UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

TRUST BOARD

MEETING TO BE HELD ON THURSDAY 5 FEBRUARY 2015 FROM 9AM IN SEMINAR ROOMS A & B, CLINICAL EDUCATION CENTRE, LEICESTER GENERAL HOSPITAL

Public meeting commences at 9am

AGENDA

Please take papers as read

Item no.	Item	Paper ref:	Lead	Discussion time
1.	**APOLOGIES**	**-**	**Chairman**	
	To receive any apologies for absence.			-
2.	**DECLARATIONS OF INTERESTS**	**-**	**Chairman**	
	Members of the Trust Board and other persons attending are asked to declare any interests they may have in the business on the public agenda (Standing Order 7 refers). Unless the Trust Board agrees otherwise in the case of a non-prejudicial interest, the person concerned shall withdraw from the meeting room and play no part in the relevant discussion or decision.			-
3.	**MINUTES**			
	Minutes of the 8 January 2015 Trust Board meeting. *For approval*	**A**	**Chairman**	-
4.	**MATTERS ARISING**			
	Action log from the 8 January 2015 meeting. *For approval*	**B**	**Chairman**	9am – 9.05am
5.	**CHAIRMAN'S MONTHLY REPORT – FEBRUARY 2015** *For noting*	**C**	**Chairman**	9.05am – 9.10am
6.	**CHIEF EXECUTIVE'S MONTHLY REPORT – FEBRUARY 2015** *For noting*	**D**	**Chief Executive**	9.10am – 9.15am
7.	**KEY ISSUES FOR DECISION/DISCUSSION**			
7.1	**PATIENT STORY** *For discussion*	**E**	**Chief Nurse**	9.15am – 9.35am
7.2	**THE PROPOSED MOVE OF LEVEL 3 CARE OFF THE LEICESTER GENERAL HOSPITAL SITE AND ITS IMPACT ON OTHER SERVICES** *For approval*	**F**	**Director of Strategy**	9.35am – 9.55am
8.	**QUALITY AND PERFORMANCE**			
8.1	**QUALITY AND PERFORMANCE REPORT – MONTH 9** *For discussion*	**G**	**QAC Chair/ IFPIC Chair**	9.55am – 10.10am

	The Non-Executive Director Chairs of the Quality Assurance Committee (QAC) and the Integrated Finance, Performance and Investment Committee (IFPIC) will introduce a summary of the month 9 issues considered at their most recent meetings (held on 29 January 2015). Minutes of the 29 January 2015 QAC and IFPIC meetings will be presented to the 5 March 2015 Trust Board meeting.	**H1 & H2**	**QAC Chair/ IFPIC Chair**	
8.2	**2014-15 MONTH 9 FINANCIAL POSITION** *For discussion and assurance*	**I**	**Director of Finance**	10.10am – 10.25am
8.3	**EMERGENCY CARE PERFORMANCE REPORT** *For discussion and assurance*	**J**	**Chief Operating Officer**	10.25am – 10.35am
9.	**GOVERNANCE**			
9.1	**FIT AND PROPER PERSONS TEST** *For approval*	**K**	**Acting Director of Human Resources**	10.35am – 10.45am
9.2	**BOARD ASSURANCE FRAMEWORK** *For discussion and assurance*	**L**	**Chief Nurse**	10.45am – 10.55am
10.	**EDUCATION**			
10.1	**QUARTERLY UPDATE ON MEDICAL EDUCATION ISSUES** *For discussion and noting*	**M**	**Medical Director**	10.55am – 11.10am
11.	**REPORTS FROM BOARD COMMITTEES**			
11.1	**AUDIT COMMITTEE** Minutes of the 8 January 2015 meeting for noting and endorsement of any recommendations.	**N**	**Audit Committee Chair**	11.10am – 11.15am
12.	**CORPORATE TRUSTEE BUSINESS**			
12.1	**CHARITABLE FUNDS COMMITTEE** Minutes of the 19 January 2015 meeting will be presented to the 5 March 2015 Trust Board meeting.	**-**	**-**	-
13.	**TRUST BOARD BULLETIN – FEBRUARY 2015**	**P**	**-**	-
14.	**QUESTIONS FROM THE PUBLIC RELATING TO BUSINESS TRANSACTED AT THIS MEETING**		**Chair**	11.15am – 11.30am
15.	**ANY OTHER BUSINESS**		**Chair**	11.30am – 11.35am
16.	**DATE OF NEXT MEETING**			
	The next Trust Board meeting will be held on Thursday 5 March 2015 from 9am in the C J Bond Room, Clinical Education Centre, Leicester Royal Infirmary site.			
17.	**EXCLUSION OF THE PRESS AND PUBLIC** It is recommended that, pursuant to the Public Bodies (Admission to Meetings) Act 1960, the press and members of the public be excluded from the following items of business, having regard to the confidential nature of the			

	business to be transacted, publicity on which would be prejudicial to the public interest (items 18-24).			
5 minute comfort break (11.35am to 11.40am)				
18.	**DECLARATIONS OF INTERESTS** Members of the Trust Board and other persons attending are asked to declare any interests they may have in the business on the agenda (Standing Order 7 refers). Unless the Trust Board agrees otherwise in the case of a non-prejudicial interest, the person concerned shall withdraw from the meeting room and play no part in the relevant discussion or decision.			
19.	**CONFIDENTIAL MINUTES** Confidential Minutes of the 8 January 2015 Trust Board meetings. *For approval*	**Q**	**Chairman**	-
20.	**MATTERS ARISING** Confidential action log from the 8 January 2015 Trust Board. *For approval*	**R**	**Chairman**	11.40am – 11.45am
21.	**REPORT FROM THE CHIEF EXECUTIVE** *For approval* *Commercial in confidence*	**S**	**Chief Executive (on behalf of the Chief Information Officer)**	11.45am – 12noon
22.	**REPORTS FROM THE INTERIM DIRECTOR OF ESTATES AND FACILITIES** *For approval* *Commercial in confidence*	**T**	**Interim Director of Estates and Facilities**	12noon – 12.15pm
23.	**REPORTS FROM BOARD COMMITTEES**			
23.1	**INTEGRATED FINANCE, PERFORMANCE AND INVESTMENT COMMITTEE** To receive a summary of the confidential issues considered at the 29 January 2015 meeting. Minutes of that meeting will be presented to the 5 March 2015 Trust Board meeting. *Prejudicial to the conduct of public affairs*	**U**	**Chairman**	
23.2	**REMUNERATION COMMITTEE** Confidential Minutes of the 22 December 2014 meeting for noting. *Prejudicial to the conduct of public affairs*	**V**	**Chairman**	
24.	**ANY OTHER BUSINESS**	**-**	**Chairman**	

Kate Rayns
Acting Senior Trust Administrator

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF A MEETING OF THE TRUST BOARD, HELD ON THURSDAY 8 JANUARY 2015 AT 9AM IN THE C J BOND ROOM, CLINICAL EDUCATION CENTRE, LEICESTER ROYAL INFIRMARY

Voting Members Present:
Mr K Singh – Trust Chairman
Col (Ret'd) I Crowe – Non-Executive Director
Dr S Dauncey – Non-Executive Director
Dr K Harris – Medical Director
Mr R Mitchell – Chief Operating Officer
Ms R Overfield – Chief Nurse
Mr P Panchal – Non-Executive Director (from Minute 4/15)
Mr M Traynor – Non-Executive Director (from Minute 4/15)
Mr P Traynor – Director of Finance
Mr M Williams – Non-Executive Director
Ms J Wilson – Non-Executive Director

In attendance:
Ms D Baker – Service Equality Manager (for Minute 7/15/2)
Mr P Gowdridge – Head of Strategic Finance (for Minute 6/15/2)
Mr D Henson – LLR Healthwatch Representative (up to and including Minute 10/15)
Mr R Kinnersley – Major Projects Technical Director (for Minute 6/15/2)
Mr A Kulkarni – Orthopaedic Consultant (for Minute 6/15/1)
Ms H Leatham – Assistant Chief Nurse (for Minute 6/15/1)
Ms A Lynds – Deputy Sister, Ward 14, LGH (for Minute 6/15/1)
Mrs K Rayns – Acting Senior Trust Administrator
Ms C Rix – Sister, Ward 14, LGH (for Minute 6/15/1)
Mr W Rose – Staff Nurse, Ward 14, LGH (for Minute 6/15/1)
Ms K Shields – Director of Strategy
Mr M Slow – Physiotherapist, Ward 14, LGH (for Minute 6/15/1)
Ms E Stevens – Acting Director of Human Resources
Ms M Thompson – Patient Experience Sister (for Minute 6/15/1)
Mr S Ward – Director of Corporate and Legal Affairs
Mr M Wightman – Director of Marketing and Communications (from part of Minute 6/15/1)

ACTION

1/15 APOLOGIES

Apologies for absence were received from Mr J Adler, Chief Executive, Dr A Bentley, Leicester City CCG representative, and Professor D Wynford-Thomas, Non-Executive Director.

2/15 DECLARATIONS OF INTERESTS IN THE PUBLIC BUSINESS

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

3/15 MINUTES

Resolved – that the Minutes of the 22 December 2014 Trust Board (paper A) be confirmed as a correct record and signed by the Trust Chairman accordingly. **CHAIR**

4/15 MATTERS ARISING FROM THE MINUTES

Paper B detailed the status of previous matters arising and the expected timescales for

resolution. The Board received updated information on the following items:-

(a) item 3 (Minute 320/14/1(c) of 22 December 2014) – a risk summit had been held on 23 December 2014 to explore an urgent local resolution to improve the quality of care and patient experience at UHL during periods of unprecedented emergency demand and an update on this matter would be provided during the substantive agenda item on Emergency Care Performance (Minute 6/15/3 below refers);

(b) item 7 (Minute 324/14/2 of 22 December 2014) – the Chairman had written to the 3 CCG Chairs to consult them on the arrangements for joint CCG representation at UHL's Trust Board and QAC meetings. Responses had been received and a formal meeting had been arranged for the third week in January 2015 to confirm these arrangements, and

(c) item 9 (Minute 298/14 of 27 November 2014) – it was confirmed that an analysis of UHL's myNHS data (relating to Consultant level outcomes) had been circulated to Board members on 5 January 2015. In response to a query, the Medical Director confirmed that this Consultant level outcomes data was now in the public domain and a link to the data was available on the Trust's external website.

Resolved – that the update on outstanding matters arising and the timescales for resolution be noted.

5/15 CHAIRMAN'S ANNOUNCEMENTS

The Chairman wished everyone a happy New Year and welcomed Ms E Stevens, Acting Director of Human Resources to the meeting. He congratulated Dr B Collett, recently retired UHL Pain Management Consultant and Professor N Samani, Professor of Cardiology and Consultant Cardiologist on their awards in the Queen's New Year Honours (OBE and Knighthood, respectively).

The Chief Executive was absent from this meeting due to his attendance at a TDA event in London to explore a potential partnership between the NHS and the Virginia Mason Institute. The Board noted that UHL was one of a small number of UK Trusts (nationally) that had been invited to participate in this event.

Resolved – that the position be noted.

6/15 KEY ISSUES FOR DECISION/DISCUSSION

6/15/1 Patient Story – Ward 14 LGH

A UHL patient and Mr A Kulkarni, Orthopaedic Consultant attended the meeting, together with members of the patient experience team and staff from Ward 14 LGH (as indicated above) to present oral feedback on this patient's personal experiences of the care he had received during his admission for hip surgery on Ward 14 at the LGH. Paper C provided a brief summary of the issues highlighted during the presentation.

The patient particularly commented upon the efficiency of the pre-operative assessment at Glenfield Hospital, the compassionate treatment during surgery (which was performed under a local anaesthetic) and the care provided during his recovery period. Within 3 weeks of the operation, he had been able to walk unaided. In general, the whole period of his treatment had been a pleasurable experience and he had not found any grounds to criticise the care received. Staff attitudes had been very positive, kind and considerate.

In response, the Ward Sister thanked the patient for his kind comments and provided the Trust Board with background information on recent Friends and Family feedback results for Ward 14, which had risen from 46.2 in November 2013 to 77.4 in November 2014. She

reported on the positive impact of increased support to improve team working and staff communications (including a staff newsletter and regular staff meetings), through team building exercises and the Nursing into Action Programme.

Mr Kulkarni, Orthopaedic Consultant thanked the patient for taking the time to provide his feedback. He updated the Trust Board on the key factors which he felt had contributed to this positive patient experience, noting his true belief that the service was delivering "Caring at its Best", that the excellent communications between staff and between staff and patients ensured that consistent messaging was provided, and that the various elements of the service were working well together as one team: from initial outpatient assessment through to theatres, ward based care and physiotherapy/rehabilitation.

In discussion on the patient story, the Board considered ways in which this excellent example of patient experience might be replicated across the Trust, noting that:-

(a) improved team working was generally more effective for this type of elective inpatient ward;
(b) embedded clinical teams and integrated clinical leadership were working well together;
(c) the majority of training opportunities for ward teams were provided "on the job" through exposure to different situations and the development of link roles;
(d) patient stories (both positive and negative) were shared through CMG Board meetings, a shared patient experience network drive, a booklet called "Sharing Success", and the Nursing into Action Programme, and
(e) there was a potential opportunity for the ward to apply for charitable funding to purchase the additional patient radios and televisions for use in the side rooms (as referenced on page 2 of paper C).

Finally, the Chairman thanked the patient for his valuable feedback and invited any further comments from him, noting that patients were at the centre of UHL's core activities. In response, the patient reiterated the efficient and pleasant treatment he had received and commented upon his preference for a longer length of stay and some additional support he had received post-discharge in relation to use of compression stockings. Members highlighted some similarities between hospitals and hotels and the available feedback mechanisms (such as Trip Advisor and NHS Choices).

<u>Resolved</u> – that (A) the patient story and the related discussion be noted, and

(B) opportunities be explored to purchase additional patient radios and televisions for use in the side rooms from charitable funds (if appropriate). **CN**

6/15/2 <u>Draft Emergency Floor Full Business Case</u>

The Director of Strategy introduced paper D, seeking Trust Board approval of the draft Emergency Floor full business case for submission to the TDA, recognising that the final business case would be submitted for the Board's approval in February 2015, following receipt of feedback from the TDA. The Major Projects Technical Director and the Head of Strategic Finance attended the meeting for this item. During the discussion on this item, the Trust Board:-

(a) noted the potential impact of the General Election and the period of purdah (which was due to commence on 20 March 2015) upon the business case, if the TDA did not support the business case at their meeting on 19 March 2015;
(b) received additional assurance from the Major Projects Technical Director in respect of the proposed design and construction and confidence in UHL's ability to manage and control the arrangements to deliver the scheme;
(c) considered the responses to the issues raised by the Finance and Performance Committee on 18 December 2015 (as set out in paragraphs 7 to 11 on pages 3 and 4 of

paper D), with a particular focus on the activity modelling and the flexibility of the design if future growth surpassed the Better Care Together activity modelling;

(d) queried whether the activity modelling and flexibility of the design had been tested to determine the upper range of this flexibility (eg whether the new department would be able to cope with a 20% increase in emergency activity). In response, the Director of Strategy and the Medical Director confirmed that the design of the infrastucture and the patient flow arrangements were built into the operational model and that this would strengthen the links with assessment units and base wards. In addition, there was scope to build an additional floor at a later stage (if required);

(e) noted the importance of obtaining a green rating for the Gateway 3 review of the full business case and the need to ensure that any residual issues arising from the Gateway 2 review were fully resolved, and

(f) expressed concern regarding the short timescale for incorporating any TDA feedback on the draft FBC and obtaining TDA approval of the final FBC.

Resolved – that (A) the Trust Board endorse the draft Emergency Floor full business case for onward submission to the TDA, and **DS**

(B) the finalised Emergency Floor full business case be submitted to the next available Trust Board meeting (upon receipt of TDA feedback). **DS**

6/15/3 Emergency Care Performance Report

Further to Minute 320/14/1 of 22 December 2014, the Chief Operating Officer updated the Trust Board on the outputs of the 23 December 2014 risk summit held with LLR healthcare partners to progress an urgent local resolution to improve the quality of patient care and patient experience during periods of unprecedented level of emergency activity. Paper E provided the monthly Trust Board briefing on recent emergency care performance and progress against the LLR action plan.

Following the risk summit, the Chairman had written to each of the CCG Chairs and the LPT Chair, outlining the 5 actions agreed at that meeting and detailed below. In addition, all parties had agreed to a joint statement being issued before Christmas drawing attention to the available advice from primary care and pharmacists as an alternative to attending ED for non-emergencies.

The Chief Operating Officer highlighted the short interval between this meeting and the 22 December 2014 Trust Board meeting, and he commented upon the impact of the 3 recent bank holidays and challenging levels of weekend activity. He acknowledged that collective concerns had been escalated in respect of the UHL and health economy risk assessments but expressed concern that attendances and admissions had continued to increase, despite the agreed response actions and record numbers of acutely unwell patients were still being admitted to UHL. In general, his concerns were noted to be more of a more serious nature now than they had been on 22 December 2014.

In respect of the 5 actions agreed on 23 December 2014, the Chief Operating Officer provided the following updated information:-

(1) communications regarding non-emergency care – the Director of Marketing and Communications continued to work on the "choose wisely" messaging and commented upon the NHS England campaign to seek help for elderly frail patients before their condition deteriorated further;

(2) delayed transfers of care – the Chief Nurse and Deputy Chief Nurse were working with nursing colleagues across the health economy to improve discharge processes;

(3) nursing home and care home bed capacity – no additional capacity had yet been identified and there was an understandable reluctance to place any additional pressure on the existing facilities;

(4) surge capacity across LLR – no additional capacity had been identified in the community and all available UHL capacity was open. Any key decisions made now in respect of increasing capacity were likely to have a 3-month lead in time attached to them, and
(5) a collective risk assessment across LLR – this had been undertaken and it had been agreed that all 5 key risks currently resided with UHL although GP referral patterns had not been changed to take this into account.

The Chief Nurse recorded her concerns regarding UHL's nurse staffing levels in view of the additional capacity beds now open and the underlying vacancy level. She drew the Board's attention to deteriorating trends in respect of pressure ulcer damage, infection rates and staff sickness absence and commented upon the lack of supervisory elements of nursing roles which (in turn) hampered the ability to plan patient discharges earlier in the day.

The Medical Director supported the Chief Nurse's comments, advising that patient outcomes were known to deteriorate as hospitals became more overcrowded and medical and nursing staff were stretched to capacity. He drew members' attention to the graph on page 3 of paper E showing the forecast adult emergency admissions for January to March 2015. The national media attention on emergency care performance was seen as a positive factor and the causes of this trend were almost certainly multi-factorial based upon patient expectations of service delivery and access to primary care services. No single solution was likely to resolve the challenges, but the NHS 111 service was noted to have helped to increase access to services.

During discussion on this item, Trust Board members:-

(a) noted the context of national emergency care pressures and that no single NHS Trust had delivered the 4 hour ED target in the last week;
(b) commented on the continued pressure upon staff working within the ED, assessment units and those wards where additional bed capacity had been opened;
(c) received updated information on the 3 main factors affecting UHL's performance (inflow, internal UHL processes and outflow). As the inflow continued to increase, UHL had been able to increase the rate of discharges home, but discharges to care homes and nursing homes were being hampered by capacity issues;
(d) noted that (in respect of internal processes), work continued to deliver the actions in response to the Sturgess report, eg strengthening the arrangements for weekend working, ward rounds and timing of discharge processes earlier in the day;
(e) commented upon the challenges surrounding ward rounds for outlying patients and the impact upon cancelled elective activity;
(f) queried the assurance provided by the LLR metrics (dashboard) appended to paper E, noting its excessive length (37 pages) and that the majority of the metrics appeared to relate to UHL's performance;
(g) noted that high volumes of additional bank and agency staff were being sought, but the fill rate was significantly lower than the Trust's requirements;
(h) considered the impact of GP admissions from care home providers late in the evening and the quality of care subsequently provided whilst the ED was full to capacity and commented upon the scope to change GP behaviours in this respect;
(i) queried whether the Urgent Care Board had considered all the key issues at their last meeting, noting (in response) that an update on the 5 health economy actions would be sought at the subsequent meeting to be held on 8 January 2015;
(j) noted opportunities to change the messaging provided by some GP surgeries, where their answer phones and receptionists were automatically referring patients to the ED when the surgery was closed or when no GP appointments were available. The Director of Marketing and Communications undertook to discuss with the Chairman and the Chief Executive outside the meeting whether any additional communications workstreams were required to ensure that appropriate "signposting advice" was provided by GP surgeries and pharmacies in respect of attending ED; **DMC**

(k) queried what action was being taken to address the clinical efficacy issue in respect of over-referring GP practices and whether there was any scope to introduce systems or processes to disincentivise inappropriate referrals. The Chairman requested the Executive Team to consider this point further if it was agreed that sufficient robust data was available to evidence such referral patterns; **CE**

(l) commented upon the apparent lack of urgency within the LLR health economy response following the crisis summit held on 23 December 2014, and

(m) sought assurance regarding the monitoring arrangements for any patient harm arising from increased activity pressures and cancelled procedures. In response, the Chief Nurse confirmed that a specific set of patient metrics was being compiled to support an assessment of any additional patient harm arising from the high level of patient activity.

In summary, the Chairman proposed to write to the Urgent Care Board with a view to seeking:-

(i) an urgent update on the further work proposed to be undertaken in respect of each of the 5 actions agreed at the summit on 23 December 2014;
(ii) a review of the LLR weekly urgent care dashboard to develop a more meaningful concise version capable of differentiation between UHL and wider health economy outputs, and
(iii) assurance that the issues raised at today's meeting were being noted and acted upon with the appropriate sense of urgency.

Members requested that a response be provided by the Urgent Care Board within the next 10 working days, rather than waiting to receive an update at the 5 February 2015 Trust Board meeting. In addition, the Chairman advised that he would be meeting with the 3 CCG Chairs and the LPT Chair on a monthly basis going forwards and that he continued to liaise with them regarding CCG representation at UHL's Board meetings. **Chair**

Responding to a suggestion to seek additional input from social care services, the Chairman confirmed that representatives from the City and County Council had already been invited to attend the Trust Board thinking day on 12 February 2015.

<u>Resolved</u> – that (A) the update on emergency care performance and implementation of the recommendations arising from the Sturgess report be received and noted,

(B) the Chairman be requested to write to the Urgent Care Board seeking assurance on the issues identified in points (i) to (iii) above, **Chair**

(C) the Executive Team be requested to consider whether robust evidence was available regarding over-referrals and whether any processes could be implemented to disincentivise such behaviours, and **CE**

(D) the Director of Marketing and Communications be requested to meet with the Chairman and the Chief Executive outside the meeting to determine the extent of any additional communications workstreams required in relation to ED attendances. **DMC**

6/15/4 <u>UHL Initial Draft Annual Operational Plan for 2015-16</u>

The Director of Strategy presented paper F, providing the first draft of the Trust's Operational Plan for 2015-16 prior to submission to the NTDA on 13 January 2015. She particularly encouraged members to review the areas of risk which would be the subject of further discussion at a future Trust Board thinking day, ie the scale and pace of bed reduction plans, workforce reduction plans, the impact of the new tariff guidance and the national contract for 2015-16.

<u>Resolved</u> – that (A) the initial Draft Annual Operational Plan for 2015-16 be supported **DS**

for submission to the TDA by the 13 January 2015 deadline, and

DCLA

(B) further discussion on the key issues and risks be held at a future Trust Board thinking day.

7/15 GOVERNANCE

7/15/1 Mutuals in Health Pathfinder Update

The Acting Director of Human Resources introduced paper G providing a update on progress with taking forward the Mutuals in Health Pathfinder Programme and the procurement process for UHL's technical, legal and consultancy support. In response to a Non-Executive Director query, it was confirmed that opportunities for part-Trust Mutuals would be explored, as part of the developmental work with pilot teams.

Resolved – that the progress update on the Mutuals in Health Pathfinder Programme be received and noted.

7/15/2 Workforce Equality and Diversity Monitoring Report 2013-14

Paper H provided the 2013-14 Annual Workforce Equality Monitoring Report, an update on progress against the Equality Workforce work programme, future changes to the monitoring arrangements and sought approval of the priorities for the 2015-16 work programme. Ms D Baker, Service Equality Manager attended for this item and drew members' attention to the requirement to publish the finalised monitoring report on the internal and external web sites. Appendix 2 highlighted the targeted interventions to address any underlying trends.

The Chairman particularly noted the importance of this document in relation to the Trust's activities and its bearing on UHL's organisational culture. He noted the intention to hold a Trust Board thinking day on the theme of equality in February 2015 and confirmed that Ms Baker would be invited to attend that session. In discussion on the report, the Board:- **DCLA**

(a) endorsed the report as presented for publication on the UHL web site;
(b) commented upon the need to ensure disabled access to all future public meetings, noting that the lift in the Jarvis Building was currently "out of order";
(c) noted the ageing profile of UHL's workforce and the impact upon succession planning, and
(d) considered opportunities to work with local Higher Education providers and expand the number of training places available to strengthen UHL's workforce in the longer term.

Resolved – that (A) the 2013-14 Workforce Equality and Diversity Monitoring Report be endorsed as presented in paper H;

(B) the Service Equality Manager be invited to attend a future Trust Board thinking day for the Equality session, and **DCLA**

(C) the issue regarding public access to meetings be highlighted to the Director of Estates and Facilities (through the Minutes of this meeting). **CN/TA**

7/15/3 Board Assurance Framework (BAF)

The Chief Nurse introduced paper I detailing UHL's Board Assurance Framework as at 30 November 2014 and notifying members of a new extreme organisational risk opened during that month (as noted in appendix 3 to the report). She particularly highlighted the following key points:-

(a) principal risk 2 *(failure to implement LLR emergency care improvement plan)* had been

refreshed significantly in the light of current levels of emergency demand;

(b) principal risk 1 *(lack of progress in implementing UHL Quality Commitment)* had reached its target score, but an opportunity had been highlighted for the Medical Director and the Chief Nurse to review the narrative relating to this risk and some revised wording would be incorporated in the next iteration of the BAF; **CN/MD**

(c) principal risk 11 *(failure to meet NIHR performance targets)* – the Medical Director confirmed that in his opinion, this risk could be retired on the basis that the lower risk level had been achieved and that this risk was being managed appropriately within the organisation;

(d) principal risk 24 *(failure to implement the IM&T strategy and key projects effectively)* had reached its target score. The Chief Operating Officer queried the rationale for the current risk score rating of 9 and Non-Executive Director members suggested that it felt too early for the Trust to retire this risk. In the absence of the Chief Executive at this meeting, it was agreed to defer discussion on risk 24 to the February 2015 Trust Board meeting. **CN**

Resolved – that (A) the November 2014 Board Assurance Framework be received and noted as presented in paper I;

(B) the Chief Nurse and the Medical Director be requested to refresh the narrative relating to risk 1 (UHL Quality Commitment) for the next iteration of the BAF, and **CN/MD**

(C) Trust Board discussion on risk 24 (IM&T Strategy) be deferred to the 5 February 2015 Trust Board meeting. **CN**

8/15 REPORTS FROM BOARD COMMITTEES

8/15/1 Quality Assurance Committee

Resolved – that the Minutes of the Quality Assurance Committee meeting held on 15 December 2014 be received and noted.

8/15/2 Finance and Performance Committee

Resolved – that the Minutes of the Finance and Performance Committee meeting held on 18 December 2014 be received and noted.

9/15 TRUST BOARD BULLETIN

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

- **NHS Trust Over-Sight Self Certification return for the period ended 30 November 2014, and**
- **Quarterly update on Trust sealings.**

10/15 QUESTIONS AND COMMENTS FROM THE PRESS AND PUBLIC RELATING TO BUSINESS TRANSACTED AT THIS MEETING

The following questions and comments were received:-

(1) a query regarding the amount of penalties levied for UHL's non-compliant ED performance – in response, the Director of Finance highlighted the discussion held earlier at the 22 December 2014 Trust Board meeting (Minute 6/15/3 above refers). He agreed to share information on the quantum of fines with the requester (outside the meeting) and he highlighted the context of these penalties within the year-end settlement process; **DF**

(2) a comment regarding the apparent lack of UHL representation at CCG Board meetings

and a similar lack of CCG representation at UHL's Board meetings. In response, the Chairman advised that he had met with the Chairs of each CCG and the LPT and a joint Board to Board meeting had been arranged for the 5 February 2015. In addition, he had written to the CCG Chairs requesting nominations for formal representation at UHL's Trust Board meetings;

(3) a query regarding discharge processes and whether there was any scope to set a suitable discharge limit which was acceptable to all local health economy partners. In response the Chief Operating Officer re-iterated the discussion earlier in the meeting regarding the arrangements for strengthening discharge processes and the challenges surrounding delayed discharges to community rehabilitation and care home beds;

(4) a query regarding emergency ambulance conveyance data and whether patients had tried alternative solutions to seek medical attention. In response, the Chief Operating Officer reported on the communications processes in place to advise people to only contact EMAS in the event that the patient was acutely unwell. The requester agreed to contact EMAS directly to request the conveyance data he was seeking; **Z Haq**

(5) a query regarding whether any additional bed capacity had been made available in the community since the 22 December 2014 Trust Board meeting. In response, the Chief Operating Officer advised that the CCGs had not been able to open any additional bed capacity, nor had they been able to offer any staffing resources to support ward 2 at the LGH, and

(6) a query regarding the effectiveness of the previous "Super Weekends" and whether they might help the current position. In response, the Chief Operating Officer advised that the key actions from the "Super Weekends" had been replicated already, but the position was different this year as there was no spare bed capacity in the community.

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

11/15 EXCLUSION OF THE PRESS AND PUBLIC

Resolved – that, pursuant to the Public Bodies (Admission to Meetings) Act 1960, the press and members of the public be excluded during consideration of the following items of business (Minutes 12/15 – 17/15), having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.

12/15 DECLARATIONS OF INTERESTS IN THE CONFIDENTIAL BUSINESS

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

13/15 CONFIDENTIAL MINUTES

Resolved – that the confidential Minutes of the 22 December 2014 Trust Board be confirmed as a correct record and signed accordingly by the Trust Chairman. **CHAIR**

14/15 CONFIDENTIAL MATTERS ARISING REPORT

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

15/15 REPORTS FROM BOARD COMMITTEES

15/15/1 Quality Assurance Committee (QAC)

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

15/15/2 Finance and Performance Committee

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

16/15 ANY OTHER BUSINESS

Resolved – that no items of other business were raised.

17/15 DATE OF NEXT MEETING

Resolved – that the next Trust Board meeting be held on Thursday 5 February 2015 from 9am in Seminar rooms A & B, Clinical Education Centre, Leicester General Hospital.

The meeting closed at 11.40am

Kate Rayns
Acting Senior Trust Administrator

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

Name	Possible	Actual	% attendance	Name	Possible	Actual	% attendance
K Singh (Chair from 1.10.14)	4	4	100	R Mitchell	11	10	91
R Kilner (Acting Chair from 26.9.13 to 30.9.14)	7	7	100	R Overfield	11	11	100
J Adler	11	9	82	P Panchal	11	11	100
T Bentley*	9	7	78	K Shields*	11	11	100
K Bradley*	9	9	100	M Traynor (from 1.10.14)	4	4	100
I Crowe	11	10	91	P Traynor (from 27.11.14)	3	3	100
S Dauncey	11	10	91	S Ward*	11	11	100
K Harris	11	10	91	M Wightman*	11	11	100
D Henson*	7	7	100	M Williams	4	4	100
K Jenkins (until 30.6.14)	3	3	100	J Wilson	11	9	82
				D Wynford-Thomas	11	4	36

* non-voting members

University Hospitals of Leicester NHS Trust

Progress of actions arising from the Trust Board meeting held on Thursday, 8 January 2015

Item No	Minute Ref:	Action	Lead	By When	Progress Update	RAG status*
1	6/15/1	***Patient Story*** Opportunities to be explored to purchase additional radios and televisions for use in the side rooms on ward 14, LGH from charitable funds (if appropriate).	CN	As appropriate	Appropriate advice and application forms have been provided to the ward sister to facilitate the application process.	5
2	6/15/2	***Emergency Floor Business Case*** Draft business case to be update to reflect any TDA feedback and presented to the next available Trust Board meeting for final approval.	DS	TB 5.2.15 or 5.3.15	Provisionally re-scheduled for the 5 March 2015 Trust Board, pending TDA feedback.	4
3	6/15/3(a)	***Emergency Care Performance*** Chairman to write to the Urgent Care Board seeking assurance on progress of the actions agreed at the 23 December 2014 risk summit, a review of the LLR weekly care dashboard, and assurance that the issues raised were being acted upon with the appropriate degree of urgency.	Chair	Immediate	Actioned.	5
4	6/15/3(b)	Executive Team to consider whether sufficient robust evidence was available regarding any GP over-referrals and whether any processes could be implemented to disincentivise such behaviours.	CE	As appropriate	Under consideration.	4
5	6/15/3(c)	Director of Marketing and Communications to meet with the Chairman and the Chief Executive to agree the extent of any additional communications workstreams in relation to ED attendances.	DMC	As appropriate	In hand.	4
6	6/15/14	***UHL Initial Draft Annual Operational Plan for 2015-16*** Further discussion on the key issues arising from the draft Annual Operational Plan for 2015-16 be scheduled for discussion at a Trust Board thinking day.	DCLA	As appropriate	Discussed at the Trust Board thinking day on 15 January 2015.	5
7	7/15/2(a)	***Workforce Equality and Diversity Monitoring Report 2013-14*** Service Equality manager to be invited to attend a Trust Board thinking day on the subject of equality and diversity.	DCLA	As appropriate	Scheduled on the agenda for the Trust Board thinking day to be held on 12 February 2015.	5
8	7/15/2(b)	The issue regarding public access to meetings in the Jarvis Building at the LRI be highlighted to the Director of Estates and Facilities.	CN/TA	Urgent	Complete.	5

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

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

Item No	Minute Ref:	Action	Lead	By When	Progress Update	RAG status*
9	7/15/3(a)	***Board Assurance Framework*** The Chief Nurse and the Medical Director to refresh the narrative relating to risk 1 (Quality Commitment) for the next iteration of the BAF.	CN/MD	TB 5.2.15	Complete.	5
10	7/15/3(b)	Discussion on risk 24 (IM&T Strategy) be deferred to the 5 February 2015 Trust Board meeting.	CN	TB 5.2.15	Provisionally scheduled for discussion at the 5 February 2015 Trust Board meeting.	4

Matters arising from previous Trust Board meetings

Item No	Minute Ref:	Action	Lead	By When	Progress Update	RAG status*
22 December 2014						
11	320/14/3	***Delivering the 5 Year Strategy*** Director of Strategy to provide regular progress reports to the Trust Board on delivering the 5 Year Strategy.	DS	TBA	Reports to be scheduled on the Board agenda. Frequency to be agreed in consultation with the Director of Strategy.	4
12	324/14/1 (a)	***Duty of Candour/Fit and Proper Persons Test*** Chief Nurse to report on the arrangements for meeting the requirements of the duty of candour at the 29 January 2015 QAC meeting.	CN	QAC ~~29.1.15~~ 26.3.15	Report provisionally scheduled on the 3 March 2015 EQB agenda and the 26 March 2015 QAC agenda.	3
13	324/14/1 (b)	Acting Director of Human Resources to report on the arrangements for meeting the requirements of the fit and proper persons test at the 5 February 2015 Trust Board meeting.	DHR	TB 5.2.15	Report features on the 5 February 2015 Trust Board agenda.	5
14	324/14/2	***Board and Board Committee Governance*** Trust Chairman to write to the CCG Chairs consulting them on the arrangements for joint CCG representation on UHL Board Committees and inviting appropriate nominations.	Chair	TBA	Actioned – response of CCG Chairs awaited.	4

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

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

University Hospitals of Leicester NHS
NHS Trust

Agenda Item: Trust Board Paper C

TRUST BOARD – 5th FEBRUARY 2015

Chairman's Monthly Report

DIRECTOR:	Chairman
AUTHOR:	Chairman
DATE:	2nd February 2015
PURPOSE:	**(concise description of the purpose, including any recommendations)** To brief the Board monthly on the Chairman's perspective.
PREVIOUSLY CONSIDERED BY:	**(name of Committee)** N/A
Objective(s) to which issue relates *	√ 1. Safe, high quality, patient-centred healthcare √ 2. An effective, joined up emergency care system √ 3. Responsive services which people choose to use (secondary, specialised and tertiary care) √ 4. Integrated care in partnership with others (secondary, specialised and tertiary care) √ 5. Enhanced reputation in research, innovation and clinical education √ 6. Delivering services through a caring, professional, passionate and valued workforce √ 7. A clinically and financially sustainable NHS Foundation Trust √ 8. Enabled by excellent IM&T
Please explain any Patient and Public Involvement actions taken or to be taken in relation to this matter:	As stated in the report.
Please explain the results of any Equality Impact assessment undertaken in relation to this matter:	N/A
Organisational Risk Register/ Board Assurance Framework *	☐ **Organisational Risk Register** ☐ **Board Assurance Framework** √ **Not Featured**
ACTION REQUIRED *	For decision ☐ For assurance ☐ For information √

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

* tick applicable box

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **5 FEBRUARY 2015**

REPORT BY: **CHAIRMAN**

SUBJECT: **CHAIRMAN'S MONTHLY REPORT**

Introduction

This is the first of my reports that will be provided as part of the agenda and documentation for meetings of the Trust Board during this coming year. I have given considerable thought to how I should structure this report and to avoid needless duplication. With this in mind my reports will focus on two areas – one or two issues that I have been reflecting on (and which I have called environmental themes) and also highlighting a specific issue or two which is contained within the papers being considered by the Trust Board.

Environmental Themes

During the past two months it would have been difficult for anyone to miss the focus on accident and emergency departments (unless they did not read newspapers, listen to the radio, watch TV or participate in on line forums!). As one of the NHS Trusts with the highest attendances it is not surprising that staff, our various stakeholders and the public would show a keen interest in what has been happening. I had the opportunity myself to observe the pressures within our emergency services and the implications of this elsewhere in the Trust. I want to add my thanks to those of our Chief Executive, John Adler, to our staff who have worked tirelessly during this very challenging period. As we continue through this winter period it is important that we learn any lessons that can improve our performance even further but also ensure there is a culture throughout the Trust which focuses on being as open as possible. At a future Board meeting we will receive a report about the new statutory duty of candour which the Board and Trust must now observe. In simple English it is being open about our mistakes and using this as a driver for improvement in delivering patient centred care.

We are a large and complex organisation and we need transformative ideas coming from our staff which will contribute to our future as a sustainable organisation. This innovation theme is also important because healthcare continues to change and we must foster a mindset that continually asks the question – why do we do things in this manner and is there a more effective way? Earlier this week I welcomed the Italian Ambassador when he formally opened the pilot medicine prescribing robotic initiative taking place in our renal wards at the General Hospital site. This particular project is very interesting because it seeks to combine patient safety (with prescribing errors and delays identified as one of the top five clinical risks by the Health Foundation) with accuracy, speed and financial efficiency. We will be looking at this initiative

with some interest over the coming months as it is being evaluated. The broader issue here is that we continually need to encourage a culture in which new ideas are welcomed, some of which may not necessarily deliver the benefits that we would expect to see. If that happens we need to learn why but in a manner in which we have thought about the risks before, during and after the event. The implications of this for the Board and Trust is that whilst patient safety will be paramount, we do not become so risk averse that we are unwilling to try out new ideas. In this case we are trialling an Italian robot before anyone else in the NHS and I know that the Listening Into Action initiative seeks to support and celebrate similar initiatives.

Board Reports

I would like to briefly draw attention to two items on the Trust Board agenda for its February 2015 meeting.

The first is the standing item which we have at each Board meeting which is the patient story. This will always be near the beginning of our Board meetings because it allows us to focus on some real life scenarios involving patients and members of staff. It is important that we learn about challenges and how these were overcome as well as what the outcome of these experiences has been for patients and staff. I look forward to this discussion with my colleagues.

The second is the item dealing with a proposed reconfiguration of services and their relocation from the General Hospital site to the Royal Infirmary site. Issues such as this require careful and thorough planning and consultation with a wide range of internal and external stakeholders. As a Trust Board we would want to be guided by an emphasis on what is in the best interests of patients and the clinical safety issues associated with such changes as well as being satisfied that everything has gone to plan. I look forward to this discussion with my colleagues and taking the appropriate decisions as a group who have important collective financial and legal responsibilities.

Karamjit Singh CBE
Chairman, UHL Trust

University Hospitals of Leicester NHS
NHS Trust

Agenda Item: Trust Board Paper D

TRUST BOARD – 5th FEBRUARY 2015

MONTHLY UPDATE REPORT – FEBRUARY 2015

DIRECTOR:	CHIEF EXECUTIVE
AUTHOR:	DIRECTOR OF CORPORATE AND LEGAL AFFAIRS
DATE:	29TH JANUARY 2015
PURPOSE:	**(concise description of the purpose, including any recommendations)** To brief the Trust Board on key issues and identify changes or issues in the external environment.
PREVIOUSLY CONSIDERED BY:	**(name of Committee)** N/A
Objective(s) to which issue relates *	[√] 1. Safe, high quality, patient-centred healthcare [√] 2. An effective, joined up emergency care system [ ] 3. Responsive services which people choose to use (secondary, specialised and tertiary care) [ ] 4. Integrated care in partnership with others (secondary, specialised and tertiary care) [ ] 5. Enhanced reputation in research, innovation and clinical education [√] 6. Delivering services through a caring, professional, passionate and valued workforce [√] 7. A clinically and financially sustainable NHS Foundation Trust [ ] 8. Enabled by excellent IM&T
Please explain any Patient and Public Involvement actions taken or to be taken in relation to this matter:	N/A
Please explain the results of any Equality Impact assessment undertaken in relation to this matter:	N/A
Organisational Risk Register/ Board Assurance Framework *	[ ] **Organisational Risk Register** [ ] **Board Assurance Framework** [√] **Not Featured**
ACTION REQUIRED *	For decision [ ] For assurance [ ] For information [√]

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

* tick applicable box

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **5 FEBRUARY 2015**

REPORT BY: **CHIEF EXECUTIVE**

SUBJECT: **MONTHLY UPDATE REPORT – FEBRUARY 2015**

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

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

(a) emergency care performance;

(b) the Trust's month 9 financial position;

(c) the Emergency Floor Full Business Case;

(d) a potential partnership between NHS Trusts and the Virginia Mason Hospital; and

(e) the national tariff payment system 2015/16 consultation.

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

John Adler
Chief Executive

29th January 2015

Agenda Item: Trust Board Paper E

TRUST BOARD – 5th February 2015

The UHL Carers Charter

DIRECTOR:	Rachel Overfield, Chief Nurse
AUTHOR:	Donna Pywell, Senior Nurse Patient Experience Heather Leatham, Assistant Chief Nurse
DATE:	5th February 2015
PURPOSE:	Each month the Trust Board is presented with a 'patient story'. We ensure the board is exposed to both positive and negative stories. The purpose of this is twofold: • To ensure that feedback from patients, family and carers frames decision making at this senior level • Trust Board gains assurance through many ways including Board stories that feedback from patients leads service developments and redesign. Prior to the presentation extensive engagement with clinical staff takes place to ensure the scenario is investigated in detail both from the staff's perspective and the patient's perspective. What are presented are the patient's feelings and perception of the situation and consequences of this. The clinical teams are then supported in the understanding that even if other patients perceptions are different or the staffs perception of the situation is different changes still need to occur to ensure staff are equipped to deal with ALL patient's needs. **Introduction** To describe for Trust Board the experience of a patient and his wife when attend the Royal site following an emergency admission through the Emergency Department. The Trust would like to share this poor experience of care and use it to illustrate the commitment and drive to improve care delivery leading to patient led services. **Summary / Key Points:** A patient attending the Emergency Department with pneumonia was then admitted to the Medical Assessment Unit and then to a muscular-skeletal ward due to the lack of medical beds. This feedback is provided by the patient's wife using video feedback. There are many points raised in this video all of which have been addressed however this presentation will focus upon three main overarching aspects: • Poor levels of communication with patients wife (carer) • Patient being moved three times during hospital stay causing extreme anxiety and distress • Lack of acknowledgment of family / carer involvement in care

Specific details relevant to this families experience.

Although it is not clear in this video it is important to note the context of this family's experience. This patient has recently been diagnosed with dementia; he has a degree of insight into his diagnosis, and can feel uncertain and upset by changes around him. Being admitted to hospital was additionally distressing for this gentleman.

This gentleman's wife did not initially consider herself a carer but following this interview acknowledged that she does undertake this role. At home this gentleman would have his wife or daughter with him at all times.

Trust Response to Families Feedback

Poor Communication

To improve the experience of care there needs to be early identification of patient's communication needs and due to a diagnosis of dementia, family and /or carers, need to be included in all discussions and care planning.

The Trust has therefore developed a 'Carers Charter' following extensive feedback and engagement with carers groups and carers themselves. The draft Carers Charter (appendix 1) has been designed by carers with carers and members of staff have been commenting on this draft document.

The draft UHL Carers Charter translates information from both the City and County Carers Charters, into a document which is appropriate for an acute hospital setting. Four promises are made:

1. Identifying carers on the wards - Carers have expressed a desire to be recognised on the wards. An identification method has been developed and trialled which will be placed in the patient bed space or in the patient notes, the carer and patient will decide. This method will ensure the clinical teams include the carer in the planning of care and discharge planning.

2. Assessing carers needs - Carers would be offered on admission the opportunity to provide information allowing staff to support the carer as much as the patient, signposting to support opportunities and ensuring the carer had the necessary support to care for their loved one on discharge.

3. Ensuring open channels of communication - Ensure that the carer receives regular updates on the progress of the patient and is involved in the care and discharge planning.

4. Providing essential information - A carer's information leaflet is being produced, including - what to expect when in hospital, parking, meals and support groups in the hospital setting and in the community.

Patient being moved three times during hospital stay causing extreme anxiety and distress

The Trust has responded to this and other patient feedback, and through the Dementia Implementation Plan and Frail Older Peoples Board the 'Bed Management' Policy has been changed and from January 2015 reads:

"Patients that are not suitable to be out-lied include:

a) Patients with known or suspected dementia

	Patients with known or suspected dementia *or who cognitively impaired* ***will only be moved*** *for* ***reasons pertaining to their care and treatment.*** *It is acknowledged in cases where escalation level 3 or above is declared, there may be a substantial risk for patients. Outlying of patients may present less of a risk overall, however every effort must be made to prevent moving patients with dementia or suspected dementia* *Where this is no longer possible,* ***consent should be gained*** *from a carer or relative to agree to move the patient with a diagnosis of dementia. This can be taken as verbal consent and should be documented in the medical notes. Carers and relatives should where possible be given the opportunity to support/escort their relative to the new ward".* This patient's story illustrates the distress and anxiety caused to patients with dementia who are moved between wards. Moving this gentleman caused his behaviour to change requiring the necessity for a security guard. He told his wife that at the time this had made him feel like a prisoner. This gentleman was also asked to move during his meal time. The Trust operates a protected meal time's policy, which was clearly breached. This story is being shared with all relevant committees/boards and the requirement for protected meal times reiterated to staff on all wards including Interserve staff. <u>Lack of acknowledgment of family / carer involvement in care</u> The Trust uses a 'Patient Profile' that allows families and carers to share information about their loved one that will enhance individualised care for patients who have communication problems. Each year the Trust audits the use of the Patient Profile and this occurred across all adult inpatient areas in October 2014. At the time of audit there were 102 patients reported to auditors with a diagnosis of dementia of where 48 (47%) patients had a Patient Profile, with 35 (73%) completed. The Trust has just revised the Patient Profile in line with patient, carer and staff feedback (appendix 2). This Patient Profile clearly identifies space for family to comment on areas such as taking medications. This revised Patient Profile will be launched in February and assist in the continued improved use of this tool.
PREVIOUSLY CONSIDERED BY:	Planned for the February 2015 Nursing Executive team Meeting.
Objective(s) to which issue relates *	☑ 1. Safe, high quality, patient-centred healthcare ☐ 2. An effective, joined up emergency care system ☐ 3. Responsive services which people choose to use (secondary, specialised and tertiary care) ☐ 4. Integrated care in partnership with others (secondary, specialised and tertiary care) ☑ 5. Enhanced reputation in research, innovation and clinical education ☐ 6. Delivering services through a caring, professional, passionate and valued workforce ☐ 7. A clinically and financially sustainable NHS Foundation Trust 8. Enabled by excellent IM&T

Please explain any Patient and Public Involvement actions taken or to be taken in relation to this matter:	There has been a Carers Engagement event and the Patient Experience Team meet with community Carers organisations. The draft Charter, Assessment form and the identification method have been showcased at a Carers Rights Day event held at the Curve Leicester. A survey was conducted regarding the UHL Charter, this included patients, Carers and Staff, the results of which have been taken into consideration and the Charter has been adapted accordingly.
Please explain the results of any Equality Impact assessment undertaken in relation to this matter:	This draft Charter is for Carers of all groups of patients that come into the UHL, if agreed translation would be considered.
Strategic Risk Register/ Board Assurance Framework *	☐ **Strategic Risk Register** ☐ **Board Assurance Framework** ☒ **Not Featured**
ACTION REQUIRED *	For decision ☒ For assurance ☒ For information ☐

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* tick applicable box

UHL CARERS CHARTER

A Carer is a friend or family member who gives their time to support a person in their home environment, to an extent that the person could not remain at home if this care was not being provided. A Carer can receive Carers allowance, but not a wage for the care they are undertaking and the care that they are giving will significantly affect their own life.

We promise to look at how we can help you in your Caring role, with consent from the patient, during your time in hospital by:

Identifying Carers on the Wards Carers will be offered identification in the ward areas; this will alert the clinical teams and encourage communication.	**Offering Carers an Assessment form** • This will identify areas of support needed for Carers • Identifying the levels of involvement that Carers require.
Ensuring there are open channels of communication • Involving Carers in care and discharge planning. • Giving Carers daily progress updates. • Ensuring both Patient and Carer are prepared for discharge home.	**Providing essential information** Information directing Carers to support in the hospital, organisations and support groups in the community.

- Carers will be given open visiting, especially during protected meal times
- Carers will be offered a drink on the ward drinks rounds
- Carers can use the hospital restaurant or the RVS area to rest in break times
- Evidence for car parking fees reductions will be given to Carers
- Carers will be offered an information leaflet
- Identification sign will be put in bed area or in the patient notes

University Hospitals of Leicester NHS
NHS Trust
Caring at its best

Know me better

Patient Profile

Patient details

Name: Unit No.: Ward:

Person completing this document: Date:

The basics

Please call me:

Communication

Do you use any communication aids?
For example: glasses, hearing aids

Do you have alternative ways to express you needs?

How would we recognise if you were in any pain?

Getting about

Tell us how you normally get about. For example do you use a walking aid?
Do you need somebody with you?

My usual routine and self care

Tell us about your usual day to day life.
What can you do for yourself and what do you need help with?

am:

pm:

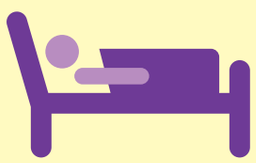
weekly:

Relaxation and sleep

How do you like to relax?
What music, if any, do you like to listen to?

What helps to make you comfortable?

What helps you to sleep?
For example: Taking any pain relief or any specific toilet routine?



Important things in my life

For example:
People, pets, places and items

Jobs, hobbies, interests and life events

What languages do you speak?

Emotional Support

Things that upset me:
How I might react:

Things that will help me:

Spiritual and cultural needs

Is there any way in which we can help you to follow your religion or belief?

Where or what do you turn to find strength in difficult times?

Personal needs

Will you need us to help you go to the toilet?

If so how?

Do you usually use any specific equipment?

Eating and drinking

Tell us about your appetite, likes and dislikes of food and drinks, where you like to eat, specific meal times and if you need any help

Do you have a special diet or allergies?

Do you wear dentures?

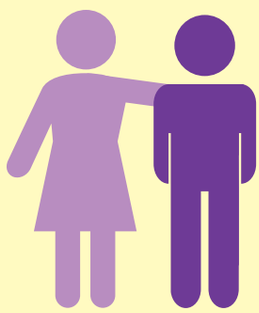
Taking medication

How do you prefer to take your medication?

Is there anything else important you would like us to know?

For Friends, Family and Carers

Please let us know if you would like to be involved in the care of your spouse, relative, partner or friend.



- Help at mealtimes ☐
- Some personal care ☐
- Activities to improve well-being ☐
- Other ☐

Please specify:

(Ward)12148591KR

If you would like this information in another language or format, please contact the Service Equality Manager on 0116 250 2959

University Hospitals of Leicester NHS
NHS Trust

Agenda Item: Trust Board Paper F

TRUST BOARD – 5 February 2015

The proposed move of level 3 care off the Leicester General Hospital site and its impact on other services

DIRECTOR:	Kate Shields, Director of Strategy
AUTHOR:	Helen Seth, Head of Partnerships (Local services and BCT Lead)
DATE:	5 February, 2015
PURPOSE:	To provide the Board with an outline: 1. Description of the issues requiring a move to rapidly consolidate Level 3 intensive care services. 2. A summary of the benefits expected by such a move. 3. An overview of the project structure, approach and governance.
PREVIOUSLY CONSIDERED BY:	Executive Strategy Board: 13th January 2015 Better Care Together - UHL Programme Board: 29th January 2015
Objective(s) to which issue relates *	[X] 1. Safe, high quality, patient-centred healthcare [ ] 2. An effective, joined up emergency care system [X] 3. Responsive services which people choose to use (secondary, specialised and tertiary care) [ ] 4. Integrated care in partnership with others (secondary, specialised and tertiary care) [ ] 5. Enhanced reputation in research, innovation and clinical education [ ] 6. Delivering services through a caring, professional, passionate and valued workforce [ ] 7. A clinically and financially sustainable NHS Foundation Trust [ ] 8. Enabled by excellent IM&T
Please explain any Patient and Public Involvement actions taken or to be taken in relation to this matter:	The staff and stakeholder implications are set out in this paper.
Please explain the results of any Equality Impact assessment undertaken in relation to this matter:	
Organisational Risk Register/ Board Assurance Framework *	[X] **Organisational Risk Register** **Board Assurance Framework** [X] **Not Featured** [ ]
ACTION REQUIRED *	For decision [X] For assurance [X] For information [ ]

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

The proposed move of level 3 care off the Leicester General Hospital site and its impact on other services

Purpose of Paper

1. The purpose of this paper is to provide the Board with an outline:

2. Description of the rationale for, and the moves required to, rapidly consolidate Level 3 intensive care services on two sites.

3. A summary of the benefits expected by such a move.

4. An overview of the project structure, approach and governance.

Context

5. The Intensive Care Unit (ICU) at the Leicester General Hospital (LGH) site will face significant operational difficulties within the next 12 months in maintaining a safe and high quality service for patients requiring level 3 (the most acute level) intensive care; reasons for this include:

6. The opportunities for critical care staff to gain adequate experience in providing care for the most ill patients is being affected by a reduction in the number of level 3 patients cared for at the LGH site.

7. Changes in the way medical training for intensive care staff is structured has led to the removal of training designation status at the LGH unit.

8. The retirement of experienced consultant grade staff.

9. Recruitment to substantive posts at the LGH has failed repeatedly owing largely to the loss of training designation and the reduction in patient acuity is making posts an unattractive proposition for applicants.

10. A national shortage of experienced critical care nursing and medical staff compounding recruitment problems.

11. This means that towards the end of 2015 the level 3 ICU service at the General Hospital will not be clinically sustainable.

Background

12. A report completed by external experts in November 2014 has shown that the LGH does not treat a sufficient number of critically unwell patients to safely maintain a level 3 critical care service on the site, in terms of both emergency and elective work. The report is based on national clinical standards and recommended the merging of units across the Trust into two larger units to improve quality, governance and efficiency. Previous reviews by the Critical Care Network showed environmental and quality issues across University Hospitals of Leicester (UHL) critical care services.

13. The Trust Executive has agreed that providing all level 3 and level 2 activity in two large critical care units on the Leicester Royal Infirmary (LRI) and Glenfield Hospital (GH) sites appears to provide the most flexible, efficient and viable option to meet national standards for critical care units. Addressing the immediate issue of unsustainable level 3 critical care cover at the LGH site is the first step in delivering this.

14. In summary, even if the current service was clinically sustainable, it would still need to undergo change to ensure modernisation of its ITU infrastructure and capacity.

Governance and Project Framework

15. An ICU reconfiguration steering group has been established by the project team which meets bi-weekly and reports into existing UHL governance structures through the UHL Bed Programme Board. The steering group oversees the work of three implementation groups established to address the following areas:

- Surgical services moving to and from the LRI
- Surgical services moving to and from the GH
- The creation of a retrievals pathway to transfer patients who require level 3 care post operation (where this could not reasonably have been anticipated) from the LGH to LRI and GH units

16. The implementation groups are chaired by clinicians and include representation from all affected Clinical Management Groups (CMG). Expertise from the East Midlands Ambulance Service (EMAS) informs the work of the retrieval pathway.

17. The working groups meet weekly and each have been charged with producing:

- A business case which sets out the potential options for changes to services on each site and a reasoned and justified rationale for selection of a preferred option
- A detailed implementation plan which will deliver the required consolidation of level 3 ICU capacity on two sites

18. Options being considered range from the do-minimum through to moving some or all of the high volumes specialties from the LGH site. Any option selected will have an impact on a number of different clinical services.

19. A request for an estate feasibility study was presented and approved by the Capital Investment Committee on the 16th January. This will help scope the likely capital consequences of the options being considered.

20. This will involve significant changes for specialties that currently rely on Level 3 critical care provision at the LGH (these are listed in Appendix 1).

21. Of these specialties General Surgery, Hepatobiliary, Nephrology, Urology, Neurology, Obstetrics and Gynaecology draw most heavily upon Level 3 critical care services. The project will assess the most suitable method to enable the delivery of these services in the immediate future, through either re-location to GH or the LRI sites or continued provision on the LGH site, supported by the establishment of a robust retrievals service.

Timeline

22. A full project plan has been compiled that sets out the key milestones and deliverables for the project;

- Options appraisals, assessing each potential site solution, to be carried out in February 2015 with the preferred way forward to be sanctioned by the ICU reconfiguration steering group

- Feasibility study currently being undertaken by the estates team to ensure full visibility of site utilisation options

- Outline Business cases and granular implementation plans to be produced by each work stream for submission to the UHL Bed Programme Board in March 2015

- Outline business cases, once authorised to progress through Better Care Together (BCT) UHL Programme Board and LLR Bed reconfiguration Board for executive approval

- Implementation of agreed action plans enabling a period of shadow running from 1st October 2015

- New model of level 3 ICU provision to be fully operational by 18th December 2015

23. Clearly this will require sensitive and detailed communication. A draft Communications strategy is included in Appendix 2.

Benefits

24. The remodelling of level 3 service provision across UHL will bring a number of important benefits:

- The ability for UHL to continue to provide specialist surgical activity for patients in Leicester, Leicestershire & Rutland

- Contribution to the rationalisation of ICU beds in UHL to two sites improving quality, safety and sustainability of care

- Improved patient experience and quality of care through maintenance of critical skills for the most acute patients

- Sustainable 24/7 consultant cover

- Better recruitment and retention, providing a more attractive proposition for the next generation of intensivists in training

- Better access to diagnostics, physiotherapy, imaging and pharmacy, by having more ICU beds on the two sites

- The potential to create a regional intensive care transport service for the East Midlands. This clearly is a longer term benefit and would require a separate business case and planned benefits realisation

25. The plan will deliver more appropriate ICU capacity where it is most needed, better clinical outcomes, shorter waits and units which are attractive to new doctors and nurses.

Risks and Issues

26. A full register of risks has been identified as part of the process described (included within Appendix 3); current red rated risks are capacity restraints to enable moves and the timescales required for delivery.

27. A risk and mitigation plan is being developed and will reflect options including alternative skill mix rota's to cover the LGH service overnight for a very short time period.

28. Failure to secure sustainable level 3 facilities will mean that consideration will need to be given to either transferring patients requiring ICU support across sites, transferring their care to another Trust or alternatively stopping the dependent service. All clearly have very significant clinical, financial and reputational risks associated with them which is why delivery of this business case is so important.

Consultation, engagement and communications

29. A communication and engagement plan is in development and will form part of the overarching messaging within the BCT communication plan. The Director of Communications and Marketing is leading on this and discussions are at an advanced stage around recruiting a communications specialist to work with the reconfiguration team. Once this post is appointed to the CMGs will have expert support in formulating and delivering their Communication and Engagement plans.

30. It will be particularly important to liaise with the local Health Overview and Scrutiny Committees who will have key role in determining formal consultation requirements around the proposed changes in service configuration. Meetings are currently being arranged to facilitate that dialogue. It is important to stress that the indicative timetable in this report

may well be impacted by the outcome of these discussions. A briefing has also been sent to local MPs (included in a wider Better Care Together briefing).

31. Each CMG will be required to run engagement events with their affected specialties and patient representative will be sought through the Intensive care, Theatres, Anaesthetics, Pain and Sleep (ITAPS) CMG Board.

Staff Engagement

32. Members of staff have been involved as part of two evening events to agree the current issues and what the future state should look like. Weekly meetings with staff are planned for the next two months and the project engagement is supported by human resources representation co-opted onto the steering group.

33. Staff meetings with ICU and theatre staff at the LGH have been taking place since November 2014 and will continue throughout January and February 2015.

Recommendations

34. The Trust Board are asked to:

- **Note** the operational and safety issues facing ICU services across UHL and **support** the need to reconfigure services rapidly

- **Agree** that the above project structure is both fit for purpose and addresses all necessary areas from the Trust's perspective

- **Agree** that the project's approach to communications and engagement is sufficient

- **Note** that the project will provide monthly updates to Executive Strategy Board (ESB). Regular updates can also be provided to the Board and/or one of the Board committees.

Appendix 1 - Current bed Numbers and activity at LGH

Summary

The below tables set out the geographical locations of the 47 currently funded level 3 ICU beds, shows that in 13/14 1,172 level 3 bed days were provided at LGH and finally shows the overall activity being recorded on the site

The current numbers of ICU/HDU beds in UHL are as follows:

Site	Physical ICU Beds	Funded ICU Beds	Satellite HDU Beds
LRI	22	19	13
LGH	12	9	4
GH	22	19	17

LGH – Patients requiring level 3 Critical Care by specialty:

Specialty	Patient Contacts	Level 3 Bed Days	Level 2 Bed Days	Non Critical-Care Bed Days
General Surgery	147	779	503	2,328
Hepatobiliary & Pancreatic Surgery	61	147	216	672
Nephrology	51	251	248	778
Urology	43	159	195	500
Renal Failure	17	86	96	287
Neurology	15	131	43	1,052
Gynaecology Oncology	7	12	8	111
Rehab Care of Elderly	7	55	27	256
Obstetrics	7	9	16	26
Transplant	7	21	24	107
Gynaecology	6	12	8	36
Critical Care Medicine	4	12	7	0
Orthopaedic Surgery	4	8	5	53
Stroke Medicine	4	19	10	336
Gastroenterology	1	11	6	115
	381	**1,712**	**1,412**	**6,657**

Overall LGH bed days by specialty

Local Specialty Name	Patient Contacts	Non Critical-Care Bed Days
Obstetrics	10,312	11,209
Urology	9,713	13,371
Orthopaedic Surgery	7,062	13,633
General Surgery	6,648	26,456
Gastroenterology	5,922	326
Gynaecology	4,219	4,607
Rheumatology	2,729	23
Sleep	2,090	215
Neurology	1,933	5,449
Nephrology	1,461	8,654
Clinical Immunology & Allergy	1,200	6
End Stage Renal Failure	799	5,506
Hepatobiliary & Pancreatic Surgery	794	4,895
Clinical Haematology	753	46
Renal Transplant	548	1,793
Integrated Medicine	499	269
Pain Management	425	3
Integrated Medicine (Elderly)	356	8,134
Chemical Pathology	296	0
Stroke Medicine	239	6,655
Renal Access Surgery	234	245
Sports Medicine	170	82
Neonatology	107	167
Dermatology	82	0
Infectious Diseases	72	9
Neonatal Intensive Care	28	415
Paediatric Other	16	0
Other	16	0
Paediatric Medical Specialties	6	14
Critical Care Medicine	5	0
Cardiology	2	112
Accident & Emergency	1	20
Trauma	1	0
	58,738	**112,314**

Data based on 13/14 activity

Appendix 2

Communication Plan:

Date	Task	Action/Info	Lead	Status
29 January	Agree 'core script' for internal / external stakeholders	Chris Allsager and Strategy Team lead agree / amend the current script	Mark Wightman	Immediate
29 January	Clarity on where we are in the process and decision making	Weekly updates to stakeholders	Mark Wightman (in the interim)	Immediate
29th January and ongoing	We need to take a view on the potential numbers of patients who may be affected by the service moves and decide how we involve stakeholders in the planning of this	Project Director / Project Manager to establish the likely impact and numbers of patients affected… then in conjunction with Mark Wightman, to determine the engagement approach.	Exec SRO (Kate Shields in interim)	In Progress
W/C 2nd February	Create presentation for staff briefings	Short Powerpoint presentation on hand for staff / external briefings	Project Manager	In Progress
Ongoing	Engagement by CMG leads with medical staff to build a consensus view	ITAPS Clinical Leaders present outline plans to their colleagues in ITAPS and other affected CMGs	Project Director / Project Manager	In progress
Ongoing	Engagement by CMG leads with nursing and other staff groups to build a consensus view	ITAPS Clinical / nursing leaders in collaboration with their peers in other CMGs present outline plans to their colleagues other affected CMGs	Project Director / Project Manager	In progress
29th January	Prepare and QA the 5th February Board Paper (In public)	Strategy Lead (borrowing from core script)	Strategy Lead	In progress
29th January	Brief / buy in from NHSE / NTDA	Need to be clear that they know about the plan and that is going into the public domain.	Kate Shields	TBC
30th January	Board papers sent out 30th January		Mark Wightman	TBC

Date	Task	Action/Info	Lead	Status
30th January	All staff message based on the core script / Board paper on January 30th	This to be sent out before the Board papers are posted online	Tiff Jones	TBC
21st January	Written stakeholder briefings (with the offer of face to face meetings) with key external stakeholders	As part of the BCT Strategic Outline Case communications	Mark Wightman / Stuart Baird	Done
6th February (TBC)	F2F MP briefings where appropriate / requested		Mark Wightman / City CCG	TBC
25th February / 10th March	Arrange briefings for City and County Health Overview and Scrutiny Committees	Meetings arranged for: County 25th February. City 10th March	Kate Shields / Chris Allsager / Mark Wightman	Done
March onwards	Maintain a rolling programme of communication and engagement within and external to the Trust	Confirm the Better Care Together programme activities ITAPS Clinical Leaders maintain regular communication with Trust colleagues	Mark Wightman Project Director / Project Manager	Planned

Key messages:

Leicester currently has 3 intensive care units, (ITUs), one at each hospital. However the service and clinical teams are spread too thinly across the three. So whilst demand for ITU grows at the Royal and the Glenfield, it has diminished at the General. Over the last few years this has meant that recruiting clinical staff to the ITU at the General has been problematic because new young intensivists want to practice in big, busy units.

The clinical teams have told us that it is time to bite the bullet and that the only way to make sure that ITU at the Royal and the Glenfield is capable of dealing with demand is to shift beds and expertise from the General, (in line with the strategy to have two, rather than three acute hospitals), and invest in two 'super ITUs' at the other hospitals. This therefore is the plan and though it is part of the overall strategy for Better Care Together, it is likely to be something that needs to be executed sooner rather than later, (within 12 months).

Spokespeople

Chris Allsager, Clinical Director, ITAPS
Andrew Furlong, Dept Medical Director
Kate Shields, Director of Strategy

Appendix 3 - Current Risk Register

Risk ID	Risk description	Likelihood (1-5)	Impact (1-5)	Risk severity (RAG)	Raised by	Risk mitigation	RAG post mitigation	Risk Owner
1	Capacity constraints within system to enable moves	4	5	Red	All groups	Rapid planning of capacity required and continuous communication throughout bed programme to determine space available through other workstreams	Amber	CA/JJ
2	Tight nature of timescale	4	5	Red	All groups	Early engagement and decision making with quick escalation of non-compliance and delays	Amber	CA/JJ
3	Failure to transfer critically ill patient in a timely manner	2	5	Amber	All groups	Clear modelling to identify capacity needed. Work with EMAS to ensure comprehensive support. Initial support at level 3 for patients needing ICU support until transport is arranged.	Amber	CA/JJ
4	Loss of DaVinci Robot activity whilst this is moved from LGH new site	2	4	Amber	All groups	Planned downtime with increased utilisation before and after move	Amber	LRI Group/ Gynae-Onc
5	Competing demands from other service changes not being accommodated in to the overall project	3	4	Amber	All groups	Project manager to provide cross fertilisation with other groups. Link into configuration cross cutting group. Cross CMG representation on all workstreams	Amber	CG
6	Deskilling of ICU nursing staff at LGH	3	4	Amber	All groups	Ensure that all staff can indicate where they would like to work in the future. Rotational posts across all three sites	Amber	CA/JJ
7	Increased bed pressures on the 2 busiest sites.	2	5	Amber	All groups	Detailed modelling to identify likely capacity needed at both sites. LRI and GGH workstream to agree co-location possibilities. Movement off LRI and GGH site of all specialities not needing to be on these sites. Consider ring-fencing of surgical beds	Amber	CA/JJ
8	Inability to replace activity moved out by LGH services moving off site	1	4	Green	All groups	Clear understanding of future use of LGH.	Green	CA/JJ

University Hospitals of Leicester NHS
NHS Trust

Agenda Item: Trust Board Paper G

TRUST BOARD – 5th FEBRUARY 2015

QUALITY AND PERFORMANCE REPORT – DECEMBER 2014

DIRECTOR:	Rachel Overfield, Chief Nurse Kevin Harris, Medical Director Richard Mitchell, Chief Operating Officer Emma Stevens, Acting Director of Human Resources
AUTHOR:	
DATE:	5th February 2015
PURPOSE:	The following report provides an overview of the December 2014 Quality & Performance report highlighting NTDA/UHL key metrics and escalation reports where required. **For the first time it includes a CEO summary of key issues.**
PREVIOUSLY CONSIDERED BY:	**Integrated Finance, Performance and Investment Committee** **Quality Assurance Committee**
Objective(s) to which issue relates *	[X] 1. Safe, high quality, patient-centred healthcare [X] 2. An effective, joined up emergency care system [X] 3. Responsive services which people choose to use (secondary, specialised and tertiary care) [X] 4. Integrated care in partnership with others (secondary, specialised and tertiary care) [X] 5. Enhanced reputation in research, innovation and clinical education [X] 6. Delivering services through a caring, professional, passionate and valued workforce [X] 7. A clinically and financially sustainable NHS Foundation Trust [ ] 8. Enabled by excellent IM&T
Please explain any Patient and Public Involvement actions taken or to be taken in relation to this matter:	
Please explain the results of any Equality Impact assessment undertaken in relation to this matter:	
Organisational Risk Register/ Board Assurance Framework *	[X] **Organisational Risk Register** [X] **Board Assurance Framework** [ ] **Not Featured**
ACTION REQUIRED *	For decision [ ] For assurance [X] For information [ ]

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

* tick applicable box

CHIEF EXECUTIVE'S ISSUES TO HIGHLIGHT REPORT

There are a large number of exception reports this month. These are automatically triggered when pre-set thresholds are met. The issues that I wish to particularly highlight/comment on for December are as follows:

Clostridium Difficile (p 10)
For the first time this year, in December we were above our monthly trajectory for both our national and local stretch targets, although we remain within the yearly trajectory for the former. Although this slight deterioration may be related to bed pressures, concern has also been raised about cleaning standards, and in particular the arrangements in place to audit these. As a result these arrangements are to be revised.

Never Events (p 12)
There have been two never events, both related to surgical errors and apparently as a result of failure to adhere to established procedures. I would expect there to be forensic follow up of these events at both EQB and QAC, so as to minimise the chances of a recurrence.

Pressure Ulcers (p15)
It is very regrettable that there was an avoidable grade 4 ulcer in December as well as an increase in avoidable grade 2 ulcers. The former is subject to a full investigation by the Chief Nurse. The latter is most likely due to severe bed pressures in month and the resulting difficulties with maintaining appropriate staffing levels on our wards.

Fractured Neck of Femur (p21)
It is disappointing that we are not seeing any improvement in this key quality metric. This pathway is now the subject of a Listening into Action team approach and I will be watching closely to see if this manages to make progress where other approaches have not.

RTT Admitted (p23)
It will be seen that there was a further improvement in month to 86.8% (standard 90%). However, detailed analysis by our new Director of Performance and Information indicates that we are unlikely to reach the standard until April. The exception report gives more detail on this. Note that this trajectory is subject to further discussions with commissioners. Note also that we remain well above the incomplete (backlog) standard, indicating that we are appropriately managing our waiting lists in accordance with the rules.

Diagnostic waits (p25)
Performance was very disappointing at 2.2%. This figure was inflated by the failure of our single DEXA scanner. We are seeking to identify contingency arrangements to stop this happening again.

Cancer (p 26)
We are showing little sign of improvement in the key headline indicators. I have reinforced to CMGs the crucial importance of prioritising cancer patients, although to be fair there were significant numbers of cancelled cancer operations in December due to operational pressures. Improving this area is a key priority for our new Director of Performance.

Ambulance turnaround (p 30)
I am pleased to report that we have reached agreement with EMAS and our CCGs to introduce a new method for recording handover times from 1st April. This will eliminate the acknowledged deficiencies of the current recording system (which inflates the figures) and allow us to focus on reducing the delays themselves.

ED 4 Hour performance
There is no exception report for this standard as it the subject of a fuller report direct to the Board. However, for completeness, December was an exceptionally poor month, with performance at 83.1%, reflecting a major deterioration across the country. January to date (to 22/1) has been somewhat better at 88.6%, with the last 7 days very much better at 97.2%.

John Adler
Chief Executive

Caring at its best

University Hospitals of Leicester NHS
NHS Trust

Quality and Performance Report

December 2014

One team shared values

CONTENTS

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **5th FEBRUARY 2015**

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

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

1.0 Introduction

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

2.0 Performance Summary

Domain	Page Number	Number of Indicators	Indicators with target to be confirmed	Number of Red Indicators this month
Safe	3	19	2	8
Caring	4	15	1	1
Well Led	5	14	7	1
Effective	6	17	0	2
Responsive	7	26	0	13
Research	8	13	0	3
Estates & Facilities	9	10	0	0
Total		114	10	28

	KPI Ref	Indicators	Board Director	Lead Director/Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	13/14 Outturn	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	YTD
Safe	S1a	Clostridium Difficile	RO	DJ	FYE = 81	NTDA	Red / ER for Non compliance with cumulative target	66	5	10	0	4	4	6	5	7	2	5	7	7	9	52
	S1b	Clostridium Difficile (Local Target)	RO	DJ	FYE = 50	UHL	Red >5 per month, ER when YTD red	66	5	10	0	4	4	6	5	7	2	5	7	7	9	52
	S2a	MRSA Bacteraemias (All)	RO	DJ	0	NTDA	Red = >0 ER = 2 consecutive mths >0	3	0	0	0	0	0	0	0	0	0	1	1	0	2	4
	S2b	MRSA Bacteraemias (Avoidable)	RO	DJ	0	UHL	Red = >0 ER = 2 consecutive mths >0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	S3	Never Events	RO	MD	0	NTDA	Red = >0 in mth ER = in mth >0	3	0	0	1	0	0	0	0	0	0	0	1	0	1	2
	S4	Serious Incidents	RO	MD	tbc	NTDA	tbc	60	4	3	4	5	4	6	3	7	2	3	4	2	4	35
	S5	Proportion of reported safety incidents that are harmful	RO	MD	tbc	NTDA	tbc	2.8%		2.3%			1.7%			2.2%						1.9%
	S6	Overdue CAS alerts	RO	MD	0	NTDA	Red = >0 in mth ER = in mth >0	2	0	0	0	0	2	2	2	3	0	0	0	0	0	9
	S7	RIDDOR - Serious Staff Injuries	RO	MD	FYE = <47	UHL	Red / ER = non compliance with cumulative target	47	4	7	2	5	3	5	1	2	2	1	2	2	1	19
	S8	Safety Thermometer % of harm free care (all)	RO	EM	tbc	NTDA	Red = <92% ER = in mth <92%	93.6%	94.0%	93.8%	94.8%	93.6%	94.6%	94.7%	94.2%	94.9%	94.4%	93.9%	94.9%	93.3%	94.1%	94.3%
	S9	% of all adults who have had VTE risk assessment on adm to hosp	KH	SH	95% or above	NTDA	Red = <95% ER = in mth <95%	95.3%	96.1%	95.6%	95.0%	95.6%	95.7%	95.9%	95.9%	96.3%	95.5%	96.2%	95.4%	95.5%	94.7% (TBC)	95.7%
	S10	Medication errors causing serious harm	RO	MD	0	NTDA	Red = >0 in mth ER = in mth >0	New NTDA Indicator - Definition to be confirmed														
	S11	All falls reported per 1000 bed stays for patients >65years	RO	EM	<7.1	QC	Red >= YTD >8.4 ER = 2 consecutive reds	7.1	7.0	6.6	7.0	6.9	6.6	7.4	7.0	8.2	7.4	5.6	5.6	6.6	9.1	7.1
	S12	Avoidable Pressure Ulcers - Grade 4	RO	EM	0	QS	Red / ER = Non compliance with monthly target	1	0	0	0	0	0	0	0	0	0	0	0	0	1	1
	S13	Avoidable Pressure Ulcers - Grade 3	RO	EM	<8 a month	QS	Red / ER = Non compliance with monthly target	71	5	7	3	6	5	5	5	5	6	6	4	6	7	49
	S14	Avoidable Pressure Ulcers - Grade 2	RO	EM	<10 a month	QS	Red / ER = Non compliance with monthly target	120	5	10	8	9	6	6	6	7	9	4	8	13	11	70
	S15	Compliance with the SEPSIS6 Care Bundle	RO	MD	All 6 >75% by Q4	QC	Red/ER = Non compliance with Quarterly target	27.0%		27.0%			47.0%			>=60%			Audit underway			47.0%
	S16	Nutrition and Hydration Metrics - Fluid Balance and Nutritional Assessment	RO	MD	Q2 80%, Q3 85%, Q4 90%	QC	Red >2% below threshold ER = 2 mths red						≥71%	≥77%	≥75%	Action Planning	≥74%	≥85%	≥84%	≥88%		≥88%
	S17	Maternal Deaths	KH	IS	0	UHL	Red / ER = Non compliance with monthly target	3	0	1	2	0	0	0	0	0	0	0	0	0	0	0

	KPI Ref	Indicators	Board Director	Lead Director/Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	13/14 Outturn	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	YTD
Caring	C1a	Inpatient Friends and Family Test - Score	RO	CR	72 (Eng Avge - Mar 14)	NTDA	Red if <3SD. ER if <3SD or 3 mths deteriorating performance	68.8	68.7	71.8	69.0	69.9	69.6	71.0	74.5	73.8	73.8	76.1	71.1	70.3	72.1	72.4
	C1b	Inpatient Friends and Family Test - Score (Local Target)	RO	CR	75	UHL	Red/ ER =<=69.9 Green >74.9	68.8	68.7	71.8	69.0	69.9	69.6	71.0	74.5	73.8	73.8	76.1	71.1	70.3	72.1	72.4
	C2a	A&E Friends and Family Test - Score	RO	CR	54 (Eng Avge - Mar 14)	NTDA	Red if <3SD. ER if <3SD or 3 mths deteriorating performance	58.5	67.4	67.6	58.7	65.5	69.4	66.0	71.4	71.7	56.3	66.1	71.1	72.3	72.8	68.3
	C2b	A&E Friends and Family Test - Score (Local Target)	RO	CR	75	UHL	Red/ ER =<=64.9 Green >74.9	58.5	67.4	67.6	58.7	65.5	69.4	66.0	71.4	71.7	56.3	66.1	71.1	72.3	72.8	68.3
	C3	Outpatients Friends and Family Test - Score	RO	CR	75	UHL	Red / ER =<=64.9	New Indicator												58.7	63.8	61.3
	C4	Daycase Friends and Family Test - Score	RO	CR	75	UHL	Red / ER =<=69.9	New Indicator					79.0	80.2	79.7	77.5	74.3	81.7	80.1	80.9	74.9	78.7
	C5	Maternity Friends and Family Test - Score	RO	CR	75	UHL	Red/ ER =<=61.9	64.3	63.7	67.3	62.1	66.7	61.2	63.5	69.5	69.7	67.3	63.0	64.1	67.7	63.8	65.6
	C6	Complaints Rate per 100 bed days	RO	MD	tbc	NTDA	tbc		0.3	0.3	0.5	0.4	0.4	0.3	0.3	0.4	0.4	0.4	0.4	0.4	0.3	0.4
	C7	Complaints Re-Opened Rate	RO	MD	<9%	UHL	Red = >10% ER = 3 mths Red or any month >15%	New Indicator for 14/15					8%	5%	8%	11%	10%	9%	11%	11%	10%	9%
	C8	Single Sex Accommodation Breaches (patients affected)	RO	CR	0	NTDA	Red = >0 ER = in mth >0	2	0	0	0	0	4	2	0	0	0	0	0	5	0	11
	C9	Improvements in the FFT scores for Older People (65+ year)	RO	CR	75	QC	Red / ER = End of Yr Targets non recoverable.	New Indicators for 14/15					73.7	73.2	75.7	76.1	78.5	83.0	76.4	72.9	76.7	76.1
	C10	Responsiveness and Involvement Care (Average score)	RO	CR	0.8 improve-ment	QC	tbc						87.6	87.5	87.5	87.8	88.1	88.4	87.4	87.9	87.8	87.9
	C10a	Q15. When you used the call button, was the amount of time it took for staff to respond generally:	RO	CR	FYE 89.7	QC	Red = <87.9 ER = Red or 3 mths deterioration						88.9	89.3	88.8	89.0	88.9	90.0	88.4	88.6	89.2	89.2
	C10b	Q16. If you needed help from staff getting to the bathroom or toilet or using a bedpan, did you get help in an acceptable amount of time?	RO	CR	FYE 92.9	QC	Red = <91.1 ER = Red or 3 mths deterioration						92.1	91.9	91.2	91.7	91.9	92.4	92.2	92.4	92.1	92.0
	C10c	Q11. Were you involved as much as you wanted in decisions about your care and treatment?	RO	CR	FYE 85.5	QC	Red = <83.6 ER = Red or 3 mths deterioration						84.6	84.3	84.9	84.9	85.6	85.2	84.6	85.1	84.8	85.0

	KPI Ref	Indicators	Board Director	Lead Director/Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	13/14 Outturn	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	YTD
Well Led	W1	Inpatient Friends and Family Test - Coverage	RO	CR	30% - Q4. 40% Mar 15	NTDA / CQUIN	Red = Non compliance with monthly target ER = 2 consecutive mths non compliance	24.3%	23.3%	24.5%	28.2%	28.8%	36.8%	38.1%	32.6%	30.8%	28.9%	33.4%	36.3%	36.0%	31.9%	33.8%
	W2	A&E Friends and Family Test - Coverage	RO	CR	15% Q1-Q3 20% for Q4	NTDA	Red = Non compliance with monthly target ER = 2 consecutive mths non compliance	14.9%	16.4%	15.6%	18.4%	16.1%	15.2%	17.8%	14.9%	10.2%	16.1%	19.1%	15.9%	14.0%	18.7%	15.8%
	W3	Outpatients Friends and Family Test - Valid responses	RO	CR	tbc	UHL	tbc	New Indicator available from October 2014				271	175	286	1879	1535	785	927	1255	1506	1053	9401
	W4	Maternity Friends and Family Test - Coverage	RO	CR	tbc	UHL	tbc	25.2%	24.8%	20.9%	23.7%	23.9%	27.2%	36.4%	25.2%	29.2%	29.9%	18.7%	15.8%	21.7%	22.1%	25.1%
	W5	Friends & Family staff survey: % of staff who would recommend the trust as place to work	KB	ES	tbc	NTDA	tbc	New NTDA Indicator - Definition to be confirmed					53.6%			53.7%			Q3 staff FFT not completed as National Survey carried out			53.7%
	W6	Friends & Family staff survey: % of staff who would recommend the trust as place to receive treatment	KB	ES	tbc	NTDA	tbc	New NTDA Indicator - Definition to be confirmed					68.3%			67.2%			Q3 staff FFT not completed as National Survey carried out			67.2%
	W7	Data quality of trust returns to HSCIC	KS	JR	tbc	NTDA	tbc	New NTDA Indicator - Definition to be confirmed														
	W8	Turnover Rate	KB	ES	<10.5%	UHL	Red = 11% or above ER = Red for 3 Consecutive Mths	10.0%	10.2%	10.6%	10.4%	10.0%	9.9%	10.0%	10.2%	10.0%	10.5%	10.3%	10.8%	10.7%	10.3%	10.3%
	W9	Sickness absence	KB	ES	> 3.0%	UHL	Red = >3.5% ER = 3 consecutive mths >3.5%	3.4%	3.8%	3.8%	3.7%	3.5%	3.4%	3.3%	3.3%	3.4%	3.5%	3.8%	4.3%	4.2%			3.7%
	W10	Total trust vacancy rate	KB	ES	tbc	NTDA	tbc	New NTDA Indicator - Definition to be confirmed														
	W11	Temporary costs and overtime as a % of total paybill	KB	ES	tbc	NTDA	tbc	New Indicator for 14/15					9.4%	9.4%	8.1%	8.5%	8.9%	8.5%	9.5%	9.0%	9.8%	9.0%
	W12	% of Staff with Annual Appraisal	KB	ES	95%	UHL	Red = <90% ER = 3 consecutive mths <90%	91.3%	92.4%	91.9%	92.3%	91.3%	91.8%	91.0%	90.6%	89.6%	88.6%	89.7%	91.8%	92.3%	92.5%	92.5%
	W13	Statutory and Mandatory Training	KB	ES	Jun 80%, Sep 85%, Dec 90%, Mar 95%	UHL	Red / ER for Non compliance with Quarterly incremental target	76%	65%	69%	72%	76%	78%	79%	79%	80%	83%	85%	86%	87%	89%	89%
	W14	% Corporate Induction attendance	KB	ES	95.0%	UHL	Red = <90% ER = 3 consecutive mths <90%	94.5%	89%	93%	89%	95%	96%	94%	92%	96%	98%	98%	98%	98%	100%	100%

	KPI Ref	Indicators	Board Director	Lead Director/Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	13/14 Outturn	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	YTD
Effective	E1	Mortality - Published SHMI	KH	PR	Within Expected	NTDA	Higher than Expected			107 (Jul12-Jun13)			106 (Oct12-Sept13)			106 (Jan13-Dec13)			105 (Apr13-Mar14)			105 (Jan13-Dec13)
	E2	Mortality - Rolling 12 mths SHMI (as reported in HED)	KH	PR	100 or below	QC	Red = >expected ER = >Expected or 3 consecutive mths increasing SHMI >100	105	108	107	106	105	103	103	103	Awaiting HED Update						103
	E3	Mortality HSMR (DFI Quarterly)	KH	PR	Within Expected	NTDA	Red = >expected ER = >Expected or 3 consecutive increasing mths >100	88		83			87			80			Awaiting DFI Update			85
	E4	Mortality - Rolling 12 mths HSMR (Rebased Monthly as reported in HED)	KH	PR	100 or below	QC	Red = >expected ER = >Expected or 3 consecutive increasing mths >100	99	101	100	100	99	97	98	99	97	96	96	96	Awaiting HED Update		96
	E5	Mortality - Monthly HSMR (Rebased Monthly as reported in HED)	KH	PR	100 or below	QC	Red = >expected ER = >Expected or 3 consecutive increasing mths >100	91	94	89	103	91	83	110	107	87	99	98	92	Awaiting HED Update		97
	E6	Mortality - Rolling 12 mths HSMR Emergency Weekday Admissions - (HED) OVERALL Rebased Monthly	KH	PR	Within Expected	NTDA	Red = >expected ER = >Expected or 3 consecutive increasing mths >100	100	102	101	101	100	99	99	100	98	97	97	96	Awaiting HED Update		96
	E7	Mortality - Monthly HSMR Emergency Weekday Admissions - (HED) OVERALL Rebased Monthly	KH	PR	Within Expected	NTDA	Red = >expected ER = >Expected or 3 consecutive increasing mths >100	100	95	93	102	94	88	100	111	86	91	99	90	Awaiting HED Update		95
	E8	Mortality - rolling 12 mths HSMR Emergency Weekend Admissions - (HED) OVERALL Rebased Monthly	KH	PR	Within Expected	NTDA	Red = >expected ER = >Expected or 3 consecutive increasing mths >100	99	103	101	102	99	95	98	97	97	97	97	98	Awaiting HED Update		98
	E9	Mortality - Monthly HSMR Emergency Weekend Admissions - (HED) OVERALL Rebased Monthly	KH	PR	Within Expected	NTDA	Red = >expected ER = >Expected or 3 consecutive increasing mths >100	99	93	84	106	82	69	137	94	94	122	99	106	Awaiting HED Update		103
	E10	Deaths in low risk conditions (Risk Score)	KH	PR	Within Expected	NTDA	Red = >expected ER = >Expected or 3 consecutive increasing mths >100	94	129	164	35	63	48	60	78	59	47	Awaiting DFI Update				59
	E11	Emergency 30 Day Readmissions (No Exclusions)	KH	PR	Within Expected	NTDA	Higher than Expected	7.9%	8.0%	8.7%	9.0%	8.8%	8.8%	8.7%	8.6%	8.3%	8.9%	8.4%	8.6%	8.9%		8.7%
	E12	No. of # Neck of femurs operated on 0-35 hrs - Based on Admissions	KH	RP	72% or above	QS	Red = <72% ER = 2 consecutive mths <72%	65.2%	72.2%	68.2%	73.7%	54.7%	56.9%	40.6%	60.3%	76.9%	59.0%	68.6%	69.6%	59.4%	57.3%	61.2%
	E13	Stroke - 90% of Stay on a Stroke Unit	RM	CF	80% or above	QS	Red = <80% ER = 2 consecutive mths <80%	83.2%	81.8%	89.3%	83.7%	83.5%	92.9%	80.3%	87.1%	78.1%	84.5%	83.2%	70.4%	73.1% TBC		80.7%
	E14	Stroke - TIA Clinic within 24 Hours (Suspected High Risk TIA)	RM	CF	60% or above	QS	Red = <60% ER = 2 consecutive mths <60%	64.2%	65.7%	60.5%	40.7%	77.9%	79.7%	58.8%	71.3%	62.8%	65.5%	72.7%	67.8%	69.0%	83.5%	70.2%
	E15	Communication - ED, Discharge and Outpatient Letters - Compliance with standards	KH	SJ	90% or above	QS	Red = <80% ER = Qrtly ER if <90% and deterioration	New Indicator for 14/15									60% (InPt)	83% (ED)	Poilcy out for consultation			83% (ED)
	E16	Published Consultant Level Outcomes	KH	SH	>0 outside expected	QC	Red = >0 Quarterly ER = >0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	E17	Non compliance with 14/15 published NICE guidance	KH	SH	0	QC	Red = in mth >0 ER = 2 consecutive mths Red	New Indicator for 14/15					0	0	0	0	0	0	0	0	0	0

Responsive

KPI Ref	Indicators	Board Director	Lead Director/Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	13/14 Outturn	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	YTD
R1	ED 4 Hour Waits UHL + UCC	RM	CF	95% or above	NTDA	Red = <95% ER via ED TB report	88.4%	90.1%	93.6%	83.5%	89.3%	86.9%	83.4%	91.3%	92.5%	91.0%	91.6%	90.2%	88.6%	83.1%	88.7%
R2	12 hour trolley waits in A&E	RM	CF	0	NTDA	Red = >0 ER via ED TB report	5	0	0	0	0	0	1	1	0	0	0	1	0	0	3
R3	RTT Waiting Times - Admitted	RM	CC	90% or above	NTDA	Red /ER = <90%	76.7%	82.0%	81.8%	79.1%	76.7%	78.9%	79.4%	79.0%	80.9%	82.2%	81.6%	84.4%	85.5%	86.8%	86.8%
R4	RTT Waiting Times - Non Admitted	RM	CC	95% or above	NTDA	Red /ER = <95%	93.9%	92.8%	93.4%	93.5%	93.9%	94.3%	94.4%	95.0%	94.9%	95.6%	94.6%	94.9%	95.2%	96.0%	96.0%
R5	RTT - Incomplete 92% in 18 Weeks	RM	CC	92% or above	NTDA	Red /ER = <92%	92.1%	91.8%	92.0%	92.6%	92.1%	93.9%	93.6%	94.0%	93.2%	94.0%	94.3%	94.8%	95.0%	95.1%	95.1%
R6	RTT 52 Weeks+ Wait (Incompletes)	RM	CC	0	NTDA	Red /ER = >0	0	1	1	0	0	0	0	0	15	1	3	3	2	0	0
R7	6 Week - Diagnostic Test Waiting Times	RM	SK	1% or below	NTDA	Red /ER = >1%	1.9%	1.4%	5.3%	1.9%	1.9%	0.8%	0.9%	0.8%	0.7%	1.0%	1.0%	0.7%	1.8%	2.2%	2.2%
R8	Two week wait for an urgent GP referral for suspected cancer to date first seen for all suspected cancers	RM	MM	93% or above	NTDA	Red = <93% ER = Red for 2 consecutive mths	94.8%	94.9%	95.3%	95.9%	95.3%	88.5%	94.7%	93.5%	92.2%	92.0%	90.6%	92.0%	92.5%		92.0%
R9	Two Week Wait for Symptomatic Breast Patients (Cancer Not initially Suspected)	RM	MM	93% or above	NTDA	Red = <93% ER = Red for 2 consecutive mths	94.0%	95.5%	96.8%	93.4%	94.3%	80.0%	95.0%	98.9%	94.9%	94.4%	95.2%	98.6%	100.0%		95.2%
R10	31-Day (Diagnosis To Treatment) Wait For First Treatment: All Cancers	RM	MM	96% or above	NTDA	Red = <96% ER = Red for 2 consecutive mths	98.1%	97.4%	97.2%	98.5%	98.2%	97.2%	92.9%	93.6%	94.4%	97.9%	91.9%	95.9%	92.5%		94.5%
R11	31-Day Wait For Second Or Subsequent Treatment: Anti Cancer Drug Treatments	RM	MM	98% or above	NTDA	Red = <98% ER = Red for 2 consecutive mths	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.8%	100.0%	97.1%	100.0%		99.5%
R12	31-Day Wait For Second Or Subsequent Treatment: Surgery	RM	MM	94% or above	NTDA	Red = <94% ER = Red for 2 consecutive mths	96.0%	92.3%	94.8%	96.4%	98.6%	95.2%	97.0%	90.8%	90.1%	87.8%	94.0%	81.9%	82.4%		89.6%
R13	31-Day Wait For Second Or Subsequent Treatment: Radiotherapy Treatments	RM	MM	94% or above	NTDA	Red = <94% ER = Red for 2 consecutive mths	98.2%	98.1%	94.8%	96.3%	99.1%	97.3%	95.6%	93.9%	97.3%	99.0%	96.5%	96.0%	94.7%		96.3%
R14	62-Day (Urgent GP Referral To Treatment) Wait For First Treatment: All Cancers	RM	MM	85% or above	NTDA	Red = <85% ER = Red in mth or YTD	86.7%	89.4%	89.1%	89.1%	92.4%	92.7%	88.5%	73.1%	85.6%	78.8%	75.5%	80.4%	77.0%		81.2%
R15	62-Day Wait For First Treatment From Consultant Screening Service Referral: All Cancers	RM	MM	90% or above	NTDA	Red = <90% ER = Red for 2 consecutive mths	95.6%	96.6%	97.1%	95.1%	91.7%	91.1%	67.4%	73.9%	73.0%	100.0%	87.5%	75.0%	94.4%		82.8%
R16	Urgent Operations Cancelled Twice	RM	PW	0	NTDA	Red = >0 ER = >0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
R17	Cancelled patients not offered a date within 28 days of the cancellations UHL	RM	PW	0	NTDA	Red = >2 ER = >0	85	8	9	2	8	10	3	1	1	1	2	2	1	3	24
R18	Cancelled patients not offered a date within 28 days of the cancellations ALLIANCE	RM	PW	0	NTDA	Red = >2 ER = >0	New Indicator for 14/15					0	0	0	0	6	0	0	1	1	8
R19	% Operations cancelled for non-clinical reasons on or after the day of admission UHL	RM	PW	0.8% or below	Contract	Red = >0.9% ER = >0.8%	1.6%	1.7%	1.6%	2.1%	1.5%	1.1%	0.8%	1.1%	0.7%	0.6%	0.8%	0.8%	1.2%	1.1%	0.9%
R20	% Operations cancelled for non-clinical reasons on or after the day of admission ALLIANCE	RM	PW	0.8% or below	Contract	Red = >0.9% ER = >0.8%	1.6%	1.7%	1.6%	2.1%	1.5%	0.6%	0.6%	0.3%	2.7%	0.0%	0.9%	1.0%	0.0%	0.8%	0.8%
R21	% Operations cancelled for non-clinical reasons on or after the day of admission UHL + ALLIANCE	RM	PW	0.8% or below	Contract	Red = >0.9% ER = >0.8%	New Indicator for 14/15					1.1%	0.8%	1.0%	0.9%	0.6%	0.8%	0.8%	1.1%	1.1%	0.9%
R22	No of Operations cancelled for non-clinical reasons on or after the day of admission UHL + ALLIANCE	RM	PW	N/A	UHL	tbc	1739	141	152	178	139	106	77	98	94	55	90	94	108	102	824
R23	Delayed transfers of care	RM	PW	3.5% or below	NTDA	Red = >3.5% ER = Red for 3 consecutive mths	4.1%	3.6%	4.6%	4.3%	3.8%	4.4%	4.2%	4.0%	3.9%	3.9%	4.5%	4.6%	5.2%	3.9%	4.3%
R24	Choose and Book Slot Unavailability	RM	CC	4% or below	Contract	Red = >4% ER = Red for 3 consecutive mths	13%	14%	10%	16%	19%	22%	25%	26%	25%	26%	25%	20%	17%	17%	22%
R25	Ambulance Handover >60 Mins (CAD)	RM	CF	0	Contract	Red = >0 ER = Red for 3 consecutive mths	868	102	52	207	111	173	253	88	71	50	106	253	343	460	1,797
R26	Ambulance Handover >30 Mins and <60 mins (CAD)	RM	CF	0	Contract	Red = >0 ER = Red for 3 consecutive mths	7,075	722	573	818	601	720	951	671	591	805	736	1,147	1,364	1,170	8,155

	KPI Ref	Indicators	Board Director	Lead Director/Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	Sep-14	Oct-14	Nov-14	Dec-14	YTD
Research	RS1	Number of participants recruited in a reporting year into NIHR CRN Portfolio studies	KH	DR	England 650,000 East Midlands 50,000	NIHR CRN	Red / ER = <90%	92%	93%	94%	93%	93%
	RS2a	A: Proportion of commercial contract studies achieving their recruitment target during their planned recruitment period.	KH	DR	England 80% East Midlands 80%	NIHR CRN	Red / ER = <60%	67%	64%	68%	54%	54%
	RS2b	B: Proportion of non-commercial studies achieving their recruitment target during their planned recruitment period	KH	DR	England 80% East Midlands 80%	NIHR CRN	Red / ER = <60%	81.0%	81.0%	73%	77%	77%
	RS3a	A: Number of new commercial contract studies entering the NIHR CRN Portfolio	KH	DR	600	NIHR CRN	tbc					
	RS3b	B: Number of new commercial contract studies entering the NIHR CRN Portfolio as a percentage of the total commercial MHRA CTA approvals for Phase II-IV studies	KH	DR	75%	NIHR CRN	Red <75%					
	RS4	Proportion of eligible studies obtaining all NHS Permissions within 30 calendar days (from receipt of a valid complete application by NIHR CRN)	KH	DR	80%	NIHR CRN	Red <80%	90.0%	89.0%	84.0%	82.0%	82.0%
	RS5a	A: Proportion of commercial contract studies achieving first participant recruited within 70 calendar days of NHS services receiving a valid research application or First Network Site Initiation Visit	KH	DR	80%	NIHR CRN	Red <80%					
	RS5b	B: Proportion of non-commercial studies achieving first participant recruited within 70 calendar days of NHS services receiving a valid research application	KH	DR	80%	NIHR CRN	Red <80%					
	RS6a	A: Proportion of NHS Trusts recruiting each year into NIHR CRN Portfolio studies	KH	DR	England 99% East Midlands 99%	NIHR CRN	Red <99%	81.0%	81.0%	81.0%	88.0%	88.0%
	RS6b	B: Proportion of NHS Trusts recruiting each year into NIHR CRN Portfolio commercial contract studies	KH	DR	England 70% East Midlands 70%	NIHR CRN	Red <70%	56.0%	56.0%	56.0%	56.0%	56.0%
	RS6c	B: Proportion of General Medical Practices recruiting each year into NIHR CRN Portfolio studies	KH	DR	England 25% East Midlands 25%	NIHR CRN	Red <25%	45.0%	45.0%	51.0%	63.0%	63.0%
	RS7	Number of participants recruited into Dementias and Neurodegeneration (DeNDRoN) studies on the NIHR CRN Portfolio	KH	DR	England 13500 East Midlands 510	NIHR CRN	Red <510 Q4	325	438	448	532	532
	RS8	Deliver robust financial management using appropriate tools - % of financial returns completed on time	KH	DR	England 100% East Midlands 100%	NIHR CRN	Red <100%	100% *Q2	100.0%			100% *Q2

	KPI Ref	Indicators	Board Director	Lead Director/Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	Sep-14	Oct-14	Nov-14	Dec-14	YTD
Estates and Facilities	E&F1	Percentage of statutory inspection and testing completed in the Contract Month measured against the PPM schedule.	AC	GL	100%	Contract KPI	Red = ≤ 98%	100.0%	100.0%	100.0%	100.0%	100.0%
	E&F2	Percentage of non-statutory PPM completed in the Contract Month measured against the PPM schedule	AC	GL	100%	Contract KPI	Red = ≤ 80%	91.5%	81.2%	95.6%	80.5%	81.2%
	E&F3	Percentage of Estates Urgent requests achieving rectification time	AC	LT	95%	Contract KPI	Red = ≤ 75%	100.0%	100.0%	100.0%	100.0%	100.0%
	E&F4	Percentage of scheduled Portering tasks completed in the Contract Month	AC	LT	99%	Contract KPI	Red = ≤ 98%	100.0%	100.0%	100.0%	100.0%	100.0%
	E&F5	Number of Emergency Portering requests achieving response time	AC	LT	100%	Contract KPI	Red = >2	0.0%	0.0%	0.0%	0.0%	0
	E&F6	Number of Urgent Portering requests achieving response time	AC	LT	95%	Contract KPI	Red = ≤ 95%	95.1%	96.2%	97.3%	97.2%	96.2%
	E&F7	Percentage of Cleaning audits in clinical areas achieving NCS audit scores for cleaning above 90%	AC	LT	100%	Contract KPI	Red = ≤ 98%	100.0%	99.1%	100.0%	100.0%	99.1%
	E&F8	Percentage of Cleaning Rapid Response requests achieving rectification time	AC	LT	92%	Contract KPI	Red = ≤ 80%	99.6%	89.9%	93.3%	90.5%	89.9%
	E&F9	Percentage of meals delivered to wards in time for the designated meal service as per agreed schedules	AC	LT	97%	Contract KPI	Red = ≤ 95%	99.4%	99.5%	100.0%	100.0%	99.5%
	E&F10	Overall percentage score for monthly patients satisfaction survey for catering service	AC	LT	85%	Contract KPI	Red = ≤ 75%	96.7%	97.3%	97.3%	96.7%	97.3%

S1b – CDIFF local target

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest month performance	YTD performance	Forecast performance for next reporting period
The cases of CDT have been the subject of Root Cause Analysis and there are no discernible factors that link these cases to date. Concerns in relation to compliance with the National Minimum Cleaning frequencies have been expressed from colleagues within all CMGs and have been identified by the IPT. Repeated requests for the current cleaning frequencies and hours aligned to each area to be made available have not been received to date. UHL is therefore not in a position to verify that the Interserve transformation team correctly implemented NCS Interserve audits previously carried out to date did not report 1st failures and therefore a false reassurance as to the standard of cleaning in some areas is felt to have been given. The CDT working party will be reviewed and the associated governance arrangements to ensure that this group is able to deliver the identified objectives	Action plans that have resulted from the RCA should be presented to the CMG Infection Prevention Groups and should follow the RCA process flow chart as described in the Infection Prevention Toolkit In line with the 'updated guidance in the diagnosis and reporting of Clostridium difficile' the cases have been sent to Commissioning Group that has been established to review each case individually. The comments from this group will be received within seven working days. This process commenced in October and sample positive cases that are the subject of RCA will be sent monthly for review. A thematic review of CDT cases will be undertaken with the results presented to the February EQB and CQRG meetings The number of cases to date mirrors last year's numbers at this time however we continue to strive for a further reduction in cases. The Chief Executive has requested that 1st audit results are used for subsequent environmental cleanliness audits. Infection Prevention Leads are to meet with the newly appointed Director of Facilities who in conjunction with the DIPAC will review current cleanliness forums in place to ensure these are fit for purpose and are monitoring and ensuring performance delivery effectively	5	7		N/A

	Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
Traj 14/15	7	8	5	7	6	7	7	7	6	7	7	7	81
Internal Traj 14/15	4	5	4	5	4	4	4	4	4	4	4	4	50
Actual Infections 14/15	4	6	5	7	2	5	7	7	11				55

Expected date to meet standard / target	TBA
Revised date to meet standard	TBA
Lead Director / Lead Officer	Elizabeth Collins

S2a MRSA bacteraemias (all)

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest month performance	YTD performance	Forecast performance for next reporting period
The cases of MRSA bacteraemia have been the subject of the Post Infection Review process. All occurred in different locations within the trust and these cases are not connected. All occurred in patients with multiple co-morbidities and have been deemed unavoidable however lapses in care were identified in all cases.	Post Infection Reviews (PIR) are carried out by the CMGs with support from the Infection Prevention Team in accordance with the NHS Commissioning Board 'Guidance on the reporting and monitoring arrangements and post infection review process for MRSA bloodstream infection from April 2013' The PIR reviews and any identified action plans that have resulted from the investigation should be presented to the CMG Infection Prevention Groups and CMG Quality and Safety Boards and follow the RCA process flow chart as described in the Infection Prevention Toolkit	0	See table below	4	N/A

MRSA	Emergency & SM			CHUGS			MSK & SS			RRC			ITAPS		Women's & Children's			GRAND TOTAL
Reporting period	Emergency	Specialist Medicine	CMG Total	Cancer & Haem	Urology, Gastro & Surgery	CMG Total	Musculo-skeletal	Specialist Surgery	CMG Total	Renal Speciality	Respiratory & Cardiac	CMG Total	ITAPS	CMG Total	Women's	Children's	CMG Total	
Date reported to PHE																		
14th Jan	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
January																		
Running Total	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
February																		
Running Total	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Month End Totals																		
Apr-14	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
May-14	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Jun-14	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Jul-14	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Aug-14	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Sep-14	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0	0	0	1
Oct-14	0	0	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	1
Nov-14	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Dec-14	0	1	1	0	1	1	0	0	0	0	0	0	0	0	0	0	0	2
Jan-15			0			0			0			0		0			0	0
Feb-15			0			0			0			0		0			0	0
Mar-15			0			0			0			0		0			0	0
2014/15 Month Ends	0	1	1	0	2	2	0	0	0	0	1	1	0	0	0	0	0	4
2014/15 Running Total	0	1	1	0	2	2	0	0	0	0	1	1	0	0	0	0	0	4

Expected date to meet standard / target	TBA
Revised date to meet standard	TBA
Lead Director / Lead Officer	Elizabeth Collins

S3 Never events

		Target	Oct 14	YTD	Fore cast
What is causing underperformance?	**What actions have been taken to improve performance?**	**NIL**	**1**	**3**	**3**

Case One: During an operation in December to replace a femoral head which had been inserted during previous hip joint revision surgery it was identified that the femoral head was the incorrect size: a 32mm head had been inserted in a 28mm cup.
There are two ball sizes for the prosthesis in question: 28 mm and 32mm. The most common size (> 95%) is the 32mm size, and it had been "assumed" that the head removed was a 32mm diameter.

Case Two: A patient was listed for surgery at Melton Hospital by a Podiatric Surgeon to straighten the 3rd toe on her right foot.

On the morning of surgery (22 December 2014) the Podiatry Assistant confirmed with the patient the site and documented consent. She marked the patient's foot on the top with an arrow pointing towards the 3rd toe.

Whilst the latter was taking place the PodiatricSurgeon reviewed the MRI images for the patient and considered that the 2nd toe on the right foot required surgery.

The patient was brought into the theatre and the WHO checklist completed whilst the Surgeon was scrubbing up. He was not fully engaged in the check and the Podiatry Assistant was not present in Theatre to participate in the checks. Surgery was undertaken on the 2nd toe.

1. To avoid any such repetition, it is proposed that in the future, all diameter sizes of the components to be revised should be recorded at the beginning, or if not known pre-operatively, during revision procedures irrespective of which components are to be revised.

1. Change in practice: marking extending to digit implemented immediately.
2. Messages regarding WHO checklist reinforced at meeting on 6 January 2015 with teams involved.
3. Podiatry Assistant must be present in theatre when WHO checklist completed.

2013/14 Performance by Quarter

13/14 Q1	13/14 Q2	13/14 Q3	13/14 Q4
0	0	1	2

Three Never Events will trigger UHL as 'red' on this indicator for 2014/15

Expected date to meet standard	N/A
Revised date to meet standard	-
Lead Director	Director of Safety and Risk

Commentary:

1. The definition of a Never Event is: “Serious, largely preventable PSIs that should not occur if the available preventative measures have been implemented by healthcare providers”.

2. In relation to UHL performance:

   - In 2012/13, UHL reported 6 Never Events
   - In 2013/14, UHL reported 3 Never Events
   - For Quarters 1 and 2 in 2014/15, there were no Never Events reports and good compliance with the regulatory framework was demonstrated. However, in Quarter 3, 2014/15, 1 Never Event was reported and in Quarter 4, 2 Never events have been reported to date.

3. Case One Never Event occurred because the surgeon made an assumption rather than undertaking a definitive check.

4. Case Two Never Event occurred because of non-compliance in respect of certain elements of the Safer Surgery Policy.

INDICATOR: S9 % of all adults who have had VTE risk assessment on admission to hospital

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly)	Latest performance	YTD performance	Forecast performance for next reporting period
UHL's performance in respect of the VTE risk assessment indicator is calculated on the number of patients who are risk assessed for venous-thromboembolism (VTE), either on an individual basis or as a patient group (cohort). Cohorts are patients belonging to a diagnosis or procedural group which is considered to have a very low risk of VTE and therefore are considered to have been risk assessed on admission. One of the largest cohort groups are those patients attending for haemodialysis. Performance data is submitted on a monthly basis to UNIFY via UHL's data warehouse and is either taken from the ePrescribing System (on ePMA wards - patients have to have a VTE risk assessment before any drugs can be prescribed) or from Patient Centre (for non ePMA wards, data is taken from the patients' case notes and manually inputted into Patient Centre by ward/audit clerks). UHL has managed to achieve the 95% threshold each month since Q2 in 13/14 but 'cohort' patients have always significantly contributed to performance. Provisional review of December's data has identified a reduction in the number of 'cohort' admissions plus an increase in the number of 'missing data' for those patients requiring individual risk assessment (i.e. non cohorts). 'Blanks' (missing data), has been a constant challenge in respect of achieving the 95% target, i.e. patients are being risk assessed but this data is not then being inputted into patient centre. For areas using ePMA this is not an issue. The greatest number of blanks in December were in CDU and Urology.	The 95% threshold was missed in December by 85 patients and therefore a retrospective notes review is being undertaken for approximately 100 'non cohort' patients who have 'blanks' in respect of VTE risk assessment on Patient Centre. Audit Clerks, supervised by the Thrombosis Nurse, will then check whether the VTE risk assessment documentation has been completed in order to retrospectively input this data into Patient Centre. The aim is to complete this work before the UNIFY submission deadline of 29th January in order to be able to report achievement of the 95% threshold. In the meantime, further discussions are being held with the CDU and Urology teams to identify what support is required to improve data inputting prospectively. Confirmation of plans for the continued roll out of ePMA is also being sought as this would then obviate the need for manual data inputting.	**95%**	**94.7% (Provisional)**	**95.67%**	**>95%**

Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14
95.67%	95.88%	95.92%	96.27%	95.54%	96.17%	95.40%	95.45%	94.70% (tbc)

VTE Risk Assessments on Admission to Hospital December's performance due to be reported via UNIFY	December
I The number of adult inpatients (ordinary admission and day case) admitted in the month who have been risk assessed for VTE using the National Tool.	26774
ii. Total number of adult inpatients (ordinary admission and day case) admitted in the month.	28272
Iii Percentage of adult patients admitted in the month who were assessed for risk of VTE on admission to hospital.	**94.70% (tbc)**

Expected date to meet standard / target	January 15 – post retrospective data inputting and data validation.
Lead Director / Lead Officer	Kevin Harris, Medical Director / Simon Rudge, Thrombosis Nurse

S14 - Avoidable Pressure Ulcers – Grade 2

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly)	Latest month performance	YTD performance	Forecast performance for next reporting period
There were 11 Grade 2 avoidable Hospital acquired pressure ulcers (HAPUs) in December (i.e. 2 above the monthly threshold of 9), which followed 13 in November. December also saw the first Grade 4 avoidable HAPU and, as agreed with commissioners, this will be treated as a 'local Never Event'. G4 HAPU - Initial analysis indicates that insufficient checks and care interventions were provided, to minimise the risk of pressure ulcer development. A full root cause analysis is underway In respect of the Grade 2 and 3 HAPUs, all pressure ulcer incidents have been subject to internal validation. It has been noted by Heads of Nursing that the increased activity, leading to the need to create additional capacity is likely to have contributed to the continued higher number of HAPUs. Other common themes identified include:- •Gaps in documentation that nursing care interventions took place consistently to minimise the risk of pressure ulcers •Pressure damage as a result of medical devices •Limited or lack of recognition of patient risk factors.	From November 2014, oversight and management of the tissue viability service transferred to the Head of Safeguarding. Keys messages from the December performance will be shared with Heads of Nursing and the Chief Nurse. Further work to improve the quality of validation reports has commenced and key learning is shared monthly across nursing forums. Work is ongoing to monitor performance and discussions are taking place through the Nursing Executive to determine further initiatives and actions to prevent avoidable pressure ulcers and to learn from national best practice. The Chief Nurse is holding a performance management meeting with staff in relation to the grade 4 HAPU.	**G4 = 0 G2= 9**	**G4 = 1 G2 = 11**	**G4 = 1 G2 = 70**	**G4 = 0 G2 = </= 9**

Table one - Avoidable Grade 2 Pressure Ulcers April - December 2014

Threshold for Grade 2 Avoidable Pressure Ulcers 2013/14													
Month	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**YTD**
Threshold	**9**	**9**	**9**	**9**	**9**	**9**	**9**	**9**	**9**	**9**	**9**	**9**	
Incidence	6	6	6	7	8 Plus 1	4	7 plus 1	13	11				**70**

Table two - Avoidable Grade 3 Pressure Ulcers April – December 2014

Threshold for Grade 3 Avoidable Pressure Ulcers 2013/14													
Month	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**YTD**
Threshold	**7**	**7**	**7**	**7**	**7**	**7**	**7**	**7**	**7**	**7**	**7**	**7**	
Incidence	5	5	5	5	6	6	4	6	7				**44**

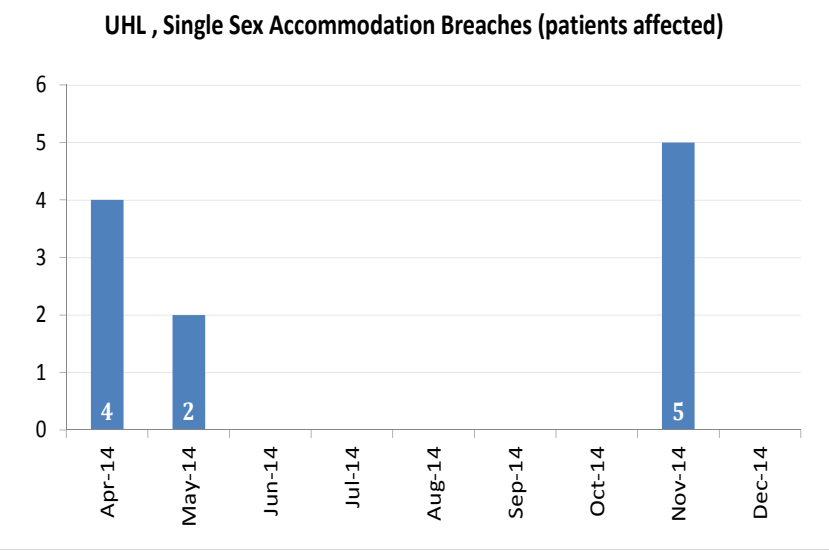
Table three - Avoidable Grade 4 Pressure Ulcers April - December 2014

Threshold for Grade 4 Avoidable Pressure Ulcers 2013/14													
Month	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**YTD**
Threshold	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**
Incidence	0	0	0	0	0	0	0	0	1				**0**

Expected date to meet standard / target	January 15
Revised date to meet standard	TBA
Lead Director / Lead Officer	Carole Ribbins, Deputy Chief Nurse/Michael Clayton, Head of Nursing

C8 Single sex accommodation breaches

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest month performance	YTD performance	Forecast performance for next reporting period
During the month of November there were five patients affected by two occasions when the Same-Sex policy was breached. On both occasions the events occurred in the HDU bay on ward 30 at the Leicester Royal Infirmary. the causes of this underperformance were: • Limited availability of base beds to move patients no longer needing HDU care. • Lack of understanding of the Same-Sex Matrix and escalation policy by staff. • Bed pressures resulting from pressure in the Emergency Department to admit patients.	Extra bed capacity has been opened in the Trust to accommodate more patients. Meetings have been held with Nursing and Duty Management leads, this information has then been cascaded to the clinical staff. A Route Cause Analysis has been completed following each episode, addressing learning needs and looking at preventing future breaches.	**0**	**0**	**11**	**0**



Expected date to meet standard / target	December 2014
Revised date to meet standard	N/A
Lead Director / Lead Officer	Heather Leatham, Assistant Chief Nurse

W9 Sickness absence

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest month performance	YTD performance	Forecast performance for next reporting period
1. Sickness absence is reported a month in arrears. 2. There has been an increase in sickness absence from July 2014 of 0.91%. 3. Sickness levels for November 2014 are reported at 4.20% and were at 4.12% in November 2013. 4. Sickness absence reporting highlights an adjustment of around 0.5% due to late closures. It is therefore expected the November 2014 sickness absence rate will be adjusted in the coming months. 5. In the last two years November 2012 to November 2014 we have seen: a. A reduction in staff taking sickness absence (November 2012 – 66.7%, November 2014 – 64.4%) b. An increase in staff taking sickness	1. Improved data through weekly SMART (Sickness Monitoring and Reporting Team) reports forwarded to lead managers highlighting open absences, closed absences and triggers (3 episodes / more than 10 days / 2 working weeks) 2. Discussion at CMG / Directorate Boards and across services / areas with specific actions confirmed 3. Circulation of breakdown of CMG performance by cost centre covering monthly and cumulative sickness absence. 4. Making it Happen Reviews, to discuss and agree actions for the management and support of open absences, 'triggers' and complex cases with line managers. 5. 6 monthly CMG Sickness Performance Reviews / Case reviews with Occupational Health and Senior and independent HR colleagues. 6. Sickness Absence training continues for line managers, and a new programme has been introduced for those administering the sickness absence paperwork.	**UHL Stretch target 3% (previous SHA target 3.4%)**	**4.2%**	**3.65% (average)**	**3.50% average (April 2015)**

Performance by CMG:

	2014 06	2014 07	2014 08	2014 09	2014 10	2014 11	Contracted Wte	Cumulative % Abs Rate (FTE)
	% Abs Rate (FTE)	% Abs Rate (FTE)	% Abs Rate (FTE)	% Abs Rate (FTE)	% Abs Rate (FTE)	% Abs Rate (FTE)		
Finance & Procurement	2.89%	2.86%	3.03%	2.44%	2.64%	6.23%	128.76	2.67%
Operations	5.63%	5.57%	5.87%	5.62%	6.61%	6.13%	104.30	5.78%
Corporate Nursing	3.07%	4.21%	4.00%	4.74%	4.60%	5.58%	186.29	3.44%
Alliance Elective Care	3.94%	3.36%	2.29%	3.02%	5.00%	5.55%	210.68	3.81%
Women's & Children's	3.43%	3.13%	3.19%	3.75%	4.43%	4.70%	1619.17	3.89%
Corporate & Legal	2.13%	1.35%	4.17%	4.74%	5.01%	4.65%	23.53	2.96%
Emergency & Specialist Medicine	4.02%	4.25%	3.77%	3.89%	3.97%	4.59%	1535.11	4.08%
ITAPS	3.20%	3.31%	3.91%	4.31%	4.17%	4.37%	1133.85	3.81%
Renal, Respiratory & Cardiac	3.00%	3.59%	3.81%	3.94%	4.38%	4.35%	1477.27	3.77%
Research CRN EM	0.22%	2.13%	6.69%	6.44%	2.48%	4.07%	40.10	2.96%
Strategy Directorate	2.25%	3.26%	1.66%	2.99%	3.64%	3.98%	51.39	2.77%
Clinical Support & Imaging Services	3.30%	3.22%	3.35%	3.58%	3.89%	3.86%	1796.59	3.62%
CHUGGS	3.64%	3.75%	3.69%	3.63%	4.01%	3.76%	1073.23	3.62%
MSK & Specialist Surgery	2.65%	2.86%	2.62%	3.35%	3.58%	3.35%	1010.88	2.98%
Human Resources & Training	1.35%	0.91%	0.46%	0.62%	2.57%	2.09%	146.94	1.86%
IM & T	0.00%	0.00%	0.00%	0.56%	0.00%	1.53%	15.80	0.74%
Research UHL	0.00%	3.54%	2.33%	0.00%	0.00%	1.45%	16.89	3.03%
Corporate Medical	0.42%	0.82%	1.14%	1.48%	2.65%	0.60%	67.96	1.72%
Communications & Ext Relations	0.00%	0.56%	0.36%	0.00%	0.19%	0.17%	20.60	0.58%
Facilities	0.00%	0.00%	0.00%	0.00%	0.41%	0.00%	23.97	0.23%
Divisional Management Codes	3.32%	4.39%	6.08%	6.67%	0.00%	0.00%	n/a	1.87%
University Hospitals of Leicester NHS Trust	3.29%	3.40%	3.43%	3.71%	4.06%	4.20%	10683.29	3.65%

What is causing underperformance?	What actions have been taken to improve performance?				
in excess of 28 days (November 2012 – 7.5%, November 2014 – 8.28%) 6. Feedback from Clinical Management Group and Directorates Leads indicates that the increased sickness absence is due to :- a. Increased operational pressures / activity b. Seasonal variations c. Inaccurate data – delays in closing absences d. Management changes / handovers e. Vacancies and other absences reducing management time f. Service pressures delaying sickness absence management	**Further Actions:** 7. In addition to the corporate sickness absence training, local training is facilitated for CMG's / Directorates in response to specific needs – management of long term absence, documentation etc. 8. Local actions to address high sickness absence include CMG Management Team 'Hot Spot' meetings, Staff Engagement events to reduce sickness absence and improve the management of sickness absence. 9. Improvement plans including timescales are discussed and agreed at CMG / Directorate level to reduce sickness absence and increase performance in the management of sickness absence.				
		Expected date to meet standard / target	Monthly Target		
		Revised date to meet standard	April 2015		
		Lead Director / Lead Officer	Emma Stevens, Acting Director of Human Resources Kalwant Khaira, CMG HR Lead (HR Sickness Absence Lead)		

INDICATOR: Statutory and Mandatory Training W13

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest performance	YTD performance	Forecast performance for next reporting period
We note that Statutory and mandatory Training is underperforming for the first time in 2014/15 and organisationally we have seen a significant improvement in month by month performance. This minimal underperformance (1%) results primarily from a slight reduction in attendance at face to face training sessions and completion of eLearning during December 2014 given service demands and pressures. We recognise that attendance at face to face training relies on staff being covered to attend, particularly in clinical areas and therefore generally completion rates for fire, resuscitation and manual handling training are lower than previous months.	1,200 team leaders (as recorded on the eUHL System) with access to the 'Team Builder' function have been contacted directly and requested to focus upon Fire Safety, Resuscitation and Infection Prevention Training (lowest performing areas). The Core Training Team has liaised with the Moving & Handling team to improve engagement and clarity regarding attendance and access to their training sessions. The ITAP and CSI CMGs have been restructured on the eUHL System to increase the number of areas within each CMG that are reported upon. These changes have been made to maximise engagement from the Heads of Service and service leads. All Subject Matter Experts are being contacted to identify and share across the group successful strategies. A new guide to 'Checking your Required Training' will be distributed to all staff over coming weeks to improve compliance levels and increase awareness of the targets and the necessity of training completion.	**31st, Dec, 2014 – 90%** **31st March, 2015 – 95%**	**9th Jan, 2015 – 89%**	**89%**	**95% at end of Quarter 4 / Year End**

*This section to incude Commentary on perforamance / benchmarking data or performance by CMG etc – (***SEE BELOW***)*

Expected date to meet standard / target	90% - 31ST, January 2015 95% - 31st March 2015
Lead Director / Lead Officer	Emma Stevens, Acting Director of Human Resources Bina Kotecha, Assistant Director of Learning and OD

UHL Statutory & Mandatory Training Summary – 09/01/15

CMG / Corporate Directorates	Fire Training	Moving & Handling	Infection Prevention	Equality & Diversity	Informat'n Gover'ce	Safeguard Children	Conflict Resolution	Safeguard Adults	Health & Safety	Resus - BLS Equivalent	Average Compliance
CHUGS	81%	80%	86%	93%	84%	93%	91%	92%	89%	83%	87%
CSI	87%	90%	89%	95%	91%	93%	94%	91%	93%	76%	90%
Emergency & Specialist Medicine	85%	85%	84%	90%	83%	92%	90%	90%	86%	86%	87%
ITAPS	87%	94%	91%	95%	88%	96%	95%	95%	93%	89%	92%
Musculoskeletal & Specialist Surgery	80%	81%	83%	92%	85%	92%	91%	90%	90%	77%	86%
Renal, Respiratory & Cardiac	82%	86%	87%	93%	88%	92%	90%	91%	90%	87%	89%
Womens & Childrens	82%	81%	81%	90%	86%	94%	90%	87%	87%	84%	86%
The Alliance	93%	88%	92%	92%	91%	94%	91%	91%	92%	87%	91%
Corporate Directorates	84%	88%	85%	95%	89%	96%	93%	93%	89%	80%	89%
Total compliance by subject	84%	86%	86%	93%	87%	94%	92%	91%	89%	84%	
UHL staff are this compliant with their mandatory & statutory training from the key 10 subjects											89%
Performance Against Trajectory (Set at 95% by March 31st, 2015)											6% behind

Compliance Levels below 90%
Compliance Levels 90% upto 95%
Compliance Levels 95% and above

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

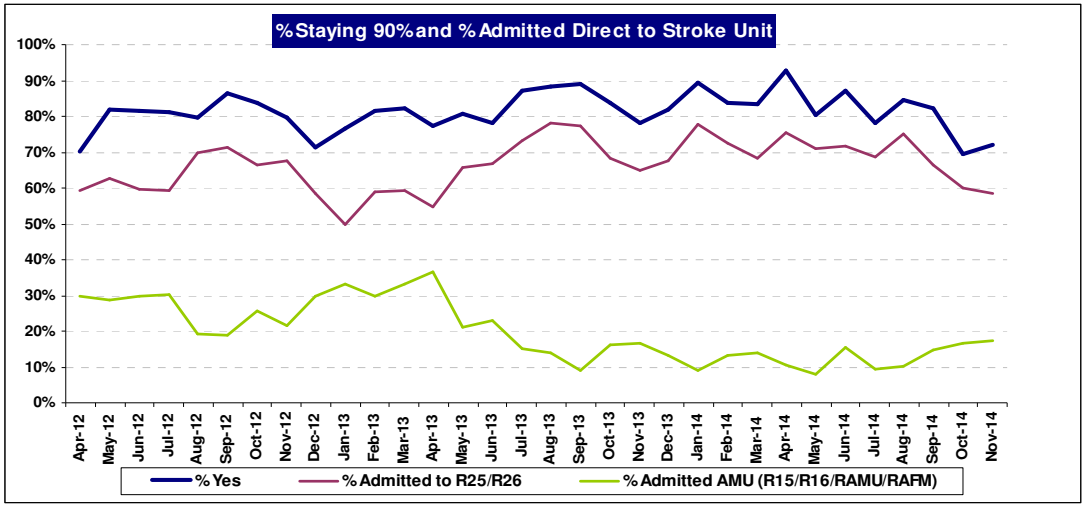
INDICATOR: E 13 Patients who spend at least 90% of their stay on a stroke unit.

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest performance	YTD performance	Forecast performance for next reporting period
A recent audit performed by Dr Rachel Marsh has highlighted a number of issues (a full report is available) Main issues: Lack of stroke beds at times of high in flow in terms of both stroke patients and all admissions Insufficient access to therapy services leading to longer lengths of stay Delays in transfers of care Social care delays Diagnostic confusion at first presentation. Referral delays	**Actions taken thus far:** Support from executive leads including the CE to ring fence beds. Daily list of patients awaiting rehabilitation beds emailed to bed bureau and bed managers to support better 'out flow'. Monthly audit of notes to confirm presence of stroke where 90% not achieved Recruitment of fixed term occupational therapist to cover maternity leave **Actions planned:** Introduce daily record of any non stroke patients on the stroke unit and reason Monthly audit of coding plus reason for patients not achieving 90% stay Develop a business plan with therapy services to increase physiotherapy and occupational therapists Review of LPT contract to increase Speech and Language therapists Escalate delays in transfers of care. Ensure the stroke bed policy is robustly enforced and re-issue the policy via senior management. Review bed usage across the stroke unit to ensure capacity is maximised. Review exclusion criteria regarding 90% stay including ITU and surgical stays.	**80%**	**72.1%**	**80.3%**	**75.0%**

All Commissioners

Apr-14	6	12.3	79	13.3	85	13.2	92.9%
May-14	15	7.7	61	12.2	76	11.3	80.3%
Jun-14	11	7.2	74	13.6	85	12.7	87.1%
Jul-14	21	12.3	75	14.9	96	14.3	78.1%
Aug-14	15	6.9	82	15.2	97	13.9	84.5%
Sep-14	18	12.1	83	15.4	101	14.8	82.2%
Oct-14	33	11.6	75	10.0	108	10.5	69.4%
Nov-14	29	9.9	75	15.7	104	14.0	72.1%

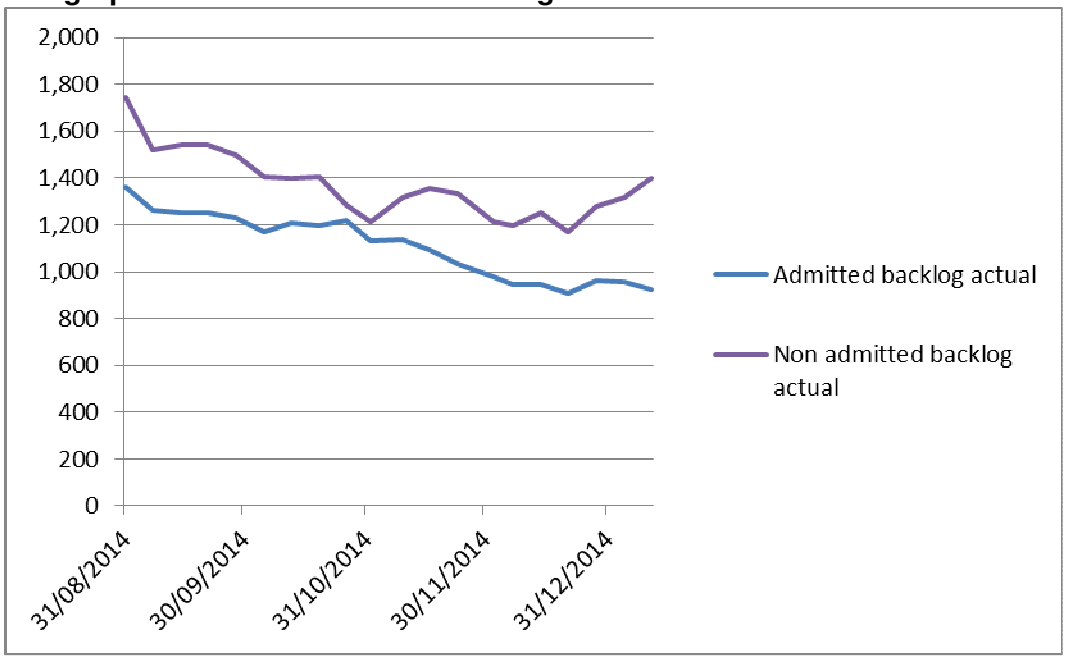
2014/15	**148**	**10.0**	**604**	**13.8**	**752**	**13.1**	**80.3%**



Expected date to meet standard / target	January 2015.
Lead Director / Lead Officer	Dr Ian Lawrence, Clinical Director for ESM / Dr Rachel Marsh, Head of Stroke Services

INDICATOR: R3 RTT waiting times - Admitted					
What is causing underperformance?	**What actions have been taken to improve performance?**	**Target (mthly / end of year)**	**Latest performance**	**YTD performance**	**Forecast performance for next reporting period**
Although the admitted backlog has reduced significantly as illustrated in the graph in this report, further significant backlog reduction needs to take place in order for the Trust to achieve and sustain the admitted standard. **By key speciality:** -Ophthalmology, continues to perform well - ENT adult , achieved the standard in December a significant development - General surgery, backlog continues to reduce as planned - Urology, backlog has remained static - Max fax backlog has reduced but the paediatric element has been hampered by lack of paediatric elective capacity as have both paediatric surgery and urology - Gynaecology, has seen a steady reduction in the backlog -Orthopaedics, backlog has steadily reduced , but is continually a risk due to the unstainable non admitted backlog position	The Trust is achieving 2 of the 3 RTT standards: Non admitted performance is 96% against a target of 95%. Incomplete performance 95% against a target of 92%. The weekly access meeting is changing as is the predictive ability of ensuring delivery. - Additional activity at weekends until the end of March - Urology additional in house and independent sector activity will start in January - Additional weekend work across the paediatric specialities is planned from January onwards - Additional work in house but also with the local independent sector - Orthopaedics and Urology remain the greatest risk to the Trust RTT performance. Weekend working continues, additional outsourcing to the local Independent sector for elective activity has been agreed and will start mid January. Outsourcing of referrals for outpatients will continue.	90% of patients treated within 18 weeks	86.8% (UHL and Alliance)	86.8%	86%

The graph below illustrates the backlog reduction at Trust level



Risks

Orthopaedics and Urology backlog sizes are a risk to the Trust. Overall the level of admitted backlog reduction required by the end of February to assure achievement of the admitted standard in March is very significant. (Circa 400 admitted reduction)

Mitigation

All key speciality plans being reviewed by Director of Performance and Information.
Re modelling of anticipated performance.
Ongoing additional activity in key specialities.
Additional outsourcing of activity in January to March, supported by TDA additional

		funding. Weekly CCG RTT meetings. There is currently a signficant revision to the performance management around 18 weeks which will ensure more conistent delivery as well as supporting earlier corrective actions.	
		Expected date to meet standard / target	March 2015
		Lead Director / Lead Officer	W Monaghan C Carr

R7: 6 week diagnostics tests waiting time

<table>
<tr><th>What is causing underperformance?</th><th>What actions have been taken to improve performance?</th><th>Standard</th><th>December 2014</th><th>YTD performance</th><th>Forecast performance for next reporting period</th></tr>
<tr><td rowspan="5">The Trust is measured on the waiting times of the top 15 diagnostic modalities, these are reported at the end of each month.

NB: these modalities cross all CMG's
There are a number of factors that have caused this underperformance:

Imaging (accounting for 31% of breaches)

- Cardiac CT and MRI, there remains insufficient capacity – this is ongoing issue and these are supervised scans so need consultant radiologist availability
- MSK MRI , these are consultant specific test

Dexa (accounting for 35%of breaches)
- During November there was a system failure resulting in the breaching of the standard. No alternative capacity available

Endoscopy (accounting for 19% of breaches)
- Colonoscopy / Flexi sigmoidoscopy / Gastroscopy

Additionally, there were small volumes of breaches of the standard in a number of other modalities.

Collectively these have caused a breach of the standard a total of 219 patients waiting over 6 weeks.</td><td rowspan="5">Cardiac CT and MRI
Additional sessions being carried out by cardiologists during December to February. With a business case for substantive capacity increase going to the CMG board in January
MSK imaging capacity
New MSK radiologist starts in January 20I5

Dexa
Scanner now repaired. Contingency plan between Imaging and Rheumatology being finalised. Dealing with the backlog of patients waiting over 6 weeks should be completed in February.
Endoscopy
Additional endoscopy work is being carried out by Medinet on UHL site from mid January

All other modalities
Robust waiting list management, additional capacity where there is risk of breaching , dating patients in date order</td><td><1% over 6 weeks</td><td>1) UHL and Alliance combined 2.2%</td><td>2.2%</td><td><1.8%</td></tr>
<tr><td colspan="4">Risks:
There remain risks to achievement of this standard due to the instability of a number of diagnostic modalities which collectively make up this standard.</td></tr>
<tr><td colspan="3">Expected date to meet standard / target</td><td colspan="2">November 2014</td></tr>
<tr><td colspan="3">Revised date to meet standard</td><td colspan="2">March 2015</td></tr>
<tr><td colspan="3">Lead Director / Lead Officer</td><td colspan="2">Richard Mitchell
Suzanne Khalid / Jo Fawcus / Jane Edyveane</td></tr>
</table>

Cancer Waiting Times Performance R8 – R 15

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest month performance November	Performance to date 2014/15	Forecast performance for December
R8 1) There has been an annualised increase of 18% in 2WW suspected cancer referrals in 2014/15 to date 2) This is likely to continue to grow 3) This has not been matched by increased provision of carved out availability, nor sufficient response to individual cancer type awareness campaigns 4) December performance additionally impaired by patient choice over Christmas period **R10, 12, 14, 15** The system for the integration of complex cancer pathways remains in place (**R14, R15**) Access to cancer diagnostics remains good. The delivery of timely treatments (**R10, R12**) lies within the gift of services for surgery, and the oncology department for chemotherapy and radiotherapy. Chemotherapy and radiotherapy treatments have remained timely for the most part. The issue is adequate access to surgical capacity. There is no shortage of overall surgical capacity, the poor performance results from the failure to appropriately prioritise cancer pathways in the face of competing priorities.	The Cancer Centre has taken the following actions to further strengthen the support offered to the CMGs in delivering cancer performance; 1) All 2WW referrals processed within 24 hours of receipt since December 2014 2) Revision to Monday CAB meetings to ensure that patient level management may be expedited whilst reducing the time commitment of the meeting 3) Cancer tracking reaching earlier into pathways to flag delays to services empowered to expedite "next steps" maximising opportunities for host services to deliver treatment dates within breach. These corporate actions are facilitating. Delivery of cancer performance will continue to depend upon CMGs prioritising cancer patient pathways in recognition of their complexity and the tight time lines compared with other elective care standards. The Cancer Centre and Director of Performance will meet with the CMGs to review how best they can be supported in the delivery of these standards.	**R8 2WW 93%**	**92.5%**	**92%**	**92.1%**
		R10 31 day 1st 96%	**92.5%**	**94.5%**	**93%**
		R12 31 day sub (Surgery) 94%	**82.4%**	**89.6%**	**81.5%**
		R14 62 day RTT 85%	**77%**	**81.2%**	**81.8%**
		R15 62 screening 90%	**94.4%**	**82.8%**	**93.3%**

Performance by Quarter

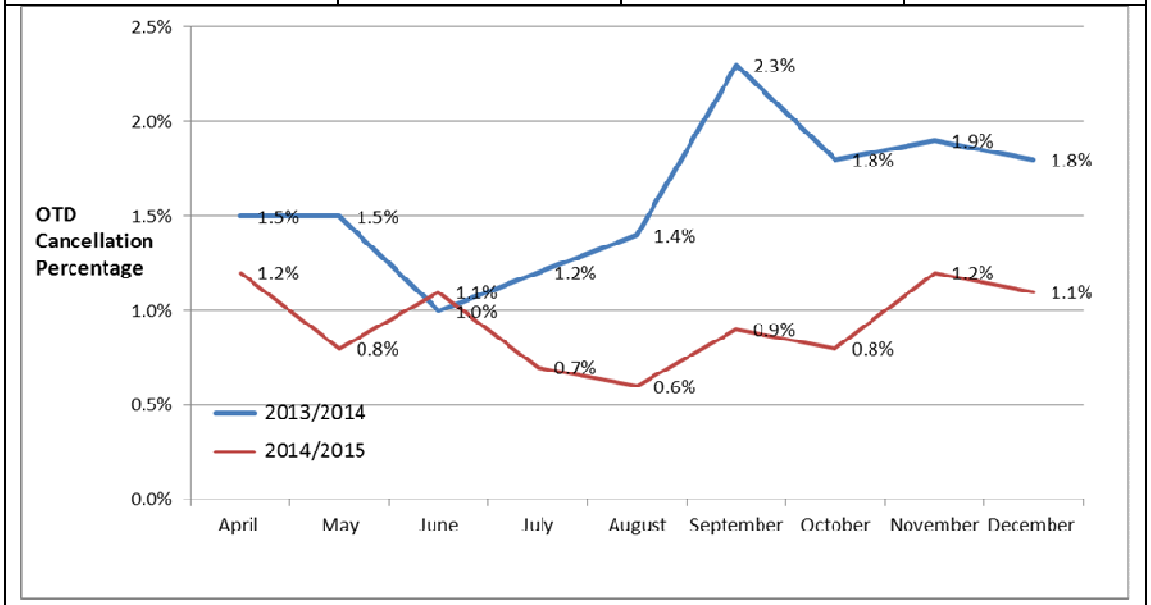
	13/14 FYE	14/15 Q1	14/15 Q2	14/15 Q3	14/15 Q4
R8	**94.8%**	**92.2%**	**91.6%**		
R10	**98.1%**	**94.6%**	**94.6%**		
R12	**98.2%**	**94.2%**	**90.5%**		
R14	**86.7%**	**84.1%**	**79.9%**		
R15	**95.6%**	**78%**	**85%**		

Expected date to meet standard / target	R8 – Recovery possible December R10,12 – Recovery possible January '15 R14,15 – Recovery possible February '15
Revised date to meet standard	Each target has slipped one month since the last report
Lead Director / Lead Officer	Will Monaghan Matt Metcalfe

R16-R22 : cancelled operations

INDICATORs: The cancelled operations target comprises of three components: 1. The % of cancelled operations for non-clinical reasons On The Day(OTD) of admission **2**.The number 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.

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly) 1)On day=0.8% 2) 28 day = 0	Latest month performance – Dec14	YTD performance (inc Alliance)	Forecast performance for next reporting period
The reasons for OTD cancellations changed in December. Out of 97 cancellations there were 26 patients cancelled due to HDU and ITU bed unavailability. 23 of these was adult HDU and ITU bed unavailability. This ITU capacity issue was on all sites – LRI (9), GGH (9) and LGH (5). Emergency admissions to the ITU at LRI increased significantly this year compared to the last three years. This added pressure to elective activity causing OTD cancellations and 28 days breaches in December. There were 21 OTD cancellations due to ward bed unavailability. On 17 of these occasions, cancellations occurred due to emergency bed pressures. There were three, 28 day breaches. This was as a result of last month's paediatric OTD cancellations. Two patients have already been treated and the other patient is listed for 27 of January.	The key action to ensure on-going performance is the daily tracking of patients at risk of cancellation and following the UHL cancelled escalation policy. For those cancelled on the day, it is vital that they adhere to the Trust policy of escalating to CMG General Managers for resolution, prior to agreeing any cancellations. A number of work streams have started aimed at reducing OTD cancellations including a LIA project. <u>Risks to delivery of recovery plan</u> Limited HTU and ITU bed availability for elective work due to emergency admissions is still a risk to OTD cancellations and 28 day breaches. The situation has been monitored on a daily basis to prevent OTD cancellations. Plans are on placed to improve the patient booking processes to maintained realistic number of elective bookings in critical care in the winter months when there is most pressure to admit emergency patients.	1) 1.1% 2) 3	1) 1.1% 2) 3	1) 0.9% 2) 33	1) 1.0% 2) 5

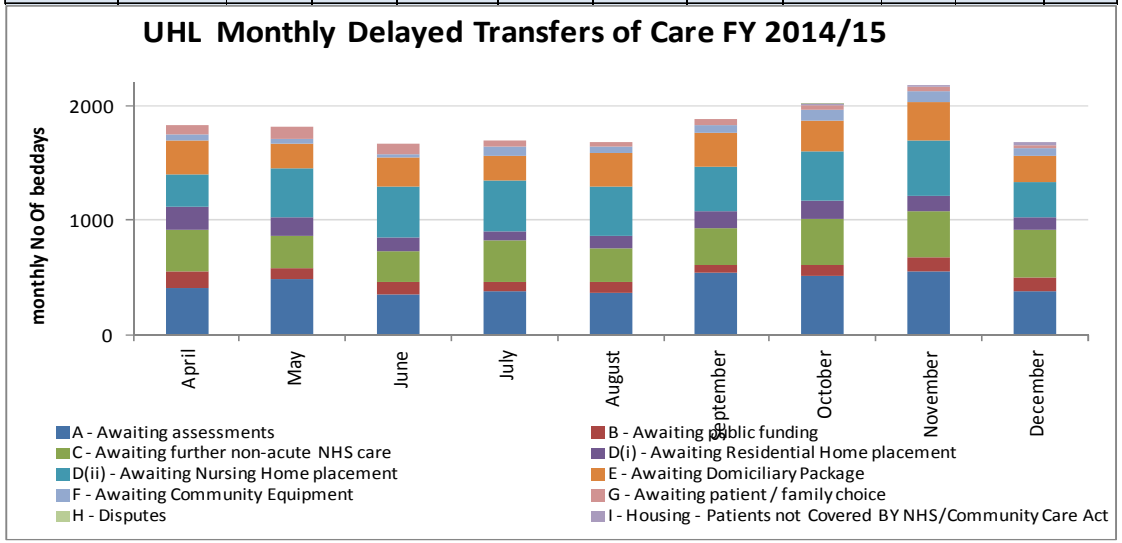


Expected date to meet standard / target	On the day cancellations – January 2015 28 day rebooking - February
Lead Director / Lead Officer	Richard Mitchell/Phil Walmsley

R23 Delayed Transfers of Care

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest month performance	YTD performance	Forecast performance for next reporting period
There has been a reduction in delays due to DTOC in December compared to the preceding three months. Areas of concern remain availability of packages of care in the County Local Authority. Interim placements in care homes are offered to patients but are not always accepted. There continue to be a number of DTOCs due to slow discharges to care homes. This is caused by families being slow to find appropriate care homes, carehomes being slow to come in to assess the patient as suitable or waiting for a bed to become available.	There has been a considerable reduction in the number of patients waiting, which will be partly due to the increased external support to get patients out of hospital over the Christmas period. Community teams continue to attend wards to identify patients that they could take directly in to their home based services. This has extended to supporting Glenfield with positive results	3.5%	3.9%	4.3%	4.0%

Row Labels	A - Awaiting assessments	B - Awaiting public funding	C - Awaiting further non-acute NHS care	D(i) - Awaiting Residential Home placement	D(ii) - Awaiting Nursing Home placement	E - Awaiting Domiciliary Package	F - Awaiting Community Equipment	G - Awaiting patient / family choice	H - Disputes	I - Housing - Patients not Covered BY NHS/Community Care Act	Grand Total
April	407	148	356	207	285	285	55	87			1830
May	494	90	277	166	425	218	34	113			1817
June	353	103	277	122	433	253	36	89			1666
July	387	77	353	82	444	215	85	54			1697
August	371	87	302	98	430	294	61	41			1684
September	546	57	333	141	394	286	65	57			1879
October	520	84	402	159	434	266	95	40	4	3	2007
November	561	119	392	134	484	343	88	46		9	2176
December	384	120	408	113	312	222	74	26		21	1680
Grand Total	**4023**	**885**	**3100**	**1222**	**3641**	**2382**	**593**	**553**	**4**	**33**	**16436**



Performance by Quarter

13/14 FYE	14/15 Q1	14/15 Q2	14/15 Q3	14/15 Q4
4.1%	4.2%	4.1%	4.6%	

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

R24 Choose and Book

<table>
<tr><td></td><td></td><td>Target</td><td></td><td></td><td></td></tr>
<tr><td>What is causing underperformance?</td><td>What actions have been taken to improve performance?</td><td><4% ASI</td><td>December</td><td>YTD performance</td><td>Forecast performance for next reporting period</td></tr>
<tr><td rowspan="5">The Trust is measured on the % of Appointment Slot Unavailability (ASI) per month.

The Trust has not met the required the <4% standard for circa 2 years and where it has met this standard it has been unable to maintain it for consecutive months.

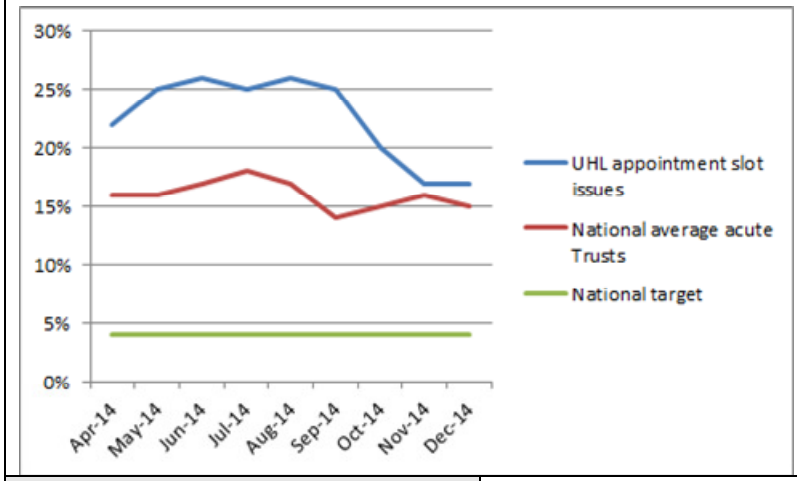
The two most significant factors causing underperformance are:

- Shortage of capacity in outpatients
- Inadequate recurrent training and education of administrative staff in the set up and use of the choose and book process

The issues are notably: General Surgery and orthopaedics and Urology</td><td rowspan="5">Capacity

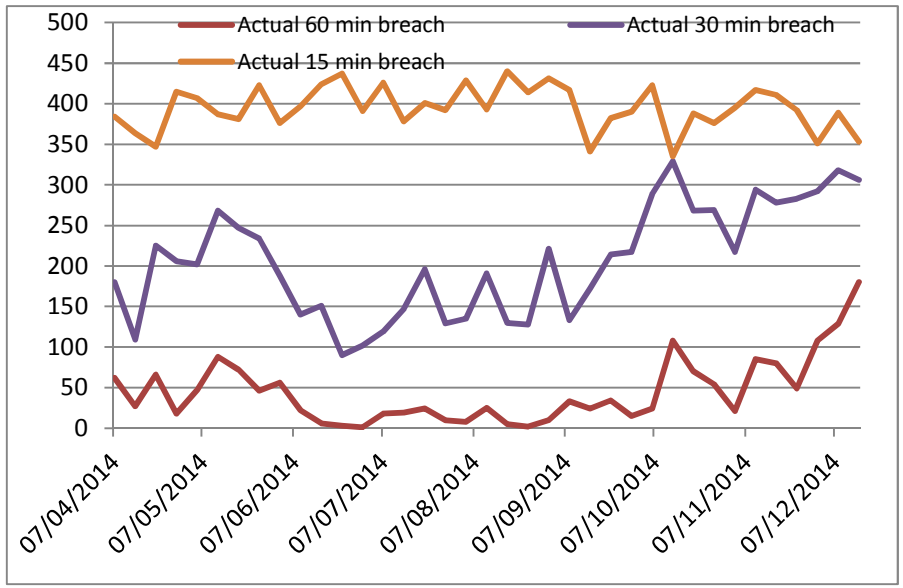
Additional capacity in key specialties is part of the RTT recovery plans

Training and education

The comprehensive training and education of relevant staff in key specialties continues, to ensure that choose and book is correctly set up and that supporting administrative purposes are fit for purpose.
A speciality level ‘score card’ to highlight areas required for improvement is being distributed weekly to CMGs. This highlights areas for concern and actions required.</td><td><4%</td><td>17%</td><td>22%</td><td>15%</td></tr>
<tr><td colspan="4">National performance varies significantly by Trust, with average performance of Acute Trusts nationally at 15% in November
 
</td></tr>
<tr><td colspan="2">Expected date to meet standard / target</td><td colspan="2">January 2015</td></tr>
<tr><td colspan="2">Revised date to meet standard</td><td colspan="2">March 2015</td></tr>
<tr><td colspan="2">Lead Director / Lead Officer</td><td colspan="2">Richard Mitchell
Charlie Carr</td></tr>
</table>

R25 and R26 Ambulance handover > 30 minutes and >60 minutes

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest month performance	YTD performance	Forecast performance for next reporting period
Pressures in accessing beds continue to lead to a backlog in the assessment area of ED. This delays movement out of the assessment area and delays handover. December was difficult from a bed occupancy perspective and this is evidenced in the handover performance for over 60 minutes which has deteriorated significantly. It should be noted that the overall attendances via ambulance have gone up by around 100 per week in December	**Resuscitation** An audit of patients being handed over in resuscitation has been completed. This shows that all patients going in to resuscitation are handed over within the 15 minute timeline. EMAS need to reinforce the new processes with their staff regarding back timing the point of handover. UHL audit in December indicates that numbers achieving 15 minutes is being under reported. EMAS response to this audit is awaited. **Paediatrics** Audit taking place to validate data on Paeds patients - this is indicating all arrive and handed over in 15 mins **60 minutes** The audit of over 60 minutes delays has not been repeated yet due to difficulties in meeting with EMAS. This has been escalated to the CCG. This audit showed discrepancies between UHL and EMAS data. (Audit from 14th Oct 60 min plus showed only 8 agreed by UHL and these were due to GGH capacity and evacuation of EDU due to fire alarm). Discussions are taking place over the method of collecting information on handover times. This is to be agreed with EMAS and taken back to the CCGs as an agreed approach for February.	0 delays over 15 minutes	> 60 min 6% 30-60 min – 24% 15-30 min – 33%	> 60 min 3% 30-60 min – 17% 15-30 min – 36%	



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

RS2A

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest month performance	YTD performance	Forecast performance for next reporting period
HLO2A: Proportion of commercial contract studies achieving their recruitment target during their planned recruitment period East Midlands is currently 6th of the 15 LCRNs for this metric with no LCRN currently achieving the 80% target, highest is currently 65% A lot of variables impact on recruitment achieved, after the recruitment target is set, for example: • Impact of global performance and earlier end dates giving less time to recruit • Changes in UK practice during set up/ recruitment • Protocol changes prior to initiation • Understanding of targets and alignment on the source of the target sites are measured on	Migration of the performance data for all open and closed commercial research onto one internet based system to track performance for 2014/15. Implementation of a provisional performance management process involving the Industry Team and Delivery Managers to escalate studies not recruiting to target within 24 hours and to align targets. Meetings with key research teams to discuss the importance of target setting and aligning the approach across the region so the target is reflective of the contract figure. 6 to 8 weekly performance meetings with delivery managers have been introduced to address this issue from the start of December. Collation of local information to report on the actual figure to take account for the lag in National reporting.	**80%**	**68% (Amber)**	**54%**	**54%**
		Expected date to meet standard / target			
		Revised date to meet standard	April 2015		
		Lead Director / Lead Officer	May 2015		

RS6A

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest month performance	YTD performance	Forecast performance for next reporting period
HLO6A: Proportion of NHS Trusts recruiting each year into non-commercial NIHR CRN Portfolio studies The NIHR Clinical Research Network has an HLO with the Department of Health for 99% of Trusts in England to recruit to CRN Portfolio research each year. This has been passed down to local research networks. There are 16 Trusts within the East Midlands region, with 14 Trusts currently reporting recruitment. The two who have not reported any recruitment are: ● East Midlands Ambulance Service NHS Trust (EMAS) ● Lincolnshire Community Health Services (LCHS)	1. **EMAS**: have received funding in 2014/15 for a Research Paramedic. This post currently supports two NIHR Portfolio studies that do not report recruitment in the traditional way due to patient assent taken rather than consent. EMAS have four studies in the pipeline that are due to open this financial year. One of those studies, AIRWAYS II, may report report participant recruitment this financial year. 2. **LCHS**: this Trust supports several CRN Portfolio studies, however the consent event occurs in the primary care setting so the recruitment is attributed to Clinical Commissioning. There is scope for research within the community services (paediatrics, district nursing) that is being investigated, however it is unlikely that this Trust will report recruitment this financial year.	**99%**	**81% (red)**	**88% (red)**	**88%**
		Expected date to meet standard / target			
		Revised date to meet standard	It is unlikely we will make the 99% target due to the nature of the services provided by LCHS. We may reach 94% by April 2015.		
		Lead Director / Lead Officer			

RS6b

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest month performance	YTD performance	Forecast performance for next reporting period
HLO6B: Proportion of NHS Trusts recruiting each year into commercial NIHR CRN Portfolio studies There are 16 Trusts within the East Midlands region, with 9 Trusts currently recruiting to commercial studies. The seven who have not reported any recruitment are: • East Midlands Ambulance Service NHS Trust (EMAS) • Derbyshire Community Health Services NHS Foundation Trust (DCHS) • Lincolnshire Community Health Services (LCHS) • Leicestershire Partnership NHS Trust (LePT) • Lincolnshire Partnership NHS Trust (LiPT) • Nottinghamshire Healthcare NHS Foundation Trust (NHFT) • Derbyshire Healthcare NHS Foundation Trust (DHFT)	**EMAS**: Currently no open commercial studies nationally run by ambulance services on the NIHR portfolio, therefore unlikely that EMAS will open a commercial study this financial year. Industry team currently reviewing studies previously run at other ambulance services across the country to gain insight. Meeting with Trust and RDM for Division 6 to discuss this month **DCHS**: due to the nature of research within this Trust, they are unlikely to be involved in commercial research, Have met with Trust and a preliminary plan is in place to take this forward. **LCHS**: due to the nature of research within this Trust, they are unlikely to be involved in commercial research. Met on the 18th December and a preliminary plan is in place to take this forward. **LePT**: Selected for one study, due to open by the end of 2014. One study also being taken forward with sponsor and awaiting confirmation if selected **LiPT**: have been involved in commercial research in the past and the site is actively seeking commercial opportunities **NHFT**: One trial initiated at the end of November 2014, 2nd UK site to open **DHFT**: One trial recently opened to recruitment closed early prior to recruitment. 2 studies in the pipeline	**70%**	**56% (red)**	**56% (red)**	**56%**
		Expected date to meet standard / target			
		Revised date to meet standard	April 2015		
		Lead Director / Lead Officer	June 2015		

2014/15 NTDA METRICS AND WEIGHTINGS

Responsiveness Domain

Metric	Standard	Weighting
Referral to Treatment Admitted	90	10
Referral to TreatmentNon Admitted	95	5
Referral to Treatment Incomplete	92	5
Referral to Treatment Incomplete 52+ Week Waiters	0	5
Diagnostic waiting times	1	5
A&E All Types Monthly Performance	95	10
12 hour Trolley waits	0	10
Two Week Wait Standard	93	2
Breast Symptom Two Week Wait Standard	93	2
31 Day Standard	96	2
31 Day Subsequent Drug Standard	98	2
31 Day Subsequent Radiotherapy Standard	94	2
31 Day Subsequent Surgery Standard	94	2
62 Day Standard	85	5
62 Day Screening Standard	90	2
Urgent Ops Cancelled for 2nd time (Number)	0	2
Proportion of patients not treated within 28 days of last minute cancellation	0	2
Delayed Transfers of Care	3.5	5
TOTAL - 18 Indicators		78

Effectiveness Domain

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

Safe Domain

Metric	Standard	Weighting
Clostridium Difficile - Variance from plan		10
MRSA bactaraemias	0	10
Never events	0	5
Serious Incidents rate	0	5
Patient safety incidents that are harmful		5
Medication errors causing serious harm	0	5
CAS alerts	0	2
Maternal deaths	1	2
VTE Risk Assessment	95	2
Percentage of Harm Free Care	92	5
TOTAL - 11 Indicators		51

Caring Domain

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

Well Led Domain

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

CQC – Intelligent Monitoring Report

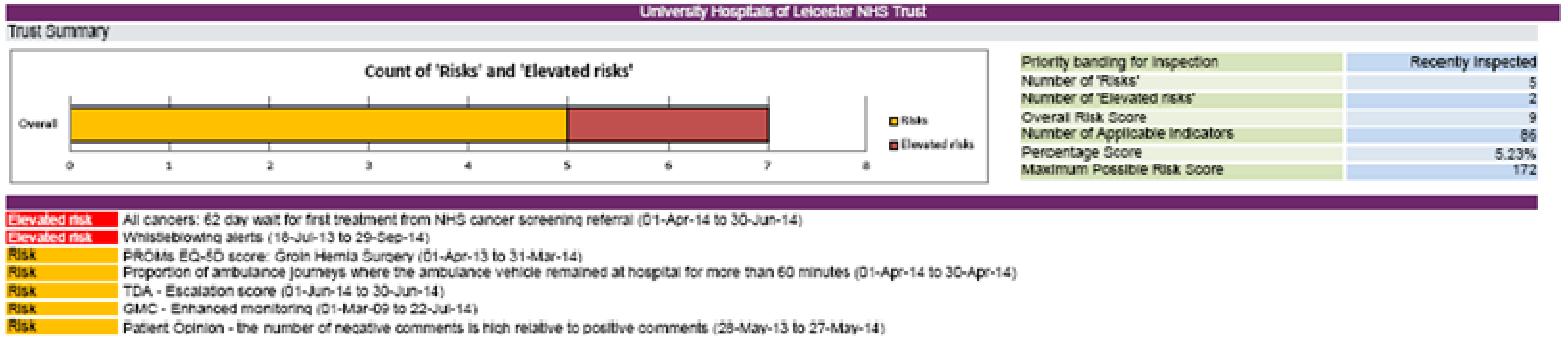
The latest CQC Intelligent Monitoring Report (IMR) was published on 3rd December 2014.

The IMR evaluates against a range of indicators relating to the five key questions used by the CQC as part of their inspections - is the organisation safe, effective, caring, responsive, and well-led?

Within each area of questions a set of indicators has been developed and each indicator has then been analysed to identify the following levels of risk for each organisation:

- 'no evidence of risk'
- 'risk'
- 'elevated risk'

One elevated risk remains unchanged (whistleblowing alerts), one new elevated risk has been added (cancer waiting times), three indicators are unchanged at risk (ambulance times, TDA and GMC) and PROMs (groin hernia surgery) and patient opinion comments are new risks (not flagged in the previous IMR).



Quality Schedule and CQUIN Performance Summary – Predicted RAG for Quarter 3

Ref	Indicator Title	Q1 RAG	Q2 RAG	Q3 RAG	Commentary
	QUALITY SCHEDULE				
PS01	Infection Prevention and Control Reduction. - C Diff	G	A	G	Monthly reporting of C Diff. Threshold for 14/15 is 81. UHL is aiming to achieve a reduction on last year's total of 66 and has given itself a Target of 50 . 52 cases as at end of November which is below the NTDA trajectory. Amber RAG for Q3 to be revised upon receipt of Multi-Drug Resistant Bacteraemia data.
PS02	HCAI Monitoring - MRSA	0	1	2	1 in October and 2 in December. All reviews to date confirm these were unavoidable..
PS03	Patient Safety – SIs, Never Events	G	G	2	0 Never Events in Q1 in Q2. 1 in October (relating to 'Retained Swab ties) and 1 in December (wrong site surgery). Reduction in Patient Safety Incidents but increase in % causing harm. Further increase in number of PSIs awaiting review. Increase in GP concerns
PS04	Duty of Candour	0	0	0	No breaches.
PS05	Complaints and user feedback Management (excluding patient surveys).	A	A	A	Complaints responses performance improved slightly although still below threshold. Deterioration for responding to 're-opened complaints.
PS06	Risk Assurance and CAS Alerts	A	A	G	Amber RAG for Q2 relates to overdue CAS alerts for July. No overdue CAS alerts and all risk reviews and actions on Track
PS07	Safeguarding – Adults and Children	G	G	G	Assurance documentation due to be sent to CCG Safeguarding leads for their review ahead of their observational visit to the Trust. Discussions underway regarding CONI requirements (Care of Next Infant) and changes proposed to the SAAF.
PS08	Reduction in Pressure Ulcer incidence.	G	G	A	Monthly thresholds met for G3 HAPUs and no G4s, however 4 above the monthly trajectory for Grade 2 HAPUs in November and 2 above for December.
PS09	Medicines Management Optimisation	A	G	G	Commissioners noted improvement in Controlled Drugs audit report. Progress made with developing LLR Medicines Optimisation Strategy.
PS10	Medication Errors	G	G	G	Increased reporting of errors and actions being taken.
PS11	Venous Thromboembolism (VTE) and RCAs of Hospital Acquired Thrombosis	95.7%	96.1%	tbc	Performance above the national set threshold of 95% for Oct and Nov. Provisional data shows performance below 95% for December. Predominantly due to missing data. Retrospective review of case notes in progress and 95% threshold expected to be confirmed in time for reporting to DoH. RCAs in progress for Q3 Hospital Acquired Thrombosis.
PS12	Nutrition and Hydration	G	>80%	>85% tbc	Work programme on track for nutrition, some delays with hydration actions. December data to be validated.
PE1	Same Sex Accommodation Compliance and Annual Estates Monitoring	2	0	2	0 breaches reported for Q2. 2 breaches in November with 5 patients affected – relates to non Level 2 patients being in mixed sex accommodation in HDU.
PE2	Patient Experience, Equality and Listening to and Learning from Feedback.	G	G	tbc	Good progress made with triangulation of data. Waiting time main area for improvement.
PE3	Improving Patient Experience of Hospital Care (NPS)	N/A	N/A	N/A	Not due to be reported until March 15
PE4	Equality and Human Rights	G	G	G	Progress reported to the September CQRG with further information provided in October – relating to actions being taken to capture BME data
CE01	Communication – Content (ED, Discharge & Outpatient Letters)	A	A	A	Clinical Problem Solving Group held to agree key priorities. Letters policy finalised and due to be launched end of Jan 15.
CE02	Intra-operative Fluid Management	G	>80%	tbc	Q3 RAG dependent upon confirmation of 80% trajectory being maintained.

Ref	Indicator Title	Q1 RAG	Q2 RAG	Q3 RAG	Commentary
CE03	Clinical Effectiveness Assurance – NICE and Clinical Audit	A	A	tbc	Small number of outstanding responses for NICE Clinical Guideline / Quality Standards documents. Actions being taken where audits behind schedule
CE04	Women's Service Dashboard	A	A	tbc	Amber RAG for Q2 relates to increase in C Section Rate. .
CE05	Children's Service Dashboard	A	A	tbc	Q2 Amber RAG relates to SpR training
CE06	Patient Reported and Clinical Outcomes (PROMs and Everyone Counts)	A	A	G	Groin Hernia PROMs deteriorated and reported as a Risk in the embargoed CQC Intelligent Monitoring Report. Individual patient data now obtained. Initial review against patient case notes not identified any clinical issues. Consultant Outcomes published and all consultants in line with national average
CE07	#NOF - Dashboard	51%	67.9%	62.1%	72% threshold not met for any month in Q3. Mainly relates to peaks in activity and spinal patients.
CE08a	Stroke monitoring	86%	81.6	71.7% tbc	Although '90% stay on stroke Unit' not achieved for October and potentially below threshold for November, improvements made for other stroke indicators (time to scan, admission to stroke unit, thrombolysis)
CE08 b	TIA monitoring	76%	67%	73.4%	Threshold achieve for each month for high risk patients and performance improved for low risk patients being seen within 7 days.
CE09	Mortality (SHMI, HSMR)	A	A	A	UHL's SHMI remains above 100. Mortality alert reviews completed on track and MRC work programme is on schedule.
CE10	Making Every Contact Count (MECC)	A	G	G	Referrals to STOP and ALW continue. 'Healthy Eating and Physical Activity publicity campaign due to commence in General Surgery and Sleep Clinics.
AS01	Cost Improvement Programme (CIP) Assurance	A	G	G	Q2 RAG revised upon receipt of additional assurance.
AS02	Ward Healthcheck (Nursing Establishment, Clinical Measures Scorecard)	G	G	G	Recruitment of additional nurses continues. Not all wards meeting 'Nurse to bed Ratio' but actions in place. Support being provided to those wards not meeting thresholds in the Clinical Measures Scorecard.
AS03	Staffing governance	A	A	A	Thresholds not met for Appraisal, Sickness and Corporate Induction or Turnover although improvement noticed. Medical Staffing Strategy submitted.
AS04	Involving employees in improving standards of care. (Whistleblowing)	G	G	G	Actions taken to address concerns raised.
AS05	Staff Satisfaction	G	G	G	
AS06	External Visits and Commissioner Quality Visits	G	G	G	
AS07	CQC Registration	A	G	G	
	NATIONAL CQUINS				
Nat 1.1a	F&FT 1a - Staff	G	G	G	Implemented during Q1/2. No Staff F&FT survey undertaken in Q3 as National Staff Survey.
Nat 1.1b	F&FT 1b - OutPt & Day Case	G	G	G	F&FT already happening in Day Case and has started in Outpatients.
Nat 1.2	F&FT 1.2 - Increased participation - ED	16.%	15.1%	16.2%	Performance dropped significantly in November but up to 18.7% in December and YTD rate of 15.8% . Need to achieve 20% for Q4 to meet CQUIN requirements.
Nat 1.3	F&FT 1.3 - Inpt increase in March	35.8%	31%	34.7%	Drop in December from 36% to 31.9% but still on track to achieve Q4 30% threshold. Need to achieve 40% for March 15 for additional CQUIN monies.
Nat 2.1	ST 2.1 - ST data submission	G	G	G	Data collection continues for all 4 harms.
Nat 2.2	ST 2.2 - LLR strategy	G	G	G	UHL contributing to the LLR Pressure Ulcer group and workstreams
Nat 3.1	Dementia 3.1 - FAIR	G	G	G	90% thresholds met for all parts of the Dementia FAIR CQUIN.

Ref	Indicator Title	Q1 RAG	Q2 RAG	Q3 RAG	Commentary
Nat 3.2	Dementia 3.2 - Training & Leadership	G	G	tbc	Nicky Morgan is new Clinical Lead Dementia Training Programme reviewed and revised. Q3 RAG dependent on evidence of increased staff attending training.
Nat 3.3	Dementia 3.3 - Carers	G	G	G	Surveys carried out and evidence of actions being taken
	LOCAL CQUINS				
Loc 1	Urgent Care 1 (Discharge)	G	G	tbc	RAG dependent upon commissioners' support for work undertaken in Q3. Thresholds revised in order to reflect 2 year timescale of CQUIN scheme
Loc 2	Urgent Care 2 (Consultant Assessment)	G	G	tbc	60% Q2 threshold achieved due to significant improvement in AMU. Q3 audit being undertaken to see if Q3 threshold of 65% achieved.
Loc 3	Improving End of Life Care (AMBER)	G	G	G	AMBER implemented on 4 wards during Q2 and progress made with training. New facilitators in post and so should be back on track by end of Q3
Loc 4	Quality Mark	G	G	G	Quality Mark achieved for 6 out of the 8 wards to date.
Loc 5	Pneumonia	A	G	tbc	CQUIN payments reapportioned and so reduced loss of income for Q1. Q2 threshold achieved for all aspects of CQUIN scheme. Q3 audit being undertaken.
Loc 6	Think Glucose	G	G	G	Think Glucose programme on track.
Loc 7	Sepsis Care pathway	≥47%	≥60%	tbc	Care Bundle thresholds achieved and good progress made against action plan.
Loc 8	Heart Failure	≥49.5%	≥63%	tbc	Commissioner reviewed progress with both the Care Bundle and also IV diuretic Service.
Loc 9	Medication Safety Thermometer	G	G	G	90% of Wards participating in the Medication Safety Thermometer
	SPECIALISED CQUINS				
SS1	National Quality Dashboards	G	G	t of CQUIN scheme.Q 1 as although threshold just missed, acknowled ged increased activity and good progress made with other aspectbc	Dashboards now open for data submission at end of Q3
SS2	Breast Feeding in Neonates	61%	66%	tbc	Thresholds achieved for Q2 and on track for Q3.
SS3	Clinical Utilisation Review of Critical Care	N/A*	G	tbc	CCMDS and ICNARC data now being collected for ACB and plans in place to commence in other HDUs by end of March 15.
SS4	Acuity Recording	N/A*	G	G	Acuity recording in place for all areas. RAG dependant upon being able to demonstrate effective use of Acuity data.
SS5	Critical Care Standards - Disch	N/A*	G	tbc	RAG dependant on being able to demonstrate reduction in 4 hr discharge delays from Critical Care Units
SS6	Critical Care Outreach Team	N/A*	G	tbc	RAG dependant upon being able to demonstrate increased data collection for Outreach response times.
SS7	Consultant Assessment	G	G	tbc	Links to the CCG CQUIN.

Ref	Indicator Title	Q1 RAG	Q2 RAG	Q3 RAG	Commentary
SS8	Highly Specialised Services Collaborative Workshop	G	G	G	Q3 threshold is to provide update regarding participation in Clinical Benchmarking for both ECMO and PCO.

University Hospitals of Leicester NHS
NHS Trust

Trust Board Paper H1

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT BY TRUST BOARD COMMITTEE TO TRUST BOARD

DATE OF TRUST BOARD MEETING: 5 February 2015

COMMITTEE: Quality Assurance Committee

CHAIR: Dr S Dauncey, Non-Executive Director

DATE OF MEETING: 29 January 2015

This report is provided for the Trust Board's information in the absence of the formal Minutes, which will be submitted to the Trust Board on 5 March 2015.

SPECIFIC RECOMMENDATIONS FOR THE TRUST BOARD:

- None

SPECIFIC DECISIONS:

- None

DISCUSSION AND ASSURANCE:

- **EPMA Update** - the QAC supported the ePMA Board's preferred option of stopping rollout and focussing resources on ensuring that ePMA was used effectively within the current 'live' areas. The EQB on 3 February 2015 would make a decision in respect of the options put forward by the EPMA Board and would focus on actions that needed to be taken to mitigate any risks. An update on learning lessons from post investment reviews (i.e. ePMA) would need to be presented to IFPIC, as appropriate;
- **Update on Renal Transplant Unit** – endorsed the recommendations following the external review and EQB to report to QAC if there were any issues;
- **Patient Safety Report** – particularly noted that a number of policies had surpassed the review date and needed to be reviewed. Work was underway to resolve this matter;
- **Complaints Engagement Events Update Report and Action Plan** – recommendations were supported and some minor changes to the terms of reference of the Independent Complaints Review Panel were suggested. The Review Panel was requested to attend the Trust Board in October 2015 to present a patient story in respect of a complaint that had been reviewed by the panel;
- **CQC Should Dos** – majority of actions were either 'complete' or 'on track'. Two actions had been rated 'amber' on the action plan:- (i) action was required in respect of 'improving facilities for teenagers within hospital' – the QAC provided some suggestions to take forward this action, and (ii) Having different medication systems in different hospitals made tracking patients' medications difficult at times – issues re. EPMA would negate the planned actions and therefore would need to be reassessed;
- **Claims and Inquests Report including an update on Regulation 28 Letters** – received and noted;

- **Nursing Report** – a brief update on real time staffing, vacancies, premium pay and nursing clinical dashboard was provided. Wards 38 and 17 had triggered some concerns, however work was in-train to ensure appropriate actions were put in place and action plans were monitored;
- **Months 8 and 9 Quality and Performance Report** – particular note was made in respect of deterioration in #NOF target, pressure ulcers, and ED 4 hour performance. A brief update on the two never events was provided;
- **Statutory Duty of Candour** – a standing report on this topic would feature on QAC agendas from February/March 2015;
- **NHSLA Scorecard** – received and noted;
- **Complaints Briefing Report** – this report would now feature as a substantive item on future QAC agendas instead of an 'item for information'. A briefing on the existing Quality Commitment had been scheduled to take place soon after the QAC meeting on 26 February 2015. Executive and Non-Executive Directors including the Deputy Chief Nurse, Director of Safety and Risk and Director of Clinical Quality would be invited to attend this session, and
- **CQC Registration Update** – UHL hosted the Alliance activity and therefore registered this with the CQC. When the initial applications were made in April 2014, Rutland Memorial Hospital applied to be able to provide surgical activity. This was now deemed to be inappropriate. An application therefore had been made to this effect to remove from the registration certificate.

DATE OF NEXT COMMITTEE MEETING: 26 February 2015

Dr S Dauncey – Committee Chair
30 January 2015

University Hospitals of Leicester NHS
NHS Trust

Trust Board paper H2

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT BY TRUST BOARD COMMITTEE TO TRUST BOARD

DATE OF TRUST BOARD MEETING: 5 February 2015

COMMITTEE: Integrated Finance, Performance and Investment Committee

CHAIR: Ms J Wilson, Non-Executive Director

DATE OF MEETING: 29 January 2015

This report is provided for the Trust Board's information in the absence of the formal Minutes, which will be submitted to the Trust Board on 5 March 2015.

SPECIFIC RECOMMENDATIONS FOR THE TRUST BOARD:

- a confidential report from the Clinical Support and Imaging CMG.

SPECIFIC DECISIONS:

- matter arising (1) – an update on reception opening hours to be scheduled for March 2015;
- matter arising (2) – a financial awareness session for Board members to be scheduled for a future Trust Board thinking day (date to be agreed), and
- 5 Year Strategy Enabling Workstreams – the governance structure was welcomed. Future iterations to include the arrangements for building capacity and capability, transfer of skills and making better use of available predictive analysis resources. UHL's Strategy for strengthening patient engagement to be presented to a future Trust Board meeting (aligned with the Better Care Together workstream).

DISCUSSION AND ASSURANCE:

- matter arising (3) – concern expressed regarding the delays with Empath Business case development and the associated lost opportunities for realising financial benefits;
- presentation received from the CHUGGS CMG highlighting the following issues:-
    - robust financial performance for 2014-15,
    - challenges surrounding identification of CIP schemes for 2015-16,
    - nursing acuity changes and the submission of a bid for additional funding;
    - infection prevention performance;
    - RTT backlogs in General Surgery and Urology;
    - cancer performance in Urology and the increasing rate of referrals – a detailed review to be undertaken by the Quality Assurance Committee;
    - JAG accreditation for Endoscopy units and the associated implications for endoscopy activity;
    - robotic surgery programme – a post implementation review of the Da Vinci robot was scheduled for the February 2015 meeting;
    - opportunities to increase patient and public engagement in service developments;

- Workforce Plan update – opportunities to improve joined up working under the Better Care Together Programme and increase innovation in respect of education commissioning;
- 5 Year Strategy Enabling Workstreams – governance structure was welcomed, future iterations to include the arrangements for building capability, transfer of skills and making better use of the available predictive analysis resources;
- Month 9 Financial Performance – assurance regarding the completed discussions for the 2014-15 CCG contract and progress towards agreement on the specialised commissioning contract;
- Cost Improvement Programme – continued good progress with 2014-15 and the increased focus on 2015-16 CIP schemes;
- Response to National Contract and Tariff Guidance for 2015-16 – received and noted;
- PLICS/SLR update – areas for future focus were identified as space utilisation, overheads, nursing acuity and the development of a CMG-level dashboard. UHL's participation in a Monitor pilot relating to costings technical engagement was noted;
- Month 9 Quality and Performance – the Chief Executive's summary of key issues was welcomed. Cancer performance and cancelled operations were considered in some detail and further discussion was required at that afternoon's Quality Assurance Committee meeting regarding the arrangements for monitoring any patient harm arising from delayed treatments, and
- RTT Performance – a presentation was received from the MSS CMG in respect of the arrangements for improving Orthopaedics RTT performance. The key challenges related to spinal surgery, the recruitment of additional spinal surgeons and a potential fee for service arrangement for additional outpatient activity.

ITEMS DEFERRED TO THE NEXT MEETING:

- Update on the transfer of Clinical Services to the Alliance – deferred due to time constraints. An updated report to be presented to the 26 February 2015 meeting.

DATE OF NEXT COMMITTEE MEETING: 26 February 2015

Ms J Wilson – Committee Chair
29 January 2015

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **5TH FEBRUARY 2015**

REPORT FROM: **PAUL TRAYNOR - DIRECTOR OF FINANCE**

SUBJECT: **2014/15 FINANCIAL POSITION TO MONTH 9 (DECEMBER)**

1. INTRODUCTION AND CONTEXT

1.1. This paper provides the Trust Board with an update on performance against the Trust's key financial duties, namely:

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

1.2. The paper provides further commentary on financial performance by the CMGs and Corporate Directorates, risk and assumptions and makes recommendations for the relevant Directors.

1.3 The paper also provides detail on the forecast outturn for 2014/15 including risk and opportunities.

2. KEY FINANCIAL DUTIES

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

Financial Duty	YTD Plan £'Ms	YTD Actual £'Ms	RAG	Forecast Plan £'Ms	Forecast Actual £'Ms	RAG
Delivering the Planned Deficit	(27.7)	(30.3)	A	(40.7)	(40.7)	G
Achieving the EFL	44.1	34.1	G	50.3	50.3	G
Achieving the Capital Resource Limit	34.3	23.1	A	46.2	46.2	G

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

Better Payment Practice Code	April - Dec YTD 2014	
	Number	Value £000s
Total bills paid in the year	110,479	497,698
Total bills paid within target	55,054	346,044
Percentage of bills paid within target	**50%**	**70%**

Key Issues:

- In month adverse movement to plan of £1.2m, which is £0.3m worse than forecast
- YTD adverse movement to plan of £2.6m
- Agreement has been reached with local CCGs regarding 2014/15 income. Work is ongoing to agree a settlement with NHSE (Specialised Commissioning)
- Pay is adverse to plan by £0.6m. This is the first time this year pay has been in excess of plan
- Year end forecast of £40.7m can be delivered. CMGs and Directorates must deliver to control totals to ensure this
- CIP programme has identified £48m of plans against the £45m target. Development of plans for 2015/16 is underway with an aim to have 80% of the target amber or green by 31st January 2015

3. FINANCIAL POSITION (MONTH 9 - DECEMBER)

3.1. The Month 9 results may be summarised as follows and as detailed in Appendix 1:

	December 2014			April - December 2014		
	Plan £m	Actual £m	Var (Adv) / Fav £m	Plan £m	Actual £m	Var (Adv) / Fav £m
Income						
Patient income	58.3	58.7	0.3	526.5	525.3	(1.2)
Teaching, R&D	6.8	6.3	(0.5)	61.1	60.8	(0.3)
Other operating Income	3.1	3.4	0.4	27.9	28.7	0.9
Total Income	**68.2**	**68.4**	**0.2**	**615.5**	**614.8**	**(0.7)**
Operating expenditure						
Pay	41.2	41.8	(0.6)	371.5	368.7	2.8
Non-pay	26.5	27.2	(0.8)	238.7	243.2	(4.5)
Total Operating Expenditure	**67.7**	**69.1**	**(1.3)**	**610.2**	**611.9**	**(1.7)**
EBITDA	**0.4**	**(0.6)**	**(1.1)**	**5.3**	**3.0**	**(2.4)**
Net interest	0.0	0.0	0.0	0.1	0.0	0.0
Depreciation	(2.7)	(2.6)	0.1	(25.2)	(25.2)	0.0
Impairment	(1.4)	(4.4)	(3.0)	(1.4)	(4.4)	(3.0)
PDC dividend payable	(0.8)	(1.0)	(0.2)	(7.9)	(8.1)	(0.2)
Net deficit	**(4.5)**	**(8.8)**	**(4.2)**	**(29.2)**	**(34.8)**	**(5.6)**
EBITDA %		**-0.9%**			**0.5%**	
Less Impairments	1.4	4.5	3.1	1.4	4.5	3.1
RETAINED SURPLUS / (DEFICIT)	**(3.1)**	**(4.3)**	**(1.2)**	**(27.7)**	**(30.3)**	**(2.6)**

3.2 In the month of December, the Trust delivered a deficit of £4.3m against a planned deficit of £1.2m, an adverse variance of £1.2m. This was £0.3m worse than forecast.

3.3 Year to date, the deficit at the end of December is £30.3m, £2.6m worse than the £27.7m planned deficit.

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

Income

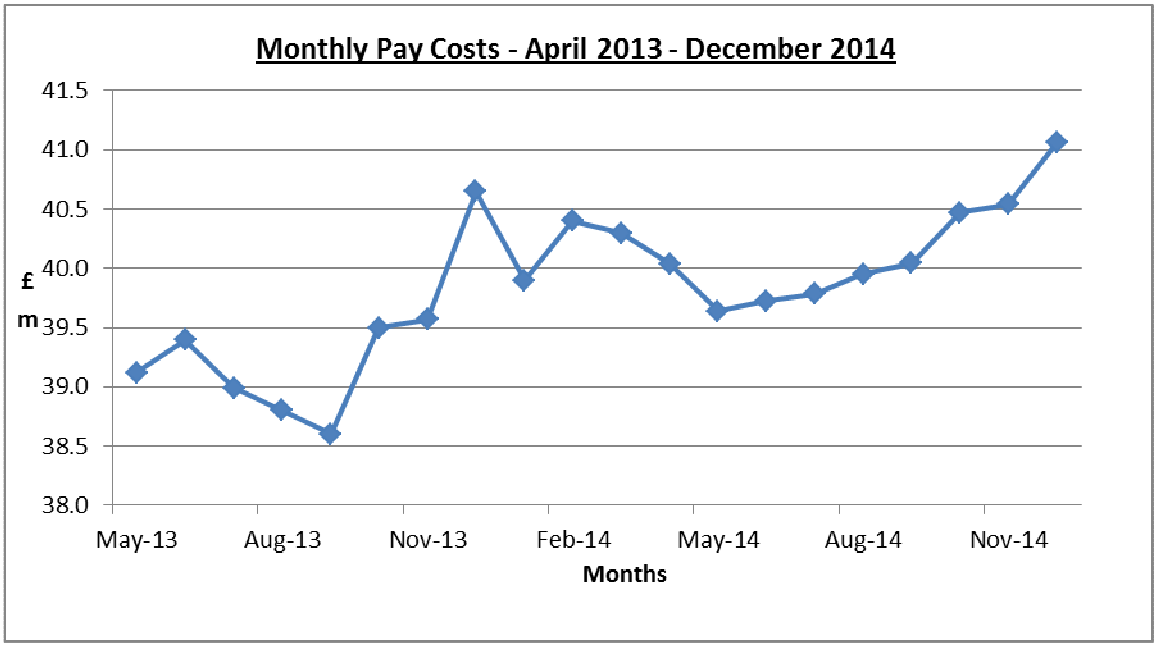
3.5 Patient care income is £0.3m favourable to plan. YTD patient income is £1.2m adverse to plan. Key areas of movement in month are as follows with year to date movements seen in Table 2:

- Daycase and elective activity £0.4m worse than plan, mainly in MSS
- Emergency and non elective activity £0.1m better than plan after MRET adjustment, however 649 patients more than plan
- Outpatients £0.2m worse than plan, mainly in ESM
- A&E £0.1m better than plan
- Critical Care £0.1m worse than plan
- Direct Access £0.1m worse than plan in Pathology
- Maternity £0.1m better than plan
- Operational resilience monies £1.1m better than plan, including funding for RTT and emergency resilience monies

Further detail on income can be seen in Appendix 2.

Pay

3.6 Pay costs are above plan in December by £0.6m, although in line with forecast. This is an increase of £0.3m compared to November. Overspends represent costs of additional beds, cover of vacancies and costs of delivery of RTT work. Premium pay spend has risen to £4.3m in month, an increase of £0.4m compared to November, a total of 10.4% of the paybill. Costs reflect cover of vacancies, additional emergency pressures and delivery of RTT.



Non Pay

3.7 Operating non pay spend is £0.8m adverse to plan in November and £4.5m adverse to plan YTD.

- In month overspends relate to security costs £0.2m and clinical supplies and services, £0.6m, split evenly across RRC, CHUGGS and ITAPS. This is a continuation of trends from previous months representing costs of delivery of activity performance

- Year to date, the key drivers of the overspend relate to consumables £4.3m, security £0.8m, printing and postage £0.6m, consultancy £0.5m, international nurse recruitment cost £0.3m, offset with phased release of reserves and supplier discounts of £2.2m

A more detailed financial analysis of CMG and Corporate performance (see Appendix 3) is provided through the Executive Performance Board financial report and reviewed by the Integrated Finance, Performance & Investment Committee.

Cost Improvement Programme

3.8 Appendix 3 shows CIP performance in December by CMG and Corporate Directorate against the 2014/15 CIP plan. This currently shows an over delivery against the target YTD of £1.6m.

The year end forecast reflects identified schemes of £48m against a target of £45m. Planning is well underway for identification of 2015/16 schemes with an indicative target of £41m.

4. FORECAST OUTTURN

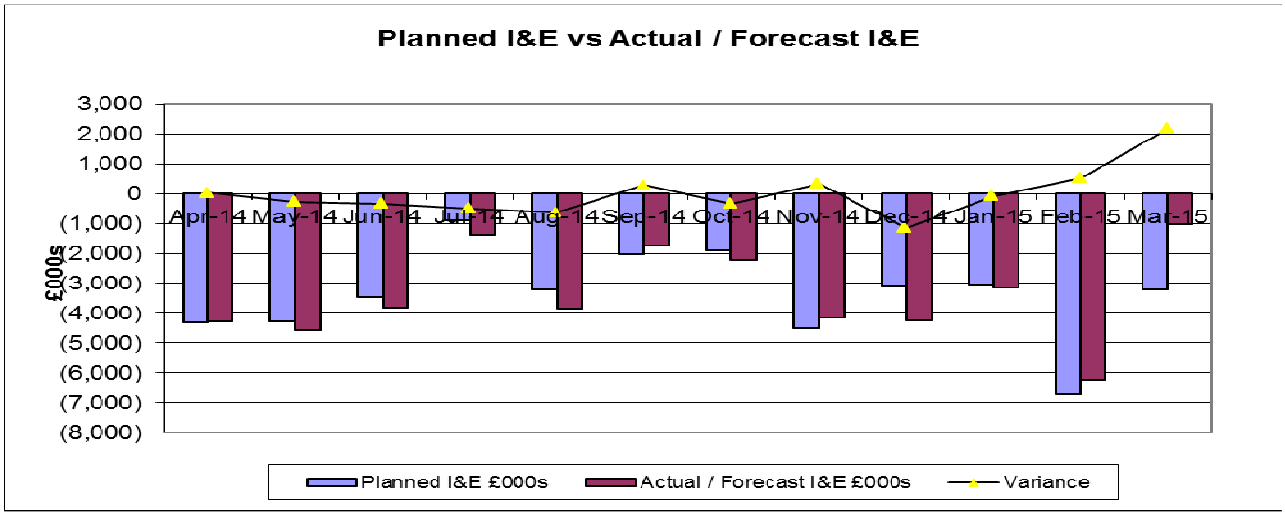
4.1 The table below details the forecast outturn delivering in line with the planned deficit:

	Year End Forecast		
	Plan £m	Forecast £m	Var (Adv) / Fav £m
Income			
Patient income	701.7	705.8	4.1
Teaching, R&D	81.4	80.6	(0.8)
Other operating Income	37.7	38.5	0.8
Total Income	**820.8**	**824.8**	**4.0**
Operating expenditure			
Pay	499.7	496.8	2.9
Non-pay	319.2	327.8	(8.6)
Total Operating Expenditure	**818.9**	**824.6**	**(5.7)**
EBITDA	**1.9**	**0.2**	**(1.7)**
Net interest	0.1	0.1	0.0
Depreciation	(32.3)	(29.8)	2.6
Impairment	(1.4)	(4.4)	(3.0)
PDC dividend payable	(10.4)	(11.3)	(0.8)
Net deficit	**(42.2)**	**(45.2)**	**(3.0)**
EBITDA %		**0.0%**	
Less Impairments	1.4	4.5	3.1
RETAINED SURPLUS / (DEFICIT)	**(40.7)**	**(40.7)**	**-**

4.2 The assumptions included are as follows:

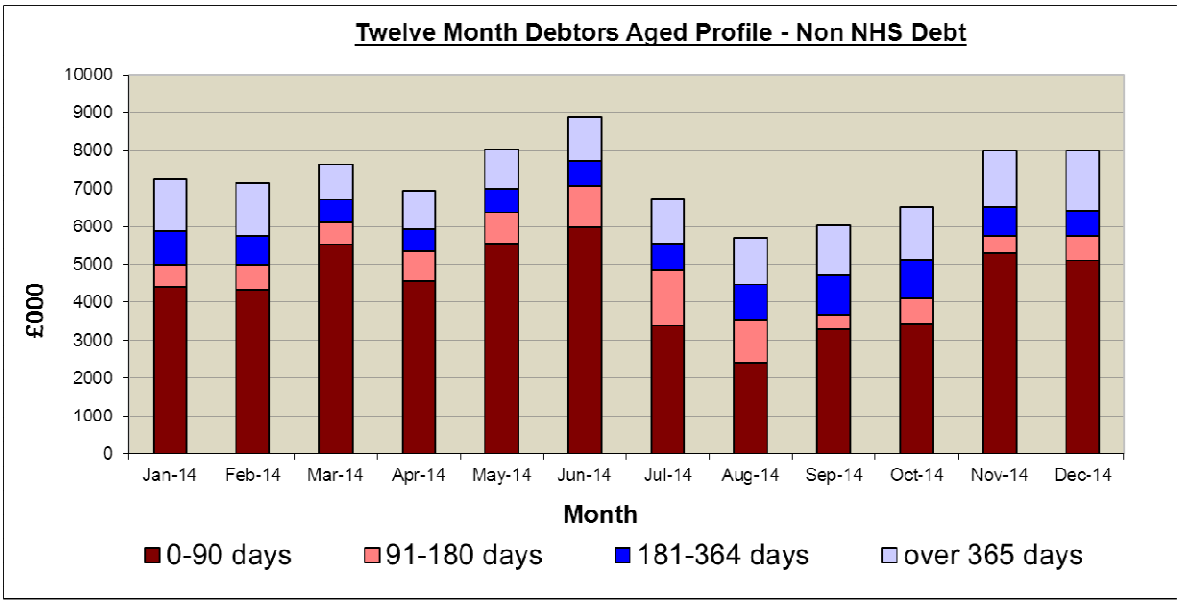
- All CMGs and Directorates deliver to their control
- Commit to a release of reserve contingency of £1m to support the position, making it unavailable for commitment elsewhere
- Receipt of operational resilience funding of £3m for winter
- Receipt of operational resilience funding of £2.9m for RTT
- Costs of £1.9m for delivery of RTT and winter above those already in the plan

4.3 Key to meeting the forecast is the delivery of CMG and Directorate positions. The chart below shows the planned and actual/forecast deficit for each month. The forecast shows improvement to the position in the final quarter.



5. BALANCE SHEET AND CASHFLOW

5.1 The effect of the Trust's financial position on its balance sheet is provided in Appendix 4. The retained earnings reserve has reduced by the Trust's deficit for the year to date. The level of non-NHS debt has fluctuated across the year as shown in the following table:



5.2 The overall level of non-NHS debt at the end of December has remained at £7.9m. Total debt over 90 days is £2.9m and this has increased by £0.2m from November.

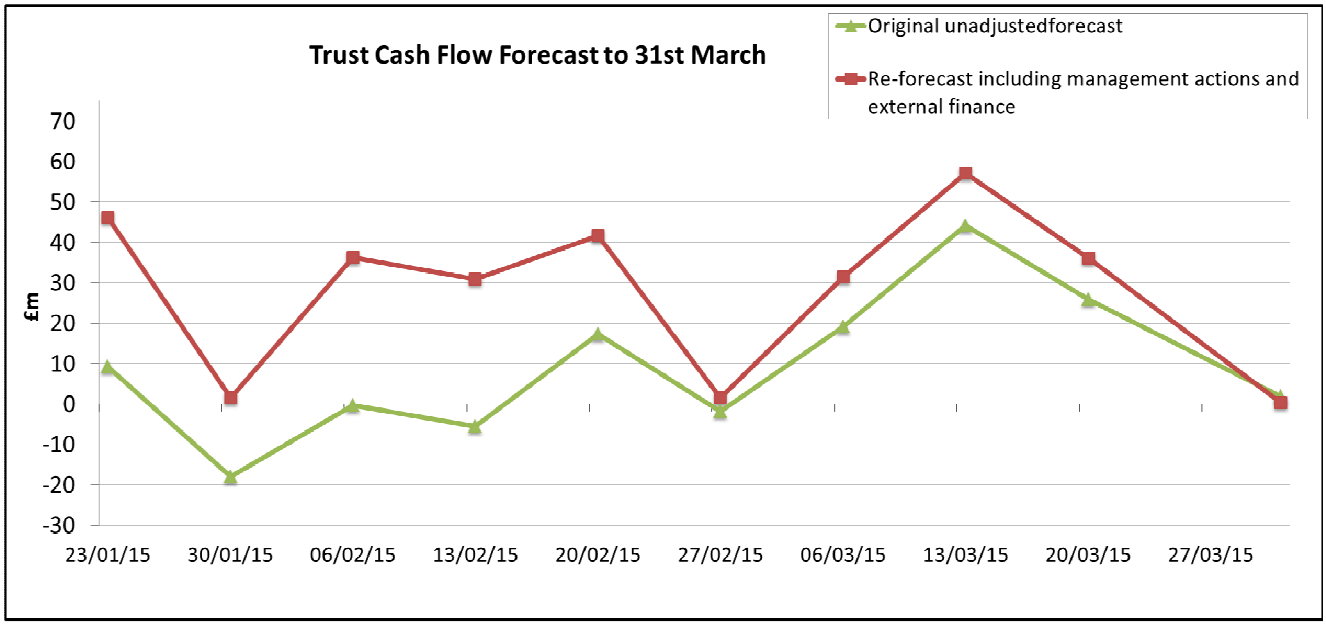
5.3 The proportion of total debt over 90 days has increased from 34% to 36%. £1.8m of this debt relates to overseas patients where we expect a low recovery rate of approximately 25%. All overseas patient debt over 90 days old is provided for in full within the Trust's bad debt provision.

5.4 The Better Payments Practice Code (BPPC) performance for end of December YTD, shown in the table below, shows an improvement from 67% to 70% in terms of invoices paid within 30 days by value.

	By Volume Number	By Value £000s
Current Month YTD		
Total bills paid in the year	110,479	497,698
Total bills paid within target	55,054	346,044
Percentage of bills paid within target	**50%**	**70%**
Prior month YTD		
Total bills paid in the year	106,813	357,794
Total bills paid within target	53,288	240,398
Percentage of bills paid within target	**50%**	**67%**

5.5 The Trust's cashflow forecast is consistent with the income and expenditure position. The cash balance at the end of December was £9.8m which is £1.4m below plan of £11.2m.

5.6 The Trust's cash forecast to the year-end is shown in the graph below. This indicates that, with the management actions and additional external financing, we will avoid being significantly overdrawn at the end of January and will achieve the planned year-end cash balance of £0.3m.



5.7 The Department of Health has set a date of 23rd February 2015 for the repayment of the £46m temporary borrowing that we have received in the year to date. On the same date, we are expecting to draw down the full £58m PDC approved for 2014/15 by the Independent Trust Financing Facility (ITFF) to:

- Fund our £40.7m deficit for 2014/15
- Improve our liquidity by £5.3m
- Fund £12m of capital expenditure

5.8 Our initial cash requirement to improve liquidity was £12.7m, and £5.3m was finally approved following discussions with the NTDA. Due to this shortfall, we expect to have a backlog of authorised and unpaid invoices of £8.5m at the end of 2014/15 compared to a balance of £12.7m at the end of 2013/14. We will apply for temporary borrowing to be received in early April to enable us to make these payments and minimise the potential impact on our suppliers.

5.9 We will also not achieve the BPPC target of 95% for 2014/15 as the value of the approved funding will enable us to achieve 72% against the BPPC by value. We are currently on course to achieve this as the YTD performance is currently 70% as shown in 5.4.

6. CAPITAL

6.1 The total capital expenditure at the end of December was £23.5m against the year to date plan of £34.4m, an underspend of £10.9m (32%). The capital plan and expenditure can be seen in Appendix 5.

6.2 At the end of December, there was a total of £11.2m of outstanding orders. The combined position is that we have spent or committed £34.7m, or 75% of the annual plan and this is also higher than the year to date plan.

6.3 The following table details the capital plan at the start of the year compared with the revised plan at the end of December as well as forecast expenditure. We reduced our external capital funding requirement by £4.3m following advice from the NTDA. After a detailed review of schemes, forecast spend has reduced from £55.0m to £49.0m.

6.4 The over-commitment against the capital funding has therefore reduced from £4.1m to £2.4m and this will be managed to ensure there is no overspend for the full year.

	Original plan	Revised plan	Movement
	£000's	£000's	£000's
Capital Resource Limit	34,207	34,207	-
Plus Donations	300	300	-
Plus Anticipated PDC	16,322	12,000	(4,322)
TOTAL Funding	**50,829**	**46,507**	**(4,322)**
Forecast Spend	(54,932)	(48,956)	5,976
Over Commitment	**(4,103)**	**(2,449)**	**1,654**

7. RISKS

7.1 Within the financial position and year end plan, there continues to be the following potential risks:

- **Delivery of the forecast outturn position** has become challenging following revised forecasts from CMGs and Corporate Directorates. All areas must deliver to control totals

  Mitigation: Regular performance meetings with CMGs to monitor performance against plan and forecast and agreed control totals

- **Capacity requirements** for theatres and beds beyond the levels planned resulting in premium costs not forecasted or planned for

Mitigation: The Trust is planning to open an additional 15 beds for which capital and revenue costs are within the financial plan. Work is ongoing on a theatres capacity plan

- **CCG Contract (including Contractual Fines and Penalties)**

  The CCG contract has been signed with a penalty cap of £10m. In addition, CCGs have raised Activity Query Notices around emergency admissions and outpatients, Letters of Enquiry regarding Critical Care activity and Imaging activity and a number of contractual queries

  Mitigation: Agreement has been reached regarding an affordable settlement for 2014/15 encompassing all activity queries and penalties

- **Referral To Treat (RTT) and Elective/Day Case Activity**

  There is a risk to the delivery of the RTT target resulting in additional premium costs to ensure delivery of income lower than forecast in particular theatre costs not identified. In addition, there is a risk that activity continues to be lower than the plan and forecast

  Mitigation: RTT plan performance managed through fortnightly meeting with CCG/NTDA and IST to review robustness of the plan. Additional costs to weekend theatre sessions have been identified within the forecast and embedded in proposed control totals

- **CIP Delivery**

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

  Mitigation: External consultancy support from Ernst & Young, along with revised CIP governance arrangements, a weekly CIP Board and CMG Performance Management meetings. £48m has been identified for 2014/15 and the programme for development of plans for £41m for 2015/16 is in place

- **Liquidity**

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

  Mitigation: Loan funding of £58m approved by the Independent Trust Financing Facility to support the deficit and the capital plan

- **Unforeseen Events**

  The Trust has very little flexibility and no contingency remains in reserves

  Mitigation: The Trust is aware of commitments made and the constraints of specific funding streams

- **Contractual Challenges (Non Patient Care)**

  The Trust is aware of potential contract challenges around the Interserve Contract, particularly relating to the impact of TUPE transfers and catering volumes

Mitigation: The Trust has reviewed the contract and has further contractual claims to more than negate the counter claims. Legal advice is being taken and both parties are currently engaged in formal mediation.

8. CONCLUSION

8.1. The Trust, at the end of Month 9, has an adverse position of £2.6m against the planned deficit of £30.3m but is forecasting the delivery of all its financial duties at year end.

9. NEXT STEPS AND RECOMMENDATIONS

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

- **Note** the contents of this report
- **Discuss and agree** the actions required to address the key risks/issues

Paul Traynor
Director of Finance

5th February 2015

Appendix 1

	December 2014			April - December 2014		
	Plan £ 000	Actual £ 000	Variance (Adv) / Fav £ 000	Plan £ 000	Actual £ 000	Variance (Adv) / Fav £ 000
Elective	5,934	5,449	(484)	55,245	**53,635**	(1,611)
Day Case	4,785	4,835	49	45,653	**44,142**	(1,511)
Emergency (incl MRET)	14,947	15,078	131	131,998	**131,922**	(76)
Outpatient	8,428	8,255	(174)	79,212	**78,156**	(1,057)
Penalties	(292)	(1,038)	(747)	(2,625)	**(5,862)**	(3,237)
Non NHS Patient Care	477	583	106	4,211	**4,738**	527
Resilience Funding	0	1,055	1,055	0	**2,489**	2,489
Other	24,052	24,447	395	212,847	**216,099**	3,252
Patient Care Income	**58,332**	**58,664**	**332**	**526,542**	**525,318**	**(1,224)**
Teaching, R&D income	6,774	6,323	(451)	61,107	**60,787**	(320)
Other operating Income	3,064	3,431	367	27,856	**28,739**	883
Total Income	**68,170**	**68,418**	**248**	**615,505**	**614,844**	**(661)**
Pay Expenditure	**41,237**	41,812	**(575)**	**371,468**	**368,704**	**2,764**
Non Pay Expenditure	**26,484**	27,248	**(764)**	**238,689**	**243,184**	**(4,495)**
Total Operating Expenditure	**67,721**	**69,060**	**(1,339)**	**610,157**	**611,888**	**(1,731)**
EBITDA	**449**	**(642)**	**(1,091)**	**5,348**	**2,956**	**(2,392)**
Interest Receivable	8	7	(1)	72	**61**	(11)
Interest Payable	0	(3)	(3)	0	**(26)**	(26)
Depreciation & Amortisation	(2,729)	(2,625)	104	(25,187)	**(25,173)**	14
Impairment	(1,445)	(4,447)	(3,002)	(1,445)	**(4,447)**	(3,002)
Surplus / (Deficit) Before Dividend and Disposal of Fixed Assets	**(3,717)**	**(7,710)**	**(3,993)**	**(21,212)**	**(26,629)**	**(5,417)**
Profit / (Loss) on Disposal of Fixed Assets	(1)	(1)	0	(11)	**(1)**	10
Dividend Payable on PDC	(826)	(1,040)	(214)	(7,949)	(8,135)	(186)
Net Surplus / (Deficit)	**(4,544)**	**(8,751)**	**(4,207)**	**(29,172)**	**(34,765)**	**(5,593)**
Less Impairments	1,445	4,447	3,002	1,445	4,495	3,050
RETAINED SURPLUS / (DEFICIT)	**(3,099)**	**(4,304)**	**(1,205)**	**(27,727)**	**(30,270)**	**(2,543)**

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

Case mix	Plan to Date (Activity)	Total YTD (Activity)	Variance YTD (Activity)	Variance YTD (Activity %)	Plan to Date (£000)	Total YTD (£000)	Variance YTD (£000)	Variance YTD (Activity %)
Day Case	74,211	73,413	(798)	(1.08)	45,653	44,142	(1,511)	(3.31)
Elective Inpatient	17,681	16,385	(1,296)	(7.33)	55,245	53,635	(1,611)	(2.92)
Emergency / Non-elective Inpatient	75,535	78,264	2,729	3.61	136,883	139,098	2,215	1.62
Marginal Rate Emergency Threshold (MRET)	0	0	0	0.00	(4,885)	(7,176)	(2,291)	46.89
Outpatient	688,315	680,880	(7,435)	(1.08)	79,212	78,156	(1,057)	(1.33)
Emergency Department	107,253	114,789	7,536	7.03	11,633	12,754	1,121	9.64
Penalties	0	0	0		(2,625)	(5,862)	(3,237)	123.33
Other	6,320,657	6,261,703	(58,954)	(0.93)	205,425	210,572	5,147	2.51
Grand Total	**7,283,653**	**7,225,434**	**(58,219)**	**(0.80)**	**526,542**	**525,318**	**(1,224)**	**(0.23)**

Average tariff	Price Variance YTD %	Volume Variance YTD %	Price / Mix Variance (£000)	Volume Variance (£000)	Variance YTD (£000)
Day Case	(2.3)	(1.1)	(1,020)	(491)	(1,511)
Elective Inpatient	4.8	(7.3)	2,438	(4,049)	(1,611)
Emergency / Non-elective Inpatient	(1.9)	3.6	(2,731)	4,945	2,215
Marginal Rate Emergency Threshold (MRET)			(2,291)	0	(2,291)
Outpatient	(0.3)	(1.1)	(201)	(856)	(1,057)
Emergency Department	2.4	7.0	304	817	1,121
Penalties			(3,237)		(3,237)
Other			0	5,147	5,147
Grand Total	**0.6**	**(0.8)**	**(6,737)**	**5,513**	**(1,224)**

Financial Performance by CMG & Corporate Directorate

I&E and CIP – to December 2014

	Year to Date					
	I&E			CIP		
CMG / Directorate	YTD Budget £000s	YTD Actual £000s	Variance £000s	YTD Plan £000s	YTD Actual £000s	Variance £000s
CMGs:						
C.H.U.G.S	33,225	33,499	273	3,534	3,604	70
Clinical Support & Imaging	-27,317	-27,428	-111	3,277	3,200	-77
Emergency & Specialist Med	13,666	15,152	1,486	5,056	5,670	614
I.T.A.P.S	-32,446	-34,436	-1,990	3,178	2,921	-258
Musculo & Specialist Surgery	30,660	26,219	-4,441	3,691	3,664	-27
Renal, Respiratory & Cardiac	24,231	23,622	-609	4,372	4,748	376
Womens & Childrens	33,189	33,173	-16	4,780	4,853	73
	75,208	**69,800**	**-5,408**	**27,887**	**28,659**	**772**
Corporate:						
Communications & Ext Relations	-543	-512	32	40	40	0
Corporate & Legal	-2,581	-2,620	-39	50	63	14
Corporate Medical	-1,351	-1,285	66	56	56	0
Facilities	-29,459	-28,605	854	207	237	31
Finance & Procurement	-5,154	-4,729	425	2,568	3,032	464
Human Resources	-4,298	-4,097	201	192	374	182
Im&T	-7,477	-7,331	147	126	212	86
Nursing	-15,943	-15,608	336	34	43	9
Operations	-5,178	-5,357	-180	80	109	29
Strategic Devt	-2,030	-1,779	251	118	121	3
	-74,014	**-71,922**	**2,092**	**3,469**	**4,285**	**816**
Other:						
Alliance Elective Care	17	-16	-34			
R&D	3	204	201			
Central	-28,936	-28,339	597	4	0	-4
	-28,916	**-28,151**	**764**			
Total	**-27,722**	**-30,273**	**-2,551**	**31,360**	**32,945**	**1,584**

Appendix 4

Balance Sheet

	Mar-14 £000's Actual	Apr-14 £000's Actual	May-14 £000's Actual	Jun-14 £000's Actual	Jul-14 £000's Actual	Aug-14 £000's Actual	Sep-13 £000's Actual	Oct-13 £000's Actual	Nov-14 £000's Actual	Dec-13 £000's Actual	Mar-15 £000's Forecast
Non Current Assets											
Property, plant and equipment	362,465	360,188	359,769	358,289	359,152	359,238	359,534	361,704	399,441	396,190	380,902
Intangible assets	8,019	7,788	7,555	7,338	7,109	6,877	6,636	6,408	6,180	6,452	5,327
Trade and other receivables	3,123	3,311	3,152	3,115	3,002	3,004	3,043	3,065	3,087	3,163	2,503
TOTAL NON CURRENT ASSETS	**373,607**	371,287	370,476	368,742	369,263	369,119	369,213	371,177	408,708	**405,805**	**388,732**
Current Assets											
Inventories	13,937	13,711	14,633	14,627	15,390	14,894	14,579	15,215	15,040	15,009	14,200
Trade and other receivables	49,892	44,492	44,580	51,192	47,903	38,966	32,335	36,344	36,383	32,211	46,932
Cash and cash equivalents	515	13,850	5,838	13,662	14,954	8,430	7,560	3,205	9,931	9,846	277
TOTAL CURRENT ASSETS	**64,344**	72,053	65,051	79,481	78,247	62,290	54,474	54,764	61,354	**57,066**	**61,409**
Current Liabilities											
Trade and other payables	(109,135)	(102,381)	(100,604)	(100,725)	(100,661)	(88,023)	(86,892)	(91,232)	(102,723)	(85,350)	(92,743)
Dividend payable	0	(1,025)	(1,894)	(2,763)	(3,632)	(4,540)	0	0	(2,080)	(3,120)	0
Borrowings	(6,590)	(6,590)	(6,590)	(6,590)	(6,590)	(6,590)	(2,919)	(2,919)	(3,753)	(4,170)	(2,800)
Provisions for liabilities and charges	(1,585)	(1,585)	(1,585)	(1,585)	(1,585)	(1,585)	(1,585)	(1,585)	(1,585)	(512)	(426)
TOTAL CURRENT LIABILITIES	**(117,310)**	(111,581)	(110,673)	(111,663)	(112,468)	(100,738)	(91,396)	(95,736)	(110,141)	**(93,152)**	**(95,969)**
NET CURRENT ASSETS (LIABILITIES)	**(52,966)**	(39,528)	(45,622)	(32,182)	(34,221)	(38,448)	(36,922)	(40,972)	(48,787)	**(36,086)**	**(34,560)**
TOTAL ASSETS LESS CURRENT LIABILITIES	**320,641**	331,759	324,854	336,560	335,042	330,671	332,291	330,205	359,921	**369,719**	**354,172**
Non Current Liabilities											
Borrowings	(5,890)	(5,794)	(5,785)	(5,730)	(5,676)	(5,683)	(9,179)	(9,186)	(8,075)	(7,663)	(9,356)
Other Liabilities	0	0	0	0	0	0	0	0	0	0	0
Provisions for liabilities and charges	(2,070)	(2,048)	(2,022)	(2,006)	(1,830)	(1,207)	(1,171)	(1,156)	(1,110)	(2,194)	(1,873)
TOTAL NON CURRENT LIABILITIES	**(7,960)**	(7,842)	(7,807)	(7,736)	(7,506)	(6,890)	(10,350)	(10,342)	(9,185)	**(9,857)**	**(11,229)**
TOTAL ASSETS EMPLOYED	**312,681**	323,917	317,047	328,824	327,536	323,781	321,941	319,863	350,736	**359,862**	**342,943**
Public dividend capital	282,625	298,125	298,125	311,625	311,625	311,625	311,625	311,625	311,625	329,837	353,602
Revaluation reserve	64,598	64,598	64,598	64,598	64,598	64,598	64,598	64,598	104,278	99,785	64,628
Retained earnings	(34,542)	(38,806)	(45,676)	(47,399)	(48,687)	(52,442)	(54,282)	(56,360)	(65,167)	(69,760)	(75,287)
TOTAL TAXPAYERS EQUITY	**312,681**	323,917	317,047	328,824	327,536	323,781	321,941	319,863	350,736	**359,862**	**342,943**

Capital Plan

December 2014	Annual Budget £'000	Actual Spend £'000	Outstanding Commitments £'000	Total £'000	Variance £'000	Full Year Forecast Outurn £'000	Full Year Forecast Variance £'000
CHUGGS CMG							
Endoscopy GH	309	228	0	229	80	250	59
Lithotripter Machine	430	430	1	430	(0)	430	0
Sub-total: CHUGGS CMG	**739**	**658**	**1**	**659**	**80**	**680**	**59**
CSI CMG							
Aseptic Suite	400	290	106	396	4	350	50
MES Installation Costs	1,302	1,387	98	1,485	(183)	1,750	(448)
Sub-total: CSI CMG	**1,702**	**1,677**	**204**	**1,881**	**(179)**	**2,100**	**(398)**
Women's and Children's CMG							
Maternity Interim Development	1,000	820	19	839	161	1,000	0
Bereavement Facilities	62	113	0	113	(51)	162	(100)
Life Studies Centre	650	1	48	49	601	325	325
Sub-total: Women's & Children's CMG	**1,712**	**934**	**67**	**1,001**	**711**	**1,487**	**225**
Renal, Respiratory & Cardiac CMG							
Renal Home Dialysis Expansion	708	142	0	142	566	535	173
Sub-total: Renal, Respiratory & Cardiac CMG	**708**	**142**	**0**	**142**	**566**	**535**	**173**
Emergency & Specialist Medicine CMG							
Brain Injury Unit (BIU) Works	47	49	0	49	(2)	49	(2)
Equipment: 8th Resus Bay	40	42	0	42	(2)	42	(2)
DVT Clinic Air Conditioning	30	14	0	14	16	14	16
Sub-total: Emergency & Specialist Medicine CMG	**117**	**104**	**0**	**104**	**13**	**105**	**12**
ITAPS CMG							
da Vinci Robot equipment	103	103	0	103	0	103	0
GH Theatre 6 Equipment	177	145	0	145	32	145	32
Sub-total: ITAPS CMG	**280**	**248**	**0**	**248**	**32**	**248**	**32**
Corporate / Other Schemes							
Stock Management Project	6	5	0	5	1	5	1
Medical Equipment Executive	3,237	2,285	208	2,494	743	2,952	285
LiA Schemes	250	59	35	94	156	250	0
Odames Library	1,500	736	560	1,296	204	1,500	0
Safecare Module	66	77	0	77	(11)	77	(11)
Other Developments	0	110	30	140	(140)	140	(140)
Donations	300	403	0	403	(103)	403	(103)
Sub-total: Corporate / Other Schemes	**5,359**	**3,676**	**833**	**4,508**	**851**	**5,327**	**32**
IM&T Schemes							
IM&T Sub Group Budget	2,000	632	441	1,073	927	2,000	0
Safer Hospitals Technology Fund	1,150	142	166	309	841	1,150	0
EDRM System	3,300	705	604	1,310	1,990	3,300	0
EPR Programme	3,100	1,355	13	1,367	1,733	3,100	0
LRI Managed Print	412	74	351	425	(12)	413	(1)
Unified Comms	1,850	135	0	135	1,715	850	1,000
Sub-total: IM&T Schemes	**11,812**	**3,044**	**1,575**	**4,619**	**7,193**	**10,813**	**999**
Facilities / NHS Horizons Schemes							
Facilities Backlog Budget	5,500	1,135	1,271	2,405	3,095	5,500	0
Accommodation Refurbishment	52	10	12	22	30	52	0
CHP Units LRI & GH	800	626	0	626	174	800	0
Multi-Storey Car Park (MSCP)	250	123	187	310	(60)	250	0
Sub-total: Facilities / NHS Horizons Schemes	**6,602**	**1,894**	**1,469**	**3,053**	**3,299**	**6,602**	**0**
Reconfiguration Schemes							
Theatre Recovery LRI	2,785	922	465	1,388	1,397	2,350	435
Interim ITU LRI	590	377	151	528	62	590	0
Ward 4 LGH	1,000	859	25	884	116	1,000	0
Additional Beds (GH & LRI)	2,000	42	62	104	1,896	400	1,600
Feasibility Studies	100	(10)	0	(10)	110	100	0
Sub-total: Reconfiguration Schemes	**6,475**	**2,191**	**704**	**2,895**	**3,580**	**4,440**	**2,035**
Over Commitment	(5,321)					(2,449)	(2,872)
Total Schemes funded via internal sources	30,185	14,567	4,853	19,420	16,086	29,888	297
Schemes to be funded via external loan / PDC							
ED Enabling Schemes							
Modular Wards LRI	3,700	4,759	275	5,034	(1,334)	5,000	(1,300)
Clinic 1 & 2 Works	814	70	29	99	715	814	0
Old Cancer Centre Conversion	1,050	904	49	953	97	1,050	0
Oliver Ward Conversion	1,260	1,681	38	1,719	(459)	1,260	0
Clinical Genetics	158	62	2	64	94	158	0
Chapel Relocation	315	102	15	117	198	315	0
Victoria Main Reception	525	81	19	101	424	525	0
Sub-total: ED Enabling schemes	**7,822**	**7,659**	**427**	**8,086**	**(264)**	**9,122**	**(1,300)**
Emergency Floor	6,000	1,259	4,244	5,503	497	6,400	(400)
GGH Vascular Surgery	2,500	48	1,693	1,741	759	1,200	1,300
Sub-total: External Loans	16,322	8,966	6,363	15,330	992	16,722	(400)
Total Capital Plan	46,507	23,533	11,217	34,750	17,079	46,610	(103)

University Hospitals of Leicester NHS
NHS Trust

Agenda Item: Trust Board Paper J

TRUST BOARD – 5 February 2015

Emergency Care Performance Report

DIRECTOR:	Richard Mitchell , Chief Operating Officer
AUTHOR:	Richard Mitchell
DATE:	5 February 2015
PURPOSE:	a) To update the Board on recent emergency care performance b) To update on progress against the LLR action plan
PREVIOUSLY CONSIDERED BY:	Emergency Quality Steering Group, Urgent Care Board and System Resilience Group
Objective(s) to which issue relates *	[ ] 1. Safe, high quality, patient-centred healthcare [x] 2. An effective, joined up emergency care system [ ] 3. Responsive services which people choose to use (secondary, specialised and tertiary care) [ ] 4. Integrated care in partnership with others (secondary, specialised and tertiary care) [ ] 5. Enhanced reputation in research, innovation and clinical education [ ] 6. Delivering services through a caring, professional, passionate and valued workforce [ ] 7. A clinically and financially sustainable NHS Foundation Trust [ ] 8. Enabled by excellent IM&T
Please explain any Patient and Public Involvement actions taken or to be taken in relation to this matter:	Healthwatch representatives on UCB and involved in BCT workstream.
Please explain the results of any Equality Impact assessment undertaken in relation to this matter:	None undertaken but will be in respect of new pathways within BCT.
Organisational Risk Register/ Board Assurance Framework *	[ ] **Organisational Risk Register** [x] **Board Assurance Framework** [ ] **Not Featured**
ACTION REQUIRED * For decision [x] For assurance [ ] For information [ ]	

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

REPORT TO:	**Trust Board**
REPORT FROM:	**Richard Mitchell, Chief Operating Officer**
REPORT SUBJECT:	**Emergency Care Performance Report**
REPORT DATE:	**5 February 2015**

Key Points

- There are signs of recent improvement in the emergency care system. ED performance for the month to 18 January 2015 (part month effect) was **89.7%** compared to **93.6%** in January 2014 (full month data), and represents an improvement over **82.9%** in December 2014. Performance for week ending 26 January was **97.04%**
- Emergency Admissions (Adult) continued to rise month-on-month, with **5,323** admissions to 15 January 2015 (part month effect), compared to **6,442** for January 2014 (full month). The current projection for January 2015 (full month, estimate) is in the region of **6,600** admissions. Emergency Admissions (Adult) totalled **6,759** for December 2014, compared to just over **6,000** during December 2013, an increase of 12% year on year
- Emergency admissions during January 2015 averaged **224** per day, compared to **215** per day for the same period in January 2014, an increase of 4.2% year on year
- Delayed transfers of care continue to reduce within year, with data from the most recently reported period down from **5.2%** in November to **3.9%** in December 2014 (compared to **3.6%** in December 2013)

Performance Overview

Hospitals across the country have been facing unprecedented emergency care pressures. Our weekly performance for w/e 18 January 2015 was 94.16%, ranking us 2nd overall out of 8 trusts in the East Midlands and 46th overall out of 139 trusts nationally. Performance for the period 22 December 2014 to 18 January 2015 was 86.13%, ranking us 3rd overall out of the 8 trusts in the East Midlands and 86th overall nationally.

Following last month's Trust Board discussion, the Chairman raised the Board's concerns about the performance of the wider emergency care system with the Chair of the Urgent Care Board. There is no doubt that in recent weeks the wider system has stepped up its response, in particular by extending on-site presence of community and social care staff. This has been of significant benefit and it is important that this input is maintained. Action orientated daily conference calls have also been taking place 7 days a week at Director level to ensure that problems are tackled in real time.

Actions since Trust Board held 8 January 2015

Good progress continues to be made with the UHL actions contained within the LLR Operational Winter Emergency Care Action Plan. This plan details the actions required by partner organisations and which will positively influence demand, flow and discharge of patients across all parts of the Urgent Care system.

The plan includes a total of 55 actions in respect of UHL which detail and expand upon the following over-arching areas for improvement:

Areas for Improvement	
1	Improve 'front-door' interface and alignment (ED / Urgent Care Centre)
2	Improve ambulance turnaround times
3	Implement the Ambulatory Emergency Care strategy
4	Improve the resilience of ED processes
5	Review ED staffing
6	Increase the proportion of GP bed referrals going directly to AMU
7	Reduce the time to assessment by a consultant on AMU
8	Improve Middle Grade staffing resilience in AMU
9	Reduce bed occupancy on the base wards
10	Improve the discharge process in Medicine and Cardio-respiratory
11	Reduce discharge delays caused by To Take Outs (TTOs)

1. Improving the 'front door interface

Key successes have included the establishment of a good interface between ED and the Urgent Care Centre, working to ensure that patients can be directed to the most appropriate setting and then seen by the most appropriate person for their need. Following the introduction of consultant-led telephone triage to GP referrals, an audit across two weeks in early January of evening-only referrals demonstrated that out of 36 telephone triage contacts, 4 patients (11%) did not need to attend ED and a further 11 patients (34%) were correctly diverted to a more appropriate setting or service. This pilot is continuing and will then be evaluated.

2. Improving ambulance turnaround times

We continue to focus on efforts to improve ambulance turnaround times. We have employed additional nurses to work in the assessment bays to support improvements in ambulance handover and turnaround times. The Trust continues to work closely with East Midlands Ambulance Service (EMAS), and is in the process of introducing new touchscreens in ED aimed at improving turnaround times and supporting single person handover. Staff training for this will commence in March 2015, with a plan to fully implement from April. Data for December 2014 reflects the scale of this challenge – we accepted 3,048 ambulance drop-offs during this period, of which 749 (24.6%) experienced a handover delay of 30 minutes and 250 (8.2%) experienced a handover delay of over 60 minutes.

3. Introduce the Ambulatory Emergency Care strategy

The Trust is now a Cohort 6 member of the Ambulatory and Emergency Care (AEC) Delivery Network, and received a positive report following a visit by the Network which took place on 7 January 2015. Data analysis of agreed pathways through ED is now underway, aiming to further enhance and refine priority pathways as appropriate.

4. Improving the resilience of ED processes

We have worked to strengthen processes within ED, including holding weekly 'journey meetings' which review any delays in patient's ED pathways. The trust's 'Gold Command' now meets regularly, is well attended, and is focused on the appropriate flow and discharge of patients through ED. This system is now led by a Director 7 days a week. A Whole Hospital Response process is being revised, and ED has also reviewed and implemented changes to its Standard Operating Procedures (SOPs) to ensure it correctly manages spikes in activity or any delayed discharges.

5. Review ED staffing

Medical staffing has been reviewed to ensure that the Trust has a forward plan addressing its recruitment needs and workforce model. Programme management work is underway to develop and implement a simulation model to ensure the optimum balance between demand and capacity.

6. Increase the proportion of GP referrals going directly to AMU

We have worked closely with CCG colleagues to support the correct flow of GP referrals direct to AMU. Senior decision-maker presence now features within AMU from 0800 through 1700 to facilitate this. A programme of

construction work to increase by 3 the number of beds in the Acute Medical Clinic is underway, and is expected to complete in early March 2015.

7. Reduce the time to assessment by a consultant on AMU

In order to reduce the time taken for patients to be assessed by a consultant in the Acute Medical Unit (AMU), we have ensured that consultant presence on AMU is continuous and supported by roving ward rounds between 0800 and 2300 Monday to Friday and 0800 and 2000 at weekends.

8. Improve Middle Grade staffing resilience in AMU

A review of Middle Grade remuneration rates for temporary medical staff on AMU has now taken place, and a proposal to ensure resilience of these roles is being developed by the AMU management team. This links to trust-wide work on middle and junior grades through the manpower planning project.

9. Reduce bed occupancy on the base wards

Actions are underway to support a 5% reduction in occupancy on the base wards, aiming to discharge patients in a timely manner and complete with any necessary prescriptions. We aim to ensure that all patients leaving the assessment unit have a main diagnosis, plan and Expected Date of Discharge (EDD). The Trust is piloting the use of tablet computers to provide real-time bed status information to clinical and managerial staff. Consultant presence on short stay and key speciality base wards (34, 37 and 38) has been increased at weekends. Additionally, a programme of support and coaching has commenced with nursing and therapies staff to ensure they have the necessary skills and experience to positively and correctly influence the discharge process in support of reducing overall bed occupancy.

10. Improve the discharge process in Medicine and Cardio-respiratory

Work is progressing well to improve the discharge process for medicine and cardiorespiratory including multi-disciplinary team led board rounds 7 days per week, and successfully supporting our nursing and therapies staff on wards to prioritise simple discharges through systems of support including coaching as mentioned above.

11. Reduce discharge delays caused by TTOs

In order to reduce the numbers of discharges delayed by TTOs, we are increasing the volume of Discharge Summaries completed for patients the day before discharge. Pharmacy support to base wards and discharge areas is also being enhanced, and a business case for additional pharmacist input to facilitate improved discharge process has been submitted to the |Revenue Investment Committee.

The table below summarises the current status of the Trusts 55 actions listed within the LLR Action Plan, in turn reporting to the UCB. The majority of actions are now either complete or complete and moved to a process of monthly review (30 actions in total). A further 13 actions have commenced and are on track to deliver as planned. For those actions not currently on track but expected to complete as planned, a process of regular assurance to the EQSG provides oversight of progress. Additionally, 2 actions are currently experiencing delays (implementation of ED SOPs, and final arrangements with EMAS regarding funding and introduction of touchscreens in ED). Finally, 2 actions have commencement dates in the future (March 2015).

Status	RAG	Notes to support status	Count
Not yet commenced	White	The action has yet to start and is not beyond the expected start date for the action	2
Significant delay – unlikely to be completed as planned	Red	The action may not have started and is beyond the expected start date and is now unlikely to be completed as planned; or the action has started and has such a significant delay that the action will not be will be completed as planned	2
Some delay – expected to be completed as planned	Amber	The action may not have started and is beyond the expected start date but the action is expected to be completed as planned; or the action has started and has	8

Status	RAG	Notes to support status	Count
		a minor delay but will be completed as planned	
On track	Green	The action has started and is expected to be delivered as planned on time	13
Complete	Green	The action has been completed and there is no follow up review for the UCB	7
Complete and regular review	Blue	The action has been completed but regular review is required for reporting to the UCB	23

Programme management support for the delivery of the 55 actions contained within the UHL plan has been implemented, within three priority work streams:

Priority Work Streams		Clinical Lead
1	ED work-stream	Dr Ben Teasdale
2	AMU work-stream	Dr Lee Walker
3	Base Ward and Discharge work-stream	Dr Ian Lawrence

Next Steps

Delivery of the 55 actions continues during February, in support of achieving sustainable improvements by the end of March 2015. There will be a process of agreeing any additional actions for inclusion, during February. On-going governance and monitoring of the 55 actions within our plan is overseen by both the trust-level Emergency Quality Steering Group (EQSG) and the system-wide Urgent Care Board (UCB) to which we are partners. Sustained improvements, supported by evidence, will also be rolled-out at Glenfield Hospital and Leicester General Hospital.

Regular monitoring of actions and progress will provide assurance as to improvement against the agreed Key Performance Indicators (KPI's):

Core Key Performance Indicators (KPI's)	
1	90% of patients triaged within 20 minutes
2	50% reduction in waits over 30 minutes, and 50% reduction in waits over one hour
3	5% reduction in admissions (approximately 4 patients per day)
4	70% of time ED occupancy less than 55, and
5	No more than one hour wait to be seen by a consultant
6	Greater than 40% in Q3 and greater than 70% in Q4 of GP referrals go directly to AMU
7	Greater than 40% in Q3 and greater than 70% in Q4 of patients are seen by a consultant within 6 hours
8	Supports 5% (total) reduction in medical bed occupancy by the end of Q4

Conclusion

As perviously stated, achievement of sustained improvement requires all part of the health economy to improve and to function effectively within the wider system. January has seen a period of good, high quality improvements delivered by the Trust, and which we continue to monitor and further refine through our governance structure.

Although we have seen a period of improved performance, it is too early to be certain that this will be sustained. In particular, spikes in admissions may well threaten performance as the capacity of the system is relatively finite.

Recommendations

The Trust Board is recommended to:

- **Note** the contents of the report
- **Note** the actions taken since January's Trust Board
- **Note** the UHL update against the delivery of the new operational plan
- Seek **assurance** on UHL and LLR progress

University Hospitals of Leicester NHS
NHS Trust

Agenda Item: Trust Board Paper K

TRUST BOARD – 5 February 2015

Fit and Proper Person's Test

DIRECTOR:	Emma Stevens, Acting Director of Human Resources
AUTHOR:	Emma Stevens, Acting Director of Human Resources/Helen Atwell, Recruitment Services Manager
DATE:	5 February 2015
PURPOSE:	In response to the Francis Inquiry, the Government announced its intention to introduce a number of new measures aimed at improving openness and transparency and setting minimum standards of care. This means that new regulations setting out fundamental standards of care will come into force for all care providers required to register with the Care Quality Commission (CQC) from 1 April 2015. As part of these new regulations, from 27th November all NHS Trusts must meet the new Regulation 5: fit and proper persons test for Directors. Health service providers currently have a general obligation to ensure that they only employ individuals who are fit for their role and UHL undertakes this through following the NHS Employers Good Practice Guidance in relation to employment checks. The introduction of the fit and proper persons requirement for Directors imposes an additional requirement. The purpose is to require providers to take proper steps to ensure that their Directors (or equivalent) are fit and proper for the role. The scope of the new requirements cover all NHS bodies - including NHS Trusts, NHS Foundation Trusts and Special Health Authorities that are required to register with the Care Quality Commission (CQC). It will apply to all Directors: Executive, Non-Executive, permanent, interim, associate positions, or functions equivalent or similar to the functions of Director. It excludes Governors of Foundation Trusts but includes governors if they are a member of a Trust Board. The Trust must ensure that it only employs Directors, or their equivalent, who are fit for their role. Summary of checks required, to which standard they relate to and how the process will operate at UHL are detailed in the attached report.
PREVIOUSLY CONSIDERED BY:	**Trust Board 22 December 2014**
Objective(s) to which issue relates *	[√] 1. Safe, high quality, patient-centred healthcare [ ] 2. An effective, joined up emergency care system [ ] 3. Responsive services which people choose to use (secondary, specialised and tertiary care) [ ] 4. Integrated care in partnership with others (secondary, specialised and tertiary care) [ ] 5. Enhanced reputation in research, innovation and clinical education [√] 6. Delivering services through a caring, professional, passionate and valued workforce [ ] 7. A clinically and financially sustainable NHS Foundation Trust [ ] 8. Enabled by excellent IM&T

Please explain any Patient and Public Involvement actions taken or to be taken in relation to this matter:	The implementation of the new requirements is at the heart of the Government's approach to increasing transparency and accountability in the health and social care systems.
Please explain the results of any Equality Impact assessment undertaken in relation to this matter:	In line with current recruitment practice.
Organisational Risk Register/ Board Assurance Framework *	☐ **Organisational Risk Register** ☐ **Board Assurance Framework** ☑ **Not Featured**

ACTION REQUIRED *

For decision ☑ For assurance ☐ For information ☐

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

* tick applicable box

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **5 February 2015**

REPORT BY: **ACTING DIRECTOR OF HUMAN RESOURSES**

SUBJECT: **FIT AND PROPER PERSONS TEST: DIRECTORS (REGULATION 5)**

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1. INTRODUCTION

1.1 Against the backdrop of the Francis Inquiry report, the Government has legislated (via the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014) and made important changes to health and social care standards which are regulated by the Care Quality Commission (CQC). A report to the Trust Board on 22 December 2014 summarised the key changes and identified immediate actions to be taken in response.

1.2 This report provides an update on the requirements placed on NHS provider organisations as of 27 November 2014 to ensure Director level appointments meet the 'fit and proper persons test' which have been integrated into the CQC's registration requirements. The Trust has responsibility to ensure that all Directors meet the fitness test and do not meet any of the 'unfit' criteria.

2. REGULATION 5: FIT AND PROPER PERSONS: DIRECTORS

2.1 Health Service providers currently have a general obligation to ensure that they only employ individuals who are fit for their role and UHL undertakes this through following NHS Employers Good Practice Guidance in relation to employment checks.

2.2 The introduction of the fit and proper persons requirement for Directors imposes an additional requirement. The purpose is to require providers to take proper steps to ensure that their Directors (or equivalent) are fit and proper for the role.

2.3 The fit and proper persons test will apply to Directors (both Executive Directors and Non-Executive Directors) and individuals "performing the functions of, or functions equivalent or similar to the functions of, such a Director". The test will therefore apply to senior managers who exercise functions similar to the Directors of the organisation. Advice has been taken from the NTDA with regard to the interpretation of the 'Director' category and the advice was that the Fit and Proper Persons Test applies to Directors who regularly attend the Trust Board and/or are Directors who report directly to the Chief Executive.

2.4 The Regulations provide that health service bodies must not appoint or have in place an individual as a Director or equivalent unless:-

- the individual is of good character;

- the individual has the qualifications, competence, skills and experience which are necessary for the relevant office or position or the work for which they are employed;

- the individual is able by reason of their health, after reasonable adjustments are made, of properly performing tasks which are intrinsic to the office or position for which they are appointed or to the work for which they are employed;

- can supply information to the CQC as set out in Schedule 3 of the Regulations;

2.5 The regulations also list categories of persons who are prevented from holding office and for whom there is no discretion:-

- The person has been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity, or discharging any functions relating to any office or employment with a service provider;

- The person is an undischarged bankrupt or a person whose estate has had a sequestration awarded in respect of it and who has not been discharged;

- The person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland;

- The person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986(40);

- The person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it;

- The person is included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland;

- The person is prohibited from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment.

2.6 The regulations require the Chair of the Trust to:-

- Confirm to the CQC that the fitness of all new Directors has been assessed in line with the regulations and
- Declare to the CQC in writing that they are satisfied that they are fit and proper individuals for that role.

A notification to the CQC is already required following a new Director level appointment. The CQC will cross-check notifications about new Directors against other information that they hold or have access to, to decide whether we want to look further into the individual's fitness. They will also have regard to any other information that they hold or

obtain about Directors in line with current legislation on when convictions, bankruptcies or similar matters are to be considered 'spent'.

2.7 The CQC has the right to require the provision of information set out in Schedule 3 of the Regulations and such other information as set out in the pre-employment checklist at Appendix 2.

3 UHL PROCESS

3.1 In order to comply with Regulation 5, attached at **Appendix 1** are the specific requirements of the fit and proper person test (for sections 2.4 and 2.5 above) and sets alongside those requirements how the Trust intends to assure itself about the suitability of individuals. In addition, Appendix 1 outlines the annual checks which will be required.

3.2 The introduction of the Fit and Proper Persons Test will require new/amended documentation for employees meeting the definition as follows:-

(i) Specific Pre Employment Checklist (Appendix 2) which would be completed with the issuing of a Conditional Offer letter
(ii) Pre-Employment and Annual Declaration Form (Appendix 3)
(iii) Revised insert into the Reference Request Form (Appendix 4)
(iv) Revised Insert into Contract of Employment (Appendix 5)

4 RECOMMENDATION

4.1 The Trust Board are asked to comment and approve the implementation of the:-

- The advice from the NTDA regarding the definition of 'Director ' for this purpose is adopted
- Revised/New documents as attached as Appendices
- Approve the implementation of the Annual Declaration Form with immediate effect which will be signed off by the Chief Executive and Director of HR for posts reporting to the Chief Executive and by the Chairman and Director of HR for the Chief Executive and Non Executive Directors

Appendix 1

University Hospitals of Leicester NHS Trust
Compliance with Regulation 5 – Fit and Proper Persons Test

(*) indicates newly-introduced requirements to address the regulations

	Standard	Assurance	Evidence
1.	**The Individual is of Good Character**		
1.1	Providers should make every effort to ensure that all available information is sought to confirm that the individual is of good character as defined in Schedule 4, Part 2 of the regulations. *(Sch.4, Part 2: Whether the person has been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom, would constitute an offence. Whether the person has been erased, removed or struck-off a register of professionals maintained by a regulator of health care or social work professionals.)*	Employment checks are undertaken in accordance with NHS Employers pre-employment check standards and include: ▪ Two references, one of which must be most recent employer ▪ qualification and professional registration checks ▪ right to work checks ▪ identity checks ▪ occupational health clearance ▪ DBS checks (A standard check would be undertaken in line with DBS Requirements unless direct patient care is required and then an enhanced check would be required) In addition, we also carry out: ▪ Declarations of fitness by candidates ▪ Search of insolvency and bankruptcy register (*) ▪ Search of disqualified directors register (*)	Fit and Proper Person Pre Employment Checklist (*)

	Standard	Assurance	Evidence
1.2	Where a provider deems the individual suitable despite not meeting the characteristics outlined in Schedule 4, Part 2 of these regulations, the reasons should be recorded and information about the decision should be made available to those that need to be aware.	This would be the subject of debate at the Appointments Committee and subsequently at the Remuneration Committee. The minutes should record such decisions. The Chair will take advice from internal and external advisors as appropriate.	Appointment Committee notes /Minutes of Remuneration Committee meetings.
2.	**Individual has the qualifications, competence, skills and experience**		
2.1	Where specific qualifications are deemed by the provider as necessary for a role, the provider must make this clear and should only employ those individuals that meet the required specification, including any requirements to be registered with a professional regulator.	This requirement is included within the job Person Specification for relevant posts and is checked as part of the pre-employment checks.	Person Specification Fit and Proper Persons Recruitment Pre Employment Checklist (*) Appointment Committee notes
2.2	The provider should have appropriate processes for assessing and checking that the individual holds the required qualifications and has the competence, skills and experience required, (which may include appropriate communication and leaderships skills and a caring and compassionate nature), to undertake the role; these should be followed in all cases and relevant records kept.	Employment checks include a candidate's qualifications and employment references. The recruitment process also includes qualitative assessment and values-based questions. The Appointment Committee assessment is undertaken in line with the Person Specification for the role	Recruitment policy and procedure Values-based questions Appointment Committee notes

	Standard	Assurance	Evidence
2.3	The provider may consider that an individual can be appointed to a role based on their qualifications, skills and experience with the expectation that they will develop specific competence to undertake the role within a specified timeframe.	Any such decision would be discussed by the Appointments Committee and should be minuted. Any subsequent actions required would be subject to follow-up as part of on-going review and appraisal.	Appointment Committee notes Appraisal Paperwork
3.	**Health**		
3.1	When appointing relevant individuals the provider has processes for considering a person's physical and mental health in line with the requirements of the role.	All post-holders are subject to clearance by occupational health as part of the pre-employment process.	Occupational health clearance as part of Recruitment pre-employment checks
3.2	Wherever possible, reasonable adjustments are made in order that an individual can carry out the role.	Pre Employment Health Screening would take place and process re adjustments is already included in the Trust's Sickness Absence Policy.	Appropriate Occupational Health Report and Sickness Absence Policy
4.	**Check of Persons Prevented from holding office**		

	Standard	Assurance	Evidence
4.1	The provider has processes in place to assure itself that the individual has not been at any time responsible for, privy to, contributed to, or facilitated, any serious misconduct or mismanagement in the carrying on of a regulated activity; this includes investigating any allegation of such potential behaviour. Where the individual is professionally qualified, it may include fitness to practise proceedings and professional disciplinary cases. *("Responsible for, contributed to or facilitated" means that there is evidence that a person has intentionally or through neglect behaved in a manner which would be considered to be or would have led to serious misconduct or mismanagement.* *"Privy to" means that there is evidence that a person was aware of serious misconduct or mismanagement but did not take the appropriate action to ensure it was addressed.* *"Serious misconduct or mismanagement" means behaviour that would constitute a breach of any legislation/enactment CQC deems relevant to meeting these regulations or their component parts.")*	This has been incorporated as a specific declaration as part of the pre-employment process. It is also incorporated into a revised reference request template for all director and director-equivalent posts.	References received that form part of the Fit and Proper Persons Pre-Employment Checklist (*)
4.2	Only individuals who will be acting in a role that falls within the definition of a "regulated activity" as defined by the Safeguarding Vulnerable Groups Act 2006 will be eligible for a check by the Disclosure and Barring Service (DBS). As part of the recruitment/appointment process, providers should establish whether the individual is on a relevant barring list.	DBS checks are undertaken for those posts which fall within the definition of a "regulated activity" or which are otherwise eligible for such a check to be undertaken. Eligibility for DBS checks will be assessed for each vacancy arising.	DBS Policy DBS checks for eligible post-holders

	Standard	Assurance	Evidence
4.3	The person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland; The person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986(40); The person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it;	Search undertaken of Insolvency and Bankruptcy Register Pre-Employment Checks	Screen print for Personal file Fit and Proper Persons Recruitment Pre-Employment Checklist (*)
4.4	The person is prohibited from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment;	Search undertaken of Disqualified DirectorsRegister – Company's House Pre-Employment Checks	Screen print for Personal file Fit and Proper Persons Recruitment Pre-Employment Checklist (*)
5.	**On-going Checks**		
5.1	The fitness of directors is regularly reviewed by the provider to ensure that they remain fit for the role they are in; the provider should determine how often fitness must be reviewed based on the assessed risk to business delivery and/or the service users posed by the individual and/or role.	Post-holders undertake annual declarations of fitness to continue in post. Checks of insolvency and bankruptcy register and register of disqualified directors to be undertaken each year as part of the declaration process. (*)	Annual Declaration (*)
5.2	The provider has arrangements in place to respond to concerns about a person's fitness after they are appointed to a role, identified by itself or others, and these are adhered to.	The Disciplinary and Capability policies provide these arrangements, and revised contracts (for EDs and director-equivalents) and the Annual Declaration incorporate maintenance of fitness as a requirement (*)	Disciplinary and Capability Policies Contracts of Employment
5.3	The provider investigates, in a timely manner, any concerns about a person's fitness or ability to carry out their duties, and where concerns are substantiated, proportionate, timely action is taken; the provider must demonstrate due diligence in all actions.	This will be undertaken if concerns are identified and revised contracts provide for termination if individuals fail to meet necessary standards.	Disciplinary and Capability Policies Revised employment contracts

	Standard	Assurance	Evidence
5.4	Where a person's fitness to carry out their role is being investigated, appropriate interim measures may be required to minimise any risk to service users.	This would be reviewed when concerns are identified.	Disciplinary and Capabilities policies.
5.5	The provider informs others as appropriate about concerns/findings relating to a person's fitness; for example, professional regulators, CQC and other relevant bodies, and supports any related enquiries/investigations carried out by others.	This would be completed if any concerns were identified.	Referrals made to other agencies.

(*) indicates newly-introduced requirements to address the regulations

In the table above, unless the contrary is stated or the context otherwise requires, "ED" means executive directors and director-equivalent

Appendix 2

PRE-EMPLOYMENT CHECKLIST FOR DIRECTOR AND DIRECTOR-LEVEL EQUIVALENTS

Standard	Evidence Received/Comment	Photocopy taken and Placed on Personal File
Proof of identity including a recent photograph.		
A copy of a Criminal Record Certificate issued at the appropriate level.		
Satisfactory evidence of good conduct in previous employment concerned with the provision of services relating to: (a) Health or social care, or, (b) Children or vulnerable adults		
Where a person has been previously employed in a position whose duties involved working with children or vulnerable adults, satisfactory verification, so far as reasonably practicable, of the reason why a person's employment in that position ended		
In so far as it is reasonably practicable, to obtain satisfactory documentary evidence of any qualification relevant to the duties for which the person is employed or appointed to perform.		
A full employment history, together with a satisfactory written explanation of any gaps in employment.		
Satisfactory information about any physical or mental health conditions which are relevant to the person's capability, after reasonable adjustments are made.		

Form Completed By _____

Name:- _____

Job Title:- _____

Date:- _____

Appendix 3

PRE-EMPLOYMENT AND ANNUAL DECLARATION FOR DIRECTOR AND DIRECTOR-EQUIVALENT POSTS

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST ("the Trust")

"FIT AND PROPER PERSON" DECLARATION

1. It is a condition of employment that those holding director and director-equivalent posts provide confirmation in writing, on appointment and thereafter on demand, of their fitness to hold such posts. Your post has been designated as being such a post. Fitness to hold such a post is determined in a number of ways, including (but not exclusively) by the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 ("the Regulated Activities Regulations").

2. By signing the declaration below, you are confirming that you do not fall within the definition of an "unfit person" or any other criteria set out below, and that you are not aware of any pending proceedings or matters which may call such a declaration into question.

Fit and Proper Persons Regulation 5 (Health and Social Care Act 2008 (regulated Activities) Regulations 2014

3. Registration conditions of the Care Quality Commission requires that the Trust shall not appoint as a director any person who is an unfit person.

4. An "unfit person" is defined as:

   (a) an individual:

      (i) who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged; or

      (ii) who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it; or

      (iii) who within the preceding five years has been convicted in the British Islands of any offence and a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him; or

      (iv) who is subject to an unexpired disqualification order made under the Company Directors' Disqualification Act 1986; or

   (b) a body corporate, or a body corporate with a parent body corporate:

(i) where one or more of the Directors of the body corporate or of its parent body corporate is an unfit person under the provisions of sub-paragraph (a) of this paragraph, or

(ii) in relation to which a voluntary arrangement is proposed under section 1 of the Insolvency Act 1986, or

(iii) which has a receiver (including an administrative receiver within the meaning of section 29(2) of the 1986 Act) appointed for the whole or any material part of its assets or undertaking, or

(iv) which has an administrator appointed to manage its affairs, business and property in accordance with Schedule B1 to the 1986 Act, or

(v) which passes any resolution for winding up, or

(vi) which becomes subject to an order of a Court for winding up.

Regulated Activities Regulations

6. Regulation 5 of the Regulated Activities Regulations states that the Trust must not appoint or have in place an individual as a director, or performing the functions of or equivalent or similar to the functions of, such a director, if they do not satisfy all the requirements set out in paragraph 3 of that Regulation.

7. The requirements of paragraph 3 of Regulation 5 of the Regulated Activities Regulations are that:

(a) the individual is of good character;

(b) the individual has the qualifications, competence, skills and experience which are necessary for the relevant office or position or the work for which they are employed;

(c) the individual is able by reason of their health, after reasonable adjustments are made, of properly performing tasks which are intrinsic to the office or position for which they are appointed or to the work for which they are employed;

(d) the individual has not been responsible for, privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity; and

(e) none of the grounds of unfitness specified in Part 1 of Schedule 4 apply to the individual.

8. The grounds of unfitness specified in Part 1 of Schedule 4 to the Regulated Activities Regulations are:

(a) the person is an undischarged bankrupt or a person whose estate has had sequestration awarded in respect of it and who has not been discharged;

(b) the person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland;

(c) the person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986;

(d) the person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it;

(e) the person is included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland;

(f) the person is prohibited from holding the relevant office or position, or in the case of an individual for carrying on the regulated activity, by or under any enactment.

9. The Fit and Proper Persons Regulation 5 (Health and Social Care Act 2008 (regulated Activities) Regulations 2014 places a number of restrictions on an individual's ability to become or continue as a director. A person may not become or continue as a director of the Trust if:

(a) they are a member of the council of governors, or a governor or director of an NHS body or another NHS foundation trust;

(b) they are a member of the patients' forum of an NHS organisation;

(c) they are the spouse, partner, parent or child of a member of the board of directors of the Trust;

(d) they are a member of a local authority's scrutiny committee covering health matters;

(e) they have been adjudged bankrupt or their estate has been sequestrated and in either case they have not been discharged;

(f) they have made a composition or arrangement with, or granted a Trust deed for, their creditors and have not been discharged in respect of it;

(g) they have within the preceding five years been convicted in the British Islands of any offence, and a sentence of imprisonment (whether suspended or not) for a period of three months or more (without the option of a fine) was imposed;

(h) they are the subject of a disqualification order made under the Company Directors Disqualification Act 1986;

(i) in the case of a non-executive director, they are no longer a member of the public constituency;

(j) they are a person whose tenure of office as a Chair or as a member or director of a health service body has been terminated on the grounds that their appointment is not in the interests of the health service, for non-attendance at meetings, or for non-disclosure of a pecuniary interest;

(k) they have had their name removed, other than by reason of resignation, from any list prepared under sections 91, 106, 123 and 146 of the 2006 Act and have not subsequently had their name included on such a list;

(l) they have within the preceding two years been dismissed, otherwise than by reason of redundancy, from any paid employment with a health service body;

(m) in the case of a non-executive director they have refused to fulfil any training requirement established by the Board of Directors; or

(n) they have refused to sign and deliver to the Secretary a statement in the form required by the Board of Directors confirming acceptance of the code of conduct for directors.

I acknowledge the extracts from the provider licence, Regulated Activities Regulations above. I confirm that I do not fit within the definition of an "unfit person" as listed above and that there are no other grounds under which I would be ineligible to continue in post. I undertake to notify the Trust immediately if I no longer satisfy the criteria to be a "fit and proper person" or other grounds under which I would be ineligible to continue in post come to my attention.

Name: **[Name]** Signed:

_____

Position: **[Position]** Date:

_____

Appendix 4

Insert into Reference Request Inclusion for Director and Director-Level Equivalents

For Fit and Proper Person posts only:

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 state that the Trust must not appoint or have in place an individual as a director, or who performs the functions of or equivalent or similar functions of a director if they do not fulfil the following requirements:

(a) the individual is of good character;

(b) the individual has the qualifications, competence, skills and experience which are necessary for the relevant office or position or the work for which they are employed;

(c) the individual is able by reason of their health, after reasonable adjustments are made, of properly performing tasks which are intrinsic to the office or position for which they are appointed or to the work for which they are employed;

(d) the individual has not been responsible for, privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity; and

None of the grounds of unfitness specified in Part 1 of Schedule 4 apply to the individual.The grounds of unfitness specified in Part 1 of Schedule 4 to the Regulated Activities Regulations are:

(a) the person is an undischarged bankrupt or a person whose estate has had sequestration awarded in respect of it and who has not been discharged;
(b) the person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland;
(c) the person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986;
(d) the person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it;
(e) the person is included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland;
(f) the person is prohibited from holding the relevant office or position, or in the case of an individual for carrying on the regulated activity, by or under any enactment.

Considering these requirements, and based on your knowledge of the individual, would you have any concerns as to their suitability for appointment? **Yes** ☐ **No:** ☐

If you have answered "yes", please expand below:

Appendix 5

Insert into Contracts of Employment for Director and Director Level Equivalents (For FPPR)

"Regulated Activities Regulations"means The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014;

Terms and Conditions of Service

1.0 It is a condition of your employment that you agree to the public disclosure of information by the Trust in relation to your employment in accordance with the National Health Service Act 2006, and/or any other legal or regulatory requirements that may be imposed on the Trust from time to time. If information is requested to be withheld this should be discussed with the Director of Corporate and Legal affairs and Chief Executive.

2.0 You are required to confirm in writing in such form as may be prescribed by the Trust, on appointment and thereafter on demand, that:

2.1 you are not subject to any restrictions which would prevent you from holding the office of director of the Trust;

2.2 you do not fall within the definition of an "unfit person" as specified in Part 1 of Schedule 4 of the Regulated Activities Regulations

2.3 you satisfy the requirements of Regulation 5(3) of the Regulated Activities Regulations; and

2.4 you do not meet any of the criteria for disqualification as a director outlined within the Regulated Activities Regulations

2.5 You shall notify the Trust as soon as practicable (and in any event within 7 days) of any change in circumstances that means the written confirmation that you have provided in accordance with clause 2.4 above is no longer accurate.

2.6 You warrant that you are entitled to work in the United Kingdom without any additional approvals and you will notify the Trust immediately if you cease to be so entitled during your employment.

2.7 Failure to provide the confirmation or notification described in clauses 2.1 to 2.6 (inclusive) above without good reason within 14 days of such confirmation or notification being demanded or required shall be referred to the Remuneration Committee and is likely to be considered a disciplinary matter.

University Hospitals of Leicester NHS
NHS Trust

Agenda Item: Trust Board Paper L

TRUST BOARD – 5th FEBRUARY 2015

UHL RISK REPORT INCORPORATING THE BOARD ASSURANCE FRAMEWORK 2014/15

DIRECTOR:	RACHEL OVERFIELD – CHIEF NURSE
AUTHOR:	PETER CLEAVER – RISK AND ASSURANCE MANAGER
DATE:	5TH FEBRUARY 2015
PURPOSE:	This report provides the Trust Board (TB) with:- a) A copy of the UHL BAF and action tracker as of 31ST December 2014. b) Notification of any new extreme or high risks opened during December 2014. c) Summary of all open risks as of 31st December 2014 scoring 15 – 25 (i.e. extreme/ high). 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;
PREVIOUSLY CONSIDERED BY:	**UHL Executive team**
Objective(s) to which issue relates *	[X] 1. Safe, high quality, patient-centred healthcare [Y] 2. An effective, joined up emergency care system [Y] 3. Responsive services which people choose to use (secondary, specialised and tertiary care) [Y] 4. Integrated care in partnership with others (secondary, specialised and tertiary care) [Y] 5. Enhanced reputation in research, innovation and clinical education [Y] 6. Delivering services through a caring, professional, passionate and valued workforce

	☒ 7. A clinically and financially sustainable NHS Foundation Trust ☒ 8. Enabled by excellent IM&T
Please explain any Patient and Public Involvement actions taken or to be taken in relation to this matter:	N/A
Please explain the results of any Equality Impact assessment undertaken in relation to this matter:	N/A
Strategic Risk Register/ Board Assurance Framework *	☐ **Organisational Risk Register** ☑ **Board Assurance Framework** ☐ **Not Featured**
ACTION REQUIRED *	For decision ☑ For assurance ☑ For information ☐

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

* tick applicable box

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **5th FEBRUARY 2015**

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 UHL BAF and action tracker as of 31st December 2014.
b) Notification of any new extreme or high risks opened during December 2014.
c) Summary of all open risks scoring 15 -25 (i.e. extreme and high).

2. BAF POSITION AS OF 31ST DECEMBER 2014

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

2.2 The TB is asked to note the following points:

a. Principal risks one, seven and 22; there are no further gaps in control/assurance identified and therefore consideration should be given to reducing the current risk score to the level of the target score. Alternatively any additional gaps and mitigating actions should be identified and brought to the attention of the UHL corporate risk team.

b. The TB is asked to note the deterioration of actions 2.4 and 3.1 to a RAG rating of red reflecting the current difficulties in reducing admissions and increasing discharges and therefore the increasing risk to the achievement of our ED waiting time target.

c. Principal risk five; the risk score has increased from 9 to 16 reflecting the difficulties in achieving the admitted RTT trajectory. A revised 'admitted' trajectory has been submitted to the Trust Development Agency (TDA) and CCG for agreement. UHL is currently in line with this trajectory.

d. Principal risk 11; the current risk score has reduced to target score and no further gaps in control/ assurance have been identified and the TB is asked to consider whether there is assurance that the existing controls are effective and to accept this risk as treated.

e. Principal 21; all actions have been completed and the TB is asked to consider whether these have been successful in mitigating the gaps in control/ assurance listed and whether the current risk score can be reduced to the target and the risk accepted as treated.

2.3 It has previously been agreed that the monthly TB review of the BAF be structured so as to include all the principal risks relating to an individual strategic objective. The following objective is therefore submitted to this TB for discussion and review:

'A clinically and financially sustainable NHS Foundation Trust'. (Incorporating principal risks 18, 19, 20, 21and 22).

3. DEVELOPMENT OF THE 2015/16 BAF

3.1 To develop a robust BAF there are a number of key actions that must be taken in sequence:

- Establish strategic objectives (and their owners).
- Identify the principal risks to the achievement of the strategic objectives (and, in addition, identify the risk owners).
- Identify the key control measures to achieve the strategic objectives and mitigate the principal risks.
- Identify the mechanisms by which the TB receives assurance that controls are effective.
- Identify any gaps in control or gaps in assurance
- Put in place actions to address any gaps identified.

3.2 It is proposed that the above will take place in a series of steps culminating in a 2015/16 BAF being submitted for endorsement at the April 2015 TB meeting. The first stage will be:

- For the UHL Executive Team (ET) to revise the current strategic objectives, ensuring they are relevant, accurately articulated, measurable and reflect our direction of travel.

- For the ET to revise the principal risks to accurately reflect the high level risks to the achievement of the Trust's strategic objectives The most appropriate executive lead for each of any new risks should be identified at this stage.

3.3 Stage two, will be submission of the revised objectives and risks to a Trust Board development session (TBDS)) on 12th February 2015. At this point new risk entries will not be fully populated with controls/gaps/actions, etc., however this submission will allow Non-Executive TB members to be involved at the initial development stage and will provide the opportunity for them to review any changes to objectives and risks and consider whether these reflect an accurate picture.

3.4 Stage three will be for the corporate risk team to meet individually with the executive leads in order to populate remaining fields within the BAF.

3.5 Stage four will be submission of the 2015/16 BAF to the April 2015 TB meeting for endorsement.

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

4.1 To inform the TB of significant operational risks, a summary of all extreme and high risks open as of 31st December 2014 is attached at appendix three.. There are 45 risks on the organisational risk register scoring 15 and above.

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

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Risk ID	Risk Title	Risk Score	CMG/ Directorate
2467	Outlying Extra Capacity - Winter months	25	ESM
2471	There is a risk of Radiotherapy Treatment on the Linac (Bosworth) being compromised due to poor Imaging capability of this machine	16	CHUGS
2466	Risk of Patient Harm due to delays in timely review of results and Monitoring in Rheumatology	16	ESM

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);

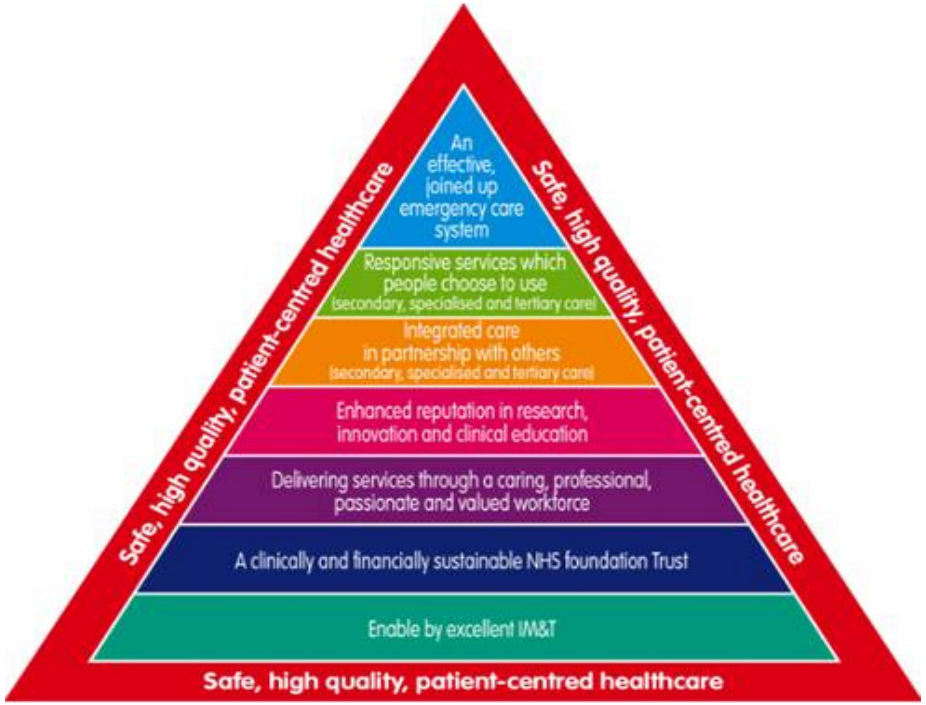
(c) identify any areas which it feels that the Trust's controls are inadequate and do not, therefore, effectively manage the principal risks to the organisation achieving its objectives;

(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;

Peter Cleaver,
Risk and Assurance Manager,
28 January 2015.

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: DECEMBER 2014

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

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

BAF Consequence and Likelihood Descriptors:

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Corporate leads agreed for each goal and identified leads for each work stream of the Quality Commitment.	Q&P Report. Reports to EQB and QAC.			
KPIs agreed for all parts of the Quality Commitment.	Reports to EQB and QAC based on key outcome/KPIs.	No gaps identified		
Clear work plans agreed for all parts of the Quality Commitment.	Action plans reviewed regularly at EQB and annually reported to QAC. Annual reports produced. Summary report scheduled for EQB February 2015	No gaps identified		
Committee structure is in place to oversee delivery of key work streams – led by appropriate senior individuals with appropriate support.	Regular committee reports. Annual reports. Achievement of KPIs.	No gaps identified		

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 2	Failure to implement LLR emergency care improvement plan.	**Overall level of risk to the achievement of the objective**	**Current score 4 x 5 = 20**	**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) Emergency admissions are not reducing (C) Discharges are not increasing and delayed discharge rate has not changed	Review effectiveness of specific LLR improvement actions to deliver a reduction in admissions and increase in discharges (2.4)	LLR MD review Feb 2015
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.	(C) IS's time with the health economy finishes in mid-November 2014	Arrangements for IS to return for a two week period (2.5)	Mar 2015 RM
Allocation of winter monies	Allocation of winter monies is regularly discussed in the LLR steering group	None	N/A	

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Emergency care action team meeting has been remodelled as the 'emergency quality steering group' (EQSG) chaired by CEO and significant clinical presence in the group. Four sub groups are chaired by three senior consultants and chief nurse.	Trust Board are sighted on actions and plans coming out of the EQSG meeting.	C) Emergency admissions are not reducing (C) Discharges are not increasing and delayed discharge rate has not changed	Review effectiveness of specific LLR improvement actions to deliver a reduction in admissions and increase in discharges (3.1)	Feb 2015 COO
Reworked emergency plans are focussing on the new dashboard with clear KPIs which indicates which actions are working and which aren't	Dashboard goes to EQSG and Trust Board	(C) ED performance against national standards	As 3.1	Feb 2015 COO
Further change leadership support has been identified to help embed the required clinically led changes	Trust Board are sighted on actions and plans coming out of the EQSG meeting.	C) Emergency admissions are not reducing (C) Discharges are not increasing and delayed discharge rate has not changed	As 3.1	Feb 2015 COO

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 5	Failure to deliver RTT improvement plan.	**Overall level of risk to the achievement of the objective**	**Current score** 4x4=16	**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**
Weekly RTT meeting with commissioners to monitor overall compliance with plan	Trust Board receives a monthly report detailing performance against plan	(c) There is a revised admitted trajectory which is awaiting agreement with TDA and CCG. UHL is in line with the revised trajectory.	Action plans to be developed in key specialities to regain trajectory for admitted RTT(5.1)	April 2015 COO
Weekly meeting with key specialities to monitor detailed compliance with plan	Trust Board receives a monthly report detailing performance against plan	(c) There is a revised admitted trajectory which is awaiting agreement with TDA and CCG. UHL is in line with the revised trajectory.	As above 5.1	As above COO
Intensive support team back in at UHL (July 2014) to help check plan is correct	IST report including recommendations to be presented to Trust Board	(c) Recommendations from IST report not yet implemented.	Act on findings from recently published IST report (5.2)	Mar 2015 COO

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
1. PPI / stakeholder engagement Strategy Named PPI leads in all CMGs 2. PPI reference group meets regularly to assess progress against CMG PPI plans 3. Patient Advisors appointed to CMGs 4. Patient Advisor Support Group Meetings receive regular updates on PPI activity and advisor involvement 5. Bi-monthly Membership Engagement Forums 6. Health watch representative at UHL Board meeting 7. PPI input into recruitment of Chair / Exec' Directors 8. Quarterly meetings with LLR Health watch organisations, including Q's from public. 9. Quarterly meetings with Leicester Mercury Patient Panel	Emergency floor business case (Chapel PPI activity) PPI Reference group reports to QAC July Board Development session discussion about PPI resource. Health watch updates to the Board Patient Advisor Support Group and Membership Forum minutes to the Board.	PPI/ stakeholder engagement strategy requires revision	Update the PPI/stakeholder engagement strategy (6.1)	Feb 2015 DMC

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

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

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
(i) Regional partnerships: UHL is actively engaging with partners with a view to: • establishing a Leicestershire Northamptonshire and Rutland partnership for the specialised service infrastructure in partnership with Northampton General Hospital and Kettering General Hospital • establishing a provider collaboration across the East Midland's as a whole • Developing an engagement strategy for the delivery of the long term vision for and East Midlands network for both acute and specialised services	Minutes of the April 2014 Trust Board meeting: ○ Paper presented to the April 2014 UHL Trust Board meeting, setting out the Trust's approach to regional partnerships Project Initiation Document (PID): ○ Developed as part of UHL's Delivering Care at its Best (DC@IB) ○ Reviewed at the June 2014 Executive Strategy Board (ESB) meeting ○ Updates (DC@IB Highlight Report reviewed at ESB meetings	(c) Lack of Programme Plan	Programme Plan to be developed (8.3)	Apr 2015 DS
(ii) Academic and commercial partnerships. (iii) Local partnerships	Project Initiation Document (PID): ○ Developed as part of UHL's Delivering Care at its Best (DC@IB) ○ Reviewed at the August 2014 Executive Strategy Board (ESB) meeting ○ Updates (DC@IB Highlight Report reviewed at ESB meetings	(c) Lack of PID for local partnerships	PID for Local Partnerships to be developed by the Head of Local Partnerships (8.7)	Jan 2015 DS
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.			

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 12	Failure to retain BRU status.	**Overall level of risk to the achievement of the objective**	**Current score 3 x 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)	(c) Requirement to replace senior staff and increase critical mass of senior academic staff in each of the three BRUs.	BRUs to re-consider theme structures for renewal, identifying potential new theme leads. (12.1) BRUs to identify potential recruits and work with UoL/LU to structure recruitment packages. (12.2) UHL to use RCF to pump prime appointments if possible and LU planning new academic appointments to support lifestyle BRU. (12.3)	Jun 2015 MD June 2015 MD Jun 2015 MD
	Athena Swan Silver Status by University of Leicester and Loughborough University. (The Athena Swan charter applies to higher	(c) Athena Swan Silver not yet achieved by UoL and Loughborough	UoL and LU to ensure successful applications for	Mar2016 MD

	education institutions)	University. This will be required for eligibility for NIHR awards	Silver swan status and. Individual medical school depts will need to separately apply for Athena Swan Silver status. (12.4) Special meeting of Joint BRU Board: planning to secure BRU funding at the next NIHR competition. Further meetings planned. (12.5)	 Mar 2015 MD

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

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

	Accreditation visits	(c) Trainee Drs in community – anomalous location in DCE budgets	appraisal methodology to CMG s (13.4) Work to relocate anomalous budgets to HR as other Foundation doctor contracts (13.5)	MD Apr 2015 MD
UHL Education Committee	CMG Education Leads sit on Committee. Education Committee delivers to the Workforce Board twice monthly and Prof. Carr presents to the Trust Board Quarterly.	(c) No system of appointing to College Tutor Roles (c) UHL does not support College Tutor roles	Develop more robust system of appointment and appraisal of disparate roles by separating College Tutor roles in order to be able to appoint and appraise as College Tutors (13.6)	Jan 2015 MD

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 14	Lack of effective partnerships with universities.	**Overall level of risk to the achievement of the objective**	**Current score 3 x 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 Developing relationships with key academic partners. Existing well established partners: • University of Leicester • Loughborough University	Minutes of joint UHL/UoL Strategy meetings Minutes of Joint BRU Board Minutes of NCSEM Management Board	(c) New relationships need to be developed and nurtured with the new VC and President for UHL. New Dean of Medical School expected 2015.	UHL CE to meet with VC in near future. (14.1) LU strategy to be discussed at joint BRU board. (14.2) UHL membership of NCSEM management board (14.3) Meeting with LU VC, UHL MD, UHL DRD and BRU Director to discuss strategy (14.4)	Mar 2015 CEO Mar 2015 Mar 2015 Jun 2015
Developing partnerships; • De Montfort University • University of Nottingham • University College London (Life Study) • Cambridge University (100k project)	100k genome and Life study reports to ESB monthly. Joint meetings held with R&D team for NUH - reported through R&D Exec minutes to ESB. EM CLAHRC Management Board reports via R&D Exec to ESB	(c) Contacts with DMU could be developed more closely	Develop regular meeting with DMU (14.5)	Jun 2015

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) including an integrated approach to workforce planning with LPT.	Reduction in number of 'hotspots' for staff shortages across UHL reported as part of workforce plan update. Executive Workforce Board will consider progress in relation to the overarching workforce plan through highlight report from CMG action plans.	(c) Workforce planning difficult to forecast more than a year ahead as changes are often dependent on transformation activities outside UHL (e.g. social services/ community services and primary care and broad based planning assumptions around demographics and activity). (c) Difficulty in recruiting to hotspots as frequently reflect a national shortage occupation (e.g. nurses)	Develop Innovative approaches to recruitment and retention to address shortages. (15.4) Develop new roles that address competency and skill gaps in service delivery areas (15.9)	Mar 2015 DHR Mar 2015 DHR

			Develop Workforce Planning Template to include detailed plans by staff group relating to reduction and growth which triangulate with finance and activity (15.10) Develop Cross Cutting Workforce Programme Board with work streams covering Medical, Nursing, Premium Spend and .3-5 year planning (15.11)	Mar 2015 Feb 2015
Nursing Recruitment Trajectory and international recruitment plan in place for nursing staff	Overall nursing vacancies are monitored and reported monthly by the Board and NET as part of the Quality and Performance Report NHS Choices will be publishing the planned and actual number of nurses on each shift on every inpatient ward in England			
Development of an Employer Brand and Improved Recruitment Processes	Reports of the LIA recruitment project Reports to Executive Workforce Board regarding innovative approaches to recruitment	(c) Capacity to develop and build employer brand marketing (c) capacity to build innovative approaches to consultant recruitment	Deliver our Employer Brand group to share best practice and develop social media techniques to promote opportunities at UHL (15.6) Consultant recruitment review team to develop professional	Mar 2015 DHR April 2015 DHR

			assessment centre approach to recruitment utilising outputs to produce a development programme (15.8)	

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

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

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Year 2 Listening into Action (LiA) Plan (2014 to 2015) including five work streams: Year 3 Listening into Action (LiA) Plan (2015 to 2016) to be developed in March 2015 for next 12 months. To include continued work with 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 to be conducted March 2015 Update reports provided to JSCNC meetings	(a) Lack of triangulation of LiA Pulse Check Survey results with National Staff Opinion Survey and Friends and Family Test for Staff (a) Organisational Health Dashboard yet to be developed for reporting in EWB and to be available to CMG Management team for monthly actions.	Listening into Action activity within CMGs / Corporate Divisions to be one of the reported Performance Indicators within the Organisational Health Dashboard (17.7)	Mar 2016 DHR
Work stream Two: **Thematic LiA** • Supporting senior leaders to host Thematic LiA activities. These activities will respond to emerging priorities within Executive Directors' portfolios. Each Thematic event will be hosted and led by a member of the Executive Team or delegated lead.	Quarterly reports to Executive Workforce Board (EWB) and Trust Board Updates provided to LiA Sponsor group on each thematic activity Update reports provided to JSCNC meetings	(a) Number of Listening events being held within each division unclear due to range of LiA work streams.	See action 17.7	Mar 2016 DHR
Work stream Three: **Management of Change LiA** • LiA Engagement Events held as a precursor to change projects associated with service transformation and / or HR Management of Change (MoC) initiatives.	Quarterly reports to Executive Workforce Board (EWB) and Trust Board Updates provided to LiA Sponsor group on each thematic activity	(c Reliant on IBM / HR to notify LiA Team of MoC activity	CMG HR Leads to notify LiA Team of any listening events – proforma developed to	Mar 2016 DHR

	Update reports provided to JSCNC meetings		capture activities and to be reported in Organisational Health Dashboard. (17.8)	
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	LiA to be rolled out within Alliance utilising Alliance Management Team to support the implementation and to report activity via LiA Sponsor Group (17.9)	Mar 2016 DHR
Work stream Five: **Nursing into Action (NiA)** • Support all nurse led Wards or Departments to host a listening event aimed at improving quality of care provided to patients and implement any associated actions.	Quarterly reports to Executive Workforce Board (EWB) and Trust Board Updates provided to LiA Sponsor group every 6 months on success measures per set and reports on Pulse Check improvements Update reports provided to JSCNC meetings Monthly updates to Nursing Executive Team (NET) meetings via Heads of Nursing per CMG	(c) Lack of a clear system for sharing lessons learned and success outcomes from each of the NiA Ward / Department areas to maximise spread of learning and sharing best practice.	Success outcomes to be shared with nursing workforce via new annual Nursing Conference – first one scheduled for April 2015. (17.10)	Mar 2016 DHR/ Chief Nurse
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	(a) Lack of triangulation of National Staff Survey results with local Pulse Check Results (Work stream One: Classic LiA / Work stream Five: NiA) and other indicators of staff engagement such as Friends and Family Test for Staff	Workshop on 2014 survey results priorities and actions with CEO & DHR on 27 January2015 leading to 2015 / 16 engagement plan for the Trust – to be shared via appropriate management forums and CE	Mar 2016 DHR

	monthly to Board via Quality and Performance report Results of National staff survey and local patient polling reported to Board on a six monthly basis. Improving staff satisfaction position.		Briefing (March & April 2015). TB paper on March Trust Board And ET Paper for March 2015. (17.11)	
Friends and Family Test for NHS Staff	Quarterly survey results for Quarter 1, 2 and 4 to be submitted to NHS England for external publication: Submission commencing 28 July 2014 for quarter 1 with NHS England publication commencing September 2014 Local results of response rates to be CQUIN Target for 2014/15 – to conduct survey in Quarter 1 (achieved)	(a) Survey completion criteria variable between NHS organisations per quarter. (a) Survey to include 'NHS Workers' and not restricted to UHL staff therefore creating difficulty in comparisons between organisations as unable to identify % response rates. (c) No guidance available regarding how NHS England will present the data published in September 2014, i.e. same format at FFT for Patients or format for National Staff Opinion and Attitude Survey. (a) Lack of triangulation of Friends and Family Test for Staff results with local Pulse Check Results (Work stream One: Classic LiA / Work stream Five: NiA) and	Workshop on 2014 survey results priorities and actions with CEO & DHR on 27 January 2015. (17.12) See action 17.7 Workshop outputs to lead to 2015/16 engagement plan for the Trust – to be	Mar 2015 DHR Mar 2016 DHR Mar 2016 DHR

		other indicators of staff engagement such as National Staff Survey	shared via appropriate management forums and CE Briefing (March & April 2015). TB and ET Paper for March 2015. (17.13)	
Workforce Sickness Absence levels	Attendance management policy and procedures available to staff and managers. Compliance reports via Workforce Informatics Manager sent to CMGs monthly to support management of individual cases. ESR recording of attendance. Monthly reports available to CMGs / Corporate Divisions HR CMG Teams support front line managers to manage staff in line with policy Sickness levels reported via CE Briefings per month Sickness levels incorporated into Organisational Health Dashboard monthly reporting via EWB quarterly meetings and available to CMG HR Leads via SharePoint Sickness absence rates reported to UHL Leadership Community via CE Briefings per month	(a) Lack of triangulation between the use of premium rate staff to support non-compliance with UHL target for 2014/15 sickness absence rates, with increasing levels of sickness reported for some CMGs / staff groups	Organisational Health Dashboard quarterly via EWB / monthly reports available via SharePoint (17.14) Annual performance target set with CMG breakdown available per month for CMG Board Meetings. (17.15) Workforce KPIs included in Quarterly CMG Workforce meetings from January 2015 – to be attended by HR CMG Leads and Workforce Development Manager (17.16) Premium spend / pay group to be established in February 2015 as part of the CIP	Mar 2016 Mar 2016 /17

			Workforce Charter to review use of premium pay and reasons for use – to support CMGs to identify links to, for example, sickness absence, recruitment, & increased activities during 2015/16 (17.17)	
Mutuals in Health Pathfinder Programme	Submitted application to Cabinet Office (CO) and Department of Health (DH) to participate in the programme as one of the Trusts nationally. Selected to participate in the Pathfinder Programme – 1st January 2015 – 31 March 2015 Mutuals Programme Board established – January 2015 chaired by CEO. Programme Lead identified (Assistant Director of OD & Learning) to work with the assigned external partners (Hempsons, Stepping Out & Albion) Monthly update reports to Executive Team. Progress Report to be presented to EWB in March 2015 Programme of work relates to delivery of 3 pillars identified for UHL – 1. Exploring organisational forms with whole Trust 2. Autonomous Incentivised Teams – elective orthopaedics & trauma team 3. Improving engagement within UHL Production of a Feasibility Report (Business Case) to DH/CO by 31 March 2014 Attendance at national workshops to learn from other Trusts – knowledge transfer. Organise internal workshops on each of the 3 pillars and encourage appropriate attendance by CMG Managers and nominated staff.	a) Due to tight timeframes for delivery of the Feasibility Report (FBC) will the Trust Board and Executive Team be fully signed up to the final produced report and proposals for transferability of lessons learned to UHL service and workforce models.	Feasibility Report (Known as Full Business Case by CO/DH) by 31 March 2015 with Trust Board approval. To be presented to TB in March and EWB in March 2015 (17.18)	Mar 2015 DHR

	Pathfinder Programme Risk Register to be managed by external partners with CO/DH.			

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Leadership into Action Strategy (2014:16) including six work streams: 'Providing Coaching and Mentoring' by developing an internal coaching and mentoring network, with associated framework and guidance which will be piloted in agreed areas (targeting clinicians at phase 1).	Quarterly Reports to Executive Workforce Board (EWB) as part of Organisational Development Plan and Learning, Education and Development Update as set out in Risk 16.			
'Shadowing and Buddying' by creating shadowing opportunities and devising a buddy system for new clinicians or those appointed into new roles.	Quarterly Reports to Executive Workforce Board as part of Organisational Development Plan and Learning, Education and Development Update as set out in Risk 16.	(c) Buddying / Shadowing System Requires Development	System being developed in partnership with HEEM and Assistant Medical Director to ensure support provided to newly appointed Consultants at initial phase (18.3)	Apr 2015 DHR
'Improving local communications and 360 degree feedback' by developing and implementing a 360 Degree feedback Tool for all leaders and developing nurse leaders to facilitate Listening Events in all ward and clinical department areas as set out in Risk 17.	Quarterly Reports to Executive Workforce Board as part of Organisational Development Plan and Learning, Education and Development Update as set out in Risk 16. Updates provided to LiA Sponsor group every 6 months on success measures Monthly updates to Nursing Executive Team (NET) meetings via Heads of Nursing per CMG	(a) 360 Feedback Tool not yet developed		
'Shared Learning Networks' by creating and supporting learning	Quarterly Reports to Executive Workforce Board as			

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Delivering recurrent balance via effective management controls including SFIs, SOs and on-going Finance Training Programme Health System External Review has defined the scale of the financial challenge and possible solutions UHL Service & Financial Strategy including Reconfiguration/ SOC	Monthly progress reports to F&P Committee, Executive Board, & Trust Board Development Sessions TDA Monthly Meetings Chief Officers meeting CCGs/Trusts TDA/NHSE meetings Trust Board Monthly Reporting UHL Programme Board, F&P Committee, Executive Board & Trust Board	(c) Lack of supporting service strategies to deliver recurrent balance	Production of a financial strategy to accelerate the recovery programme (19.2)	Feb 2015 DF
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 CIP Quality Impact assessments			
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.			
Financially and operationally deliverable by contract signed off by UHL and CCGs and Specialised Commissioning on 30/6/14	Agreed contracts document through the dispute resolution process/arbitration Regular updates to F&P Committee, Executive Board,			

	Escalation meeting between CEOs/CCG Accountable Officers			
Securing capital funding by linking to Strategy, Strategic Outline Case (SOC) and Health Systems Review and Service Strategy	Regular reporting to F&P Committee, Executive Board and Trust Board	(c) Lack of clear strategy for reconfiguration of services.	Production of Business Cases to support Reconfiguration and Service Strategy (19.10)	On-going action - Review monthly DF
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 an outcome of submission of SOC/ business cases (19.11)	On-going action – Review March 2015 DF

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) PMO structure not yet in place to ensure continuity of function	Recruit substantive staff to vacant posts (20.2)	Feb 2015 COO
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	Simplify cross cutting themes to workforce, beds, outpatients and theatres (20.1)	Feb 2015 COO

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

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

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. A paper briefing the TB on the outcome of the DH Gateway 0 review and the actions taken to address them in the form of a Programme Brief and governance arrangements was presented to the December 2014 TB meeting			

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	EPR Board now needs to be re-shaped from procurement to delivery	Review governance arrangements and alignment with other major programmes (23.7)	CIO – Jan 2015
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.			
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.	EPR Board now needs to be re-shaped from procurement to delivery	See action 23.7	CIO – Jan 2015

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 3x3 = 9**	**Target score 3 x 3 = 9**
Executive Risk Lead(s)	Chief Information Officer			
Link to strategic objectives	Enabled by excellent IM&T			

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

Appendix two

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

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

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
1	**Lack of progress in implementing UHL Quality Commitment.**					
2	**Failure to implement LLR emergency care improvement plan.**					
2.4	Review effectiveness of specific LLR improvement actions to deliver a reduction in admissions and increase in discharges	COO / LLR MD		Review ~~December 2014~~ February 2015	The actions taken are not having the desired effect. The required changes are being tracked through the LLR urgent care working group	2
2.5	Arrangements for IS to return for a two week in January 2015 (2.5)	COO		~~January 2015~~ March 2015	IS's availability has changed and we are working with the new CMGD to review the best way to use IS's experience if he returns in March 2015	3
3	**Failure to effectively implement UHL Emergency Care quality programme.**					
3.1	Review effectiveness of specific LLR improvement actions to deliver a reduction in admissions and increase in discharges. **NB:** *Original action reworded by COO – Dec 2014*	COO		February 2015	The actions taken are not having the desired effect. The required changes are being tracked through the LLR urgent care working group	2
4	**Delay in the approval of the Emergency Floor Business Case.**					

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

4.1	Regular communication with NTDA	MD		March 2015	Regular communication with the NTDA about the required timeline for approval of the ED business case has continued to ensure all parties understand the critical time dependencies within the scheme. Communication will continue until the submission dates and beyond to keep the NTDA on track therefore this action will be on-going until March 2015. Deadline extended to reflect this.	4
5	**Failure to deliver RTT improvement plan.**					
5.1	Action plans to be developed in key specialities to regain trajectory in admitted RTT	COO		~~September~~ ~~October~~ ~~December 2014~~ ~~February 2015~~ April 2015	Action plans completed. There is a revised admitted trajectory which is awaiting agreement with TDA and CCG. UHL is in line with the revised trajectory. Compliance with RTT target anticipated April 2015	2
5.2	Act on findings from recently published IST report	COO		~~August~~ ~~October 2014~~ March 2015	UHL plan to implement findings and recommendations to be developed. IST commissioned to be working with the Trust until end March 2015, Project plan developed and action deadline extended to reflect this.	4
6	**Failure to achieve effective patient and public involvement**					
6.1	Update the PPI/stakeholder engagement strategy	DMC		February 2015	Board development session on Jan 15th. Final strategy to the Board February 2015	4
6.2	Revised PPI plan			N/A	This action replicates 6.1 above and will therefore be deleted from future versions of the action tracker	N/A
6.3	OD team involvement to reenergise the vision and purpose of Patient Advisors	DMC	PPIMM	~~October~~ November 2014	**Complete**	5
7	**Failure to effectively implement Better Care together (BCT) strategy.**					

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

7.4	BCT SOC to be presented at the December 2014 Trust Board meeting for approval. Action reworded by DS – Dec 2014	DS		December 2014	**Complete.** The BCT SOC and PID were approved at the December 2014 TB meeting.	5
8	**Failure to respond appropriately to specialised service specification.**					
8.3	Programme Plan to be developed	DS		April 2015		4
8.7	PID for Local Partnerships to be developed by the Head of Local Partnerships	DS		~~December 2014~~ January 2015	Timescale extended as Head of Local Partnerships only recently appointed	3
9	**Failure to implement network arrangements with partners.**					
	Actions, 8.1, 8.2, 8.3 and 8.5 refer to risk 9. Action 7.3 refer to risk 7, therefore refer above for progress				See risks 7 & 8	
9.2	*Action removed from BAF / action tracker by DS following further review of content of risk number 9.*	N/A		N/A	See risks 7 & 8	N/A
10	**Failure to develop effective partnership with primary care and LPT.**					
10.1	**Action removed from upon request of DS as action encompassed in risk 7.**	N/A		N/A	See risk 7	N/A
11	**Failure to meet NIHR performance targets.**					
12	**Failure to retain BRU status.**					
12.1	BRUs to re-consider theme structures for renewal, identifying potential new theme leads. (12.1)	MD	DR&D	June 2015	Awaiting National Guidance on structure required for future bids	4
12.2	BRUs to identify potential recruits and work with UoL/LU to structure recruitment packages.	MD	DR&D	June 2015		4
12.3	UHL to use RCF to pump prime appointments if possible and LU planning new academic appointments to support lifestyle BRU.	MD	DR&D	June 2015		4

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

12.4	UoL and LU to ensure successful applications for Silver swan status and. Individual medical school depts will need to separately apply for Athena Swan Silver status.	MD	DR&D	March 2016	VC and President has re-constituted group leading Medical School Bid with appointment of new project manager.	4
12.5	Special meeting of Joint BRU Board: planning to secure BRU funding at the next NIHR competition. Further meetings planned.	MD	DR&D	March 2015		4
13	**Failure to provide consistently high standards of medical education.**					
13.1	To work with Finance to ensure transparency and accountability of undergraduate and postgraduate medical training tariffs *(reworded October 2014)*	MD	AMD (CE)	~~October 2014~~ January 2015	Work on investigating this is taking longer than anticipated and requires coordination with the new Director of Finance.	3
13.2	Ensure appropriate Consultant Job descriptions include job planning	MD	AMD (CE)	January 2015		4
13.3	Develop appraisal methodology for educational roles	MD	AMD (CE)	January 2015	Information to support appraisers developed and include in appraiser development sessions. A new module in Prep is being explored to support appraisal of education roles	4
13.4	Disseminate approved appraisal methodology to CMGs.	MD	AMD (CE)	~~December~~ February 2015	Date changed as appraisal methodology will not be developed until January 2015 (see action 13.3)	3
13.5	Work to relocate anomalous budgets to HR as other Foundation doctor contracts	MD	AMD (CE)	~~January~~ April 2015	Budgets will be relocated at the beginning of 2015/16 financial year to avoid potential confusion of transferring part year budgets. Deadline changed to reflect this.	3
13.6	Develop more robust system of appointment and appraisal of disparate roles by separating College Tutor roles in order to be able to appoint and appraise as College Tutors	MD	AMD (CE)	January 2015	We have a role description agreed between UHL and HEEM – problem is unlike other Trusts UHL does not support College Tutor roles	4

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

14	**Lack of effective partnerships with universities.**					
14.1	UHL CE to meet with VC in near future.	CEO		March 2015	UHL Chairman has already met with VC	4
14.2	LU strategy to be discussed at joint BRU board.	MD	DR&D	March 2015		4
14.3	UHL membership of NCSEM management board	MD	DR&D	March 2015	Currently MD and DR&I attending	4
14.4	Meeting with LU VC, UHL MD, UHL DRD and BRU Director to discuss strategy	MD	DR&D	June 2015	Invitation sent to LU VC	4
14.5	Develop regular meeting with DMU	MD	DR&D	June 2015	Regular meetings established at Exec level – relevant subgroups established	4
15	**Failure to adequately plan the workforce needs of the Trust.**					
15.4	Develop Innovative approaches to recruitment and retention to address shortages.	DHR		March 2015	Medical Workforce Strategy in place and to be updated following feedback from HEEM quality visit and the Clinical Senate. Aim to present to March 2015 Board Consultant recruitment process has been improved to incorporate assessment centres. Services are developing a portfolio to reflect provision in better attracting consultant to services	4

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

15.6	Delivering our Employer Brand group to share best practice and development social media techniques to promote opportunities at UHL	DHR		March 2015	Webpage review originally planned for end of August now changed to end of January 2015. Resource identified to develop website. Hotspots areas now producing career profiles which are successfully attracting into difficult to recruit areas. We will be using Twitter and other social media techniques to attract staff to UHL. Service areas are to provide an overview of the future of their services for use when advertising consultant posts. Scheme to promote managerial and leadership posts to existing NHS MTS scheme graduates to be developed and in place for March 2015. Scheme will include a unique offer in terms of development in order to attract high calibre applicants.	4
15.8	Consultant recruitment review team to develop professional assessment centre approach to recruitment utilising outputs to produce a development programme	DHR		April 2015	Proposal prepared for review by DHR and MD. Agreed to make small adjustments to selection process in first instance and evaluate impact.	4

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

15.9	Develop new roles that address competency and skill gaps in service delivery areas	DHR		March 2015	UHL New Roles Group established with 3 sub-groups with the remit of delivering new roles in Assistant Practitioner, Advanced Practitioner and Physician Assistant. Roles developed will consider work undertaken by the Clinical Senate relating to building the Team Around the Patient. The first cohort of assistant practitioners is planned for March 2015 focused on ITU and HDU areas and the Advanced Practitioner role is underway in ED to be spread into priority recruitment hotspots areas HEEM Funding of £250k has been approved to enable LLR providers to introduce US Physicians Assistants into the workforce. For UHL this means improved capacity of 20-30 Associates to support medical staff particularly in recruitment hotspot areas identified in the annual workforce planning process.	4
15.10	Refine the workforce elements of the Operational Planning cycle to ensure robust workforce plans to support organisational transformation, activity and finance	DHR		March 2015	Template defined which analyses the workforce implications of both CIP and growth schemes. Template also describes workforce improvement which leads to improvement in quality. Schemes to be triangulated with finance and activity and confirmed through Executive dialogue. Final submission of workforce plan will be March 31 2015.	4

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

15.11	Development of Cross Cutting Programme to support focus on workforce efficiency, productivity and development	DOF and DHR		February 2015 established and on-going work programme through 2015/16	Charter to be agreed in January 2015. 4 work streams covering medical, nursing, premium spend and 3-5 year planning with specified actions and deliverables for improving pay governance and efficiency.	4
16	**Inability to recruit and retain staff with appropriate skills.**					
16.1	Team Health Dashboard to be developed and implemented	DHR		~~September 2014~~ December 2014	**Complete.** Health Dashboard will be incorporated into CMG and Corporate performance management arrangements to show the right things are in place to develop a high performing organisation.	5
16.2	eUHL system updates required to meet Trust needs	DHR		March 2015	Supplier selected following tendering process to commence developments during January 2015	4
16.3	Robust ELearning policy and procedures to be developed to reflect P&GC approach	DHR		January 2015	The E-learning policy and procedures will form part of the Core Training Policy currently under development and due for final approval by end of January 2015. Deadline extended to reflect this	4
17	**Failure to improve levels of staff engagement**					
17.1	Team Health Dashboard to be developed – mock up to be presented to EWB at September 2014	DHR		March 2015	**Complete**	5

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

17.2	Ensure IBM aware of requirements.	DHR		March 2015	**Complete.** and .3-5 year planning.□□CIO aware of LiA MoC associated with IBM related projects. Meetings held with IBM representatives to coach and guide on LiA principles and approach. Further plans to include LiA in pilot of Paediatric Areas for Electronic Document Record Management. MoC information included on Organisational Health Dashboard	5
17.3	HR Senior Team aware of need to include Engagement event prior to formal consultation (with MoC impacting on staff – more than 25 people)	DHR		March 2015	**Complete.** MoC (HR) including LiA as a precursor to formal consultation. A number of events have been concluded using LiA. A specific resource for LiA MoC has been developed	5
17.4	Include as regular agenda item on LiA sponsor group identifying activity and anticipated resources required	DHR		March 2015	**Complete.** Each of the LiA Work streams is included as standing items on LiA Sponsor Group meetings.	5
17.6	Develop draft internal reports in development in readiness for possible analysis methodology used by NHS England in September 2014.	DHR		~~September~~ ~~October~~ December 2014	**Complete.** **Friends and Family Test for Staff:** Submission of first UNIFY report submitted to NHS England in compliance with deadline and CQUIN target. Internal analysis of free text themes being undertaken. UHL data to be included in CE Briefing. Cannot be benchmarked against other organisations as NHS England has still not published results. Awaiting information from NHS England on analysis methodology. Deadline extended to reflect this	5

17.7	Listening into Action activity within CMGs / Corporate Divisions to be one of the reported Performance Indicators within the Organisational Health Dashboard	DHR		March 2016		4
17.8	CMG HR Leads to notify LiA Team of any listening events – proforma developed to capture activities and to be reported in Organisational Health Dashboard.	DHR		March 2016		4
17.9	LiA to be rolled out within Alliance utilising Alliance Management Team to support the implementation and to report activity via LiA Sponsor Group	DHR		March 2016		4
17.10	Success outcomes to be shared with nursing workforce via new annual Nursing Conference – first one scheduled for April 2015.	DHR/ CN		March 2016		4
17.11	Workshop on 2014 survey results priorities and actions with CEO & DHR on 27 January 2015 leading to 2015 / 16 engagement plan for the Trust – to be shared via appropriate management forums and CE Briefing (March & April 2015). TB paper on March Trust Board And ET Paper for March 2015.	DHR		March 2016		4
17.12	Workshop on 2014 survey results priorities and actions with CEO & DHR on 27 January 2015. (17.12)	DHR		March 2015		4
17.13	Workshop outputs to lead to 2015/16 engagement plan for the Trust – to be shared via appropriate management forums and CE Briefing (March & April 2015). TB and ET Paper for March 2015.	DHR		March 2016		4

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

17.14	Organisational Health Dashboard quarterly via EWB / monthly reports available via SharePoint	DHR		March 2016		4
17.15	Annual performance target set with CMG breakdown available per month for CMG Board Meetings.	DHR		March 2016		4
17.16	Workforce KPIs included in Quarterly CMG Workforce meetings from January 2015 – to be attended by HR CMG Leads and Workforce Development Manager (	DHR		March 2016		4
17.17	Premium spend / pay group to be established in February 2015 as part of the CIP Workforce Charter to review use of premium pay and reasons for use – to support CMGs to identify links to, for example, sickness absence, recruitment, & increased activities during 2015/16.	DHR		March 2016/17		4
17.18	Feasibility Report (Known as Full Business Case by CO/DH) by 31 March 2015 with Trust Board approval. To be presented to TB in March and EWB in March 2015	DHR		March 2015		4
18	**Lack of effective leadership capacity and capability**					
18.2	Improve internal coaching and mentoring training provision in collaboration with HEEM and at phase 1 establish process for assigning coaches and mentors to newly appointed clinicians	DHR		December 2014	**Complete**	5
18.3	'Shadowing and Buddying' System being developed in partnership with HEEM and Assistant Medical Director to ensure support provided to newly appointed Consultants at initial phase (18.3)	DHR		April 2015	Consultant Forum in place	4

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

18.5	Support national and regional Talent Management and Succession Planning Projects by National NHS Leadership Academy , EMLA and NHS Employers	DHR		March 2015	UHL staff nominated to access National Leadership Academy Programme based on talent conversations.	4
18.6	Board Coach (on appointment) to facilitate Board Development Session	DHR		~~October 2014~~ February 2015	Board development session completed on 16/10/14. Board Coach identified subject to agreement with the Trust Chairman. Awaiting decision and deadline extended to reflect this	4
18.7	Update of UHL Leadership Qualities and Behaviours to reflect Board Development, UHL 5 Year Plan and new NHS Healthcare Leadership Model	DHR/ CE		January 2015	As above, at the initial phase the Trust Board will discuss and agree : (a) the overall leadership model the Board and Executive Team are seeking to build; and (b) the Board culture that it is seeking to shape and exemplify.	4
19	**Failure to deliver financial strategy (including CIP).**					
19.2	Production of a financial strategy to accelerate the recovery programme (action reworded and timescale amended by DF to more accurately portray required action)	DF		~~August Review September 2014~~ February 2015	Amending the consolidated capital investment Program. Refreshed financial strategy to be presented to TB and TDA during February 2015. Timescale reflected to reflect this.	4
19.5	Expedite agreement of CIP quality impact assessments with UHL and CCGs	DF		~~August Review September~~ October 2014	**Complete.** Process in place for on-going submission of CIP quality impact assessments to the CCGs following sign off by the Chief Nurse and Medical Director.	5
19.6	PMO Arrangements need to be finalised	DF		~~August~~ October 2014	**Complete.**	5
19.8	Restructuring of financial management via MoC	DF		~~July Review August~~ October 2014	**Complete.**	5

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

19.10	Business Cases to support Reconfiguration and Service Strategy	DF		~~July Review September 2014~~ On-going as per individual business case timeline	BCT SOC approved by UHL and all LLR partners. SOC submitted to TDA and NHS England and are awaiting approval. Individual business cases will be submitted to the Trust Board and TDA as per the overall reconfiguration strategy	4
19.11	Agreement of long-term loans as an outcome of submission of SOC/ business cases	DF		~~June August~~ On-going action – review March 2015	Trust received a £29m cash loan in line with the Plan and trajectory submitted to the TDA. Application for further loans (via SOC/business cases)to be submitted as necessary	4
20	**Failure to deliver internal efficiency and productivity improvements.**					
20.1	Simplify cross cutting themes to workforce, beds, outpatients and theatres. Action reworded by COO- Dec 2014	COO		~~August 2014~~ February 2015	On track	4
20.2	Recruit substantive staff to vacant posts to ensure continuity of function of PMO	COO		February 2015	On track	4
21	**Failure to maintain effective relationships with key stakeholders**					
21.2	Appoint to new Head of Partnerships role	DS		December 2014	**Complete.** Head of Local and Regional Partnerships are both now in post.	5
22	**Failure to deliver service and site reconfiguration programme and maintain the estate effectively**.					
22.4	Action plan an resource plan in response to the Gateway 0 review to be developed	DS		December 2014	**Complete.** A paper briefing the TB on the outcome of the DH Gateway 0 review and the actions taken to address them in the form of a Programme Brief and governance arrangements was presented to the December 2014 TB meeting	5
23	**Failure to effectively implement EPR programme**					
23.7	Review governance arrangements and alignment with other major programmes	CIO		Jan 2015	On track	4

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

24	**Failure to implement the IM&T strategy and key projects**

Key

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

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

Appendix 2

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Reference to BAF
2467	Emergency and Specialist Medicine		Outlying Extra Capacity - Winter months	03/12/2014	31/12/2014	There is a risk that owing to the increase in medical admissions that the bed base over winter months will be insufficient resulting in the need to out lie into other speciality/CMG beds jeopardizing delivery of the RTT targets. There is a requirement to outlie medical patients because of: 8% increase in medical admissions and current insufficient medical bed capacity Daily admission levels warranting the need to outlie ahead of the winter months - winter capacity needed Discharge processes not as efficient as they should be internally impacting patient flow and patients waiting in ED for admission Continued delayed transfers of care On-going risks and potential harm to patients as a consequence of overcrowding in ED OOH teams have to make decisions to use all available capacity to cope with pressures in ED The ability to open extra beds within the CMG is compounded by: >100 Nursing vacancies (200 nursing vacancies in the CMG this time last year) Geriatrician and 2.4 Acute Physician vacancies Junior medical staffing shortages	Patients	* Review of capacity requirements throughout the day 4 X daily * Issues escalated at Gold command meetings and outlying plans executed as necessary taking into account impact on elective activity * Opportunities to use community capacity (beds and community services) promoted at site meetings. * Daily board rounds and conference calls to confirm and challenge requirements for patients who have met criteria for discharge and where there are delays * FJW and Ward 2 capacity increased/flexed before patients are outlied * ICRS in reach in place . PCC roles fully embedded * Plans in place for a phased opening of modular wards supported by a surge plan to use "buffer/flex" beds - Papers presented to Executive Team and Emergency Quality Steering Group * Discharges before 11am and 1pm monitored weekly supported by review of weekly ward based metrics * Ward based discharge group working to implement new ways of delivering safe and early discharge *Explicit criteria for outliying in place supported by recent clarification from Assistant HON * Review of complaints and incidents * Safety rota developed to ensure there is an identified consultant to review outliers on non medical wards	Extreme	Almost certain	25	Develop clear escalation plans supported by a decision tree for opening flex/buffer beds (CMG decision only) - 15/12/14 Revised Emergency Quality Steering Group action plan - 15/12/14 Maintain additional beds on ward 2 LGH (21 beds to 27 beds) - 15/12/14 Phase opening of modular beds - 02/01/15 Raise staff awareness re winter plans and access to community resources to enable patients to be discharged in a timely manner - 31/03/15 CMG to access and act on additional corporate support to focus on discharge processes - 31/03/15	9	JE	b

Risk ID	CMG	Specialty	Risk Title	Review Date Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Reference to BAF
2236	Emergency and Specialist Medicine	ED	There is a risk of overcrowding due to the design and size of the ED footprint	31/03/2015 04/10/2013	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 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 assessment bay causes delay in time to assessment. Paramedics unable to reach turnaround targets. Inability to meet CQUIN targets. Risk of patient deterioration. Delay in diagnosis and treatment. Increased staff stress. Patient complaints. Lack of dignity and privacy. Serious incident risk. Design and size of minors results in delay in receiving medical assessment and treatment. Patient complaints. Four hour target. Increased violence and aggression. Design and size footprint in streaming rooms causes threat to CQUIN target and four hour target. Staff stress. Delay in diagnosis and management. Injury to staff and patients. Increased risk of violence and aggression. Design and size of footprint in EDU causes delay in accessing mental health assessment. Four hour target.	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. The Resus Bed area is being created. Dr Ian Sturges has been employed by the trust to work towards improving flow of patients from the emergency department to the assessment units and wards.	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 - due 31/12/15 . There is to be a receptionist staffing paeds reception at all times(Completed 01/07/2013) creation of "single front door" - all ambulatory ED arrivals now first seen in UCC, thereby reducing total ED attendances.(Completed 10/09/2013) The number of toilets in majors is to be increased to 2 and shower facilities are to be installed(Completed 01/11/2013) Side rooms 2 and 3 are to be converted into formal assessment bays. (Completed 31/10/2013) 3 additional phone lines to be installed in assessment bay(Completed 01/11/2013) The trips and falls hazard in children's ED is to be removed by changing the layout of the minors work area(Completed 22/11/2013) See and treat rooms being made into extra Paeds bays(Completed 30/06/2014) Allocated nurse (and doctor when numbers permit), for patients placed in Majors middle(Completed 30/06/2014) Resus space to be increased to 8 bays(Completed 30/04/2014) The resus viewing room is to be made into a fully equipped resus bay(Completed 30/04/2014) Bays to be allocated and staffed appropriately in majors to act as resus step-down bays for when space in resus is at a premium and some patients are well enough to be moved to majors with the appropriate level of observation(Completed 14/07/2014) Hourly Intentional Rounds by Area Nurse (Completed 02/07/2014)	16	JE	b

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	Reference to BAF
2414	CHUGS	Gastroenterology	The LGH Endoscopy has not passed JAG acrreditation	29/09/2014	30/06/2015	Endoscopy units do not meet JAG standards for dirty to clean flow. Positioning of changing facilities breach SSA guidelines / lack of privacy and dignity for patients. Lack of toilets for relatives and patients in waiting room, does not meet JAG standards / lack of privacy and dignity for patients. Position of enema room on DC2 requires patients post enema to cross main corridor in a gown, breaching privacy and dignity. Due to LGH not passing JAG accreditation , there will be a 5% loss of tariff for procedures carried out at LGH, and loss of training status to run national courses and train SpRs / Nurse Endoscopists., and Loss of national reputation. Patients privacy and dignity compromised. Cost implication for Trust - will have to pay for 3 separate accreditation visits / costs	Quality	JAG accreditation not passed in September 2014 therefore will loose 5% tariff on procedures carried out at LGH.	Major	Almost certain	20	Feasibility of building options to be considered along with director of Operations via walk round - 31/03/15. Relocation of enema room to another area - 31/03/15. Consistent access of relatives to recovery ward areas across the CMG - - 31/03/15. Decluttering in Endoscopy suite - 31/03/15. Implement centralised booking - 31/03/15. Option appraisal required to agree whether to have an unaccredited unit or move the unit to another venue, or close the unit and move the work to another site. Agree plan with CHUGGS management board and Trust Board - 31/03/15. Implementation of computerised booking - 31/03/15. Actions from JAG visit on 26/9/14 to be implemented - 31/03/15.	4	GK	a

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	Reference to BAF
2423	RRC	Respiratory Medicine	Outstanding clinic letters and inability to act on results impacting on patient safety in respiratory services	30/09/2014	31/12/2014	Causes: Cardiology and Respiratory medicine have a significant number of secretarial and typist vacancies. Staff are leaving their posts due to work pressures, low morale and the decrease in secretarial staff. Much of the decrease of staff has been caused by the on-going Management of Change, which is still to reach resolution and has left new recruits on a different banding to existing ones, reducing staff morale further. The planned support to manage these known reductions was due to be undertaken by Audio Typists and Dictate IT. Increased use of ICE was meant to reduce the administrative workload associated with generating individual letters. However, difficulties in recruiting Audio Typists, continuous delay / poor performance of Dictate IT and lack of ICE support have placed unprecedented pressures on the existing staff. Core business functions in the departments of respiratory medicine and cardiology (communication, documentation, acting on results) are no longer deliverable. Consequences: 1.□A large typing backlog The backlog within the Respiratory (as at 23/09/14) is 1795 letters and the oldest letter waiting to be typed is 24/07/14 (8 weeks old). 78% of the outstanding letters are greater than 10 days old and there is a risk that both the backlog figure and the figure in excess of ten days will increase further throughout the summer. Cardiology (as at 23/09/14) has 2356 letters in the back log, 43% are over 10 days and the oldest letter is 19/08/14. 2.□Patients are at risk of significant harm/injury due to the delay in receipt of treatment/care plan information, including medication changes. 3.□Patients are also at risk due to the limited availability of timely clinic letters (which include diagnostic ,treatment and referral information) to GPs and other health care professionals involved in the treatment of the patient. 4.□Consultants are no longer able to reliably act on results	Quality	1.□Recruitment for Audio typists. These roles have been advertised for a third time and so far 2 WTE have started. 2.□Overtime offered to all secretarial and audio typing staff 3.□Continued attempt to get cover through bank/recruitment agency staff. 4.□Additional typing support through Ops Manager, Team Leader and PA's. 5.□Clinical Immunology & Renal secretaries have been offered typing overtime to support Respiratory. 6.□Secretarial staff have been asked to concentrate on the oldest typing first, regardless of whether the dictating Clinician is one they would normally provide administrative support to 7.□Recruitment of Support Secretaries from Cardiology has been undertaken to help cover the shortfall 8.□Use the Dictation service DICT8 to eradicate the typing backlog, 9.□Recruited two Agency Audio Typists for minimum 8 weeks 10.□Other CMG staff working overtime to help manage the backlog of letters - topping and tailing DICT8 files.	Major	Almost certain	20	Ensure named IM&T support for ICE implementation Employ personal user voice recognition software to fill ICE templates Recruitment of two WTE secretary - 31/12/14. Recruitment of two WTE Audio Typists - 31/12/14. Stress Risk assessment to be carried out - 31/12/14.	6	AGIB	α

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	Reference to BAF
2445	Emergency and Specialist Medicine		SpR gaps on the ESM CMG Medical Rota	04/11/2014	31/12/2014	Causes: These vacancies are caused by a national shortage of trainees applying for specialties which have a general medicine component. This is further compounded by sickness and unexpected absence which makes the rotas very vulnerable to short notice absences. Given the high number of vacancies the CMG is unable to fill these all with locum and agency staff. Consequences: There is a delay in assessing patients admitted to the assessment units out of hours or overnight. This may result in delays in recognising severity of illness or initiation of treatment which in may cause harm (death, longer LoS). Delays in decision making which means patients cannot be moved from the assessment unit to base ward beds. This may have the knock on effect of causing crowding in the ED which endangers patients there (see overcrowding in ED risk - number 2236). There is a risk to patients coming to harm on the base wards if there are insufficient senior medical staff to assess unwell patients both in assessment units and on the wards. Staff are unable to take rest breaks which may impact on their ability to take safe decisions and work within their specified working regulations. There is a risk that trainees will be removed from UHL by HEEM if we cannot ensure that they have a manageable workload when on call which will further compound the problem.	Patients	All known vacancies are out to locum bookers - the CMG actively recruits locum and agency staff and works closely with locum bookers and Maria McAuley in order to maximise fill rates. Fortnightly recruitment meetings for medical vacancies (all grades) with HR and service managers to proactively manage vacancies. Recruitment into non training grade positions from international graduates in order to fill gaps in the SpR rota. 8 day in advance schedule for on call rota produced daily and reviewed by senior manager to ensure gaps are cited and acted upon issued daily. 2 weekly advance scheduling shared with base wards to identify short falls and promote action. Monitoring in line with Trust requirements undertaken across key periods during the working year. Maintain advanced look forward for requests to maximise fill of gaps and ensure that all request are a minimum 6 weeks in advance for known vacancies. Daily review of skill mix and reallocation of SpRs following risk and dependency assessments across the CMG.	Major	Almost certain	20	Continue to progress recruitment actively and monitor deanery allocations - 31/12/14. Actively engage medical director for education (Sue Carr) and HEEM to ensure all mid and long term solutions to attracting and retaining SpRs are pursued - 31/12/14. Creative short term appointments offering fixed term opportunities within specialities to maximise interest within the local market - 31/12/14. Continue and progress the allocation of LAS doctors into the Acute rota - replacing the intended LGH team of Trust registrars (all to be in post by mid December) - 31/12/14. Trust to explore other ways of staffing medical rotas (ANPs etc) - 31/03/15.	9	CFRE	f

Risk ID	CMG	Specialty	Risk Title	Review Date Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Reference to BAF
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	30/05/2015 04/10/2013	Causes: Consultant vacancies. Middle grade vacancies. Due to a National Shortage of available trainees. Trainee attrition. Trainees not wanting to apply for consultant positions. Reduced cohesiveness as a trainee group. Junior grade vacancies. Juniors defecting to other specialties. 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 subspeciality interest. Reduced ability to train and supervise junior doctors. Deskilling of consultants without subspeciality interest. Suboptimals 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 the green locum induction book, which introduces trust policies such as hand hygiene. Locums work only in a supervised environment (either by an ED consultant or a substantive middle grade). There is a specific consultant who is concerned with locum issues as per their job plan (Ashok Kumar). Poorly performing locums are not permitted to continue working and this is fed back to their agencies. Locum doctors are only placed in paeds ED in exceptional circumstances. Consultants have been allocated specific time in paediatrics on the consultant rota. The grid paediatric trainees shift pattern has changed in the evening, allowing better matching of clinical experience to peak demand. Employment of	Extreme	Likely	20	Deanery report actions, completed 01/10/2013. Guidelines to be created governing minimum standards of locum doctor approval completed 01/09/2013. An internal induction document to be produced for locum grade doctors, completed 01/09/2013 Review of shift vs rota and the required number of juniors per shift, completed 30/04/2014. Doctor In Induction' badges have now been ordered to distinguish staff who cannot yet make decisions, completed 02/07/2014. New rota for August 2014 juniors with higher number of doctors at CT3 level. Although there are still gaps at the Senior Registrar levels ST4 and above, completed 31/08/2014.	6	BTD	f

Risk ID	CMG	Specialty	Risk Title	Review Date	Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Reference to BAF
2333	ITAPS	Anaesthesia	Lack of paediatric cardiac anaesthetists to maintain a WTD compliant rota leading to service disruption and loss of resilience	30/03/2015	17/04/2014	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 oncall 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	Interviews are being undertaken 12/01/15	8	DTR	f
2415	ITAPS	Critical Care	There is a risk of loss of ITU facilities at the LGH site	31/03/2015 03/09/2014		There will be a loss of Consultant cover, services and capacity at the LGH ITU due to: - Planned move of services from the LGH site makes the recruitment of new Consultant Intensivists difficult -Impending retirement of some current Consultant Intensivists -Lack of Consultant cover reduces ability for other specialties (Urology/Renal/General Surgery/HPB) to undertake planned and emergency major surgery. -Crucial to now down grade surgery at the LGH site. Management of some patient groups could be directed to the LRI site adding additional pressure to the emergency flow at LRI. - Move to a 1:8 rotas may add to further Consultant departures.	Patients	- Cross site cover from current Consultant workforce -Recruitment campaign - Acting down on shifts to cover rotas deficits - ITAPs leading change of ITU level and service moves across to the other 2 sites.	Major	Almost certain	20	Commence Recruitment campaign for one Consultant Intensivist 31/03/15. ITAPs management team to work with the Trusts Strategy leads and speciality leads to start to plan timescales, scope movement of services from the LGH site and scope required environmental and workforce impacts. 30/12/15	2	CAL	a

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	Reference to BAF
698	Clinical Support and Imaging	Pharmacy	Risk to the production of aseptic pharmaceutical products	03/05/2007	31/01/2015	Causes Provision of aseptically prepared chemotherapy is being undertaken from a temporary rental unit. Temporary nature and age of facility indicates high probability of failure. Arrangements for segregation of in-process and completed items is inadequate leading to high possibility of error. Current temporary unit is outside the range of the department's temperature monitoring system. Failure of refrigerated storage will remain undetected outside working hours, and has already occurred. Planning permission for temporary unit only valid until August 2012 Contingency arrangements are insufficient and could only provide for the very short term. Project is already 6 months behind schedule Storage, receipts and dispensing facility for dose-banded chemotherapy and other outsourced items purchased. Alternative arrangements will need to be found when unit is refurbished Consequences Failure of Current Temporary Facility; Inability to provide 50% of current chemotherapy products for adult services. Inability to provide chemotherapy for paediatric services. Substantial delay in re-establishing service provision from alternative supplier Limitations of treatments that can be sourced from an alternative supplier. Inability to support research where aseptic compounding required. High cost of sourcing required products from alternative supplier at short notice. Increase in datix incidents pertaining to the Aseptic Unit.	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 - due28/2/2015	3	GH	a

Risk ID	CMG	Specialty	Risk Title	Review Date	Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Reference to BAF
2409	Women's and Children's		There is an insufficient number or middle-grade doctors, both registrars and SHO's to provide adequate service cover	31/01/2015	26/08/2014	Causes: Historically there have been 4 funded SPR posts, 2 paediatric trainee SHO posts on rotation which are usually filled and 1 trust funded SHO post. As the service and demand has grown these posts have remained the same leaving the middle-grade cover inadequate. Consequences: In accordance with the European Working Time Directive on-call rotas should be 1 in 6. The shortfall in middle-grade staff means that 2/6 nights and weekends are not covered and the registrars are over worked during the day. The lack of SHO's also means they are unable to provide resident out-of-hours cover for ward 30 and that HDU patients cannot be managed on the ward. Consultants often have to take time away from their activity, which can often only be done by a consultant, to provide middle-grade cover which is inefficient use of time and resources.	Quality	Consultant cover. The workload is increasing and there is an inadequate number of consultants to provide ward level cover as required	Extreme	Likely	20	Review of medical staffing arrangements due 31/01/15	10	LCOW	f
2391	Women's and Children's		Inadequate numbers of Junior Doctors to support the clinical services within Gynaecology & Obstetrics	31/01/2015	24/06/2014	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 29/06/2015 CMG to pursue overseas recruitment of Drs - 31/1/2015 Further development of robust training programme for Junior Drs by Clinical Tutor & Programme Director due 29.06.15	8	ACURR	f

Risk ID	CMG	Specialty	Risk Title	Review Date Opened		Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Reference to BAF
847	Women's and Children's	Maternity	Lack of Capacity in maternity services	31/01/2015	28/09/2007	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	Complete transfer of all EL CS to level 1 - due 31/01/15	12	EBROU	f
2330	Medical Directorate		Risk of increased mortality due to ineffective implementation of best practice for identification and treatment of sepsis	31/03/2015	11/04/2014	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 - 31/01/15 Increased visibility of sepsis care pathway - 31/03/15 Implement 'sepsis boxes' for use in clinical areas - 30/04/15	6	JPARK	a

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	Reference to BAF
2403	Corporate Nursing	IPC	Changes in the organisational structure have adversely affected water management arrangements in UHL	19/08/2014	28/02/2015	Causes National guidance from the Health and Safety Executive advise that water management should fall under the auspices of hospital infection Prevention (IP) teams Resources are not available within the UHL IP team to facilitate the above. Lack of clarity in UHL water management policy/plan Since the award of the Facilities Management contract to Interserve the previous assurance structure for water management has been removed and a suitable replacement has not yet been implemented. Consequences Resources not identified at local (i.e. ward/ CMG) or corporate (e.g. Interserve /IPC) level to perform flushing of water outlets leading to infection risks, including legionella pneumophila and pseudomonas aeruginosa to patients, staff and visitors from contaminated water. Non-compliance with national standards and breeches in statutory duty including financial penalty and/or prosecution of the Chief Executive by the HSE Adverse publicity and damage to reputation of the Trust and loss of public confidence Loss/interruption to service due to water contamination Potential for increase in complaints and litigation cases	HR	Instruction re: the flushing of infrequently used outlets is incorporated into the Mandatory Infection Prevention training package for all clinical staff. Infection Prevention inbox receives all positive water microbiological test results and an IPN daily reviews this inbox and informs affected areas. This is to communicate/enable affected wards/depts to ensure Interserve is taking necessary corrective actions. Flushing of infrequently used outlets is part of the Interserve contract with UHL and this should be immediately reviewed to ensure this is being delivered by Interserve All Heads of Nursing have been advised through the Nursing Executive Team and via the widely communicated National Trust Development Action Plan (following their IP inspection visit in Dec 2013) that they must ensure that their wards and depts are keeping records of all flushing undertaken and this must be widely communicated Monitoring of flushing records has been incorporated into the CMG Infection Prevention Toolkit (reviewed monthly) and the Ward Review Tool (reviewed quarterly)	Major	Almost certain	20	To review and agree Water Safety Plan due 28/02/15. Submit business case for additional funding to provide sufficient resource to either the IP team or NHS Horizons to enable the trust to carry out the requirements of the statutory and regulatory documents, with potential for full introduction and management of the "compass" system. - 28/02/15 Review procedures and practices in other Trusts to ensure that UHL is reaching normative standards of practice - 28/02/15	4	LCOL	a

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	Reference to BAF
2404	Corporate Nursing	IPC	Inadequate management of Vascular Access Devices resulting in increased morbidity and mortality	19/08/2014	31/03/2015	Causes There is currently no process for identifying patients with a centrally placed vascular access (CVAD) device within the trust Lack of compliance with evidence based care bundles identified in areas where staff are not experienced in the management of CVAD's There are no processes in place to assess staff competency during insertion and ongoing care of vascular access devices Inconsistent compliance with existing policies Consequences Increased morbidity, mortality, length of stay, cost of additional treatment non-compliance with epic-3 guidelines 2014, non-compliance with criteria 1, 6 and 9 of the Health and Social Care Act 2010 and non-compliance with UHL policy B13/2010 revised Sept 2013, and UHL Guideline B33/2010 2010, non-compliance with MRSA action plan report on outcomes of root cause analyses submitted to commissioners twice yearly	Quality	Policies are in place to minimise the risk to patients.	Major	Almost certain	20	CVAD's identified on Nerve Centre - 31/03/15. Development of an education programme relating to on-going care of CVAD's - 31/03/15. Targeted surveillance in areas where low compliance identified via trust CVC audit - 31/03/15. Support the recommendations of the Vascular Access Group action plans to reduce the risk of harm to patients and improve compliance with legislation and UHL policies - 31/03/15.	8	LCOL	a

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2471	CHUGS		There is a risk of Radiotherapy Tx on the Linac (Bosworth) being compromised due to poor Imaging capability of this machine.	05/12/2014	31/03/2015	Causes: "□Poor quality images due to deterioration of the imaging panel make it difficult and occasionally impossible to compare planned and set-up positions using the acquired images. This could lead to a geographic miss i.e. incorrect area treated. "□Unavailability of online correction capability may result in acquisition of several high dose images in order to safely correct and check patient position. These high dose images are used since the ageing technology available on this machine does not support good quality low dose kilovoltage imaging. Consequences: "□Dependent upon dose and fractionation this could result in a significant amount of the intended dose being delivered to the wrong area with significant damage to the patient resulting in a reportable incident. "□Repeated high dose imaging due to deteriorating MV imaging panel increases the risk of exceeding current dose limits. "□If kV or cone beam imaging is required, patients will need transferring from Bosworth to Varian machines. This transfer process will entail patients missing treatment days to give staff time to produce back-up plans that are labour intensive. "□There is a risk of increasing waiting times leading to potential breaches in cancer waiting time targets since all complex treatments requiring advanced imaging cannot be performed on Bosworth. "□Restricted participation in National Clinical Trials, due to lack of current imaging technologies such as cone beam CT.	Quality	"□Increase in imaging dose (up to 10 MU) to produce a usable image. This however restricts the number of times an image may be repeated (due to dose limits). N.B imaging dose of 1MU is used on the Varian treatment machines. "□Pre-selection of patients with a reduced imaging requirement are booked on Bosworth. However this list is getting fewer and fewer due to best practice and national guidelines. "□We have introduced long day working on Varian machines to absorb patients that cannot be treated on Bosworth due to imaging limitations "□Clear Set-Up instructions plus photographs are provided to treatment staff to aid set-up. These do not fully eliminate the risk due to variable patient stability and condition hence the need for on-treatment imaging.	Major	Likely	16	Develop business plan for replacement of treatment machine. Briefing paper to be submitted to the Investment Committee Meeting - 31/03/15. Replacement of Imaging panel to improve image quality and reduce imaging dose. However this does not solve the lack of online correction capability -31/03/15. Restriction of patient numbers to be treated on Bosworth. This will have a large impact on the departments waiting times and potential breach patients - 31/03/15.	4	LWI	a

Risk ID	CMG	Specialty	Risk Title	Review Date Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Reference to BAF
2422	CHUGS	GENSUR	There is a risk to patient safety and quality due to the nurse staffing levels on SAU LRI	31/01/2015 29/09/2014	Causes: The nurse staffing levels within the Surgical Assessment Unit at the Leicester Royal Infirmary are at a critical level with poor retention of staff. Of the recruitment of 6 International nurses, 2 newly qualified nurses and a development band 6 nurse - 7 of these nurses have left or are leaving reporting high workload as the reason. Due to it being a busy, high activity area - it is difficult to get staff to work on the area from the nursing bank and agency. The levels of vacancies are 1 band 6 7wte band 5. We include the recruitment with 2 band 5 waiting to start who will require support an supernumerary time. Consequences: Poor quality of care to patients including increasing patient harms, delays for treatment/care. High levels of complaints for the ward (seven complaints over the past 6 months). Poor Patient Experience (The Friends and Family Test score has been consistently low. (<55).	Quality	1.□ Shifts escalated to bank and agency at an early stage. 2.□ Increased the numbers of Band 6's to provide leadership support. 3. Agency contract in place for one nurse on day shift and night shift to increase nursing numbers.	Major	Likely	16	Increase the number of Deputy Sister posts on the ward for operational leadership on each shift - 31/01/15. Review the possibility of rotational shifts for staff across other surgical/GI med wards to increase attractiveness to staff - 31/01/15. Review established nurse staffing levels for the ward and complete case of need to increase nurse staffing in line with other SAU's - 31/01/15. Continue to actively recruit to the area - 31/01/15.	4	GK	f

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	Reference to BAF
2320	CHUGS	RADT	Inadequate staffing levels in therapy radiography and radiotherapy physics causing a serious radiotherapy treatment error	21/03/2014	31/01/2015	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 changes make human error more likely (with potential for misadministration of radiation) Participation in radiotherapy trials reduced. Staff training compromised. Potential for increased external scrutiny. Low morale and difficulties in retaining staff. Managerial and administrative functions compromised.	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	Treatment bookings adjusted with staff working shifts, physicists and radiographers appointed with start dates given - 31/01/15 Protected time for training / development (dependant on business case) - 31/01/15 Increase treatment imaging to 100% to prevent risk of treatment error, aim to increase imaging to 100% of patients (dependant on business case) - Imaging on Bosworth in need of replacement see separate risk assessment 31/01/15 Submit second business case to increase in linac capacity by generating income from further increase in activity / complexity - Draft written to be submitted Jan 2015 31/01/15 Secure resource for quality system - appoint dedicated staff member to update and maintain quality system. Interview date 17.12.14 anticipated start date March 2015- 31/03/15.	4	LWI	f

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	Reference to BAF
2388	Emergency and Specialist Medicine	ED	There is risk of delivering a poor and potentially unsafe service to patients presenting in ED with mental health conditions	29/10/2014	31/12/2014	Causes: An increase of over 20% in ED attendances relating to mental health conditions in the past 5yrs. Inappropriate referrals into the ED of patients with mental health conditions. Limited resources and experience of staff in the ED to manage mental health conditions. The number of security staff has not increased with the increase in patient numbers (and are unable to restrain patients currently- see associated risk). The facilities in which to manage this patient group are inadequate for this patient group as not currently staffed. Poor systems in place between UHL, LPT, Police & EMAS to manage this patient group. High workload issues in the ED overall and overcapacity. National shortage of mental health beds, leading to placement delays for patients requiring in patient mental health beds. CAMHS service is limited. Consequences: Potentially vulnerable patients are able to leave the ED and are therefore at risk of coming to harm. There have been incidents reported where patients have been able to self harm whilst in the ED. Patients receive sub optimal care in terms of their mental health needs. Increased and serious incidents reported regarding various aspects of care of mental health patients. Patients' privacy and dignity is adversely affected. Risk of staff physical and mental injury/harm.	Patients	Security staff allocated to ED via SLA agreement (can intervene if staff become at risk). Violence & Aggression policy. Staff in ED undergo training with regard to mental health. Staff attend personal awareness training. Mental health pathway and assessment process in place in ED. Mental health triage nurse based in MH assessment area of ED, covering UCC and ED. ED Mental Health Nurse Practitioner employed in ED. Medical lead for mental health identified in ED from Consultant body.	Major	Likely	16	Task & Finish group to review security arrangements in terms of Control & Restraint practice in ED - complete Missing persons process for ED to append to UHL Missing Patients Policy - Complete Agreement of role of security staff in ED and agree service level agreement to reflect this - 31/12/14. Training to be available for ED staff with regard to management of aggressive patients, to include breakaway techniques - 31/12/14. Roll out of Mental Health Study Day for ED staff during 2014/15 - 31/03/15. Develop plans in line with Government's "Mandate" to ensure no one in crisis will be turned away by - 31/03/15. Partnership working group set up to include UHL, LPT, EMAS & Police to look at improving response times and access to assessment for people with MH issues. Local area will have its own crisis care declaration including a joint statement which demonstrates the Concordat principles - 31/12/14.	6	JE	f

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2466	Emergency and Specialist Medicine	Rheumatology	Risk of Patient Harm due to delays in timely review of results and Monitoring in Rheumatology	31/03/2015	03/12/2014	1.□High Volume of paper results that need daily review by registered Nurse, 2.□There is duplication of results as some patients will have results reported through DAWN database and some patients will not (patients on other immunosuppressant drugs); therefore nurses checking all paper copies 3.□There is a gap in the nursing establishment 4.□Only one person trained to input data on DAWN system; they have given notice and will finish end of November	Patients	The Rheumatology Department follows the 'BSR/BHPR guideline for disease-modifying anti-rheumatic drug (DMARD) therapy in consultation with the British Association of Rheumatologists (2). This stipulates the type and frequency of blood test monitoring, as well as recommendations for actions if results are found to be abnormal. Service management team are negotiating more live patient licences with 4s Systems and more users as well as training requirements. Action plan in place to identify and act on further risks, process review supported by LiA programme.	Major	Likely	16	Site visit and further support from 4s systems requested to identify further monitoring of biologics patients - This is an action until support from 4s is in place. LiA work stream to address risks and plan future working - 26/03/15 Every patient on DMARD to be on DAWN system and monitored in real time - 31/03/15.	1	GST	a
2191	Musculoskeletal and Specialist Surgery	Ophthalmology	Follow up backlogs and capacity issues in Ophthalmology	01/03/2015	12/06/2013	Causes: Lack of capacity within outpatient 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 outpatients 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 ongoing. 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 - 31/01/15.	8	DTR	a

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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	02/01/2015 22/12/2006	Causes: Failure to implement electronic tracking for blood and blood products to provide full traceability from donor to recipient At UHL blood is tracked electronically up to the point of transfer of blood from local fridge to patient with a manual system thereafter which is not 100% effective (currently approximately 1 - 2% (approx 1200 units) of all transfusion recording is non-compliant = 98% compliance). Non-compliance with blood transfusion policies resulting in incorrect identification processes resulting in sample identification and labeling error resulting in wrong blood cross-matched and / or provided for patient (last incident of ABO incompatibility by wrong transfusion approx 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 sample. Critical report received from MHRA in October 2012 in relation to UHL having no credible strategy for compliance with Blood Safety Regulations. Consequences: Potential loss of blood bank licence (via MHRA) with severe impact on surgery and transfusion dependent patients served by UHL. Financial penalty for non-compliance due to increased number of inspections Delay in timely supply of blood and blood components for new surgical and transfusion clinic patients. Increased potential for 'Never event' (i.e. wrong transfusion) leading to increased morbidity /mortality. Potential loss of Trust's good reputation via publication of critical reports.	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	Develop LIMS (Laboratory Information Management System) the IT system which interfaces the laboratory analysers with the Trust system. Implementation plan 02.02.2015; Full implementation of LIMS Feb 2015; Full implementation Blood Track May 2015	4	KJON	a

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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	31/01/2015	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	Recruitment to 6th Radiologist post - 28/02/2015	4	JGI	f

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	Reference to BAF
2248	Clinical Support and Imaging	Medical Physics	Lack of IR(ME)R training records held across the Trust	14/11/2013	28/02/2015	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 inspection or follow up to an adverse event and consequent effects on the reputation of the Trust. Increased patient radiation doses due to lack of training. Increased staff doses due to lack of awareness of the potential doses if training is inadequate Potential damage to expensive equipment if training on how to use it is inadequate Management unable to easily identify which staff are trained to undertake a task involving radiation Breach of statutory duty Negative effect on the reputation of the Trust	Quality	There is a defined method of recording training across the Trust in the Trust Radiation Safety policy. Although this is working in some areas it is not working consistently in all areas. The issue has been raised at the Trust Radiation Protection Committee numerous times where representatives of each Division have been in attendance. This has not so far led to a an increase in compliance. Radiation Protection produced a specific plan of what is required to demonstrate compliance. Mock audit completed 2/12/13. 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 ongoing monitoring of training - 1/5/14 Identify Trust staff with responsibilities under IRMER - completed 1/8/14	Major	Likely	16	Implement e-learning module on e-UHL - 28/2/15	4	MNO	a

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2378	Clinical Support and Imaging	Pharmacy	Pharmacy workforce capacity	19/01/2015	19/06/2014	there is a risk that arises because of pharmacy workforce capacity across multiple teams which will result in reduced staff presence on wards or clinics, as well as capacity for core functions. This will result in reduced prescription screening capacity and the ability to intervene to prevent prescribing errors and other medicines governance issues in a number of areas including some high risk. high levels of vacancies and sickness high levels of activity training requirements for newly recruited staff	Patients	extra hours being worked by part time staff team leaders involved in increased 'hands' on delivery staff time focused on patient care delivery (project time, meeting attendance reduced) Prioritisation of specific delivery issues e.g. high risk areas and discharge prescriptions, chemo suite	Major	Likely	16	recruit specialist staff - due 19/01/15	8	CELL	f
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	01/02/2015	24/06/2014	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	Undertake a peer review visit to Sheffield due 31/03/15 Review of Consultant working patterns and extension of presence on the DS and MAU due 28/02/15 Development of a decision education package focusing on the management of the 2nd stage of labour due 30/04/15. Further review of times of day when babies with HIE are born due 28/02/15	8	ACURR	a

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2153	Women's and Children's	Paediatrics	Shortfall in the number of qualified nurses in Children's Hospital including ECMO staffing and Capacity	31/03/2015 05/03/2013	Causes The Children's Hospital is currently experiencing a shortfall in the number of appropriately qualified Children's nurses. This is in part due to the increased numbers of staff on maternity leave and the issues with recruiting Children's trained nurses. The demand for PICU beds currently outweighs capacity. There is an establishment of 6.5 beds but due to vacancies and long-term sickness/maternity leave the unit is currently only able to run at maximum capacity of 6 beds and on specific days only 5 beds (depending on the overall ECMO activity across adults and children). In addition to NHS activity the Trust has contracted to provide cardiac surgery for a cohort of Libyan children. At the time that the contract was developed (Nov-December 2012) it was assessed that there would be sufficient capacity to operate on one child per week without impacting on NHS Activity. However, the current staffing and long-term profile of patients on PICU has resulted in pressures on both NHS work and the delivery of the Libyan contract. Currently there are vacancies for 5.82 wte qualified and 1 wte unqualified nurse within the Children's cardio respiratory services, which cover PICU, ward 30 and the COPD. The ECMO services have vacancies for qualified staff. Consequences There is a short fall in the number of appropriately qualified children's nurses in the Children's Hospital which could impact on patient care. Balancing the demand for PICU beds between NHS contracted activity, emergency cases and Libyan private patients increases the risk of cancellations and increased waiting times. Unsafe staffing levels, therefore unable to provide the recommended nurse to bed ratios in an intensive environment. Staff from PICU are moved to cover ward shifts to ensure minimum nurse to bed requirement. Consequently this	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	Likely	Major	16	Continue to recruit to remaining 5wte vacancies - due 30/4/2015 Completion of a period of perceptorship for newly qualified nurses - due 31/1/2015 Completion of a period of perceptorship for new international qualified nurses - due 30/6/15	8	EA	f

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2237	Medical Directorate		Risk of results of outpatient diagnostic tests not being reviewed or acted upon resulting in patient harm.	31/10/2015 07/10/2013		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 in imaging for time to test and time to report. Consequences Potential for mismanagement of patients to include: Severe harm or death to patient. Suboptimal treatment. Delayed diagnosis. Increased potential for incidents, complaints, inquests and claims. Risk of adverse publicity to UHL leading to loss of good	Patients	Abnormal pathology results escalation process Suspicious imaging findings escalated to MDTs Trust plan to replace iCM (to include mandatory fields requiring clinicians to acknowledge results).	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	1

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2338	Medical Directorate		There is a risk of patients not receiving medication and patients receiving the incorrect medication due to an unstable homecare	31/03/2015	01/05/2014	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. Patients have not been able to get through to H @H via their telephone helpline. 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. Bath ASU usually have a 5 day lead time on this, currently this has been increased to 2 weeks. Bath ASU are prioritising hospitals that do not have the facility to manufacture their own dose banded chemotherapy. Currently we do not have the facility to compound all of our dose banded chemotherapy, and there are concerns about supply over the next few weeks. Alcura 1)Experiencing difficulties that have resulted in failed deliveries and possible breaches of patient confidentiality. 2)There are on-going issues with invoicing. No invoices for Alcura have been paid since November from UHL. This is a national issue and there is a concern that the company may experience a cash-flow problem resulting in closure. Consequences Existing providers of homecare services are having	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 had 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 speciality teams to ensure that any necessary clinical pathway changes are supported Repatriation of urgent drugs back to UHL out-patient provider Self - assessment against Hackett criteria against all homecare schemes	Major	Likely	16	Monitoring of control measures - 31/03/15	9	CELL	1

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	Reference to BAF
2093	Medical Directorate	R&D	Athena Swan - potential Biomedical Research Unit funding issues.	08/08/2014	31/03/2015	The Athena SWAN Charter is a recognition scheme for UK universities and celebrates good employment practice for women working in science, engineering and technology (SET) departments. Standards required for next round of Biomedical Research Unit (BRU) submissions. Academic partners required to be at least Silver Status. Failure for the University to achieve this will result in UHL being unable to bid successfully for repeat funding of the BRUs. There is a very real possibility that UHL will loose ALL BRUs if this is not adequately addressed.	Economic	Every meeting with the University, Athena Swan is on the Agenda. Out of UHL control directly, but every avenue is being used to keep the emphasis high at the University.	Major	Likely	16	Add Athena Swan to every agenda at Leicester & Loughborough Universities attended by UHL R&D Personnel	4	CMAL	e
2365	IMT		IBM lack NHS specific knowledge	17/06/2014	31/07/2015	IBM lack NHS specific knowledge (e.g. PbR, CDS, NHS information structures, mandatory data flows) required to deliver IM&T Business Intelligence service to the expected standard. UHL fails to satisfy mandatory reporting requirements (e.g. CDS) , incurs penalties and reputational damage.	Business	Transition approach is to ensure that key implied knowledge relating to UHL bespoke systems is transferred to MBP staff and documented where possible. Risk cannot be mitigated, is inherent to the MBP offshore delivery model. 03/07/2014: Additional UHL role to be added to IM&T structure to work with MBP to prioritise work correctly and translate business to technical requirements. Interim role in place from 14/07/2014.	Major	Likely	16	Completion of documentation knowledge base as part of MBP transition phase - 31/07/15. Additional post to be added to IM&T structure to provide business knowledge, assist with prioritisation and work with IBM to translate UHL/NHS requirements to requests for technical delivery - 31/07/15.	12	JCK	f

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	Reference to BAF
2247	Corporate Nursing	Nursing	There are significant numbers of RN vacancies in UHL leading to a deterioration in service/ adverse effect on financial position	30/10/2013	31/03/2015	Causes: Shortage of available Registered Nurses (RN) 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 emphasis on nursing roles.	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. - 31/03/15 Utilise other roles to liberate nursing time - 31/103/15	12	CRIB	f

Risk ID	CMG	Specialty	Risk Title	Review Date Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Reference to BAF
2325	Corporate Nursing	Nursing	Risk to patient/staff safety due to security staff not assisting with restraint	28/02/2015 03/04/2014	Causes Interserve refusal to provide trained staff to carry out non-harmful physical intervention, holding and restraint skills, where patient control is necessary to deliver essential critical care to patients lacking capacity to consent to treatment. Insufficient UHL staff trained in use of non-harmful physical intervention and restraint skills to carry out patient control. Termination of Physical skills training contract with LPT provider in January 2014. Consequence Inability to deliver safe clinical interventions for patients lacking capacity who resist treatment and/or examination. Increased risk of Life threatening or serious harm to patients resisting clinical intervention Increased risk of injuries to patients due to physical interventions by inexperienced/untrained staff. Increased risk of injuries to untrained staff carrying out physical interventions. Increased risk of injuries to staff carrying out clinical procedures Requirement for increased staffing presence to carry out safe procedures Reduced quality of service due to diverted staff resources Increased risk of sick absence due to staff injury. Increased risk of complaints from patients and visitors Increased risk of failure to meet targets Adverse publicity	Patients	UHL Nursing and Horizons colleagues have met with Interserve 12/03/14 and UHL have agreed to issue a temporary indemnity notice that will provide vicarious liability cover for Interserve staff in these situations (supported by our legal team). This was rejected by Interserve Management Cover with more UHL employed staff where there may be patients requiring this type of restraint; Staff must take risk assessed decisions about the use of restraint and ensure incidents are reported using the Trust's incident reporting database. In extreme cases staff should be aware that the police should be called Continue to communicate with all staff about the current position.	Major	Likely	16	High priority recruitment of physical skills trainer - 28/02/15	6	DLO	a

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	Reference to BAF
2316	Operations	Emergency Planning	Flooding from fluvial and pluvial sources	06/03/2014	30/06/2015	Causes (hazard) Pluvial flooding (all sites) external and internally Fluvial flooding (LRI) from the River Soar Heavy, prolonged rain fall Winter snow/ice melt Blocked drains Consequence (harm / loss event) Loss of service areas/buildings/site To the full extent of the river soar flood plain the majority of the LRI would be flooded Sewage ingress Contamination of infrastructure Patient safety Loss of electrical supplies Loss of mains water and drainage Disruption to supply lines Staff difficulties getting in Staff difficulties getting home - staff car parks and vehicles flooded Reputation and publicity on the impact of flooding, the development of a site at risk from flooding, the response and recovery	Targets	Flood Plan - LRF and UHL Response teams IPC Policy Business Continuity Plans Major Incident Plan UHL/Multi-agency communications plan Insurance Policy Cooperate with LRF partners to test the LRF plans	Major	Likely	16	Update UHL flood plan to identify services and equipment at risk and identify control measures - 30/06/15	12	PWA	a

Risk ID	CMG	Specialty	Risk Title	Review Date Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Reference to BAF
2318	Operations	Emergency Planning	Blocked drains causing leaks and localized flooding of sewage	30/06/2015 17/03/2014	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 above their bays/beds. Whilst repairs are underway it may become necessary to isolate and turn of showers, toilets and washing facilities elsewhere in the building. Potential media coverage (one request for information from Leicester Mercury during August) which could result in a loss of reputation and patient satisfaction scores Quality and safe delivery of care will be compromised in areas of sewage leaks resulting in suspension/scaled back delivery of services Risk to health and safety of staff from an unsafe working environment resulting in contamination, slips and falls Increased risk of infections and patient safety	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). single choice patient wipes Surveys done in Kensington and Balmoral Jet washing pipes Reporting of the number of blockages	Major	Likely	16	Cost of replacement of stacks to be assessed. Nigel Bond - due 31/03/15. NHS Horizons to identify additional measures to reduce blockages - Nigel Bond 31/03/15	2	PWA	a

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	Reference to BAF
1693	Strategy	Coding	Risk of inaccuracies in clinical coding	02/08/2011	31/01/2015	Casenote availability and casenote documentation. HISS/PatientCentre constraints (HRG codes not generated due to old version of Patient Administration System) High workload (coding per person above national average). Unable to recruit to trained coder posts (band 4/5) Inaccuracies / omissions in source documentation (e.g. case notes and discharge summaries may not include co-morbidities, high cost drugs may not be listed). Coding proformas/ ticklists designed (LiA scheme and previously) but not widely used. Electronic coding (Medicode Encoder) implemented February 2012 but not updated since (old versions of HRG). The system has no support model with IM&T, so errors are difficult to resolve. Mandatory training not undertaken for 3 years (the maximum span permitted) Consequences: Loss of income (PbR). Potential outlier for SHMI/HSMR data. Non- optimisation of HRG. Loss of Trust reputation.	Economic	Backlog of uncoded episodes actively managed from September 2014 and reduced from 11,000 to 4,000 (as at Dec 14). Where casenotes are delivered to the coding offices, these are coded within 24 hours. This has increased coverage of coding from notes (rather than other electronic sources) and reduced the unnecessary movement of notes between departments. 4 Trainee coders have been appointed to commence in Jan15. Comprehensive training required before able to code independently. Recruitment and retention strategy being developed with support of HR. Currently advertising for replacement band 6 site lead and band 5/6 coding trainer posts. Agency coders being used to backfill vacant positions. Medicode has been upgraded in the test environment. This needs to be applied in the live environment. A comprehensive IT support model is being developed for the system. When upgraded, Medicode will provide an audit functionality to facilitate regular audit of coding Lead clinicians identified to move coding closer to the clinician. Scorecard redevelopment to demonstrate improvements and benchmark against other Trusts. 3 year refresher training to be in place and funded recurrently Regular updates to the Audit Committee. Coding managers present overview for Junior doctor induction PbR CIP Project Group commenced April 2014.	Major	Likely	16	Minimise backlog of coding, monitoring coding quality, appointing to substantive posts to reduce reliance on agency coders - 31/03/15	8	JRO	f

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	Reference to BAF
2354	RRC		Overcrowding in the Clinical Decisions Unit	28/05/2014	31/12/2014	CAUSES 1.□CDU originally designed to take in a 24 hour period 25-30 patients, on average it is now taking 50-60 patients/24 hr period. Therefore the foot print of the unit is inadequate to cope with this number of patients. There is not the physical space to see/examine/review the number of patients that are currently presenting to CDU, particularly in the afternoon and evening. 2.□The workforce on CDU (medical, nursing, therapy, admin/clerical) has not increased in accordance with the increase in the number of patients that require processing in the department. 3.□Due to the pressures within the Emergency Department at the LRI the level 1 and 2 diverts are enacted on a regular basis, compounding the overall processing power within CDU and impacting on bed capacity. 4.□The out of hour's provision from support services such as pharmacy, radiology and pathology does not match the requirements of an increasing emergency take at the GH. CONSEQUENCES 1.□Significant delays in patients being assessed and treated due to inadequate workforce resource to meet demand. This compounds the space issue as patients are not being assessed and treated in an efficient manner. 2.□Overcrowded department leads to inefficiencies ie no physical space to review or examine patients; therefore there are delays in them being assessed and receiving treatment. 3.□Patients dissatisfied with their experience: CDU patient survey results/Friends and Families Score reflect the long waits patients are experiencing. The results are amongst the lowest in the Trust. The detractors all relate to wait times, overcrowding whilst waiting and inappropriate	Patients	1.□Respiratory Consultant on CDU 5 days/week 0800-20 00 hrs 2.□Respiratory Consultant on CDU at weekends and bank holidays 0800-1200 hrs and on call thereafter 3.□Cardio Respiratory Streaming flow, including referral criteria and acceptance 4.□Short stay ward adjacent to CDU 5.□Discharge Lounge utilised 6.□GH duty Manager present 24/7 7.□Patient flow Coordinator 7 days/week daytime 8.□CDU dash board 9.□UHL bed state details CDU current status as well as ED 10.□Daily nurse staffing review with plan to ensure safe staffing levels on CDU 11.□EDIS operational on CDU 12.□Daily patient census conference calls 13.□Daily board rounds across all wards	Moderate	Almost certain	15	ECAT on GH site once/month - Meeting with support services- radiology, pharmacy and Pathology - Review of work force resource- to be prepared for discussion at next ECAT meeting on GH site and then action appropriately - 31/12/14 Plan to hold a CDU flow mapping exercise - to fully utilise the ambulatory area - 31/12/14	3	SM	a

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2328	ITAPS	Anaesthesia	Risk of inadvertent wrong route administration of anaesthetic medicines during epidural and regional anaesthesia.	16/04/2014	31/10/2016	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) - 31/10/16. Introduction of Non-Luer giving sets(following introduction of ISO standard) - 31/10/16. Introduction of Non-Luer connector to epidural filter (following introduction of ISO standard) - 31/10/16.	5	CAL	a
1196	Clinical Support and Imaging		No comprehensive out of hours on call rota and PM cover for consultant Paediatric radiologists	29/06/2009	31/01/2015	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. Lack of cover for PM work 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. Delays in reports for Pathology and Coroner	Patients	To provide as much cover as possible within the working time directive. Registrars cover within the capability of their training period. Other Radiologists assist where practical however have limited experience and are unable to give interventional support. Locums are used when available.	Moderate	Almost certain	15	Recruit to Consultants vacancies - due 30/06/2015	12	RG	f

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	Reference to BAF
2380	Clinical Support and Imaging		Imaging - Risk of breach of Same Sex Accommodation Legislation	23/06/2014	31/01/2015	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.Explore options around redesigning the cubicles and waiting area in the MRI and CT zone - due 01/02/2015 LGH Action Plan:- Where feasible, implement appropriate changes, based on business case, costings approval and planning. Options to consider include: "□Increasing numbers of cubicles "□Provision of solid doors on cubicles instead of curtains "□Investigate possibility of single sex sessions, i.e. males in the morning, females in the afternoon, for both inpatients and outpatients "□Creating single sex recovery areas "□Area D: utilise chair area for dressed patients only. Undressed patients could wait in the cubicles. Trolley area could have cubicles and chairs removed so that curtained area can be created to accommodate 1 trolley patient, allowing maximum of 2 patients in this area at a time. If opposite sex, one could be curtained behind the screened area. 01/02/2015	3	JHA	α

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2426	Clinical Support and Imaging	Dietetics	Compromised safety for pateints with complex nutritional requirements	31/03/2015 28/10/2014	Causes: Increased workload with greater number of patient referrals. Inability to staff the PN round daily due to shortage of staffing resource. Consequences: Increased length of stay, prescription errors, delays in reviewing patients, reduced quality of care, loss of patency of lines and reduced efficiency around checking patients' blood results. Delayed response to complex Home Parenteral Nutrition patients' contacts/referrals due to further increase in inpatient workload. Increased risk of prescribing errors due high workload and pressures to respond quickly. Insufficient nursing and dietetic cover to action promptly the increasing numbers of all referrals in-house and in the community, resulting in a number of patients receiving delayed reviews. Increased levels of stress amongst the team, which could result in increased sickness absence, which would further exacerbate the risks above. Risks to patient safety due to not being reviewed daily, particularly unstable patients. HIFNET bid will fail due to current staffing establishment. Loss of regional and national intestinal failure status. Loss of income from HIFNET bid. This will affect other services throughout the Trust (e.g. bariatric services).	Patients	Temporary controls following previous risk assessment December 2013, in the form of funding 1.0 WTE at Band 6 nurse and 0.21 at Band 8a nurse and 1.0 WTE Band 6 Dietitian, on a temporary basis, currently in place until 30/3/15.	Moderate	Almost certain	15	1. Review possibility of capping numbers of HPN referrals with the clinical teams. Review possibility of capping inpatient PN tailored bags - 31/03/15. 2. Consider converting temporary posts to permanent contracts to ensure continuity of staffing and training needs- 31/03/15. 3. Urgent review of the NST service to ascertain requirements for further uplift in staffing levels - 31/03/15. 4. Consider the option to Identify and facilitate professional checking by qualified pharmacist of the HPN prescriptions on a daily basis - 31/03/15. 5. Review current response times for enteral and HOS referrals, with a view to lengthening (current standard is within 24 hours) on a short term basis, to reduce pressure on the team - 31/03/15. 6. Complete stress risk assessments on all members of the nutrition nurse team and take any identified actions - 31/03/15. 7. Urgent review of job plans to all members of the NST to meet high risk priorities - 31/03/15. 8. Audit readmissions of HPN patients - 31/03/15. 9. To create and develop a specialist pharmacist post dedicated to nutrition in line with the current Pharmacy workforce optimisation review - 31/03/15.	3	MSC	a
2407	Women's and Children's		Failure to meet national non admitted target of 18 weeks	31/01/2015 26/08/2014	Causes: Recent increase in referrals 1.0 wte consultant gynaecologist vacancy Failure to appoint to permanent post or locum position Consequences: Increase in waiting time for appointment 18-30+ weeks Failure to meet 95% performance target Impact on performance with a possibility of 50% performance rate by end August 2014 Performance gone down since June	Patients	Letters sent to GP's advising them of waiting time delays and the need to prioritise the patients they refer Working with GP representative to ensure all GP's are aware Out of area referrals discontinued SpR on maternity leave to return 1 month early Cancer Geneticist increasing workload -assisting with 1 clinic per week	Moderate	Almost certain	15	Recruit into the consultant vacancy - due 31/01/2015	3	DMARS	a

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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	28/02/2015 17/12/2013	Causes: Inadequate staffing levels and inappropriate quality systems in place. ISO 15189 accreditation would be an outcome if the service was adequately staffed with appropriate quality systems in place. Consequences: Patient safety and quality issues if unable to deliver service. Financial impact if patients choose to move elsewhere or NHS contracts not obtained. Risk to Trust reputation. Challenging external recommendations/improvement notice from HFEA - critical report received Feb 2013.	Statutory	1 fulltime trained Embryologist to a national recognised level 3 part time trained Embryologist to a national recognised level 1 0.8wte Band 6 BMS	Moderate	Almost certain	15	Band 6 to be advertised & recruited to - due 28/02/2015 Overhaul of specimen request, collection and delivery procedures - due 28/02/2015.	6	DMARS	a

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	Reference to BAF
2402	Corporate Nursing		Inappropriate Decontamination practise within UHL may result in harm to patients and staff	31/03/2015	19/08/2014	Causes Endoscope Washer Disinfector (EWD) reprocessing is undertaken in multiple locations within UHL other than the Endoscopy Units. These areas do not meet current guidelines with regard to a. Environment b. Managerial oversight c. Education and Training of staff There is decontamination of Trans Vaginal probes being undertaken within the Women's CMG and Imaging CMG according to historical practice, that is no longer considered adequate. Bench top sterilisers within Theatres continue to be used. The use of these sterilisers is monitored by an AED. Purchase of Equipment is not always discussed with the Decontamination Committee Consequences Lack of oversight of Decontamination practice across the Trust Equipment purchased may not be capable of adequate decontamination if not approved by Infection Prevention Current Endoscope Washer Disinfectors (EWD) re-processing locations (other than endoscopy units) are unsatisfactory. All of the above having the potential for inadequately decontaminated equipment to be used Patient harm due to increased risk of infection Risk to staff health either by infection or chemical exposure Reputational damage to the organisation Financial penalty Risk of litigation Additional cost to the organisation when further equipment must be purchased	Statutory	Surgical instrument decontamination outsourced to third party provider. Joint management board and operational group oversee this contract. The endoscopy units undergo Joint Advisory Group on GI endoscopy (JAG) accreditation. This is an external review that includes compliance with decontamination standards. All units are currently compliant. Current policy in place for decontamination of equipment at ward level. Equipment cleanliness at ward level is audited as part of monthly environmental audits and an annual Trust wide audit is carried out. Benchtop sterilisers are serviced by a third party Endoscope washer disinfectors are serviced as part of a maintenance contract Infection prevention team are auditing current decontamination practice within UHL. Position paper sent to Trust Infection Prevention Assurance Committee in November 2013 Infection prevention team provide advice and support to service users if requested Endoscopy water test results monitored by IP team. Failed results sent to the team by Food and Water laboratory and these are followed up with relevant teams to ensure actions have been taken.	Moderate	Almost certain	15	Complete full review of decontamination practice within UHL and make recommendations for future practice - 31/03/15 Review all education and training for staff involved in reprocessing reusable medical equipment - 31/03/15 Review the use of equipment and the appropriateness of their current placement according to national guidance - 31/03/15	3	LCOL	a

Risk ID	CMG	Specialty	Risk Title	Review Date	Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Reference to BAF
1551	Corporate Nursing	QS	Failure to manage Category C documents on UHL Document Management system (Insite)	30/06/2015	14/03/2011	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 - 30/06/15 Compile a list of local guidelines requiring review and send to CMGs for action - 30/06/15 CMGs to advise 'CRESPO' of any guidelines requiring urgent revision/ attention or that need to be removed from InSite - 30/06/15 Provide a message on InSite to inform staff that work to improve the system is ongoing and if necessary advise can be sought from Rebecca Broughton/ Claire Wilday - 30/06/15 Implement shared mailbox to receive responses from CMGs - 30/06/15 Ensure input from IM&T to make InSite more effective as a document library - 30/06/15 Continue work to assign review dates and authors to all CAT C documents 30/06/15	9	SH	4

Agenda Item: Trust Board Paper M

TRUST BOARD – 5 FEBRUARY 2015

Update on Medical Education

DIRECTOR:	Dr Kevin Harris – Medical Director
AUTHOR:	Professor Sue Carr – Associate Medical Director, Clinical Education
DATE:	5 February 2015
PURPOSE:	**Update on medical education issues in UHL** 1. Outcome of Health Education East Midlands quality management visit 2014 2. Increase accountability for UG and PG education and training resources (appendix) 3. Continue to develop a facilities strategy for education and training 4. Redistribution of training posts across East Midlands and Broadening Foundation report and implications for workforce 5. Outline a strategy for simulation training for UHL
PREVIOUSLY CONSIDERED BY:	**Trust Board**
Objective(s) to which issue relates *	☐ 1. Safe, high quality, patient-centred healthcare ☐ 2. An effective, joined up emergency care system ☐ 3. Responsive services which people choose to use (secondary, specialised and tertiary care) ☐ 4. Integrated care in partnership with others (secondary, specialised and tertiary care) ☑ 5. Enhanced reputation in research, innovation and clinical education ☐ 6. Delivering services through a caring, professional, passionate and valued workforce ☐ 7. A clinically and financially sustainable NHS Foundation Trust ☐ 8. Enabled by excellent IM&T
Please explain any Patient and Public Involvement actions taken or to be taken in relation to this matter:	
Please explain the results of any Equality Impact assessment undertaken in relation to this matter:	
Organisational Risk Register/ Board Assurance Framework *	☐ **Organisational Risk Register** ☑ **Board Assurance Framework** ☐ **Not Featured**

ACTION REQUIRED *					
For decision		For assurance	√	For information	√

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

* tick applicable box

Medical education and training issues in UHL 2014: Update

Postgraduate Medical Education

1. Health Education East Midlands (HEEM) Quality management visits 2014

HHEM conducted a Level 2 multi-professional quality review visit which was largely positive (O&G report still outstanding)
The full report is attached as an Appendix

The visiting team from HEEM acknowledged Trust wide, areas of good practice:

- The appointment of Education Leads within each CMG
- Development of a Quality Dashboard
- Implementation of the Education Strategy
- Establishment of the Medical Education Committee
- Work on the new library and provision of e-learning resources (including 'Up-to-date'- the point-of-care clinical information resource)
- Sustained improvement of education and training within the Emergency Department and dissemination of this work regionally
- Further development of the system for identification of different training grades

Across the specialities visited, the high level of Trainee support and commitment of the Consultant body to teach doctors in training was noted.
High quality training environments were specifically identified in Haematology and Respiratory, associated with excellent examination results.
Anaesthetics and Gastroenterology were noted to have effective and comprehensive departmental inductions.
The visiting team for the Dental trainees also commented on the comprehensive departmental induction and a positive training environment for the dental trainees.

The Trust has been given a number of requirements to address and these have been sent to relevant services for a response. The Trust wide issues will be taken forward by Department of Clinical Education (DCE). The report also contains a number of recommendations for consideration.

Requirements

1. Trust-wide: Ensure more regular trainee access to the Sim. Man (This issue had been identified previously and the DCE has prepared a draft strategy that will be submitted to Executive Workforce Board)

2. Anaesthetics: Ensure all rotas are at least 1 in 8. This is currently a Royal College requirement, although HEEM recognises that remains a challenge across the East Midlands;

3. Anaesthetics: The Trust needs to assure HEEM, within three weeks of receipt of the final, agreed report, that it has processes in place to ensure that all new starters in Anaesthetics have

access to the information they need to work effectively and safely in clinical areas before they commence work in these areas;

4. General Internal Medicine: A response from the Trust to the patient safety concern regarding medical cover at night at the LRI is required within three weeks of receipt of the final, agreed version of this report;

5. Cardiology: Work towards reducing the clinics burden on HSTs within an appropriate and realistic timeframe (to be agreed). Both trainees and trainers felt that there may be non-medical workforce solutions to this.

6. Cardiology: A response from the Trust regarding the issue of consultant presence on the CDU and provision of advice over the telephone, including an assessment of the risk to patient care, is required within three weeks of the receipt of the final, agreed version of this report.

Enhanced Monitoring concerns – update

Emergency Medicine and Renal Medicine remain under enhanced monitoring concerns Ophthalmology is also under enhanced monitoring but as a region-wide issue which happens to include Leicester.

2. HEEM proposed redistribution of training posts across East Midlands and Broadening Foundation

HEEM has launched a project involving 4 workstreams: driving up quality, broadening Foundation programme, review of future specialty training posts in surgery and medicine, redistribution of emergency medicine training posts. The project aims to achieve a more equitable distribution of trainees across East Midlands (per population numbers) and this may have significant implications for UHL at all training levels.

UHL is represented on 2 of the working groups by Professor Carr, Director of Medical Education and Dr Teasdale from Emergency Medicine.

A document has been produced by Health Education England "Broadening Foundation" describing the recommendations and implementation plan for a restructuring of foundation programmes across the UK. In summary, Foundation doctors will no longer be to allowed rotate into two posts within the same speciality grouping i.e. medical specialities or surgical specialities. This affects 21 UHL Foundation rotations - 16 F1 rotations and 5 F2. Work has commenced to develop bids to try to retain the 3 out of 5 Foundation 2 level posts by January 2015 (to commence August 2016). However, bids for new F1 posts need to be submitted by August and this requires a strategic Trust level cooperation and consultation with new roles group etc.

It is essential that CMG's work together to develop new posts to offer and that this issue feeds into new roles group and workforce strategies.

When considered together these changes could be extremely challenging and could create significant issues for clinical service and rotas in UHL.

3. Accountability and transparency of education funding

The Department of Clinical Education and Finance have worked to identify £32 million pounds of SIFT and MADEL funding in CMG budgets. This will now be transparent in CMG budget lines and a process of discussion will commence re education expenditure and accountability. This will be very important in retaining our education funding and we are one of few Trusts to achieve this.

MADEL postgraduate tariff

Study leave funding: HEEM will top slice the placement tariff by £600/trainee for study leave and each Trust will be able to account for use of the additional £100 that they are receiving in tariff, which would have been allocated to trainee study leave in the past – HEEM have suggested

that this use is audited by the Heads of Finance and DMEs. A report from each Trust DME and HoF will be required at the end of the year asking how this money was spent. This action is intended to allow DME's to access a more ring-fenced fund to use for postgraduate medical education initiatives.

3. Undergraduate education

Following the Learning Development agreement (LDA) meeting 17.7.14 approximately £1 million SIFT funding has been withheld pending further discussion about improved facilities and delivery of undergraduate IPE and Final examinations (RKCSB proposal) and an identification of Phase 1 funding. The Phase 1 money (£70,000) has been identified and required developments are in progress.
A letter was received from HEEM 23.1.15 to release a further £480,000 towards further developments to improve delivery of the undergraduate Finals examinations. A meeting has been held between Mr Kinnersley and the University about the facilities for exams and a plan to develop the RKCSB ground floor is progressing.

Education Facilities

a) **Odames project update** – Work in progress and the library being open in February 2015. Dr Godlee, Editor of the BMJ has been invited to open officially. The project team have secured additional funding for computers etc. from Charitable funds

b) The DCE has submitted an outline strategy for further education facilities on LRI site to Mr Kinnersley. A draft strategy for Simulation facilities is in development and there is a need for improved facilities - A meeting has been arranged to discuss collaboration with nursing and other healthcare educators to ensure a joint education facilities strategy is developed. The education centre at LRI (and lecture theatre) will need relocation/rebuilding as part of the maternity enabling works

Provision of high quality education and training facilities is an essential part of promoting UHL as an excellent training organisation and to support recruitment and retention of medical and other staff.

KPIs and education quality dashboard (EQDB) ensuring quality of training posts and being able to demonstrate this will be a critical factor in retaining training posts in UHL or attracting new posts. A quality dashboard is now being produced to EWB and KPIs have being identified for reporting

Key priorities

1. Respond to requirements of HEEM quality management visit. The formal O&G report is awaited but issues have been identified.
2. Proposed HEEM redistribution of postgraduate medical training posts - poses a significant issue and UHL will needs to be able to demonstrate accountability for funding and quality of education & training delivered to retain as many posts as possible to attract new posts.
3. There remain issues re SIFT accountability and smooth delivery of the UG examinations is a high priority in 2015 if UHL wishes to retain this funding and status. Further work is required and ongoing to achieve accountability of MADEL placement fee aspects of postgraduate training tariff
4. Progress is being made on a facilities strategy for education and training and a collaborative approach across healthcare professionals is progressing.
5. Work with local universities to maximise our potential in educational innovation, scholarship and research as a "USP" for Leicester and as a means to enhance recruitment and retention of local trainees

Appendix

THE NHS CONSTITUTION
the NHS belongs to us all

NHS
Health Education East Midlands

University Hospitals of Leicester NHS Trust

Outcomes Report

for healthcare, education and training

More to do.
More to see.
More to become.

Report For:	University Hospitals of Leicester
Completed by:	Dr. Richard Higgins
Role and Contact Details:	Quality Manager Health Education East Midlands
Date:	24/10/2014
Date sent to Local Education Provider:	Final version: 05/11/2014

1. Executive Summary

Health Education East Midlands (HEEM) visited University Hospitals of Leicester NHS Trust on 2nd and 3rd October 2014. The visiting team heard directly from learners (including trainee doctors, student nurses and allied healthcare professionals) and those who deliver their education and training at the Leicester Royal Infirmary, Glenfield Hospital and the Leicester General Hospital. Evidence gathered prior to the visit determined which areas of the Trust HEEM focused on. This was a level 2 visit.

The Trust's Executive and Education Teams provided an overview of achievements, challenges and future plans in relation to both medical and non-medical education and training and also showcased good practice and improvement projects. This demonstrated the Trust's engagement with, and commitment to, education and training. Engagement with HEEM's new approach to quality management was also positive.

The visit was largely positive in outcome, especially in relation to the use of non-medical tariff funding and the support experienced by non-medical learners, mentors and new starters, which may be a model transferable to medical training. There were also pockets of good practice in some specialties, where service demands were treated as opportunities for learning rather than a barrier (for example, Respiratory Medicine).

In general, the Trust has made good progress in implementing HEEM's *East Midlands Multi-professional Quality Standards for local training and education providers.* However, there are some areas for improvement and also a few patient safety concerns (although none requiring escalation to the General Medical Council or Care Quality Commission). Most notably, the Trust must ensure that it has robust and sustainable plans in place so that staffing levels and service delivery models do not skew the service / training balance towards service to the detriment of curricula delivery. This is especially an issue for postgraduate medical education and training. HEEM recognises the significance of this challenge in the context of high patient throughput, recruitment difficulties (regionally and nationally) and reliance on the postgraduate medical workforce to deliver service (excluding consultants, nearly 90% of the medical workforce are doctors in training). HEEM welcomes the Trust's honesty in acknowledging its challenges and will work collaboratively to support improvement initiatives.

2: Introduction

Health Education East Midlands (HEEM) is the vehicle for providers and professionals, working as part of NHS Health Education England (HEE), to improve the quality of education and training outcomes so that they meet the needs of service providers, patients and the public. The statutory Postgraduate Dean's role directly carries specific accountability on behalf of the General Medical Council (GMC) where education and training is delivered within employing organisations. In addition, because practice placements and training posts are critical to education quality and professional outcomes, there is a legal, tripartite relationship between the Higher Education Institutions, the placement / training post providers and HEEM through both the Education Contract and the Learning Development Agreement. This ensures that employers are held to account for the quality of any learning provision they are involved in across the healthcare workforce. To this end, HEEM has developed a multi-professional approach to its Quality Management Visits (QMVs) to Local Education Providers (LEPs) and has produced the *East Midlands Multi-professional Quality Standards for local training and education providers* against which to assess the quality of learning environments.

This is the first year of HEEM's new, multi-professional approach to visiting, and HEEM would like to thank University Hospitals of Leicester NHS Trust (UHL) for the positive way in which it has engaged with the new process. A collaborative approach was taken to determine the focus and level of visit. A conference call, involving both HEEM and Trust representatives, looked at evidence from a variety of sources, including the Trust's self-assessment document, the GMC's National Training Survey results and workforce intelligence, and a decision was taken to undertake a level 2 visit. There are 3 levels of visit and a level 2 visit indicates 'medium risk' - "… *there are risks to meeting the standards for Training and Education. This level of visit aims to understand where the risks are and provide support to reduce negative impact on learners and outcomes*".

The Trust is comprised of three main hospital sites – the Leicester Royal Infirmary (LRI), the Leicester General Hospital (LGH) and the Glenfield Hospital (GH). Over two days, visit teams met with a range of medical and non-medical learners and their supervisors / mentors across all three sites. Areas of focus included Anaesthetics, Cardiology, Clinical Oncology Gastroenterology, Haematology, Histopathology, Medical Microbiology and Respiratory Medicine. In addition, the Trust's Senior and Education Teams presented developments from the last visit, future initiatives and challenges. A showcase session was also held for the Trust to highlight areas of innovation and improvement projects in relation to both medical and non-medical education.[1]

In parallel to this visit, the new East Midlands Dental Dean and his team visited the dental department to review education and training arrangements. The outcome was positive and a summary of the findings is included within this report in Section 4 – 'Good Practice and Innovation'. A copy of the dental full will be sent separately to the Trust.

[1]The pre-visit conference call had also identified Obstetrics & Gynaecology as an area of focus, but this session had to be cancelled at short notice due to unforeseen circumstances (hence this is an interim report). A separate visit to this specialty is planned and the visit report will be updated accordingly.

3: Progress since last year

The last Quality Management Visit to the Trust took place on 25th and 26th June 2013[2]. Areas of focus for that visit, which were selected again to be seen on this visit, included Anaesthetics and Obstetrics & Gynaecology (with the latter yet to be visited – see footnote on previous page). There were also Trust-wide issues raised in 2013, progress on which was able to be tested on this visit, plus other specific issues relating to learner groups we met with this year (for example, staffing in Clinical Oncology).

Educational governance

The Trust has reorganised its clinical directorates into seven Clinical Management Groups (CMGs). Within each CMG, an Education Lead has been appointed. This is a welcome development at it has the potential to further raise the profile of education and training within the Trust and enable CMGs, previously driven primarily by service targets, to also be performance managed in relation to the quality of the training each delivers (facilitated by the Trust's new Quality Dashboard). As these roles develop, HEEM is keen to understand how they engage with external bodies, such as HEEM's Postgraduate Specialty Schools and Royal Colleges. A strong commitment to support the new Education Leads from the Trust's senior team and from Service Leads was evident during the visit. The team was also pleased to hear about the Trust's Education Strategy and how there is a clear route for education and training issues to be regularly communicated to the Trust Board and Executive Workforce Board.

Recommendation

Consider how the new Education Leads can be embedded in UHLs educational and financial governance structures as well as engage and work with external educational stakeholders, including HEEM's Foundation and Specialty Schools and the Royal Colleges.

Educational resources

It has been a longstanding ambition of the Trust to enhance its educational facilities. At the last visit, and from the results of recent national training surveys, trainees provided consistently negative feedback about educational resources. The visit team was pleased to learn that construction work on the new library is underway, with the new facility opening in early 2015. The visit team was impressed by the plans for the library, which were presented at the showcase session.

Of course, educational resources are not just about physical learning space; e-learning resources and infrastructure are also key. This has been recognised by UHL and the Trust is enhancing access to electronic resources (for example, 'UpToDate' – the point-of-care clinical information resource). However, the Trust should be mindful that trainees need access to computers (or other electronic devices) to make the most of these resources.

[2]The 2013 visit focussed on postgraduate medical education only.

3: Progress since last year (cont'd)

Emergency Department

HEEM decided not to focus on Emergency Medicine at this visit due to the progress that has been made in delivering and sustaining high quality education and training within arguably the most challenging of service environments. The work of Dr. Acheson and his team is commended and initiatives implemented at UHL have attracted attention from elsewhere (for example Dr. Acheson has been invited to speak at the School of Medicine's Acute Medicine Education event) and are being rolled-out across the East Midlands. Dr. Acheson updated the visit team on developments at the showcase session and described future plans. HEEM will monitor, with interest, the impact of the planned extension of the Emergency Department.

Patient safety

At the last visit, the team was concerned about poor recognition of different training grades of junior doctors and what they could be expected to be capable of. As a result, there was a danger that some doctors were being asked to work beyond their competence. This was compounded by some Foundation Year 1 (FY1) trainees working on Foundation Year 2 (FY2) / Core Trainee (CT) resident on-call rotas. A system of colour-coded lanyards for trainee doctors, with information posters about levels of competence of each training grade, is now well established and has helped to address this issue. Also, all FY1 trainees have been removed from all FY2 / CT rotas.

Anaesthetics

During the 2013 visit, feedback indicated low morale, trainees feeling under-valued, a lack of team-working and little on-the-job learning. Feedback from this visit was more positive. Service pressures and tight rotas continue to impact on training as well as on consultants' abilities to coordinate and manage education and maximise training opportunities. However, there is a cohort of relatively new consultants in the department, which is committed to training and, coupled with the recent appointment of an Education Lead for the CMG, there are plans in place to improve the training environment and some evidence of improvement already (for example, trainees are no longer being pulled from training lists to cover service lists). HEEM was reassured that service leads will support initiatives to improve training, although sustainability in the face of onerous service demands will need to be closely monitored.

Of particular note, there was good engagement with the education and training agenda demonstrated by both educational and service leads, as well as praise from trainees for some excellent trainers, effective departmental induction and better coordination and management of training.

The trainees raised concerns about Trust induction failing to provide them with all the information they needed in a timely fashion prior to commencing work. Specifically, the trainees referred to IT logins, swipe access, ID badges and pay services, and felt this was a potential patient safety issue.

3: Progress since last year (cont'd)

Specific areas for improvement include better access to the Sim. Man for simulated training, the move to 1 in 8 rotas and more regular, consultant-led, departmental teaching sessions. However, the visit team notes that there are plans for a half-day teaching session (to rotate between the three hospital sites), while there is already a monthly, combined audit / mortality and morbidity meeting (also rotating between sites).

Requirement

Ensure more regular access to the Sim. Man. This is an issue extending to other specialties.

Requirement

Ensure all rotas are at least 1 in 8 within a timescale to be agreed with HEEM. This is currently a Royal College requirement.

Recommendation

Review the current departmental teaching opportunities and develop a timetable of formal teaching sessions. This may include the establishment of monthly, half-day teaching (in coordination with surgical colleagues so that lists are timetabled to facilitate the sessions), potentially drawing on the 'divisional day' model already established for Anaesthetics in the North of the East Midlands.

Requirement

The Trust needs to assure HEEM, within three weeks of receipt of the final, agreed version of this report, that it has processes in place to ensure that all new starters in Anaesthetics have access to the information they need to work effectively and safely in clinical areas before they commence work in these areas.

Requirement

The Trust needs to assure HEEM, within three weeks of receipt of the final, agreed report, that it has processes in place to ensure that all new starters have access to clinical systems on commencement at the Trust.

3: Progress since last year (cont'd)

Clinical Oncology

While at the 2013 visit, Clinical Oncology was not a focus, during a cross-specialty feedback session with trainees it was reported that the middle-grade tier in the department had previously been understaffed and that the resulting need to cross-cover service had impacted negatively on training. The trainees felt that this would be reflected in the 2013 GMC training survey (conducted April 2013), and indeed it was, with half of the indicator scores (at HST level) being negative outliers. However, at the time of the visit (June 2013), the trainees reported that staffing levels had improved and this had benefitted training.

It was of some concern that the 2014 GMC survey results again showed a number of negative outliers for this specialty and, primarily due to this, the specialty was a focus of the 2014 visit.

During this visit, trainees reported good access to formal teaching, appropriate senior supervision and, in general, a high quality training experience within the department. All of the trainees seen by the visiting team would be happy for friends or family to be treated in the department and would recommend the department as a place within which to train.

However, medical staffing levels had again been impacting negatively on training. In particular, trainees were being asked to cover gaps in the rota and this had hindered trainees' access to clinics. Trainees felt that this prevented exposure to some of the more interesting aspects of the specialty, especially attendance at out-patient clinics, and this may impact on recruitment and retention (potentially compounding the staffing situation).

The visit team welcomed the plans for a more coordinated approach to consultant working from November 2014, which should streamline consultant on-call and ward round arrangements and improve organisation and efficiency within the department, thereby enabling trainees to be released more frequently to attend clinics.

Recommendation

Explore the potential for other healthcare professionals to expand their roles within the department and provide a multi-professional solution to the medical staffing issues, which, in the long term, would be more sustainable. This may link in with the work of the Trust's New Roles Group.

4: Good practice and innovation

There are some areas of good practice already identified in Section 3 – 'Progress since last visit'. These emerged from the improvement work undertaken following that visit and include:

- ✓ The appointment of Education Leads within each CMG
- ✓ Development of a Quality Dashboard
- ✓ Implementation of the Education Strategy
- ✓ Establishment of the Medical Education Committee
- ✓ Work on the new library and provision of e-learning resources
- ✓ Sustained improvement of education and training within the Emergency Department and dissemination of this work regionally
- ✓ Further development of the system for identification of different training grades

The following are additional areas of good practice identified during the 2014 visit.

Effective use of educational funding to support non-medical education and training

This was the first year that HEEM has adopted a multi-professional approach to its quality management visits.

All non-medical student placements attract payment of a tariff to organisations providing the placements and holding a Learning Development Agreement (LDA) with HEEM. It is vital that this funding should be used to facilitate the provision of quality placements and meet regulatory standards (such as those of the Nursing and Midwifery Council (NMC) and the Health and Care Professions Council (HCPC)).

Over the last twelve months, UHL has been making effective use of the tariff funding to support the non-medical learning environment. Throughout the visit, the teams encountered evidence directly linking the use of the tariff funding to clinical quality and patient safety initiatives and to the quality of learning environments (see below).

Recommendation

The Trust should continue to support the HPCP tariff group in effectively utilising tariff funding to support patient safety and education and training initiatives.

The learning environment for nurse students and learners within other allied healthcare professions

Members of the team met with a range of learners on placements at UHL, including nursing students, students on the Operating Department Practitioners (ODP) diploma course, Physiotherapy students, Occupational Therapy students, Diatetics students and student Radiographers, as well as their mentors / supervisors and practice placement managers.

4: Good practice and innovation (cont'd)

The overall impression gained by the visit team was that all groups of learners were very happy with their placements and had no negative issues to raise. In particular, they felt:

- ✓ well supported and supervised at all times;
- ✓ able to raise concerns if necessary (and knew how to do this);
- ✓ that struggling students were well supported;
- ✓ that the relationships with the Higher Education Institutions were positive;
- ✓ that opportunities for inter-professional working and learning were strongly promoted across all the 'non-medical' workforce.

These views were shared by their mentors / supervisors and practice placement managers.

During the visit, one member of the team made an unannounced visit to a number of clinical areas at the LRI, including the Haematology department, Ward 29 and Acute Medical admissions areas. They talked with a range of staff within these areas. These conversations provided further, strong evidence of the Trust's support for non-medical training, including the support of learners on placements as well as their mentors / supervisors and the wider healthcare workforce (for example, through induction and preceptorships).

Trust leads for non-medical education and training also showcased a range of quality improvement and patient safety initiatives, including:

- ✓ the competent, caring, capable workforce project (developing a culture of compassion);
- ✓ the further development of inter-professional learning opportunities and multi-professional learning resources;
- ✓ clinical education to improve patient safety;
- ✓ supporting learning beyond registration.

Recommendation

Explore the extent to which the model for supporting the non-medical workforce could be transferrable to medical training.

Respiratory Medicine

The visit team met with trainee doctors and their trainers working in Respiratory Medicine at the Glenfield Hospital. While the feedback may have been skewed slightly by the fact the all of the trainees in the session were based on the Clinical Decisions Unit (CDU), the reports were of an excellent education and training environment, with consultants keen to teach. Of note was the fact that the workload is very high but that this is treated positively rather than regarded as a hindrance to learning – i.e. the many clinical events were, wherever possible, capitalised on by consultants as opportunities to teach their trainees.

4: Good practice and innovation (cont'd)

Cardiology

While there are a number of areas for improvement identified in Cardiology (see Section 5), the department was regarded as having excellent and unique clinical and academic opportunities and, with the expertise of the consultants, had the potential to be a centre of excellence. Also, the multi-disciplinary and electrophysiology meetings were singled out as excellent learning opportunities.

Gastroenterology

Induction and on-going support for junior trainees was reported as effective and comprehensive.

Histopathology

Trainees reported a high level of support from their consultants, with a good balance of supervision and autonomy.

Haematology

Trainees at all levels felt well supported, able to meet their curriculum requirements and would highly recommend the department as a place to train. The department has a track record of attracting trainees to Haematology at UHL and also of successfully providing examination support to trainees outside of the region. At the time of the visit, UHL had a 100% pass rate for the Fellowship Examination of the Royal College of Pathologists. The trainers should be commended for their work.

Dental training

In parallel to this visit, the new East Midlands Dental Dean and his team visited the Dental Department to review education and training arrangements. The visiting team met with Dental Core Trainees and separately with their trainers. The team encountered a department endeavouring to provide a positive training experience and no serious concerns were identified. Trainees reported some frustrations arising from not getting hands-on oral surgery experience for the first eight weeks of their placement, but that this was now beginning to happen. The trainers reflected that they had perhaps been overly cautious in their approach and would review this for next year. Comprehensive induction materials, provided to trainees, were shared with the visit team, and this was considered to be an example of good practice. Trainees felt that their placements at the LRI would provide them with good experience of managing a wide range of patients, especially now that they are being given their own minor oral surgery lists.

4: Good practice and innovation (cont'd)

Recommendation

Identify whether the models of teaching and training in place in Respiratory Medicine and Haematology can provide a template for other departments, particularly those which are struggling to maintain an appropriate training / service balance due to high service demands.

5. Areas of improvement

There are a number of areas for improvement identified in section 3. – 'Progress since last visit'. All recommendations and requirements are listed in section 6. This section identifies new areas for improvement identified from the 2014 visit.

Non-medical / medical education and training

While there was evidence of the development of inter-professional learning within non-medical professions, opportunities for doctors to learn with, and from, nursing staff and other allied healthcare professionals is (as in other areas of the East Midlands) in its infancy.

Also, the Trust's self-assessment highlighted inconsistency of practices across non-medical professions, particularly around feedback mechanisms for raising concerns.

Recommendation

Develop further inter-professional learning opportunities across both medical and non-medical groups.

Recommendation

Continue the work highlighted to HEEM to better standardise practices across non-medical healthcare professions, with the longer term aspiration to extend this to all healthcare groups (medical and non-medical).

General Internal Medicine on-call rota

Through feedback sessions with trainees and via conversations with staff in a range of clinical areas, the visit team became very concerned with overnight medical cover at the LRI. It was reported that three HST level doctors are required to provide cover to the medical wards at night but that, on a number of occasions, only one HST level doctor has been based at the LRI (for example if one is required at the LGH and the other has not been available). The trainees considered this to be a patient safety issue.

Requirement

A response from the Trust is required about the overnight medical cover at the LRI within three weeks of receipt of the final, agreed version of this report.

5. Areas of improvement (cont'd)

Cardiology

At HST level, Cardiology trainees described the department as offering fantastic and unique training and research opportunities and working alongside consultants with tremendous expertise. However, they felt unable to capitalise on the opportunities and expertise at present since their education and training was being compromised by high service demands and having to cover more than the recommended number of clinics per week (although they were already working with managers to resolve this). This poses a risk to trainees acquiring the required number of procedures to demonstrate competence and progress through their ARCPs. In particular, academic trainees felt that their academic time was not protected due to service demands. There also seemed to be a low threshold from those at the LRI seeking cardiac advice and for transferring patients, thereby exacerbating the workload problem. As a result of all of this, trainees reported that Cardiology at the Glenfield had a poor reputation for clinical training nationally (albeit a good reputation for academic opportunities) and that they would not recommend to colleagues and friends to train at UHL. Moreover, while the trainees at Foundation and Core level reported an excellent education and training experience and seemed unaffected by the service pressures experienced at HST level, they would not apply to Glenfield for specialty training as they had witnessed the problems experienced by their HST colleagues. This may have future workforce implications.

The provision of cardiac advice over the telephone was considered a patient safety issue, with trainees sometimes feeling uncomfortable about offering advice about patients they could not physically see and with no direct link to see ECGs.

It was reported that there is a lack of consultant presence on the CDU as the consultants are more often working in the Cardiac Catheterisation laboratory. While a HST level doctor will usually be present to assess patients before they are transferred to a ward, it is possible for patients to not receive a consultant review for a number of days (for example, if admitted to the CDU at the weekend and then transferred to ward where the consultant does not conduct a ward round until the middle of the week). The trainees suggested that this also poses a potential risk to patient safety.

Requirement

Work towards reducing the clinics burden on HSTs within an appropriate and realistic timeframe (to be agreed with HEEM). Both trainees and trainers felt that there may be non-medical workforce solutions to this.

Requirement

A response from the Trust regarding the issue of consultant presence on the CDU and provision of advice over the telephone, including an assessment of the risk to patient care, is required within three weeks of the receipt of the final, agreed version of this report.

5. Areas of improvement (cont'd)

Recommendation

Review the model of service delivery and staffing. This may result in small changes rather than large scale service reconfiguration. For example, it was suggested that a Cardiologist triaging directly within A&E might reduce the workload at the Glenfield Hospital and / or that Acute Medicine trainees (or from other specialties such as Geriatric Medicine) might benefit from time in Cardiology to increase their confidence to deal with straightforward cardiac cases when working at the LRI (as well as contributing to support the service at the Glenfield site). As already suggested, there may also be non-medical workforce solutions to reduce the workload for the Cardiology HSTs.

Gastroenterology

While, generally, trainees reported good education and training, the heavy workload, compounded by rota gaps (a national recruitment issue), is adversely impacting on their training, and would be impacting on patient safety also without the dedication of trainees working beyond their contracted hours on a regular basis. The current staffing levels appear to be unsustainable. While additional trainees and staff grade doctors might not be a feasible option, the department needs to link into the wider Trust work to look at new and existing clinical roles (as well as innovative Fellowship posts) and how these may be utilised to support services.

Histopathology

The trainees reported an on-going issue with facilities and a lack of resources and equipment.

The trainees would also welcome more constructive feedback from their trainers on a regular basis. It may be that service pressures on consultants has been a barrier to this.

Recommendation

While there are limitations to the physical space available at the LRI, if equipment is not fit-for-purpose and this is a barrier to training, then a business case for investment in equipment needs to developed by the department / Specialty School.

Medical Microbiology

Workload is high and the department is extremely busy but trainees feel that it is essential that education and training are prioritised.

While trainees do not routinely work alongside consultants and a model of peer-to-peer training appears to have been in place, there is now a move away from this; trainees have been organising a programme of local teaching with invited speakers and a consultant is now available for one hour per day to provide supervision and feedback.

5. Areas of improvement (cont'd)

In general, there has been an increase in on-the-job feedback provided by consultants. Trainees commented that the laboratory staff is always supportive and keen to teach.

The low level of direct, consultant supervision and opportunities for feedback may reflect the relatively low number of consultants within the department (with some working part-time and one having to dedicate time to a wider Trust role with apparently no back-fill).

Haematology

Although expected, and encouraged by trainers, to attend clinics, medical staffing levels make it difficult for Core Medical Trainees to leave the ward. This is further compounded by a large number of trainees working less-than-full-time in what appears to be an increasingly feminised medical workforce

Recommendation

Linking in with the wider Trust work to look at new clinical roles, the department should explore the potential for other healthcare professionals to support some of the activities traditionally undertaken by doctors only.

6. Recommendations and Requirements

Recommendations

1. Trust-wide: Consider how the new CMG Education Leads can engage, and work, with HEEM's Foundation and Specialty Schools and the Royal Colleges;

2. Anaesthetics: Review the current departmental teaching opportunities and develop a timetable of formal teaching sessions. This may include the establishment of monthly, half-day teaching (in coordination with surgical colleagues so that lists are timetabled to facilitate the sessions), potentially drawing on the 'divisional day' model already established for Anaesthetics in the North of the East Midlands;

3. Clinical Oncology: Explore the potential for other healthcare professionals to expand their roles within the department and provide a multi-professional solution to the medical staffing issues, which, in the long term, would be more sustainable. This may link in with the work of the Trust's New Roles Group;

4. Trust-wide: Explore the extent to which the model for supporting the non-medical workforce could be transferrable to medical training;

5. Trust-wide: Identify whether the excellent models of teaching and training in place in Respiratory Medicine and Haematology can provide a template for other departments, particularly those which are struggling to maintain an appropriate training / service balance due to high service demands;

6. Trust-wide: Develop further inter-professional learning opportunities across both medical and non-medical groups;

7. Trust-wide: Continue the work highlighted to HEEM to better standardise practices across non-medical healthcare professions, with the longer term aspiration to extend this to all healthcare groups (medical and non-medical).

8. Cardiology: Review the model of service delivery and staffing. This may result in small changes rather than large scale service reconfiguration. For example, it was suggested that a Cardiologist triaging directly within A&E might reduce the workload at the Glenfield Hospital and / or that Acute Medicine trainees and those from some other medical specialties (e.g. Geriatric Medicine) might benefit from time in Cardiology to increase their confidence to deal with straightforward cardiac cases when working at the LRI (as well as contributing to support the service at the Glenfield site). As already suggested, there may also be non-medical workforce solutions to reduce the workload for the Cardiology HSTs;

6. Recommendations and Requirements (cont'd)

9. Histopathology: While there are limitations to the physical space available at the LRI, if equipment is not fit-for-purpose and this is a barrier to training, then a business case for investment in equipment needs to developed by the department / Specialty School;

10. Haematology: Linking in with the wider Trust work to look at new clinical roles, the department should explore the potential for other healthcare professionals to support some of the activities traditionally undertaken by doctors only.

Requirements

1. Trust-wide: Ensure more regular trainee access to the Sim. Man. This is an issue extending to other specialties;

2. Anaesthetics: Ensure all rotas are at least 1 in 8. This is currently a Royal College requirement, although HEEM recognises that remains a challenge across the East Midlands;

3. Anaesthetics: The Trust needs to assure HEEM, within three weeks of receipt of the final, agreed report, that it has processes in place to ensure that all new starters in Anaesthetics have access to the information they need to work effectively and safely in clinical areas before they commence work in these areas;

4. The Trust needs to assure HEEM, within three weeks of receipt of the final, agreed report, that it has processes in place to ensure that all new starters have access to clinical systems on commencement at the Trust;

5. General Internal Medicine: A response from the Trust to the patient safety concern regarding medical cover at night at the LRI is required within three weeks of receipt of the final, agreed version of this report;

6. Cardiology: Work towards reducing the clinics burden on HSTs within an appropriate and realistic timeframe (to be agreed). Both trainees and trainers felt that there may be non-medical workforce solutions to this;

7. Cardiology: A response from the Trust regarding the issue of consultant presence on the CDU and provision of advice over the telephone, including an assessment of the risk to patient care, is required within three weeks of the receipt of the final, agreed version of this report.

7. Action plan

8. Providers response

	HEEM EDUCATION VISIT ON 2ND & 3RD OCTOBER 2014					
Recommendation or Requirement	**CMG**	**Issue**	**Grade**	**Specialty**	**UHL Lead**	**UHL Response**
REQUIREMENT (within 3 weeks)	ITAPS	The Trust needs to assure HEEM, within three weeks of receipt of this report, that it has processes in place to ensure that all trainees and learners have access to the information they need to work effectively and safely in clinical areas before they commence work in these areas.	**All**	Anaesthetics	Rajini Annamaneni and Sarah Turner	A further update was provided by HEEM, to advise the main concern was in relation trainees having access UHL IT sytems. The CMG will ensure that a JDA or a senior administrator will attend the Trust Junior Doctors Induction to issue network logins, which will allow junior doctors the opportunuty to check that they have adequate access to the applications required, whist at the Trust Induction. In August 2014 the Trust introduced an external web page to all new starters to access information in relation to the Trust and Induction prior to commencing.
REQUIREMENT (within 3 weeks)	RRC	A response from the Trust regarding the issue of consultant presence on the CDU and provision of advice over the telephone, including an assessment of the risk to patient care.		Cardiology	Nick Moore	It was reported that there is a lack of consultant presence on the CDU as the consultants are more often working in the Cardiac Catheterisation Laboratory. While a HST level doctor will usually be present to assess patients before they are transferred to a ward, it is possible for patients to not receive a consultant review for a number of days (for example, if admitted to the CDU at the weekend and then transferred to ward where the consultant does not conduct a ward round until the middle of the week). The trainees suggested that this also poses a potential risk to patient safety'. We currently have a policy for referrals between sites and specialities in place. Changes implemented in November 2014: o Appointed first CDU cardiologist-physician to take leadership in CDU o Agreement from the Cardiologists who cover CCU and CDU 1:8 that they will ensure a presence on CDU in the afternoons, thus strengthening senior leadership in CDU. The CMG will also be undertaken further actions, which include: By end of December 2014, o Consultant job plan review will take place ensuring ward and board rounds are embedded in job plans daily. o Discussion / education with the Cardiology trainees about how to report concerns internally with their consultant or via Datix o Feedback to the Cardiology HST Level doctors that if there is any doubt they should be admitting the patients. By the end of March 2015 in discussion with Cardiology Consultants re developing a post take ward round to ensure appropriateness of referrals and as a training opportunity for HST level doctors.
REQUIREMENT (within 3 weeks)	Emergency and Specialist Medicine	Through feedback sessions with trainees and via conversations with staff in a range of clinical areas, the visit team became very concerned with overnight medical cover at the LRI. It was reported that three HST level doctors are required to provide cover to the medical wards at night but that, on a number of occasions, only one HST level doctor has been based at the LRI (for example if one is required at the LGH and the other has not been available). The trainees considered this to be a patient safety issue.			Catherine Free/ Mark Ardron	The ED and Specialist Medicine Clinical Management Group (CMG) recognises this as one of our most pressing patient safety concerns and is listed on the Trust's Risk Register with a full action plan in order to reduce the risk by actively filling vacant posts. At present there are three ST3+ doctors rostered to provide cover during the night period. An audit of a 4 month period found there were 20 out of 117 nights where there were less that the required three ST3+ doctors on duty overnight. Of those 20 nights, 3 nights did have partial cover. It is very rare to move doctors from the LRI to provide cover at the LGH, however in the same 4 month period on two occasions ST3+ doctors were moved to provide cover at the LGH site. At present there are eight ST3+ gaps, which will reduce to six gaps by March 2015. In addition by March 2015 four of our new international recruits will be able to work at ST3+ level which will help to alleviate service pressures. There has been significant focus on managing gaps and filling vacancies and the CMG are taking the following actions: The CMG has a Medical Workforce Planning and Monitoring Group, which is chaired by the Deputy CMG Clinical Director and attended by the Educational Lead, Training Programme Director, Heads of Service, Clinical Tutor and Human Resources. The group currently meets weekly and is supported by the CMG Clinical Director. The role of the group is primarily to ensure recruitment is progressing for short-term gaps, to review staffing for any operational changes, such as new wards, and to discuss strategies to attract trainees to UHL. The Deputy CMG General Manager has been overseeing this and the Junior Doctors Administrators office in order to give senior support to recruit on a medium to long term basis as well as to fill gaps at short notice. The Trust is currently exploring new roles such as Advanced Nurse Practitioners and Physicians Assistants in order to broaden the medical workforce in the future and create a better balance between training needs and service delivery. In addition UHL has recently appointed an Associate Medical Director to oversee Medical Workforce Planning at UHL which will ensure emphasis on Medical Workforce Planning across the Trust.

University Hospitals of Leicester NHS
NHS Trust

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT BY TRUST BOARD COMMITTEE TO TRUST BOARD

DATE OF TRUST BOARD MEETING: 5 February 2015

COMMITTEE: Audit Committee

CHAIRMAN: Mike Williams, Interim Non-Executive Director

DATE OF COMMITTEE MEETING: 8 January 2015

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

None

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

- Assurance around the risk management process in the Clinical Services and Imaging CMG (Minute 05/15 refers), and
- Review of Governance Arrangements for Empath (Minute 07/15/1b refers).

DATE OF NEXT COMMITTEE MEETING: 5 March 2015

Mike Williams
30 January 2015

DRAFT

UNIVERSITY HOSPITALS OF LEICESTER NHS Trust

MINUTES OF A MEETING OF THE AUDIT COMMITTEE HELD ON THURSDAY 8 JANUARY 2015 AT 2:00PM IN THE CJ BOND ROOM, CLINICAL EDUCATION CENTRE, LEICESTER ROYAL INFIRMARY

Present:
Mr M Williams – Non-Executive Director (Interim Chair)
Col (Ret'd) I Crowe – Non-Executive Director
Dr S Dauncey – Non-Executive Director
Mr P Panchal – Non-Executive Director

In Attendance:
Mr N Callow – Director of Finance, Empath Pathology Services (for Minute 7/15/1b)
Mr P Cleaver – Risk and Assurance Manager (for Minutes 4/15-5/15 inclusive)
Miss M Durbridge – Director of Safety and Risk (for Minutes 4/15-5/15 inclusive)
Ms J Halborg – Clinical Services and Imaging CMG (for Minute 5/15)
Mrs H Majeed – Trust Administrator
Mr A McGregor – Consultant Pathologist, Empath Pathology Services (for Minute 7/15/1b)
Mr A Rickett – Deputy Clinical Director, Clinical Services and Imaging CMG (for Minute 5/15)
Mr C Shatford – Acting General Manager, Clinical Services and Imaging CMG (for Minute 5/15)
Mr P Shaw – Managing Director, Empath Pathology Services (for Minute 7/15/1b)
Mr N Sone – Financial Controller
Mr M Traynor – Non-Executive Director
Mr P Traynor – Director of Finance
Mr S Ward – Director of Corporate and Legal Affairs
Ms J Wilson – Non-Executive Director

Mr M Curtis – Local Counter Fraud Specialist (East Midlands Internal Audit Services) (until and including Minute 6/15/3)

Mr D Hayward – KPMG (the Trust's External Auditor)
Ms S Rai – KPMG (the Trust's External Auditor)

Ms A Breadon – Director, PwC (the Trust's Internal Auditor)

RESOLVED ITEMS **ACTION**

1/15 APOLOGIES

Apologies for absence were received from Ms R Overfield, Chief Nurse.

2/15 MINUTES

Resolved – that the Minutes of the meeting held on 6 November 2014 (papers A and A1 refer) be confirmed as correct records.

3/15 MATTERS ARISING FROM THE MINUTES

In response to a query from the Interim Audit Committee Chair, the Financial Controller advised that the thresholds for the authorisation limits for spend and invoices were different to discretionary procurement waiving limits (as detailed under reference 79/14/1 in paper B).

Resolved – that the matters arising report (paper B) be received and noted.

4/15 UHL RISK MANAGEMENT REPORT INCORPORATING THE BOARD ASSURANCE FRAMEWORK (BAF) FOR THE PERIOD ENDING 30 NOVEMBER

The Director of Safety and Risk and the Risk and Assurance Manager attended the meeting to present paper C, providing an overview of the development of the UHL 2014-15 BAF and assurance in relation to the effectiveness of risk management processes within UHL.

The following points were highlighted in particular:-

(a) the intention to hold a thinking day in February 2015 in respect of the 2015-16 BAF;
(b) during the reporting period there had been no instances of elapsed risk review dates or action due dates;
(c) four high risks had been on the UHL risk register for greater than five years – a brief update on these was provided. Two of these risks were in the Clinical Services and Imaging (CSI) CMG. Members noted that the CSI CMG could be challenged regarding these risks when they would be attending the Audit Committee shortly (Minute 5/15 below refers), and
(d) the current risk score assigned to principal risk 2 (failure to implement LLR emergency care improvement plan) had been increased to 20 (i.e. likelihood score increased from 4 to 5) due to a number of recent internal major incidents within the Trust which reflected extreme pressures within the Trust's Emergency Department. Responding to a query from Mr P Panchal, Non-Executive Director, it was noted that all processes were systematically followed in respect of the internal major incidents and this was meticulously reviewed by the Chief Operating Officer.

In response to a query from Ms J Wilson, Non-Executive Director, the Director of Safety and Risk undertook to arrange for the risk score and actions to address the gaps in relation to Principal Risk 5 (Failure to deliver RTT improvement plan) to be reviewed. Responding to a query from the Interim Audit Committee Chair, the Director of Safety and Risk agreed to also arrange for Principal Risk 24 (Failure to implement the IM&T strategy and key projects effectively) to be reviewed. **DSR** **DSR**

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

(B) the Director of Safety and Risk be requested to arrange for the risk score and actions to address the gaps in relation to Principal Risk 5 (Failure to deliver RTT improvement plan) and Principal Risk 24 (Failure to implement the IM&T strategy and key projects effectively) to be reviewed. **DSR**

5/15 CLINICAL SERVICES AND IMAGING (CSI) CMG PRESENTATION – UPDATE ON RISK MANAGEMENT PROCESS IN THE CMG

Mr A Rickett, Deputy Clinical Director, Mr C Shatford, Acting General Manager and Ms J Halborg, Head of Nursing from the CSI CMG attended the meeting to present paper D, an update on risk identification, management and maintenance of the risk register within the CSI CMG.

The Deputy Clinical Director briefed members on the multifaceted spectrum of services provided by the CMG, highlighting the variety and complexity of different specialties which included Pathology, Pharmacy, Imaging etc.

In response to a query on the risk management process followed within the CMG, it was noted that the leads of each service in the CMG were required to provide an update on any risks at the CMG's monthly Quality and Safety Group, CMG Board and Assurance and Performance meetings.

Members challenged the CMG colleagues in respect of the two high risks which

had been on the CMG risk register for greater than five years (Minute 4/15 above refers) – the Head of Nursing explained the background to these risks which were in relation to (a) the Asceptic Unit, and (b) failure to implement electronic tracking for blood and blood products to provide full traceability from donor to recipient. She provided a brief overview of the issues and the actions that had been put in place to mitigate the risks.

The Acting General Manager advised that in terms of financial risk management, the CMG had robust governance of Cost Improvement Programme management.

There were a number of risks around levels of staffing which were due to the need to recruit Specialists (i.e. Pharmacists, Physiotherapists, and Paediatric Radiologists etc.) in some areas within and outside the CMG. Responding to a query from the Interim Chair of the Audit Committee, the CMG Head of Nursing advised that 'mixed sex accommodation' was an area of concern within the CMG highlighting that the CMG recognised all of the pertinent issues and was working to resolving them. It was also highlighted that acting on results and interaction with GPs were also areas where the CMG was working towards improving the current position.

Audit Committee members were assured that the CMG had a robust risk management process despite the challenges that were highlighted at the meeting.

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

6/15 ITEMS FROM THE LOCAL COUNTER FRAUD SPECIALIST

6/15/1 Local Counter Fraud Specialist (LCFS) Progress Report

Paper E provided assurance regarding the actions taken to mitigate the risk of fraud, bribery or corruption within the Trust. Mr M Curtis, Local Counter Fraud Specialist advised that he had commenced a review of the Trust's efforts to prevent and detect pre-contract procurement fraud and invoice fraud, to ensure actions were taken in line with NHS Protect's Provider Standards. The Counter Fraud eLearning module had been issued to the Trust's Core Training Lead and was being prepared for distribution to staff.

In respect of contract performance, 59% of the annual plan was complete and work was in-train for the remainder of 2014-15. The Committee's view was that, given the size of UHL, the current number of fraud cases seemed 'low' – the Local Counter Fraud Specialist acknowledged this highlighting that the distribution of cases varied significantly between geographical regions.

In discussion on whether the National Fraud Initiative matching processes would be able to highlight issues in relation to staff working in other Trusts whilst sick, it was noted that these issues might not be raised through the matching process. Members noted the importance of ensuring staff were made aware that the Trust undertook these checks in order to help deter the risk of fraud.

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

6/15/2 Update on National Fraud Trends

Paper F, a report issued by NHS Protect to Local Counter Fraud Specialists dated November 2014 aimed to provide a strategic understanding of the economic crime risks facing NHS providers and the efforts being undertaken locally within the NHS to tackle these. Payroll fraud was the most prevalent type of non-patient fraud reported to NHS Protect in the calendar year 2014. NHS Protect took the view that

procurement fraud and corruption in the NHS was likely to be significantly under-reported and under-detected due to the complex and diverse nature of this type of fraud.

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

6/15/3 On-going Cases

The Local Counter Fraud Specialist tabled a report with the list of open fraud investigations highlighting that in future, this report would be incorporated into the Local Counter Fraud Specialist Progress report.

Resolved – that the contents of the tabled report be received and noted.

7/15 ITEMS FROM INTERNAL AUDIT

7/15/1 Internal Audit Reviews

a. Delayed Transfers of Care (DTOC) Review

The Director, PwC advised that, further to recommendations arising from the DTOC review, Trust staff had advised that a process/software would be piloted to resolve the issues raised. The Audit Committee requested that a written update be provided to the Audit Committee in May 2015 further to the embedding of this software. The Director, PwC undertook to feedback the Audit Committee's request to the Chief Operating Officer and the Head of Operations. **IA**

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

(B) the Internal Auditors be requested to feedback to the Chief Operating Officer and the Head of Operations regarding the Audit Committee's request for a written update to the May 2015 Committee meeting on the Delayed Transfers of Care (DTOC) position further to the processes/software being put in place to resolve the DTOCs issues. **IA**

b. Review of Governance Arrangements for Empath

Paper G1 included details of Internal Audit's review of the governance arrangements of Empath. The final report had been classified as high risk with 3 findings reported as follows:-

- 2 high rated operating effectiveness findings, and
- 1 medium rated operating effectiveness finding.

The Joint Venture Agreement (JVA) set out a number of compliance requirements for Empath and the Parent Trusts. The Internal Audit review had identified a number of areas of non-compliance with the JVA and had raised a recommendation in the report to set out how this should be dealt with. This included the preparation of an annual business plan, within which the JVA required a number of financial reports, including a cash flow statement, monthly projected profit and loss account, operating budget, management report and financial report. The review of the 2014-15 plan had found that there was a lack of adequate financial information, including only proposed budget and projected business development income.

Mr P Shaw, Managing Director, Mr N Callow, Director of Finance and Mr A McGregor, Consultant Pathologist, Empath Pathology Services attended the meeting to provide a management response to the findings from the review. They advised that Empath had become operational in 2012 and was led by a Managing Director, hosted by both parent Trusts (UHL and Nottingham University Hospital

NHS Trusts). Empath did not operate as a separate legal entity. They advised that the Empath Board had acknowledged that the current model of governance and reporting arrangements needed to be reviewed.

Empath colleagues briefed members on a transitional plan to resolve the issues identified. The financial management framework was still being developed. The shortfalls identified in financial management reflected the constraints of operating across two different Trust finance systems, policies and procedures. The lack of segmental reporting in relation to Empath within parent Trust accounts had restricted the ability to produce a balance sheet and cashflow statement as required within the Joint Venture Agreement.

There were currently 3 risk registers relating to Empath including inconsistencies in the recording and monitoring of risks across the joint venture. Significant risks to the joint venture or pathology services could potentially be overlooked due to the challenge of managing three risk registers. The Managing Director advised that a business case for a new IT system would hopefully soon be approved by the NHS Trust Development Authority, allowing each Trust and Empath to then monitor risks using the same system.

In discussion on these issues and taking into account the history of the development of Empath, the following actions were agreed. Empath colleagues were requested to:- **Empath colleagues**

(a) work up a transitional plan pending options being explored on the best possible way to give effect to the provisions set out in the Joint Venture Agreement,
(b) explore the opportunities available to accelerate the timescale for completion of actions which were being put in place in respect of the 'Ongoing financial management and monitoring' and 'Risk Management' findings, and
(c) ensure that a plan was put in place to resolve all of the issues raised by the Internal Auditors in their review and provide a further update to the Audit Committee before December 2015.

<u>Resolved</u> – that (A) the contents of paper G1 be received noted, and

(B) Empath colleagues be requested to undertake actions (a) to (c) above. **Empath colleagues**

c. <u>Implementation of NICE Guidance</u>

Paper G2 detailed Internal Audit's review of the Implementation of NICE Guidance and the report had been classified as low risk with 4 findings reported as follows:-

- 1 low rated control design finding, and
- 3 low rated operating effectiveness findings.

The Director, PwC highlighted that the Trust had a documented process and approved policy for the implementation of the National Institute for Health and Care Excellence (NICE) guidance which included procedures for providing assurance that the Trust was compliant with the guidance. The policy relied on staff confirming that they had complied with the guidance, however there were no further checks to confirm whether, infact, the staff had complied with the guidance. It was noted that adhoc follow-ups were undertaken. The Interim Audit Committee Chair queried whether non-compliance with NICE guidance was presented to the Quality Assurance Committee (QAC) – in response, the QAC Chair advised that this matter did not feature on the QAC agenda specifically and she undertook to liaise with the Director of Clinical Quality and Head of Outcomes and Effectiveness outwith the meeting regarding the process for the QAC to be notified of any non-compliance with NICE Guidance. **QAC Chair**

Resolved – that (A) the contents of paper G2 be received and noted, and

(B) the QAC Chair be requested to liaise with the Director of Clinical Quality and Head of Outcomes and Effectiveness outwith the meeting regarding the process for the QAC to be notified of any non-compliance with NICE Guidance. **QAC Chair**

d. Review of Charitable Funds

Paper G3 included details of the report classification and findings of the 2014-15 Internal Audit review of Charitable Funds which had been classified as medium risk with 5 findings reported as follows:-

- 1 medium rated control design finding, and
- 4 low rated operating effectiveness findings.

Resolved – that the contents of paper G3 be received and noted.

e. Corporate Planning

Paper G4 included details of the report classification and findings of the 2014-15 Internal Audit review of the Corporate Planning process. The final report had been classified as low risk with 1 low rated control design finding and 1 low rated operating effectiveness finding.

Resolved – that the contents of paper G4 be received and noted.

f. IT General Controls

Paper G5 included details of the report classification and findings of the 2014-15 Internal Audit review of the IT General Controls. The final report had been classified as low risk with 2 low rated control design findings.

Resolved – that the contents of paper G5 be received and noted.

7/15/2 Internal Audit Progress Report

The Director, PwC presented paper H, an update on progress made against the 2014-15 Internal Audit Risk Assessment and Plan. Following a request from the Director of Estates and Facilities, Internal Auditors had agreed with the Director of Finance to use the time available in the plan to undertake a review of car parking income collection. The Mortality and Morbidity Review had now been deferred to 2015-16. Fieldwork for the review had been completed in December 2014. The Director of Finance also highlighted the possibility that a review regarding the use of R&D funds might also be included within the 2014-15 plan.

The Interim Audit Committee Chair requested that an update on the total number of days allocated and utilised in respect of the Internal Audit work be included in the progress report for the Audit Committee in March 2015. **IA**

In discussion on the list of overdue and outstanding Internal Audit actions, the Director of Corporate and Legal Affairs was requested to coordinate and ensure that a consolidated list of outstanding and in-progress actions following Internal Audit, External Audit and LCFS recommendations was submitted to the March 2015 Audit Committee meeting and to each subsequent Committee meeting. **DCLA**

Resolved – that (A) the contents of paper H, Internal Audit progress report for 2014-15 be received and noted;

(B) an update on the total number of days allocated and utlised in respect of the Internal Audit work be included in the progress report for the Audit Committee in March 2015, and **IA**

(C) the Director of Corporate and Legal Affairs be requested to coordinate and ensure that a consolidated list of outstanding and in-progress actions following Internal Audit, External Audit and LCFS recommendations was submitted to the March 2015 Audit Committee meeting and to each subsequent Committee meeting. **DCLA**

8/15 ITEMS FROM EXTERNAL AUDIT

8/15/1 External Audit Progress Report

Paper I detailed the External Audit progress report updating the Committee on work undertaken in the last quarter, planned for the next quarter and provided technical updates, for information. Ms S Rai, KPMG highlighted the following:-

- the External Audit opinion and ISA260 report for Leicester Hospitals Charity for 2013-14 had been issued in December 2014;
- meetings continued with key officers at the Trust, including the Financial Controller, to discuss emerging technical topics and identify significant issues that would contribute to the audit approach, and
- the External Audit plan would be presented to the Audit Committee in March 2015.

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

9/15 FINANCE

9/15/1 Discretionary Procurement Actions

Paper J outlined the discretionary procurement actions for the period November to December 2014 in line with the Trust's Standing Orders. The Director of Finance advised that the number of cases remained low. The submitted cases of need were largely for specialist support for specific areas of work and had also been approved by the Chief Executive.

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

09/15/2 Month by Month Private Patient Income to the Trust

Paper K informed the Audit Committee of the level of monthly private patient Trust income between April 2012 and November 2014, the areas within the Trust which had attracted 70% of the private patient income and the customers which comprised 70% of the Trust's private patient income. The Financial Controller advised that the Head of Partnerships would be submitting a report on the development of the private patient strategy to the Executive Strategy Board in February 2015.

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

09/15/3 Update on UHL's Progress Against EA ISA 260 Recommendations

Paper L outlined the progress against the recommendations raised in External Audit's 2013-14 ISA 260 report, as at the end of December 2014. The detail of the recommendations and progress against them was included in Appendix 1 of paper

L. Due to the nature of the 4 recommendations raised, these were on-going and full implementation would be evidenced at year-end.

In discussion on the full revaluation of the Trust's land and buildings which had been undertaken in September 2014, the Interim Audit Committee Chair requested the Financial Controller to confirm to him the expenditure outwith the meeting. **FC**

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

(B) the Financial Controller be requested to confirm to the Interim Audit Committee Chair, the expenditure on the revaluation of the Trust's land and buildings. **FC**

9/15/4 Timetable for 2014-15 Accounts

Paper M provided an update on the 2014-15 year-end accounting processes and timetable. Responding to queries, the Financial Controller advised that appropriate plans were in place for the ledger closedown, accounts and annual report production, and audit sign off.

Resolved – that the contents of paper M and verbal update be received and noted.

10/15 REVIEW OF AUDIT COMMITTEE ANNUAL WORK PROGRAMME

Further to Minute 82/14/1 of 6 November 2014 and in discussion on paper N, the Audit Committee annual work programme, the Director of Finance suggested that the reports from the Local Counter Fraud Specialist be excluded for the Audit Committee meetings in May. The Director of Corporate and Legal Affairs undertook to update the work programme accordingly. **DCLA**

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

(B) the Director of Corporate and Legal Affairs be requested to update the Audit Committee work programme by excluding the need for reports from the Local Counter Fraud Specialist for the Audit Committee meeting in May 2015. **DCLA**

11/15 ITEMS FOR INFORMATION

11/15/1 Confirmation of Auditor Appointment from 2015-16

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

11/15/2 Clinical Coding Update on Backlog Reduction

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

(B) the Director of Finance be requested to ensure that the clinical coding backlog position was discussed with CMGs at the weekly Monday afternoon performance management sessions. **DF**

12/15 ASSURANCE GAINED FROM THE FINANCE AND PERFORMANCE COMMITTEE (FPC), QUALITY ASSURANCE COMMITTEE (QAC) AND CHARITABLE FUNDS COMMITTEE (CFC)

12/15/1 Quality Assurance Committee

Resolved – that the Minutes of the Quality Assurance Committee meetings

held on 29 October 2014 (paper Q refers), 26 November 2014 (paper Q1 refers) and 15 December 2014 (paper Q2 refers) be received and noted.

12/15/2 Finance and Performance Committee

Resolved – that the Minutes of the Finance and Performance Committee meetings held on 26 November 2014 (paper R refers) and 18 December 2014 (paper R1 refers) be received and noted.

12/15/3 Charitable Funds Committee

Resolved – that the Minutes of the Charitable Funds Committee meeting held on 17 November 2014 (paper S) be received and noted.

13/15 ANY OTHER BUSINESS

13/15/1 Delegated Authority Limits

The Director of Finance undertook to review the delegated authority limits for signing-off discretionary procurement actions and provide an update to the Audit Committee meeting in March 2015. **DF**

Resolved – that the Director of Finance to review the delegated authority limits for signing-off discretionary procurement actions and provide an update to the Audit Committee meeting in March 2015. **DF**

14/15 IDENTIFICATION OF KEY ISSUES THAT THE COMMITTEE WISHES TO DRAW TO THE ATTENTION OF THE TRUST BOARD

Resolved – that the following items be brought to the attention of the Trust Board:-

- **Assurance around the risk management process in the Clinical Services and Imaging CMG (Minute 05/15 refers), and** **Interim AC Chair**
- **Review of Governance Arrangements for Empath (Minute 07/15/1b refers).**

15/15 DATE OF NEXT MEETING

Resolved – that the next meeting be held on Thursday, 5 March 2015, 2:00pm-4:00pm in the CJ Bond Room, Clinical Education Centre, Leicester Royal Infirmary.

The meeting closed at 16:09pm.

Hina Majeed,
Trust Administrator

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

Name	Possible	Actual	% attendance
K Jenkins (Chair)	2	2	100%
M Williams (Interim Chair)	2	2	100%
I Crowe	5	4	80%
S Dauncey	3	2	66%
P Panchal	5	5	100%

Attendees

DRAFT

Name	Possible	Actual	% attendance
P Hollinshead	2	2	100%
S Ward	5	5	100%
R Overfield	5	1	20%
S Sheppard	1	1	100%
P Traynor	2	2	100%

Trust Board Paper P

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

Trust Board Bulletin – 5 February 2015

The following report is attached to this Bulletin as an item for noting, and is circulated to UHL Trust Board members and recipients of public Trust Board papers accordingly:-

- **NHS Trust Over-Sight Self Certification return for the period ended 31 December 2014 (as submitted to the NTDA on 30 January 2015)** – Lead contact point Mr S Ward, Director of Corporate and Legal Affairs (0116 258 8721) – **paper 1.**

It is intended that these papers will not be discussed at the formal Trust Board meeting on 5 February 2015, unless members wish to raise specific points on the reports.

This approach was agreed by the Trust Board on 10 June 2004 (point 7 of paper Q). Any queries should be directed to the specified lead contact point in the first instance. In the event of any further outstanding issues, these may be raised at the Trust Board meeting with the prior agreement of the Chairman.

NHS Trust Oversight Self-Certification

In accordance with the Accountability Framework, the Trust is required to complete two self certifications in relation to the Foundation Trust application process. Copies of the self certifications submitted in January 2015 (December 2014 position) are attached as Appendices A and B.

Stephen Ward
Director of Corporate and Legal Affairs

NHS TRUST DEVELOPMENT AUTHORITY

tda Trust Development Authority
Quality. Delivery. Sustainability.

OVERSIGHT: Monthly self-certification requirements - Compliance Monitor

Monthly Data.

CONTACT INFORMATION:

Enter Your Name: * John Adler

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

Full Telephone Number: * 01162588940 Tel Extension: 8940

SELF-CERTIFICATION DETAILS:

Select Your Trust: * University Hospitals Of Leicester NHS Trust

Submission Date: * 30/01/2015 Reporting Year: * 2014/15

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NHS TRUST DEVELOPMENT AUTHORITY

Select the Month *

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

COMPLIANCE WITH MONITOR LICENCE REQUIREMENTS FOR NHS TRUSTS:

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

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

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

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

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

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16% Complete

NHS TRUST DEVELOPMENT AUTHORITY

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COMPLIANCE WITH MONITOR LICENCE REQUIREMENTS FOR NHS TRUSTS:

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

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18% Complete

NHS TRUST DEVELOPMENT AUTHORITY

Quality. Delivery. Sustainability.

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

4. Condition G8
Patient eligibility and selection criteria. *

Yes

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39% Complete

NHS TRUST DEVELOPMENT AUTHORITY

Quality. Delivery. Sustainability.

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

5. Condition P1
Recording of information. *
Yes

6. Condition P2
Provision of information. *
Yes

7. Condition P3
Assurance report on submissions to Monitor. *
Yes

8. Condition P4
Compliance with the National Tariff. *
Yes

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45% Complete

NHS TRUST DEVELOPMENT AUTHORITY

Quality. Delivery. Sustainability.

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

9. Condition P5
Constructive engagement concerning local tariff modifications. *

Yes

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73% Complete

NHS TRUST DEVELOPMENT AUTHORITY

Quality. Delivery. Sustainability.

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

10. Condition C1
The right of patients to make choices. *
Yes

11. Condition C2
Competition oversight. *
Yes

12. Condition IC1
Provision of integrated care. *
Yes

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NHS TRUST DEVELOPMENT AUTHORITY

tda Trust Development Authority
Quality. Delivery. Sustainability.

OVERSIGHT: Monthly self-certification requirements - Board Statements

Monthly Data.

CONTACT INFORMATION:

Enter Your Name: * John Adler

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

Full Telephone Number: * 01162588940 Tel Extension: 8940

SELF-CERTIFICATION DETAILS:

Select Your Trust: * University Hospitals Of Leicester NHS Trust

Submission Date: * 30/01/2015 Reporting Year: * 2014/15

Select the Month *

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

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NHS TRUST DEVELOPMENT AUTHORITY

BOARD STATEMENTS:

CLINICAL QUALITY
FINANCE
GOVERNANCE

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

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

NHS TRUST DEVELOPMENT AUTHORITY

BOARD STATEMENTS:

For CLINICAL QUALITY, that

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

1. CLINICAL QUALITY
Indicate compliance. *

Yes

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16% Complete

NHS TRUST DEVELOPMENT AUTHORITY

BOARD STATEMENTS:

For CLINICAL QUALITY, that

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

2. CLINICAL QUALITY
Indicate compliance. *

Yes

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22% Complete

NHS TRUST DEVELOPMENT AUTHORITY

Trust Development Authority
Quality. Delivery. Sustainability.

BOARD STATEMENTS:

For CLINICAL QUALITY, that

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

3. CLINICAL QUALITY
Indicate compliance. *

Yes

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28% Complete

NHS TRUST DEVELOPMENT AUTHORITY

BOARD STATEMENTS:

For FINANCE, that

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

4. FINANCE
Indicate compliance. *

Yes

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34% Complete

NHS TRUST DEVELOPMENT AUTHORITY

Quality. Delivery. Sustainability.

BOARD STATEMENTS:

For GOVERNANCE, that

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

5. GOVERNANCE
Indicate compliance. *

Yes

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40% Complete

NHS TRUST DEVELOPMENT AUTHORITY

BOARD STATEMENTS:

For GOVERNANCE, that

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

6. GOVERNANCE
Indicate compliance. *

Yes

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46% Complete

NHS TRUST DEVELOPMENT AUTHORITY

BOARD STATEMENTS:

For GOVERNANCE, that

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

7. GOVERNANCE
Indicate compliance. *

Yes

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52% Complete

NHS TRUST DEVELOPMENT AUTHORITY

BOARD STATEMENTS:

For GOVERNANCE, that

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

8. GOVERNANCE
Indicate compliance. *

Yes

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58% Complete

NHS TRUST DEVELOPMENT AUTHORITY

Quality. Delivery. Sustainability.

BOARD STATEMENTS:

For GOVERNANCE, that

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

9. GOVERNANCE
Indicate compliance. *

Yes

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64% Complete

NHS TRUST DEVELOPMENT AUTHORITY

Quality. Delivery. Sustainability.

BOARD STATEMENTS:

For GOVERNANCE, that

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

10. GOVERNANCE
Indicate compliance. *

Risk

Timescale for compliance: *

30/04/2015

RESPONSE:

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

The 29 January 2015 UHL NHS Trust Integrated Finance, Performance and Investment and Quality Assurance Committees received reports identifying the causes of underperformance on the following indicators, and endorsed the remedial actions being taken to achieve compliance. The individual anticiapated compliance dates are shown below against relevant indicators:-

S1a Clostridium Difficile (Jan 2015); S2a MRSA Bacteraemias (Jan 2015); S3 Never Events (Jan 2015); R1 ED 4-hour waits (Mar 2015); R3 RTT waiting times (admitted) (Apr 2015); R7 6 week Diagnostic test waiting times (Feb 2015); R8 Cancer-2-week waits (Feb 2015); R10 Cancer 31-day wait for first treatment (Feb 2015); R12 Cancer 31-day wait for second or subsequent treatment: surgery (Mar 2015); R14 Cancer 62-day wait for first treatment from GP referral (Mar 2015), and R23 DTOCs (Mar 2015).

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70% Complete

NHS TRUST DEVELOPMENT AUTHORITY

BOARD STATEMENTS:

For GOVERNANCE, that

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

11. GOVERNANCE
Indicate compliance. *

Yes

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76% Complete

NHS TRUST DEVELOPMENT AUTHORITY

BOARD STATEMENTS:

For GOVERNANCE, that

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

12. GOVERNANCE
Indicate compliance. *

Yes

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82% Complete

NHS TRUST DEVELOPMENT AUTHORITY

Quality. Delivery. Sustainability.

BOARD STATEMENTS:

For GOVERNANCE, that

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

13. GOVERNANCE
Indicate compliance. *

Yes

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88% Complete

NHS TRUST DEVELOPMENT AUTHORITY

BOARD STATEMENTS:

For GOVERNANCE, that

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

14. GOVERNANCE
Indicate compliance. *

Yes

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