Trust Board paper Y

To:	**Trust Board**
From:	**Rachel Overfield - Chief Nurse**
Date:	**31 July 2014**
CQC regulation:	Outcome 16 – Assessing and Monitoring the Quality of Service Provision

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

Author/Responsible Director: Chief Nurse

Purpose of the Report:

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

a) A copy of the revised UHL BAF as of 23rd July 2014.
b) Notification of any new extreme or high risks opened during June 2014
c) Notification of all extreme and high risks that are on the UHL risk register as of 30th June 2014.

The Report is provided to the Board for:

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

Summary :

- A revised suite of risks based on the recently revised UHL objectives is included in the 2014/15 BAF.
- The format of the BAF has changed to provide the TB with a greater level of assurance.
- A simplified table of likelihood and consequence descriptors has been developed for the 2014/15 BAF in order to provide a consistent and less subjective approach to risk scoring.
- As of 30th June 2014 there were 34 risks on the organisational risk register scoring 15 and above (i.e. 32 high and two extreme risks).
- Three new high risks have been opened on the UHL register during May 2014.

Recommendations:

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

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

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

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

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

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

principal objectives; (f) Endorse the UHL 2014/15 BAF as 'fit for purpose' (notwithstanding the additional work required as described in section 2.1 of this report).	
Board Assurance Framework Yes	**Performance KPIs year to date** N/A
Resource Implications (eg Financial, HR) N/A	
Assurance Implications: Yes	
Patient and Public Involvement (PPI) Implications: Yes	
Equality Impact N/A	
Information exempt from Disclosure: No	
Requirement for further review? Yes. Monthly review by the TB	

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **31 JULY 2014**

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

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

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1. INTRODUCTION

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

a) A copy of the revised UHL BAF as of 23rd July 2014.

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

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

2. BAF POSITION AS OF 23rd JULY 2014

2.1 Following the revision of the UHL's 2014/15 strategic objectives and the TB approval of the five year integrated business plan a revised suite of principal risks have been worked up through the Executive Team. At the same time consideration has been given to a change in format of the BAF. This formed the basis of discussions at a Trust Board Development Session (TBDS) that took place on 17th July 2014. During these discussions three additional principal risks were identified (i.e. 6, 18 and 21) and have been included in the BAF that is attached at appendix one. Further work from their executive leads is required in order to provide a completed BAF, however notwithstanding this the UHL 2014/15 BAF is submitted to the TB for endorsement. In doing so the TB is asked to note the following:

a. The change in format to the BAF is designed to provide the TB with a greater level of assurance by focussing on how we measure / monitor the effectiveness of each control in relation to moving us towards our objectives. The assurance element will record performance against the relevant key performance indicators.

b. A simplified table of likelihood and consequence descriptors has been developed for the 2014/15 BAF in order to provide a consistent and less subjective approach to risk scoring and is included within the BAF for ease of reference. Each risk will also have a current and target rating assigned indicating the level of risk to the objective not being achieved. For completeness, all scores are calculated by multiplying the consequence score by the likelihood score.

c. Future iterations of the BAF will be accompanied by a summary sheet to show the movement of scores from one month to the next and an action tracker to reflect progress in implementing actions from the BAF.

d. The corporate risk team will carry out an exercise to ensure that where risks from the previous BAF are not included in the 2014/15 version they are included on the UHL risk register under the ownership of the appropriate director.

4. 2014/15 QUARTER ONE EXTREME AND HIGH RISK REPORT.

4.1 A summary of all currently open extreme and high risks is attached at appendix two and the details of these risks are attached at appendix three. As of 30th June 2014 there were 34 risks on the organisational risk register scoring 15 and above (i.e. 32 high and two extreme risks).

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

Risk ID	Risk Title	Risk Score	CMG/ Directorate
2391	Inadequate numbers of Junior Doctors to support the clinical services within Gynaecology & Obstetrics	20	W & C
2384	There is an increased risk in the incidence of babies being born with HIE (moderate & severe) within UHL	16	W & C
2380	Risk of breach of Same Sex Accommodation Legislation	15	CSI

5. RECOMMENDATIONS

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

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

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

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

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

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

(f) Endorse the UHL 2014/15 BAF as 'fit for purpose' (notwithstanding the additional work required as described in section 2.1 of this report).

Peter Cleaver,
Risk and Assurance Manager,
24 July 2014.

UHL BOARD ASSURANCE FRAMEWORK 2014/15

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

STRATEGIC OBJECTIVES

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

PERIOD: JULY 2014

Risk No.	Link to objective	Description	Risk owner	Current Score C x L	Target Score C x L
1.	Safe, high quality, patient centred healthcare	Lack of progress in implementing UHL Quality Commitment.	CN	12	8
2.	An effective joined up emergency care system	Failure to implement LLR emergency care improvement plan.	COO	12	6
3.		Failure to effectively implement UHL Emergency Care quality programme	COO	12	6
4.		Delay in the approval of the Emergency Floor Business Case.	MD	9	6
5.	Responsive services which people choose to use (secondary, specialised and tertiary care)	Failure to deliver RTT improvement plan.	COO	9	6
6.		Failure to achieve effective patient and public involvement	DMC		
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	9	6
12.		Failure to retain BRU status.	MD	9	6
13.		Failure to provide consistently high standards of medical education.	MD	9	6
14.		Lack of effective partnerships with universities.	MD	9	6
15.	Delivering services through a caring, professional, passionate and valued workforce	Failure to adequately plan workforce needs of the Trust.	DHR	12	8
16.		Inability to recruit and retain staff with appropriate skills.	DHR	12	8
17.		Failure to improve levels of staff engagement.	DHR	9	6
18	A clinically and	Lack of effective leadership capacity and capability	DHR		

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

Consequence and Likelihood Descriptors:

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Establishment of emergency care delivery and improvement group with named sub groups	Meetings are minuted with actions circulated each week. Trust Board emergency care report references the LLR steering group actions.	(C) Format of LLR meeting has changed recently and regularity of meetings and membership needs to be confirmed	Chair of group will confirm membership and sub group activities in the next fortnight	Aug 14 Dave Briggs
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.	(A) Dr Sturgess is contracted to finish work here in mid-November 2014.	CEO and Dr Sturgess are agreeing plans to ensure his legacy is sustainable	August 2014 John Adler
Allocation of winter monies	Allocation of winter monies is regularly discussed in the LLR steering group	(C) Allocation of money across the health economy has not been confirmed – i.e. how much will UHL receive?	Dr Sturgess tasked with chairing a group that recommends how the money can be used most effectively.	July 2014 Dave Briggs

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Emergency care action team meeting has been remodelled as the 'emergency quality steering group' (EQSG) chaired by CEO and significant clinical presence in the group. Four sub groups are chaired by three senior consultants and chief nurse.	Trust Board are sighted on actions and plans coming out of the EQSG meeting.	(C) Progress has been made with actions outside of ED and we now need to see the same level of progress inside it	One of the subgroups is focussed on the front end of the pathway	Sept 14 Mark Ardron
Reworked emergency plans are focussing on the new dashboard with clear KPIs which indicates which actions are working and which aren't	Dashboard goes to EQSG and Trust Board	(C) ED performance against national standards	As above	As above

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Monthly ED project program board to ensure submission to NTDA as required Gateway review process Engagement with stakeholders	Monthly reports to Executive Team and Trust Board Gateway review	Inability to control NTDA internal approval processes	Regular communication with NTDA	Aug 14 Kevin Harris

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 developed in key specialities – general surgery and ENT to regain trajectory	Sept 14 Richard Mitchell
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	Action plans developed in key specialities – general surgery and ENT to regain trajectory	Sept 14 Richard Mitchell
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	Aug 14 Richard Mitchell

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**	**Target score**
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**

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

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

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**
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 ○ Reviewed at the June 2014 Executive Strategy Board (ESB) meeting	(C) Head of External Partnership Development with administrative support to be appointed (C) Programme Plan to be developed	Highlight report to be presented at the August 2014 ESB meeting for sign off.	December 2014 Kate Shields
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) Progress will be monitored via the Contracts Team as part of their interface with CMG Managers / Service Managers	Contracts Team to develop simple monthly reporting to track progress	Sept 2014 Kate Shields

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			
Director of Strategy	Integrated care in partnership with others (secondary, specialised and tertiary care)			

Integrated care in partnership with others (secondary, specialised and tertiary care)	**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**
Network relationships with partners: Directional 5 year Integrated Business Plan (IBP) submitted to the NHS Trust Development Authority (NTDA) defines three principle partnership networks to support the integration of services (Local, regional and academic). These will progress in a structured and methodical way. Clear lines of reporting have been established through the Executive Strategy Board (ESB) Delivering Care at its Best structure. Highlight reports will be presented to monitor progress.	Minutes of the April 2014 Trust Board meeting: ○ Paper presented to the April 2014 UHL public Trust Board meeting, describing the development of an East Midlands Provider Partnership Project Initiation Document (PID): ○ Developed as part of UHL's Delivering Care at its Best ○ Reviewed at the June 2014 ESB meeting	(C) PID to be developed for local partnerships (Executive Lead Mark Wightman) and academic partnerships (Executive Lead Nigel Brunskill – DR&D) - to be presented at the August 2014 ESB meeting.	PIDs and overarching highlight report to be presented at the August 2014 ESB meeting for sign off.	August 2014 Nigel Brunskill / Mark Wightman
Delivery of Better Care Together: 1) UHL is activelyengaged in the Better Care Together governance structure, from an operational to strategic level: • John Adler is the Chair of the Strategy Delivery Group • Kate Shields is a member of the LLR Strategy Delivery Group • Peter Hollinshead / Simon Sheppard are members of the finance sub-group 2) Better Care Together plans are co–created in partnership with LLR partners e.g. sub-acute project with LPT	LLR Better Care Together Executive Summary (directional plan): ○ received and approved at the June 2014 UHL Trust Board meeting	(C) LLR BCT plan submitted on 20 June to NHS England and the NTDA is 'directional' i.e. it outlines the broad direction of travel. Detailed delivery plans to be discussed and agreed between June and September 2014.	Work plan developed by the LLR BCT Strategy Delivery Group to be considered by the BCT Programme Board at the end of August 2014.	August 2014 Kate Shields

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			
Director of Strategy	Integrated care in partnership with others (secondary, specialised and tertiary care)			

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

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 3 = 9**	**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 3 = 9**	**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 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**
Medical Education Strategy	A joint Programme and project methodology is in place between UHL and IBM for managing and tracking activities.			
UHL Education Committee	Reports to Trust Board (quarterly)			

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 3 = 9**	**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 eg social services/ community services and primary care and broad based planning assumptions around demographics and activity. (c) Difficulty in recruiting to hotspots as frequently reflect a national shortage occupation	We are working on an integrated approach to workforce planning with LPT in the first instance in order that we can plan an overall workforce to deliver the right care in right place at the right time. A joint group of strategy, finance and workforce leads is being established to share plans and numbers Mulitprofessional new roles group to be established to devise and monitor processes for the creation of new roles particularly those focused on	Oct 2014 Kate Bradley Oct 2014 Rachel Overfield

			reducing known gaps in the workforce. Innovative approaches to recruitment and retention to address shortages. Each CMG has clearer picture of supply and demand trajectories and actions to close gaps	March 2015 Kate Bradley
Nursing Recruitment Trajectory	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	(C) Nurse staffing vacancies	International recruitment plan in place for nursing staff	On-going Rachel Overfield
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 (C) Capacity to build innovative approaches to recruitment of future service/ operational managers	Delivering our Employer Brand group is sharing best practice and development social media techniques to promote opportunities at UHL Development of internship model and potential management trainee model supported by robust education	March 2015 Kate Bradley November 2014 Kate Bradley

		(c) capacity to build innovative approaches to consultant recruitment	programme and education scheme. Consultant recruitment review team to develop professional assessment centre approach to recruitment utilising outputs to produce a development programme	Date to be confirmed Kate Bradley

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source**(Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Refreshed Organisational Development Plan (2014-16) including five work streams: 'Live our Values' by embedding values in HR processes including values based recruitment, implementing our Reward and Recognition Strategy (2014-16) and continuing to showcase success through Caring at its Best Awards	Quarterly reports to EWB and Trust Board and measured against implementation plan milestones set out in PID	(a) Improvements required in 'measuring how we are doing'	Team Health Dashboard to be developed – mock up to be presented to EWB at September Meeting	September 2014 Kate Bradley
'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 againstImplementation 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-learningdevelopment	eUHL system updates required to meet Trust needs Robust ELearningpolicy and procedures to be developed to reflect P&GC approach	March 2015 Kate Bradley Oct 2014 Kate Bradley

'Quality Improvement and innovation' by implementing quality improvement education, continuing to develop quality improvement networks and creating a Leicester Improvement and Innovation Centre	Quarterly reports to EQB and EWB and measured against implementation plan milestones set out in PID.	No gaps identified		
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) 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)	March 2015 Kate Bradley
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 / orr 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. HR Senior Team aware of need to include Engagement event prior to formal	March 2015 Kate Bradley

			consultation (with MoC impacting on staff – more than 25 people)	
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	March 2015 Kate Bradley
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) 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	Team Health Dashboard to be developed – mock up to be presented to EWB at September 2014 meeting (Please see Principal Risk 15)	March 2015 Kate Bradley

	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)	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 (as at 8 July 2014) 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. Triangulation of Friends and Family Test for Staff results with local Pulse Check Results (Work stream One: Classic LiA / Work stream Five: NiA) and other indicators of staff engagement such as National Staff Survey	National data on UHL workforce numbers to be used by NHS England to get a sense of how many staff completed the survey (Same calculations being used for all other Trusts so variables consistent nationally). Various draft internal reports in development in readiness for possible analysis methodology used by NHS England in September 2014. Team Health Dashboard to be developed – mock up to be presented to EWB at September 2014 meeting (Please see Principal Risk 15)	First report published by NHS England September 2014 March 2015 Kate Bradley

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**

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**	**Target score**
			5 x 3 = 15	**5 x 2 = 10**
Executive Risk Lead(s)	Director of Finaince			
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 and SOs	Monthly progress reports to F&P Committee, Executive Board, & Trust Board Development Sessions TDA Monthly Meetings Chief Officers meeting CCGs/Trusts TDA/NHSE meetings Trust Board Monthly Reporting UHL Programme Board, F&P Committee, Executive Board & Trust Board	(C) Varying level of financial understanding/ control within the organisation. (C) Lack of supporting service strategies to deliver recurrent balance	Finance Training Programme Production of a FRP to deliver recurrent balance within three years Health System External Review to define the scale of the financial challenge and possible solutions Production of UHL Service & Financial Strategy including Reconfiguration/ SOC	Jul 2014 Simon Sheppard Aug 2014 Simon Sheppard Jul 2014 Simon Sheppard Jul 2014 Simon Sheppard
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	Expedite agreement	Aug 2014 Simon Sheppard

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

		(c) PMO structure not yet in place to ensure continuity of function following departure of Ernst & Young	PMO Arrangements need to be finalised	Aug 2014 Simon Sheppard
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) The organisation has not effectively identified its service model. (c) Varying level of financial understanding/ control within the organisation. (c) Finance department having difficulties in recruiting to finance posts leading to temporary staff being employed.	Production of Integrated Business Plan (Activity, Capacity, Operational Targets, Workforce, CIPS, Budgets, Capital & Risks) (1.27) Finance Training Programme (1.21) Restructuring of financial management via MoC (1.28)	Jul 2014 Simon Sheppard Jul 2014 Simon Sheppard Jul 2014 Simon Sheppard
Seeking to agree financially and operationally deliverable by contract arbitration and TDA mediation	Agreed contracts document through the dispute resolution process/arbitration Regular updates to F&P Committee, Executive Board, Escalation meeting between CEOs/CCG Accountable Officers	(c) Failure to agree appropriate levels of financial impact for QIPP, fines and penalties and MRET. (c) Failure to agree levels of operational performance in relation to the above.	Negotiate realistic contracts with CCGs and Specialised Commissioning - QIPP - Fines & Penalties - MRET rebase - Counting & Coding CCG Non Recurring Funding	Jul 2014 Simon Sheppard

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	Jul 2014 Simon Sheppard
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	June 2014 Simon Sheppard

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	Expedite agreement PMO Arrangements need to be finalised	Aug 2014 Simon Sheppard Aug 2014 Simon Sheppard
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	Will be actioned through the monthly cross cutting theme delivery board	August 2014 Richard Mitchell

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**	**Target score**
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**

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source**(Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Governance in place to manage the procurement of the solution	EPR project board with executive and Non-Executive members. Standard boards in place to manage IBM; Commercial board, transformation board and the joint governance board. UHL reports progress to the CCG IM&T Strategy Board	(C) OBC/FBC approval with NTDA	Working closely with finance, procurement and the NTDA to navigate the approvals process to submit OBC	Aug 2014 John Clarke
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	Ensure all clinicians have an opportunity to contribute Re-align the timetable to ensure best fit with clinical workload Improvement in communications to clinical staff/teams	July 2014 John Clarke
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.	Sep 2014 John Clarke

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

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

Appendix 2 - UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – RISK REGISTER SUMMARY (RISKS SCORING 15 OR ABOVE)

PERIOD: AS AT 30 JUNE 2014

ID	RISK TITLE	CURRENT SCORE	TARGET SCORE	RISK MOVEMENT
2236	There is a risk of overcrowding due to the design and size of the ED footprint	25	16	⇔
2325	Risk to patient/staff safety due to security staff not assisting with restraint	25	6	⇔
2234	There is a medical staffing shortfall resulting in a risk of an understaffed Emergency Department	20	6	⇔
2333	Lack of paediatric cardiac anaesthetists to maintain a WTD compliant rota leading to service disruption and loss of resilience	20	8	⇔
2330	Risk of increased mortality due to ineffective implementation of best practice for identification and treatment of sepsis	20	6	⇔
2339	Potential risk to Renal transplant patients as a result of deterioration of team working & deviation from policy and procedures	20	5	⇔
698	Risk to the production of aseptic pharmaceutical products	20	3	⇔
847	Lack of Capacity in maternity services	20	12	⇔
2391	Inadequate numbers of Junior Doctors to support the clinical services within Gynaecology & Obstetrics	20	8	NEW
2320	Inadequate staffing levels in therapy radiography and radiotherapy physics causing a serious radiotherapy treatment error	16	4	⇔
2193	Risk of unplanned loss of theatre and/or recovery capacity at the LRI	16	4	⇔
2256	There is a risk of harm to patients, staff and the four hour target due to inadequate nurse staffing levels.	16	6	⇔
2194	Risk of unplanned loss of theatre, recovery or Critical Care capacity across UHL due to insufficient nursing staffing	16	4	⇔
2338	There is a risk of patients not receiving medication and patients receiving the incorrect medication due to an unstable homecare	16	9	⇔
2191	Follow up backlogs and capacity issues in Ophthalmology	16	8	⇔
607	Failure of UHL BT to fully comply with BCSH guidance and BSRs may adversely impact on patient safety and service delivery	16	4	⇔
2300	There is a risk of not meeting the national guidelines for out of hours Vascular cover	16	4	⇔
2248	Lack of IR(ME)R training records held across the Trust	16	4	⇔
2384	There is an increased risk in the incidence of babies being born with HIE (moderate & severe) within UHL	16	8	NEW
2341	Long term follow up outpatient appointments not made	16	2	⇔
2153	Shortfall in the number of qualified nurses in Children's Hospital including ECMO staffing and Capacity	16	8	⇔
2237	Risk of results of outpatient diagnostic tests not being reviewed or acted upon resulting in patient harm	16	8	⇔
2247	500 Registered Nurse vacancies across UHL leading to a deterioration in service and adverse effect on financial position	16	12	⇔
2318	Blocked drains causing leaks and localized flooding of sewage	16	2	⇔
1693	Risk of inaccuracies in clinical coding	16	8	⇔
1737	Inappropriate environment and infection prevention Renal Transplant	15	15	⇔
2070	Harborough Lodge environment stops staff safely delivering haemodialysis	15	5	⇔
2380	Risk of breach of Same Sex Accommodation Legislation	15	3	NEW
1196	No comprehensive out of hours on call rota for consultant Paediatric radiologists	15	2	⇔
2328	Risk of inadvertent wrong route administration of anaesthetic medicines during epidural and regional anaesthesia	15	5	⇔
2278	Risk that the Leicester Fertility Centre could have its licence for the provision of treatment and services withdrawn	15	6	⇔
2270	Failure to achieve compliance of 75% attendance at Fire Safety training may cause UHL to fail to meet its statutory obligation	15	9	⇔
2269	Failure to meet UHL target of a minimum of 75% of clinical staff undertaking IP/Hand hygiene training	15	10	⇔
1551	Failure to manage Category C documents on UHL Document Management system (DMS)	15	9	⇔

⇔ = Risk score not changed from previous reporting period
NEW = New risk entered during this reporting period
↑ = Risk score increased from previous reporting period

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

OPERATIONAL RISKS SCORING 15 OR ABOVE FOR THE PERIOD XX/XX/XX

REPORT PRODUCED BY: UHL CORPORATE RISK MANAGEMENT TEAM

Key

Red	Extreme risk (risk score 25)
Orange	High risk (risk score 15 - 20)
Yellow	Moderate risk (risk score 8 - 12)
Green	Low risk (risk score below 8)
⮝	Risk score increased from initial risk score
⮟	Risk score decreased from initial risk score
★	New risk since previous reporting period
⇔	No Change in risk score since previous reporting period

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2236	Emergency and Specialist Medicine	ED	There is a risk of overcrowding due to the design and size of the ED footprint	04/10/2013	31/07/2014	Design and size of footprint in paediatrics causes delay in being seen by clinician. Risk of deterioration. Risk of four hour target and local CQUINS. Lack of patient confidentiality. Increased violence and aggression. Design and size of footprint in resus causes delay in definitive treatment, delay in obtaining critical care, risk of serious incidents, increased crowding in majors, risk to four hour target. Poorer quality care. Risk of rule 43. Lack of privacy and dignity. Increased staff stress. Design and size of majors causes delay in definitive treatment and medical care. Poor quality care. Lack of privacy and dignity. High number of patient complaints. Risk of deterioration. Difficulty in responding to unwell patient in majors. Risk of adverse media interest. Staff stress. Risk of serious incident. Inability to meet four hour target resulting in patient safety and financial consequences. High number of incidents. Increased staff stress. Infection control risk. Risk of rule 43. Design and size of assessment bay causes delay in time to assessment. Paramedics unable to reach turnaround targets Design and size of minors results in delay in receiving medic Design and size footprint in streaming rooms causes threat t	Patients	The Emergency Care Action Team, which was established in spring 2013 aims to improve emergency flow and therefore reduce the ED crowding. The Emergency department is actively engaging in plans to increase the ED footprint via the 'hot floor' initiative, but in the shorter term to increase the capacity of assessment bay and resus.	Extreme	Almost certain	25	New ED plus associated hot floor rebuild approved by the trust and OBC (Outline Business Case) submitted and first phase of construction of new ED to completed by December 2015 .	16	JE

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2325	Corporate Nursing	Nursing	Risk to patient/staff safety due to security staff not assisting with restraint	03/04/2014	30/09/2014	**Causes** Interserve refusal to provide trained staff to carry out non-harmful physical intervention, holding and restraint skills, where patient control is necessary to deliver essential critical care to patients lacking capacity to consent to treatment. Insufficient UHL staff trained in use of non-harmful physical intervention and restraint skills to carry out patient control. Termination of Physical skills training contract with LPT provider in January 2014. **Consequence** Inability to deliver safe clinical interventions for patients lacking capacity who resist treatment and/or examination. Increased risk of Life threatening or serious harm to patients resisting clinical intervention Increased risk of injuries to patients due to physical interventions by inexperienced/untrained staff. Increased risk of injuries to untrained staff carrying out physical interventions. Increased risk of injuries to staff carrying out clinical procedures Requirement for increased staffing presence to carry out safe procedures Reduced quality of service due to diverted staff resources Increased risk of sick absence due to staff injury. Increased risk of complaints from patients and visitors Increased risk of failure to meet targets Adverse publicity	Patients	UHL Nursing and Horizons colleagues have met with Interserve 12/03/14 and UHL have agreed to issue a temporary indemnity notice that will provide vicarious liability cover for Interserve staff in these situations (supported by our legal team). This was rejected by Interserve Management Cover with more UHL employed staff where there may be patients requiring this type of restraint; Staff must take risk assessed decisions about the use of restraint and ensure incidents are reported using the Trust's incident reporting database. In extreme cases staff should be aware that the police should be called Continue to communicate with all staff about the current position.	Extreme	Almost certain	25	High priority recruitment of physical skills trainer - 30/09/14	6	DLO

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2339	RRC	Renal Transplant	Potential risk to Renal transplant patients as a result of deterioration of team working & deviation from policy and procedures	02/05/2014	30/11/2014	**Causes** Poor lines of communication Poor interpersonal relationships Lack of clarity of procedures and policies **Consequences** Potential for patient harm Suboptimal transplant outcomes Potential for morbidity and mortality related to transplant process.	Targets	Clear lines of communication have been defined The 4 surgical consultants have agreed significantly improved ways of working and are demonstrating significantly improved team working skills and attitudes. Appointment of an external clinical lead (Chris Rudge) who will be working with the team 2 days a week for 3 - 6 months Policies / guidelines have been written for ward rounds, OPD and kidney acceptance MDT's and M&M's will be in place for the restart of the process	Extreme	Likely	20	Completion and ratification of ward policies and protocols document - 30/11/14 Review panel returned on 2.7.14 and currently awaiting the final report (as at 2/7/14).	5	SLEA

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2234	Emergency and Specialist Medicine	ED	There is a medical staffing shortfall resulting in a risk of an understaffed Emergency Department impacting on patient care	04/10/2013	31/08/2014	**Causes:** Consultant vacancies. Middle grade vacancies. Risk of losing trainees due to incorrect service/training balance. Trainee attrition. Trainees not wanting to apply for consultant positions. Reduced cohesiveness as a trainee group. Junior grade vacancies. Juniors defecting to other specialties. Poorer quality of training resulting in poor deanery reports. Non ED medical consultants. Locums. Increased consultant workload. Lack of uniformity. Paediatric medical staffing. Poorer quality care for paediatric population. **Consequences:** Poor quality care. Lack of retention. Stress, poor morale and burnout. Increased sickness. Increased incidents (SUI's), claims and complaints. Inability to do the general work of the department, including breaches of 4 hour target. Financial impacts. Reduced ability to maintain CPD commitments for consultants/medical staff with subspecialty interest. Reduced ability to train and supervise junior doctors. Deskilling of consultants without subspecialty interest. Suboptimal training.	Patients	The chief executive and medical director have met with senior trainees in Leicester ED to invite them to apply for consultant positions. The East Midlands Local Education and training board has recognised middle grade shortages as a workforce issues and has set up several projects aiming to attract and retain emergency medicine trainees and consultants. Advanced nurse practitioners and non-training CT1 grades have been employed in order to backfill the shortage of SHO grade junior doctors. There has been shared teaching sessions in which non ED consultants and ED consultants have shared skills, (i.e. ED consultants learning about collapse in the elderly and elderly medicine consultants doing ALS). The non ED consultants have been set up on a specific mailing list so that new developments and departmental 'mini-teaches' (= learning cases from incidents) can be shared. Only approved locum agencies are used for ED internal locums and their CVs are checked for suitability prior to appointing them. Locums receive a brief shop floor induction on arrival and also must sign Locum doctors are only placed in paeds ED in except The grid paediatric trainees shift pattern has changed ED employs medical registrars to work night shifts in E ED consultants have extended their shop-floor hours f ED employs locum medical consultants to improve se ED has employed several well performing locums on ED has employed oversees doctors at specialty and tr	Extreme	Likely	20	New rota for August 2014 juniors - 31/07/14	6	BTD

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2333	ITAPS	Anaesthesia	Lack of paediatric cardiac anaesthetists to maintain a WTD compliant rota leading to service disruption and loss of resilience	17/04/2014	30/12/2014	**Causes:** 1. Retirement of previous consultants 2. Ill health of consultant 3.lack of applicants to replace substantively **Consequence:** 4.need for remaining paeds anaesthetists to work a 1:2 rota on call 5.Lack of resilience puts cardiac workload at risk 6. May adversely affect the national reputation of GGH as a centre of excellence 7.current rota non complaint WTD 8. patients requiring urgent paeds surgery may be at risk of having to be transferred to other centres 9. Income stream relating to paeds cardiac surgery may be subsequently affected 10. risk of suboptimal treatment	Quality	1. 1:2 rota covered by experience colleagues 2. 12 month locum appointed	Major	Almost certain	20	1. Continue with substantive recruitment strategy and Job to go out to advert - 30/12/14	8	DTR

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
698	Clinical Support and Imaging	Pharmacy	Risk to the production of aseptic pharmaceutical products	03/05/2007	31/08/2014	**Causes** Provision of aseptically prepared chemotherapy is being undertaken from a temporary rental unit. Temporary nature and age of facility indicates high probability of failure. Arrangements for segregation of in-process and completed items is inadequate leading to high possibility of error. Current temporary unit is outside the range of the department's temperature monitoring system. Failure of refrigerated storage will remain undetected outside working hours, and has already occurred. Planning permission for temporary unit only valid until August 2012 Contingency arrangements are insufficient and could only provide for the very short term. Project is already 6 months behind schedule Storage, receipts and dispensing facility for dose-banded chemotherapy and other outsourced items purchased. Alternative arrangements will need to be found when unit is refurbished **Consequences** Failure of Current Temporary Facility; Inability to provide 50% of current chemotherapy products for adult services. Inability to provide chemotherapy for paediatric services. Substantial delay in re-establishing service provision from alt Limitations of treatments that can be sourced from an alterna Inability to support research where aseptic compounding req	Targets	Planned servicing & maintenance of temporary facility being undertaken. Constant environmental monitoring of facility in place. Contingency arrangement for supply from external source currently being pursued. Business Case for new unit (refurbishment of facility within the Windsor building) has been presented and approved by the commercial exec board in 2011. Facilities are working with Pharmacy and commercial architects in order to finalise plans and get refurbishment started. Project to refurbish the aseptic unit has now started - nov 2013	Extreme	Likely	20	New unit in operation - due 31/8/2014	3	GH

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2391	Women's and Children's		Inadequate numbers of Junior Doctors to support the clinical services within Gynaecology & Obstetrics	24/06/2014	31/08/2014	Currently there are not enough Junior Doctors on the rota to provide adequate clinical cover and service commitments within the specialties of Gynaecology & Obstetrics. **Consequences:** Failure to meet the Junior Drs training needs in accordance with the LETB requirements. Potential to lose Junior Drs training within the CMG. Reduced training opportunities and inconsistencies in placements. Increased risk of Junior Doctors seeing complex patients in clinics unsupervised. On call rota gaps/ Increased requirement for locums to fill gaps. Potential for LETB to remove training accreditation within obstetrics and gynaecology. This will lead to the removal of training posts. Increased potential for mismanagement / delay in patients treatment/pathway.	Patients	Locums where available. Specialist Nurses being used to cover the services where possible and appropriate.	Major	Almost certain	20	Business Case to be developed re. how to meet service commitments by backfilling with Consultants, Specialist Nurses, etc due 31.08.14 CMG to continue to pursue recruitment of junior doctors eg Clinical Fellows, Trust grade doctors due 31.08.14 Further development of robust training programme for Junior Drs by Clinical Tutor & Programme Director due 31.08.14	8	ACURR

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
847	Women's and Children's	Maternity	Lack of Capacity in maternity services	28/09/2007	20/07/2014	**Causes** Continuing increase to the birth-rate in Leicester . The number of maternity beds has decreased. Consultant cover for Delivery Suite is 60 hours a week with long term business plans to increase the hours in accordance with Safer Childbirth Recommendations. **Consequences** Midwifery staffing levels are not in accordance with national guidance however they are in line with regional averages. Transfer of activity between the LGH and LRI occurs on a frequent basis with Leicestershire having to close to maternity admissions on a number of occasions. Increase in incidents reported where there has been a delay in elective CS, IOL and augmentation due to lack of beds. Staff frequently go without meal breaks. Increased waiting time in MAC and therefore increased risk of a clinical adverse outcome to both mother and baby.	Patients	Length of postnatal stay in hospital as short as possible. Community staff prepare women for early discharge home if straightforward delivery. Extra triage room on Delivery Suite, LRI completed July 2012. Triage and admission areas in acute units to ensure no category x women sitting on delivery suite. Use of Escalation Plan to inform staff on actions required if capacity is high. Capacity is managed between the two acute units by temporarily transferring care if one site is busy. Liaison with neighbouring maternity hospitals if high risk of closure of Leicestershire Maternity Hospitals. Prioritisation of both elective and 'emergency' work according to clinical urgency and need. On call Manager. On call SOM. Funded midwife places increased to 1:32. Escalation and contingency plans in place. Relocation of all elective gynaecology beds to LGH.	Extreme	Likely	20	Increase ward capacity on LRI site by opening 13 AN beds on level 1 - completed Complete transfer of all EL CS to level 1 - due 30/9/14	12	EBROU

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2330	Medical Directorate		Risk of increased mortality due to ineffective implementation of best practice for identification and treatment of sepsis	11/04/2014	30/08/2014	**Causes** Failure of clinical staff to consistently recognise and act on early indicators of sepsis Lack of system to 'red flag' early indicators of sepsis. Complex anti-microbial prescribing guidance. **Consequences** Sub-optimal care/ death of patients (2 x SUI reports of death related to sepsis) Potential for increased complaints and claims/ inquests Additional costs to the organisation (estimated additional cost of £4k per patient if best practice is not consistently applied). Risk of adverse media attention and questions in the house in relation to sepsis deaths	Patients	UHL Sepsis working group including representatives from clinical areas Education and training Regular sepsis audits Early Warning scores Regular reporting to Executive Quality Board Sepsis rates monitored via CQUIN performance monitoring Sepsis Care Package	Major	Almost certain	20	Develop sepsis scoring methodology and incorporate into EWS observations - 30/8/14 Roll out of above - 30/9/14 Increased visibility of sepsis care pathway - 30/8/14 'Sepsis champions' to be trained by J Parker and Sepsis Nurse - 30/8/14 Simplification of anti-microbial prescribing for sepsis - 30/8/14 Implement 'sepsis boxes' for use in clinical areas - 30/9/14	6	JPARK

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2320	CHUGS	Radiotherapy	Inadequate staffing levels in therapy radiography and radiotherapy physics causing a serious radiotherapy treatment error	21/03/2014	31/08/2014	**Causes** Inadequate staffing levels caused by insufficient budget to recruit to recommended levels. Increased demand and complexity of activity **Consequences** Staff fatigue (due to increased overtime working) resulting in greater risk of error with potential for severe patient injury. Lack of resilience in case of unplanned events such as staff sickness / machine breakdown. Inability to cope with increases in demand Non compliance with national recommendations (i.e. only 75% of patients receive on-treatment verification - national recommendation 100% and possible failure to meet NHS England standard for IMRT capacity). Shortage of Medical Physics Expert (MPE) cover leading to lack of ability to deal with unusual cases requiring variation from protocol and delays in approving new protocols / techniques. (MPE cover is legal requirement under IRMER) Inadequate oversight of new techniques/trials Lack of strategic planning and delays to service critical developments such as IGRT, SABR. Change management process (including risk assessments) not consistently applied potentially meaning that process cha Participation in radiotherapy trials reduced. Staff training compromised. Potential for increased external scrutiny. Low morale and difficulties in retaining staff.	Quality	Planned shifts limit daily working hours Practice controlled by quality system with training/competency records. New techniques can only be authorised by senior staff. Processes carefully defined with checklists Minimum senior staffing levels	Major	Likely	16	Ensure realistic treatment booking, increase planned work hours with staff working shifts (dependant on business case) - 31/08/14 Protected time for training / development (dependant on business case) - 1/10/14 Increase treatment imaging to 100% to prevent risk of treatment error, aim to increase imaging to 100% of patients (dependant on business case) - 1/10/14 Submit second business case to increase in linac capacity by generating income from further increase in activity / complexity - 1/10/14 Enforce change management process to include risk assessment of new development and controlled documentation - 31/8/14 Identify resource for quality system - appoint dedicated staff member to update and maintain quality system - 1/9/14	4	LWI

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2256	Emergency and Specialist Medicine	ED	There is a risk of harm to patients, staff and the four hour target due to inadequate nurse staffing levels.	27/11/2013	31/07/2014	Approximately 25% of footfall within ED is paediatric, accounting for 36,000 patients per year. There are only two paediatric band 7 nurses and one paediatric matron. The band 7 nurses are frequently required to cover the main shop floor as the nurse in charge or nurse co-coordinating majors, which results in reduced opportunity for supervision and training in the main paeds ED. There is concern that this has lead to increased staff attrition due to lack of support and increased patient risk due to lack of skill, training and supervision of junior nurses. Currently in paeds ED there are junior nurses who require senior support and supervision. The aim of the department is to cover 75% of the time but there is insufficient capacity of available senior PED nurses time. The risk has an impact on patient safety and quality delivered to children in the Paeds ED. **Causes:** There are significant vacancies in paediatric trained nurses, including four vacancies at band 5. As a result of this, the paediatric area is often staffed with non-paeds ED trained nurses, many of which are quite junior. These members of st Band 5 staff have insufficient experience and knowledge to r Paediatric Band 7 nurses currently are allocated to 63 hours Paeds ED is having 2 adult trained staff rotated into the depa Due to a successful recruitment drive, there has been an inc	Patients	To try and maintain senior band 7 nurse presence in paeds ED as much as possible particularly on the late shifts. New appointment of advanced nurse practitioner roles (x 4 with an additional supernumerary) Rolling advert for paediatric nurses, plus rotational roles being offered Two dedicated ENP's who can support the Paediatric nursing team. Advert and appointment of Paeds ED Band 7. From 3rd February 2014 the current Band 7 nurses and matrons have allocated 37.5 hours as clinical supervisors shifts. This addresses supervision but not an increase of clinical hours. Increase in Band 7 appointments across the whole department will help to deliver the allocated 63 hours a week for current staff. The NIC is always available to assist and support junior staff allocated to PED. There is also cover from a senior decision maker (medic) until 10pm daily to support the junior nursing staff.	Major	Likely	16	Continue to recruit band 5 paediatric trained nurses - due 31/08/14	6	LLA

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2193	ITAPS	Theatres	Risk of unplanned loss of theatre and/or recovery capacity at the LRI	28/06/2013	30/11/2014	**Causes:** The Theatre and Recovery estate and supporting plant(s) are old, unsupported from a maintenance perspective and not fit for purpose. There is recent history of unplanned loss of surgical functionality at the LRI site due to plant failure, problems with sluice plumbing and ventilation. In addition, the poor quality of the floors, walls, doors, fittings and ceilings mean an unfit working environment from a working life, infection prevention and patient experience perspectives. There is insufficient electricity and medical gas outlets per bed. Aged electrical sockets resulting in actual and potential electrical faults - fire in theatres at LRI (Theatre 4) in July 2013. **Consequences:** Periodic failure of the theatre estate (ventilation etc) so elective operating has to cease. Risk of complete failure of the theatre estate so elective and emergency operating has to stop. Increase risk of patient infections. Poor staff morale working in an aged and difficult working environment. Difficulty in recruiting and retaining specialised staff (theatre and anaesthetic) due to poor working environment. Poor patient experience - our most vulnerable patients arrive May impair delivery of life support technologies.	HR	1. Regular contact with plant manufacturers to ensure any possible maintenance is carried out 2. Use of limited charitable funds available to purchase improvements such as new staff room chairs and anaesthetic stools - improve staff morale. 3. TAA building work has started 4. Plan to develop full business case for new recovery build 2013 - start 2014 5. 5S'ing events taking place within the theatre transformation project frame work 6. Compliance with all IP&C recommendations where estate allows 7. Purchase of new disposable curtains for recovery area, reducing infection risk and improving look of environment	Major	Likely	16	Recovery re-build - due 01/08/15 Capital investment and refurbishment of LRI theatres - plan in place and commenced - due 01/12/15	4	PV

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2194	ITAPS	Theatres	Risk of unplanned loss of theatre, recovery or Critical Care capacity across UHL due to insufficient nursing staffing	28/06/2013	30/09/2014	**Causes:** Locally, ITU and theatre nursing staff have been historically difficult to recruit and retain. Turnover regularly negates recruitment efforts and the effects of a poor working environment in a high stress and risk area has meant difficulties in resolving the issue previously. **Consequences:** Increased overtime and waiting list payments required to run the core service. Tired and unmotivated staff in post. Poor staff morale working in an aged and difficult working environment. Difficulty in recruiting and retaining specialised staff (theatre and Critical care) due to poor working environment and low staff morale in general. Reduction in critical care capacity across UHL. Inability to respond to increases in demand in theatre, recovery and critical care capacity. Elective patient cancellations including cancer patients. Critical Care alternatives becoming the norm for high level of care patients e.g. Kinmonth, overnight PACU and specialty "HDU's". Poor patient and carer experience for some of our sickest patients.	HR	1. Use of Bank and Agency staff with block contracts for consistency and cost effectiveness. 2. Regular team and leadership meetings/training events. 3. Rolling adverts in place. 4. International recruitment with HRSS and relevant agencies commenced. 5. Exit interviews used regularly and in line with trust policy to understand issues exacerbating higher than wanted turnover of staff. 6. PULSE check underway/ Health and Safety Stress Assessments 7. Staff engagement strategy being devised and implemented	Major	Likely	16	Recruit ITU staffing to provide additional 5 level 3 beds due to open September 2014 - 30/09/14. Continue to recruit Theatre staff to deliver 6 day working - January 2015	4	JHOL

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2191	Musculoskeletal and Specialist Surgery	Ophthalmology	Follow up backlogs and capacity issues in Ophthalmology	12/06/2013	31/10/2014	**Causes:** Lack of capacity within services. Junior Doctor decision makers resulting in increased follow-ups. Follow-ups not protocol led. No partial booking. Non adherence to 6/52 leave policy. Clinic cancellation process unclear, inadequate communication and escalation. **Consequences:** Backlog of patients to be seen. Risk of high risk patients not being seen/delayed. Poor patient outcomes. Increased complaints and potential for litigation.	Patients	Outpatient efficiency work on going. Full recovery plan for improvements to ophthalmology service are in process . Outsourcing of follow up patients to Newmedica (IS) has been agreed. All overdue patients will be triaged by them, with the company following up the appropriate patients. The company have agreed to flag high risk patients to us for follow up that do not meet their criteria	Major	Likely	16	Monitor and review impact of NEW MEDICA - 01/10/14.	8	DTR
607	Clinical Support and Imaging	Blood Transfusion	Failure of UHL BT to fully comply with BCSH guidance and BSQR in relation to traceability and positive patient identification (PP	22/12/2006	02/07/2014	**Causes:** Failure to implement electronic tracking for blood and blood products to provide full traceability from donor to recipient At UHL blood is tracked electronically up to the point of transfer of blood from local fridge to patient with a manual system thereafter which is not 100% effective (currently approximately 1 - 2% (approx 1200 units) of all transfusion recording is non-compliant = 98% compliance). Non-compliance with blood transfusion policies resulting in incorrect identification processes resulting in sample identification and labelling error resulting in wrong blood cross-matched and / or provided for patient (last incident of ABO incompatibility by wrong transfusion approx. 4 years ago (yr 2008); approximately 6 near misses per year). New British Committee for Standards in Haematology (BCSH) guidelines state that unless a secure electronic PPI system is in place for the taking of blood transfusion samples, except in cases of acute clinical urgency, 2 samples on 2 separate occasions should be tested prior to blood issue. An electronic system would require only 1 samp Critical report received from MHRA in October 2012 in relatic **Consequences:** Potential loss of blood bank licence (via MHRA) with severe Financial penalty for non-compliance due to increased numb	Quality	Policies and procedures in place for correct patient identification and blood/ blood product identification to reduce risk of wrong transfusion. Paper system provides a degree of compliance with the regulations. Training and competency assessment for UHL staff involved in the transfusion process including e-learning and induction training with competency assessment for key staff groups. Regular monitoring and reporting system in relation to blood/ blood product traceability performance within department, to clinical areas and Transfusion Committee.	Major	Likely	16	IMT project approval ;board approval 02.07.2014 ; Develop implementation plan 30.07.2014	4	KJON

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2300	Clinical Support and Imaging	Cardiovascular Procedures	There is a risk of not meeting the national guidelines for out of hours Vascular cover	03/03/2014	31/08/2014	**Causes** From April 2014 there is a requirement to meet a 1in 6 cover for Vascular radiology out of hours service 1 members of staff unable to cover vascular work out of hours Not all staff covering out of hours trained in EVAR procedures **Consequence** Failure to comply with guidelines loss of reputation and service standard Stress for those staff members covering the extra work currently 1in 5 Patient safety Loss of contract income loss/interruption to service provision	HR	Locum cover and partime cover Extra worked covered by existing staff	Major	Likely	16	Provide training in EVAR technique to those lacking the skills - 30/08/14 Recruitment to 6th Radiologist post - 30/08/14	4	JGI

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2248	Clinical Support and Imaging	Medical Physics	Lack of IR(ME)R training records held across the Trust	14/11/2013	30/07/2014	Although the Trust Radiation Protection Policy states that "IRMER training records must be managed and maintained by individual Directorates (to be changed to Clinical Business Units in the current review) involved in the use of radiation" audits carried out routinely find that these training records are not sufficient, particularly for medical staff. Audits therefore suggest the policy is not being followed. **Causes** Current training records are poorly designed and / or incomplete / do not exist Inadequate or missing training records for IR(ME)R defined roles due to lack of compliance with the Trust policy in some areas. Staff working independently without reaching full competency No central records are kept of which staff have responsibilities under IRMER **Consequence** Lack of suitable training records may result in a failure to comply with standards set by regulatory and healthcare agencies (e.g. HSE / CQC). Failure at assessment might result in financial penalty and / or warning notices being issued. Non-compliance with national standards leading to enforcement action taken on the Trust following a routine ins Increased patient radiation doses due to lack of training. Increased staff doses due to lack of awareness of the potent	Quality	There is a defined method of recording training across the Trust in the Trust Radiation Safety policy. Although this is working in some areas it is not working consistently in all areas. The issue has been raised at the Trust Radiation Protection Committee numerous times where representatives of each Division have been in attendance. This has not so far led to a an increase in compliance. Radiation Protection produced a specific plan of what is required to demonstrate compliance. Mock audit completed 2/12/13. Investigate potential of using e-UHL to deliver a centralised record of IRMER training - Completed 3/3/14 7. CMG and service to manage and maintain records for the staff groups identified - completed 3/3/14 Policy updated on training and on going monitoring of training - 1/5/14	Major	Likely	16	1. Identify Trust staff with responsibilities under IRMER - due 30/7/2014 2. Implement e-learning module on e-UHL - 31/10/14	4	MNO

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2384	Women's and Children's	Maternity	There is an increased risk in the incidence of babies being born with HIE (moderate & severe) within UHL	24/06/2014	25/08/2014	**Causes:** Increased incidence of Hypoxic Ischemic Encephalopathy (HIE) within UHL 2012 2.3/1000 (2013 - further increase - incidence not defined). Compared to Trent & Yorkshire incidence 1.4/1000 births. Decision-making/capacity /CTG interpretation Midwifery staffing levels/Capacity Medical staffing levels overnight @LGH **Consequences:** Mismanagement of patient care Litigation risk Adverse publicity	Patients	Interim solution to increase capacity Monthly figures of HIE to be included in W&C dashboard Mandatory training for CTG/CTG Masterclass Weekly session to discuss CTG interpretation with junior doctors Active recruitment process for midwifery staff	Major	Likely	16	Monthly review of all cases of babies born with a diagnosis of HIE due 31.08.14 Undertake a peer review visit to Sheffield ude 31.07.14 Review of Consultant working patterns and extension of presence on the DS and MAU due31.08.14 Development of educational meetings for Dr's & midwives with specific focus on HIE, CS and porr outcomes due 31.07.14 Development of a decision education package focusing on the management of the 2nd stage of labour due 31.07.14 Re-launch 'fresh Eyes approach' with regards to CTG interpretation due 15.08.14 Further review of times of day when babies with HIE are born due 31.08.14	8	ACURR

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2153	Women's and Children's	Paediatrics	Shortfall in the number of qualified nurses in Children's Hospital including ECMO staffing and Capacity	05/03/2013	30/08/2014	**Causes** The Children's Hospital is currently experiencing a shortfall in the number of appropriately qualified Children's nurses. This is in part due to the increased numbers of staff on maternity leave and the issues with recruiting Children's trained nurses. The demand for PICU beds currently outweighs capacity. There is an establishment of 6.5 beds but due to vacancies and long-term sickness/maternity leave the unit is currently only able to run at maximum capacity of 6 beds and on specific days only 5 beds (depending on the overall ECMO activity across adults and children). In addition to NHS activity the Trust has contracted to provide cardiac surgery for a cohort of Libyan children. At the time that the contract was developed (Nov-December 2012) it was assessed that there would be sufficient capacity to operate on one child per week without impacting on NHS Activity. However, the current staffing and long-term profile of patients on PICU has resulted in pressures on both NHS work and the delivery of the Libyan contract. Currently there are vacancies for 5.82 wte qualified and 1 wt **Consequences** There is a short fall in the number of appropriately qualified c Balancing the demand for PICU beds between NHS contract Unsafe staffing levels, therefore unable to provide the recom	HR	The bed base in Leicester Royal infirmary has been reduced. There is an active campaign being undertaken to recruit new nurses from around the country. Additional health care assistance have been employed to support the shortfall of qualified nurses. No further Libyan patients are being operated on until agency staff can be recruited to support their PICU stay or until the patient flow changes on PICU to allow week-end operating which does not compromise week-day operating or access to PICU. Active Recruitment in progress Educational team cover clinical shifts Cardiac Liaison Team cover Outpatient clinics Overtime, bank & agency staff requested Lead Nurse, Matron and ECMO Co-ordinator cover clinical shifts Children's Hospital & Adult ICU staff cover shifts The beds on Ward 30 have been reduced from 13 to 10 PICU beds are closed where necessary	Major	Likely	16	Recruitment of suitably trained/experienced agency PICU/ECMO/ward nurses - due 30/8/14	8	EA

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2237	Medical Directorate		Risk of results of outpatient diagnostic tests not being reviewed or acted upon resulting in patient harm.	07/10/2013	31/12/2014	**Causes** Outpatients use paper based requesting system and results come back on paper and electronically. Results not being reviewed acknowledged on IT results systems due to; Volume of tests. Lack of consistent agreed process. IT systems too slow and 'lock up'. Results reviewed not being acted upon due to; No consistent agreed processes for management of diagnostic test results. Actions taken not being documented in medical notes due to; Volume of work and lack of capacity in relation to medical staff. Lack of agreed consistent process. Referrals for some tests still being made on paper with no method of tracking for receipt of referral, test booked or results. Poor communication process for communicating abnormal results back to referring clinician; Abnormal pathology results- cannot always contact clinician that requested test and paper copies of results not being sent to correct clinicians or being turned off to some areas. Suspicious imaging findings- referred to MDT but not always also communicated back to clinician that referred for test. Lack of standards or meeting standards for diagnostic tests i	Patients	Abnormal pathology results escalation process Suspicious imaging findings escalated to MDTs	Major	Likely	16	Implementation of Diagnostic testing policy across Trust - to ensure agreed speciality processes for outpatient management of diagnostic tests results. June 15 Development IT work with IBM to improve results system for clinicians and Trust to develop EPR with fit for purpose results management system. - Jan 16	8	CER

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2338	Medical Directorate		There is a risk of patients not receiving medication and patients receiving the incorrect medication due to an unstable homecare	01/05/2014	31/08/2014	**Causes** A major homecare company has left the Homecare market requiring remaining companies to take on large numbers of patients. These companies are now experiencing difficulties in maintaining their current levels of service. UHL patients are now being affected. One homecare supplier has changed their compounding to Bath ASU causing concerns about UHL supply of chemotherapy drugs over the next few weeks. Healthcare at Home (H@H) 1)H@H have changed their logistics provider (to Movianto). There are IT incompatibilities between both providers resulting in a large number of failed deliveries. 2) H@H no longer accepting new referrals for CF, respiratory and haemophilia patients who need to be repatriated to UHL urgently. There are also patients in whom homecare has been agreed and they are now referring back 3) H@H have changed their compounding to Bath ASU. This has resulted in Bath ASU not having enough capacity to carry out their routine production. UHL is a large user of dose banded chemotherapy. Currently we do not have the facility to compound all of our dose banded chemotherapy, a Alcura 1)Experiencing difficulties that have resulted in failed deliveri 2)There are on-going issues with invoicing. No invoices for A **Consequences**	Quality	UHL Homecare team liaising with homecare companies to try and resolve issues of which they are made aware. H@H high risk patients currently being repatriated to UHL. UHL procurement pharmacist in discussion with NHS England (statement due out soon - timeframe unsure), and with the CMU. Patient groups and peer group discussions also been held to support patient education and support during this uncertain period. Reviewing which medicines can be done through UHL out-patient provider or through UHL Discussions with Medical Director and CMG (CSI) and clinical specialty teams to ensure that any necessary clinical pathway changes are supported	Major	Likely	16	Financial risk associated with repatriation and highlight this to commissioners - 31/08/14	9	CELL

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2247	Corporate Nursing	Nursing	There are 500 Registered Nurse vacancies in UHL leading to a deterioration in service and adverse effect on financial position	30/10/2013	31/07/2014	**Causes:** Shortage of available Registered Nurses in Leicestershire. Nursing establishment review undertaken resulting in significant vacancies due to investment. Insufficient HRSS Capacity leading to delays in recruitment. **Consequences:** Potential increased clinical risk in areas. Increase in occurrence of pressure damage and patient falls. Increase in patient complaints. Reduced morale of staff, affecting retention of new starters. Risk to Trust reputation. Impact on Trust financial position due to premium rate staffing being utilised to maintain safety. Increased vacancies across UHL. Increased pay bill in terms of cover for establishment rotas prior to permanent appointments. HRSS capacity has not increased to coincide and support the increase in vacancies across the Trust. Delays in processing of pre employment checks due to increased recruitment activity. Delayed start dates for business critical posts. Benefits of bulk and other recruitment campaigns not being realised as effectively as anticipated and expected. Service areas outside of nursing being impacted upon due to	Patients	HRSS structure review. A temporary Band 5 HRSS Team Leader appointed. A Nursing lead identified. Recruitment plan developed with fortnightly meetings to review progress. Vacancy monitoring. Bank/agency utilisation. Shift moves of staff. Ward Manager/Matron return to wards full time.	Major	Likely	16	Over recruit HCAs. - 31/07/14 Utilise other roles to liberate nursing time - 31/07/14	12	CRIB

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2341	Operations	Outpatients	Long term follow up outpatient appointments not made	06/05/2014	31/07/2014	As the result of one specialty (rheumatology) finding they were not managing long term follow up appointments in accordance with clinical requirements, the Trust has undertaken a further assessment across all specialties of the risk of the same occurring. Initial assessment indicates that there are 24, 582 patient records on HISS / PAS where follow up appointments are not being managed in a timely way. These fall into 4 categories: 1) Patients with outcomes of waiting reports , but they have no follow up appointment booked 2)Outcome of long term follow up not made and patients are not on a waiting list and do not have a future appointment 3) Those on an outpatient waiting list but they are overdue their date to be seen 4)Outcome of future appointment but no appointment has been made. Full validation of patient level records is required to determine the size of the real risk in particular to patient care. Each CMG is required to make this assessment and report back to the Governance group on a weekly basis.(this is part of the action plan) **Causes:** The root cause for this failure has not yet been established a Potential consequences: (NB: until validation of all patient re Adverse impact on patient safety / care, potential for irrevers	Patients	-A Governance group, chaired by the Chief Operating Officer and Medical Director set up 23rd April , meeting weekly, terms of reference agreed and reporting to Executive Quality Board - Trust wide action plan written , updated weekly. Including clear instructions to CMG management teams - From 6th May patient level validation at specialty level underway , with weekly monitoring of progress	Major	Likely	16	Communicate required actions to all CMGs - Weekly Collate weekly returns to monitor validation progress - Weekly Run weekly Trust wide report to monitor progress of validation - Weekly CMGs to provide weekly update action plans on progress - Weekly Undertake Root Cause Analysis incident investigation - 15/07/14 Arrange standard external communication to patients - on track	2	KHAR

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2318	Operations	Business continuity	Blocked drains causing leaks and localized flooding of sewage	17/03/2014	31/07/2014	**Causes (hazard)** Aging infrastructure that can no longer cope with the volume of sewage due to restrictions and narrowing of the pipes Staff, visitors and patients placing materials other than toilet paper into the drainage system Staff placing non maceratorable items in the macerators causing breakages and loss of containment Back flow sink drains are unprotected resulting in foreign bodies **Consequence (harm / loss event)** Blockages build up easier and the older pipes cannot cope with the additional pressure causing leaks of raw sewage into occupied areas. Approximately 250 calls a month are being received by LRI estates relating to blockages Pipes cannot cope with the non-degradable materials and flooding occurs Localised flooding of clinical areas often involving areas on the floors below Foreign bodies block the drains and cause back fill and overspill of sinks and other facilities Clinical areas and staff areas become contaminated with raw sewage, ED 21st September, 12th August EDU 25th September, Ward 8 23rd August, ITU and CT 5th August. Patients contaminated with sewage from leaks in the ceilings Whilst repairs are underway it may become necessary to iso Potential media coverage (one request for information from L Quality and safe delivery of care will be compromised in area Risk to health and safety of staff from an unsafe working env	Statutory	Interserve and Hospital response teams. Awareness raised at local inductions. Business Continuity Plans. Communications and awareness with staff - poster campaign (launched September 2013). Approval for drain survey (Kensington and Balmoral Building).	Major	Likely	16	Samples of suitable wipes to be considered (dissolvable/maceratorable) to NET and decide from there. Liz Collins - due 01/08/14 Implement single choice patient wipes from end of March. Liz Collins/ Jeff Oliver - due 01/08/14 Discuss use of patient wipes in toilets with NET. Liz Collins - due 01/08/14. Survey being done in Kensington and Balmoral. Nigel Bond - due 31/07/14. Cost of replacement of stacks to be assessed. Nigel Bond - due 31/07/14. Need to link to new emergency floor. Phil Walmsley - due 01/08/14. Jet washing pipes. Andrew Martin due 01/08/14. To check macerator posters and if necessary contact with company with regards to posters on limiting numbers of items in macerator. Aaron Vogel - due 01/08/14.	2	PWA

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1693	Strategy	Coding	Risk of inaccuracies in clinical coding	02/08/2011	31/07/2014	**Causes:** Case note availability and case note documentation. HISS constraints (HRG codes not generated). High workload (coding per person above national average). Inaccuracies / omissions in source documentation (e.g. case notes may not include co-morbidities, high cost drugs may not be listed). Inability to provide training to large groups of coders due to coding backlog. High level of uncoded spells backlog (10,500 at June 2014) **Consequences:** Loss of income (PbR). Outlier for SHMI/HSMR data. Non- optimisation of HRG. Loss of Trust reputation.	Economics	Coding improvement project initiated April 2011. Project Board commenced September 2011 (PID, project plan and highlight report agreed). Electronic coding implemented February 2012 and to be upgraded November 2012 - HRG code generated. Will aid with audit, implementation of local policies and performance management. Task and finish groups completed in Divisions review improvements in coding using PeRL, PLICs, CHKS and medicode (encoder). New process for medical records retrieving notes. Due to changes in recording and payment of EDU and CAU episodes number of episodes coded has reduced. Shifts from day case to outpatient will reduce workload. Lead clinicians identified and Trust wide communication to move coding closer to the clinician. Tick lists introduced in both the ward area and discharge letter. Bank staff and overtime authorised to meet deadline. Scorecard developed to demonstrate improvements and benchmark against other Trusts. 3 year refresher programme completed November 2011. Quarterly updates/briefings to be led by Asst Director of Information - commenced April 2012. Team restructure Annual External Audit Internal Audit - commences November 2013 Audit Committee updates Clinical Coding Manager has a regular slot on Junior I PbR CIP Project Group commenced April 2014	Major	Likely	16	LIA - application successful with listening event booked for 1qtr 2014 - due 31/07/14	8	JRO

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
1737	RRC	Renal Transplant	Inappropriate environment and infection prevention Renal Transplant	25/10/2011	31/12/2014	**Causes:** Insufficient side room capacity. Inadequate space in existing side room for haemodialysis and line procedures. Insufficient en suite facilities in side rooms. Vascular access and % of patients with dialysis catheters. Procedure room on ward 10 not fit for purpose. Inappropriate areas used for renal biopsy on ward 17. Inadequate drug preparation areas. Inadequate domestic storage areas. No separate facility for isolating patients in ward 10/17 DCU. Movement of patients to accommodate admissions or haemodialysis in another area. **Consequences:** Poor compliance with cannula care. Challenges in maintaining integrity of commode lids using Chlorclean. Infection prevention risks. Transportation of contamination through patient occupied areas (15N/A).	Patients	Preventing Transmission of Infection including Isolation Guidelines (DMS 47699) MRSA Screening policy Weekly MRSA audits undertaken by IP Team Local Infection Prevention Group Communication of IP issues regular agenda item on local meetings Link Nurse Network Daily side room list Monthly Nursing Metrics audits Monthly HII audits Monthly Environment audits Recent refurbishment and upgrade of ward 15N/A accommodation Steam cleaning post CDT patients Vascular access being monitored by CQUIN & EMRN Medically led Vascular Access coordination Expert specialty trained competent staff Use 'cohort facility' as required On going competency based programme for the training and implementation of ANTT	Extreme	Possible	15	Development of renal relocation plan - 31/01/2017	15	JPR
2070	RRC	Satellite Units	Harborough Lodge environment stops staff safely delivering haemodialysis	16/08/2012	31/07/2014	**Causes:** Insufficient space to: Safely carry out dialysis procedures. Safely carry out manual handling procedures. Safely carry out emergency procedures. Maintain patient privacy & dignity. Poor state of repair of within clinical areas. **Consequences:** Cross contamination/infection. Manual handling injury to staff/patient/visitor. Poor patient experience. Negative reputation of Trust. Increase in number of complaints.	Patients	Specialist haemodialysis trained and competency assessed staff. Haemodialysis/other clinical policies. Annual manual handling training. Annual infection prevention training. Infection prevention policy. Infection prevention audits. Environment audits. Curtains at each bed space. Minimum cleaning standards.	Extreme	Possible	15	UHL undertake Duty of Care review and produce recommendations - 31/07/2014	5	JPR

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2328	ITAPS	Anaesthesia	Risk of inadvertent wrong route administration of anaesthetic medicines during epidural and regional anaesthesia.	16/04/2014	30/09/2014	**Causes** Continued use of Luer fitting syringes, needles etc increases the risk of anaesthetic medicines being administered via the wrong route. Distractions during anaesthetic procedure. **Consequences** Permanent injury on irreversible health effects. Death of patient Adverse publicity affecting reputation of the Trust and its staff Litigation leading to medical negligence claim	Patients	Labelling of syringes to indicate content Two people to check drugs during 'drawing up' procedure wherever possible. Training	Extreme	Possible	15	Use of Non-Luer syringes for all LA injections(following introduction of ISO standard) - 30/09/14 Introduction of Non-Luer giving sets(following introduction of ISO standard) - 30/09/14 Introduction of Non-Luer connector to epidural filter (following introduction of ISO standard) - 30/09/14	5	PSE

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2380	Clinical Support and Imaging		Risk of breach of Same Sex Accommodation Legislation	23/06/2014	01/09/2014	**Causes:** Inpatients and outpatients of the opposite sex have to wait together whilst wearing gowns/nightwear. **Consequences:** Breach of Same Sex Accommodation statutory legislation. Reduction in privacy and dignity for patients. Potential for increasing complaints. Potential for psychological harm/distress to patients. Repeated failure of internal standards around Same Sex Accommodation. Public expectations around Same Sex Accommodation and privacy and dignity not being met.	Patients	Imaging staff can provide patients with wrap-around gowns (or two gowns, one worn backwards) to reduce exposure, but this practice is inconsistent. Patients can be offered the opportunity to wait in the cubicles (where available) if preferred, but again this practice is inconsistent. Portable screens are available in CT waiting area for use when inpatients overflow into this area. (LRI)	Moderate	Almost certain	15	Glenfield Action Plan:- 1. Ascertain feasibility of splitting areas into separate male and female provision: " Waiting Area B " Room 2 " Room 3 " CT/MRI Waiting Area C Where not feasible, review options around providing privacy screens to separate male and female patients. Where feasible, implement appropriate changes, based on business case, costings approval and planning. 01/09/14 2. Ascertain feasibility of creating an additional cubicle in Barium Waiting Room to allow sufficient space for all patients to wait in the cubicle. 01/09.14 3. Ascertain costings associated with replacing cubicle curtains with solid doors to improve privacy & dignity whilst changing/waiting in cubicles. This applies to the cubicles in Waiting Areas A, B and MRI/CT area. 01/09/14 4. Explore options around redesigning the cubicles and waiting area in the MRI and CT zone, including relocation of storage area to create an additional cubicle, reallocate the current open waiting area into a fourth large cubicle. All cubicles to have solid doors. 01/09/14 5. Investigate possibility of single sex sessions, i.e. r 6. Create standard operating procedure to ensure th	3	JHA

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
1196	Clinical Support and Imaging		No comprehensive out of hours on call rota for consultant Paediatric radiologists	29/06/2009	30/07/2014	**Causes** There are Consultant Radiologists on call however there are not sufficient numbers to provide an on call service. Registrars are available but they have variable experience. **Consequences** Delays for patients requiring Paediatric radiological investigations. Sub-optimal treatment. Paediatric patients may have to be sent outside Leicester for treatment. Potential for patient dissatisfaction / complaints. Consultants are called in when they are not officially on call and they take lieu time back for this, resulting in loss of expertise during the normal working day.	Patients	There are Consultant Radiologists on call however there are not sufficient numbers to provide an on call service. Registrars are available but they have variable experience. Non Paediatric radiology consultants are not able to perform or interpret Paediatric radiological interventions.	Moderate	Almost certain	15	Recruit to Consultants vacancies - due 01/09/14	2	RG
2278	Women's and Children's	Family Planning	Risk that the Leicester Fertility Centre could have its licence for the provision of treatment and services withdrawn	17/12/2013	17/07/2014	**Causes:** Inadequate staffing levels and inappropriate quality systems in place. ISO 15189 accreditation would be an outcome if the service was adequately staffed with appropriate quality systems in place. **Consequences:** Patient safety and quality issues if unable to deliver service. Financial impact if patients choose to move elsewhere or NHS contracts not obtained. Risk to Trust reputation. Challenging external recommendations/improvement notice from HFEA - critical report received Feb 2013.	Statutory	1 fulltime trained Embryologist to a national recognised level 3 part time trained Embryologist to a national recognised level 1 0.8wte Band 6 BMS	Moderate	Almost certain	15	Formulation of business plan for Quality Manager post - due 31/7/2014. Overhaul of specimen request, collection and delivery procedures - due 31/7/2014.	6	DMARS

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2270	Corporate Nursing	Fire	Failure to achieve compliance of 75% attendance at Fire Safety training may cause UHL to fail to meet its statutory obligation	11/12/2013	31/08/2014	**Causes:** CMG mandatory training study days may not be capturing the specific Fire Safety training as an individual component of the day therefore bringing into question the accuracy of e-UHL data. Difficulty in releasing staff to attend Fire Safety training (10 - 15% rate of non-attendance following booking). Lack of venues for additional sessions. Lack of managerial action re repeat non-attendees. **Consequences:** Non-compliance with statutory obligation. Potential non-compliance with CQC outcomes. Potential for staff / patient safety to be adversely affected in the event of a fire (it must be noted that no incidents recorded are attributable to lack of staff training). Loss of good reputation.	HR	Existing training developed to ensure that refresher training on alternate years can be via a e-learning module for non-clinical staff. Face to face training run at differing times in an attempt to satisfy everyone's needs.	Moderate	Almost certain	15	Increase the number of fire safety training sessions to two per month at each site (if venues are available) - 31/08/14. Education leads to be made aware that mandatory training days must be broken into their specific components on e-UHL in order to ensure attendance is accurately recorded - 31/08/14. Raise awareness of fire safety training via utilisation of Intranet and PC desktop messages - 31/08/14. Incentivise medical staff attendance - 31/08/14.	9	GBRO

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2269	Corporate Nursing	IPC	Failure to meet UHL target of a minimum of 75% of clinical staff undertaking IP/Hand hygiene training	11/12/2013	31/07/2014	**Causes:** Poor attendance rates for all staff groups (UHL compliance 58%). Staff not released to undertake IP face-face training. e-UHL has not signposted Infection Prevention training for Clinical Staff. UHL is unable to demonstrate that all clinical staff within the trust has received Infection Prevention Training (including Hand Hygiene). **Consequences:** Poor attendance may be a contributory factor to patients acquiring Healthcare Associated Infections. Financial impact of CDT infections in relation to CCG fines. Potential risk of staff acquiring infections through lack of basic hand hygiene. Non-compliance with national standards (CQC, Health and Social care Act 2010).	Patients	High risk areas (e.g. with increased infection rates, SI) targeted for focused training. Active liaison with Clinical Skills Unit and UHL Education and Training team to resolve issues.	Extreme	Possible	15	e-learning package to be re-developed to meet core skills framework and UHL requirements. 29/07/14. Hold discussions with Medical Director to incentivise medical staff attendance for hand hygiene 29/07/14.. Ensure e-UHL accurately signposts relevant staff to their role specific Infection Prevention training requirements. 29/07/14.. Ensure e-UHL accurately signposts relevant staff to their mandatory Infection Prevention training requirements 29/07/14.. Develop more robust links with medical staff training team. 29/07/14.. Refine job role of link staff network to support ward managers in raising IP awareness at a local level. 29/07/14.. Ward Managers to use observed assessment of ANTT for nurses and discuss the process for assessment of medical staff with medical staff training team. 29/07/14.	10	LCOL

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
1551	Corporate Nursing	Quality	Failure to manage Category C documents on UHL Document Management system (Insite)	14/03/2011	26/07/2014	**Causes:** Lack of resource at CMG/directorate level to check review dates and enter local guidance onto the system in a timely manner. Lack of resource in CASE team effectively 'police' cat C documents Clinical guidelines very difficult to locate due to difficulties in navigating on InSite During migration from SharePoint 2007 to SharePoint 2010 searched documents displayed the titles of the files rather than the titles of documents. **Consequences** InSite may not contain the most recent versions of all category C documents. There may be duplication of documents with older versions being able to be accessed in addition to the most recent version. Staff may be following incorrect guidance (clinical or non-clinical) which could adversely impact on patient care.	Quality	Reports run from SharePoint to show review dates of guidelines for each CMG A review date and author have now been assigned to each Cat C where this is possible.	Moderate	Almost certain	15	Make contact with lead authors in relation to out of review date documents - 31/12/14 Compile a list of local guidelines requiring review and send to CMGs for action - 31/12/14 CMGs to advise 'CRESPO' of any guidelines requiring urgent revision/ attention or that need to be removed from InSite 31/12/14 Provide a message on InSite to inform staff that work to improve the system is on going and if necessary advise can be sought from Rebecca Broughton/ Claire Wilday - 31/12/14 Implement shared mailbox to receive responses from CMGs - 31/12/14 Ensure input from IM&T to make InSite more effective as a document library - 31/12/14 Continue work to assign review dates and authors to all CAT C documents 31/12/14	9	SH

Trust Board paper Z

	TRUST BOARD
From:	Rachel Overfield, Kevin Harris, Richard Mitchell Kate Bradley Simon Sheppard
Date:	**31st July 2014**
CQC regulation	All

Title:	**Quality & Performance Report**

Author/Responsible Director: R Overfield, Chief Nurse
K. Harris, Medical Director
R, Mitchell, Chief Operating Officer
K. Bradley, Director of Human Resources
S. Sheppard, Acting Director of Finance & Procurement

Purpose of the Report:
To provide members with an overview of UHL quality and safety, patient experience, operational and finance performance against national and local indicators for the month of June 2014.

The Report is provided to the Board for:

Decision		Discussion	√
Assurance	√	Endorsement	

Summary / Key Points:

Compliant

- MRSA zero cases reported for Qtr 1
- C Difficile – 15 cases reported for Qtr 1 against national threshold of 20 for Qtr1 although slightly behind on local target which is 12 for Qtr1.
- Pressure ulcers – Zero grade 4 pressure ulcers since October 2013. All trajectories for Grade 2 and Grade 3 pressure ulcers have been achieved for the month and the quarter.
- VTE - The VTE risk assessment within 24 hours of admission threshold of 95% has been achieved since July 2013.
- Theatres – 100% WHO compliant for since January 2013.

Areas to watch:-

- Inpatient Friends and Family Test - performance for June was 74.5.
- Diagnostic waiting times– although the target was achieved with performance at 0.8%, the target was missed in Qtr 4.
- #NoF to theatre within 36hrs below target with performance at 60.3%. In spite of the sustained high activity, performance in June shows a vast improvement on May's performance.
- RTT Non-admitted for June was achieved at 95% which is 2 months earlier than expected.
- The percentage of stoke patients spending 90% of their stay on a stroke ward year target is 79.5%. The position is likely to improve following validation.

Non Compliant/Contractual Queries:-

- ED 4hr target - Performance for emergency care 4hr wait in June was 91.3% with a year to date performance of 86.9%.
- RTT admitted– Trust level compliant admitted performance is expected in November 2014. Further details can be found in the RTT Improvement Report – Appendix 3.
- Choose and book slot availability performance for June was 26% with the national average at 11%. Resolution of slot unavailability requires a reduction in waiting times for 1st outpatient appointments in key specialties.
- Cancelled Operations – % of short notice cancellations in June was 1.0%. The number of patients breaching the 28 day rebook standard in June (UHL and Alliance) was 1 with performance at 99.0%.
- Quarter 1 has seen a dip in cancer performance across many of the targets. For further details refer to Appendix 4 – Cancer performance and remedial action plan.

Finance key issues:

- Shortfall of £1.4m on the forecast CIP delivery against the £45m target.
- YTD adverse variance to plan of £0.6m. Forecast year end delivery of £40.7m deficit.
- The Trust now has an agreed contract with all commissioners.
- Capital Plan is currently over-committed and is predicated on Emergency Floor external funding, the commitments may be in advance of the receipt of funding.

Recommendations: Members to note and receive the report	
Strategic Risk Register	**Performance KPIs year to date** CQC/NTDA
Resource Implications (eg Financial, HR) Penalties for missing targets.	
Assurance Implications Underachieved targets will impact on the NTDA escalation level, CQC Intelligent Monitoring and the FT application	
Patient and Public Involvement (PPI) Implications Underachievement of targets potentially has a negative impact on patient experience and Trust reputation	
Equality Impact considered and no impact	
Information exempt from Disclosure N/A	
Requirement for further review? Monthly review	

University Hospitals of Leicester NHS
NHS Trust

Caring at its best

Quality and Performance – June 2014

Trust Board

Thursday 31st July 2014

One team shared values

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UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **31st JULY 2014**

REPORT BY: **KEVIN HARRIS, MEDICAL DIRECTOR**
RACHEL OVERFIELD, CHIEF NURSE
RICHARD MITCHELL, CHIEF OPERATING OFFICER
KATE BRADLEY, DIRECTOR OF HUMAN RESOURCES
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SUBJECT: **JUNE 2014 QUALITY & PERFORMANCE SUMMARY REPORT**

1.0 INTRODUCTION

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

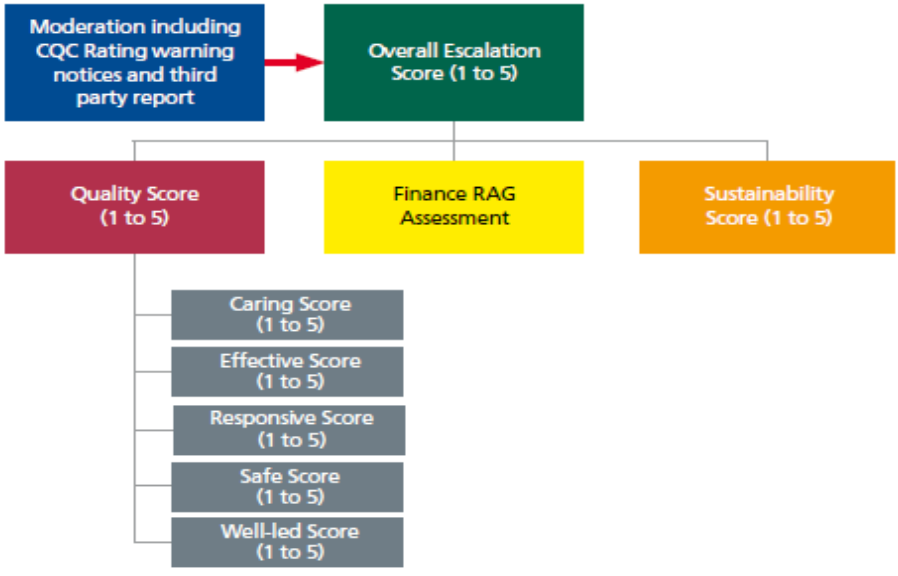
2.0 2014/15 NTDA Oversight and Escalation Level

2.1 NTDA 2014/15 Indicators

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

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

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



The oversight process also sets out how the NTDA will score and categorise NHS trusts with a clearer approach to both intervention and support for organisations at different levels of escalation. Draft supporting documentation which contains the detailed information about the scoring methodology was made available by the NTDA mid June. The Trust is still waiting for thresholds for a number of the indicators and as soon as that information is made available the domain scores will be estimated.

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

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

Caring	Target	2013/14	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	YTD
Inpatient scores from Friends and Family Test	TBC	68.8	73.9	64.9	66.0	69.6	67.6	66.2	70.3	68.7	71.8	69.0	69.9	69.6	71.0	74.5	71.6
A&E scores from Friends and Family Test	TBC	59.5	47.3	60.6	57.0	59.6	57.6	58.8	58.6	67.4	67.6	58.7	65.5	69.4	66.0	71.4	68.7
Complaints - rate per 1,000 bed days	TBC	2014-15 New Indicator												2.2	1.9	2.0	2.0
Mixed Sex Accommodation Breaches	0	2	0	0	0	0	0	0	2	0	0	0	0	4	2	0	6
Inpatient Survey: Q68 Overall I had a very poor/good experience	TBC	2014/15 New Indicator - awaiting further NTDA guidance															

Effective	Target	2013/14	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	YTD
Summary Hospital Mortality Indicator	TBC		104.5	104.5	104.9	104.9	104.9	106.4	106.4	106.4	107.1	107.1	107.1	106.1	106.1	106.1	106.1
Hospital Standardised Mortality Ratio (DFI Quarterly)	TBC	92.4	93.5		91.2			86.0			82.4			AWAITING DATA			88.0
Hospital Standardised Mortality Ratio - weekend (DFI Quarterly)	TBC	96.0	99.4		91.3			82.9			78.1			AWAITING DATA			87.4
Hospital Standardised Mortality Ratio - weekday (DFI Quarterly)	TBC	90.8	91.2		91.0			86.5			82.9			AWAITING DATA			87.7
Deaths in low risk conditions (DFI Quarterly)	TBC	88.6	107.7		86.3			92.2			88.3			AWAITING DATA			93.6
Emergency re-admissions within 30 days	TBC	7.9%	7.8%	7.7%	7.5%	7.6%	7.8%	7.9%	7.8%	8.0%	8.7%	9.0%	8.8%	8.7%	8.7%		8.7%

Safe	Target	2013/14	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	YTD
CDIFF	81	66	7	2	6	5	9	6	6	5	10	0	4	4	6	5	15
CDIFF (local target)	50	66	7	2	6	5	9	6	6	5	10	0	4	4	6	5	15
MRSA	0	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0
Never events	0	3	0	0	0	0	1	0	0	0	0	1	0	0	0	0	0
Serious Incidents	TBC	2014-15 New Indicator												12	9	12	33
Proportion of reported safety incidents that are harmful	TBC	2014/15 New Indicator - awaiting further NTDA guidance															
Medication errors causing serious harm	TBC	2014/15 New Indicator - awaiting further NTDA guidance															
CAS alerts	TBC	20	9	15	36	10	10	14	15	12	11	14	20	11	10	15	15
Maternal deaths	0	3	0	0	0	0	0	0	0	0	1	2	0	0	0	0	0
Proportion of patients risk assessed for VTE	95%	95.3%	94.5%	93.1%	95.9%	95.2%	95.4%	95.5%	96.7%	96.1%	95.6%	95.0%	95.6%	95.7%	95.9%	95.9%	95.8%
Percentage of Harm Free Care	TBC	93.6%	93.7%	93.6%	93.8%	93.5%	93.1%	94.7%	93.9%	94.0%	93.8%	94.8%	93.6%	94.6%	94.7%	94.2%	94.5%
Admissions to adult facilities of patients who are under 16 years	TBC	2014/15 New Indicator - awaiting further NTDA guidance															

Well-Led	Target	2013/14	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	YTD
Inpatient response rate from Friends and Family Test	25.0%	24.3%	21.4%	25.3%	24.8%	22.0%	25.8%	21.7%	25.4%	23.3%	24.5%	28.2%	28.8%	36.8%	38.1%	32.6%	35.8%
A&E response rate from Friends and Family Test	15.0%	14.9%	14.2%	16.6%	14.6%	16.1%	11.1%	16.3%	18.4%	16.4%	15.6%	18.4%	16.1%	15.2%	17.8%	14.9%	16.0%
NHS Staff Survey: Percentage of staff who would recommend the trust as a place to work	TBC	2014/15 New Indicator - awaiting further NTDA guidance															
NHS Staff Survey: Percentage of staff who would recommend the trust as place to receive treatment	TBC	2014/15 New Indicator - awaiting further NTDA guidance															
Data Quality of trust returns to HSCIC	TBC	2014/15 New Indicator - awaiting further NTDA guidance															
Trust Turnover	10.0%	10.0%	8.9%	9.2%	9.5%	9.3%	9.7%	9.6%	9.7%	10.2%	10.6%	10.4%	10.0%	9.9%	10.0%	10.2%	10.2%
Trust level total sickness (Reported One Month in Arrears)	3.0%	3.4%	3.1%	3.0%	3.2%	3.1%	3.1%	3.3%	3.5%	3.8%	3.8%	3.7%	3.5%	3.5%	3.6%		3.5%
Total trust vacancy rate	TBC	2014/15 New Indicator - awaiting further NTDA guidance															
Temporary costs and overtime as % total paybill	TBC	2014-15 New Indicator												9.1%	9.2%	8.0%	
Percentage of staff with annual appraisal	95%	91.3%	90.2%	90.7%	92.4%	92.7%	91.9%	91.0%	91.8%	92.4%	91.9%	92.3%	91.3%	91.8%	91.0%	90.6%	90.6%

UHL Quality Indicators		2013/14	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	YTD
Incidence of MSSA	TBC	30	2	5	1	4	3	1	1	1	3	2	2	2	0	3	5
C-sections rates	<25%	25.2%	26.1%	26.1%	25.0%	25.2%	24.6%	25.6%	27.5%	25.2%	23.9%	25.5%	24.3%	27.3%	25.0%	25.1%	25.8%
WHO surgical checklist compliance	100%	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Avoidable Pressure Ulcers Grade 3	<8 per month	72	4	8	7	8	5	4	4	5	7	3	6	5	5	5	15
Avoidable Pressure Ulcers Grade 4	0	1	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0
Statutory and Mandatory Training	80%	76%	46%	46%	48%	49%	55%	58%	60%	65%	69%	72%	76%	78%	79%	79%	79%
% Corporate Induction attendance rate	95%	90%	82%	95%	90%	94%	94%	91%	87%	89%	93%	89%	95%	96%	94%	92%	94%

2.2 UHL 2013/14 NTDA Escalation Level

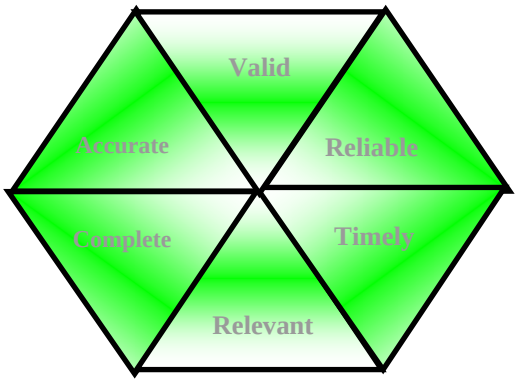
The 2013/14 Accountability Framework set out five different categories by which Trust's are defined, depending on key quality, delivery and finance standards.

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

1) No identified concerns (18 Trusts)
2) Emerging concerns (27 Trusts)
3) Concerns requiring investigation (21 Trusts)
4) Material issue (29 Trusts)
5) Formal action required (5 Trusts)

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

3.0 DATA QUALITY DIAMOND



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

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

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

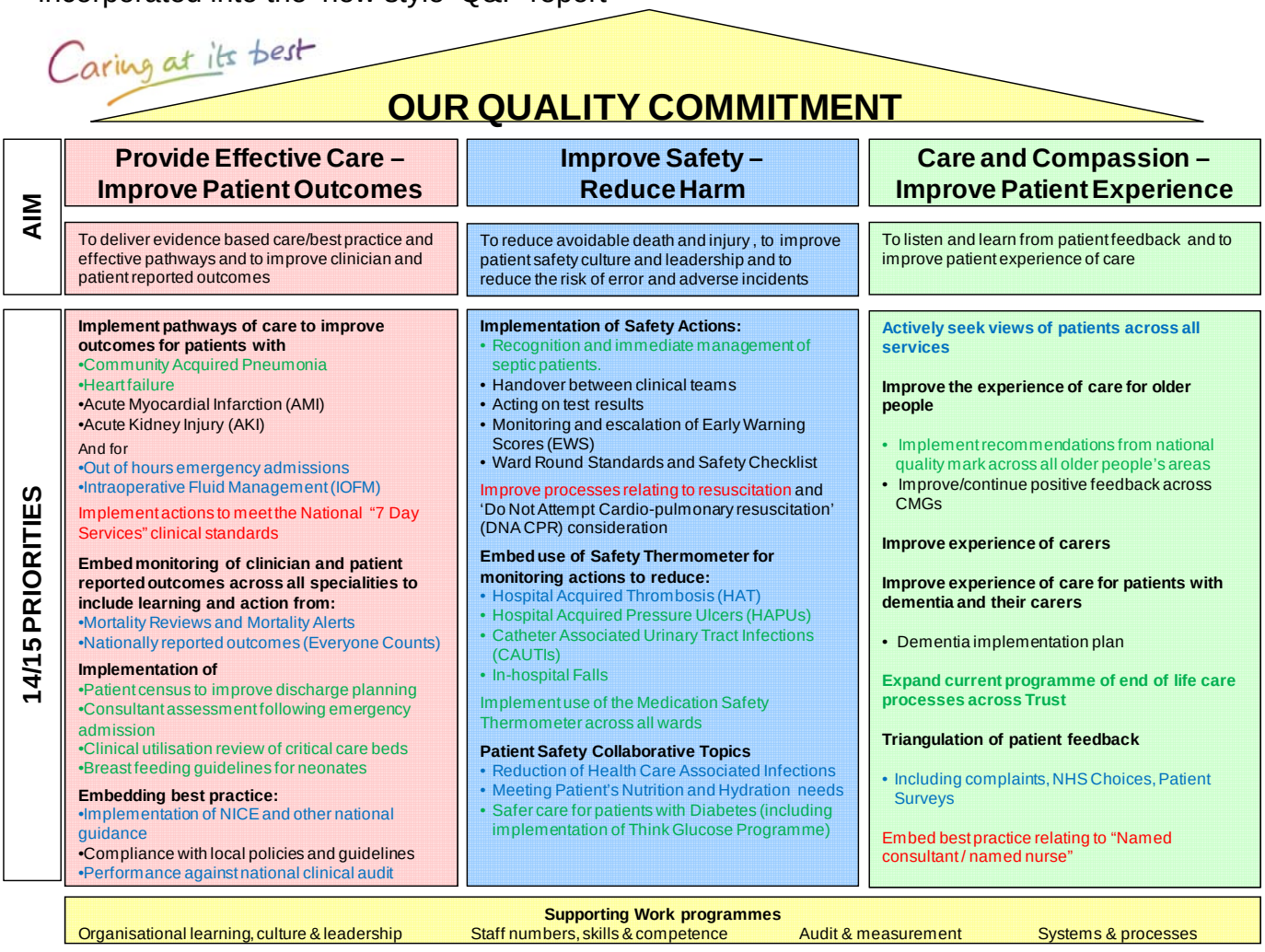
The data quality diamond assessment is included in the Quality and Performance report against indicators that have been assessed.

4.0 QUALITY AND PATIENT SAFETY – KEVIN HARRIS/RACHEL OVERFIELD

4.1 Quality Commitment

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

The first of the quarterly reports will be reported to the Executive Quality Board at its meeting on the 6th August. Consideration is being given to how the Quality Commitment will be incorporated into the 'new style' Q&P report

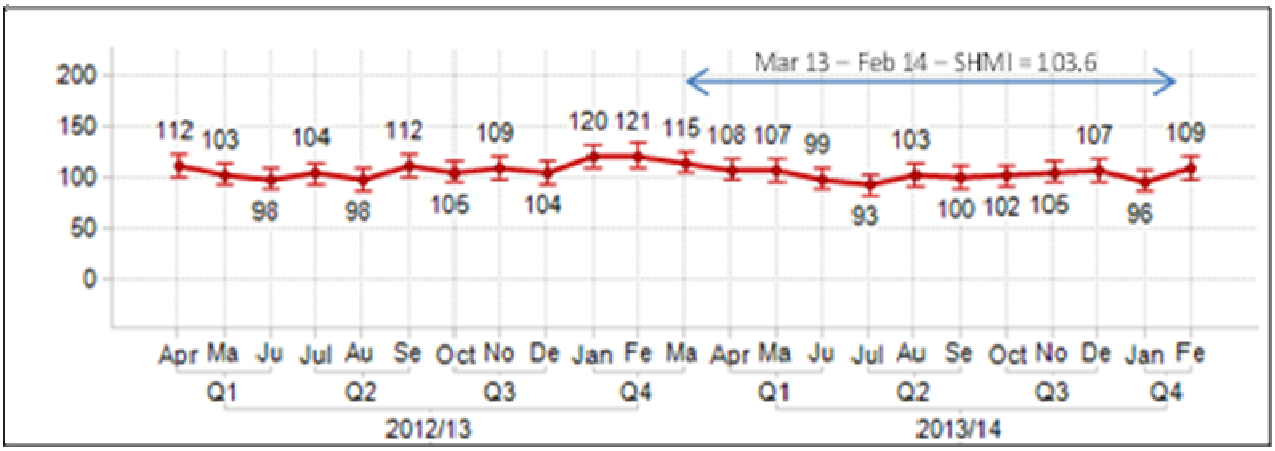


4.2 Mortality Rates

2013/14	Mth	YTD

SUMMARY HOSPITAL MORTALITY INDEX (SHMI)

The SHMI is published as a rolling 12 month figure by the Health and Social Care Information Centre (HSCIC). The next SHMI will be published on 30th July and will cover the 12 month period of January to December 2013. The current SHMI for UHL is 106 and it is anticipated that the Trust's SHMI for 2013 will remain at 106 and will be in Band 2 (i.e. within expected). UHL is now able to use the Hospital Evaluation Dataset tool (HED) to internally monitor our SHMI on a monthly basis using more recent data.



For the most recent 12 months available in the tool (Mar 13 to Feb 14) UHL's SHMI is reported as 103.6. The 'official' SHMI for the full financial year 2013/14 will be published in October 14.

HOSPITAL STANDARDISED MORTALITY RATIO (HSMR)

UHL's HSMR (as reported by HED) for the financial year Apr 13 to Mar 14 is 99.1 which is below the national average.

CRUDE MORTALITY

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

As can be seen from the table below, whilst there is 'month on month' variation, the overall rate for 13/14 is slightly lower than in 12/13 both in terms of 'rate' and 'numbers of in-hospital deaths'. This reduction appears to be continuing into 14/15. The crude morality rate was higher in February and, as seen in previous years, is related to the reduced elective activity (due to the shorter month).

Month	12/13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	13/14	Apr-14	May-14	14/15 YTD
Admissions	221,146	17,872	18,693	17,736	19,136	17,893	18,199	19,676	18,688	17,902	19,615	18,015	19,465	222,890	18,556	19,232	37,788
Deaths	3,177	277	254	229	229	233	218	253	251	267	245	262	242	2,960	207	256	463
Rate	1.4%	1.5%	1.4%	1.3%	1.2%	1.3%	1.2%	1.3%	1.3%	1.5%	1.2%	1.5%	1.2%	1.3%	1.1%	1.3%	1.2%

ACTIONS BEING TAKEN

Improving UHL's mortality rates, both in terms of the SHMI and HSMR, was one of the aims of the Trust's Quality Commitment for 13/14.

There were two specific work-streams relating to improving outcomes in 13/14, implementation of:

- the Respiratory pathway and the Pneumonia Care Bundle – identified because of the higher mortality risk associated with community acquired pneumonia
- Hospital 24/7 – prioritised in recognition of the increased acuity of patients and the need for continuity of care out of hours.

Other work-stream in the Quality Commitment, included the Critical Safety Actions (Ward Round Standards, Acting on Results, Responding to EWS, Clinical Handover and Sepsis Care Bundle).

The trust's commitment to increasing the nursing establishment and the international nurse recruitment programme has supported all of the above.

Embedding each of these initiatives across all areas of the trust will be the priority for 14/15 and are all included in the Quality Commitment for this year.

In addition, the trust is working towards implementation of the 'Seven Day Services' 10 Clinical Standards which includes increasing the frequency of senior clinical review for emergency patients on admission and all patients during their hospital stay.

A further development, made possible through the implementation of the electronic clinical handover system, is improved monitoring of patients' level of acuity which will support earlier planning for any increased care needs.

There has also been much work undertaken across the whole of the health economy, to ensure that those patients whose care could be better provided at home, are able to do so, including patients who are receiving 'end of life care'. Avoiding an unnecessary admission to UHL at the end of life will reduce UHL's SHMI.

Clearer documentation of patients' diagnosis and co-morbidities in their clinical records will also have lead to more accurate clinical coding, which will be reflected in the SHMI and HSMR risk adjusted mortality data.

4.3 Maternal Deaths

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

4.4 Patient Safety

2013/14	Mth	YTD

In June a total of 12 new Serious Untoward Incidents (SUIs) were escalated within the Trust. Four of these were patient safety incidents, seven related to Hospital Acquired Pressure Ulcers and one Healthcare Acquired Infections were reported for this month. No Never Events were reported in June. One SUI relates to Cancer, Haematology, Urology, Gastro and Surgery (CHUGGS) CMG, one to Emergency and Specialist Medicine (ESM) and one to Musculoskeletal and Specialist Surgery. Some immediate actions have been implemented to avoid a recurrence and a full Root Cause Analysis investigation is underway in line with Trust policy.

Five root cause analysis investigation reports were signed off in June. The learning and action from these has been presented to and discussed at the Executive Quality Board and these will be considered for further review at the Trust's 'Learning from Experience Group'.

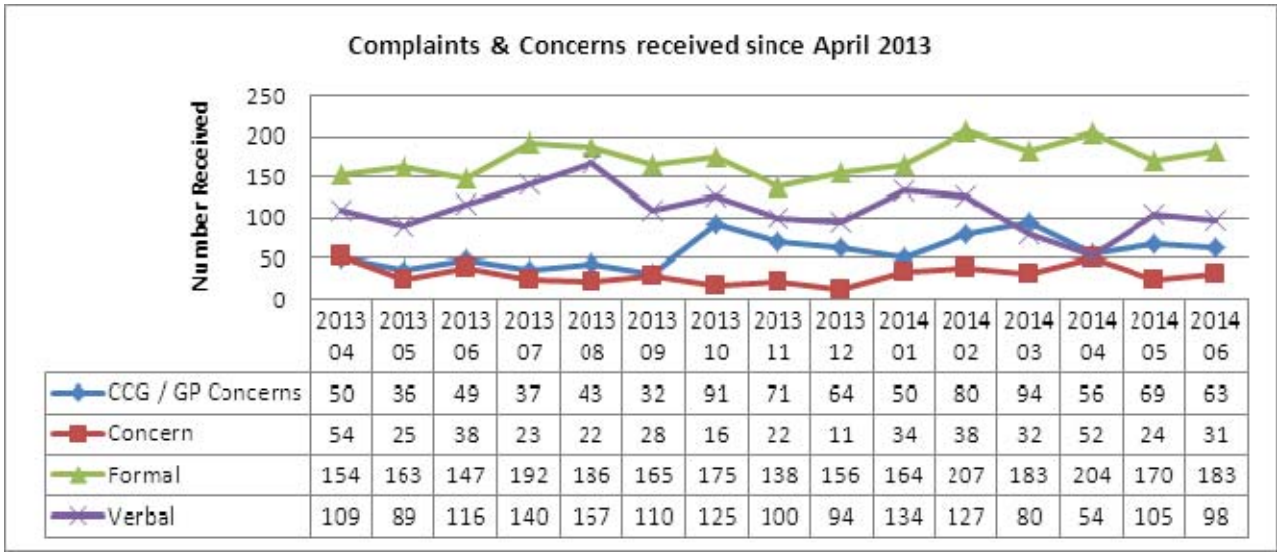
Last month there were no calls made to the 3636 Staff Concerns Reporting Line and no whistleblowing concerns received from the CQC.

For June, UHL had two CAS alerts which had not been completed within specified deadlines. The context for this is that both of these alerts are NHS England National Patient Safety Alerting System (NPSAS) alerts that are subject to national scrutiny and are included on monthly reports provided by NHS England to NHS Choices. During June UHL was flagged red in this report due to a small number of NPSAS alerts breaching their deadlines. Additionally the changes to the CAS process and the new CMG management arrangements for CAS (i.e. CAS process now managed at local level by Heads of Nursing) has identified a number of issues causing delays in alert closure. The UHL CAS team continue to respond to queries from CMGs and continue to provide support to CMGs during these early phases of the implementation however CMGs must ensure that the completion of alerts within specified timescales becomes a priority, firstly to ensure patient safety and secondly to ensure that the Trust does not continue to be flagged as an organisation that regularly has alerts open past their deadline for completion dates.

June continued to see high complaints activity with a total of 198 formal written complaints received. The top 5 themes have altered slightly to:-

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

CMGs continue to review their complaints monthly and take actions for improvement but these complaints show the tremendous strain on the emergency system and the increased activity leading to further increases in waiting times and operation and procedure cancellations**.** The rate of complaints per 1000 bed days for June is 2.0. Below is the trend graph which shows complaints activity over the past 15 months.



	2013 04	2013 05	2013 06	2013 07	2013 08	2013 09	2013 10	2013 11	2013 12	2014 01	2014 02	2014 03	2014 04	2014 05	2014 06
CCG / GP Concerns	50	36	49	37	43	32	91	71	64	50	80	94	56	69	63
Concern	54	25	38	23	22	28	16	22	11	34	38	32	52	24	31
Formal	154	163	147	192	136	165	175	138	156	164	207	183	204	170	183
Verbal	109	89	116	140	157	110	125	100	94	134	127	80	54	105	98

4.5 Critical Safety Actions

2013/14 | Mth | YTD

The aim of the 'Critical safety actions' in the Quality Commitment is to see a reduction in avoidable mortality and morbidity. The key indicator being focused upon by commissioners is a reduction in Serious Untoward Incidents related to Sepsis only for 2014/15.

1. **Improving Clinical Handover**.

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

Actions:-

- Nerve centre handover for nurses has been rolled out to all adults nurses with the exception of ED.
- Childrens is set for Go Live on 8th July 2014.
- Plan for roll out to medical staff to be confirmed, work for mobile devices and handover task lists progressing.
-

2. Relentless attention to Early Warning Score triggers and actions

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

Actions:-

- Work is now underway to confirm the parameters and triggers for the electronic observation system incorporating NEWS for UHL by the outreach and EWS lead ready for roll out initially in the 5 Pioneer wards at LRI site during the summer.

3. Acting on Results

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

Actions:-

- The only outstanding specialities not to have submitted an agreed process for Managing Diagnostic Tests is Gynaecology and Metabolic Medicine. CMG deputy directors have been contacted to chase these required processes.
- Management of Diagnostic Testing Procedures policy being reviewed.
- Work initiated with LIA to engage staff on a ICM replacement programme project.

4. Senior Clinical Review, Ward Rounds and Notation

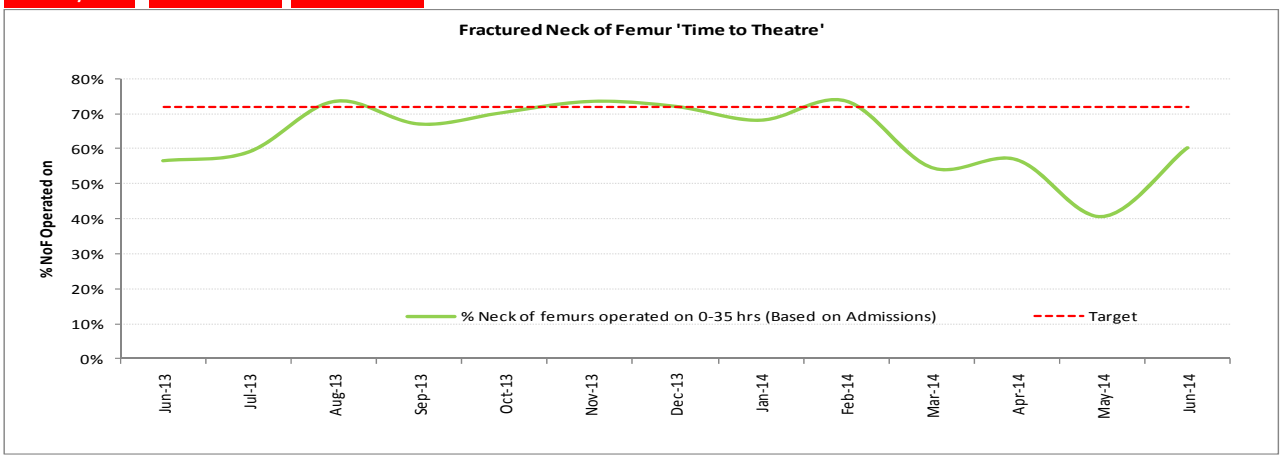
Aim - To meet national standards for clinical documentation. To provide strong medical leadership and safe and timely senior clinical reviews and ensure strong clinical governance.

Actions:-

- Audit tool discussed and confirmed with children's and obstetrics audit leads. Prospective audit of the use of ward round documentation to be undertaken in July for all children's and all obstetrics wards within UHL.
- Work has commenced with the development of an education and training programme using simulated training with video feedback.

4.6 Fractured Neck of Femur 'Time to Theatre'

2013/14 | Mth | YTD



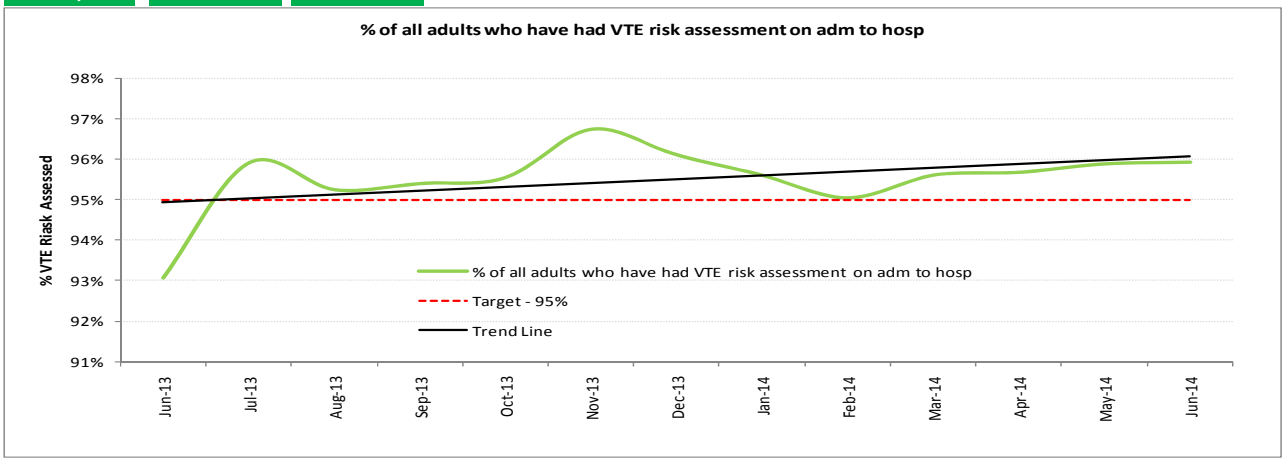
The percentage of patients admitted with fractured neck of femur during June who were operated on within 36hrs was 60.3% (35 out of 58 #NOF patients) against a target of 72%.

Neck of Femur activity has remained high for both June and July with only week commencing 30/6 seeing a significant reduction. In spite of the sustained high activity, performance in June shows a vast improvement on May's performance. With the exception of time to theatre <36 hours the team met all of the remaining criteria for BPT in full.

The NOF action plan has been updated with a particular focus on time to theatre. Initial work from this has produced a significant improvement in the percentage of patients getting to theatre under 36 hours with two out of three weeks in July meeting the target.

4.7 Venous Thrombo-embolism (VTE) Risk Assessment

2013/14 | Mth | YTD



The 95% threshold for VTE risk assessment within 24 hours of admission was 95.9% in June.

4.8 Quality Schedule and CQUIN Schemes

May's performance against the QS and CQUIN indicators reported monthly was reviewed and RAG rated by Commissioners at the Clinical Quality Review Group meeting on 17th July – See summary in the table below.

	Ref	Indicator	YTD (Apr/May)	Commentary
QUALITY SCHEDULE INDICATORS	**PS01**	Infection Prevention and Control Reduction. - C Diff	10	6 Cases in May. The nationally set Clostridium Difficile infections threshold for 14/15 is 81. However, UHL is aiming to achieve a reduction on last year's total of 66.
	PS02	HCAI Monitoring – MRSA Bacteraemias	0	
	PS03	Patient Safety - Never Events	0	There were no Never Events in Q1.
	PS04	Duty of Candour breaches	0	All patients have been notified of any moderate or serious incidents, where applicable.
	PS06	Risk Assurance - New Risks	R	There were 8 Risks where the timescales for review or action completion had elapsed at the time of reporting to Commissioners. These have now all been addressed.
	PS08a	Reduction in Pressure Ulcer incidence. - Grade 2 HAPUs	12	6 HAPUs for May and both April and May were below the monthly threshold of 9.
	PS08b	Reduction in Pressure Ulcer incidence. - Grade 3 HAPUs	9	5 HAPUs for May and both April and May were below the monthly threshold of 7.
	PS08c	Reduction in Pressure Ulcer incidence. - Grade 4 HAPUs	0	There have been no Grade 4 avoidable hospital acquired pressure ulcers
	PS09	Medicines Management Optimisation - Publication of Formulary	Published	This is a new indicator, in response to national contractual guidance. A Red RAG has been given for the Trusts' performance in respect of Controlled Drugs Compliance as performance has deteriorated since the previous audit.
	PS11	Venous Thrombo-embolism Risk Assessment	95.78%	95.88% for May. Performance continues to be just above the national set threshold of 95%
	PE1	Same Sex Accommodation - No of Breaches	2	There were breaches in both April and May but none in June. Both breaches related to High Dependence Units and actions have been taken to prevent further occurrences.
	CE08a	Stroke - 90% stay on stroke ward	86.2	Provisional data for May shows performance to have dropped. It is anticipated that validated data will show that the 80% threshold has been met for both April and May.
	CE08b	TIA Clinic - High risk patients scanned and seen within 24 hrs	80%	58.8% for May which is below the monthly threshold. April's high performance was considered to be related to low number of referrals, whilst May saw a higher number of referrals. Actions being taken by the Team to increase capacity within the clinic.
	AS02	Ward Health-check and Nurse Staffing	Report Submitted	Recruitment of additional nurses continues but not all wards at correct establishment.
	AS03	Staffing governance	A	UHL's thresholds for Corporate Induction, Staff Turnover & Mandatory training achieved in April but not for Sickness or Appraisal.
CQUINS	**Nat 1.2a**	F&FT Participation Score – ED	16.5%	17.8% for May an improvement on April's performance.
	Nat 1.2b	F&FT Participation Rate - Inpatients	37.5%	38.1% for May which is an increase on April's performance

4.9 Theatres – 100% WHO compliance

2013/14 | Mth | YTD

The theatres checklist has been fully compliant since January 2012.

4.10 C-sections rate

2013/14 | Mth | YTD

The C-section rate for June is 25.1% against a target of 25%. The year to date performance is 25.8%.

4.11 Safety Thermometer

Areas to note for the June 2014 Safety Thermometer:-

- UHL reported 94% Harm Free Care for June 2014
- The total of newly acquired harms increased (but noting that harm cannot always be attributed to an organisation). The increase appears to be a result of new VTEs and pressure ulcers but not all attributable to UH

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

		Apr-14	May-14	Jun-14
	Number of patients on ward	1573	1611	1545
All Harms	Total No of Harms - Old (Community) and Newly Acquired (UHL)	88	87	93
	No of patients with no Harms	1488	1525	1455
	% Harm Free	94.60%	94.66%	94.17%
New Harms	Total No of Newly Acquired (UHL) Harms	39	28	42
	No of Patients with no Newly Acquired Harms	1536	1583	1503
	% of UHL Patients with No Newly Acquired Harms	97.65%	98.26%	97.28%
Harm One	No of Patients with an OLD or NEWLY Acquired Grade 2, 3 or 4 PU	58	65	60
	No of Newly Acquired Grade 2, 3 or 4 PUs	20	12	15
Harm Two	No of Patients with falls in a care setting in previous 72 hrs resulting in harm	5	5	4
	No of patients with falls in UHL in previous 72 hrs resulting in harm	3	2	3
Harm Three	No of Patients with Urinary Catheter and Urine Infection (prior to or post admission)	12	9	12
	Number of New Catheter Associated UTIs	1	3	6
Harm Four	Newly Acquired community or hospital acquired VTE (DVT, PE or Other)	13	8	16
	Hospital Acquired Thrombosis (HAT)	6	1	6

DETAILED ANALYSIS OF FOUR HARMS

a) Falls Prevalence

UHL Reported four falls on the ST in June. This is a reduction of one from the previous month. Three of the falls occurred within UHL and the patients all sustained a level 2 harm. The injuries were lacerations to the elbow, head and hand. The fourth fall occurred in the patient's own home. The patient had a care package and sustained a level 2 harm.

b) Pressure Ulcer Prevalence

New Pressure Ulcer prevalence increased slightly in June. The Trust achieved the threshold for pressure ulcer incidence for this month.

c) VTE Prevalence

The ST VTE data for June 2014 confirmed that 6 cases are confirmed as NEW VTE/ Potential hospital acquired. RCAs will be carried out on two of these 2 of these cases only as the rest do not meet the criteria (upper limb/subclavian VTE associated with a line insertion, incidental finding following a scan)

d) CAUTI Prevalence

The prevalence of patients with urinary catheter and urine infection (prior to or post admission) and new catheter associated UTIs has increased slightly. The prevalence of new catheter associated UTIs has increased slightly. A Continence Trigger Tool Questionnaire is being implemented across the Trust and actions to reduce catheterisation and developing

nurse led 'Trial With Out Catheters' (TWOC) are being implemented on the Frailty Unit at the LRI (high usage of urinary catheters).

PRESSURE ULCER INCIDENCE

For June and for Q1, the trajectories for hospital acquired grade 2, 3 and 4 pressure ulcers have been achieved.

Table one - Avoidable Grade 2 Pressure Ulcers June 2014

Trajectory for Grade 2 Avoidable Pressure Ulcers 2013/14													
Month	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**YTD**
Trajectory	**9**	**9**	**9**	**9**	**9**	**9**	**9**	**9**	**9**	**9**	**9**	**9**	
Incidence	6	6	6										**18**

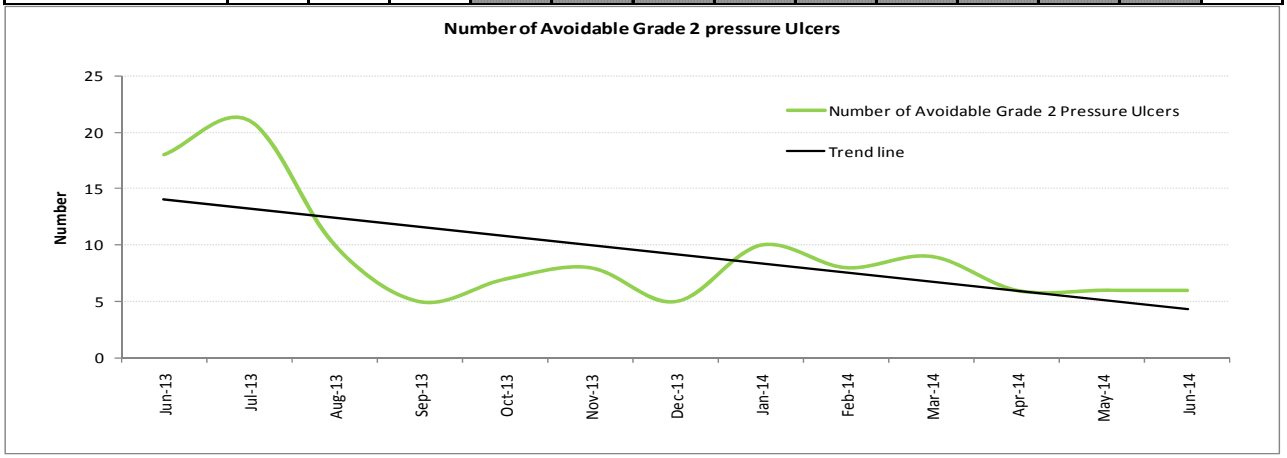


Table two - Avoidable Grade 3 Pressure Ulcers June 2014

Trajectory for Grade 3 Avoidable Pressure Ulcers 2013/14													
Month	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**YTD**
Trajectory	**7**	**7**	**7**	**7**	**7**	**7**	**7**	**7**	**7**	**7**	**7**	**7**	
Incidence	5	5	5										**15**

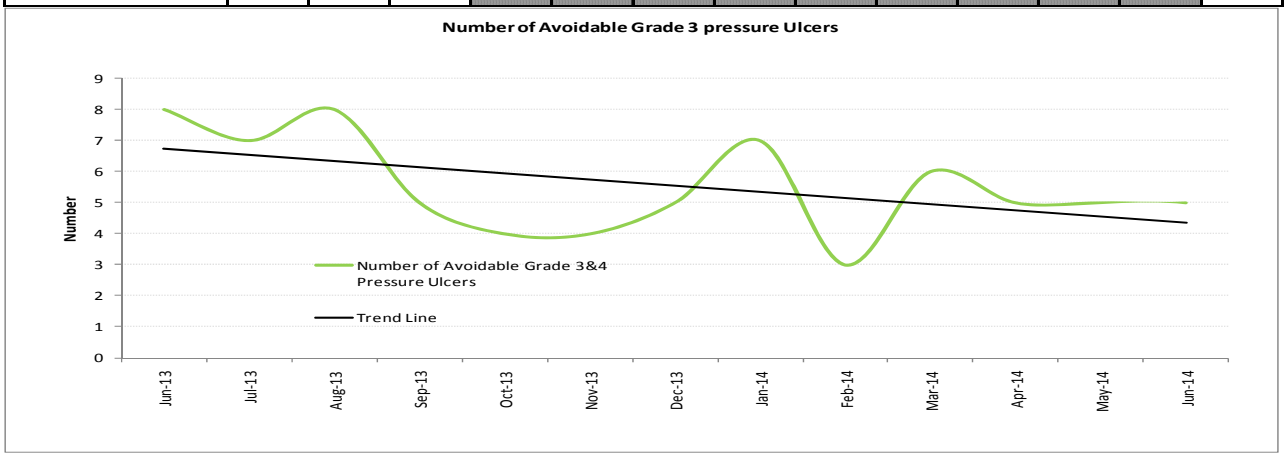
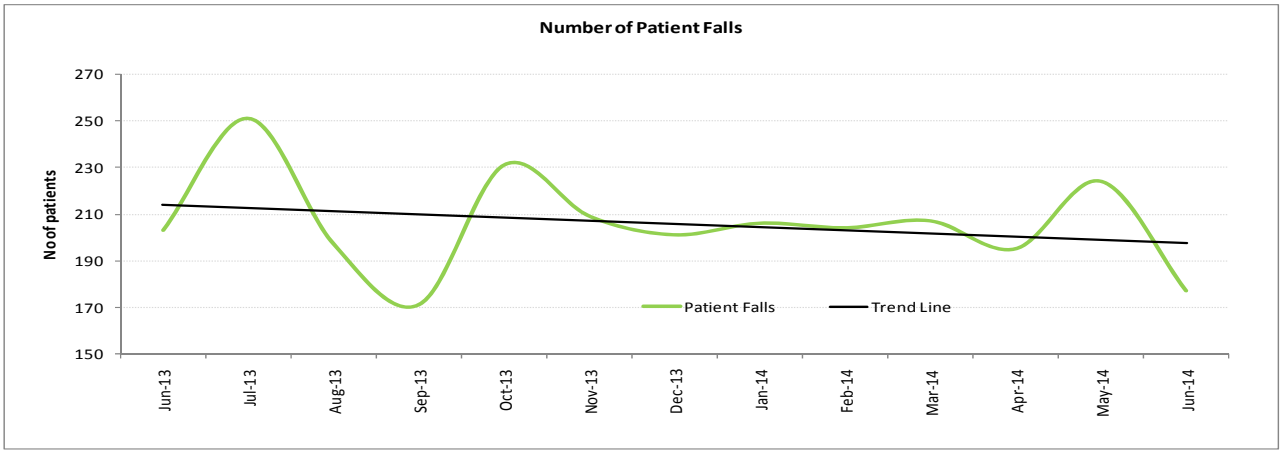


Table three - Avoidable Grade 4 Pressure Ulcers June 2014

Trajectory for Grade 4 Avoidable Pressure Ulcers 2013/14													
Month	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**YTD**
Trajectory	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Incidence	0	0	0										**0**

Patient Falls (Incidence via Datix)



Falls incidence for June 2014 was 177. This may be subject to change due to outstanding Datix incidents being closed by ward managers. A review into the increase in falls incidence for May 2014 has not identified any areas of concern. Falls validation has confirmed that the majority of falls were 'unavoidable' and so all risk assessments and falls prevention strategies were in place.

5.0 PATIENT EXPERIENCE – RACHEL OVERFIELD

5.1 Infection Prevention

a) MRSA

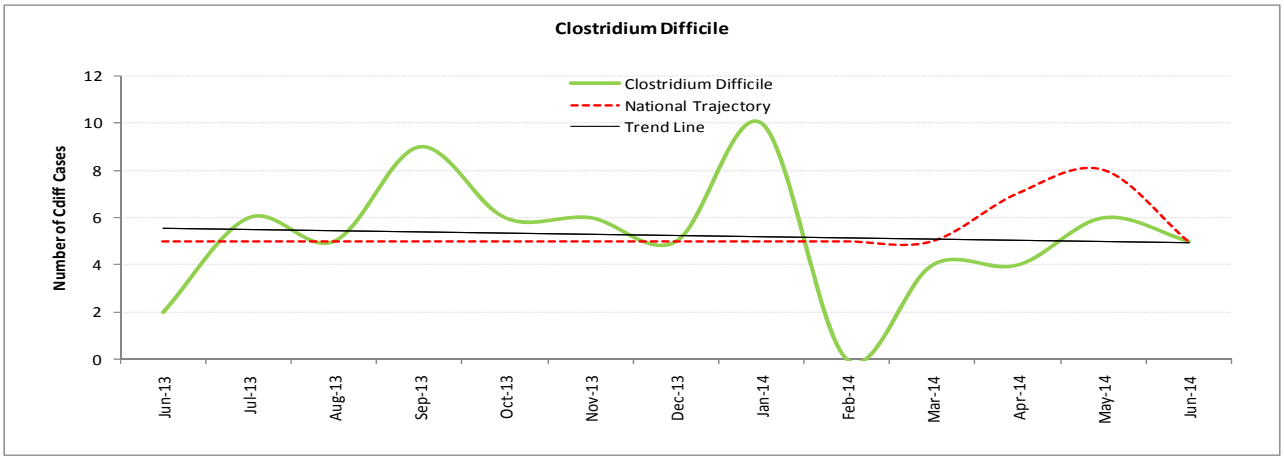
2013/14	Mth	YTD

There were no avoidable MRSA cases reported in the first quarter of 2014/15.

b) Clostridium Difficile

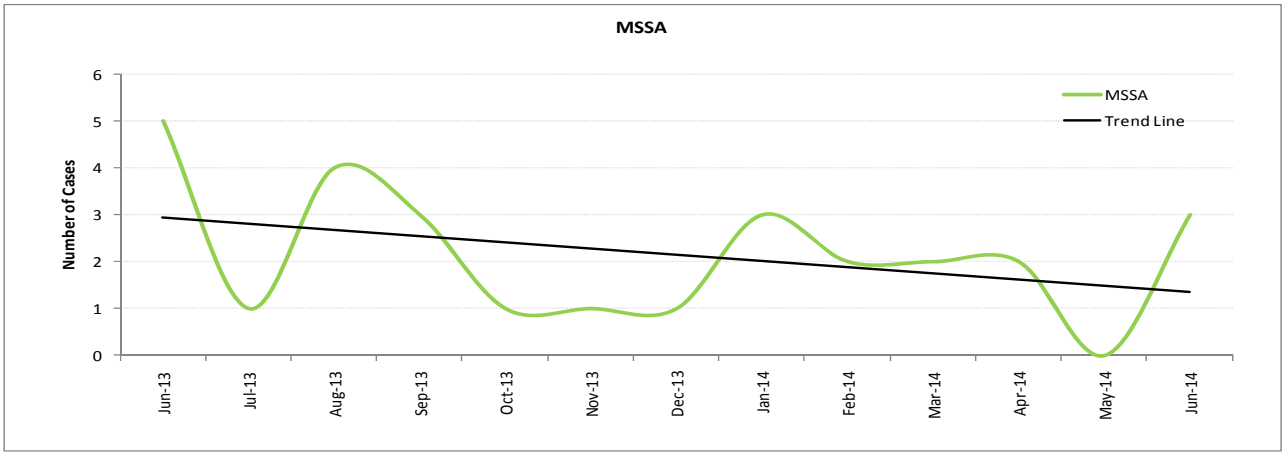
2013/14	Mth	YTD

There were 5 cases reported in June with a year to date position of 15 against a national trajectory of 20.



The Trust has set an internal target of no more than 50 cases for the year. For Quarter 1 the Trust is 3 cases behind the internal target i.e. 15 cases reported against an internal target of 12.

c) The number of MSSA cases reported during June was 3.



5.2 Patient Experience

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

In June 2014, 6,809 Patient Experience Surveys were returned this is broken down to:

- 3,379 paper inpatient/day case surveys
- 2,884 electronic surveys
- 531 ED paper surveys
- 15 maternity paper surveys

Share Your Experience – Electronic Feedback Platform

In June 2014, a total of 2,884 electronic surveys were completed via email, touch screen, SMS Text, our Leicester's Hospitals web site or handheld devices. A total of 108 emails were sent to patients inviting them to complete a survey. The table below shows how this breaks down across the trust.

SHARE YOUR EXPERIENCE SURVEY	Email	Touch Screen	Sms	Tablet	Web	Total Completions	Emails sent
A&E Department	1	68	0	0	5	74	1
Carers Survey	0	0	0	0	2	2	0
Childrens Urgent and ED Care	0	0	0	0	0	0	0
FFT Eye Casualty	0	14	0	255	0	269	0
Glenfield CDU	0	0	0	0	15	15	0
Glenfield Radiology	2	0	0	0	0	2	5
Hope Clinical Trials Unit	0	0	0	4	0	4	0
IP, Daycase and Childrens IP Wards	0	0	77	0	9	86	0
Maternity Survey	0	0	0	460	1	461	0
Neonatal Unit Survey	0	0	0	0	18	18	0
Outpatient Survey	14	1	70	1856	9	1950	102
Windsor Eye Clinic	0	3	0	0	0	3	0
Total	17	86	147	2575	59	2884	108

Treated with Respect and Dignity

2013/14	Mth	YTD

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

Friends and Family Test

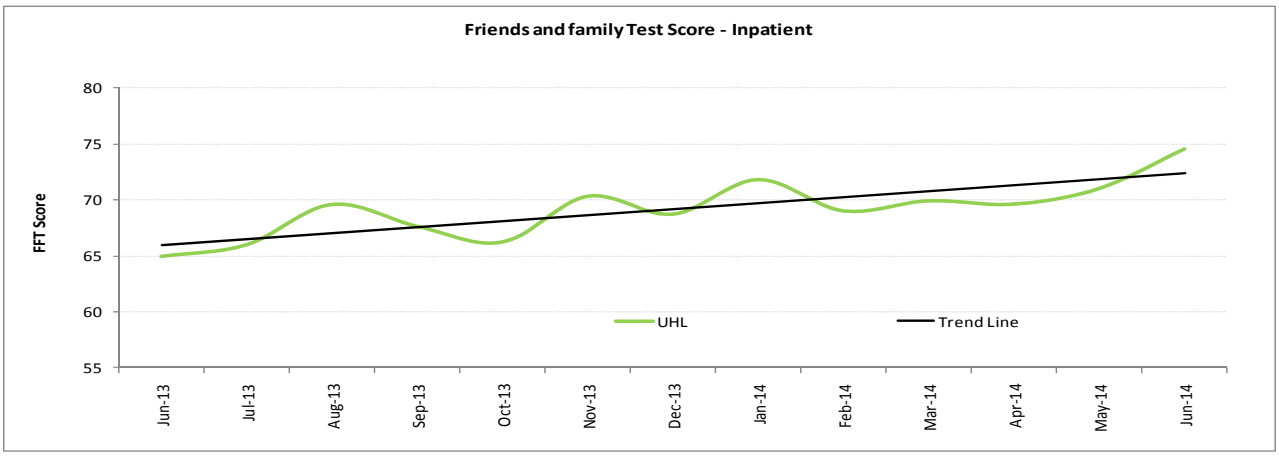
Inpatient

The inpatient surveys include the Friends and Family Test question; **How likely are you to recommend this ward to friends and family if they needed similar care or treatment?'** Of all the surveys received in May, 2,585 surveys included a response to this question and were considered inpatient activity (excluding day case / outpatients) and therefore were included in the Friends and Family Test score for NHS England.

Overall there were 6,880 patients in the relevant areas within the month of June 2014. The Trust easily met the 25% target achieving coverage of 32.6%.

The Friends & Family Test responses broken down to:

Extremely likely:	1,720
Likely:	447
Neither likely nor unlikely:	46
Unlikely	8
Extremely unlikely	6
Don't know:	13
Overall Friends & Family Test Score	**74.5**



Responses and Coverage:

Responses received in June fell to 2240, down on the record level of responses received in May 2014. Footfall coverage also fell to 32.6% in June (previous May coverage 38.1%).

UHL Overall performance

Performance on the FFT score was 74.5 in June. The highest FFT Score achieved to date, and an improvement on the score of 71.0 achieved in May.

The proportion of 'promoters' was 77% this month. A three percentage point increase compared to May, as respondents switched from being 'passive' to 'promoters' this month. See data tables below.

	Apr-14	May-14	Jun-14
UHL Trust Level Totals	**69.6**	**71.0**	**74.5**
Total no. of responses	*2391*	*2585*	*2240*
Number of promoters	*1742*	*1742*	*1720*
Number of passives	*546*	*588*	*447*
Number of detractors	*88*	*79*	*60*
Number of don't know	*15*	*12*	*13*

UHL	May-14		Jun-14	
Promoters as % of response	74%	⬆	77%	⬆
Passives as % of response	23%	⬌	20%	⬇
Detractors as % of response	3%	⬇	3%	⬌
Excluded as % of response	0%	⬇	1%	⬆

CMG Performance Changes

All CMGs performed well this month showing good improvement on their FFT Score compared to the previous month, with the exception of CHUGS and Emergency and Specialist Medicine, who showed only small declines in their scores.

The FFT score for Renal, Respiratory and Cardiac rose to 82, the highest score achieved to date and well above the overall performance achieved across UHL.

Emergency and Specialist Medicine maintained the increase in their FFT score achieved in May. Their FFT score was 63 in April, rising to 72 in May, and remaining at this level in June.

CHUGS showed a small decline in their FFT score this month as they received a higher number of 'detractor' responses.

Musculoskeletal and Specialist Surgery's performance rose this month to 78, due to a large increase in the proportion of promoters and a reduction in the proportion of detractor responses. The score achieved in June is above the UHL level of performance and matches their highest FFT score achieved to date.

Women's and Children's showed a large improvement in their score of over 12 percentage points, resulting in their highest FFT score achieved to date. Both GAU at the LRI, and Ward 31 at the LGH, have both shown clear improvements in their FFT score this month resulting in the large rise in the FFT score for Women's and Children's.

FFT Scores by CMG

	Apr-14	May-14	Jun-14	Point Change in FFT Score (Mar - Apr 14)
UHL Trust Level Totals	**69.6**	**71.0**	**74.5**	**3.5**
Renal, Respiratory and Cardiac	79	76	82	**6.3**
Emergency and Specialist Medicine	63	72	72	**-0.3**
CHUGS	62	65	63	**-1.9**
Musculoskeletal and Specialist Surgery	74	71	78	**7.4**
Women's and Children's	70	70	83	**12.7**
Emergency Department	69	66	71	**5.4**

Percentage point changes in each of the elements of the FFT Score by CMG between May and June 2014:

	Renal, Respiratory and Cardiac	Emergency and Specialist Medicine	CHUGS	Musculoskeletal and Specialist Surgery	Women's and Children's
Promoters as % of response	5	0	1	7	10
Passives as % of response	-4	0	0	-4	-8
Detractors as % of response	-1	0	1	-2	-2
Excluded as % of response	0	1	0	-1	0

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

May 2014 Data Published Nationally

The National Table reports the scores and responses for 171 Trusts

If we filter out the Private and Single Speciality Trusts, and those that achieved less than 20% footfall, the UHL score of **71** ranks 86th out of **136** Trusts.

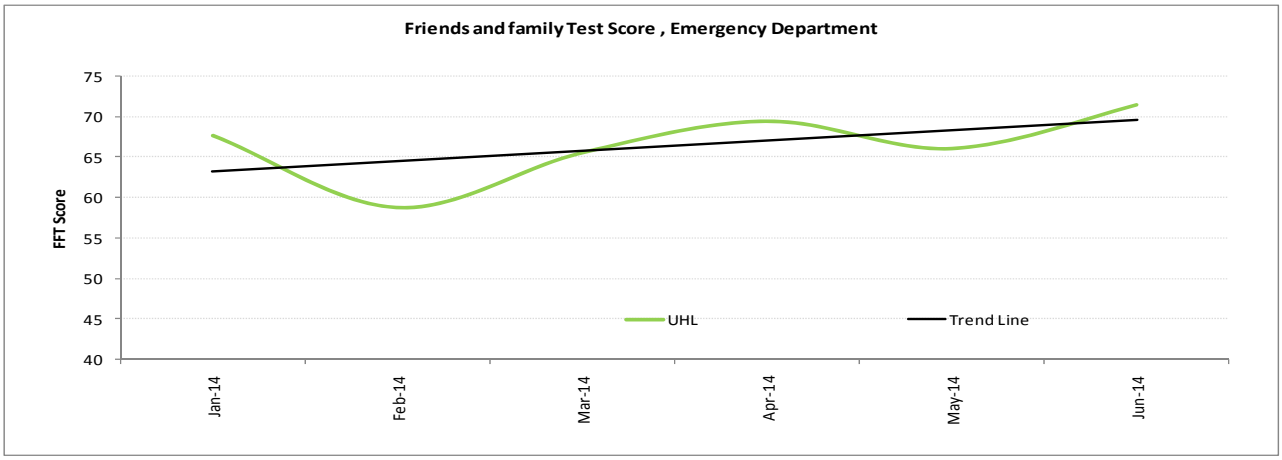
The overall National Inpatient Score (not including independent sector Trusts) was **73**.

Emergency Department & Eye Casualty

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

Overall there were 6,118 patients who were seen in A&E and then discharged home within the month of June 2014. The Trust surveyed 914 eligible patients meeting **14.9%** of the footfall. The Friends & Family test responses break down to:

Extremely likely:	688
Likely:	184
Neither likely nor unlikely:	25
Unlikely	5
Extremely unlikely	8
Don't know:	4
Overall Friends & Family Test Score	**71.4**



Breakdown by department	No. of	FFT Score	Total no. of patients

	responses		eligible to respond
Emergency Dept Majors	137	65.2	1313
Emergency Dept Minors	355	63.3	2673
Emergency Dept – not stated	48	68.8	-
Emergency Decisions Unit	115	64.0	749
Eye Casualty	259	89.6	1383

May 2014 Data Published Nationally

The National Table reports the scores and responses for 143 Trusts

If we filter out the Trusts that achieved less than 15% footfall, the UHL score of **66** ranks 26th out of the remaining 99 Trusts

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

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

Maternity Services

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

Overall there were 3,373 patients in total who were eligible within the month of June 2014. The Trust surveyed 851 eligible patients meeting **25.2%** of the footfall. The Friends & Family test responses break down to:

Extremely likely:	618
Likely:	198
Neither likely nor unlikely:	14
Unlikely	11
Extremely unlikely	5
Don't know:	5

Overall Maternity Friends & Family Test Score 69.5

Breakdown by maternity journey stage	No. of responses	FFT Score	Total no. of patients eligible to respond
Antenatal following 36 week appointment	35	51.4	898
Labour Ward/Birthing centre following delivery	434	73.6	852
Postnatal Ward at discharge	381	66.4	672
Postnatal community – 10 days after birth	1	*	951

* No score shown due to too few survey numbers

May 2014 Data Published Nationally

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

Antenatal

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

With single speciality and Trusts that achieved less than a 20% footfall excluded, the UHL Friends and Family Test score of **69** ranks the Trust 25th out of the remaining 54 Trusts.

Birth

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

With single speciality and Trusts that achieved less than a 20% footfall excluded, the UHL Friends and Family Test score of **63** ranks the Trust 78th out of the remaining 85 Trusts.

Postnatal Ward

The average Friend and Family Test score for England (excluding independent sector providers) was **65**.

With single speciality and Trusts that achieved less than a 20% footfall excluded, the UHL Friends and Family Test score of **55** ranks the Trust 76th out of the remaining 92 Trusts.

Postnatal Community Provision

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

If we filter out the Trusts that are single speciality or achieved less than 20% footfall, then we are left with 35 Trusts. However our UHL Score of **83** does not feature among these as the 20% footfall was not achieved.

5.3 Nursing workforce

5.3.1 Vacancies

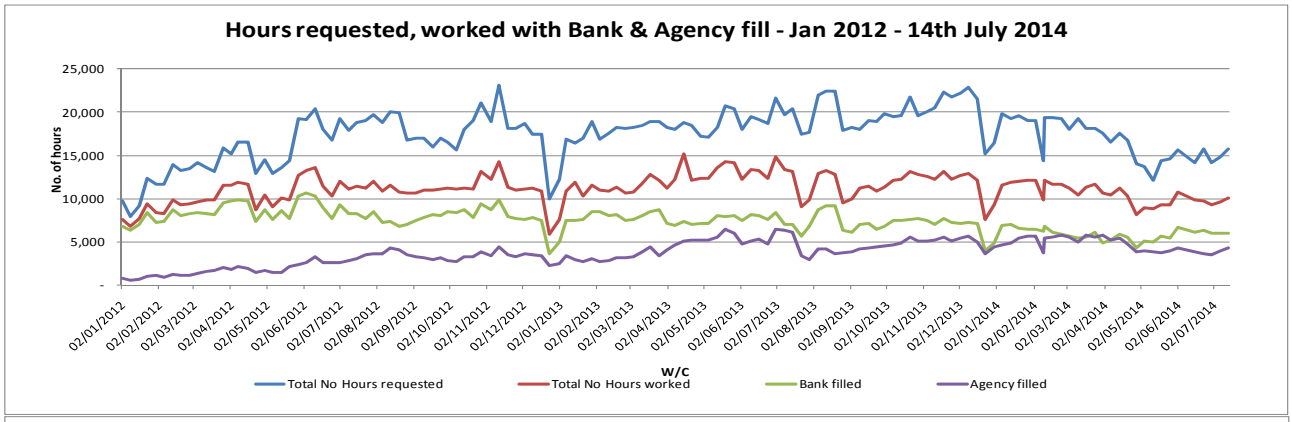
The overall vacancies for June are at 422wte, 377 wte RN and 44 wte HCA. With 140 wte RNs waiting to start and 56 wte HCA's waiting to start.

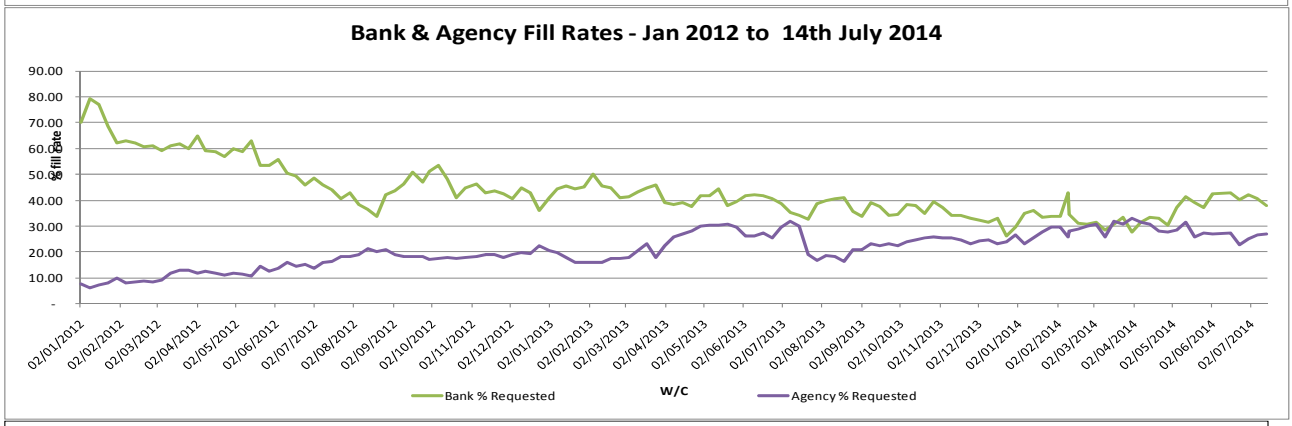
5.3.2 Real Time Staffing

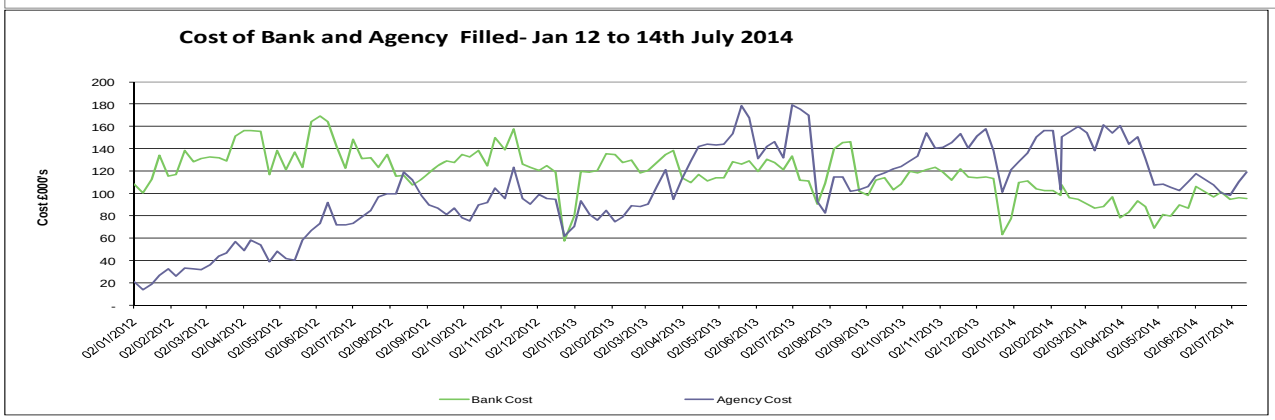
Monitoring across the Trust continues and supports our monthly Safer Staffing submissions on our public facing website and NHS Choices.

5.3.3 Bank and Agency

Bank and agency information is shown in the following graphs.







5.4 Ward Performance

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

5.5 Same Sex Accommodation

2013/14 | Mth | YTD

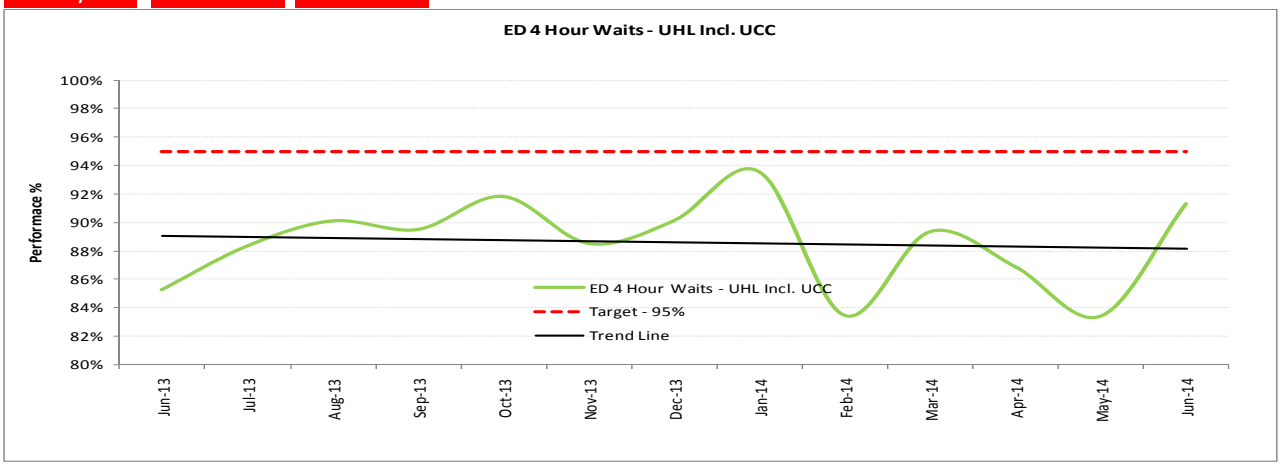
There were 0 non-clinically justified same sex accommodation breaches during June.

6 OPERATIONAL PERFORMANCE – RICHARD MITCHELL

Responsive	Target	2013/14	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	YTD
A&E - Total Time in A&E (UHL+UCC)	95%	88.4%	85.3%	88.3%	90.1%	89.5%	91.8%	88.5%	90.1%	93.6%	83.5%	89.3%	86.9%	83.4%	91.3%	86.9%
12 hour trolley waits in A&E	0	5	1	0	0	1	0	1	0	0	0	0	0	1	0	1
RTT waiting times – admitted	90%	76.7%	85.6%	89.1%	85.7%	81.8%	83.5%	83.2%	82.0%	81.8%	79.1%	76.7%	78.9%	79.4%	79.0%	79.0%
RTT waiting times – non-admitted	95%	93.9%	96.0%	96.4%	95.5%	92.0%	92.8%	91.9%	92.8%	93.4%	93.5%	93.9%	94.3%	94.4%	95.0%	95.0%
RTT - incomplete 92% in 18 weeks	92%	92.1%	93.8%	93.1%	92.9%	93.8%	92.8%	92.4%	91.8%	92.0%	92.6%	92.1%	93.9%	93.6%	94.0%	94.0%
RTT - 52+ week waits	0	0	0	0	0	0	0	0	1	1	0	0	3	0	2	5
Diagnostic Test Waiting Times	<1%	1.9%	0.6%	0.6%	0.8%	0.7%	1.0%	0.8%	1.4%	5.3%	1.9%	1.9%	0.8%	0.9%	0.8%	0.8%
2 week wait - all cancers	93%	94.8%	94.8%	94.2%	94.6%	93.0%	94.9%	95.7%	94.9%	95.3%	95.9%	95.3%	88.5%	94.7%		91.5%
2 week wait - for symptomatic breast patients	93%	94.0%	93.2%	93.6%	92.0%	95.2%	93.0%	91.3%	95.5%	96.8%	93.4%	94.3%	80.0%	95.0%		87.5%
31-day for first treatment	96%	98.1%	99.0%	98.3%	99.7%	99.1%	98.9%	96.2%	97.4%	97.2%	98.5%	98.2%	97.5%	92.9%		95.2%
31-day for subsequent treatment - drugs	98%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%
31-day wait for subsequent treatment - surgery	94%	96.0%	97.5%	100.0%	98.4%	88.6%	96.4%	97.1%	92.3%	94.8%	96.4%	98.6%	94.9%	97.0%		96.0%
31-day wait subsequent treatment - radiotherapy	94%	98.2%	99.1%	100.0%	100.0%	97.7%	97.5%	98.5%	98.1%	94.8%	96.3%	99.1%	97.2%	95.6%		96.5%
62-day wait for treatment	85%	86.7%	85.9%	85.8%	88.2%	87.4%	86.4%	85.7%	89.4%	89.1%	89.1%	92.4%	92.8%	88.4%		90.6%
62-day wait for screening	90%	95.6%	95.0%	90.6%	97.2%	96.2%	100.0%	97.0%	96.6%	97.1%	95.1%	91.7%	90.6%	67.4%		80.2%
Urgent operation being cancelled for the second time	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Cancelled operations re-booked within 28 days	100%	95.1%	86.4%	99.1%	96.0%	98.6%	94.2%	97.7%	94.3%	94.1%	98.9%	94.2%	90.6%	96.1%	99.0%	95.0%
Cancelled operations on the day (%)	0.8%	1.6%	1.0%	1.2%	1.4%	2.3%	1.7%	1.8%	1.7%	1.6%	2.1%	1.5%	1.1%	0.8%	1.0%	1.0%
Cancelled operations on the day (vol)		1739	81	114	124	208	171	172	141	152	178	139	106	77	98	281
Delayed transfers of care	3.5%	3.6%	3.8%	4.0%	3.9%	4.2%	4.6%	4.4%	3.6%	4.6%	4.3%	3.8%	4.5%	4.4%	4.2%	4.4%
Stroke - 90% of Stay on a Stroke Unit	80%	83.1%	78.0%	87.1%	88.5%	89.1%	83.7%	78.0%	81.8%	89.3%	83.7%	83.5%	92.9%	79.5%		86.5%
Stroke - TIA Clinic within 24 Hours (Suspected TIA)	60%	64.2%	72.0%	60.5%	73.6%	64.6%	62.4%	76.8%	65.7%	60.5%	40.7%	77.9%	79.7%	58.8%	71.3%	69.2%
Choose and Book Slot Unavailability	4%	13%	13%	15%	14%	11%	16%	17%	14%	10%	16%	19%	22%	25%	26%	24%
Ambulance Handover > 60 mins	0	868	41	55	16	21	25	59	102	52	207	111	188	253	89	530
Ambulance Handover > 30 mins < 1Hr	0	7,075	500	566	383	484	705	689	722	573	818	601	822	1,014	644	2,480

6.1 Emergency Care 4hr Wait Performance

2013/14 | Mth | YTD



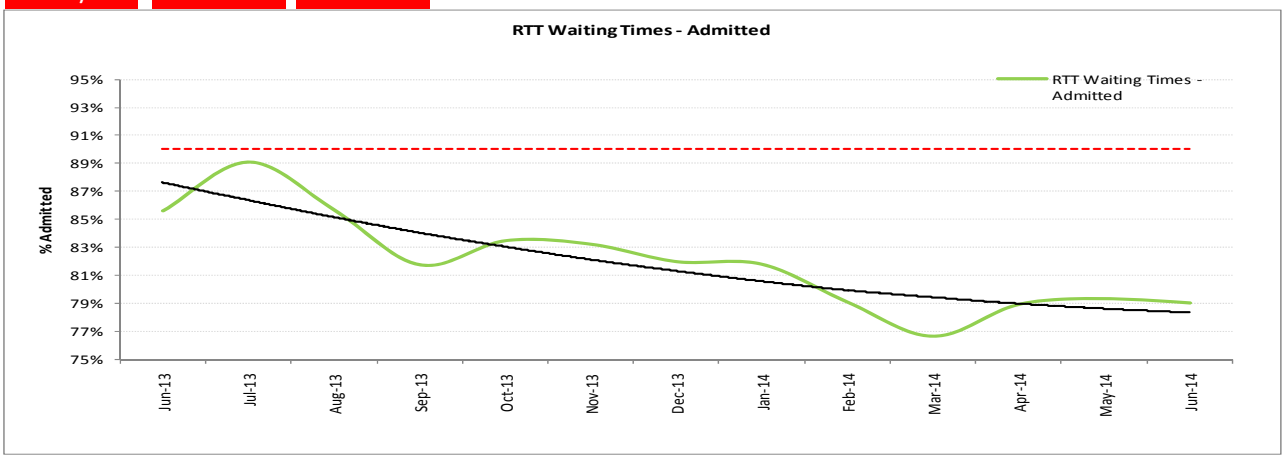
Performance for emergency care 4hr wait in June submitted via the weekly SITREP was 91.3% with a year to date performance of 86.9%. Actions relating to the emergency care performance are included in the ED exception report.

UHL was ranked 106 out of 144 Trusts with Type 1 Emergency Departments in England for the four weeks up to 6th July 2014. Over the same period 82 out of 144 Acute Trusts delivered the 95% target.

6.2 RTT – 18 week performance including Alliance performance

a) RTT Admitted performance

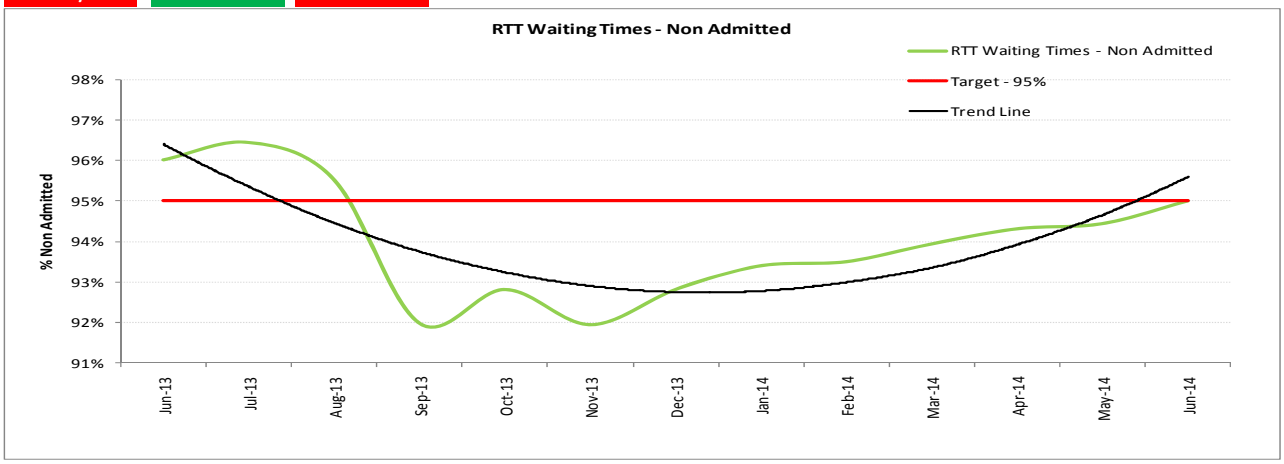
2013/14 | Mth | YTD



RTT admitted performance (UHL and Alliance) for June was 79.0% with significant speciality level failures in ENT, General Surgery, Maxillofacial, Ophthalmology and Orthopaedics. Further details can be found in the RTT Improvement Report – Appendix 3.

b) RTT Non Admitted Performance

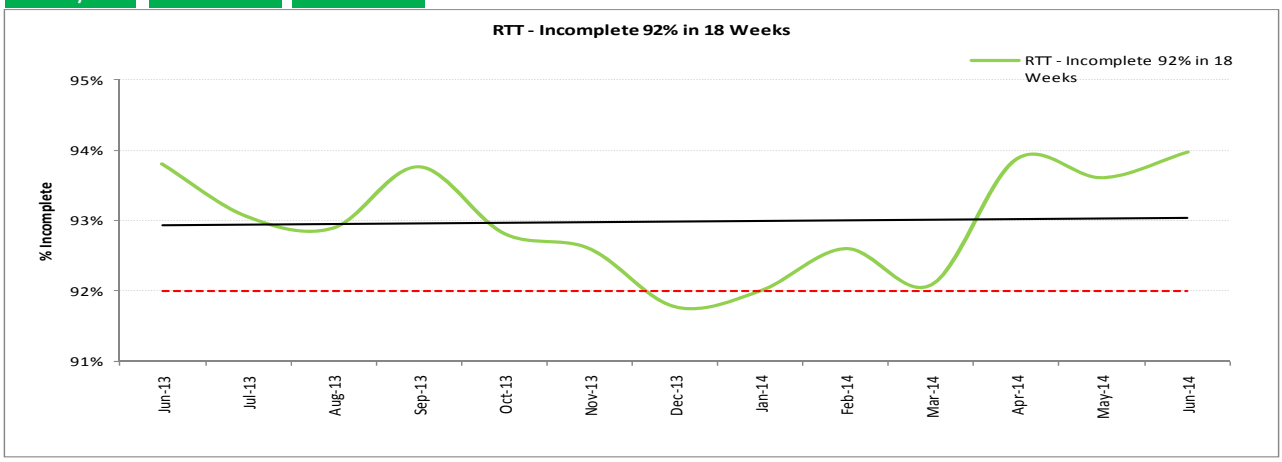
2013/14 Mth YTD



Non-admitted performance (UHL and Alliance) during June was compliant at 95.0%, two months ahead of expected compliance. Further details can be found in the RTT Improvement Report – Appendix 3.

c) RTT Incomplete Pathways

2013/14 Mth YTD



RTT incomplete (i.e. 18+ week backlog) for UHL and Alliance is compliant at 94.0%.

This table details at a Trust level the size of the UHL admitted and non-admitted backlogs (over 18 weeks)

UHL Trust level backlog over 18 weeks	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14
Non-Admitted Backlog Number	1917	1558	1704	1527	1481	1594
Admitted Backlog Number	1416	1512	1527	1551	1412	1420
Total	3333	3070	3231	3078	2893	3014

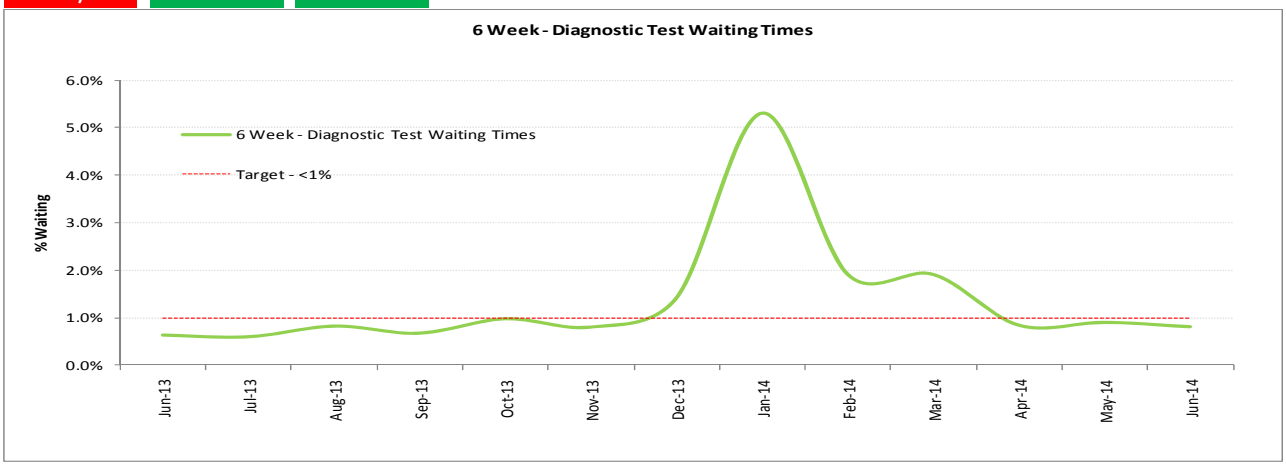
Recovery of the non admitted standard at Trust level was expecetd in August 2014 and for admitted performance is expected in November 2014. The table below shows performance at specialty level.

Specialty Level Trajectory

	Admitted Trust level RTT														
	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Trajectory	80.8%	80.5%	81.2%	81.2%	82.3%	84.3%	86.9%	87.7%	88.8%	89.5%	90.5%	90.5%	90.5%	90.4%	92.0%
Actual	81.8%	79.3%	76.7%	75.7%	76.8%	77%									
UHL + Alliance				78.9%	79.4%	79%									
	Non admitted Trust level RTT														
	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Trajectory	92.3%	92.7%	92.8%	93.1%	93.6%	94.1%	94.8%	95.1%	95.3%	95.3%	95.5%	96.1%	96.1%	96.1%	96.1%
Actual	93.4%	93.5%	93.9%	93.4%	93.9%	94.3%									
UHL + Alliance				94.3%	94.4%	95.0%									
	Adult Ophthalmology Admitted RTT														
	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Trajectory	58.8%	61.0%	62.3%	63.1%	69.5%	80.4%	90.1%	90.2%	90.3%	90.6%	90.6%	90.5%	90.8%	90.7%	90.8%
Actual	57.8%	60.0%	53.6%	50.3%	52.5%	57.9%									
	Adult Ophthalmology Non admitted RTT														
	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Trajectory	83.7%	83.1%	82.3%	85.3%	88.8%	89.1%	93.5%	95.4%	95.1%	95.0%	95.2%	95.2%	95.1%	95.1%	95.1%
Actual	86.6	90.2	91.46	89.80%	92.3%	93.8%									
	Paediatric Ophthalmology Admitted RTT (other category)														
	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Trajectory	80.8%	80.5%	81.2%	81.2%	82.1%	84.4%	84.4%	86.6%	90.6%	90.2%	90.5%	90.5%	90.5%	90.4%	92.0%
Actual			80.1%	73.10%	72.5%	75.3%									
	Paediatric Ophthalmology Non admitted RTT(other category)														
	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Trajectory	92.3%	92.7%	92.8%	93.3%	92.7%	95.1%	95.4%	95.6%	95.6%	95.6%	95.7%	95.3%	95.3%	95.3%	95.3%
Actual			93%	93.20%	93.9%	94%									
	Adult ENT Admitted RTT														
	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Trajectory	62.6%	64.5%	61.3%	61.1%	66.1%	72.8%	75.0%	83.1%	90.5%	90.5%	90.4%	90.3%	90.3%	90.2%	90.4%
Actual	69.8%	56.3%	61.8%	61.90%	56.4%	59.2%									
	Adult ENT Non admitted RTT														
	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Trajectory	89.0%	90.7%	90.4%	93.3%	92.4%	92.4%	93.4%	95.1%	95.4%	95.3%	95.5%	95.5%	95.5%	95.5%	95.5%
Actual	86%	82.7%	86.3%	86.70%	85.1%	87.6%									
	Paediatric ENT Admitted RTT (other category)														
	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Trajectory	80.8%	80.5%	81.2%	81.2%	82.1%	84.4%	84.4%	86.6%	90.6%	90.2%	90.5%	90.5%	90.5%	90.4%	92.0%
Actual			80.1%	73.10%	72.5%	75.3%									
	Paediatric ENT Non admitted RTT(other category)														
	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Trajectory	92.3%	92.7%	92.8%	93.3%	92.7%	95.1%	95.4%	95.6%	95.6%	95.6%	95.7%	95.3%	95.3%	95.3%	95.3%
Actual			93%	93.20%	93.9%	94%									
	Orthopaedics Admitted RTT														
	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Trajectory	70.0%	69.7%	75.3%	75.5%	74.4%	76.2%	78.6%	75.9%	77.6%	79.7%	81.0%	82.3%	82.2%	82.3%	90.1%
Actual	70.1%	70.5%	66.5%	70.50%	71.5%	70.4%									
	Orthopaedics Non admitted RTT														
	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Trajectory	78.8%	79.3%	80.4%	78.4%	80.7%	81.2%	82.0%	83.4%	84.1%	85.0%	86.0%	95.2%	95.1%	95.1%	95.1%
Actual	78.30%	78.40%	80.5%	76%	80.2%	81.1%									
	General surgery Admitted RTT														
	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Trajectory	75.2%	72.8%	73.7%	74.4%	74.6%	73.3%	77.4%	82.5%	84.2%	88.2%	90.2%	90.2%	90.2%	90.2%	90.2%
Actual	65.9%	56.9%	66.2%	74.20%	71.6%	73%									
	General surgery Non admitted RTT														
	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Trajectory	95.1%	95.1%	95.9%	95.1%	95.3%	95.9%	95.1%	95.3%	95.2%	95.3%	95.6%	95.1%	95.1%	95.1%	95.1%
Actual	84%	75.1%	96.7%	95.9%	96.1%	95.1%									

6.3 Diagnostic Waiting Times

2013/14 | Mth | YTD



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

6.4 Cancer Targets

Quarter 1 has seen a dip in cancer performance across many of the targets;

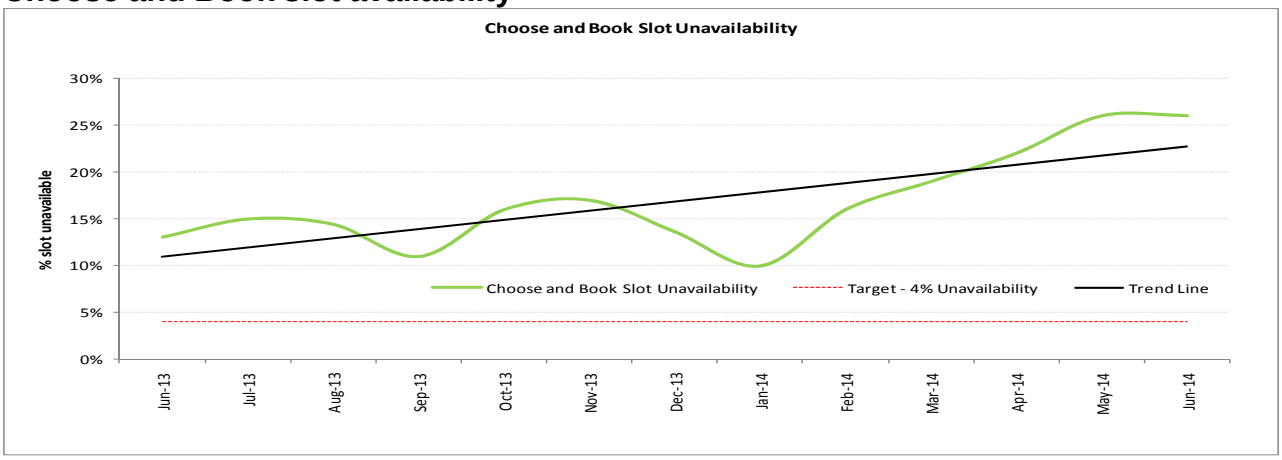
CWT standard (target)	2013/4 Q4 performance	2014/5 Q1 performance
2WW (93%)	95.5%	91.6%
62 day (GP ref) (85%)	90.1%	83.7%
Screening 62 day (90%)	94.4%	76.9%
31 day first treatment (96%)	97.9%	93.1%
31 day subsequent treatment (surgery) (94%)	96.5%	92.5%
31 day subsequent treatment (radiotherapy) (94%)	96.6%	95.3%
31 day subsequent treatment (chemotherapy) (98%)	100%	100%

Key points to note:-

- There has been a significant increase in 2ww referrals in April and a sustained increase in breast referrals for 3 months.
- June 2ww, 31 and 62 day standards have not been achieved, 31 and 62 day standards are at risk for July.
- The number of patients over 62 days has significantly increased across a number of tumour sites the reasons for the delays are understood.
- Recovery is expected by end Q2

For further details refer to Appendix 4 – Cancer performance and remedial action plan.

6.5 Choose and Book slot availability



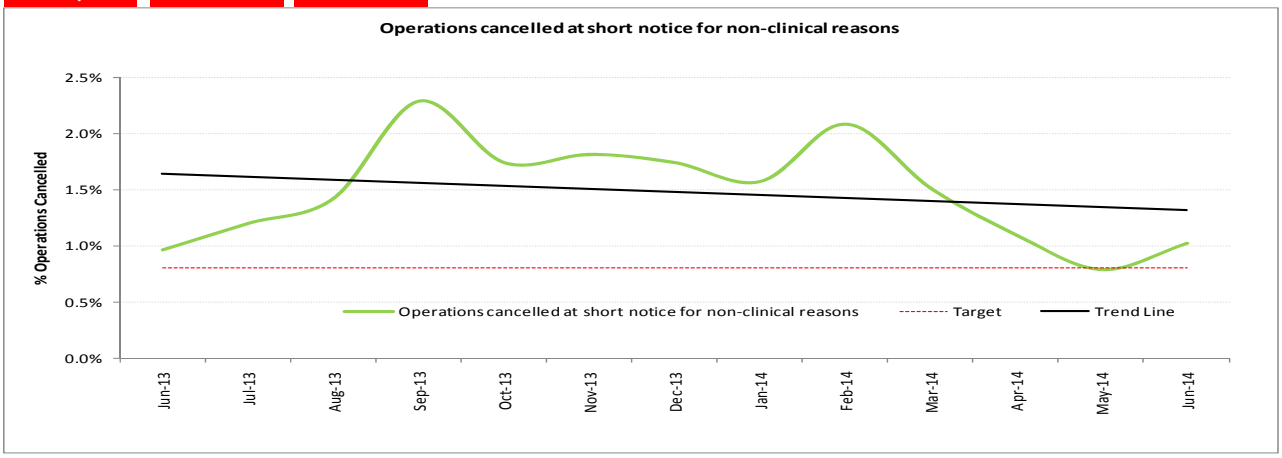
Choose and book slot availability performance for June was 26% with the national average at 11%. Resolution of slot unavailability requires a reduction in waiting times for 1st outpatient appointments in key specialties. For ENT, General surgery and Orthopaedics, this forms part of the 18 week remedial action plan, the effect of these plans will be seen quarter 2 and quarter 3 of 2014/15.

Specialty level actions include:-

- Orthopaedics, now outsourcing to local IS
- General surgery, doing additional clinics, also looking to start outsourcing
- ENT , adult and paediatrics , additional clinics in July and August
- Neurology , locum consultant in post
- Urology , capacity issues being picked up by new service manager in post July

6.6 Short Notice Cancelled Operations

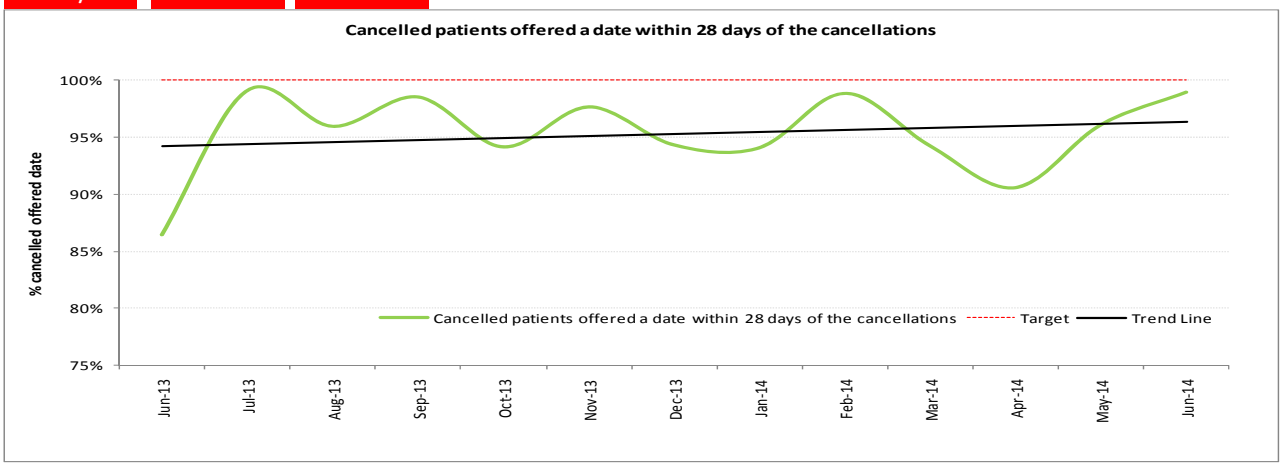
2013/14 | Mth | YTD



The percentage of operations cancelled on/after the day activity for non-clinical reasons during June (UHL and Alliance) was non-compliant at 1.0%. Further details are provided in Appendix 5.

Cancelled patients offered a date within 28 days

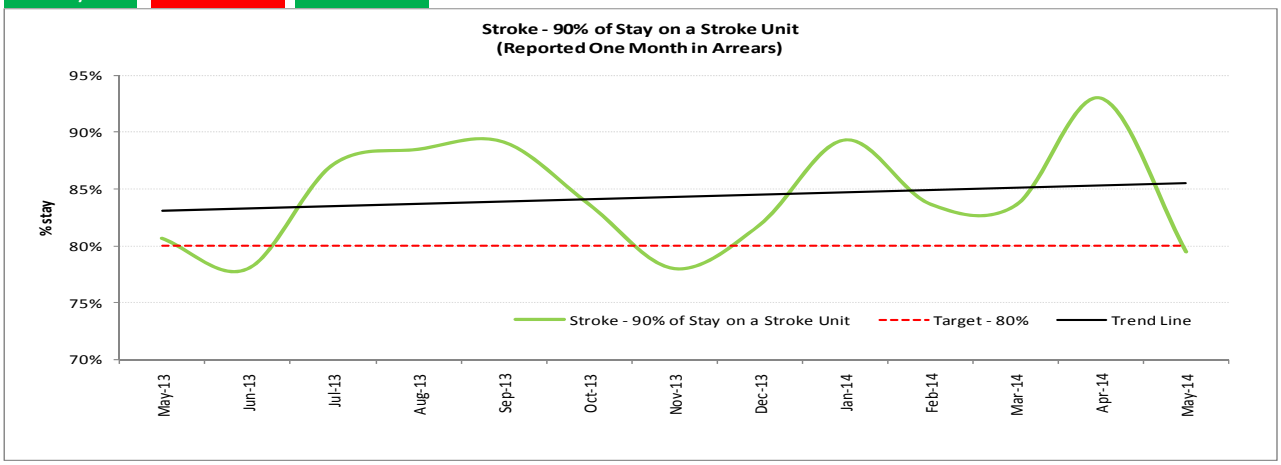
2013/14 Mth YTD



The number of patients breaching this standard in June (UHL and Alliance) was 1 with 99.0% offered a date within 28 days of the cancellation. Further details are provided in Appendix 5.

6.7 Stroke % stay on stroke ward

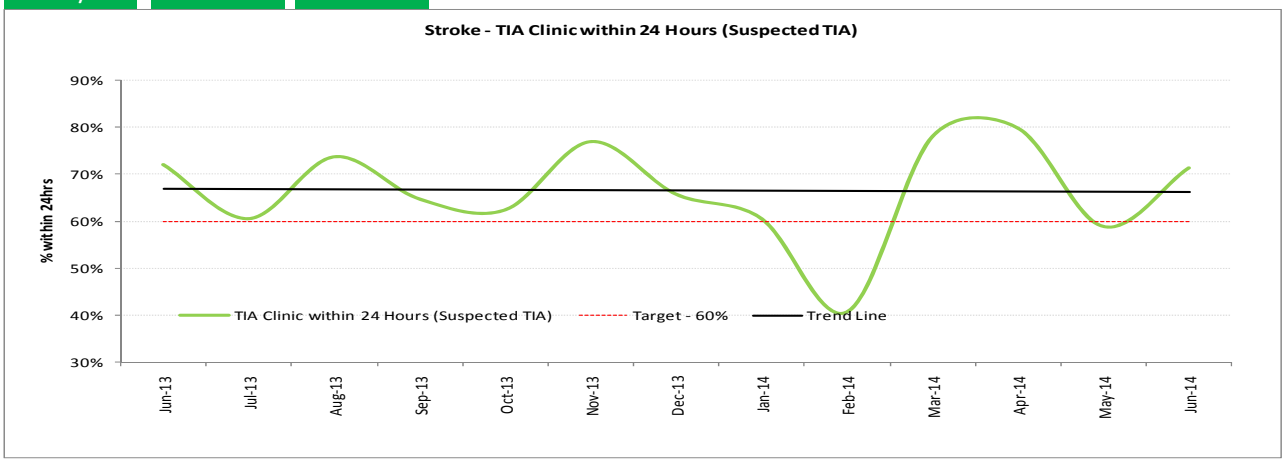
2013/14 Mth YTD



The percentage of stoke patients spending 90% of their stay on a stroke ward in May (reported one month in arrears) is 79.5% against a target of 80%. It is anticipated that validated data will show that the 80% threshold has been met for both April and May.

6.8 Stroke TIA

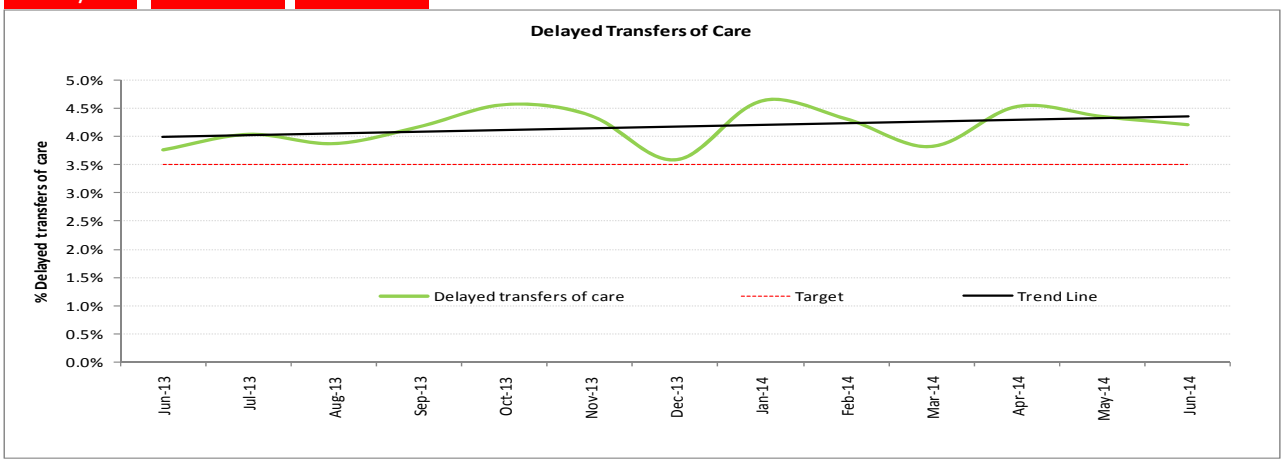
2013/14 Mth YTD



The percentage of high risk suspected TIAs receiving relevant investigations and treatment within 24 hours of referral for June is 71.3% and for quarter 1 69.2%, against a target of 60.0%. This target is being measured on a quarterly basis by the commissioners.

6.9 Delayed Transfers of Care

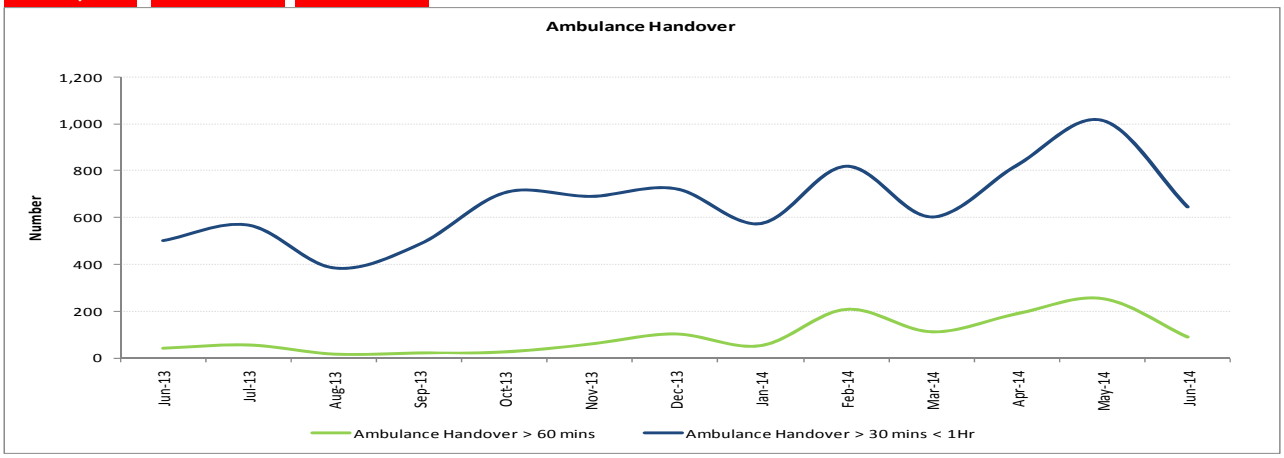
2013/14 | Mth | YTD



The delayed transfer of care performance for June was 4.2% against a target of 3.5%. Daily and weekly performance is monitored at the weekly Urgent Care Working Group.

6.10 Ambulance Handover Times

2013/14 | Mth | YTD



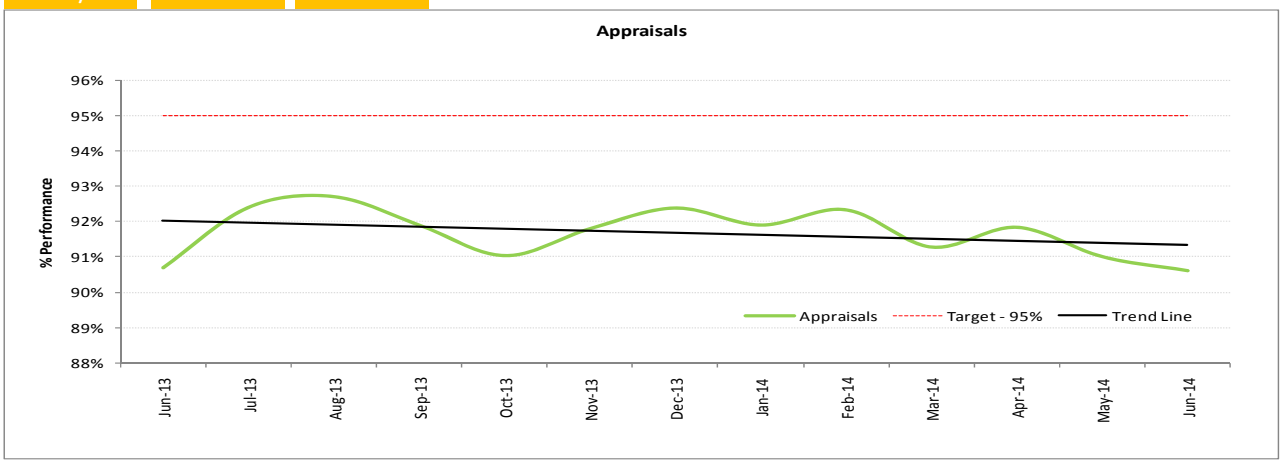
Actions to address the ambulance turnaround delays include:-

- A joint meeting with EMAS and ED to review the process and handover /measurement data collection points.
- A detailed timings study will be conducted by medical students measuring all agreed steps in handover process.
- There will be a correlation of data collected with current data collected by EMAS.
- The data will be jointly analysed and process reviewed by both EMAS and ED.
- Review of direct referral process to Urgent Care and Minors has taken place and protocols to be shared and signed off by all organisations.
- The escalation process and divert to Glenfield Hospital to be reviewed and agreed.
- Batching of ambulance journeys does cause problems for both EMAS and UHL. A review of options on how to manage and respond to demand is underway e.g. dedicated vehicle for admissions).

7 HUMAN RESOURCES – KATE BRADLEY

7.1 Appraisal

2013/14 | Mth | YTD

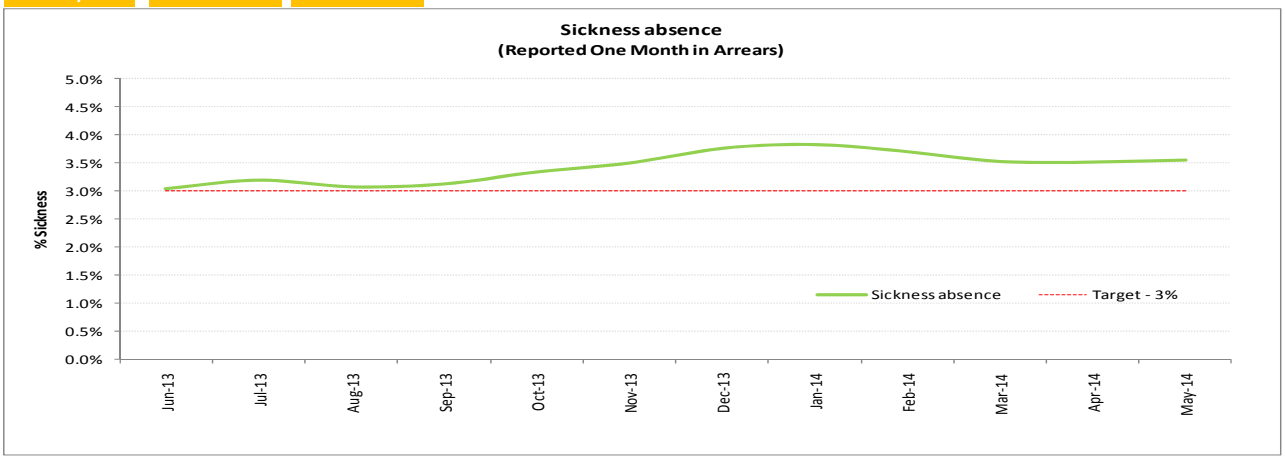


Appraisal performance is at 90.6% at the end of June 2014. HR continues to roll out to all CMGs and the larger Divisions the ability to directly input the appraisal information into Electronic Staff Record (ESR); this change is improving the central data capture and recording of additional information.

A Task and Finish Group has been established to review the appraisal template and simplify the documentation taking into account audit findings in ensuring that emphasis is placed on the appraisal/talent conversation. As part of this review, the group will conduct a benchmarking exercise with other NHS and commercial organisations in identifying areas best practice.

7.2 Sickness

2013/14 | Mth | YTD



The sickness rate for May 2014 is 3.6% (reported one month in arrears) and the April figure has now adjusted to 3.5% (from 3.7%) to reflect closure of absences. The overall cumulative sickness figure is 3.4%. This is close to the target of 3.4% but slightly above the Trust stretch target of 3%.

When reviewing the reasons for sickness absence, some of the highest reasons are stress/ depression, back/musculo-skeletal problems and pregnancy related absences. To support staff Health and Wellbeing the Emotional Resilience Workshops are continuing this year and the

format has been changed to increase the places available. The fast track physiotherapy provision through Occupational Health remains in place, as well as the Self referral provision at Glenfield Hospital. In addition, a physiotherapy self referral pilot will be launched at the Leicester Royal Infirmary from 4 August 2014 to 27 February 2015. In the last quarter, we have seen a reduction in stress /depression absence episodes from 152 to 103 episodes and back/musculo-skeletal absences from 299 to 248.

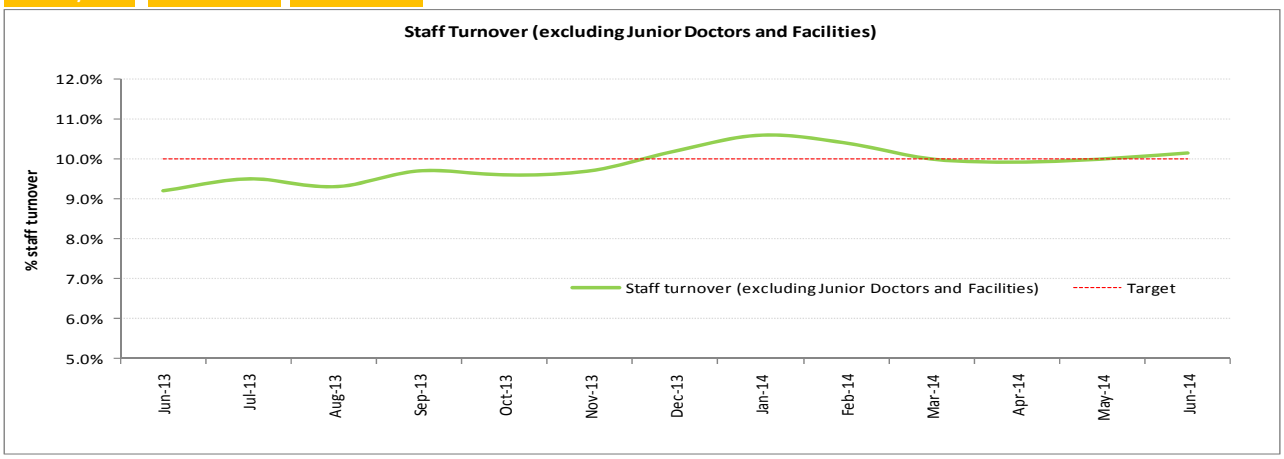
To support pregnant employees, as well as ensuring a New and Expectant Mothers Risk Assessment, support and advice from Occupational Health and reasonable adjustments in the workplace, the Health and Wellbeing Group are now working with Maternity Services to meet the cost of a Pregnancy Workshop for UHL pregnant employees to support their health and wellbeing in the early stages of pregnancy.

The annual UHL Family Fun day took place on Saturday 28 June with over 500 people attending throughout the day. We increased our attractions this year and the climbing wall proved very popular with the all. We had a diverse choice of food and there was something for everyone. It was a great day and fun for all.

As we move towards the winter we are preparing for flu jabs for our staff. We have over 60 volunteer Peer Vaccinators who will vaccinate their colleagues across the Trust. Well Being funds will be used to purchase vouchers for a monthly draw for the 4 months of the flu campaign for the Peer Vaccinators. There will also be a monthly draw for staff who have their vaccination as an incentive for more staff to be vaccinated.

7.3 Staff Turnover

2013/14 | Mth | YTD



The cumulative Trust turnover figure (excluding junior doctors) has increased slightly from 10 % to 10.2%. The latest figure includes the TUPE transfer of 27 IM &T staff to IBM on 30 November 2013 and the transfer of 65 sexual health services staff to Staffordshire and Stoke on Trent Partnership NHS Trust and therefore skews the overall turnover figures.

7.4 Statutory and Mandatory Training

2013/14 | Mth | YTD

UHL Statutory & Mandatory Training Summary - 1st July 2014

CMG / Corporate Directorates	Fire Training	Moving & Handling	Infection Preventio n	Equality & Diversity	Informat'n Gover'ce	Safeguard Children	Conflict Resolution	Safeguard Adults	Health & Safety	Resus - BLS Equivalent	Average Compliance
CHUGS	76%	72%	81%	83%	80%	86%	83%	84%	64%	75%	79%
Corporate Directorates	83%	84%	85%	88%	84%	89%	85%	84%	68%	76%	82%
CSI	84%	87%	85%	91%	90%	93%	89%	89%	73%	75%	86%
Emergency & Speciality Medicine	73%	77%	78%	79%	74%	82%	74%	74%	50%	67%	73%
ITAPS	78%	89%	86%	90%	86%	91%	87%	88%	71%	76%	84%
Musculoskeletal & Specialist Surgery	73%	74%	80%	82%	79%	85%	82%	80%	57%	72%	76%
Renal, Respiratory & Cardiac	76%	81%	84%	86%	84%	87%	85%	83%	70%	73%	81%
The Alliance	31%	18%	34%	26%	29%	49%	40%	49%	31%	46%	35%
Womens and Childrens	78%	76%	82%	84%	84%	92%	84%	78%	61%	82%	80%
Total compliance by subject	76%	79%	81%	84%	82%	87%	82%	81%	63%	74%	
UHL staff are this compliant with their mandatory & statutory training from the key 10 subjects											79%
Performance Against Trajectory (Set at 80% at 1st July, 2014)											1% behind target

Compliance Levels below 75%
Compliance Levels 75% upto 84%
Compliance Levels 85% and above

At the end of June we were reporting against the ten core subjects, identified by the Skills for Health, Core Skills Training Framework, in relation to Statutory and Mandatory Training.

The period between May and June staff compliance against Statutory and Mandatory Training has remained at 79% across the ten core areas. This is due to the introduction of the Health & Safety eLearning module, which currently has a lower compliance level and the inclusion of TUPE staff (Alliance) who are now employed by directly UHL.

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

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

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

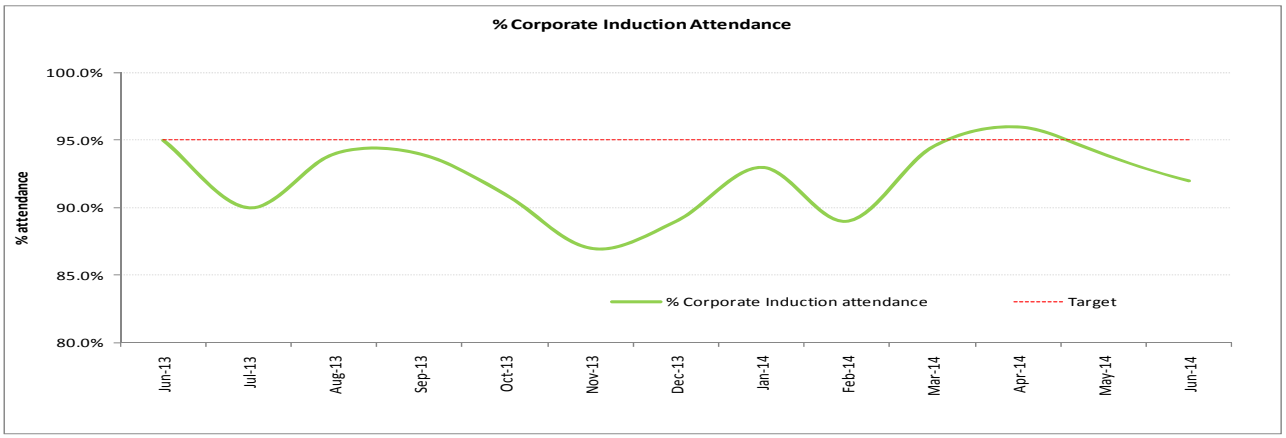
These trajectories are as follows:

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

The Dashboard and Team Builder sections of eUHL, along with all Trust reports will be updated to reflect the new red, amber and green (RAG) trajectories and a key will be added to add clarity to any training data being produced.

7.5 Corporate Induction

2013/14	Mth	YTD



Corporate Induction performance is at 90% at the end of June 2014. As the result of the implementation of the new weekly Corporate Induction Programme, overall we have seen an average improvement in attendance levels. The attendance figures continue to reflect numbers booked onto Corporate Induction against actual attendance. The process for following-up non-attendees continues to be implemented at a local level in line with the Induction Policy.

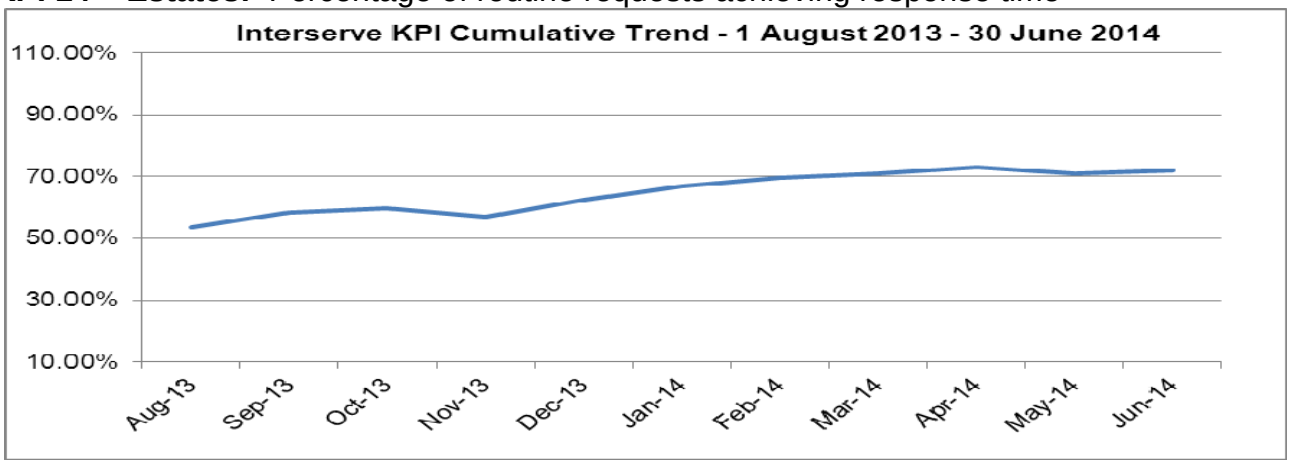
8 UHL - FACILITIES MANAGEMENT– RACHEL OVERFIELD

8.1 Introduction

This report covers a review of overall performance on the Facilities Management (FM) service delivery provided by Interserve FM (IFM) for the month of June 2014. The FM contract provides 14 different services to the Trust and is underpinned by 77 Key Performance Indicators (KPIs). The contract is managed and monitored by NHS Horizons. The summary information and trend analysis below details a snapshot of 5 of the key indicators.

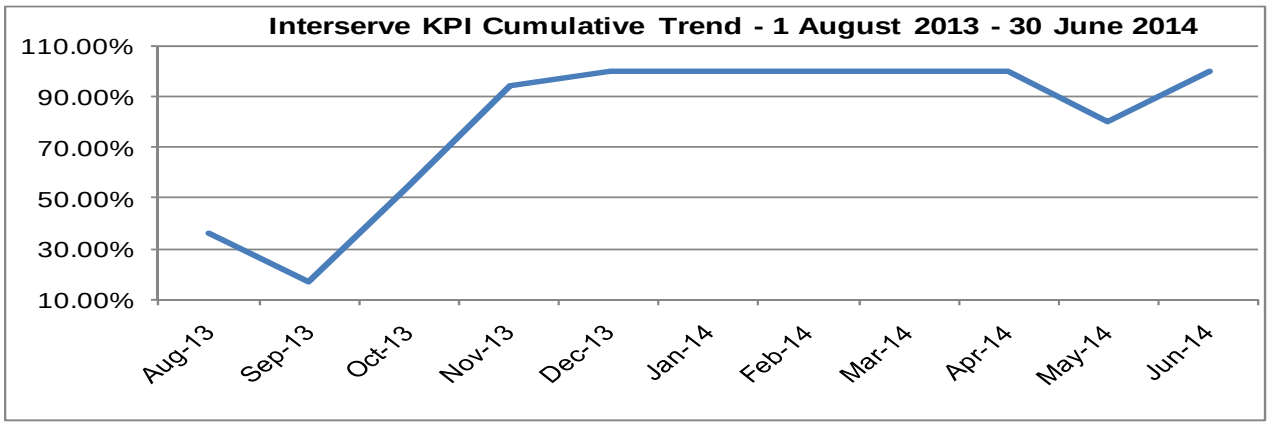
8.2 Key Performance Indicators

KPI 14 – Estates: Percentage of routine requests achieving response time



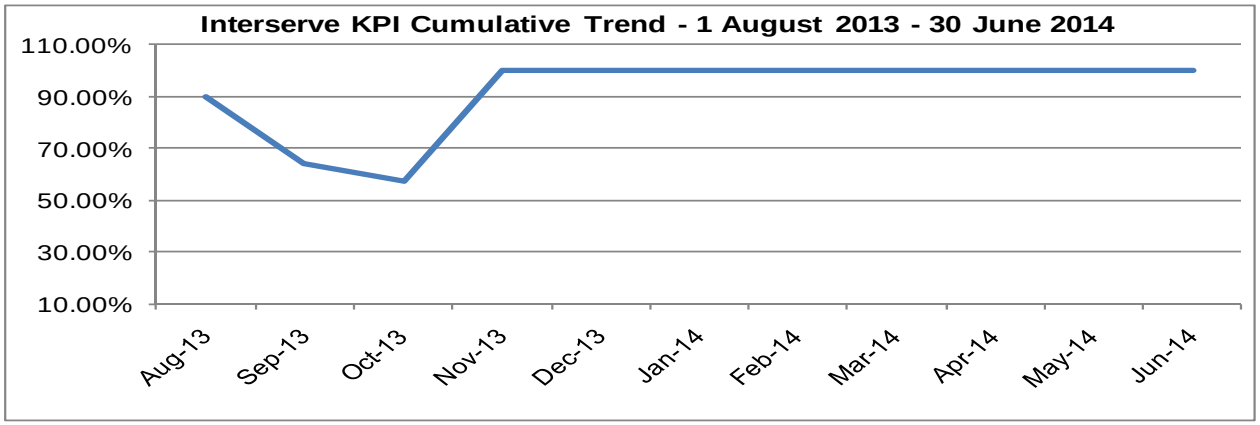
June has seen a slight improvement however the volume of blockages continues to be an issue by way of lack of resources to deal with both these and competing requests. IFM report that some 22% of calls logged relate to blockages, leaks or flooding. The Trust have received the results of a commissioned survey of the drainage systems at the LRI and are currently reviewing this to identify where the main issues are and looking at what remedial action can be taken to address those areas where the problems are greatest.

KPI 18 – Minor & Additional Work: % of quotations submitted within 10 working days.



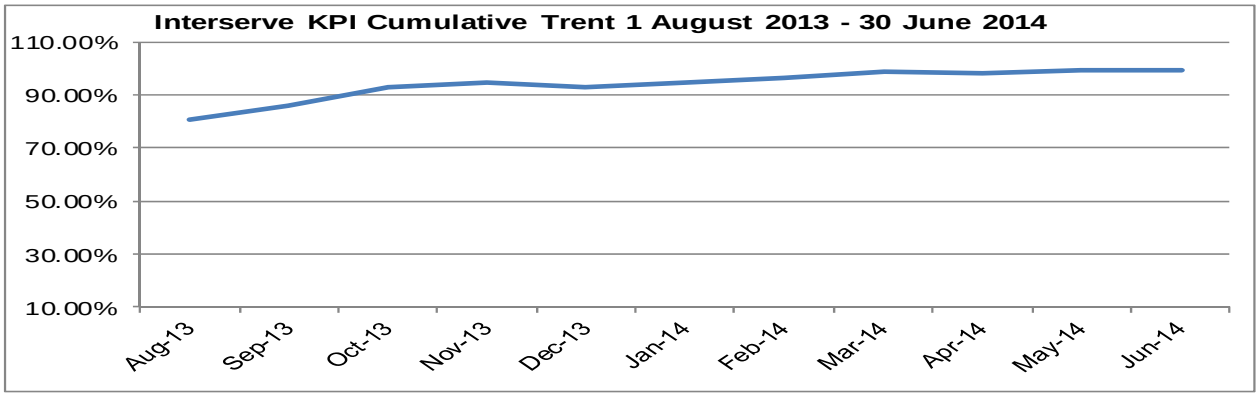
There has been significant improvement in the performance for KPI 18 in June and it is anticipated that the new systems and processes for delivery of quotations will continue to have a positive impact on this service. The Performance & Quality team continue to attend weekly meetings with IFM to review the tracker for minor and new works. Technical assessments carried out by IFM on initial requests are contributing to improved data capture which assures the Trust of valid requests which meet Trust policy procedures prior to authorisation and completion of works.

KPI 27 – Portering: Percentage of emergency portering tasks achieving response time.



IFM have maintained 100% achievement for this KPI.

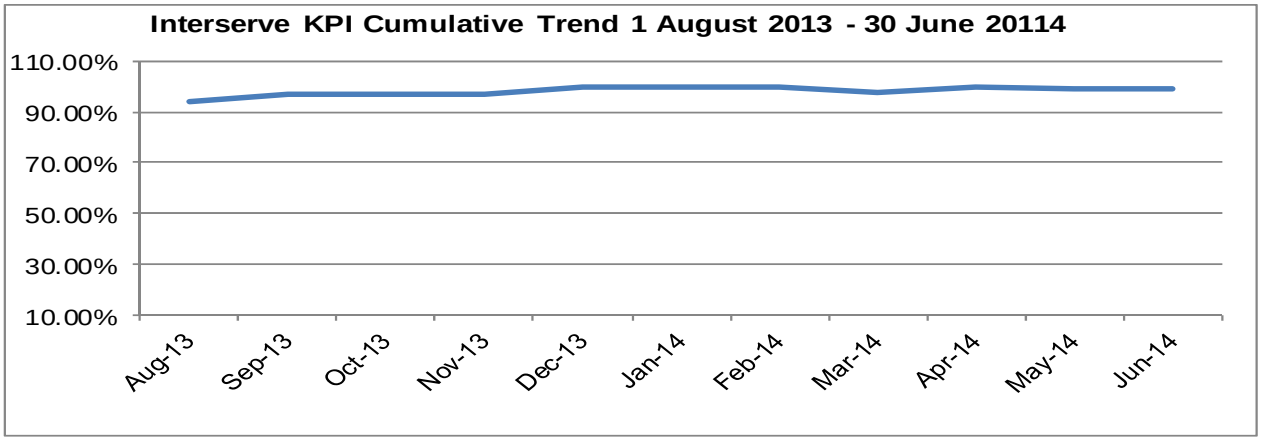
KPI 46 – Cleaning: Percentage of audits within clinical areas achieving 90% or above.



The KPI for for cleaning audit results is reported at 99.51% for June indicating a slight improvement. Further development of Servicetrac, the electronic audit tool for recording cleaning

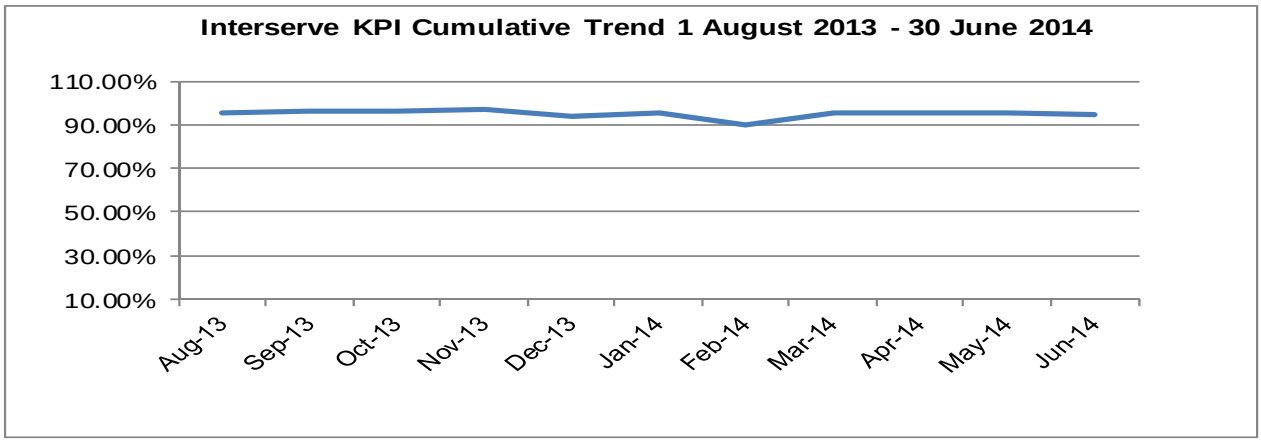
performance, is required in order to capture more detailed information in order to introduced the agreed revised KPIs and for reporting purposes. The Performance & Quality team (P&Q) team are actively using the tool when carrying out audits and are working with IFM to resolve issues identified with the software system and the reports produced to further improve the recording.

KPI 57 – Catering: Percentage of meals delivered to wards in time for the designated meal service as per agreed schedules



The result for June has remained consistent with recorded 99.40% achieved. Feedback received from patients during the recent Patient Led Assessments of the Care Environment (PLACE) was in the main very positive regarding the service and quality of food provided. The recorded patient satisfaction survey score has improved in June with 95.30% reported by IFM.

KPI 81 – Customer Services Centre (CSC): Percentage of telephone calls answered within 5 rings using non-automated solution.



The Customer Service Centre (CSC) performance has dipped slightly during June with 94.47% of the 24,203 calls received answered in line with the KPI response time. The P & Q team continue to carry out monthly validation audits with IFM.

8.3 General Summary

The Performance and Quality team continue to proactively monitor services by way of onsite and electronic evidence audits to validate the reported KPI results. There is positive interaction with IFM Performance and Service Manager to support improved service delivery.
Estates continue to have a varied performance in part due to blockages within the LRI drainage systems for which the Trust commissioned a survey of the systems. The results of this survey

are currently being analysed to identify priority areas where action could be taken to improve the systems and reduce the number of blockages.

The reviewed structure for the new works team is to be implemented 1 July 2014 Weekly meetings continue to take place relating to all Lot 1 new works requests to monitor the impact of the revised systems and process implemented to assure improved service delivery and value for money.

IFM are still to implement the audit process for cleaning in line with contractual obligation to meet the National Specification for Cleanliness standard. NHS Horizons are discussing this with IFM and seeking timelines for implementation.

9 IM&T Service Delivery Review

9.1 IT Service Review

There were 8105 (6694 previous month) incidents logged during June, out of which 6307 (5888 previous month) were resolved. Incidents logged via X8000, email and self-service. There were 6131 telephone calls to X8000 with995 (888 previous month) incidents were closed on first contact.

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

Number of official complaints relating to service reduced to 10 in month (12 in previous month) There were 937 (937 previous month) incidents logged out of hours via the 24/7 service desk function.

9.2 Issues

Interserve work for Managed Print held up.

9.3 Future Action

Workshops being held with Clinicians for EPR

9.4 IM&T Service Desk Heatmap

Telephone

Metric	
Total Calls Answered	5933
Total Calls Abandoned	198
Total Calls Received	6131
Answered in 30secs (SLA 90%)	93.51%

NOTE

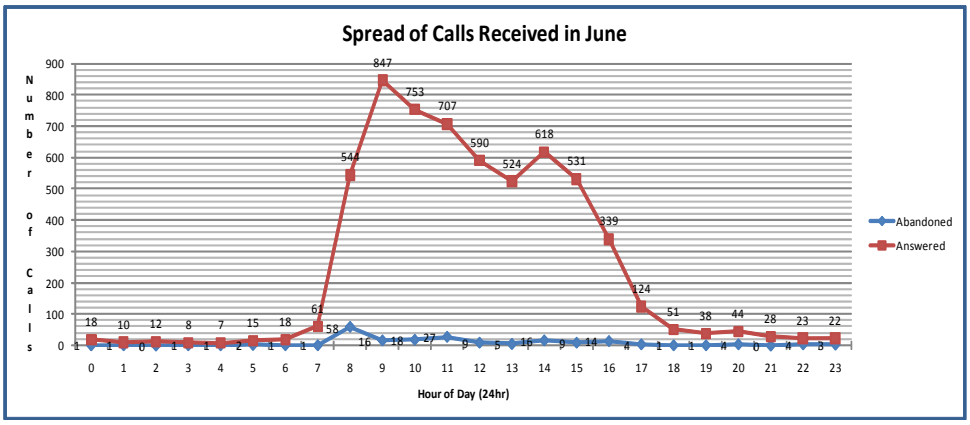
Incident Logging Route

SD Request email - email to sdrequest@uhl-tr.nhs.uk

SelfService Portal - LANDesk web portal for end user

Service Desk - call to x8000

SS/WebDesk - Resolving Analysts logged own incident



Incident Logging Route

	SD Request email		Self Service Portal		Service Desk		SS/WebDesk		Total Logged
	Logged	%	Logged	%	Logged	%	Logged	%	
June 2013	1113	23.13%	733	15.24%	2580	53.63%	385	8.00%	4811
July 2013	1391	23.65%	643	10.93%	3097	52.66%	750	12.75%	5881
August 2013	1737	23.44%	385	5.19%	3788	51.11%	1501	20.25%	7411
September 2013	1609	21.86%	458	6.22%	3830	52.04%	1463	19.88%	7360
October 2013	1735	22.19%	702	8.98%	4195	53.66%	1186	15.17%	7818
November 2013	1961	25.36%	654	8.46%	4059	52.50%	1058	13.68%	7732
December 2013	2178	27.17%	685	8.55%	4350	54.27%	802	10.01%	8015
January 2014	2697	29.75%	776	8.56%	4676	51.58%	912	10.06%	9066
February 2014	2685	34.01%	598	7.58%	3944	49.96%	667	8.45%	7894
March 2014	2294	31.97%	525	7.32%	4225	58.89%	131	1.83%	7175
April 2014	2704	35.21%	615	8.01%	4292	55.89%	68	0.89%	7679
May 2014	2450	36.60%	548	8.19%	3614	53.99%	82	1.22%	6694
June 2014	2814	34.72%	747	9.22%	4449	54.89%	95	1.17%	8105

Incidents Resolved when Logged

	AD Password Reset	Contact/ Technical Query	RA Services	Total	% of Total Logged
June 2013	951	777	0	1728	29.38%
July 2013	1788	2082	0	3870	52.22%
August 2013	2397	4116	0	6513	88.49%
September 2013	2352	3618	0	5970	76.36%
October 2013	2253	3090	0	5343	69.10%
November 2013	1956	2718	0	4674	58.32%
December 2013	1629	1995	0	3624	39.97%
January 2014	660	654	279	1593	20.18%
February 2014	580	501	263	1344	18.73%
March 2014	518	215	229	962	12.53%
April 2014	572	322	287	1181	15.38%
May 2014	509	160	219	888	13.27%
June 2014	450	272	273	995	12.28%

NOTE

Incidents

The following incidents have been resolved at the time of logging and **are included in the total calls logged**. The majority come into the Service Desk through the x8000 number with some being logged through Self Service or the SD request mailbox.

AD Pasword Reset - Network login password reset
Query Incident - Technical question or request for contact details
RA Services - Registration Authority/Smartcard activity (recorded from 1/1/2014)

10 FINANCE – SIMON SHEPPARD

10.1 Introduction

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

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

The paper also provides further commentary on the key risks.

10.2 Financial Duties

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

Financial Duty	YTD Plan £'Ms	YTD Actual £'Ms	RAG	Forecast Plan £'Ms	Forecast Actual £'Ms	RAG
Delivering the Planned Deficit	(12.1)	(12.7)	A	(40.7)	(40.7)	G
Achieving the EFL	(7.6)	(14.2)	G	62.1	62.1	G
Achieving the Capital Resource Limit	6.0	2.8	G	34.2	34.2	G

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

Better Payment Practice Code	April - June YTD 2014	
	Number	Value £000s
Total bills paid in the year	33,846	159,184
Total bills paid within target	19,658	108,343
Percentage of bills paid within target	**58%**	**68%**

Key issues

- YTD adverse variance to plan of £0.6m. Forecast year end delivery of £40.7m deficit.
- The Trust now has an agreed contract with all commissioners.
- Shortfall of £1.4m on the forecast CIP delivery against the £45m target.
- Capital Plan is currently over-committed and is predicated on Emergency Floor external funding, the commitments may be in advance of the receipt of funding.

10.3 Finance RAG Assessment

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

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

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

3.2. This RAG rating criteria highlights the following;

An overall RAG rating of Red.

The rating is driven by;

- The yearend forecast deficit position of £40.7m (indicator 1a)
- Under delivery against the YTD CIP plan (indicator 2a)
- An underlying deficit (indicator 3)
- A forecast for PDC to support liquidity (indicator 5)

APPENDIX 1

Friends & Families Test

What is the Friends & Family test?

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

Patients can choose from one of the following answers:

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

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

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

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

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

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

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

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

								JUNE SCORE BREAKDOWN				
		Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Total Responses	Promoters	Passives	Detractors	Score
GLENFIELD HOSPITAL	GH WD 15	85	95	85	82	79	80	39	32	6	1	80
	GH WD 16 Respiratory Unit	83	81	90	80	78	95	37	35	2	0	95
	GH WD 17	74	69	90	79	70	72	25	19	5	1	72
	GH WD 20	62	56	75	85	59	69	42	31	9	2	69
	GH WD 23A	89	80	89	86	84	92	25	23	2	0	92
	GH WD 24	86	80	97	85	79	64	22	15	6	1	64
	GH WD 26	91	90	100	94	82	75	24	18	6	0	75
	GH WD 27	96	86	96	90	89	100	19	18	0	0	100
	GH WD 28	68	69	74	74	72	85	40	34	6	0	85
	GH WD 29 EXT 3656	82	85	96	93	88	79	25	19	5	0	79
	GH WD 30	0	-	100	100	0	90	10	9	1	0	90
	GH WD 31	100	100	89	81	96	100	22	22	0	0	100
	GH WD 32	96	84	88	83	83	86	99	85	14	0	86
	GH WD 33	83	77	95	85	77	94	46	43	3	0	94
	GH WD 33A	95	95	90	68	87	92	25	23	2	0	92
	GH WD Clinical Decisions Unit	66	58	39	58	58	70	64	50	9	5	70
	GH WD Coronary Care Unit	94	78	88	94	100	81	37	30	7	0	81

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

								JUNE SCORE BREAKDOWN				
		Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Total Responses	Promoters	Passives	Detractors	Score
LEICESTER GENERAL HOSPITAL	LGH WD 1	0	90	80	0	0	74	23	19	2	2	74
	LGH WD 10	70	73	80	80	75	100	15	15	0	0	100
	LGH WD 14	88	71	81	80	74	73	51	39	10	2	73
	LGH WD 15N Nephrology	100	60	78	67	100	62	16	8	5	0	62
	LGH WD 16	83	76	79	73	82	80	45	37	7	1	80
	LGH WD 17 Transplant	78	90	89	71	33	85	39	33	6	0	85
	LGH WD 18	69	83	95	84	73	84	32	27	5	0	84
	LGH WD 19	0	80	71	0	0	90	31	28	3	0	90
	LGH WD 2	0	-	50	25	81	83	47	38	8	0	83
	LGH WD 22	45	55	75	35	61	75	40	31	8	1	75
	LGH WD 23	90	64	68	71	63	45	49	27	17	5	45
	LGH WD 26 SAU	71	57	52	56	58	65	46	32	12	2	65
	LGH WD 27	50	74	53	73	56	59	68	44	20	4	59
	LGH WD 28 Urology	65	50	53	46	61	68	51	35	14	1	68
	LGH WD 29 EMU Urology	43	54	47	62	65	56	78	45	32	1	56
	LGH WD 3	50	-	50	67	38	33	6	3	2	1	33
	LGH WD 31	80	75	83	71	69	78	73	60	10	3	78

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

								JUNE SCORE BREAKDOWN				
		Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Total Responses	Promoters	Passives	Detractors	Score
LEICESTER ROYAL INFIRMARY	LRI WD 12 Bal L4	75	-	55	0	86	100	16	16	0	0	100
	LRI WD 15 AMU Bal L5	58	-	67	54	59	69	81	57	23	1	69
	LRI WD 17 Bal L5	30	50	40	32	65	65	26	17	9	0	65
	LRI WD 18 Bal L5	0	57	70	59	37	54	28	16	11	1	54
	LRI WD 19 Bal L6	41	88	46	35	52	55	20	11	9	0	55
	LRI WD 23 Win L3	47	100	100	86	63	100	7	7	0	0	100
	LRI WD 24 Win L3	62	36	37	58	54	52	22	14	4	3	52
	LRI WD 25 Win L3	90	95	95	74	100	96	23	22	1	0	96
	LRI WD 26 Win L3	95	100	67	94	68	38	17	8	6	2	38
	LRI WD 29 Win L4	71	79	70	55	79	64	22	14	8	0	64
	LRI WD 30 Win L4	0	56	95	89	77	91	22	19	2	0	91
	LRI WD 31 Win L5	90	75	65	64	70	71	34	25	8	1	71
	LRI WD 32 Win L5	86	62	50	25	66	92	25	24	0	1	92
	LRI WD 33 Win L5	79	66	67	57	63	64	50	32	18	0	64
	LRI WD 34 Windsor Level 5	81	71	100	53	76	61	23	16	5	2	61
	LRI WD 36 Win L6	84	60	88	81	96	80	26	21	3	1	80
	LRI WD 37 Win L6	72	100	49	58	81	76	34	26	6	1	76
	LRI WD 38 Win L6	96	93	78	60	83	87	31	27	2	1	87
	LRI WD 39 Osb L1	70	86	65	80	82	73	41	30	11	0	73
	LRI WD 40 Osb L1	63	68	77	77	69	81	42	34	8	0	81
	LRI WD 41 Osb L2	56	73	68	76	78	77	30	24	5	1	77
	LRI WD 7 Bal L3	48	53	87	80	70	79	72	58	13	1	79
	LRI WD 8 SAU Bal L3	39	56	23	40	48	28	36	17	12	7	28

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

								JUNE SCORE BREAKDOWN				
		Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Total Responses	Promoters	Passives	Detractors	Score
	LRI WD Bone Marrow	0	77	100	86	82	100	4	4	0	0	100
	LRI WD Fielding John Vic L1	85	69	82	77	73	92	26	24	2	0	92
	LRI WD GAU Ken L1	70	48	78	70	70	85	103	88	15	0	85
	LRI WD IDU Infectious Diseases	71	53	50	79	76	65	31	21	9	1	65
	LRI WD Kinmonth Unit Bal L3	81	74	60	73	78	100	12	12	0	0	100
	LRI WD Osborne Assess Unit	56	69	80	76	91	59	27	18	7	2	59

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								JUNE SCORE BREAKDOWN				
		Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Total Responses	Promoters	Passives	Detractors	Score
EMERGENCY DEPARTMENT	ED - Majors	58	52	56	65	54	65	137	95	33	7	65
	ED - Minors	64	57	60	68	68	63	355	246	86	22	63
	ED - (not stated)	69	61	66	55	65	69	48	35	11	2	69
	Eye Casualty	83	64	85	91	71	90	259	234	23	2	90
	Emergency Decisions Unit	58	65	58	54	72	64	115	78	31	5	64

APPENDIX 2 - MONTHLY CLINICAL MEASURES DASHBOARD: June '14

Division		Ward	Budgeted Qualified %	Total vacancies %	Total vacancies (WTE)	Current appraisal Rate % (rolling 12 months)	Sickness Absence % (month in arrears)	Friends & Family score	No. of complaints	Safety Thermometer - No new harms %	Hand Hygiene %	Pressure Ulcers - Grade 2 (avoidable)	Pressure Ulcers - Grade 3 (avoidable)	Pressure Ulcers - Grade 4 (avoidable)	No. MRSA Bacteraemias (post 48 hrs)	MRSA Screening - Non elective %	MRSA Screening - Elective %	No. of C Diff cases (post 48 hrs)	No. of falls	No. of patient safety SUI's (severe)	No. Patient safety incidents (moderate)	No. Patient safety incidents (low)	No. of medication errors
	GREEN THRESHOLD		> = 60%	0 - 4.9%	< = 5	> = 95%	< = 3%	> = 75.0	< = 1	> = 95%	> = 90%	0	0	0	0	> = 100%	> = 100%	0	0	0	0	0	0
	AMBER THRESHOLD		-	5 - 10 %	-	-	3.1% - 3.9%	56 - 74	2	-	-	-	-	-	-	-	-	-	1 - 3	-	1	1 - 4	-
	RED THRESHOLD		< 60%	> 10%	> 5	< 95%	> = 4%	< = 55.0	> 2	< 95%	< 90%	> = 1	> = 1	> = 1	> = 1	< 100%	< 100%	> = 1	> = 4	> = 1	> 1	> = 5	> = 1
CHUGS	DC	F25E	-	-	-	-	-	↓ 83.3	↔ 0	-	0%	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	-	↔ 0	↔ 0	↔ 0	↓ 0	0.00	↔ 0
CHUGS	DC	FGI	-	-	-	-	-	-	↔ 0	-	0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	0.00	↔ 0
CHUGS	DC	GDC1	-	-	-	-	-	↓ 83.3	↔ 0	-	↔ 100%	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	-	↔ 0	↔ 0	↔ 0	↔ 0	0.00	0.00
CHUGS	DC	GDC2	-	-	-	-	-	-	↔ 0	-	↔ 100%	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	-	↔ 0	↔ 0	↔ 0	↔ 0	0.00	0.00
CHUGS	DC	GEND	-	-	-	-	-	↑ 94.1	↔ 0	-	79%	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	-	↔ 0	↔ 0	↔ 0	↔ 0	0.00	0.00
CHUGS	DC	RCHM	-	-	-	-	-	↑ 75.9	↔ 0	-	0%	↔ 0	↔ 0	↔ 0	↔ 0	0.56	-	↔ 0	↔ 0	↔ 0	↔ 0	2.00	1.00
CHUGS	DC	RHAD	-	-	-	-	-	↑ 80.8	↔ 0	-	0%	↔ 0	↔ 0	↔ 0	↔ 0	0.75	-	↔ 0	↔ 0	↔ 0	↔ 0	0.00	0.00
CHUGS	DC	RHAM	-	-	-	-	-	↑ 100.0	↔ 0	-	0%	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	-	↔ 0	↔ 0	↔ 0	↔ 0	0.00	0.00
CHUGS	DC	RHTU	-	-	-	-	-	-	↔ 0	-	0%	↔ 0	↔ 0	↔ 0	↔ 0	0.27	-	↔ 0	0.00	↔ 0	↔ 0	0.00	0.00
CHUGS	IP	G20	↔ 44%	↔ 14.7%	↔ 0.80	↔ 100%	↓ 0.0%	-	↓ 0	-	0%	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	-	↔ 0	↔ 0	↔ 0	↔ 0	0.00	0.00
CHUGS	IP	G22	↓ 60%	↓ -34.5%	↓ -8.85	↓ 41%	↓ 0.6%	↑ 75.0	↔ 0	↔ 100%	0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↓ 0	↔ 0	↔ 0	0.00	0.00
CHUGS	IP	G23	↓ 62%	↓ 8.7%	↓ 1.44	↑ 100%	↓ 1.8%	↓ 44.9	-	↔ 100%	-	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	-	-	-	-	-
CHUGS	IP	G26	↔ 66%	↓ 3.5%	↓ 0.98	↑ 96%	↓ 4.2%	↑ 65.2	↑ 2	↔ 100%	0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↓ 2	↔ 0	↔ 0	1.00	↓ 0
CHUGS	IP	G27	↔ 61%	↑ 17.0%	↑ 4.34	↓ 93%	↓ 5.4%	↑ 58.8	↑ 1	↔ 100%	↑ 90%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 1	↑ 2	↔ 0	↔ 0	0.00	0.00
CHUGS	IP	G28	↔ 61%	↔ 8.9%	↔ 3.03	↓ 59%	↓ 6.8%	↑ 68.0	↔ 1	↔ 100%	↓ 0%	↔ 0	↔ 0	↔ 0	↔ 0	-	>= 100%	↔ 0	↓ 0	↔ 0	↓ 0	0.00	↓ 0
CHUGS	IP	G29	-	-	-	-	-	-	-	↓ 92%	-	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	-	-	-	-	-
CHUGS	IP	GSAC	↔ 68%	↔ 6.4%	↔ 1.06	↔ 100%	↑ 7.0%	↑ 90.0	↔ 0	-	↔ 100%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	0.00	0.00
CHUGS	IP	GUEA	↓ 58%	↓ 6.0%	↓ 2.30	↑ 93%	↑ 3.4%	↓ 56.4	↔ 0	-	0%	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	>= 100%	↔ 0	↔ 0	↔ 0	↔ 0	0.00	0.00
CHUGS	IP	R22	↓ 63%	↓ 0.5%	↓ 0.19	↓ 74%	↑ 6.7%	↑ 61.1	↔ 2	↓ 96%	↓ 85%	↔ 1	↑ 1	↔ 0	↔ 0	0.88	-	↔ 0	↔ 0	↔ 0	↑ 1	2.00	0.00
CHUGS	IP	R39	↔ 65%	↓ 1.7%	↓ 0.40	↑ 100%	↑ 0.3%	↓ 73.2	↔ 1	↓ 89%	↓ 0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↑ 6	↔ 0	↔ 0	3.00	0.00
CHUGS	IP	R40	↔ 69%	↓ -0.8%	↓ -0.20	↑ 100%	↑ 4.9%	↑ 81.0	↓ 0	↓ 95%	0%	↔ 0	↑ 1	↔ 0	↔ 0	-	-	↔ 0	↓ 0	↔ 0	0	1.00	1.00
CHUGS	IP	R29	↔ 61%	↓ 4.4%	↓ 1.56	↑ 100%	↑ 6.4%	↓ 63.6	↔ 0	↓ 97%	↓ 0%	↑ 1	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↓ 5	↔ 0	↓ 1	3.00	1.00
CHUGS	IP	R30	↔ 60%	↔ 12.4%	↔ 4.92	↓ 86%	↓ 3.2%	↑ 90.5	↓ 0	↑ 100%	↓ 0%	↓ 0	↔ 0	↔ 0	↔ 0	-	-	↓ 0	↑ 10	↔ 0	↓ 0	2.00	0.00
CHUGS	IP	RBMT	↔ 97%	↔ 6.6%	↔ 1.00	↔ 100%	↓ 2.5%	↑ 100.0	↔ 0	100%	↓ 0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	0.00	0.00
CHUGS	IP	REND	-	-	-	-	-	↓ 70.0	↓ 0	-	0%	↔ 0	↔ 0	↔ 0	↔ 0	0.00	-	↔ 0	↔ 0	↔ 0	↔ 0	0.00	0.00
CHUGS	IP	R41	↓ 71%	↓ 2.5%	↓ 0.80	↓ 89%	↑ 6.7%	↓ 76.7	-	↑ 100%	-	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	-	↔ 0	-	-	-	-	-
CHUGS	IP	ROND	↔ 76%	↔ 11.1%	↔ 1.48	↔ 100%	↓ 0.0%	↓ 59.3	↔ 0	-	↔ 90%	↔ 0	↔ 0	↔ 0	↔ 0	-	>= 100%	↔ 0	↔ 0	↔ 0	↔ 0	0.00	0.00
CHUGS	IP	RSAU	↓ 57%	↓ 12.7%	↓ 5.86	↓ 59%	↓ 2.6%	↓ 27.8	↔ 0	↔ 100%	↔ 80%	↔ 0	↔ 0	↔ 0	↔ 0	-	>= 100%	↔ 0	↑ 1	↔ 0	↑ 1	4.00	0.00
Emergency & Specialist Medicine	DC	G1	-	-	-	-	-	↑ 73.9	↔ 0	-	0%	↔ 0	↔ 0	↔ 0	↔ 0	0.64	-	↔ 0	↔ 0	0.00	↔ 0	0.00	0.00
Emergency & Specialist Medicine	IP	RAMU	↓ 57%	↑ 12.3%	↑ 14.99	↑ 97%	↓ 2.4%	-	-	-	-	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	-	-	-	-	-
Emergency & Specialist Medicine	IP	R16	↓ 57%	↑ 12.3%	↑ 14.99	↑ 97%	↓ 2.4%	-	↓ 0	↑ 100%	0%	↔ 0	↔ 0	↔ 0	↔ 0	-	>= 100%	↔ 0	↓ 3	↔ 0	↑ 2	9.00	1.00
Emergency & Specialist Medicine	IP	R24	↔ 60%	↑ 28.2%	↑ 10.90	↑ 52%	↓ 2.7%	↓ 52.4	↓ 0	↓ 96%	↓ 0%	↑ 1	↓ 0	↔ 0	↔ 0	-	-	↔ 0	↓ 4	↔ 0	↔ 1	8.00	10.00
Emergency & Specialist Medicine	IP	R25	↔ 70%	↑ 20.3%	↑ 11.79	↓ 91%	↑ 8.3%	↓ 95.7	↓ 0	↑ 100%	↓ 0%	↔ 0	↔ 0	↔ 0	↔ 0	-	>= 100%	↔ 0	↓ 6	↔ 0	↔ 1	4.00	3.00
Emergency & Specialist Medicine	IP	R33	↔ 57%	↑ 23.1%	↑ 11.10	↓ 83%	↓ 4.0%	↑ 64.0	↔ 0	↔ 100%	↓ 0%	↔ 0	↔ 0	↔ 0	↔ 0	-	>= 100%	↔ 0	↓ 1	↔ 0	↔ 0	9.00	1.00
Emergency & Specialist Medicine	IP	R37	↓ 56%	↑ 28.9%	↑ 12.50	↓ 93%	↓ 7.4%	↓ 75.8	↔ 2	↑ 100%	0%	↓ 0	↓ 0	↔ 0	↔ 0	-	-	↔ 0	↑ 10	↔ 0	0	7.00	2.00
Emergency & Specialist Medicine	IP	R38	↔ 60%	↑ 21.3%	↑ 7.72	↔ 100%	↓ 8.8%	↑ 86.7	↔ 1	↑ 96%	↓ 80%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↑ 12	↔ 0	↓ 0	5.00	1.00
Emergency & Specialist Medicine	IP	RACB	↔ 57%	↑ 23.1%	↑ 11.10	↓ 83%	↓ 4.0%	-	↔ 0	-	0%	↔ 0	↔ 0	↔ 0	↔ 0	-	>= 100%	↔ 0	↔ 0	↔ 0	↔ 0	0.00	0.00
Emergency & Specialist Medicine	IP	REDU	↓ 64%	↑ 27.6%	↑ 8.93	↔ 100%	↑ 3.6%	-	↔ 1	↓ 93%	↓ 0%	↔ 0	↔ 0	↔ 0	↔ 0	-	>= 100%	↔ 0	↑ 2	↔ 0	↔ 0	3.00	0.00
Emergency & Specialist Medicine	IP	RIDU	↔ 60%	↑ 8.3%	↑ 1.95	↓ 96%	↓ 0.0%	↓ 64.5	↔ 0	↓ 94%	↔ 100%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↑ 2	↔ 0	↔ 0	4.00	0.00
Emergency & Specialist Medicine	IP	G2	↔ 60%	↓ 14.5%	↓ 4.03	↑ 79%	↑ 4.1%	↑ 82.6	↔ 0	↓ 94%	↓ 0%	↔ 0	↓ 0	↔ 0	↔ 0	-	-	↔ 0	↓ 3	↑ 1	↓ 0	5.00	0.00
Emergency & Specialist Medicine	IP	GBIU	↔ 70%	↓ 21.3%	↓ 5.83	↓ 36%	↓ 10.6%	↑ 66.7	↔ 0	↑ 100%	0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↑ 1	↔ 0	↔ 0	0.00	0.00
Emergency & Specialist Medicine	IP	GYDU	↔ 60%	↔ 45.7%	↔ 15.23	↓ 73%	↓ 5.3%	↑ 100.0	↔ 0	↓ 90%	0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	0.00	0.00
Emergency & Specialist Medicine	IP	R19	↔ 60%	↓ 15.9%	↓ 6.73	↑ 66%	↑ 9.3%	↑ 55.0	↔ 1	↓ 93%	0%	↓ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↑ 12	↔ 0	↔ 0	5.00	0.00
Emergency & Specialist Medicine	IP	R23	↔ 60%	↑ 30.5%	↑ 12.07	↓ 83%	↓ 0.6%	↑ 100.0	↔ 0	↓ 96%	↓ 0%	↑ 1	↔ 0	↔ 0	↔ 0	-	-	↓ 0	↓ 0	↔ 0	↑ 1	6.00	0.00
Emergency & Specialist Medicine	IP	R31	↔ 60%	↑ 13.7%	↑ 5.78	↓ 85%	↓ 2.6%	↑ 70.6	↔ 0	↔ 100%	↔ 100%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↓ 0	↓ 3	↔ 0	↑ 2	3.00	0.00
Emergency & Specialist Medicine	IP	R34	↔ 60%	↓ -18.7%	↓ -6.16	↓ 82%	↑ 7.5%	↓ 60.9	↓ 1	↔ 100%	↑ 98%	↑ 1	↓ 0	↔ 0	↔ 0	-	-	↔ 0	↓ 0	↔ 0	↓ 0	0.00	0.00
Emergency & Specialist Medicine	IP	R36	↔ 60%	↑ 20.2%	↑ 7.98	↓ 88%	↓ 11.0%	↓ 80.0	↔ 0	↔ 96%	↓ 0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↑ 10	↔ 0	↔ 1	5.00	0.00
Emergency & Specialist Medicine	IP	RFJW	↔ 60%	↓ 16.8%	↓ 5.39	↓ 92%	↓ 4.0%	↑ 92.3	↔ 0	↑ 100%	↔ 100%	↔ 0	↑ 1	↔ 0	↔ 0	-	-	↔ 0	↔ 3	↔ 0	↔ 0	6.00	2.00
Emergency & Specialist Medicine	IP	G3	↔ 60%	↑ 18.0%	↑ 4.96	↓ 78%	↑ 11.1%	↓ 33.3	↔ 0	↓ 93%	↓ 86%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↓ 1	↔ 0	↑ 1	2.00	0.00
Musculoskeletal & Specialist Surgery	DC	F23A	↔ 63%	↓ 1.9%	↓ 0.67	↓ 87%	↑ 7.1%	↑ 92.0	↔ 0	↔ 100%	0%	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	-	↔ 0	↔ 0	↔ 0	↔ 0	0.00	↔ 0
Musculoskeletal & Specialist Surgery	DC	RDAY	-	-	-	-	-	↓ 72.2	↔ 0	-	0%	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	-	↔ 0	↔ 0	↔ 0	↔ 0	0.00	0.00
Musculoskeletal & Specialist Surgery	DC	GSM	↔ 100%	↔ 0.0%	↔ 0.00	↔ 100%	↔ 0.0%	-	↔ 0	-	0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	0.00	0.00
Musculoskeletal & Specialist Surgery	DC	ROMO	↑ 60%	↑ 16.9%	↑ 6.30	↓ 87%	↑ 2.4%	-	↔ 0	-	↔ 100%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	0.00	0.00
Musculoskeletal & Specialist Surgery	DC	ROPS	-	-	-	-	-	↑ 81.0	↔ 0	-	0%	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	-	↔ 0	↔ 0	↔ 0	↔ 0	0.00	0.00
Musculoskeletal & Specialist Surgery	IP	R07	↔ 58%	↔ 9.4%	↔ 3.18	↓ 94%	↑ 5.4%	↑ 79.2	↓ 1	-	↔ 100%	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	>= 100%	↔ 0	↑ 3	↔ 0	↔ 0	1.00	2.00
Musculoskeletal & Specialist Surgery	IP	R17	↔ 56%	↔ 2.7%	↔ 1.13	↓ 94%	↑ 2.9%	↑ 65.4	↓ 0	↓ 93%	↑ 84%	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	>= 100%	↔ 0	↔ 5	↔ 0	↓ 0	2.00	1.00
Musculoskeletal & Specialist Surgery	IP	R18	↔ 54%	↔ 3.1%	↔ 1.26	↓ 76%	↑ 1.9%	↑ 53.6	0	↔ 100%	↑ 80%	↔ 0	↔ 0	↔ 0	↔ 0	-	>= 100%	↔ 0	↓ 2	↔ 0	↓ 0	2.00	0.00
Musculoskeletal & Specialist Surgery	IP	R21	↔ 61%	↔ 3.0%	↔ 1.02	↓ 94%	↓ 0.5%	↑ 87.2	↓ 0	↓ 96%	↑ 95%	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	-	↓ 0	↓ 3	↔ 0	↔ 0	5.00	0.00
Musculoskeletal & Specialist Surgery	IP	RKIN	↔ 62%	↓ -5.4%	↓ -1.31	↓ 93%	↑ 0.6%	↑ 100.0	↔ 0	↑ 100%	↑ 80%	↔ 0	↑ 1	↔ 0	↔ 0	>= 100%	>= 100%	↔ 0	↔ 1	↔ 0	↑ 1	3.00	0.00
Musculoskeletal & Specialist Surgery	IP	G14	↔ 70%	↔ -8.4%	↔ -1.86	↔ 100%	↑ 1.9%	↓ 72.5	↔ 0	↔ 100%	↑ 96%	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	-	↔ 0	↑ 2	↔ 0	↔ 0	1.00	2.00
Musculoskeletal & Specialist Surgery	IP	G16	↔ 64%	↔ -7.3%	↔ -1.50	↔ 100%	↑ 7.8%	↓ 80.0	↔ 0	↔ 100%	↓ 60%	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	-	↔ 0	↑ 3	↔ 0	↔ 0	1.00	2.00
Musculoskeletal & Specialist Surgery	IP	G19	↔ 72%	↔ -8.8%	↔ -0.95	↑ 100%	↓ 5.6%	↑ 90.3	↔ 0	↔ 100%	↓ 80%	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	-	↔ 0	↓ 0	↔ 0	↔ 0	1.00	0.00
Musculoskeletal & Specialist Surgery	IP	R32	↔ 57%	↔ 9.1%	↔ 3.65	↓ 87%	↑ 2.8%	↑ 92.0	↑ 1	↓ 90%	↓ 0%	↔ 0	↑ 1	↔ 0	↔ 0	-	>= 100%	↔ 0	↔ 3	↔ 0	↔ 0	8.00	1.00
Musculoskeletal & Specialist Surgery	IP	G18	↔ 61%	↑ 1.7%	↑ 0.39	↔ 100%	↑ 2.5%	↑ 84.4	↔ 0	-	↓ 95%	↓ 0	↔ 0	↔ 0	↔ 0	>= 100%	-	↔ 0	↑ 1	↔ 0	↔ 0	1.00	0.00
Musculoskeletal & Specialist Surgery	IP	F29	↓ 61%	↑ 18.4%	↑ 5.58	↓ 80%	↓ 0.7%	↓ 79.2	↔ 0	↓ 94%	↓ 50%	↓ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↓ 3	↔ 0	↔ 0	1.00	↓ 1

NURSING METRICS

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

Division		Ward	1 Fluid Balance chart	2 Nutrition & Hydration-Protected Meal Time	2 Nutrition & Hydration-Patient assessment	2 Nutrition & Hydration-Staff Knowledge	3 Urinary Catheter	4 Falls-Patient assessment	4 Falls-Stage Two assessment	5 Hygiene-Patient assessment	5 Hygiene-Ward observations	6 Patient observations & EWS	7 Pressure Ulcer care-Patient assessment	7 Pressure Ulcer care-Staff knowledge	8 Privacy & Dignity-Observation of Practice	8 Privacy & Dignity-Staff Knowledge	9 Discharge	10 Infection Prevention-Patient review	10 Infection Prevention-Ward review	11 Resuscitation Equipment	12 Medicines Management-Patient assessment	12 Medicines Management-Ward assessment	13 Safeguarding Children & Young people	14Communication/Partnership
CHUGS	DC	F25E	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
CHUGS	DC	FGI	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
CHUGS	DC	GDC1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
CHUGS	DC	GDC2	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
CHUGS	DC	GEND	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
CHUGS	DC	RCHM	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
CHUGS	DC	RHAD	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
CHUGS	DC	RHAM	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
CHUGS	DC	RHTU	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
CHUGS	IP	G20	N/A	N/A	↔ 100%	↓ 87%	N/A	↑ 100%	N/A	↔ 100%	↔ 100%	↑ 100%	↑ 100%	↔ 100%	↔ 100%	↔ 100%	↔ 100%	↓ 80%	↔ 100%	↑ 100%	↔ 100%	N/A	-	-
CHUGS	IP	G22	↑ 100%	↔ 100%	↓ 90%	↔ 100%	↓ 90%	↑ 95%	N/A	↑ 100%	↔ 100%	↓ 73%	↑ 88%	↔ 100%	↓ 75%	↔ 100%	↓ 70%	↓ 80%	↔ 100%	↔ 100%	↔ 100%	100%	-	-
CHUGS	IP	G23	↓ 75%	↔ 50%	↓ 95%	↑ 100%	90%	↓ 94%	N/A	↔ 100%	↔ 100%	↓ 90%	↓ 93%	↔ 100%	↔ 100%	↔ 100%	↓ 55%	↔ 100%	↔ 100%	↓ 67%	↔ 100%	100%	-	-
CHUGS	IP	G26	↑ 100%	↔ 100%	↔ 80%	↔ 100%	↑ 97%	↑ 92%	N/A	↑ 96%	↔ 100%	↓ 67%	↑ 87%	↔ 100%	↔ 88%	↔ 100%	↑ 85%	↓ 80%	↑ 100%	↓ 67%	↓ 97%	100%	-	-
CHUGS	IP	G27	↓ 87%	↔ 100%	↓ 67%	↔ 100%	↔ 100%	↑ 100%	N/A	↑ 100%	↔ 100%	↑ 100%	↑ 94%	↔ 100%	↑ 100%	↔ 100%	↓ 90%	↔ 100%	↔ 100%	↔ 100%	↑ 100%	100%	-	-
CHUGS	IP	G28	↑ 100%	↑ 50%	↓ 92%	↑ 100%	↓ 80%	↑ 100%	N/A	↓ 64%	↔ 100%	↑ 63%	↓ 78%	↔ 100%	↑ 100%	↔ 100%	↓ 50%	↔ 60%	↓ 40%	↔ 100%	↑ 100%	100%	-	-
CHUGS	IP	G29	↑ 100%	↓ 50%	↑ 100%	↔ 100%	↑ 100%	↑ 100%	N/A	↓ 80%	↔ 100%	↓ 77%	↓ 74%	↓ 93%	↑ 100%	↔ 95%	↓ 55%	↓ 70%	↓ 60%	↑ 100%	↔ 100%	100%	-	-
CHUGS	IP	GSAC	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
CHUGS	IP	GUEA	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
CHUGS	IP	R22	↓ 80%	↔ 100%	↑ 97%	↑ 100%	↑ 100%	↑ 100%	N/A	↑ 64%	↓ 75%	↑ 91%	↑ 95%	↔ 100%	↑ 100%	↓ 95%	↑ 85%	↑ 90%	↑ 100%	↑ 100%	↔ 100%	100%	-	-
CHUGS	IP	R39	↓ 80%	↔ 100%	↓ 63%	↔ 100%	↓ 80%	↑ 98%	↓ 83%	↓ 88%	↔ 100%	↓ 69%	↑ 99%	↓ 87%	↔ 100%	↔ 81%	↑ 55%	↔ 100%	↔ 100%	↔ 67%	↔ 100%	100%	-	-
CHUGS	IP	R40	↓ 60%	↔ 100%	↑ 96%	↓ 93%	↓ 50%	↔ 100%	↑ 83%	↓ 80%	↔ 100%	↑ 83%	↓ 86%	↑ 87%	↓ 88%	↑ 81%	↑ 55%	↑ 100%	↔ 100%	↓ 67%	↑ 100%	100%	-	-
CHUGS	IP	R29	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
CHUGS	IP	R30	↓ 83%	↓ 0%	↑ 82%	↔ 100%	↑ 100%	↑ 100%	↑ 75%	↔ 100%	↔ 100%	↑ 83%	↓ 88%	↓ 80%	↑ 100%	↔ 100%	↑ 70%	↔ 100%	↑ 100%	↑ 100%	↑ 100%	100%	-	-
CHUGS	IP	RBMT	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
CHUGS	IP	REND	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
CHUGS	IP	R41	↔ 100%	↑ 100%	↑ 100%	↔ 100%	N/A	↑ 100%	N/A	↔ 100%	↔ 75%	↑ 100%	↑ 100%	↑ 100%	↑ 100%	↓ 81%	↑ 75%	↑ 100%	↔ 80%	↔ 100%	↔ 100%	100%	-	-
CHUGS	IP	ROND	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
CHUGS	IP	RSAU	↑ 96%	↔ 100%	↓ 47%	↓ 93%	↓ 95%	↑ 100%	92%	↑ 92%	↔ 100%	↓ 91%	↑ 97%	↓ 93%	↔ 88%	↓ 86%	↑ 90%	↑ 80%	↔ 100%	↑ 100%	↔ 100%	100%	-	-
Emergency & Specialist Medicine	DC	G1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Emergency & Specialist Medicine	IP	RAMU	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Emergency & Specialist Medicine	IP	R16	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Emergency & Specialist Medicine	IP	R24	↑ 72%	↓ 50%	↓ 47%	↑ 100%	↑ 82%	↓ 77%	↑ 57%	↓ 68%	↓ 75%	↓ 61%	↓ 57%	↔ 67%	↓ 75%	↓ 57%	↓ 35%	↔ 100%	↓ 40%	↓ 33%	↓ 87%	33%	-	-
Emergency & Specialist Medicine	IP	R25	↓ 72%	↑ 100%	↓ 60%	↔ 100%	↑ 78%	↓ 86%	↑ 80%	↓ 60%	↔ 100%	↓ 59%	↓ 66%	↑ 100%	↑ 100%	↑ 100%	↓ 50%	↔ 100%	↓ 80%	↓ 67%	↓ 97%	100%	-	-
Emergency & Specialist Medicine	IP	R33	↑ 100%	↔ 0%	↔ 100%	↔ 100%	↑ 90%	↓ 98%	↑ 100%	↑ 96%	↔ 100%	↑ 86%	↓ 96%	↓ 87%	↔ 100%	↔ 100%	↔ 100%	↔ 100%	↔ 100%	↔ 100%	↔ 100%	100%	-	-
Emergency & Specialist Medicine	IP	R37	↑ 93%	↔ 100%	↑ 73%	↑ 93%	↑ 88%	↓ 93%	↑ 83%	↓ 64%	↔ 100%	↓ 77%	↓ 87%	↔ 80%	↓ 75%	↔ 71%	↓ 7%	↔ 100%	↑ 100%	↔ 67%	↓ 80%	67%	-	-
Emergency & Specialist Medicine	IP	R38	↓ 67%	↓ 50%	↑ 67%	↔ 100%	↑ 90%	↓ 91%	↓ 60%	↓ 68%	↔ 100%	↑ 86%	↓ 80%	↓ 67%	↔ 88%	↓ 67%	↔ 20%	↔ 100%	↔ 60%	↑ 100%	↑ 97%	33%	-	-
Emergency & Specialist Medicine	IP	RACB	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Emergency & Specialist Medicine	IP	REDU	N/A	N/A	↑ 100%	↑ 100%	N/A	↔ 100%	↔ 100%	↑ 100%	↔ 100%	↑ 90%	↔ 100%	↔ 100%	↓ 75%	↔ 100%	↔ 100%	↑ 100%	↔ 100%	↑ 100%	↔ 100%	100%	-	-
Emergency & Specialist Medicine	IP	RIDU	↑ 100%	↔ 100%	↓ 83%	↑ 100%	↑ 100%	↓ 98%	↓ 75%	↓ 80%	↔ 100%	↑ 84%	↑ 93%	↑ 100%	↑ 88%	↓ 95%	↓ 65%	↔ 100%	↔ 100%	↓ 67%	↓ 90%	67%	-	-
Emergency & Specialist Medicine	IP	G2	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Emergency & Specialist Medicine	IP	GBIU	↑ 93%	↔ 100%	↑ 87%	↑ 100%	↑ 95%	↓ 93%	↑ 87%	↑ 100%	↓ 75%	↑ 91%	↓ 77%	↑ 87%	↓ 75%	↔ 76%	↑ 20%	↔ 80%	↔ 60%	↔ 67%	↓ 94%	67%	-	-
Emergency & Specialist Medicine	IP	GYDU	↑ 73%	↑ 100%	↓ 63%	↑ 80%	↑ 93%	↑ 89%	↑ 87%	↑ 64%	↔ 75%	↑ 83%	↓ 73%	↓ 60%	↔ 88%	↓ 43%	↓ 0%	↑ 100%	↔ 60%	↑ 100%	↑ 97%	67%	-	-
Emergency & Specialist Medicine	IP	R19	↓ 67%	↔ 100%	↓ 48%	↔ 100%	↓ 70%	↓ 91%	↑ 83%	↑ 88%	↔ 100%	↑ 76%	↓ 67%	↑ 73%	↑ 100%	↑ 95%	↓ 0%	↔ 100%	↓ 60%	↑ 100%	↓ 97%	100%	-	-
Emergency & Specialist Medicine	IP	R23	↑ 80%	↔ 100%	↑ 63%	↓ 93%	↓ 75%	↑ 96%	↑ 73%	↑ 84%	↔ 100%	↓ 67%	↑ 94%	↑ 93%	↑ 88%	↑ 100%	↑ 33%	↔ 100%	↔ 100%	↔ 100%	↑ 100%	100%	-	-
Emergency & Specialist Medicine	IP	R31	↑ 92%	↔ 100%	↓ 73%	↔ 100%	↔ 80%	↓ 90%	↓ 58%	↓ 56%	↔ 100%	↓ 83%	↓ 87%	↑ 100%	↑ 88%	↑ 100%	↓ 0%	↔ 100%	↑ 100%	↔ 100%	↑ 100%	100%	-	-
Emergency & Specialist Medicine	IP	R34	↓ 55%	↓ 50%	↓ 56%	↓ 93%	↓ 70%	↓ 75%	↑ 71%	↓ 68%	↔ 100%	↓ 70%	↓ 65%	↓ 87%	↓ 50%	↓ 76%	↔ 55%	↑ 100%	↓ 40%	↔ 67%	↑ 97%	100%	-	-
Emergency & Specialist Medicine	IP	R36	↓ 70%	↑ 50%	↑ 69%	↑ 100%	↑ 88%	↑ 95%	↓ 50%	↑ 96%	↔ 100%	↓ 70%	↓ 67%	↑ 100%	↓ 88%	↑ 100%	↔ 50%	↔ 100%	↓ 60%	↑ 67%	↑ 97%	100%	-	-
Emergency & Specialist Medicine	IP	RFJW	↓ 83%	↔ 100%	↑ 81%	↔ 100%	↓ 70%	↔ 100%	↓ 77%	↓ 96%	↔ 100%	↑ 91%	↑ 89%	↑ 87%	↑ 100%	↔ 100%	↓ 20%	↔ 100%	↓ 80%	↑ 100%	↔ 100%	100%	-	-
Emergency & Specialist Medicine	IP	G3	↓ 97%	↔ 100%	↓ 66%	↔ 100%	↑ 100%	↓ 80%	↓ 90%	↓ 88%	↔ 100%	↓ 77%	↓ 89%	↔ 100%	↔ 100%	↔ 100%	↓ 30%	↑ 80%	↔ 80%	↓ 33%	↑ 86%	100%	-	-
Musculoskeletal & Specialist Surgery	DC	F23A	100%	↔ 100%	↔ 100%	↑ 100%	N/A	↔ 100%	N/A	↔ 100%	↔ 100%	↑ 86%	↑ 100%	↑ 100%	↔ 100%	↔ 100%	↔ 100%	↓ 25%	↔ 100%	↑ 100%	↑ 100%	100%	-	-
Musculoskeletal & Specialist Surgery	DC	RDAY	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Musculoskeletal & Specialist Surgery	DC	GSM	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Musculoskeletal & Specialist Surgery	DC	ROMO	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Musculoskeletal & Specialist Surgery	DC	ROPS	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Musculoskeletal & Specialist Surgery	IP	R07	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Musculoskeletal & Specialist Surgery	IP	R17	↔ 76%	↔ 100%	↓ 60%	↔ 100%	↓ 20%	↑ 96%	50%	↑ 96%	↔ 100%	↓ 63%	↑ 84%	↔ 100%	↓ 63%	↔ 100%	↑ 75%	↔ 100%	↔ 100%	↔ 100%	↓ 97%	100%	-	-
Musculoskeletal & Specialist Surgery	IP	R18	↓ 75%	↔ 100%	↓ 58%	↔ 100%	↑ 80%	↓ 94%	N/A	↔ 100%	↔ 100%	↓ 63%	↓ 89%	↔ 100%	↓ 50%	↑ 100%	↓ 45%	↔ 100%	↔ 100%	↓ 67%	↓ 88%	100%	-	-
Musculoskeletal & Specialist Surgery	IP	R21	N/A	↔ 100%	↑ 89%	↓ 93%	↓ 74%	↑ 98%	↑ 83%	↔ 84%	↔ 100%	↓ 74%	↑ 83%	↑ 100%	↑ 100%	↔ 100%	↑ 85%	↑ 90%	↔ 100%	↔ 100%	↓ 97%	100%	-	-
Musculoskeletal & Specialist Surgery	IP	RKIN	↓ 96%	↔ 100%	↑ 100%	↓ 87%	↑ 93%	↑ 100%	N/A	↑ 100%	↔ 100%	↑ 91%	↑ 93%	↓ 0%	↑ 100%	↓ 90%	↑ 100%	↑ 80%	↔ 100%	↑ 100%	↑ 100%	100%	-	-
Musculoskeletal & Specialist Surgery	IP	G14	↔ 90%	↔ 100%	N/A	↔ 100%	↑ 100%	↔ 100%	N/A	↔ 100%	↔ 100%	↓ 97%	↓ 97%	↑ 100%	↑ 100%	↔ 100%	↑ 100%	↔ 100%	↑ 100%	↔ 100%	↔ 100%	100%	-	-
Musculoskeletal & Specialist Surgery	IP	G16	↑ 100%	N/A	N/A	↔ 100%	↓ 67%	↔ 100%	83%	↑ 100%	↔ 100%	↑ 100%	↑ 93%	↔ 100%	↔ 88%	↔ 100%	↑ 100%	↔ 100%	↔ 80%	↔ 100%	↔ 100%	100%	-	-
Musculoskeletal & Specialist Surgery	IP	G19	N/A	N/A	N/A	↔ 100%	N/A	↓ 96%	N/A	↔ 100%	↔ 100%	↔ 100%	↑ 100%	↑ 93%	↔ 100%	↑ 100%	↑ 100%	↔ 100%	↑ 100%	↔ 100%	↔ 100%	100%	-	-
Musculoskeletal & Specialist Surgery	IP	R32	↓ 92%	↔ 100%	↔ 100%	↔ 100%	↓ 93%	↑ 100%	↔ 100%	↔ 100%	↔ 100%	↔ 94%	↑ 99%	↔ 100%	↓ 75%	↔ 100%	↑ 100%	↔ 100%	↔ 100%	↔ 100%	↑ 100%	100%	-	-
Musculoskeletal & Specialist Surgery	IP	G18	↔ 100%	↑ 100%	N/A	↑ 100%	↔ 80%	↓ 96%	↓ 25%	↔ 100%	↔ 100%	↓ 94%	↑ 99%	↔ 100%	↔ 100%	↔ 100%	↑ 100%	↔ 100%	↔ 100%	↔ 100%	↔ 100%	100%	-	-
Musculoskeletal & Specialist Surgery	IP	F29	↓ 92%	↔ 100%	↓ 73%	↔ 100%	↓ 75%	↑ 94%	↑ 92%	↑ 100%	↔ 100%	↓ 80%	↓ 93%	↓ 73%	↑ 100%	↓ 90%	↓ 70%	↓ 80%	↓ 80%	↓ 33%	↓ 94%	100%	-	-

APPENDIX 2 - MONTHLY CLINICAL MEASURES DASHBOARD: June '14

			Budgeted Qualified %	Total vacancies %	Total vacancies (WTE)	Current appraisal Rate % (rolling 12 months)	Sickness Absence % (month in arrears)	Friends & Family score	No. of complaints	Safety Thermometer - No new harms %	Hand Hygiene %	Pressure Ulcers - Grade 2 (avoidable)	Pressure Ulcers - Grade 3 (avoidable)	Pressure Ulcers - Grade 4 (avoidable)	No. MRSA Bacteraemias (post 48 hrs)	MRSA Screening - Non elective %	MRSA Screening - Elective %	No. of C Diff cases (post 48 hrs)	No. of falls	No. of patient safety SUI's (severe)	No. Patient safety incidents (moderate)	No. Patient safety incidents (low)	No. of medication errors
	GREEN THRESHOLD		> = 60%	0 - 4.9%	< = 5	> = 95%	< = 3%	> = 75.0	< = 1	> = 95%	> = 90%	0	0	0	0	> = 100%	> = 100%	0	0	0	0	0	0
	AMBER THRESHOLD		-	5 - 10 %	-	-	3.1% - 3.9%	56 - 74	2	-	-	-	-	-	-	-	-	-	1 - 3	-	1	1 - 4	-
	RED THRESHOLD		< 60%	> 10%	> 5	< 95%	> = 4%	< = 55.0	> 2	< 95%	< 90%	> = 1	> = 1	> = 1	> = 1	< 100%	< 100%	> = 1	> = 4	> = 1	> 1	> = 5	> = 1
Renal, Respiratory and Cardiac	DC	G10D	-	-	-	-	-	-	↔ 0	-	0%	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	-	↔ 0	↓ 0	↔ 0	↔ 0	0.00	0.00
	DC	F32	↓ 66%	↓ 3.4%	↓ 0.60	↑ 100%	↓ 2.6%	↑ 85.9	↔ 0	-	↔ 100%	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	-	↔ 0	↔ 0	↔ 0	↔ 0	0.00	↔ 0
	DC	F20	-	-	-	-	-	↑ 69.0	↔ 0	↔ 100%	78%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↑ 1	↔ 0	↔ 0	1.00	↓ 0
	DC	FCID	-	-	-	↓ 95%	↑ 3.7%	-	↔ 0	-	0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	0.00	↔ 0
	IP	F27	↔ 62%	↔ 0.6%	↔ 0.20	↓ 93%	↑ 2.9%	↑ 100.0	↔ 0	↓ 96%	↓ 80%	↔ 0	↔ 0	↔ 0	↔ 0	-	>= 100%	↔ 0	↓ 1	↔ 0	↔ 0	1.00	↑ 1
	IP	F31	↔ 75%	↑ 5.7%	↑ 2.56	↔ 100%	↓ 2.8%	↑ 100.0	↔ 0	↔ 100%	↓ 92%	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	>= 100%	↔ 0	↓ 2	↔ 0	↓ 0	1.00	↔ 0
	IP	FCCU	↔ 76%	↓ 7.6%	↓ 4.01	↓ 97%	↑ 6.6%	↓ 81.1	↔ 0	↔ 100%	↔ 100%	↔ 0	↔ 0	↔ 0	↔ 0	-	>= 100%	↔ 0	↑ 3	↔ 0	↔ 0	4.00	↓ 0
	IP	FCDU	↔ 63%	↓ 6.6%	↓ 6.33	↓ 93%	↑ 6.9%	↑ 70.3	↓ 0	↓ 93%	↑ 78%	↔ 0	↔ 0	↔ 0	↔ 0	-	>= 100%	↔ 0	↓ 0	↔ 0	↑ 1	3.00	↔ 0
	IP	G15A	↔ 84%	↓ 21.0%	↓ 6.04	↑ 96%	↓ 0.6%	↓ 20.0	↔ 0	↓ 83%	↑ 100%	↔ 0	↓ 0	↔ 0	↔ 0	-	>= 100%	↑ 1	↑ 2	↔ 0	↓ 0	1.00	0.00
	IP	G17	↔ 71%	↓ 4.8%	↓ 0.96	↑ 100%	↓ 0.5%	↑ 84.6	↓ 0	↑ 100%	↔ 100%	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	>= 100%	↔ 0	↔ 0	↔ 0	↔ 0	2.00	↓ 0
	IP	G10	↔ 61%	↑ 12.1%	↑ 4.78	↑ 100%	↓ 1.9%	↑ 100.0	↔ 0	↔ 100%	↔ 100%	↔ 0	↔ 0	↔ 0	↔ 0	-	>= 100%	↔ 0	1.00	↔ 0	↔ 0	2.00	0.00
	IP	G15N	↔ 65%	↑ 18.5%	↑ 6.26	↑ 97%	↑ 3.0%	↓ 61.5	↔ 0	↔ 100%	↑ 100%	↔ 0	↔ 0	↔ 0	↔ 0	-	>= 100%	↔ 1	↑ 1	↔ 0	↔ 0	0.00	1.00
	IP	F16	↓ 63%	↓ 9.6%	↓ 3.45	↑ 92%	↑ 3.9%	↔ 94.6	↔ 0	↓ 86%	70%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↓ 4	↔ 0	↔ 0	4.00	↓ 0
	IP	F33	↑ 70%	↓ 4.5%	↓ 1.49	↑ 95%	↑ 5.2%	↑ 93.5	↓ 0	↓ 96%	↑ 72%	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	-	↔ 0	↑ 4	↔ 0	↔ 0	3.00	↑ 1
	IP	F15	↓ 60%	↓ 10.7%	↓ 4.18	↑ 98%	↓ 1.5%	↑ 79.5	↔ 1	↑ 100%	↔ 100%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↓ 3	↔ 0	↓ 0	0.00	↓ 1
	IP	F17	↓ 74%	↓ 1.3%	↓ 0.52	↑ 100%	↓ 2.4%	↑ 72.0	↔ 0	↓ 89%	88%	↑ 1	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↓ 2	↔ 0	↔ 0	2.00	↔ 0
	IP	F24	↔ 67%	↔ -11.9%	↔ -1.72	↔ 100%	↑ 9.9%	↓ 63.6	↔ 1	↓ 96%	100%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↑ 1	↑ 4	↔ 0	↔ 0	2.00	↔ 0
	IP	F26	↔ 77%	↑ 18.2%	↑ 5.62	↑ 94%	↑ 5.3%	↓ 75.0	↔ 0	↔ 100%	↓ 90%	↔ 0	↔ 0	↔ 0	↔ 0	0.97	>= 100%	↔ 0	↓ 1	↔ 0	↔ 0	5.00	↓ 0
	IP	F28	↔ 60%	↑ 14.8%	↑ 5.11	↓ 94%	↓ 8.3%	↑ 85.0	↑ 1	↔ 100%	↓ 94%	↔ 0	↔ 0	↔ 0	↔ 0	-	>= 100%	↔ 0	↔ 1	↔ 0	↔ 0	2.00	↔ 0
	IP	F31H	↔ 75%	↑ 5.7%	↑ 2.56	↔ 100%	↓ 2.8%	-	↔ 0	-	0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	0.00	↔ 0
	IP	F33A	↔ 64%	↓ 1.7%	↓ 0.44	↔ 100%	↓ 2.7%	↑ 92.0	↔ 0	↔ 90%	↓ 94%	↑ 1	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↓ 2	↔ 0	↔ 0	1.00	↓ 0
	IP	FCHD	↑ 70%	↓ 4.5%	↓ 1.49	↑ 95%	↑ 5.2%	-	↔ 0	-	0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	0.00	↔ 0
	IP	F26H	↔ 77%	↑ 18.2%	↑ 5.62	↑ 94%	↑ 5.3%	-	↔ 0	-	0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	0.00	↔ 0
	IP	F30	↑ 78%	↑ 16.7%	↑ 3.53	↑ 96%	↑ 7.8%	↑ 90.0	↔ 0	↔ 100%	0%	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	-	↔ 0	↔ 0	↔ 0	↔ 0	2.00	↑ 3
	IP	FPIC	↔ 95%	↓ 12.7%	↓ 5.77	↓ 79%	↑ 6.1%	↔ 100.0	↔ 0	-	81%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	1.00	↑ 9
	IP	FREC	↔ 92%	↑ 18.7%	↑ 4.83	↔ 100%	↑ 6.7%	-	↔ 0	-	↔ 100%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	0.00	↔ 0
Women's and Children's	DC	G11	-	-	-	-	-	↓ 78.6	-	-	-	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	-	-	-	-	-
	DC	RGAU	↔ 69%	↑ 14.2%	↑ 3.95	↓ 97%	↓ 0.0%	↑ 85.4	↔ 0	↔ 100%	100%	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	>= 100%	↔ 0	↔ 0	↔ 0	↑ 1	5.00	0.00
	DC	RPOD	-	-	-	-	-	-	↔ 0	-	0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	0.00	0.00
	DC	RCDW	-	-	-	-	-	-	↔ 0	-	0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	0.00	0.00
	IP	R28	↔ 74%	↓ 7.3%	↓ 1.92	↓ 86%	↓ 1.0%	↑ 53.3	↔ 0	↔ 100%	0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	0.00	2.00
	IP	RPSS	-	-	-	-	-	-	↔ 0	-	0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	0.00	0.00
	IP	G30	↔ 74%	↓ 2.2%	↓ 2.61	↑ 98%	↑ 8.3%	-	↓ 0	↔ 100%	↔ 100%	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	-	↔ 0	↔ 0	↔ 0	↔ 0	1.00	↓ 2
	IP	G31	↔ 61%	↑ 0.7%	↑ 0.19	↔ 100%	↑ 3.8%	↑ 78.1	↓ 0	↔ 100%	0%	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	-	↔ 0	↔ 1	↔ 0	↓ 0	2.00	22.00
	IP	R27	↔ 80%	↔ 13.4%	↔ 3.82	↓ 79%	↓ 0.5%	↔ 100.0	1	↔ 100%	0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	2.00	0.00
	IP	R27A	↔ 80%	↔ 13.4%	↔ 3.82	↓ 79%	↓ 0.5%	-	↔ 0	-	0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	0.00	0.00
	IP	RCAU	↔ 69%	↓ 4.4%	↓ 1.15	↓ 77%	↓ 2.6%	↓ 42.9	↔ 0	-	0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↑ 1	↔ 0	1.00	0.00
	IP	RSCB	↔ 90%	↓ 1.5%	↓ 1.39	↓ 95%	↓ 1.0%	-	↔ 0	-	0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	2.00	3.00
	IP	R10	↔ 69%	↓ 10.1%	↓ 2.78	↑ 100%	↑ 3.4%	↑ 69.3	0	↔ 100%	0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↑ 1	↔ 0	↔ 0	0.00	0.00
	IP	R14	↔ 70%	↔ 3.9%	↔ 1.06	↔ 100%	↑ 0.1%	↑ 85.7	0	↔ 100%	0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↑ 2	↔ 0	↔ 0	5.00	3.00
	IP	R11	↔ 70%	↔ 1.4%	↔ 0.51	↑ 98%	↓ 0.1%	↑ 92.3	0	↔ 100%	0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	1.00	1.00
	IP	R12	↔ 83%	↑ 12.7%	↑ 3.69	↑ 93%	↑ 2.5%	↑ 100.0	0	↔ 100%	0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	1.00	2.00
	IP	R05	↔ 60%	↓ 12.9%	↓ 5.13	↓ 73%	↓ 2.5%	-	0	-	↔ 100%	↔ 0	↔ 0	↔ 0	↔ 0	-	>= 100%	↔ 0	↔ 0	↔ 0	↔ 0	2.00	1.00
	IP	R06	↔ 63%	↑ 3.9%	↑ 1.66	↑ 93%	↓ 5.2%	-	↓ 0	-	↓ 90%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	3.00	7.00
	IP	R12A	↔ 83%	↑ 12.7%	↑ 3.69	↑ 93%	↑ 2.5%	-	0	-	0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	0.00	0.00
	IP	RCIC	↔ 95%	↓ 12.7%	↓ 5.77	↓ 79%	↑ 6.1%	↔ 100.0	↔ 0	100%	0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	5.00	8.00
ITAPS	IP	FITU	↔ 93%	↓ 2.6%	↓ 3.41	↑ 95%	↓ 6.5%	↔ 100.0	↔ 0	-	↓ 90%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	0.00	↔ 0
	IP	GDCM	↔ 94%	↓ -2.5%	↓ -1.53	↑ 97%	↓ 2.6%	↓ 77.8	↓ 0	-	↑ 89%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	4.00	0.00
	IP	RITU	↔ 91%	↑ 10.6%	↑ 12.11	↑ 96%	↑ 5.1%	↑ 92.9	↔ 0	↓ 92%	↔ 90%	↔ 0	↔ 0	↔ 0	↔ 0	-	>= 100%	↑ 1	↑ 1	↔ 0	↔ 0	6.00	3.00
	IP	GSL	-	-	-	-	-	-	↓ 0	-	0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	0.00	0.00

NURSING METRICS

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

			1 Fluid Balance chart	2 Nutrition & Hydration-Protected Meal Time	2 Nutrition & Hydration-Patient assessment	2 Nutrition & Hydration-Staff Knowledge	3 Urinary Catheter	4 Falls-Patient assessment	4 Falls-Stage Two assessment	5 Hygiene-Patient assessment	5 Hygiene-Ward observations	6 Patient observation & EWS	7 Pressure Ulcer care-Patient assessment	7 Pressure Ulcer care-Staff knowledge	8 Privacy & Dignity-Observation of Practice	8 Privacy & Dignity-Staff Knowledge	9 Discharge	10 Infection Prevention-Patient review	10 Infection Prevention-Ward review	11 Resuscitation Equipment	12 Medicines Management-Patient assessment	12 Medicines Management-Ward assessment	13 Safeguarding Children & Young people	14Communication/Partnership
Renal, Respiratory and Cardiac	DC	G10D	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	DC	F32	17%	↔ 100%	↓ 85%	↓ 73%	N/A	↑ 96%	N/A	N/A	↑ 100%	↓ 80%	↓ 72%	↓ 73%	↓ 75%	↑ 62%	↔ 100%	↑ 70%	↑ 100%	↔ 100%	↑ 94%	100%	-	-
	DC	F20	N/A	↑ 100%	↑ 80%	↓ 67%	N/A	↑ 91%	N/A	↔ 52%	↔ 100%	↑ 86%	↑ 89%	↑ 80%	↑ 88%	↑ 100%	↓ 50%	↑ 60%	↑ 60%	↔ 67%	↑ 100%	100%	-	-
	DC	FCID	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	IP	F27	↓ 95%	↑ 100%	↑ 100%	↔ 100%	↓ 85%	↑ 100%	↓ 83%	↑ 100%	↔ 100%	↔ 93%	↔ 100%	↓ 87%	↓ 75%	↓ 95%	↓ 73%	↓ 70%	↔ 80%	↑ 67%	↑ 97%	100%	-	-
	IP	F31	↓ 89%	↔ 100%	↓ 85%	↑ 80%	↓ 80%	↑ 95%	↑ 100%	↑ 96%	↔ 100%	↓ 83%	↑ 97%	↓ 80%	↔ 88%	↔ 62%	↑ 90%	↔ 80%	↑ 100%	↑ 100%	↔ 97%	100%	-	-
	IP	FCCU	↔ 100%	↔ 100%	↔ 90%	↔ 100%	N/A	↑ 100%	↔ 100%	↔ 100%	↔ 100%	↔ 100%	↔ 100%	↔ 100%	↓ 88%	↑ 100%	↓ 75%	↔ 100%	↔ 100%	↓ 33%	↔ 100%	100%	-	-
	IP	FCDU	92%	↑ 50%	↑ 93%	↔ 100%	0%	↔ 100%	N/A	↔ 100%	↔ 100%	↑ 91%	↓ 93%	↔ 100%	↑ 100%	↑ 100%	↑ 85%	↑ 100%	↔ 100%	↔ 100%	↔ 100%	100%	-	-
	IP	G15A	↑ 100%	↔ 100%	↑ 89%	↔ 100%	N/A	↑ 100%	↑ 87%	↑ 84%	↔ 100%	↔ 100%	↑ 99%	↔ 100%	↔ 75%	↔ 100%	N/A	↓ 80%	↓ 60%	↔ 100%	↔ 100%	100%	-	-
	IP	G17	↓ 79%	↑ 100%	↓ 80%	↔ 100%	90%	↓ 98%	100%	↓ 80%	↔ 100%	↓ 97%	↓ 91%	↔ 100%	↔ 100%	↔ 100%	↑ 92%	↓ 50%	↑ 100%	↔ 100%	↔ 100%	100%	-	-
	IP	G10	↔ 100%	↔ 100%	↑ 100%	↔ 100%	↔ 100%	↔ 100%	↔ 100%	↔ 100%	↔ 100%	↔ 100%	↔ 100%	↔ 100%	↔ 100%	↔ 100%	↔ 100%	↔ 100%	↑ 100%	↔ 100%	↔ 100%	100%	-	-
	IP	G15N	↓ 88%	↔ 100%	N/A	↔ 100%	N/A	↑ 93%	↑ 83%	↑ 96%	↔ 100%	↓ 94%	↑ 96%	↔ 100%	↑ 100%	↔ 100%	↑ 95%	↔ 100%	↑ 100%	↑ 100%	↓ 97%	100%	-	-
	IP	F16	↑ 83%	↑ 100%	↑ 93%	↓ 80%	↑ 100%	↑ 98%	56%	↑ 92%	↔ 100%	↓ 51%	↑ 93%	↑ 100%	↑ 88%	↑ 76%	↓ 60%	↑ 100%	↑ 100%	↑ 100%	↑ 100%	100%	-	-
	IP	F33	↓ 60%	↔ 100%	↑ 80%	↔ 100%	N/A	↓ 98%	↓ 90%	↔ 96%	↔ 100%	↑ 100%	↓ 93%	↓ 93%	↔ 100%	↔ 100%	↓ 47%	↑ 100%	↔ 100%	↔ 33%	↔ 100%	67%	-	-
	IP	F15	↓ 42%	↔ 100%	↑ 96%	↔ 100%	↓ 90%	↑ 100%	↑ 75%	↓ 84%	↔ 100%	↓ 80%	↓ 92%	↔ 100%	↔ 88%	↔ 100%	↓ 55%	↑ 100%	↔ 100%	↔ 100%	↓ 90%	100%	-	-
	IP	F17	↓ 79%	↔ 100%	↓ 96%	↔ 100%	↓ 65%	↓ 93%	↑ 75%	↑ 100%	↔ 100%	↔ 83%	↑ 99%	↓ 80%	↓ 88%	↓ 90%	↑ 87%	↔ 100%	↔ 100%	↑ 100%	↑ 100%	100%	-	-
	IP	F24	↔ 80%	↔ 100%	↓ 94%	↔ 80%	↓ 85%	↔ 100%	58%	↑ 100%	↔ 100%	↓ 87%	↑ 96%	↑ 93%	↑ 100%	↑ 86%	↓ 65%	↑ 100%	↑ 100%	↔ 100%	↑ 97%	100%	-	-
	IP	F26	↔ 90%	↑ 50%	↓ 83%	↑ 87%	↓ 67%	↑ 96%	↓ 50%	↓ 44%	↔ 100%	↔ 100%	↓ 88%	↑ 80%	↔ 75%	↓ 81%	↔ 70%	↓ 80%	↓ 40%	↓ 67%	↑ 100%	67%	-	-
	IP	F28	↔ 87%	↔ 100%	↓ 95%	↔ 100%	↑ 70%	↓ 98%	↓ 72%	↔ 100%	↔ 100%	↑ 87%	↓ 96%	↑ 93%	↔ 100%	↔ 100%	↓ 53%	↔ 60%	↔ 60%	↔ 33%	↓ 95%	100%	-	-
	IP	F31H	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	IP	F33A	↑ 100%	↔ 100%	↑ 95%	↔ 100%	↑ 93%	↑ 100%	↑ 100%	↑ 100%	↑ 100%	↑ 100%	↓ 97%	↓ 87%	↓ 88%	↓ 95%	↓ 53%	↓ 60%	↔ 80%	↔ 67%	↔ 100%	100%	-	-
	IP	FCHD	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	IP	F26H	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	IP	F30	94%	88%	0%	0%	N/A	100%	0%	100%	100%	100%	100%	60%	100%	95%	67%	100%	100%	100%	100%	100%	86%	80%
	IP	FPIC	↔ 100%	↓ 75%	↔ 0%	↔ 0%	↔ 80%	↔ 100%	↔ 0%	↓ 80%	↔ 100%	↑ 100%	↔ 100%	↓ 60%	↔ 100%	↑ 86%	↔ 100%	↑ 100%	↔ 100%	↓ 33%	↔ 100%	100%	100%	↑ 100%
	IP	FREC	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Women's and Children's	DC	G11	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	DC	RGAU	↑ 89%	↔ 100%	100%	↔ 100%	N/A	N/A	N/A	↑ 100%	↔ 100%	↔ 100%	↑ 100%	↔ 100%	↔ 100%	↔ 100%	↓ 95%	↔ 100%	↑ 100%	↔ 100%	↔ 100%	67%	-	-
	DC	RPOD	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	DC	RCDW	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	IP	R28	↑ 100%	↑ 96%	↔ 0%	↔ 0%	N/A	↑ 100%	↔ 0%	↑ 100%	↑ 100%	↑ 100%	↑ 100%	↑ 100%	↑ 100%	↑ 100%	↑ 100%	↔ 100%	↑ 100%	↑ 67%	↑ 100%	100%	100%	↑ 100%
	IP	RPSS	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	IP	G30	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	IP	G31	↓ 83%	↔ 100%	N/A	↔ 100%	N/A	↑ 100%	N/A	↔ 100%	↔ 100%	↓ 97%	↔ 100%	↔ 100%	↔ 100%	↔ 100%	↔ 100%	↔ 100%	↔ 100%	↔ 100%	↔ 100%	100%	-	-
	IP	R27	↑ 100%	↑ 100%	↔ 0%	↔ 0%	N/A	↔ 100%	↔ 0%	↔ 100%	↔ 100%	↑ 90%	N/A	↔ 100%	↑ 100%	↔ 100%	↓ 0%	↓ 0%	↑ 100%	↓ 33%	↑ 100%	100%	100%	↔ 100%
	IP	R27A	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	IP	RCAU	N/A	100%	0%	0%	N/A	N/A	0%	N/A	100%	87%	N/A	100%	75%	100%	N/A	N/A	100%	33%	100%	100%	100%	80%
	IP	RSCB	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	IP	R10	↔ 100%	↑ 86%	↔ 0%	↔ 0%	N/A	↓ 93%	↔ 0%	↔ 100%	↔ 100%	↓ 93%	↔ 100%	↔ 100%	↓ 88%	↔ 100%	↔ 100%	↔ 100%	↔ 100%	↑ 100%	↔ 100%	100%	100%	↔ 100%
	IP	R14	↑ 100%	↑ 89%	↔ 0%	↔ 0%	N/A	↑ 100%	↔ 0%	↔ 100%	↔ 100%	↑ 100%	N/A	↔ 100%	↑ 100%	↔ 100%	↑ 100%	N/A	↑ 100%	↔ 100%	↑ 100%	100%	100%	↑ 100%
	IP	R11	N/A	↓ 78%	↔ 0%	↔ 0%	N/A	↑ 100%	↔ 0%	↑ 100%	↔ 100%	↔ 100%	↑ 100%	↔ 100%	↔ 100%	↑ 100%	↑ 100%	↔ 100%	↔ 100%	↔ 100%	↔ 100%	100%	100%	↔ 100%
	IP	R12	↔ 100%	↑ 100%	↔ 0%	↔ 0%	N/A	↑ 100%	↔ 0%	↔ 100%	↔ 100%	↓ 97%	↑ 100%	↔ 100%	↔ 100%	↔ 100%	↔ 100%	↔ 100%	↔ 100%	↔ 33%	↑ 107%	100%	100%	↔ 100%
	IP	R05	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	IP	R06	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	IP	R12A	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	IP	RCIC	↔ 100%	↔ 100%	↔ 0%	↔ 0%	↔ 100%	↔ 100%	↔ 0%	↔ 100%	↔ 100%	↑ 100%	↔ 100%	↔ 100%	↔ 88%	↔ 100%	↔ 100%	↑ 90%	↔ 100%	↔ 33%	↑ 100%	100%	100%	↔ 100%
ITAPS	IP	FITU	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	IP	GDCM	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	IP	RITU	↔ 100%	↑ 100%	↑ 96%	↔ 100%	↑ 100%	↓ 87%	N/A	↔ 100%	↔ 100%	↔ 100%	↑ 100%	↔ 100%	↑ 88%	↓ 81%	↔ 100%	↔ 100%	↔ 100%	↓ 33%	↔ 100%	100%	-	-
	IP	GSL	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

Trust Board paper Z appendix 3

To:	**Trust Board**
From:	**Richard Mitchell, Chief Operating Officer**
Date:	**31 July 2014**
CQC regulation:	**As applicable**

Title:	Appendix 3 - RTT Improvement Report

Author: Richard Mitchell, Chief Operating Officer

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

The Report is provided to the Board for:

Decision		Discussion	
Assurance	√	Endorsement	

Summary / Key Points:

- Reasons for RTT deterioration are well known
- There are four challenged specialities; ophthalmology, ENT, orthopaedics and general surgery.
- Some specialities have begun to improve waiting times / reductions in waiting list size
- Admitted compliant performance is expected in November 2014
- Non-admitted compliant performance was expected in August 2014 , but has been delivered in June 2014
- The Trust Development Authority have stipulated that they require Trust level performance to be delivered against both admitted and non admitted RTT standards by the end of September (September published data).The Trust in conjunction with CCGs cannot commit to delivering the admitted 90% by September.
- The plan remains very high risk

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

Previously considered at another UHL corporate Committee N/A

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

Resource Implications (eg Financial, HR)
Yes

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

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

Equality Impact
N/A

Information exempt from Disclosure
N/A

Requirement for further review
Monthly

APPENDIX 3

REPORT TO:	**Trust Board**
REPORT FROM:	**Richard Mitchell, Chief Operating Officer**
REPORT SUBJECT:	**RTT Improvement Report**
REPORT DATE:	**31 July 2014**

Introduction

The reasons for UHL's deterioration in RTT performance are well documented. This report is the fifth monthly update. The high level trajectories are detailed below and attached. For June the Trust is behind on trajectory for admitted performance, however for non admitted performance the Trust has achieved the 95% national target ahead of trajectory (this includes the Alliance activity).

Ongoing delivery of the non admitted standard at Trust level is expected to continue. Admitted performance is expected to deliver in November 2014. The Trust Development Authority have stipulated that they require Trust level performance to be delivered against both admitted and non admitted RTT standards by the end of September (September published data). The Trust in conjunction with CCGs have re submitted plans which anticipate best case position of 86% admitted performance in September. Funding to support additional activity and additional costs incurred (including premium payments) is anticipated. This could be circa £4m if plans are agreed by the TDA. The payment structure will be 50% payment up front, the further 50% on delivery of agreed milestones.

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 and Circle Nottingham. 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 will seek full patient consent prior to diverting any referrals
- Validation of the UHL elective waiting list. Patients who are on an RTT pathway over 12 weeks, who have been added to an elective waiting list more than 6 weeks ago and do not have an operation date have been written to ask if they still require treatment. NB: no patient will be removed from the waiting list unless they clearly state that they wish to. Clinical review of their condition will also take place.
- Additional administrative staff are being recruited to support these processes.

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

The high level risks to the plan are detailed below.

Performance overview

UHL's RTT performance is mainly challenged in four specialties; ENT, ophthalmology, orthopaedics and general surgery. The table below details the expected rate of improvement. The two Appendices goes into greater detail showing performance at speciality level and waiting list sizes for both outpatient and electives (key indicators of RTT backlog reduction).

Progress is being made in orthopaedic and ophthalmology elective waiting list size reductions. Additional activity is scheduled in general surgery during July and August and in ENT further recovery plans are being developed.

	Admitted Trust level RTT														
	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Trajectory	80.8%	80.5%	81.2%	81.2%	82.3%	84.3%	86.9%	87.7%	88.8%	89.5%	90.5%	90.5%	90.5%	90.4%	92.0%
Actual	81.8%	79.3%	76.7%	75.7%	76.8%	77%									
UHL + Alliance				78.9%	79.4%	79%									
	Non admitted Trust level RTT														
	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Trajectory	92.3%	92.7%	92.8%	93.1%	93.6%	94.1%	94.8%	95.1%	95.3%	95.3%	95.5%	96.1%	96.1%	96.1%	96.1%
Actual	93.4%	93.5%	93.9%	93.4%	93.9%	94.3%									
UHL + Alliance				94.3%	94.4%	95.0%									

This table details at a Trust level the size of the admitted and non-admitted backlogs (over 18 weeks)

UHL Trust level backlog over 18 weeks	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14
Non-Admitted Backlog Number	1917	1558	1704	1527	1481	1594
NoAdmitted Backlog Number	1416	1512	1527	1551	1412	1420
Total	3333	3070	3231	3078	2893	3014

The joint RTT Performance Board continues to meet every two weeks to monitor recovery plans and performance, membership includes representation from the Trust Development Authority.

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, in particular the early delivery of the non admitted trajectory
- Acknowledge the key risks.

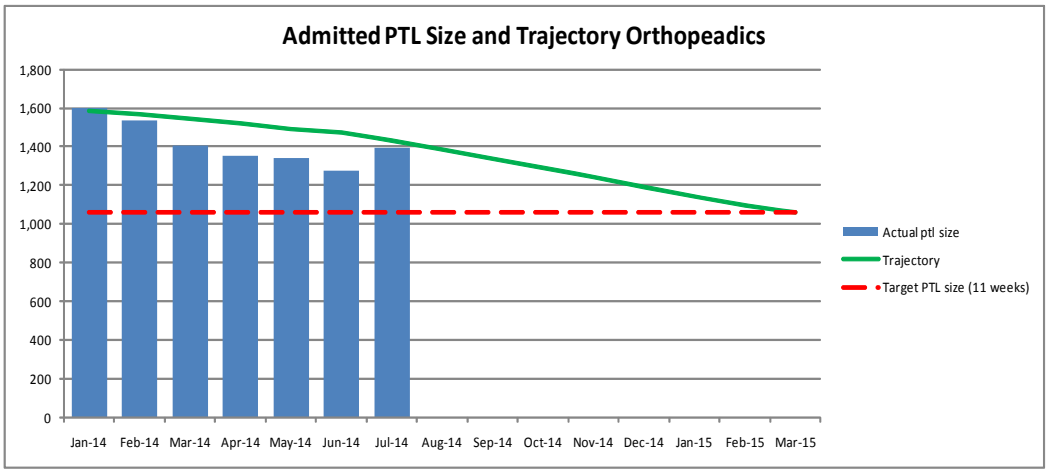
Specialty Level Trajectory

	Admitted Trust level RTT														
	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Trajectory	80.8%	80.5%	81.2%	81.2%	82.3%	84.3%	86.9%	87.7%	88.8%	89.5%	90.5%	90.5%	90.5%	90.4%	92.0%
Actual	81.8%	79.3%	76.7%	75.7%	76.8%	77%									
UHL + Alliance				78.9%	79.4%	79%									
	Non admitted Trust level RTT														
	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Trajectory	92.3%	92.7%	92.8%	93.1%	93.6%	94.1%	94.8%	95.1%	95.3%	95.3%	95.5%	96.1%	96.1%	96.1%	96.1%
Actual	93.4%	93.5%	93.9%	93.4%	93.9%	94.3%									
UHL + Alliance				94.3%	94.4%	95.0%									
	Adult Ophthalmology Admitted RTT														
	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Trajectory	58.8%	61.0%	62.3%	63.1%	69.5%	80.4%	90.1%	90.2%	90.3%	90.6%	90.6%	90.5%	90.8%	90.7%	90.8%
Actual	57.8%	60.0%	53.6%	50.3%	52.5%	57.9%									
	Adult Ophthalmology Non admitted RTT														
	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Trajectory	83.7%	83.1%	82.3%	85.3%	88.8%	89.1%	93.5%	95.4%	95.1%	95.0%	95.2%	95.2%	95.1%	95.1%	95.1%
Actual	86.6	90.2	91.46	89.80%	92.3%	93.8%									
	Paediatric Ophthalmology Admitted RTT (other category)														
	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Trajectory	80.8%	80.5%	81.2%	81.2%	82.1%	84.4%	84.4%	86.6%	90.6%	90.2%	90.5%	90.5%	90.5%	90.4%	92.0%
Actual			80.1%	73.10%	72.5%	75.3%									
	Paediatric Ophthalmology Non admitted RTT(other category)														
	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Trajectory	92.3%	92.7%	92.8%	93.3%	92.7%	95.1%	95.4%	95.6%	95.6%	95.6%	95.7%	95.3%	95.3%	95.3%	95.3%
Actual			93%	93.20%	93.9%	94%									
	Adult ENT Admitted RTT														
	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Trajectory	62.6%	64.5%	61.3%	61.1%	66.1%	72.8%	75.0%	83.1%	90.5%	90.5%	90.4%	90.3%	90.3%	90.2%	90.4%
Actual	69.8%	56.3%	61.8%	61.90%	56.4%	59.2%									
	Adult ENT Non admitted RTT														
	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Trajectory	89.0%	90.7%	90.4%	93.3%	92.4%	92.4%	93.4%	95.1%	95.4%	95.3%	95.5%	95.5%	95.5%	95.5%	95.5%
Actual	86%	82.7%	86.3%	86.70%	85.1%	87.6%									
	Paediatric ENT Admitted RTT (other category)														
	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Trajectory	80.8%	80.5%	81.2%	81.2%	82.1%	84.4%	84.4%	86.6%	90.6%	90.2%	90.5%	90.5%	90.5%	90.4%	92.0%
Actual			80.1%	73.10%	72.5%	75.3%									
	Paediatric ENT Non admitted RTT(other category)														
	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Trajectory	92.3%	92.7%	92.8%	93.3%	92.7%	95.1%	95.4%	95.6%	95.6%	95.6%	95.7%	95.3%	95.3%	95.3%	95.3%
Actual			93%	93.20%	93.9%	94%									
	Orthopaedics Admitted RTT														
	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Trajectory	70.0%	69.7%	75.3%	75.5%	74.4%	76.2%	78.6%	75.9%	77.6%	79.7%	81.0%	82.3%	82.2%	82.3%	90.1%
Actual	70.1%	70.5%	66.5%	70.50%	71.5%	70.4%									
	Orthopaedics Non admitted RTT														
	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Trajectory	78.8%	79.3%	80.4%	78.4%	80.7%	81.2%	82.0%	83.4%	84.1%	85.0%	86.0%	95.2%	95.1%	95.1%	95.1%
Actual	78.30%	78.40%	80.5%	76%	80.2%	81.1%									
	General surgery Admitted RTT														
	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Trajectory	75.2%	72.8%	73.7%	74.4%	74.6%	73.3%	77.4%	82.5%	84.2%	88.2%	90.2%	90.2%	90.2%	90.2%	90.2%
Actual	65.9%	56.9%	66.2%	74.20%	71.6%	73%									
	General surgery Non admitted RTT														
	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Trajectory	95.1%	95.1%	95.9%	95.1%	95.3%	95.9%	95.1%	95.3%	95.2%	95.3%	95.6%	95.1%	95.1%	95.1%	95.1%
Actual	84%	75.1%	96.7%	95.9%	96.1%	95.1%									

Inpatient waiting list size

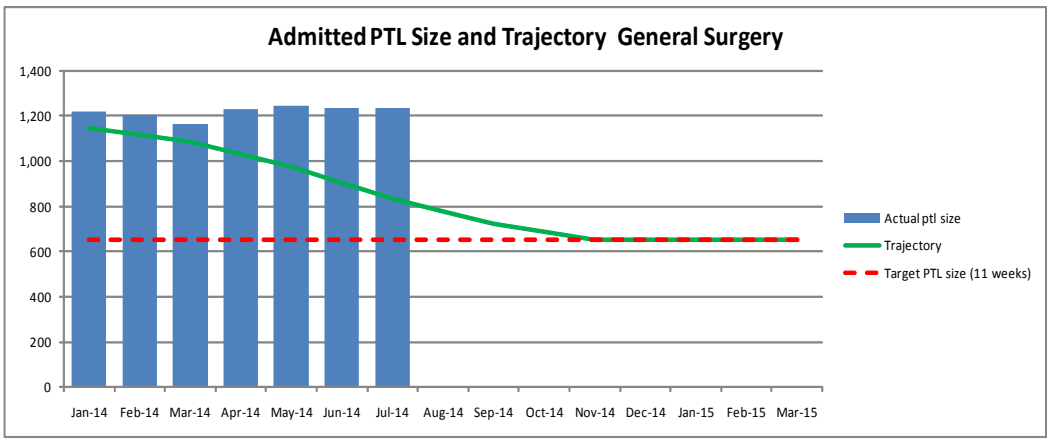
Othopaedics

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



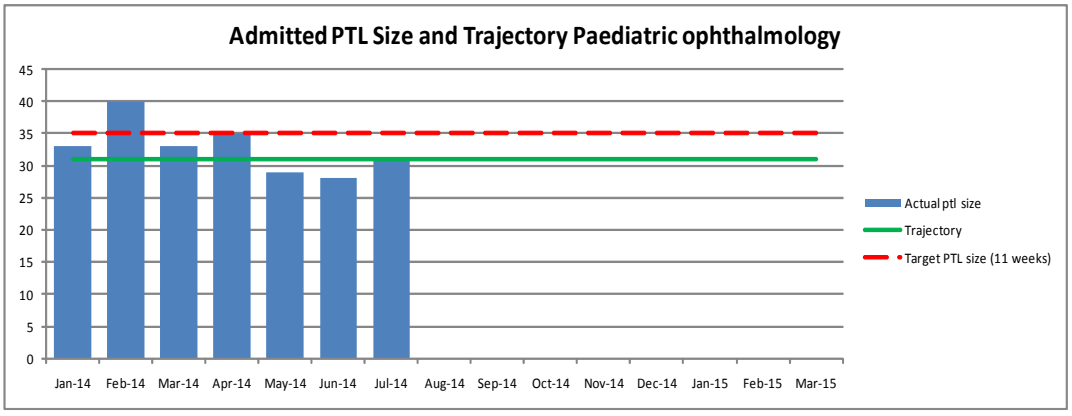
General surgery

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



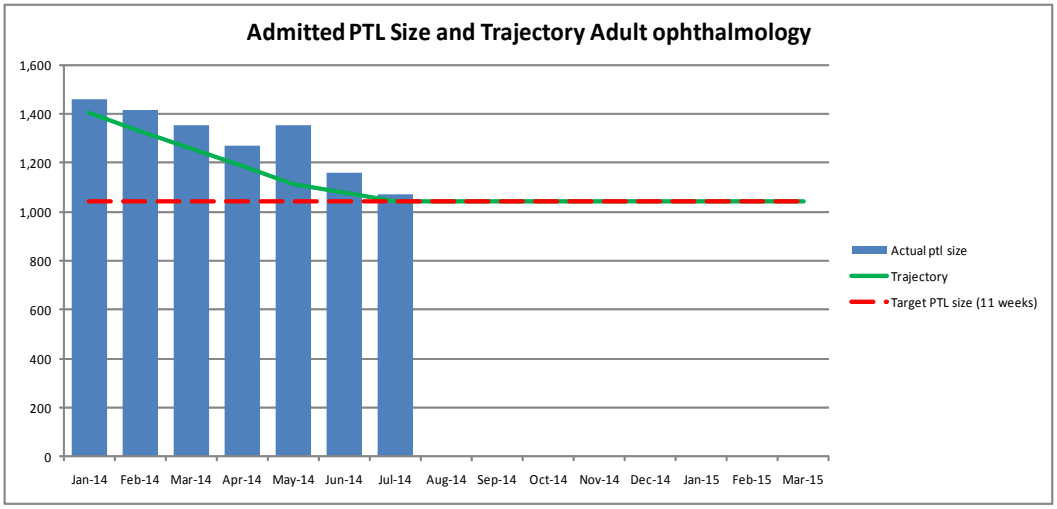
Paediatric ophthalmology

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



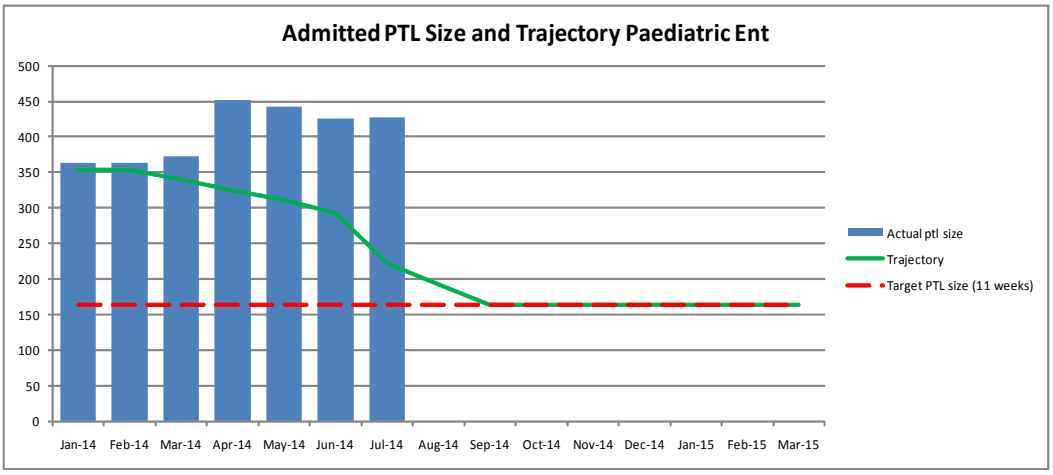
Adult ophthalmology

	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Actual ptl size	1,458	1,415	1,355	1,271	1,353	1,160	1,070	-	-						
Trajectory	1,402	1,330	1,258	1,186	1,114	1,078	1,042	1,042	1,042	1,042	1,042	1,042	1,042	1,042	1,042
Target PTL size (11 weeks)	1,042	1,042	1,042	1,042	1,042	1,042	1,042	1,042	1,042	1,042	1,042	1,042	1,042	1,042	1,042



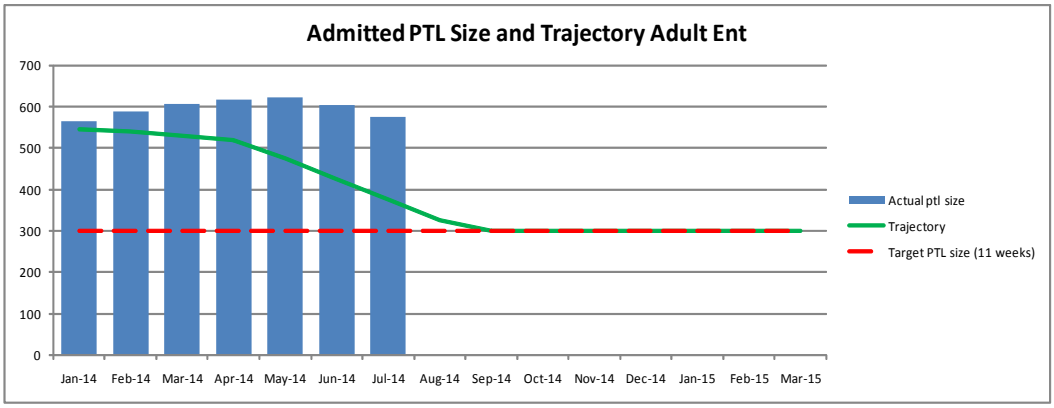
Paediatric ENT

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



Adult Ent

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



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

Title:	Appendix 4 - Cancer performance (Reporting on April-June 2014 performance)

Author: Richard Mitchell, Chief Operating Officer
Matthew Metcalfe, Cancer Centre Clinical Lead

Purpose of the Report:
To provide an overview on April performance and future predicted performance

The Report is provided to the Board for:

Decision		Discussion	√
Assurance	√	Endorsement	

Summary / Key Points:

- UHL cancer performance since Q4 13/14 has deteriorated
- There has been a significant increase in 2ww referrals in April and a sustained increase in breast referrals for 3 months
- June 2ww, 31 and 62 day standards have not been achieved, 31 and 62 day standards are at risk for July
- The number patients over 62 days has significantly increased across a number of tumour sites the reasons for the delays are understood
- Recovery is expected by end Q2

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

Previously considered at another UHL corporate Committee N/A

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

Resource Implications (eg Financial, HR)
Yes

Assurance Implications
Meeting all cancer standards

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

Equality Impact
N/A

Information exempt from Disclosure
N/A

Requirement for further review
Monthly

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

OPERATIONAL PERFORMANCE EXCEPTION REPORT

REPORT TO: **TRUST BOARD**

DATE: **31 July 2014**

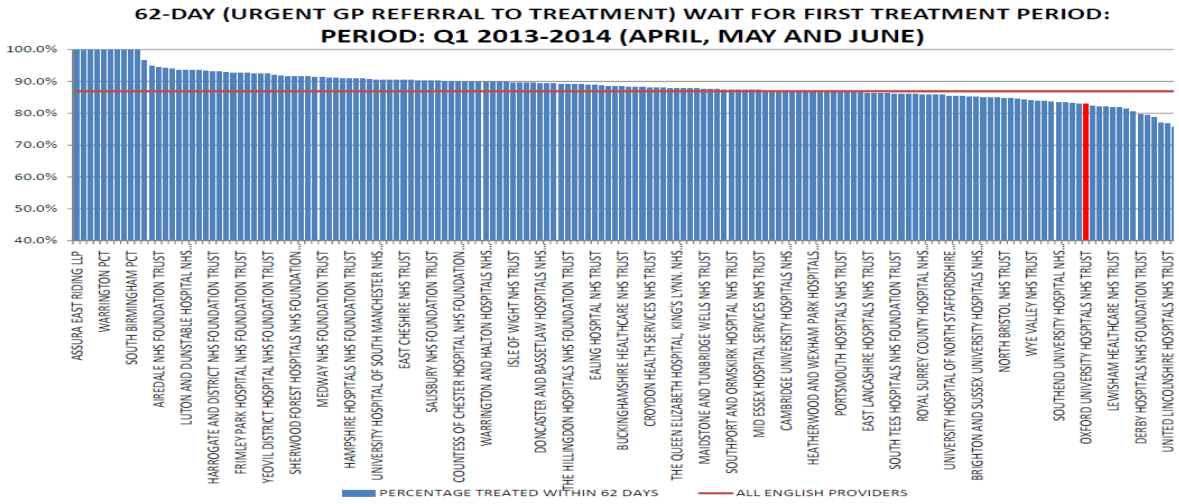
REPORT BY: **Richard Mitchell, Chief Operating Officer**

AUTHOR: **Matt Metcalfe, Cancer Centre Clinical Lead**

SUBJECT: **Cancer performance (reporting on April- June 2014 performance)**

Background

Performance against cancer waiting times targets (CWT) for UHL fell below the national standard for the 62 day referral to treatment target for 2011/12 and 2012/13, with UHL firmly in the lower quartile of cancer provider trusts nationally. This picture was maintained in Q1 of 2013/14, with UHL ranked bottom against our 6 "Better Care, Better Value" (BCBV) comparator trusts.



A remedial action plan was agreed with the commissioners and effected within UHL via a restructured Cancer Centre operating through weekly Cancer Action Board (CAB) meetings with CBU/CMG representatives and monthly Cancer Board and Cancer Clinical Nurse Specialist meetings.

The resulting trust level performance by Q4 for the 62 day target saw UHL ranked 23 nationally, and top of our BCBV comparator trusts.

Current cancer performance

Q1 has seen a dip in cancer performance across many of the targets;

CWT standard (target)	2013/4 Q4 performance	2014/5 Q1 performance
2WW (93%)	95.5%	91.6%
62 day (GP ref) (85%)	90.1%	83.7%
Screening 62 day (90%)	94.4%	76.9%
31 day first treatment (96%)	97.9%	93.1%
31 day subsequent treatment (surgery) (94%)	96.5%	92.5%
31 day subsequent treatment (radiotherapy) (94%)	96.6%	95.3%

31 day subsequent treatment (chemotherapy) (98%)	100%	100%

In addition the median number of patients waiting over 100 days for treatment on a 62 day pathway during Q4 of 2013/4 was 4. The current number for this indicator, which attracts considerable external scrutiny, is 17.

Early warning indicator for Cancer Performance

In light of the abrupt deterioration in cancer performance and the inevitable lag between instigation of remedial measures and performance recovery whilst the backlog is treated consideration has been given to whether a clear early warning indicator of threats to performance can be developed. Following review it can be demonstrated that it does appear indicative to use the number of patients within 3 weeks of breach date (day 40-62 of pathway) as an early warning indicator for a likely challenges in performance. How this data can be used in an 'at a glance' report for key stakeholders is shown at appendix A – this report will be generated by the Cancer Centre weekly.

Remedial Actions

1) The CMGs have submitted recovery plans for each tumour site. These are currently going through a process of confirm and challenge to ensure they allow delivery of 2013/14 Q4 level performance by M6 2014/15. These will be signed off by the end of July.
2) A monthly CMG general managers meeting with the Cancer Centre management team and Chief Operating Officer instigated to monitor cancer performance management and the recovery plan progress. Commenced June.
3) These cross CMG cancer meetings will be augmented by a series of 1:1 meetings between the CMG and Cancer Centre management teams and the Chief Operating Officer. Commencing August.
4) The monthly Cancer Board meetings, a clinically lead forum with CMG support, has mandated CMG management and tumour site specific clinical lead attendance endorsed by the Chief Operating Officer and the Medical Director. Commencing August.
5) The Early Warning Indicator for Cancer performance has been developed, which will be generated by the Cancer Centre and circulated to the Executive Performance Board and the CMG general managers weekly commencing August.
6) Cancer performance will be a standing item on the agenda of CMG board meetings and the relevant minutes copied to the cancer centre.

Details of senior responsible officers

Charlie Carr, Head of Performance Improvement
Matt Metcalfe, Cancer Centre Clinical Lead
Michelle Wain, Cancer Centre Manager

Appendix A

Weekly Cancer Predictive Performance Dashboard

Week commencing 05/08/14

Tumour site	Backlog (threshold)	In Month Performance (target 85%)	100 day + Backlog (threshold)	40-62 day indicator (threshold)
Breast	12	88.9%	3	10 (5)
Lung	8	40.9%	1	10 (10)
Haematology	1	0%	1	3 (4)
Upper GI	5	33.3%	1	5 (6)
Lower GI	6	50%	1	10 (10)
Skin	1	100%	1	2 (2)
Gynaecology	6	100%	4	31 (16)
CNS	0	N/A	0	0 (0)
Urology	6	86.7%	3	16 (23)
Head and Neck	0	28.6%	0	7 (6)
Sarcoma	1	N/A	1	2 (6)
Hepatobiliary	1	N/A	1	0 (3)
Trust Level	**47 (30)**	**70.1%**	**17 (6)**	**96 (91)**

Foot notes:

1. Breast screening performance remains very challenged – circa 70% threatening trust bottom line yearend position for this CWT target – wire localisation slots and their efficient utilisation rate limiting
2. Endoscopy process affecting Upper and Lower GI performance, work streams with the CMG to address this against agreed standards
3. 2WW capacity a significant pressure across multiple tumour sites, most particularly Gynaecology, Dermatology and Breast
4. Lung RAL clinic capacity significantly limited
5. Imaging in Cancer performance slipped from 80% request to report turnaround time within 7 days to 60% over last 2 months

APPENDIX 5

To:	**Trust Board**
From:	**Richard Mitchell, Chief Operating Officer**
Date:	**31 July 2014**
CQC regulation:	**As applicable**

Title:	Cancelled operations report

Author: Phil Walmsley , Head of Operations

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

The Report is provided to the Board for:

Decision		Discussion	
Assurance	√	Endorsement	

Summary / Key Points:

- The percentage of operations cancelled on/after the day for non-clinical reasons during June was 1.0% against a target of 0.8%. Performance for up to the 20th July is 0.6%.
- The % of patients cancelled who are offered another date within 28 days of the cancellation. The number of patients breaching this standard in June was 1 with 99% offered a date within 28 days of the cancellation. This is an improved position against May.
- The number of urgent operations cancelled for a second time ; Zero
- The Trust is recruiting an Operational Manager to ensure on-going delivery

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

Previously considered at another UHL corporate Committee N/A

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

Resource Implications (eg Financial, HR)
Yes

Assurance Implications

Patient and Public Involvement (PPI) Implications
Impact on patient experience due to cancelling of operations

Equality Impact
N/A

Information exempt from Disclosure
N/A

Requirement for further review
Monthly

APPENDIX 5

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

OPERATIONAL PERFORMANCE EXCEPTION REPORT

REPORT TO: **TRUST BOARD**

DATE: **31st July 2014**

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

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

CMG GENERAL MANAGER: **Phil Walmsley, Interim General Manager, ITAPS Phil Walmsley**

SUBJECT: **Short notice cancelled operations (Alliance data not included)**

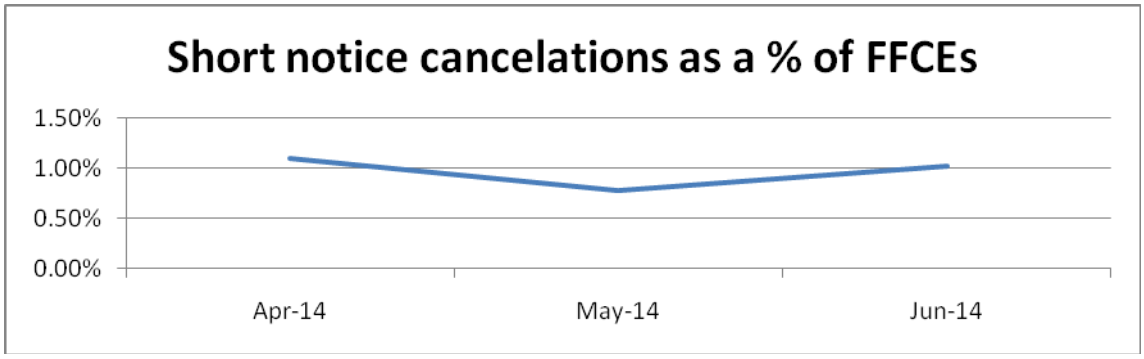
Introduction

The cancelled operations target comprises of three components:

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

Trust performance in March:-

1. *The percentage of operations cancelled on/after the day* for non-clinical reasons with Alliance activity included during June was 1.0% against a target of 0.8%. Performance for July (up to 20th July) is 0.6%.
2. *The % of patients cancelled who are offered another date within 28 days of the cancellation.* The number of patients breaching this standard in June was 1 with 99% offered a date within 28 days of the cancellation. This is an improved position against May.
3. *The number of urgent operations cancelled for a second time* ; Zero



Against standard 1) The focus is on reducing the number of non bed related cancellations (over which the Trust has greater control). The table below is the agreed trajectory reduction, with a residual number of 10 which are unavoidable , such as complications in surgery resulting in cancelling patients.

Reduction in non bed related cancellations	Apr-14	May-14	Jun-14	Jul-14	Aug-14
Monthly trajectory	40	34	26	18	10
Actual number	37	35	34		

The key action to ensure on-going good performance is the daily reporting of patients cancelled requiring redating within 28 days and escalating to CMG Directors and General Managers for resolution.
The Trust has interviewed and offered the post of 'Cancelled Operations' manager following interviews in

June (similar to the Nottingham University Hospitals post) , it is anticipated that they will be in post within 2 months.

Risks to delivery of recovery plan

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

Details of senior responsible officer

CMG SRO: P Walmsley

Corporate Ops: P Walmsley