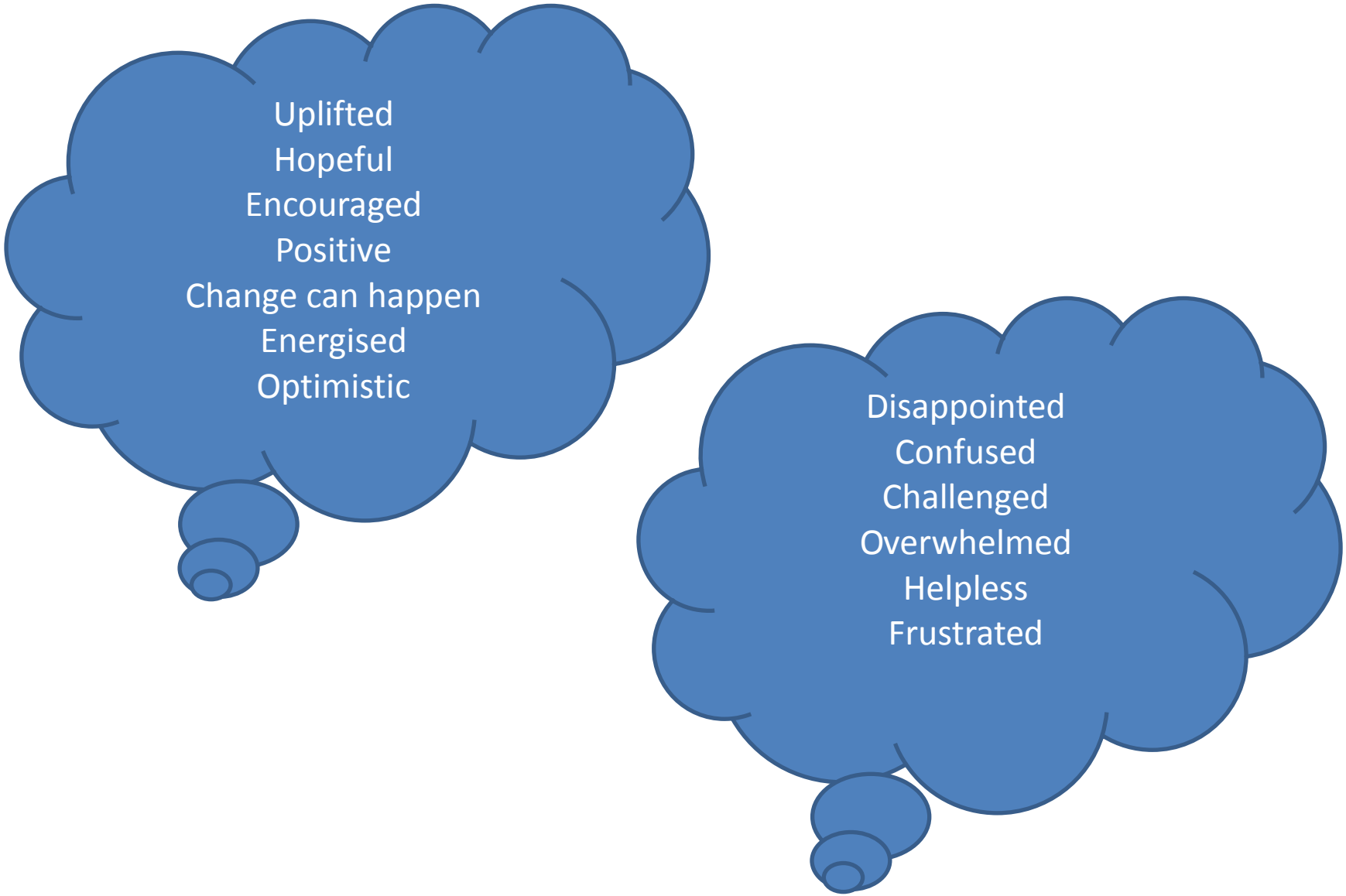
Key outcomes for the next quarter are as follows:

- Fast response to implement actions from the Listening events
- Repeat clinical event to ensure implementation of the actions and continues clinical engagement
- System clinical leadership development
- Identification of outcome indicators to ensure we can demonstrate progress
- Development of quality champions
- Agreement on the methodology to repeat the Learning Lessons study to allow us to benchmark ourselves.

4. RECOMMENDATIONS

Boards are requested to note the progress of the Learning Lessons to Improve Care Clinical Task Force.

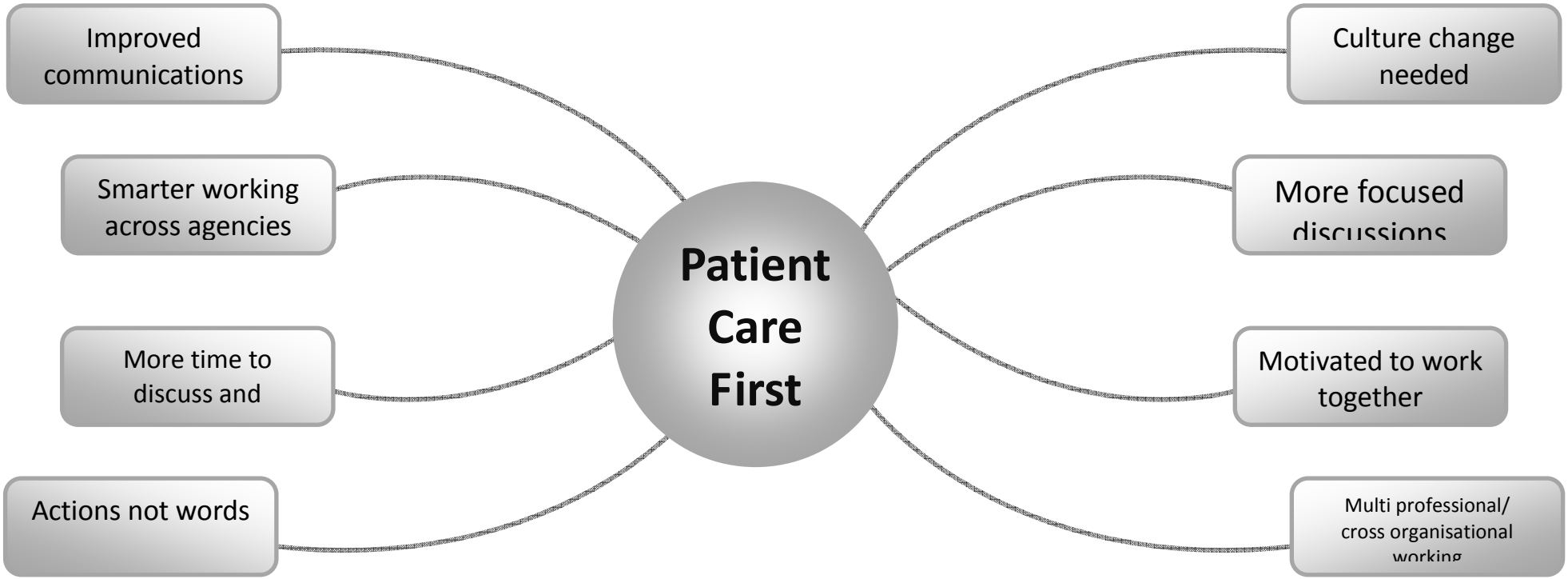
Appendix 2 – evaluation from Listening into action event



Learning Lessons to Improve Care

NHS

Learning Lessons to Improve Care



Appendix 2 - PLANNING GRID

MONTH	ACTION	LEAD	RESULTS/OUTCOME	COMMENT	ON-GOING
	Product, initiative event				Specific response to thematic analysis via clinical & operational huddles.
October	Clinical Summit - LIA, Public event	CTrev/RM	Clinical leadership & specific themes & actions. Patient &carer engagement,		
November	Postcards – shared decision making. Public events Impact report of bereaved relative stories. Communication highlight progress with individual institutional action plans Patient safety report.	RM/SV CTrev/RM CTrev RM Susan	Patient culture change & empowering patients, external facing LLR wide. Patient & carer engagement. Further development of the action plan. Duty of candour.		

	Serious incidents. Paper to all public Boards. Quick wins from LIA event. Commission learning lesson website & feedback mechanism (positive & negative) Receive IS report & agree appropriate actions for the task force. Journal article outlining work of CCGs in managing system quality.	Clennet. CTrev CTrev RM ML/KH ML	To monitor progress.		
December	Is quality and safety improving in LLR? Need performance dashboard commissioned by PwC. Way forward on repeat review by external organisation. Task force/LMC summit	ML CTF ML& KH	Metrics about joined up care in the whole health economy. Committed to a further study, awarding of the contract.		

	Launch hello my name is – across LLR.	Carole Ribbins.	Clinical leadership & engagement & top tips for GPs.		
January	Best example of integrated care & exceptional leadership Quality & care champions. Institutions to share their leadership strategy with the workforce. Event to encourage system leadership masterclass. PwC or Aiden Halligan	Carole Ribbins & Jude Smith DL, CTrev & CoB. CTF ML/KH	Measurement of clinical engagement, scale, plus xxx number of champions/leaders. System wide response. Culture development.		
February	Recognise the dying patient & talking to relatives about ACP upskilling. Shared record viewing EPR for EOL care.	RP/LF TB RP	Upskilled health economy in EOL care. UHL/practice interaction.		

	Enhanced SPN capability.				
March	Completion of review.				
April					
May					
June					
July					
August					
September	Conference to review progress & celebrate.				

University Hospitals of Leicester NHS
NHS Trust

Agenda Item: Trust Board paper G

TRUST BOARD – 30th October 2014

Cancer Centre Highlight Report

DIRECTOR:	Richard Mitchell
AUTHOR:	Matthew Metcalfe/Michelle Wain
DATE:	23 October 2014
PURPOSE:	**To update the Board on UHL cancer performance and patient experience, and recommendations for improvement;** • Support is sought for the multi-faceted approach suggested for sustainable recovery in Cancer Performance (as set out in point 6), capable of recovering performance standard by December 2014 • Assurance is derived from the actions to mitigate risk as set out in section 7.0
PREVIOUSLY CONSIDERED BY:	**N/A**
Objective(s) to which issue relates *	[Y] 1. Safe, high quality, patient-centred healthcare [ ] 2. An effective, joined up emergency care system [Y] 3. Responsive services which people choose to use (secondary, specialised and tertiary care) [Y] 4. Integrated care in partnership with others (secondary, specialised and tertiary care) [ ] 5. Enhanced reputation in research, innovation and clinical education [Y] 6. Delivering services through a caring, professional, passionate and valued workforce [ ] 7. A clinically and financially sustainable NHS Foundation Trust [ ] 8. Enabled by excellent IM&T
Patient and Public Involvement actions taken or to be taken in relation to this matter:	Establishment of patient user group to support the Patient Experience work plan
Equality Impact assessment undertaken in relation to this matter:	To be undertaken by user group
Organisational Risk Register/ Board Assurance Framework *	[ ] **Organisational Risk Register** [ ] **Board Assurance Framework** [ ] **Not Featured**
ACTION REQUIRED *	For decision [X] For assurance [X] For information [X]

♦ We treat people how we would like to be treated ♦ We do what we say we are going to do
♦ We focus on what matters most ♦ We are one team and we are best when we work together
♦ We are passionate and creative in our work

1.0 Executive Summary

The delivery of timely, high quality cancer care, as reflected by performance against cancer waiting times standards, was transformed during 2013/14 through a Cancer Centre work programme. UHL became a high performing cancer centre, sustained over 12 consecutive months. This transformation has been reversed abruptly, starting in Q1 of 2014/15.

Increased referral rates, particularly for breast cancer, have not been associated with an increase in cancers diagnosed, and so do not entirely account for the deterioration in performance. Referral rates for suspected cancer are likely to continue to increase, and this needs to be planned for.

Cancer pathways are complex requiring the integration and coordination of multiple services through diagnosis to treatment. The waiting times are short. Cancer pathways are therefore inherently fragile. Performance depends on process and systems that prioritise and expedite patients through these pathways.

The system for integration of care for cancer patients and promoting clinical engagement remains in place. Diagnostic support for the CMGs "hosting" individual types of cancer (tumour sites) remains excellent. Operating theatre capacity (surgery) and access to oncology services (radiotherapy and chemotherapy) are sufficient to support timely treatment for patients once diagnosed. Delivery of performance for individual types of cancer therefore lies within the gift of the host CMGs. The host CMG processes to support cancer pathways need to be effective in the face of parallel priorities. Cancer recovery plans from the CMGs produced at the end of Q1 have not resulted in recovery by end of Q2.

Welcome improvements in cancer patient experience at UHL across a broad range of measures are probably a reflection of improvements in the quality and timeliness of cancer pathways. Restoring the timeliness is therefore also a pre-requisite for continuing improvement to cancer patient experience in addition to recovering performance.

UHL has demonstrated the ability to deliver and maintain excellent cancer performance against waiting times standards. Learning from the recent experience of challenges in sustaining cancer performance whilst attending to other key priorities, the following actions are now agreed;

I. CMGs to assume and plan for a further 20% growth in urgent suspected cancer referral (2WW) over the next 12 months, and anticipate and accommodate peaks associated with awareness campaigns for individual types of cancer
II. CMGs to implement SOPs covering their internal structure and process to provide dedicated cancer pathway support
III. Monthly exception reports by tumour site where predicted performance not meeting internal standards to Cancer Board and Executive Performance Board.

2.0 Background and Introduction

In June 2013 after 6 consecutive months of not meeting the 62 day standard for the treatment of cancer patients referred under 2WW criteria the Cancer Centre was re-structured and undertook a programme of work to recover the standard. This programme focussed on the timely delivery of high quality clinical pathways rather than pushing through bursts of reactive additional activity, having agreed a cumulative recovery trajectory with the CCGs.

The main elements of this work programme were;

1) Establishment of a weekly Cancer Action Board (CAB) for the then CBU managers to develop and deliver recovery plans for the elements of cancer pathways they were responsible for.
2) Development of individual tumour site dashboards with performance data and patient level detail for those delayed on pathway to monitor and pro-actively manage care. Patients with delayed pathways were discussed individually with all relevant departments present at CAB meetings.
3) Introduction of a monthly clinically lead Cancer Board for clinical feedback on the challenges in delivering high quality and timely cancer care within UHL. The membership of this board includes the MDT lead clinicians for the individual tumour sites.
4) A transformational project within the imaging service to deliver 80% of cancer related imaging reports within 7 days of the request, compared with the previous 15%, was implemented

This work programme delivered 12 consecutive months of achieving cancer waiting times standards, and in particular the 62 day urgent referral to treatment standard at UHL. As the elements of the work programme gained traction performance continued to improve. UHL was in the bottom quartile for cancer treatment providers nationally in Q1 of 2013/14, and 7th of 7 peer large tertiary service acute trusts. In Q4 UHL was an upper quartile performer nationally, outperforming our peer organisations. The improvements in performance at UHL were achieved against a national picture of a gradual decline in performance against the 62 day standard.

This period of continuous improvement came to an abrupt halt with a sharp decline in 62 day performance by the end of Q1 of 2014/15, which has proved refractory to early measures taken to restore high performance.

This paper sets out;

I. A summary of current performance
II. A summary of the 2013/14 National Cancer Patient Experience Survey
III. An analysis of the causes of the deterioration in performance within UHL
IV. The planned recovery of the cancer waiting times standards

V. The measures in place to monitor and mitigate clinical risk associated with current performance

3.0 Current performance

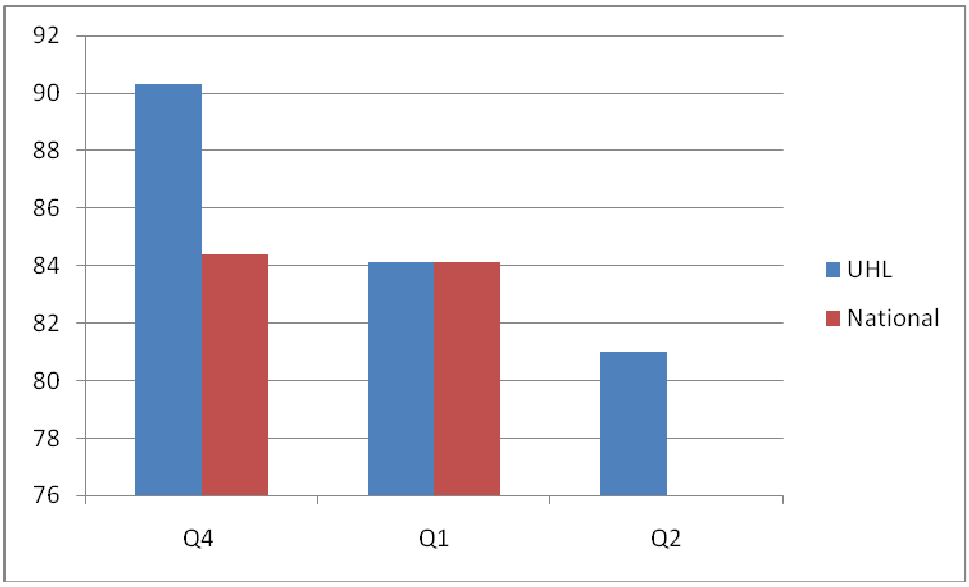
For the purposes of this paper the performance standards referred to are the 2WW urgent referral to appointment standard (93% to be seen within 14 days) and the 62 day urgent referral to treatment standard (85% to commence treatment within 62 days when cancer confirmed in a 2WW referral).

2WW performance for UHL over the last 3 quarters has been as follows;

Target	2013/14 Q4	2014/15 Q1	2014/15 Q2
93%	95.5%	92.2%	90.6% *

**Subject to final validation*

62 day performance over the same time reporting periods is set out in the graph below, with UHL benchmarked against national performance.



Target 85%, Q2 data for UHL subject to validation, Q2 National data not yet reported

A hallmark of the deterioration in 62 day performance is that pathways have been elongated relatively little. As an illustration of this, if a week was shaved off each patient pathway for those who breached the standard, performance in Q2 would have been met for Q2.

4.0 Results of the 2013/14 National Cancer Experience Survey for UHL

This annual survey comprehensively covers the cancer patient's experience of their journey from referral through diagnosis, staging, treatment and discharge through 70 questions.

UHL has seen a significant improvement in its results compared with the 2012/13 survey. In a marked "right shift" the scores for the overwhelming majority of these

domains have improved. As a result UHL is now “in the red” (lowest 20% of trusts) for 13 of the 70 domains, compared with 33 for the previous year. UHL is “in the green” for 2 domains (upper 20% of trusts) compared with none the year before.

A work programme is in progress, covering trust level and individual tumour site level actions as appropriate. This is coordinated by the Cancer Centre Lead Nurse. Central to a further stepwise improvement will be the establishment of a user group.

It is noted that performance and patient experience go hand in hand in so far as a timely service at a time of inevitable stress inevitably improves experience. Of particular interest is the improvement in the experience reported in relation to diagnostic imaging elements of pathways.

5.0 Analysis of the cause of deterioration in performance

A clear understanding of the internal and external factors responsible for the deterioration in performance is a pre-requisite to implementing an effective and sustainable recovery plan.

5.1 External factors

Referral rates

Increased rates of 2WW referral without an increase in the numbers of cancers diagnosed from these referrals effectively means that more resource is required per cancer diagnosed.

In detail;

The overall rates of new cancers treated at UHL have remained unchanged between months 1 to 5 of 2014/15 and the corresponding period in 2013/14 (captured under the 31 day first treatment target). The number of new cancers diagnosed as a result of 2WW referral during the same period is also unchanged (the 62 day target).

By comparison there has been a substantial increase in the rate of 2WW referrals – 11.7% higher in 2014/15 than 2013/14, which in itself comes on a background of a 14.6% increase in 2WW referrals in 2013/14 over the preceding year.

This equates to an additional 209 referrals per month with no additional yield in terms of cancer diagnosis.

This trust level data is summarised below:

	M1-5 2013/14	M1-5 2014/15	Change
2WW referrals(patients/month)	1,784	1,993	+11.7%
62 Day new cancers(Patients/month)	192	189	-1.5%
Conversion rate	8.9%	8.0%	-10%

The breakdown of this data by tumour site demonstrates that although this pattern is repeated throughout all the high volume 2WW referral sites (over 100 referrals per month) the predominant impact has come from increased referrals to Breast under 2WW.

	M1-5 2013/14	M1-5 2014/15	Change
Breast			
2WW referrals(patients/month)	360	537	+49.1%
62 Day new cancers(Patients/month)	32	35	+9%
Conversion rate	8.9%	6.5%	-2.4%
Gynaecology			
2WW referrals(patients/month)	171	206	+20.5%
62 Day new cancers(Patients/month)	7	11.4	+62.8%
Conversion rate	4.1%	5.5%	+1.4%
Head and Neck			
2WW referrals(patients/month)	140	154	+10%
62 Day new cancers(Patients/month)	7.4	5.6	-24.3%
Conversion rate	5.3%	3.6%	-1.7%
Colorectal			
2WW referrals(patients/month)	184	206	+12%
62 Day new cancers(Patients/month)	11.4	12	+5.3%
Conversion rate	6.2%	5.8%	-0.3%
Skin			
2WW referrals(patients/month)	271	308	+13.6%
62 Day new cancers(Patients/month)	23.8	26	+9.2%
Conversion rate	8.7%	8.4%	-0.3%
Gastro-oesophaegeal			
2WW referrals(patients/month)	140	154	+28%
62 Day new cancers(Patients/month)	13	13	0%
Conversion rate	9.3%	7.3%	-2.0%
Urology			
2WW referrals(patients/month)	192	191	-0.5%
62 Day new cancers(Patients/month)	31	26	-16.1%
Conversion rate	16.1%	13.6%	-2.5%

The National context in which the UHL performance should be considered is informative. Comparative data is currently only available for Q1 of 2014/15. 2WW performance nationally has fallen from 95.5% to 93.5% with referrals increased 18% over the same quarter in 2013/14. The conversion rate to a diagnosis of cancer had reduced from 9.5% to 8.5%. 62 day performance nationally deteriorated from 86.9% to 84.1% from Q1 2013/14 to Q1 2014/15.

There is a clear National drive led by government and cancer charities to promote cancer symptom awareness and early referral under 2WW for cancer exclusion. The rationale for this is that this drive will result in earlier diagnosis and therefore better outcomes. The tendency for late presentation and therefore more advanced stage at time of diagnosis is the key factor in the residual “gap” in terms of outcomes in cancer care between the UK and the rest of Europe.

The increase in 2WW demand therefore is likely to represent a sustained trend.

Tertiary referrals

As a large tertiary centre UHL receives a large number of referrals from other acute providers for specialist treatment. Inevitably these tend to be the more complex cases with a higher inherent risk of delays to pathways. UHL receives a substantial number of these referrals, often very close to or after their 62 day breach date, and this has a detrimental impact on trust level performance. However this has not abruptly changed, and therefore does not account for the deterioration in performance.

It is noteworthy that in support of the trust's strategic direction further developing as a provider of specialised cancer care robust and slick processes between providers will need to be in place.

Key examples include the introduction of robotic cancer surgery and centralisation in Leicester of specialised cancer multidisciplinary teams.

Oncology services

The Oncology service at Northampton General Hospital, also providing a service to Kettering, has experienced substantial challenges in recruiting and retaining clinical staff. In the interests of providing safe and high quality services to patients and in recognition of the close working relationship with our partners in Northamptonshire, the oncology service in Leicester has diverted significant resource to supporting the delivery of chemotherapy and radiotherapy to Northamptonshire patients. This has been closely monitored and not contributed to the timely delivery of chemotherapy or radiotherapy to UHL patients. A combined South East Midlands Oncology service with a unified management structure for Leicestershire and Northamptonshire patients will provide a sustainable solution to the oncology needs of the populations.

PET-CT imaging

The availability of CT-PET imaging, essential in the diagnostic phase for many patients suitable for radical treatment, has been variable and dependent upon a central contract through NHS England. Issues with capacity, booking and reporting processes and IT have all at various stages significantly delayed patient pathways and adversely affected performance to an extent.

5.2 Internal factors

Integration of services for cancer pathways

The system put in place which delivered 12 months of continuous improvements in cancer performance is still in operation. It is noteworthy that the representation provided by the services and CMGs provided for the weekly CAB meetings has drifted from General Manager/Service Manager to Service Manager/Operational

Manager and in general the empowerment to actively intervene in delayed pathways appears diminished in association with this.

Support for diagnostic and treatment phases of pathways

Imaging and histopathology provide timely and responsive services in support of the diagnostic phases of patient journeys. Theatre capacity and access to Oncology is adequate to support the delivery of timely treatments for cancer patients. It is therefore acknowledged that delivering cancer performance is within the gift of the CMGs and services which host individual tumour sites.

CMG administrative structure

The transformational work done with imaging to deliver rapid and responsive support of cancer pathways was underpinned by embedded structural change and detailed SOPs dedicated to cancer. Imaging performance for cancer pathways has remained consistently high.

As cancer performance is in the gift of the host CMGs to deliver for each cancer type, the CMGs were asked to produce recovery plans in June based on their analysis of patient level detail for patients who had breached the 62 day standard, with the brief of returning cancer performance to the level reported in Q4 2013/14 by the end of Q2 of 2014/15. These recovery plans have not resulted in improved performance to date.

Parallel priorities

It is likely that parallel priorities are detracting from cancer performance. It is not suggested that this is in any way due to conscious displacement of cancer activity, but rather due to the apparent lack of effective dedicated cancer administrative structure and processes within CMGs and services.

Clinical engagement

Clinical engagement with the delivery of high quality and timely cancer care remains high, in the face of the current operational delivery challenges.

6.0 Recovery Plan

1) Embedding dedicated cancer pathway procedures within CMGs;
    a. The model of the Imaging in Cancer transformation is used as the basis for the trust wide approach, as the work on structure and process required for this in 2013/14 was extensive and detailed, and currently stands out as an area of high performance for cancer.
    b. The CMG level cancer SOPs to cover internal structure, processes escalation procedures and Internal monitoring.
    c. The internal standards required for elements of pathways are;

i. Daily review of 2WW capacity available to meet peak daily referral demand.
ii. Internal diagnostic or staging procedures – endoscopy, biopsies, diagnostic surgical procedures – all patients to be offered procedure within 7 days of request.
iii. Treatments;
    a) Minor surgical treatments, within 14 days of decision to treat.
    b) Major surgical treatments, to be offered treatment within 3 weeks of decision to treat.
    c) Oncology – chemotherapy – to start within 2 weeks
    d) Oncology – radical radiotherapy – within 3 weeks
    e) Oncology – palliative radiotherapy – within 10 days
    f) ITAPS – pre-assessment within 3 working days of referral
    g) ITAPS - high risk anaesthetic assessment within 7 days

2) Representation at the weekly Cancer Action Board by all services required to support cancer care at service manager level.

3) CMGs and services to anticipate and provide capacity for a further annual growth in 2WW referrals at 20% per annum, and respond proactively to national cancer awareness campaigns.

4) A clinically lead review of cancer pathways is underway.

5) Working together with the CCGs, a clinically led review of cancer performance, focussing on 2WW referral criteria and practice.

6) In order to make sustainable performance for some of our most complex cancer cases possible, the trust is investing in an on-site PET-CT scanning facility with control of capacity and process to support pathways in the long term.

The prompt implementation of these actions will return cancer performance to standard by December 2014.

7.0 Mitigation of Clinical Risk (in light of current performance)

As highlighted above in the overview of performance, the elongation of cancer pathways has been relatively modest. It is reasonable to surmise that there is highly unlikely to be increased clinical risk associated with the deterioration in performance. Nevertheless measures to monitor and mitigate risk for patients with lengthy cancer pathways were put in place during the period of high performance, and these remain in place now;

- ***From day 34-39 on a 62 day pathway***

All 62 day pathway patients who reach day 34 without a confirmed treatment date within breach are discussed at a PTL meeting between the relevant service manager and the relevant Cancer Centre tracker to review the case and management plan.

- ***From day 40-62 on a 62 cancer pathway***

All patients within 3 weeks of breach date and without a treatment start date scheduled before breach date are discussed at the Cancer Action Board to identify and address avoidable delays in pathways. These patients are identified to the MDT lead clinician for the type of cancer and to the consultant responsible for the patient to highlight the risk of delayed treatment and offer support in dealing with any obstacles to care.

- ***From day 63-99 on a 62 day cancer pathway***

These patients are discussed first at the weekly Cancer Action Board and their care is prioritised over patients who have not yet breached, accepting the adverse impact this has on performance.

- ***From day 100 onwards***

All 100 day plus breach patients are referred directly for weekly review by the MDT lead clinician for the relevant cancer type, and discussed fortnightly in the formal setting of the MDT meeting. The purpose of this is to expedite management where possible, and obtain a clinical assessment of any potential harm caused to the patient by the delay. “Harm reports” are returned to the cancer centre, and any cases of potential harm are discussed at Cancer Board. To date no cases of actual or likely harm have been reported due to treatment delay.

These mitigations have been discussed at length during a “Deep Dive” review of Cancer Centre governance at UHL by our commissioners, and deemed appropriately rigorous.

8.0 Conclusions

UHL has demonstrated that it is capable of delivering high quality, timely cancer care reflected in recent high performance and improved patient experience.

The system for the integration of cancer pathways underpinning performance remains in place. Diagnostic services and treatment capacity are not rate limiting.

Overhaul of internal processes within CMGs will restore UHL to a high performing cancer centre by December 2014.

9.0 Recommendations/Actions

- This report to be noted

- Support is sought for the multi-faceted approach suggested for sustainable recovery in Cancer Performance (as set out in point 6)
- Assurance is derived from the actions to mitigate risk as set out in section 7.0

University Hospitals of Leicester NHS
NHS Trust

Agenda Item: paper H

TRUST BOARD – 30th October 2014

UHL Development Support Plan

DIRECTOR:	Director of Strategy
AUTHOR:	Director of Strategy
DATE:	30th October 2014
PURPOSE:	**(concise description of the purpose, including any recommendations)** To seek Trust Board approval of the Development Support Plan to be submitted to the NHS Trust Development Authority
PREVIOUSLY CONSIDERED BY:	**(name of Committee)**
Objective(s) to which issue relates *	☑ 1. Safe, high quality, patient-centred healthcare ☑ 2. An effective, joined up emergency care system ☑ 3. Responsive services which people choose to use (secondary, specialised and tertiary care) ☑ 4. Integrated care in partnership with others (secondary, specialised and tertiary care) ☑ 5. Enhanced reputation in research, innovation and clinical education ☑ 6. Delivering services through a caring, professional, passionate and valued workforce ☑ 7. A clinically and financially sustainable NHS Foundation Trust ☐ 8. Enabled by excellent IM&T
Please explain any Patient and Public Involvement actions taken or to be taken in relation to this matter:	Patient and public involvement has been identified as one of the Trust's improvement priorities in the Development Support Plan
Please explain the results of any Equality Impact assessment undertaken in relation to this matter:	N/A
Strategic Risk Register/ Board Assurance Framework *	☑ **Strategic Risk Register** ☑ **Board Assurance Framework** ☐ **Not Featured**
ACTION REQUIRED *	For decision ☑ For assurance ☐ For information ☐

♦ We treat people how we would like to be treated ♦ We do what we say we are going to do
♦ We focus on what matters most ♦ We are one team and we are best when we work together
♦ We are passionate and creative in our work

***** tick applicable box

University Hospitals of Leicester Development Support Plan

Background

1) In December 2013 the NHS Trust Development Authority (NTDA) published *Securing Sustainability Planning Guidance for NHS Trust Boards, 2014/15 to 2018/19.*

2) This guidance sets out the requirement for NHS Trust Boards to provide a description of their development needs in the form of a Development Support Plan. Development needs should be linked to the Trust's overall organisational development plan and the NTDA will work with the Trust to understand whether improvement needs:

   - Can be met through existing mechanisms or
   - Whether the NTDA need to play a role in developing a specific package of support

3) A draft Development Support Plan submission was made to the NTDA on the 30th September 2014. This draft submission set out the Trust's intention to hold an Executive Team workshop and a Board Development Session in October 2014. The purpose of these sessions being to enable the Executive Team, Clinical Management Groups (CMGs) and the Trust Board to fully explore, debate and agree the Trust's the organisation's weaknesses and challenges, development interventions and support and time scales.

4) To enable the Trust's Development Support Plan to be signed off by our new Chairman, it was agreed with the NTDA that a final submission of the Trust's Development Support Plan would be submitted following approval at the October 2014 Trust Board meeting.

Developing the content of the Development Support Plan

5) On the 14th October 2014, a two hour workshop attended by members of the Executive Strategy Board and CMG managers was held. Papers circulated in advance set out four potential key development priorities for the Trust:

   - Culture and behaviours in teams
   - Clinical leadership
   - Patient involvement
   - Financial Sustainability

6) The purpose of the workshop was to address the following 5 questions:

   - Do we sign up to the 4 themes identified?
   - Are there any gaps in the content presented and discussed today?
   - Are there any themes missing?
   - What resources are required to deliver the Plan?
   - What help do we need from the NTDA?

7) During the Executive Team workshop, improvement methodology and Trust Board development were added to the list of key development priorities for the Trust.

8) The outputs from this workshop were summarised in the form of a slide deck, circulated to members of the Trust Board ahead of a Trust Board Development Session held on 16th October 2014.

9) Following the Trust Board Development Session, members of the Board were asked for their comments and views in relation to the following key questions.

10) For the purposes of the Development Support Plan:-

a) Do you think that we have identified the Trust's key organisational weaknesses and challenges?

b) Do you think that we have identified the right key development priorities?
   i. Culture & behaviours in teams
   ii. Clinical leadership
   iii. Patient involvement
   iv. Financial sustainability
   v. Improvement methodology
   vi. Trust Board Development

c) Do you think that we have identified the key development interventions? (what is required to address the development needs identified)

d) Do you think that we have identified the right development support? (how we propose to undertake the development initiative and what support we might seek from the NTDA to deliver it)

e) What outcomes should we expect for these interventions and by when?

11) The outputs from the Executive Team workshop, TB Development Session and the responses from members of the Trust Board have been incorporated into the draft Development Support Plan attached as Appendix A to this paper.

Recommendations

12) The Trust Board is asked to approve the UHL Development Support Plan attached as Appendix A

Appendix A

University Hospitals of Leicester
Development Support Plan

Development Priority (Give a brief description)	**Organisational weaknesses and challenges** (Describe the Trust's needs analysis i.e. the evidence that Trust has that led it to identify the need for a development intervention)	**Development intervention** (Description of what is required to address the development need that has been identified)	**Development Support** (How is the Trust undertaking or proposing to undertake the development initiative, including identifying what support from the NTDA it might need to deliver it?)	**Timescale and outcome** (What does the Trust expect to deliver and by when?)
Trust Board development- embedding Board disciplines	The Trust Board needs to ensure that the right information is presented in the right format so that the Board can fulfil its functions. This will support the Board in working together as a unitary Board in a more effective and forward looking way. Need to ensure that our support plan fits into a wider strategic view.	Review current flows of information and the training requirements for both the development of appropriate reporting formats and the ability to analyse data.	Require resources for coaching and training in order to produce shorter reports that have analysed data to produce information and drawn out key issues.	Immediately. Work in train to assess requirements and co-ordinate an appropriate response. Will contribute to a Trust Board development programme

Development Priority (Give a brief description)	**Organisational weaknesses and challenges** (Describe the Trust's needs analysis i.e. the evidence that Trust has that led it to identify the need for a development intervention)	**Development intervention** (Description of what is required to address the development need that has been identified)	**Development Support** (How is the Trust undertaking or proposing to undertake the development initiative, including identifying what support from the NTDA it might need to deliver it?)	**Timescale and outcome** (What does the Trust expect to deliver and by when?)
Clinical leadership **The Board Assurance Framework sets out key risks:** • Lack of effective leadership capacity and capability	Recent report from Ian Sturgess (on the Emergency Care Pathway at UHL) identified: • Issues with strong and consistent clinical leadership • Inconsistent engagement with quality improvement • Sub-optimal clinical relationships within and between some departments and staff groups	Define Clinical Leadership behaviours (distinct from clinical management) – link to job planning and annual appraisal Develop a leadership compact, explicitly setting expectations for all parties – link to job planning and annual appraisal Establish a leadership community – clinical senate, leadership faculty etc. Implement UHL Leadership in to action priorities that would drive engagement	Work with **NHS IQ and the Leadership academy** to systematically develop structures and processes for developing and garnering clinical leadership. Have clear expectations and sanctions as part of job planning and annual appraisal – train appraisers Clinical senate established Establish a similar model for nursing and midwifery Cross cutting theme which will need to respond to all areas of development	Immediate implementation to improve clinical ownership and drive to address clinical improvement Commence now as part of job planning and appraisal. This will allow explicit discussions to take place about appropriate behaviours and attitudes April 2015 Continue links into East Midlands Leadership Academy • Front line nursing leadership programme • Operational Leadership series

Development Priority (Give a brief description)	**Organisational weaknesses and challenges** (Describe the Trust's needs analysis i.e. the evidence that Trust has that led it to identify the need for a development intervention)	**Development intervention** (Description of what is required to address the development need that has been identified)	**Development Support** (How is the Trust undertaking or proposing to undertake the development initiative, including identifying what support from the NTDA it might need to deliver it?)	**Timescale and outcome** (What does the Trust expect to deliver and by when?)
Culture and behaviours in teams **The Board Assurance Framework sets out key risks:** • Failure to improve levels of staff engagement • Lack of effective leadership capacity and capability	Recent external feedback identifies**:** • Aspects of staff disengagement and a sense of a lack of staff having "permission to act" • Inconsistent engagement with quality improvements or reluctance to follow new ways of working In-effective collaborative working • Evidence of silo working between departments /specialities leading to mistrust between colleagues	A sense of shared purpose from the top (linked to the 5 year plan and the Trust's values) Support all staff to consistently 'live the values': From the Trust Board all the way down and to have a clear 'unity of purpose' from the Executive Team Clarity about what acceptable behaviour is / isn't and 'grey areas': Develop a framework - 'leading by example' and Tools to help leaders and address poor behaviours. On-going development workshops with CMG senior teams - focus on setting team expectations / team improvement priorities and actions against four quadrants i.e. Quality,	Develop a programme brief that describes the scope of change planned, the anticipated benefits and outcomes of the 5-year plan and aligns this to the strategic priorities and values of the organisation Thorough engagement with staff to own the plan. To use LiA event to provide clarity of roles and responsibilities (for all staff) to deliver the 5 year plan Supporting everyone to live the values by having a focus through the appraisal process. Setting expectations at all levels and holding staff to	Immediate. Shared vision, understanding and ownership of the 5-year plan January 2015. Drive ownership and clarity about the rationale for the 5-year plan and the necessity for delivery Immediate

Development Priority (Give a brief description)	**Organisational weaknesses and challenges** (Describe the Trust's needs analysis i.e. the evidence that Trust has that led it to identify the need for a development intervention)	**Development intervention** (Description of what is required to address the development need that has been identified)	**Development Support** (How is the Trust undertaking or proposing to undertake the development initiative, including identifying what support from the NTDA it might need to deliver it?)	**Timescale and outcome** (What does the Trust expect to deliver and by when?)
		Finance, People and Performance Developing Practice Crucial Conversation Sessions (across CMG) in partnership with Momentum – working through real situations / challenges	account: Coaching and development of the Executive Team and Developing and continue Practice Crucial Conversation Sessions (across CMG) in partnership with Momentum – working through real situations / challenges Building on-the ground change capacity with NHS IQ Support	March 2015 – Build on practice conversation sessions March 2015– need to build a structure and process for sustainable cultural change in partnership with NHSIQ In development. Mutuals in Health Pathfinder Programme – Launched October 2014 with the full pathfinder programme scheduled to run from January 2015-March 2015

Development Priority (Give a brief description)	**Organisational weaknesses and challenges** (Describe the Trust's needs analysis i.e. the evidence that Trust has that led it to identify the need for a development intervention)	**Development intervention** (Description of what is required to address the development need that has been identified)	**Development Support** (How is the Trust undertaking or proposing to undertake the development initiative, including identifying what support from the NTDA it might need to deliver it?)	**Timescale and outcome** (What does the Trust expect to deliver and by when?)
Patient & Public involvement **The Board Assurance Framework sets out key risks:** • Failure to achieve effective patient and public involvement Principal risk 6) • Failure to maintain effective relationships with key stakeholders	Risks from inadequate public engagement on the Trust's five year plan include: • Service developments may not meet user expectations or needs • Some changes to service delivery may be unpopular / misunderstood… we need 'permission' from our stakeholders • In failing to engage in a timely and appropriate manner the Trust may lose credibility with its stakeholders (i.e. Health watch and other patient representative groups) • Consultation outcomes may not support our plans • Failure to engage our local communities on proposals may result in services that do not adequately meet their diverse needs • Time, people resource and economic pressures within the Trust may diminish the appetite for good engagement	Empowering people in the engagement process An engagement strategy that describes our commitment to involving and listening to patients and the public directly in the development of our services. Clear governance arrangements in place that encourage and support active participation in improving care and services; and promoting openness and transparency both in the way we work and information about the work we do	More time and resource invested in to CMGs to free up staff time to engage within the Trust and in the wider community Seek support and guidance from NHS England, in developing a PPI strategy that will seek to strengthen our PPI within the Trust as well as linking into the wider community Link into the Patient and Public Voice Team at NHS England to help UHL to develop a supportive and sustainable network (Advisory group) that will ensure PPI Lay Members are supported in their roles	CMG leads now attend the Patient Involvement, Patient Experience and Equality Assurance Committee (PIPEEAC) Medical representation also being sought for PIPEEAC Exploring how to better integrate PPI in to the development of business cases etc. November-December 2014 - • CMG PPI leads to undertake PPI training • Board Support for the development of 'Patient Partners • More time spent by Board members on engagement activities / visibility • NTDA "critical friend" support in the

Development Priority (Give a brief description)	**Organisational weaknesses and challenges** (Describe the Trust's needs analysis i.e. the evidence that Trust has that led it to identify the need for a development intervention)	**Development intervention** (Description of what is required to address the development need that has been identified)	**Development Support** (How is the Trust undertaking or proposing to undertake the development initiative, including identifying what support from the NTDA it might need to deliver it?)	**Timescale and outcome** (What does the Trust expect to deliver and by when?)
	Historically the instigation of PPI activity across the Trust has been variable. While some CMGs are proactively engaging patients, others could improve their performance; • Good engagement is likely to generate a more positive response in wider consultations • Greater involvement will improve public confidence in the Trust • Meaningful engagement inevitably results in services that meet the needs of users • PPI is not yet embedded in to the culture of most services • External /community engagement is sporadic and infrequent	Increased central PPI resource i.e. more than a single leader Medical Leader with experience of leading change and engagement across multiple stakeholders	Access to medical leaders in other health economies who are prepared to coach/enthuse support our CMG leadership teams.	planning process With the outcome that UHL CMG leaders increasingly understand PPI, take ownership and ensure that this influences planning.

Development Priority (Give a brief description)	**Organisational weaknesses and challenges** (Describe the Trust's needs analysis i.e. the evidence that Trust has that led it to identify the need for a development intervention)	**Development intervention** (Description of what is required to address the development need that has been identified)	**Development Support** (How is the Trust undertaking or proposing to undertake the development initiative, including identifying what support from the NTDA it might need to deliver it?)	**Timescale and outcome** (What does the Trust expect to deliver and by when?)
Financial sustainability **The Board Assurance Framework sets out key risks:** • Failure to deliver financial strategy including CIP • Failure to deliver internal efficiency and productivity improvements	£39.7m deficit in 2013/14 and £40.7m planned deficit in 2014/15 with inefficient service configuration including dated models of care Failed to deliver surplus position and breakeven duty. Breakeven plan only by 2019/20 Lack of financial awareness and poor understanding of the financial impacts of decisions made (lower levels of staff) Previous gaps in governance around decision making on areas that have a financial impact. A perceived view by stakeholders of the plan lacking pace and ambition (lots of small schemes rather than fundamental change) Requirement to join the dots i.e. a lot of efficiencies require cross health economy ownership (not just UHL) to deliver	Consistent financial framework with key messages Contractual framework and relationships Use of benchmarking to identify opportunities for improvement (not as a one off exercise but continually and more in depth than previously i.e. specialty level) Continued rollout and embedding of Service Review to identify opportunities. Push forward with Service Line Management and ensure accuracy of data to engage clinicians Developing capacity and capability in CIP, reconfiguration and financial transformation Joint working and accountability with other organisations	A clear CIP identification, planning and monitoring framework has been implemented. This has evidenced a step change in performance in CIP (current forecast exceeds target) Enabling resource has been implemented for CIP which includes CMG specific support and also a number of cross cutting themes, each led by an Executive Director. This will be further refined in 15/16 to focus on four main areas (Beds, Outpatients, theatres and workforce) A five year internal CIP plan has been drafted and is currently in consultation with senior leader.	Sign off of business cases (OBC and FBC) in line with the trajectory (e.g Emergency Floor) from the Trust, CCG partners, the TDA and other stakeholders Securing the funding (revenue, capital and cash) to implement the business cases Deliver a more efficient service configuration including new models of care via delivery of business cases Maintain the enhanced cost control, supported by service reconfiguration, to deliver the annual CIP targets

Development Priority (Give a brief description)	**Organisational weaknesses and challenges** (Describe the Trust's needs analysis i.e. the evidence that Trust has that led it to identify the need for a development intervention)	**Development intervention** (Description of what is required to address the development need that has been identified)	**Development Support** (How is the Trust undertaking or proposing to undertake the development initiative, including identifying what support from the NTDA it might need to deliver it?)	**Timescale and outcome** (What does the Trust expect to deliver and by when?)
	opportunities. Lack of belief that non UHL areas will deliver i.e. demand management which is required for UHL activity reductions.	Workforce review, role redesign, new ways of working (needs to be more bold) • Financial awareness and training (across lower levels of staff) • Incentivising teams and individuals • Making sure staff are aware of the 'value' of things • Showcasing quick wins	External work-streams via Better Care Together to support financial sustainability, service and pathway change. Requirement to provide an umbrella view and hold the interdependent areas (including organisations) to account to deliver the whole. Externally the Better Care Together programme SOC will outline the system requirement for transitional funding and capital and cash resources to successfully deliver system and organisational reconfiguration	Recurrent financial balance by 2019/20 after successful consolidation of services on to 2 acute sites This will require a number of individual business cases (OBC and FBC) which will require NTDA support to move through the approvals process in a timely manner

Development Priority (Give a brief description)	**Organisational weaknesses and challenges** (Describe the Trust's needs analysis i.e. the evidence that Trust has that led it to identify the need for a development intervention)	**Development intervention** (Description of what is required to address the development need that has been identified)	**Development Support** (How is the Trust undertaking or proposing to undertake the development initiative, including identifying what support from the NTDA it might need to deliver it?)	**Timescale and outcome** (What does the Trust expect to deliver and by when?)
Improvement & Innovation methodology	Devising a UHL approach to system wide improvement ensuring alignment with LiA approach, 'Everybody Counts Campaign' and Better Care together programmes which aligns operational excellence with delivery of high quality and safe care.	Agreeing and rolling out an improvement approach (within an overall change management framework) Communication and branding (consistent messaging) Building improvement capability Agreeing priorities and run a series of projects using agreed approach. Identifying key stakeholders and lead roles Programme management (and programme management tool) aligned to the delivery of the overall reconfiguration programme	Agree a methodology and agree the deployment across UHL Develop communications plan that aligns improvement and innovation with the overall programme management arrangements for delivering the 5-year plan	November 2014 January 2015 Prioritised Projects launched using agreed approach December 2014, review March 2015 Agree project management approach and implement with roll out of new projects November 2014

University Hospitals of Leicester NHS
NHS Trust

Agenda Item: Trust Board paper I

TRUST BOARD – 30 OCTOBER 2014

UHL RISK REPORT INCORPORATING THE BOARD ASSURANCE FRAMEWORK (BAF)

DIRECTOR:	RACHEL OVERFIELD – CHIEF NURSE
AUTHOR:	PETER CLEAVER – RISK AND ASSURANCE MANAGER
DATE:	30 OCTOBER 2014
PURPOSE:	This report is provided to enable Trust Board scrutiny of the contents of the Board Assurance Framework BAF) and to inform of significant (i.e. extreme and high) operational risks within UHL. 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; (f) Note the significant operational risks listed at appendix three.
PREVIOUSLY CONSIDERED BY:	**UHL EXECUTIVE TEAM**
Objective(s) to which issue relates *	[x] 1. Safe, high quality, patient-centred healthcare [v] 2. An effective, joined up emergency care system [v] 3. Responsive services which people choose to use (secondary, specialised and tertiary care) [v] 4. Integrated care in partnership with others (secondary, specialised and tertiary care) [v] 5. Enhanced reputation in research, innovation and clinical education [v] 6. Delivering services through a caring, professional, passionate and valued workforce [v] 7. A clinically and financially sustainable NHS Foundation Trust [v] 8. Enabled by excellent IM&T

Please explain any Patient and Public Involvement actions taken or to be taken in relation to this matter:	N/A
Please explain the results of any Equality Impact assessment undertaken in relation to this matter:	N/A
Strategic Risk Register/ Board Assurance Framework *	☐ **Organisational Risk Register** ☒ **Board Assurance Framework** ☐ **Not Featured**
ACTION REQUIRED *	
For decision ☒	For assurance ☒ For information ☒

• We treat people how we would like to be treated • We do what we say we are going to do
• We focus on what matters most • We are one team and we are best when we work together
• We are passionate and creative in our work

* tick applicable box

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **30th OCTOBER 2014**

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

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

---

1. INTRODUCTION

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

a) A copy of the revised UHL BAF and action tracker as of 30 September 2014.

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

c) Notification of all extreme and high risks that are on the UHL risk register as of 30th September 2014.

2. BAF POSITION AS OF 30th SEPTEMBER 2014

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

2.2 In relation to the BAF the TB is asked to note the following points:

a. Outcomes from the LLR review are included within the UHL Quality Commitment (QC) with the exception of *'discharge letters'* and '*clerking documentation'* Following discussion with the Head of Outcomes and Effectiveness these two elements are to be considered for mid-term inclusion in the QC. These exceptions are now identified as gaps in control for principal risk 1.

b. There are no changes to principal risk scores for this reporting period.

c. Principal risk 2 has no gaps identified and no further actions to take and therefore the TB should consider the current risk score with a view to reducing it to the target level. If this is not felt to be appropriate the TB is asked to identify the gaps in control and/ or assurance that are causing the current risk score to remain elevated.

d. Many of the *'controls'*, *'assurances'*, '*gaps in assurance/ control'* and *'actions'* within principal risks 9 and 10 were duplicated in risks 7 and 8. To reduce this duplication, principal risks 9 and 10 now reference back to 7 and 8.

e. Updates to actions 3.1 and 20.1 have not yet been received. The Chief Operating Officer is therefore asked to provide a verbal update to the TB if required.

2.3 At the TB meeting in August 2014 it was agreed that the monthly TB review of the BAF be structured so as to include all the principal risks relating to an individual strategic objective. The following objective is therefore submitted to this TB for discussion and review:

- *'Integrated Care in Partnership with others'* (incorporating principal risks 7, 8, 9 and 10).

3. 2014/15 QUARTER TWO EXTREME AND HIGH RISK REPORT.

3.1 To inform the TB of significant operational risks, a summary of all currently open extreme and high risks is attached at appendix three.. As of 30th September 2014 there are 43 risks on the organisational risk register scoring 15 and above (i.e. 41 high and two extreme risks).

3.2 Three new high risks have opened during September 2014 as described below. The details of these risks are included at appendix three for information

.

Risk ID	Risk Title	Risk Score	CMG/ Directorate
2423	Outstanding clinic letters and inability to act on results impacting on patient safety in respiratory services	25	RRC
2414	There is a risk that Endoscopy LGH will not pass JAG accreditation	16	CHUGS
2422	There is a risk to patient safety and quality due to the nurse staffing levels on SAU LRI	16	CHUGS

4. RECOMMENDATIONS

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

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

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

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

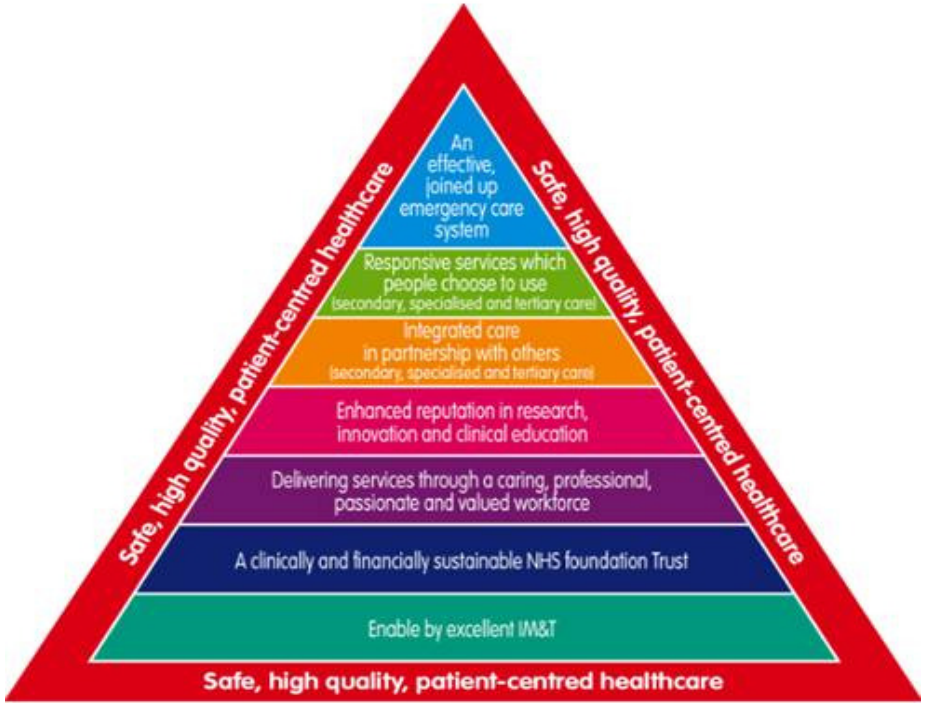
(d) identify any gaps in assurances about the effectiveness of the controls in place to manage the principal risks and consider the nature of, and timescale for, any further assurances to be obtained;

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

(f) Note the significant operational risks listed at appendix three

Peter Cleaver,
Risk and Assurance Manager,
22 October 2014.

UHL BOARD ASSURANCE FRAMEWORK 2014/15



UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

STRATEGIC OBJECTIVES

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

PERIOD: SEPTEMBER 2014

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

22.		Failure to deliver service and site reconfiguration programme and maintain the estate effectively.	DS	10	5
23.	Enabled by excellent IM&T	Failure to effectively implement EPR programme.	CIO	15	9
24.		Failure to implement the IM&T strategy and key projects effectively	CIO	15	9

BAF Consequence and Likelihood Descriptors:

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Corporate leads agreed for each goal and identified leads for each work stream of the Quality Commitment.	Q&P Report. Reports to EQB and QAC.			
KPIs agreed for all parts of the Quality Commitment.	Reports to EQB and QAC based on key outcome/KPIs.			
Clear work plans agreed for all parts of the Quality Commitment.	Action plans reviewed regularly at EQB and annually reported to QAC. Annual reports produced.	(c) Two elements of the LLR mortality review (i.e. 'discharge letters' and 'clerking documentation') are not included in the current iteration of the Quality Commitment	To be included 'mid-term into QC	November 2014
Committee structure is in place to oversee delivery of key work streams – led by appropriate senior individuals with appropriate support.	Regular committee reports. Annual reports. Achievement of KPIs.	No gaps identified		

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 2	Failure to implement LLR emergency care improvement plan.	**Overall level of risk to the achievement of the objective**	**Current score 4 x 4 = 16**	**Target score 3 x 2 = 6**
Executive Risk Lead(s)	Chief Operating Officer			
Link to strategic objectives	An effective joined up emergency care system			

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 3	Failure to effectively implement UHL Emergency Care quality programme.	**Overall level of risk to the achievement of the objective**	**Current score 4 x 4 = 16**	**Target score 3 x 2 = 6**
Executive Risk Lead(s)	Chief Operating Officer			
Link to strategic objectives	An effective joined up emergency care system			

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 4	Delay in the approval of the Emergency Floor Business Case.	**Overall level of risk to the achievement of the objective**	**Current score 4 x 3 = 12**	**Target score 3 x 2 = 6**
Executive Risk Lead(s)	Medical Director			
Link to strategic objectives	An effective joined up emergency care system			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Monthly ED project program board to ensure submission to NTDA as required Gateway review process Engagement with stakeholders	Monthly reports to Executive Team and Trust Board Gateway review	(c) Inability to control NTDA internal approval processes	Regular communication with NTDA (4.1)	Ongoing action to complete in Mar 2015 MD

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Better Care Together (BCT) Strategy: • UHL actively engaged in the Better Care Together governance structure, from an operational to strategic level • Better Care Together plans co–created in partnership with LLR partners • Final approval of the 5 year strategic plan, Programme Initiation Document (PID – 'mobilises' the Programme) and SOC to be made at the Partnership Board of 20th November 2014 • Better Care Together planning assumptions embedded in the Trust's 2015/16 planning round	• BCT resource plan, identifying all work books named leads (SRO, Implementation leads and clinical leads) • Workbooks for all 8 clinical work streams and 4 enabling groups • Feedback from September 2014 Delivery Board and Clinical Reference Group workshops • LLR BCT refreshed 5 year strategic plan approved by the BCT Partnership Board • Minutes and Action Log from the BCT Programme Board	(a) Final approval of the strategic plan, PID and SOC	Final approval of the strategic plan, PID and SOC to be made at the November 2014BCT Partnership Board (7.4)	Dec 2014
Effective partnerships with primary care and Leicestershire Partnership Trust (LPT): 1) Active engagement and leadership of the LLR Elective Care Alliance 2) LLR Urgent Care and Planned Care work streams in partnership with local GPs 3) A joint project has been established to test the concept of early transfer of sub-acute care to a community hospitals setting or home in partnership with LPT. The impact of this is reflected in UHLs, LPTs the LLR BCT 5 year plans 4) Mutual accountability for the delivery of shared objectives are reflected in the LLR BCT 5 year directional plan 5) Active engagement in the BCT LTC work stream. Mutual accountability for the delivery of shared objectives are reflected in the LLR BCT 5 year directional plan	• Minutes of the June public Trust Board meeting: o Trust Board approved the LLR BCT 5 year directional plan and UHLs 5 year directional plan on 16 June, 2014 o Urgent care and planned care work streams reflected in both of these plans • BCT resource plan, identifying all work books named leads (SRO, Implementation leads and clinical leads agreed at the BCT Partnership Board (formerly the BCT Programme Board) meeting held on 21st August 2014 Workbooks for all 8 clinical work streams and 4 enabling groups underway – progress overseen by implementation	(a) Final approval of the strategic plan, PID and SOC	See action 7.4	Dec 2014

	group and the Strategy Delivery Group which reports to BCT Partnership Board.			

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
(i) Regional partnerships: UHL is actively engaging with partners with a view to: • establishing a Leicestershire Northamptonshire and Rutland partnership for the specialised service infrastructure in partnership with Northampton General Hospital and Kettering General Hospital • establishing a provider collaboration across the East Midland's as a whole • Developing an engagement strategy for the delivery of the long term vision for and East Midlands network for both acute and specialised services	Minutes of the April 2014 Trust Board meeting: ○ Paper presented to the April 2014 UHL Trust Board meeting, setting out the Trust's approach to regional partnerships Project Initiation Document (PID): ○ Developed as part of UHL's Delivering Care at its Best (DC@IB) ○ Reviewed at the June 2014 Executive Strategy Board (ESB) meeting ○ Updates (DC@IB Highlight Report reviewed at ESB meetings	(c) No Head of External Partnership Development or administrative support (c) Lack of Programme Plan	Appoint Head of Partnerships and admin support (8.2) Programme Plan to be developed (8.3)	Dec 2014 DS Apr 2015 DS
(ii) Academic and commercial partnerships. (iii) Local partnerships	Project Initiation Document (PID): ○ Developed as part of UHL's Delivering Care at its Best (DC@IB) ○ Reviewed at the August 2014 Executive Strategy Board (ESB) meeting ○ Updates (DC@IB Highlight Report reviewed at ESB meetings	(c) Lack of PID for local partnerships		
Specialised Services specifications: CMGs addressing Specialised Service derogation plans	Plans issued to CMGs in February 2014. Follow up meetings being convened for w/c 14th July 2014to identify progress to date.	(a) Currently no mechanism in place to monitor progress	UHL to confirm compliance / non-compliance against service specifications to Area Team by end Oct 2014 (8.6)	Oct 2014 DS

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Regional partnerships	See risk 8	See risk 8	See risk 8	See risk 8
Academic and commercial partnerships	See risk 8	See risk 8	See risk 8	See risk 8
Local partnerships	See risk 8	See risk 8	See risk 8	See risk 8
Delivery of Better Care Together:	See risk 7	See risk 7	See risk 7	See risk 7

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Effective partnerships with LPT	See risk 7	See risk 7 for other gaps c) UHLs and LPTs 5 year plans yet to be reconciled and developed in enough detail to support operational delivery.	See risk 7 for other actions PID & draft Terms of Reference to be reviewed at the August 2014 ESB meeting. (10.1)	Oct 2014 DS/COO –
Effective partnerships with primary care	See risk 7	(c) Work Programme for the Alliance yet to be agreed	Work Programme for the Alliance to be developed (10.2)	Oct 2014 DS

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

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

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
UHL Workforce Plan (by staff group)	Reduction in number of 'hotspots' for staff shortages across UHL reported as part of workforce plan update. Executive Workforce Board will consider progress in relation to the overarching workforce plan through highlight report from CMG action plans.	(c) Workforce planning difficult to forecast more than a year ahead as changes are often dependent on transformation activities outside UHL (e.g. social services/ community services and primary care and broad based planning assumptions around demographics and activity).	Develop an integrated approach to workforce planning with LPT so we can plan workforce to deliver the right care in right place at the right time. (15.1)	Oct 2014 DHR
			Establish a joint group of strategy, finance and workforce leads to share plans and numbers (15.2)	Oct 2014 DHR
		(c) Difficulty in recruiting to hotspots as frequently reflect a national shortage occupation (e.g. nurses)	Establish Multi-professional new roles group to devise and monitor processes for creation of new roles (15.3)	Oct 2014 CN
			Develop Innovative	Mar 2015

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

			utilising outputs to produce a development programme (15.8)	

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

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

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

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

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

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Leadership into Action Strategy (2014:16) including six work streams: 'Providing Coaching and Mentoring' by developing an internal coaching and mentoring network, with associated framework and guidance which will be piloted in agreed areas (targeting clinicians at phase 1).	Quarterly Reports to Executive Workforce Board (EWB) as part of Organisational Development Plan and Learning, Education and Development Update as set out in Risk 16.	UHL Coaching and Mentoring Framework requires development	Improve internal coaching and mentoring training provision in collaboration with HEEM and at phase 1 establish process for assigning coaches and mentors to newly appointed clinicians (18.2)	December 2014 DHR
'Shadowing and Buddying' by creating shadowing opportunities and devising a buddy system for new clinicians or those appointed into new roles.	Quarterly Reports to Executive Workforce Board as part of Organisational Development Plan and Learning, Education and Development Update as set out in Risk 16.	Buddying / Shadowing System Requires Development	System being developed in partnership with HEEM and Assistant Medical Director to ensure support provided to newly appointed Consultants at initial phase (18.3)	April 2015 DHR
'Improving local communications and 360 degree feedback' by developing and implementing a 360 Degree feedback Tool for all leaders and developing nurse leaders to facilitate Listening Events in all ward and clinical department areas as set out in Risk 17.	Quarterly Reports to Executive Workforce Board as part of Organisational Development Plan and Learning, Education and Development Update as set out in Risk 16.	360 Feedback Tool not yet developed		

	Updates provided to LiA Sponsor group every 6 months on success measures Monthly updates to Nursing Executive Team (NET) meetings via Heads of Nursing per CMG			
'Shared Learning Networks' by creating and supporting learning networks across the Trust, developing action learning sets across disciplines and initiating paired learning.	Quarterly Reports to Executive Workforce Board as part of Organisational Development Plan and Learning, Education and Development Update as set out in Risk 16.			
'Talent Management and Succession Planning' by developing a talent management and succession planning framework, reporting on talent profile across the senior leadership community, aligning talent activity to pay progression and ensuring succession plans are in place for business critical roles.	Quarterly Reports to Executive Workforce Board as part of Organisational Development Plan and Learning, Education and Development Update as set out in Risk 16.	Talent Management and Succession Planning Framework requires development at regional and national level with alignment to the new NHS Health Care Leadership Model	Support national and regional Talent Management and Succession Planning Projects by National NHS Leadership Academy , EMLA and NHS Employers (18.5)	March 2015 DHR
'Leadership Management and Team Development' by developing leaders in key areas, team building across CMG leadership teams, tailored Trust Board Development and devising a suite of internal eLearning programmes	Quarterly Reports to Executive Workforce Board as part of Organisational Development Plan and Learning, Education and Development Update as set out in Risk 16.	Improvement required in senior leadership style and approach as identified as part of Board Effectiveness Review (2014)	Board Coach (on appointment) to facilitate Board Development Session (18.6) Update of UHL Leadership Qualities and Behaviours to reflect Board Development, UHL 5 Year Plan and new NHS Healthcare Leadership Model (18.7)	October 2014 January 2015 CE / DHR

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

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

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
CIP performance management including CIP s as part of integrated performance management	Monthly reports to F&P committee and Trust Board. Formal sign-off documents with CMGs as part of agreement of IBPs	(c) CIP Quality Impact Assessments not yet agreed internally or with CCGs (c) PMO structure not yet in place to ensure continuity of function following departure of Ernst & Young	Please see action 19.5 (Risk 19) Please see action 19.6 (Risk 19)	
Cross cutting themes are established.	Executive Lead identified. Monthly reports to F&P committee and Trust Board	(A) Not all cross cutting themes have agreed plans and targets for delivery	Agree plans and targets through the monthly cross cutting theme delivery board (20.1)	August 2014 COO

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Stakeholder Engagement Strategy (including a clinical task force to drive the improvements that come out of learning lessons to improve care)	Annual Stakeholder surveys presented to the Board Feedback from stakeholders in Board 360 as part of Foresight review. BCT strategy and planning Regular meeting with: CCGs and GPs and Health watch(s) Mercury Panel MPs and local politicians TDA / NHSE On-going review of effectiveness of clinical task force via EQB and QAC	(c) No structured key account management approach to commercial relationships (c) Commissioner (clinical) relationships can be too transactional i.e. not creative / transformational.	TBA with DS / DoF (21.2)	TBA

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Capital Monitoring Investment Committee Chaired by the Director of Finance & Procurement – meets monthly. All capital projects are subject to robust monitoring and control within a structured delivery platform to provide certainty of delivery against time, cost and scope. Project scope is monitored and controlled through an iterative process in the development of the project from briefing, through feasibility and into design, construction, commissioning and Post Project Evaluation. Project budget is developed at feasibility stage to enable informed decisions for investment and monitored and controlled throughout design, procurement and construction delivery. Project timescale is established from the outset with project milestone aspirations developed at feasibility stage. Process to follow: • Business case development • Full business case approvals • TDA approvals • Availability of capital • Planning permission • Public Consultation • Commissioner support	Minutes of the Capital Monitoring Investment Committee meetings. Capital Planning & Delivery Status Reports. Minutes of the March 2014 public Trust Board meeting - Trust Board approved the 2014/15 Capital Programme. Project Initiation Document (PID) (as part of UHL's Delivering Care at its Best) and minutes of the May 2014 Executive Strategy Board (ESB) meeting. Estates Strategy - submitted to the NTDA on 20th June in conjunction with the Trust's 5 year directional plan.	(C) Lack of integrated governance framework for the delivery of a sustainable clinical services strategy	Reconfiguration Board (reporting to ESB) to be established (22.2) DoH Heath Gateway Team to carry out a Gateway 0 review of the reconfiguration project commencing 20th October, over 4 days	Oct 2014 DS Oct 2014 DS

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Governance in place to manage the procurement of the solution	EPR project board with executive and Non-Executive members. Standard boards in place to manage IBM; Commercial board, transformation board and the joint governance board. UHL reports progress to the CCG IM&T Strategy Board			
Clinical acceptability of the final solution	Clinical sign-off of the specification. Clinical representation on the leadership of the project. The creation of a clinically led (Medical Director) EPR Board which oversees the management of the programme. Highlight reports on objective achievement go through to the Joint Governance Board, chaired by the CEO. The main themes and progress are discussed at the IM&T clinical advisory group.	(C) Not all clinicians can be part of the process	Continue to communicate with the wider/non-involved clinicians throughout the procurement process (23.6)	Oct2014 CIO
Transition from procurement to delivery is a tightly controlled activity	EPR board has a view of the timeline. Trust Board and ESB have had an outline view of the delivery timelines.	(c) No detailed plan is in place for the delivery phase of the project until the vendor is chosen	When the final vendor is chosen we will create and communicate the detail delivery plan and its dependencies.	Oct 2014 CIO

			(23.5)	

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Project Management to ensure we are only proceeding with appropriate projects	Project portfolio reviewed by the ESB every two months. Agreements in place with finance and procurement to catch projects not formally raised to IM&T.			
Ensure appropriate governance arrangements around the deliverability of IM&T projects	Projects managed through formal methodologies and have the appropriate structures, to the size of project, in place. KPIs are in place for the managed business partner and are reported to the IM&T service delivery board			
Signed off capital plan for 2014/15 and 2015/16	2 year plan in place and a 5 year technical in place highlighting future requirements - signed off by the capital governance routes			
Formalised process for assessing a project and its objectives	All projects go through a rigorous process of assessment before being accepted as a proposal	(C) Lack of transparency of the process and unachievable delivery expectations based on the priority of the project	All CMGs to hold formal monthly meeting with IM&T service delivery lead where these issues can be solved (24.3)	Review Oct 2014 CIO/CMGs

Appendix two

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST
ACTION TRACKER FOR THE 2014/15 BOARD ASSURANCE FRAMEWORK (BAF)

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

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
1	**Lack of progress in implementing UHL Quality Commitment.**					
1.1	Corporate leads to embed QC into organisation	CN	DCQ	September 2014	**Complete.** QC included in CEO brief September. QC reporting included in EQB work programme. QC included in CMG reviews.	5
1.2	Corporate leads to develop KPIs	CN	DCQ	September 2014	**Complete.** KPIs in place for work streams/committees.	5
1.3	Corporate leads to complete action plans	CN	DCQ	September 2014	**Complete.** Action plans systematically being reviewed at EQB as part of EQB work programme.	5
1.4	Include 'discharge letters' and 'clerking documentation' into QC	CN		November 2014		4
2	**Failure to implement LLR emergency care improvement plan.**					
2.2	CEO and Dr Sturgess to agree plans to ensure his legacy is sustainable	Chief Executive		~~August 2014~~ September 2014	**Complete.** 2 week re-engagement agreed for Feb 2015. Approach being embedded through work of EQSG.	5
3	**Failure to effectively implement UHL Emergency Care quality programme.**					
3.1	Subgroup to focus on the front end of the pathway to ensure progress within ED	COO	M Ardron	September 2014	Update awaited	4
4	**Delay in the approval of the Emergency Floor Business Case.**					

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

4.1	Regular communication with NTDA	MD		March 2015	Regular communication with the NTDA about the required timeline for approval of the ED business case has continued to ensure all parties understand the critical time dependencies within the scheme. Communication will continue until the submission dates and beyond to keep the NTDA on track therefore this action will be on-going until March 2015. Deadline extended to reflect this.	4
5	**Failure to deliver RTT improvement plan.**					
5.1	Action plans to be developed in key specialities – general surgery and ENT to regain trajectory	COO		~~September~~ October 2014	Currently behind planned backlog reduction. Additional activity (including super weekends to continue into November)	3
5.2	Await publication of IST report and act on findings and recommendations	COO		~~August~~ October 2014	IST report received. UHL plan to implement findings and recommendations to be developed by 10/14. Deadline extended to reflect this	4
6	**Failure to achieve effective patient and public involvement**					
6.1	Update the PPI/stakeholder engagement strategy	DMC		Dec 2014/ Jan 2015	In progress board development session held in Sept 14. Final to the Board Dec/ Jan. Deadline extended to reflect this	3
6.2	Revised PPI plan			N/A	This action replicates 6.1 above and will therefore be deleted from future versions of the action tracker	N/A
6.3	OD team involvement to reenergise the vision and purpose of Patient Advisors	DMC	PPIMM	~~October~~ November 2014	Date agreed for this session November. Deadline extended to reflect this	3
7	**Failure to effectively implement Better Care together (BCT) strategy.**					
7.3	Detailed work books to be developed	DS		October 2014	**Complete.** BCT workbooks completed and submitted by workbook leads	5
7.4	Final approval of the strategic plan, PID and SOC to be made at the November 2014BCT Partnership Board	DS		December 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

8	**Failure to respond appropriately to specialised service specification.**					
8.2	Appoint Head of External Partnership development and admin support	DS		December 2014	Interviews for Head of Partnerships held 10th October 2014	4
8.3	Programme Plan to be developed	DS		April 2015		4
8.4	Contracts Team to develop monthly reporting tool to track progress	DS		September 2014	**Complete.** Contracts Team now monitoring CMG compliance against specialised services	5
8.5	PIDs to be developed for academic, commercial and local partnerships and overarching highlight report to be presented at the August 2014 ESB for sign off.	DMC		~~August~~ October 2014	**Complete.** PID for Academic agreed at the 08/14 ESB, Local Partnerships captured within the Delivering Caring at its Best (DC@IB)	5
8.6	UHL to confirm compliance / non-compliance against service specifications to Area Team by end Oct 2014	DS		October 2014		4
9	**Failure to implement network arrangements with partners.**					
	Actions, 8.1, 8.2, 8.3 and 8.5 refer to risk 9. Action 7.3 refer to risk 7, therefore refer above for progress				See risks 7 & 8	
9.2	*Action removed from BAF / action tracker by DS following further review of content of risk number 9.*	N/A		N/A	See risks 7 & 8	N/A
10	**Failure to develop effective partnership with primary care and LPT.**					
10.1	PID & draft Terms of Reference to be reviewed at the August 2014 ESB meeting.	DS/ COO		~~August~~ October 2014	Agreed at 08/14 ESB, Local Partnerships to be captured within the Delivering Caring at its Best (DC@IB) PID for comms, engagement & marketing. PID to be presented at the 10/14 ESB meeting. Deadline extended to reflect this	3

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

10.2	Work Programme for the Alliance to be developed (10.2). *Action reworded 10/9/14*	DS		~~August~~ October 2014	Alliance Work programme to be presented at the October Alliance Leadership Board. An Alliance Highlight Report will be presented at the 10/14 ESB meeting. Deadline extended to reflect this	4
10.4	Detailed work books to be developed by 19th September 2014	DS		October 2014	**Complete.** See action 7.3	5
11	**Failure to meet NIHR performance targets.**					
12	**Failure to retain BRU status.**					
13	**Failure to provide consistently high standards of medical education.**					
13.1	To work with Finance to ensure transparency and accountability of undergraduate and postgraduate medical training tariffs *(reworded October 2014)*	MD	AMD (CE)	October 2014		4
13.2	Ensure appropriate Consultant Job descriptions include job planning	MD	AMD (CE)	January 2015		4
13.3	Develop appraisal methodology for educational roles	MD	AMD (CE)	January 2015		4
13.4	Disseminate approved appraisal methodology to CMGs.	MD	AMD (CE)	~~December~~ February 2015	Date changed as appraisal methodology will not be developed until January 2015 (see action 13.3)	3
13.5	Work to relocate anomalous budgets to HR as other Foundation doctor contracts	MD	AMD (CE)	~~January~~ April 2015	Budgets will be relocated at the beginning of 2015/16 financial year to avoid potential confusion of transferring part year budgets. Deadline changed to reflect this.	3
14	**Lack of effective partnerships with universities.**					
15	**Failure to adequately plan the workforce needs of the Trust.**					
15.1	Develop an integrated approach to workforce planning with LPT in order that we can plan an overall workforce to deliver the right care in right place at the right time.	DHR		October 2014	Group has been established to link workforce, strategy and finance. Second meeting 26/8/14. Meeting to be held 15 October to focus on implications of UHL bed reduction for 2015/16	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

15.2	Establish a joint group of strategy, finance and workforce leads to share plans and numbers	DHR		October 2014	See 15.1. Next meeting scheduled for 23 October. Detailed discussions to be captured in Workforce Workbook – requires input from Clinical Work stream leads on predicted workforce changes	4
15.3	Establish multi-professional new roles group to devise and monitor processes for the creation of new roles	CN		October 2014	Date set for first meeting. Terms of Reference drafted. Discussed with CMGs. First meeting 29 Sept. Three subgroups established to progress Assistant/Advanced Practitioners and Physician Associates	4
15.4	Develop Innovative approaches to recruitment and retention to address shortages.	DHR		March 2015	Medical Workforce Strategy in place which addresses mechanisms to improve recruitment and retention	4
15.6	Delivering our Employer Brand group to share best practice and development social media techniques to promote opportunities at UHL	DHR		March 2015	Webpage review originally planned for end of August now changed to end December). Marketing materials prepared for Jobs Show Event in September. Hotspots areas now producing career profiles which are successfully attracting into difficult to recruit areas	4
15.7	Development of internship model and potential management trainee model supported by robust education programme and education scheme	DHR		November 2014	Five internships planned to commence in 10/14 – advertisement in place. Trainee management proposal to be shared with Executive Workforce Board 16/9/14. Trainee Management Model approved in principle. Work to scope education programme underway. View to advertise Jan/Feb 2015.	4
15.8	Consultant recruitment review team to develop professional assessment centre approach to recruitment utilising outputs to produce a development programme	DHR		April 2015	Proposal prepared for review by DHR and MD. Agreed to make small adjustments to selection process in first instance and evaluate impact.	4
16	**Inability to recruit and retain staff with appropriate skills.**					

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

16.1	Team Health Dashboard to be developed and implemented	DHR		~~September 2014~~ December 2014	Organisational Health Dashboard mock up presented to the Executive Workforce Board on 16 September 2014. This will be refined to take into account feedback and the full dashboard functionality will be live from the end of December 2014. Deadline extended to reflect this.	4
16.2	eUHL system updates required to meet Trust needs	DHR		March 2015	Working through single supplier specification with Head of Procurement and IBM colleagues	4
16.3	Robust ELearning policy and procedures to be developed to reflect P&GC approach	DHR		October 2014	Draft document produced. This will form part of the Core Training Policy currently under development.	4
17	**Failure to improve levels of staff engagement**					
17.1	Team Health Dashboard to be developed – mock up to be presented to EWB at September 2014	DHR		March 2015	Please refer to Item 16.1	4
17.2	Ensure IBM aware of requirements.	DHR		March 2015	CIO aware of LiA MoC associated with IBM related projects. Meetings held with IBM representatives to coach and guide on LiA principles and approach. LiA process included in pilot phase of Managed Print roll out at Glenfield. Further plans to include LiA in pilot of Paediatric Areas for Electronic Document Record Management	4
17.3	HR Senior Team aware of need to include Engagement event prior to formal consultation (with MoC impacting on staff – more than 25 people)	DHR		March 2015	MoC (HR) including LiA as a precursor to formal consultation. A number of events have been concluded using LiA. A specific resource for LiA MoC has been developed	4
17.4	Include as regular agenda item on LiA sponsor group identifying activity and anticipated resources required	DHR		March 2015	Each of the LiA Work streams is included as standing items on LiA Sponsor Group meetings.	4

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

17.5	National data on UHL workforce numbers to be used by NHS England to get a sense of how many staff completed the survey	NHS England		September 2014	**Complete**	5
17.6	Develop draft internal reports in development in readiness for possible analysis methodology used by NHS England in September 2014.	DHR		~~September~~ October 2014	**Friends and Family Test for Staff:** Submission of first UNIFY report submitted to NHS England in compliance with deadline and CQUIN target. Internal analysis of free text themes being undertaken. UHL data to be included in CE Briefing. Awaiting information on how the data will be analysed and published by NHS England. Deadline extended to reflect this	4
18	**Lack of effective leadership capacity and capability**					
18.1	Leadership into Action Strategy to be reviewed by Executive Workforce Board in September 2014	DHR		September 2014	**Complete.** Strategy presented at the meeting of 16 September 2014. The strategy will be refined to reflect EWB feedback and live from the end of October 2014	5
18.2	Improve internal coaching and mentoring training provision in collaboration with HEEM and at phase 1 establish process for assigning coaches and mentors to newly appointed clinicians	DHR		December 2014	Mentoring / Coaching development programme in place. Bespoke Consultant Programme planned for 10/14 in partnership with HEEM	4
18.3	'Shadowing and Buddying' System being developed in partnership with HEEM and Assistant Medical Director to ensure support provided to newly appointed Consultants at initial phase (18.3)	DHR		April 2015	Consultant Forum in place	4
18.5	Support national and regional Talent Management and Succession Planning Projects by National NHS Leadership Academy , EMLA and NHS Employers	DHR		March 2015	UHL staff nominated to access National Leadership Academy Programme based on talent conversations.	4

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

18.6	Board Coach (on appointment) to facilitate Board Development Session	DHR		October 2014	Board development session planned for 16/10/14. DHR in discussion with The Foresight Partnership on the appointment of Board 'Coach'. Sue Rubinstein has agreed to act as the Board Coach but is subject to agreement with the Trust Chairman.	4
18.7	Update of UHL Leadership Qualities and Behaviours to reflect Board Development, UHL 5 Year Plan and new NHS Healthcare Leadership Model	DHR/ CE		January 2015	As above, at the initial phase the Trust Board will discuss and agree : (a) the overall leadership model the Board and Executive Team are seeking to build; and (b) the Board culture that it is seeking to shape and exemplify.	4
19	**Failure to deliver financial strategy (including CIP).**					
19.2	Production of a FRP to deliver recurrent balance within three years	DDF		~~August Review September 2014~~ December 2014	On track, though the timescale is 6 years subject to TDA approval of the LTFM. Awaiting formal feedback from the TDA on the LTFM submitted on 20/6/14. Following the Board to Board with the TDA further work will be required on the financial strategy before December 2014	3
19.5	Expedite agreement of CIP quality impact assessments with UHL and CCGs	DDF		~~August Review September~~ October 2014	UHL continues to submit CIP quality impact statements to the CCGs where appropriate, following sign off by the Chief Nurse and Medical Director. We have also requested quality impact statements from the CCGs for their QIPP plans	3
19.6	PMO Arrangements need to be finalised	DDF		~~August~~ October 2014	Whilst the structure is agreed we have extended the EY contract until the end of 10/14. Deadline extended to reflect this	3

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

19.8	Restructuring of financial management via MoC	DDF		~~July Review August~~ October 2014	MoC consultation ended 6/6/14; recruitment to vacant posts on-going. All senior posts have now been successfully recruited to – all will be in post by the end of 10/14. Deadline extended to reflect this	3
19.10	Business Cases to support Reconfiguration and Service Strategy	DDF		~~July Review September 2014~~ On-going as per individual business case timeline	The TDA have now confirmed that the previously submitted IBP/LTFM will act as the overall SOC. Individual business cases will be submitted to the Trust Board and TDA as per the overall reconfiguration strategy	4
19.11	Agreement of long-term loans as part of June Service and Financial plan	DDF		~~June August~~ October 2014	The Trust has received a £29m cash loan in line with the Plan and trajectory submitted to the TDA. Application for further loans submitted and on-going work with the TDA between now and 17/10/14 when the application will be formally reviewed by ITFF panel. Application submitted to the ITFF panel for review at the meeting on 17 October 2014.	3
20	**Failure to deliver internal efficiency and productivity improvements.**					
20.1	Agree plans and targets for cross-cutting themes through the monthly cross cutting theme delivery board	COO		August 2014	Update awaited	4
21	**Failure to maintain effective relationships with key stakeholders**					
21.1	Qualitative survey by Trust Internal Audit (PWC)	DMC		October 2014	**Complete.** Draft received from PWC. For consideration at future Audit Committee and Board	5
21.2	TBA DS & DF			TBA		

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

21.3	Create a platform to launch Clinical Task Group	MD		September 2014	**Complete.** A clinical task force has been created to drive the improvements that come out of learning lessons to improve care. All LLR health partners are involved. An LiA event has been held (Oct14) and further cross community engagement events are planned over the next 3 months. Progress will be tracked through EQB and QAC and via 3 monthly reports to the TB. In addition UHL clinicians remain fully engaged with CRG of BCT through deputy MD.	5
22	**Failure to deliver service and site reconfiguration programme and maintain the estate effectively**.					
22.2	Reconfiguration Board (reporting to ESB) to be established – 1st meeting in Oct 2014	DS		October 2014	First reconfiguration Board meeting 14th October 2014	4
22.3	DoH Heath Gateway Team to carry out a Gateway 0 review of the reconfiguration project.	DS		October 2014	Gateway review commences 20th October 2014	4
23	**Failure to effectively implement EPR programme**					
23.5	When the final vendor is chosen we will create and communicate the detail delivery plan and its dependencies.	CIO		~~September~~ October 2014	Plans are being developed to take this forward and the final selection will be happening in October in support of the FBC production. Currently we are working with the final two vendors to maintain a competitive conversation. Deadline extended to reflect this.	3
23.6	Continue to communicate with the wider/non-involved clinicians throughout the procurement process	CIO		October 2014		4
24	**Failure to implement the IM&T strategy and key projects**					
24.1	Develop, disseminate and implement the new prioritisation matrix	CIO		~~August~~ September 2014	**Complete.** This is now operating but will be reviewed monthly to ensure that it is meeting the needs of UHL	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

24.3	CMGs to hold formal monthly meeting with IM&T service delivery lead where issues can be solved	CIO		~~September~~ Review October 2014	Not yet in place for all CMGs Not all CMGs have returned a representative. This has been escalated for resolution.	3

Key

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

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

Risk ID	CMG	Risk Title	Current Risk Score	Target Risk Score	Movement from previous month
2423	RRC	Outstanding clinic letters and inability to act on results impacting on patient safety in respiratory services	25	6	NEW
2236	Emergency and Specialist Medicine	There is a risk of overcrowding due to the design and size of the ED footprint	25	16	↔
2234	Emergency and Specialist Medicine	There is a medical staffing shortfall resulting in a risk of an understaffed Emergency Department impacting on patient care	20	6	↔
2333	ITAPS	Lack of paediatric cardiac anaesthetists to maintain a WTD compliant rota leading to service disruption and loss of resilience	20	8	↔
2398	ITAPS	There is a risk of patient cancellations due to the limited number of Cardiac Scrub Nurses with competence to perform the task	20	6	↔
698	Clinical Support and Imaging	Risk to the production of aseptic pharmaceutical products	20	3	↔
2391	Women's and Children's	Inadequate numbers of Junior Doctors to support the clinical services within Gynaecology & Obstetrics	20	8	↔
2409	Women's and Children's	There is an insufficient number or middle-grade doctors, both registrars and SHO's to provide adequate service cover	20	10	↔
847	Women's and Children's	Lack of Capacity in maternity services	20	12	↔
2330	Medical Directorate	Risk of increased mortality due to ineffective implementation of best practice for identification and treatment of sepsis	20	6	↔
2403	Nursing	Changes in the organisational structure have adversely affected water management arrangements in UHL	20	4	↔
2404	Nursing	Inadequate management of Vascular Access Devices resulting in increased morbidity and mortality	20	8	↔
2414	CHUGS	There is a risk that Endoscopy LGH will not pass JAG acrreditation	16	4	NEW
2422	CHUGS	There is a risk to patient safety and quality due to the nurse staffing levels on SAU LRI	16	4	NEW
2320	CHUGS	Inadequate staffing levels in therapy radiography and radiotherapy physics causing a serious radiotherapy treatment error	16	4	↔
2343	RRC	There is a risk that an increase in demand for asthma and allergy nurse services will impact on patient safety	16	6	↔
2399	ITAPS	Risk of not being able to deliver enough theatre additional sessions to meet the RTT Target for the Trust.	16	2	↔
2193	ITAPS	Risk of unplanned loss of theatre and/or recovery capacity at the LRI	16	4	↔
2194	ITAPS	Risk of unplanned loss of theatre, recovery or Critical Care capacity across UHL due to insufficient nursing staffing	16	4	↔
2191	Musculoskeletal and Specialist Surgery	Follow up backlogs and capacity issues in Ophthalmology	16	8	↔
607	Clinical Support and Imaging	Failure of UHL BT to fully comply with BCSH guidance and BSQR in relation to traceability and positive patient identification	16	4	↔
2300	Clinical Support and Imaging	There is a risk of not meeting the national guidelines for out of hours Vascular cover	16	4	↔
2248	Clinical Support and Imaging	Lack of IR(ME)R training records held across the Trust	16	4	↔
2384	Women's and Children's	There is an increased risk in the incidence of babies being born with HIE (moderate & severe) within UHL	16	8	↔
2153	Women's and Children's	Shortfall in the number of qualified nurses in Children's Hospital including ECMO staffing and Capacity	16	8	↔
2237	Medical Directorate	Risk of results of outpatient diagnostic tests not being reviewed or acted upon resulting in patient harm.	16	8	↔
2338	Medical Directorate	There is a risk of patients not receiving medication and patients receiving the incorrect medication due to an unstable homecare	16	9	↔
2093	Medical Directorate	Athena Swan - potential Biomedical Research Unit funding issues.	16	4	↔
2325	Nursing	Risk to patient/staff safety due to security staff not assisting with restraint	16	6	↔
2247	Nursing	There are 500 Registered Nurse vacancies in UHL leading to a deterioration in service and adverse effect on financial position	16	12	↔
2316	Operations	Flooding from fluvial and pluvial sources	16	12	↔
2341	Operations	Long term follow up outpatient appointments not made	16	2	↔
2318	Operations	Blocked drains causing leaks and localized flooding of sewage	16	2	↔
1693	Strategy	Risk of inaccuracies in clinical coding	16	8	↔
2354	RRC	Overcrowding in the Clinical Decisions Unit	15	3	↔
949	Emergency and Specialist Medicine	Inadequate toxicity monitoring for DMARDS	15	3	↑
2328	ITAPS	Risk of inadvertent wrong route administration of anaesthetic medicines during epidural and regional anaesthesia.	15	5	↔
2380	Clinical Support and Imaging	Risk of breach of Same Sex Accommodation Legislation	15	3	↔
1196	Clinical Support and Imaging	No comprehensive out of hours on call rota and PM cover for consultant Paediatric radiologists	15	2	↔
2407	Women's and Children's	Failure to meet national non admitted target of 18 weeks	15	3	↔
2278	Women's and Children's	Risk that the Leicester Fertility Centre could have its licence for the provision of treatment and services withdrawn	15	6	↔
2402	Nursing	Inappropriate Decontamination practise within UHL may result in harm to patients and staff	15	3	↔
1551	Nursing	Failure to manage Category C documents on UHL Document Management system (Insite)	15	9	↔

Agenda Item: Trust Board paper J

TRUST BOARD – 30th October 2014

Patient Experience story – You never get a second chance to create a first impression

DIRECTOR:	Rachel Overfield, Chief Nurse
AUTHOR:	Jeanette Halborg, Head of Nursing CSI CMG Rona Gidlow, Consultant Radiographer and Q&S Lead for Imaging Michelle Scowen, Matron CSI/Imaging
DATE:	30th October 2014
PURPOSE:	To describe for Trust Board the experience of a patient when attending a radiology investigation at Leicester General Hospital and how services have been changed in response to this experience. The CSI Clinical Management Group (CMG) takes all feedback from patients very seriously and uses feedback to review practices and care. The CMG would like to share this poor experience of care with Trust Board and use it to illustrate their commitment and drive to improve care delivery leading to patient led services. **Summary / Key Points:** A patient attending for a radiology procedure shares their experience using video feedback. There are three main aspects: 1. The embarrassment this female patient felt sitting in a waiting room with male patients only clothed in a procedure gown 2. The dismissive way she was spoken to by a member of staff 3. Lack of explanation given during the procedure. **Actions in Response to Feedback** At all staff meeting's this patient's experience has been discussed, allowing staff to see the services they provide from the patients perspective. This has proved very powerful and the issues of privacy, attitude and information provision have been discussed in a constructive manner, allowing staff to learn and improve. **Elimination of Mixed Sex Waiting Area Facilities** There have been improvements in the provision of single sex facilities at Leicester General Hospital imaging department as follows: ➢ The new build to accommodate a second CT scanner has meant that it has now been possible to provide separate male and female waiting areas ➢ Patients having a plain film x-ray with the requirement to wear a gown now have separate areas within the imaging department to ensure that undressed patients in gowns are not sitting in waiting areas with fully clothed patients ➢ There are a large number of patients having investigations that require wearing a gown. The processes have changed ensuring those patients are encouraged to wait in individual changing cubicles until their procedure. This has prevented the need for patients to wait in a mixed sex waiting area. If the patient wishes to wait in the waiting room this is entirely their choice. ➢ Notices have been placed in the cubicles where patients change to ensure that they are aware they can wait inside the cubicle should they wish until called for their investigation, this reinforces the verbal guidance given by staff.

- Gowns used at the Leicester General Hospital are either paper or cloth. The cloth gowns are only one size, go on over the head and have an opening at the back. The patients' size and shape will depend on the level of dignity maintained. The paper gown fastens with a belt. This is a similar problem in other areas across the Trust and has now been raised with the Patient Experience Team who are currently investigating options. Until a suitable alternative is found, dressing gowns at an additional cost will be provided for patients.

- The Matron for the Imaging Department has conducted a full audit of the privacy and dignity issues for the Leicester General Hospital Imaging Department and a risk assessment has been added to the risk register scoring 15. An action plan to resolve the issues highlighted is in the process of being implemented.

Poor Attitude of Staff and Patient Explanation
The Radiographer who performed the CT scan for this patient was identified and asked to review/reflect on the concerns raised regarding their manner and communication style. On discussion the member of staff acknowledged that on occasions, they may come across as abrupt and lacking in empathy.

The member of staff has been set clear performance objectives in relation to communication and patient perceptions of compassionate care. One of the many objectives was to attend a bespoke communication day arranged for cross sectional imaging staff in September this year. At a subsequent review meeting for this staff member the individual indicated they found the communication course very helpful and now has a better understanding of how and why they need to modify their approach to patients.

A recurrent theme in complaints received within Imaging relates to staff attitude, therefore a bespoke communication development day has been organised with De Montfort University to address the issues relating to staff communication both verbally and non-verbally. All Imaging staff has attended this development opportunity.

The CMG, with support from the Organisational Development Team, have also developed its own in-house course relating to communication and customer care called Delivering Fundamentals. This course focuses upon information provision and ensuring clear explanation for patients. To date 30 members of staff have attended and another 20 members of staff are booked to attend. The course will be evaluated from feedback received and impact on the service to determine if further courses are required.

Future Actions
The CMG take seriously any concerns raised by patients, their families and the public and review all feedback and lessons to learn at the CMG Quality and Safety Committee and CMG Board.

As a result of this patients feedback the CMG have reviewed other areas across the CMG. All transferable improvements have been incorporated as appropriate within imaging facilities on all three sites and improvement plans agreed. The following improvements have already begun:

The Light Therapy Treatment Facility at the Leicester Royal Infirmary currently fails to meet the expected single sex changing facilities and privacy agenda that the CMG strive to achieve. A charitable funds proposal costing £8.5K to refurbish the area allowing separate male and female changing has been submitted and accepted and building work should start in the near future.

	The planned rebuild of the Emergency Department Imaging service has incorporated all of the expected single sex changing facilities and privacy and dignity agenda that the CMG require. The architect's plans incorporate all the recommendations that the Imaging team submitted ensuring high levels of privacy across the new facilities.
PREVIOUSLY CONSIDERED BY:	None
Objective(s) to which issue relates *	[v] 1. Safe, high quality, patient-centred healthcare [ ] 2. An effective, joined up emergency care system [v] 3. Responsive services which people choose to use (secondary, specialised and tertiary care) [ ] 4. Integrated care in partnership with others (secondary, specialised and tertiary care) [ ] 5. Enhanced reputation in research, innovation and clinical education [v] 6. Delivering services through a caring, professional, passionate and valued workforce [ ] 7. A clinically and financially sustainable NHS Foundation Trust [ ] 8. Enabled by excellent IM&T
Please explain any Patient and Public Involvement actions taken or to be taken in relation to this matter:	1. Patients are encouraged to share their stories of care within the trust. 2. CSI CMG has a PPI action plan which is discussed at the CMG Quality and Safety Committee, CMG Board and with the Patient Advisors for the CMG. 3. The Head of Nursing and Matron for CSI meet monthly with both Patient Advisors who are actively involved in the CMG.
Please explain the results of any Equality Impact assessment undertaken in relation to this matter:	N/A
Strategic Risk Register/ Board Assurance Framework *	[X] **Strategic Risk Register** [X] **Board Assurance Framework** [ ] **Not Feature**
ACTION REQUIRED *	For decision [ ] For assurance [X] For information [ ]

♦ We treat people how we would like to be treated ♦ We do what we say we are going to do
♦ We focus on what matters most ♦ We are one team and we are best when we work together
♦ We are passionate and creative in our work

* tick applicable box

University Hospitals of Leicester NHS
NHS Trust

Agenda Item: Trust Board paper K

TRUST BOARD 30 October 2014

Making Every Contact Count (MECC) Work Programme for 14/15

DIRECTOR:	Mark Wightman, Director of Marketing and Communications
AUTHOR:	Rebecca Broughton, Head of Outcomes & Effectiveness
DATE:	October 2014
PURPOSE:	To seek approval for the 14/15 MECC Work Programme, noting that Trust Board approval is a requirement expected by the local public health teams, who are the ring holders for Making Every Contact Count. The aim of Making Every Contact Count (MECC) is to improve the health of the population by using every NHS contact with an individual as an opportunity to maintain or improve their mental and physical health and wellbeing. This means that there are approximately 1 million opportunities every year for UHL staff to talk to patients not only about their specific condition, disease or injury but to also reflect on lifestyle issues such as drinking, smoking and exercise which either exacerbate the patient's condition now or will lead to ill health in the future. The plan on page which accompanies this cover sheet describes the actions we are taking and their current status.
PREVIOUSLY CONSIDERED BY:	**Executive Quality Board**
Objective(s) to which issue relates *	[v] 1. Safe, high quality, patient-centred healthcare [ ] 2. An effective, joined up emergency care system [ ] 3. Responsive services which people choose to use (secondary, specialised and tertiary care) [v] 4. Integrated care in partnership with others (secondary, specialised and tertiary care) [ ] 5. Enhanced reputation in research, innovation and clinical education [ ] 6. Delivering services through a caring, professional, passionate and valued workforce [ ] 7. A clinically and financially sustainable NHS Foundation Trust [ ] 8. Enabled by excellent IM&T
Please explain any Patient and Public Involvement actions taken or to be taken in relation to this matter:	Whilst the key MECC interventions (smoking, drinking, diet and exercise) are prescribed; the approach to messaging is not. As such part of the programme for 2014/15 will necessarily involve the co-creations and testing of messaging with patients and the public.
Please explain the results of any Equality Impact assessment undertaken in relation to this matter:	No EIA has been completed to date. The MECC lead will therefore involve the Trust's Equality Lead to assure that the components of the plan and the subsequent messaging are congruent with our requirement to not *through omission or intervention* discriminate against groups or individuals

Organisational Risk Register/ Board Assurance Framework *	☐ **Organisational Risk Register** ☐ **Board Assurance Framework** ☒ **Not Featured**
ACTION REQUIRED *	
For decision ☒	For assurance ☐ For information ☐

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* tick applicable box

UHL 14/15 MAKING EVERY CONTACT COUNT (MECC) WORK PROGRAMME

Ref	Work Stream	Action to be taken	Work-stream Lead	Reporting frequency / Completion Deadline	Progress RAG	Progress update/comment
1a	Healthy Eating and Physical Activity	Review and Revise Information included in the UHL Information for patients and visitors 'Bed Book' relating to Healthy Eating and Physical Activity aspect of MECC	HOE / CDM-PH	Nov 14	4	Bed Booklet includes info re Smoking Cessation and Alcohol but not about healthy eating. Healthy Eating wording to be drafted for incorporating into MECC section of Booklet, in line with timescales for including new 'Think Glucose' section.
1b		Review of Pre-Assessment process and documentation to identify areas for increased 'signposting' / prompting of MECC healthy eating advice	PACS	Oct 14	4	Recent drop in referrals believed to be activity related.
1c		Poster campaign in the Orthopaedic Pre-Assessment area	HOE / CDM-PH	Nov 14	4	
1d		Scope and plan introduction of Healthy Eating advice/referrals as part of pre-assessment process for patients undergoing Groin Hernia Surgery	HOE / Pre-Assessment Matrons	Oct 14	4	
1e		Pilot and Evaluate Healthy Eating advice / offering of referrals	Pre-Assessment Matrons	Nov 14	1	

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**	Work stream/ action Revised

Ref	Work Stream	Action to be taken	Work-stream Lead	Reporting frequency / Completion Deadline	Progress RAG	Progress update/comment
2a	Smoking Cessation	Review processes for recording smoking status on Patient Centre and potential use of e-Handover to capture this information	HOE / STOP Advisor	Nov 14	4	Variable recording of smoking status on patient centre. Discussed use of e-Handover with ADNS
2b		Implement Smoking Cessation Bedside pilot and evaluation for impact on referrals	STOP Advisor	Dec 14	4	Commenced.
2c		Scope development of e-learning teaching package	CEF	Nov 14	1	
2d		Continue with Awareness raising of the Service – ie STOPtober and the APM	STOP	Nov 14	4	Attended APM.
3a	Alcohol Reduction	Continue providing teaching sessions within Medicine and ED to raise awareness and encourage referrals	ALS TL	Quarterly	4	Referrals continue to increase slightly.
3b		Alcohol Awareness Week	ALS TL	Nov 14	4	
3c		Confirm continued funding of ALS with extended hours at weekend	ALS TL	Dec 14	4	
4a	MECC for Staff	Confirm access to Healthy Eating / Smoking Cessation consultation on each site	HOE	Oct 14	4	
		MECC stands as part of the Wellbeing Fayre	All	tbc	1	

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**	Work stream/ action Revised

University Hospitals of Leicester NHS
NHS Trust

Agenda Item: Trust Board paper L

TRUST BOARD – 30 October 2014

Appointment of Responsible Officer

DIRECTOR:	Dr Kevin Harris – Medical Director
AUTHOR:	Dr Kevin Harris – Medical Director
DATE:	30 October 2014
PURPOSE:	To describe the process for strengthened appraisal and revalidation, outline progress to date, and describe the role of the Responsible Officer (currently the Medical Director). **To recommend to the Trust Board the appointment of Dr Peter Rabey as the Responsible Officer for the University Hospitals of Leicester NHS Trust.**
PREVIOUSLY CONSIDERED BY:	**N/A**
Objective(s) to which issue relates *	[x] 1. Safe, high quality, patient-centred healthcare [ ] 2. An effective, joined up emergency care system [ ] 3. Responsive services which people choose to use (secondary, specialised and tertiary care) [ ] 4. Integrated care in partnership with others (secondary, specialised and tertiary care) [x] 5. Enhanced reputation in research, innovation and clinical education [x] 6. Delivering services through a caring, professional, passionate and valued workforce [ ] 7. A clinically and financially sustainable NHS Foundation Trust [ ] 8. Enabled by excellent IM&T
Please explain any Patient and Public Involvement actions taken or to be taken in relation to this matter:	None
Please explain the results of any Equality Impact assessment undertaken in relation to this matter:	Not applicable
Organisational Risk Register/ Board Assurance Framework *	[ ] **Organisational Risk Register** [ ] **Board Assurance Framework** [X] **Not Featured**
ACTION REQUIRED *	For decision [X] For assurance [ ] For information [ ]

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♦ We are passionate and creative in our work

* tick applicable box

RESPONSIBLE OFFICER

1.0 INTRODUCTION

This paper is to seek the Trust Board's endorsement for the appointment of Dr Peter Rabey as the Responsible Officer (RO) for the University Hospitals of Leicester

2.0 BACKGROUND

Doctors with a license to practice have a prescribed connection to a designated body and relate to the RO appointed by the designated body.

The Department of Health in July 2010 produced guidance on the Role of the Responsible Officer (The Role of Responsible Officer; Closing the gap in medical regulation – Responsible Officer Guidance) and this is attached in full at Appendix 1. Responsible officers must have regard to this guidance under the Medical Profession (Responsible Officers) Regulations 2010. It relates to the role of responsible officers to be nominated or appointed by those bodies designated under the Medical Act 1983 (as amended by the Health and Social Care Act 2008). The regulations came into force on 1st January 2011

The roles of the RO include:

- to protect patients by ensuring that the GMC's standards are met by licensed doctors.
- Ensure doctors are properly supported and managed in sustaining and, where necessary, raising their professional standards
- For the very small minority of doctors who fall short of the high professional standards expected, ensure that there are fair and effective local systems to identify them and ensure appropriate remedial, performance or regulatory action to safeguard patients; and
- Increase public and professional confidence in the regulation of doctors.
- Provide recommendations to the GMC about the revalidation (or otherwise) of doctors with a prescribed connection to the designated body over a 5 year cycle.

The RO must be appropriately trained and participate in appropriate on-going RO training and development and have a PDP related to the role of RO as part of annual appraisal.

The designated body has a statutory responsibility to provide the necessary resources to support appraisal and revalidation.

The University Hospitals of Leicester NHS Trust has a well established and effective system for the appraisal and revalidation of its doctors. Annual reports of the performance have been provided to the Board. Currently the appraisal revalidation process is overseen by NHS England Regional Areas Teams who full fill the role of the designated body for an RO

The University Hospitals of Leicester NHS Trust is a designated body and currently its RO is the Medical Director Dr Kevin Harris.

3.0 ISSUE

Initially the majority of designated bodies appointed their Medical Director as their RO.

When the RO regulations were introduced there was discussion about the potential conflict of interests between the role of Medical Director (who has a primary responsibility to the Trust) and the role of Responsible Officer (who has a primary responsibility to the GMC and to maintain patient safety). However, in reality this potential conflict has not emerged.

However what has become clear, especially in large organisations with a large number of doctors, is that by combining the two roles the workload implications for the Medical Director can become unmanageable due to the time consuming nature of the RO role. As a result a number of large Trusts (eg Leeds Teaching Hospital) have now dissociated the role of Medical Director and RO.

4.0 PROPOSAL

UHL appoints Dr Peter Rabey Deputy Medical Director as its RO moving forward. The Medical Director would no longer be RO but would retain the accountability to the Board for the performance of doctors.

Dr Rabey has undertaken RO training from NHS England in June 2014, and is fully connected to UHL's governance systems. He attended the national RO conference organised by NHS England in Spring 2014, and is familiar with the East Midlands RO Network. He is thus is a completely suitable individual for such a role. This has been discussed with both the GMC and NHS England who would support the appointment subject to the Board's approval.

5.0 RECOMMENDATION

The Trust Board approves the appointment of Dr Peter Rabey as the RO for the University Hospitals of Leicester NHS Trust.

If this recommendation is accepted NHS England and the GMC would be informed of the change in RO for UHL with immediate effect.

University Hospitals of Leicester NHS
NHS Trust

Agenda Item: Trust Board paper M

TRUST BOARD – October 30, 2014

National Institute for Health Research Clinical Research Network: East Midlands: Host Update for University Hospitals of Leicester Trust Board

DIRECTOR:	Kevin Harris, Medical Director
AUTHOR:	David Rowbotham, Clinical Director, National Institute for Health Research Clinical Research Network: East Midlands
DATE:	October 30, 2014
PURPOSE:	**UHL is the host organisation for the National Institute for Health Research Clinical Research Network: East Midlands. As such, UHL's Trust Board is responsible for its governance. This paper gives the background to the establishment of this network (April 2014) and describes present achievements and challenges, including key performance data.**
PREVIOUSLY CONSIDERED BY:	**Executive Strategy Board, March 28, 2014**
Objective(s) to which issue relates *	[ ] 1. Safe, high quality, patient-centred healthcare [ ] 2. An effective, joined up emergency care system [ ] 3. Responsive services which people choose to use (secondary, specialised and tertiary care) [ ] 4. Integrated care in partnership with others (secondary, specialised and tertiary care) [x] 5. Enhanced reputation in research, innovation and clinical education [ ] 6. Delivering services through a caring, professional, passionate and valued workforce [ ] 7. A clinically and financially sustainable NHS Foundation Trust [ ] 8. Enabled by excellent IM&T
Please explain any Patient and Public Involvement actions taken or to be taken in relation to this matter:	No action required by Trust Board. The network has established a PPI infrastructure.
Please explain the results of any Equality Impact assessment undertaken in relation to this matter:	Not applicable to this report.
Strategic Risk Register/ Board Assurance Framework *	[x] **Strategic Risk Register** [x] **Board Assurance Framework** [ ] **Not Featured**
ACTION REQUIRED *	For decision [ ] For assurance [x] For information [x]

♦ We treat people how we would like to be treated ♦ We do what we say we are going to do
♦ We focus on what matters most ♦ We are one team and we are best when we work together
♦ We are passionate and creative in our work

* tick applicable box

National Institute for Health Research Clinical Research Network: East Midlands

Host Update for University Hospitals of Leicester Trust Board

1. Background

1.1 The National Institute for Health Research (NIHR) was established in April 2006, partly in response to a near terminal decline in clinical trial activity within the NHS. This decline was caused by a sluggish and unresponsive clinical trial approval process combined with an inability to recruit the required numbers of patients within the funding and timing envelope of individual clinical trials. We were still reasonable at making basic scientific discoveries but we had become one of the worst countries in the world for clinical trials delivery.

1.2 The NIHR is funded by the Department of Health with a mission to improve the health and wealth of the nation through research. It has developed into the most integrated clinical research system in the world benefiting our patients and the economy. The NIHR has transformed clinical research in the NHS by increasing the volume and quality of applied health research, vastly improving the delivery of clinical trials to time and target, driving faster translation of basic science discoveries into available new treatments and creating a large national cadre of professionals who design, deliver and contribute to applied health research.

1.3 A key early strategy of the NIHR was the establishment of clinical research networks tasked with reversing poor clinical research delivery and restoring the UK as one of the best places in the world to perform clinical research. The first networks covered specific specialities (cancer, stroke, diabetes, medicines for children, mental health, primary care, dementia) in selected geographical areas and, as a result of their success, Comprehensive Local Research Networks (CLRN) were established nationally to cover those specialties not represented in the topic-specific networks. Eventually, more than 100 clinical research networks were established in England hosted by NHS Trusts in adjacent localities. Trusts in the East Midlands hosted 10 such networks (5 hosted in UHL), each with their own budget, senior management team, staff and facilities.

1.4 There is no doubt that the networks have been a great success. For example, they have vastly increased numbers of patients recruited to clinical studies giving early availability to new treatments, reduced study approval times, started to reverse the decline in life science industry investment in the UK, increased public understanding of research and created research cultures in many areas of the NHS where this was lacking.

1.5 However, the historical development of this system of networks led to several problems, especially the creation of a large number of networks and host organisations with examples of inflexible silo working, unclear lines of accountability and inefficient management. Also, the system was often confusing to research partners e.g. clinical researchers, research

funders, life sciences industry. As a result of this, the NIHR embarked upon a national restructuring exercise (termed "transition") to form one clinical research network in England covering all specialities with a "branch" in each NHS region (n=15) known as *Local Clinical Research Networks (LCRN)*.

1.6 In 2013, University Hospitals of Leicester (UHL) NHS Trust applied successfully to host the LCRN in the East Midlands from April 2014. This regional network is also referred to as the *NIHR Clinical Research Network: East Midlands*. UHL's Trust Board approved this application and has subsequently approved the LCRN's annual plan, budget plan and governance framework.

2. Host governance

2.1 UHL's Trust Board is accountable for the good governance of the LCRN. The governance structure and key strategic and operational groups of LCRNs are mandated by the NIHR in the host contract. UHL's Chief Executive is the LCRN Accountable Officer and the Medical Director is the nominated Executive Lead. The Trust has established a LCRN Executive Group chaired by the Executive Lead; its purpose is to oversee and deliver good governance of the LCRN as defined by the host contract and LCRN Operating Framework.

2.2 LCRN issues are included in UHL's risk register and, as of this month, the Board receives key performance data and exception reporting via the Quality and Performance report. Also, the work of the LCRN will be included in the programme of work undertaken by the Trust's auditors (Price, Waterhouse, Coopers).

2.3 UHL has convened the LCRN Partnership Group which is a formal forum of LCRN partners i.e. those receiving significant funding from the LCRN. Its role is to provide active oversight and constructive mutual challenge on LCRN plans, activities, performance and reports in order to support the LCRN to achieve its objectives and raise the ambitions for clinical research of the LCRN Partners. The Trust has appointed an independent Chair (Peter Miller, Chief Executive, Leicestershire Partnership NHS Trust).

2.4 In addition to these oversight/strategic groups, UHL has ensured that the various mandated operational groups and systems have been established.

3. Budget and finances

3.1 LCRN finances are monitored by the LCRN Executive Group chaired by the Board Executive lead.

3.2 The network provides funding to healthcare providers in the East Midlands, mainly NHS Trusts (n=15) and Primary Care (via Clinical Commissioning Groups). These are defined as LCRN partners. At the start of this financial year, we funded 978 posts (259 full time, 719 part time), 238 consultant medical sessions, service support costs and staff support costs. UHL employs the LCRN senior managers as the host. All other posts are employed by the

partners (including UHL in its role as a partner of the LCRN – distinct and separate from its role as host).

3.3 The LCRN budget for 2014-15 is £21.539 M. This is 4.8% less than the indicative budget giving the network a saving target of £ 1.9 M. Overseen by the Executive Group, we have worked to deliver this saving and the target is presently approx. £ 650K. We are confident that, working with partners, we will deliver this by year end. No financial liability with respect to this rests with UHL in their hosting function.

4. Achievements

Significant achievements so far include:

(i). Through a management of change process involving the senior managers of the previous 10 research networks in the East Midlands and in partnership with other trusts in the region who employed them, we have established a fully operational senior management team.

(ii). All management structures/groups have been established and are working effectively (although this needs to be improved further).

(iii). NIHR feedback on the NIHR on the Annual Plan and Finance Plan 2014-15 was excellent.

(iv). We are confident that we will achieve our challenging budget savings (see 3.3).

(v). We have harmonised several processes/systems throughout the region, although more work is needed.

(vi). Relationships with network partners has improved significantly.

(vii). We have made significant progress in achieving our aspirational targets on patient recruitment into clinical trials (see below).

5. Challenges

Our present major challenges include:

(i). Full integration (functional and cultural) of the previous 10 research networks into a single network.

(ii). Progressing further our ambition to be transparent, flexible, responsive, and patient- and customer-focused.

(iii). Increasing research into dementia is a significant challenge in the East Midlands as this speciality was not well represented previously. We have a detailed and robust action plan and dedicated team to achieve this.

(iv). We need to develop a new financial allocation model for 2015-16 that reflects our ambitions around flexibility, transparency and value for money. This will require major negotiations with partners and others.

(v). We need to improve our performance with respect to commercial studies (see below).

6. Performance data

Key LCRN performance data is now reported to the UHL's Trust Board and Board members may have seen our first submission this month; members may wish to ask questions about this submission when considering this paper. However, some key performance data as of October 14, 2014 taken from our monthly performance report for network staff and partners is presented in the appendix to this paper:

(i). We are 5th of 15 for total patients recruited (page 1) and recruitment related to population (page 2) since April 2014. This is a significant improvement compared with quarter 1 data. We have set an ambitious total target for recruitment; presently, we are achieving 92% of this target (page 3).

(ii). Recruitment by partner organisations in the East Midlands (including study complexity) is shown on page 4.

(iii). Our challenge with respect to commercial studies is highlighted on page 4. Although the number of commercial studies undertaken in the East Midlands is similar to the national average, the numbers of patients recruited is significantly less. The major reason for this is that our present trials require relatively small recruitment for their completion. We are focussing on this presently.

(iv). An important performance measure for the network is the time taken to approve studies before they are allowed to start. Presently, we are better than the NIHR target and 4th of 15 nationally (page 5).

7. Conclusion

UHL Trust Board is requested to note this paper and be reassured as to progress to date. We welcome any further involvement of the Board members in our activities.

David Rowbotham
Clinical Director, NIHR Clinical Research Network: East Midlands

Appendix

NHS
National Institute for Health Research
Clinical Research Network East Midlands

Summary Report October 14, 2014

Clinical Research Network: East Midlands

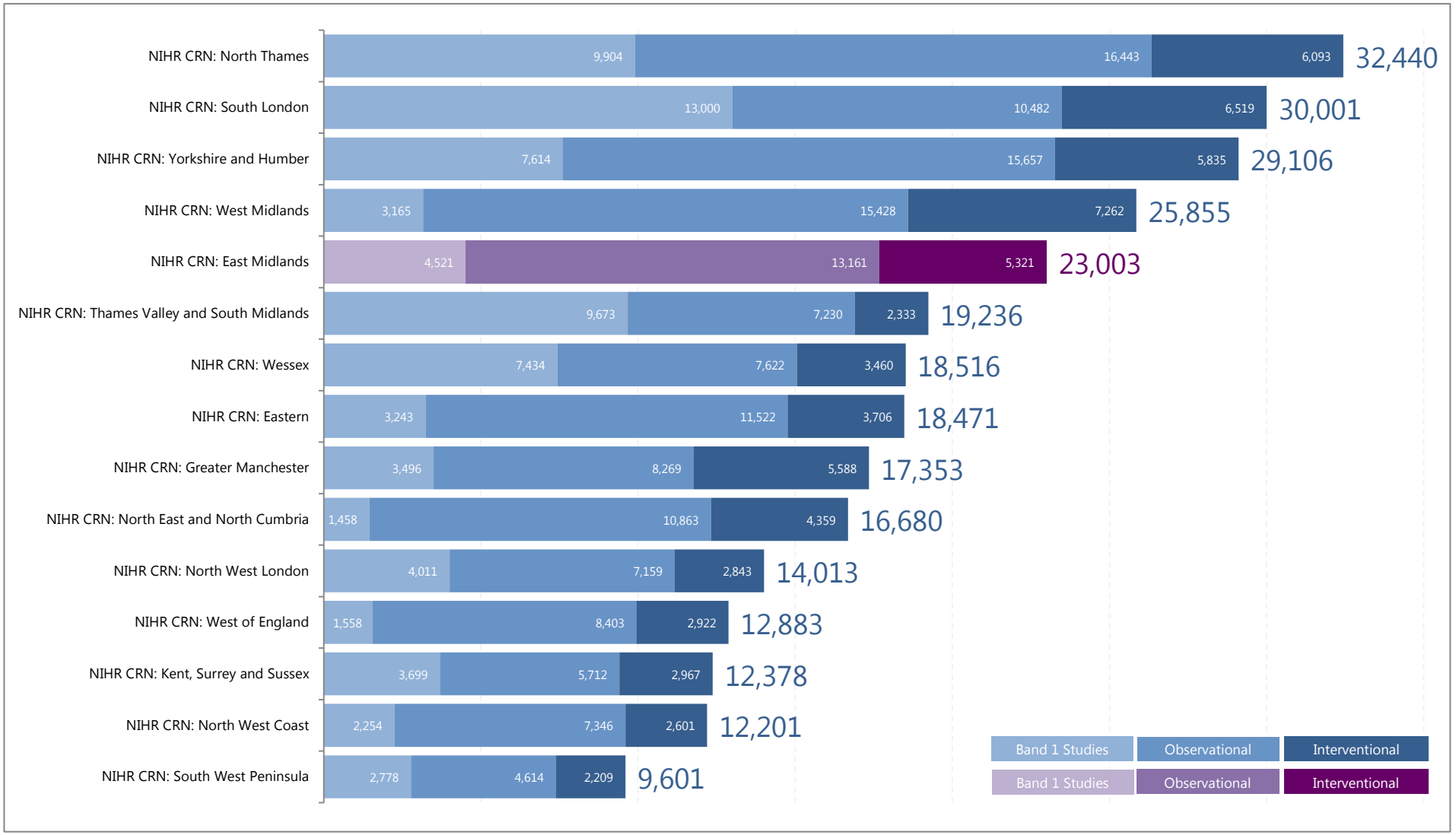
Data Extracted: 2014-10-13 (where not otherwise indicated)

Version 1.1

Source: NIHR Co-ordinating centre RAW data files and the Open Data Platform.

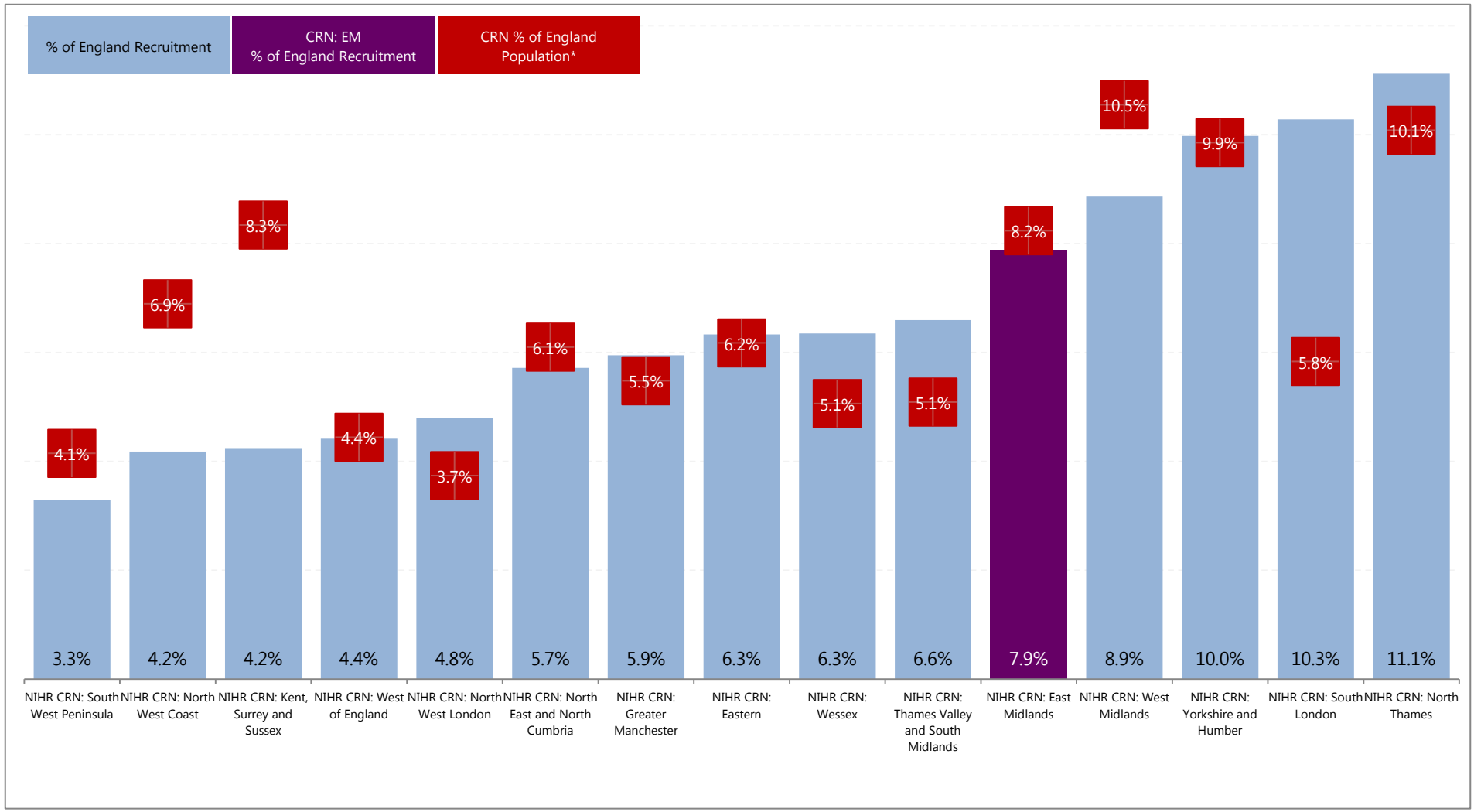
Scope: This reports on recruitment where the participant was recruited into in a complete calendar month - not the *current* month; e.g. For September 2014 reporting, a recorded participant entry of 20/09/2014 would not contribute to the metric (but would do so in October 2014).

National Recruitment into NIHR Portfolio studies by Clinical Research Network



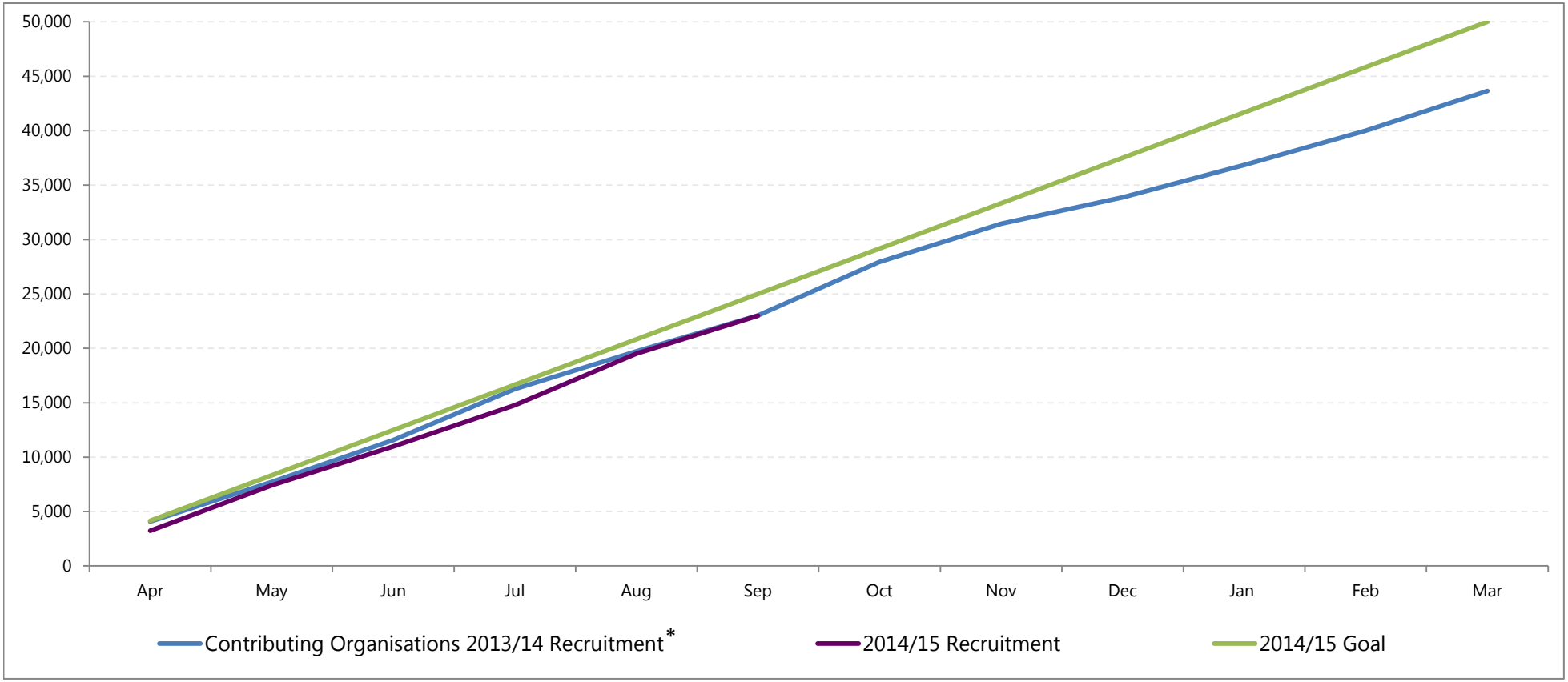
Source: NIHR CRN - 2014/15 recruitment data is produced from the recent recruitment figures provided by NIHR CRN, and includes all recruitment reported to the end of the month preceding publication of this report.Where study design is 'not specified' this is counted as an Observational Study. Where a study design is 'both' this is classed as 'Interventional'. This metric relates to NIHR CRN HLO 1, see appendix

National Recruitment into NIHR Portfolio studies as a % of Total Recruited and Total Population



Source: NIHR CRN - 2014/15 recruitment data is produced from the recent recruitment figures provided by NIHR CRN, and includes all recruitment reported to the end of the month preceding publication of this report. This metric relates to NIHR CRN HLO 1, see appendix. ***Population data** sourced from "Annual Mid-year Population Estimates, 2011 and 2012", ONS 08-08-2013. England Only, no devolved nation data.

Local Clinical Research Network recruitment into NIHR Portfolio studies



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD to Goal
Goal 2014/15	4,167	8,333	12,500	16,667	20,833	25,000	29,167	33,333	37,500	41,667	45,833	50,000	
YTD 2014/15	3,231	7,403	10,984	14,776	19,514	23,003							92%
								Red	0 - 89%	Amber	90 - 99%	Green	≥ 100%

Source: NIHR CRN - 2014/15 recruitment data is produced from the recent recruitment figures provided by NIHR CRN, and includes all recruitment reported to the end of the month preceding publication of this report. * 'Contributing Organisations' is defined as the combined recruitment of the local Comprehensive / Topic Networks represented within the contemporary CRN geography. This metric relates to NIHR CRN HLO 1, see appendix

Partners Maximise Engagement in NIHR Research

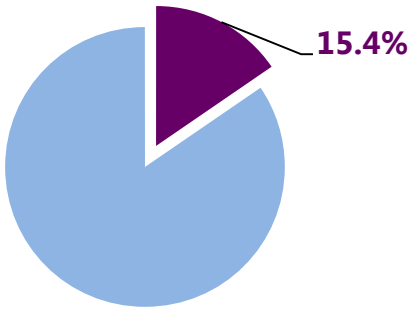
	2014/15 Recruitment	Observational / Interventional
Chesterfield Royal Hospital NHS Foundation Trust	243	72% / 28%
Derbyshire Community Health Services NHS Trust	0	
Derby Hospitals NHS Foundation Trust	1,565	79% / 21%
Derbyshire Healthcare NHS Foundation Trust	721	98% / 2%
East Midlands Ambulance Service NHS Trust	0	0%
Kettering General Hospital NHS Foundation Trust	469	81% / 19%
Leicestershire Partnership NHS Trust	554	54% / 46%
Lincolnshire Community Health Services NHS Trust	0	
Lincolnshire Partnership NHS Foundation Trust	149	73% / 27%
NHS Corby CCG	42	100%
NHS East Leicestershire and Rutland CCG	127	68% / 32%
NHS Erewash CCG	15	100%
NHS Hardwick CCG	36	17% / 83%
NHS Leicester City CCG	1,672	90% / 10%
NHS Lincolnshire East CCG	22	59% / 41%
NHS Lincolnshire West CCG	109	18% / 82%
NHS Mansfield and Ashfield CCG	71	27% / 73%
NHS Nene CCG	333	23% / 77%
NHS Newark and Sherwood CCG	69	62% / 38%
NHS North Derbyshire CCG	163	7% / 93%
NHS Nottingham City CCG	1,318	94% / 6%
NHS Nottingham North and East CCG	75	40% / 60%
NHS Nottingham West CCG	19	42% / 58%
NHS Rushcliffe CCG	1,183	98% / 2%
NHS South Lincolnshire CCG	31	13% / 87%
NHS South West Lincolnshire CCG	7	86% / 14%
NHS Southern Derbyshire CCG	137	44% / 56%
NHS West Leicestershire CCG	789	86% / 14%
Northampton General Hospital NHS Trust	578	89% / 11%
Northamptonshire Healthcare NHS Foundation Trust	373	81% / 19%
Nottingham University Hospitals NHS Trust	4,673	58% / 42%
Nottinghamshire Healthcare NHS Trust	550	80% / 20%
Sherwood Forest Hospitals NHS Foundation Trust	426	81% / 19%
United Lincolnshire Hospitals NHS Trust	518	79% / 21%
University Hospitals of Leicester NHS Trust	5,966	77% / 23%

Source: NIHR CRN - 2014/15 recruitment data is produced from the recent recruitment figures provided by NIHR CRN, and includes all recruitment reported to the end of the month preceding publication of this report.

Industry Proportion of active commercial sites / recruitment

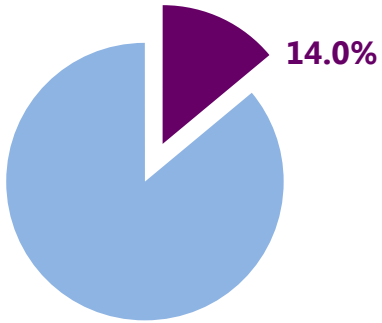
% of Active Study Portfolio (Commercial / Non-Commercial)

All CRNs



14008 Non-Commercial | 2559 Commercial

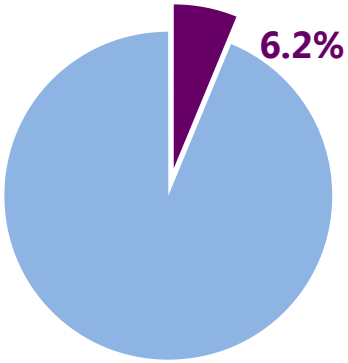
CRN: East Midlands



919 Non-Commercial | 149 Commercial

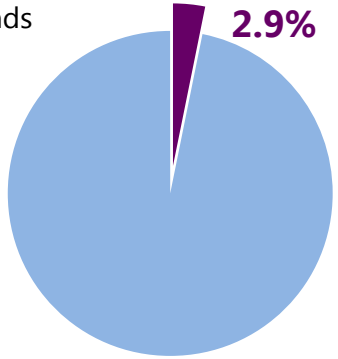
% of 2014/15 YTD Recruitment (Commercial / Non-Commercial)

All CRNs



309346 Non-Commercial | 20592 Commercial

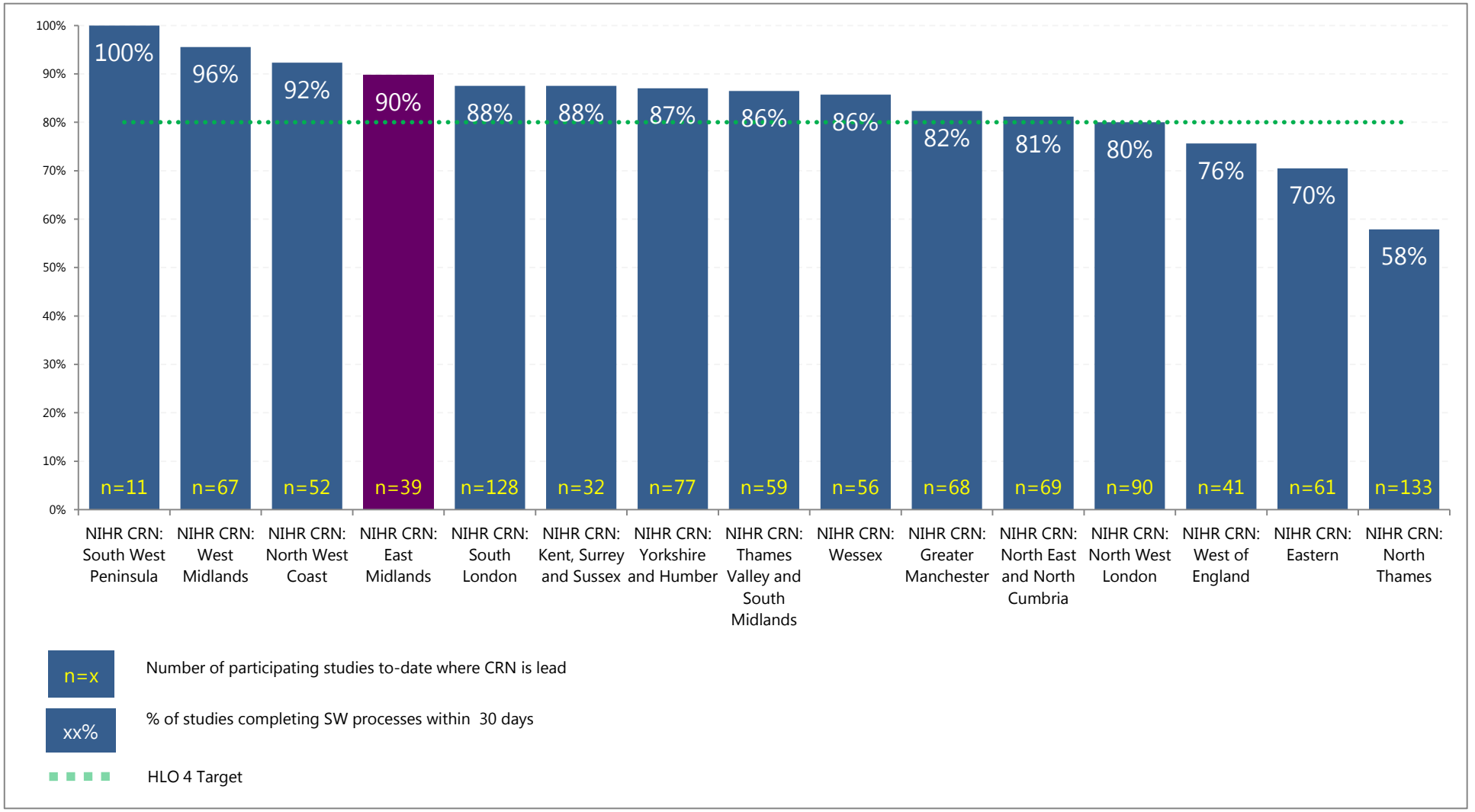
CRN: East Midlands



22272 Non-Commercial | 731 Commercial

Source: NIHR CRN - 2014/15 recruitment data is produced from the recent recruitment figures provided by NIHR CRN, and includes all recruitment reported to the end of the month preceding publication of this report.'% Active' is defined a study that has recorded recruitment since April 2014. This metric relates to NIHR CRN HLO 3, see appendix

Processes % of Study-Wide processes completed within 30 days



Source: Open Data Platform, 2014-10-14. This metric relates to NIHR CRN HLO 4, see appendix

University Hospitals of Leicester NHS
NHS Trust

Agenda Item: Trust Board paper N

TRUST BOARD – 30TH OCTOBER 2014

QUALITY AND PERFORMANCE REPORT – SEPTEMBER 2014

DIRECTOR:	Rachel Overfield, Chief Nurse Kevin Harris, Medical Director Richard Mitchell, Chief Operating Officer Kate Bradley, Director of Human Resources
AUTHOR:	
DATE:	30th October 2014
PURPOSE:	The following report provides an overview of the September 2014 Quality & Performance report highlighting NTDA/UHL key metrics and escalation reports where required.
PREVIOUSLY CONSIDERED BY:	**Finance & Performance Committee** **Quality Assurance Committee**
Objective(s) to which issue relates *	☑ 1. Safe, high quality, patient-centred healthcare ☑ 2. An effective, joined up emergency care system ☑ 3. Responsive services which people choose to use (secondary, specialised and tertiary care) ☑ 4. Integrated care in partnership with others (secondary, specialised and tertiary care) ☑ 5. Enhanced reputation in research, innovation and clinical education ☑ 6. Delivering services through a caring, professional, passionate and valued workforce ☑ 7. A clinically and financially sustainable NHS Foundation Trust ☐ 8. Enabled by excellent IM&T
Please explain any Patient and Public Involvement actions taken or to be taken in relation to this matter:	
Please explain the results of any Equality Impact assessment undertaken in relation to this matter:	
Organisational Risk Register/ Board Assurance Framework *	☑ **Organisational Risk Register** ☑ **Board Assurance Framework** ☐ **Not Featured**
ACTION REQUIRED *	For decision ☐ For assurance ☑ For information ☐

♦ We treat people how we would like to be treated ♦ We do what we say we are going to do
♦ We focus on what matters most ♦ We are one team and we are best when we work together
♦ We are passionate and creative in our work

* tick applicable box

Caring at its best

University Hospitals of Leicester NHS
NHS Trust

Quality and Performance Report

September 2014

One team shared values

CONTENTS

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **30TH OCTOBER 2014**

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

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

1.0 Introduction

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

Research metrics are reported for the first time in this month's Q&P. Clinical Education metrics are being developed for inclusion in next month's Q&P.

2.0 Performance Summary

18 of the 103 indicators were RAG rated Red for this month (20 last month).

Domain	Page Number	Number of Indicators	Indicators with target to be confirmed	Number of Red Indicators this month
Safe	4	18	0	1
Caring	5	15	1	0
Well Led	6	14	7	3
Effective	7	17	0	0
Responsive	8	26	0	12
Research	9	13	0	2
Total		103	8	18

Exception reports:

Well Led – Appraisal rates

Effective - #NOF

Responsive – ED (separate report), RTT, diagnostic waits, cancer waits, cancelled operations, choose and book, delayed transfers and ambulance handovers.

Research - the thresholds/exception reporting criteria are to be reviewed but that in the meantime exception reports have been included for amber and red indicators.

3.0 Research - NIHR Clinical Research Network: East Midlands

UHL is the Host Organisation for the CRN: East Midlands. As Host, UHL will receive £22.3 million from the National Institute of Health Research (NIHR) to fund NIHR CRN Portfolio research across the East Midlands. Funding for 2014/15 has been distributed through 16 NHS Trusts and 19 Clinical Commissioning Groups. The Trust has established a CRN: East Midlands Executive Group chaired by Dr Kevin Harris. The purpose of the group is to oversee and deliver good governance of the CRN: East Midlands as defined by the Host contract and CRN Performance and Operating Framework. The framework outlines the key performance metrics for the Network. These include seven High Level Objectives (HLOs) and 8 Host Performance Indicators.

The dashboard on page 9 shows current Network performance against these metrics. Only 1 Host Performance Indicator is included in the dashboard, the remaining 7 are not monitored in year but assessed at the end of the financial year. These will be included in future reports as data becomes available.

Safe | Caring | Well Led | Effective | Responsive | Research

	KPI Ref	Indicators	Board Director	Lead Director/Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	13/14 Outturn	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	YTD
Safe	S1a	Clostridium Difficile	RO	DJ	FYE = 81	NTDA	Red / ER for Non compliance with cumulative target	66	5	9	6	6	5	10	0	4	4	6	5	7	2	5	29
	S1b	Clostridium Difficile (Local Target)	RO	DJ	FYE = 50	UHL	Red >5 per month, ER when YTD red	66	5	9	6	6	5	10	0	4	4	6	5	7	2	5	29
	S2a	MRSA Bacteraemias (All)	RO	DJ	0	NTDA	Red = >0 ER = 2 consecutive mths >0	3	0	1	0	0	0	0	0	0	0	0	0	0	0	1	1
	S2b	MRSA Bacteraemias (Avoidable)	RO	DJ	0	UHL	Red = >0 ER = 2 consecutive mths >0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0
	S3	Never Events	RO	MD	0	NTDA	Red = >0 in mth ER = in mth >0	3	0	1	0	0	0	0	1	0	0	0	0	0	0	0	0
	S4	Serious Incidents	RO	MD	tbc	NTDA	tbc	60	5	4	5	8	4	3	4	5	4	6	3	7	2	3	25
	S5	Proportion of reported safety incidents that are harmful	RO	MD	tbc	NTDA	tbc	2.8%	3.1%		2.3%			2.3%			1.7%			2.2%			1.9%
	S6	Overdue CAS alerts	RO	MD	0	NTDA	Red = >0 in mth ER = in mth >0	2	1	0	0	0	0	0	0	0	2	2	2	3	0	0	9
	S7	RIDDOR - Serious Staff Injuries	RO	MD	FYE = <47	UHL	Red / ER = non compliance with cumulative target	47	3	4	6	4	4	7	2	5	3	5	1	2	2	1	14
	S8	Safety Thermometer % of harm free care (all)	RO	EM	tbc	NTDA	Red = <92% ER = in mth <92%	93.6%	93.5%	93.1%	94.7%	93.9%	94.0%	93.8%	94.8%	93.6%	94.6%	94.7%	94.2%	94.9%	94.4%	93.9%	94.4%
	S9	% of all adults who have had VTE risk assessment on adm to hosp	KH	SH	95% or above	NTDA	Red = <95% ER = in mth <95%	95.3%	95.2%	95.4%	95.5%	96.7%	96.1%	95.6%	95.0%	95.6%	95.7%	95.9%	95.9%	96.3%	95.5%	96.2%	95.9%
	S10	Medication errors causing serious harm	RO	MD	0	NTDA	Red = >0 in mth ER = in mth >0	New NTDA Indicator - Definition to be confirmed															
	S11	All falls reported per 1000 bed stays for patients >65years	RO	EM	<7.5	QC	Red >= YTD >8.4 ER = 2 consecutive reds	7.1	6.9	5.9	7.9	7.0	7.0	6.6	7.0	6.9	7.1	8.5	8.1	8.4	8.8	6.0	7.7
	S12	Avoidable Pressure Ulcers - Grade 4	RO	EM	0	QS	Red / ER = Non compliance with monthly target	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0
	S13	Avoidable Pressure Ulcers - Grade 3	RO	EM	<8 a month	QS	Red / ER = Non compliance with monthly target	71	8	5	5	4	5	7	3	6	5	5	5	5	6	6	32
	S14	Avoidable Pressure Ulcers - Grade 2	RO	EM	<10 a month	QS	Red / ER = Non compliance with monthly target	120	10	5	7	8	5	10	8	9	6	6	6	7	8	4	37
	S15	Compliance with the SEPSIS6 Care Bundle	RO	MD	All 6 >75% by Q4	QC	Red/ER = Non compliance with Quarterly target	27.0%	New Indicator					27.0%			47.0%			Audit underway			47.0%
	S16	Nutrition and Hydration Metrics - Fluid Balance and Nutritional Assessment	RO	MD	Q2 80%, Q3 85%, Q4 90%	QC	Red >2% below threshold ER = 2 mths red		New Indicator for 14/15								≥71%	≥77%	≥75%	Action Planning	≥74%	≥85%	≥76.4%

	KPI Ref	Indicators	Board Director	Lead Director/Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	13/14 Outturn	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	YTD
Caring	C1a	Inpatient Friends and Family Test - Score	RO	CR	72 (Eng Avge - Mar 14)	NTDA	Red if <3SD. ER if <3SD or 3 mths deteriorating performance	68.8	69.6	67.6	66.2	70.3	68.7	71.8	69.0	69.9	69.6	71.0	74.5	73.8	73.8	76.1	73.0
	C1b	Inpatient Friends and Family Test - Score (Local Target)	RO	CR	75	UHL	Red/ ER =<=69.9 Green >74.9	68.8	69.6	67.6	66.2	70.3	68.7	71.8	69.0	69.9	69.6	71.0	74.5	73.8	73.8	76.1	73.0
	C2a	A&E Friends and Family Test - Score	RO	CR	54 (Eng Avge - Mar 14)	NTDA	Red if <3SD. ER if <3SD or 3 mths deteriorating performance	58.5	59.6	57.6	58.8	58.6	67.4	67.6	58.7	65.5	69.4	66.0	71.4	71.7	56.3	66.1	66.4
	C2b	A&E Friends and Family Test - Score (Local Target)	RO	CR	75	UHL	Red/ ER =<=64.9 Green >74.9	58.5	59.6	57.6	58.8	58.6	67.4	67.6	58.7	65.5	69.4	66.0	71.4	71.7	56.3	66.1	66.4
	C3	Outpatients Friends and Family Test - Score	RO	CR	75	UHL	Red / ER =<=64.9	New Indicator Repoerted in November															
	C4	Daycase Friends and Family Test - Score	RO	CR	75	UHL	Red / ER =<=69.9	New Indicator									77.3	79.0	78.1	74.0	73.7	80.4	77.1
	C5	Maternity Friends and Family Test - Score	RO	CR	75	UHL	Red/ ER =<=61.9	64.3			64.8	62.1	63.7	67.3	62.1	66.7	61.2	63.5	69.5	69.7	67.3	63.0	65.7
	C6	Complaints Rate per 100 bed days	RO	MD	tbc	NTDA	tbc		0.4	0.4	0.4	0.3	0.3	0.3	0.5	0.4	0.4	0.3	0.3	0.4	0.4	0.4	0.4
	C7	Complaints Re-Opened Rate	RO	MD	<9%	UHL	Red = >10% ER = 3 mths Red or any month >15%	New Indicator for 14/15									8%	5%	8%	11%	10%	9%	8%
	C8	Single Sex Accommodation Breaches	RO	CR	0	NTDA	Red = >0 ER = in mth >0	2	0	0	0	2	0	0	0	0	4	2	0	0	0	0	6
	C9	Improvements in the FFT scores for Older People (65+ year)	RO	CR	75	QC	Red / ER = End of Yr Targets non recoverable.	New Indicators for 14/15									73.7	73.2	75.7	76.1	78.5	83.0	76.4
	C10	Responsiveness and Involvement Care (Average score)	RO	CR	0.8 improve-ment	QC	tbc										87.6	87.5	87.7	88.0	88.2	88.8	87.9
	C10a	Q15. When you used the call button, was the amount of time it took for staff to respond generally:	RO	CR	FYE 89.7	QC	Red = <87.9 ER = Red or 3 mths deterioration										88.9	89.3	89.0	89.2	89.0	90.3	89.3
	C10b	Q16. If you needed help from staff getting to the bathroom or toilet or using a bedpan, did you get help in an acceptable amount of time?	RO	CR	FYE 92.9	QC	Red = <91.1 ER = Red or 3 mths deterioration										92.1	91.8	91.3	91.8	91.9	92.8	91.9
	C10c	Q11. Were you involved as much as you wanted in decisions about your care and treatment?	RO	CR	FYE 85.5	QC	Red = <83.6 ER = Red or 3 mths deterioration										84.6	84.4	85.2	85.4	85.9	85.6	85.1

	KPI Ref	Indicators	Board Director	Lead Director/Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	13/14 Outturn	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	YTD
Well Led	W1	Inpatient Friends and Family Test - Coverage	RO	CR	30% - Q4. 40% - Mar 15	NTDA / CQUIN	Red = Non compliance with monthly target ER = 2 consecutive mths non compliance	24.3%	22.0%	25.8%	21.7%	25.4%	23.3%	24.5%	28.2%	28.8%	36.8%	38.1%	32.6%	30.8%	28.9%	33.4%	33.3%
	W2	A&E Friends and Family Test - Coverage	RO	CR	20% for Q4	NTDA	Red = Non compliance with monthly target ER = 2 consecutive mths non compliance	14.9%	16.1%	11.1%	16.3%	18.4%	16.4%	15.6%	18.4%	16.1%	15.2%	17.8%	14.9%	10.2%	16.1%	19.1%	15.6%
	W3	Outpatients Friends and Family Test - Valid responses	RO	CR	tbc	UHL	tbc	New Indicator available from October 2014								271	34	187	1406	1305	642	730	4304
	W4	Maternity Friends and Family Test - Coverage	RO	CR	tbc	UHL	tbc	25.2%			27.7%	30.3%	24.8%	20.9%	23.7%	23.9%	27.2%	36.4%	25.2%	29.2%	29.9%	18.7%	27.8%
	W5	NHS staff survey: % of staff who would recommend the trust as place to work	KB	ES	tbc	NTDA	tbc	New NTDA Indicator - Definition to be confirmed									53.7%						53.7%
	W6	NHS staff survey: % of staff who would recommend the trust as place to receive treatment	KB	ES	tbc	NTDA	tbc	New NTDA Indicator - Definition to be confirmed									68.3%						68.3%
	W7	Data quality of trust returns to HSCIC	KS	JR	tbc	NTDA	tbc	New NTDA Indicator - Definition to be confirmed															
	W8	Turnover Rate	KB	ES	<10%	UHL	Red = >10% ER = 3 consecutive mths >10%	10.0%	9.3%	9.7%	9.6%	9.7%	10.2%	10.6%	10.4%	10.0%	9.9%	10.0%	10.2%	10.0%	10.5%	10.3%	10.2%
	W9	Sickness absence - 12 mths rolling	KB	ES	3.5% rolling 12 mths post validation	UHL	Red = >3.5% ER = 3 consecutive mths >3.5%	3.4%	3.1%	3.1%	3.3%	3.5%	3.8%	3.8%	3.7%	3.5%	3.5%	3.4%	3.3%	3.6%	3.8%		3.5%
	W10	Total trust vacancy rate	KB	ES	tbc	NTDA	tbc	New NTDA Indicator - Definition to be confirmed															
	W11	Temporary costs and overtime as a % of total paybill	KB	ES	tbc	NTDA	tbc	New Indicator for 14/15									9.4%	9.4%	8.1%	8.5%	8.9%	8.5%	8.5%
	W12	% of Staff with Annual Appraisal	KB	ES	95%	UHL	Red = <90% ER = <90%	91.3%	92.7%	91.9%	91.0%	91.8%	92.4%	91.9%	92.3%	91.3%	91.8%	91.0%	90.6%	89.6%	88.6%	89.7%	90.2%
	W13	Statutory and Mandatory Training	KB	ES	Jun 80%, Sep 85%, Dec 90%, Mar 95%	UHL	Red / ER for Non compliance with incremental target	76%	49%	55%	58%	60%	65%	69%	72%	76%	78%	79%	79%	80%	83%	85%	85%
	W14	% Corporate Induction attendance	KB	ES	95.0%	UHL	Red = <90% ER = <90%	94.5%	94.0%	94.0%	91.0%	87.0%	89.0%	93.0%	89.0%	94.5%	96.0%	94.0%	92.0%	96.0%	98.0%	98.0%	95.7%

Effective

KPI Ref	Indicators	Board Director	Lead Director/Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	13/14 Outturn	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	YTD
E1	Mortality - Published SHMI	KH	PR	Within Expected	NTDA	Higher than Expected		104 (Jan12-Dec12)		106 (Apr12-Mar13)			107 (Jul12-Jun13)			106 (Oct12-Sept13)			106 (Jan13-Dec13)			106 (Jan13-Dec13)
E2	Mortality - Rolling 12 mths SHMI (as reported in HED)	KH	PR	100 or below	QC	Red = >expected ER = >Expected or 3 consecutive mths increasing SHMI >100	105.3	108.9	107.5	107.5	107.4	108.0	106.7	106.4	105.3	103.5	102.9	102.8	Awaiting HED Update			102.8
E3	Mortality HSMR (DFI Quarterly)	KH	PR	Within Expected	NTDA	Red = >expected ER = >Expected or 3 consecutive mths >100	87.9	91.2		86.0			83.1			82.7			Awaiting DFI Update			82.7
E4	Mortality - Rolling 12 mths HSMR (Rebased Monthly as reported in HED)	KH	PR	100 or below	QC	Red = >expected ER = >Expected or 3 consecutive mths >100	99.0	103.2	102.0	101.6	101.9	101.2	100.0	100.3	99.0	97.1	97.2	97.3	95.3	Awaiting HED Update		95.3
E5	Mortality - Monthly HSMR (Rebased Monthly as reported in HED)	KH	PR	100 or below	QC	Red = >expected ER = >Expected or 3 consecutive mths >100	90.9	105.8	96.8	96.5	100.6	93.9	89.3	102.9	90.9	82.9	103.2	101.5	83.1	Awaiting HED Update		92.5
E6	Mortality - Rolling 12 mths HSMR Emergency Weekday Admissions - (HED) OVERALL Rebased Monthly	KH	PR	Within Expected	NTDA	Red = >expected ER = >Expected or 3 consecutive mths >100	100.5	102.0	100.7	100.9	102.2	101.9	101.2	101.1	100.5	98.9	98.3	98.8	96.3	Awaiting HED Update		96.3
E7	Mortality - Monthly HSMR Emergency Weekday Admissions - (HED) OVERALL Rebased Monthly	KH	PR	Within Expected	NTDA	Red = >expected ER = >Expected or 3 consecutive mths >100	100.5	105.8	97.1	97.8	107.1	95.4	92.6	101.9	94.2	86.3	95.0	105.0	80.3	Awaiting HED Update		91.4
E8	Mortality - rolling 12 mths HSMR Emergency Weekend Admissions - (HED) OVERALL Rebased Monthly	KH	PR	Within Expected	NTDA	Red = >expected ER = >Expected or 3 consecutive mths >100	98.7	109.1	108.6	106.8	105.0	103.2	101.0	102.4	98.7	95.5	97.5	96.0	95.4	Awaiting HED Update		95.4
E9	Mortality - Monthly HSMR Emergency Weekend Admissions - (HED) OVERALL Rebased Monthly	KH	PR	Within Expected	NTDA	Red = >expected ER = >Expected or 3 consecutive mths >100	98.7	116.2	99.0	98.2	93.4	93.4	84.1	106.2	81.5	70.6	128.0	87.2	92.8	Awaiting HED Update		94.9
E10	Deaths in low risk conditions	KH	PR	Within Expected	NTDA	Red = >expected ER = >Expected or 3 consecutive mths >100	93.6	123.3	103.0	98.0	51.5	129.2	163.8	35.1	63.3	47.5	60.4	78.0	Awaiting DFI Update			78.0
E11	Emergency 30 Day Readmissions (No Exclusions)	KH	PR	Within Expected	NTDA	Higher than Expected	7.9%	7.6%	7.8%	7.9%	7.8%	8.0%	8.7%	9.0%	8.8%	8.7%	8.7%	8.6%	8.4%	8.9%		8.7%
E12	No. of # Neck of femurs operated on 0-35 hrs - Based on Admissions	KH	RP	72% or above	QS	Red = <72% ER = 2 consecutive mths <72%	65.2%	73.6%	67.1%	70.5%	73.6%	72.2%	68.2%	73.7%	54.7%	56.9%	40.6%	60.3%	76.9%	59.0%	68% Provisional	58.8%
E13	Stroke - 90% of Stay on a Stroke Unit	RM	CF	80% or above	QS	Red = <80% ER = 2 consecutive mths <80%	83.2%	88.5%	89.1%	83.7%	78.0%	81.8%	89.3%	83.7%	83.5%	92.9%	80.3%	87.1%	78.1%	84.5%		84.5%
E14	Stroke - TIA Clinic within 24 Hours (Suspected High Risk TIA)	RM	CF	60% or above	QS	Red = <60% ER = 2 consecutive mths <60%	64.2%	73.6%	64.6%	62.4%	76.8%	65.7%	60.5%	40.7%	77.9%	79.7%	58.8%	71.3%	62.8%	65.5%	72.7%	68.3%
E15	Communication - ED, Discharge and Outpatient Letters	KH	SJ	80% or above	QS	Red = <80% ER = 3 consecutive mths below <80%	New Indicator for 14/15													60% (InPt)	83% (ED)	71%
E16	Published Consultant Level Outcomes	KH	SH	>0 outside expected	QC	Red = >0 Quarterly ER = >0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
E17	Non compliance with 14/15 published NICE guidance	KH	SH	0	QC	Red = in mth >0 ER = 2 consecutive mths Red	New Indicator for 14/15									0	0	0	0	0	0	0

Responsive

KPI Ref	Indicators	Board Director	Lead Director/Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	13/14 Outturn	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	YTD
R1	ED 4 Hour Waits UHL + UCC	RM	CF	95% or above	NTDA	Red = <95% ER via ED TB report	88.4%	90.1%	89.5%	91.8%	88.5%	90.1%	93.6%	83.5%	89.3%	86.9%	83.4%	91.3%	92.5%	91.2%	91.7%	89.3%
R2	12 hour trolley waits in A&E	RM	CF	0	NTDA	Red = >0 ER via ED TB report	5	0	1	0	1	0	0	0	0	0	1	1	0	0	0	2
R3	RTT Waiting Times - Admitted	RM	CC	90% or above	NTDA	Red /ER = <90%	76.7%	85.7%	81.8%	83.5%	83.2%	82.0%	81.8%	79.1%	76.7%	78.9%	79.4%	79.0%	80.9%	82.2%	81.6%	81.6%
R4	RTT Waiting Times - Non Admitted	RM	CC	95% or above	NTDA	Red /ER = <95%	93.9%	95.5%	92.0%	92.8%	91.9%	92.8%	93.4%	93.5%	93.9%	94.3%	94.4%	95.0%	94.9%	95.6%	94.6%	94.6%
R5	RTT - Incomplete 92% in 18 Weeks	RM	CC	92% or above	NTDA	Red /ER = <92%	92.1%	92.9%	93.8%	92.8%	92.4%	91.8%	92.0%	92.6%	92.1%	93.9%	93.6%	94.0%	93.2%	94.0%	94.3%	94.3%
R6	RTT 52 Weeks+ Wait	RM	CC	0	NTDA	Red /ER = >0	0	0	0	0	0	1	1	0	0	3	0	2	16	9	17	17
R7	6 Week - Diagnostic Test Waiting Times	RM	SK	1% or below	NTDA	Red /ER = >1%	1.9%	0.8%	0.7%	1.0%	0.8%	1.4%	5.3%	1.9%	1.9%	0.8%	0.9%	0.8%	0.7%	1.0%	1.0%	1.0%
R8	Two week wait for an urgent GP referral for suspected cancer to date first seen for all suspected cancers	RM	MM	93% or above	NTDA	Red = <93% ER = Red for 2 consecutive mths	94.8%	94.6%	93.0%	94.9%	95.7%	94.9%	95.3%	95.9%	95.3%	88.5%	94.7%	93.5%	92.2%	92.0%		92.1%
R9	Two Week Wait for Symptomatic Breast Patients (Cancer Not initially Suspected)	RM	MM	93% or above	NTDA	Red = <93% ER = Red for 2 consecutive mths	94.0%	92.0%	95.2%	93.0%	91.3%	95.5%	96.8%	93.4%	94.3%	80.0%	95.0%	98.9%	94.9%	94.4%		93.5%
R10	31-Day (Diagnosis To Treatment) Wait For First Treatment: All Cancers	RM	MM	96% or above	NTDA	Red = <96% ER = Red for 2 consecutive mths	98.1%	99.7%	99.1%	98.9%	96.2%	97.4%	97.2%	98.5%	98.2%	97.2%	92.9%	93.6%	94.4%	97.8%		95.2%
R11	31-Day Wait For Second Or Subsequent Treatment: Anti Cancer Drug Treatments	RM	MM	98% or above	NTDA	Red = <98% ER = Red for 2 consecutive mths	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.8%		99.7%
R12	31-Day Wait For Second Or Subsequent Treatment: Surgery	RM	MM	94% or above	NTDA	Red = <94% ER = Red for 2 consecutive mths	96.0%	98.4%	88.6%	96.4%	97.1%	92.3%	94.8%	96.4%	98.6%	95.2%	97.0%	90.8%	89.9%	87.3%		91.9%
R13	31-Day Wait For Second Or Subsequent Treatment: Radiotherapy Treatments	RM	MM	94% or above	NTDA	Red = <94% ER = Red for 2 consecutive mths	98.2%	100.0%	97.7%	97.5%	98.5%	98.1%	94.8%	96.3%	99.1%	97.3%	95.6%	93.9%	97.3%	99.0%		96.7%
R14	62-Day (Urgent GP Referral To Treatment) Wait For First Treatment: All Cancers	RM	MM	85% or above	NTDA	Red = <85% ER = Red in mth or YTD	86.7%	88.2%	87.4%	86.4%	85.7%	89.4%	89.1%	89.1%	92.4%	92.7%	88.5%	73.1%	85.6%	78.3%		83.3%
R15	62-Day Wait For First Treatment From Consultant Screening Service Referral: All Cancers	RM	MM	90% or above	NTDA	Red = <90% ER = Red for 2 consecutive mths	95.6%	97.2%	96.2%	100.0%	97.0%	96.6%	97.1%	95.1%	91.7%	91.1%	67.4%	73.9%	73.0%	100.0%		80.7%
R16	Urgent Operations Cancelled Twice	RM	PW	0	NTDA	Red = >0 ER = >0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
R17	Cancelled patients not offered a date within 28 days of the cancellations UHL	RM	PW	0	NTDA	Red = >2 ER = >0	85	5	3	10	4	8	9	2	8	10	3	1	1	1	2	18
R18	Cancelled patients not offered a date within 28 days of the cancellations ALLIANCE	RM	PW	0	NTDA	Red = >2 ER = >0	New Indicator for 14/15									0	0	0	0	6	0	6
R19	% Operations cancelled for non-clinical reasons on or after the day of admission UHL	RM	PW	0.8% or below	Contract	Red = >0.9% ER = >0.8%	1.6%	1.4%	2.3%	1.7%	1.8%	1.7%	1.6%	2.1%	1.5%	1.1%	0.8%	1.1%	0.7%	0.6%	0.9%	0.9%
R20	% Operations cancelled for non-clinical reasons on or after the day of admission ALLIANCE	RM	PW	0.8% or below	Contract	Red = >0.9% ER = >0.8%	1.6%	1.4%	2.3%	1.7%	1.8%	1.7%	1.6%	2.1%	1.5%	0.6%	0.6%	0.3%	2.7%	0.0%	0.9%	0.9%
R21	% Operations cancelled for non-clinical reasons on or after the day of admission UHL + ALLIANCE	RM	PW	0.8% or below	Contract	Red = >0.9% ER = >0.8%	New Indicator for 14/15									1.1%	0.8%	1.0%	0.9%	0.6%	0.9%	0.9%
R22	No of Operations cancelled for non-clinical reasons on or after the day of admission UHL + ALLIANCE	RM	PW	N/A	UHL	tbc	1739	124	208	171	172	141	152	178	139	101	72	96	71	55	87	482
R23	Delayed transfers of care	RM	PW	3.5% or below	NTDA	Red = >3.5% ER = Red for 3 consecutive mths	4.1%	3.9%	4.2%	4.6%	4.4%	3.6%	4.6%	4.3%	3.8%	4.6%	4.4%	4.2%	4.0%	4.1%	4.5%	4.3%
R24	Choose and Book Slot Unavailability	RM	CC	4% or below	Contract	Red = >4% ER = Red for 3 consecutive mths	13%	14%	11%	16%	17%	14%	10%	16%	19%	22%	25%	26%	25%	26%	25%	25%
R25	Ambulance Handover >60 Mins (based on weekly figures)	RM	CF	0	Contract	Red = >0 ER = Red for 3 consecutive mths	868	16	21	25	59	102	52	207	111	173	253	88	71	50	106	741
R26	Ambulance Handover >30 Mins and <60 mins (based on weekly figures)	RM	CF	0	Contract	Red = >0 ER = Red for 3 consecutive mths	7,075	383	484	705	689	722	573	818	601	720	951	671	591	805	736	4,474

Research

KPI Ref	Indicators	Board Director	Lead Director/Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	Sep-14	YTD
RS1	Number of participants recruited in a reporting year into NIHR CRN Portfolio studies	KH	DR	England 650,000 East Midlands 50,000	NIHR CRN	Red / ER = <90%	92%	92%
RS2a	A: Proportion of commercial contract studies achieving their recruitment target during their planned recruitment period.	KH	DR	England 80% East Midlands 80%	NIHR CRN	Red / ER = <60%	67%	67%
RS2b	B: Proportion of non-commercial studies achieving their recruitment target during their planned recruitment period	KH	DR	England 80% East Midlands 80%	NIHR CRN	Red / ER = <60%	81.0%	81.0%
RS3a	A: Number of new commercial contract studies entering the NIHR CRN Portfolio	KH	DR	600	NIHR CRN	tbc		
RS3b	B: Number of new commercial contract studies entering the NIHR CRN Portfolio as a percentage of the total commercial MHRA CTA approvals for Phase II-IV studies	KH	DR	75%	NIHR CRN	Red <75%		
RS4	Proportion of eligible studies obtaining all NHS Permissions within 30 calendar days (from receipt of a valid complete application by NIHR CRN)	KH	DR	80%	NIHR CRN	Red <80%	90.0%	90.0%
RS5a	A: Proportion of commercial contract studies achieving first participant recruited within 70 calendar days of NHS services receiving a valid research application or First Network Site Initiation Visit	KH	DR	80%	NIHR CRN	Red <80%		
RS5b	B: Proportion of non-commercial studies achieving first participant recruited within 70 calendar days of NHS services receiving a valid research application	KH	DR	80%	NIHR CRN	Red <80%		
RS6a	A: Proportion of NHS Trusts recruiting each year into NIHR CRN Portfolio studies	KH	DR	England 99% East Midlands 99%	NIHR CRN	Red <99%	81.0%	81.0%
RS6b	B: Proportion of NHS Trusts recruiting each year into NIHR CRN Portfolio commercial contract studies	KH	DR	England 70% East Midlands 70%	NIHR CRN	Red <70%	56.0%	56.0%
RS6c	B: Proportion of General Medical Practices recruiting each year into NIHR CRN Portfolio studies	KH	DR	England 25% East Midlands 25%	NIHR CRN	Red <25%	45.0%	45.0%
RS7	Number of participants recruited into Dementias and Neurodegeneration (DeNDRoN) studies on the NIHR CRN Portfolio	KH	DR	England 13500 East Midlands 510	NIHR CRN	Red <510 Q4	325	325
RS8	Deliver robust financial management using appropriate tools - % of financial returns completed on time	KH	DR	England 100% East Midlands 100%	NIHR CRN	Red <100%	100% (*June)	100% (*June)

W12 – Appraisal Rates

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest month performance	YTD performance	Forecast performance for next reporting period
1. There is a slight improvement in performance over the last month, from 88.62% to 89.67% (against a trajectory of 90%) 2. Feedback from Clinical Management Group and Directorates Leads indicates that the reduction in performance is caused by:- a. Line manager / appraiser omissions in data return b. Appraiser / senior staff sickness in some areas c. Service pressures preventing the release of staff to conduct or attend appraisal	1. Discussion at CMG / Directorate Boards and across services / areas 2. Circulation of breakdown of performance by cost centre covering review period 3. Performance management being pursued for areas that persistently remain below 95% 4. Recovery plans in place across all underperforming areas with trajectories set (at appraisee/ team level) 5. Review of management structures to ensure appropriate devolving and span of control for direct staff 6. Clear expectations set regarding reporting requirements 7. Data capture process re-circulated. 8. Close monitoring at a local level on a weekly basis	**95%**	**89.6%**	**90.2% (average)**	**92% (Oct)**

Performance by CMG

CMG	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
Alliance Elective Care		100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
CHUGGS	87.14%	87.85%	88.00%	87.65%	85.41%	82.09%	85.47%
Clinical Support & Imaging Services	95.09%	94.72%	94.12%	94.97%	93.24%	93.51%	90.80%
Emergency & Specialist Medicine	90.48%	90.24%	89.05%	86.68%	87.22%	88.76%	91.46%
ITAPS	92.80%	93.79%	91.09%	94.01%	94.03%	88.67%	88.44%
MSK & Specialist Surgery	94.11%	96.61%	95.19%	90.94%	92.59%	88.69%	88.31%
Renal, Respiratory & Cardiac	88.09%	89.62%	90.77%	91.90%	92.23%	93.46%	93.41%
Women's & Children's	89.22%	91.25%	90.14%	89.79%	85.92%	85.79%	89.19%
Corporate	94.3%	91.1%	89.9%	86.9%	85.5%	82.3%	86.9%

CMG Trajectories

CMG	Sept	Oct	Nov
CHUGGS	84%	87%	95%
Clinical Support & Imaging Services	94%	95%	95%
Emergency & Specialist Medicine	90%	95%	95%
ITAPS	92%	94%	95%
MSK & Specialist Surgery	89%	90%	95%
Renal, Respiratory & Cardiac	95%	95%	95%
Women's & Children's	88%	92%	95%
Corporate	83%	89%	95%

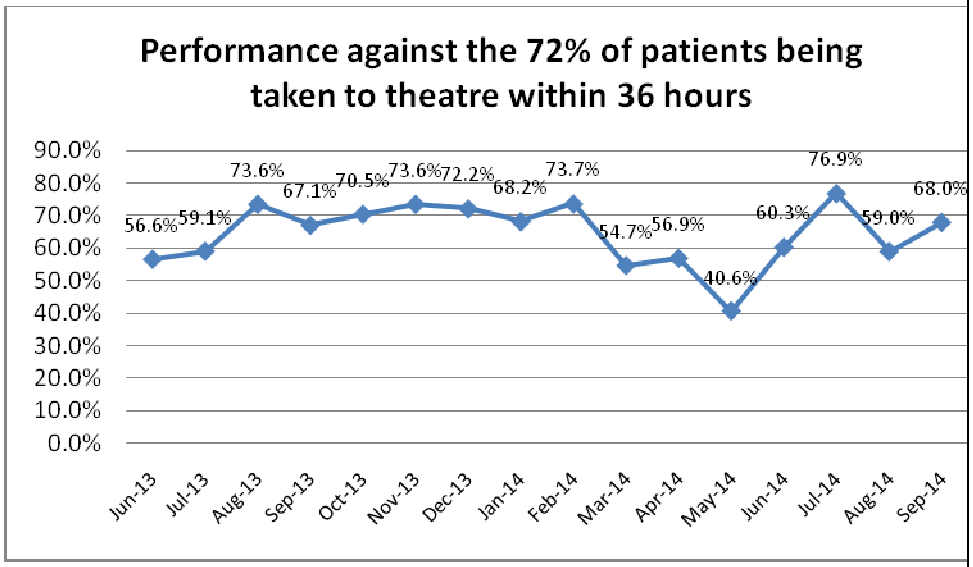
Performance by Quarter

13/14 FYE	14/15 Q1	14/15 Q2	14/15 Q3	14/15 Q4
91.3%	90.6%	86.3%		

Expected date to meet standard / target	Monthly Target
Revised date to meet standard	End November 2014
Lead Director / Lead Officer	Kate Bradley, Director of Human Resources Bina Kotecha, Assistant Director of Learning and OD

E12 – No. of # Neck of femurs operated on 0-35 hrs - Based on Admissions

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest month performance	YTD performance	Forecast performance for next period
Whilst the 'time to surgery within 36 hours' threshold was achieved for July and there has been an improvement since Quarter 1, it is still below the 72% threshold for Quarter 2 overall. Although the number of admissions for 14/15 to date is lower than this time last year, there is still significant in month variability with a peak in September of 9 admissions in one day. There is an average of 61 patients admitted with #NOF a month.	An action plan has been drafted which details the work that is currently being scoped and implemented. Specific blockers include Theatre List start and finish times, Orthogeriatric capacity and Theatre process delays. A Listening into Action application has been submitted in the hope that this will support the specialty and CMG with getting greater input and sign up from all of the pathway stakeholders and lead to quicker implementation of changes that are already recognised as essential. The specialty are looking at pathway improvements which reduce the demand in other areas such as fracture clinic which would positively impact on the ability to see patients in a more timely way when they are admitted with a fractured neck of femur. The service had started to use one of the Bays on Ward 18 as a 'step down' from the dedicated #NOF Ward (W32) but was unable to take direct admissions due to lack of Orthogeriatrician cover. However it is envisaged that this Bay will become a direct admission area in the winter months when activity is predicted to increase. Orthogeriatrician input will also increase from October as the second post of the two ESM consultants will have started. It is hoped that this will reduce the current cover issues however it is recognised that this will still not be sufficient job planned input to cover the two wards fully.	**72%**	**68%**	**60.3%**	

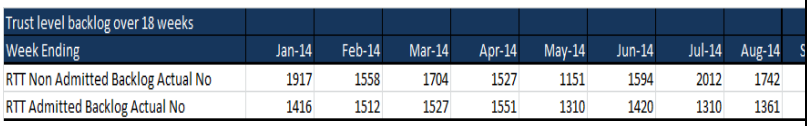


Performance by Quarter

13/14 FYE	14/15 Q1	14/15 Q2	14/15 Q3	14/15 Q4
65%	52%	68%		

Expected date to meet standard / target	Dec 14
Revised date to meet standard	
Lead Director / Lead Officer	Richard Power, MSS CD / Maggie McManus, MMS Deputy CMG Manager

R3, R4 and R6 Referral to Treatment – Admitted, Non-Admitted and 52+ Weeks

Referral to Treatment		Target	Latest performance (September)	Year to date	Forecast for next reporting period
What is causing underperformance?	**What actions have been taken to improve performance?**	**95% Non Adm 90% Adm**	**93.9% 79.5%**	**NA**	**95% 80%**
Background The reasons for UHL's deterioration in RTT performance are well documented. This report is the eighth monthly update. UHL's RTT performance is mainly challenged in the following specialities; ENT, orthopaedics and general surgery. The high level trajectories are detailed in the attached Appendices. **Performance overview** For September the Trust is behind trajectory for admitted performance at a Trust Level, even when including Alliance activity. However this reduced performance is as a result of doing additional activity during the month to reduce backlog over 18 weeks. This is set to continue during October and into November. This is particularly in: General surgery, Orthopaedics, ENT and Maxillofacial. For 'non admitted performance' the Trust is also behind trajectory even with the Alliance included. This is as a result of reducing backlog in max fax and other specialities. There are ongoing risks to non admitted performance with orthopaedics and restorative dentistry being of particular concern. The Trust aims to deliver admitted performance in November 2014. Funding to support additional activity and additional costs incurred has been confirmed by CCGs.	To support the delivery the following actions are being taken in addition to those already in place: • Additional use of the independent sector both locally, Circle Nottingham and Ramsay health. This will be partly UHL sub contracting but CCGs have additionally agreed to the diverting of patients at receipt of referral for whole pathways of care. NB: UHL is seek full patient consent prior to diverting any referrals • Additional MRI activity to reduce non admitted waits for orthopaedics • Ongoing validation of all RTT records, from mid October validation is of all records at 14+ weeks. The Trust is continuing additional in house activity, mostly out of hours and at weekends, notably general surgery with between 8-10 additional lists each weekend for 10 weeks.	 Trust level backlog over 18 weeks Week Ending | Jan-14 | Feb-14 | Mar-14 | Apr-14 | May-14 | Jun-14 | Jul-14 | Aug-14 RTT Non Admitted Backlog Actual No | 1917 | 1558 | 1704 | 1527 | 1151 | 1594 | 2012 | 1742 RTT Admitted Backlog Actual No | 1416 | 1512 | 1527 | 1551 | 1310 | 1420 | 1310 | 1361 **Risks** The key risks remain the same as in previous reports and are in summary: • Ability to deliver agreed capacity improvements including theatre, bed and outpatient space and staffing resources within agreed timelines • Changes to emergency demand • Patients unable or unwilling to transfer their care to alternative providers **Recommendations** The board are asked to: • Note the contents of the report • Acknowledge the improvement trajectory and additional admitted clock s tops compared to this period last year • Acknowledge the key risks.			

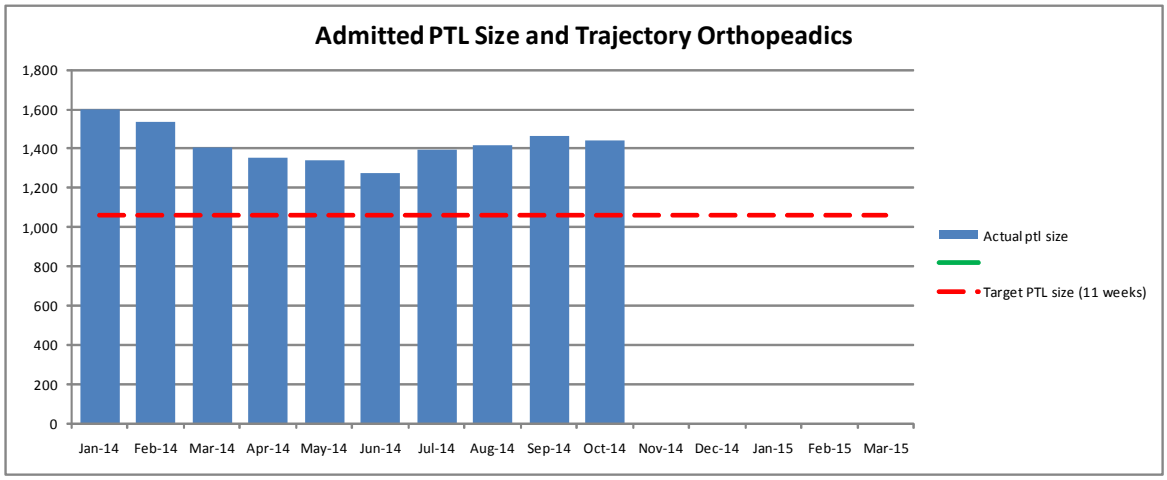
Referral to Treatment		Referral to Treatment	Latest performance	Year to date	Forecast for next reporting period
What is causing underperformance?	**What actions have been taken to improve performance?**	**95% Non Adm 90% Adm**	**As above**	**NA**	**As above**
Ophthalmology continues to perform strongly on both admitted and non admitted. ENT admitted backlogs have continued to reduce in the past month. The planned additional elective activity for general surgery started (mid September) and is set to continue for 10 weeks, with the anticipated treatment of an additional circa 500 cases. This work is taking place at weekends. The effect of this work can be seen in the reduction in total admitted waiting list size. Appendix 2. All of the restorative dentistry patients who breached the 52 week standard have now been treated. There has been no patient harm due to the excessive waits. During September further 9, 52 week patients were identified in Paediatrics, the cause of this was incorrect waiting list management. 5 have been treated the remaining patients will be treated by end of November. All have been clinically reviewed and there have been no reports of harm.	An ongoing programme of training and education is being provided to staff.	**Expected date to meet standard**		Admitted in November 2014 Non admitted in August 2014	
		Revised date to meet standard		Admitted November Non admitted October	
		Lead Director		Richard Mitchell, Chief Operating Officer	
		Clinical Lead		CMG Clinical Directors	
		Managerial Lead		Charlie Carr , Head of Performance	

Specialty Level Trajectory

Inpatient Waiting List

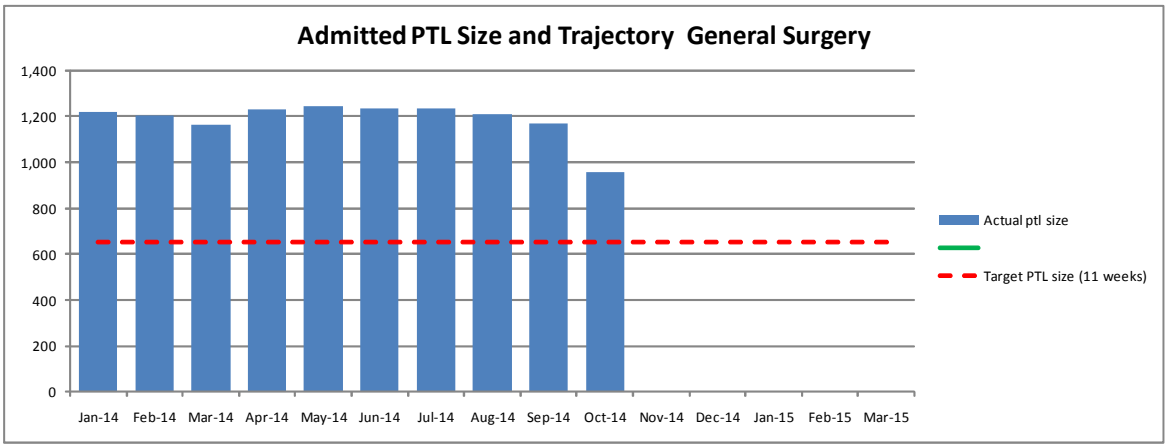
Othopaedics

	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Actual ptl size	1,602	1,536	1,405	1,351	1,339	1,278	1,392	1,420	1,465	1442					
Target PTL size (11 weeks)	1,062	1,062	1,062	1,062	1,062	1,062	1,062	1,062	1,062	1,062	1,062	1,062	1,062	1,062	1,062



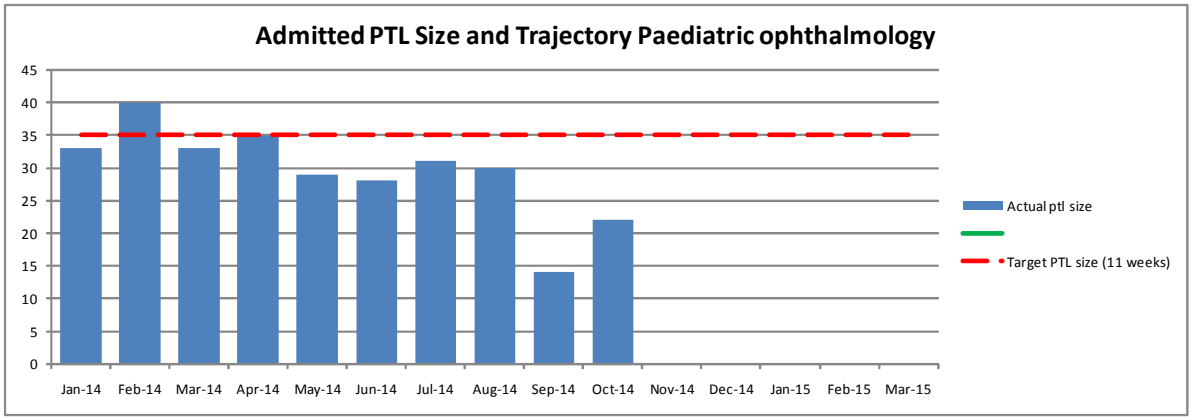
General surgery

	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Actual ptl size	1,220	1,205	1,162	1,227	1,242	1,236	1,236	1,209	1,168	957					
Target PTL size (11 weeks)	651	651	651	651	651	651	651	651	651	651	651	651	651	651	651



Paediatric ophthalmology

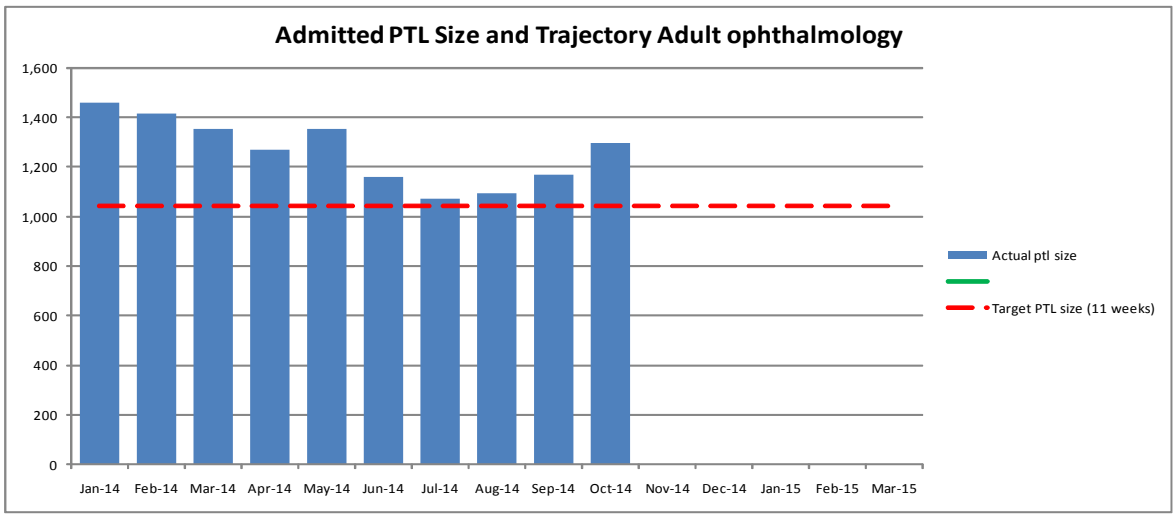
	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Actual ptl size	33	40	33	35	29	28	31	30	14	22					
Target PTL size (11 weeks)	35	35	35	35	35	35	35	35	35	35	35	35	35	35	35



Inpatient Waiting List (continued)

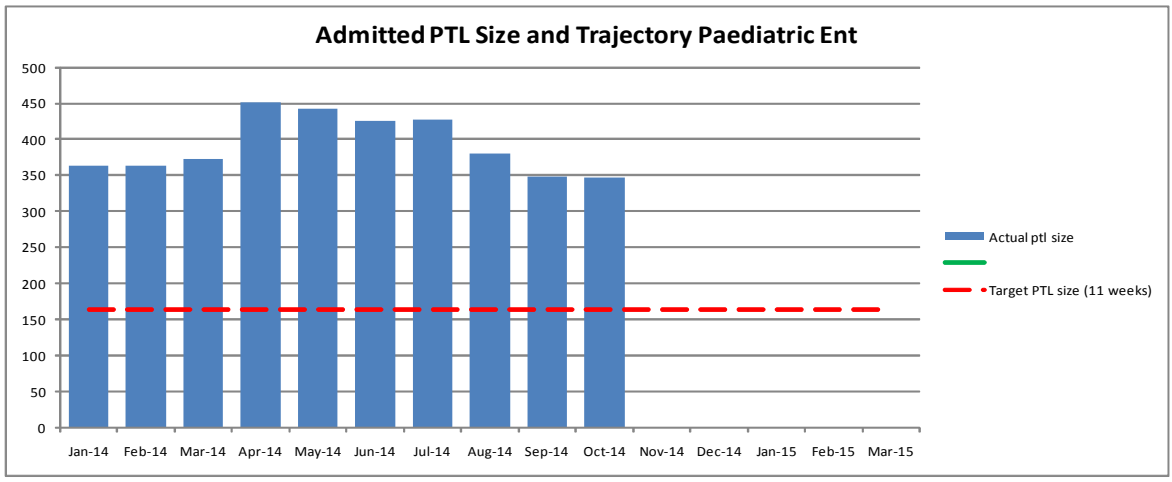
Adult ophthalmology

	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Actual ptl size	1,458	1,415	1,355	1,271	1,353	1,160	1,070	1,092	1,168	1296					
Target PTL size (11 weeks)	1,042	1,042	1,042	1,042	1,042	1,042	1,042	1,042	1,042	1,042	1,042	1,042	1,042	1,042	1,042



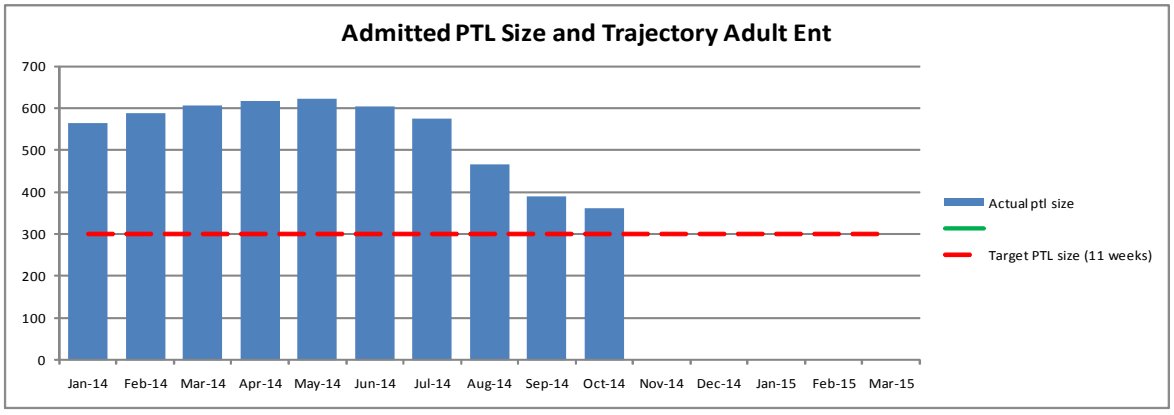
Paediatric ENT

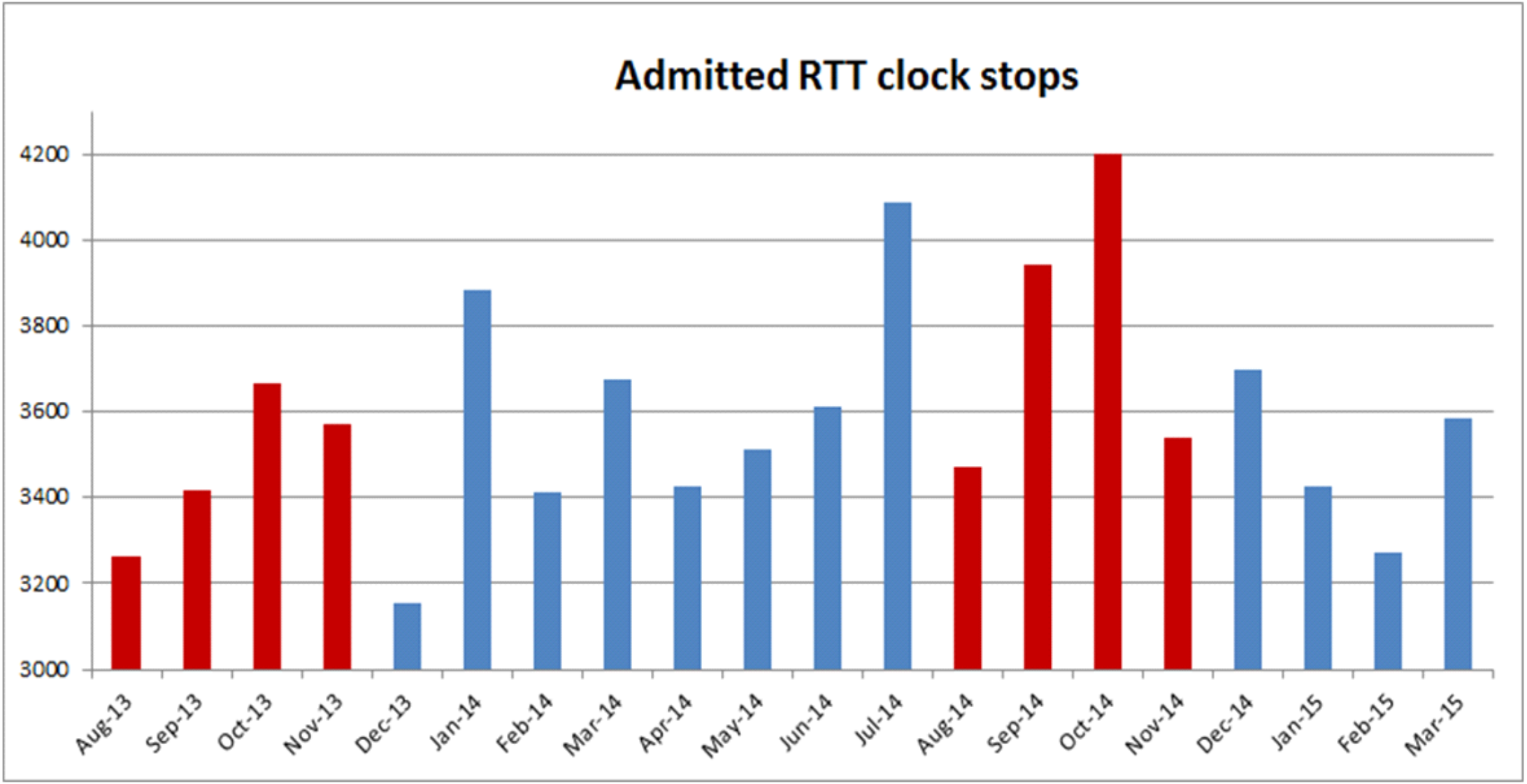
	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Actual ptl size	364	364	372	452	442	425	428	380	348	347					
Target PTL size (11 weeks)	163	163	163	163	163	163	163	163	163	163	163	163	163	163	163



Adult Ent

	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Actual ptl size	565	589	606	618	621	604	575	467	390	361					
Target PTL size (11 weeks)	300	300	300	300	300	300	300	300	300	300	300	300	300	300	300




Admitted RTT clock stops
4200
4000
3800
3600
3400
3200
3000
Aug-13
Sep-13
Oct-13
Nov-13
Dec-13
Jan-14
Feb-14
Mar-14
Apr-14
May-14
Jun-14
Jul-14
Aug-14
Sep-14
Oct-14
Nov-14
Dec-14
Jan-15
Feb-15
Mar-15

R7 - 6 Week Diagnostic Waiting Time

<table>
<tr><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>What is causing underperformance?</td><td>What actions have been taken to improve performance?</td><td colspan="2">Standard</td><td>August</td><td>YTD performance</td><td>Forecast performance for next reporting period</td></tr>
<tr><td rowspan="5">The Trust is measured on the waiting times of the top 15 diagnostic modalities, these are reported at the end of each month.

NB: these modalities cross all CMG’s

There are a number of factors that have caused this underperformance:

In volume terms imaging accounts for circa 70% of the top 15 diagnostics reported. Key issues were:

- CT insufficient cardiac CT capacity – this is ongoing issue and these are supervised scans so need consultant radiologist availability
- MRI -Some specific hotspots cardiac stress and heart. Linked to PET CT slot availability. Work is ongoing to explore a fixed site scanner of mobile scanner and is linked in with national spec commissioning review of PET CT

Additionally, there were small volumes of breaches of the standard in a number of other modalities including: Endoscopy , Cystoscopy , sleep studies, in both adult and paediatric services

However collectively these have caused a breach of the standard. A total of 127 patients waiting over 6 weeks.</td><td rowspan="5">Cardiac CT

The manpower to support cardiac CT is currently under review as well as a review of whether any scans can be unsupervised

MRI

Additional van and agency staff to cover is ongoing

Other modalities

Robust waiting list management, additional capacity where there is risk of breaching , dating patients in date order

Risks:

There remain risks to achievement of this standard due to the instability of a number of diagnostic modalities w which collectively make up this standard.</td><td><1% over 6 weeks</td><td colspan="2">1) UHL 1.09%
2) UHL and Alliance combined 1.0%</td><td>1.0%</td><td><1.0%</td></tr>
<tr><td colspan="5"></td></tr>
<tr><td colspan="3">Expected date to meet standard / target</td><td colspan="2">September 2014</td></tr>
<tr><td colspan="3">Revised date to meet standard</td><td colspan="2">November 2014</td></tr>
<tr><td colspan="3">Lead Director / Lead Officer</td><td colspan="2">Richard Mitchell
Suzanne Khalid / Jo Fawcus / P Walmsley / D Yeomanson</td></tr>
</table>

R17 – R22 Operations Cancelled on the Day and 28 Day Re-books

<table>
<tr><th>What is causing underperformance?</th><th>What actions have been taken to improve performance?</th><th>Target (mthly)</th><th>Latest month performance (September 14)</th><th>YTD</th><th>Forecast performance for next reporting period</th></tr>
<tr>
<td rowspan="5">The cancelled operations target comprises of three components:

1. The % of cancelled operations for non clinical reasons on the day of admission (R19-R22)

2. The number of patients cancelled who are offered another date within 28 days of the cancellation (R17-R18)

3. The number of urgent operations cancelled for a second time. (R16)

The Trust achieved the target for <0.8% cancellations on the day in August but not in September.</td>
<td rowspan="5">The key action to ensure on going good performance is the daily expediting of patients at risk of cancellation on the day, following the UHL cancelled operations policy.

For those cancelled on the day, adhering to the Trust policy of escalating to CMG Directors and General Managers for resolution.

The ‘Cancelled Operations’ manager started in post at the end of September.

The key focus of their role will be to ensure both bed and non bed related cancellations continue to reduce and that all patients cancelled are rebooked within 28 days within UHL.

<u>Risks to delivery of recovery plan</u>

There are risks to delivery of the plan to reduce cancellations on the day. These are mainly associated with bed availability. Circa 75% of cancellations on the day are due to no bed.</td>
<td>R19-22)
On day= 0.8%

R17+R18)
28 day = 0</td>
<td>R19-R22
0.9% UHL only, R21)

0.89% UHL and Alliance

R17+R18)
UHL= 2 patients
Alliance= 0 patients</td>
<td>(UHL and Alliance)

R21) = 0.88%

R17+18) = 24</td>
<td>0.8%

R17+R18 = 2</td>
</tr>
<tr><td colspan="4">UHL performance against standards

1. The percentage of operations cancelled on/after the day for non-clinical reasons during September was 0.9% against a target of 0.8%.
2. The number of patients cancelled who breached the standard of being offered another date within 28 days in September was 2. One was treated in September the other in early October.
3. The number of urgent operations cancelled for a second time ; Zero

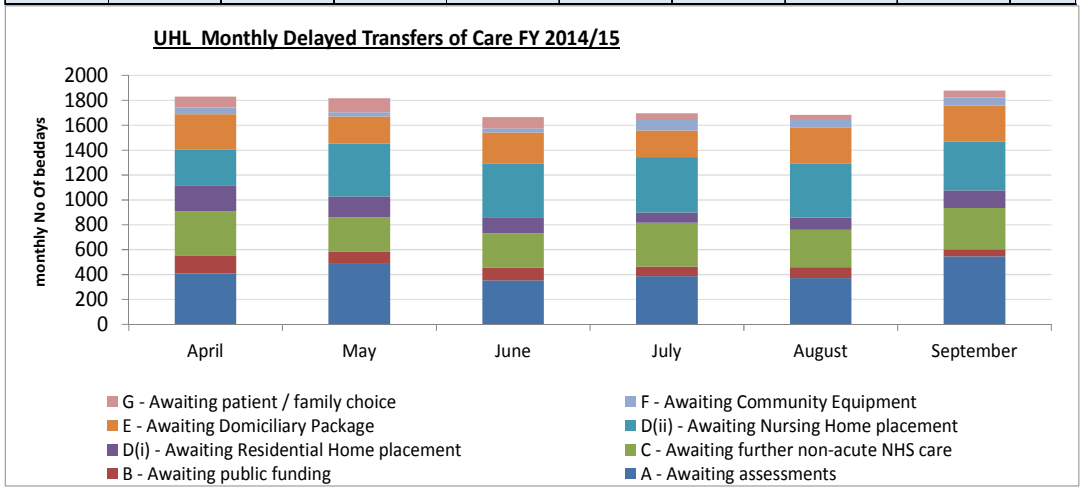
Alliance performance
R21 - 0.9% cancelled on the day. R18+18 and Alliance)□□□ No breaches of the 28 day standard.

<table>
<tr><th>13/14 FYE</th><th>14/15 Q1</th><th>14/15 Q2</th><th>14/15 Q3</th><th>14/15 Q4</th></tr>
<tr><td>1.6%</td><td>0.97%</td><td>0.8%</td><td></td><td></td></tr>
</table></td></tr>
<tr><td colspan="2">Expected date to meet standard / target</td><td colspan="2">R19-21) August 2014
R17-18) July 2014</td></tr>
<tr><td colspan="2">Revised date to meet standard</td><td colspan="2">November 2014</td></tr>
<tr><td colspan="2">Lead Director / Lead Officer</td><td colspan="2">Richard Mitchell
Phil Walmsley</td></tr>
</table>

R23 Delayed Transfers of Care

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest month performance	YTD performance	Forecast performance for next reporting period
There was an increase in delays due to DTOC across UHL in September. There continue to be a number of DTOCs due to slow discharges to care homes. This is caused by families being slow to find appropriate care homes, care homes being slow to come in to assess the patient as suitable or waiting for a bed to become available. There has also been a significant reduction in the number of community hospital beds available. This has been evidenced through reduced community hospital bed availability. Discussions are taking place with LPT regarding this. Social care support. – Due to an on-going demand in the number and size of package there have been difficulties and delays in POC availability within the County. UHL is currently looking at an external company to assess their ability to support transferring patients to their own homes or to care homes more efficiently.	The ICRS and ICS teams are attending wards to identify patients that they could take directly in to their home based services. Whilst there is often community hospital capacity it is often in the wrong hospital geographically, so patients refuse to move out of UHL. Choice letters are now issued following refusal of an identified rehab bed. Discussions take place with therapists regarding reducing the required package of care to try to ensure faster discharge. This links in to the joint working between Social Care and health therapy teams to risk assess package sizing.	3.5%	4.5%	4.3%	4.0%

	A - Awaiting assessments	B - Awaiting public funding	C - Awaiting further non-acute NHS care	D(i) - Awaiting Residential Home placement	D(ii) - Awaiting Nursing Home placement	E - Awaiting Domiciliary Package	F - Awaiting Community Equipment	G - Awaiting patient / family choice	Grand Total
April	407	148	356	207	285	285	55	87	1830
May	494	90	277	166	425	218	34	113	1817
June	353	103	277	122	433	253	36	89	1666
July	387	77	353	82	444	215	85	54	1697
August	371	87	302	98	430	294	61	41	1684
September	546	57	333	141	394	286	65	57	1879
Grand Total	2558	562	1898	816	2411	1551	336	441	10573



Performance by Quarter

13/14 FYE	14/15 Q1	14/15 Q2 to date	14/15 Q3	14/15 Q4
4.1%	4.4%	4.4%		

Expected date to meet standard / target	TBA

		Revised date to meet standard	TBA
		Lead Director / Lead Officer	Richard Mitchell/Phil Walmsley

R24 Choose and Book

		Target			
What is causing underperformance?	**What actions have been taken to improve performance?**	**<4% ASI**	**September**	**YTD performance**	**Forecast performance for next reporting period**
The Trust is measured on the % of Appointment Slot Unavailability (ASI) per month. The Trust has not met the required the <4% standard for circa 2 years and where it has met this standard it has been unable to maintain it for consecutive months. The two most significant factors causing underperformance are: - Shortage of capacity in outpatients - Inadequate recurrent training and education of administrative staff in the set up and use of the choose and book process	**Capacity** Additional capacity in key specialties is part of the RTT recovery plans Notably: Ophthalmology, ENT, General Surgery and Orthopaedics. But additionally other specialities as and when required. **Training and education** The comprehensive training and education of all relevant staff in all specialties is required, to ensure that choose and book is correctly set up and that supporting administrative purposes are fit for purpose. An interim Project Manager is in post (15th September) with the specific remit of managing the recovery plan and ensuring that a robust recurrent education programme is in place. The recovery plan is currently on track. It is anticipated that recovery will take circa 3 months due to the complexity and volume of work required.	<4%	25%	25%	23%
		National performance varies significantly by Trust, with average performance at circa 10%			
		Expected date to meet standard / target	December 2014		
		Revised date to meet standard			
		Lead Director / Lead Officer	Richard Mitchell Charlie Carr		

R25 and R26 Ambulance Handover > 30 Minutes and > 60 Minutes

<table>
<tr><th>What is causing underperformance?</th><th>What actions have been taken to improve performance?</th><th>Target (mthly / end of year)</th><th>Latest month performance</th><th>YTD performance</th><th>Forecast performance for next reporting period</th></tr>
<tr><td rowspan="4">Delays in moving patients out of the assessment bay leads to delays in ambulance staff handing over to ED staff.

Delays in the assessment bay remain due to lack of capacity in majors. This remains an issue with processing in majors and patients not flowing out of ED

Delays in booking patients onto EDIS is also a factor attributed to the delays in assessment bay

Data quality issues with the ‘time to handover’ data provided by EMAS.</td><td rowspan="4">An audit of handover occurred in Aug/Sept. The results of the audit are being finalised. Preliminary results show a discrepancy in data of timings from time on site to handover being different from the calculated time of 1.43 minutes to 4-5 minutes.

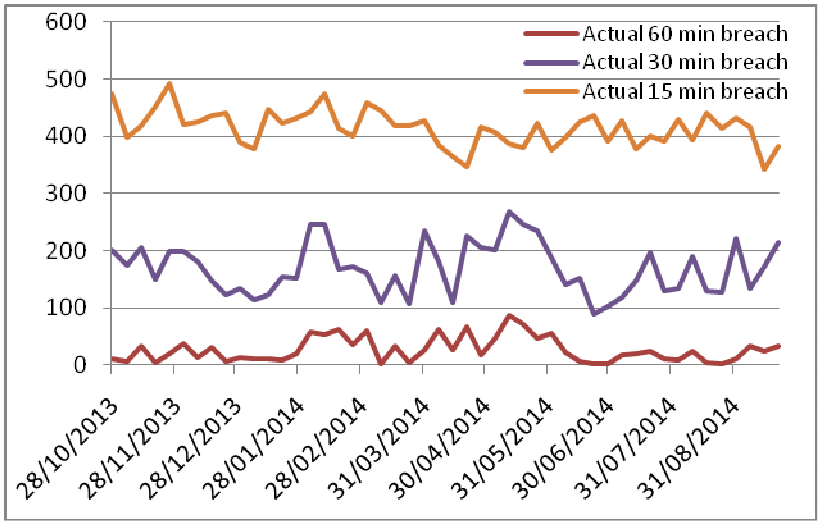
There is a discrepancy in completed handover times up to 20 minutes difference. The audit also showed a discrepancy of 6-30 minutes difference when UHL saw the crew leave the department to EMAS data. The audits displayed that around 18.30 on one audit day 10 crews arrived within 18 minutes.

All patients going to resuscitation are now coded as a zero delay which commenced in August. EMAS data shows 1-3 patients that arrive by ambulance from Resus are missing from the ambulance data.

3 band 4 audit staff recruited to ensure that the audit of handovers continues in a sustainable way.

An Audit is looking at direct admissions to the acute medical unit as these should also be coded as no delay.

A scanner is being sought in order to scan paper handover documents to speed up the process of booking patients onto EDIS. Reception ways of working are being reviewed in order to reduce queues in Assessment Bay.

In reviewing the hour+ delays there is a discrepancy of up to 30 minutes when handover was completed.</td><td>0 delays over 30 minutes</td><td>> 60 min 3%
30-60 min – 16%
15-30 min – 35%</td><td>> 60 min 3%
30-60 min – 16%
15-30 min – 37%</td><td></td></tr>
<tr><td colspan="4"> 
</td></tr>
<tr><td colspan="2">Expected date to meet standard / target</td><td colspan="2"></td></tr>
<tr><td colspan="2">Revised date to meet standard</td><td colspan="2"></td></tr>
<tr><td colspan="2">Lead Director / Lead Officer</td><td colspan="2">Richard Mitchell</td></tr>
</table>

RS1 Number of participants recruited into NIHR CRN Portfolio Studies

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest month performance	YTD performance	Forecast performance for next reporting period
CRN: EM is the 5th highest recruiting LCRN in England (out of 15). This is a very aspirational target that was set with the aim of ensuring we receive an increase in funding from NIHR in the 2015/16 financial year. NIHR CRN's annual allocation for local Clinical Research Networks is a capped budget issued to the 15 LCRNs based on a series of criteria, but predominately influenced by retrospective participant recruitment numbers. Whether your recruitment target is met does not influence funding allocation, relative performance against other LCRNs does. Setting a high target was to ensure that the network did not reach target early on and become complacent, and to ensure that we always strive to increase recruitment. Due to the aspirational target, the network is satisfied with our current progress, especially as since this, the LCRN transitioned from ten smaller research networks into one East Midlands-wide network.	1. Division structure within the LCRN that is responsible for the performance management of studies that fall within their specialty areas. 2. Each Division has a Clinical Lead and individual clinical Specialty Leads to promote engagement amongst clinical staff. 3. Reports have been produced for our Partner organisations (Trusts in receipt of NIHR CRN funding) to illustrate areas of good and poor performance. These are used as a performance management tool by both Partners and Network staff, and to receive useful feedback to improve data quality. 4. Regular engagement events attended by Partners to discuss any overarching performance issues and concerns.	**24,038 / 50,000**	**92%**	**92%**	**92% (Nov)**

Expected date to meet standard / target	Expect performance of 90% and above Quarter 3.
Revised date to meet standard	
Lead Director / Lead Officer	Elizabeth Moss, Chief Operating Officer

RS2a Proportion of commercial contract studies achieving their recruitment target during their planned recruitment period

<table>
<tr><th>What is causing underperformance?</th><th>What actions have been taken to improve performance?</th><th>Target (mthly / end of year)</th><th>Latest month performance</th><th>YTD performance</th><th>Forecast performance for next reporting period</th></tr>
<tr><td rowspan="5">East Midlands is currently the top performing of the 15 LCRNs for this metric with no LCRN currently achieving the 80% target

A lot of variables impact on recruitment achieved, after the recruitment target is set, for example:

• Impact of global performance and earlier end dates giving less time to recruit
• Changes in UK practice during set up/ recruitment
• Protocol changes prior to initiation
• Understanding of targets and alignment on the source of the target sites are measured on</td><td rowspan="5">1. Migration of the performance data for all open and closed commercial research onto one internet based system to track performance for 2014/15

2. Implementation of a provisional performance management process involving the Industry Team and Delivery Managers to escalate studies not recruiting to target within 24 hours and to align targets

3. Meetings with key research teams to discuss the importance of target setting and aligning the approach across the region so the target is reflective of the contract figure</td><td>80%</td><td>68% (Amber)</td><td>68%</td><td>68% (Nov)</td></tr>
<tr><td colspan="4" rowspan="4"></td></tr>
<tr><td>Expected date to meet standard / target</td><td colspan="2">April 2015</td></tr>
<tr><td>Revised date to meet standard</td><td colspan="2">April 2015</td></tr>
<tr><td>Lead Director / Lead Officer</td><td colspan="2">Daniel Kumar, Industry Delivery Manager</td></tr>
</table>

RS6A : Proportion of NHS Trusts recruiting each year into non-commercial NIHR CRN Portfolio studies

<table>
<tr><th>What is causing underperformance?</th><th>What actions have been taken to improve performance?</th><th>Target (mthly / end of year)</th><th>Latest month performance</th><th>YTD performance</th><th>Forecast performance for next reporting period</th></tr>
<tr><td rowspan="5">HLO5A: Proportion of NHS Trusts recruiting each year into non-commercial NIHR CRN Portfolio studies

There are 16 Trusts within the East Midlands region, with 13 Trusts currently reporting recruitment. The three who have not reported any recruitment are:
East Midlands Ambulance Service NHS Trust (EMAS)
Derbyshire Community Health Services NHS Foundation Trust (DCHS)
Lincolnshire Community Health Services (LCHS)</td><td rowspan="5">EMAS: have received funding for a Research Paramedic. This post currently supports two NIHR Portfolio studies that do not report recruitment in the traditional way due to patient assent taken rather than consent. EMAS have four studies in the pipeline that are due to open this financial year that will report participant recruitment.
DCHS: this Trust is unlikely to have recruitment directly attributed as all the studies that are supported by funded staff, occur in primary care settings. Therefore the recruitment will be allocated to a Clinical Commissioning Group within the East Midlands.
LCHS: this Trust supports several studies however the consent event occurs in the primary care setting so the recruitment is attributed to Clinical Commissioning. There is scope for research within the community services (paediatrics, district nursing) that is being investigated.</td><td>99%</td><td>81% (red)</td><td>81% (red)</td><td>81% (Nov)</td></tr>
<tr><td colspan="4"></td></tr>
<tr><td>Expected date to meet standard / target</td><td colspan="3">It is unlikely we will make the 99% target due to the nature of the services provided by DCHS and LCHS. We are likely to reach 85% by April 2015.</td></tr>
<tr><td>Revised date to meet standard</td><td colspan="3"></td></tr>
<tr><td>Lead Director / Lead Officer</td><td colspan="3">Elizabeth Moss, Chief Operating Officer</td></tr>
</table>

RS6b Proportion of NHS Trusts recruiting each year into commercial NIHR CRN Portfolio studies

<table>
<tr><th>What is causing underperformance?</th><th>What actions have been taken to improve performance?</th><th>Target (mthly / end of year)</th><th>Latest month performance</th><th>YTD performance</th><th>Forecast performance for next reporting period</th></tr>
<tr><td rowspan="4">HLO5B: Proportion of NHS Trusts recruiting each year into commercial NIHR CRN Portfolio studies

There are 16 Trusts within the East Midlands region, with 9 Trusts currently recruiting to commercial studies. The seven who have not reported any recruitment are:
East Midlands Ambulance Service NHS Trust (EMAS)
Derbyshire Community Health Services NHS Foundation Trust (DCHS)
Lincolnshire Community Health Services (LCHS)
Leicestershire Partnership NHS Trust (LePT)
Lincolnshire Partnership NHS Trust (LiPT)
Nottinghamshire Healthcare NHS Foundation Trust (NHFT)
Derbyshire Healthcare NHS Foundation Trust (DHFT)</td><td rowspan="4">EMAS: Currently no open commercial studies nationally run by ambulance services on the NIHR portfolio, therefore unlikely that EMAS will open a commercial study this financial year.
DCHS: due to the nature of research within this Trust, they are unlikely to be involved in commercial research.
LCHS: due to the nature of research within this Trust, they are unlikely to be involved in commercial research.
LePT: Selected for one study, due to open by the end of 2014.
LiPT: have been involved in commercial research in the past and the site is actively seeking commercial opportunities
NHFT: One trial in set up, due to open at the end of November 2014
DHFT: One trial recently opened to recruitment, yet to recruit</td><td>70%</td><td>56% (red)</td><td>56% (red)</td><td>62% (Nov)</td></tr>
<tr><td colspan="4"></td></tr>
<tr><td colspan="2">Expected date to meet standard / target</td><td colspan="2">April 2015</td></tr>
<tr><td colspan="2">Revised date to meet standard</td><td colspan="2">April 2015</td></tr>
<tr><td colspan="2">Lead Director / Lead Officer</td><td colspan="2">Daniel Kumar, Industry Delivery Manager</td></tr>
</table>

2014/15 NTDA METRICS AND WEIGHTINGS

Responsiveness Domain

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

Effective Domain

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

Caring Domain

Metric	Standard	Weighting
Inpatient Scores from Friends and Family Test	60	5
A&E Scores from Friends and Family Test	46	5
Complaints	tbc	5
Mixed Sex Accommodation Breaches	0	2
Inpatient Survey Q 68 - Overall, I had a very poor/good experience	tbc	2
TOTAL - 5 Indicators		19

Safe Domain

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

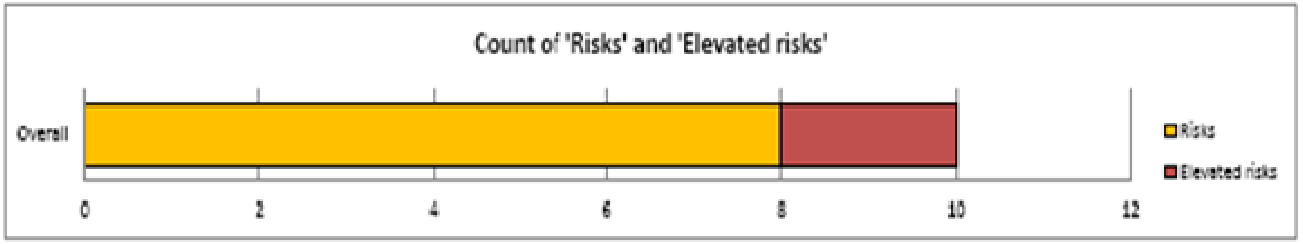
Well Led Domain

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

CQC – Intelligent Monitoring Report

University Hospitals of Leicester NHS Trust

Trust Summary



Priority banding for inspection	Recently inspected
Number of 'Risks'	8
Number of 'Elevated risks'	2
Overall Risk Score	12
Number of Applicable Indicators	95
Percentage Score	6.32%
Maximum Possible Risk Score	190

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

Quality Schedule and CQUIN Performance Summary

CONFIRMED Q1 RAGs AS REVIEWED AT THE OCTOBER CQRG AND ANTICIPATED Q2 RAGS FOR MONTHLY REPORTED INDICATORS

Ref	Indicator Title	Q1 RAG	Sept RAG	Commentary
	QUALITY SCHEDULE			
PS01	Infection Prevention and Control Reduction.	G	G	Monthly reporting of C Diff. Threshold for 14/15 is 81. UHL is aiming to achieve a reduction on last year's total of 66. 29 cases as at end of September which is below the NTDA trajectory.
PS02	HCAI Monitoring - MRSA	0	1	1 unavoidable MRSA bacteraemias in September
PS03	Patient Safety – compliance with NHS SI framework and demonstrate lessons learnt and actions taken	0	0	0 Never Events to date.
PS04	Duty of Candour	0	0	All patients have been notified of any moderate or serious incidents where applicable to end of September
PS06	Risk Assurance	A	G	All Risks reviewed and actions on Track. Some delays with CAS alerts in Q1 but none now overdue.. 5 new risks reported for September.
PS08	Reduction in Hospital Acquired Pressure Ulcer incidence.	G	G	Monthly thresholds achieved for both Grade 2 and Grade 3 HAPUs for all of Quarter 2. 0 Grade 4s.
PS09	Medicines Management Optimisation	A	G	Controlled Drugs Reaudit reported to Oct CQRG and improved compliance noted.. Progress made with development of LLR Medicines Optimisation Strategy.
PS11a	Venous Thromboembolism (VTE)	95.7%	96.2%	Q2 average = 96% which is above the national threshold of 95%.
PS11b	RCAs of Hospital Acquired Thrombosis (HAT)	A	G	RCAs completed for all Q1 inpatient HATs. . On track to achieve the Q2 Threshold = 100% inpatient and 60% post discharge
PE1	Same Sex Accommodation Compliance	6	0	No breaches for Q2
PE4	Equality and Human Rights	G	G	Additional assurance provided around actions being taken to collect Protected Characteristics data, as per Commissioners request.
CE07	#NOF - Dashboard	51%	A	72% 'time to theatre' threshold not met for any month in Q1. For Q2 indicators green except for:% of # NOFs to theatre within 36 hours = 68%
CE08a	Stroke monitoring	86%	83.4%	81.3% of stroke patients in Quarter 2 had 90% Stay on the Stroke Unit with

Ref	Indicator Title	Q1 RAG	Sept RAG	Commentary
CE08b	TIA monitoring	70%	66%	67% of patients with suspected 'High Risk TIA' being seen within 24 hour of referral.
AS02	Nursing Workforce and Ward Health-check	G	G	Recruitment of additional nurses continues and assurance provided about actions taken to address 'fill rates'.
AS03	Staffing governance	A	A	Due to non achievement of internal thresholds. September's performance - Appraisal = 88.6% Sickness = 3.9 (Jul) Staff Turnover = 10.5% Statutory & Mandatory Training =83% Corporate Induction = 98%
	NATIONAL CQUINS			
Nat 1.2	F&FT 1.2 - Increased participation	G	G	Q2 participation for Inpatients = 31% which is above end of year threshold. Q2 for ED is 15.1% which is above baseline but below the 20% end of year target significant drop in performance in July (10%). September = 19.1%.
	LOCAL CQUINS			
Loc 5	**Pneumonia**	A	G	Full CQUIN payment received for Pneumonia Care Bundle part of CQUIN scheme. 50% payment received for 'Virtual Respiratory Clinic' as whilst ICM referral process not live, patients being identified and reviewed by pneumonia nurses. No payment received for either 'post discharge telephone follow up service' or '6 week xray follow up' due to lack of baseline data.

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 October 2014

COMMITTEE: Finance and Performance Committee

CHAIRMAN: Mr R Kilner, Non-Executive Director

DATE OF COMMITTEE MEETING: 24 September 2014

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

- **Minute 99/14 – Mitigating actions to deliver a balanced capital programme 2014-15.**

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

- **Minute 104/14/3 – Clinical Letters Performance, and**
- **Minute 104/14/4 – Ambulance Turnaround Action Plan.**

DATE OF NEXT COMMITTEE MEETING: 29 October 2014

Mr R Kilner
24 October 2014

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF A MEETING OF THE FINANCE AND PERFORMANCE COMMITTEE, HELD ON WEDNESDAY 24 SEPTEMBER 2014 AT 8.30AM IN THE SEMINAR ROOMS A AND B, CLINICAL EDUCATION CENTRE, LEICESTER GENERAL HOSPITAL

Present:
Mr R Kilner – Acting Chairman (Committee Chair)
Mr J Adler – Chief Executive
Colonel (Retired) I Crowe – Non-Executive Director
Mr R Mitchell – Chief Operating Officer (from part of Minute 103/14/1)
Mr S Sheppard – Acting Director of Finance
Mr G Smith – Patient Adviser (non-voting member)
Ms J Wilson – Non-Executive Director

In Attendance:
Ms L Bentley – Head of Financial Management and Planning
Ms E MacLellan-Smith – Ernst Young (for Minute 105/14/1)
Mr G Maton – Project Manager, Transforming Transcription (for Minute 104/14/3)
Ms D Mitchell – Interim Alliance Director (for Minute 103/14/3)
Mr R Power – Clinical Director, MSS (for Minute 103/14/1)
Mrs K Rayns – Trust Administrator
Ms K Shields – Director of Strategy (for Minutes 103/14/2 and 103/14/3)
Ms S Taylor – General Manager, MSS (for Minute 103/14/1)
Mr S Turner – Active Plan/Space Manager, NHS Horizons (for Minute103/14/5)
Mr P Walmsley – Acting General Manager, ITAPS (for Minute 103/14/1)

RECOMMENDED ITEM **ACTION**

99/14 CAPITAL PROGRAMME

The Acting Director of Finance introduced paper N, seeking the Committee's endorsement of proposals to deliver a balanced Capital Programme for 2014-15. The expected impact of the mitigating actions detailed in the report were summarised (by scheme) in the Capital Expenditure report provided at appendix 1. Discussion took place regarding the following key changes:-

(a) increases in budget for MES installation and feasibility studies;
(b) Stock Management System to commence on 1 April 2015;
(c) deferred IMT projects into 2015-16;
(d) accommodation refurbishment to commence on 1 April 2015;
(e) revised bed budget allocation to reflect the reduced bed requirement;
(f) removal of ED early works (double counted costs), and
(g) revised forecasts for the Emergency Floor and Vascular Schemes.

In respect of item (g) above, the Emergency Floor scheme was still assumed to be progressing in 2015-16, but the works relating to demolition, diversions and isolations were not due to commence until February 2015 – a delay of 2 months. Further consideration would be taking place at the next meeting of the Emergency Floor Board and assurance would be sought that this delay would not adversely affect the timescale for the overall scheme, eg create an additional winter period without the expanded facilities – subject to planning consent.

Recommended – that (A) the revised Capital Programme for 2014-15 be endorsed for Trust Board approval on 30 October 2014, and **ADF**

(B) the Finance and Performance Committee's concerns regarding potential delays in the timescale for the Emergency Floor development (subject to planning consent) be highlighted at the September 2014 Trust Board meeting. **Acting Chair**

RESOLVED ITEMS

100/14 APOLOGIES

An apology for absence was received from Mr C Allsager, Clinical Director, ITAPS and it was noted that the Chief Operating Officer had been delayed and would be arriving late.

101/14 MINUTES

Resolved – that the draft Minutes of the 27 August 2014 Finance and Performance Committee meeting (papers A and A1) be confirmed as correct records.

102/14 MATTERS ARISING PROGRESS REPORT

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

(a) Minute 90/14(b) of 27 August 2014 – the Acting Director of Finance provided feedback from meetings held between UHL and the CCGs to develop and agree a Memorandum of Understanding (MoU) to address activity query notices relating to emergencies, outpatients, QIPP and cancer and a key line of inquiry relating to critical care activity. It was hoped that a mutually agreed MoU to cover the key issues identified above would be developed by the end of that week and that this would help to support an agreed position relating to depth of clinical coding and Commissioner engagement relating to planned patient pathway changes going forwards; **CE/ADF**

(b) Minute 91/14/2(c) and (d) of 27 August 2014 – these 2 issues related to revised patient restraint guidance for Interserve security staff and additional restraint training for UHL staff. The Committee Chairman requested the Trust Administrator to seek confirmed dates for assurance to be provided to the Committee that both of these issues had been progressed appropriately; **TA/CN**

(c) Minute 91/14/6(c) of 27 August 2014 – a thematic analysis of headcount movements had been circulated to Finance and Performance Committee members outside the meeting;

(d) Minute 78/14(b) of 30 July 2014 – a follow-up report on the error rate for TTO prescriptions would be scheduled for discussion at the October 2014 QAC meeting; **QAC Chair**

(e) Minute 81/14(b) of 30 July 2014 – the Committee Chairman had attended the EY CIP masterclass for Women's and Children's on 9 September 2014 and he provided a positive evaluation of that session, and

(f) Minute 67/14/8(d) of 25 June 2014 – the Acting Director of Finance briefed members on the review of opportunities for Asteral to support the Alliance. He particularly noted discussions between UHL, the CCGs, NHS England and the TDA in respect of potential capital investment. He was due to meet with Ms H Seth, Head of Planning and Business Development on this subject later that afternoon and an update would be provided to the October 2014 Finance and Performance Committee meeting (under matters arising). **ADF**

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

103/14 STRATEGIC MATTERS

103/14/1 Joint CMG Presentation – ITAPS and MSS Financial Recovery Plans

Before the CMG representatives attended the meeting, the Chief Executive briefed the Committee on financial recovery plan discussions held at the Executive Performance Board on 23 September 2014. In respect of ITAPS, the CMG had developed a challenging but deliverable plan with a forecast year end deficit of £1m and this had been broadly accepted. However, MSS had not been able to develop a recovery plan to deliver the target £1.5m deficit and they were currently forecasting a year end deficit of £2.9m. This had not been accepted and further work was taking place to identify the scope for achievable improvements. A further meeting with MSS was being scheduled within the next 2 weeks, to consider the outputs from this workstream and agree the next steps. **CE/ADF**

The Committee considered and agreed the following key issues for the CMG representatives to focus upon during their presentation:-

a) Critical Care/Intensive Therapy revenue and an associated Commissioner letter of inquiry;
b) MSS to be invited to articulate their understanding of the financial position and the reasons for the CMG's significant variances to plan;
c) theatre capacity planning;
d) whether any repatriation of independent sector activity was planned, and
e) any further support required from the Finance and Performance Committee, or the Executive Team to support the financial recovery plans.

The Clinical Director and General Manager, MSS and the Acting General Manager, ITAPS attended the meeting at this point in the meeting to present their financial recovery plans. Paper C provided a set of presentation slides, which were taken as read. The Committee Chairman outlined the key issues to be covered during the presentation (as noted above) and queried whether any additional items were required for discussion.

The Clinical Director, MSS briefed the Committee on the following issues:-

- theatre capacity and utilisation rates, noting the impact of Consultant delivered services and that it had taken longer than planned to build the additional sessions for RTT, but the additional lists and flexible job plans were now in place. He highlighted the need to introduce a more robust system of equitable planning and monitoring of annual leave. The Chief Executive advised that all CMG Clinical Directors had been requested to review their arrangements for controlling annual leave, to avoid the peaks and troughs in activity during the summer and half term school holidays; **CD, MSS**
- an additional 6 beds were likely to be required on the LGH site as theatre utilisation rates and throughput increased. There was some scope to create this by reconfiguring the existing wards and decompressing the admissions side by creating a theatre arrivals area adjacent to theatres 10 to 14 and discussions were underway with Mr R Kinnersley, Major Projects Technical Director in this respect; **CD, MSS**
- (in response to a request to articulate the CMG's deviation from plan) – not all aspects of the deviation were fully understood, but the key recovery actions were considered to be maximising theatre occupancy and reducing administrative delays in patient pathways;
- the £1.1m reduction in emergency vascular and trauma activity could not have been predicted, nor was the CMG able to influence this, although a market analysis exercise had been undertaken and the Trust did not appear to be losing activity to other centres. It was feasible that improved screening processes were having the desired effect of reducing emergency admissions. In addition, there were some concerns regarding the accuracy of clinical coding and whether all activity had been captured. A national change in epidemiology for trauma cases had occurred over recent years, with presentation of more elderly fragility fractures (who typically took longer to recover).

- it had recently been identified that approximately 400 outpatient visits had not been recorded (or paid for) during April 2014 and work was taking place with the data warehouse to establish the reason for this. It was crucial that all OPD activity was properly counted and coded as the impact of this omission alone was estimated at £40k, and
- opportunities for additional vascular and spinal surgery activity were being explored with Lincolnshire and Northamptonshire (respectively). If these discussions were successful, then additional spinal theatre capacity would be required.

The Acting General Manager, ITAPS reported on the following additional issues:-

- a lack of clarity regarding the commissioned activity levels for each service and ongoing discussions with the CMGs regarding their baseline to deliver 49 weeks per year of a set number of lists per week for each service. Conversations were underway to agree the process to identify and control which 49 weeks out of the 52 actually required resourcing by ITAPS, otherwise the CMG ended up resourcing the full 52 week period, and
- since 3 additional critical care beds had been opened, total activity had increased but the patient acuity mix had decreased, ie more level 2 non-ventilated HDU type cases were being treated. This had resulted in an appropriate reduction in the average patient care income. A review of UHL's total critical care capacity was being undertaken currently and the draft report was expected at the end of September 2014. The outputs of the review would be used to inform Commissioning plans and staffing models going forwards. The Committee Chairman requested an update on the Intensive Care Strategy be provided to the December 2014 Finance and Performance Committee meeting. **AGM/ CD, ITAPS**

In addition, the Chief Operating Officer advised that the admitted RTT backlog had almost been addressed and he briefed members on the process to retract additional theatre sessions and repatriate any independent sector activity going forwards. Approximately 20 additional (out of hours) lists per week were still being carried out and the plan was to develop a 7 day working culture to encompass this activity within UHL's baseline.

Finally, discussion took place regarding the following areas where it was considered that additional Corporate support would be helpful:-

1) theatre capacity for emergency spinal surgery on the LRI site;
2) sustainable arrangements for ring fencing of beds to protect elective capacity;
3) junior doctor and dental specialty recruitment plans to support gaps in the on-call rotas – this was noted to be a Trust-wide issue and there was felt to be some scope to aggregate specialty level solutions and develop a more systematic approach. Proposals would be developed for consideration at a future Finance and Performance Committee meeting. The Clinical Director, MSS requested that any new ANP roles that were developed were task specific rather than generic; **MD/ DHR**
4) turnaround times for reporting of diagnostic imaging (up to 10 weeks) were unacceptable as a maximum of 4 to 6 weeks was required. The quality of some outsourced images was considered to be sub-standard. It was agreed to invite representatives from the Imaging Service to the October 2014 meeting to provide an update on this matter; **COO**
5) assurance on the timescales for moving UHL's pain service into the Alliance contract and clarity regarding the associated impact on the financial position;
6) improved theatre utilisation data flows – the information support to theatres under IBM had deteriorated and data was now being provided monthly in arrears. Ideally, ITAPS need to receive this information weekly. The Chief Executive had raised this issue previously with the Chief Information Officer who had confirmed that the position was up-to-date – he asked the Chief Operating Officer to forward details of current IBM performance to him for further escalation; **COO**

7) clarity regarding the potential plans to downgrade the LGH ITU within the next 12 to 18 months as part of UHL's reconfiguration of services. A clear vision for this service was required to inform and motivate staff and to mitigate any impact upon other services on the LGH site (as part of the reconfiguration programme), and **AMD/ MD**
8) the scope to progress refurbishment works to the theatre estate on the LRI site and the associated requirement to provide decant theatres to enable the refurbishment works.

Resolved – that (A) the presentation and discussion on the financial recovery plans for ITAPS and MSS be received and noted;

(B) an improved mechanism for controlling Consultant leave to improve theatre utilisation rates be progressed through the Theatre Board and medical productivity workstream; **CD/GM ITAPS**

(C) proposals for a theatre arrivals area on the LGH site be progressed appropriately (to increase bed capacity and improve theatre throughput); **CD/GM ITAPS**

(D) plans to mitigate the financial shortfall within the MSS CMG be progressed and a revised year end forecast submitted to the October 2014 Executive Performance Board meeting; **CE**

(E) UHL's Intensive Care Strategy be presented to the December 2014 Finance and Performance Committee meeting; **AMD/ MD**

(F) a more systematic approach to junior doctor recruitment challenges be considered at a future Finance and Performance Committee meeting; **MD/ DHR**

(G) Imaging Services be invited to the October 2014 Finance and Performance Committee to present proposals for improving turnaround time for reporting of images and the quality of outsourced images, and **COO/ TA**

(H) the Chief Operating Officer be requested to forward details of IBM's current information performance relating to theatre utilisation rates to the Chief Executive for onward escalation with the Chief Information Officer. **COO**

103/14/2 Report by the Director of Strategy

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

103/14/3 Review of Current Alliance Contract Performance

The Interim Director of the Alliance and the Director of Strategy attended the meeting to present paper E, providing an overview of current financial and operational performance against the Alliance contract. The Interim Director of the Alliance particularly drew members' attention to the following matters:-

(a) cancelled operations in July 2014 and September 2014 relating to the quality of air and water supplies to some non-UHL healthcare premises. This had arisen as a result of higher infection prevention and control standards being applied following the transfer of services to the Alliance;
(b) the Alliance contract was due to change over from a block contract to a Payment by Results (PbR) contract on 1 October 2014;
(c) informatics support was currently provided by LPT and the data flows were not working as effectively as possible due to non-acute expertise. Meetings were being held urgently to identify the best way forward for capturing and managing the data to

report the Alliance's performance against the contract;

(d) an ongoing investigation into an information governance incident at Hinckley and a historical duty of candour issue which pre-dated the contract with the Alliance;

(e) the success of Listening into Action (LiA) events – 2 of the 3 events had been held to date and these had been well-received by staff;

(f) opportunities being explored to increase the take-up of UHL's plain film imaging. In respect of MRI scanning, it was noted that there was insufficient capacity to transfer this to UHL, and

(g) insufficient management resources – the Director of Strategy was supporting the Interim Director of the Alliance to build capacity and capability within the team. A range of CVs were being reviewed for interim appointments and the recruitment processes for substantive Service Manager and General Manager posts were due to commence shortly.

The Director of Strategy commented upon opportunities to transform UHL services prior to transferring them across to the Alliance to ensure that UHL received any CIP benefits attributed to service improvements. She felt that this concept had not been readily understood by all CMGs. The Acting Director of Finance also noted the scope to flag any projected loss of income through the Better Care Together bid for transformational funding. The Committee requested that a high level programme for the transformation of services (and the potential consequences for UHL) be presented to the November 2014 Finance and Performance Committee meeting and that this work be linked into the Trust's strategic planning processes. **IDA/DS**

<u>Resolved</u> – that (A) the update and discussion on current Alliance performance be received and noted, and

(B) a high level programme for transformation of clinical services be presented to the November 2014 FPC meeting. **IDA/DS**

103/14/4 <u>Arrangements for Monitoring Operational and Clinical Performance of Small Clinical Teams</u>

Further to Minute 45/14/1(c) of 23 April 2014, paper F provided a copy of the guidance that had been issued to each CMG by the Medical Director on the general themes for a functional service. This guidance had arisen from a recent review of UHL's kidney transplant service alongside a number of other reviews. Finance and Performance Committee members noted that compliance with the guidance was being reviewed at the quarterly extended CMG Quality and Performance review meetings and it was agreed that the Medical Director and the Chief Nurse would be invited to provide feedback to the Quality Assurance Committee in 6 months' time regarding the ongoing monitoring process. **MD/CN**

Ms J Wilson, Non-Executive Director queried the scope for an Independent Audit review of compliance and it was suggested that any relevant audit work be considered at that point.

<u>Resolved</u> – that the Medical Director and the Chief Nurse be invited to present an update on compliance with the thematic guidance for functional services to the Quality Assurance Committee in March 2015.

103/14/5 <u>Progress of Workstream to Review the Apportionment of Clinical Academic Posts and Landlord Elements of UHL Premises Occupied by the University of Leicester (UoL)</u>

Further to Minute 56/14/4 of 28 May 2014, the Acting Director of Finance and the Head of Financial Management and Planning introduced papers G and G1, summarising progress of the 2 separate workstreams identified above. Mr S Turner, Active Plan/Space Manager, NHS Horizons also attended the meeting to support the discussion on paper

G1, outputs of the NHS Horizons space utilisation data exercise.

In respect of paper G, the Committee particularly noted that:-

(a) the University of Leicester had agreed the general principals and heads of terms to move towards a Service Level Agreement (SLA) approach based upon individuals' actual costs and the work undertaken in relation to their job plans;
(b) initially the split would be on a 50/50 basis (with some specific post exemptions) moving towards individual SLAs in line with their job plans, and
(c) there were not thought to be any significant cost pressures for UHL arising from this workstream.

Members commended this transparent approach towards fairly apportioning medical staffing costs between UHL and UoL, noting the timescales for completion of the SLAs would be end of October 2014 and that the UHL budgets would be aligned with the SLAs with effect from 1 April 2015. Assurance was provided that the SLAs would be kept under continual review to ensure delivery against plan.

Paper G1 set out the rationale, desired outcomes, progress and future management arrangements for the Space Utilisation Project to inform service line reporting in respect of accommodation costs and occupation of space by UHL services and third party organisations. Sample graphical and tabular reports were appended to the report. Members noted that the data collection exercise had now been completed and NHS Horizons were in the process of sense checking the data prior to seeking sign off by the relevant service leads (within and outside of UHL).

Discussion took place regarding the potential commercial rental value of accommodation going forwards (the quantum of which was not yet known) and how this would impact upon the service users once the full operational costs and overhead charges were applied. It was expected that services would place a more appropriate value on the space they occupied and that the occupied space would begin to reduce over the next 5 years or so, in line with the Space Utilisation Policy.

In terms of the process for agreeing landlord elements of the accommodation occupied by the University, a target date for reconciliation of the data had been set for 1 November 2014 and it was agreed that an update would be provided to the Finance and Performance Committee on 26 November 2014. **ADF**

<u>Resolved</u> – that (A) SLAs for the apportionment of clinical academic post funding between UHL and the University of Leicester be confirmed by the end of October 2014 and these be kept under review to monitor delivery against plan; **ADF**

(B) CMG budgets be aligned with the clinical academic post SLAs with effect from 1 April 2015, and **ADF**

(C) an update on the outcome of reconciliation work between the UHL and UoL site surveys and the process for implementing a space utilisation charging mechanism be presented to the November 2014 Finance and Performance Committee meeting. **ADF**

104/14 PERFORMANCE

104/14/1 <u>Month 5 Quality and Performance Report</u>

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 31 August 2014. The Chief Operating Officer reported on the following aspects of the report:-

(a) Emergency care 4 hour waits – performance stood at 91.2% for August against the 95% target and a detailed report was scheduled on the 25 September 2014 Trust Board agenda. Performance had now exceeded 90% for the last 4 consecutive months, but already that day there had been 11 breaches (some of which had related to the pace of senior clinical decision making);

(b) RTT 18 weeks – performance against the non-admitted target had been met. Admitted performance was slightly behind trajectory due to additional in-month activity to reduce the over 18 week backlog, but this was still expected to be achieved for November 2014;

(c) 6 week diagnostic waits – the maximum 1% breach had been narrowly missed (by 2 patients) for the month of August 2014;

(d) 2 week wait for symptomatic breast patients – performance remained challenging as the service continued to experience a 15% increase in referrals, and

(e) cancelled operations – an exception report was included on page 15. Performance had been compliant with the percentage of cancellations on the day for non-clinical reasons (0.5%) but the target for re-booking patients within 28 days had not been achieved.

The Committee Chairman noted that the percentage of patients receiving surgery for fractured neck of femur within the timescale 0 – 35 hours had dipped to 59% (against the target of 72%). He commented upon the level of additional investment in this service some 2 years previously and noted (in response) that the Quality Assurance Committee Chair would be undertaking a review of this performance at the 29 October 2014 meeting. The Chief Operating Officer highlighted 2 key actions being taken to improve fractured neck of femur care – 8am Gold Command meetings (whereby additional theatre sessions were established to cope with any peaks in activity) and plans to establish a "Chief of Residence" post to better manage the process.

QAC Chair

Resolved – that (A) the month 5 Quality and Performance report (paper H) and the subsequent discussion be received and noted, and

(B) a review of UHL's fractured neck of femur performance be undertaken at the 29 October 2014 Quality Assurance Committee meeting.

QAC Chair

104/14/2 Progress Report on RTT Improvement Plan

The Finance and Performance Committee noted that a verbal update on RTT Improvements had been provided earlier during discussion on the Quality and Performance report (Minute 104/14/1 above refers). Members noted that if a fully compliant RTT position was delivered in November 2014 (as planned) then this would be considered to be a success story for the organisation. The Chief Executive reminded members of the background surrounding the Trust's previous RTT performance which had not reflected the true position (due to a number of patients being treated out of chronological order) and the Chief Operating Officer commended the efforts of Mr A Dennison, Consultant Surgeon, in reducing the backlog within General Surgery. He also confirmed that the TDA had been supportive of UHL's RTT improvement work.

Resolved – that the verbal information on RTT improvements (as provided under Minute 104/14/1 above) be received and noted.

104/14/3 Clinical Letters Performance

Further to Minute 80/14/1 of 30 July 2014, Mr G Maton, Transforming Transcription Project Manager, attended the meeting to introduce paper J, providing a progress report on the number of outpatient letters awaiting typing and the actions underway to reduce

UHL's backlog. Appendix 1 to paper J provided a "snapshot" of the specialty level position as at 3 September 2014, but further work was being undertaken to understand the overall trend.

Since the last report on this subject to the Committee, it was noted that Dictate IT had become a supported system within the IBM portfolio and that an interface between Dictate IT and ICE had been developed and was being tested. Subject to satisfactory testing, rollout of the interface was programmed to commence at the end of October 2014 (at the rate of 2 specialties per week) and be completed early in December 2014. Opportunities to rationalise the number of clinic template variations were also being pursued.

The Chief Operating Officer briefed the Committee on discussions held at the 23 September 2014 Executive Performance Board meeting, noting the need for UHL to develop a standardised approach to clinical letter generation. The Committee supported this approach, recognising the impact of poor performance upon patient experience and GPs' confidence in UHL's ability to deliver a high quality service. It was agreed that the Chief Executive and the Chief Operating Officer would progress this issue outside the meeting and that proposals for a single technical solution would be presented to the 26 November 2014 Finance and Performance Committee meeting. **CE/COO**

<u>Resolved</u> – that (A) the Chief Executive and the Chief Operating Officer be requested to progress a strategy for a single technical solution for clinical letters generation, and **CE/COO**

(B) outline proposals be presented to the 26 November 2014 Finance and Performance Committee meeting. **COO**

104/14/4 <u>Ambulance Turnaround Action Plan</u>

The Chief Operating Officer presented paper K, providing a summary of the key issues affecting UHL's ambulance handover and turnaround performance and the key actions underway to address this. Within the 2014-15 contract, members noted that the Trust was liable for fines up to the value of £4m, although agreement had been reached that 50% of such fines would be reinvested in UHL's services to support system improvement.

Particular discussion took place regarding the inaccuracies of the current CAD system which was used to capture UHL's data (instead of the more widely used RFID tagging system). The CCGs appeared to be reluctant to transfer to RFID tagging because of the take-up rate by EMAS, although EMAS had now confirmed that 66% of crews visiting UHL had RFID tagging on their equipment and that this was the highest take up rate within the East Midlands.

The Committee received assurance that all actions within the Trust's control were being taken to improve patient flows, including improvements to the functionality of the assessment bays and strengthening specialty in-reach to ED, but concern was expressed that data inaccuracy would prove to be the rate-limiting factor. Manual audits had being undertaken to observe and record the ambulance crews' movements and this data had been compared to the CAD data. In one notable example, the handover time had been manually recorded as 8 minutes but the system had recorded this as 45 minutes (which had included a refreshment break for the ambulance crew).

The Committee Chairman noted the scale of ambulance penalties being incurred and queried whether the Trust had considered seeking any expert logistics advice to support this workstream. In response, the Chief Operating Officer advised that he had contacted a national expert on ambulance handover times who was not able to reconcile the level of penalties currently being levied against the Trust.

Resolved – that (A) the update on actions underway to improve UHL's ambulance turnaround performance be received and noted;

(B) the Chief Operating Officer be requested to meet with Commissioners to agree a fair, transparent and robust method for collating ambulance turnaround data; **COO**

(C) the Acting Director of Finance be requested to co-ordinate the arrangements to activate UHL's ambulance penalty rebate clause, and **ADF**

(D) a further report on the ambulance turnaround action plan be presented to the November 2014 Finance and Performance Committee meeting (including the scope for a "fresh eyes" approach). **COO**

105/14 FINANCE

105/14/1 2014-15 Cost Improvement Programme (including a progress report on the cross-cutting CIP schemes and an update on 2015-16 schemes)

Further to Minute 93/14/1 of 27 August 2014, the Chief Operating Officer and Ms E MacLellan-Smith, Ernst Young introduced paper L, updating the Committee in respect of progress towards the 2014-15 CIP target of £45m, noting that the total value of schemes on the CIP tracker now stood at £48.92m (part year effect) and the risk adjusted value stood at £45.01m. Work was continuing to maximise the level of savings in 2014-15 and identify robust schemes for 2015-16 (including the cross cutting themes).

Section 3 of paper L focused upon progress with the workforce review savings (targets set at 1% in year and 2% recurrently) and section 4 summarised the key risks surrounding income assumptions and recruitment plans in order to reduce agency expenditure. The report also detailed progress with cross cutting CIP schemes and service reviews in loss making specialties.

Outline CMG plans for 2015-16 CIP schemes had been submitted by the 22 September 2014 deadline. These were currently being assessed, but a breakdown of the first draft submissions was tabled at the meeting. Members noted that approximately 70% of the £40.73m target had been identified and that (of this 70% total) 15% related to pay, 10% related to non-pay, 22% related to income and 23% related to combined savings.

CIP planning workshops had been well-attended although it was noted that 2 CMGs had elected not to receive additional Ernst Young supporting resources. Consideration was being given to the planning approach within these CMGs and whether CIP workshops would be beneficial in these areas. **COO/ EY**

A draft structure for UHL's 5 year CIP strategy was appended to paper L and discussion took place regarding the scale of workforce savings, outputs from the Better Care Together workstreams and the extent of savings incorporated into business cases. The Committee agreed that consideration should be given to scheduling a Trust Board or Trust Board development discussion to reinforce the scale of changes required to the shape and size of UHL's workforce over the next 5 years. **Acting Chair**

The Ernst Young representative left the meeting at this point and the Committee briefly discussed the position for continued support to the Trust's CIP Programme, once the existing EY resources concluded at the end of October 2014. Substantive recruitment to a number of CIP roles was underway, but It was agreed that additional resources might be required to accelerate progress across a number of the cross cutting themes. The Chief Executive and the Chief Operating Officer agreed to develop proposals for consideration by the Finance and Performance Committee and Trust Board at their respective October 2014 meeting dates. **CE/ COO**

Resolved – that (A) the 2014-15 CIP update be received and noted;

(B) scope to be explored to hold additional CIP workshops within the 2 CMGs which had elected not to receive EY supporting resources; **COO/ EY**

(C) consideration be given to scheduling a Trust Board or TB development discussion on the scale of changes required to the shape and size of UHL's future workforce, and **Acting Chair**

(D) a review of EY workstreams and resources (post October 2014) to be undertaken and proposals for additional resources to be submitted to the October 2014 Finance and Performance Committee and Trust Board meetings for approval. **CE/ COO**

105/14/2 2014-15 Financial Position to Month 5

Papers M and M1 provided an update on UHL's performance against the key financial duties surrounding delivery of a planned surplus, achievement of the External Financing Limit (EFL) and achievement of the Capital Resource Limit (CRL), as submitted to the 25 September Trust Board and the 23 September Executive Performance Board (respectively).

The Acting Director of Finance took the reports as read but he summarised the continuing themes affecting the Trust's financial performance which had resulted in an in-month £0.6m adverse variance to plan, including an adverse variance in patient care income of £1m and a non-pay adverse variance of £0.1m. Monthly pay expenditure was noted to be £0.5m favourable to plan. All Acute Trusts which were reporting a projected deficit of £0.75m (or more) had been asked to submit their trajectories for financial recovery to the TDA by the end of 3 October 2014. **ADF**

Particular discussion took place regarding the forecast outturn (based upon the gross forecasts submitted by the CMGs and Corporate Directorates), assumptions relating to reinvestment of ambulance turnaround penalties and up to £1.1m of resilience funding for RTT activity and winter pressures. A number of financial assumptions were noted to have changed since the original LTFM submission to the TDA and it was agreed that the next iteration of the financial performance report would clarify these areas of variation (eg the agreed cap on performance related penalties). **ADF**

Following consideration at the Executive Performance Board on 23 September 2014, it had been agreed that revised control totals would be issued to the appropriate CMGs and Directorates. **CE/ADF**

Finally, the Acting Director of Finance updated the Committee on the process for agreeing UHL's loan application, advising that since the re-submission the TDA had raised 67 queries and requested a response by 26 September 2014. A further update on this matter would be provided to the next meeting. **ADF**

Resolved – that (A) the briefings on UHL's Month 5 financial performance be received and noted as papers M and M1;

(B) UHL's financial recovery trajectory be submitted to the TDA by the end of 3 October 2014; **ADF**

(C) the October 2014 iteration of the financial performance report to include a comparison with the original LTFM submission to the TDA to clarify the areas where variances had occurred (eg capped penalties); **ADF**

(D) revised financial control totals be issued to the appropriate CMGs and Corporate Directorates, and **CE/ADF**

(E) the Acting Director of Finance be requested to respond to the 67 queries received from the TDA in respect of UHL's loan application. **ADF**

106/14 SCRUTINY AND INFORMATION

106/14/1 2015-16 and 2016-17 Integrated Planning Guidance

Resolved – that the 2015-16 and 2016-17 Integrated Planning Guidance be received and noted as paper O.

106/14/2 Clinical Management Group (CMG) Performance Management Meetings

Resolved – that the action notes arising from the August 2014 Performance Management meetings (paper P) be received and noted.

106/14/3 Executive Performance Board

Resolved – that the notes of the 26 August 2014 Executive Performance Board meeting (paper Q) be received and noted.

106/14/4 Quality Assurance Committee (QAC)

Resolved – that the 27 August 2014 QAC Minutes be presented to the 29 October 2014 Finance and Performance Committee meeting.

107/14 ITEMS FOR DISCUSSION AT THE NEXT FINANCE AND PERFORMANCE COMMITTEE

Paper R provided a draft agenda for the 29 October 2014 meeting and it was agreed that the agenda would be revised following discussion at today's meeting and re-circulated accordingly.

Resolved – that the items for consideration at the Finance and Performance Committee meeting on 29 October 2014 be revised and re-circulated. **TA**

108/14 ANY OTHER BUSINESS

108/14/1 Mr Richard Kilner – Committee Chairman

The Committee Chairman noted that this would be his last Finance and Performance Committee meeting as he would be leaving the Trust on 31 October 2014. He thanked members for their support. In response, Ms J Wilson, Non-Executive Director recorded the Committee's appreciation to Mr Kilner for Chairing the Finance and Performance Committee since July 2013.

Resolved – that the information be noted.

108/14/2 Alliance Premises

Colonel (Retired) I Crowe, Non-Executive Director noted some of the environmental concerns relating to Alliance premises (as raised under Minute 103/14/3 above) and he queried how UHL's Non-Executive Directors could support such issues going forwards. In response, the Committee Chairman requested the Trust Administrator to contact the Patient Safety Team with a view to the Alliance premises being incorporated into the programme of regular safety walkabouts.

Resolved – that the Trust Administrator be requested to contact the Patient Safety Team to arrange for all healthcare premises under the Alliance contract to be **TA**

included in the schedule of UHL Safety Walkabouts.

109/14 ITEMS TO BE HIGHLIGHTED TO THE TRUST BOARD

Resolved – that the following issues be highlighted verbally to the Trust Board meeting on 25 September 2014:- **Acting Chair**

- **Minute 99/14 – Capital Programme for 2014-15;**
- **Confidential Minute 103/14/2 – report by the Director of Strategy;**
- **Minute 104/14/3 – Clinical Letters Performance, and**
- **Minute 104/14/4 – Ambulance Turnaround Action Plan.**

110/14 2015 MEETING DATES AND DATE OF NEXT MEETING

Resolved – that (A) the proposed schedule of 2015 meeting dates be approved (as detailed in paper S):-

- **Wednesday 28 January 2015;**
- **Wednesday 25 February 2015;**
- **Wednesday 25 March 2015;**
- **Wednesday 29 April 2015;**
- **Wednesday 27 May 2015;**
- **Wednesday 24 June 2015;**
- **Wednesday 29 July 2015;**
- **Wednesday 26 August 2015;**
- **Wednesday 23 September 2015;**
- **Wednesday 28 October 2015;**
- **Wednesday 25 November 2015;**
- **Wednesday 23 December 2015, and**

(B) the next Finance and Performance Committee be held on Wednesday 29 October 2014 from 8.30am – 11.30am in Seminar Rooms A and B in the Clinical Education Centre at Leicester General Hospital.

The meeting closed at 11:26am

Kate Rayns, Trust Administrator

Attendance Record 2014-15

Name	Possible	Actual	% attendance	Name	Possible	Actual	% attendance
R Kilner (Chair)	6	6	100%	P Hollinshead	3	3	100%
J Adler	6	6	100%	S Sheppard	3	3	100%
I Crowe	6	5	83%	G Smith *	6	6	100%
R Mitchell	6	6	100%	J Wilson	6	5	83%

* non-voting members

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 October 2014

COMMITTEE: Quality Assurance Committee

CHAIRMAN: Ms J Wilson, Non-Executive Director

DATE OF COMMITTEE MEETING: 27 August 2014

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

- **None.**

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

- **the work on-going into patient falls (Patient Safety Report – Minute 65/14/3)**
- **progress in respect of the work of the Resuscitation Committee (Minute 65/14/6), and**
- **the Triangulation of Patient Feedback (Minute 67/14/3).**

DATE OF NEXT COMMITTEE MEETING: 24 September 2014

Dr S Dauncey
Acting QAC Chairman for 27 August 2014 meeting
24 October 2014

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF A MEETING OF THE QUALITY ASSURANCE COMMITTEE HELD ON WEDNESDAY 27 AUGUST 2014 AT 12.30PM IN SEMINAR ROOMS A AND B, CLINICAL EDUCATION CENTRE, LEICESTER GENERAL HOSPITAL

Present:
Dr S Dauncey – Non-Executive Director (Acting Chair)
Mr J Adler – Chief Executive
Mr M Caple – Patient Adviser (non-voting member)
Dr A Furlong – Deputy Medical Director (deputising for Dr K Harris, Medical Director)
Ms R Overfield – Chief Nurse
Mr P Panchal – Non-Executive Director

In Attendance:
Mrs G Belton – Trust Administrator
Dr T Bourne – Lead Clinician, EPMA (for Minute 66/14/1)
Dr B Collett – Associate Medical Director (Clinical Effectiveness)
Ms C Ellwood – Acting Chief Pharmacist (for Minute 65/14/1)
Ms S Hotson – Director of Clinical Quality
Dr P Rabey – Deputy Medical Director and Chair of the Resuscitation Committee (for Minute 65/14/6)
Mrs C Ribbins – Director of Nursing – from Minute 66/14/6

RESOLVED ITEMS **ACTION**

62/14 APOLOGIES

Apologies for absence were received from Miss M Durbridge, Director of Safety and Risk, Dr K Harris, Medical Director, Ms C O'Brien, Chief Nurse and Quality Officer, East Leicestershire CCG, Ms J Wilson, Non-Executive Director and QAC Chair and Professor D Wynford-Thomas, Non-Executive Director and Dean of the University of Leicester Medical School.

63/14 MINUTES

Resolved – that the Minutes of the previous meeting held on 30 July 2014 (papers A and A1) be confirmed as a correct record, subject to correction of the typographical error in the spelling of Dr Dauncey's name (page 2, point (m) refers).

64/14 MATTERS ARISING

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

(i) Minute 53/14a – Mr Caple reported verbally to confirm that the Patient Advisers were happy with the proposal that they field deputies at Trust Committee meetings when the nominated Patient Adviser could not attend. He had discussed this matter with the Director of Communications and Marketing who, in turn, would be raising this with the Director of Corporate and Legal Affairs for progression, as appropriate. It was agreed that this action would be removed from future iterations of the Matters Arising log; **TA**

(ii) Minute 54/14/5 (re checking of any capacity issues in respect of Level 3 safeguarding training) – the Director of Nursing confirmed that there were no capacity issues, and this action could be closed down on the log;

(iii) Minute 55/14/2 (re the need to ascertain the structural mechanism for taking forward the LLIC health community-wide action plan) – the Chief Executive reported verbally to advise that there had been several subsequent discussions on this matter, and it was intended that a proposal that this work be progressed as a **TA**

workstream within 'Better Care Together' would be submitted to the System Management meeting for approval. A decision would also need to be taken as to who would provide the required project management; **CE**

(iv) Minute 55/14/7b (relating to planned discussion with the Director of Human Resources of the need for any quality and safety issues arising from EWB's review of the clinical workforce to be submitted to QAC as and when required) – this had been discussed and this action could now be RAG-rated '5' (completed); **TA**

(v) Minute 55/14/7c (relating to consideration of convening a development session on the revised Q & P report following the appointment of the new Non-Executive Directors) – this proposal had been discussed with the Director of Corporate and Legal Affairs, who would discuss this with the newly appointed Trust Chairman. This action could therefore now be RAG-rated '5" (completed); **TA**

(vi) Minute 55/14/10 (regarding the Acting Chair's intention to write to the IP Team congratulating them on the work outlined in their Annual Report and requesting completion of a revised front sheet in future submissions) – it was noted that the Acting Chair had prepared this communication in draft and was awaiting a copy of the template for the revised front sheet prior to sending. It was noted that if this was not yet available, she would send the communication and send the template on to follow when it became available; the Director of Clinical Quality undertook to check the position with the Senior Trust Administrator; **DCQ/AC**

(vii) Minute 43/14/l (regarding circulation of the In-Patient Survey to the Trust Board) – given the particular focus now being placed on FFT, it was agreed that the Acting Chair would discuss this matter with the QAC Chair to determine the most appropriate action; **AC**

(viii) Minute 44/14/7d (regarding reviewing the out-puts of the ED Risk Review at the EQB) – this action had now been completed, and could be RAG-rated '5' accordingly; **TA**

(ix) Minute 45/14/2 (regarding making photocopies of the Trust's Quality Account available at the Trust's APM) - this action had now been completed, and could be RAG-rated '5' accordingly; **TA**

(x) Minute 40/14/7 (regarding determination of an appropriate Chair for the Organ and Tissue Donation Committee) - this action had now been completed, and could be RAG-rated '5' accordingly; **TA**

(xi) Minute 34/14/1b and 34/14/1c (regarding specific actions underway within the Women's and Children's CMG) – confirmation of the action undertaken to-date was awaited and would be included in the next iteration of the log; **TA**

(xii) Minute 13/14/3 (regarding the planned work to review and amend the QAC work plan) – it was noted that a meeting was scheduled to progress this work during the following week, and this item would be scheduled on the September QAC agenda, and **TA/Chair**

(xiii) further to Minute 56/14/1 of the previous meeting, at which time the results of the latest PLACE audits had been discussed, note was made that a number of questions had arisen at the last APM regarding PLACE audits, and it was therefore agreed helpful to circulate paper Q from the meeting held on 30 July 2014 to members of the Trust Board for their information. **TA**

Resolved – that (A) the matters arising report (paper B) and the actions outlined above be noted and undertaken by those staff members identified, and

(B) the Trust Administrator be requested to undertake the action outlined under point (xiii) above.

65/14 SAFETY

65/14/1 Report by the Acting Chief Pharmacist

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

65/14/2 Report by the Director of Safety and Risk

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

65/14/3 Patient Safety Report

In the absence of the Director of Safety and Risk, the Associate Medical Director presented paper 'E', which detailed the monthly Patient Safety report and specifically detailed information in respect of: Sign Up to Safety, 3636 Staff Concerns Report line, weekly tracking of harms and formal complaints, SUIs reported and closed in July 2014, Executive Safety Walkabout Themes for quarter 1, CAS performance for July 2014 and 45 day RCA performance.

Specific note was made of the fact that the Trust had registered for the new national 'Sign Up for Safety' initiative and had weaved many of the sign up for safety pledges into existing Quality Commitment KPIs.

Note was also made of the number of reported incidents, and a query was raised as to the specific action undertaken in response to patient falls. The Chief Nurse confirmed the actions undertaken by the Heads of Nursing in response to reported patient falls and of the resulting lessons learned which were shared across the team and reported at the Nursing Executive Team. The Chief Nurse undertook to provide a quarterly report on patient falls for QAC at a future meeting. **CN/TA**

Discussion took place regarding specific SUIs, namely W1440179 and W149106, and the Associate Medical Director undertook to ascertain the result of the investigation into the latter referenced SUI (i.e. W149106) for Mr Caple, at his request. The action taken in response to this incident was noted, as was the fact that the planned move to an electronic patient record would assist in preventing future such incidents. **AMD**

Specific discussion also took place in respect of communications back to staff as to action taken in response to feedback they have provided. Whilst efforts had been made to feedback to staff either verbally or via official channels, it was acknowledged that it would be appropriate for nursing staff to know what had been said to any junior doctors involved in incidents, via their Educational Supervisors, and the Associate Medical Director undertook to progress this matter with the Deanery. The Chief Executive noted that he would wish to see specific reference within the Incident Policy as to the type of feedback provided for each type of incident, and it was agreed that the Chief Nurse would progress this accordingly. **AMD** **CN**

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

(B) the Chief Nurse be requested to:
(i) provide a quarterly report on patient falls at a future QAC meeting, and
(ii) progress the issue raised regarding the Incident Policy (as detailed above), **CN**

(C) the Associate Medical Director be requested to:
(i) ascertain and feedback to Mr Caple the results of the investigation into SUI reference W149106, and
(ii) progress, with the Deanery, the issue of feedback following specific incidents. **AMD**

65/14/4 Report by the Deputy Medical Director

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

65/14/5 Ebola Virus

The Chief Nurse reported verbally to assure the Committee of actions undertaken within the Trust to ensure that staff were informed, prepared and able to implement immediately the required actions should a patient being treated within the Trust be suspected or confirmed to be suffering from the ebola virus.

Resolved – that this verbal information be noted.

65/14/6 Resuscitation Committee (Work Plan and KPIs)

Dr P Rabey, Deputy Medical Director and Chair of the Resuscitation Committee, attended to present paper 'F', which made reference to the recent significant changes made to the Resuscitation Committee and detailed the most recently agreed work programme and KPIs for the work of the Committee, for the purpose of providing assurance to QAC.

Dr Rabey highlighted the actions taken to ensure the production of outcome data for the Resuscitation Team, the first trust-wide results of which should be available in three month's time. He also noted the work on-going in respect of processes for responding to cardiac arrests, particularly at the LGH, and in respect of resuscitation training.

Particular discussion took place regarding public perception of issues concerning resuscitation and the potential need for public assurance in this respect. Dr Rabey noted the particular focus on End of Life Care as arising from the recommendations of the LLIC Review, and noted that a policy had been submitted to the Policy and Guideline Committee this month for approval. Note was made of the need for discussions with patients regarding DNAR, and of the need to gradually build trust in this respect. It was noted that a series of Listening Events around Learning Lessons to Improve Care were due to be held in September and October 2014.

Members also discussed particular issues relating to training, including the fact that staff who had left the Trust were not automatically removed from the trust-wide systems which tracked training, resulting in it appearing that less staff had received required training than was actually the case. Work was underway to link this system to the Electronic Staff Record to overcome this current limitation. Sufficient slots existed for the provision of resuscitation training, and the team providing the training had been requested to overbook sessions to overcome issues with anticipated non-attendance by a proportion of staff on the day. Attendance at resuscitation training was incorporated into the job description of relevant staff and pay progression for both Consultant staff and Trust Grade doctors would require attendance at such training sessions.

Resolved – that the contents of this report, and the additional verbal information provided, be received and noted.

66/14 QUALITY

66/14/1 EPMA Update – Current Position of Electronic Prescribing and the ePMA-ICE TTO Interface

Dr T Bourne, Lead Clinician EPMA, attended to present paper 'G', which sought to update the Committee on the current position of electronic prescribing and the ePMA-TTO ICE interface. A summary of the key points of the report was detailed on page 1 of paper G, along with the recommendation that further deployment of the ePMA system should not take place until two specific conditions had been met (as also detailed on page 1 of the report). Assurance was also being sought from the external provider that the ePMA-ABxAlert interface being developed would not impact unduly on performance of ePMA. Note was also made of the importance of undertaking a review of the processes required to achieve the IT component of the Doctor's induction programme for all grades in light of lessons learned from the Junior Doctor changeover on 1 August 2014.

Members queried where oversight of this work was monitored, in response to which it was confirmed that this was through the Executive Team. The Associate Medical Director noted the need to ensure a robust prescribing system was in place when the Trust went live with EPR.

In conclusion, the Chair thanked Dr Bourne for attending to provide this update and requested that a further update was provided at the QAC meeting in November 2014.

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

(B) Dr Bourne be requested to provide a further update on progress at the QAC meeting in November 2014. **LC, EPMA/ TA**

66/14/2 Stroke and TIA Clinical Report

As Mr A Palmer, Senior Service Manager, had been unable to attend today's meeting to present paper 'H', and as no one within the service had been able to attend to present on his behalf, it was agreed to defer this item until the next meeting of the Quality Assurance Committee.

As it was anticipated that members would have queries in relation to aspects of this report, it was agreed that the Director of Clinical Quality would make contact with the QAC Chair to ask that these issues were fed back to the service so that they could be addressed within an update report to be submitted to the September 2014 meeting.

Resolved – that (A) this report be deferred for consideration at the next (September 2014) QAC meeting, and **SSM/TA**

(B) the Director of Clinical Quality be requested to make contact with the QAC Chair for the purpose described above. **DCQ**

66/14/3 CQC Action Plan

The Director of Clinical Quality presented paper 'I', which provided an update on progress against compliance actions detailed in the CQC action plan.

Specific discussion took place regarding:

(i) paediatric post dental extraction – the Director of Operations was progressing this issue accordingly;
(ii) ref 6b (re improved compliance with mandatory training for maternity staff) – whilst the overall target date for completion of this action was March 2015, it was noted that there was a quarterly trajectory for improvement in place;
(iii) ref 7b (re review of paediatric bed capacity) and whether this was achievable within the timescale set (of September 2014) – note was made this this was currently RAG-rated '3', and
(iv) in response to a query, confirmation was provided that the action plan was reviewed in detail at the EQB (and its various sub-committees) with audits / checks undertaken as appropriate.

Resolved – that the contents of this report and the additional verbal information, be received and noted.

66/14/4 CQC Report – Areas identified for Improvement

The Director of Clinical Quality presented paper 'J', which provided the Committee with an update on progress against "should do" actions following the CQC inspection in January 2014, noting the aspirational nature of some of the items.

Members noted the good progress being made in this respect.

A specific query was raised by Mr Caple, Patient Adviser, in respect of ref (6f) on page 13 which made reference to the fact that 24/7 interpreting and translation services were available at the Trust, and he questioned why staff had not advised the CQC of this. In response, the Director of Clinical Quality advised that a communication campaign was being undertaken in this respect to ensure that all staff were aware of the availability of this service within the Trust.

66/14/5 PwC Review of Quality Assurance Arrangements

The Director of Clinical Quality presented paper 'K', which informed the Committee of the outcome of PWC's review of UHL's Quality Assurance Framework, and she noted that she, along with the Chief Nurse and the Director of Corporate and Legal Affairs had met with the auditors and agreed actions to address the findings.

In response to a query, note was made that some of the actions with an August deadline may extend into September 2014 due to the August holiday period. A key action related to the escalation framework, which was to be signed off by December 2014. It was agreed that an update would be provided to QAC at their October 2014 meeting.

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

(B) a further update on progress be submitted to the QAC meeting in October 2014. **DCQ/TA**

66/14/6 Month 4 – Quality and Performance Update

Members received and noted the contents of the revised format Quality and Performance Update for Month 4.

Specific discussion took place regarding the following points:

(i) the intended incorporation of the TDA standards (when available);
(ii) performance within cancer services in light of the increased referral rate with reference made to the exception report on page 15, and the current absence of a mechanism by which to review this in detail;
(iii) means by which the detail of the Q & P report could be triangulated with financial information – the difficulties in so doing were acknowledged and note was made of the actions undertaken to ensure all relevant staff (including the Director of Finance) were present at forums discussing quality and safety (e.g. through the recent changes made to the EQB forum), and
(iv) the discharge of patients awaiting placements in Nursing Homes, and the resulting implications for the Trust.

Resolved – that the contents of this report be received and noted.

66/14/7 Nursing Workforce Report

The Chief Nurse presented paper 'M', which sought to assure the Committee that matters relating to the nursing workforce were being managed and that risk was being mitigated wherever possible. The report detailed the latest figures for staff in post, the current recruitment position and the mitigation of workforce gaps. Note was made that this report would also be discussed at the public Trust Board meeting the following day.

Specific discussion took place regarding the following:

(i) the fact that paediatric and critical care areas flexed their beds up and down according to demand, however the system utilised to produce this report did not take account of this, and it was anticipated that this represented a national issue;

(ii) the action being undertaken to ensure completion of safety statements (appendix 2 refers);
(iii) the nursing turnover rate, and how vacancies were prioritised so that the posts required most urgently were filled first – note was made of the need for there to be an element of choice amongst nursing staff, with staff transferred internally where they wished to;
(iv) the Trust's retainment of its overseas nursing staff, and its very positive experience to-date of such staff and the valuable skills and experience they brought to the Trust (and the excellent mixed economy of skills achieved by having overseas nursing staff working alongside home-grown staff), and
(v) the improving FFT score month on month and the reduction in reliance on bank and agency staff.

Resolved – that the contents of this report and the additional verbal information provided were received and noted

67/14 PATIENT EXPERIENCE

67/14/1 Complaints Performance Report

In the absence of the Director of Safety and Risk, the Director of Clinical Quality presented paper 'N', which detailed monthly complaints performance, specifically reporting on: the trend relating to formal complaints, data relating to all complaints activity broken down by type, theme and CMG, trend lines of PILS activity, a breakdown of complaints activity for July, re-opened complaints information and complaints performance against Quality Schedule requirements.

Particular note was made that the revised complaints plan would be submitted to the next QAC meeting. **DSR/TA**

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

(B) the revised complaints plan be submitted to the next QAC meeting. **DSR/TA**

67/14/2 Patient Experience Feedback – Quarter 1

The Director of Nursing presented paper 'O', which provided an update on the Patient and Family Experience Feedback for Quarter 1 (April – June 2014). It was the last time that this report would be presented in this format, with the intention to provide a briefer report to future meetings.

Particular discussion took place regarding the following:

(i) the introduction of FFT to out-patients and its inherent challenges;
(ii) the success of wards in achieving the Quality Mark (page 14 of the report refers) and the planned publicity around this achievement;
(iii) the positive themes being observed through 'Message through a Volunteer';
(iv) improvements in the FFT for ED, and the decline in the FFT for maternity (particularly in antenatal) – work was underway to review in more detail the possible reason for the decline, and
(v) the frequency of visits to those wards scoring less than 55, and whether this was appropriate – it was noted that there was a need to balance frequent monitoring against providing time for changes to be made and embedded.

Resolved – that the contents of this report and the additional verbal information provided be received and noted.

67/14/3 Triangulation of Patient Feedback – Quarterly Report

The Director of Nursing presented paper 'P', which provided an update on the triangulation of patient feedback for quarter 1 (April – June 2014), and she expressed particular thanks to Mr C Walker, Clinical Audit Manager, for his assistance in the progression and advancement of this work.

Particular note was made of the top theme of 'waiting times' as reported by patients and discussion took place regarding the triangulation of the Trust response to feedback, ensuring that one area of the organisation learned from another area, as appropriate. The Director of Nursing advised of work underway to ensure that all the Trust's response letters contained the same relevant general information, irrespective of which CMG provided the response. Work relating to the sharing of information and good practice from one CMG to others would be taken forward through the Patient Experience Group.

Resolved – that the contents of this report be received and noted.

68/14 ITEMS FOR THE ATTENTION OF QAC

68/14/1 EQB Meeting of 6 August 2014 – Items for the attention of QAC

The action notes of the EQB meeting held on 6 August 2914 were presented as paper 'Q'. Action note 1 detailed specific items for the attention of QAC.

Resolved – that the contents of paper Q, detailing the action notes arising from the EQB meeting held on 6 August 2914 be received and noted.

69/14 MINUTES FOR INFORMATION

69/14/1 Finance and Performance Committee

Members received and noted the public Minutes of the Finance and Performance Committee meeting held on 30 July 2014 (paper R refers) noting that assurance on any implications arising out of the Vascular Services Outline Business Case would be reported through to EQB and QAC accordingly. QAC requested that such assurance was provided at its October 2014 meeting.

Resolved – that (A) the public Minutes of the Finance and Performance Committee meeting held on 30 July 2014 be received and noted, and

(B) a report on any implications arising out of the Vascular Services Outline Business Case be submitted to the October 2014 QAC meeting. **DS/TA**

69/14/2 Executive Performance Board

Resolved – that the action notes arising from the Executive Performance Board meeting held on 29 July 2014 (paper S refers) be received and noted.

70/14 ANY OTHER BUSINESS

Resolved – that there were no further items of business.

71/14 IDENTIFICATION OF ANY KEY ISSUES FOR THE ATTENTION OF THE TRUST BOARD

Resolved – that the QAC Chair be requested to bring the following issues to the attention of the Trust Board at its meeting the following day:

- **the work on-going into patient falls (Patient Safety Report – Minute 65/14/3)**
- **progress in respect of the work of the Resuscitation Committee (Minute 65/14/6), and**
- **the Triangulation of Patient Feedback (Minute 67/14/3).**

72/14 **DATE OF NEXT MEETING**

Resolved – that the next meeting of the Quality Assurance Committee be held on Wednesday 24 September 2014 from 12.30pm until 3.30pm in Seminar Rooms A & B, Clinical Education Centre, Leicester General Hospital.

The meeting closed at 3.02pm.

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

Name	*Possible*	*Actual*	*% Attendance*	*Name*	*Possible*	*Actual*	*% Attendance*
J Adler	5	4	80	*R Overfield*	5	4	80
*M Caple**	5	3	60	*P Panchal*	5	4	80
S Dauncey	5	4	80	*J Wilson*	5	3	60
K Harris	5	3	60	*D Wynford-Thomas*	5	1	20
K Jenkins	1	0	0				
*C O'Brien**	5	2	40				

***** non-voting members

Gill Belton
Trust Administrator

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 October 2014

COMMITTEE: Quality Assurance Committee

CHAIRMAN: Ms J Wilson, Non-Executive Director

DATE OF COMMITTEE MEETING: 24 September 2014

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

- **None.**

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

- **medical workforce issues (Minute 77/14/4);**
- **positive progress on stroke/TIA performance (Minute 78/14/1);**
- **fractured neck of femur performance and the intention to receive a further report at the November 2014 QAC (Minute 78/14/4);**
- **progress on UHL's SHMI and HSMR (Minute 78/14/4), and**
- **communication re: national benchmarking/RAG ratings for nurse staffing reports (Minute 78/14/5).**

DATE OF NEXT COMMITTEE MEETING: 29 October 2014

Ms J Wilson
QAC Chairman
24 October 2014

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF A MEETING OF THE QUALITY ASSURANCE COMMITTEE HELD ON WEDNESDAY 24 SEPTEMBER 2014 AT 12:30PM IN SEMINAR ROOMS A&B, CLINICAL EDUCATION CENTRE, LEICESTER GENERAL HOSPITAL

Present:
Ms J Wilson – Non-Executive Director (Chair)
Dr S Dauncey – Non-Executive Director
Mr J Adler – Chief Executive (from Minute 75/14)
Mr M Caple – Patient Adviser (non-voting member)
Dr K Harris – Medical Director
Ms C O'Brien – Chief Nurse and Quality Officer, East Leicestershire CCG
Ms R Overfield – Chief Nurse (from Minute 75/14)
Professor D Wynford-Thomas – Non-Executive Director

In Attendance:
Miss M Durbridge – Director of Safety and Risk (from Minute 75/14)
Dr R Marsh – Head of Service, Stroke (for Minute 78/14/1)
Mr A Palmer – Senior Service Manager, Stroke (for Minute 78/14/1)
Ms C Ribbins – Deputy Chief Nurse (from Minute 75/14)
Mr I Scudamore – Clinical Director, Women's and Children's CMG (for Minute 77/14/1)
Ms H Stokes – Senior Trust Administrator

RESOLVED ITEMS **ACTION**

73/14 APOLOGIES

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

74/14 MINUTES

It was noted that due to unforeseen and unavoidable circumstances, the Minutes of the 27 August 2014 QAC were not available, and would instead be provided to the October 2014 QAC for approval. **TA**

Resolved – that the Minutes of the 27 August 2014 QAC be considered at the 29 October 2014 QAC. **TA**

75/14 MATTERS ARISING REPORT

Members received and noted the contents of paper A, noting that (as per usual practice) any actions reported as complete (RAG rated 5) would be removed from future iterations of this report. Members specifically reported on progress in respect of the following actions:-

(a) **Minute 65/14/3** of 27 August 2014 – an update on falls was scheduled accordingly for the 29 October 2014 QAC; **CN**
(b) **Minute 65/14/3** of 27 August 2014 – an update on the incident in question would be provided under Minute 77/14/5 below, and **CN/MD**
(c) **Minute 65/14/3** of 27 August 2014 – the Medical Director confirmed that any trainee incidents were reported as appropriate to the training superviser and documented on the trainee's record. It was agreed to remove this action from the action log; **TA**
(d) **Minute 55/14/2** of 30 July 2014 – the Chief Executive updated members on follow-up discussions re: the LLR 'learning lessons to improve care' quality review, including ongoing governance, project management and resourcing issues. He also noted that end of life care issues would now be captured within the action plan arising from that LLR-wide quality review;
(e) **Minute 53/14a** of 30 July 2014 – views were now awaited from UHL's incoming

Chairman re: proposals to have Patient Adviser deputies available to attend Trust Committees. This item could therefore be removed from the log; **TA**

(f) **Minute 44/14/1** of 30 July 2014 – a report on this SUI was scheduled for the October 2014 EQB and would be escalated to QAC if necessary;

(g) **Minute 34/14/1b** of 30 July 2014 – confirmation of the actions taken in respect of the perinatal mortality alert would be resolved outside the meeting – this action could therefore be removed from the log; **DCQ/TA**

(h) **Minute 34/14/1c** of 30 July 2014 – the relevant spot checks had now been undertaken, and

(i) the following actions had been completed and could therefore be removed from the log:- Minute 67/14/1 of 27 August 2014, and Minutes 55/14/10 and 44/14/7c of 30 July 2014. **TA**

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

76/14 QAC DRAFT WORK PROGRAMME

Paper B set out a proposed high-level annual work programme for the QAC, showing the core business items reported and their reporting frequency. The next step would be to programme those items into specific months through the year and thus develop a more detailed calendar of QAC business in the same format as that used for the Executive Quality Board (EQB). In discussion on the proposed work programme, QAC members:-

(a) discussed a query from the Patient Adviser on how to capture Interserve issues, noting that the Managing Director of the LLR Facilities Management Collaborative (LLRFMC) would be providing an Interserve contract performance report to each monthly Finance and Performance Committee meeting. The Patient Adviser commented on feedback from his colleagues re: CMGs' experience of Interserve performance, and agreed to discuss this further with the Chief Nurse outside the meeting. Although noting the reporting routes for operational performance issues, the QAC Chair considered that there were also relevant quality aspects which could be covered by QAC (eg PLACE results, which needed adding in to the work programme) – the Chief Nurse agreed to consider this further and provide outline proposals accordingly to the October 2014 QAC (potentially as a verbal matter arising at that meeting); **PA/CN** **TA** **CN**

(b) noted the need for Trust Board sub-Committees to focus on outputs rather than inputs, which would be covered in detail at Executive-level; **TA**

(c) were advised that QAC would receive a quarterly safeguarding report on any serious case reviews, in addition to the Safeguarding Annual Report; **TA/DCN**

(d) were advised that the quarterly end of life care updates would be provided through the End Of Life Care Committee rather than through PIPEEAC, and

(e) agreed the need to include the quarterly triangulated report re: patient experience. **CN**

<u>Resolved</u> – that (A) noting the need to focus on outputs rather than inputs, the draft QAC work programme be updated as per points (a) – (e) above and Minute 78/1/43 below; **DCQ/TA/ EDs**

(B) once updated as outlined above, a detailed month-by-month QAC work programme be developed as per the EQB work programme format; **DCQ/TA**

(C) the October 2014 QAC be advised (either verbally or in writing) of proposed reporting route(s) for quality concerns over Interserve performance, and **CN**

(D) the Chief Nurse meet with Mr M Caple, Patient Adviser, to discuss concerns raised with him re: Interserve performance. **CN/PA**

77/14 SAFETY

77/14/1 Update on Puerperal Sepsis

The Clinical Director, Women's and Children's Clinical Management Group (CMG) attended for this item and tabled a brief update as provided to the September 2014 Clinical Quality and Review Group. Actions 1c(iii), 1d and 1e of the action plan remained outstanding, although implementation of the clinical review process at the LGH had resulted in significant improvements to puerperal sepsis rates. Work was now underway to implement the flowchart process consistently at the LRI very shortly, and the proposed benchmarking would then take place thereafter. An audit was planned for early 2015 (action 1e). The Clinical Director Women's and Children's CMG was confident that the planned improvement processes were appropriate to prevent a CQC re-alert. In discussion on the update, QAC members:-

(a) noted varying views on whether the flowchart process was easy to follow – the Clinical Director Women's and Children's CMG advised that its working would be reviewed at an appropriate time. Positive feedback had been received from coding staff however;

(b) noted comments from the Chief Nurse and Quality Officer, East Leicestershire CCG that this further update was helpful, as it had not been reported at the CQRG meeting. She emphasised the need for improvements to be sustainable, however, and

(c) agreed to receive a further update on the planned audit, at the 25 March 2015 QAC. **CD WCCMG**

Resolved – that an update on the puerperal sepsis action plan (including the audit) be provided to the 25 March 2015 QAC. **CD WCCMG**

77/14/2 Renal Transplant Action Plan Update

The Medical Director provided a verbal update on this issue, noting that Professor C Rudge would be invited to re-review the position of UHL's renal transplant service later in 2014 – a written update could then be provided to the January 2015 QAC following that re-visit. It was noted that any specific service concerns arising in the interim period would be reported to QAC by exception. **MD** **MD**

Resolved – that (A) Professor C Rudge be invited to provide a written update to (and attend) the 28 January 2015 QAC, following his re-visit to the renal transplant unit, and **MD**

(B) any additional concerns over the service (prior to the revisit) be escalated to QAC as appropriate. **MD**

77/14/3 Outpatient Follow-Up – Monthly Update

The action plan arising from this investigation had now been finalised and would be circulated to QAC members for information. In response to a query from the QAC Chair, the Medical Director advised that the actions had a variety of timescales attached, with some already having been completed and some scheduled for mid-2015. **TA**

Resolved – that the outpatient follow-up action plan be circulated to QAC members for information. **TA**

77/14/4 Patient Safety Report and Patient Safety Annual Report 2013-14

The monthly patient safety report at paper C had also been considered at the 9 September 2014 EQB, where a robust discussion had taken place re: medical workforce

issues (covering both senior and junior grades and reflecting a wider national picture). Work was now underway on specialty-level assessments of medical staffing levels, for appropriate interlinking with UHL's overarching medical workforce strategy. The Medical Director and the Chief Nurse advised that the position locally was exacerbated by the East Midlands being perceived as a less attractive place for staff to work (not limited only to medical staff). The QAC Chair advised that she would highlight this issue to the September 2014 Trust Board. In further discussion on paper C, the Director of Safety and Risk drew QAC members' attention to the following issues:- **QAC CHAIR**

(a) work by the Regional Patient Safety Collaboratives on a potential safety/ management clinical fellowship post, to attract doctors to the East Midlands;
(b) the end of November 2014 timescale for Sir Robert Francis QC to report on his 'Freedom to Speak Up' review to the Secretary of State for Health;
(c) the intention to open up UHL's 3636 staff concerns reporting helpline to medical students as of 1 October 2014. The Chief Nurse queried whether this helpline was currently open to other types of student within UHL;
(d) her plans to include a further 'doughnut' diagram in the October 2014 iteration of the report, showing comparative numbers of patient safety incidents;
(e) the welcome improvement in central alerting system broadcasts performance for August 2014, due primarily to the efforts of CMGs. In response to a query, the Director of Safety and Risk considered that this improvement was sustainable provided that the overall number of CAS alerts being issued did not itself rise significantly;
(f) the 6 serious untoward incidents in August 2014 (learning from which was being shared with staff), and
(g) the valuable lessons emerging through the 'Learning from Experience Group'.

With regard to the 2013-14 Patient Safety Annual Report (paper C1), the Director of Safety and Risk noted work underway to produce a more user-friendly, outward-facing 4-page summary to include benchmarking information and more explanation of the figures. The format of the full report reflected quality schedule requirements but was not particularly user-friendly. A similar summary was also being developed for the Complaints Annual Report 2013-14 (Minute 79/14/2 below refers). Development of such summaries for patients and the public was supported by Mr M Caple, Patient Adviser. In discussion on the 2013-14 Patient Safety Annual Report, QAC members:- **DSR**

(i) noted comments from the Patient Adviser on the number of Interserve issues raised via the Executive Patient Safety Walkabouts. It was noted, however, that the period covered by the report had ended in March 2014, and that Interserve performance complaints had declined since that time;

(ii) noted that 10% patient safety incidents per admission was the national average, and

(iii) requested that all dates be reviewed to ensure they related to the 2013-14 year. **DSR**

<u>Resolved</u> – that (A) medical workforce issues be highlighted verbally to the 24 September 2014 Trust Board; **QAC CHAIR**

(B) a brief outward-facing summary of the 2013-14 Patient Safety Annual Report be produced, for public access and information (to include bench-marking information etc), and **DSR**

(C) subject to ensuring that all dates referred to 2013-14, the Patient Safety Annual Report 2013-14 be approved. **DSR**

77/14/5 <u>Report from the Director of Safety and Risk</u>

<u>Resolved</u> – that this Minute be classed as confidential and reported in private accordingly.

77/14/6 Leicester Innovation and Improvement Patient Safety Unit (LIIPS)

Paper D from the Medical Director advised QAC of a new local NHS-academia collaborative initiative in the shape of the Leicester Innovation and Improvement Patient Safety Unit (LIIPS). Work was at a relatively embryonic stage, with governance issues being discussed further on 29 September 2014. LIIPS had received a 'soft launch' to date, with a pilot year planned from September 2014 followed by full launch of the Unit (subject to a successful pilot) in September 2015. In response to a query from Professor D Wynford-Thomas, Non-Executive Director re: rolling-out LIIPS to other non-Leicester stakeholders, the Medical Director advised that this would be discussed further on 29 September 2014 although it was likely that LIIPS would cover LLR only (in the first instance). The QAC Chair noted her support for the LIIPS initiative, and queried how to ensure that learning was appropriately shared between the partners. She also requested that a further 6-month update on LIIPS be provided to UHL's Trust Board in 6 months' time (noting that the Trust Board would be advised of LIIPs' establishment at its meeting on 25 September 2014). **MD**

Resolved – that (A) the LIIPS initiative be supported by QAC, and

(B) an update on LIIPS progress be provided to the UHL Trust Board in March/ April 2015. **MD**

77/14/7 Report from the Director of Safety and Risk

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

78/14 QUALITY

78/14/1 Stroke and TIA Report

Mr A Palmer, Senior Service Manager Stroke and Dr R Marsh, Head of Service Stroke attended for this item, introducing paper F (deferred from the August 2014 QAC). The report outlined the continued progress in meeting the 90% stroke unit stay target for stroke patients, including introduction of a more robust ringfenced stroke beds policy and additional specialist nurses in ED. The service was confident of achieving the target for August 2014 (subject to data validation), and noted that all specialist nurses were now in post. A new Consultant had also been recruited to work within the TIA clinic (to ensure that the stroke target improvements were not achieved at the expense of lower-risk patients) and the running of that clinic had been reviewed to increase the number of patients seen each day. Any slippage on the action plan was due primarily to recruitment issues, although it was still considered that movement towards a 7-day service was realistic. In discussion on paper F, QAC members:-

(a) noted that although vey few patients were incorrectly coded, the small number of patients overall meant that any miscoding had a significant impact. Coding was an issue which was being reviewed;
(b) welcomed the sensible and pragmatic approach to Consultant jobplanning within the service;
(c) noted moves to expand the early supported discharge team, to enable UHL also to take county patients – however, the Head of Service Stroke noted the difficulties presented by cuts to external Social and Reablement Services in terms of the care packages able to be offered to the most disabled patients within the early supported care service. QAC discussed the best route for raising this concern within the LLR community – noting that good links were currently in place with Leicester City Social Services the Chief Nurse and Quality Officer, East Leicestershire CCG agreed to advise the Stroke Service outside the meeting of similar links to Leicestershire County Social Services; **CNQO ELCCG**
(d) noted (in response to a Patient Adviser query) the steps taken to enhance

patient involvement in the redesign of the stroke and TIA services, including moves to include a patient representative on the LLR Stroke Group;

(e) noted (in response to a query) that the 2 ringfenced stroke beds were usually adequate for demand, despite winter peaks in stroke activity. The Chief Executive asked the service to notify him direct of any slippage in the observance of that ringfencing; **SSM/ HoS Stroke**

(f) noted that the action re: increased SALT provision was being pursued through the contracting meetings and development of an appropriate SLA (SALT being an LPT-provided service), and

(g) noted recent increases in the level of therapy provision (action F2 of the report) – therapies were managed by a different CMG however, and dialogue therefore continued between the Emergency and Specialist Medicine and the Clinical Support and Imaging CMGs.

Resolved – that (A) the Chief Nurse and Quality Officer, East Leicestershire CCG, advise the Head of Service, Stroke, of appropriate contacts to pursue with Leicestershire County Social Services, and **CNQO ELCCG**

(B) the Head of Service and the Senior Service Manager, Stroke, advise the Chief Executive of any slippage on the availability of the ringfenced stroke beds. **SSM/ HoS Stroke**

78/14/2 CQC Action Plan Update (Compliance Actions)

The monthly update at paper G outlined progress against the compliance actions detailed in the CQC action plan. The Chief Nurse drew members' particular attention to action 7c re: recovery of paediatric patients post-dental extraction; although the CMG was working on a remedial plan this issue was unlikely to be resolved in line with the September 2014 timeline, and the CQC had been made aware accordingly. The Chief Nurse and Quality Officer, East Leicestershire CCG noted that this issue had been discussed at the most recent CQRG meeting, and she requested details of any other services involved – the Chief Nurse agreed to brief her accordingly and share the final report once available. In further consideration of paper G, the Chief Nurse also noted the beneficial involvement of the new Resuscitation Committee Chairs in moving action 1a forward. **CN**

It was agreed that the monthly CQC action plan to the October 2014 QAC would include further detail on the issues within actions 1a and 7c above (October 2014 EQB reports could be used for this purpose, where appropriate). **CN/DCQ**

Resolved – that (A) the Chief Nurse brief the Chief Nurse and Quality Officer, East Leicestershire CCG on paediatric dental service issues, and share the final report as appropriate, and **CN**

(B) further detail on the issues re: in actions 1a and 7c of the CQC action plan be included in the next monthly update to the October 2014 QAC. **CN/DCQ**

78/14/3 Quality Commitment Key Performance Indicators (KPIs)

Paper H outlined KPIs for UHL's Quality Commitment, as also discussed at the September 2014 EQB. The Committee Chair requested that a review of the working of UHL's Quality Commitment as a whole be factored in to the QAC annual work programme (Minute 76/14 above refers). **DCQ/TA**

Resolved – that a 2015 review of the working of UHL's Quality Commitment be included in the QAC annual work programme. **DCQ/TA**

78/14/4 Month 5 Quality and Performance Report

The Chief Nurse drew members' attention to quality issues within the month 5 quality

and performance report at paper I, noting that stroke/TIA issues had been covered in Minute 78/1/41 above and that further detail on fractured neck of femur performance was already scheduled to be presented to the October 2014 QAC. The Chief Nurse also voiced her disappointment that UHL's first MRSA case in 12 months had just occurred – a review of the circumstances was now underway. In further discussion on paper I, the Medical Director noted significant positive progress on UHL's SHMI and HSMR mortality rates, which would be highlighted to the Trust Board on 24 September 2014. **MD/QAC Chair**

The QAC Chair voiced concern over the continued performance issues in relation to cancer targets (exception report appended to paper I), and queried the extent of any clinical impact/risk (noting that the operational performance aspects were under review by UHL's Finance and Performance Committee). Although recognising the potential psychological impact on patients, the Medical Director provided assurance that any clinical risk was being appropriately managed. The cancer specialties' performance recovery plans had also been reviewed by the 23 September 2014 Executive Performance Board. The Chief Nurse and Quality Officer ELCCG also confirmed plans to convene a 'clinical problem solving working group' in the next few weeks to review this issue. The QAC Chair noted the November 2014 timescale for compliance with the 62-day target and requested a deeper dive into this issue if that timeline slipped further. **MD**

The Chief Nurse sought QAC views on whether the lead clinicians for any monthly quality and performance exception reports should be invited to attend QAC and present their remedial plans – in response, the QAC Chair suggested it would be helpful for the cancer leads to attend in October 2014 and brief the Committee further on the planned cancer actions.***

****** post-meeting note – it was subsequently agreed that the Cancer lead (Mr M Metcalfe) would attend the October 2014 Trust Board to present on both the quality and operational performance aspects of the cancer targets, rather than presenting them separately to the October 2014 QAC and Finance and Performance Committee.***

Resolved – that the month 5 quality and performance report be noted;

(B) progress on UHL's SHMI and HSMR be highlighted to the 24 September 2014 Trust Board; **MD/QAC CHAIR**

(C) a deeper dive be undertaken if the November 2014 compliance deadline for the cancer 62-day target slipped further, and **MD**

(D) it be noted that Mr M Metcalfe, CHUGGS CMG, would present both the quality and operational performance aspects of the cancer target under-performance to the October 2014 Trust Board rather than (separately) than to the October 2014 QAC and Finance and Performance Committees.

78/14/5 Nursing Workforce Report

Paper J detailed the latest position in respect of UHL's nursing workforce and the measures being taken to mitigate risks where possible. Real-time staffing issues had improved, and previous issues over safety statements being completed had been resolved. Agency use continued to reduce, and an additional 45 international nurses had recently arrived at UHL. However, the vacancy position continued to be affected by turnover issues. Further detail was still awaited on national RAG ratings as part of the 'Hard Truths' reporting framework now required of Trusts – this issue had also been discussed by the CQRG and it was reiterated that the information reflected only the fill-rate against Trusts' initial nurse staffing plans rather than being a judgement on the appropriateness (or otherwise) of those plans. The QAC Chair noted the need to involve UHL's Director of Marketing and Communications in the appropriate communication of those national RAGs and benchmarking (once finalised), and commented that she **CN/DMC** **QAC**

would highlight this issue to the September 2014 Trust Board accordingly. In further discussion, the Chief Nurse noted that the nurse:bed ratio information previously requested was not attached to paper J – this would be circulated outside the meeting on this occasion and attached to all future reports on this issue. **Chair** **CN**

Resolved – that (A) the Director of Marketing and Communications be consulted re: appropriate communication of the nursing workforce indicators, once national benchmarking/RAG ratings were available; **CN/DMC**

(B) the communication issue above be flagged to the September 2014 Trust Board, and **QAC CHAIR**

(C) information on the nurse:bed ratio be appended to each monthly nursing workforce report to QAC. **CN**

79/14 PATIENT EXPERIENCE

79/14/1 Complaints Process Review and Engagement Event

Paper K summarised the attendance at, and outcomes from, a complaints engagement event held in June 2014, noting that this would also be discussed at the September 2014 Trust Board. 60 members of the public/stakeholder groups/UHL staff had attended, and Mr M Caple, Patient Adviser commented favourably on the inclusive style of the event. Mr Caple would also be attending the September 2014 Trust Board to present this report, and to communicate the view that some form of subsequent external review by patient representative(s) of (anonymised) complaint files would be useful, to gain assurance that Trust investigations and responses were appropriately patient-centred. He acknowledged the need for any such review panel to be appropriately populated, with a need for careful training and a clear purpose – the findings of such a panel could then be reported back to the Trust via (eg) QAC. In response to a Commissioner query, the Director of Safety and Risk advised that patients would be advised in their final complaint response from UHL that their complaint might be subject to subsequent review by an external panel and offering them the opportunity to opt-out of that process if they so wished. The QAC Chair suggested that it would be helpful to seek a view on the overall review process from Internal Audit, and both the Chief Nurse and Mr M Caple Patient Adviser supported the involvement of a UHL Non-Executive Director in the review process (even if only in an observer role).

The Patient Adviser then also outlined 2 further key themes emerging from the complaints engagement event, namely (i) the need for a culture change towards a more 'can do' approach, and (ii) the need for appropriate resourcing of Trust teams to manage any new approach to complaints. In response to a query from the QAC Chair, the Director of Safety and Risk advised that feedback on the event would be provided electronically to attendees. The QAC Chair also queried how to ensure that UHL's complaints process was appropriately accessible to traditionally hard-to-reach sectors of the community – the Chief Nurse agreed that this had been omitted from the action plan, which would be updated accordingly (noting that potential 'clinic' events in the community were being considered, although resourcing of such events would be a challenge). Via discussion at UHL's PIPEEAC, appropriate input would also be sought from UHL's Service Equality Manager on how best to engage with hard to reach groups. **DSR** **DCN**

Resolved – that (A) the issue of access to the process for lodging complaints /concerns, be added to the action plan, and **DSR**

(B) community links/wider access issues be discussed at the PIPEEAC, with appropriate input from UHL's Service Equality Manager. **DCN**

79/14/2 Complaints Annual Report 2013-14

Paper K1 provided an overview of complaints activity and performance for 2013-14 – as noted in Minute 77/14/4 above it was also planned to produce a more user-friendly, outward-facing summary for patients and the public. Activity had risen by 30% across all sectors covered by UHL's Patient Information and Liaison Service (PILS), with GP concerns constituting a particularly significant increase – these contacts were currently managed in the same way as complaints and would have a marked impact on resources if the numbers continued to rise in this way. In discussion, the Chief Nurse and Quality Officer ELCCG outlined CCGs' approach to GP concerns, which had changed following the mid-Staffs review and reflected the need for Trusts to be appropriately organisationally-sighted to such concerns. QAC members agreed that further Executive-level discussion was needed on the most appropriate internal process to resolve GP concerns. **DSR** **CN/MD/ EDs**

Waiting times and cancellations continued to be a key source of patient complaints, and the Director of Safety and Risk noted the significant CMG effort being put into resolving complaints. She also confirmed that QAC would receive a quarterly complaints performance report from November 2014 onwards, as per the QAC work programme. It was also reiterated that only a very small percentage of all the patients treated by UHL went on to make a complaint. **DSR**

Resolved – that (A) the Complaints Annual Report 2013-14 be endorsed, noting the intention to produce a brief, outward-facing summary for public access and information; **DSR**

(B) Executive-level discussion take place re: the most appropriate process for handling GP concerns, and **CN/MD/ EDs**

(C) a quarterly complaints report be submitted to QAC from November 2014 **DSR**

80/14 ITEMS FOR THE ATTENTION OF QAC FROM EQB

80/14/1 EQB Meeting of 9 September 2014 – Items for the attention of QAC

Reporting verbally, the Chief Nurse highlighted the following issues for the attention of QAC from the September 2014 EQB meeting:-

- the work of the Frail Older People's Strategy Board, which would hold its second meeting in September 2014 (remit and membership as per paper L);
- a CQC pilot inspection of mental health crisis review services, taking place on 24-26 September 2014 – a verbal update on this inspection would be provided to the October 2014 QAC via the matters arising report. **DCQ**

Resolved – that verbal feedback from the CQC pilot inspection of mental health crisis review services be provided to the 29 October 2014 QAC (under matters arising). **DCQ**

81/14 MINUTES FOR INFORMATION

81/14/1 Finance and Performance Committee

Resolved – that the public Minutes of the 27 August 2014 Finance and Performance Committee be received and noted.

81/14/2 Executive Performance Board

Resolved – that the action notes of the 26 August 2014 Executive Performance Board be received and noted.

82/14 ANY OTHER BUSINESS

82/14/1 Report from the Chief Nurse

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

82/14/2 Nutrition Forum

In response to a query from the QAC Chair, the Chief Nurse outlined the reporting line for the Nutrition Forum – as nutrition was now covered by the Quality Commitment the Nursing Executive Team received a monthly update accordingly. The Chief Nurse agreed to circulate those reports to the QAC Chair for information (this issue would be included on the October 2014 QAC agenda, pressure of other business permitting). **CN**

Resolved – that the NET reports on nutrition be circulated to the QAC Chair for information, and included on the October 2014 QAC agenda for information (pressure of business allowing). **CN**

83/14 IDENTIFICATION OF ANY KEY ISSUES FOR THE ATTENTION OF THE TRUST BOARD

Resolved – that the QAC Chair be requested to bring the following issues to the attention of the Trust Board at its meeting the following day: **QAC CHAIR**

- **medical workforce issues (Minute 77/14/4)**
- **positive progress on stroke/TIA performance (Minute 78/14/1);**
- **fractured neck of femur performance and the intention to receive a further report at the November 2014 QAC (Minute 78/14/4);**
- **progress on UHL's SHMI and HSMR (Minute 78/14/4), and**
- **communication re: national benchmarking/RAG ratings for nurse staffing reports (Minute 78/14/5).**

84/14 DATE OF NEXT MEETING

Resolved – that the next meeting of the Quality Assurance Committee be held on Wednesday 29 October 2014 from 12.30pm until 3.30pm in Seminar Rooms A & B, Clinical Education Centre, Leicester General Hospital.

The meeting closed at 3.24pm.

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

Name	*Possible*	*Actual*	*% attendance*	*Name*	*Possible*	*Actual*	*% attendance*
J Adler	6	5	83	*R Overfield*	6	5	83
*M Caple**	6	4	67	*P Panchal*	6	3	50
S Dauncey	6	5	83	*J Wilson (Chair)*	6	5	83
K Harris	6	5	83	*D Wynford-Thomas*	6	3	50
K Jenkins	1	0	0				
*C O'Brien – East Leicestershire/Rutland CCG**	6	4	67				

** non-voting members*

Helen Stokes – **Senior Trust Administrator**

University Hospitals of Leicester NHS
NHS Trust

Agenda Item: Trust Board paper O

TRUST BOARD MEETING – 30TH OCTOBER 2014

2014/15 FINANCIAL POSITION (MONTH 6)

DIRECTOR:	Simon Sheppard – Acting Director of Finance and Procurement
AUTHOR:	Simon Sheppard – Acting Director of Finance and Procurement
DATE:	30th October 2014
PURPOSE:	This paper provides the Trust Board with an update on performance against the key financial duties: • Delivery against the planned deficit • Achieving the External Financing Limit (EFL) • Achieving the Capital Resource Limit (CRL) The paper also provides further commentary on the key risks
PREVIOUSLY CONSIDERED BY:	Not applicable
Objective(s) to which issue relates *	☐ 1. Safe, high quality, patient-centred healthcare ☐ 2. An effective, joined up emergency care system ☐ 3. Responsive services which people choose to use (secondary, specialised and tertiary care) ☐ 4. Integrated care in partnership with others (secondary, specialised and tertiary care) ☐ 5. Enhanced reputation in research, innovation and clinical education ☐ 6. Delivering services through a caring, professional, passionate and valued workforce ☑ 7. A clinically and financially sustainable NHS Foundation Trust ☐ 8. Enabled by excellent IM&T
Please explain any Patient and Public Involvement actions taken or to be taken in relation to this matter:	Considered but not relevant to this paper
Please explain the results of any Equality Impact assessment undertaken in relation to this matter:	Considered but not relevant to this paper
Organisational Risk Register/ Board Assurance Framework *	☑ **Organisational Risk Register** ☑ **Board Assurance Framework** ☐ **Not Featured**
ACTION REQUIRED *	For decision ☐ For assurance ☑ For information ☐

♦ We treat people how we would like to be treated ♦ We do what we say we are going to do
♦ We focus on what matters most ♦ We are one team and we are best when we work together
♦ We are passionate and creative in our work

* tick applicable box

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **30TH OCTOBER 2014**

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

SUBJECT: **2014/15 FINANCIAL POSITION TO MONTH 6**

1. INTRODUCTION AND CONTEXT

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

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

1.2. The paper provides further commentary on financial performance by the CMGs and Corporate Directorates, risk and assumptions and makes recommendations for the relevant Directors.

1.3 The paper also provides detail on the forecast outturn for 2014/15 including risk and opportunities.

2. KEY FINANCIAL DUTIES

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

Financial Duty	YTD Plan £'Ms	YTD Actual £'Ms	RAG	Forecast Plan £'Ms	Forecast Actual £'Ms	RAG
Delivering the Planned Deficit	(18.2)	(19.6)	R	(40.7)	(40.6)	G
Achieving the EFL	39.6	19.5	G	62.1	51.3	G
Achieving the Capital Resource Limit	22.5	11.1	A	46.2	46.2	G

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

Better Payment Practice Code	April - Sept YTD 2014	
	Number	Value £000s
Total bills paid in the year	73,548	332,438
Total bills paid within target	38,594	230,282
Percentage of bills paid within target	**52%**	**69%**

Key issues

- In month positive movement to plan of £0.3m, with a year to date deficit to plan of £1.4m. The in month positive movement is as a result of agreement on Operational Resilience funding for RTT. Of the £2.9m agreed, £0.7m has been shown in the year to date position, offsetting premium costs incurred
- The in month position was £1.5m better than forecast
- Year end forecast of £40.7m can be delivered. CMGs and Directorates must deliver on their forecasts
- CIP programme has identified £48.1m of plans against the £45m target. Development of plans for 2015/16 has begun

3. FINANCIAL POSITION (MONTH 6)

3.1. The Month 6 results may be summarised as follows and as detailed in Appendix 1:

	September 2014			April - September 2014		
	Plan £m	Actual £m	Var (Adv) / Fav £m	Plan £m	Actual £m	Var (Adv) / £m
Income						
Patient income	59.1	59.5	0.4	349.5	346.7	(2.8)
Teaching, R&D	6.5	6.5	0.0	40.8	40.5	(0.3)
Other operating Income	2.9	3.2	0.3	18.5	19.2	0.7
Total Income	**68.5**	**69.2**	**0.7**	**408.8**	**406.4**	**(2.4)**
Operating expenditure						
Pay	41.2	40.8	0.5	246.4	243.4	3.0
Non-pay	25.5	26.5	(1.0)	157.9	159.9	(2.0)
Total Operating Expenditure	**66.7**	**67.2**	**(0.5)**	**404.3**	**403.3**	**1.0**
EBITDA	**1.8**	**2.0**	**0.2**	**4.5**	**3.1**	**(1.4)**
Net interest	0.0	0.0	0.0	0.0	0.0	0.0
Depreciation	(2.9)	(2.9)	-	(17.6)	(17.6)	0.0
PDC dividend payable	(0.9)	(0.8)	0.0	(5.2)	(5.2)	0.0
Net deficit	**(2.0)**	**(1.8)**	**0.3**	**(18.2)**	**(19.6)**	**(1.4)**
EBITDA %		**2.9%**			**0.8%**	

3.2 In the month of September, the Trust delivered a deficit of £1.76m against a planned deficit of £2.04m, an adverse variance of £0.28m.

3.3 Year to date, the deficit at the end of September is £19.6m, £1.4m worse than the £18.2m planned deficit.

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

Income

Income is £0.4m favourable to plan in month and other income £0.3m favourable to plan. YTD income is £2.4m adverse to plan:

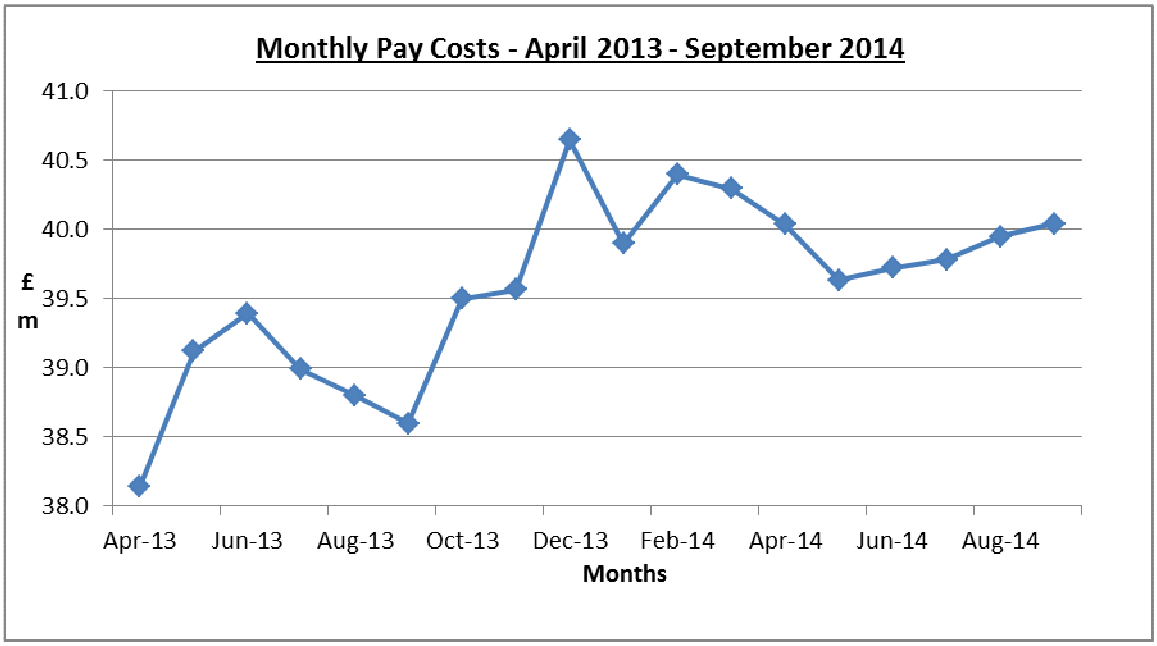
- Operational Resilience Funding for RTT of £0.7m YTD reflected in the position in month, following agreement of £2.9m in total

- Daycase and elective IP activity is £0.6m below plan in month, entirely within MSK. YTD activity is £2.3m below plan, of which £1.9m is within the 4 specialties invested in to deliver RTT; General Surgery, Ophthalmology, ENT and Orthopaedics
- Outpatients are £0.1m below plan in month, all within ESM. YTD outpatients are £0.1m below plan with MSK £0.4m below plan
- Critical Care activity is £0.1m better than plan in month following increased activity in ITAPS. YTD critical care is £0.7m below plan, £1.1m below in W&C, £0.6m below in ITAPS offset with £0.8m above in ESM
- Penalties are £0.7m better than plan in month due to the national waiving of RTT penalties for July, August and September. Penalties YTD are £2.4m worse than plan
- Continuing ED over-performance of £0.2m in month and £0.8m YTD. Activity is 7% above plan
- Emergency inpatients, including MRET deduction was £0.1m below plan in month, but 450 cases over plan. YTD emergency performance is £0.5m above plan and 2,089 cases in activity above plan
- End Stage Renal Failure, £0.1m below plan in month and £0.9m YTD
- Research income was £424k better than plan in month as a result of alignment of budgets between income and non pay, making the year to date position a more accurate reflection of plans

Further detail on income can be seen in Appendix 2.

Pay

- Pay costs are £0.5m under plan in September and £3.0m under plan year to date
    - Pay costs climbed again in September in particular in Research (offset with income), medical staffing and other clinical staffing. Chart 1 below shows the pay cost trend, after excluding the impact of the Alliance Contract and the 2014/15 pay award
    - Premium pay has reduced slightly compared to Month 5 and is a total of 9% of the total pay bill



Non Pay

- Non pay costs are £159.9m against a budget of £157.9m year to date, resulting in a £1m adverse position

- In month, £0.5m represents a realignment of budget between non pay and income within Research, which better shows the year to date position
- In month clinical supplies and services were £305k overspent of which £200k was a payment to Accenture for work done on the Prosthesis contract in MSK. This will show savings in future months. In addition, there were £100k of costs associated with international nurse recruitment
- Year to date, the overspend in non pay is due to clinical supplies and services, £0.6m, independent sector use, £0.3m, printing and stationery, £0.3m, postage £0.1m, consultancy £0.3m, nurse recruitment costs £0.2m

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

Cost Improvement Programme

Appendix 3 shows CIP performance in September by CMG and Corporate Directorate against the 2014/15 CIP plan. This currently shows an over delivery against the YTD target of £1.1m.

The year end forecast reflects identified schemes of £48.1m against a target of £45m. Planning has now begun for identification of 2015/16 schemes with an indicative target of £41m.

4. FORECAST OUTTURN

4.1 All areas have reforecast at Month 6. The table below details the forecast outturn delivering in line with the planned deficit:

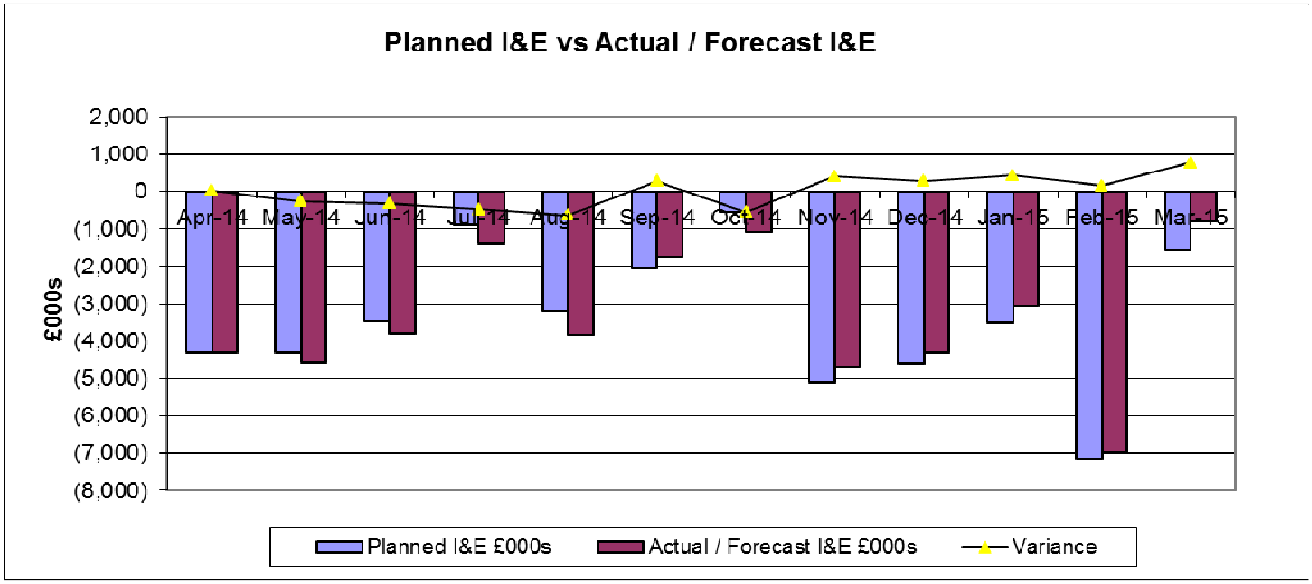
	Year End Forecast		
	Plan £m	Forecast £m	Var (Adv) / £m
Income			
Patient income	700.9	703.3	2.4
Teaching, R&D	81.4	81.0	(0.4)
Other operating Income	37.6	38.3	0.7
Total Income	**819.9**	**822.6**	**2.7**
Operating expenditure			
Pay	499.4	496.4	3.0
Non-pay	315.8	321.4	(5.6)
Total Operating Expenditure	**815.2**	**817.8**	**(2.6)**
EBITDA	**4.7**	**4.9**	**0.1**
Net interest	0.1	0.1	0.0
Depreciation	(35.1)	(35.1)	(0.0)
PDC dividend payable	(10.4)	(10.4)	0.0
Net deficit	**(40.7)**	**(40.6)**	**0.1**
EBITDA %		**0.6%**	

4.2 The assumptions included in the year end forecast are as follows:

- No inclusion of stretch targets above those submitted by CMGs and within the £48.4m
- Ambulance penalties reinvestment of £1m

- Challenge to income from CCGs in ESM is unsuccessful - £1m
- Improved Corporate forecasts by £1.2m as these are overly prudent. Corporate Directorates have already committed to £0.9m of this
- Commit to a release of reserve contingency of £1m to support the position, making it unavailable for commitment elsewhere
- Receipt of operational resilience funding of £3m for winter
- Receipt of operational resilience funding of £2.9m for RTT
- Assume costs of £1.8m not already in the plan for delivery of RTT and winter

4.3 It can be seen that key to meeting the forecast is the delivery of CMG and Directorate positions. Chart 3 below shows the planned and actual/forecast deficit for each month. The forecast shows that each month will deliver a position better than forecast going from November onwards.



5. RISKS

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

- **Delivery of the forecast outturn position** has reduced in risk compared to last month given the agreement around operational resilience funding, however CMGs and Directorates must deliver on their forecast positions

  Mitigation: Regular performance meetings with CMGs to monitor performance against plan and forecast

- **Capacity requirements** for theatres and beds beyond the levels planned resulting in premium costs not forecasted or planned for

  Mitigation: The Trust is planning to open an additional 15 beds for which capital and revenue costs are within the financial plan. Work is ongoing on a theatres capacity plan

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

  The CCG contract has been signed with a penalty cap of £10m. In addition, CCGs have raised Activity Query Notices around emergency admissions and outpatients, as well as Letters of Enquiry regarding Critical Care activity and Imaging activity

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

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

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

  Mitigation: RTT plan performance managed through fortnightly meeting with CCG/NTDA and IST to review robustness of the plan. The independent sector is being used to support delivery and additional weekend theatre sessions in General Surgery. These costs are included in the forecast

- **CIP Delivery**

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

  Mitigation: External consultancy support from Ernst & Young, along with revised CIP governance arrangements, a weekly CIP Board and CMG Performance Management meetings. £48m has been identified for 2014/15 and the programme for development of plans for £41m for 2015/16 is in place

- **Liquidity**

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

  Mitigation: Application and successful receipt of Temporary Borrowing. £15.5m received in April and a further £13.5m in June. Further application has been made for long term borrowing for discussion by the Independent Trust Financing Facility. A verbal update will be given to the Executive Performance Board

- **Unforeseen Events**

  The Trust has very little flexibility and a minimal contingency, with only £1.4m of reserves remaining uncommitted. Unforeseen financial pressures will impact on this

  Mitigation: The Trust is still holding contingency at the end of Month 6 to support unforeseen events

- **Contractual Challenges (Non Patient Care)**

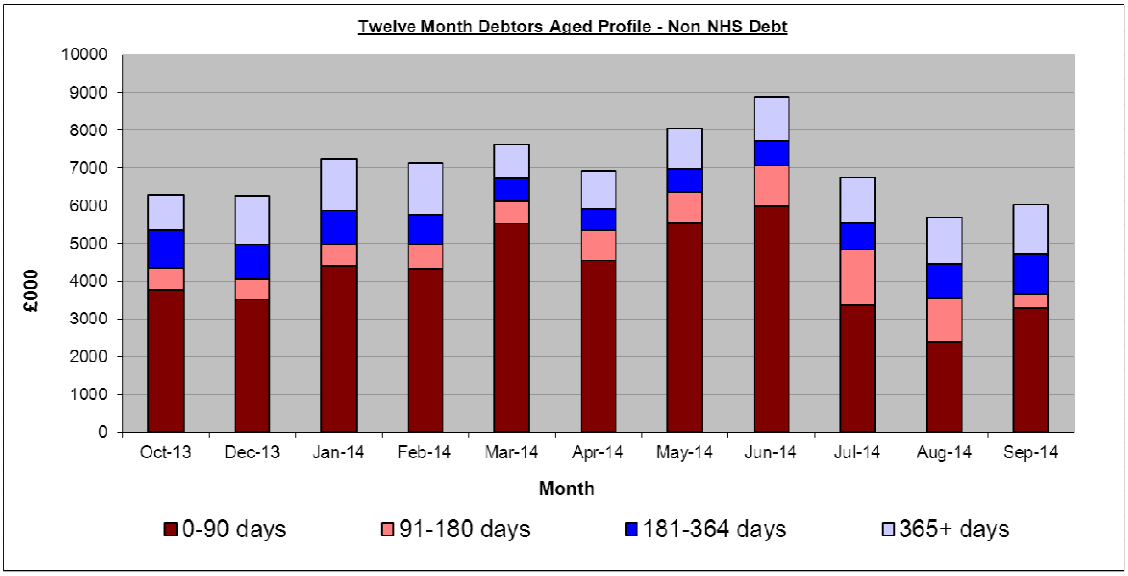
  The Trust is aware of potential contract challenges around the Interserve Contract, particularly relating to the impact of TUPE transfers and catering volumes

  Mitigation: The Trust has reviewed the contract and has further contractual claims to more than negate the counter claims. Further legal advice will be sought to confirm the value and timescales for resolution

6. BALANCE SHEET

6.1. The effect of the Trust's financial position on its balance sheet is provided in Appendix 4. The retained earnings reserve has reduced by the Trust's £19.6m deficit for the year to date.

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



6.3. The overall level of non-NHS debt at the end of September has increased slightly from the previous month from £5.7m to £6.0m. Total debt over 90 days is £2.7m and this has decreased by £0.6m from £3.3m in the previous month.

6.4. The proportion of total debt over 90 days has reduced to 45% from 58% in the prior month and £1.2m of this debt relates to overseas patients where we expect a low recovery rate of approximately 25%. All overseas patient debt over 90 days old is provided for in full within the Trust's bad debt provision.

6.5. The Better Payments Practice Code (BPPC) performance for the end of September YTD, shown in the table below, is an improvement from the prior month in terms of the percentage of invoices paid within 30 days of receipt:

	By Volume Number	By Value £000s
Current Month YTD		
Total bills paid in the year	73,548	332,438
Total bills paid within target	38,594	230,282
Percentage of bills paid within target	**52%**	**69%**
Prior month YTD		
Total bills paid in the year	62,982	275,694
Total bills paid within target	31,098	185,203
Percentage of bills paid within target	**49%**	**67%**

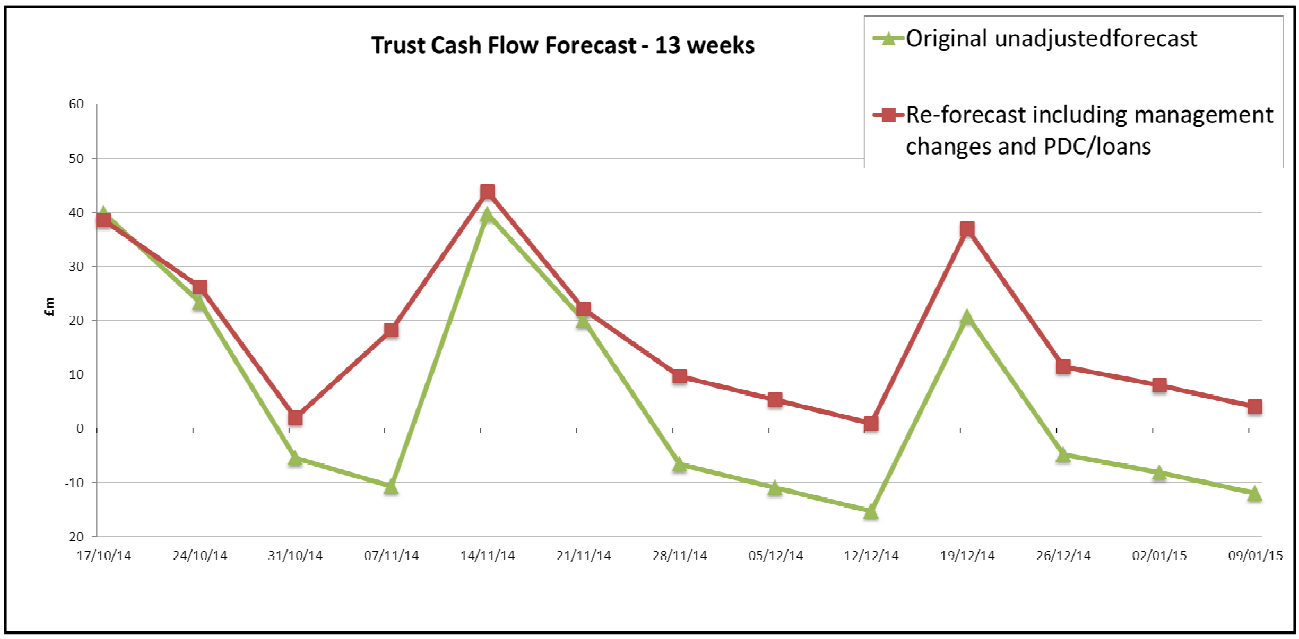
6.6 The Trust is starting to see an improvement in the BPPC performance as more invoices are being paid on, or slightly earlier, than the due date in order to meet the BPPC target. This is possibly due to the cash management measures that have taken place and the receipt of external financing.

7. CASH FLOW FORECAST

7.1. The Trust's cashflow forecast is consistent with the income and expenditure position. Cash has increased by £7.0m from the year end and this is predominantly due to the receipt of £29m of short term Temporary Borrowing Loans (TBLs) from the Department of Health (DoH).

7.2. We have been informally notified that our application for £58m PDC funding has been approved by the DoH and that we will be able to start drawing this down at the end of November. This funding is necessary to cover our £40.7m deficit for 2014/15; to improve our liquidity by £5.3m; and to fund £12m of capital expenditure.

7.3. The Trust's 13 week cash forecast is shown in the graph below and indicates that, without any management actions or external financing, we will be significantly overdrawn in early December and January:



7.4 We will need to draw down £45m of the PDC at the end of November in order to repay the £29m TBLs and to cover an additional £16m cash requirement. This will improve our cash position to a satisfactory level as shown by the re-forecast line in the above graph. We will be able to manage the shortfall at the end of October through internal measures such as managing the value of payment runs.

8. CAPITAL

8.1 The total capital expenditure at the end of September 2014 was £11.2m against the year to date plan of £16.3m, an underspend of £4.1m. The capital plan and expenditure to date can be seen in Appendix 11.

8.2 At the end of September, there were £12.0m of orders outstanding. The combined position is that we have spent or committed £23.2m, or 50% of the annual plan.

8.3 The table below details the capital plan at the start of the year compared to the revised plan at the end of September as well as forecast expenditure. The capital funding has reduced by £4.3m following advice from the NTDA on securing funding via a loan. After a detailed review of schemes, forecast spend has reduced from £55m to £48m. The over-commitment against the capital funding has therefore reduced from £4.1m to £1.7m.

8.4 The capital programme will continue to be monitored by the Capital Monitoring and Investment Committee to ensure delivery of the £46.5m year end funding.

Capital plan and forecast spend

	Original Plan	Revised Plan	Movement
	£000s	£000s	£000s
Capital Resource Limit	34,207	34,207	0
Plus Donations	300	300	0
Plus Anticipated PDC (Loan)	16,322	12,000	(4,322)
TOTAL Funding	**50,829**	**46,507**	**(4,322)**
Forecast Spend	54,932	48,159	6,773
Over Commitment	**(4,103)**	**(1,652)**	**2,451**

9. CONCLUSION

9.1. The Trust, at the end of Month 6, has an adverse position of £1.4m against the planned deficit of £18.2m but is forecasting the delivery of all its financial duties at year end.

10. NEXT STEPS AND RECOMMENDATIONS

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

- **Note** the contents of this report
- **Discuss and agree** the actions required to address the key risks/issues

Simon Sheppard
Acting Director of Finance & Procurement

30th October 2014

Income and Expenditure Account for the Period Ended 30 September 2014

	September 2014			April - September 2014		
	Plan £ 000	Actual £ 000	Variance (Adv) / Fav £ 000	Plan £ 000	Actual £ 000	Variance (Adv) / Fav £ 000
Elective	6,557	6,447	(110)	36,558	**35,719**	(839)
Day Case	5,429	4,988	(441)	30,449	**28,946**	(1,503)
Emergency (incl MRET)	14,420	14,248	(173)	87,474	**86,997**	(477)
Outpatient	8,850	8,621	(230)	52,743	**51,743**	(1,000)
Penalties	(292)	373	665	(1,750)	**(3,149)**	(1,399)
Non NHS Patient Care	468	707	239	2,767	**3,257**	490
Resilience Funding	0	700	700	0	**700**	700
Other	23,703	23,440	(263)	141,244	**142,464**	1,220
Patient Care Income	**59,136**	**59,523**	**387**	**349,485**	**346,677**	**(2,808)**
Teaching, R&D income	6,484	6,510	26	40,785	**40,527**	(258)
Other operating Income	2,881	3,203	322	18,547	**19,198**	651
Total Income	**68,501**	**69,236**	**735**	**408,817**	**406,402**	**(2,415)**
Pay Expenditure	**41,245**	40,784	**461**	**246,431**	**243,413**	**3,018**
Non Pay Expenditure	**25,494**	26,453	**(959)**	**157,858**	**159,882**	**(2,024)**
Total Operating Expenditure	**66,739**	**67,237**	**(498)**	**404,289**	**403,295**	**994**
EBITDA	**1,762**	**1,999**	**237**	**4,528**	**3,107**	**(1,421)**
Interest Receivable	8	6	(2)	48	**43**	(5)
Interest Payable	0	(3)	(3)	0	**(17)**	(17)
Depreciation & Amortisation	(2,932)	(2,932)	0	(17,592)	**(17,585)**	7
Surplus / (Deficit) Before Dividend and Disposal of Fixed Assets	**(1,162)**	**(930)**	**232**	**(13,016)**	**(14,452)**	**(1,436)**
Profit / (Loss) on Disposal of Fixed Assets	(7)	0	7	(7)	**0**	7
Dividend Payable on PDC	(869)	(826)	43	**(5,214)**	**(5,171)**	43
Net Surplus / (Deficit)	**(2,038)**	**(1,756)**	**282**	**(18,237)**	**(19,623)**	**(1,386)**
EBITDA MARGIN		**2.9%**			**0.8%**	

Appendix 2

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

Case mix	Plan to Date (Activity)	Total YTD (Activity)	Variance YTD (Activity)	Variance YTD (Activity %)	Annual Plan (£000)	Plan to Date (£000)	Total YTD (£000)	Variance YTD (£000)	Variance YTD (Activity %)
Day Case	44,942	43,277	(1,665)	(3.71)	60,744	30,449	28,946	(1,503)	(4.94)
Elective Inpatient	11,781	10,981	(800)	(6.79)	74,019	36,558	35,719	(839)	(2.29)
Emergency / Non-elective Inpatient	49,863	51,389	1,526	3.06	181,592	90,724	91,436	712	0.78
Marginal Rate Emergency Threshold (MRET)	0	0	0	0.00	(6,484)	(3,251)	(4,439)	(1,188)	36.56
Outpatient	401,697	398,905	(2,792)	(0.69)	105,398	52,743	51,743	(1,477)	(2.80)
Emergency Department	71,372	76,135	4,763	6.67	15,440	7,741	8,540	799	10.32
Penalties	0	0	0		(3,500)	(1,750)	(3,149)	(1,399)	79.92
Other	4,157,696	4,127,938	(29,758)	(0.72)	268,162	136,270	137,881	2,088	1.53
Grand Total	**4,737,351**	**4,708,625**	**(28,726)**	**(0.61)**	**695,372**	**349,485**	**346,677**	**(2,808)**	**(0.80)**

Average tariff	Price Variance YTD %	Volume Variance YTD %	Price / Mix Variance (£000)	Volume Variance (£000)	Variance YTD (£000)
Day Case	(1.3)	(3.7)	(375)	(1,128)	(1,503)
Elective Inpatient	4.8	(6.8)	1,644	(2,483)	(839)
Emergency / Non-elective Inpatient	(2.2)	3.1	(2,065)	2,777	712
Marginal Rate Emergency Threshold (MRET)			(1,188)	0	(1,188)
Outpatient	(1.2)	(0.7)	(634)	(844)	(1,477)
Emergency Department	3.4	6.7	282	517	799
Penalties			(1,399)		(1,399)
Other			0	2,088	2,088
Grand Total	**(0.2)**	**(0.6)**	**(3,734)**	**926**	**(2,808)**

Appendix 3

Financial Performance by CMG & Corporate Directorate

I&E and CIP - to August 2014

	Year to Date					
	I&E			CIP		
CMG / Directorate	YTD Budget £000s	YTD Actual £000s	Variance £000s	YTD Plan £000s	YTD Actual £000s	Variance £000s
CMGs:						
C.H.U.G.S	19,438	18,878	-560	2,613	2,624	11
Clinical Support & Imaging	-19,715	-19,570	145	2,820	2,753	-67
Emergency & Specialist Med	5,613	6,714	1,101	3,138	3,720	582
I.T.A.P.S	-23,043	-24,302	-1,259	1,882	1,496	-386
Musculo & Specialist Surgery	18,299	15,165	-3,134	2,237	1,984	-254
Renal, Respiratory & Cardiac	14,134	13,165	-969	2,751	3,173	422
Womens & Childrens	19,044	19,071	27	3,202	3,322	120
	33,770	**29,121**	**-4,649**	**18,644**	**19,072**	**428**
Corporate:						
Communications & Ext Relations	-362	-343	20	34	34	0
Corporate & Legal	-1,717	-1,762	-45	43	53	11
Corporate Medical	-1,588	-1,556	32	48	48	0
Facilities	-20,093	-19,185	908	2,201	2,622	421
Finance & Procurement	-3,424	-3,288	136	164	340	176
Human Resources	-2,266	-2,154	112	108	181	73
Im&T	-5,120	-4,858	262	29	36	7
Nursing	-10,629	-10,331	298	180	202	22
Operations	-3,774	-3,966	-192	64	77	13
Strategic Devt	-1,341	-1,153	188	101	101	0
	-50,316	**-48,597**	**1,719**	**2,972**	**3,695**	**723**
Other:						
Alliance Elective Care	-2	-25	-23			
R&D	2	106	104			
Central	-1,692	-229	1,464			
	-1,692	**-148**	**1,544**			
Total	**-18,238**	**-19,623**	**-1,387**	**21,615**	**22,766**	**1,151**

Appendix 4

Balance Sheet

	Mar-14 £000's Actual	Apr-14 £000's Actual	May-14 £000's Actual	Jun-14 £000's Actual	Jul-14 £000's Actual	Aug-14 £000's Actual	Sep-14 £000's Actual	Mar-15 £000's Forecast
Non Current Assets								
Property, plant and equipment	362,465	360,188	359,769	358,289	359,152	359,238	359,534	380,902
Intangible assets	8,019	7,788	7,555	7,338	7,109	6,877	6,636	5,327
Trade and other receivables	3,123	3,311	3,152	3,115	3,002	3,004	3,043	2,503
TOTAL NON CURRENT ASSETS	**373,607**	371,287	370,476	368,742	369,263	369,119	**369,213**	**388,732**
Current Assets								
Inventories	13,937	13,711	14,633	14,627	15,390	14,894	14,579	14,200
Trade and other receivables	53,483	44,492	44,580	51,192	47,903	38,966	32,335	46,932
Cash and cash equivalents	515	13,850	5,838	13,662	14,954	8,430	7,560	277
TOTAL CURRENT ASSETS	**67,935**	72,053	65,051	79,481	78,247	62,290	**54,474**	**61,409**
Current Liabilities								
Trade and other payables	(112,726)	(102,381)	(100,604)	(100,725)	(100,661)	(88,023)	(86,892)	(92,743)
Dividend payable	0	(1,025)	(1,894)	(2,763)	(3,632)	(4,540)	0	0
Borrowings	(6,590)	(6,590)	(6,590)	(6,590)	(6,590)	(6,590)	(2,919)	(2,800)
Provisions for liabilities and charges	(1,585)	(1,585)	(1,585)	(1,585)	(1,585)	(1,585)	(1,585)	(426)
TOTAL CURRENT LIABILITIES	**(120,901)**	(111,581)	(110,673)	(111,663)	(112,468)	(100,738)	**(91,396)**	**(95,969)**
NET CURRENT ASSETS (LIABILITIES)	**(52,966)**	(39,528)	(45,622)	(32,182)	(34,221)	(38,448)	**(36,922)**	**(34,560)**
TOTAL ASSETS LESS CURRENT LIABILITIES	**320,641**	331,759	324,854	336,560	335,042	330,671	**332,291**	**354,172**
Non Current Liabilities								
Borrowings	(5,890)	(5,794)	(5,785)	(5,730)	(5,676)	(5,683)	(9,179)	(9,356)
Provisions for liabilities and charges	(2,070)	(2,048)	(2,022)	(2,006)	(1,830)	(1,207)	(1,171)	(1,873)
TOTAL NON CURRENT LIABILITIES	**(7,960)**	(7,842)	(7,807)	(7,736)	(7,506)	(6,890)	**(10,350)**	**(11,229)**
TOTAL ASSETS EMPLOYED	**312,681**	323,917	317,047	328,824	327,536	323,781	**321,941**	**342,943**
Public dividend capital	282,625	298,125	298,125	311,625	311,625	311,625	311,625	353,602
Revaluation reserve	64,598	64,598	64,598	64,598	64,598	64,598	64,598	64,628
Retained earnings	(34,542)	(38,806)	(45,676)	(47,399)	(48,687)	(52,442)	(54,282)	(75,287)
TOTAL TAXPAYERS EQUITY	**312,681**	323,917	317,047	328,824	327,536	323,781	**321,941**	**342,943**

Capital Plan

September 2014	Annual Budget £'000	Actual Spend £'000	Outstanding Commitments £'000	Total £'000	Variance £'000	Full Year Forecast Outturn £'000	Full Year Forecast Variance £'000	Plan Revisions Change £'000	Plan Revisions Budget £'000
CHUGGS CMG									
Endoscopy GH	309	236	0	236	73	275	34	-34	275
Lithotripter Machine	430	0	430	430	0	430	0		430
Sub-total: CHUGGS CMG	**739**	**236**	**430**	**666**	**73**	**705**	**34**	**-34**	**705**
CSI CMG									
Aseptic Suite	400	294	120	415	(15)	400	0		400
MES Installation Costs	1,302	815	297	1,112	190	1,750	(448)	448	1,750
Sub-total: CSI CMG	**1,702**	**1,109**	**418**	**1,527**	**175**	**2,150**	**(448)**	**448**	**2,150**
Women's and Children's CMG									
Maternity Interim Development	1,000	520	283	804	196	1,000	0		1,000
Bereavement Facilities	62	0	0	0	62	162	(100)	100	162
Life Studies Centre	650	0	0	0	650	650	0	-35	615
Sub-total: Women's & Children	**1,712**	**520**	**283**	**804**	**908**	**1,812**	**(100)**	**65**	**1,777**
Renal, Respiratory & Cardiac CMG									
Renal Home Dialysis Expansion	708	(4)	145	142	566	535	173	-144	564
Sub-total: Renal, Respiratory &	**708**	**(4)**	**145**	**142**	**566**	**535**	**173**	**-144**	**564**
Emergency & Specialist Medicine CMG									
Brain Injury Unit (BIU) Works	47	3	0	3	44	47	0		47
Equipment: 8th Resus Bay	40	18	24	42	(2)	40	0		40
DVT Clinic Air Conditioning	30	14	1	14	16	30	0		30
Sub-total: Emergency & Specia	**117**	**34**	**24**	**59**	**58**	**117**	**0**	**0**	**117**
ITAPS CMG									
da Vinci Robot equipment	103	86	0	86	17	103	0		103
GH Theatre 6 Equipment	177	138	0	138	39	177	0		177
Sub-total: ITAPS CMG	**280**	**224**	**0**	**224**	**56**	**280**	**0**	**0**	**280**
Corporate / Other Schemes									
Stock Management Project	2,212	6	0	6	2,206	6	2,206	-2,212	0
Medical Equipment Executive	3,237	878	506	1,385	1,852	3,237	0		3,237
LiA Schemes	250	7	82	89	161	250	0		250
Odames Library	1,500	129	1,215	1,344	156	1,500	0		1,500
Safecare Module	66	0		0	66	66	0	66	132
Multi-Storey Car Park								247	247
Other Developments	0	267	34	301	(301)	210	(210)	267	267
Donations	300	97	0	97	203	300	0		300
Sub-total: Corporate / Other Sc	**7,565**	**1,384**	**1,837**	**3,221**	**4,344**	**5,569**	**1,996**	**-1,632**	**5,933**
IM&T Schemes									
IM&T Sub Group Budget	2,000	181	287	468	1,532	2,000	0		2,000
Safer Hospitals Technology Fund	1,150	0	0	0	1,150	1,150	0		1,150
EDRM System	3,300	292	93	385	2,915	3,300	0	-700	2,600
EPR Programme	3,100	987	0	987	2,113	3,100	0	-1,484	1,616
LRI Managed Print	412	0	413	413	(0)	412	0		412
Unified Comms	1,850	0	0	0	1,850	1,850	0	-750	1,100
Sub-total: IM&T Schemes	**11,812**	**1,460**	**792**	**2,252**	**9,560**	**11,812**	**0**	**-2,934**	**8,878**
Facilities / NHS Horizons Schemes									
Facilities Backlog Maintenance	5,500	830	404	1,233	4,267	5,500	0		5,500
Accommodation Refurbishment	1,200	10	12	22	1,178	22	1,178	-1,200	0
CHP Units LRI & GH	800	160	4	164	636	1,012	(212)	212	1,012
Sub-total: Facilities / NHS Hori	**7,500**	**1,000**	**419**	**1,419**	**6,081**	**6,534**	**966**	**-988**	**6,512**
Reconfiguration Schemes									
Theatre Recovery LRI	2,785	106	2,649	2,755	30	2,785	0	46	2,831
Interim ITU LRI	590	299	155	454	136	590	0		590
Ward 4 LGH	1,000	749	107	856	144	1,000	0		1,000
Additional Beds (GH & LRI)	2,000	25	62	87	1,913	1,400	600	-600	1,400
Feasibility Studies	100	2	4	6	95	100	0		100
Sub-total: Reconfiguration Sch	**6,475**	**1,181**	**2,976**	**4,158**	**2,317**	**5,875**	**600**	**-554**	**5,921**
Over Commitment against CRL	(4,103)				(4,103)	(1,232)	(2,871)	2,451	-1,652
Total Schemes funded via inte	**34,507**	**7,144**	**7,326**	**14,470**	**20,038**	**34,157**	**350**	**-3,322**	**31,185**
Schemes to be funded via external loans									
ED Enabling Schemes									
Clinic 1 & 2 Works	814	18	10	28	786	814	0		814
Old Cancer Centre Conversion	1,050	453	482	935	115	1,050	0		1,050
Oliver Ward Conversion	1,260	887	371	1,258	2	1,260	0		1,260
Clinical Genetics	158	15	6	21	137	158	0		158
Chapel Relocation	315	35	24	60	255	315	0		315
Victoria Main Reception	525	29	21	50	475	525	0		525
Modular Wards LRI	3,700	2,325	779	3,104	596	3,700	0		3,700
Sub-total: ED Enabling scheme	**7,822**	**3,762**	**1,694**	**5,456**	**2,366**	**7,822**	**0**	**0**	**7,822**
Emergency Floor	6,000	181	2,339	2,520	3,480	6,000	0		6,000
GGH Vascular Surgery	2,500	66	673	740	1,760	2,500	0	-1,000	1,500
Sub-total: External Loans	**16,322**	**4,009**	**4,707**	**8,715**	**7,607**	**16,322**	**0**	**-1,000**	**15,322**
Total Capital Plan	**50,829**	**11,152**	**12,033**	**23,185**	**27,644**	**50,479**	**350**	**-4,322**	**46,507**

University Hospitals of Leicester NHS
NHS Trust

Agenda Item: Trust Board paper P

TRUST BOARD – 30 October 2014

Emergency Care Performance Report

DIRECTOR:	Richard Mitchell
AUTHOR:	Richard Mitchell
DATE:	30 October 2014
PURPOSE:	This paper explains the steps being taken and identifies two recommendations to deliver a sustainably improved emergency care pathway, which is the most important priority for the University Hospitals of Leicester and wider Leicester, Leicestershire and Rutland health economy.
PREVIOUSLY CONSIDERED BY:	**None**
Objective(s) to which issue relates *	☑ 1. Safe, high quality, patient-centred healthcare ☑ 2. An effective, joined up emergency care system ☑ 3. Responsive services which people choose to use (secondary, specialised and tertiary care) ☑ 4. Integrated care in partnership with others (secondary, specialised and tertiary care) ☐ 5. Enhanced reputation in research, innovation and clinical education ☑ 6. Delivering services through a caring, professional, passionate and valued workforce ☑ 7. A clinically and financially sustainable NHS Foundation Trust ☑ 8. Enabled by excellent IM&T
Please explain any Patient and Public Involvement actions taken or to be taken in relation to this matter:	This service cares for some of the most vulnerable patients in LLR. Patient and public involvement is central to this and members from Health watch attend the monthly Urgent Care Steering Group.
Please explain the results of any Equality Impact assessment undertaken in relation to this matter:	
Organisational Risk Register/ Board Assurance Framework *	☐ **Organisational Risk Register** ☑ **Board Assurance Framework** ☐ **Not Featured**
ACTION REQUIRED *	For decision ✓ For assurance ☐ For information ☐

♦ We treat people how we would like to be treated ♦ We do what we say we are going to do
♦ We focus on what matters most ♦ We are one team and we are best when we work together
♦ We are passionate and creative in our work

* tick applicable box

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

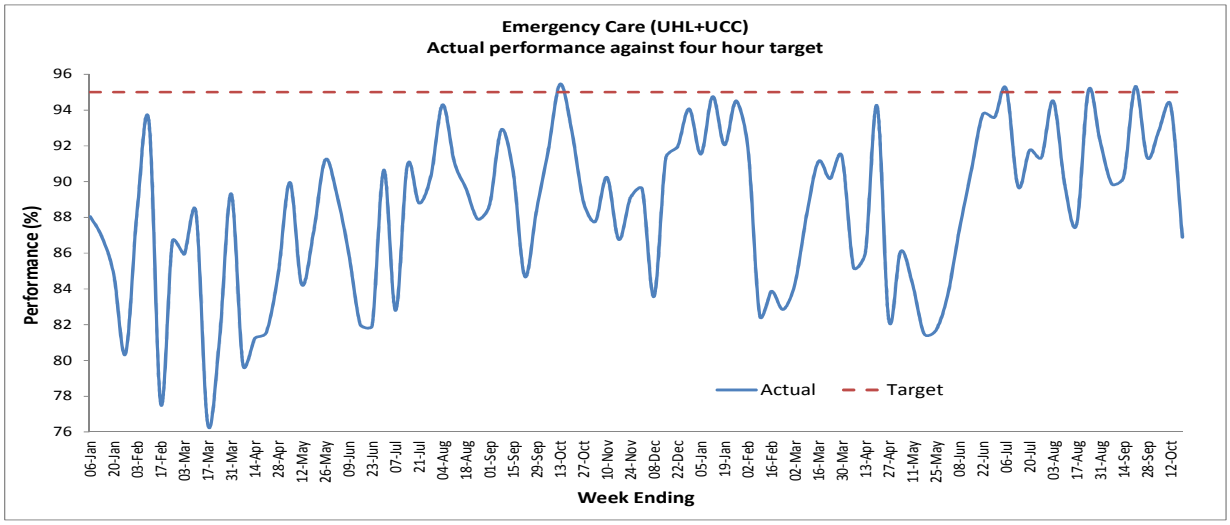
Introduction

Delivering a sustainably improved emergency care pathway is the most important priority for the University Hospitals of Leicester and wider Leicester, Leicestershire and Rutland health economy. UHL is the only part of the emergency care pathway that has unregulated demand and the Leicester Royal Infirmary and Glenfield General Hospital feel the majority of the emergency pressures across the health economy.

- Performance in September 2014 was **91.8%** compared to **89.5%** in September 2013 and **91.26%** in August 2014.
- October 2014, month to date (23/10/14) is **91.52%**. October will be the fifth month in a row where performance has been better than 90%.
- Emergency admissions (adult) continue to steadily rise in September; **209** compared to **207** per day in August and **204** per day the month before.
- Emergency admissions (adult) in September 2013 were **190** per day.
- Delayed transfers of care remain continually above the agreed performance level at **4.8%**. Twenty seven per cent of delays are internal reasons, 49% are external and 24% are nursing homes.

Performance overview

Weekly performance is detailed in graph one below. There was one week of compliant performance in September, with the four weeks performance; 89.9%, 90.3%, 95.3% and 91.4%.

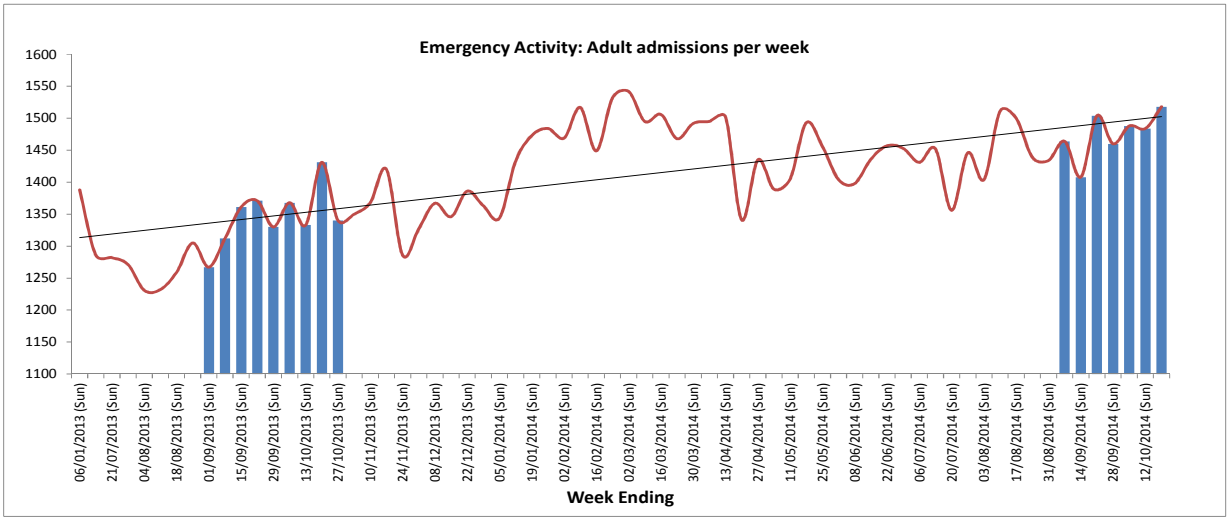


(graph one)

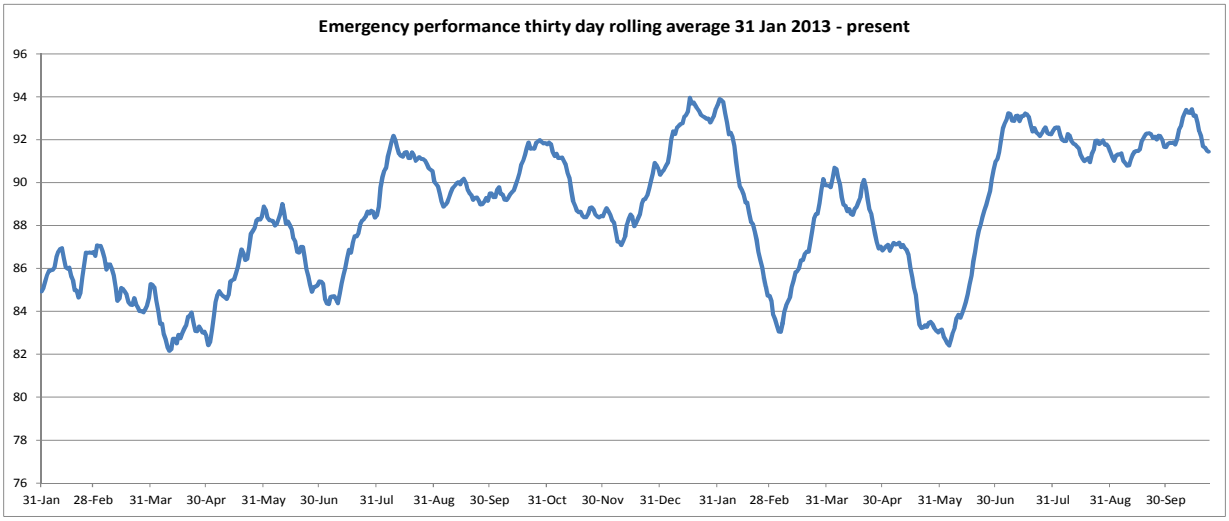
Performance is, in general, more stable than it has been for the last 22 months. Graph two plots the rolling 30 day average of performance. The rolling average has been over 90% for 118 days, including 14 weeks out of 19 over 90% and three weeks over 95%.

Admissions continue to increase and as detailed above are much higher (9.0%) than at the same time last year (graph three). UHL has not been able to open any more beds over this period of time so the increase in activity has been accomodated by productivity improvement. It is important to note that the

increase in admissions will only be paid at 30% of tariff with the other 70% of tariff being spent on activities outside of UHL designed to reduce admissions.



(graph two)



(graph three)

Delivering sustainable emergency performance across LLR requires progress against all three of the interlinked components; reduction in emergency admissions, internal UHL improvements, improvement in the discharge function.

Reduction in emergency admissions

It is apparent that despite many efforts and much money being spent outside of UHL, emergency admissions are not reducing. The health economy strategic plan is for a reduction of 3.5% but admissions are consistently running at 9.0% higher than the same time last year. Joint LLR audits have been completed on the notes of patients who are admitted on the emergency pathway and there is no evidence that UHL clincians are incorrectly admitting patients. There is evidence though that patients are being admitted because out of hospital services are inconsistently available. The importance of reducing emergency admissions is evident. Last week (w/e 19 October 2014), was the third highest week of emergency admissions on the LRI site in the last 104 weeks and performance dropped by 8% compared to the week before. There is more UHL needs to do to deal with peaks in demand and to reduce fragility but if a patient attends A&E or is referred in by a GP, there is a chance they will be admitted. If a patient does not attend, there is no chance they will be admitted. We need to concentrate on ensuring fewer patients attend or are referred in by their GPs, especially out of hours.

It is recommended that a thorough review of the LLR plans for reducing emergency admissions takes place with joint agreement on how the MRET, emergency readmissions and winter monies can be most effectively spent.

Internal UHL improvements

- Internal flow has been much better apart from the week with the very high numbers of admissions.
- ED leadership – the increased efforts from the ED leadership are evident.
- Expansion of #everybodycounts social media campaign. The videos have been watched over 17,000 times.
- Emergency quality steering group continues to meet with focus on quality dashboard and discharges linked to internal delays.
- Rapid cycle testing initiatives continue in ED, MAU, base wards and CDU.
- The gold, silver and bronze command management structure is fully embedded.
- Changes have been made to the assessment bay model in ED.
- Specialities are providing more support to ED out of hours.

Improvement in the discharge function

As detailed above, delayed transfers of care remain continually above the agreed performance level at **4.8%**. Twenty seven per cent of delays are internal reasons, 49% are external and 24% are nursing homes. The UHL emergency quality steering group is refocusing on discharges because of internal delays but wider LLR work is required. Discharging is made more difficult by there being substantially fewer community beds open this winter than last winter.

It is recommended that a thorough review of LLR discharges is completed with a clear plan put in place including the request to commissioners and other LLR provider functions that at least the same number of winter beds are open this year as last winter.

Winter monies

UHL and the wider LLR health economies have received winter monies this year to improve performance. UHL is spending its money on opening 16 additional beds on the LRI site and transferring the ward two function from LGH to LRI. Money will also be spent on increasing out of hours support on the emergency pathway and supporting seven day services.

It is important to note that the emergency pathway is for life not just Christmas. The winter monies will help performance over the next six months but significant reconfiguration of the emergency pathway is required to maintain the current levels of improvement and to permanently move to 95%.

National context

Many of our peers continue to struggle to improve with a number of big local trusts delivering performance between 80 and 85%.

Recommendations

The board are asked to:

- Note the contents of the report
- Support the two recommendations
- Support the actions being taken to improve performance.

University Hospitals of Leicester NHS
NHS Trust

Agenda Item: Trust Board paper Q

TRUST BOARD – 30 October 2014

NHS Trust Oversight Self-Certification

DIRECTOR:	Stephen Ward – Director of Corporate and Legal Affairs
AUTHOR:	Helen Stokes – Senior Trust Administrator
DATE:	30 October 2014
PURPOSE:	At the beginning of April 2013, the NHS Trust Development Authority (NTDA) published a single set of systems, policies and processes governing all aspects of its interactions with NHS Trusts in the form of '*Delivering High Quality Care for Patients: The Accountability Framework for NHS Trust Boards'.* In accordance with the Accountability Framework, the Trust is required to complete two self certifications in relation to the Foundation Trust application process. Copies of the self certifications submitted in September 2014 (August 2014 position) are attached as Appendices A and B. In a change to the previous approach (and as agreed with the Chief Executive), the month 5 quality and performance exception reports (where they applied to NTDA indicators) were used as the basis for the self-certifications. Subject to discussion at the October 2014 Trust Board meeting on matters relating to operational and financial performance, and review of the month 6 quality and performance exception reports, the Trust Board is recommended to approve that the self certifications against Monitor Licensing Requirements (Appendix A) and Trust Board Statements (Appendix B) be updated following the meeting to reflect the September 2014 position and submitted to the NHS Trust Development Authority accordingly.
PREVIOUSLY CONSIDERED BY:	**N/A**
Objective(s) to which issue relates *	[x] 1. Safe, high quality, patient-centred healthcare [x] 2. An effective, joined up emergency care system [x] 3. Responsive services which people choose to use (secondary, specialised and tertiary care) [ ] 4. Integrated care in partnership with others (secondary, specialised and tertiary care) [ ] 5. Enhanced reputation in research, innovation and clinical education [x] 6. Delivering services through a caring, professional, passionate and valued workforce [x] 7. A clinically and financially sustainable NHS Foundation Trust [ ] 8. Enabled by excellent IM&T
Please explain any Patient and Public Involvement actions taken or to be taken in relation to this matter:	None
Please explain the results of any Equality Impact assessment undertaken in relation to this matter:	Not applicable

Organisational Risk Register/ Board Assurance Framework *	☐	**Organisational Risk Register**	☒	**Board Assurance Framework**	☐ **Not Featured**

ACTION REQUIRED *

For decision ☒ For assurance ☐ For information ☐

♦ We treat people how we would like to be treated ♦ We do what we say we are going to do
♦ We focus on what matters most ♦ We are one team and we are best when we work together
♦ We are passionate and creative in our work

* tick applicable box

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:* 01162288940 Tel Extension: 8940

SELF-CERTIFICATION DETAILS:

Select Your Trust:* University Hospitals Of Leicester NHS Trust

Submission Date:* 30/09/2014 Reporting Year:* 2014/15

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NHS TRUST DEVELOPMENT AUTHORITY

Select the Month*

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

COMPLIANCE WITH MONITOR LICENCE REQUIREMENTS FOR NHS TRUSTS:

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

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

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

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

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

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16% Complete

NHS TRUST DEVELOPMENT AUTHORITY

COMPLIANCE WITH MONITOR LICENCE REQUIREMENTS FOR NHS TRUSTS:

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

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

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

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

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18% Complete

NHS TRUST DEVELOPMENT AUTHORITY

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

4. Condition G8
Patient eligibility and selection criteria.*

Yes

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39% Complete

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NHS TRUST DEVELOPMENT AUTHORITY

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

5. Condition P1
Recording of information.*
Yes

6. Condition P2
Provision of information.*
Yes

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

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

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45% Complete

NHS TRUST DEVELOPMENT AUTHORITY

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

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

Yes

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73% Complete

NHS TRUST DEVELOPMENT AUTHORITY

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

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

11. Condition C2
Competition oversight.*
Yes

12. Condition IC1
Provision of integrated care.*
Yes

Prev Submit Page 7 of 7

NHS TRUST DEVELOPMENT AUTHORITY

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

CONTACT INFORMATION:

Enter Your Name:* John Adler

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

Full Telephone Number:* 01162588940 Tel Extension: 8940

SELF-CERTIFICATION DETAILS:

Select Your Trust:* University Hospitals Of Leicester NHS Trust

Submission Date:* 30/09/2014 Reporting Year:* 2014/15

Select the Month*

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

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NHS TRUST DEVELOPMENT AUTHORITY

BOARD STATEMENTS:

CLINICAL QUALITY
FINANCE
GOVERNANCE

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

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

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16% Complete

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NHS TRUST DEVELOPMENT AUTHORITY

BOARD STATEMENTS:

For CLINICAL QUALITY, that

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

1. CLINICAL QUALITY Yes
Indicate compliance.*

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16% Complete

NHS TRUST DEVELOPMENT AUTHORITY

BOARD STATEMENTS:

For CLINICAL QUALITY, that

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

2. CLINICAL QUALITY Yes
Indicate compliance.*

Prev Next Page 4 of 16

22% Complete

NHS TRUST DEVELOPMENT AUTHORITY

BOARD STATEMENTS:

For CLINICAL QUALITY, that

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

3. CLINICAL QUALITY Yes
Indicate compliance.*

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28% Complete

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NHS TRUST DEVELOPMENT AUTHORITY

BOARD STATEMENTS:

For FINANCE, that

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

4. FINANCE
Indicate compliance.*

Yes

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34% Complete

NHS TRUST DEVELOPMENT AUTHORITY

BOARD STATEMENTS:

For GOVERNANCE, that

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

5. GOVERNANCE
Indicate compliance.*

Yes

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40% Complete

NHS TRUST DEVELOPMENT AUTHORITY

BOARD STATEMENTS:

For GOVERNANCE, that

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

6. GOVERNANCE
Indicate compliance.*

Yes

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46% Complete

NHS TRUST DEVELOPMENT AUTHORITY

BOARD STATEMENTS:

For GOVERNANCE, that

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

7. GOVERNANCE
Indicate compliance.*

Yes

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52% Complete

NHS TRUST DEVELOPMENT AUTHORITY

BOARD STATEMENTS:

For GOVERNANCE, that

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

8. GOVERNANCE Yes
Indicate compliance.*

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58% Complete

NHS TRUST DEVELOPMENT AUTHORITY

BOARD STATEMENTS:

For GOVERNANCE, that

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

9. GOVERNANCE
Indicate compliance.*

Yes

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64% Complete

NHS TRUST DEVELOPMENT AUTHORITY

BOARD STATEMENTS:

For GOVERNANCE, that

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

10. GOVERNANCE
Indicate compliance.*

Risk

Timescale for compliance:* 31/03/2015

RESPONSE:

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

The 25 September 2014 UHL NHS Trust Board received reports identifying the causes of underperformance on the following indicators, and endorsed the remedial actions being taken to achieve compliance. The individual anticipated compliance dates submitted to the Trust Board are shown against relevant indicators:-
- ED 4-hour waits (September 2014); - RTT waiting times (admitted) (November 2014); - RTT 52-week waits (September 2014); - 6-week diagnostic test waiting times (September 2014); - cancelled patients not offered a date within 28 days of cancellation (October 2014); - delayed transfers of care; - cancer 2-week waits (October 2014); - cancer 31-day waits for 2nd subsequent treatment (October 2014); - cancer 62-day waits for first treatment (January 2015).

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70% Complete

NHS TRUST DEVELOPMENT AUTHORITY

BOARD STATEMENTS:

For GOVERNANCE, that

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

11. GOVERNANCE
Indicate compliance.*

Yes

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76% Complete

NHS TRUST DEVELOPMENT AUTHORITY

BOARD STATEMENTS:

For GOVERNANCE, that

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

12. GOVERNANCE
Indicate compliance.*

Yes

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82% Complete

NHS TRUST DEVELOPMENT AUTHORITY

BOARD STATEMENTS:

For GOVERNANCE, that

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

13. GOVERNANCE Yes
Indicate compliance.*

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88% Complete

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NHS TRUST DEVELOPMENT AUTHORITY

BOARD STATEMENTS:

For GOVERNANCE, that

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

14. GOVERNANCE Yes
Indicate compliance.*

Prev Submit Page 16 of 16

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT BY TRUST BOARD COMMITTEE TO TRUST BOARD

DATE OF TRUST BOARD MEETING:	**30 October 2014**

COMMITTEE:	**Charitable Funds Committee**
CHAIRMAN:	**Mr P Panchal, Non-Executive Director**
DATE OF COMMITTEE MEETING:	**15 September 2014**

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

- **The Trust Board are invited to endorse all recommendations.**

OTHER KEY ISSUES IDENTIFIED BY THE COMMITTEE FOR NOTING BY THE PUBLIC TRUST BOARD:

- **None**

DATE OF NEXT COMMITTEE MEETING: 17 November 2014.

P Panchal, Non-Executive Director
24 October 2014

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF A PART-INQUORATE MEETING OF THE CHARITABLE FUNDS COMMITTEE HELD ON MONDAY 15 SEPTEMBER 2014 AT 11AM IN THE LARGE COMMITTEE ROOM, LEICESTER GENERAL HOSPITAL**

***** inquorate items are therefore recommended***

Present:
Mr P Panchal – Non-Executive Director (Chair)
Col (Ret'd) I Crowe – Non-Executive Director (up to and including Minute 43/14)
Mr S Sheppard – Acting Director of Finance

In Attendance:
M T Diggle – Head of Fundraising
Mr M Khan – Consultant Urological Surgeon (for Minute 43/14)
Ms L Napier – Cazenove Investment Managers (for Minute 55/14)
Mr N Sone – Charity Finance Lead
Mr P Spiers – Chairman of the Medical Equipment Executive (MEE)
Ms H Stokes – Senior Trust Administrator
Mr S Ward – Director of Corporate and Legal Affairs
Mr M Wightman – Director of Marketing and Communications

RECOMMENDED ITEMS (denotes inquorate items)** **ACTION**

41/14 LEICESTER HOSPITALS CHARITY ACCOUNTS AND ANNUAL REPORT 2013-14

Paper D presented the 2013-14 audited accounts for Leicester Hospitals Charity, the Trustee's annual report, and the letter of representation for Charitable Funds Committee endorsement and recommendation on for Trust Board approval (as Corporate Trustee). However, it was noted that the ISA 260 report had not yet been received from the Auditors, which was also required for Trust Board approval – it was agreed to chase this accordingly. In response to a query from the Charitable Funds Committee Chair, it was confirmed that the charity's accounts and annual report 2013-14 would then also be presented to the Leicester Hospitals Charity AGM on 9 October 2014, following Trust Board approval on 25 September 2014 (subject to receipt of the ISA 260 as outlined above). **CFL/ DCLA**

Recommended – that (A) subject to receipt of the ISA 260 report from Auditors, the Leicester Hospitals Charity 2013-14 final accounts, annual report and letter of representation be endorsed and recommended for Trust Board approval on 25 September 2014, and **CFC CHAIR**

(B) receipt of the ISA 260 report be chased accordingly. **CFL/ DCLA**

42/14 SPENDING PLANS/FUTURE SIZE AND STRUCTURE OF UHL CHARITABLE FUNDS**

Paper E updated members on progress in reviewing the structure of the Charity's funds and on the production of future spending plans. The overall thrust of the proposal was to reduce the number of funds from 189 to 55 or below (removing any dormant and *de minimus* funds), and to simplify the fund types, whilst ensuring that all funds had a valid purpose which met the current aims of the Charity. If supported by the Charitable Funds Committee then the charitable funds team would meet with CMGs and explain what the proposals meant for their particular areas. The Committee endorsed the proposals as detailed in paper E, and emphasised the importance of dialogue with CMGs to discuss the implications – it was agreed therefore to receive a further update at the November 2014 Charitable Funds Committee, to include detail on how the changes were being implemented and any feedback received. **CFL** The Acting Director of Finance also suggested contacting R&D colleagues for any 'lessons learned' from their similar exercise some 18 months previously. In response to a query from the Committee Chair, the Charity Finance Lead agreed to confirm the number of UHL's restricted funds outside the meeting, noting that this number was also intended to reduce. **CFL** It was also agreed to submit a report on the changes to the Executive Team prior to November 2014. **ADF**

Recommended – that (A) the proposals re: the future size and structure of UHL's charitable funds be endorsed as outlined in paper E, and a report be presented accordingly to the Executive Team for information; **ADF**

(B) contact be made with R&D colleagues, to learn any appropriate lessons from their recent consolidation of funds; **CFL**

(C)a further report on the implementation of the changes be provided to the 17 November 2014 Charitable Funds Committee, and **CFL**

(D) the current number of restricted funds be advised to the Charitable Funds Committee Chair outside the meeting. **CFL**

43/14 ITEMS FOR APPROVAL**

Paper F outlined the grant applications received since the June 2014 Charitable Funds Committee meeting, noting that all bids received had been pre-reviewed as per current guidelines. The Charity Finance Lead considered that all applications fell within the scope of the funds, were affordable, and had been appropriately authorised by the fund advisers. Applications totalling £275,661 had been approved by the Charity Finance Lead through the scheme of delegation (they did not, therefore, require additional Charitable Funds Committee approval), and were detailed in appendix 1 of paper F.

The Committee then considered the applications presented for approval, as detailed in appendices 4-17 of paper F. Mr M Khan, Consultant Urological Surgeon attended in support of applications 5138, 5139, and 5154 (appendices 9, 10 and 11 respectively). The Committee's recommendations on the applications were as detailed below:-

(a) applications **supported** by the Charitable Funds Committee (for onwards approval by the Trust Board as Corporate Trustee):- **CFC CHAIR/ ADF**

(i) Staff Christmas meal 2014 (appendix 3 of paper F, involving a transfer between unrestricted funds and being a precommitment on UHL's General Purpose Charitable Fund) – supported up to a maximum cap of £10 spend per head;
(ii) **application 5065** (LIIPS unit lead) for £24,872 from General Purpose Funds – supported on the basis that it was for a 1-year post;
(iii) **application 5078** (provision of secure turn patient turners [rotundas] for use in ED and Acute Medicine clinical areas) for £1007.88;
(iv) **application 5090** (purchase of 10 i-Pads and lockable cases to enable patients to complete the Patient Reported Outcome Measures independently) for £4553.08 – supported in principle, subject to receiving confirmation that the purchase of i-Pads was justified (exploring therefore cheaper alternatives) and fitted with UHL's overall IM&T strategy (that confirmation to be provided outside the meeting); **CFL**
(v) **application 5138** (cryoprobe for performing transperineal template prostate biopsies) for £13,500 – supported on the understanding that half the money being requested was being funded by ProstAid. It was also agreed that this bid would be reviewed at the Medical Equipment Executive on 17 September 2014, thus providing additional assurance to the Charitable Funds Committee that the purchase aligned with UHL's overall equipment strategy; **MEE CHAIR**
(vi) **application 5139** (TRUS probe) for £13,500 – noting that this bid would also be reviewed by the supported on the understanding that half the money being requested was being funded by ProstAid. As with application 5138 above, it was agreed that this bid would be reviewed at the Medical Equipment Executive on 17 September 2014, thus providing additional assurance to the Charitable Funds Committee that the purchase aligned with UHL's overall equipment strategy; **MEE CHAIR**
(vii) **application 5154** (urology ultrasound machine to treat kidney stones) for £37,150 – noting that this bid would also be reviewed by the Medical Equipment Executive on 17 September 2014, thus providing additional assurance to the Charitable Funds Committee that the purchase aligned with UHL's overall equipment strategy; **MEE CHAIR**
(viii) **application 5157** (bedside tables and lockers for LRI wards 17 and 18) for **CFL**

£27,643.80 – supported subject to further confirmation on the costs, which the Committee considered were expensive. It was approved on the basis that the funding was sourced from an appropriate CMG fund rather than General Purposes;
(ix) **application 5158** (vernacare commodes with pulp liner to promote independence) for £2,985;
(x) **application 5160** (upgrade of changing cubicles in the LRI outpatients department) for £8454.30 – noting a query from the Charitable Funds Committee Chair on whether Same Sex Accommodation breaches affected any other areas of the Trust;
(xi) **application 5040** (GE iDXA Advance with corescan) for £94,140 – this application addressed the queries raised at the June 2014 Charitable Funds Committee (Minute 37/14 refers);
(xii) **application 4419** (refurbishment of parents' accommodation for the Children's Intensive Care Unit) for £32,700 [retrospective approval sought for the remaining balance of expenditure which was now available as a result of a donation, and

(b) applications **not supported** by the Charitable Funds Committee:-
(i) **application 5088** (conversion of Sister's office into a medicines/IV drug preparation room and upgrading of an existing storage area into a clinical treatment room, converting current administration area into a new Sister's office and upgrading the existing nurses' station – elective gynaecology service) for £37,806.42 – consideration was deferred to the November 2014 Charitable Funds Committee to enable checking of the costs, which the Committee considered seemed overly expensive; **CFL**
(ii) **application 5099** (improvement of office facilities for the Breast Administration Team) for £14088.09 – consideration was deferred to the November 2014 Charitable Funds Committee to enable checking of the costs, which the Committee considered overly expensive, and **CFL**
(iii) **application 5159** (pump-priming of a research project to assess a need for a chaplaincy service for non-religious patients) for £38,100 – consideration was deferred to a meeting when the Chief Nurse was present, noting also the need for an impact assessment if this project was approved. **CFL/CN**

In general discussion on the bids presented, the Charitable Funds Committee also requested that:-

(1) the Executive Team be advised of the Charitable Funds Committee's views on the need for UHL's core planning process to reflect service developments and related equipment needs, and **ADF/ DMC**
(2) for future reports, the bidding process include confirmation that future estates changes had been appropriately factored in to the bids. **ADF/CFL**

Recommended – that (A) noting the need to address any caveats raised above, applications (a) (i) –(xii) above be supported and recommended for Trust Board approval as Corporate Trustee; **CF CHAIR/ ADF/CFL**

(B) any caveats/further information sought in respect of supported applications (a) (i)-(xii) above be progressed by the relevant named lead; **CFL**

(C) the applications in (a) (v), (vi) and (vii) above be reviewed by the Medical Equipment Executive on 17 September 2014 to provide additional assurance to the Charitable Funds Committee; **MEE CHAIR**

(D) consideration of the applications in (b)(i) and (ii) above be deferred to the November 2014 Charitable Funds Committee to review the costs; **CFL**

(E) consideration of the application in (b)(iii) above be deferred until a Charitable Funds Committee meeting when the Chief Nurse was present; **CFL/ CN**

(F) the Executive Team be advised of the Charitable Funds Committee's views on the need for UHL's core planning process to reflect service developments and related equipment needs, and **ADF/ DMC**

(G) for future reports, the charitable funds bidding process include confirmation that **ADF/CFL**

future estates changes had been appropriately factored in to the bids.

44/14 FINANCE AND GOVERNANCE REPORT**

Paper G from the Charity Finance Lead detailed the financial position of the Charity overall and of the General Purpose Fund for the month ending 31 August 2014. Additional legacies totalling £430k had been received, and certain outstanding commitments against the General Purpose Fund were outlined in Minute 43/14 above.

Recommended – that the finance and governance report be noted.

45/14 FUNDRAISING UPDATE**

Paper H from the Head of Fundraising detailed recent fundraising and promotional activities by the Charity, noting that a separate report on the Baby Loss Appeal was covered in Minute 47/14 below. The Head of Fundraising particularly drew members' attention to (i) a legacy bequest of £70k to buy equipment for the Glenfield breast care centre, and (ii) progress on creating a dedicated Leicester Hospitals Charity Headquarters at Belgrave House on the LGH site – 3 additional staff had now been recruited, in addition to an internal promotion to a new post of Legacy Manager. It was hoped to have the expanded charity fundraising team in place by November 2014.

Recommended – that the fundraising update be noted.

46/14 LEICESTER LIFE STUDY**

Further to Minute 29/14 of 9 June 2014, the Head of Fundraising provided a verbal update on his discussions with the UHL Director of R&D re: the Leicester Life Study, noting his view that the timescale was too short for a charitable capital appeal. A Leicester Life Study bid was also now under consideration by the Trust's Capital Monitoring and Investment Committee (CMIC), with a decision anticipated shortly. The Charitable Funds Committee Chair emphasised that no decision on charitable funding (including any charitable loan) could be taken until that CMIC route had been appropriately exhausted – it was agreed to clarify this process issue to the Executive Team accordingly. **DCLA/ ADF**

Recommended – that the appropriate process for seeking charitable funding/loans be reinforced to the Executive Team. **DCLA/ ADF**

47/14 LEICESTER BABY LOSS APPEAL – UPDATE**

A donation of £100k had been received from Leicester City Football Club to support the Baby Loss Appeal – this would enable the 3rd element of the appeal to be progressed re: provision of enhanced parent/carer accommodation facilities at the Leicester General Hospital. LCFC had also expressed an interest in supporting a children's physiotherapy gym at the LRI and was now working closely with the Trust accordingly and also considering offering UHL a share of Foxes Foundation fundraising monies at the end of the football season. The Committee welcomed this generous offer and noted the good working relationship being established with the club by the fundraising team.

In discussion, the Charitable Funds Committee noted the need for appropriate communication to enhance the Charity's current and future relationships with potential donors. With regard to the specific issue of family accommodation facilities, the Committee also noted the need to ensure that the Trust's Major Projects Technical Director was appropriately sighted to such capital developments. **HoF/ DMC** **HoF**

Recommended – that (A) an appropriate communication strategy be developed to enhance Leicester Hospitals Charity's relationships with donor families and organisations, and **HoF/DMC**

(B) UHL's Major Projects Technical Director be sighted to the intended LGH parents' accommodation (in light of the Trust's wider estates strategy). **HoF**

48/14 PLANNED CHARITABLE APPEAL TO SUPPORT THE NEW DA VINCI ROBOT**

Paper J outlined a proposed charitable appeal to secure additional funding to support the cost of consumables for (up to) the first 50 patients to benefit from the Trust's new Da Vinci robot. As the appeal was being supported by Prostaid, it would be targeted towards prostate cancer procedures and would aim to raise up to £250k. In response to a query from the Committee Chair, the Acting Director of Finance confirmed that the Da Vinci Robot business case approved by the Trust Board was financially viable – this appeal money would be additional funding over and above that. The Charitable Funds Committee supported the proposed charitable appeal noting, however, the need for appropriately sensitive communication and messaging. **HoF/ DMC**

<u>Recommended</u> – that the appropriate messaging of this appeal (as now supported by the Charitable Funds Committee) be considered by the Director of Marketing and Communications and the Head of Fundraising. **HoF/ DMC**

49/14 LEICESTER HOSPITALS CHARITY AGM – 9 OCTOBER 2014**

Paper K outlined the proposed arrangements for the first Leicester Hospitals Charity AGM on 9 October 2014, the list of invitees for which would be circulated for information. In discussion, the Director of Marketing and Communications commented that he had anticipated a somewhat larger-scale event held off-site (more mirroring the Trust's own APM, for example) rather than the arrangements outlined in the report – this view was echoed by the Charitable Funds Committee Chair, who voiced concern, however, over the ability to change the arrangements at this relatively short notice. It was agreed that the Head of Fundraising and the Director of Marketing and Communications would discuss potential alternative options outside this meeting. If feasible, the Committee Chair noted his support for deferring the event in order to make it more of a showcase for the Charity – in any case the timing might be affected by the availability (or otherwise) of the auditors' opinion on the accounts (Minute 41/14 above refers). **HoF** **DMC/ HoF**

<u>Recommended</u> – that (A) the current list of invitees be circulated to Charitable Funds Committee members for their information, and **HoF**

(B) discussions be pursued urgently outside the meeting on the scope for a more large-scale and outward facing Charity AGM event on 9 October 2014. **DMC/ HoF**

50/14 ANY OTHER BUSINESS**

There was no other business raised.

51/14 DATE OF NEXT MEETING AND MEETING DATES 2015**

<u>Recommended</u> – that (A) the next Charitable Funds Committee be held on Monday 17 November 2014 (time to be confirmed), and

(B) provisional 2015 meeting dates be circulated based on the same frequency as for 2014. **STA**

<u>RESOLVED ITEMS</u>

52/14 APOLOGIES FOR ABSENCE

Apologies for absence were received from Ms R Overfield, Chief Nurse, and Mr P Burlingham, Patient Adviser. Discussions continued over a potential new Patient Adviser for the Charitable Funds Committee, which would be pursued outside the meeting by the Committee Chair. **CFC CHAIR**

53/14 MINUTES

Resolved – that the Minutes of the 9 June 2014 Charitable Funds Committee meeting be confirmed as a correct record.

54/14 MATTERS ARISING FROM THE MINUTES

Members reviewed the matters arising report at paper B, which covered both the immediately preceding and historic Charitable Funds Committee meetings. Specific discussion took place in respect of the following items, noting that all items currently designated as a '5' rating (complete) would be removed from the log, and that an update on all "ongoing" actions would be agenda'd for the November 2014 Charitable Funds Committee:- **STA**

(a) **Minute 27/14** of 9 June 2014 – contacts for Leicester community groups would be sent to the Director of Marketing and Communications by the Committee Chair; **CFC CHAIR**

(b) **Minute 27/14a** of 9 June 2014 – confirmation would be sought outside the meeting of whether future wi-fi provision would be by Interserve or IBM; **CN**

(c) **Minute 27/14b** of 9 June 2014 – a briefing on the training available for staff dealing with patients experiencing miscarriage/repeated miscarriage, would be presented to the November 2014 Charitable Funds Committee; **CN/HoF**

(d) **Minute 278/14d** of 9 June 2014 – a position statement on the use of charitable funding for training would be presented to the November 2014 Charitable Funds Committee; **CFL**

(e) **Minute 30/14a** of 9 June 2014 – information benchmarking UHL's comparative position in terms of attracting legacies, would be presented to the November 2014 Charitable Funds Committee; **HoF**

(f) **Minute 35/14** of 9 June 2014 – the Charity Finance Lead noted that the original 2001 paperwork for the charity's endowments was yet to be located. The value of the endowments was in excess of £1m, and they could be released in consultation with the Charity Commission. The Charitable Funds Committee Chair noted the need to bear this issue in mind during the investment managers' presentation to the Committee today;

(g) **Minute 36/14** of 9 June 2014 – the Charitable Funds Committee Chair would brief the new UHL Chairman on the Committee's discussions about the approach to charitable funds spending plans and investments; **CFC CHAIR**

(h) **Minute 37/14a** of 9 June 2014 – the Paediatric ED bid for i-Pads would be re-presented to the November 2014 Charitable Funds Committee, as the CMG had not yet had time to trial alternatives as requested; **CFL**

(i) **Minute 7/14** of 14 April 2014 – the issue of longer term funding for the Meaningful Activities Coordinator posts would be discussed at the November 2014 Charitable Funds Committee, and **CN**

(j) **Minute 2/13** of 18 January 2013 – an update on application 3747 (virtual ward for training purposes) would be provided to the November 2014 Charitable Funds Committee, noting the need to resolve this outstanding issue. **CFL**

Resolved – that the discussion above and any associated actions, be noted and progressed by the appropriate lead. **Named leads**

55/14 UPDATE FROM THE CHARITABLE FUNDS INVESTMENT MANAGERS

Ms L Napier attended from Cazenove Capital Management (investment managers for Leicester Hospitals Charity) to provide an annual update on the performance of the Charity's portfolio and to seek the Committee's views on the investment strategy moving forward. She advised members on the current split of the Charity's portfolio (62% of which was held in equities), the spread of its exposure and the relative risk levels involved, noting

that the current approach involved maximising the return from the Charity's investments in a low risk environment. She confirmed that Cazenove had exceeded the Charity's required 3% cash yield. In discussion on the presentation, the Charitable Funds Committee:-

(a) queried whether the Charity's exposure to the Asia markets should continue, or whether it would be preferable to have more holdings in the (more lucrative) American market. Members also queried how responsive UHL's portfolio was (eg how quickly its investments could be changed in-year to maximise returns) in reacting to both financial and political developments;

(b) considered 3 'strategic asset allocation' options as now presented by Cazenove for managing the Charity's portfolio, each involving a varying degree of risk and potential return, and noting that if the 'progressive' risk profile was adopted (option C), the Charity would need to relinquish its current £1m cash requirement. Cazenove recommended certain changes to UHL's existing strategic asset allocation, involving (slight) rises in the levels of UK equities, fixed interest elements, and property holdings. In response to queries raised at the June 2014 Charitable Funds Committee over whether the Charity should seek to increase its property holdings, the Cazenove representative advised that she would not lift the property element above 6%, and noted that Charities should ideally avoid property investments requiring stamp duty payment;

(c) noted the need for a Trust Board-level discussion on risk appetites in respect of the Charity's investment portfolio. The timing of that discussion would be considered outside this meeting and an update reported accordingly to the November 2014 Charitable Funds Committee (with appropriate input from the incoming Director of Finance). **DCLA/DF /DMC/ CFC CHAIR**

<u>Resolved</u> – that (A) the annual investment managers' update be noted, and

(B) a strategic discussion re: the future nature of UHL's charitable investment portfolio and relative risk appetites, take place with the incoming UHL Director of Finance with a view to reporting to the November 2014 Charitable Funds Committee and then onwards to the Trust Board. **DCLA/DF /DMC/ CFC CHAIR**

<u>The meeting closed at 1pm.</u>

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

Name	Possible	Actual	% attendance
P Panchal (Chair)	3	3	100
I Crowe	1	1	100
P Burlingham *	3	1	33
T Diggle *	3	3	100
P Hollinshead*	2	1	50
K Jenkins	2	0	0
R Overfield	3	1	33
S Sheppard	1	1	100
N Sone *	3	3	100
P Spiers *	3	2	67
M Wightman*	3	3	100
S Ward *	3	2	67
R Kilner	1	1	100

* non-voting members

Helen Stokes - **Senior Trust Administrator**

University Hospitals of Leicester NHS
NHS Trust

Agenda Item: Trust Board paper S

TRUST BOARD – 30 October 2014

Charitable Funds Application no. 5201– Above Bed Name Boards

DIRECTOR:	Simon Sheppard (Acting Director of Finance and Procurement)
AUTHOR:	Nick Sone (Financial Controller)
DATE:	30 October 2014
PURPOSE:	The report covers a charitable funding application (5201) for £38k from the Charity's general purposes fund relating to the provision of A3 and A4 dry wipe magnetic boards to go above every inpatient bed. New guidance was issued following the Francis report and each patient should have a responsible consultant and named nurse with their name recorded above their bed. The embedding of this best practice forms part of the UHL Quality Commitment Care and Compassion Improving Patient Experience. **Recommendation** The Trust Board is asked to approve this application
PREVIOUSLY CONSIDERED BY:	**None**
Objective(s) to which issue relates *	☑ 1. Safe, high quality, patient-centred healthcare ☐ 2. An effective, joined up emergency care system ☐ 3. Responsive services which people choose to use (secondary, specialised and tertiary care) ☐ 4. Integrated care in partnership with others (secondary, specialised and tertiary care) ☐ 5. Enhanced reputation in research, innovation and clinical education ☑ 6. Delivering services through a caring, professional, passionate and valued workforce ☐ 7. A clinically and financially sustainable NHS Foundation Trust ☐ 8. Enabled by excellent IM&T
Please explain any Patient and Public Involvement actions taken or to be taken in relation to this matter:	This is a patient experience improvement agreed through UHL's Quality Commitment. Currently not all wards have above bed boards that will enable the new guidance to be met.
Please explain the results of any Equality Impact assessment undertaken in relation to this matter:	
Organisational Risk Register/Board Assurance Framework *	☐ **Organisational Risk Register** ☐ **Board Assurance Framework** ☑ **Not Featured**
ACTION REQUIRED *	For decision ☑ For assurance ☐ For information ☐

♦ We treat people how we would like to be treated ♦ We do what we say we are going to do
♦ We focus on what matters most ♦ We are one team and we are best when we work together
♦ We are passionate and creative in our work

* tick applicable box

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **CHARITABLE FUNDS COMMITTEE**

DATE: **22/09/14**

REPORT FROM: **Heather Leatham Head of Nursing**

SUBJECT: SUPPORTING INFORMATION FOR GRANT APPLICATION: 5201

APPLICATION DETAILS

Amount: £38325.60

Fund number and type: P802 Patients

BRIEF DESCRIPTION OF THE GOODS/SERVICES TO BE FUNDED

A3 and A4 white dry wipe magnetic boards to go above every inpatient bed Following the Francis Report new guidance was issued by the Academy of Medical Colleges in June 2014. Each patient should have a responsible consultant and a named nurse with their name recorded above the bed. Embedding this 'best practice' forms part of the UHL Quality Commitment Care and Compassion- Improving Patient Experience.

WHY IS FUNDING THROUGH THE TRUST REVENUE/CAPITAL BUDGETS NOT APPROPRIATE

This is a patient experience improvement agreed through UHL's Quality commitment Currently not all wards have above bed boards that will enable the new guidance to be met. Many of the existing boards in the Trust are scratched and damaged. A task and finish group decided on the design and the need for standardisation across the Trust to implement this new guidance. Supporting this purchase will help us meet national and local standards and will benefit patients and relatives as they will be able to see who is responsible for their care and treatment at a glance.

WHAT ADDITIONALITY DOES THIS PROVIDE TO PATIENTS/STAFF OVER AND ABOVE THE TRUST'S CORE ACTIVITY

The 'name over the bed' initiative is part of UHL's 2014-15 Quality Commitment. It will make it clear to patients, their carers, nurses and relatives, the Consultant who is responsible for their overall care. The guidelines also say a 'Named Nurse' should be available to provide patients with information about their care and should be a primary point of contact. This initiative supports one of the Francis Report's key recommendations that if a named clinician were accountable throughout a patient's treatment in hospital then patient safety and the overall quality of care could be improved. It will help make sure that patients are only discharged if it is in their best interests, with appropriate support from friends, family or carers and when it is safe and clinically appropriate to so, particularly if a patient is vulnerable.

VALUE FOR MONEY CONSIDERATIONS

Two companies who already provide boards within the Trust provided sample boards, Ward Henry provided a sample of a Perspex board and Keith Rawson provided a dry magnetic white board sample. Both samples that were priced the same for the A3 board and installation were taken to a task and finish group were nurses from each CMG were represented, for ease of use it was agreed that the magnetic dry white board would be most suitable. Information was also sent by a 3rd company, Find, however the board costs were more than double of those we had received from the other companies and did not cover installation costs

WHAT ARE THE IMPLICATIONS IF THE APPLICATION IS UNSUCCESSFUL?

UHL would not be able to fully follow best practice guidance and would be unable to deliver on an agreed item in UHL Quality Commitment to improve patient experience by embedding the practise of named nurse and named consultant being displayed above the bed

DOES THIS ISSUE FEATURE ON YOUR CBU RISK REGISTER?

No

IS THIS APPLICATION SUPPORTED BY YOUR DIVISIONAL MANAGER AND/OR DIRECTOR?

Yes-Rachel Overfield fully supports this application

IS THIS APPLICATION FOR STANDARD EQUIPMENT WHICH WOULD NORMALLY BE IN USE WITHIN THE TRUST?

No

Trust Board Paper T

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

Trust Board Bulletin – 30 October 2014

The following reports are attached to this Bulletin as items for noting, and are circulated to UHL Trust Board members and recipients of public Trust Board papers accordingly:-

- **Declarations of Interests from Mr K Singh, Trust Chairman and Mr M Traynor, Non-Executive Director** – Lead contact point Mr S Ward, Director of Corporate and Legal Affairs (0116 258 8721) – **paper 1.**
- **Quarterly update on Trust sealings** – Lead contact point Mr S Ward, Director of Corporate and Legal Affairs (0116 258 8721) – **paper 2.**
- **Members' Engagement Forum meeting (11 September 2014) minutes** – Lead contact point Mr M Wightman, Director of Marketing and Communications (0116 258 8952) – **paper 3.**

It is intended that these papers will not be discussed at the formal Trust Board meeting on 30 October 2014, unless members wish to raise specific points on the reports.

This approach was agreed by the Trust Board on 10 June 2004 (point 7 of paper Q). Any queries should be directed to the specified lead contact point in the first instance. In the event of any further outstanding issues, these may be raised at the Trust Board meeting with the prior agreement of the Chairman.

The following declarations of Trust Board interests have been received:-

NAME	POSITION	INTEREST(S) DECLARED
Karamjit Singh	Chairman	Trustee, Joseph Rowntree Foundation Trustee, Joseph Rowntree Housing Trust Council Member of Justice Trustee, Malaysian Commonwealth Studies Centre, Cambridge University
Martin Traynor OBE	Non-Executive Director	Partner – Traynor Consulting & Training LLP Non- Executive Chairman – The Forest Experience Ltd Non- Executive Chairman – King Richard lll Visitor Centre Trust Ltd Non-Executive Director – Leicestershire Promotions Ltd Trustee-The National Forest Charitable Trust Ltd Trustee – Leicestershire Rural Community Council Ltd Trustee - LOROS Ltd Trustee – Menphys Member – HM Govt's Regulatory Policy Committee

The Trust Board is invited to note the above, which will be maintained in a publicly-available register as required.

Stephen Ward

Director of Corporate and Legal Affairs

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **30 OCTOBER 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 the 2014-15 financial year to date (by quarter).

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 2, 2014/15

There were no Trust sealings for Quarter 2.

University Hospitals of Leicester NHS Trust

Members' Engagement Forum Meeting 11/09/2014

Minutes

In attendance
Richard Kilner, Acting Chairman, UHL
John Adler, Chief Executive
Jane Wilson, Non Executive Director
Ian Crowe, Non Executive Director
Mark Wightman, Director of Communications and Marketing
Karl Mayes, Patient and Public Involvement / Membership Manager

Apologies
Stephen Ward, Director of Corporate and Legal Affairs

1. Welcome and Introductions

1.1 Participants were welcomed to the meeting by Mr Richard Kilner, Acting Chair of the Trust who started the meeting with an update on Trust business. He spoke about the recent LLR Quality Review which went public in the preceding month. Richard noted that we were the first health economy to undertake such an exercise and said that the review aimed to actively identify any issues in care and medical management of patients. Cases for 350 patients were reviewed, two thirds of whom died in hospital. The review asked whether, in each case, there was any indication that patients had not received an appropriate quality of care. Looking across the health economy the review did identify situations where care had not been acceptable. A number of issues related to end of life care. Following the publication of the review each part of the health economy now has a detailed action plan which they are acting upon.

1.2 Richard then spoke about the Trust's Referral to Treatment (RTT) targets saying that the Trust was now back on track and had agreed a plan with its clinicians. Overall cancer performance has been good in the last few months despite a significant increase in referrals which has been challenging. Part of the forward plan is an "early warning" system which seeks to identify patients earlier on in their cancer journey.

1.3 The Emergency Department (ED) has faced a number of challenges since the group last met. Richard had mentioned the support the Trust was receiving from Dr Ian Sturgess last time. Ian will be with the Trust until November 2014 and he has identified "consistency" as our key challenge; not just over the working week, but throughout each day. One plan that the Trust is already implementing is its "Super Weekends" which are already generating improvements in performance.

1.4 Richard covered the Trust's financial position, saying that we had a deficit of 40 Million forecast for the year. As of month 3 we were on track to not go over this but month four saw some slippage of around half a million. 800,000 of that figure relates to receiving less income than the Trust had expected. Richard noted that we were in discussion with Commissioners about this and were working on how we manage with a reduced income and how we control both pay and non pay expenditure.

1.5 Richard then informed the group about the "Safe and Sustainable" review of paediatric cardiac surgery, noting that a new evaluation had just begun. One of the key changes to this next phase of review is a standard that such surgery needs to be co-located with other Children's' services on one site. The Trust Board has committed to supporting Children's cardiac surgery. As such, we now need to create a single Children's hospital which will be located at the LRI site. This will result in better services.

1.6 Richard then gave some examples for the regular "You Said We Did" slot in this meeting. He referred to the election of a deputy chair for the group, noting that with the arrival of a new Chairman we wanted to take his views into account regarding the governance of this group and would therefore review this once he had had a chance to consider. Richard said that the group had asked that there be some patient and public involvement in the appointment of the new Chairman. He said that a community stakeholder panel had been assembled which met with each of the short listed candidates before their interview. The views of the panel were then fed in to the appointment process.

1.7 Richard then paused to allow the group to ask any questions.

1.8 Q: With rising referrals to the cancer service, will UHL take on board the need to liaise with the psycho – oncology service?

1.9 John Adler said that this service was managed by LPT but noted the question and would pick this up with LPT.

1.10 Q: There is an issue, particularly with the South Asian population, of not presenting themselves to a psycho – oncology specialist. Generally people aren't aware of the service.

1.11 Richard reiterated that this was an LPT run service and suggested that the best opportunity to raise this would be at the forthcoming LPT AGM.

1.12 Q End of life Care. What can we do about the gap between discharge and the point where social care pick up care?

1.13 Mark Wightman said that one of the key actions in the review 9mentioned earlier) was the formation of a new team to ensure that people take responsibility for this gap following discharge. John Adler noted that this was not just an issue for those at the end of life but related to the handover from one agency to another. He said that there was already a great deal of work going on to address this.

2. Presentation – John Adler: Reconfiguration

2.1 John Adler shared some of the Trust's reconfiguration plans with the group. He emphasised that the Trust's five year plan will be informed by, and must be consistent with the Better Care Together programme which will shape how healthcare is delivered locally in the future. John said that the reconfiguration work can be complex and there were many interdependencies to consider. Morevoer, a number of key moves will be subject to consultation which will happen next year. .

2.2 John acknowledged that since the demise of Pathway there hasn't been a whole system plan in place. The reconfiguration will concentrate on co-location. For example, we currently have emergency surgery on two sites.

2.3 Another key aspect of the reconfiguration work will be the provision of more services in community settings. This work has already begun with the establishment of the "Alliance" group who manage day case and outpatient services in the county community hospitals.

2.4 Reconfiguration can impact on training (particularly medical) and also research. As such we must be mindful of how best to group research teams together.

2.5 John said that we currently do not have a dedicated day case centre, but such a facility would provide a more reliable experience for patients. The Trust is currently finalising two options, to be sited either at the LGH or GH. Thus far clinicians prefer the GH option. However consideration needs to be given to how much space we need and to what needs to go with what (adjacencies) in order to improve pathways.

2.6 There are various options open to the Trust to achieve its vision. For example, developing obstetrics on one site. However, lower risk pregnancies could equally be managed in other ways such as midwifery led units. The Trust's reconfiguration work will be subject to consultation in 2015 and John noted that the Trust was likely to consult on the "whole picture" as well as specific service developments which will need the involvement of specific audiences.

2.7 John said that for each scheme the Trust needs to develop a business case which would identify the clinical and financial cases and articulate a benefits analysis etc.

2.8 Speaking of the new ED Floor development John shared an artist's impression of what the ED floor would look like once complete. He said that this was a £42 Million scheme with an £8 – 9 Million cost for enabling works. As such it is a significant development for the Trust. TO date the Trust Board have approved the business case and with TDA approval work will begin in November.

2.9 John added that the Trust had made a commitment to build a multi storey car park along with this development. He also noted that the Mayor of Leicester supported better links with the Park and Ride service.

3. Older People's Strategy

3.1 Mark Wightman then shared the Trust's Older People's strategy with the group, noting that compassion and care of older people was a core concern of the modern NHS.

3.2 Mark said that an assumption is often made that one must be old to be frail. While this is not always the case, clearly the two are often linked. The Trust's Older People's strategy is primarily concerned with the "oldest old" and sought to view these patients in a more positive and compassionate light.

3.3 Mark made the point that the term "elderly" ought to be dropped. A view which reflects the full and active contribution of people 75+ in contemporary life.

3.4 Some statistics were shared with the group. During the next 16 years we will see…

- 101% more people aged 85 and over in England in 2030 compared to 20102
- Over 50% more people with three or more long-term conditions in England by 2018 compared to 2008
- Over 80% more people aged 65 and over with dementia (moderate or severe cognitive impairment) in England and Wales by 2030 compared to 2010.
- People with diabetes: up by over 45%
- People with arthritis, coronary heart disease, stroke: each up by over 50%
- People with dementia (moderate or severe cognitive impairment): up by over 80% to 1.96 million
- People with moderate or severe need for social care, up by 90%.

As Mark put it, frail older people are not a cohort they are increasingly THE patient.

3.5 Working with University colleagues and the Trust's medical director we are developing a mandatory training requirement on the care of older people. Indeed, we aim to develop Leicester as somewhere recognised as a centre of excellence for the care of the oldest old.

3.6 Mark spoke of the need to "design for frailty" citing the ED floor development as the first frailty friendly ED in the country.

3.7 Mark said that the strategy recognised the need to work with carers, involving them in the development of a personal profile for patients which can be referred to be staff. He also noted the need to develop standards with our staff and ensure these are adhered to.

3.8 Mark also pointed to some collaborative work that the Trust has been doing with Age UK. The project is called the "Loneliness Prescription" which seeks, through a network of volunteers, to identify vulnerable people and intervene before a crisis occurs.

3.9 Summarising Mark made the following points;

The "oldest old" are THE patients and it is time to act accordingly…

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

4. Questions

4.1 Richard Kilner thanked Mark for his presentation and invited questions from the group.

Q. What is the time scale for areas addressed in the [older people's] presentation?

4.2 Mark said that he and Rachel Overfield, our Chief Nurse, had already set up a task group to engage with key clinicians. The group will establish a timeline for each of the challenges identified in the presentation.

Q. When John spoke about co-locating children's services, was he referring to a Children's Hospital?

4.3 John said that the answer to this was both yes and no. The Trust is not in a position to build a new building. Rather, this is more about creating an identifiable Children's centre, most likely to be situated in the Windsor building, with an identifiable brand. This is where children's cardiac services will go.

Q. Will all older people's services move to the LRI?

4.4 John said that most of our older people's services are actually already at the LRI. Mark noted that all acute emergency surgical work will move away from the LGH but made the point that an increasing amount of care will be delivered out in the community or in the patient's own home.

Q. What happened to the plan to move outpatients 1 – 4 and locate the new ED floor in that space?

4.5 Richard Kilner said that when the detail of this proposal was looked in to this was not the right solution in terms of practicality and cost. The new build will represent a greater fit for purpose. John added that building in an existing space involved too many compromises and that the new build would bring better results all round.

Q. How much engagement has been conducted with ED staff on the new development?

4.6 John said that a great deal of engagement had been undertaken; not just with ED staff but with other services and stakeholders.

4.7 Richard Kilner thanked the group for their participation and said that if anyone had suggestions for future agenda items they were welcome to contact Karl Mayes, PPI & Membership Manager on 01162588685 or by email on karl.mayes@uhl-tr.nhs.uk

5. Date and time of next meeting

The next meeting will be held on December 15th at 6pm in the Education Centre, Leicester General Hospital.