UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

TRUST BOARD

MEETING TO BE HELD ON THURSDAY 7 MAY 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 apologies for absence from Ms K Shields, Director of Strategy.			-
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 2 April 2015 Trust Board meeting. *For approval*	**A**	**Chairman**	-
4.	**MATTERS ARISING**			
	Action log from the 2 April 2015 meeting. *For approval*	**B**	**Chairman**	9am – 9.05am
5.	**CHAIRMAN'S MONTHLY REPORT MAY 2015** *For discussion and approval*	**C**	**Chairman**	9.05am – 9.10am
6.	**CHIEF EXECUTIVE'S MONTHLY REPORT MAY 2015** *For discussion and approval*	**D**	**Chief Executive**	9.10am – 9.20am
7.	**KEY ISSUES FOR DECISION/DISCUSSION**			
7.1	**PATIENT STORY** *For discussion*	**E**	**Acting Chief Nurse**	9.20am – 9.35am
7.2	**ANNUAL OPERATIONAL PLAN 2015-16** *For approval*	**F**	**Head of Strategic Development (on behalf of Director of Strategy)**	9.35am – 9.50am
7.3	**FINAL FINANCIAL PLAN 2015-16** *For approval*	**G**	**Director of Finance**	9.50am – 10am
8.	**EDUCATION**			
8.1	**QUARTERLY UPDATE ON MEDICAL EDUCATION ISSUES** *For discussion and assurance*	**H**	**Acting Medical Director**	10am – 10.15am

9.	**QUALITY AND PERFORMANCE**			
9.1	**QUALITY ASSURANCE COMMITTEE (QAC)** To receive a summary of the key issues considered at the 30 April 2015 meeting. The formal Minutes will be presented to the Trust Board on 4 June 2015.	**I**	**QAC Chair**	10.15am – 10.20am
9.2	**INTEGRATED FINANCE, PERFORMANCE AND INVESTMENT COMMITTEE (IFPIC)** To receive a summary of the key issues considered at the 30 April 2015 meeting. The formal Minutes will be presented to the Trust Board on 4 June 2015.	**J**	**IFPIC Chair**	10.20am – 10.25am
9.3	**QUALITY AND PERFORMANCE REPORT – MONTH 12** The Chief Executive to introduce his monthly overview of quality and performance and the relevant Lead Executive Directors (Acting Medical Director, Acting Chief Nurse, Chief Operating Officer and Acting Director of Human Resources) to be invited to comment by exception on their respective sections of the detailed report. *For discussion and assurance*	**K**	**Chief Executive, Acting Medical Director, Acting Chief Nurse, Chief Operating Officer and Acting Director of Human Resources**	10.25am – 10.40am
9.4	**2014-15 MONTH 12 FINANCIAL POSITION** *For discussion and assurance*	**L**	**Director of Finance**	10.40am – 10.50am
9.5	**EMERGENCY CARE PERFORMANCE REPORT** *For discussion and assurance*	**M**	**Chief Operating Officer**	10.50am – 11.05am
10.	**GOVERNANCE**			
10.1	**UHL RISK REPORT INCORPORATING THE BOARD ASSURANCE FRAMEWORK** *For discussion and approval*	**N**	**Acting Medical Director**	11.05am – 11.25am
11.	**REPORTS FROM BOARD COMMITTEES**			
11.1	**QUALITY ASSURANCE COMMITTEE (QAC)** To receive the Minutes of the 26 March 2015 meeting for noting and endorsement of any recommendations.	**O**	**QAC Chair**	-
11.2	**INTEGRATED FINANCE, PERFORMANCE AND INVESTMENT COMMITTEE (IFPIC)** To receive the Minutes of the 26 March 2015 meeting for noting and endorsement of any recommendations.	**P**	**IFPIC Chair**	-
12.	**CORPORATE TRUSTEE BUSINESS**			
12.1	**CHARITABLE FUNDS COMMITTEE** To receive the Minutes of the 2 April 2015 meeting for noting and endorsement of any recommendations.	**Q**	**Chairman**	-
12.2	**MEANINGFUL ACTIVITY SERVICE FOR PATIENTS WITH DEMENTIA** *For approval*	**R**	**Acting Chief Nurse**	11.25am – 11.35am
13.	**TRUST BOARD BULLETIN – MAY 2015**	**S**	**-**	-
14.	**QUESTIONS FROM THE PUBLIC RELATING TO BUSINESS TRANSACTED AT THIS MEETING**		**Chairman**	11.35am – 11.45am
15.	**ANY OTHER BUSINESS**		**Chairman**	11.45am – 11.50am

16.	**DATE OF NEXT MEETING**			
	The next Trust Board meeting will be held on Thursday 4 June 2015 from 10am 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).			-
10 minute comfort break (11.50am – 12noon)				
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** To receive the confidential Minutes of the 2 April 2015 Trust Board meeting. *For approval*	**T**	**Chairman**	-
20.	**MATTERS ARISING** Confidential action log from the 2 April 2015 Trust Board meeting. *For approval*	**U**	**Chairman**	12noon – 12.05pm
21.	**REPORT FROM THE DIRECTOR OF ESTATES AND FACILITIES** *Commercial in confidence for assurance*	**V**	**Director of Estates and Facilities**	12.05pm – 12.45pm
22.	**REPORTS FROM BOARD COMMITTEES**			
22.1	**QUALITY ASSURANCE COMMITTEE** To receive the confidential Minutes of the 26 March 2015 meeting. *Personal data and prejudicial to the conduct of public affairs*	**W**	**QAC Chair**	-
22.2	**INTEGRATED FINANCE, PERFORMANCE AND INVESTMENT COMMITTEE** To receive the confidential Minutes of the 26 March 2015 meeting and a summary of the confidential issues considered at the 30 April 2015 meeting (formal Minutes of the latter meeting will be presented to the Trust Board on 4 June 2015). *Prejudicial to the conduct of public affairs*	**X & X1**	**IFPIC Chair**	-
22.3	**REMUNERATION COMMITTEE** To receive the confidential Minutes of the 2 April 2015 meeting. *Personal data and prejudicial to the conduct of public affairs*	**Y**	**Chairman**	-
23.	**CORPORATE TRUSTEE BUSINESS**			
23.1	**REPORT BY THE DIRECTOR OF MARKETING AND**	**Z**	**Director of Marketing and Communications**	12.45pm – 12.55pm

	COMMUNICATIONS			
24.	**ANY OTHER BUSINESS**	**-**	**Chairman**	12.55pm – 1pm

Kate Rayns
Acting Senior Trust Administrator

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF A MEETING OF THE TRUST BOARD, HELD ON THURSDAY 2 APRIL 2015 AT 10AM IN SEMINAR ROOMS 2 AND 3, CLINICAL EDUCATION CENTRE, GLENFIELD HOSPITAL

Voting Members Present:
Mr K Singh – Trust Chairman
Mr J Adler – Chief Executive (up to and including Minute 82/15)
Col (Ret'd) I Crowe – Non-Executive Director
Mr A Furlong – Acting Medical Director
Mr R Mitchell – Chief Operating Officer
Mr R Moore – Non-Executive Director
Ms C Ribbins – Acting Chief Nurse
Mr M Traynor – Non-Executive Director
Mr P Traynor – Director of Finance
Ms J Wilson – Non-Executive Director

In attendance:
Mr D Henson – LLR Healthwatch Representative (up to and including Minute 78/15)
Ms H Leatham – Assistant Chief Nurse (for Minute 71/15/1)
Ms J Lemon – Fundraising Manager, Mesothelioma UK (for Minute 71/15/1)
Ms E Moss – Chief Operating Officer, EM Local Clinical Research Network (for Minute 73/15/1)
Dr R Palin – Leicester, Leicestershire and Rutland CCG Representative (up to and including Minute 78/15)
Mrs K Rayns – Acting Senior Trust Administrator
Ms S Savoury – Lung Cancer Clinical Nurse Specialist (for Minute 71/15/1)
Ms K Shields – Director of Strategy
Mr N Sone – Financial Controller (for Minute 71/15/3)
Ms E Stevens – Acting Director of Human Resources
Mr S Ward – Director of Corporate and Legal Affairs
Mr M Wightman – Director of Marketing and Communications

ACTION

65/15 APOLOGIES

An apology for absence was noted from Dr S Dauncey, Non-Executive Director.

66/15 DECLARATIONS OF INTERESTS IN THE PUBLIC BUSINESS

There were no declarations of interest.

67/15 CHAIRMAN'S ANNOUNCEMENTS

The Chairman welcomed Mr R Moore, Non-Executive Director and Audit Committee Chair, and Mr A Furlong, Acting Medical Director to the meeting. He commented upon the forthcoming General Election and encouraged Board members to refrain from making any statements which might be perceived as being of a party political nature during the build up to the elections. The Director of Communications and Marketing was requested to circulate a briefing note to all Board members, setting out the guidance relating to purdah.

Resolved – that a briefing note on the rules of purdah be circulated to all Board members. **DMC**

68/15 MINUTES

Resolved – that the Minutes of the 5 March 2015 Trust Board (paper A) be confirmed as a correct record and signed by the Trust Chairman accordingly. **CHAIR**

69/15 MATTERS ARISING FROM THE MINUTES

Paper B detailed the status of previous matters arising and the expected timescales for resolution. Members noted that all items were either marked as (5) complete or (4) proceeding on track.

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

70/15 CHIEF EXECUTIVE'S MONTHLY REPORT – APRIL 2015

The Chief Executive introduced his monthly update report (paper C), noting that substantive reports on emergency care performance and the Trust's month 11 financial position featured later in the agenda. He briefed the Board on the following key issues:-

(a) activity and capacity planning – a copy of the report recently endorsed by the Better Care Together Programme Board was appended to paper C, setting out a comprehensive set of principles and processes to be applied in future activity and capacity modelling and noting the key issues and constraints (such as double running costs and lack of transitional funding);
(b) progress with Executive and Associate Director recruitment – following an open and competitive application process, Mr Darryn Kerr had been appointed as the substantive Director of Estates and Facilities (formal start date to be confirmed). The recruitment processes for the posts of Chief Nurse and Director of Workforce and Organisational Development would be concluded by the end of April 2015;
(c) active participation in the NHS Change Day on 11 March 2015. Since this report had been written, it had been confirmed that Dr Kate Granger would be visiting UHL as part of the tour to launch her "Hello my name is …" campaign;
(d) changes in the timetable for submission of the Trust's Annual Operational Plan for 2015-16 as a result of delays with the national tariff for 2015-16 and the ongoing contract negotiations with local commissioners. He confirmed that the contract for specialised commissioning had been agreed;
(e) a detailed options assessment for the Mutuals in Health Pathfinder project had been undertaken and the key findings had been circulated to Board members for their comments. Proposals for a staged approach in the medium to long-term would be submitted to the 7 May 2015 Trust Board meeting;
(f) new care models, eg Vanguard sites – a number of interesting partnerships were being explored in response to the 5 Year Forward View. Such developments would be viewed potentially as a delivery vehicle for the Better Care Together Programme, and
(g) the NHS England national review of maternity care would be taking place over the next few months and was likely to be concluded in the Autumn of 2015.

The final draft strategic objectives and annual priorities for 2015-16 were attached to paper C. The Chief Executive summarised the key changes and sought the Board's formal approval. In response, the Trust Board:-

(i) confirmed that these were a good reflection of the discussions held at the Trust Board thinking day on 12 February 2015;
(ii) queried progress with the approvals process to enable the previously identified cost pressures to be taken forwards. The Chief Executive advised that following consideration by the Executive Team, £3.5m had been allocated to enable any cost pressures which were deemed to be "unavoidable". As a consequence, the Trust's CIP target would now be increased by £2m;
(iii) queried the arrangements for sighting Board members to any areas of delivery exposure, eg patient and public involvement (PPI) in the strategic implications for the Trust. The Chief Executive confirmed that these would be managed within the existing PPI resources, but he agreed to highlight any "hotspots" for the Board's attention;

(iv) noted the constraints arising from the lack of agreed transitional funding and that this might (in turn) hamper the pace of change;
(v) considered the impact of a recent change in the timescale for the next CQC inspection which was now likely to take place during quarter 3 (between 1 October and 31 December 2015);
(vi) agreed that an assessment of any additional resource requirements would be undertaken, submitted to a future meeting of the Integrated Finance, Performance and Investment Committee (IFPIC) and communicated internally;
(vii) noted the forthcoming work with Board Intelligence to develop the programme of regular Trust Board reporting and rolling programme of "deep dives";
(viii) considered the scope to compare and contrast UHL's strategic objectives and annual priorities with those of its partner organisations (eg LPT and the CCGs), noting feedback provided by the LLR CCG Representative that these were broadly consistent, although the CCG priorities contained a higher emphasis on the "left shift" of services from Acute Trusts into the community setting. The Director of Strategy was requested to arrange for a correlation to be undertaken between the various organisations' objectives and priorities;
(ix) suggested that sharing of the strategic objectives and annual priorities be developed as a two-way process and that this might be undertaken at the meeting with the CCG Board members on 9 April 2015, and
(x) received assurance from the Acting Chief Nurse that UHL already carried out a range of joint working initiatives with LPT and the CCGs in respect of the Quality Schedule and CQUIN workstreams.

Resolved – that (A) the draft strategic objectives and annual priorities for 2015-16 be approved;

(B) an assessment of any additional resource requirements to deliver the Trust's strategic objectives and annual priorities be presented to a future IFPIC meeting, and **CE**

(C) the Director of Strategy be requested to arrange for a compare and contrast correlation to be undertaken between UHL's strategic ojectives and annual priorities and those of LPT and CCGs. **DS**

71/15 KEY ISSUES FOR DECISION/DISCUSSION

71/15/1 Patient Story – Patient Experience on Ward 22 at the Leicester Royal Infirmary

The Acting Chief Nurse introduced paper D, providing a summary of the Lung Cancer team's response to feedback from the national patient experience survey in 2014, recognising that UHL's performance for providing information about patient support groups was 10% below the national average. Ms H Leatham, Assistant Chief Nurse, Ms S Savoury, Lung Cancer Clinical Nurse Specialist and Ms J Lemon, Fundraising Manager, Mesothelioma UK attended the meeting and showed a short video clip recounting the positive experiences of patients and their families who attended the monthly Luncheon Club social events for Mesothelioma and Lung Cancer patients.

One of the patients featured in the video (Linda) attended the meeting for this item and she detailed ways in which the Luncheon Club had supported, reassured and informed her, enabling her to cope with the impact of her Mesothelioma diagnosis, surgery and after care. Another patient (Patricia) had written a poignant letter which was read out to the Board detailing her experiences before joining the Luncheon Club when she had declined treatment and became quite despondent. Since joining the Luncheon Club, Patricia had been inspired by the progress of other patients and had decided to proceed with her surgery and chemotherapy and she had since returned to work.

Board members noted the particular benefits of meeting other patients in a social setting

and the practical advice and support that was shared by healthcare professionals and other patients. Specialist guest speakers were invited periodically and recent discussion topics had included medication, nutrition, pain management, emotional support and practical advice for improving the quality of life, given the prognosis for many of these patients. In general, patients who attended such support groups tended to feel less isolated, more informed and less fearful of their condition. The group had been running for 12 months now and had approximately 60 members. The Macmillan Charity had provided the initial funding (for the first year) and arrangements were in hand to seek ongoing financial support from the Trust's Charitable Funds.

In discussion on the patient story, Board members:-

(a) queried how widespread such services were within the Trust, noting in response that the Lung Cancer Team was a pioneer of such services at UHL, but there was a significant opportunity to roll out this type of patient support model to other tumour sites for cancer and other long term patient conditions;
(b) noted that the consistency of the group and the clinical specialists had contributed significantly to its success;
(c) sought and received additional information regarding the publication of patient support group information on UHL's external website (which also contained a link to the Mesothelioma UK website), Trust magazines and primary care literature;
(d) commended the collaborative approach, noting the benefits for improving health outcomes and reducing the demands on health systems, and suggesting that patients should be allowed to help shape their services as part of the wider arrangements for rolling out this initiative to other services;
(e) commented upon opportunities for UHL to improve the strategic approach to dispersal of charitable funds, and
(f) considered opportunities to work collaboratively with Healthwatch in the development of new support groups for particular cohorts of patients.

In summary, the Trust Chairman confirmed the Board's support for patient support groups of this nature and invited the Lung Cancer Nurse Specialist and the Acting Chief Nurse to present their closing comments. In response they reiterated their passionate belief that the Luncheon Club provided measurable benefits to Mesothelioma and Lung Cancer patients and demonstrated that the Trust was delivering "Caring at its Best". They invited Board members to access one of their meetings to witness the impact for themselves.

Resolved – that the patient story and the related discussion be noted.

71/15/2 Draft Financial Plan 2015-16

Further to consideration at the 26 March 2015 Integrated Finance, Performance and Investment Committee (Minute 25/15 refers), paper E provided an update on the development of the Trust's Financial Plan for 2015-16, including the current position on contractual negotiations with the 3 LLR CCGs, budget setting at CMG and Directorate levels, the draft capital plan, cash management arrangements and CIP progress.

The Director of Finance sought the Board's approval of the draft plan, advising that the final iteration would be presented to the Trust Board on 7 May 2015. He confirmed that the final plan would incorporate the additional cost pressures supported by the Executive Team and the impact upon the Trust's 2015-16 CIP target.

Ms J Wilson, Non-Executive Director and IFPIC Chair confirmed that the draft financial plan and been reviewed in detail by that Committee on 26 March 2015 and that the Committee had supported the approach to the contract for patient activity, subject to appropriate terms and conditions being agreed by all parties.

Resolved – that (A) the draft 2015-16 financial plan be approved, subject to finalisation of CMG and Directorate level budgets and agreement of the contract plans with Commissioners, **DF**

(B) the borrowing requirement of £130m to support the 2015-16 capital plan and the planned £36.1m deficit be noted, and **DF**

(C) the final 2015-16 financial plan be presented to the Trust Board on 7 May 2015. **DF**

71/15/3 Working Capital Strategy 2015-16

Further to consideration at the 26 March 2015 Integrated Finance, Performance and Investment Committee (Minute 26/15 refers), the Director of Finance presented paper F, setting out the approach to managing the Trust's working capital to fulfil its financial obligations and deliver the agreed objectives and advising that a working capital report would be presented to future IFPIC meetings on a quarterly basis.

The Financial Controller attended the meeting for this item, providing a summary of the circumstances leading up to the submission of a DoH loan application for £21.9m Revolving Working Capital Facility on 30 March 2015 using the Emergency Powers provided to the Chief Executive and the Chairman, in consultation with at least 2 Non-Executive Directors, under the Trust's Standing Orders (as outlined in paper F).

Non-Executive Director members welcomed the additional focus on the Trust's cash management arrangements and thanked the Director of Finance for scheduling a financial awareness session for Board members on 30 April 2015 (immediately following the IFPIC and QAC meetings). The Director of Finance advised Trust Board members not to underestimate the level of financial support that the Trust would need over the next 3 to 4 years to support its financial recovery and investment strategy. He stressed the importance of a strong focus on cash management arrangements going forwards and highlighted his desire to embed a common understanding of the issues faced by the Trust. He invited all Board members to attend the training session on 30 April 2015.

In further discussion, members noted the need for the narrative on cash management to be very clear ahead of the planned Board to Board meeting with the TDA on 16 April 2015, including a thorough assessment of the value of any borrowing on the balance sheet and the associated risks. The Director of Communications and Marketing advised that the Trust's Strategic Direction was currently being re-drafted and that this document (once finalised) would provide the narrative going forwards. In addition, the Director of Strategy noted the need to make the Board informed of additional activity and workstreams being undertaken within existing resources (and thus avoiding additional costs).

Resolved – that (A) the Working Capital Strategy for 2015-16 be approved, and **DF**

(B) the following approvals by IFPIC (under Emergency Powers) on 26 March 2015 be ratified:- **DF**

- **the terms of the interim revolving working capital support facility be approved;**
- **the Director of Finance be nominated to execute the agreement;**
- **the Director of Finance be nominated to manage the agreement, and**
- **compliance with additional terms and conditions be confirmed.**

71/15/4 Emergency Floor Full Business Case

Further to Minute 6/15/2 of 8 January 2015, paper G summarised the key recommendations arising from the Gateway Review 3, and the NTDA's review of the outline business case, and sought Trust Board approval of the final full business case for onward submission to the NTDA National Capital Group on 22 April 2015. The Chief Executive introduced this item,

commenting upon the early adoption of the new Board Intelligence approach to Trust Board reporting, which now aimed to identify the key questions and conclusions at the very beginning of the report, rather than the traditional introductory approach. In discussion on the business case, the Trust Board:-

(a) noted that the full business case had already been endorsed by the Trust's Integrated Finance, Performance and Investment Committee on 26 March 2015 (Minute 24/15 refers), and that appropriate responses to all of the Committee's queries and comments had now been incorporated into paper G;
(b) welcomed the inclusion of a letter of support prepared by the Managing Director of the Leicester City CCG and written on behalf of the three LLR CCGs (appendix 1 refers);
(c) commented upon the impact of changing the funding assumptions from Public Dividend Capital (PDC) to Interest Bearing Debt (IBD). As set out in section 5.9 of the business case, the additional annual revenue costs of the IBD loan facility would be in the region of £250,000;
(d) received additional assurance regarding the rationale for non-compliance with the DoH Health Building Notes in respect of some room sizes;
(e) commended the significant contributions by Ms N Topham, Project Director, Site Reconfiguration in respect of the business case development and the patient, public and stakeholder engagement workstreams, noting the organisation learning that had been achieved from this process and that a lessons learned report would be presented to a future meeting of the Integrated Finance, Performance and Investment Committee; **DS**
(f) commented upon the potential clinical and efficiency benefits of UHL operating the urgent care stream of the emergency floor and the scope to commence discussions with Commissioners in this respect (subject to formal procurement processes being followed);
(g) considered recent recommendations arising from the LLR Emergency Care report prepared by Dr Ian Sturgess and feedback from LLR Healthwatch which suggested that an urgent care service led and managed by UHL would deliver additional benefits to patient care and organisational effectiveness;
(h) sought and received additional assurance from the Director of Finance regarding the affordability of the scheme using the IBD loan facility, noting that whilst this would remain affordable, PDC would still be the Trust's preferred financing option;
(i) highlighted the support provided by the Bishop of Leicester, local County Councillors, the Deputy Mayor of Leicester and UHL's Chaplaincy team in respect of the challenging patient and public involvement and engagement activity leading to planning permission being granted to demolish UHL's existing chapel. The Trust Chairman expressed a desire to formally acknowledge this support and requested the Director of Marketing and Communications to prepare appropriate correspondence for his signature, and **DMC**
(j) suggested that early consideration be given to inviting appropriate individuals to officiate over the topping out, laying of first stone and formal opening ceremonies. **DMC**

<u>Resolved</u> – that (A) the Trust Board endorse the final full business case for the Emergency Floor (as set out in paper G) for onward submission to the NTDA National Capital Group on 22 April 2015; **DF**

(B) a summary of the lessons learned in respect of the business case development process be presented to a future meeting of the Trust's Integrated Finance, Performance and Investment Committee; **DS**

(C) the Director of Marketing and Communications be requested to:-

- **formally acknowledge the support provided in respect of planning consent for the emergency floor, and** **DMC**
- **give early consideration to inviting appropriate individuals to help the Trust to celebrate key milestones within the project timeline.** **DMC**

71/15/5 <u>Emergency Care Performance</u>

The Chief Operating Officer introduced paper H, updating the Trust Board on recent emergency care performance and progress against the agreed LLR action plan. He noted that despite a 10% increase in admissions, 9 out of 10 patients had still been seen within the 4 hour target during 2014-15 and 87% of the ED patients surveyed by Healthwatch in early January 2015 would recommend UHL as a place to receive treatment. In December 2014, 6 collective key actions had been agreed across LLR to support improvements in emergency care performance. Progress against the discharge-related action had been achieved, but the remaining 5 actions required some additional focus.

The Director of Communications and Marketing briefed Board members on progress of the "choose better" campaign (as launched on 1 April 2015) and he highlighted opportunities to strengthen the links between the UHL and CCG communications teams. He also highlighted the importance of robust communications between UHL and GPs and care homes regarding the arrangements for their risk stratified patients.

Dr R Palin, CCG representative provided assurance that the CCGs were fully committed to improving emergency care performance through the work of the Urgent Care Board, development of care plans and re-commissioning of the Urgent Care Centre service, despite national increases in demand and a diminishing GP workforce.

The Chief Executive commended the significant progress made in respect of the internal UHL components of the action plan and the arrangements for improving discharge processes. However, he highlighted the need to re-focus on the inflow side of the health economy plan to address rising admissions, noting the sensitive nature of emergency care performance in response to small changes in activity trends.

The Trust Board supported the proposal to raise this issue for discussion at the 9 April 2015 meeting with the 3 LLR CCGs. It was also agreed that the Trust Board would undertake a deep dive into the health economy issues affecting attendance and admissions, to identify any areas where the actions being taken did not appear to be making much impact. It was also suggested that a fundamental collective re-think of admissions avoidance workstreams might be required as part of the BCT strategy.

Finally, the Chief Operating Officer commented on a number of similar conversations held over the last 5 months, suggesting that more discussions of the same nature were not likely to achieve the required results. He recommended that opportunities to strengthen UHL's front door triage arrangements be explored as a key area for future focus.

<u>Resolved</u> – that (A) the update on emergency care performance be received and noted as paper H;

(B) further discussion on the health economy actions being undertaken to address inflow be scheduled with the CCGs at the 9 April 2015 meeting, and **CE**

(C) a deep dive into the health economy actions affecting attendances and admissions be undertaken at a future Trust Board meeting. **COO**

72/15 WORKFORCE

72/15/1 <u>Organisational Development Strategy – Quarterly Update</u>

The Acting Director of Human Resources introduced paper I highlighting progress with implementation of UHL's Organisational Development Plan. She particularly drew members' attention to sections 3.3 (detailing the success of the Trust's Salary Maxing schemes and Total Reward Statements) and 5.1 (surrounding the development of new roles to deliver new models of care, eg assistant and advanced practitioners). In discussion on the report, Board members:-

(a) queried whether there was any available evidence to demonstrate that Salary Maxing schemes helped to support staff retention. In response, it was noted that UHL's staff turnover stood at approximately 10% which was on a par with other Trusts. Changes to the NHS pension rules, might mean that staff would be more cautious about accessing such benefits in future;
(b) highlighted statistics relating to staff suffering from stress and received assurance that UHL was rolling out a programme of emotional resilience training for staff affected by such issues;
(c) considered the arrangements for building UHL's brand as an employer and the scope to develop a joint branding approach with LPT, possibly rotating staff between the 2 Trusts and exploring the scope to make joint appointments;
(d) highlighted opportunities to promote Leicester as a place to live and to include such information within UHL's recruitment packs, and
(e) noted that the next Caring at its Best Awards ceremony would be held on 24 September 2015 and that all Board members were invited to attend this event.

Resolved – that the quarterly update on the Organisational Development Strategy be received and noted.

72/15/2 National Staff Survey Results 2014

The Acting Director of Human Resources presented paper J providing highlights of the 2014 National Staff Survey results. The detailed appendices set out the impact of the 2013 action plan upon the 2014 results, a summary of the key findings, a comparison of the overall staff engagement scores for other Acute Trusts in 2013 and 2014, the results of local questions and the pulse check surveys.

Discussion took place regarding a small deterioration in the Trust's staff engagement score which now stood at 3.64 (compared to 3.68 in 2013) and the broad framework for actions planned to improve the score in future years. A detailed action plan would be developed through focus groups with the CMGs and Directorates and this was expected to be available by the end of June 2015. However, it was noted that a more immediate focus would be applied towards removing some of the everyday frustrations reported by staff.

The Trust Chairman queried whether there was much variance in the staff survey scores between the CMGs and noted in response that CMG level staff survey data would be reviewed by the Integrated Finance, Performance and Investment Committee during the rolling programme of CMG presentations.

The Chief Executive voiced his disappointment in the overall results, which he had expected to improve, given the work that the Trust had completed in respect of Listening into Action (LiA). However, he noted that some significant improvements had been demonstrated in the particular areas where LiA workstreams had been active (eg recruitment processes) and he highlighted an opportunity to increase the pace of other LiA workstreams accordingly.

The Director of Communications and Marketing drew members' attention to the survey questions which focused on (a) whether staff would recommend the Trust as a place to work or be treated and (B) how staff rated communications between senior management and staff. Ms J Wilson, Non-Executive Director highlighted the Trust's performance in respect of the Well Led Dashboard provided on page 5 of the Quality and Performance report (paper O refers), noting that the target and the red RAG rating thresholds were yet to be confirmed.

Resolved – that (A) the key messages arising from the analysis of the 2014 National Staff Survey results be received and noted, and

(B) a detailed action plan be presented to the 2 July Trust Board meeting for approval. ADHR

73/15 RESEARCH AND INNOVATION

73/15/1 Clinical Research Network (CRN): East Midlands – Bi-Yearly Update and Annual Plan Submission for 2015-16

Paper K provided an update on progress with the NIHR CRN: East Midlands, and sought Trust Board approval of the Network's Annual Business Plan for 2015-16. The Acting Medical Director introduced this item and Ms E Moss, Chief Operating Officer, CRN: East Midlands attended the meeting to support the discussion.

The business plan had already been endorsed by the CRN Host Executive Group (chaired by Dr K Harris, the Trust's previous Medical Director) and submitted to the NIHR on 1 April 2015 to comply with their deadline. However the NIHR had recognised that the business plan had not yet been approved formally by the UHL Trust Board (as host Trust) and it was confirmed that any changes arising from today's discussion would be incorporated accordingly. The Board noted that Mr A Furlong, Acting Medical Director would be assuming the role of Executive Director for the CRN until a substantive appointment was made to the post of UHL Medical Director.

Discussion took place regarding the Network's achievements, challenges, opportunities and any additional support that the UHL Trust Board might be able to provide in respect of generating additional local research and improving recruitment rates to studies to meet national targets. The Acting Medical Director confirmed that clear plans were in place to address consistent Network performance and that a process had been agreed to ensure that the financial rewards were fair and equitable. Finally, discussion took place regarding opportunities to reschedule an opening ceremony which had been deferred due to the aesthetics of the local environment at the time.

Resolved – that (A) the progress update on NIHR CRN: East Midlands be received and noted, and

(B) the NIHR CRN: East Midlands Annual Plan for 2015/16 be approved. **AMD**

73/15/2 Quarterly Update on Research and Innovation at UHL

The Acting Medical Director introduced paper L, providing the quarterly update on research and innovation issues for discussion and assurance. He noted a slight dip in performance at the beginning of the year, but provided assurance that the Trust was currently meeting its performance targets and that financial performance would improve once the process for fair share payment allocations was finalised and implemented. The Board received brief updates on the following key projects and particular discussion took place regarding items (3), (4), (5) and (6):-

(1) Precision Medicine Catapault;
(2) Breathanomics Pathology Node;
(3) Adult and Children's Clinical Research Facility – the Chief Executive expressed disappointment with progress and he queried whether there was any scope to apply for charitable funding to help bridge the gap;
(4) HOPE Unit at Glenfield Hospital – funding had been identified to refurbish an appropriate clinical area, but a suitable space was yet to be identified, pending the provision of detailed site reconfiguration plans;
(5) Life Study – the costs for refurbishment of the building to be used as the Life Study centre appeared to have escalated and a further analysis was taking place to verify this, and
(6) 100,000 Genome Project – an update on this project was due to be received at the Executive Strategy Board meeting on 14 April 2015.

Resolved – that the quarterly update on research and innovation issues at UHL be received and noted.

74/15 QUALITY AND PERFORMANCE

74/15/1 Quality Assurance Committee (QAC)

On behalf of the QAC Chair, Ms J Wilson, Non-Executive Director introduced a summary of the key issues considered at the 26 March 2015 QAC meeting (paper M refers) and confirmed that the Minutes of that meeting would be presented to the 7 May 2015 Trust Board meeting. She particularly drew members' attention to the following issues:-

(i) the 2015-16 Quality Commitment (as approved by the Committee) – it was agreed that copies of this would be circulated to Trust Board members outside the meeting for information, and
(ii) applications made to the CQC to include 2 additional premises on UHL's registration:-
- National Centre for Sports and Exercise Medicine, and
- Syston Health Centre for surgical procedures as part of the Alliance contract.

Resolved – that (A) copies of the 2015-16 Quality Commitment be circulated to Trust Board members, and **ASTA**

(B) the changes to the CQC registration detailed in item (ii) above be noted.

74/15/2 Integrated Finance, Performance and Investment Committee (IFPIC)

Ms J Wilson, Non-Executive Director and IFPIC Chair presented paper N, providing a summary of the issues discussed at the 26 March 2015 IFPIC meeting. She particularly noted that substantive reports featured on today's Trust Board agenda for each of the 3 recommendations arising from this meeting. The Minutes of the 26 March 2015 IFPIC meeting would be presented to the 7 May 2015 Trust Board meeting.

Resolved – that the summary of key issues considered at the 26 March 2015 IFPIC meeting be received and noted.

74/15/3 Quality and Performance Report – Month 11 (February 2015)

Paper O provided an overview of the Trust's quality and operational performance and detailed performance against key UHL and TDA metrics. Escalation reports were appended to the report detailing any areas of underperformance. The Chief Executive confirmed that a review of the key issues contained within his highlight report had been undertaken during the 26 March 2015 QAC and IFPIC meetings. The following Executive Directors commented upon their respective sections of the report:-

(a) the Acting Medical Director noted that a recent improvement in fractured neck of femur performance was considered to be the result of a natural fluctuation in activity. He advised that the Musculoskeletal and Specialist Surgery CMG had submitted a revenue scheme to support further improvements in performance and this had been identified as a level 1 priority for the Trust and had been supported accordingly;
(b) the Acting Chief Nurse advised that updates on infection prevention performance and pressure ulcer damage featured in the Chief Executive's highlight report. She highlighted recent improvements in the Friends and Family Test scores for Maternity Services, noting the impact of strong leadership within this service, and
(c) the Acting Director of Human Resources commended the Trust's achievement of the new 95% target for compliance with statutory and mandatory training during March 2015.

Resolved – that the month 11 Quality and Performance report (paper O) and the subsequent discussion be received and noted.

74/15/4 2014-15 Financial Position – Month 11 (February 2015)

The Director of Finance presented paper P, updating the Board on performance against the Trust's key financial duties and providing further commentary on the month 11 financial performance by CMG and Corporate Directorates, and the associated risks and assumptions. He provided assurance that the planned £40.7m deficit for 2014-15 would be delivered and that performance against the 3 financial duties set out in section 2.1 of paper P was forecast to be compliant.

Members noted the Director of Finance's continued concerns regarding pay expenditure trends moving into the 2015-16 financial year and received an update on progress of the cross-cutting CIP theme relating to workforce. Despite some in-year slippage against the Trust's 2014-15 Capital Programme, assurance had been provided to the Integrated Finance, Performance and Investment Committee that the overall plan would be delivered.

Resolved – that the month 11 financial performance report (paper P) and the subsequent discussion be received and noted.

75/15 GOVERNANCE

75/15/1 Board Assurance Framework (BAF)

The Acting Medical Director introduced paper Q detailing UHL's Board Assurance Framework as at 28 February 2015 and advising that no new extreme or high risks had been opened during February 2015. Under paragraph 2.2, of paper Q the Trust Board was invited to undertake a detailed review of the 3 risks linked to the strategic objective *"an effective, joined-up emergency care system"*, incorporating principal risks 2, 3 and 4. However, the Trust Chairman suggested that this review be deferred until after the forthcoming Board to Board meeting with the TDA, once the 2015-16 BAF became available.

Non-Executive Director members expressed concern that the timescale for submission of the 2015-16 BAF was likely to slip from May 2015 to June 2015 and they queried whether there would be any scope to submit an early draft to the 7 May 2015 Trust Board meeting. The Chief Executive supported this approach, noting that the new BAF would link directly with the Trust's Annual Priorities.

Resolved – that (A) the February 2015 Board Assurance Framework (BAF) be received and noted as presented in paper Q and

(B) the first draft of the 2015-16 BAF be presented to the Trust Board on 7 May 2015 for approval. **AMD**

76/15 REPORTS FROM BOARD COMMITTEES

76/15/1 Audit Committee

On behalf of the Interim Audit Committee Chair, Mr R Moore, Non-Executive Director and substantive Audit Committee Chair, introduced the Minutes of the 5 March 2015 Audit Committee meeting (paper R refers), particularly highlighting the useful presentation from the Musculoskeletal and Specialist Surgery CMG, the review of off payroll engagements and the arrangements for circulating a draft version of the Annual Governance Statement to Audit Committee members for comments prior to submission to the 27 May 2015 Audit

Committee for formal approval and recommendation to the Trust Board.

Resolved – that the Minutes of the Audit Committee meeting held on 5 March 2015 be received and noted.

76/15/2 Quality Assurance Committee (QAC)

Resolved – that the Minutes of the QAC meeting held on 26 February 2015 (paper S) be received and noted.

76/15/3 Integrated Finance, Performance and Investment Committee (IFPIC)

Resolved – that the Minutes of the IFPIC meeting held on 26 February 2015 (paper T) be received and noted and the recommendations contained therein be endorsed.

77/15 TRUST BOARD BULLETIN – APRIL 2015

Resolved – that the Trust Board Bulletin containing the annual updated Trust Board declarations of interest be noted.

78/15 QUESTIONS AND COMMENTS FROM MEMBERS OF STAFF AND PUBLIC RELATING TO BUSINESS TRANSACTED AT THIS MEETING

The following comments and suggestions were received from a member of staff:-

(1) a comment regarding opportunities to strengthen the Trust's workforce by improving the recruitment advertisements to focus more on the positive aspects of working for UHL and living and working in Leicester and the surrounding areas. The Trust Chairman agreed that there were ways in which the Trust could sell itself better as an employer;
(2) a comment that some good staff were leaving the Trust because of issues with car parking and a suggestion that the position could deteriorate further as part of the reconfiguration of services onto 2 acute sites. The Trust Chairman confirmed that the Board was conscious of the sensitive issues relating to staff car parking and was committed to ensuring a fair and transparent allocation process for staff permits. He highlighted opportunities to improve the way that staff perceptions regarding car parking was managed in the future, and
(3) an offer of help in supporting the Trust's recruitment process. The Acting Director of Human Resources agreed to follow up this kind offer with the member of staff following the meeting. **ADHR**

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

79/15 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 80/15 – 88/15), having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.

80/15 DECLARATIONS OF INTERESTS IN THE CONFIDENTIAL BUSINESS

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

81/15 CONFIDENTIAL MINUTES

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

82/15 CONFIDENTIAL MATTERS ARISING REPORT

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

83/15 REPORT FROM THE ACTING DIRECTOR OF HUMAN RESOURCES

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

84/15 REPORT FROM THE ACTING MEDICAL DIRECTOR

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

85/15 REPORT FROM THE DIRECTOR OF STRATEGY

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

86/15 REPORTS FROM BOARD COMMITTEES

86/15/1 Quality Assurance Committee (QAC)

Resolved – that the summary of the confidential issues discussed at the 26 March 2015 QAC meeting be received and noted.

86/15/2 Integrated Finance, Performance and Investment Committee (IFPIC)

Resolved – that the confidential Minutes of the 26 February 2015 IFPIC meeting and the summary of issues discussed at the 26 March 2015 meeting be received and noted.

86/15/3 Audit Committee

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

87/15 ANY OTHER BUSINESS

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

88/15 DATE OF NEXT MEETING

Resolved – that the next Trust Board meeting be held on Thursday 7 May 2015 from 9am in Seminar Rooms A and B, Clinical Education Centre, Leicester General Hospital.

The meeting closed at 1.40pm

Kate Rayns
Acting Senior Trust Administrator

Cumulative Record of Attendance (2015-16 to date):

Voting Members:

Name	Possible	Actual	% attendance	Name	Possible	Actual	% attendance
K Singh	1	1	100	R Moore	1	1	100
J Adler	1	1	100	C Ribbins	1	1	100
I Crowe	1	1	100	M Traynor	1	1	100
S Dauncey	1	0	0	P Traynor	1	1	100
A Furlong	1	1	100	J Wilson	1	1	100
R Mitchell	1	1	100				

Non-Voting Members:

Name	Possible	Actual	% attendance	Name	Possible	Actual	% attendance
D Henson	1	1	100	E Stevens	1	1	100
R Palin	1	1	100	S Ward	1	1	100
K Shields	1	1	100	M Wightman	1	1	100

University Hospitals of Leicester NHS Trust

Progress of actions arising from the Trust Board meeting held on Thursday, 2 April 2015

Item No	Minute Ref:	Action	Lead	By When	Progress Update	RAG status*
1	67/15	Director of Marketing and Communications to circulate a briefing note on the rules of purdah to all Board members.	DMC	Immediate	Complete.	5
2	70/15 (b)	An assessment of any additional resource requirements to deliver the Trust's strategic objectives and annual priorities to be presented to a future IFPIC meeting.	CE	IFPIC 28.5.15	Provisionally scheduled for the 28 may 2015 IFPIC meeting.	4
3	70/15 (c)	Director of Strategy to arrange for a correlation to be undertaken between UHL's strategic objectives and annual priorities and those of LPT and the CCGs.	DS	TBA	Correlation exercise has been completed – LPT objectives align with UHL objectives as expected. Moreover, there is specific reference in LPT plans to joint initiatives and enablers for UHL objectives eg supporting left shift. Correlation exercise also completed between UHL and CCGs (and BCT) which shows strong alignment / no surprises.	5
4	71/15/2	Final 2015-16 Financial Plan to be presented to the May 2015 Trust Board.	DF	TB 7.5.15	Report features on the 7 May 2015 Trust Board agenda.	5
5	71/15/4 (b)	Summary of lessons learned from the development of the Emergency Care business case to be presented to a future IFPIC meeting.	DS	IFPIC 28.5.15	Report provisionally scheduled on the IFPIC agenda for 28 May 2015.	4
6	71/15/4 (c)	Director of Marketing and Communications to acknowledge the support received in respect of planning consent for the emergency floor and give consideration to inviting appropriate individuals to celebrate key milestones within the project timeline.	DMC	TBA	Will be taken forward as part of the communications plan for FBC.	4
7	71/15/5 (b)	Discussion on the health economy actions to address inflow to be held with CCGs on 9 April 2015.	CE	B2B 9.4.15	Complete.	5
8	71/15/5 (c)	Deep dive into health economy actions affecting attendances and admissions to be scheduled at a future Trust Board meeting.	COO	TB 4.6.15	An update will be provided to the Trust Board on 4 June 2015 (once the new LLR plan is in place).	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***

Item No	Minute Ref:	Action	Lead	By When	Progress Update	RAG status*
9	72/15/2	Detailed action plan in response to the 2014 National Staff Survey Results to be presented to the July 2015 Trust Board meeting.	ADHR	TB 2.7.15	Report provisionally scheduled on the Trust Board agenda for 2 July 2015.	4

Matters arising from previous Trust Board meetings

Item No	Minute Ref:	Action	Lead	By When	Progress Update	RAG status*
5 March 2015						
10	49/15/3	***Institute of Frail Elderly Medicine*** Further report on the proposed partnership with DMU and the proposed governance arrangements to be presented to the Trust Board in June 2015.	AMD	TB 4.6.15	Provisionally scheduled on the June 2015 Trust Board agenda.	4
11	49/15/4	***PPI and Community Engagement Strategy*** Formal review to be undertaken in 12 months' time and the outcomes to be reported to the Trust Board.	DMC	TB March 2016	To be scheduled on the appropriate Trust Board agenda.	4
12	52/15/1	***Board Assurance Framework*** 2015-16 version of the BAF to be presented to the Trust Board on 7 May 2015 for approval.	AMD	TB 7.5.15	Report features on the May 2015 Trust Board agenda.	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***

Chairman's Note

Author: Karamjit Singh Date: [May 2015]

Paper C

Dear Board Member,

Key considerations

Since we last met the key things on my mind have been:

- As a large organisation within the community at large we will seek to engage as a Trust Board (and organisation) with different audiences but how should we assess the outcomes?
- As a leading employer within the wider community we would want to encourage high quality applications and the development of our employees but how should we assess the outcomes ?

Priority Items & Questions

In preparation for our next board meeting I would like to highlight the following priority items and a few specific questions to consider.

1. During the past two weeks I have met the Chairs of three NHS Trusts (the Nottingham University Hospitals, the East Midlands Ambulance Service and Coventry/Warwickshire University Hospitals). During the same period I also attended the Leicester Mercury Business Awards Dinner and the Community Representatives Dinner hosted by the Chairman of Leicestershire County Council. Next week I will be attending the Midlands Region Business Awards hosted by the Asian Media Group. I know that each of you will also be meeting individuals or attending events as part of your professional and personal networks.
   1.1. Given all this engagement activity what should our strategic objectives be ?
   1.2. How do we try and measure success in this area and what does it look like?
2. Last week I visited the Coding Department and was immensely impressed by the professionalism and commitment of staff in this 'behind the scenes' area of activity and which is so important both in the calculation of our income but also in making comparisons with other organisations. I was very surprised to discover that in common with other NHS organisations we have ongoing problems in recruiting experienced staff in this area. This specific example posed wider questions in my mind :

2.1. As one of the largest employers within this region what strategy should we adopt in seeking to meet our immediate and longer term workforce shortages in the light of demographic, financial and training challenges?
2.2. How do we try and measure success in this area and what does it look like?

I look forward to seeing you at our forthcoming board meeting on 7th May 2015

Regards,

Karamjit Singh

Chairman, University Hospitals of Leicester NHS Trust

University Hospitals of Leicester NHS
NHS Trust

Agenda Item: Trust Board Paper D

TRUST BOARD – 7th MAY 2015

MONTHLY UPDATE REPORT – MAY 2015

DIRECTOR:	CHIEF EXECUTIVE
AUTHOR:	DIRECTOR OF CORPORATE AND LEGAL AFFAIRS
DATE:	30th APRIL 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: **7 MAY 2015**

REPORT BY: **CHIEF EXECUTIVE**

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

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1. The Chief Executive submits a written report to each Board meeting detailing the 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 12 financial position;

(c) Executive and Associate Director recruitment - progress;

(d) declaration of a major incident on 22nd April 2015 following a waste pipe leak at the Leicester Royal Infirmary site which resulted in the closure of the Resuscitation Department for a period of time;

(e) Mutuals in Health - pathfinder programme; and

(f) UHL's application to participate in the NHS Trust Development Authority's development programme.

3. The Trust Board is asked to consider the Chief Executive's report and, 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

30th April 2015

Mutuals in Health Pathfinders

University Hospitals of Leicester NHS Trust ('UHL')

Detailed Options Assessment

Executive Summary

HEMPSONS

stepping out

Albion

1. Executive Summary

1.1 Introduction

The Mutuals in Health Pathfinder Programme (MIH) has been established by the Cabinet Office and Department of Health in order to:

- consider how mutual models could increase staff engagement across the organisation through greater staff control and/or ownership;
- explore and fully appraise the feasibility and potential benefits of a mutual model for the entire organisation of participating trusts or significant parts of their services;
- build skills, knowledge and capability in participating trusts in relation to appraising mutual models and contribute to wider knowledge sharing on mutuals models across new areas of the health sector including the acute sector; and
- support and inform any potential future policy around mutuals in new areas of the health sector by enabling government to build up an understanding of the practical, regulatory and legislative steps it may need to consider to facilitate new governance and ownership models.

University Hospitals of Leicester NHS Trust ("UHL" or "the Trust")) was successful in its bid to become a MIH Pathfinder. The partnership of Hempsons solicitors, Stepping Out (a business development consultancy specialised in mutuals) and Albion Care Alliance CIC (an alliance of three spin-outs providing community health services) ("HASO") was commissioned by Cabinet Office to work with UHL to deliver the assignment focused on UHL's objectives:

1.1. Explore the whole Trust mutual:

- develop a - high level- business case i.e. "this is what it could look like and how it could be done here"

1.2. Autonomous Teams (for UHL: Elective Orthopaedics, Trauma and Theatres):

- develop the framework and rules of engagement
- work with pilot teams to get them up and running

1.3. Embed staff engagement and a sense of ownership:

- research best practice
- develop plans to further embed staff engagement in the Trust's structure

Our work has confirmed the potentially significant benefits which could flow from a 'Whole Trust Mutualisation' (WTM), but also the significance of the barriers. Issues in relation to legislation, financial viability, access to finance, asset transfer and VAT have been identified as - under current policy and legislation - insurmountable barriers. Adding to that the implementation risks that are associated with mutualisation during a time of significant change for UHL, make the option of WTM as yet unattainable.

However, as the financial and non-financial benefits of the mutual model are highly attractive, and certain 'mutual' elements can be implemented without being affected by aforementioned barriers, we are not ruling out the WTM option, in the longer term, if the circumstances are right, and as such recommend a staged approach that allows UHL to achieve the benefits of mutualisation, as follows:

Stage 1: Creating an Autonomous Team within the Trust structure, whilst

Implementing improved Staff Engagement Measures elsewhere in the Trust

Stage 2: Enhancing the Trust model ("NHS Trust Plus") to include governance elements of a mutual in its legal structure, specifically staff and patient involvement in decision-making. This will require a change to law.

Stage 3: Transition into Foundation Trust Plus ("FT Plus"), once UHL meets the FT criteria, but subject to the FT model being enhanced with improved staff and patient governance elements. This will also require a change to law.

Stage 4: Moving into a Whole Trust Mutual, assuming that by then issues regarding the deficit, VAT and asset transfers have been addressed and it is clear at that time that there would be sufficient benefit over and above Stages 1-3. Again, this will require a change to law and policy to make this viable.

1.2 Strategic Considerations

1.2.1 The strategic context

As one of the largest acute NHS Trusts in the country, with 12,000+ staff, £800+m budget and treating over 1 million patients a year from three hospital sites, UHL has its complexities and challenges. It operates one of the busiest A&E sites in the country, runs one of the country's leading heart centres and areas of world-renowned expertise include diabetes, cancer and cardio-respiratory diseases.

UHL's strategic challenges include its historic and ongoing operational deficit (forecast to be c. £40m for 14/15), its £320m capital re-configuration plan (to include development of the Emergency Floor, a new Treatment Centre and an investment in a new Children's Hospital and maternity service) as well as the requirement to respond to the NHS' strategic direction as laid out in the Five Year Forward View and the Dalton Review which outline new models of care and alternative organisational forms to support service integration and sustainability.

UHL has an important strategic partnership in place to address some of the challenges in the local health economy, through Better Care Together (focused on health and social care in Leicester, Leicestershire and Rutland) which is in line with its own strategic directional plan.

Furthermore, UHL has been challenged by the NHS Trust Development Authority ("NTDA") to go "further, faster" in the implementation of its programmes.

1.2.2 The case for change

Although UHL has been delivering good outcomes and made impressive progress in recent years, it is ambitious in achieving more for its patients. Staff Engagement has been identified as one of the key enablers. A lot of work has gone into improving staff engagement through its Listening into Action Programme (LiA), though results from the most recent survey suggest further improvements are possible.

Research shows that Mutuals have a track record of outstanding staff engagement scores. This translates into better patient outcomes whilst achieving significant financial benefits for the organisation. Mutuals generally substantially outscore other healthcare organisations in the areas of staff sickness rates, staff turn-over, patient satisfaction, Friends & Family Tests and staff satisfaction surveys.

As such the central question for this study has been "How can mutualisation help UHL take staff engagement to the next level", and thereby improving patient outcomes, reduce costs and be an enabler for the large programmes of complex change.

1.3 Economic considerations

1.3.1 The long list

Our study has looked into the feasibility and desirability of a range of models along a number of agreed criteria. This long list of models was established as follows:

Option 1: Current Trust	Doing more within the current NHS Trust framework, building on UHL's transformational work to date including the autonomous incentivised teams
Option 2: Foundation Trust	Doing more within a Foundation Trust model. This will include exploring the potential offered by the mooted 'FT Plus' model
Option 3: Service mutual	Transfer one or more UHL services or businesses into another legal structure (which could be owned by UHL, separate from it, or a pre-existing structure) with 'mutual' characteristics. This will explore the appetite and feasibility of specific services 'spinning out' of UHL and mutualising
Option 4: Pathway mutual	Transfer one or more UHL services or businesses into another legal structure in the same way as for Option 3, but linking the transfer to a pathway by involving other partners delivering services on the pathway as well (such as community, primary and voluntary sector providers)

Option 5: Whole Trust Mutual	UHL itself becoming a mutual by 'spinning out' into a new legal structure
Option 6: Joint Venture	Working with a joint venture partner to achieve any of the above. This could be on a contractual basis by setting up a new legal structure distinct from the partners, or by using an existing legal structure belonging to a partner

1.3.2 The short list

After debating the results from the Feasibility Study, the following shortlist of options emerged which we have subsequently studied more in-depth, to clarify how each option might work, how they are to be implemented, what risks and benefits are associated with each and any hurdles that might be encountered.

1.3.2.1 Shortlist option 1 – Current Trust model: enhancing engagement within current framework

Within this option, improvements may come from building on LiA, strengthening formal recognition ("Caring at its Best"), continued leadership development ensuring focus on coaching, feedback, informal recognition & effective communication etc.

Possible benefits include incremental improvement in patient care and staff involvement, improved leadership capability, better inter-departmental collaboration etc, without the need to overhaul the structure of the organisation.

1.3.2.2 Shortlist option 2 – Autonomous Team(s)

This option involves the creation of an Autonomous Team led by a Committee of the Board with significant powers and freedoms delegated to it by the Trust Board as defined in a "Mandate". It would allow the Trust to experiment with mutual-like governance arrangements within the confines of its current framework.

Improvements may therefore come from active involvement of staff (and patients) in decision-making, a - virtual - sense of 'ownership', being incentivised through re-investment in the service and possible other non-financial incentives.

The potential benefits of this option include the simplification of processes, speeding up of decisions and ultimately better patient care. Furthermore, this is a low risk option requiring low investment but with a high potential upside.

1.3.2.3 Shortlist option 3 – Whole Trust Mutual

The Whole Trust Mutual (WTM) option would involve transferring the Trust organisation into a new legal entity based on a mutual footprint, i.e. predominantly owned by staff and patients, with a strong element of empowerment of frontline staff. The option could involve splitting UHL into a "PropCo" to hold assets, and - possibly - access finance, and an "OpCo" to run the business and deliver services on the footprint of a mutual.

Based on our experience, this option could potentially provide the best possibility for UHL to gain the financial and non-financial benefits that mutuals achieve. Our modelling suggests a hypothetical financial benefit could amount to £17m p.a. by year 5 as a result of mutualisation.

However, significant barriers exist which make this option currently unviable, which include the issues of UHL's deficit, irrecoverable VAT (potentially adding up to £29m to the cost base), question marks around access to finance (essential for UHL in view of its deficit and estate reconfiguration programme), whether assets would be permitted to transfer to the new entity and procurement issues relating to the award of service contracts to the new entity. Without these barriers being removed by changes in law or policy, WTM remains realistically unattainable for UHL.

1.3.4 Recommended approach: Four Stage Implementation

Having considered in more detail the implications, benefits and barriers of the Shortlist Options described, the study arrived at the conclusion that in effect these options are not mutually exclusive. Rather, they can be considered as part of a staged approach towards potential mutualisation, thereby allowing UHL:

- To keep implementation risk and investments low
- Learn from early experiences

- Bring staff and stakeholders along on the way to mutualisation
- Allow national policy changes to emerge which will enable UHL to take the next step on its journey.
- Make each stage a well-controlled and considered decision for the Trust Board, requiring significant and demonstrable benefits to be expected over and above achievements in the previous stage.

As such we recommend that UHL considers a staged implementation consisting of the following elements:

Stage 1: Creating an Autonomous Team within the Trust structure along the lines of Shortlist Option 2, whilst

Implementing improved Staff Engagement Measures elsewhere in the Trust

Stage 2: Enhancing the Trust model ("NHS Trust Plus") to include governance elements of a mutual in its legal structure, specifically staff and patient involvement in decision-making. This will require a change to law.

Stage 3: Transition into Foundation Trust Plus ("FT Plus"), once UHL meets the FT criteria, but subject to the FT model being enhanced with improved staff and patient governance elements. This will also require a change to law.

Stage 4: Moving into a Whole Trust Mutual as described in Shortlist Option 3, assuming that by then issues regarding the deficit, VAT and asset transfers have been addressed and it is clear at that time that there would be sufficient benefit over and above Stages 1-3. Again, this will require a change to law and policy to make this viable.

1.4 Commercial considerations

Stages 1, 2 and 3 do not raise specific commercial considerations in themselves. Stage 4 raises a number of commercial considerations that will need to be addressed, including financial and procurement law issues, legal form of any new mutual entity and regulatory issues.

1.5 Financial case

Stages 1, 2 and 3 do not raise specific financial considerations in themselves, except in relation to financial incentives for staff if remuneration policy is changed to permit greater freedom for this.

Mutualisation does bring financial challenges. Through our modelling we have identified:

- irrecoverable VAT impact based upon current reclaimed VAT on contracted out services (potentially £19m per annum)
- potential additional VAT from charges for asset use if assets are not transferred to the new mutual and instead are to be leased from a so-called PropCo (potentially £10m per annum)
- Corporation Tax payable if the new organisation moves into surplus (potentially around £3m per annum).

In order to realistically consider WTM, there is therefore a need to deal with these downside issues through recommendations to be made to Cabinet Office and Treasury.

Our modelling also suggests that the hypothetical financial benefit of WTM (under the assumption that the above issues are addressed and on a like-for-like basis of current Trust projections) could amount to up to £17m p.a. or £55m over 5 years. The main drivers of these benefits are lower costs as a result of reduced staff sickness and turnover, and further efficiencies related to improved working practices.

The Four Stage Implementation will avoid any of VAT, tax and asset issues in the early stages, but these are also less likely to deliver on the full expected benefits. The staged approach will allow UHL to monitor the impact of the changes made, and make an informed decision whether moving on to the next stage is the right thing to do.

1.6 Management considerations

Realistically this is a multi-year programme spanning at least 5 years. We anticipate that implementing Stage 1 could take approximately 6 months for the Autonomous Team (though

assessing its impact will take at least another year), whereas implementing other improved staff engagement measures depends on the scope decided upon.

In view of their unique 'mutual' elements, both the Autonomous Team stage and Whole Trust Mutual stage will require a combination of internal, corporate and external resources and UHL may benefit from some external resources too when considering moving into NHS Trust Plus and FT Plus. In view of the strategic importance of the programme, the project governance should have appropriately senior reporting lines and reflect the mixed nature of resources.

A high-level estimate of implementation costs for both internal and external resources suggests costs between £100 and £200k in the first instance for an AT implementation and costs would rise considerably in the event of Whole Trust Mutualisation.

Naturally each proposed stage has risks attached to it, and we present these in some detail in our report. However, we believe that the staged nature of the implementation allows UHL to minimise and assess most of these risks as it progresses from one stage to the next. It is therefore important to make each stage a well-controlled and considered decision for the Trust Board, requiring significant and demonstrable benefits to be expected over and above achievements in the previous stage.

Ultimately, UHL is a complex organisation in deficit on an ambitious journey of transformation, and the main risks with any long-term transition process is associated with whether it can bring its stakeholders along, and whether mutualisation is regarded as a distraction or enabler.

For the option of WTM the identified barriers as well as the need to be clear about what a possible failure regime should look like are its key risks.

1.7 Conclusions & Recommendations

A number of conclusions and recommendations have resulted from our study, some relating to UHL, others directed towards policy makers and influencers in Government. Most of our

conclusions and recommendations have been touched upon in this Executive Summary. We summarise them below.

1.7.1 Recommendations for UHL

In view of all things considered we acknowledge the significant potential benefits (financial and non-financial) that come with mutualisation. We are not ruling out the WTM option, in the longer term, if the circumstances are right, and as such recommend a staged approach that allows UHL to achieve the benefits of mutualisation. This will keep risks and interdependencies manageable, allows the organisation to grow into its proposed Mutual mould over time at its own pace, and enables policy and/or legislative changes to take shape in the meantime.

We firmly believe that the staff - and stakeholder - ownership element to a WTM as well as its financial independence are key ingredients to what makes mutuals so successful and it is for this reason we recommend that the WTM option remains of interest to UHL in the longer term.

Furthermore, we recommend that the established momentum is kept and both the Autonomous Team and Staff Engagement Improvement programmes are mobilised in the short term.

Finally, it is our experience that it takes a considerable amount of time for staff, management, directors and other stakeholders to get used to the ideas and concepts involved in mutualisation. Winning hearts and minds is generally greatly helped by seeing mutuals in action. As such we recommend that UHL develop an exchange programme with existing mutuals in health, so that those initial trepidations are overcome and concepts and ways of working are adopted more naturally into the organisation.

1.7.2 Recommendations for Cabinet Office / Department of Health

In order for mutuals in health to become a viable option for organisations of scale and complexity, key issues need to be tackled. Our recommendations therefore refer first and

foremost to the technical issues raised regarding irrecoverable VAT, access to finance and the ability to retain assets.

Secondly, both the NHS Trust governance model and the Foundation Trust governance model would be greatly enhanced by giving a more prominent role for staff and patients. There are several ways of achieving this but these roles need to be meaningful and encompass real power.

Finally, it has become clear that for mutualisation to stand a chance in NHS organisations a slow and gentle pace is required. A fair amount of anxiety regarding the concept has been detected at all levels in the organisation and this is evidently reflected in other Pathfinder organisations. In our view it will take time for organisations to arrive at a balanced view of the facts and whether mutualisation is right for them. In fairness, even the most successful mutuals have taken several years from inception to implementation. We would recommend that - in future - studies like these are given more time with a stronger focus on learning and exploration.

University Hospitals of Leicester NHS
NHS Trust

Agenda Item: Trust Board Paper E

TRUST BOARD – 7th May 2015

Patient Experience Story – Care and Attention Beyond Expectation

<table>
<tr><td>DIRECTOR:</td><td>Carole Ribbins, Acting Chief Nurse</td></tr>
<tr><td>AUTHOR:</td><td>Elizabeth Callaghan, Ward Sister
Chris Kent, Oncology Specialist Registrar</td></tr>
<tr><td>DATE:</td><td>7th May 2015</td></tr>
<tr><td>PURPOSE:</td><td>
<u>Introduction</u>
To describe the excellent experience of care a patient received when attending ward 39, Leicester Royal Infirmary. This story illustrates the ward teams on-going commitment and drive to improve care in line with patient feedback.

<u>Ward 39 Friends & Family Test – March 2015</u>

<table>
<tr><td colspan="2">% of patients who would recommend the ward</td><td rowspan="2">Neither likely nor unlikely, don't know</td><td colspan="2">% of patients who would not recommend the ward</td></tr>
<tr><td colspan="2">98%</td><td colspan="2">2%</td></tr>
<tr><td>Extremely likely</td><td>Likely</td><td>Unlikely</td><td>Extremely Unlikely</td></tr>
<tr><td>57</td><td>6</td><td>0</td><td>1</td><td>0</td></tr>
</table>

Ward 39 are the highest achieving ward for submitting the minimum weekly target for patient experience surveys - minimum target of 8 surveys a week.

<u>This patient story identifies:</u>

• The excellent care and support offered from diagnosis of cancer, during chemotherapy, to the care provided on ward 39
• How all members of staff carried out their duties professionally, with care and going the extra mile
• It was the small things that made a difference irrelevant on how busy the ward staff were. An example of this was being offered a cup of tea prior to patients being nil by mouth
• The personal touch of the ward sister going to every patient on the ward enquiring 'how are you' and listening
• The only negative experience was a lack of information while waiting for a procedure.

A core element of this patient story is the excellent collaborative working across all disciplines and specialties to co-ordinate this ladies treatment plan. This is also echoed in feedback from other patients and their families.
</td></tr>
</table>

	On Ward 39 feedback surveys in March 2015 there were a number of comments about the effective team working: • From cleaners and especially nurses - excellent doctors- consultants kept you informed • Excellent team dynamics - including ward clerk and hotel service staff - a team that really cares about delivering high quality care demonstrated in their daily work • Nurses are very kind Doctors always answer the query face to face • The level of service provided I could not fault. From start to finish the staff at all levels went above and beyond to make my stay restful and stress free. <u>Changing Care in Response to Patient Feedback</u> During the last three months the team have made the following changes in response to feedback: 1. The team shared this feedback with the team responsible for bronchoscopy procedures. Patients and family members waiting are now both advised if there are any delays in procedures 2. Building work is due to commenced to create a nurses station in the bays to ensure ease of identification of the named nurse, greater patient visibility and greater communication 3. A patient fridge now located on the ward so patients can bring their own drinks or food in 4. Patients expressed difficulty reaching the toilet roll due to location of the holders. New holders based at the side of the toilet have been ordered 5. Roller blinds to maintain privacy and dignity are to be placed in the bay windows 6. Once discharge has been identified the completion of take home medication and discharge letters in a timely manner dependent on the clinical needs of the other patients. <u>Recommendations:</u> The Trust Board is asked to: • Receive and listen to the patient's story.
PREVIOUSLY CONSIDERED BY:	None
Objective(s) to which issue relates *	[Y] 1. Safe, high quality, patient-centred healthcare [ ] 2. An effective, joined up emergency care system [Y] 3. Responsive services which people choose to use (secondary, specialised and tertiary care) [ ] 4. Integrated care in partnership with others (secondary, specialised and tertiary care) [ ] 5. Enhanced reputation in research, innovation and clinical education [Y] 6. Delivering services through a caring, professional, passionate and valued workforce [ ] 7. A clinically and financially sustainable NHS Foundation Trust [ ] 8. Enabled by excellent IM&T

Please explain any Patient and Public Involvement actions taken or to be taken in relation to this matter:	This paper provides assurance that ward 39 and the wider multi-disciplinary team are listening and acting upon patient feedback to improve patient's experience of care. Patients are encouraged to share their stories of care within the Trust.
Please explain the results of any Equality Impact assessment undertaken in relation to this matter:	An equality impact assessment was not required in relation to this patient story.
Strategic Risk Register/ Board Assurance Framework *	☐ **Strategic Risk Register** ☐ **Board Assurance Framework** ☒ **Not Featured**
ACTION REQUIRED *	For decision ☐ For assurance ☒ For information ☒

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

* tick applicable box

Agenda Item: Trust Board Paper F

TRUST BOARD

Thursday 7th May 2015

Draft Annual Operational Plan 2015/16

DIRECTOR:	Kate Shields, Director of Strategy
AUTHOR:	Gino DiStefano, Head of Strategic Development
DATE:	7th May 2015
PURPOSE:	**Context**: NHS Trusts require annual operational plans as set out in the planning guidelines published by the NHS Trust Development Authority (NTDA), 'Delivering in a Challenging Environment: Refreshed Plans for 2015/16' Our plan for 2015/16 sets out the objectives and priorities for the second year of our five year strategy. Enclosed is Annex A of our draft annual operational plan, which provides an overall narrative and summarises the plan's component parts (technical planning returns for activity, finance, workforce, and self-certification checklists). **Questions** (that this paper seeks to answer): 1. What are the key risks associated with the plan? 2. Is the plan completely finalised? 3. If not, what are the next steps? **Conclusions**: 1. The key risks (to successful delivery of our plan) include: • System and/or Trust failure to deliver improvement initiatives in line with plans, including new models of care / service reconfiguration • Increasing demand for acute care which may stretch beyond activity and capacity plans • Failure to enact change / new models underpinning our planning assumptions. • Failure to deliver CIP (in full) • Failure to secure capital investments needed to realise our plans • Lack of certainty around the cost of borrowing (capital) • Managing the pay bill - failure to reduce premium spend (through substantive recruitment) in line with plans 2. Our plan is well developed and close to completion. However, we are constantly receiving feedback from the NTDA which informs further changes and/or requires additional assurance. We have had the opportunity to review draft / high level feedback over recent days which highlights two areas that are likely to require further work / assurance, finance and performance. Formal and detailed feedback from the NTDA on our previous submission (dated 7th April) is expected week commencing the 4th May. On receipt, we will consider the feedback / actions in full and update our plan accordingly. 3. Next steps include: • Reviewing the formal NTDA feedback when it is received • Considering what changes, if any, are required to our plan and/or component parts, including the consequences of non-compliance • Providing additional levels of assurance to the NTDA where necessary • Submitting the final plan to the NTDA on the 14th May (subject to Trust Board approval – see input sought, below).

	Input Sought: The Trust Board is asked to: 1. Provide comments and feedback on the current draft plan, enclosed. 2. Delegate authority for the formal review and sign off of the annual operational plan (when finalised over the coming week) to Mr Karamjit Singh, Chairman, and Mr John Adler, Chief Executive Officer ahead of the formal submission to the NTDA on the 14th May.
PREVIOUSLY CONSIDERED BY:	Integrated Finance, Performance, Investment Committee, 30th April Executive Performance Board, 28th April Executive Strategy Board, 14th April Executive Strategy Board, 10th March Trust Board, 8th January
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 Trust X 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 reported previously, engagement throughout the planning process has been via the Better Care Together Programme, which frames the system's strategic planning. In addition, our annual priorities were shaped with internal and external stakeholders, including the Clinical Senate. From September 2014 the Trust, along with other NHS and social care organisations, has been working closely with the 'BCT Patient, Public, Involvement Forum' (a lay body of local stakeholders from the likes of Healthwatch, Patient Public Groups, 3rd sector, media reps), to ensure appropriate involvement and engagement.
Please explain the results of any Equality Impact assessment undertaken in relation to this matter:	There is no formal requirement to conduct an Equality Impact Assessment (EIA) for the annual operational plan at a global level. However, EIA is integral to each individual business case / proposed service change described within the plan. Therefore, the plan will require several EIAs to be undertaken and some have already been concluded e.g. Emergency Floor.
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

SUMMARY OF ONE YEAR OPERATIONAL PLAN 2015/16

University Hospitals of Leicester NHS Trust

1. Strategic context and direction

1.1. Introduction - Our purpose, values and 5 year strategy

University Hospitals of Leicester NHS Trust (UHL), a leading teaching hospital, is one of the ten largest trusts in the country and has a significant research portfolio. We provide acute and specialised services to the local population of Leicester, Leicestershire and Rutland (LLR) and, for some services, to people from a much wider catchment.

Our five-year plan - published in June 2014 - is ambitious, as is that of the wider health economy's Better Care Together (BCT) plan, which reflect the scale of the challenge ahead. It states:

> *"In five years' time, we expect to be delivering better care to fewer patients; we will be significantly smaller, more specialised, and financially sustainable".*

Our plan touches every part of the organisation and requires all services to transform in an incredibly tight timescale. Integral to this plan is an ambitious estate modernisation programme and the consolidation of acute services onto a smaller footprint (two sites instead of three) to deliver the clinical co-locations described in our clinical strategy. We will grow our specialised, teaching and research portfolio, only providing in hospital the acute care that cannot be provided in the community.

1.2. Delivery of 2014/15 Plan

In terms of laying the strong foundations needed ahead of wide scale transformation, our two year operational plan (2014/15 to 2015/16) identified three cross cutting themes / priorities:

1. Effectively lead and manage service provision (and **performance**) in line with defined quality standards whilst delivering our financial plan and improving **productivity**;
2. Build **effective strategic partnerships** to support delivery of safe and sustainable core and specialised services; and,
3. Prepare for large scale change – including improvement activities at scale and pace and **early enabling capital schemes**.

During 2014/15, our primary focus has been on the first item, improving quality, financial resilience and operational performance.

1.2.1. Quality Standards

The Care Quality Commission (CQC) visited the Trust in January 2014. As anticipated, the CQC highlighted some areas for improvement, many of which already feature in our plans. The overall rating for our acute services was "requires improvement".

CQC Indicator (Jan 14 Rating)	Progress To Date
Safe (Requiring Improvement)	To date, there has been an improvement in safety-related key performance indicators (KPIs), with 12 out of 16 being amber or green RAG rated. We have made particularly good progress on compliance with the SEPSIS6 Care Bundle and the incidence of pressure ulcers within our hospitals.
Caring (Good)	To date, 11 out of 13 KPIs for the caring domain for which targets have been agreed are RAG rated green or amber. Performance continues to be monitored and action plans are in place to address low outpatient friends and family test scores and single sex accommodation breaches.
Effective (Good)	In 2013/14, 13 of 14 KPIs for 'effective care' were RAG rated amber or green. Importantly, the trust's SHMI remains within the expected range. The number of fractured Neck of Femurs (NOF) operated on between 0-35 hours from

	admission was lower than target in 2013/14 and continues to be a challenge.
Responsive (Requiring Improvement)	This continues to be a significant challenge. To date, 9/25 'responsive' KPIs are RAG rated amber or green despite increasing demand. Sustained improvement in and achievement of the Emergency Department (ED) 95% target remains the most significant challenge for UHL and partners in the local health system. Poor performance and care in the ED and Clinical Decisions Unit (CDU) is symptomatic of wider system failure which is being compounded by further increases in emergency hospital admissions. This pattern is being replicated nationally.
Well Led (Yes)	Related KPIs show this continues to be the case. All but one of the 2013/14 KPIs were RAG rated amber or green. In 2014/2015 our performance improved further in a number of areas. Friends and Family Test coverage has increased to target levels; statutory and mandatory training completion rates are at 87% (compared to year end in 2013/14 of 76%) and is on target to hit our improvement trajectory at the end of March, 2015 (95%); 98% of staff have attended a corporate induction (against a target of 95%).
CQUIN	Performance against Commissioning for Quality and Innovation (CQUIN) indicators has been exemplary in 2014/15 with only 1 out of 60 CQUIN indicators being RAG rated red. This was due to an isolated Methicillin-resistant Staphylococcus Aureus (MRSA) bacteraemia which was retrospectively confirmed as unavoidable.

1.2.2. Finance (including Cost Improvement)

Robust cost control has been central to delivery of our 2014/15 financial plan underpinned by feasible mitigations including enhanced non-pay control, strengthened vacancy management, filling post substantively (reducing premium pay).

Our cost improvement programme (CIP) for 2014/15 totalled £45m – reflecting 5.3% of our cost base and we will deliver £47.5m in year, a surplus of £2.5m. We have had the benefit of additional support from Ernst & Young which has helped to enhance governance and support delivery. This will continue into 2015/16.

1.2.3. Performance

The following table summarises our performance against national standards in 2014/15.

	Performance Indicator	Target	2014/15	Compared to 2013/14
Access to A&E	A&E - Total Time in A&E (4hr wait)	95%	89.1%	▲
Infection Control	MRSA (All)	0	6	▲
	Clostridium Difficile	81	73	▲
Referral to Treatment (RTT)	RTT - admitted patients (within 18 weeks of referral)	90%	84.4%	▲
	RTT - non-admitted patients	95%	95.5%	▲
	RTT - incomplete pathways	92%	96.7%	▲
	Diagnostic Test Waiting Times (99% within less than 6 weeks)	<1%	0.9%	▼
Access to Cancer Services (April 14 to Feb 14)	Cancer: 2 week wait from referral to date first seen - all cancers	93%	92.2%	▼
	Cancer: 2 week wait from referral to date first seen, for symptomatic breast patients	93%	94.0%	◀▶
	All Cancers: 31-day wait from diagnosis to first treatment	96%	94.4%	▼
	All cancers: 31-day for second or subsequent treatment - anti cancer drug treatments	98%	99.3%	▼
	All Cancers: 31-day wait for second or subsequent treatment - surgery	94%	89.1%	▼
	All Cancers: 31-day wait for second or subsequent cancer treatment - radiotherapy treatments	94%	95.8%	▼
	All Cancers:- 62-day wait for first treatment from urgent GP referral	85%	81.1%	▼
	All Cancers:- 62-day wait for first treatment from consultant screening service referral	90%	84.1%	▼

As the table shows, our overall 4 hour A&E (or ED) performance continues to be below target but we have seen an improvement despite increasing demand.

We are making good progress across all RTT standards and with backlogs (patients waiting over 18 weeks) in particular with improvements against every standard since 2014/15.

Our performance against the cancer two week wait target remains a significant challenge and, like ED, demand has increased. During 2015/16, cancer 2 week wait referrals increased by 18% without impact on the incidence of cancer diagnosis. We plan to deliver against the all cancer standards by July 2015.

1.2.4. Strategic Partnerships

We have agreed, with the support of NHS England and local commissioners in Northamptonshire, a strategic alliance for specialised services with Kettering General Hospital and Northampton General Hospital. The principles behind this collaboration focus on improving services and access to specialised services for patients, securing sustainable services into the future delivered locally wherever possible and sharing resources and clinical expertise between organisations. Early work has included successful joint appointments in cancer services to support the delivery of a single oncology service across Leicestershire, Northamptonshire and Rutland which, serving a population in excess of 1.5 million, will be one of the largest oncology services in England.

Clinicians from the children's hospitals at UHL and Nottingham University Hospitals, working with the strategic clinical network, are building on the success of the joint children's cancer treatment centre to look at other services where closer collaborations will result in better services for patients. A website containing a directory of children's services across both hospitals is currently under construction and when complete will form a valuable resource for clinicians, parents and carers.

1.2.5. Enabling large scale change

We have made good progress across our six major capital business cases, central to our estate modernisation programme. For example, the development of a new Emergency Floor (encompassing a new emergency department and medical assessment unit) is now at the full business case stage. The vascular services outline business case - to consolidate cardiovascular services onto one site - has been approved by the NHS Trust Development Authority (NTDA) and is now progressing to full business case. This will see the development of a hybrid theatre – this will provide patients with access to enhanced, inter-operative imaging improve clinical outcomes and reduce the need for travel to out of region quaternary centres.

In terms of wider enabling work, progress against our Organisational Development Plan is going well. Examples include the:

- introduction of an 'Organisational Health Dashboard' for key HR indicators;
- involvement of the UHL Clinical Senate in developing medical leadership; and,
- introduction of value based recruitment processes.

We continue to facilitate Listening into Action (LiA) 'Pass it on' events. LiA is becoming 'the way we do things at UHL'. 'Nursing into Action' for wards is progressing well with a focus on listening events to improve the quality of care and patient experience.

1.3. Plan for 2015/16

We have revised our strategic objectives and plan for 2015/16 to reflect our commitment to the vision set out in the Five Year Forward View and NHS England's headline goals in its business plan for 2015/16.

We engaged internal and external stakeholders in shaping our objectives and annual priorities, including the clinical senate, which informed a number of key amendments.

Strategic Objectives	Annual Priorities for 2015/16
1. Safe, high quality, patient centred healthcare	• Reduce our mortality rate (SHMI) to under 100 (Quality Commitment 1) • Reduce patient harm events by 5% (Quality Commitment 2) • Achieve a 97% Friends and Family test score (Quality Commitment 3) • Achieve an overall "Good" rating following CQC inspection • Develop a "UHL Way" of undertaking improvement programmes • Implement the new Patient and Public Involvement Strategy

2. An effective and integrated emergency care system	• Reduce emergency admissions through more comprehensive use of ambulatory care • Improve the resilience of the Clinical Decisions Unit at Glenfield Hospital (GH) • Improve the resilience of the Emergency Department (ED) in the evening and overnight • Reduce emergency medicine length of stay through better clinical and operational processes • Substantially reduce ED ambulance turnaround times
3. Services which consistently meet national access standards	• Deliver the three 18 week RTT access standards • Deliver the three key Cancer access standards • Deliver the diagnostics access standard • Implement tools and processes that allow us to improve our overall responsiveness through tactical planning
4. Integrated care in partnership with others	• Deliver the Better Care Together year 2 programme of work • Participate in BCT formal public consultation • Develop and formalise partnerships with a range of providers including tertiary and local services (e.g. with Northamptonshire) • Explore new models and partnerships to deliver integrated care
5. Enhanced delivery in research, innovation and clinical education	• Develop a robust quality assurance process for medical education • Further develop relationships with academic partners • Deliver the Genomic Medicine Centre project • Comply with key NIHR and CRN metrics • Prepare for Biomedical Research Unit re-bidding • Develop a Commercial Strategy to encourage innovation
6. A caring, professional and engaged workforce	• Accelerate the roll out of LiA • Take Trust-wide action to remove “things that get in the way” • Embed a stronger more engaged leadership culture • Develop and implement a Medical Workforce Strategy • Implement new actions to respond to the equality and diversity agenda including compliance with the new Race Equality Standard • Ensure compliance with new national whistleblowing policies

7. A clinically sustainable configuration of services, operating from excellent facilities	• Deliver the actions required for year two of the five year plan:
	  • Develop Site Development Control Plans for all 3 sites
	  • Improve Intensive Therapy Unit (ITU) capacity issues including transfer of Level three beds from Leicester General Hospital (LGH)
	  • Commence Phase one construction of the Emergency Floor
	  • Complete vascular full business case
	  • Commence enabling works indicated in the business cases
	  • Deliver outline business cases for
	  o Planned Treatment Centre
	  o Maternity
	  o Children’s Hospital
	  o Theatres
	  o Beds
	  • Develop a major charitable appeal to enhance the investment programme
	  • Deliver key operational estates developments:
	  o Construction of the multi-storey car park
	  o Infrastructure improvements at Leicester Royal Infirmary (LRI) and GH
	  o Phase one refurbishment of wards and theatre

8. A financially sustainable NHS organisation	• Deliver the agreed 2015/16 Income & Expenditure (I&E) control total - £36m deficit • Fully achieve our CIP target for 2015/16 • Revise and sign off by Trust Board and NTDA of the Trust's five year financial strategy • Continue the programme of service reviews to ensure their viability
9. Enabled by excellent IM&T	• Prepare for delivery of the Electronic Patient Record (EPR) in 2016/17 • Ensure that we have a robust IM&T infrastructure to deliver the required enablement • Review IBM support to ensure that we have the right resources in place to enable IM&T excellence

1.3.1. System Alignment and Governance

The BCT programme brings together key partners across the local health and social care economy under one planning and delivery framework – this ensures transformational change is coordinated and well governed.

The BCT five year strategic plan is ambitious and provides a blueprint for the future configuration of services in LLR which will improve health and wellbeing outcome that matter to them our communities, enhance the quality of care and reducing cost across the public sector (to within allocated resources) by restructuring the provision of safe, high quality services into the most efficient and effective settings.

Our plan (to be smaller, more specialised) is critically interdependent to the delivery of the wider BCT plan, as well as the local authority Better Care Fund (BCF) programmes which seek to address increasing urgent care pressures.

Due to this interdependency, and following a Department of Health Gateway 0: Strategic Assessment[1], we have established an internal delivery programme (governance framework) to improve alignment between our internal transformation and reconfiguration activities and BCT / external activities. This governance framework also aligns CIP plans with BCT reconfiguration activities through a number of enabling cross cutting workstreams (see Appendix 1) with the major productivity projects - beds, outpatients, theatres and workforce.

This now provides the framework within which the Trust, Clinical Management Groups (CMG's) and specialties develop operational delivery plans. Governance arrangements have been put in place to monitor progress and mitigate risks to delivery with Executive input and oversight. We have also set up a Trust BCT Delivery Board as the mechanism to carry out this function and to align with the wider health economy BCT Programme.

Our focus in 2015/16 will continue to be on realising internal efficiencies and working with partners to move prioritised activity to lower acuity / community settings. To do this we will need to build effective strategic partnerships to support delivery of safe and sustainable core and specialised services and build strong foundations for forthcoming, large scale transformation.

In light of more recent key drivers, we have made some revisions to the underpinning planning assumptions driven by:

1. Anticipated requirements of clinical standards
2. Publication of NHS England's Five Year Forward View (November 2014) and the Dalton Review (December 2014)
3. The challenge from the National Trust Development Authority (NTDA) to go "further, faster" to reconfiguration
4. Actions required in response to external reports
5. Service sustainability: The need to consolidate ITU services on grounds of clinical safety.

[1]The primary purposes of a Health Gateway Review 0: Strategic assessment, are to review the outcomes and objectives for a given programme of work (and the way they fit together) and confirm that they make the necessary contribution to government, departmental, NHS or organisational overall strategy.

1.3.2. Progress Anticipated in 2015/16

In delivering BCT and Trust objectives, we will progress a number of key schemes in 2015/16 including:

- **Emergency floor development** - the full business case is expected to be approved in May 2015 by the NTDA which will provide the funding to commence construction of the new emergency floor. This will be completed in two key phases:
  - Phase one (complete construction of new ED) will be operational in 2016/17.
  - Phase two (medical assessment units and complete construction) will be in place by 2017/18.
- **Consolidation of vascular services -** this involves the transfer of vascular surgery from the LRI to the GH. We will progress this at pace since it will vacate ward space at the LRI which will help facilitate the consolidation of ITU at the LRI, outlined below.
- **Consolidation of intensive therapy unit (ITU)** - the relocation of ITU (and associated clinical services that use ITU beds) from the LGH to the LRI and GH will take place by December 2015. The ITUs at the LRI and GH will be upgraded as part of the relocation and this will happen in two stages – an interim solution will be provided in 2015/16, followed by a long term upgrade. In order to accommodate the services (specialty bed requirement) that will also need to relocate from the LGH to the LRI, we will need to release a significant number of the existing wards at the LRI. This will be facilitated by the acceleration in the transfer of patients who no longer require acute care and can be managed in community settings (see accelerated out of hospital community care, below)
- **Single Children's Hospital**- an outline business case to provide a children's hospital with a single identity at the LRI will be developed in 2015/16.
- **Strategic partnerships** - we have carefully considered the best operational model that will help the service rise to the challenge of the forthcoming clinical standards for congenital heart services. Throughout 2015/16 we will explore the establishment of a strategic alliance with Birmingham Children's Hospital which could provide a collaborative model of delivery, governance, research and development and is in line with some of the opportunities outlined in the Dalton Review.
- **Ensuring a sustainable configuration of maternity services** – the model of care and preferred option will be subject to public consultation as part of the BCT programme in the autumn. We will then develop an outline business case.
- **Treatment centre** - our plans for the development of a treatment centre have been brought forward with work starting in 2015/16. Work will commence with the confirmation of which services will be provided in the treatment centre which will be located at the GH. This service development will be subject to public consultation as part of the BCT programme in the autumn following which the outline business case will then be developed in 2015/16. This together with an increase in planned activity delivered through the LLR Planned Care Alliance in Leicestershire community hospitals should have significant impact on the sustainable achievement of the RTT standard.
- **Accelerated out of hospital community care** (for patients no longer requiring acute intervention) is part of the Trust and BCT plan. LLR partners have agreed to work together to support the early transfer of patients who no longer require acute care, ideally back to their home. Based on the need to release estate footprint to relocate LGH ITU and the challenge to go "further, faster" the Trust is working with Leicestershire Partnership NHS Trust (LPT) to deliver this change over the next two years starting with a shift in 130 beds worth of activity to non-bedded alternatives in the community.

2. Contract Arrangements 2015/16

We have agreed contracts for 2015/16 with local CCGs and with NHS England (for specialised services).

To support delivery of our plans, we have developed a collaborative contracting model / risk share framework with local CCGs, which includes tariff payments for elective activity, marginal payments for non-elective activity over the plan (no financial change if activity falls below the plan) and a block for other activity. This arrangement provides some stability and certainty over income and expenditure levels for each partner. This approach will encourage a focus on the necessary transformational change rather than the detailed transaction of contracting mechanisms.

For example, we have agreed four priority areas with LPT and LLR CCGs as part of the 2015/16 contracting round to ensure alignment of planning assumptions underpinning the BCT programme, commissioning intentions and organisational plans:

1. Bed movements to ensure more people are supported in the community and at home;
2. Urgent care models that support system sustainability by ensuring people are managed in the most appropriate clinical setting
3. Planned care delivered closer to people's homes; and,
4. Mental health access (including during crisis) and integration with physical health services.

Our contract with NHS England is the standard tariff contract.

3. Quality and Safety 2015/16

3.1. Quality Commitment

Our 'Quality Commitment' defines our approach to quality improvement and reflects the largely positive findings of the 2014 CQC inspection.

We have robust governance structures, processes and controls in place to promote safety and excellence in patient care; identify, prioritise and manage risk arising from clinical care; ensure the effective and efficient use of resources through evidence-based clinical practice; and protect the health and safety of patients, public and Trust employees.

Each clinical service sets annual quality priorities aligned to 14 strategic quality goals agreed across the Trust. Our Trust Board sets annual quality priorities, drawing these from patient and stakeholder feedback, national standards, and local CQUIN and contract requirements. The agreed priorities then form a framework for CMG and service level quality priorities and reflect specific patient needs. These are developed through discussion with clinicians, including nursing and medical staff taking into account incidents, risks, complaints and feedback.

A key area of focus for 2015/16 is to make progress against five of the 7 day service standards. In 2015/16 the Trust we will focus its efforts on:

1. CS01 – patient experience
2. CS04 – handover
3. CS06 – intervention/key services
4. CS09 – transfer to community, primary and social care
5. CS10 – quality improvement

3.2. LLR Quality Review and the Sturgess Report

Following the publication of the LLR Quality Review, commissioned to identify areas where care quality delivered across the healthcare system could be improved, we have developed new quality action plans.

To ensure quality initiatives were fully aligned across the healthcare system, a multi-partner Task Force has been established. The Task Force is chaired by the Chairman of West Leicestershire CCG, (also a practicing GP locally), and the group has constant executive-level representation from each healthcare organisation involved in the review. Meetings are also attended by Healthwatch and Local Medical Council.

In addition to the Quality Review, Dr Ian Sturgess, an expert in emergency care pathways, was commissioned by LLR partners to provide recommendations on how the emergency pathway can improve.

Recommendations / priorities included:

- **Admission avoidance** – ensuring people receive care in the setting best suited to their needs rather than the ED. This fits with the work programme of the Better Care Together programme more specifically the Urgent Care, Long Term Condition and Frail Older Person workstreams.

- **Preventative care** – putting more emphasis on helping people to stay well with particular support to those with known long-term conditions or complex needs. This fits with the work programme of the Better Care Together programme and CCG specific proactive care strategies.
- **Improving internal processes** – reducing waste, maximising efficiency, and improving flow
- **Discharge processes across whole system** - ensuring there are simple discharge pathways with swift and efficient transfers of care.

The quality action plans respond to both reviews and the new governance structure to support changes has been integrated within the wider BCT programme.

4. Delivery of operational performance standards 2015/16

We will continue to place high priority on delivery of operational performance standards.

In doing so, we will continue to work with partners across LLR through the BCT programme to improve operational performance standards in the short, medium and long term – this reflects the system wide effort needed to deliver NHS Constitution Standards. Improving discharge processes remains key, and greater numbers of external partners are in-reaching into the Trust to support earlier transfer of care when patients no longer require acute hospital care.

We will also continue to make improvements to our internal process through service reviews, the CIP programme and the four cross cutting workstreams (see appendix 1). Examples include greater management and clinical input on wards at weekends, the opening of additional capacity on the LRI site and focussing on earlier ward rounds across all three sites.

Weekly delivery meetings between executive directors and CMG operational and clinical leads will continue throughout 2015/16 to ensure transparency, challenge and confirm and, where needed, development of recovery plans as part of the wider performance arrangements.

5. Workforce plans

Our workforce plan for 2015/16 reflects the immediate demand for Trust services (and the need to ensure adequate staffing is in place to deliver key performance standards such as the 4 hour ED target, RTT and cancer standards) and our CIP. Our plan shows that the closing position for worked whole time equivalents (WTE) for March 2015 was 11336. The closing position for the end of March 2016 is expected to be 11341 WTEs, which is an overall growth of 5 WTEs.

CIP schemes are included within this change in WTE with the principle initiatives relating to theatre and bed productivity efficiencies. We have also invested in our workforce across several areas to account for increased clinical acuity, ED Assessment Bays (to ensure improved patient flow) and investment to ensure a sustainable trauma service. Reconfiguration programmes linked to BCT are currently in progress and plans will be amended to reflect changes arising from these assumptions later in the year.

We are focused on reducing the dependency on agency staff and recruiting on a substantive basis with new roles (advanced practitioners, assistant practitioners and physician associates) where appropriate. This will enable us to reduce the average cost per WTE. There are robust performance management arrangements in place to ensure that local areas deliver against our agreed premium spend reduction trajectories.

In addition, a workforce cross cutting theme has been established to identify mechanisms which enable cross CMG processes and initiatives to improve workforce efficiency i.e. reduction in premium pay spend, improved efficiency of job planning and maximisation of electronic rostering implementation. This will ensure that robust processes are in place to identify further workforce CIP opportunities, proportionate to the size of our paybill.

Key to delivery of a successful workforce model will be the continued focus on staff engagement and support through Listening in to Action (LiA); our actions resulting from analysis of the staff feedback (survey / friends & family) and consultation with staff / staff side.

6. Financial and investment strategy (including Cost Improvement Programme)

6.1. Financial Plan for 2015/16

Our financial plan for 2015/16 is to deliver a planned deficit of £36.1m, which is consistent with year two of our five year financial plan and assumes the following:

- Tariff deflation and cost inflation are as per the Enhanced Tariff Option.
- Increased capital charges and borrowing costs as a result of planned capital spend and loans to support the deficit and capital programme.
- No assumed contractual benefits from contract terms or counting and coding agreements.

Unfortunately, our financial plans for 2015/16 will not deliver statutory duties due to the planned deficit position.

We continue to monitor CMG and Directorate performance closely on an ongoing basis to ensure cost control.

6.2. CIP 2015/16

Our CIP target for 2015/16 is £41m plus a further £2.3m to fund cost pressures.

Our Chief Nurse and Medical Director review CIP schemes to ensure there is no impact on patient safety or quality of care or that mitigating actions are sufficient (and in place) to reduce any detrimental effects to front line services.

Building upon the success of the cross cutting workstreams in 2014/15, we will focus on four high impact areas in 2015/16:

1. Beds;
2. Outpatients;
3. Theatres; and,
4. Workforce.

The combined contribution of these Trust wide workstreams will deliver circa 30% of the overall savings target. Each workstream is led by an Executive Director.

Our financial plan assumes the full delivery of £41m CIP savings, plus the £2.3m of cost pressures.

7. Longer term financial sustainability, income, costs, activity, capital and risk mitigation

Our LTFM, developed to reflect our five year plan, shows a 2014/15 planned (and delivered) deficit of £40.7m reducing to c£30m by 2018/19, primarily as a result of increasing productivity and efficiency. The final £30m is associated with the estates modernisation and the consolidation of acute services onto two sites (from three) to deliver the benefits described in our clinical strategy and release revenue costs.

This is a hugely ambitious plan within the context of national planning assumptions but one which all local health economy partners are signed up to (including the timeframe) through BCT.

Our financial plan for 2015/16 is in line with our original trajectory, at a bottom line level, in that the five year plan had a deficit of £36.1m in 2015/16 and that is what is now planned for the year ahead.

In addition, as an active partner in the BCT programme, we have contributed towards the development of a LLR Financial Model which is being adopted by all partners across the health economy. This reflects the planning assumptions within our LTFM.

8. Plans to improve efficiency and productivity through the more effective use of information and technology

We are investing in information technology at an operational and strategic level to support improvement in efficiency and productivity.

At a strategic level, we have selected our preferred partner for an Electronic Patient Record (EPR). This will move in to implementation in 2015/16.

At an operational level, we have purchased QlikSense which facilitates the monitoring, analysis and presentation of information to support:

- Patient outcomes and safety;
- Patient experience;
- Clinical staff resourcing;
- Quality schedule and CQUIN indicators; and,
- Performance management and financial management.

This will empower staff to make better and more efficient use of data and information across multiple domains. Benefits include the rapid development of Emergency Care Data Pack for immediate use and real time clinical coding to help drive improvements in capturing all co-morbidities.

We also have access to a range of benchmarking tools including CHKS and Healthcare Evaluation Data (HED). Both are on-line tools which help identify clinical and productivity opportunities by comparing our performance with that of other NHS Trusts.

9. Organisational relationships and capability

As stated previously, our five year plan is set within the wider context of the LLR BCT programme – therefore, engagement with stakeholders has primarily been under the auspices of BCT.

Along with other NHS and social care organisations, we have been working closely with the 'BCT PPI Forum' (a lay body of local stakeholders from the likes of Healthwatch, Patient Public Groups, 3rd sector, media reps) to ensure that involvement and engagement is hardwired into the developing BCT plans and to co-create the approach to wider public engagement and consultation post the May election.

10. Development priorities and actions that the Trust is taking to meet its development needs

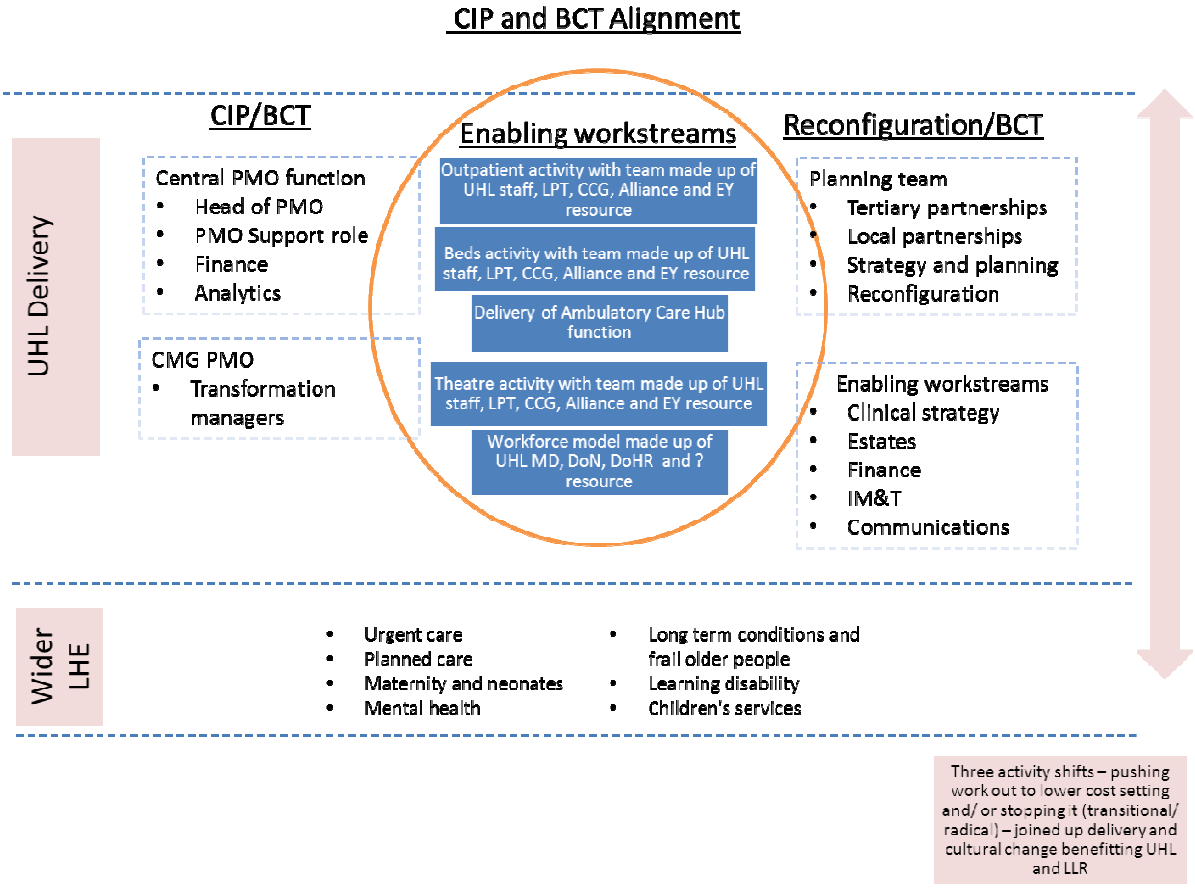
The key headlines can be summarised as follows:

Development Priority	Planned Action
1. Trust Board development- embedding Board disciplines	Secure resources for coaching and training to produce shorter reports, informed by analysis and identifying key issues to be addressed
2. Clinical leadership	Work with NHS Improving Quality (NHS IQ) and the Leadership Academy in developing structures and process for garnering clinical leadership; set out clear expectations and sanctions as part of job planning and annual appraisal; train appraisers; clinical senate established; establish a similar model for nursing and midwifery
3. Culture and behaviours in teams	Develop a programme brief that describes the scope of change planned, the anticipated benefits and outcomes of the five-year plan and aligns this to the strategic priorities and values of the organisation; thorough engagement with staff to establish ownership of the plan; use the LiA methodology to provide clarity of roles and responsibilities (for all staff) to deliver the 5 year plan; coaching and development of the Executive Team and continue Practice Crucial Conversation Sessions (across CMG) in partnership with Momentum; building on-the ground change capacity with the support of NHS IQ Support
4. Patient & Public involvement	Consider ways to ensure more time and resource is available to (or within) CMGs as part of our reconfiguration process to free up staff time to engagement activities (within the Trust and across the wider community); seek support and guidance from NHS England in further developing our PPI strategy that will seek to strengthen our PPI within the Trust as well as linking into the wider community; link into the Patient and Public Voice Team at NHS England; access to medical leaders in other health economies who

	are prepared to coach/enthuse support our CMG leadership teams.
5. Financial sustainability	Enabling resource has been implemented for CIP which includes CMG specific support and also a number of cross cutting themes, each led by an Executive Director. This will be further refined in 15/16 to focus on four main areas (Beds, Outpatients, theatres and workforce) ; a five year internal CIP plan has been drafted and is currently in consultation with senior leader; external work-streams via BCT to support financial sustainability, service and pathway change. Requirement to provide an umbrella view and hold the interdependent areas (including organisations) to account to deliver the whole; externally the BCT programme SOC will outline the system requirement for transitional funding and capital and cash resources to successfully deliver system and organisational reconfiguration
6. Improvement & Innovation methodology	Agree a methodology and agree the deployment across UHL; develop communications plan that aligns improvement and innovation with the overall programme management arrangements for delivering the five year plan Consider participation (via application process) in the NTDA's development programme for quality improvement.

END

Appendix 1


CIP and BCT Alignment
CIP/BCT
Enabling workstreams
Reconfiguration/BCT
UHL Delivery
Central PMO function
Head of PMO
PMO Support role
Finance
Analytics
CMG PMO
Transformation managers
Outpatient activity with team made up of UHL staff, LPT, CCG, Alliance and EY resource
Beds activity with team made up of UHL staff, LPT, CCG, Alliance and EY resource
Delivery of Ambulatory Care Hub function
Theatre activity with team made up of UHL staff, LPT, CCG, Alliance and EY resource
Workforce model made up of UHL MD, DoN, DoHR and ? resource
Planning team
Tertiary partnerships
Local partnerships
Strategy and planning
Reconfiguration
Enabling workstreams
Clinical strategy
Estates
Finance
IM&T
Communications
Wider LHE
Urgent care
Planned care
Maternity and neonates
Mental health
Long term conditions and frail older people
Learning disability
Children's services
Three activity shifts – pushing work out to lower cost setting and/ or stopping it (transitional/ radical) – joined up delivery and cultural change benefitting UHL and LLR

Appendix 2

UHL Major Business Cases

Major Business Cases	2015/16 £k	2016/17 £k	2017/18 £k	2018/19 £k	2019/20 £k	Total £k	OBC Internal start	OBC Internal Approval	OBC Sent to TDA	OBC Approved by TDA	FBC Internal Approval	FBC Sent to TDA	FBC Approved by TDA	Construction Start	Construction Complete
Emergency Floor	17,698	18,341	353	-	-	**36,392**				Mar-15	Apr-15	Apr-15	May-15	Jun-15	Dec-16
ICU interim solution & Vascular Hybrid Theatre	9,778	2,322	-	-	-	**12,100**		tbc	tbc	tbc	tbc	tbc	tbc	tbc	tbc
Treatment Centre	5,000	7,000	25,000	16,000	5,000	**58,000**	Mar-15	Jan-16	Jan-16	Mar-16	Jul-16	Jul-16	Sep-16	Oct-16	Jul-19
ITU LRI	-	-	14,000	2,000	-	**16,000**	Oct-15	Mar-16	Apr-16	Jun-16	Dec-16	Jan-17	Mar-17	tbc	tbc
Women's services	1,000	26,200	26,600	12,100	-	**65,900**	Mar-15	Mar-16	Mar-16	May-16	Dec-16	Dec-16	Feb-17	Mar-17	Mar-19
Multi Storey Car Park LRI	4,229	-	-	-	-	**4,229**					May-15	N/A	N/A	Jun-15	Dec-15
Childrens' Hospital	400	3,600	4,000	9,000	-	**17,000**	Jan-15	Jun-15	Jul-15	Sep-15	Mar-16	Apr-16	Jun-16	tbc	tbc
Interim EMCH	3,500	-	-	-	-	**3,500**	tbc	tbc	N/A	N/A	tbc	N/A	N/A	tbc	tbc
Theatres LRI	1,650	4,000	7,000	-	-	**12,650**	Jan-15	tbc	tbc	tbc	tbc	tbc	tbc	tbc	tbc
Entrance LRI	-	-	2,000	10,000	-	**12,000**	tbc	tbc	tbc	tbc	tbc	tbc	tbc	tbc	tbc
Wards/Beds LRI	2,000	8,000	10,000	2,000	-	**22,000**	Jan-15	Jun-15	Jul-15	Aug-15	Jan-16	Feb-16	Mar-16	tbc	tbc
Wards/Beds GH	6,000	9,000	15,000	-	-	**30,000**	Jan-15	Jun-15	Jul-15	Aug-15	Jan-16	Feb-16	Mar-16	tbc	tbc
Identified reconfiguration projects	**51,255**	**78,463**	**103,953**	**51,100**	**5,000**	**289,771**									
Imaging GH	3,000	3,000	-	-	-	**6,000**	tbc	tbc	N/A	N/A	tbc	N/A	N/A	tbc	tbc
Outpatients LRI	-	-	3,000	2,000	-	**5,000**	tbc	tbc	N/A	N/A	tbc	N/A	N/A	tbc	tbc
Pathology GH	-	-	3,000	-	-	**3,000**	tbc	tbc	N/A	N/A	tbc	N/A	N/A	tbc	tbc
Supporting infrastructure	-	4,000	4,000	-	-	**8,000**	tbc	tbc	N/A	N/A	tbc	N/A	N/A	tbc	tbc
Other reconfiguration projects	**3,000**	**7,000**	**10,000**	**2,000**	**-**	**22,000**									
EPR Programme	33,511	22,091	463	-	-	**56,065**		N/A	N/A	N/A	Nov-14	Dec-14	Jun-15	N/A	N/A
Other major business case capital expenditure	**33,511**	**22,091**	**463**	**-**	**-**	**56,065**									
TOTAL MAJOR BUSINESS CASE CAPITAL	**87,766**	**107,554**	**114,416**	**53,100**	**5,000**	**367,836**									
Operational Capital Business Cases															
Facilities Sub-Group	5,355	6,000	6,000	6,000	6,000	**29,355**									
MES Installation Costs	1,500	1,500	1,500	1,500	1,500	**7,500**									
Aseptic Suite	440	-	-	-	-	**440**									
Lloyds Pharmacy Extension	126	-	-	-	-	**126**									
Theatre Recovery LRI	2,750	-	-	-	-	**2,750**									
Life Studies Centre	850	-	-	-	-	**850**									
IM&T Sub-Group	4,000	5,570	8,000	6,000	6,000	**29,570**									
Managed Print	1,323	-	-	-	-	**1,323**									
EDRM	3,000	-	-	-	-	**3,000**									
Safecare Software System	58	-	-	-	-	**58**									
Electronic Blood Tracking System	996	-	-	-	-	**996**									
Medical Equipment Executive Budget	5,500	6,000	6,000	6,000	6,000	**29,500**									
Linear Accelerators	3,000	1,775	-	500	1,750	**7,025**									
Relocation of ICU level 3	3,000	-	-	-	-	**3,000**									
Donations	300	300	300	300	300	**1,500**									
LiA Schemes	250	250	250	250	250	**1,250**									
Contingency	1,671	3,905	250	9,750	10,500	**26,076**									
TOTAL OPERATIONAL CAPITAL	**34,119**	**25,300**	**22,300**	**30,300**	**32,300**	**144,319**									
TOTAL CAPITAL EXPENDITURE	**121,885**	**132,854**	**136,716**	**83,400**	**37,300**	**512,155**									
Funded by:															
CRL operational capital	33,819	25,000	22,000	30,000	32,000	**142,819**									
CRL contribution to reconfiguration	-	7,000	10,000	2,000	-	**19,000**									
Capital receipts	-	-	-	-	28,350	**28,350**									
Internal capital resource	**33,819**	**32,000**	**32,000**	**32,000**	**60,350**	**190,169**									
Donations	300	300	300	300	300	**1,500**									
External borrowing	87,766	100,554	104,416	51,100	(23,350)	**320,486**									
External capital resource	**88,066**	**100,854**	**104,716**	**51,400**	**(23,050)**	**321,986**									
TOTAL CAPITAL FUNDING	**121,885**	**132,854**	**136,716**	**83,400**	**37,300**	**512,155**									
	-	-	-	-	-	-									

Note: timelines based on understanding of NTDA timescales, further clarification of DH/Treasury approvals process needs to be factored in.

Other outstanding issues

Beds reduction profile/plan
Support accomodation
Medical equipment
Internally generated funding likely to increase as result of capital expenditure increase - not included in the plan
Affordability of contribution from CRL
Measure of total level of borrowing possible
Financial benefits of above programme need to be more clearly linked to business cases
- backlog maintenance
- contribution to efficiency improvements
- link to key capacity metrics - i.e. number of beds, theatres and consulting rooms

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **7 MAY 2015**

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

SUBJECT: **2015-16 FINANCIAL PLAN AND BUDGET BOOK**

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1. INTRODUCTION

1.1 This paper updates the Trust Board on the financial plan for 2015/16. It also includes the full budget book and details the likely areas of risk in 2015/16.

1.2 The draft plan has been received by both IFPIC and Trust Board in March and this plan is consistent with what has been received and approved previously.

2. 2015/16 FINANCIAL PLAN

2.1 The Trust has submitted a draft financial plan to the TDA prior to the full and final submission on 14th May 2015.

2.2 The Trust is planning for a £36.1m deficit in 2015/16 and a capital plan of £121.9m. Cash required to support this will be £128.8m (£41m needed for deficit and working capital).

2.3 The business planning process has built the plan from a bottom up basis, ensuring that each CMG has plans that triangulate across activity, workforce and finance.

3. INCOME AND EXPENDITURE ACCOUNT

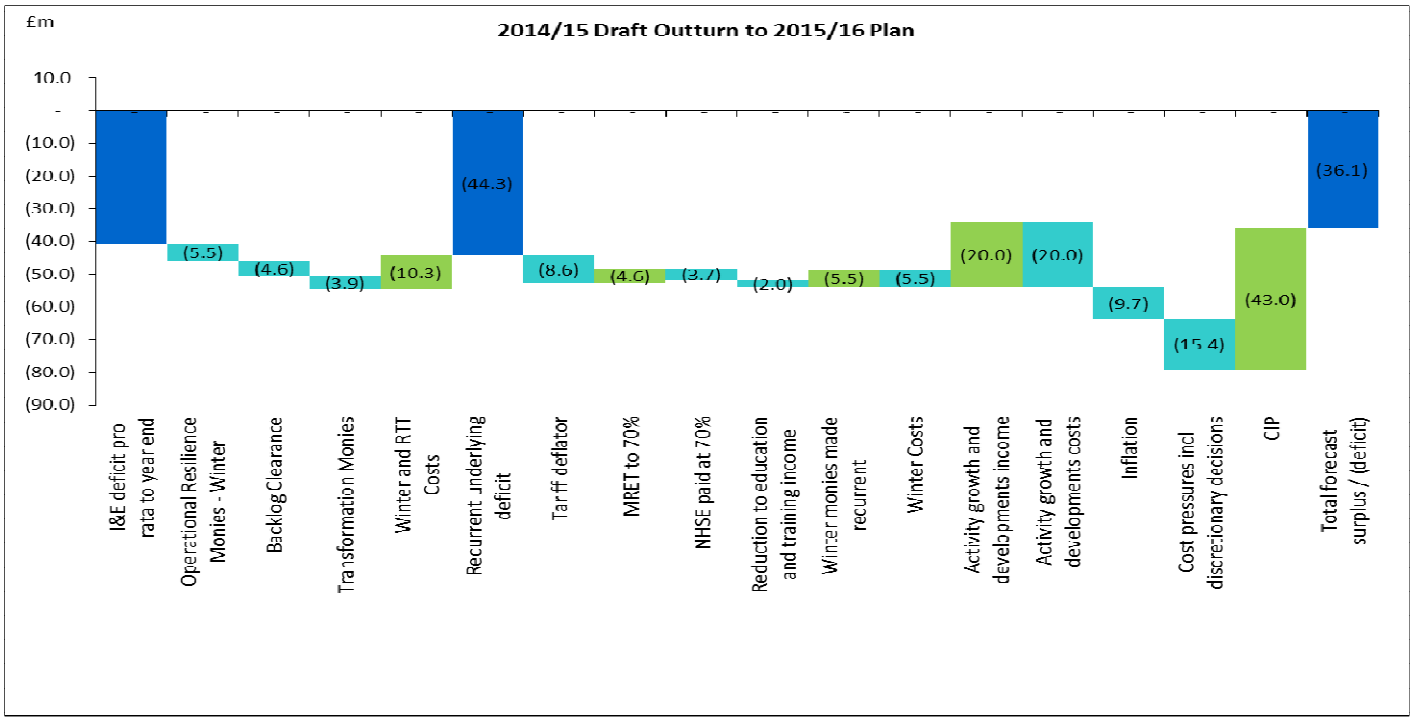
3.1 The income and expenditure account can be seen in table 1 below.

Table 1 – Income and Expenditure account 2015/16

	April 2014 to March 2015 Draft Outturn			April 2015 - March 2016	Increase / (Decrease) from 2014/15 Outturn
	Plan £ 000	Actual £ 000	Variance (Adv) / Fav £ 000	Plan £ 000	Plan £ 000
NHS Patient Care Income	701,721	707,152	5,431	723,587	16,435
Non NHS Patient Care	5,660	6,376	716	6,325	(51)
Teaching, R&D income	81,429	82,096	667	75,377	(6,719)
Other operating Income	37,429	38,752	1,323	37,161	(1,591)
Total Income	**826,239**	**834,376**	**8,137**	**842,450**	**8,074**
Pay Expenditure	**497,630**	**497,278**	**352**	**503,744**	**6,466**
Non Pay Expenditure	**325,733**	**334,298**	**(8,565)**	**329,275**	**(5,023)**
Total Operating Expenditure	**823,363**	**831,576**	**(8,213)**	**833,018**	**1,442**
EBITDA	**2,876**	**2,800**	**(76)**	**9,432**	**6,632**
Interest Receivable	96	**83**	(13)	77	(6)
Interest Payable	0	**(27)**	(27)	(1,682)	(1,655)
Depreciation & Amortisation	(33,887)	**(33,232)**	655	(33,019)	213
Impairment	(1,445)	**(6,761)**	(5,316)	0	6,761
Surplus / (Deficit) Before Dividend and Disposal of Fixed Assets	**(32,360)**	**(37,137)**	**(4,777)**	**(25,192)**	**5,184**
Profit / (Loss) on Disposal of Fixed Assets	(14)	**13**	27	**0**	(13)
Dividend Payable on PDC	(10,428)	**(10,369)**	59	**(11,514)**	(1,145)
Net Surplus / (Deficit)	**(42,802)**	**(47,493)**	**(4,691)**	**(36,706)**	**10,787**
EBITDA MARGIN		**0.34%**		**1.12%**	
Less: Impairments	1,445	**6,761**	5,316	**0**	(6,761)
Less: Adjustments in respect of donated assets	612	**84**	(528)	**606**	
RETAINED SURPLUS / (DEFICIT)	**(40,745)**	**(40,648)**	**97**	**(36,100)**	**4,548**

3.2 Chart 1 below details the bridge between years.

Chart 1 – Bridge between 2014/15 draft outturn and 2015/16 plan



3.5 Significant movements between years are as follows:

- An underlying recurrent deficit of £44.3m, after adjustment for non recurrent income and spend on winter and RTT in 2014/15.
- Tariff deflator of £8.6m as per the ETO.
- MRET is rebased to 70% (£4.6m)
- NHSE growth (incl high cost drugs and devices) is paid at 70% - £3.7m
- Reduction to education and training income of £2m as new tariffs for this area are introduced and transitional funding is reduced.
- Winter monies of £5.5m are made recurrent as these are now included in CCG allocations, with equivalent cost made recurrent
- Demographics, RTT and internally approved business cases mean growth of £20m with equal cost to deliver. Any contribution from growth is included within the CIP plan.
- Inflation costs of £9.7m for pay and non pay.
- Cost pressures of £15.4m, including quality investments (see 3.6), financing costs, IBM costs, reconfiguration costs and other unavoidable costs
- Delivery of £43m of CIP

3.6 A number of cost pressures were submitted by CMGs and Directorates in support of quality and performance. A process led by the executive team, established priorities within this list and agreed funding as per table 2 below. These costs will be funded through an increase in the CIP target by £2.3m and repatriation of work from outside the area and the independent sector.

Table 2 – Discretionary decisions funding

Scheme	CMG / Directorate	2015/16 cost
CDU flow, including Cardiologist, Ward Clerks, Nurse led triage, discharge coordinators, flow coordinators, pharmacists, additional matron	RRC	1,195
Acuity	CHUGGS	500
Development of a sustainable trauma service	MSS	350
Cancer centre staffing	Ops	80
Ambulance charges	Ops	720
ESR admin posts to support pay award and increment policy	HR	20
Policy and Guidelines administrator	Nursing	20
April funding - emergency pressures	Ops	80
Emergency performance Q1	Ops	160
Additional nurses for assessment	ESM	325
Total		**3,450**

3.7 The full budget book for the I&E can been seen in Appendix 1.

4. CAPITAL PLAN

4.1 The capital plan can be seen in the table below. In total an estimated £122m will be committed, with £88m requiring borrowing to support.

CAPITAL EXPENDITURE	UHL Approval	CMG	£k
INTERNALLY FUNDED CAPITAL			
Estates & Facilities			
Facilities Sub-Group	N/A	UHL	5,355
MES Installation Costs	N/A	UHL	1,500
Aseptic Suite	Approved	CSI	440
Lloyds Pharmacy Extension	Approved	CSI	126
Theatre Recovery LRI	Approved	ITAPS	2,750
Life Studies Centre	Approved	W&C	850
Sub-total: Estates & Facilities			**11,021**
IM&T Schemes			
IM&T Sub-Group	N/A	UHL	4,000
LRI Managed Print	Under review	UHL	1,323
EDRM	Under review	UHL	3,000
Safecare Software System	Approved	UHL	58
Electronic Blood Tracking System	Approved	CSI	996
Sub-total: IM&T Schemes			**9,377**
Medical Equipment Schemes			
Medical Equipment Executive Budget	N/A	UHL	5,500
Linear Accelerators	Not Approved		3,000
Sub-total: Medical Equipment			**8,500**
Reconfiguration Schemes			
Relocation of ICU level 3	Not Approved	UHL	3,000
Sub-total: Reconfiguration Schemes			**3,000**
Corporate / Other Schemes			
Stock Management Project	Under review	UHL	0
Donations	N/A	UHL	300
LiA Schemes	Not Approved	UHL	250
Contingency	Not Approved	UHL	1,671
Sub-total: Corporate / Other Schemes			**2,221**
Sub total: Internally funded capital expenditure			**34,119**
EXTERNALLY FUNDED CAPITAL			
Emergency Floor	Approved	ESM	17,698
EPR Programme	Approved	UHL	33,511
Imaging GH	Not Approved	CSI	3,000
Theatres LRI	Not Approved	ITAPS	1,650
ICU interim solution & Vascular Hybrid Theatre	Not Approved	UHL	9,778
Multi-storey Car Park Development	Not Approved	UHL	4,229
Treatment Centre	Not Approved	UHL	5,000
Wards / Beds LRI	Not Approved	UHL	2,000
Wards / Beds GH	Not Approved	UHL	6,000
Women's service	Not Approved	W&C	1,000
EMCH Interim Solution	Not Approved	W&C	3,500
Children's Hospital	Not Approved	W&C	400
Sub total: Externally funded capital expenditure			**87,766**
GRAND TOTAL CAPITAL EXPENDITURE			**121,885**

5. CASH

5.1 In order to support the planned deficit and the capital programme there will be a need for further borrowing in 2015/16. Currently it is forecast that £129m of borrowing will be required to support the deficit, capital programme and improvements in working capital. This will be refined as business cases for large projects are approved and the mechanisms for application of loans are finalised by the TDA. This is consistent with the working capital strategy received in March.

6. RISKS

6.1 There are a number of risks, both in finalising the plan and delivering in 2015/16. These are detailed below with mitigation.

6.1.1 CIP delivery is key to delivery of the planned I&E position, any under delivery is a risk to this.

Mitigation – EY continue to support the identification and management of the CIP programme, with recruitment having been undertaken for specific individuals to support this going forward. CIP performance is monitored on a monthly basis through CMG performance meetings and reporting to EPB and IFPIC.

6.1.2 There is a risk that the paybill continues to increase and is in excess of budget. This is a particular risk for medical staffing

Mitigation – The workforce workstream is concentrating on delivery of savings on the paybill, with focus on nursing, medical staffing and premium pay. In addition performance management with CMGs will remain in place to tackle areas of pressure.

6.1.3 There is a risk in year of there being unidentified cost pressures that place pressure on delivery of the plan

Mitigation – The planning process has been robust in identification of costs required to deliver activity as well as the communication of what is not supported. The Trust holds a small contingency (£3.5m) for the support of unavoidable cost pressures identified in year. Any new costs above this will require identification of a specific funding source

6.1.4 CMGs and Directorates do not deliver to within their plan

Mitigation – CMGs and Directorates will have finalised plans for 31st March, with any remaining items being based on decisions from commissioners. CMG financial positions will be reported through the performance meetings, as well as overall Trust positions at EPB and IFPIC.

6.1.5 The planned deficit position means there is insufficient cash to support expenditure

Mitigation – The Trust has access to Interim Revolving Working Capital Support (temporary borrowing) to meet cash requirements, prior to a full application to the Integrated Trust Financing Facility. The cash requirement for the Trust has been well identified outside the organisation.

7. CONCLUSION AND RECOMMENDATIONS

7.1 The Trust Board is asked to

- **Approve** the final budget for 2015/16
- **Note** the risks to delivery

Paul Traynor
Director of Finance
30 April 2015

University Hospitals of Leicester NHS
NHS Trust

2015/16 FINANCIAL PLAN BUDGET BOOK

Planned Income and Expenditure Account for the Period Ended 31 March 2016

	April 2014 to March 2015 Draft Outturn			April 2015 - March 2016	Increase / (Decrease) from 2014/15 Outturn
	Plan	Actual	Variance (Adv) / Fav	Plan	Plan
	£ 000	£ 000	£ 000	£ 000	£ 000
NHS Patient Care Income	701,721	707,152	5,431	723,587	16,435
Non NHS Patient Care	5,660	6,376	716	6,325	(51)
Teaching, R&D income	81,429	82,096	667	75,377	(6,719)
Other operating Income	37,429	38,752	1,323	37,161	(1,591)
Total Income	**826,239**	**834,376**	**8,137**	**842,450**	**8,074**
Pay Expenditure	**497,630**	**497,278**	**352**	**503,744**	**6,466**
Non Pay Expenditure	**325,733**	**334,298**	**(8,565)**	**329,275**	**(5,023)**
Total Operating Expenditure	**823,363**	**831,576**	**(8,213)**	**833,018**	**1,442**
EBITDA	**2,876**	**2,800**	**(76)**	**9,432**	**6,632**
Interest Receivable	96	**83**	(13)	77	(6)
Interest Payable	0	**(27)**	(27)	(1,682)	(1,655)
Depreciation & Amortisation	(33,887)	**(33,232)**	655	(33,019)	213
Impairment	(1,445)	**(6,761)**	(5,316)	0	6,761
Surplus / (Deficit) Before Dividend and Disposal of Fixed Assets	**(32,360)**	**(37,137)**	**(4,777)**	**(25,192)**	**5,184**
Profit / (Loss) on Disposal of Fixed Assets	(14)	**13**	27	**0**	(13)
Dividend Payable on PDC	(10,428)	**(10,369)**	59	**(11,514)**	(1,145)
Net Surplus / (Deficit)	**(42,802)**	**(47,493)**	**(4,691)**	**(36,706)**	**10,787**
EBITDA MARGIN		**0.34%**		**1.12%**	
Less: Impairments	1,445	**6,761**	5,316	**0**	(6,761)
Less: Adjustments in respect of donated assets	612	**84**	(528)	**606**	
RETAINED SURPLUS / (DEFICIT)	**(40,745)**	**(40,648)**	**97**	**(36,100)**	**4,548**

CMG and Directorate budgets

	2014/15 Draft Outturn £000s				Plan 2015/16 £000s						
CMG / Directorate	Income	Pay	Non Pay	Net I&E	Income	Pay	Non Pay	Net I&E	Income Change	Pay and Non Pay Change	I&E Movement
C.H.U.G.S	137,394	48,738	43,788	44,868	140,556	49,394	44,508	46,654	3,162	1,376	1,786
Clinical Support & Imaging	41,618	73,264	5,088	(36,735)	43,196	72,326	2,436	(31,566)	1,578	(3,591)	5,169
Emergency & Specialist Med	132,885	75,478	38,896	18,510	145,304	73,718	41,155	30,431	12,419	498	11,921
I.T.A.P.S	33,944	57,202	22,132	(45,391)	39,720	56,949	20,926	(38,155)	5,776	(1,459)	7,235
Musculo & Specialist Surgery	107,451	48,976	22,428	36,047	101,242	49,401	20,495	31,346	(6,209)	(1,507)	(4,702)
Renal, Respiratory & Cardiac	142,125	61,299	49,445	31,380	150,423	61,922	46,628	41,873	8,298	(2,195)	10,492
Womens & Childrens	144,307	75,431	25,170	43,705	144,867	75,811	25,936	43,120	560	1,145	(586)
CMG Total	**739,723**	**440,389**	**206,948**	**92,385**	**765,306**	**439,522**	**202,084**	**123,701**	**25,583**	**(5,732)**	**31,316**
Communications & Ext Relations	45	583	117	(655)	49	626	79	(656)	4	4	(0)
Corporate & Legal	0	2,302	1,281	(3,583)	0	2,301	1,182	(3,483)	(0)	(100)	100
Corporate Medical	3,148	4,014	785	(1,651)	2,731	3,683	633	(1,585)	(418)	(483)	66
Divisional Management Codes	0	(5)	1	5	0	0	0	0	0	5	(5)
Facilities	13,929	1,273	52,601	(39,946)	13,819	1,456	51,948	(39,586)	(110)	(470)	360
Finance & Procurement	59	4,470	2,207	(6,617)	50	4,784	2,159	(6,893)	(9)	267	(276)
Human Resources	1,727	5,253	1,844	(5,369)	1,418	5,401	1,199	(5,182)	(309)	(496)	187
Im&T	114	798	9,131	(9,816)	122	903	10,161	(10,942)	7	1,134	(1,127)
Nursing	1,590	7,571	13,874	(19,855)	179	8,035	12,122	(19,978)	(1,412)	(1,289)	(123)
Operations	511	5,936	6,047	(11,472)	2	6,476	2,995	(9,469)	(508)	(2,512)	2,004
Strategic Devt	15	522	370	(877)	0	1,080	36	(1,116)	(15)	224	(239)
Alliance	21,485	9,675	11,327	482	23,038	9,722	13,315	0	1,553	2,036	(482)
Directorate Total	**42,623**	**42,391**	**99,586**	**(99,354)**	**41,406**	**44,468**	**95,829**	**(98,890)**	**(1,216)**	**(1,681)**	**464**
R&D Total	**37,857**	**12,960**	**24,569**	**328**	**35,713**	**12,484**	**22,975**	**254**	**(2,143)**	**(2,069)**	**(74)**
Central Total	**14,173**	**1,538**	**46,643**	**(34,007)**	**24**	**7,270**	**53,919**	**(61,165)**	**(14,149)**	**13,008**	**(27,157)**
Trust Total	**834,376**	**497,278**	**377,747**	**(40,648)**	**842,450**	**503,744**	**374,807**	**(36,100)**	**8,074**	**3,526**	**4,548**

BUDGET BOOK 2015/16

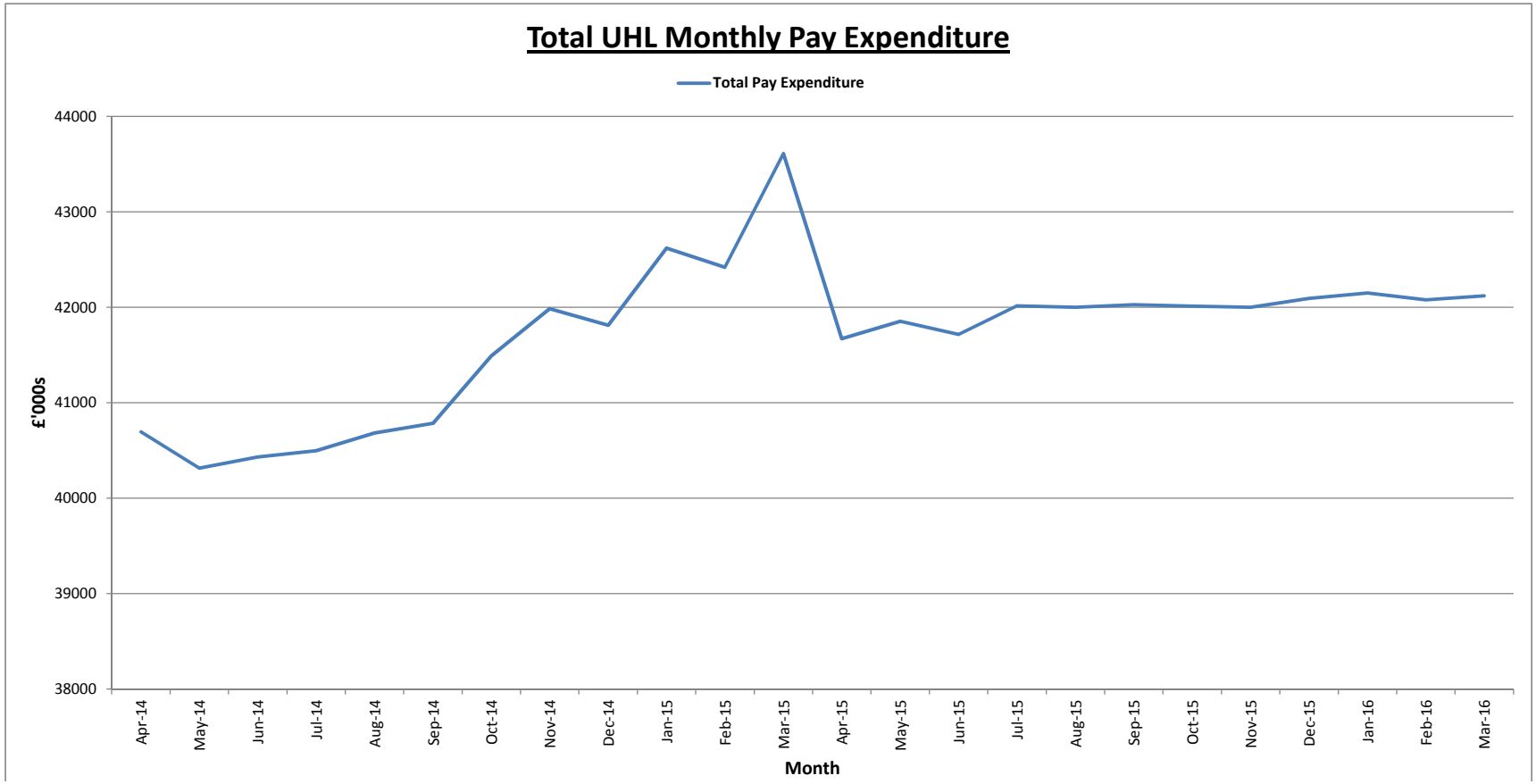
Pay Trends

CMG / Directorate	2014/15 draft Pay outturn £000s	Apr-15 £000s	May-15 £000s	Jun-15 £000s	Jul-15 £000s	Aug-15 £000s	Sep-15 £000s	Oct-15 £000s	Nov-15 £000s	Dec-15 £000s	Jan-16 £000s	Feb-16 £000s	Mar-16 £000s	Total Plan 2015/16	Increase / (decrease)
C.H.U.G.S	48,738	4,041	4,046	4,017	4,105	4,121	4,126	4,151	4,151	4,156	4,161	4,161	4,161	49,394	656
Clinical Support & Imaging	73,264	6,032	6,021	6,029	6,010	6,010	6,011	6,024	6,034	6,042	6,040	6,036	6,037	72,326	(939)
Emergency & Specialist Med	75,478	6,195	6,203	6,203	6,126	6,126	6,163	6,040	6,109	6,187	6,149	6,109	6,109	73,718	(1,760)
I.T.A.P.S	57,202	4,753	4,791	4,715	4,715	4,782	4,722	4,741	4,734	4,749	4,768	4,721	4,759	56,949	(253)
Musculo & Specialist Surgery	48,976	3,765	3,745	3,806	4,276	4,212	4,252	4,252	4,232	4,220	4,201	4,220	4,220	49,401	426
Renal, Respiratory & Cardiac	61,299	5,297	5,322	5,294	5,129	5,101	5,101	5,121	5,095	5,095	5,123	5,122	5,123	61,922	623
Womens & Childrens	75,431	6,224	6,360	6,303	6,308	6,297	6,300	6,336	6,297	6,297	6,363	6,363	6,363	75,811	379
CMG Total	**440,389**	**36,306**	**36,488**	**36,367**	**36,668**	**36,649**	**36,675**	**36,664**	**36,652**	**36,747**	**36,804**	**36,732**	**36,772**	**439,522**	**(868)**
Communications & Ext Relations	583	53	53	53	53	53	53	51	51	51	51	51	51	626	43
Corporate & Legal	2,302	192	192	192	192	192	192	192	192	192	192	192	192	2,301	(1)
Corporate Medical	4,014	307	307	307	307	307	307	307	307	307	307	307	307	3,683	(331)
Divisional Management Codes	- 5	-	-	-	-	-	-	-	-	-	-	-	-	-	5
Facilities	1,273	121	121	121	121	121	121	121	121	121	121	121	121	1,456	183
Finance & Procurement	4,470	399	399	399	399	399	399	399	399	399	399	399	399	4,784	315
Human Resources	5,253	448	448	448	448	448	451	451	451	451	451	451	451	5,401	149
Im&T	798	77	77	77	77	77	77	74	74	74	74	74	74	903	105
Nursing	7,571	668	668	668	668	670	670	670	670	670	670	670	670	8,035	464
Operations	5,936	565	565	535	535	535	535	535	535	535	535	535	535	6,476	540
Strategic Devt	522	90	90	90	90	90	90	90	90	90	90	90	90	1,080	558
Alliance	9,675	810	810	810	810	810	810	810	810	810	810	810	810	9,722	47
Directorate Total	**42,391**	**3,730**	**3,730**	**3,700**	**3,700**	**3,703**	**3,706**	**3,700**	**3,700**	**3,700**	**3,700**	**3,700**	**3,700**	**44,468**	**2,076**
R&D Total	**12,960**	**1,040**	**1,040**	**1,040**	**1,040**	**1,040**	**1,040**	**1,040**	**1,040**	**1,040**	**1,040**	**1,040**	**1,040**	**12,484**	**(475)**
Central Total	**1,538**	**596**	**596**	**608**	**608**	**608**	**608**	**608**	**608**	**608**	**608**	**608**	**608**	**7,270**	**5,732**
Trust Total	**497,278**	**41,672**	**41,854**	**41,716**	**42,017**	**42,000**	**42,029**	**42,012**	**42,000**	**42,095**	**42,152**	**42,080**	**42,120**	**503,744**	**6,466**

UNIVERSITY HOSPITALS LEICESTER NHS TRUST

BUDGET BOOK 2015/16

Pay Trends



Non Pay Trends

CMG / Directorate	2014/15 draft Non Pay outturn £000s	Apr-15 £000s	May-15 £000s	Jun-15 £000s	Jul-15 £000s	Aug-15 £000s	Sep-15 £000s	Oct-15 £000s	Nov-15 £000s	Dec-15 £000s	Jan-16 £000s	Feb-16 £000s	Mar-16 £000s	Total Plan 2015/16	Increase / (decrease)
C.H.U.G.S	43,788	3,598	3,479	3,838	3,946	3,585	3,827	3,827	3,706	3,706	3,585	3,706	3,706	44,508	720
Clinical Support & Imaging	5,088	- 124	177	271	164	239	207	140	295	272	238	344	213	2,436	(2,652)
Emergency & Specialist Med	38,896	3,054	3,184	3,553	3,711	3,192	2,939	3,622	3,923	3,507	3,498	3,488	3,484	41,155	2,259
I.T.A.P.S	22,132	1,720	1,727	1,776	1,891	1,695	1,825	1,876	1,641	1,580	1,692	1,692	1,810	20,926	(1,207)
Musculo & Specialist Surgery	22,428	1,636	1,578	1,771	1,847	1,645	1,771	1,780	1,703	1,713	1,645	1,694	1,713	20,495	(1,933)
Renal, Respiratory & Cardiac	49,445	3,890	3,908	3,903	3,934	3,826	3,856	3,937	3,843	3,908	3,894	3,823	3,905	46,628	(2,818)
Womens & Childrens	25,170	2,136	2,044	2,158	2,197	2,170	2,178	2,204	2,161	2,174	2,184	2,135	2,195	25,936	766
CMG Total	**206,948**	**15,910**	**16,098**	**17,269**	**17,691**	**16,352**	**16,602**	**17,386**	**17,272**	**16,859**	**16,736**	**16,882**	**17,026**	**202,084**	**(4,865)**
Communications & Ext Relations	117	7	7	7	7	7	7	7	7	7	7	7	7	79	(39)
Corporate & Legal	1,281	99	99	99	99	99	99	99	99	99	99	99	99	1,182	(99)
Corporate Medical	785	53	53	53	53	53	53	53	53	53	53	53	53	633	(152)
Divisional Management Codes	1	-	-	-	-	-	-	-	-	-	-	-	-	-	(1)
Facilities	52,601	4,329	4,329	4,329	4,329	4,329	4,329	4,329	4,329	4,329	4,329	4,329	4,329	51,948	(653)
Finance & Procurement	2,207	180	180	180	180	180	180	180	180	180	180	180	180	2,159	(48)
Human Resources	1,844	100	100	100	100	100	100	100	100	100	100	100	100	1,199	(645)
Im&T	9,131	867	859	863	843	849	839	841	839	839	841	839	846	10,161	1,030
Nursing	13,874	1,010	1,010	1,010	1,010	1,010	1,010	1,010	1,010	1,010	1,010	1,010	1,010	12,122	(1,753)
Operations	6,047	394	394	394	394	394	394	105	105	105	105	105	105	2,995	(3,052)
Strategic Devt	370	3	3	3	3	3	3	3	3	3	3	3	3	36	(334)
Alliance	11,327	1,110	1,110	1,110	1,110	1,110	1,110	1,110	1,110	1,110	1,110	1,110	1,110	13,315	1,989
Directorate Total	**99,586**	**8,150**	**8,142**	**8,146**	**8,126**	**8,132**	**8,122**	**7,835**	**7,833**	**7,833**	**7,835**	**7,833**	**7,840**	**95,829**	**(3,757)**
R&D Total	**24,569**	**1,915**	**1,915**	**1,915**	**1,915**	**1,915**	**1,915**	**1,915**	**1,915**	**1,915**	**1,915**	**1,915**	**1,915**	**22,975**	**(1,594)**
Central Total	**46,643**	**4,463**	**4,474**	**4,480**	**4,475**	**4,480**	**4,485**	**4,497**	**4,504**	**4,517**	**4,491**	**4,509**	**4,546**	**53,919**	**7,275**
Trust Total	**377,747**	**30,437**	**30,628**	**31,809**	**32,207**	**30,878**	**31,123**	**31,633**	**31,524**	**31,124**	**30,977**	**31,139**	**31,327**	**374,807**	**(2,940)**

Income Trends

CMG / Directorate	2014/15 draft Income outturn £000s	Apr-15 £000s	May-15 £000s	Jun-15 £000s	Jul-15 £000s	Aug-15 £000s	Sep-15 £000s	Oct-15 £000s	Nov-15 £000s	Dec-15 £000s	Jan-16 £000s	Feb-16 £000s	Mar-16 £000s	Total Plan 2015/16	Increase / (decrease)
C.H.U.G.S	137,394	11,286	11,029	12,015	12,488	11,394	12,015	12,140	11,667	11,775	11,411	11,559	11,775	140,556	3,162
Clinical Support & Imaging	41,618	3,472	3,405	3,634	3,736	3,475	3,632	3,671	3,563	3,664	3,618	3,641	3,685	43,196	1,578
Emergency & Specialist Med	132,885	11,824	11,629	12,202	12,593	11,976	12,384	12,422	12,155	12,242	11,926	11,783	12,168	145,304	12,419
I.T.A.P.S	33,944	3,251	3,300	3,297	3,392	3,323	3,297	3,369	3,274	3,346	3,323	3,202	3,346	39,720	5,776
Musculo & Specialist Surgery	107,451	8,109	7,856	8,715	9,067	8,159	8,715	8,764	8,412	8,462	8,159	8,363	8,462	101,242	(6,209)
Renal, Respiratory & Cardiac	142,125	12,207	12,223	12,634	13,077	12,436	12,634	12,864	12,421	12,650	12,436	12,191	12,650	150,423	8,298
Womens & Childrens	144,307	11,744	11,881	12,049	12,454	11,996	12,049	12,308	11,902	12,267	12,157	11,804	12,255	144,867	560
CMG Total	**739,723**	**61,893**	**61,323**	**64,546**	**66,807**	**62,759**	**64,726**	**65,537**	**63,394**	**64,406**	**63,030**	**62,544**	**64,340**	**765,306**	**25,583**
Communications & Ext Relations	45	4	4	4	4	4	4	4	4	4	4	4	4	49	4
Corporate & Legal	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(0)
Corporate Medical	3,148	228	228	228	228	228	228	228	228	228	228	228	228	2,731	(418)
Divisional Management Codes	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Facilities	13,929	1,152	1,152	1,152	1,152	1,152	1,152	1,152	1,152	1,152	1,152	1,152	1,152	13,819	(110)
Finance & Procurement	59	4	4	4	4	4	4	4	4	4	4	4	4	50	(9)
Human Resources	1,727	118	118	118	118	118	118	118	118	118	118	118	118	1,418	(309)
Im&T	114	10	10	10	10	10	10	10	10	10	11	10	10	122	7
Nursing	1,590	15	15	15	15	15	15	15	15	15	15	15	15	179	(1,412)
Operations	511	0	0	0	0	0	0	0	0	0	0	0	0	2	(508)
Strategic Devt	15	0	0	0	0	0	0	0	0	0	0	0	0	0	(15)
Alliance	21,485	1,836	1,753	2,003	2,087	1,836	2,003	2,003	1,920	1,920	1,836	1,920	1,920	23,038	1,553
Directorate Total	**42,623**	**3,367**	**3,284**	**3,534**	**3,617**	**3,367**	**3,534**	**3,534**	**3,450**	**3,450**	**3,368**	**3,450**	**3,450**	**41,406**	**(1,216)**
R&D Total	**37,857**	**2,976**	**2,976**	**2,976**	**2,976**	**2,976**	**2,976**	**2,976**	**2,976**	**2,976**	**2,976**	**2,976**	**2,976**	**35,713**	**(2,143)**
Central Total	**14,173**	**13**	**(20)**	**21**	**(5)**	**(17)**	**21**	**(9)**	**17**	**(13)**	**(17)**	**46**	**(13)**	**24**	**(14,149)**
Trust Total	**834,376**	**68,249**	**67,563**	**71,077**	**73,395**	**69,085**	**71,257**	**72,038**	**69,838**	**70,820**	**69,358**	**69,017**	**70,754**	**842,450**	**8,074**

Patient Care Activity and Income

Clinical Management Group	Activity Type	15/16 SLA Activity	15/16 SLA Value £000s
Alliance	IP	10,410	6,607,111
	OP	110,656	11,411,550
	DA	62,453	2,162,355
	DI	8,744	836,636
	Other	8,663	1,535,592
	CQUIN	-	484,419
Alliance Total		200,925	23,037,662
Central	IP	-	(10,822,792)
	O/S Coding & Counting	-	(467,871)
	Other	-	(12,103,799)
	CQUIN	-	15,039,254
Central Total		-	(8,355,208)
CHUGGS	IP	71,685	67,085,086
	OP	159,711	16,291,968
	BMT	80	2,957,626
	CC	757	712,851
	O/S Coding & Counting	-	252,000
	Other	3,141	31,865,526
	RT	38,246	6,195,461
	UB	55,959	6,954,614
CHUGGS Total		329,579	132,315,132
CSI	IP	266	440,659
	OP	102	33,041
	DA	7,763,001	14,735,854
	DI	116,454	10,445,822
	Other	163,388	6,290,910
CSI Total		8,043,211	31,946,286
Emergency and Specialist Medicine	IP	34,604	53,617,166
	OP	153,396	22,501,970
	AE	131,052	16,683,168
	CC	2,944	2,486,217
	DA	5,040	325,179
	Other	668	34,107,885
	UB	11,536	4,292,004
Emergency and Specialist Medicine Total		339,241	134,013,588
Facilities	Other	-	371,880
Facilities Total		-	371,880
ITAPS	IP	4,202	2,550,469
	OP	22,442	2,240,080
	CC	22,129	25,757,134
	O/S Coding & Counting	-	-
	Other	432	5,668,432
	UB	2	1,821
ITAPS Total		49,207	36,217,937
Musculoskeletal and Specialist Surgery	IP	30,020	58,027,955
	OP	273,155	25,596,688
	AE	18,033	1,556,426
	O/S Coding & Counting	-	219,000
	Other	96,857	10,217,300
	UB	3	336
Musculoskeletal and Specialist Surgery Total		418,068	95,617,705
Renal Respiratory and Cardiac	IP	32,830	71,901,224
	OP	88,200	13,047,248
	CC	8,417	7,050,152
	DA	8,333	639,238
	DI	12,052	691,674
	Other	14,915	19,650,577
	PTS	-	1,263,828
	RL	187,485	29,140,307
	UB	4,525	35,531
Renal Respiratory and Cardiac Total		356,757	143,419,779
Women's and Children's	IP	43,623	61,453,628
	OP	120,828	18,853,751
	CC	21,979	18,639,739
	DA	1,504	42,387
	Maternity Tariffs	26,442	22,795,584
	O/S Coding & Counting	-	630,963
	Other	6,207	12,543,474
	UB	1,195	238,712
Women's and Children's Total		221,780	135,198,239
Grand Total		**9,958,767**	**723,783,000**

Cost Improvement Programme

CMG or Corporate	CMG Name	TOTAL £'000
CMG	CHUGGS	5,532
	CSI	4,867
	ESM	7,168
	ITAPS	4,123
	MSS	4,875
	RRC	6,577
	W&C	4,751
CMG Total		**37,893**
Corporate	Communications	49
	Corporate & Legal	69
	Corporate Medical	148
	Corporate Nursing	493
	Facilities	523
	Finance & Procurement	301
	Human Resources	429
	IMT	18
	Operations	344
	Research and Development	250
	Strategic Development	193
	To be allocated	2,290
Corporate Total		**5,107**
CIP Total		**43,000**

CAPITAL EXPENDITURE	UHL Approval	CMG	£k
INTERNALLY FUNDED CAPITAL			
Estates & Facilities			
Facilities Sub-Group	N/A	UHL	5,355
MES Installation Costs	N/A	UHL	1,500
Aseptic Suite	Approved	CSI	440
Lloyds Pharmacy Extension	Approved	CSI	126
Theatre Recovery LRI	Approved	ITAPS	2,750
Life Studies Centre	Approved	W&C	850
Sub-total: Estates & Facilities			**11,021**
IM&T Schemes			
IM&T Sub-Group	N/A	UHL	4,000
LRI Managed Print	Under review	UHL	1,323
EDRM	Under review	UHL	3,000
Safecare Software System	Approved	UHL	58
Electronic Blood Tracking System	Approved	CSI	996
Sub-total: IM&T Schemes			**9,377**
Medical Equipment Schemes			
Medical Equipment Executive Budget	N/A	UHL	5,500
Linear Accelerators	Not Approved		3,000
Sub-total: Medical Equipment			**8,500**
Reconfiguration Schemes			
Relocation of ICU level 3	Not Approved	UHL	3,000
Sub-total: Reconfiguration Schemes			**3,000**
Corporate / Other Schemes			
Stock Management Project	Under review	UHL	0
Donations	N/A	UHL	300
LiA Schemes	Not Approved	UHL	250
Contingency	Not Approved	UHL	1,671
Sub-total: Corporate / Other Schemes			**2,221**
Sub total: Internally funded capital expenditure			**34,119**
EXTERNALLY FUNDED CAPITAL			
Emergency Floor	Approved	ESM	17,698
EPR Programme	Approved	UHL	33,511
Imaging GH	Not Approved	CSI	3,000
Theatres LRI	Not Approved	ITAPS	1,650
ICU interim solution & Vascular Hybrid Theatre	Not Approved	UHL	9,778
Multi-storey Car Park Development	Not Approved	UHL	4,229
Treatment Centre	Not Approved	UHL	5,000
Wards / Beds LRI	Not Approved	UHL	2,000
Wards / Beds GH	Not Approved	UHL	6,000
Women's service	Not Approved	W&C	1,000
EMCH Interim Solution	Not Approved	W&C	3,500
Children's Hospital	Not Approved	W&C	400
Sub total: Externally funded capital expenditure			**87,766**
GRAND TOTAL CAPITAL EXPENDITURE			**121,885**

University Hospitals of Leicester NHS
NHS Trust

Agenda Item: Trust Board Paper H

TRUST BOARD – MAY 2015

Update on Medical Education

DIRECTOR:	Medical Education
AUTHOR:	Professor Sue Carr
DATE:	7 May 2015
PURPOSE:	**(concise description of the purpose, including any recommendations)** **Update on medical education issues in UHL** 1. Health Education East Midlands quality management visit issues 2. Medical education funding update 3. Education facilities 4. Redistribution of training posts across East Midlands and Broadening Foundation report and implications for workforce 5. 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

Following the HEEM Quality Management Visit (QMV) in October 2014 an interim visit took place in February and responses, provided by the services, were accepted by HEEM. A further interim visit is planned in May and a follow up visit to Obstetrics and Gynaecology scheduled for June 12th. The 2015 QMV is scheduled for Nov 5th and 6th.

The 2015 National Trainee Survey (NTS) is currently open and will close on May 6th. An analysis of the results will be provided in the next report. As of April 23rd, UHL has received10 patient safety and 3 undermining concerns from the GMC trainee survey.

The UHL Education Quality Dashboard has been updated for the second quarter. Data has been collated from the CMG Education Leads, a local UHL Trainee Survey and the Department of Clinical Education (Appendix)

GMC Enhanced Monitoring concerns – update

Emergency Medicine and Renal Medicine remain under enhanced monitoring. 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

Health Education England "Broadening Foundation" plans a restructuring of Foundation programmes across the UK. Foundation doctors will no longer be allowed rotate into two posts within the same speciality. This affects 21 UHL Foundation rotations - 16 F1 rotations and 5 F2. Bids to retain 3 F2 posts were successful. Work has commenced to develop bids to try to retain the 16 F1 posts at risk. It is essential that CMGs work together to develop new posts and that this issue feeds into new roles group and workforce strategies.

HEEM has indicated it wishes to achieve a more equitable distribution of core and specialty trainees across East Midlands (using per Consultant episode/admission or per population numbers) and this may have significant implications for UHL at all training levels. HEEM data re specialty post redistribution presents a worst case scenario where Leicestershire would reduce by 7-10 CMT posts and up to? 43 SPR level posts (7 in Emergency medicine) although numbers are uncertain.
When considered together these changes could be extremely challenging and could create significant issues for clinical service in UHL and impact of quality of remaining training posts.

3. Medical 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 is now transparent in CMG budget lines and meetings with CMGs are in progress to discuss education expenditure and accountability for this funding.

Developing transparency and accountability of funding will be essential in retaining our education funding - so far we are one of few Trusts to achieve this.

However, E&T funding is decreasing as training is moved out to community and DGH hospitals (in addition to some unavoidable changes e.g. reduced medical student funding £360,000 this year.

UHL funding	**2011/12**	**12/13**	**13/14**	**14/15**	**15/16**
	£'000s				
MADEL	26,750	26,495	25,684	25,075	25,112
SIFT	18,490	17,807	15,200	14,006	12,811
Head of School etc.	406	396	482	416	
Totals	**47,473**	**46,692**	**44,496**	**42,883**	**40,819**
Less Transitional support				-2,000	-1,106
TOTAL	**47,473**	**46,692**	**44,496**	**40,883**	**39,713**

Education Facilities
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.

a) **Odames library** – Library is open and official opening will be by Fiona Godlee, Editor of the BMJ.
b) **RKCSB patient unit** – plan for UHL to support progressing
c) The DCE has prepared an outline strategy for further medical education facilities. The education centre at LRI (and lecture theatre) will need relocation/rebuilding as part of the maternity enabling works

Simulation

There is an increasing need to provide simulated training in an appropriate environment. The Executive Workforce Board has supported the development of a draft inter-professional strategy for Simulation training and associated facilities.

Gripes tool

The UHL Gripe Tool was developed by UHL Department of Clinical Education, in collaboration with Director of Safety and Risk and University of Leicester Sapphire group (LIPPS). This tool allows junior doctors to report their work based patient safety concerns quickly and easily using the Gripe Tool webpage on Insite. http://insite.xuhl-tr.nhs.uk/homepage/clinical/clinical-education/doctors-in-training-committee/gripe-reporting-tool
This project aimed to improve real-time reporting of low level safety concerns to enable UHL to be proactive in addressing issues early. The Gripe Tool has been piloted since February 9 2015 and has already received 96 Gripes. During the pilot period we have proactively dealt with Gripes and had successful resolutions of many problems.

Key priorities

1. Respond to requirements of HEEM quality management visit.
2. Medical workforce – loss of posts and vacancies pose a significant threat to UHL's ability to provide high quality training and to attract and retain medical staff. Proposed HEEM redistribution of postgraduate medical training posts - poses an additional risk for UHL.

The Trust needs to be able to demonstrate its role as a teaching centre of excellence to attract and retain trainees and to compete for reducing education funding. In this climate it is essential to demonstrate quality control of training delivered and accountability for funding we receive for education & training.

3. Progress is being made on a facilities strategy for education and training and a collaborative approach across healthcare professionals is progressing with the planned development of a simulation strategy.
4. 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

UHL Quality Dashboard

Date:

RAG Rating: Green: Full Evidence or >85% /Amber: Partial Evidence or 50-74% /Red: No Evidence or <50%

UHL wide requirements

Requirement	CHUGS	CSI		Emergency and Specialist Medicine	ITAPS	Musculo-skeletal and Specialist Surgery	Renal, Respiratory and Cardiac	Women's and Children's	
		Imaging	Histopathology					Women's	Children's
Safe Learning Environment									
% CMG trainees with an identified Clinical Supervisor									
% trainee attendance at Departmental induction									
Formal, timetabled handover process in place BEFORE and AFTER Nights									
% trainees completed UHL mandatory training									
Governance and Quality									
There is a Medical Education Lead in the CMG									
Overall trainee satisfaction									
Evidence that Education and Training Issues are integrated into CMG Governance processes									
Workforce plans are in place to manage shortfalls or changes in the medical workforce									
Support and development of trainees									
Junior doctor forum in CMG and CMG rep on UHL Doctors in Training committee									
Foundation trainees able to attend at least 70% of education sessions	F1 69.5% F2 50%	N/A to imaging	N/A to Histopathology	F1 70% F2 50%	F1 68% F2 72%	F1 78% F2 77%	F1 69% F2 51%	F1 72% F2 64%	
Core and Higher level trainees able to attend at least 70% teaching sessions,									
Core and Higher level trainees have timetabled access to required theatre lists and out-patient clnics		N/A to imaging	N/A to Histopathology						
Trainees are supported to access study leave									
Trainer/Mentor Support									
Supervisors trained for role (%)									
Consultants with educational roles, have these roles embedded within job plans (%) including those in wider organisation/LETB and Medical School									
Education Facilities									
Trainees and trainers have access local educational resources									
Funding Streams									
Educational funding streams are identified within the CMG									

University Hospitals of Leicester NHS
NHS Trust

Trust Board Paper I

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT BY TRUST BOARD COMMITTEE TO TRUST BOARD

DATE OF TRUST BOARD MEETING: 7 May 2015

COMMITTEE: Quality Assurance Committee

CHAIR: Dr S Dauncey, Non-Executive Director

DATE OF MEETING: 30 April 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 4 June 2015.

SPECIFIC RECOMMENDATIONS FOR THE TRUST BOARD:

- **East Midlands Congenital Heart Centre** - the Committee endorsed the recommendations following the external review and requested a further update at QAC meeting in 3 months' time. The report to be sent to the TDA and NHS England;
- **Whistle Blowing Update** – the contents of the paper were received and noted, QAC were supportive of the investigation and the ownership at CMG level with future corporate challenge, the process of which had yet to be identified via NET. It was agreed that the report would be submitted to CQC;
- **Jimmy Savile Investigation** – the content and recommendations of the Kate Lampard 'Savile Report', and UHL's proposed response to it, were discussed. The response forms the basis of the report requested by the TDA and outlines UHL's position on the recommendations. The response and action plan are attached. This has been brought to the Trust Board for information and approval and it should be noted that this needs to be provided to the TDA by the end of May. QAC was fully assured by the response and action plan;
- **Update on CQC Applications** – the Committee noted that;
  - an application had been made to remove Harborough Lodge from UHL's registration;
  - an application had been made to add the Northampton Renal and Dialysis Unit (Riverside House) as a new location, and
  - a declaration of non-compliance regulation 22 (staffing) at the Northampton Renal and Dialysis Unit (Riverside House) and it was planned to be compliant by 31 August 2015.

SPECIFIC DECISIONS:

- None

DISCUSSION AND ASSURANCE:

- **Update Regarding Reasons for TTO errors and any further actions that could be taken** – the Committee noted the contents of the report and the action plan. Further assurance on the action plan was requested with an update at QAC in four or five month's time;
- **Feedback re.Theatre Production 'Inside Out of Mind'** – received and noted and discussed the

opportunity for shared learning;

- **Patient Safety Monthly Report** – the new style of report was well received and further consideration to be given to featuring a dashboard on RIDDOR;
- **Freedom to Speak Up Report** – the Committee supported the continuing work and requested that the progress updates be submitted to QAC whilst the gap analysis work continued and would then progress to the Trust Board once completed;
- **Prevent Training** – received and noted;
- **Months 12 Quality and Performance Report** – particular note was made in respect of deterioration in #NOF target, performance in respect of pressure ulcers and nutrition assessments. Improvements had been made with mortality rates;
- **Nursing Report** – a brief update on real time staffing, vacancies, premium pay and the nursing clinical dashboard was provided;
- **Friends and Family Test Scores** – received and noted;
- **CQUINS and Quality Schedule Monthly Report** – received and noted in particular amendments to the ratings of PS02, PS03, PS08, PS12 and CE08;
- **AOB** – the Committee received a briefing on an ongoing court case: the next hearing would be on Friday 1 May 2015 and the trial would commence 5 October 2015, and
- **CQC Intelligent Monitoring Report** – the Committee was sighted to the fact that the Trust had received a priority band rating of 4.

DATE OF NEXT COMMITTEE MEETING: 28 May 2015

Dr S Dauncey – Committee Chair
30 April 2015

University Hospitals of Leicester NHS
NHS Trust

Agenda Item: Paper I

Quality Assurance Committee – 30 April 2015

Proposed Response to the Kate Lampard 'Savile Report'

DIRECTOR:	Carole Ribbins, Acting Chief Nurse
AUTHOR:	Michael Clayton Head of Safeguarding
DATE:	30 April 2015
PURPOSE:	The purpose of this report is to alert Executive Quality Board to the recently published NHS report relating to the relationship of Savile with the NHS. The report outlines the Trust position to the recommendations in the Kate Lampard Report as requested by the Trust Development Authority.
PREVIOUSLY CONSIDERED BY:	None
Objective(s) to which issue relates *	[x] 1. Safe, high quality, patient-centred healthcare [ ] 2. An effective, joined up emergency care system [ ] 3. Responsive services which people choose to use (secondary, specialised and tertiary care) [ ] 4. Integrated care in partnership with others (secondary, specialised and tertiary care) [ ] 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:	To note that a proportionate approach is recommended in response to national recommendation to maintain effective public relations.
Please explain the results of any Equality Impact assessment undertaken in relation to this matter:	None
Organisational Risk Register/ Board Assurance Framework *	[ ] **Organisational Risk Register** [ ] **Board Assurance Framework** [x] **Not Featured**
ACTION REQUIRED *	For decision [x] For assurance [ ] For information [x]

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

* tick applicable box

Paper I

University Hospitals of Leicester NHS Trust

Report to: Quality Assurance Committee

From: Michael Clayton, Head of Safeguarding

Date: 30 April 2015

Subject: Proposed Response to the Kate Lampard 'Savile Report'

Purpose Of The Report

The purpose of this paper is to update members of the recommendations from the Department of Health National review of the association with Jimmy Savile and the NHS.

The paper outlines progress against these recommendations and areas for development together with implications for the Trust.

Background

Following the death of Jimmy Savile a number of allegations were made about his conduct in NHS establishments which led to an independent review undertaken by Kate Lampard.

The findings of this review were published in February 2015 which confirmed that it is likely that Jimmy Savile sexually abused staff and patients over a number of decades, but that systems did not enable the effective reporting of allegations.

The review also identified concerns regarding the use of charitable funds and the influence of Jimmy Savile over the management of NHS organisations and the role of volunteers within NHS establishments.

Following the publication of the report a number of recommendations have been made and subsequently, the Trust Development Authority will be seeking assurance that Trust Boards have considered the recommendations contained in the report. In particular the nine recommendations are reviewed and progress against these reported to the Trust Development Authority by 31 May 2015 (Appendix 1).

Implications for the Trust

The recommendations derived from the Savile Report have been considered by the respective Trust leads for

- Volunteer Services
- Safeguarding
- Recruitment and Selection
- Media and Communications
- Charitable Funds

The action plan has been completed and this has identified that overall the Trust follows current guidance and standards. The review has identified that most of the recommendations made in Kate Lampard's Report can be incorporated into existing practice, with the exception of recommendation V and VI, where further guidance is being sought from NHS England and the Trust Development Authority.

Progress to Date

The Trust received the correspondence from the Trust Development Authority on 11 March 2015 and work has been undertaken to determine the current position against the recommendations.

The Head of Safeguarding has liaised with interested parties within the Trust to pull together a position statement and associated action plan. Part of this process included seeking clarification from NHS England Area Team and NHS employees in relation to recommendations as required.

The enclosed Action Plan highlights the actions to be taken by 31 May 2015 to achieve compliance.

It is proposed that once approved and signed off at the Trust Board, update reports and actions plans are shared with the local Safeguarding Boards.

Conclusion

This report outlines the proposed steps to be taken to ensure that the recommendations made in the Savile Report are met as requested by the Trust Development Authority.

It has outlined the key areas where assurance is currently being sought and more detail will be provided in an update report for the May Trust Board.

The QAC is requested to:

- Note the content and recommendations made in the NHS Savile Report as requested by the Trust Development Authority.
- To note approve and sign off the attached Action Plan.

Michael Clayton
Head of Safeguarding
April 2015

Annex A: REPORT ON TRUST PROGRESS IN RESPONSE TO KATE LAMPARD'S LESSONS LEARNT REPORT

NAME OF TRUST:	University Hospitals of Leicester

Recommendation	Issue identified	Planned Action	Progress to date	Due for completion
I. All NHS hospital trusts should develop a policy for agreeing to and managing visits by celebrities, VIPs and other official visitors.	Policy in place	None	The Trust has a policy in place which was created in April 2014.	N/A
II. All NHS trusts should review their voluntary services arrangements and ensure that: • They are fit for purpose; • Volunteers are properly recruited, selected and trained and are subject to appropriate management and supervision; and, • All voluntary services managers have development opportunities and are properly supported.	That the Trust Volunteer Policy will be updated, and the recommendations of the report will be considered in revisions.	The Trust Volunteer Policy will be reviewed in April 2015 and will take into account the findings of Kate Lampard's report in its revisions.	The Trust has a current Volunteer Policy in place which is due to be renewed in April 2015. All volunteers are subject to a recruitment process which includes a DBS check, interview and are overseen by the Trust Volunteer Manager.	May 2015
III. All NHS hospital staff and volunteers should be required to undergo formal refresher training in safeguarding at the appropriate level at least every three years.	That volunteer training information is contained in the Trust's Quarterly Safeguarding Report.	To include in the Trust safeguarding reports, safeguarding training compliance figures for volunteers.	Training is provided to all staff and volunteers on safeguarding adults and children on induction and	May 2015

			has to be refreshed every three years. Training data is reported quarterly across the organisation to the Executive Quality Board.	
IV. All NHS Hospital trusts should undertake regular reviews of: • Their safeguarding resources, structures and processes (including their training programmes); and, • The behaviours and responsiveness of management and staff in relation to safeguarding issues. • to ensure that their arrangements are robust and operate as effectively as possible.	To include additional safeguarding performance data in the Trusts annual safeguarding report	The Safeguarding Annual Report is in the process of being written. In response to the Kate Lampard report a section will be included regarding actions taken to include specific assurance information on: • Training compliance. • Numbers of allegations received relating to staff. • New policy and procedures.	The Trust produces an annual Safeguarding Report which describes service developments, performance, service pressures and referral information. Quarterly Safeguarding Reports are submitted to the Executive Quality Board and for review by the Clinical Commissioning Group (CCG). Staff's knowledge of safeguarding procedure is spot checked	May 2015

			through unannounced visits by the Safeguarding Team within the Clinical Managed Group.	
V. All NHS Hospital trusts should undertake DBS checks (including, where applicable, enhanced DBS and barring list checks) on their staff and volunteers every three years. The implementation of this recommendation should be supported by NHS Employers.	Current NHS Employers standards do not require employees to have a three yearly DBS check, NHS Employers have advised that they are awaiting further guidance from the Department of Health	None	The Trust works to NHS Employers standards. The Human Resource Department have checked on 26 March 2015 with NHS Employers whether there is an intention to change current standards, and they have advised they are waiting Department of Health guidance The Trust is also part of a scheme to ensure that medical and nursing staff have three yearly DBS	

			checks.	
VI. All NHS hospital trusts should devise a robust trust-wide policy setting out how access by patients and visitors to the internet, to social networks and other social media activities such as blogs and Twitter is managed and where necessary restricted. Such policy should be widely publicised to staff, patients and visitors and should be regularly reviewed and updated as necessary.	Following discussion with the Trust Communications Department and the Trust Development Authority, it is believed that to place restrictions on peoples access to the internet and social media may infringe human rights legislation.	The Head of Safeguarding will formally write to the Trust Development Authority to seek further clarity on this recommendation.	Patients and visitors are unable to access the internal websites. Information is made available to the general pubic regarding taking pictures in hospital. Media comments about the Trust are monitored through the Trust communications department	April 2015
VII. All NHS hospital Trusts should ensure that arrangements and processed for the recruitment, checking, general employment and training of contract and agency staff are consistent with their own internal HR processes and standards and are subject to monitoring and oversight by their own HR managers.	That not all agency bookings are overseen by Corporate Nursing. Some Clinical Management Groups organise their own locum and agency staff.	To ensure that across the Trust all areas comply with the Trust standards for employment and use of agency staff. This assurance will be provided to the Trust Safeguarding Assurance Group	The Trust has a system and standard in place to ensure that agencies supplying staff for the Trust meet the required standard, which is overseen by the Corporate Human Resource Team	May 2015

VIII. NHS Hospital Trusts should review their recruitment, checking, training and general employment processes to ensure they operate in a consistent and robust manner across all departments and functions, and that overall responsibility for these matters rests with a single Executive Director.	That policies and procedures currents exceed the minimum standards required by NHS employers	To include in the Trust Annual Safeguarding Report, assurance information on recruitment and selection process checks.	The Trust has a recruitment and selection policy. Spot checks are undertaken monthly of recruitment checks and process. A minimum of 12 audits are conducted each year and these take place more frequently if issues arise	May 2015
IX. NHS Hospital Trusts and their associated charities should consider the adequacy of their policies and procedures in relation to the assessment and management of the risks to their brand and reputation, including as a result of their associations with celebrities and major donors, and whether their risk registers adequately reflect this.	That the content and recommendations made in the Kate Lampard Report should be discussed at the Charitable Funds Committee	That current Trust practice will be benchmarked against the Kate Lampard Report recommendations and an Action Plan produced by May 2015.	That content of the report is due to be discussed at the Trust Charitable Funds Committee	May 2015

I confirm that this Trust Board has reviewed the full recommendations in Kate Lampard's lessons learnt report:

SIGNED: DATE:

CE NAME:

University Hospitals of Leicester NHS
NHS Trust

Trust Board Paper J

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT BY TRUST BOARD COMMITTEE TO TRUST BOARD

DATE OF TRUST BOARD MEETING: 7 May 2015

COMMITTEE: Integrated Finance, Performance and Investment Committee

CHAIR: Ms J Wilson, Non-Executive Director

DATE OF MEETING: 30 April 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 4 June 2015.

SPECIFIC RECOMMENDATIONS FOR THE TRUST BOARD:

- ***Annual Operational Plan 2015-16*** – finalised version to be presented to the 7 May 2015 Trust Board meeting, subject to clarification of the timing of the requirement for the Equality Impact Assessment and the arrangements for CMG-level patient and public engagement resources;
- ***Final Financial Plan 2015-16*** – endorsed for Trust Board approval on 7 May 2015.

SPECIFIC DECISIONS:

- none

DISCUSSION AND ASSURANCE:

- ***Matters arising*** – the substantive Alliance Director had now commenced in post and delegated approvals limits would be developed accordingly. The delegated approvals limits would be confirmed at the IFPIC meeting in June 2015;
- ***ITAPS CMG Presentation*** – the key issues discussed included:-
  - RTT performance in the most challenged specialties of Orthopaedics, ENT and Paediatric ENT;
  - improvements in financial performance during the second half of the 2014-15 financial year;
  - good financial awareness and expenditure control processes;
  - robust CIP plans for 2015-16;
  - improved arrangements for triangulating activity plans, workforce plans and budgets for 2015-16;
  - implementation of theatre trading model;
  - continued due diligence arrangements for supporting the Vascular service (until June 2015), noting that this service had transferred to RRC on 1 April 2015;
  - two issues affecting the Orthodontics and Restorative Dentistry service: (a) Commissioner approval of the business case to deliver additional capacity to reduce waiting lists, and (b) clinical and administrative validation of patients currently on the waiting lists for treatment;
  - continued recruitment and workforce challenges in relation to spinal surgeons for the Trauma and Orthopaedics service and junior doctors;
  - support being sought to progress the pace of Paediatric bed changes without reducing elective

capacity and throughput;

- ***University of Leicester Apportionment of Clinical Academic Funding*** – subject to the resolution of the final outstanding technical queries, the SLA for medical staff recharges between UHL and UoL was considered to be complete. The Committee received additional assurance that this approach would align with future workforce changes and be sustainable in the longer term. Members commended the positive impact upon UHL's relationship with the University;
- ***Da Vinci Robot Post Implementation Review*** – the Committee noted the need to create a standardised template for post investment reviews going forwards and agreed that a 12 month interval would allow for more meaningful feedback on the clinical outcomes to be gathered. A further review would be scheduled in November 2015;
- ***Month 12 Quality and Performance***
  - RTT performance for incomplete pathways, admitted and non-admitted;
  - cancer performance for 2 week wait, 31 day and 62 day standards – a new patient leaflet had been produced to inform patients on the cancer exclusion pathways and an audit was being undertaken to monitor the briefing information provided from primary care. The Director of Performance and Information agreed to ensure that this leaflet was available for GPs to download from the "Prism" system;
  - ambulance handovers – issues relating to data collection and underlying processes were being addressed and full implementation of the data capture mechanism would be in place by the beginning of June 2015;
  - cancellations and re-booking within 28 days performance remained strong;
  - an extended role had been developed for Mr M Metcalfe to oversee improvements in RTT performance in addition to his current role relating to cancer performance;
- ***Month 12 financial performance***
  - delivery of the 2014-15 financial control total and all statutory duties (subject to audit);
  - a continued focus on pay expenditure trends via the workforce cross-cutting CIP theme;
  - opportunities to strengthen the arrangements for business case development and engagement with SLR, SLM and PLICS – a financial awareness session was to be held on 28 May 2015 on this subject and the Trust was planning to participate in a related pilot scheme led by Monitor;
- ***Cost Improvement Programme***
  - achievement of £48.04m CIP savings in 2014-15 (against the target of £45.01m);
  - identification of £35.92m CIP schemes for 2015-16 (against a target of £41m plus an additional £2.3m to fund cost pressures);
  - progress with recruitment of UHL Transformation Managers and the arrangements for skills transfer and handovers from EY resources. Mr S Barton, UHL Programme Director had now commenced in post and attended his first IFPIC meeting, but assurance was provided that EY would continue to support the PMO until at least October 2015;
  - arrangements for closing the gap in respect of CIP schemes for 2015-16 and monitoring progress against the 5 cross-cutting workstreams;
- ***Workforce Cross-Cutting CIP and Workforce Plan*** – a target 10% reduction in premium pay expenditure had been agreed, but the targets for the medical productivity and nursing/midwifery productivity workstreams would be agreed within the next week. The Committee received a summary of the workforce plan for 2015-16 and discussed progress with validation of Consultant job plans and ensuring that these were available electronically;
- ***2015-16 Contracts with CCGs and NHS England*** – the Committee received and noted the briefing report, supporting this direction of travel, noting that this would apply for 1 year only;
- ***Executive Performance Board*** – the Committee received briefing information on the planned data centre shutdown and development of the 2015-16 Board Assurance Framework (as discussed at the EPB meeting on 28 April 2015), and
- ***Any Other Business*** – the Committee received feedback from a recent Non-Executive Director visit to the Coding Centre and considered opportunities for the IFPIC to review clinical coding at a future IFPIC meeting.

DATE OF NEXT COMMITTEE MEETING: 28 May 2015

Ms J Wilson – Committee Chair 30 April 2015

University Hospitals of Leicester NHS
NHS Trust

Agenda Item: Trust Board Paper K

TRUST BOARD – 7th MAY 2015

QUALITY AND PERFORMANCE REPORT – MARCH 2015

DIRECTOR:	Carol Ribbins, Acting Chief Nurse Andrew Furlong, Interim Medical Director Richard Mitchell, Chief Operating Officer Emma Stevens, Acting Director of Human Resources Darryn Kerr, Director of Estates and Facilities
AUTHOR:	
DATE:	7th May 2015
PURPOSE:	The following report provides an overview of the March Quality & Performance report highlighting NTDA/UHL key metrics and escalation reports where required. It includes a Chief Executive's 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 HIGHLIGHT REPORT – AN OVERVIEW OF 2014/15

For this report I have focussed on providing an overview of performance in the year just completed. Green indicates compliant performance or that good progress was made, yellow that there was some progress but there remains more to do and red that there was either no progress or performance actually deteriorated. All figures are for the whole year unless otherwise stated, and comparisons are with 2013/14.

It will be seen that whilst there has been progress in a range of areas, that progress is not universal and there remains work to be done to achieve consistently high performance.

Clostridium difficile
We ended the year on 73 cases against a "limit" of 81. However, in 2014/15 we had only 66 cases so although we met the target our performance deteriorated slightly.

MRSA
We had 6 cases compared with 3 in 2013/14. However, only one of those was avoidable.

Never events
There were 3 never events, the same number as in 2013/14.

Serious incidents
The number of serious incidents dropped from 60 to 41.

Falls
Our falls rate fell from 7.1 to 6.9, indicating some progress particularly in the second half of the year.

Pressure ulcers
The total number of Grade 2, 3, and 4 avoidable pressure ulcers fell by 16%, indicating the impact of work in this area. Evidence indicates that there is a direct correlation between pressure ulcer numbers and staffing levels, emphasising the need to maintain the programme of investment in nurse staffing.

Friends and Family Test
There was positive progress across all of the Inpatient, A&E and maternity tests. A&E was most striking, rising from 58.5 to 69.3. There were also major improvements in coverage, with a new high of 44.8% inpatient coverage achieved for March.

Staff Appraisal
Staff appraisal rates were maintained at a healthy 91.4% but judging by the staff survey there is more to do to make these more valued by staff themselves.

Mandatory Training
We met our target to achieve 95% compliance by the end of March 2015. This compares to 76% in March 2014.

Fractured Neck of Femur
There was no real progress on this issue during the year, with performance actually deteriorating from 65.2% to 61.4%. This area is subject to a Listening into Action intervention and should also benefit from investment in 2015/16 into a new trauma service model.

RTT Waiting Times
All three RTT standard showed in improvement in year. Both the non-admitted and incomplete targets were compliant by year end on a sustainable basis. Admitted backlog reduced by over 900 patients (63%) between March 2014 and March 2015 and admitted performance improved from 76.7% to 84.4% over the same period. This standard is planned to reach the 90% standard by May 2015.

Emergency Care 4 hour target
Overall performance for the year was 89.1% compared to 88.4% in 2013/14. Although our absolute performance was broadly stable, our relative performance improved markedly, moving us from the bottom 10 of the 140 A&E providers to mid-table. Nevertheless, the standard is 95% and we need to do more to get there, hence the continued focus on emergency care in our priorities for 2015/16.

Cancer
After a strong performance in 2013/14, we struggled all year to meet our cancer standards, only starting to make real progress in the second half of the year. We do not yet have full year validated data but the 14 and 31 day standards are expected to be met in March. 62 day compliance is expected to be achieved in July 2015.

Operations Cancelled on the Day for Non-Clinical Reasons
There percentage of operations cancelled on the day for non-clinical reasons reduced to 0.9% in 2014/15 compared to 1.6% in 2013/14, resulting in 736 fewer patients having their operation cancelled.

Delayed Transfers of Care
There was very good progress with DTOCs in the second half of the year, reaching a record low of 1.8% in March 2015. The overall rate for the year was 3.9% compared to 4.1% in 2013/14.

Ambulance Handover
There was a major deterioration in reported performance against this indicator in 2014/15. There were 3,067 over 60 minute delays compared to 868 in 2013/14 and there were 11,315 over 30 minute delays compared to 7,075. Although there have been concerns about data accuracy, this is clearly an unacceptable position and we need to focus our efforts on improving it significantly. This specific area has been identified as one of the Trust's corporate priorities for 2015/16.

Mortality Rates
The SHMI data for the most recent quarter has not yet been published. It is hoped that we will be able to give a verbal update at the Trust Board.

John Adler
23rd April 2015

Caring at its best

University Hospitals of Leicester NHS
NHS Trust

Quality and Performance Report

March 2015

One team shared values

CONTENTS

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **7th MAY 2015**

REPORT BY: **CAROL RIBBINS, ACTING CHIEF NURSE**
ANDREW FURLONG, INTERIM MEDICAL DIRECTOR
RICHARD MITCHELL, CHIEF OPERATING OFFICER
EMMA STEVENS, ACTING DIRECTOR OF HUMAN RESOURCES
DARRYN KERR, DIRECTOR OF ESTATES AND FACILITIES

SUBJECT: **MARCH 2015 QUALITY & PERFORMANCE SUMMARY REPORT**

1.0 Introduction

The following report provides an overview of the March 2015 Quality & Performance report highlighting TDA/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	5
Caring	4	15	1	1
Well Led	5	14	7	2
Effective	6	17	0	1
Responsive	7	26	0	10
Research – UHL	9	5	5	0
Research - Network	9	13	0	3
Estates & Facilities	10	10	0	1
Total		119	15	23

Safe | Caring | Well Led | Effective | Responsive | Research | Estates and Facilities

	KPI Ref	Indicators	Board Director	Lead Director/Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	13/14 Outturn	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	YTD
Safe	S1a	Clostridium Difficile	CR	DJ	FYE = 81	NTDA	Red / ER for Non compliance with cumulative target	66	4	4	6	5	7	2	5	7	7	11	7	5	7	73
	S1b	Clostridium Difficile (Local Target)	CR	DJ	FYE = 50	UHL	Red >5 per month, ER when YTD red	66	4	4	6	5	7	2	5	7	7	11	7	5	7	73
	S2a	MRSA Bacteraemias (All)	CR	DJ	0	NTDA	Red = >0 ER = 2 consecutive mths >0	3	0	0	0	0	0	0	1	1	0	2	0	1	1	6
	S2b	MRSA Bacteraemias (Avoidable)	CR	DJ	0	UHL	Red = >0 ER = 2 consecutive mths >0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	1
	S3	Never Events	CR	MD	0	NTDA	Red = >0 in mth ER = in mth >0	3	0	0	0	0	0	0	0	1	0	1	1	0	0	3
	S4	Serious Incidents	CR	MD	tbc	NTDA	tbc	60	5	4	6	3	7	2	3	4	2	4	3	2	1	41
	S5	Proportion of reported safety incidents that are harmful	CR	MD	tbc	NTDA	tbc	2.8%		1.7%			2.2%			1.4%			2.3%			1.9%
	S6	Overdue CAS alerts	CR	MD	0	NTDA	Red = >0 in mth ER = in mth >0	2	0	2	2	2	3	0	0	0	0	0	0	0	1	10
	S7	RIDDOR - Serious Staff Injuries	CR	MD	FYE = <47	UHL	Red / ER = non compliance with cumulative target	47	5	3	5	1	2	2	1	2	2	1	0	3	2	24
	S8	Safety Thermometer % of harm free care (all)	CR	EM	tbc	NTDA	Red = <92% ER = in mth <92%	93.6%	93.6%	94.6%	94.7%	94.2%	94.9%	94.4%	93.9%	94.9%	93.3%	94.1%	95.0%	92.1%	93.6%	94.1%
	S9	% of all adults who have had VTE risk assessment on adm to hosp	AF	SH	95% or above	NTDA	Red = <95% ER = in mth <95%	95.3%	95.6%	95.7%	95.9%	95.9%	96.3%	95.5%	96.2%	95.4%	95.5%	95.0%	96.3%	96.2%	95.6%	95.8%
	S10	Medication errors causing serious harm	CR	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	CR	EM	<7.1	QC	Red >= YTD >8.4 ER = 2 consecutive reds	7.1	6.9	7.0	7.5	7.1	7.3	7.3	5.9	6.4	7.5	6.9	7.1	6.7	6.3	6.9
	S12	Avoidable Pressure Ulcers - Grade 4	CR	EM	0	QS	Red / ER = Non compliance with monthly target	1	0	0	0	0	0	0	0	0	0	1	0	0	1	2
	S13	Avoidable Pressure Ulcers - Grade 3	CR	EM	<8 a month	QS	Red / ER = Non compliance with monthly target	71	6	5	5	5	5	6	6	4	6	7	5	9	6	69
	S14	Avoidable Pressure Ulcers - Grade 2	CR	EM	<10 a month	QS	Red / ER = Non compliance with monthly target	120	9	6	6	6	7	9	4	8	13	11	7	5	9	91
	S15	Compliance with the SEPSIS6 Care Bundle	CR	MD	All 6 >75% by Q4	QC	Red/ER = Non compliance with Quarterly target	27.0%		47.0%			>=60%			<65%						<65%
	S16	Nutrition and Hydration Metrics - Fluid Balance and Nutritional Assessment	CR	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%	≥86%	≥83%	≥84%	≥82%	≥83%
	S17	Maternal Deaths	AF	IS	0	UHL	Red / ER = Non compliance with monthly target	3	0	0	0	0	0	0	0	0	0	0	1	0	0	1

	KPI Ref	Indicators	Board Director	Lead Director/Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	13/14 Outturn	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	YTD
Caring	C1a	Inpatient Friends and Family Test - Score	CR	CR	72 (Eng Avge - Mar 14)	NTDA	Red if <3SD. ER if <3SD or 3 mths deteriorating performance	68.8	69.9	69.6	71.0	74.5	73.8	73.8	76.1	71.1	70.3	72.1	70.8	71.7	74.4	72.4
	C1b	Inpatient Friends and Family Test - Score (Local Target)	CR	CR	75	UHL	Red/ ER =<=69.9 Green >74.9	68.8	69.9	69.6	71.0	74.5	73.8	73.8	76.1	71.1	70.3	72.1	70.8	71.7	74.4	72.4
	C2a	A&E Friends and Family Test - Score	CR	CR	54 (Eng Avge - Mar 14)	NTDA	Red if <3SD. ER if <3SD or 3 mths deteriorating performance	58.5	65.5	69.4	66.0	71.4	71.7	56.3	66.1	71.1	72.3	72.8	72.4	73.1	71.3	69.3
	C2b	A&E Friends and Family Test - Score (Local Target)	CR	CR	75	UHL	Red/ ER =<=64.9 Green >74.9	58.5	65.5	69.4	66.0	71.4	71.7	56.3	66.1	71.1	72.3	72.8	72.4	73.1	71.3	69.3
	C3	Outpatients Friends and Family Test - Score	CR	CR	75	UHL	Red / ER =<=64.9	New Indicator									58.7	63.8	65.2	64.3	67.6	65.0
	C4	Daycase Friends and Family Test - Score	CR	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	78.5	78.7	79.5	78.7
	C5	Maternity Friends and Family Test - Score	CR	CR	75	UHL	Red/ ER =<=61.9	64.3	66.7	61.2	63.5	69.5	69.7	67.3	63.0	64.1	67.7	63.8	74.5	74.5	69.5	67.8
	C6	Complaints Rate per 100 bed days	CR	MD	tbc	NTDA	tbc		0.4	0.4	0.3	0.3	0.4	0.4	0.4	0.4	0.4	0.3	0.3	0.3	0.4	0.4
	C7	Complaints Re-Opened Rate	CR	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%	17%	13%	11%	10%
	C8	Single Sex Accommodation Breaches (patients affected)	CR	CR	0	NTDA	Red = >0 ER = in mth >0	2	0	4	3	0	0	0	0	0	5	0	1	0	0	13
	C9	Improvements in the FFT scores for Older People (65+ year)	CR	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	76.6	76.9	75.3	76.1
	C10	Responsiveness and Involvement Care (Average score)	CR	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	88.5	89.0	88.6	88.3
	C10a	Q15. When you used the call button, was the amount of time it took for staff to respond generally:	CR	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	88.7	89.9	90.1	89.3
	C10b	Q16. If you needed help from staff getting to the bathroom or toilet or using a bedpan, did you get help in an acceptable amount of time?	CR	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	92.7	92.6	92.1	92.2
	C10c	Q11. Were you involved as much as you wanted in decisions about your care and treatment?	CR	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	86.1	86.7	85.9	85.6

Safe | Caring | Well Led | Effective | Responsive | Research | Estates and Facilities

Well Led

KPI Ref	Indicators	Board Director	Lead Director/Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	13/14 Outturn	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	YTD
W1	Inpatient Friends and Family Test - Coverage	CR	CR	30% - Q4. 40% - Mar 15	NTDA / CQUIN	Red = Non compliance with monthly target ER = 2 consecutive mths non compliance	24.3%	28.8%	36.8%	38.1%	32.6%	30.8%	28.9%	33.4%	36.3%	36.0%	31.9%	34.6%	41.0%	44.8%	40.1%*
W2	A&E Friends and Family Test - Coverage	CR	CR	15% Q1-Q3 20% for Q4	NTDA	Red = Non compliance with monthly target ER = 2 consecutive mths non compliance	14.9%	16.1%	15.2%	17.8%	14.9%	10.2%	16.1%	19.1%	15.9%	14.0%	18.7%	25.3%	21.2%	21.9%	22.8%*
W3	Outpatients Friends and Family Test - Valid responses	CR	CR	tbc	UHL	tbc	New Indicator available	271	175	286	1,879	1,535	785	927	1,255	1,506	1,053	1,259	1,245	1,280	13,185
W4	Maternity Friends and Family Test - Coverage	CR	CR	tbc	UHL	tbc	25.2%	23.9%	27.2%	36.4%	25.2%	29.2%	29.9%	18.7%	15.8%	21.7%	22.1%	25.8%	46.5%	40.2%	28.0%
W5	Friends & Family staff survey: % of staff who would recommend the trust as place to work	ES	ES	tbc	NTDA	tbc	New NTDA Indicator - Definition to be confirmed		53.7%			53.7%			Q3 staff FFT not completed as National Survey carried out			54.9%			54.2%
W6	Friends & Family staff survey: % of staff who would recommend the trust as place to receive treatment	ES	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			71.4%			69.2%
W7	Data quality of trust returns to HSCIC	RM	JR	tbc	NTDA	tbc	New NTDA Indicator - Definition to be confirmed														
W8	Turnover Rate	ES	ES	<10.5%	UHL	Red = 11% or above ER = Red for 3 Consecutive Mths	10.0%	10.0%	9.9%	10.0%	10.2%	10.0%	10.5%	10.3%	10.8%	10.7%	10.3%	10.1%	10.1%	11.5%	11.5%
W9	Sickness absence	ES	ES	< 3.0%	UHL	Red = >3.5% ER = 3 consecutive mths >3.5%	3.4%	3.5%	3.5%	3.3%	3.3%	3.4%	3.4%	3.7%	4.0%	4.0%	4.5%	4.3%	4.2%		3.7%
W10	Total trust vacancy rate	ES	ES	tbc	NTDA	tbc	New NTDA Indicator - Definition to be confirmed														
W11	Temporary costs and overtime as a % of total paybill	ES	ES	tbc	NTDA	tbc	New Indicator for 14/1		9.4%	9.4%	8.1%	8.5%	8.9%	8.5%	9.5%	9.0%	9.8%	10.5%	9.8%	11.5%	9.4%
W12	% of Staff with Annual Appraisal	ES	ES	95%	UHL	Red = <90% ER = 3 consecutive mths <90%	91.3%	91.3%	91.8%	91.0%	90.6%	89.6%	88.6%	89.7%	91.8%	92.3%	92.5%	90.9%	91.0%	91.4%	91.4%
W13	Statutory and Mandatory Training	ES	ES	Jun 80%, Sep 85%, Dec 90%, Mar 95%	UHL	Red / ER for Non compliance with Quarterly incremental target	76%	76%	78%	79%	79%	80%	83%	85%	86%	87%	89%	89%	90%	95%	95%
W14	% Corporate Induction attendance	ES	ES	95.0%	UHL	Red = <90% ER = 3 consecutive mths <90%	94.5%	95%	96%	94%	92%	96%	98%	98%	98%	98%	100%	99%	100%	97%	100%

* Quarter 4 Average

Effective

KPI Ref	Indicators	Board Director	Lead Director/Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	13/14 Outturn	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	YTD
E1	Mortality - Published SHMI	AF	PR	Within Expected	NTDA	Higher than Expected			106 (Oct12-Sept13)			106 (Jan13-Dec13)			105 (Apr13-Mar14)			105 (Jul13-Jun14)			105 (Jul13-Jun14)
E2	Mortality - Rolling 12 mths SHMI (as reported in HED)	AF	PR	100 or below	QC	Red = >expected ER = >Expected or 3 consecutive mths increasing SHMI >100	105	105	105	105	106	105	103	102	102	101	99	Awaiting HED Update			99
E3	Mortality HSMR (DFI Quarterly)	AF	PR	Within Expected	NTDA	Red = >expected ER = >Expected or 3 consecutive increasing mths >100	88		99			93			88			Awaiting DFI Update			93
E4	Mortality - Rolling 12 mths HSMR (Rebased Monthly as reported in HED)	AF	PR	100 or below	QC	Red = >expected ER = >Expected or 3 consecutive increasing mths >100	99	99	97	98	98	97	96	96	96	95	95	96	Awaiting HED Update		96
E5	Mortality - Monthly HSMR (Rebased Monthly as reported in HED)	AF	PR	100 or below	QC	Red = >expected ER = >Expected or 3 consecutive increasing mths >100	91	91	82	108	105	86	97	98	96	88	96	97	Awaiting HED Update		95
E6	Mortality - Rolling 12 mths HSMR Emergency Weekday Admissions - (HED) OVERALL Rebased Monthly	AF	PR	Within Expected	NTDA	Red = >expected ER = >Expected or 3 consecutive increasing mths >100	100	100	98	99	99	97	96	95	95	95	95	95	Awaiting HED Update		95
E7	Mortality - Monthly HSMR Emergency Weekday Admissions - (HED) OVERALL Rebased Monthly	AF	PR	Within Expected	NTDA	Red = >expected ER = >Expected or 3 consecutive increasing mths >100	100	94	85	98	109	84	91	99	95	90	97	94	Awaiting HED Update		95
E8	Mortality - rolling 12 mths HSMR Emergency Weekend Admissions - (HED) OVERALL Rebased Monthly	AF	PR	Within Expected	NTDA	Red = >expected ER = >Expected or 3 consecutive increasing mths >100	99	99	95	98	97	96	97	97	97	97	97	100	Awaiting HED Update		100
E9	Mortality - Monthly HSMR Emergency Weekend Admissions - (HED) OVERALL Rebased Monthly	AF	PR	Within Expected	NTDA	Red = >expected ER = >Expected or 3 consecutive increasing mths >100	99	82	69	135	93	93	121	99	107	89	98	110	Awaiting HED Update		101
E10	Deaths in low risk conditions (Risk Score)	AF	PR	Within Expected	NTDA	Red = >expected ER = >Expected or 3 consecutive increasing mths >100	94	63	64	81	105	79	69	63	102	22	47	Awaiting DFI Update			71
E11	Emergency 30 Day Readmissions (No Exclusions)	AF	PR	Within Expected	NTDA	Higher than Expected	7.9%	8.8%	8.8%	8.8%	8.6%	8.4%	8.9%	8.4%	8.6%	8.9%	9.1%	8.2%	8.5%		8.6%
E12	No. of # Neck of femurs operated on 0-35 hrs - Based on Admissions	AF	RP	72% or above	QS	Red = <72% ER = 2 consecutive mths <72%	65.2%	54.7%	56.9%	40.6%	60.3%	76.9%	59.0%	68.6%	69.6%	59.4%	57.3%	57.9%	67.2%	61.5%	61.4%
E13	Stroke - 90% of Stay on a Stroke Unit	RM	CF	80% or above	QS	Red = <80% ER = 2 consecutive mths <80%	83.2%	83.5%	91.8%	80.3%	87.1%	77.1%	84.5%	83.2%	70.4%	72.4%	75.2%	82.5%	83.5%		80.4%
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%	77.9%	79.7%	58.8%	71.3%	62.8%	65.5%	72.7%	67.8%	69.0%	83.5%	80.6%	64.0%	77.3%	71.2%
E15	Communication - ED, Discharge and Outpatient Letters - Compliance with standards	AF	SJ	90% or above	QS	Red = <80% ER = Qrtly ER if <90% and deterioration	New Indicator for 14/15						60% (InPt)	83% (ED)	Policy launch, audit not undertaken						
E16	Published Consultant Level Outcomes	AF	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	AF	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	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	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	YTD
R1	ED 4 Hour Waits UHL + UCC (Sit Rep)	RM	CF	95% or above	NTDA	Red = <95% ER via ED TB report	88.4%	89.3%	86.9%	83.4%	91.3%	92.5%	90.9%	91.5%	90.1%	88.5%	83.0%	90.2%	89.2%	91.1%	89.1%
R2	12 hour trolley waits in A&E	RM	CF	0	NTDA	Red = >0 ER via ED TB report	5	0	0	1	1	0	0	0	1	0	0	1	0	0	4
R3	RTT Waiting Times - Admitted	RM	CC	90% or above	NTDA	Red /ER = <90%	76.7%	76.7%	78.9%	79.4%	79.0%	80.9%	82.2%	81.6%	84.4%	85.5%	86.9%	85.0%	85.9%	84.4%	*82.8%
R4	RTT Waiting Times - Non Admitted	RM	CC	95% or above	NTDA	Red /ER = <95%	93.9%	93.9%	94.3%	94.4%	95.0%	94.9%	95.6%	94.6%	94.9%	95.2%	96.0%	95.4%	95.3%	95.5%	*95.1%
R5	RTT - Incomplete 92% in 18 Weeks	RM	CC	92% or above	NTDA	Red /ER = <92%	92.1%	92.1%	93.9%	93.6%	94.0%	93.2%	94.0%	94.3%	94.8%	95.0%	95.1%	95.2%	96.2%	96.7%	*94.7%
R6	RTT 52 Weeks+ Wait (Incompletes)	RM	CC	0	NTDA	Red /ER = >0	0	0	0	0	0	15	1	3	3	2	0	0	0	0	0
R7	6 Week - Diagnostic Test Waiting Times	RM	SK	1% or below	NTDA	Red /ER = >1%	1.9%	1.9%	0.8%	0.9%	0.8%	0.7%	1.0%	1.0%	0.7%	1.8%	2.2%	5.0%	0.8%	0.9%	*1.4%
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%	95.3%	88.5%	94.7%	93.5%	92.2%	92.0%	90.6%	92.0%	92.5%	93.0%	92.2%	93.5%		92.2%
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%	94.3%	80.0%	95.0%	98.9%	94.9%	94.4%	95.2%	98.6%	100.0%	93.0%	92.5%	91.5%		94.0%
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%	98.2%	97.2%	92.9%	93.6%	94.4%	97.9%	91.9%	95.9%	92.5%	95.2%	91.7%	95.1%		94.4%
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%	98.8%	100.0%	97.1%	100.0%	96.7%	100.0%	100.0%		99.3%
R12	31-Day Wait For Second Or Subsequent Treatment: Surgery	RM	MM	94% or above	NTDA	Red = <94% ER = Red for 2 consecutive mths	96.0%	98.6%	95.2%	97.0%	90.8%	90.1%	87.8%	94.0%	81.9%	82.4%	80.3%	89.2%	94.2%		89.1%
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%	99.1%	97.3%	95.6%	93.9%	97.3%	99.0%	96.5%	96.0%	94.7%	95.5%	87.6%	99.0%		95.8%
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%	92.4%	92.7%	88.5%	73.1%	85.6%	78.8%	75.5%	80.4%	77.0%	84.8%	79.3%	78.6%		81.1%
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%	91.7%	91.1%	67.4%	73.9%	73.0%	100.0%	87.5%	75.0%	94.4%	93.8%	88.9%	79.4%		84.1%
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	10	4	1	2	1	2	2	0	3	4	3	1	33
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	2	1	0	11
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%	1.5%	1.1%	0.8%	1.1%	0.7%	0.6%	0.8%	0.8%	1.2%	1.1%	0.8%	0.7%	1.0%	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%	1.5%	0.6%	0.6%	0.3%	2.7%	0.0%	0.9%	1.0%	0.0%	0.8%	1.4%	0.0%	0.4%	0.9%
R21	% Operations cancelled for non-clinical reasons on or after the day of admission UHL + ALLIANCE	RM	PW	0.8% or below	Contract	Red = >0.9% ER = >0.8%	New Indicator for 14/15		1.1%	0.8%	1.0%	0.9%	0.6%	0.8%	0.8%	1.1%	1.1%	0.8%	0.7%	0.9%	0.9%
R22	No of Operations cancelled for non-clinical reasons on or after the day of admission UHL + ALLIANCE	RM	PW	N/A	UHL	tbc	1739	139	106	77	98	94	55	90	94	108	102	85	64	98	1071
R23	Delayed transfers of care	RM	PW	3.5% or below	NTDA	Red = >3.5% ER = Red for 3 consecutive mths	4.1%	3.8%	4.4%	4.2%	4.0%	3.9%	3.9%	4.5%	4.6%	5.2%	3.9%	3.2%	2.9%	1.8%	3.9%
R24	Choose and Book Slot Unavailability	RM	CC	4% or below	Contract	Red = >4% ER = Red for 3 consecutive mths	13%	19%	22%	25%	26%	25%	26%	25%	20%	17%	16%	13%	19%	26%	21%
R25	Ambulance Handover >60 Mins (CAD)	RM	PW	0	Contract	Red = >0 ER = Red for 3 consecutive mths	868	111	173	253	88	71	50	106	253	343	460	353	499	418	3,067
R26	Ambulance Handover >30 Mins and <60 mins (CAD)	RM	PW	0	Contract	Red = >0 ER = Red for 3 consecutive mths	7,075	601	720	951	671	591	805	736	1,147	1,364	1,170	1,167	970	1,023	11,315

* Yearly Average

Compliance Forecast for Key Responsive Indicators

Standard	March actual	April predicted	Month by which to be compliant	RAG rating of required month delivery	Commentary
Emergency Care					
4+ hr Wait (95%) - Calendar month	91.1%				
Ambulance Handover (CAD)					
Ambulance Handover >60 Mins (CAD)	418	320			
Ambulance Handover >30 Mins and <60 mins (CAD)	1023	1056			
RTT (inc Alliance)					
Admitted (90%)	84.4%	88.0%	May		87% current prediction for April. Will require significant improvement to deliver April. Informed TDA and CCG of slip to May due to Orthoapedics and ENT.
Non-Admitted (95%)	95.5%	95.6%	Continued Delivery		March including Alliance has achieved. Predicting ongoing compliance.
Incomplete (92%)	96.7%	96.2%	Continued Delivery		Backlog clearance improving sustainability. Performance is now29 out of 148 trusts.
Diagnostic (inc Alliance)					
DM01 (<1%)	0.9%	0.9%	March		March delivered. Predicted April delivery.
Cancelled Ops (inc Alliance)					
Cancelled Ops (0.8%)	0.9%	0.8%	Continued delivery		April currently being validated.
Not Rebooked within 28 days (0 patients)	1	2	March		April currently being validated.
Cancer (predicted)					
Two Week Wait (93%)	91.5%	91.2%	March		Patient choice now the dominant reason for failure all UHL tumour sites compliant for capacity and speed of offering patients dates.
31 Day First Treatment (96%)	93.6%	89.5%	May		Skin patients have chosen to wait longer and no clock pause can be applied in non-admitted setting. Currently reviewing the 20 breaches to understand the potential recovery actions in month.
31 Day Subsequent Surgery Treatment (94%)	81.0%	88.5%	April		Urology backlog clearance during March.
62 Days (85%)	83.3%	77.7%	July		62 Day backlog increasing in LOGI, Lung and Gynae. Urology reducing as per plan. All tumour sites have returned with confidence about return to trajectory.

Research UHL

KPI Ref	Indicators	Board Director	Lead Director/Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	YTD
RU1	Median Days from submission to Trust approval (Portfolio)	AF	NB	tbc	tbc	tbc	3.0			2.0			3.0						
RU2	Median Days from submission to Trust approval (Non Portfolio)	AF	NB	tbc	tbc	tbc	2.0			3.5			2.0						
RU3	Recruitment to Portfolio Studies	AF	NB	Aspirational target=10920/year (910/month)	tbc	tbc	941	1092	963	1075	1235	900	1039	1048	604	920	759		
RU4	% Adjusted Trials Meeting 70 day Benchmark (data sunbmitted for the previous 12 month period)	AF	NB	tbc	tbc	tbc	(Jul13-Jun14) 43.4%			(Oct13-Sep14) 70.5%			(Nov13-Dec14) 70.5%						
RU5	Rank No. Trials Submitted for 70 day Benchmark (data submitted for the previous 12 month period)	AF	NB	tbc	tbc	tbc	(Jul13-Jun14) Rank 17/61			(Oct13-Sep14) Rank 18/60			(Nov13-Dec14) Rank 18/59						
RU6	%Closed Commercial Trials Meeting Recruitment Target (data submitted for the previous 12 month period)	AF	NB	tbc	tbc	tbc	(Jul13-Jun14) 50%			(Oct13-Sep14) 52%			(Nov13-Dec14)48%						

Research (CLINICAL RESEARCH NETWORK)

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	Jan-15	Feb-15	Mar-15	YTD
RS1	Number of participants recruited in a reporting year into NIHR CRN Portfolio studies	AF	DR	England 650,000 East Midlands 50,000	NIHR CRN	Red / ER = <90%	92%	93%	94%	93%	91%	90%	90%	90%
RS2a	A: Proportion of commercial contract studies achieving their recruitment target during their planned recruitment period.	AF	DR	England 80% East Midlands 80%	NIHR CRN	Red / ER = <60%	67%	64%	68%	54%	56%	47%	54%	54%
RS2b	B: Proportion of non-commercial studies achieving their recruitment target during their planned recruitment period	AF	DR	England 80% East Midlands 80%	NIHR CRN	Red / ER = <60%	81.0%	81.0%	73%	77%	77%	86.0%	77%	77%
RS3a	A: Number of new commercial contract studies entering the NIHR CRN Portfolio	AF	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	AF	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)	AF	DR	80%	NIHR CRN	Red <80%	90.0%	89.0%	84.0%	82.0%	83.0%	83.0%	88.0%	88.0%
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	AF	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	AF	DR	80%	NIHR CRN	Red <80%								
RS6a	A: Proportion of NHS Trusts recruiting each year into NIHR CRN Portfolio studies	AF	DR	England 99% East Midlands 99%	NIHR CRN	Red <99%	81.0%	81.0%	81.0%	88.0%	88.0%	88.0%	88.0%	88.0%
RS6b	B: Proportion of NHS Trusts recruiting each year into NIHR CRN Portfolio commercial contract studies	AF	DR	England 70% East Midlands 70%	NIHR CRN	Red <70%	56.0%	56.0%	56.0%	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	AF	DR	England 25% East Midlands 25%	NIHR CRN	Red <25%	45.0%	45.0%	51.0%	63.0%	54.0%	54.0%	61.0%	61.0%
RS7	Number of participants recruited into Dementias and Neurodegeneration (DeNDRoN) studies on the NIHR CRN Portfolio	AF	DR	England 13500 East Midlands 510	NIHR CRN	Red <510 Q4	325	438	448	532	624	729	954	954
RS8	Deliver robust financial management using appropriate tools - % of financial returns completed on time	AF	DR	England 100% East Midlands 100%	NIHR CRN	Red <100%	100% *Q2	100.0%				100%	100%	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	Jan-15	Feb-15	Mar-15	YTD
Estates and Facilities	E&F1	Percentage of statutory inspection and testing completed in the Contract Month measured against the PPM schedule.	DK	GL	100%	Contract KPI	Red = ≤ 98%	100.0%	100.0%	100.0%	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	DK	GL	100%	Contract KPI	Red = ≤ 80%	91.5%	81.2%	95.6%	80.5%	86.6%	97.4%	99.5%	90.3%
	E&F3	Percentage of Estates Urgent requests achieving rectification time	DK	LT	95%	Contract KPI	Red = ≤ 75%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	E&F4	Percentage of scheduled Portering tasks completed in the Contract Month	DK	LT	99%	Contract KPI	Red = ≤ 98%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	E&F5	Number of Emergency Portering requests achieving response time	DK	LT	100%	Contract KPI	Red = >2	0	0	0	0	0	0	0	0
	E&F6	Number of Urgent Portering requests achieving response time	DK	LT	95%	Contract KPI	Red = ≤ 95%	95.1%	96.2%	97.3%	97.2%	97.2%	98.5%	98.1%	97.1%
	E&F7	Percentage of Cleaning audits in clinical areas achieving NCS audit scores for cleaning above 90%	DK	LT	100%	Contract KPI	Red = ≤ 98%	100.0%	99.1%	100.0%	100.0%	100.0%	94.4%	96.1%	98.5%
	E&F8	Percentage of Cleaning Rapid Response requests achieving rectification time	DK	LT	92%	Contract KPI	Red = ≤ 80%	99.6%	89.9%	93.3%	90.5%	91.1%	94.1%	96.9%	93.6%
	E&F9	Percentage of meals delivered to wards in time for the designated meal service as per agreed schedules	DK	LT	97%	Contract KPI	Red = ≤ 95%	99.4%	99.5%	100.0%	100.0%	98.9%	99.9%	100.0%	99.7%
	E&F10	Overall percentage score for monthly patients satisfaction survey for catering service	DK	LT	85%	Contract KPI	Red = ≤ 75%	96.7%	97.3%	97.3%	96.7%	93.8%	95.8%	97.5%	96.4%

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 Post Infection Reviews 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 Interserve has been instructed to stop reporting audits based on re-testing of cleaning inspections and to report only the result of the first inspection. This should give a more accurate picture of any inadequate cleaning practice, allowing focused attention on these areas with the intention that this will raise the standard of cleaning, including spore removal, in these areas.	Action plans that have resulted from the PIR should be presented to the CMG Infection Prevention Groups and should follow the PIR 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 PIR will be sent monthly for review. A thematic review of CDT cases with an action plan was presented to the February TIPAC. This will also be presented to the EQB and CQRG meetings in April. 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 Director of Facilities will chair a newly formed monthly Infection Prevention Operational Group who in conjunction with a quarterly TIPAC have as their remit the review of current cleanliness forums in place, to ensure these are fit for purpose and are monitoring cleanliness and ensuring performance delivery effectively.	5	7	73	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	7	5	7	73

Expected date to meet standard / target	TBA
Revised date to meet standard	TBA
Lead Director / Lead Officer	Carole Ribbins, Acting Chief Nurse Elizabeth Collins, Clinical Lead Infection Prevention

S2a/S2b - MRSA

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 5 of the six cases have been deemed unavoidable however lapses in care were identified in all cases. The sixth case was deemed avoidable however the source of the MRSA identified within this patient could not be identified.	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 PIR process flow chart as described in the Infection Prevention Toolkit	0	1	6	N/A

Indicators	13/14 Outturn	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	YTD
MRSA Bacteraemias (All)	3	0	0	0	0	0	1	1	0	2	0	1	1	6
MRSA Bacteraemias (Avoidable)	1	0	0	0	0	0	0	0	0	0	0	1	0	1

Expected date to meet standard / target	TBA
Revised date to meet standard	TBA
Lead Director / Lead Officer	Carole Ribbins, Acting Chief Nurse Elizabeth Collins, Clinical Lead Infection Prevention

S6 Overdue CAS alert

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
One NHS England NPSAS alert deadline was breached by Musculo-Skeletal and Specialist Surgery (MSS). This was due to unplanned absence of Head of Nursing and PA who would normally administer the alerts. All actions had been taken to comply with the alert however on day of deadline there were no staff in MSK/SS who could confirm the status of the alert to the UHL CAS team.	CMG has been requested to review its management arrangements for these alerts and to consider increasing the number of staff involved in managing the alerts in order to provide additional resilience for unplanned absences.	100% of alerts completed in deadline	1 breached deadline	10 breached deadlines	No breaches

CMG	No of external alerts received by UHL during 2015 (*not including EFN's)	External alerts distributed to CMGs	Breached deadlines during March 2015
CHUGS	71*	17	0
CSI	71*	18	0
Emergency and Specialist Medicine	71*	27	0
ITAPS	71*	27	0
MSK/SS	71*	18	1
RRC	71*	23	0
W&C	71*	29	0
Alliance	71*	52	0
NHS Horizons (including EFNs)	127	65	0

Performance by Quarter

13/14 FYE	14/15 Q1	14/15 Q2	14/15 Q3	14/15 Q4
2 breached deadlines	5 breached deadlines	4 breached deadlines	0 breached deadlines	1 breached deadline

Expected date to meet standard / target	30th April 2015
Revised date to meet standard	
Lead Director / Lead Officer	Moira Durbridge, Director of Safety and Risk Peter Cleaver, Risk and Assurance Manager

S12 and S13 Hospital Acquired Pressure Ulcers (Grade 4 and Grade 3)

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
S12 – In March 2015 there was a Grade 4 avoidable HAPU on R36, believed to be as a result of incorrect prescription and use of Anti-embolic stockings (AES). Lessons were identified for medical staff as well as the nursing staff ,around ensuring that all safety checks are undertaken prior to decision to use AES for VTE prevention Another lesson is around inconsistent approach to ensuring twice daily checks of pressure areas under the AE stockings. **S13** - During the April 2015 validation process 3 additional cases from February 2015 were confirmed as avoidable pressure ulcers (two grade 3s for R41 and R17 and one grade 2 for R17). These ulcers should have been reported and validated in March and therefore have been added retrospectively to the February HAPU figures (in red in the adjacent table) resulting in the number of Grade 3s going over trajectory. The themes are confirmed as inconsistent approaches to BEST SHOT skin checks resulting in poor quality skin inspection and failure to recognise deterioration in the pressure areas; staffs' inability to recognise pressure damage in a patient with dark skin; skin damage not reported in a timely manner; failure in MDT communication and failure to comply with UHL policy for reporting all Grade 3 Pressure Ulcers on Datix.	**S12** -The Acting Chief Nurse is holding a performance management meeting with staff in relation to the Grade 4 HAPU A robust action plan is in place, led by the ward sister and some of the actions have been already implemented e.g. bespoke Pressure Ulcer prevention and Tissue Viability update for all medical SpRs, additional AES trouble shooting training for all clinical staff on R36; review of the EPMA process. As avoidable Grade 4 HAPUs are considered to be 'local Never Event', a proper MDT meeting is being organised and will be led by the Quality and Safety team as per UHL Policy. **S13** - On-going actions via the CMG team and Head of Safeguarding to increase monitoring of documentation. The UHL podiatry team have also been involved in one of these cases (R41) and personal statements issued to ensure appropriate lessons have been learned. .	**S12 - G4 = 0** **S13 – G3= 7**	**G4 = 1** **G3 = 6 (below threshold). However, retrospective data submitted for February which increased incidence to 9 (above threshold)**	**G4 = 2** **G3 = 69**	**G4 = 0** **G3 = </= 7**

*Table 1 - Avoidable **Grade 4** Pressure Ulcers April - March 2015*

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**	**0**
Incidence	0	0	0	0	0	0	0	0	1	0	0	1	**2**

*Table 2 - Avoidable **Grade 3** Pressure Ulcers April – March 2015*

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	5	9	6	**69**

*Table 3 - Avoidable **Grade 2** Pressure Ulcers April – March 2015*

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	9	4	8	13	11	7	5	9	**91**

Expected date to meet standard / target	May 1st 2015
Revised date to meet standard	May 1st 2015
Lead Director / Lead Officer	Carole Ribbins, Acting Chief Nurse Michael Clayton, Head of Nursing (Safeguarding)

S16 Nutrition and Hydration Metrics - Fluid Balance and Nutritional Assessment

What is causing underperformance?	What actions have been taken to improve performance?	Target	Latest performance	YTD performance	Forecast performance
The Nutrition and Hydration metric is made up of a suite of indicators which include both nutritional assessment, care planning, monitoring of fluid balance. For the Quality Commitment, staff knowledge is also included. Following a baseline period in Q1 it was agreed that improvement threshold would be to achieve 90% by Q4 across all the metrics within each bed holding CMG. There has been an improvement from the Q1 baseline for all CMGs with all metrics (with the exception of CHUGS for Fluid Balance Chart). However, the 90% threshold has not been achieved for ESM in respect of the Nutritional Assessment metric for any month within Quarter 4 and therefore the Indicator is RAG rated Red for the Trust as a whole. The specific metrics that are not being achieved include the Fluid Balance Chart (patient assessment) and Nutrition and Hydration (patient assessment). It is the acute medical wards and assessment unit that appear to need additional support.	Nutrition training was completed across all CMGs with the exception of ITAPs in November last year. One of the actions will be to revisit ESM wards and assessment areas for 'refresher' training. Nutrition training has also been delivered to • HCA Induction Programme • International nurses • Preceptorship. • Housekeeper forums • Volunteers Further nutrition education sessions are delivered to specialised areas such as Tissue Viability, renal, critical care, and nutrition link nurses as requested. There is intensive work being undertaken across all CMGs Priority in Q1 will be to support ESM with specific actions around nutritional assessment and maintaining fluid balance charts.	90% across all metrics within each CMG for Q4	83% for Nutritional Assessment for ESM 89% for Fluid Balance Charts for CHUGS, ESM & MSS >/= to 90% for all other metrics	3 CMGs have achieved 90% for all metrics.	>90% across all metrics within each CMG

FLUID BALANCE CHART

CMG	CHUGS	ESM	ITAPS	MSS	RRC	W&C
Q1	90%	83%	100%	83%	85%	90%
Q2	90%	88%	100%	92%	92%	99%
Q3	93%	89%	98%	95%	89%	95%
Q4	89%	89%	100%	89%	90%	96%

NUTRITIONAL SSESSMENT

CMG	CHUGS	ESM	ITAPS	MSS	RRC	W&C
Q1	85%	75%	93%	88%	83%	83%
Q2	88%	84%	85%	83%	91%	88%
Q3	90%	86%	97%	92%	92%	93%
Q4	92%	83%	91%	91%	90%	100%

STAFF KNOWLEDGE

CMG	CHUGS	ESM	ITAPS	MSS	RRC	W&C
Q1	98%	93%	99%	98%	93%	100%
Q2	99%	96%	95%	100%	96%	100%
Q3	100%	98%	100%	97%	96%	100%
Q4	99%	98%	97%	100%	98%	99%

Expected date to meet standard / target	Q1 in 15/16
Lead Director / Lead Officer	Carole Ribbins, Acting Chief Nurse Eleanor Meldrum, Asst Chief Nurse

C7 Complaints Re-opened Rate

		Target	Mar 15	Forecast
What is causing underperformance?	**What actions have been taken to improve performance?**	**<9%**	**11%**	**10%**

170 Formal complaints were received in March 2015 and **18 (11%)** were re-opened. The thresholds for an exception are >10% of complaints re-opened 3 months in a row or any month over 15%.

The following table shows the number of re-opened complaints in March '15 by CMG

CMG 1- Cancer, Haematology, Urology, Gastroenterology and Surgery (CHUGGS)	8
CMG 3- Emergency and Specialist Medicine	6
CMG 5- Musculoskeletal and Specialist Surgery	4
Totals:	18

Overall the number of re-opened complaints have continued to reduce month on month and it is anticipated that a target of <9% will be reached next month (April). There is no theme to those complaints which have re-opened.

Continued greater scrutiny of the complaint and response prior to re-opening to establish if anything further can be contributed. Complaints lead to review the final responses of a select number of re-opened complaints and consider if these were fit for purpose.

Previous Months performance

	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15
No. of Formal Complaints Received	197	162	142	157	158	170
No. Re-opened	20	15	13	25	21	18
% re-opening	10%	9%	9%	16%	13%	11%

Expected date to meet standard	March 2015
Revised date to meet standard	April 2015
Lead Director	Moira Durbridge, Director of Safety and Risk

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. There has been an increase in sickness absence from July 2014. (Table 1). 2. We have seen a reduction in sickness absence in February to 4.17 % 3. Sickness absence reporting highlights an adjustment of around 0.5% due to late closures. The January rate has now reduced from 4.53% to 4.27%. It is therefore expected the February 2015 sickness absence rate will be reduce next month to 4% or below. 4. In the last year the Trust has seen an increase in staff taking absence, 'triggers' and long term absences. (Table 2) 5. 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	1. Improved data through weekly SMART reports and monthly ESR reports 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. Making it Happen Reviews, to discuss and agree actions for the management and support of open absences, 'triggers' and complex cases with line managers. 4. 6 monthly CMG Sickness Performance Reviews / Case reviews with Occupational Health and Senior and independent HR colleagues. 5. Sickness Absence training for managers and administrators **Further Actions:** 6. Local training is facilitated for CMG's / Directorates in response to specific needs – management of long term absence, documentation etc. 7. 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. 8. 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. 9. Specific staff support and targeted management of stress related absences. 10. Review of the UHL Sickness Absence in comparison with other NHS organisations in the region. From the information available, UHL has set the lowest sickness absence target and has the second lowest sickness absence levels in the region.	**UHL Stretch target 3%** **(previous SHA target 3.4%)**	**4.53% (February 2015)**	**3.75% (average)**	**3.50% average (April 2015)**

Table 1: Monthly Trust Performance:

Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	YTD
3.5%	3.3%	3.3%	3.4%	3.4%	3.7%	4.0%	4.0%	4.5%	4.3%	4.2%		3.7%

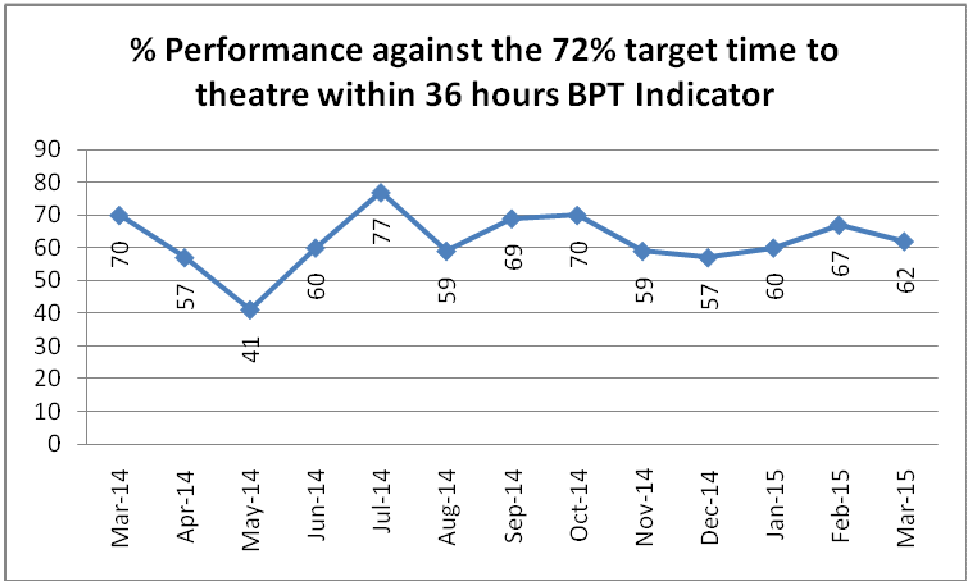
Table 2: Annual performance

February	Staff taking absence %	Staff 'triggering' %	% absences over 28 days
2013	67.2%	38.7%	7.4%
2014	64.5%	37.1%	7.7%
2015	66.3%	39.1%	8.06%

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)

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

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest month performance	YTD performance	Forecast performance for next reporting period
All of the issues set out in previous reports continue in the service and are exacerbated at times of heightened activity. Significant increases in activity though December and January have had an impact on delivery of the target and ability to operate on patients within target. The current scheduled theatre capacity is insufficient to cope with this level of trauma demand and increasing spinal work. Short notice additional operating sessions continue to be arranged as necessary. The acceptance of out of area elective and emergency spinal work continues to have a detrimental effect on the main trauma capacity as spinal patients are medically prioritised over 'other' trauma which has a knock on effect on #NOF capacity.	An action plan is to be presented to the CMG board in April which details the work that is currently being scoped and implemented from the various outputs of the LiA and other improvement projects within the specialty. Specific blockers include Theatre List start and finish times, Orthogeriatric capacity and Theatre process delays. The listening into action process continues the themes and detailed actions will be published in the action plan to be presented to the CMG board in April. Work continues within the spinal network with regards to capacity across the region and how UHL fits into the future plans.	**72%**	**63%**	**62%**	**62%**



Performance by Quarter

13/14 FYE	14/15 Q1	14/15 Q2	14/15 Q3	14/15 Q4	14/15 FYE
65%	52%	68%	63%	63%	62%

Expected date to meet standard / target	December 2014
Revised date to meet standard	Quarter 3 2015/16
Lead Director / Lead Officer	Richard Power, MSS CD Maggie McManus, MSS Deputy Head of Operations

R3 – RTT Waiting Time - Admitted

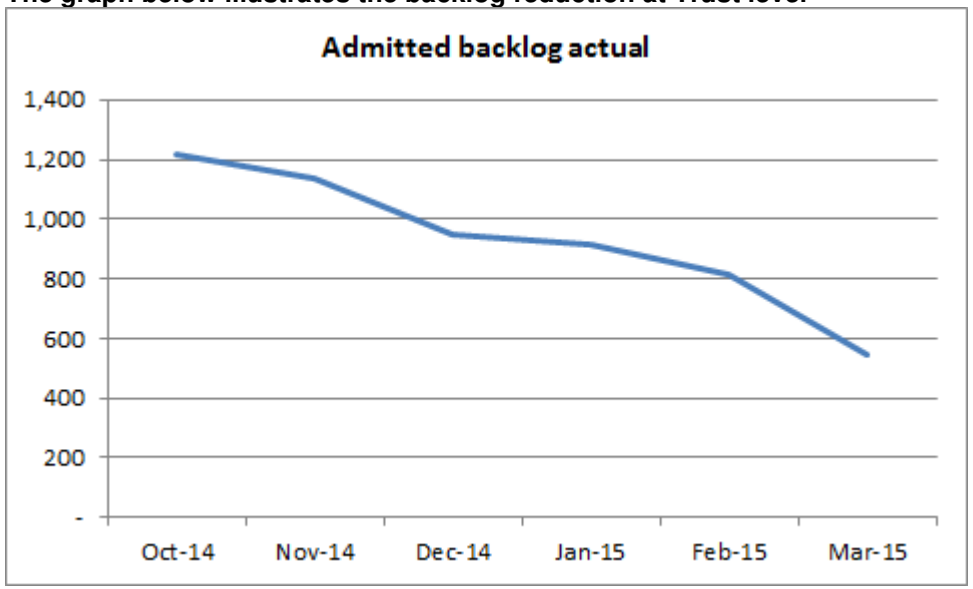
<table>
<tr><th>What is causing underperformance?</th><th>What actions have been taken to improve performance?</th><th>Target (mthly / end of year)</th><th>Latest performance</th><th>YTD performance</th><th>Forecast performance for next reporting period</th></tr>
<tr><td rowspan="3">The Trust commitment to deliver the admitted standard from May 2015 onwards remains, but this is not without its risks due to the level of backlog remaining.
The graph opposite illustrates the significant admitted backlog reduction achieved from end October 2014 (1218) to the end of March (546). This has been achieved by additional in house activity and outsourcing to the local independent sector providers. The commitment to ensure that the longest waiters are treated remains our priority.

By key speciality:
• General surgery, backlog continues to reduce as planned with weekend working in March
• Urology the backlog has reduced significantly
• Paediatric Max fax and ENT have been hampered by lack of paediatric elective capacity.
• Adult ENT, the residual backlog has increased
• paediatric surgery and urology delivered their target reductions
• Gynaecology, is on track to deliver its target reduction.
• Orthopaedics, backlog has remained static. It is a significant risk due to the unstainable non admitted backlog position</td><td rowspan="3">The Trust is achieving 2 of the 3 RTT standards: Non admitted and incompletes performance are both compliant.
The actions been taken in admitted are clearly the right actions evidenced by the backlog reductions seen in recent weeks and months.
The revised weekly access meeting is working well as is the predictive ability of ensuring delivery.

• Additional activity at weekends continues in April

• Urology additional in house and independent sector
• Additional weekend work across the paediatric specialities

• Additional in house activity

• Additional work in house but also with the local independent sector.
• Orthopaedics remains a significant risk to the Trust. Weekend working continues, additional outsourcing to the local Independent sector.</td><td>90% treated within 18 weeks</td><td>84.4%
(UHL and Alliance)</td><td>85%</td><td>86%</td></tr>
<tr><td colspan="4">The graph below illustrates the backlog reduction at Trust level
 

Risks to delivery of the admitted 90% standard in May
There are now 2 specialities that poses the greatest risk to delivery of the Trust level admitted standard in May orthopaedics (as detailed in last month's report) and ENT adult and paediatric due to the residual backlog volumes:
Mitigation
All key speciality plans being reviewed by Director of Performance and Information.
ENT is undergoing a detailed review of their admitted pathways with input from corporate team
Orthopaedics on daily reporting of key improvement metric.
Re modelling of anticipated performance.
Ongoing additional activity in key specialities.
Additional outsourcing of activity in orthopaedics</td></tr>
<tr><td colspan="4"><table>
<tr><td>Expected date to meet standard / target</td><td>May 2015</td></tr>
<tr><td>Lead Director / Lead Officer</td><td>W Monaghan, Director of Performance and Information
C Carr, Head of Performance</td></tr>
</table></td></tr>
</table>

R8-15 Cancer Waiting Times Performance

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest month performance February	Performance to date 2014/15	Forecast performance for March
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) LLR has a conversion rate from referral to cancer diagnosis significantly below the national average, raising concerns around the quality of 2WW referrals **R10, 12** Difficulties in achieving prioritisation of surgical cases in general, although significantly improved. Dermatology capacity issues. **R14, 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.	**R8** The trust have reliably and consistently delivered rapid processing of referrals and released adequate capacity quickly to meet the 2WW demand consistently for 3 months. Overwhelmingly breaches are due to patient choice. Joint workstreams with the CCGs, requiring their leadership regarding (1) correct process (2) use of appropriate clinical criteria and (3) preparation of patients for urgency of appointments are needed to achieve this standard. **R10, 12** Backlog of 31 day cases almost eliminated. Attendance to cancer prioritisation by the services with the support of the cancer centre navigators. **R14, 15** Trajectory for recovery by tumour site agreed with CMGs to deliver recovery of the standard at trust level monthly by month 4 and cumulatively by month 6. Additional administrative appointments to Cancer Centre to support services pulling patients through pathways. Development of SOP for cancer pathway management between cancer centre and services to commence in June 15.	**R8 2WW 93%**	93.5%	92.2%	90.7%
		R10 31 day 1st 96%	95.1%	94.4%	93.4%
		R12 31 day sub (Surgery) 94%	94.2%	89.1%	80.3%
		R14 62 day RTT 85%	78.6%	81.1%	85.0%
		R15 62 screening 90%	79.4%	84.1%	96.5%

Performance by Quarter

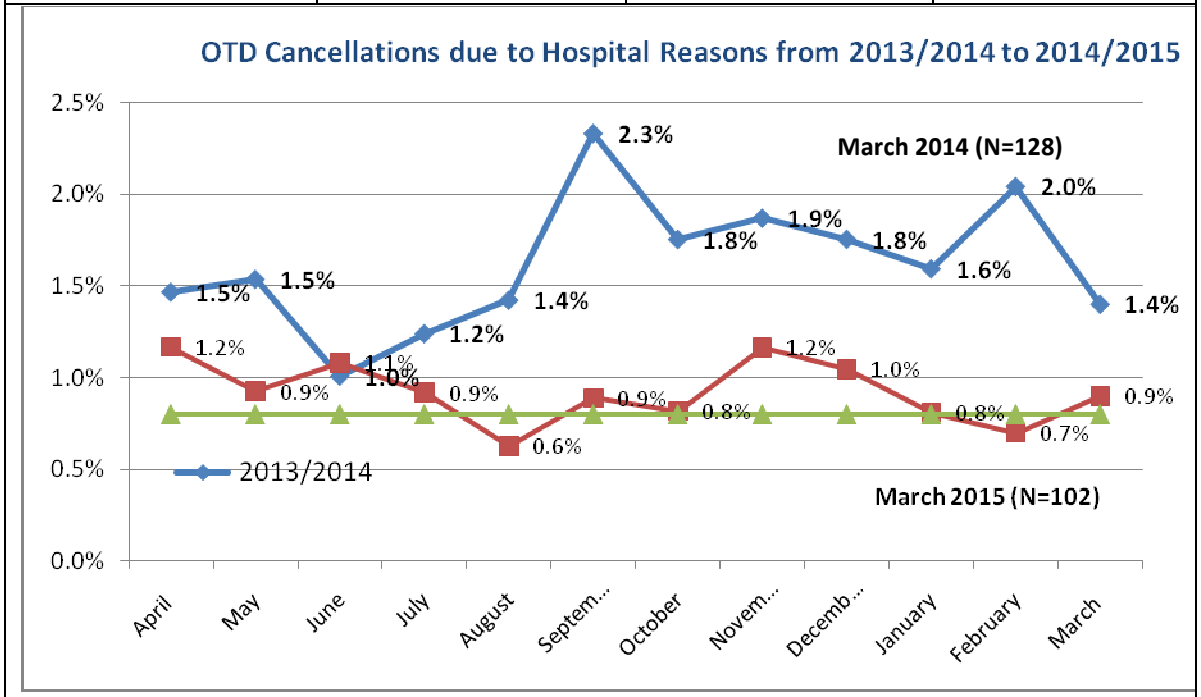
	13/14 FYE	14/15 Q1	14/15 Q2	14/15 Q3	14/15 Q4
R8	94.8%	92.2%	91.6%	92.5%	
R10	98.1%	94.6%	94.6%	94.6%	
R12	98.2%	94.2%	90.5%	81.5%	
R14	86.7%	84.1%	79.9%	80.8%	
R15	95.6%	78%	85%	89.2%	

Expected date to meet standard / target	R8 – Recovered December R10,12 – Recovery expected M12 2014/15 R14,15 – Recovery expected M6 2015/16
Revised date to meet standard	As Above, 2WW vulnerable to patient choice
Lead Director / Lead Officer	Will Monaghan, Director or Performance and Information Matt Metcalfe

R17 - cancelled operations not booked within 28 days

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 (monthly)	Latest month performance – Mar 14	YTD performance (inc Alliance)	Forecast performance for next reporting period
Causes of OTD cancellations changed this month due to paediatric bed pressures and emergency/high priority admissions. Thirteen paediatric patients were cancelled due to paediatric ward bed unavailability in LRI. Patients cancelled due to admissions of emergency/high priority admissions went up to 20 this month which is an increased of 13 compared to last month. Seven patients were cancelled due to adult ward beds unavailability in LRI (6) and LGH (1). There was one, 28 day breach. The patient was given a date for treatment within 28 days but due to ITU/HDU pressures the patient was cancelled for a second time. The patient had the operation on the 22nd of March. In March 2014, UHL had 128 OTD cancellations (1.4%). There were 26 fewer cancellations in March 2015.	A number of work streams have started aimed at reducing OTD cancellations including a LIA project. A successful LIA event was completed with participation of 48 staff in all three sites. Lots of useful feedback and a number of new ideas were provided by the staff to reduce cancellations. The LIA team are working to implement the changes suggested which include changes to the existing escalation policy and minimising number of list overruns. <u>Risks to delivery of recovery plan</u> The key action to ensure on-going performance is the daily escalation of patients at risk of cancellation, on the day as part of the UHL escalation policy. For those who may be cancelled on the day, it is vital that staff adhere to the Trust policy of escalating to CMG General Managers for resolution prior to agreeing any cancellations.	*1)* **0.8%** *2)* **0** **3) 0**	**1) 0.9%** **2) 1 (UHL)** **3) 0**	**1) 0 .9%** **2) 44** **3) 0**	**1) 0.8%** **2) 2** **3) 0**



Expected date to meet standard / target	April - On the day May – 28 day
Lead Director / Lead Officer	Richard Mitchell, Chief Operating Officer Phil Walmsley. Head of Operations, ITAPS

R24 Choose and Book

<table>
<tr><th>What is causing underperformance?</th><th>What actions have been taken to improve performance?</th><th>Target (mthly / end of year)</th><th>Latest month performance</th><th>YTD performance</th><th>Forecast performance for next reporting period</th></tr>
<tr><td rowspan="5">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

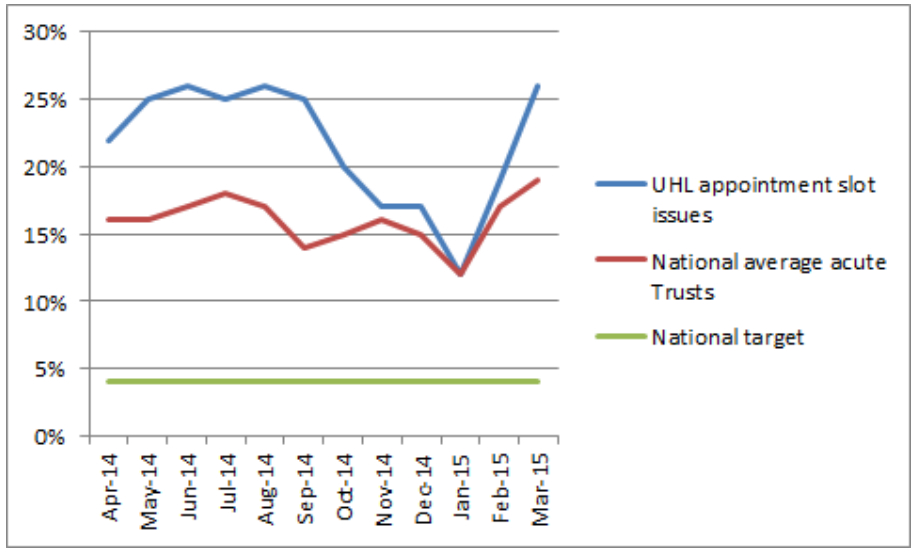
The issues are notably: General Surgery and orthopaedics, Urology, paediatrics and ENT</td><td rowspan="5">Capacity

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

Training and education

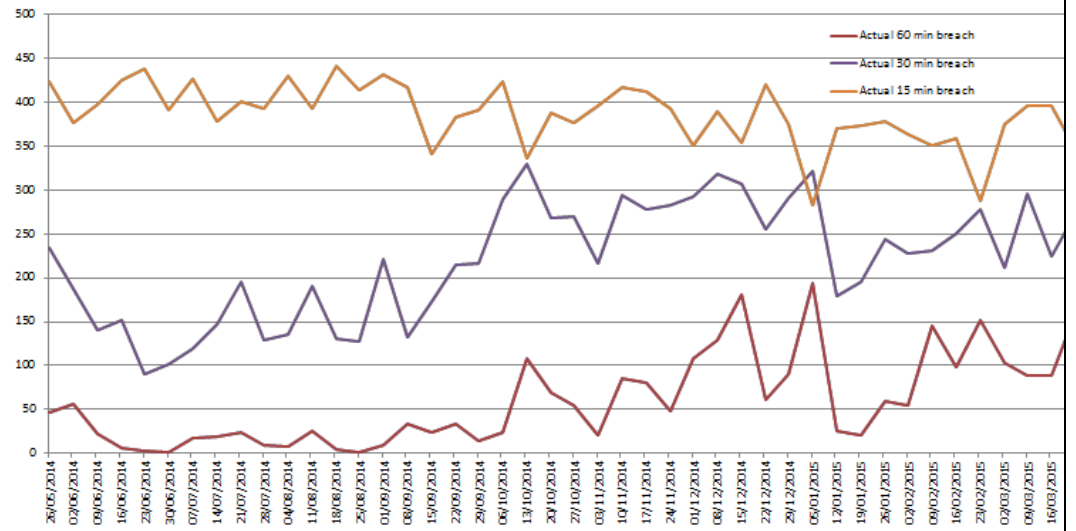
The comprehensive training and education of relevant staff in key specialties continues, to ensure that choose and book is correctly set up and that supporting administrative purposes are fit for purpose.
A speciality level ‘score card’ to highlight areas required for improvement is being distributed weekly to CMGs. This highlights areas for concern and actions required.

Interviews for a permanent post of Choose and Book Administrator are on 1st May. The new Deputy Head of Performance starts on 11th May, they will have a lead role in overseeing the improvement of this standard</td><td><4%</td><td>26%</td><td>21%</td><td>25%</td></tr>
<tr><td colspan="4">National performance varies significantly by Trust, with average performance of Acute Trusts nationally at 17% in November

 
</td></tr>
<tr><td colspan="2">Expected date to meet standard / target</td><td colspan="2">To be confirmed</td></tr>
<tr><td colspan="2">Revised date to meet standard</td><td colspan="2">Yet to be confirmed</td></tr>
<tr><td colspan="2">Lead Director / Lead Officer</td><td colspan="2">Will Monaghan, Director of Performance and Information
Charlie Carr, Head of Performance</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
Difficulties continue in accessing beds continue which leads to delays in movement out of the ED. This delays movement out of the assessment area and delays handover. March's performance remained similar to the preceding months. It should be noted that the overall attendances in March via ambulance have increased compared to Februarys activity	The CAD+ system has been demonstrated to ED via screen shots and equipment ordered for implementation. EMAS and UHL have discussed places for the equipment to be stored to enable easy access for use. Information sharing document is completed by UHL . The Training package is available once the equipment is ready for use in the Assessment Bay .	0 delays over 30 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, Chief Operating Officer, Phil Walmsley, ITAPS Head of Operations

RS2A Proportion of commercial contract studies achieving their recruitment target during their planned recruitment period

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 11th of the 15 LCRNs for this metric with no LCRN currently achieving the 80% target, highest is currently 71% and lowest 47% Historic targets set in a previous structure where this measure was not applicable, of the 127 closed studies for this measure only 6 entered the system after 1st April 2014 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	1. Recovery plan produced identifying the divisions (1,2 & 5) with high volume and low performance and prioritised 2 weekly meetings with Research Delivery Managers to improve performance 2. Collation of local information to report on the actual performance figure for 2014/15, this data gives a figure of 62% 3. Implementation of a performance management process involving the Industry Team and Delivery Managers to escalate studies not recruiting to target within 24 hours and to align targets. 4. 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. 5. Escalation to national team highlighting numerous discrepancies in the report and inconsistencies as a national level that has lead to a review. Lack of confidence in the figure of 53%. 6. Contacting sponsors direct to analyse the reasons for under-performance. 7. Summary of key reasons per division in table below for February	**80%**	**47%**	**53%**	**53%**

Breakdown of activity from Commercial Activity Report end of February 2015

Division No closed studies	RTT	Activity as % of EMCRN closed	No red	No green	Rationale for underperformance	No open studies	% of open activity
1 - 21 studies	43%	17%	12	9	Low numbers of recruits required for individual studies and narrowly missed targets Studies that struggled nationally	71	29%
2 - 30 studies	37%	24%	19	11	Low numbers of recruits required for individual studies and narrowly missed targets Studies that struggled nationally Diabetes UHL 7 closed 7 red	66	27%
3 - 10 studies	30%	8%	7	3	Came on board late to support. Short recruitment window as closed globally quicker than anticipated Imp issues so suspended but still included in CAR	23	9%
4 - 9 studies	56%	7%	4	5	Just missed target or came on board late to support trial and not enough time	20	8%
5 - 20 studies	35%	16%	13	7	Studies failed at a national level	16	7%
6 - 37 studies	70%	29%	11	26	Studies failed at a national level	50	20%
127 studies	47%	100%	67	60		246	100%

Expected date to meet standard / target	May 2015
Revised date to meet standard	May 2016
Lead Director / Lead Officer	Daniel Kumar, Industry Delivery Manager, CRN: East Midlands

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

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest month performance	YTD performance	Forecast performance for next reporting period
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 in 2015/16 including the AIRWAYS 2 study. Therefore it is unlikely that EMAS will report any recruitment before April 2015. 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%**	**88% (red)**	**88% (red)**	**88%**

Expected date to meet standard / target	This target will not be met in 2014/15.
Revised date to meet standard	
Lead Director / Lead Officer	Elizabeth Moss, Chief Operating Officer CRN: East Midlands

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

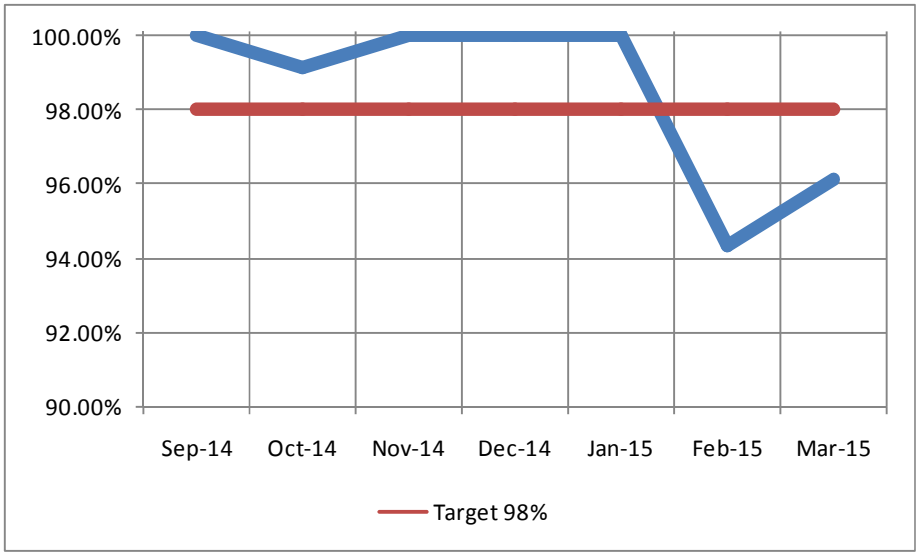
<table>
<tr><th>What is causing underperformance?</th><th>What actions have been taken to improve performance?</th><th>Target (monthly / end of year)</th><th>Latest month performance</th><th>YTD performance</th><th>Forecast performance for next reporting period</th></tr>
<tr><td rowspan="4">Proportion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

There are 16 Trusts within the East Midlands region, with 9 Trusts currently recruiting to commercial studies. The seven who have not reported any recruitment are:

● East Midlands Ambulance Service NHS Trust (EMAS)
● Derbyshire Community Health Services NHS Foundation Trust (DCHS)
● Lincolnshire Community Health Services (LCHS)
● Leicestershire Partnership NHS Trust (LePT)
● Lincolnshire Partnership NHS Trust (LiPT)
● Nottinghamshire Healthcare NHS Foundation Trust (NHFT)
● Derbyshire Healthcare NHS Foundation Trust (DHFT)</td><td rowspan="4">1. 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. Met and sent potential examples to review
2. 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.
3. 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.
4. LePT: Selected for one study,logistics being explored but study now suspended globally
5. LiPT: Have been involved in commercial research in the past and the site is actively seeking commercial opportunities. One sponsor in touch looking to take a study forward.
6. NHFT: One trial initiated at the end of November 2014, 2nd UK site to open no recruits to date as study now suspended globally but did have recruits lined up. One further site selection visit completed in March 2015 and site now selected
7. DHFT: 2 potential studies in the pipeline. One had site selection visit in February 2015 awaiting confirmation if selected.</td><td>70%</td><td>56% (red)</td><td>56% (red)</td><td>56%</td></tr>
<tr><td colspan="4" rowspan="3"></td></tr>
<tr><td>Expected date to meet standard / target</td><td>July 2015</td></tr>
<tr><td>Revised date to meet standard</td><td>September 2015</td></tr>
<tr><td>Lead Director / Lead Officer</td><td>Daniel Kumar, Industry Delivery Manager, CRN: East Midlands</td></tr>
</table>

E&F 7- Percentage of Cleaning audits in clinical areas achieving NCS audit scores for cleaning above 90%

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
Percentage of audits in clinical areas achieving NCS audit scores for cleaning above 90% Feb 15 – 94% Mar 15 - 96% 7 Audits failed to achieve the required standard in the following areas Leicester General - Hydro Pool Leicester Royal Infirmary - Balmoral Ward 22, Test Centre, OP Clinic 3; Windsor Building - Ward 37; Kensington Building – Gynae Theatres; Osborne Building – Palliative Care. The key reason for failure was the noted presence of dust. Each of these issues was rectified and subsequent audits passed. Under the current Management of Change process, there is potential impact that may be felt from staff consultation that is underway, however we are actively managing this process to limit impact on morale.	The current review of cleaning rosters and tasks across the Acute Estate is underway and this process alongside investment in equipment will support cleaning standards within the UHL. This review and changes have been documented and shared with the EFMC. We have addressed the site based failings with our staff through team meetings and to individuals working within the ward / department. We will continue to monitor and drive performance forward.	100%	96.1%	98.5%	100%



Expected date to meet standard / target	June 30th 2015
Revised date to meet standard	June 30th 2015
Lead Director / Lead Officer	Darryn Kerr, Director of Estates and Facilities Mike Hotson,

2015/16 TDA METRICS COMPARED TO 2014/15

Responsiveness Domain		
Metric	**2014/15**	**2015/16**
Referral to Treatment Admitted	✓	✓
Referral to TreatmentNon Admitted	✓	✓
Referral to Treatment Incomplete	✓	✓
Referral to Treatment Incomplete 52+ Week Waiters	✓	✓
Diagnostic waiting times	✓	✓
A&E All Types Monthly Performance	✓	✓
12 hour Trolley waits	✓	✓
Two Week Wait Standard	✓	✓
Breast Symptom Two Week Wait Standard	✓	✓
31 Day Standard	✓	✓
31 Day Subsequent Drug Standard	✓	✓
31 Day Subsequent Radiotherapy Standard	✓	✓
31 Day Subsequent Surgery Standard	✓	✓
62 Day Standard	✓	✓
62 Day Screening Standard	✓	✓
Urgent Ops Cancelled for 2nd time (Number)	✓	✓
Proportion of patients not treated within 28 days of last minute cancellation	✓	✓
Delayed Transfers of Care	✓	✓
% of acute trusts with an effective model of liaison psychiatry (all ages, appropriate to the size, acuity and specialty of the hospital		✓
Provider outpatient cancellation rates		✓
TOTAL	18	20

Effectiveness Domain		
Metric	**2014/15**	**2015/16**
Hospital Standardised Mortality Ratio (DFI)	✓	✓
Deaths in Low Risk Conditions	✓	
Hospital Standardised Mortality Ratio - Weekday	✓	
Hospital Standardised Mortality Ratio - Weekend	✓	✓
Summary Hospital Mortality Indicator (HSCIC)	✓	✓
Crude mortality rate (non-elective ordinary admissions only)		✓
Emergency re-admissions within 30 days following an elective or emergency spell at the Trust	✓	✓
Emergency re-admissions within seven days following an elective or emergency spell at the trust		✓
Emergency re-admissions within 14 days following an elective or emergency spell at the trust		✓
Emergency re-admissions within 28 days following an elective or emergency spell at the trust		✓
Stroke 60 mins		✓
Stroke Care		✓
STeMI 150 mins		✓
TOTAL	6	11

Caring Domain		
Metric	**2014/15**	**2015/16**
Inpatient Scores from Friends and Family Test	✓	
A&E Scores from Friends and Family Test	✓	
Staff FFT Percentage Recommended – Care		✓
Staff FFT Percentage Not Recommended – Care		✓
Inpatient Scores from Friends and Family Test – % positive		✓
Inpatient Scores from Friends and Family Test – % negative		✓
A&E Scores from Friends and Family Test – % positive		✓
A&E Scores from Friends and Family Test – % negative		✓
FFT – Daycases		✓
FFT – A&E departments, Walk-in Centres (WiCs) and Minor Injury Units (MIUs)		✓
FFT composite		✓
Written Complaints Rate	✓	✓
Mixed Sex Accommodation Breaches	✓	✓
Inpatient Survey Q 68 - Overall, I had a very poor/good experience	✓	
TOTAL	5	11

Safe Domain		
Metric	**2014/15**	**2015/16**
Clostridium Difficile - Variance from plan	✓	✓
Clostridium Difficile – incidence rate		✓
MRSA bactaraemias	✓	✓
Never events	✓	✓
Never events – incidence rate		✓
Never events – time since last event		✓
Never events – repeat events		✓
Serious Incidents rate	✓	✓
Medication errors causing serious harm	✓	✓
Patient safety incidents that are harmful	✓	✓
Composite of patient safety (MyNHS)		✓
Potential under-reporting of patient safety incidents		✓
Potential under-reporting of patient safety incidents resulting in death or severe harm		✓
Consistency of reporting to the National Reporting and Learning System (NRLS)		✓
NHS Staff Survey – KF15. The proportion of staff who stated that the incident reporting procedure was fair and effective		✓
CAS alerts	✓	✓
CAS alerts outstanding – time to closure		✓
Maternal deaths	✓	
VTE Risk Assessment	✓	✓
Percentage of Harm Free Care	✓	✓
Percentage of new Harms		✓
Emergency c-section rate		✓
TOTAL	10	21

Well Led Domain		
Metric	**2014/15**	**2015/16**
Temporary staff spend on nurse and medical staffing		✓
Composite risk rating of ESR items relating to staff sickness rates		✓
Individual elements of Composite risk rating of ESR items relating to staff sickness rates		✓
Composite risk rating of ESR items relating to staff registration		✓
Individual elements of Composite risk rating of ESR items relating to staff sickness rates		✓
Composite risk rating of ESR items relating to staff turnover		✓
Individual elements of Composite risk rating of ESR items relating to staff turnover		✓
Composite risk rating of ESR items relating to staff stability		✓
Individual elements of Composite risk rating of ESR items relating to staff stability		✓
Composite risk rating of ESR items relating to staff support/ supervision		✓
Individual elements of Composite risk rating of ESR items relating to staff support/ supervision		✓
Composite risk rating of ESR items relating to ratio: Staff vs bed occupancy		✓
Individual elements of Composite risk rating of ESR items relating to ratio: Staff vs bed occupancy		✓
Trust level total sickness rate	✓	✓
Trust turnover rate	✓	✓
Staff FFT response rate		✓
Inpatients response rate from Friends and Family Test	✓	✓
A&E response rate from Friends and Family Test	✓	✓
Daycases FFT response rates		✓
FFT – A&E departments,Walk-in Centres (WiCs) and Minor Injury Units (MIUs) response rate		✓
Composite FFT response rate		✓
Staff FFT Percentage Recommended – Work	✓	✓
Staff FFT Percentage Not Recommended – Work		✓
NHS Staff Survey: Percentage of staff who would recommend the trust as a place to receive treatment	✓	
Data Quality of Returns to HSCIC	✓	
Total Trust vacancy rate	✓	
Temporary costs and overtime as % of total paybill	✓	
Percentage of staff with annual appraisal	✓	
Overall safe staffing fill rate		✓
Safe staffing fill rate – wards with <80% fill rate		✓
Safe staffing fill rate – fill rate variance		✓
TOTAL	10	26

CQC – Intelligent Monitoring Report

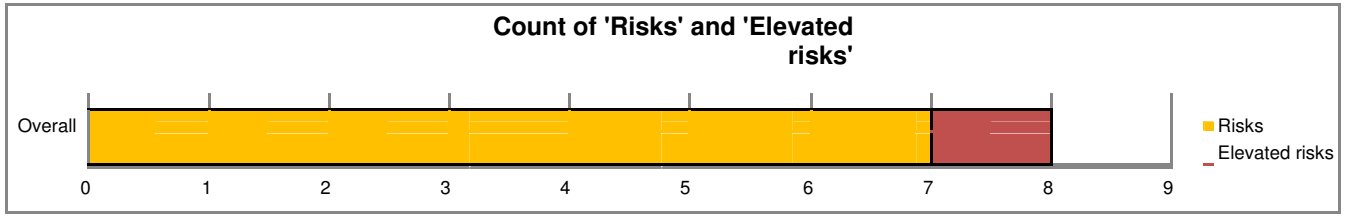
The latest CQC Intelligent Monitoring Report (IMR) was published on the CQC website on the 3rd December 2014.

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'

The next publication date is May 2015.



Priority banding for inspection	Recently inspected
Number of 'Risks'	7
Number of 'Elevated risks'	1
Overall Risk Score	9
Number of Applicable Indicators	94
Percentage Score	4.79%
Maximum Possible Risk Score	188

Elevated risk	Whistleblowing alerts (18-Jul-13 to 29-Sep-14)
Risk	PROMs EQ-5D score: Groin Hernia Surgery (01-Apr-13 to 31-Mar-14)
Risk	Composite indicator: A&E waiting times more than 4 hours (01-Jul-14 to 30-Sep-14)
Risk	All cancers: 62 day wait for first treatment from NHS cancer screening referral (01-Apr-14 to 30-Jun-14)
Risk	Proportion of ambulance journeys where the ambulance vehicle remained at hospital for more than 60 minutes (01-Apr-14 to 30-Apr-14)
Risk	TDA - Escalation score (01-Jun-14 to 30-Jun-14)
Risk	GMC - Enhanced monitoring (01-Mar-09 to 22-Jul-14)
Risk	Patient Opinion - the number of negative comments is high relative to positive comments (28-May-13 to 27-May-14)

Quality Schedule and CQUIN Schemes

Confirmed RAG's for Quarter 3 and predicted RAG's for Quarter 4.

Ref	Indicator Title	Q1 RAG	Q2 RAG	Q3 RAG	Q4 Predicted RAG	Commentary
	QUALITY SCHEDULE					
PS01	Infection Prevention and Control Reduction. - C Diff	G	A	A	tbc	Q2 and Q3 remain as Amber RAG'd as not all additional information provided around CMG IP Plan updates. Q4 RAG will be dependent upon submission of all required information to include thematic review findings for C Diff cases and MRSA and MSSA bacteraemias. C Diff. threshold achieved with 73 reported cases for 14/15 which is below the NTDA trajectory (81) but above UHL's own threshold.
PS02	HCAI Monitoring - MRSA	0	1	3	2	1 'avoidable' Bacteraemia in February and 1 'unavoidable' in March
PS03	Patient Safety – SIs, Never Events	G	G	2 G	1 (Jan) G	Q3 & Q4 Red RAG for Never Events. (relating to 'wrong sized hip prosthesis, retained Swab ties and wrong site surgery) Number of incidents reported continues to rise. But there has been a reduction in number that resulted harm.
PS04	Duty of Candour	0	0	0	0	No breaches during 14/15.
PS05	Complaints and user feedback Management (excluding patient surveys).	A	A	G	G	Complaints responses performance improved and achieved for December. Commissioners noted improvement made with response times in Q3 and Green RAG given. Improved performance sustained in Q4.
PS06	Risk Assurance and CAS Alerts	A	A	G	G 1	Amber RAG for Q2 relates to overdue CAS alerts for July. All risks scoring 15 or above have been reviewed within their required timeframe and have up to date action plans. Breach due to delayed receipt of confirmation that all actions completed in response to NPSA alert.
PS07	Safeguarding – Adults and Children	G	G	G	G	Assurance documentation due to be sent to CCG Safeguarding leads for their review ahead of their observational visit to the Trust.
PS08	Reduction in Pressure Ulcer incidence.	G	G	R (Nov & Dec)	R (Feb & Mar)	Monthly thresholds met for G2 HAPUs during Q4. Above the monthly trajectory of 7 for Grade 3 HAPUs in Feb following further validation (9). Grade 4 HAPU identified for March – related to use of Anti-embolic stockings.
PS09	Medicines Management Optimisation	A	G	A	G	Commissioners noted improvement in Controlled Drugs audit report and also Medicines Code but thresholds not fully achieved. Progress made with developing LLR Medicines Optimisation Strategy.
PS10	Medication Errors	G	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%	95.2%	96.1%	RCAs in progress for Hospital Acquired Thrombosis. Q4 RAG dependent upon achievement of 100% threshold .
PS12	Nutrition and Hydration	G	>80%	>85%	>83%	Work programme on track for nutrition, some delays with hydration actions. 90% threshold for Nutrition Assessment not achieved for any month in Quarter 4 in ESM and therefore overall Red RAG.

Ref	Indicator Title	Q1 RAG	Q2 RAG	Q3 RAG	Q4 Predicted RAG	Commentary
PE1	Same Sex Accommodation Compliance and Annual Estates Monitoring	2	0	2	1 (Jan)	Jan breach relates to patient on HDU at Glenfield. No breaches reported for Feb or March.
PE2	Patient Experience, Equality and Listening to and Learning from Feedback.	G	G	G	G	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	tbc	Not due to be reported until March 15. RAG dependent upon results in the National Patient Survey.
PE4	Equality and Human Rights	G	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	tbc	Clinical Problem Solving Group held to agree key priorities. Letters policy launched end of Jan 15. Amber RAG as audit not undertaken so unable to demonstrate improved compliance with Letter standards.
CE02	Intra-operative Fluid Management	G	>80%	<80%	tbc	Performance deteriorated during Oct/Nov. 80% achieved for December. Remedial actions in place to maintain. Q4 data to be confirmed.
CE03	Clinical Effectiveness Assurance – NICE and Clinical Audit	A	A	G	G	Responses for NICE Clinical Guideline / Quality Standards documents on track and actions being taken where audits behind schedule
CE04	Women's Service Dashboard	A	A	A	tbc	Amber RAG for Q2 relates to increase in C Section Rate. Q3 Amber RAG due to not achieving thresholds for Medical Staff Core Skills Training and C Section Rate.
CE05	Children's Service Dashboard	A	A	A	tbc	Q2 Amber RAG relates to SpR training Q3 Amber RAG due to non achievement of thresholds for SpR training and Management plans within 2 hours on the assessment unit.
CE06	Patient Reported and Clinical Outcomes (PROMs and Everyone Counts)	A	A	G	G	Groin Hernia PROMs improved, although still below the national average. Varicose Vein and Hip/Knee Replacement PROMS better or same as national. Consultant Outcomes published and all consultants in line with national average.
CE07	#NOF - Dashboard	51%	67.9%	62.1%	62.2%	72% threshold not met for any month in Q3. Mainly relates to peaks in activity and spinal patients. Improvement in February ((62.7%) from 57.9% in Jan. L/A programme in place and business case submitted to support increased theatre capacity.
CE08a	Stroke monitoring	G	G	72% Avge tbc	82.5 (Jan 15)	Improvements made for Stroke indicators (time to Scan, admission to stroke unit, thrombolysis). Green RAG for Q4 will be dependent upon achievement of the 90% stay (Jan performance >80%) and improvement in SSNAP Domain Scores.
CE08b	TIA monitoring	76%	67%	73.4%	74%	Threshold exceeded for high risk patients and performance improved for low risk patients being seen within 7 days.
CE09	Mortality (SHMI, HSMR)	A	A	A	A	Latest published SHMI = 105 (104.7) and is slowly reducing but is still above 100 (albeit within expected).
CE10	Making Every Contact Count (MECC)	A	G	G	G	Referrals to STOP and ALW continue. 'Healthy Eating and Physical Activity publicity campaign due to commence in General Surgery and Sleep Clinics. Commissioners noted all the Staff Wellbeing initiatives

Ref	Indicator Title	Q1 RAG	Q2 RAG	Q3 RAG	Q4 Predicted RAG	Commentary
AS01	Cost Improvement Programme (CIP) Assurance	A	G	G	G	Q4 RAG dependent upon provision of sufficient assurance that quality and safety issues being reviewed and actions taken where applicable..
AS02	Ward Healthcheck (Nursing Establishment, Clinical Measures Scorecard)	G	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	A	Internal 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	G	Actions taken to address concerns raised.
AS05	Staff Satisfaction	G	G	G	G	Work undertaken through the L*i*A process noted.
AS06	External Visits and Commissioner Quality Visits	G	G	G	G	Actions in response to Reviews being taken.
AS07	CQC Registration	A	G	A	G	2 Actions in response to CQC visit findings behind schedule – remedial actions being taken.
	NATIONAL CQUINS					
Nat 1.1a	F&FT 1a - Staff	G	G	G	G	Implemented during Q1/2
Nat 1.1b	F&FT 1b - OutPt & Day Case	G	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%	22.8% (Avge)	20% Q4 threshold achieved to date
Nat 1.3	F&FT 1.3 - Inpt increase in March	35.8%	31%	34.7%	44.8% (Mar)	Both the Q4 30% threshold and also the 40% threshold for March 15 achieved.
Nat 2.1	ST 2.1 - ST data submission	G	G	G	G	Data collection continues for all 4 harms.
Nat 2.2	ST 2.2 - LLR strategy	G	G	G	tbc	UHL contributing to the LLR Pressure Ulcer group and workstreams. Q4 RAG to be confirmed upon review of UHL's actions.
Nat 3.1	Dementia 3.1 - FAIR	G	G	G	G	90% thresholds met for all parts of the Dementia FAIR CQUIN.
Nat 3.2	Dementia 3.2 - Training & Leadership	G	N/A	N/A	G	Nicky Morgan is new Clinical Lead Dementia Training Programme reviewed and revised. Q4 RAG dependent on evidence of increased staff attending training.

Ref	Indicator Title	Q1 RAG	Q2 RAG	Q3 RAG	Q4 Predicted RAG	Commentary
Nat 3.3	Dementia 3.3 - Carers	G	G	G	G	Surveys carried out and evidence of actions being taken
	LOCAL CQUINS					
Loc 1	Urgent Care 1 (Discharge)	G	G	G	tbc	Further reductions in length of stay achieved. Q4 threshold to be confirmed.
Loc 2	Urgent Care 2 (Consultant Assessment)	G	G	A	tbc	65% threshold exceeded for AMU but not achieved in other assessment areas. Audit data not felt to accurately reflect practice. Q4 audit to have increased clinical input to ensure accuracy but unlikely to achieve the 75% threshold across all areas.
Loc 3	Improving End of Life Care (AMBER)	G	G	G	G	
Loc 4	Quality Mark	G	G	G	tbc	Quality Mark achieved for 6 out of the 8 wards to date. Although remaining 2 wards on track to achieve the QM, will be outside the agreed timescale for Q4.
Loc 5	Pneumonia	A	G	G	G	Q3 threshold achieved for all aspects of CQUIN scheme and work continues to achieve end of year thresholds. Q4 data to be validated.
Loc 6	Think Glucose	G	G	G	G	Think Glucose programme on track.
Loc 7	Sepsis Care pathway	≥47%	≥60%	<65%	tbc	Not all 6 aspects of the Sepsis6 Care Bundle thresholds achieved in Q3. Remedial actions in place for Q4 and data to be validated.
Loc 8	Heart Failure	≥49.5 %	≥63%	≥65%	>75%	Q4 threshold achieved.
Loc 9	Medication Safety Thermometer	G	G	G	G	All wards submitting data.
	SPECIALISED CQUINS*					
SS1	National Quality Dashboards	G	G	G	G	Dashboards now open for data submission at end of Q3
SS2	Breast Feeding in Neonates	61%	66%	55%	65%	Q4 threshold achieved.
SS3	Clinical Utilisation Review of Critical Care	N/A*	G	G	G	CCMDS and ICNARC data now being collected for all satellite HDUs.
SS4	Acuity Recording	N/A*	G	G	G	Acuity recording in place for all areas. Q4 RAG dependent upon being able to demonstrate effective use of Acuity data.

Ref	Indicator Title	Q1 RAG	Q2 RAG	Q3 RAG	Q4 Predicted RAG	Commentary
SS5	Critical Care Standards - Discharge	N/A*	G	G	G	Reduction in delays but increase in out of hours transfers during December – related to increased activity in Critical Care.
SS6	Critical Care Outreach Team 'time to response'	N/A*	G	G	G	Q3 threshold (increase data collection around 'time from referral to response) not fully achieved. Remedial actions in place.
SS7	Consultant Assessment	G	G	A	tbc	Links to the CCG CQUIN.
SS8	Highly Specialised Services Collaborative Workshop	G	G	G	G	Both ECMO and PCO participating in the national collaborative workshop.

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **7 MAY 2015**

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

SUBJECT: **2014/15 FINANCIAL POSITION TO MONTH 12 – MARCH**

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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)

2. KEY FINANCIAL DUTIES

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

Financial Duty	Full Year Plan £'Ms	Full Year Actual £'Ms	RAG
Delivering the Planned Deficit	(40.7)	(40.6)	G
Achieving the EFL	50.3	46.2	G
Achieving the Capital Resource Limit	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	2014-15 Full Year	
	Number	Value £000s
Total bills paid in the year	148,560	664,882
Total bills paid within target	78,639	466,936
Percentage of bills paid within target	**53%**	**70%**

Key issues

- Subject to audit, the I&E position is a £40.6m deficit, £0.1m better than the planned deficit of £40.7m.
- The EFL and the CRL have been delivered
- In total £48m of CIP has been delivered in 2014/15, compared to a plan of £45m

3. Financial Position (Month 12 - March)

3.1. The Month 12 results may be summarised as follows and as detailed in Appendix 1:

	March 2015			April - March 2015		
	Plan £m	Actual £m	Var (Adv) / Fav £m	Plan £m	Actual £m	Var (Adv) / Fav £m
Income						
Patient income	66.4	68.6	2.2	707.4	713.5	6.1
Teaching, R&D	7.1	7.9	0.8	81.4	82.1	0.7
Other operating Income	3.7	4.2	0.5	37.4	38.8	1.4
Total Income	**77.2**	**80.7**	**3.5**	**826.2**	**834.4**	**8.2**
Operating expenditure						
Pay	42.4	43.6	(1.2)	497.6	497.4	0.3
Non-pay	32.4	33.7	(1.3)	325.7	333.8	(8.1)
Total Operating Expenditure	**74.7**	**77.3**	**(2.6)**	**823.3**	**831.2**	**(7.8)**
EBITDA	**2.4**	**3.4**	**0.9**	**2.9**	**3.2**	**0.3**
Net interest	0.0	0.0	0.0	0.1	0.1	0.0
Depreciation	(3.3)	(2.7)	0.6	(33.9)	(33.2)	0.7
Impairment	-	(2.3)	(2.3)	(1.4)	(6.8)	(5.3)
PDC dividend payable	(0.8)	(0.5)	0.4	(10.4)	(10.7)	(0.2)
Net deficit	**(1.7)**	**(2.1)**	**(0.4)**	**(42.8)**	**(47.4)**	**(4.6)**
EBITDA %		**4.2%**			**0.4%**	
Less Impairments and donated asset adjustment	0.7	2.3	1.7	2.1	6.8	4.7
RETAINED SURPLUS / (DEFICIT)	**(1.0)**	**0.3**	**1.3**	**(40.7)**	**(40.6)**	**0.1**

3.2 In the month of March, the Trust delivered a surplus of £0.3m against a planned deficit of £1.0m, a favourable variance of £1.3m.

3.3 At year end, subject to audit, the Trust has delivered a deficit of £40.6m, £0.1m better than the planned deficit of £40.7m.

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

Income

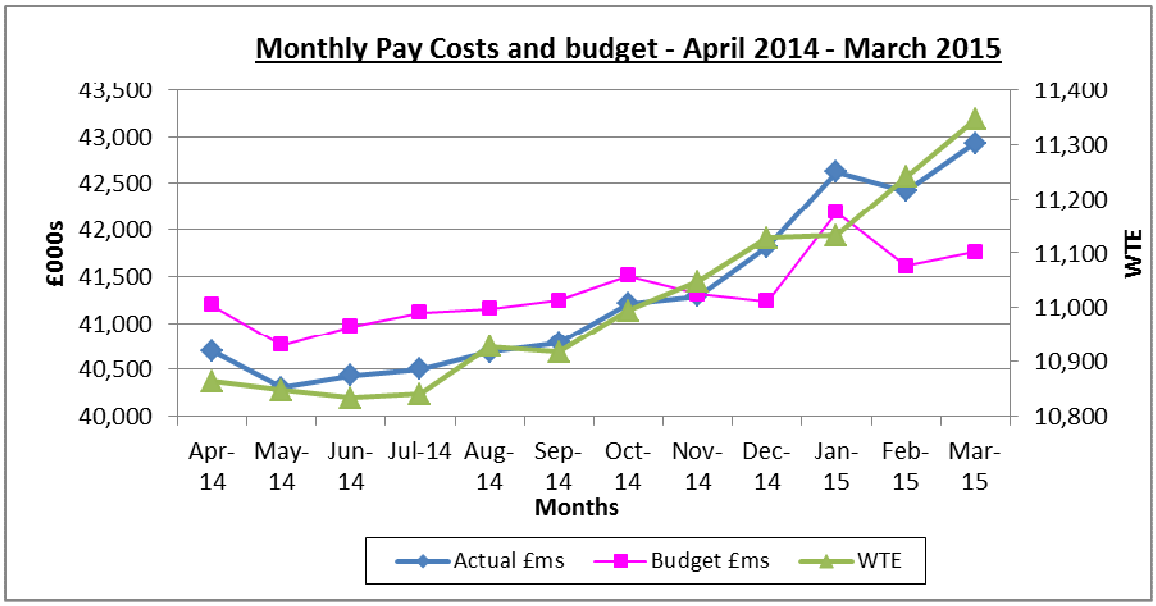
Patient care income is £3.5m favourable to plan in month following the release of operational resilience monies and the recognition of income for additional Q4 RTT activity as requested by the TDA and NHSE.

Teaching income is £0.4m better than plan following finalisation of the year end education monies and R&D income £0.4m better than plan offset with cost. Other operating income is £0.5m better than plan following the finalisation of the Alliance income.

Pay

Pay costs are £1.2m adverse to plan in March and £0.3m favourable to plan at year end. Appendix 5 details this by CMG and Directorate.

The total paybill compared to budget since April 2014 can be seen in chart 1 below, including number of WTE worked. This removes VSS costs paid in year and technical year end adjustments. This shows the sharp upward trend in cost since December, continuing in excess of budget. In addition it shows c500 wte more in post in March compared to June 2014.



The variance to plan by staff group can be seen in Table 2 below, including all premium costs. It is clear from this table that pressures on the pay budget are most prominent within Medical and Dental staffing and the risk of continued overspends in 2015/16 is high. Nursing budgets are becoming more pressured as recruitment increases and ensuring that premium spend reduces appropriately as substantive staff come into post is key.

	In Month £000s			YTD £000s			WTE		
Pay Type	Plan	Actual	Better / (worse)	Plan	Actual	Better / (worse)	Plan	Actual	Better / (worse)
Non Clinical	5,956	6,078	(123)	71,343	70,514	829	2,420	2,468	(49)
Other Clinical	5,281	5,351	(70)	63,751	60,971	2,780	1,710	1,649	62
Medical & Dental	14,468	15,542	(1,074)	167,345	172,482	(5,137)	1,745	1,731	14
Nursing & Midwifery	16,661	16,640	21	195,191	193,389	1,802	5,661	5,497	164
Total	**42,365**	**43,611**	**(1,246)**	**497,630**	**497,357**	**273**	**11,536**	**11,345**	**191**

Non Pay

Operating non pay spend is £1.3m adverse to plan in March and £8.1m adverse to plan at year end.

Of the in month overspends £0.8m relates to use of the Independent Sector to support delivery of backlog clearance. This is supported by additional income. The remainder of the overspend relates to clinical supplies and services.

Year to date the key drivers of the overspend relate to consumables £5.8m, independent sector £1.4m, security £0.8m, printing and postage £1.0m, consultancy £0.8m, international nurse recruitment cost £0.3m, NICE drugs £0.8m, offset with phased release of reserves and supplier discounts of £2.2m.

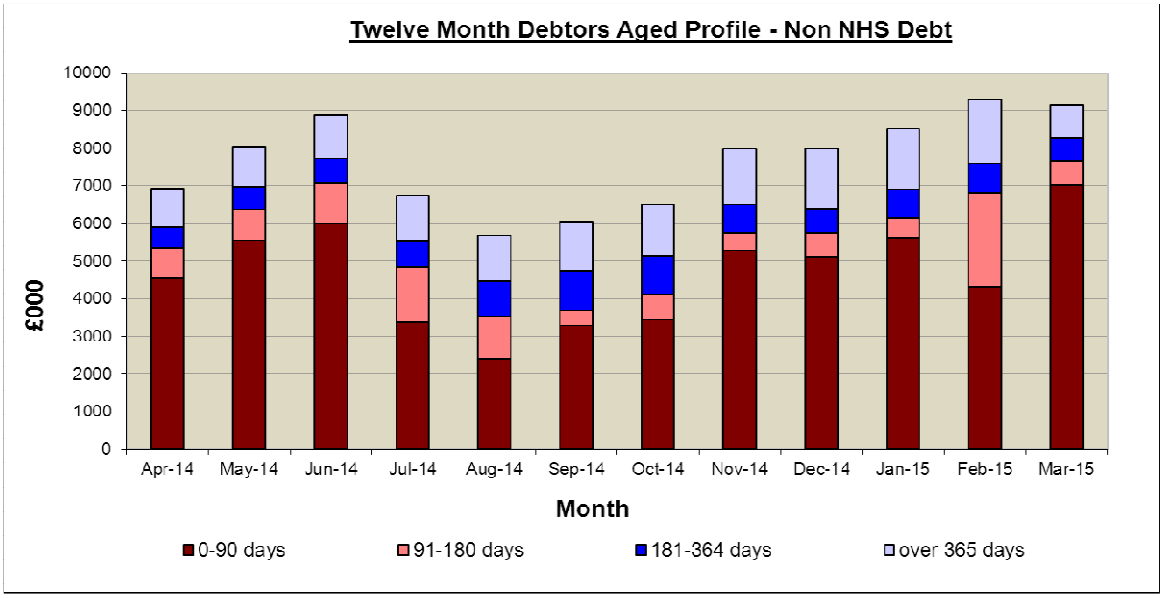
A more detailed financial analysis of CMG and Corporate performance (see Appendix 2) is provided through the Executive Performance Board financial report and reviewed by the Integrated Finance, Performance & Investment Committee.

Cost Improvement Programme

Appendix 2 shows CIP performance in March by CMG and Corporate Directorate against the 2014/15 CIP plan. This shows delivery of £48m against a target of £45m.

4. BALANCE SHEET AND CASHFLOW

The effect of the Trust's financial position on its balance sheet is provided in Appendix 3. 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.



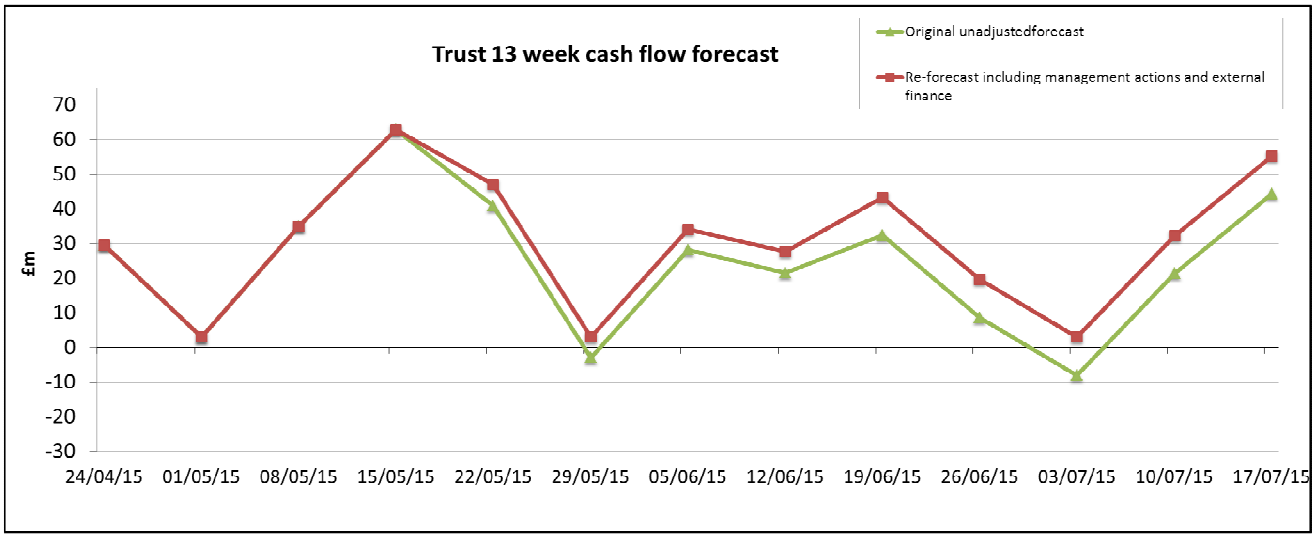
4.2 The overall level of non-NHS debt at the end of February decreased to £9.1m from £9.3m in February. Total debt over 90 days is £2.0m compared to £4.9m in March and of the £7.0m of debt under 90 days, £4.7m of this is less than 30 days and is therefore still within terms and not overdue.

4.3 The Better Payments Practice Code (BPPC) performance for the year up to the end of February, shown in the table below, shows that performance has been 70% in terms of invoices paid within 30 days by value. There has been a slight improvement in month from 51% to 53% in terms of invoices paid within 30 days by volume.

	By Volume Number	By Value £000s
Current Month YTD		
Total bills paid in the year	148,560	664,882
Total bills paid within target	78,639	466,936
Percentage of bills paid within target	**53%**	**70%**
Prior month YTD		
Total bills paid in the year	131,073	599,570
Total bills paid within target	66,849	414,784
Percentage of bills paid within target	**51%**	**69%**

4.4 The Trust's cashflow forecast is consistent with the income and expenditure position. The cash balance at the end of March was £8.5m, and this is £8.2m above the plan of £0.3m. The actual year-end balance was as expected following the draw-down of the £12m cash loan which will mainly be used to pay capital creditors outstanding at the year-end.

4.5 The Trust's cash forecast for the next 13 weeks is shown in the graph below.



4.6 We have drawn down £11m of our agreed working capital facility (out of a total available of £22m) which will provide short term funding to us in 2015-16 until we receive more permanent funding for our major capital schemes and to cover our deficit. We will draw down further amounts in late May and June to cover the cash shortfalls indicated in the above graph

5. CAPITAL

5.1 The total capital expenditure at the end of March 2015 was £46.8m. Whilst we have overspent our capital plan of £46.5m, as the overspend is due to higher donations than forecast, we remain within our Capital Resource Limit (CRL). The capital plan and expenditure can be seen in Appendix 4.

6. Conclusion

6.1. The Trust is reporting a deficit of £40.6m subject to audit, £0.1m better than the planned £40.7m deficit.

7. Next Steps and Recommendations

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

- **Note** the contents of this report and delivery of the planned deficit, subject to audit

Paul Traynor
Director of Finance
7th May 2015

	March 2015			April - March 2015		
	Plan £ 000	Actual £ 000	Variance (Adv) / Fav £ 000	Plan £ 000	Actual £ 000	Variance (Adv) / Fav £ 000
Elective	6,531	6,652	121	74,019	**71,743**	(2,276)
Day Case	5,252	4,770	(482)	60,744	**58,522**	(2,222)
Emergency (incl MRET)	14,947	15,086	139	175,406	**176,104**	698
Outpatient	9,114	9,356	242	105,399	**104,992**	(407)
Penalties	(292)	(330)	(39)	(3,500)	**(8,357)**	(4,857)
Non NHS Patient Care	483	584	101	5,660	**6,376**	716
Resilience Funding	0	0	0			0
Other	30,355	32,455	2,100	289,654	**304,149**	14,496
Patient Care Income	**66,390**	**68,573**	**2,182**	**707,381**	**713,528**	**6,147**
Teaching, R&D income	7,098	7,888	790	81,429	**82,096**	667
Other operating Income	3,718	4,210	492	37,429	**38,752**	1,323
Total Income	**77,206**	**80,671**	**3,464**	**826,239**	**834,376**	**8,137**
Pay Expenditure	**42,365**	43,533	**(1,168)**	**497,630**	**497,278**	**352**
Non Pay Expenditure	**32,391**	34,169	**(1,778)**	**325,733**	**334,298**	**(8,565)**
Total Operating Expenditure	**74,756**	**77,702**	**(2,946)**	**823,363**	**831,576**	**(8,213)**
EBITDA	**2,450**	**2,969**	**518**	**2,876**	**2,800**	**(76)**
Interest Receivable	8	6	(2)	96	**83**	(13)
Interest Payable	0	(4)	(4)	0	**(27)**	(27)
Depreciation & Amortisation	(3,318)	(2,686)	632	(33,887)	**(33,232)**	655
Impairment	0	(2,314)	(2,314)	(1,445)	**(6,761)**	(5,316)
Surplus / (Deficit) Before Dividend and Disposal of Fixed Assets	**(860)**	**(2,029)**	**(1,170)**	**(32,360)**	**(37,137)**	**(4,777)**
Profit / (Loss) on Disposal of Fixed Assets	(1)	13	14	(14)	**13**	27
Dividend Payable on PDC	(826)	(154)	672	(10,428)	(10,369)	59
Net Surplus / (Deficit)	**(1,687)**	**(2,170)**	**(484)**	**(42,802)**	**(47,493)**	**(4,691)**
Less Impairments	0	2,314	2,314	1,445	6,761	5,316
Adjustments in respect of donated assets	612	84	(528)	612	84	(528)
RETAINED SURPLUS / (DEFICIT)	**(1,075)**	**228**	**1,302**	**(40,745)**	**(40,648)**	**97**

Appendix 2

Financial Performance by CMG & Corporate Directorate

I&E and CIP – to March 2015

	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	43,941	44,868	926	5,262	5,415	153
Clinical Support & Imaging	-36,637	-36,735	-98	5,507	5,868	361
Emergency & Specialist Med	16,407	18,510	2,103	6,540	7,591	1,051
I.T.A.P.S	-43,250	-45,391	-2,140	4,328	4,107	-221
Musculo & Specialist Surgery	39,744	36,047	-3,697	5,111	5,169	58
Renal, Respiratory & Cardiac	31,329	31,380	51	5,961	6,124	163
Womens & Childrens	44,041	43,705	-335	6,335	6,483	148
	95,575	**92,385**	**-3,190**	**39,044**	**40,758**	**1,714**
Corporate:						
Communications & Ext Relations	-725	-655	69	59	59	0
Corporate & Legal	-3,609	-3,583	26	85	112	27
Corporate Medical	-1,762	-1,651	111	96	108	12
Facilities	-39,785	-39,946	-161	4,402	5,078	676
Finance & Procurement	-6,941	-6,617	324	329	559	231
Human Resources	-5,684	-5,369	315	212	366	154
Im&T	-9,840	-9,816	25	58	78	20
Nursing	-20,097	-19,855	242	349	413	64
Operations	-10,963	-11,472	-509	160	271	111
Strategic Devt	-1,172	-877	294	202	229	27
	-100,577	**-99,842**	**735**	**5,952**	**7,272**	**1,320**
Other:						
Alliance Elective Care	-5	482	487			
R&D	4	328	324			
Central	-36,354	-34,086	2,268	14	14	0
	-36,354	**-33,275**	**3,079**			
Total	**-41,356**	**-40,731**	**625**	**45,010**	**48,044**	**3,034**

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	Jan-14 £000's Actual	Feb-14 £000's Actual	Mar-15 £000's Forecast
Non Current Assets													
Property, plant and equipment	362,465	360,188	359,769	358,289	359,152	359,238	359,534	361,704	399,441	396,190	402,003	403,523	414,193
Intangible assets	8,019	7,788	7,555	7,338	7,109	6,877	6,636	6,408	6,180	6,452	6,217	5,982	10,134
Trade and other receivables	3,123	3,311	3,152	3,115	3,002	3,004	3,043	3,065	3,087	3,163	3,132	3,115	2,702
TOTAL NON CURRENT ASSETS	**373,607**	371,287	370,476	368,742	369,263	369,119	369,213	371,177	408,708	405,805	411,352	412,620	**427,029**
Current Assets													
Inventories	13,937	13,711	14,633	14,627	15,390	14,894	14,579	15,215	15,040	15,009	14,692	14,441	14,141
Trade and other receivables	49,892	44,492	44,580	51,192	47,903	38,966	32,335	36,344	36,383	32,211	33,094	23,188	35,292
Cash and cash equivalents	515	13,850	5,838	13,662	14,954	8,430	7,560	3,205	9,931	9,846	17,252	14,991	8,498
TOTAL CURRENT ASSETS	**64,344**	72,053	65,051	79,481	78,247	62,290	54,474	54,764	61,354	57,066	65,038	52,620	**57,931**
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)	(96,781)	(91,579)	(103,194)
Dividend payable	0	(1,025)	(1,894)	(2,763)	(3,632)	(4,540)	0	0	(2,080)	(3,120)	(4,160)	(5,200)	0
Borrowings / Finance Leases	(6,590)	(6,590)	(6,590)	(6,590)	(6,590)	(6,590)	(2,919)	(2,919)	(3,753)	(4,170)	(4,170)	(4,170)	(4,919)
Loan	0	0	0	0	0	0	0	0	0	0	0	0	(545)
Provisions for liabilities and charges	(1,585)	(1,585)	(1,585)	(1,585)	(1,585)	(1,585)	(1,585)	(1,585)	(1,585)	(512)	(1,585)	(1,585)	(820)
TOTAL CURRENT LIABILITIES	**(117,310)**	(111,581)	(110,673)	(111,663)	(112,468)	(100,738)	(91,396)	(95,736)	(110,141)	(93,152)	(106,696)	(102,534)	**(109,478)**
NET CURRENT ASSETS (LIABILITIES)	**(52,966)**	(39,528)	(45,622)	(32,182)	(34,221)	(38,448)	(36,922)	(40,972)	(48,787)	(36,086)	(41,658)	(49,914)	**(51,547)**
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	369,694	362,706	**375,482**
Non Current Liabilities													
Borrowings / Finance Leases	(5,890)	(5,794)	(5,785)	(5,730)	(5,676)	(5,683)	(9,179)	(9,186)	(8,075)	(7,663)	(7,668)	(7,674)	(6,869)
Other Liabilities / Loan	0	0	0	0	0	0	0	0	0	0	0	0	(11,455)
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)	(1,069)	(1,058)	(1,982)
TOTAL NON CURRENT LIABILITIES	**(7,960)**	(7,842)	(7,807)	(7,736)	(7,506)	(6,890)	(10,350)	(10,342)	(9,185)	(9,857)	(8,737)	(8,732)	**(20,306)**
TOTAL ASSETS EMPLOYED	**312,681**	323,917	317,047	328,824	327,536	323,781	321,941	319,863	350,736	359,862	360,957	353,974	**355,176**
Public dividend capital	282,625	298,125	298,125	311,625	311,625	311,625	311,625	311,625	311,625	329,837	329,725	329,725	329,837
Revaluation reserve	64,598	64,598	64,598	64,598	64,598	64,598	64,598	64,598	104,278	99,785	104,230	104,230	107,356
Retained earnings	(34,542)	(38,806)	(45,676)	(47,399)	(48,687)	(52,442)	(54,282)	(56,360)	(65,167)	(69,760)	(72,998)	(79,981)	(82,017)
TOTAL TAXPAYERS EQUITY	**312,681**	323,917	317,047	328,824	327,536	323,781	321,941	319,863	350,736	359,862	360,957	353,974	**355,176**

Capital Plan

University Hospitals of Leicester NHS Trust
Capital Expenditure Report for the Period 1st April 2014 to 31st March 2015

March 2015	CMG	Annual Budget £'000	YTD Actual £'000	Variance to Budget £'000
Estates & Facilities				
Accommodation Refurbishment	UHL	52	20	(32)
Aseptic Suite	CSI	400	236	(164)
Bereavement Facilities	W&C	62	162	100
CHP Units LRI & GH	UHL	800	804	4
Facilities Backlog Budget	UHL	5,500	4,795	(705)
Life Studies Centre	W&C	650	85	(565)
Maternity Interim Development	W&C	1,000	963	(37)
MES Installation Costs	CSI	1,302	1,769	467
Theatre Recovery LRI	ITAPS	2,785	1,775	(1,010)
Sub-total: Estates & Facilities		**12,551**	**10,609**	**(1,942)**
IM&T Schemes				
EDRM System	UHL	3,300	2,432	(868)
EPR Programme	UHL	3,100	4,618	1,518
IM&T Sub Group Budget	UHL	3,150	2,758	(392)
LRI Managed Print	UHL	412	232	(180)
Unified Comms	UHL	1,850	205	(1,645)
Sub-total: IM&T Schemes		**11,812**	**10,245**	**(1,567)**
Medical Equipment Schemes				
Lithotripter Machine	CHUGGS	430	430	0
Medical Equipment Executive	UHL	3,237	3,226	(11)
Renal Home Dialysis Expansion	RRC	708	527	(181)
Sub-total: Medical Equipment		**4,375**	**4,183**	**(192)**
Reconfiguration Schemes				
Emergency Floor	ESM	6,000	6,703	703
Endoscopy GH	CHUGGS	309	184	(125)
Feasibility Studies	UHL	100	(8)	(108)
GGH Vascular Surgery	MSS	2,500	533	(1,967)
Interim ITU LRI	ITAPS	590	387	(203)
Multi-Storey Car Park (MSCP)	UHL	250	271	21
Odames Library	UHL	1,500	1,306	(194)
Reprovision of Clinical Services	UHL	9,822	9,484	(338)
Ward 4 LGH	ESM	1,000	886	(114)
Sub-total: Reconfiguration Schemes		**22,071**	**19,746**	**(2,325)**
Corporate / Other Schemes				
LiA Schemes	UHL	250	206	(44)
Other Developments	UHL	469	1,199	730
Sub-total: Corporate / Other Schemes		**719**	**1,405**	**686**
Over Commitment	UHL	(5,321)		
Book value of assets disposed of		0	(6)	(6)
Total CRL / charge against CRL		**46,207**	**46,183**	**(24)**
Donations	UHL	300	576	276
Total Capital Plan		**46,507**	**46,759**	**251**

University Hospitals of Leicester NHS
NHS Trust

Agenda Item: Trust Board Paper M (revised)

TRUST BOARD – 7 MAY 2015

Emergency Care Performance Report

DIRECTOR:	Richard Mitchell, Chief Operating Officer
AUTHOR:	Richard Mitchell
DATE:	7 May 2015
PURPOSE:	a) To update the Board on recent emergency care performance b) To update on Board on progress against the LLR action plan c) To update the Board on the findings from the recent Dr Sturgess visit
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 ☒ 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** ☒ **Board Assurance Framework** ☐ **Not Featured**
ACTION REQUIRED * For decision ☒ For assurance ☐ For information ☐	

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

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

Review of 2014-15

- 2014-15 full year four hour performance was 89.1% compared to 88.4% the year before – 23rd greatest improvement out of 142 NHS providers with 110 provider's four hour performance deteriorating last year (national context).
- Over 7000 more patients were admitted (8% increase) last year compared to the year before.
- There were 76 days of +95% performance compared to 63 days the year before.
- Seven months of +90% compared to four months the year before.
- March 2015 performance finished at 91.1%.
- **Performance remained consistently below 95%.**

April 2015

- Performance in April 2015 (as of 28/4/15) is 92.7% compared to 87.2% in April 2014.
- **Attendances up 3.7% (18,341 v 17,684)**
- **Admissions up by 7.0% (6,622 v 6,188) compared to April 2014.**

Dr Sturgess visit

Dr Ian Sturgess revisited UHL for eight days in March 2015 focussing on both the Leicester Royal Infirmary and the Glenfield General Hospital. His full report is attached, with key findings below:

- UHL staff should take pride in what they have already achieved and have confidence in their ability to continue to make and sustain progress.
- Patient safety and experience have been improved by the changes.
- Continued risk of a 'supply side driver' due to local optimism within UHL.
- Better understanding across UHL that maintaining flow is an organisational issue and not just a concern for the Emergency Department.
- The wider health system needs to accelerate demand side management and utilise expertise from systems which are delivering demand control.

From the report we have identified 42 key recommendations which will be included in the reworked UHL component of the Leicester, Leicestershire and Rutland Urgent Care Board (LLR UCB) action plan. The recommendations relate to:

- Base Wards
- Acute medical Unit/ Short Stay
- CDU at Glenfield
- Cardio-Respiratory Base Wards
- Neurology
- Stroke
- Acute Frailty Pathway
- Oncology/ Haematology
- Paediatrics

We continue to work with health partners on delivering permanent improvements to the emergency pathway and as such we are pressing for the following five ambitious and deliverable goals for LLR in 2015-16 to be the focal point for activity:

1. 10% attendance reduction
2. 10% admission reduction – UHL very much has a role to play in this
3. 10% reduction in medical length of stay
4. 10% improvement in LPT supported discharge
5. Improvement in CDU and ED productivity and grip

These are all very much in line with BCT but need to happen quicker than the current plans. Detailed modelling has shown that delivering anything less than all five of these will result in another winter of poor patient experience and extreme pressure on staff.

The five key risks identified in the last Trust Board report remain.

Conclusion

To achieve sustainable improvement requires all parts of the health economy to improve. The fragile nature of the pathway means that slow adoption of improvements in one part of the health economy stops overall improvement.

Concerns remain about the rising level of admissions and plans to resolve this. We must therefore set challenging expectations for all parts of the health economy (including UHL) and work to ensure these expectations are rapidly met.

Recommendations

The Trust Board is recommended to:

- **Note** the contents of the report
- **Note** the findings from the second Sturgess visit
- **Note** the UHL update against the delivery of the new operational plan
- Seek **assurance** on UHL and LLR progress

Dr Ian Sturgess
IMP Healthcare Consultancy

9th April 2015

Mr John Adler
Chief Executive
University Hospitals Leicester NHS Trust

Dear John

Re: Feedback Report on Emergency Care Pathway at UHL.

Thank you for inviting IMP Healthcare Consultancy Ltd to return to review progress against some of the key recommendations within our report of November 2014.

In November it was noted that there had been 'early green shoots' of improvement occurring within UHL and a concern expressed at that time was that unless the demand side was more effectively managed by the wider system, there was the potential for a 'supply side driver' to develop. There has been further definite improvement, the 'green shoots' are now 'tender green stems', these need to be nurtured and developed further to become hardy stems and beyond. However, emergency admissions have continued to rise and there is little evidence of impact of the 'demand side' controls having much impact as yet. The risk of a 'supply side driver' due to local optimisation within UHL remains and the wider system does now need to accelerate the demand side management utilising expertise from systems who are delivering demand control. This will require enlightened system level leadership to 'take the challenge' of working with external urgent care systems that have a track record of delivering reduced admitted demand. The present systems within LLR have not to date delivered demand management. A relatively local system based in Corby appears to have demonstrated considerable success in managing demand and there are valuable lessons or opportunities for collaboration with this model of primary care and delivery of an urgent care centre process which appears to manage a level of patient acuity above that seen within the urgent care centres within LLR.

In conversations with a wide range of staff across multiple departments, there does appear to be a developing 'belief' and 'drive' that UHL can improve its processes further and there is early optimism. The conversations concerned the 'view of the possible' as opposed to the 'challenge of the impossible' which is a very significant cultural shift. There is now a clear understanding that maintaining flow is an organisational wide issue not just an Emergency Department issue. Resilience is still some way off and fragility remains although at a significantly reduced level to previously. UHL ought to be developing an increasing level of pride in what it has already achieved and in its confidence to continue to improve. There is no doubt that patient safety and experience will have been improved by the changes already achieved and there is so much more to be gained.

There will not be a specific section in the Emergency Department within this feedback since the emphasis continues to need to be on 'afterload', downstream

flow, and 'pre-load', demand management. The Emergency Department are aware that streaming of 'stable' GP referrals direct to assessment units, a more robust urgent care centre process, a 5 team 'assessment bay' function, 60 minutes maximum to 'treatment', 150 minutes to decision, 'situational awareness' supported by 2 hourly 'board rounding' focussed on these timelines and effective escalation will deliver. An 'increase' in activity that is not out with 'common cause variability' is not a reason for these timelines to drift. An escalation process, effectively delivered, based around an over-crowding 'index' with adjustment for the 3 main additional variables which can cause the ED to become challenged, namely, extent of resus cases, volume of children's cases and exit block, should ensure consistency of delivery. The escalation needs to be triggered early rather than waiting for over-crowding to occur. The EY modelling of the impact of each patient over a certain level within the majors area on journey times is impressive, as is the modelling of the number of assessment teams, inflow, exit block and even including the impact of the numbers of porters available..

There has been a strong focus on getting 'simple' discharges more timely and there is a need for this to continue. However, as a significant risk to the system, the extent of focus on the 'frailty' pathway has waned and this explains why the potential significant number of empty beds across the system has not materialised. The stranded patient metric and the 'direct return home rate' for patients aged 75 and over have not significantly improved as yet. It was disturbing to see the presentation of the 'improved delayed transfer of care' metric at the urgent care board. It was immediately apparent that this 'improvement' was as a result of a 'change in counting' with no evidence presented on how patient journey times had been improved. The LLR system was effectively 'managing the reporting' rather than 'managing the flow', essentially 'hitting the target but missing the point'.

The prevention of the adverse impact of deconditioning, a process that converts patients who could have simple discharges in to those with complex discharges and, most importantly, results in significant harm, needs to become the highest priority. It is understood that an 'integrated frailty programme' is being developed across Leicester Partnership Trust and UHL. Prevention of deconditioning, the 'Home First' principle with 'discharge to assess' for post discharge home based care needs assessment would deliver improvements in patient outcomes, particularly remaining at home, with a marked reduction in dependency on bed based solutions of the order of 150 beds or more. Programme management to support the 'acute frailty programme' is not visible and as such, the likelihood of delivering the quality and cost improvements necessary across LLR have been compromised.

A few of the high level improvements are identified below and where others have been observed at the 'day to day' level, these will be identified in the specific sections in the body of the feedback.

1. Programme management. This has been particularly well received by the clinical leaders driving the improvements. How programme management is to be continued is clearly a decision for the organisation, yet it will remain a crucial element of the ongoing improvements.
2. Governance. The Gold:Silver:Bronze process is more robust and the organisation has a far better understanding of what causes the challenges across

the patient's journey and then focusses on how these can be resolved. The daily discharge teleconference call at 11 am has become more structured and is 'supportively challenging' and includes key elements of the wider system to take away specific actions. Peer to peer reviews of key processes has as yet not become fully embedded. Peer review of long length of stay patients, board rounds and one-stop ward rounds need to be consistently delivered.

3. Clinical Leadership has continued to grow with both 'primary and secondary' leaders becoming more visible and designing and testing new ways of working to reduce variability.
4. Communication Strategy/Social Movement. This is gathering pace and now needs to spread across the wider system. The 'Exit Block' video was excellent. Celebrating more success stories, eg the Oncology 'attending model', ambulatory emergency care, the Assessment Bay, etc as well as 'individual stories' of 'what I achieved today' would strengthen the social movement further. If these can be supported by patients telling the story of an improved process, then this becomes more compelling.
5. The '4 questions' patients should be able to answer are visible as posters and there is visible re-enforcement of these principles with the 'No decisions about me without me' 'credit card' sized plastic cards.
6. Use of improvement techniques. Rapid cycle tests of charge continue to be used and the methodology appears to be well liked by the clinical teams. This could be further strengthened by building capacity and capability in improvement methodology.
7. The Medicine Consultant 'Safety' rota ensures early review of any patients waiting a bed in ED and outlier reviews after the 0800 Gold meeting. As flow continues to improve the need for this process will disappear as outliers and overnight wait for beds in ED are abolished.

OBERVATIONS AND RECOMMENDATIONS

Acute Medical Unit/Short Stay

- There has been a reduction in the variability of processes within the AMU although significant variance remains.
- Currently approximately 50%% of GP referred patients are going direct to AMU/AMC clinic, the aim is to increase this further.
- The Ambulatory Emergency Care programme has progressed and will be starting to have significant impact on flow. There remain considerable further opportunities with consistency of Consultant input, increasing the direct GP referred attends through the AEC area, direct transfer of ED referrals from the Assessment Bay utilising the AMB Score for patients who would otherwise be referred to bed based assessment.
- Use of iPads for 'order comms' and updating of Nerve Centre appears to have assisted in reducing some constraints in the system.
- The Acute Medical Clinic, which provides the AEC process, also has capacity consumed by patients who could be managed elsewhere, namely in other routine clinics and for follow up patients, a virtual space. Managing these patients in alternative settings would free up the AMC for more AEC.
- Short Stay on Ward 33 is delivering between 8-12 discharges per day.

- The patients transferred to the Short Stay Unit have a 'Short Stay Pathway' form completed.
- There are inconsistencies in Consultant rostered cover such that for 50% of the week, if not more, there is not Consultant cover from early morning. This impacts on the rate of morning discharges.
- Short Stay did not report a significant delay in the writing up of discharge letters and discharge prescriptions.
- Pharmacy cover out of hours and at weekends does appear to be affecting discharge timeliness from the Short Stay unit.
- The Consultant 'Safety Rota' to review patients awaiting a bed in ED first thing in the morning and reviewing outliers is good practice. This rota will become unnecessary when there is consistent delivery of no 'waiting for beds' in ED in the morning and no outliers.

Recommendations

1. Complete the Standard Operating Procedures/Internal Professional Standards for the AMU and then clearly define roles and responsibilities with monitoring against these standards, reported daily. 3-4 key process metrics could be summarised at the commencement of each day.
2. Continue the 'Safety Rota' until there are consistently no 'waiting for beds' in ED and no medical outliers.
3. Senior review of all GP calls. If rigorously applied, up to 25% of all GP calls can be managed by a non-same day attendance route, either advice, community based options, next hot slots in routine clinics etc.
4. Ambulance/Transport service to convey those GP referrals that do need to attend within 1 hour of GP request for transport
5. Ensure consistent Consultant cover of the AMC/AEC area.
6. Aim for 20-25% of the Medical take being managed through an AEC process, consider renaming the Acute Medical Clinic to align it with AEC.
7. Ensure that only patients who would otherwise have attended either via ED or as a bed based same day acute assessment are seen in the AEC area.
8. Continue to increase the proportion of GP referrals arriving direct in to the AEC area, aiming for 80-90% of GP referrals not going via ED. Only those with physiological instability need to go via ED.
9. Ensure consistent 7 day early morning Consultant cover, with appropriate support, of the Short Stay Unit to facilitate morning discharges.
10. Process map and optimise the dispensing of discharge prescriptions across the AMU and Short Stay for out of hours and weekends.

Medical Base Wards

- There has been some Peer to Peer reviewing of Board Round processes.
- There is an improved focus on expected date of discharge and clinical criteria for discharge although this is not fully embedded.
- The daily discharge review meeting at 11am is much more robust than last year aiming to ensure timely preparation of discharge letters/prescriptions, pre-booking transport, encouraging the use of the discharge lounge, etc. There is improved engagement with LPT and Social Care to sup[port discharges.
- Consistent peer review of 'one stop' Ward rounds is not consistently in place

- Peer review of long length of stay patients has not been consistently delivered.
- There remains risk averse behaviour relating to discharge home

Recommendations

1. Re-implement the Peer review processes, particularly for the 'long length of stay' reviews but importantly for the Board Rounds and One Stop Ward rounds.
2. Put in place simple 'standard operating procedures' or 'internal professional standards' on 'long length of stay reviews', Board Rounding and One stop ward rounds against which Peer to Peer review aims to manage the variance. The SAFER care bundle from ECIST is a useful starting point.
3. Re-enforce the 'Home First' principle'.

Acute Frailty Pathway

- This flow-stream does not appear to have been prioritised to the extent recommended in the feedback report in November 2014.
- There is no specific programme management for this flow-stream.
- There have been improvements in some cross organisational working to support discharge.
- The acute frailty front door process appears to have stalled due to lack of availability of Consultant Geriatricians. The system remains dependent on the Acute Frailty Unit, through which probably less than 50-60% of older people with frailty with acute medical problems actually pass through.
- As a consequence, the potential extent of reductions in the stranded patient metric and the expected rise in direct discharge home from UHL for patients aged 75 and over has not materialised.
- It is by optimising this flow-stream that the system will be able to release considerable numbers of beds across the system, both acute and community.

Recommendations

1. Ensure a focus on the frailty pathway to minimise in-hospital deconditioning as recommended in the November feedback.
2. Provide programme support to this flow stream to support the delivery of the expected reductions in occupied beds.

Neurology

- Neurology has implemented a 7 day attending model.
- Daily Consultant Neurology Board Rounds are in place.
- Run Chart shows a mean discharge rate of 22-24 per week from July 2014 to March 2015 compared to 15 per week throughout last year.
- An AEC Neurology rapid cycle was tested and was perceived as successful, aim has been to implement this for the week beginning 23rd March 2015. Bed occupancy restricted this PDSA.

Recommendations

1. Continue PDSA cycles of AEC Neurology area on Ward 24.
2. Continue to reduce 'admit for investigation' patients. This is deliverable through ambulatory care or through standard outpatient processes.
3. Further develop the in-reach process to AMU, as Neurology AEC expands, the numbers of neurological cases admitted to AMU should be reduced significantly.

4. Ensure that the direct emergency admits or AEC patients attending the Neurology ward are assessed in accordance with the Keogh standards.

Stroke Medicine

- It was reported that there remain variances on the discharge/transfer rate from the Acute Stroke Wards dependent on which clinical team is 'attending'.
- There are considerable differences in discharge rate between the community stroke units with ward 3 at the Leicester General Hospital having the lowest rate.
- It is reported that there is a difference in the case-mix between the community stroke units with the Leicestershire County units taking a mixture of stroke and non-stroke patients whilst Ward 3 remains solely a stroke unit. In addition, the early supported specialist stroke discharge service is much more mature in Leicester City area with the potential that the remaining in-patients have a much higher dependency.
- There remain considerable issues relating to complex discharge (both generic and stroke specific) and the CHC process across the system. If this latter issue were resolved, the need for community stroke beds would considerably reduce.

Recommendations

1. Analyse Stroke bed resource utilisation across patient journeys to understand the differential between community stroke units and Ward 3.
2. Minimise system delays with regards to discharge processes for complex patients, this is a generic recommendation.

Oncology/Haematology

- Oncology has implemented an attending model for the in-patient wards with a reduction in a length of stay and very positive feedback from trainees and nursing staff. This has not been implemented in Haematology.
- Oncology have recommended a 'ward based team' approach with Doctors in training being shared across Oncology and Haematology.
- Community based transfusions for patients' with predictable transfusion needs has not progressed as extensively as it could have done.

Recommendations

1. Implement an attending model in Haematology.
2. Implement the shared ward based Junior medical staff as proposed by Oncology.
3. Ensure that the community based transfusion programme is implemented in full to release Haemato-oncology day unit capacity.

Paediatrics

- Presently 'two' of the Paediatric Consultants provide Children's Assessment Unit (CAU) cover.
- Consultant presence not mapped to 80th centile of presentations (commencing at 0800 hrs)
- Staffing levels on CAU not consistently robust.
- There are 'legacy issues' regarding clinical risk.
- Lack of HDU facilities for Children – partly due to long term patients who could be managed in the community if there was service for them.

- 10% (high) of admissions are in children < 1 week old. It was reported that this may be due to a combination of early discharge post-partum and Community Midwifery cover. Community midwives are visiting on day 5 as opposed to day 3 which can result in children who have not 'attained 'stable breast feeding becoming dehydrated, weight loss, at risk of hypoglycaemia and competencies re phlebotomy etc for monitoring of jaundice.
- Rule of 1/3rds of children to CAU, 1/3 can be out in < 1 hour potentially a primary care stream, 1/3 out in < 8 hours, and 1/3 very ill. Same tariff for all on CAU attendance – ward attendance tariff
- Paediatric bed occupancy persistently (including summer) above 90%, issues with complex dependent children with long term neurological problems
- There is a recognition of the need to build relationships with ED
- Number of recently appointed Paediatricians and Paediatric Emergency Consultants

Recommendations

1. Building a robust CAU rota – this is currently 70% plus in place aiming for Consultant presence until at least 2100 hrs.
2. Continue to develop a 'mutual aid and support' process across Paediatric AD and CAU.
3. Robust staffing for CAU based around the 85th centile of children's attendances and not the average.
4. Co-location of CAU with Children's ED in the new build, the processes to be tested before move into the new build.
5. Develop a Primary care stream – currently UCC GPs within Paediatric CAU, aim will be to train up to manage the 1/3 with LOS < 1 hour

Cardio-Respiratory At the Glenfield Hospital

Clinical Decision Unit

- There are 25 beds on the CDU with 2 new assessment bays, a number of trolleys and chairs and 15 short stay beds.
- With an average of 48 daily attendances over the preceding 26 weeks with an 85th centile of approximately 55 per day, if assuming a 12 hr bed turn rate, this requires 27-28 chairs/trolleys/beds for assessments, investigations and initial treatment.
- The number of short stay beds is insufficient to meet the short stay demand.
- There is approximately a 60/40 split between respiratory and cardiac cases. Although there are a number of cases with 'general medical or acute frailty problems' masquerading as cardio-respiratory cases.
- There are 24 beds on the Coronary Care Unit.
- There is one Consultant Respiratory Physician, and during the two weeks of the return visit, an ad hoc Consultant Cardiologist process covering the CDU.
- There is a proposal to test the use of the AMB score to identify the potential ambulatory cases attending the CDU.
- The Consultant Respiratory Physicians cover the CDU from 0800 to 2000 weekdays and 0800 to 1300 hrs at weekends which results in the majority of the weekend take only being reviewed on a post take next day process rather than an in-day review process. This will result in fewer short stay discharges.

- The observed Consultant Cardiologist cover was sporadic and was 'fitted in' after Coronary Care Unit ward rounds.
- CDU has EDIS in place and is able to report on timelines across the assessment process.
- Time to initial assessment (nursing) is longer than the recommended time frame of 15 minutes.
- 'Time to treatment', ie commencement of medical assessment, is considerably longer than a 60 minute standard.
- It is not clear what % of patients have a Consultant assessment within 4 hours (6 hours for the Keogh standard) of arrival (0800 to 2000 hrs). The 14 hour out of hour standard will be breached at weekends.
- It was reported that a number of cross sectional imaging is shifted to an on-call radiology rota as there does not appear to be sufficient capacity during normal working hours to deliver timely diagnostics. There can be delays in return of reports from the out of hours radiology as the on-call radiologist covers both the Glenfield and the General out of hours.
- Junior Doctors from CDU are required to provide 'medical cover' for the injection of contrast out of hours which reduces 'assessment capacity'.
- Drugs to take home prescriptions out of hours appear to require the faxing of the relevant section of the in-patient prescription chart, after pulling off the relevant section, to the Pharmacy at the LRI. This causes considerable delays in drugs to take home turnaround time for patients on the CDU.
- In conjunction with all assessment units, the complexity of the process to generate discharge summaries for zero length of stay patients consumes a significant amount of 'assessment team member'.
- With this 'consumption' of assessment team member time it is debatable whether there are sufficient Junior medical staff covering the CDU.
- There are times when there are considerable backlogs of patients awaiting assessment and senior reviews despite there being empty beds on the Glenfield site. This results in an over-crowded CDU with the attendant risks. If times to assessments and senior review could be improved, particularly for patients with the potential rapid turnaround, the over-crowding within the CDU would be markedly reduced and the need for 'stopping' the take to the CDU would be abolished.
- In patients with non ST elevated Myocardial infarction without on-going instability, there are at times delays beyond the strict evidence based benefit of early angiography and proceed of 72 or 96 hours.
- For patients with STEMI after primary PCI, there appears to be a standard 3 day length of stay for uncomplicated cases. There is some published and operational evidence that this can be safely achieved after a two day length of stay, with only the first 24 hours being in a monitored bed, for potentially 70% of primary PCI STEMI patients.

Recommendations

1. Across the 'medical' assessment units, there is a need for standardisation workforce plans utilising demand;capacity analysis, reduction/elimination of non-added value tasks using 'expected' rates of assessment per hour, reviews per hour and 'discharge tasks'. The work done within the Emergency Department on this area by Professor Tim Coats could assist in this standardisation process.

2. The volume of patients for effectively one Consultant to see is excessive and constitutes a potential clinical risk. There is a need for 2 Consultants 12 hours per day 7 days per week, one Cardiology and one Respiratory. This is probably achievable within current staffing levels following a job plan review.
3. Implement a door to nurse standard of 15 minutes, a 'door to doctor' standard of either 30 minutes or 60 minutes, and a 'door to Consultant review' of 4 hours (for 0800 to 2000 hrs.
4. Implement an evening weekend Consultant review process, from 1600 hrs to 1900 hrs in the first instance, for both Cardiology and Respiratory. Ideally, there should be two Consultant present for 12 hours a day for 7 days per week.
5. Test through PDSA cycles, the impact of a 'front door' physician in the CDU providing 'early senior assessment' as within the ED at the LRI with streaming to 'ambulatory care', utilising the AMB score in the first instance, aiming to achieve rapid turnaround of this stream of patients. Diagnostic and pharmacy support to achieve this fast turnaround will also need to be tested.
6. Out of hours pharmacy provision or 'take home' pack extension to current provision would aid in supporting early discharge from the CDU and short stay.
7. Removal of the need for an assessment team doctor to supervise contrast administration.
8. Diagnostic radiology, particularly cross sectional imaging, demand:capacity analysis for the non-elective pathway at the Glenfield and the General is required with an improvement programme to minimise delays.
9. Rationalisation of discharge documentation for zero length of stay patients.
10. Cardiology to consider the safety and efficacy of a 2 day length of stay for uncomplicated primary PCI patients.
11. A 'frailty/complex' discharge support process is required and its need will increase over time. LPT will need to consider the provision of the Primary Care Co-ordinator support process to the Glenfield.

Cardio-Respiratory Base Wards

- There is considerable variability in the 'board round' process both within and between the two specialties.
- Consultant led Board rounding does not occur 5 days per week. Well scripted, focussed Board rounds take 30 minutes or less for a 24 bedded ward.
- The Respiratory Board round observed was Consultant led, focussed on discharge, clinical criteria for discharge were not 'visible' to the whole team but did appear to 'in the mind' of the lead Consultant.
- This Board round only included the patients under that Consultant (approximately 75_80% of the ward) whilst the remaning patients had near identical 'diagnosis' profiles. Effective use of EDD and clinical criteria for discharge would allow Board rounding of all patients.
- There are 'predicated' length of stay for a variety of respiratory conditions appeared to be being used. The risk is 'regression to the mean'.
- Historically there has been an 'audit' of EDD which found that EDD did not match actual discharge date. This has been interpreted as undermining the concept of EDD. However, if an EDD is set assuming 'zero delays' and is based on clinical need alone, then this 'audit result' is very encouraging. The purpose of setting an EDD assuming 'zero delays' is to assist in the identification of the 'constraints' in the system that prevent the system delivering the EDD.
- Board rounding is more variable on the cardiology base wards.

- The extent of one-stop ward rounds is variable across the cardio-respiratory base wards.

Recommendations

1. Implement the use of EDD and CCD, using the assumed non-delays principle, to drive the case management delivery.
2. Implement daily structured Consultant led Board Rounds on all wards utilising the SAFER bundle from ECIST.
3. Identify the blocks to 'one stop' ward round delivery and rectify aiming to achieve one-stop ward rounds on all wards.

Concluding Comments

There has been clear improvement in emergency care flows at UHL despite limited evidence of demand control from the wider system. There is still more to do and there was clear evidence of improved engagement in the principles of improving flow and safety and the recognition that this is 'everyone's responsibility'.

It is becoming increasingly crucial that the wider LLR system puts in place effective demand management as the continued improvement which will occur at UHL risks becoming a very significant 'supply side driver'.

The spring and summer months are an opportunity to really drive and deliver the further improvements which UHL now has the capability to achieve.

Yours sincerely

Dr Ian Sturgess FRCP (Lon)

University Hospitals of Leicester NHS
NHS Trust

Agenda Item: Trust Board Paper N

TRUST BOARD – 7th MAY 2015

UHL RISK REPORT INCORPORATING THE BOARD ASSURANCE FRAMEWORK

DIRECTOR:	ANDREW FURLONG – MEDICAL DIRECTOR
AUTHOR:	PETER CLEAVER – RISK AND ASSURANCE MANAGER
DATE:	7TH MAY 2015
PURPOSE:	This report provides the Trust Board (TB) with:- This report provides the Trust Board (TB) with:- a) The UHL 2014/15 BAF and action tracker as of 31ST March 2015. b) A draft version of the UHL BAF for 2015/16. c) Notification of new extreme or high risks opened during March 2015. d) Summary of all UHL extreme and high risks on the UHL risk register. The TB is invited to: • Receive and note this report; • review and comment upon the March 2015 iteration of the 2014/15 BAF and the draft version of the 2015/16 BAF, as it deems appropriate; • note the actions identified to address any gaps in either controls or assurances (or both); • identify any areas which it feels that the Trust's controls are inadequate and do not effectively manage the principal risks to our objectives; • identify any gaps in assurances about the effectiveness of the controls to manage the principal risks and consider the nature of, and timescale for, any further assurances to be obtained; • identify any other actions necessary to address any 'significant control issues' in order 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 [Y] 7. A clinically and financially sustainable NHS Foundation Trust [Y] 8. Enabled by excellent IM&T
Please explain any Patient and Public Involvement actions taken or to be taken in relation to this matter:	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: **7th MAY 2015**

REPORT BY: **ANDREW FURLONG – MEDICAL DIRECTOR**

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

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1. INTRODUCTION

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

a) The UHL 2014/15 BAF and action tracker as of 31ST March 2015.
b) A draft version of the UHL BAF for 2015/16.
c) Notification of new extreme or high risks opened during March 2015.
d) Summary of all UHL extreme and high risks

2. 2014/15 BAF POSITION AS OF 31st MARCH 2015

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 2014/15 BAF action tracker is attached at appendix two with changes also highlighted in red. The TB is asked to note the following points:

a. Actions 16.2 and 16.3 are deemed to be operational in nature and have been removed from the BAF to be transferred to the UHL risk register under the ownership of the HR directorate and monitored to completion via the local risk review process.

b. A significant number of actions to close gaps in control and assurance have been completed and the TB is asked to consider reducing the current risk score to the target level for risk numbers 4, 5, 6, 7, 10, 16, 17, 18, 21 and 22.

c. Actions 18.6 and 18.7 are closed (as opposed to completed) and we may not return to these until at least the second half of 2015/16 (if at all) by which time the Board should be composed of substantive post holders.

2.2 It is proposed that the strategic objective below is discussed and reviewed:

- *'Responsive services which people choose to use' (incorporating* principal risk numbers 5, 6, 7 and 8).

3. DEVELOPMENT OF THE UHL 2015/16 BAF

3.1 The (TB) has previously requested a draft version of the 2015/16 BAF and to this end executive leads have populated the attached draft BAF at appendix three. The TB will note that final version will be submitted for sign-off in June 2015. The final version will be accompanied an action tracker to track the progress of actions.

3.2 It is important to recognise that the BAF should reflect only the 'high level' strategic issues and not drill down into operational details and should also contain sufficient detail in relation to how the TB receives assurance that our controls to achieve our strategic objectives are effective.

3.3 Some entries within this draft 2015/16 BAF may benefit from more challenge and scrutiny in particular around the identification of assurance sources and risk scoring. Where necessary this challenge will be provided by the corporate risk team with feedback being provided to the executive leads. This, in addition to any comments received from TB will enable a final version of the 2015/16 BAF to be produced.

4. EXTREME AND HIGH RISK REPORT.

4.1 To inform the TB of significant operational risks, a summary of all extreme and high risks (i.e. 15 and above) open as of 31st March 2015 is attached at appendix four. There are 46 risks on the organisational risk register scoring 15 and above.

4.2 Two new high risks have opened during March 2015 as described below. The details of these risks are included at appendix four for information

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Risk ID	Risk Title	Risk Score	CMG/ Directorate
2504	Patients will wait for an unacceptable length of time for trauma surgery resulting in poor outcomes and patient satisfaction	MSS	2504
2496	The Implementation of an Electronic Blood Tracking and Traceability Management System across UHL Hospital sites will not occur within the time scales agreed with the MHRA	CSI	2496

5. RECOMMENDATIONS

5.1 The TB is invited to:

(a) Receive and note this report;

(b) review and comment upon the March 2015 iteration of the 2014/15 BAF and the draft version of the 2015/16 BAF, as it deems appropriate;

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

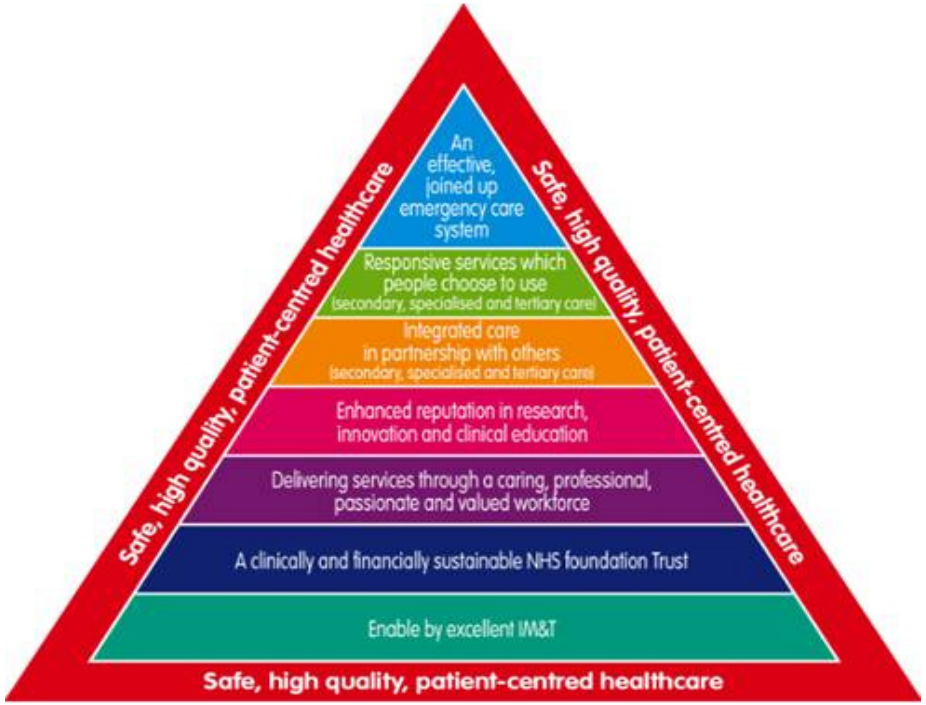
(d) identify any areas which it feels that the Trust's controls are inadequate and do not effectively manage the principal risks to our objectives;

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

(f) identify any other actions necessary to address any 'significant control issues' in order to provide assurance on the Trust meeting its principal objectives;

Peter Cleaver,
Risk and Assurance Manager,
30th April 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: MARCH 2015

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			
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 Acceptance through U C B that attendance avoidance and admission avoidance schemes have not worked. LLR partners are aiming for a 5% reduction in 2015-16.		
Appointment of Dr Ian Sturgess to work across the health economy	Weekly meetings between Dr Sturgess, UHL CEO and UHL COO. Dr Sturgess attends Trust Board.			
Allocation of winter monies	Allocation of winter monies is regularly discussed in the LLR steering group	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 Acceptance through U C B that attendance avoidance and admission avoidance schemes have not worked. LLR partners are aiming for a 5% reduction in 2015-16.		
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		
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		

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		

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.		
Weekly meeting with key specialities to monitor detailed compliance with plan	Trust Board receives a monthly report detailing performance against plan	(c) As above		
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			

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.			

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. 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 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: o Paper presented to the April 2014 UHL Trust Board meeting, setting out the Trust's approach to regional partnerships Project Initiation Document (PID): o Developed as part of UHL's Delivering Care at its Best (DC@IB) o Reviewed at the June 2014 Executive Strategy Board (ESB) meeting o 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): o Developed as part of UHL's Delivering Care at its Best (DC@IB) o Reviewed at the August 2014 Executive Strategy Board (ESB) meeting o Updates (DC@IB Highlight Report reviewed at ESB meetings			
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) Athena Swan Silver Status by University of Leicester and Loughborough University. (The Athena Swan charter applies to higher education institutions)	(c) Requirement to replace senior staff and increase critical mass of senior academic staff in each of the three BRUs. (c) Athena Swan Silver not yet achieved by UoL and Loughborough University. This will be required for eligibility for NIHR awards	BRUs to re-consider theme structures for renewal, identifying potential new theme leads. (12.1) 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. (12.4)	Jun 2015 MD Mar 2016 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			

	Accreditation visits			
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)	Jun2015 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 Developing partnerships; • De Montfort University • University of Nottingham • University College London (Life Study) • Cambridge University (100k project)	Minutes of joint UHL/UoL Strategy meetings Minutes of Joint BRU Board Minutes of NCSEM Management Board 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) New relationships need to be developed and nurtured with the new VC and President for UHL. New Dean of Medical School expected 2015.	LU strategy to be discussed at joint BRU board. (14.2)	May 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.			
Nursing Recruitment Trajectory and international recruitment plan in place for nursing staff	Overall nursing vacancies are monitored and reported monthly by the Board and NET as part of the Quality and Performance Report NHS Choices will be publishing the planned and actual number of nurses on each shift on every inpatient ward in England			
Development of an Employer Brand and Improved Recruitment Processes	Reports of the LIA recruitment project Reports to Executive Workforce Board regarding innovative approaches to recruitment	(c) Capacity to develop and build employer brand marketing	Deliver our Employer Brand group to share best practice and develop social media techniques to promote opportunities at UHL (15.6)	Jun 2015 DHR

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			
'Quality Improvement and innovation' by implementing quality improvement education, continuing to develop quality improvement networks and creating a Leicester Improvement and Innovation Centre	Quarterly reports to EQB and EWB and measured against implementation plan milestones set out in PID.	No gaps identified		
Appraisal and Objective Setting in line with Strategic Direction	Appraisal rates reported monthly via Quality and Performance Report. Appraisal performance features on CMG/Directorate Board Meetings. Board/CMG Meetings to monitor the implementation of agreed local improvement	No gaps identified		

	actions			

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			
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			
Work stream Three: **Management of Change LiA** • LiA Engagement Events held as a precursor to change projects associated with service transformation and / or HR Management of Change (MoC) initiatives.	Quarterly reports to Executive Workforce Board (EWB) and Trust Board Updates provided to LiA Sponsor group on each thematic activity Update reports provided to JSCNC meetings			

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			
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			
Annual National Staff Opinion and Attitude Survey	Annual Survey report presented to EWB and Trust Board Analysis of results in comparison to previous year's results and to other similar organisations presented to EWB and Trust Board annually Updates on CMG / Corporate actions taken to address improvements to National Survey presented to EWB Staff sickness levels may also provide an indicator of staff satisfaction and performance and are reported monthly to Board via Quality and Performance report Results of National staff survey and local patient polling reported to Board on a six monthly basis. Improving staff satisfaction position.			
Friends and Family Test for NHS Staff	Quarterly survey results for Quarter 1, 2 and 4 to be submitted to NHS England for external publication:			

	Submission commencing 28 July 2014 for quarter 1 with NHS England publication commencing September 2014 Local results of response rates to be CQUIN Target for 2014/15 – to conduct survey in Quarter 1 (achieved)			
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			
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. 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.			
'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			
'Shared Learning Networks' by creating and supporting learning networks across the Trust, developing action learning sets across disciplines and initiating paired learning.	Quarterly Reports to Executive Workforce Board as part of Organisational Development Plan and Learning, Education and Development Update as set out in Risk 16.			
'Talent Management and Succession Planning' by developing a talent management and succession planning framework, reporting on talent	Quarterly Reports to Executive Workforce Board as part of Organisational Development Plan and Learning, Education and Development Update as set			

profile across the senior leadership community, aligning talent activity to pay progression and ensuring succession plans are in place for business critical roles.	out in Risk 16.			
'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)		

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) Required development of service strategies which integrate with the financial strategy (via LTFM) to deliver recurrent financial balance'	Production of a revised financial strategy to accelerate the recovery programme (19.2)	Jun 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) Not all PMO posts have been recruited to	Recruit substantive staff to vacant posts (20.2)	Apr 2015 COO
Cross cutting themes are established.	Executive Lead identified. Monthly reports to F&P committee and Trust Board			

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		
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		

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	**March 2015**
Frequency of review:	Monthly
Date of last review:	February 2015

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
1	**Lack of progress in implementing UHL Quality Commitment.**					
1.5	Discussion at EQB March re 15/16 priorities and report to QAC	CN		March 2015	Refresh of QC complete, agreed at QAC March 2016 and included in strategic priorities and quality commitment	5
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	Acceptance through Urgent Care Board that attendance avoidance and admission avoidance schemes in 2014-15 have not worked. LLR partners are aiming for a 5% reduction in 2015-16.	2
2.5	Arrangements for IS to return for a two week in January 2015 (2.5)	COO		~~January 2015~~ March 2015	IS attended for eight days in March. He identified progress and areas for improvement. Now awaiting letter.	5
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	Acceptance through Urgent Care Board that attendance avoidance and admission avoidance schemes in 2014-15 have not worked. LLR partners are aiming for a 5% reduction in 2015-16.	2
4	**Delay in the approval of the Emergency Floor Business Case.**					
4.1	Regular communication with NTDA	MD		March 2015	**Complete.** Communication will continue until the submission dates and beyond to keep the NTDA on track.	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

5	**Failure to deliver RTT improvement plan.**					
5.2	Act on findings from recently published IST report	COO		~~August October 2014~~ March 2015	**Complete.** Improvements implemented. Compliant with two out of three measures. Aim is for the third to be compliant in April/ May 2015	5
6	**Failure to achieve effective patient and public involvement**					
7	**Failure to effectively implement Better Care together (BCT) strategy.**					
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 February 2015~~ March 2015	**Complete.** The PID is complete and is to go to ESB in May under the delivering care at its best work stream.	5
9	**Failure to implement network arrangements with partners.**					
10	**Failure to develop effective partnership with primary care and LPT.**					
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	**Complete.** Potential candidate for Respiratory BRU identified with UoL Offers of appointments made by LU for candidates to work with Lifestyle BRU	5
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	**Complete.** RCF will be used to pump prime appointment in support Respiratory BRU. Clinical component of funding being agreed with RRC CMG	5
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

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

12.5	Special meeting of Joint BRU Board: planning to secure BRU funding at the next NIHR competition. Further meetings planned.	MD	DR&D	March 2015	**Complete.** A schedule of meetings has been planned.	5
13	**Failure to provide consistently high standards of medical education.**					
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~~ ~~April 2015~~ June 2015	We have a role description agreed between UHL and HEEM – however unlike other Trusts UHL does not support College Tutor roles. A paper is being prepared for the April UHL Executive team to address this issue. Timescale for completion extended to reflect this	3
14	**Lack of effective partnerships with universities.**					
14.2	LU strategy to be discussed at joint BRU board.	MD	DR&D	~~March~~ 2015 May 2015		3
14.3	UHL membership of NCSEM management board	MD	DR&D	March 2015	Kevin Harris to attend for UHL and Nigel Brunskill to attend for UoL	5
14.4	Meeting with LU VC, UHL MD, UHL DRD and BRU Director to discuss strategy	MD	DR&D	June 2015	Breakfast meeting held in March 15 – further meetings planned as required and dictated by availability of National Guidance for future BRUs	5
14.5	Develop regular meeting with DMU	MD	DR&D	June 2015	Regular meetings established at Exec level – relevant subgroups established	5
15	**Failure to adequately plan the workforce needs of the Trust.**					
15.4	Develop Innovative approaches to recruitment and retention to address shortages.	DHR		June 2015	**Complete.** Medical Workforce Strategy to be updated following feedback from HEEM quality visit and the Clinical Senate. and incorporated into a Workforce Board Thinking Session in May or June Timescale for completion extended to reflect this Services are developing a portfolio to reflect provision in better attracting consultant to services	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

15.6	Delivering our Employer Brand group to share best practice and develop social media techniques to promote opportunities at UHL	DHR		~~March 2015~~ June 2015	Service areas need to provide an overview of the future of their services for use when advertising consultant posts. The timescales for developing this must link with plans for confirmation of CMG future operating models. These are scheduled to be completed by June 2015. Timescale extended to reflect this.	3
15.8	Consultant recruitment review team to develop professional assessment centre approach to recruitment utilising outputs to produce a development programme	DHR		April 2015	**Complete.** Consultant recruitment process has been improved to incorporate unseen presentations. This started in January 2015 and will be evaluated	5
15.9	Develop new roles that address competency and skill gaps in service delivery areas	DHR		~~March 2015~~ June 2015	**Complete.** UHL New Roles Group with the remit of delivering new roles in Assistant Practitioner, Advanced Practitioner and Physician Assistant. .	5
15.10	Refine the workforce elements of the Operational Planning cycle to ensure robust workforce plans to support organisational transformation, activity and finance	DHR		April 2015	**Complete.** Final submission of workforce plan was March 31 2015. The NTDA submission was made on 7 April 2015. The changes have been triangulated with finance and activity	5
16	**Inability to recruit and retain staff with appropriate skills.**					
16.2	eUHL system updates required to meet Trust needs. This action is operational in nature and is being removed from the BAF and will be transferred to the UHL HR risk register	DHR		March 2015	**Action transferred to organisational risk register**. Business Case presented to the Capital Investment Committee on 13 March 2015 and further work underway on understanding the procurement options, intellectual property and future sales.	N/A

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

16.3	Robust ELearning policy and procedures to be developed to reflect P&GC approach This action is operational in nature and is being removed from the BAF and will be transferred to the UHL HR risk register	DHR		~~February 2015~~ May 2015	**Action transferred to organisational risk register** Policy consultation will take place during April 2015 prior to revised policy submission to PGC during May 15. Timescale extended to reflect this	N/A
17	**Failure to improve levels of staff engagement**					
17.10	Success outcomes to be shared with nursing workforce via new annual Nursing Conference –scheduled for April 2015. To be transferred to organisational register	DHR/ CN		March 2016	**Complete.** Nursing Conference being planned.	5
17.11	Workshop on 2014 survey results priorities and actions to be shared via management forums and CE Briefing	DHR		~~March 2015~~ April 2015	**Complete.** National results known and have been analysed and compared to the previous year. A paper will be submitted to the Trust Board in April 2015. Timescale for completion extended to reflect this.	5
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	**Complete.** Awaiting the outputs from the second workshop (TBC – March 2015)	5
17.15	Annual performance target set with CMG breakdown available per month for CMG Board Meetings.	DHR		March 2016	**Complete.** Performance targets are being rolled forward for 2015/16 and will be reviewed annually thereafter.	5
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	**Complete.** HR Leads identified to attend Workforce KPI Quarterly meetings.	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

17.17	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	**Complete.**	5
17.18	Feasibility Report by 31 March 2015 with Trust Board approval. To be presented to TB in March and EWB in March 2015	DHR		March 2015	**Complete.** Update to be provided on Mutuals in Health pathfinder Programme at EWB and TB in March 2015	5
18	**Lack of effective leadership capacity and capability**					
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	**Complete.** Consultant Forum in place and key development identified to support the newly appointed consultants Three day Mentoring Programme initially for Consultants, but second and third pilot Programmes are Multi-Professional. Pilot concluded in March 2015. Quality Assurance Standards being developed. Quarterly Mentoring Forum arranged. To build UHL capacity to provide Mentoring Training Faculty.	5
18.4	Present update on Learner Management System developments and NHS Healthcare Leadership Model Resources to support the provision of 360 Feedback	DHR		~~February 2015~~ March 2015	**Complete.** Healthcare Leadership Model recommended and standards sent to EWB for comment – responses to be received before the end of April 2015	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

18.5	Support national and regional Talent Management and Succession Planning Projects by National NHS Leadership Academy , EMLA and NHS Employers	DHR		March 2015	**Complete.** UHL staff nominated to access National Leadership Academy Programme based on talent conversations. Report on talent profile of Senior Leadership Community presented to Executive Workforce Board during March 2015 and an update provided to the Remuneration Committee on 2nd April 2015	5
18.6	Board Coach (on appointment) to facilitate Board Development Session	DHR		~~October 2014~~ ~~February 2015~~ March 2015	**Closed.** This action longer applicable until such time that a full Board is appointed and we may not return to this until at least the second half of 2015/16 (if at all) by which time the Board should be composed of substantive post holders.	N/A
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~~ March 2015	**Closed** This action longer applicable until such time that a full Board is appointed and we may not return to this until at least the second half of 2015/16 (if at all) by which time the Board should be composed of substantive post holders.	N/A
19	**Failure to deliver financial strategy (including CIP).**					
19.2	Development of service strategies which integrate with the financial strategy (via LTFM) to deliver recurrent financial balance. Reworded by Director of Finance (April)	DF		~~August Review September 2014~~ ~~February 2015~~ June 2015		3

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

19.10	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.**					
20.2	Recruit substantive staff to vacant posts to ensure continuity of function of PMO	COO		~~February 2015~~ April 2015	One vacancy out of eight remains, with national advert currently out. Timescale extended to reflect this	3
21	**Failure to maintain effective relationships with key stakeholders**					
22	**Failure to deliver service and site reconfiguration programme and maintain the estate effectively**.					
23	**Failure to effectively implement EPR programme**					
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

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

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

UHL BOARD ASSURANCE FRAMEWORK 2015/16

STRATEGIC OBJECTIVES

Objective	Description	Objective Owner(s)
a	**Safe, high quality, patient centred healthcare**	**Chief Nurse** /Medical Director
b	**An effective and integrated emergency care system**	**Chief Operating Officer/** Medical Director/ Chief Nurse
c	**Services which consistently meet national access standards**	**Chief Operating Officer**
d	**Integrated care in partnership with others**	**Director of Strategy**
e	**Enhanced delivery in research, innovation and clinical education**	**Medical Director**
f	**A caring, professional and engaged workforce**	**Director of Human Resources**
g	**A clinically sustainable configuration of services, operating from excellent facilities**	**Director of Strategy** / Director of Facilities
h	**A financially sustainable NHS Foundation Trust**	**Director of Finance**
i	**Enabled by excellent IM&T**	**Chief Information Officer**

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

PERIOD: APRIL 2015

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 (QC).	CN	9	6
2.	**An effective and integrated emergency care system**	Demographic growth plus ineffective admission avoidance schemes may counteract any internal improvements in emergency pathway	COO	20	6
3.	**Services which consistently meet national access standards**	Failure to transfer elective activity to the community , develop referral pathways, and key changes to the cancer providers in the local health economy may adversely affect our ability to consistently meet national access standards	COO	9	6
4.	**Integrated care in partnership with others**	Existing and new tertiary flows of patients not secured compromising UHL's future more specialised status.	DS	15	10
5.		Failure to deliver integrated care in partnership with others including failure to: Deliver the Better Care Together year 2 programme of work Participate in BCT formal public consultation with risk of challenge and judicial review Develop and formalise partnerships with a range of providers (tertiary and local services) Explore and pioneer new models of care. Failure to deliver integrated care.	DS	15	10
6.	**Enhanced delivery in research, innovation and clinical education**	Failure to retain BRU status.	MD	9	6
7.		Clinical service pressures and too few trainers meeting GMC criteria may mean we fail to provide consistently high standards of medical education.	MD	9	4
8.		Insufficient engagement of clinical services, investment and governance may cause failure to deliver the Genomic Medicine Centre project at UHL	MD	9	6
9.		Changes in senior management/ leaders in partner organisations may adversely affect relationships / partnerships with universities.	MD	6	6
10	**A caring, professional and engaged workforce**	Gaps in inclusive and effective leadership capacity and capability , lack of support for workforce well- being, and lack of effective team working across local teams may lead to deteriorating staff engagement and difficulties in recruiting and retaining medical and non-medical staff	DHR	12	8
11.	**A clinically sustainable configuration of services, operating from excellent facilities**	Insufficient estates infrastructure capacity and the lack of capacity of the Estates team may adversely affect major estate transformation programme	DS	20	10
12.		Limited capital envelope to deliver the reconfigured estate which is required to meet the Trust's revenue obligations	DS	12	8
13.		Lack of robust assurance in relation to statutory compliance of the estate	DS		
14.		Failure to deliver clinically sustainable configuration of services	DS	12	8
15.	**A financially sustainable NHS Organisation**	Failure to deliver the 2015/16 programme of services reviews, a key component of service-line management (SLM)	DS	9	6
16		Failure to deliver UHL's deficit control total in 2015/16	DF	15	10
17		Failure to achieve a revised and approved 5 year financial strategy	DF	15	10
18	**Enabled by excellent IM&T**	Delay to the approvals for the EPR programme	CIO	16	6
19		Perception of IM&T delivery by IBM leads to a lack of confidence in the service	CIO	16	6

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 (QC).	**Overall level of risk to the achievement of the objective**	**Current score 3x3=9**	**Target score 3x2=6**
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 (QC).	3 monthly and / or 6 monthly progress reports to EQB and QAC.	Vacancies within clinical staff will affect implementation of QC	Nurse and medical workforce recruitment strategies (1.1)	Milestone review Jul 2015 MD&CN
KPIs agreed and monitored for all parts of the Quality Commitment.	Monthly Q&P Report to TB. 3 monthly and / or 6 monthly progress reports to EQB and QAC. Exception reporting where KPIs/ outcomes not achieved External validation and benchmarking data including: Dr Foster Intelligence Copeland Risk adjusted barometer (CRAB) Hospital Evaluation data	Currently only 30% of deaths are screened and there is a requirement to move to 100%. Vacancies within clinical staff grades may adversely affect our ability to implement this.	Roll out plan to be developed Audit support to be provided Monitor uptake Mortality database to be developed As action 1.1	Sep 2015 MD July 2015 MD Milestone review Jul 2015 MD&CN Milestone review Jul 2015 MD&CN
Clear work plans agreed and monitored for all parts of the Quality Commitment.	Action plans reviewed regularly at EQB and as a minimum annually reported to QAC. Annual reports produced. Internal audit review during 2014/15 for each arm of QC CQC inspection during 2015/16	(a) Internal audit review awaited	Implement actions from review as required	June 2015 CN

	Commissioner review of work plans/ progress via CQUIN.			
Robust governance and committee structures in place to ensure delivery of the quality agenda	Regular committee reports. Annual reports. Achievement of KPIs. Senior accountable individuals with appropriate support			

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 2	Demographic growth plus ineffective admission avoidance schemes may counteract any internal improvements in emergency pathway	**Overall level of risk to the achievement of the objective**	**Current score 4x5=20**	**Target score 3x2=6**
Executive Risk Lead(s)	Chief Operating Officer			
Link to strategic objectives	An effective and integrated 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**
Agree set of metrics that measure internal and external emergency care performance	Reported to UHL TB monthly Reported to EPB monthly Reported to UHL Emergency Quality Steering Group monthly Performance reported at UHL Gold Command meeting daily Reported to UCB and CCGs National benchmarking of emergency care data			
LLR Action plan to improve patient flow (i.e. admissions, reduction in discharge delays, making best use of existing ED capacity		(c) LLR action plan not fully implemented	Continue to implement and monitor progress of LLR action plan	Review Sep 2015 COO

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 3	Failure to transfer elective activity to the community , develop referral pathways, and key changes to the cancer providers in the local health economy may adversely affect our ability to consistently meet national access standards	**Overall level of risk to the achievement of the objective**	**Current score** 3x3=9	**Target score** 3x2=6
Executive Risk Lead(s)	Chief Operating Officer			
Link to strategic objectives	Services which consistently meet national access standards			

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**
Agreed set of metrics that measure referrals activity and waiting times	Reported to EPB quarterly Reported to Trust Board monthly Reported to UHL Access meeting – weekly Reported to RTT Board weekly (with representation from TDA & CCGs) Weekly diagnostics meeting Engaged with Intensive Support Team (specialist services)	(c) Currently not delivering the three 18 week RTT access standards. (c)Currently not delivering the three key Cancer access standards. (c) Currently not delivering the diagnostics access standards Have yet to implement tools and processes that allow us to improve our overall responsiveness through tactical planning	Develop performance improvement framework for failing specialties driven by the DP&I. Development and implementation of intelligence led recovery plan and trajectories. Theatre productivity improvements driven through the cross-cutting work stream.	May 2015 DP&I Jul 2015 DP&I Jul 2015 COO

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 4	Existing and new tertiary flows of patients not secured compromising UHL's future more specialised status.	**Overall level of risk to the achievement of the objective**	**Current score 15**	**Target score 10**
Executive Risk Lead(s)	Director of Strategy			
Link to strategic objectives	Integrated care in partnership with others.			

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**
Appointment to Head of Tertiary Partnerships role to lead on formalising and securing existing pathways and developing new ones.	Monthly reporting to ESB as part of Director of Strategy report.	(c) Significant amount of partnership work being taken through ESB.	Considering options/benefits/risks of establishing UHL Partnership Board. (4.1)	Jul 2015 DS
Children's and Cancer Collaborative Groups established with NUH.	Monthly reporting to ESB as part of Director of Strategy report.	(c) Significant amount of partnership being taken through ESB.	As action 4.1	As action 4.1
Memorandum of Understanding (MoU) between NUH and UHL signed in 2011.	Monthly reporting to ESB as part of Director of Strategy report.	(c) MoU was intended to support establishment of EMPATH and should include wider partnership opportunities.	MoU to be reviewed by both organisations.	Jul 2015 DS
Partnership Board for Specialised Services established in Northamptonshire. Membership includes Northants CCGs; NHS England; KGH; NGH and UHL.		(a) Does not feed into UHL Governance Structure.	Future minutes to be included DS report to ESB.	Jul 2015 DS
Meetings in place and planned at Director level with other provider organisations (regional and national) to explore partnership opportunities.	Monthly reporting to ESB as part of Director of Strategy report.	None	None	

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 5	**Failure to deliver integrated care in partnership with others including failure to:** Deliver the Better Care Together year 2 programme of work; Participate in BCT formal public consultation with risk of challenge and judicial review; Develop and formalise partnerships with a range of providers; Explore and pioneer new models of care. Failure to deliver integrated care.	**Overall level of risk to the achievement of the objective**	**Current score 15**	**Target score 10**
Executive Risk Lead(s)	Director of Strategy			
Link to strategic objectives	An effective and integrated emergency care system; Services which consistently meet national access standards; A clinically sustainable configuration of services, operating from excellent facilities; A 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**
PLANNING • BCT Programme five year directional plan developed and agreed in June 2014. • Two-year operational plan approved in April 2014. • LLR BCT Strategic Outline Case approved and submitted centrally December 2014.	LLR BCT Partnership Board bi-monthly, attended by the chief executive and medical director. Ad hoc updates from the chief executive to Trust Board as part of the chief executive report	(c) LLR Master Project Plan required to monitor progress	BCT PMO to establish plan (5.1)	May 2015 DS
GOVERNANCE - Robust BCT and UHL/BCT project governance structure: • LLR BCT Partnership Board - overarching responsibility for setting, implementing and reporting the BCT Programme • UHL/BCT Programme Board	Monthly UHL/BCT Programme Board progress reports to Executive Strategy Board	(a) Regular LLR wide performance monitoring report required for presentation to Trust Board	BCT PMO establishing a master plan	Jun 2015 DS
DELIVERY - Robust system wide project delivery structure and organisational specific delivery mechanisms • LLR project delivery through LLR Implementation Group • Organisational delivery (UHL/BCT Programme Board) Project specific delivery (UHL Beds/theatres/OP etc.)	Monthly project specific highlight reports considered at UHL/BCT Programme Board Monthly project specific highlight reports	(a)LLR wide dashboard required so that performance can be monitored (a) Lack of Triangulation and assurance of plans	LLR wide business intelligence group established. UHL dashboard in draft to be used to inform LLR wide dashboard. BCT PMO to facilitate	May 2015 DS May 2015 DS

		at organisational and system wide level.	triangulation process	
PUBLIC CONSULTATION • Update on plans for Public consultation considered and approved by LLR BCT Partnership Board in March 2015. • The programme will carry out an overarching consultation for the whole system change, paying specific attention to areas of particular public interest and is targeted to take place in autumn 2015.	Monthly reports are submitted to the LLR BCT Partnership Board, last one submitted March 2015	(c)No detailed plans for overall change. These will form the basis for the narrative for formal consultation.	Work to outline the scope and target date for consultation project by project Results of the engagement programme will be summarised and used to inform the Consultation planning. Analysis to be provided to partnership Board. Plan for consultation including a full governance roadmap to be completed.	Apr 2015 DMC May 2015 DMC May 2015 DMC Jul 2015 DMC
EXPLORING PIONEERING NEW MODELS OF CARE TO SUPPORT THE DELIVERY OF INTEGRATED CARE Proposal for proof of concept for a single Integrated Frail Older Person Service (LPT/UHL/GE Finnamore) prepared Proposed establishment of an Institute of Frail Older People Services Programme management arrangements in place (early April, 2015)	Verbal update to Executive Strategy Board (April 2015) Progress reports are to be submitted to the Executive Strategy Board on a monthly basis	Project plan and early progress not yet developed	Project plan to be developed	May 2015

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 6	Failure to retain BRU status.	**Overall level of risk to the achievement of the objective**	**Current score 3x3=9**	**Target score 3x2=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. BRUs to identify potential recruits and work with UoL/LU to structure recruitment packages. UHL to use RCF to pump prime appointments if possible and LU planning new academic appointments to support lifestyle BRU.	Jun 2015 MD Jun 2015 MD Jun 2015 MD
	Athena Swan Silver Status by University of Leicester and Loughborough University. (The Athena Swan charter applies to higher education institutions)	(c) Athena Swan Silver not yet achieved by UoL and Loughborough University. This will be	UoL and LU to ensure successful applications for Silver swan status.	Mar 2016 MD

		required for eligibility for NIHR awards	Individual medical school depts will need to separately apply for Athena Swan Silver status.	

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 7	Clinical service pressures and too few trainers meeting GMC criteria may mean we fail 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**	
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	(c) Medical Education issues not championed by Non-Executive Director	Discuss NED lead with Chairman	TBA
	Oversight by Executive Workforce Board Bi-monthly UHL Medical Education Committee meetings (including CMG representation) Database of recognised Trainers required by GMC 2016 Appointment processes for Level 3 educational roles established Appraisal of Level 2 educational roles in UHL appraisal	(c) Education facilities Identified as poor in external reports from HEEM and Leicester University	Continue to improve facilities i.e. to re-provide LRI Jarvis education centre in 1771 building, provide UHL Simulation facility and consider feasibility of Glenfield as an expanding training site	TBA
	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	(a) Lack of accountability and transparency of educational funding income and expenditure	Engagement with CMGs in ensuring education expenditure matches income	TBA

	Accreditation visits	(c) Ineffective control of clinical service pressures, vacancies and loss of posts on rotas that adversely affect quality of training and added impact of	Medical education quality dashboard, SPA time in job plans for training, support for CMG Medical Education leads and local faculty groups (College Tutors etc)	TBA

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 8	Insufficient engagement of clinical services, investment and governance may cause failure to deliver the Genomic Medicine Centre project at UHL	**Overall level of risk to the achievement of the objective**	**Current score 3x3=9**	**Target score 3x2=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**
Genomic Medicine Centre project manager for UHL in place Nominated UHL GMC lead, with UHL leads for both cancer and rare diseases Trust GMC Steering Committee in place	GMC Report to UHL R&I Executive (bimonthly) R&I minutes (inc. GMC report) to ESB bimonthly Weekly NHS England/Genomics England: Reports to UHL GMC Steering Committee via Cambridge GMC Update in R&I Report to Trust Board (quarterly) Trust GMC Steering Committee minutes (?best reporting route – ?via W&C CMG board) Local delivery monitoring against recruitment trajectory KPI via R&I Office when project live Delivery monitoring against recruitment trajectory KPI by Lead GMC Partner when project live	(c) Need for sufficient funding to CMG to support delivery of recruitment trajectory (c) Need for key staff to consent/recruit/data entry (c) Need UHL IT solution to deliver and monitor recruitment trajectory – under development (c) Need to increase awareness of GMC project amongst UHL staff	'The 100,000 Genomes Project' paper presented to Executive Strategy Board 'The 100,000 Genomes Project' paper with detailed costing to go to Revenue and Investment Committee Targeted use of Research Capability Funding Work with comms team to produce weekly UHL GMC newsletter	Apr 2015 MD May 2015 MD Apr/May 2015 MD Apr 2015 MD

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 9	Changes in senior management/ leaders in partner organisations may adversely affect relationships / partnerships with universities.	**Overall level of risk to the achievement of the objective**	**Current score 6**	**Target score 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 Developing partnerships; • De Montfort University • University of Nottingham • University College London (Life Study) • Cambridge University (100k project)	Minutes of joint UHL/UoL Strategy meetings Minutes of Joint BRU Board Minutes of NCSEM Management Board Meetings of Joint UHL/UoL research office Life steering group meets monthly EM CLAHRC Management Board reports via R&D Exec to ESB	(c) New relationships need to be developed and nurtured with the new VC and President for UoL and. New Dean of UoL Medical School expected 2015. (c) Contacts with DMU could be developed more closely	New UHL Associate MD for academic partnerships to be in place Develop regular meeting with DMU	Apr 2015 MD Jun 2015 MD

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 10	Gaps in inclusive and effective leadership capacity and capability , lack of support for workforce well-being, and lack of effective team working across local teams may lead to deteriorating staff engagement and difficulties in recruiting and retaining medical and non-medical staff	**Overall level of risk to the achievement of the objective**	**Current score 12**	**Target score 8**
Executive Risk Lead(s)	Director of Human Resources			
Link to strategic objectives	A caring, professional and engaged 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**
Organisational Development Plan	Reported to EWB quarterly Reported to Trust Board quarterly Internal Audit assurance via 2014/15 Programme Key Performance Indicators included within OD plan	Lack of scrutiny of the organisational health dashboard at CMG level	Scrutinise at CMG level the organisational health dashboard at quarterly intervals	Sep 2015 DHR
LIA Programme	LIA Sponsor Group meet monthly Reported to EWB quarterly Reported to Trust Board quarterly (as part of the OD report).	Analysis of LIA dataset has identified some key areas for improvement – coded as: Frustrations; Focus on Quality; Structures and leadership	Continue with the spread of LiA to enable staff to make contributions to changes and improvements at work	Mar 2016 DHR
Workforce Plan	Reported to EWB quarterly Reported to Trust Board quarterly (as part of OD plan) Key Performance Indicators included in organisational health dashboard and NTDA submission and include: Pay spend against plan Staff number (wte) against plan Safe staffing levels within clinical areas	Affordability against plan is an issue related to lack of substantive staff leading to increase in premium spend	CMGs to produce a trajectory of premium spend linked to recruitment with which will be monitored through the Monday CMG performance meets and Cross Cutting Workforce Meeting.	Mar 2016 DHR

Leadership into Action Strategy	Reported to EWB quarterly Reported to Trust Board quarterly (as part of OD plan) National staff survey responses Staff friends and family test responses LiA 'pulse check' responses East Midland Academy Board receives reports in relation to the monitoring of utilisation and quality of East Midlands Academy Board leadership programmes.	(c)Negative feedback from surveys in relation to leadership issues	Improvements in local leadership and the management of well led teams including holding to account for the basics	Mar 2016 DHR
Equality Action Plan	Twice yearly progress report to Trust Board, EWB,EQB and Commissioners KPIs for monitoring are contained within the Public Sector Equality duty	(c) Low BME representation at band 7 or above	NED apprenticeship scheme to be implemented Targeted interventions for BME band 5 and 6 to be developed and implemented	Mar 2016 DHR Mar 2016 DHR

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 11	Insufficient estates infrastructure capacity and the lack of capacity of the Estates team may adversely affect major estate transformation programme	**Overall level of risk to the achievement of the objective**	**Current score** 5 x 4 = 20	**Target score** 5 x 2 = 10
Executive Risk Lead(s)	Director of Facilities			
Link to strategic objectives	A clinically sustainable configuration of services, operating from excellent facilities			

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**
Link the reconfiguration investment programme demands with current infrastructure, identifying future capacity requirements Current infrastructure details being gathered for all three acute sites identifying high risk elements of engineering and building infrastructure		(a) Effective governance arrangements for oversight and scrutiny of this work are yet to be agreed (c) A programme of infrastructure improvements is yet to be identified (c) Timescale issues for infrastructure works which could impact on the overall programme have not yet been identified and quantified in relation to risk	PMO support to be engaged Develop a programme of works Develop an operational risk register for the projects	TBA Sep 2015 DoF Sep 2015 DoF
Capital programme with ring fenced capital funding to support future capacity demands	Capital Investments Monitoring Committee	(c) Currently no identified capital funding within 2015/16 programme and future years	Identification of investment required and allocation of capital funding	Sep 2015 DoF/DF

An established Estates and Facilities team with detailed knowledge of the estates and reconfiguration programme	Regular reports to Executive Performance Board (EPB)	c) Conflicting responsibilities/roles of the estates and facilities team between UHL and the LLR estate and Facilities Management Collaborative	Define resource and skills gaps and agree an enhanced team structure to support the significant reconfiguration programme	Sep 2015 DoF

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 12	Limited capital envelope to deliver the reconfigured estate which is required to meet the Trust's revenue obligations	**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 Facilities			
Link to strategic objectives	A clinically sustainable configuration of services, operating from excellent facilities			

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**
Individual project boards in place to manage and monitor schemes Merging of strategic clinical change projects into the Estates an Facilities Directorate	Project boards report to UHL Better Care Together (BCT) working group via monthly highlight reports Estates work stream reporting to the UHL – BCT Programme Board	(c) lack of Overall programme management function for the estates work stream	Additional resource support to be identified and implemented	May 2015 DoF
5 year plan agreed with individual annual programmes developed each year	Capital Investment Monitoring Committee will monitor the overall programme of capital expenditure and early warning to issues	(c) Lack of Contingency funding	Discussions between D. Kerr and P. Traynor to identify funding	Sep 2015 DoF

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 13	Lack of robust assurance in relation to statutory compliance of the estate	**Overall level of risk to the achievement of the objective**	**Current score** TBA	**Target score** TBA
Executive Risk Lead(s)	Director of Facilities			
Link to strategic objectives	A clinically sustainable configuration of services, operating from excellent facilities			

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**
Outsourced facilities management contract performance managed by the Estates and Facilities Management Collaborative Defined KPI's which Interserve FM are measured against.	LLR FMC Board Monthly Contact Management Panel, and Service Review Meeting	(a) A lack of electronic evidence by IFM on compliance (a) Limited contractual KPI's on compliance	Additional assurance to be identified through spot checks and deep dive analysis Develop improved software dashboard reporting (CASS)	July 2015 DoF TBA

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 14	**Failure to deliver clinically sustainable configuration of services**	**Overall level of risk to the achievement of the objective**	**Current score 12**	**Target score 8**
Executive Risk Lead(s)	Director of Strategy			
Link to strategic objectives	Clinically sustainable configuration of services, operating from excellent facilities			

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**
Agreed capital programme with NTDA identified what resources the NTDA need to commence their approval processes	Monthly meetings with the NTDA to discuss the whole programme of delivery and identify new cases coming up for approval A monthly highlight report is submitted to the BCT-UHL Programme Delivery Board.	(c) Lack of capacity within the NTDA to resource each of the business cases	NTDA to look at providing a management and financial lead for each of the business cases	TBA
UHL structure and resources identified for delivery of the key projects • ITU • Vascular • Emergency Floor • Planned Treatment Centre • Maternity • Children's Hospital • Theatres • Beds • multi-storey car park Business Case Project resources identified against each project	A report is submitted to the BCT-UHL Programme Delivery Board on a monthly basis that tracks progress to date, including financial assurance, risks with mitigations	(a) Further work required looking at the remaining acute services at the LGH to determine the gap in the current capital plan	Work stream to be established to identify gaps	Sep 2015 DS
Consultation- • BCT Consultation programme established • Each of the appropriate BC have a consultation and engagement plans in place and work closely through the UHL communication and engagement lead to ensure continuity with the BCT Plan	The communication lead for the business cases for women's sits on the wider BCT consultation work stream. This is led by UHL Director of Communications and Marketing. A monthly report is submitted to the BCT-UHL Programme Delivery Board from the communication and engagement work stream.	(c) Dedicated communication and engagement lead required for the reconfiguration programme	Appoint to post	May 2015 DS

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 15	Failure to deliver the 2015/16 programme of services reviews, a key component of service-line management (SLM)	**Overall level of risk to the achievement of the objective**	**Current score 3x3= 9**	**Target score 3x2= 6**
Executive Risk Lead(s)	Director of Finance			
Link to strategic objectives	A financially sustainable NHS Organisation			

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**
Overarching project plan for service reviews developed	Service Review Update and Roll Out Plan considered by ESB.	(c) Alignment with CIP and future operating model.	Discuss with the Director of CIP the Future Operating Model and that through this we will cement delivery	Jul 2015 DS
Governance arrangements established which includes: - Monthly highlight reporting process embedded (includes progress, risks, issues, and mitigation) - Monthly updates / assurance reported to Integrated Finance, Performance and Investment Committee (IFPIC) and EPB as part of the Cost Improvement Programme paper.	Monthly reporting to IFPIC and EPB as part of CIP report.	(a) Monthly updates to ESB	High level updates to be included in the Director of Strategy's monthly report for ESB.	May 2015 DS
Capacity bolstered through the appointment of: - Programme Support Officer appointed to coordinate the programme of service reviews, provide support to service leads, and to engage key stakeholders in the process e.g. heads of service, transformation managers, operational managers etc. - Transformation managers within CMGs who will support the facilitation of service reviews	N/A	(c) Capacity (within central and operational teams)and level of clinical engagement determines when service reviews can happen and how many can run at any given time	Approach and scheduling of service reviews to be reviewed to ensure process remains viable and/or to identify resource requirement.	July 2015 DS
Service reviews to be considered as part of the Clinical Strategy work stream which reports into the BCT UHL Delivery Board (and PMO) to ensure alignment with wider provision of data and intelligence designed to inform new models of care / ways of working	Monthly reporting to BCT UHL Delivery Board (PMO)	N/A	N/A	N/A

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 16	Failure to deliver UHL's deficit control total in 2015/16	**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 financially sustainable NHS organisation			

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**
Completion and delegation of final, detailed income and expenditure control totals each CMG and Department within UHL	Final agreed financial plan including detailed budget book to IFPIC (draft in April 2015) in early May 2015 Full devolution of budgets to CMGs and Departments, clarity achieved by robust integrated planning process in advance of April 2015 Monthly reporting via Exec Performance Board, IFPIC and Trust Board			
Sign off and agreement of contracts with CCGs and NHSE including activity plans for all areas and the terms and conditions attached to the contracts in 2015/16	Detail of the agreed contracts to IFPIC (draft in April 2015) in early May 2015 Full devolution of activity and performance plans to CMGs and Departments, clarity achieved by robust integrated planning process in advance of April 2015 Monthly reporting via Exec Performance Board, IFPIC and Trust Board			
Finance and CIP delivery by CMGs at UHL	Weekly reviews between DoF/COO and all CMGs, covering key areas of performance including finance and CIPs Monthly reporting via Exec Performance Board, IFPIC and Trust Board			
UHL service and financial strategy (as per SOC and LTFM)	Updates and reporting to the BCT UHL Monthly			

	Delivery Group (chaired by DS or DoF), reporting into Executive Strategy Board, IFPIC and Trust Board			
Identification and mitigation of excess cost pressures	Robust process involving the CEO to identify and fund where necessary any unavoidable cost pressures in advance of the start of 2015/16 Monthly reporting via Exec Performance Board, IFPIC and Trust Board			

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 17	Failure to achieve a revised and approved 5 year financial strategy	**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 financially sustainable NHS organisation			

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**
Overall strategic direction of travel defined through Better Care Together	The pending approval of the Better Care Together Strategic Outline Case (SOC) by TDA and NHSE	(c) SOC not yet approved	Approval currently being sought	CEO Date TBA
Financial Strategy fully modelled and agreed by all parties locally and nationally	2015/16 financial plan (as per existing LTFM) approved by both Trust Board and TDA LTFM being revised for review by Trust Board in mid-May Approval of the LTFM by the TDA will be sought late May into June depending on TDA governance process	(c)LTFM not yet approved	Production of revised LTFM and submission for approval to Trust Board and TDA	DF June 2015
Cash required for capital and existing deficit support	Trust Board have approved UHL's working capital strategy (in April 2015) In principle, TDA are supportive of the 5 year strategy and the cash/loan support that is required This will be formalised through TDA approval of BCT SOC and the revised LTFM	(c)SOC not yet approved (c)LTFM not yet approved	As above	

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 18	Delay to the approvals for the EPR programme	**Overall level of risk to the achievement of the objective**	**Current score 16**	**Target score 6**
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**
Communications with key contacts throughout the external approvals chain	Weekly meeting to discuss progress and issues. Updates on the IM&T transformation Board, EPR programme Board and the joint Governance Board.	(c) No final approvals date can be given	Further work with NTDA to progress a firm timetable to the ATP	May 2015 CIO
Communications with key contacts throughout the Internal approvals chain	Weekly meeting to discuss progress and issues. Updates on the IM&T transformation Board, EPR programme Board and the joint Governance Board.	(c) Lack of confirmed planning, hindered by the external ATP steps, could lead to delays in the internal processing of the final FBC	Further work to expose the executive and the Trust board to the likely shape of the FBC and the required internal steps.	July 2015 CIO

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 19	Perception of IM&T delivery by IBM leads to a lack of confidence in the service	**Overall level of risk to the achievement of the objective**	**Current score 16**	**Target score 6**
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**
Review of contractual deliverable and quality of service	External reviews, PWC and ISO 27001 Audit in 2014 Monthly service delivery board, covering all aspects of service delivery	(a) VfM review	Engage third party, as per contract, to asses and review VfM	Aug 2015 CIO
Communication to end users of the performance of IBM and IM&T in service delivery	Monthly service delivery board, covering all aspects of service delivery Performance reports are available on InSite Project performance is reported quarterly through the trust executive	(c) Communication about successes is not sufficiently robust	Production of a 2014/15 annual review Production of a quarterly newsletter available to all staff	May 2015 CIO Aug 2015 CIO
End user's service meets their requirements	Liaison with the CMGs to ensure we are meeting their requirements Monitoring of complaints around the service and it's delivery	(c) No formal process, post the contract award, to test the delivery principles	LiA event to surface any issues with the service delivery and the delivery model	Jun 2015 CIO

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
2467	Emergency and Specialist Medicine		Outlying Extra Capacity - Winter months	30/04/2015 03/12/2014		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: o□8% increase in medical admissions and current insufficient medical bed capacity o□Daily admission levels warranting the need to outlie ahead of the winter months - winter capacity needed o□Discharge processes not as efficient as they should be internally impacting patient flow and patients waiting in ED for admission o□Continued delayed transfers of care o□On-going risks and potential harm to patients as a consequence of overcrowding in ED o□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: o□>100 Nursing vacancies (200 nursing vacancies in the CMG this time last year) o□3 Geriatrician and 2.4 Acute Physician vacancies o□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) - 30/04/15 Revised Emergency Quality Steering Group action plan - 30/04/15 Maintain additional beds on ward 2 LGH (21 beds to 27 beds) - 30/04/15 Raise staff awareness re winter plans and access to community resources to enable patients to be discharged in a timely manner - 30/04/15 CMG to access and act on additional corporate support to focus on discharge processes - 30/04/15	9	JE

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2236	Emergency and Specialist Medicine	ED	There is a risk of overcrowding due to the design and size of the ED footprint	04/10/2013	31/05/2015	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	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 . UPdate - Full business case signed by trust board, now submitted to NTDA Patients in ED referred to any service should be reviewed by respective services in ED - (update surgeons & ACB rv resus pts, ongoing work with ortho(ED referrals should have 30 min response time) - 31/05/2015 There is to be a receptionist staffing paeds reception at all times - (Completed) Creation of "single front door" - all ambulatory ED arrivals now first seen in UCC, thereby reducing total ED attendances.(Completed) The number of toilets in majors is to be increased to 2 and shower facilities are to be installed(Completed) Side rooms 2 and 3 are to be converted into formal assessment bays. (Completed) 3 additional phone lines to be installed in assessment bay(Completed) The trips and falls hazard in children's ED is to be removed by changing the layout of the minors work area(Completed) See and treat rooms being made into extra Paeds bays(Completed) Allocated nurse (and doctor when numbers permit), for patients placed in Majors middle(Completed) Resus space to be increased to 8 bays(Completed) The resus viewing room is to be made into a fully equipped resus bay (Completed) 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)	16	JE

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2354	RRC		Overcrowding in the Clinical Decisions Unit	28/05/2014	30/06/2015	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	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	Major	Almost certain	20	Increase registered nurse staffing level on CDU - 30/06/15 Introduction of patient flow coordinator role on CDU - 30/06/15 Implement revised triage process - 30/06/15 CDU element of whole hospital response has been drafted and is being reviewed at EQSG - 30/06/15 Continue the implementation of the LIA project - 30/06/15	3	SM

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
2445	Emergency and Specialist Medicine		SpR gaps on the ESM CMG Medical Rota	31/05/2015 04/11/2014		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	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 - 30/06/15. 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 - 31/05/15. Creative short term appointments offering fixed term opportunities within specialities to maximise interest within the local market - 31/05/15. 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) - 31/05/15. Trust to explore other ways of staffing medical rotas (ANPs etc) - 31/05/15.	9	CFRE

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2234	Emergency and Specialist Medicine	ED	There is a medical staffing shortfall resulting in a risk of an understaffed Emergency Department impacting on patient care	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.	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. R & R Package to be relaunched (30/04/2015) Increase Locum Rates of pay being agreed (30/04/2015) Continue recruitment to pillar stategy (31/01/2016) Continuation of International Recruitment (31/01/2016)	6	BTD

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2488	ITAPS		Risk of vacancies on resident on call rotas being unfilled resulting in increased use of locums and Consultant acting down	31/08/2015	14/01/2015	Causes: We are currently running with 11 junior doctor vacancies across the on call rotas on all three sites This is due to failure to recruit, maternity leave and sick leave. The options for filling these gaps are 1)□Use of internal locums but due to the number of gaps it is often difficult to find an internal locum who is available. 2)□Use of appropriate external locum via locum bookers but these are also often not available. 3)□Use of consultants acting down 4)□As a last resort the non-resident consultant on call becomes resident and the rota is run with one less person available. Consequences: Increase in Consultant Acting Down payments - Increased risk of on-call consultants becoming resident which will impact on elective activity the following day - Increased risk of trainee/consultant sick leave due to workload Increased risk of clinical incidents due to the use of external locums who are unfamiliar with UHL Decreased ability to manage emergency situations if there are less people available on call	Business	Locum Bookers contacted for available doctors Internal Trainees approached for extra shifts Ongoing recruitment in process Cross site cover explored	Major	Almost certain	20	Continue pro-active recruitment to specialty doctor jobs - 31/8/15 Expand fellowship jobs to support the rotas - 31/8/15 Recruit ICM trainees - 31/8/15 Plan to recruit non trainees to a level to ensure that all rotas are fully filled - 31/8/15 Robust escalation process understood and adhered to - Completed Monthly recruitment update at Board meeting - 28/8/15 Ensure core members attend recruitment meetings - 31/8/15	12	MTI

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
2333	ITAPS	Anaesthesia	Lack of paediatric cardiac anaesthetists to maintain a WTD compliant rota leading to service disruption and loss of resilience	30/05/2015 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	1. Continue with substantive recruitment strategy - Interview 15/01/15 - Recruit by 31/03/15. Interview held 12.01.15 and candidate offered post & accepted. Start date TBC. 6. Substantive Consultant to undertake recruitment processes and start by end of May 2015	8	DTR
2415	ITAPS	Critical Care	There is a risk of loss of ITU facilities at the LGH site	30/06/2015 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	1. Commence Recruitment campaign for one Consultant Intensivist 31/03/15. 2. Cross site cover - Completed 3. Move to a 1:8 rota - Completed 4. Offer on call rota to general duties anaesthetists - Completed 5. ITAPs management team to work with the Trusts Strategy leads and specialty leads to start to plan timescale's, scope movement of services from the LGH site and scope required environmental and workforce impacts. 30/12/15	2	CAL

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
510	Clinical Support and Imaging	Blood Transfusion	Staff shortages impacting on the Blood Transfusion Service at UHL	10/05/2006	31/05/2015	Causes Staffing issues caused by turnover of staff (retirements / leavers). Post planning process poor - local and national shortages of qualified staff (BMS). Internal recruitment processes causing significant delay. Consequences : Possibility of temporary closure of satellite blood banks (LGH). Adverse impact on patient experience for patients requiring urgent transfusion (out of hours). Impact to acute services who may need to transfer admissions of acute cases between sites. Increased risk of claim /complaint. Adverse media attention / loss of reputation.	Patients	Full 24/7 rota implemented. Voluntary rota for spare sessions - sickness leave etc. Full rota has created additional sessions as satellite laboratories to comply with 24/7 working. Associate practitioners included in early and late roster sessions Associate practitioners to cover entire night at LRI Phased extended contractual hours 8 to 8 B.S & B.Transfusion Phased extended day B Transfusion to 23:00 Employed Bank/Locum BMS staff to cover short term deficiencies in rota Investigate additional lean working options to reduce pressure on laboratory staff. Introduced a forced rota Multi discipline staff to assist cover overnight B.S(24/7) at LRI Retrained Lab Manager One-off training Risk assessed the process of a "Plan B" 24/7 Rotas with voluntary sessions in place from May 2012 2 new BMS band 5 staff recruited 24/09/2012 - to complete local competecy training Feb 2013 Introduction of cross cover form NUH to support UHL BT Roster - limited cover at present (Oct 2013) Numerous meetings taken place with empath management team to raise acute risk of service failure (August 2013 to Jan 2014 & ongoing). Approval in principle agreed to replace vacancies and also create 12 month secondment role to band 8a for additional managerial support. Also to consolidate 3 x band 5 bank staff into fixed term contracts.	Extreme	Likely	20	Staff recruitment/replacement to appropriate levels - 2nd phase 01.06.2015 Develop Disaster Recovery Plan (including operational escalation plan) & treatment algorithm (design for Obstetrics but should be blue print for other services) - due 30/04/15. Investigate and option appraisal for internal Transfusion transport service - 30/04/15.	15	KJON

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
698	Clinical Support and Imaging	Pharmacy	Risk to the production of aseptic pharmaceutical products	03/05/2007	05/05/2015	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 - due 5/52015	3	GH

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
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	26/08/2014	23/05/2015	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	Reviewing out of hours medical cover to ward 30 - GH due 23/05/2015	10	LCOW

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2391	Women's and Children's		Inadequate numbers of Junior Doctors to support the clinical services within Gynaecology & Obstetrics	24/06/2014	31/05/2015	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 - 31/05/15 Further development of robust training programme for Junior Drs by Clinical Tutor & Programme Director due 29.06.15	8	ACURR
2330	Medical Directorate		Risk of increased mortality due to ineffective implementation of best practice for identification and treatment of sepsis	11/04/2014	31/05/2015	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 - 31/05/15 Increased visibility of sepsis care pathway - 31/05/15	6	JPARK

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2403	Nursing	IPC	Changes in the organisational structure have adversely affected water management arrangements in UHL	19/08/2014	31/05/2015	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	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. - 31/05/15 Review procedures and practices in other Trusts to ensure that UHL is reaching normative standards of practice - 31/05/15	4	LCOL

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2404	Nursing	IPC	Inadequate management of Vascular Access Devices resulting in increased morbidity and mortality	19/08/2014	31/05/2015	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 - 31/05/15. Development of an education programme relating to on-going care of CVAD's - 31/05/15. Targeted surveillance in areas where low compliance identified via trust CVC audit - 31/05/15. 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 - 31/05/15.	8	LCOL

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2471	CHUGS		There is a risk of Radiotherapy Tx on the Linac (Bosworth) being compromised due to poor Imaging capability of this machine.	31/05/2015	05/12/2014	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 - 31/05/15. Replacement of Imaging panel to improve image quality and reduce imaging dose. However this does not solve the lack of online correction capability -31/05/15. Restriction of patient numbers to be treated on Bosworth. This will have a large impact on the departments waiting times and potential breach patients - 31/05/15.	4	LWI

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2422	CHUGS	General Surgery	There is a risk to patient safety and quality due to the nurse staffing levels on SAU LRI	29/09/2014	31/05/2015	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 - 31/05/15. Review the possibility of rotational shifts for staff across other surgical/GI med wards to increase attractiveness to staff - 31/05/15. Review established nurse staffing levels for the ward and complete case of need to increase nurse staffing in line with other SAU's - 31/05/15. Continue to actively recruit to the area - 31/05/15.	4	GK

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
2057	RRC	Cardiac Investigations	Insufficient Echo provision cross-site impacting on planned referrals	07/08/2012	30/06/2015	Causes: Insufficient BSE accredited Cardiac Physiologists for level of current/increasing demand. Challenging recruitment programme due to national shortage. Consequences: Failure to meet National Diagnostic Target for New referrals - loss of reputation; financial penalties. Failure to meet internal standard (<48hrs) for I/P (New) referrals - increased LOS; delays for further treatment/intervention Failure to perform Planned workload - hampers clinicians to manage patient's care effectively for this group of patient's who are at an increased risk of a significant clinical event. Increased risk of RSI's for Physiologists. Staff retention & recruitment issues - due to very limited training (including Mandatory); essential development in routine/advanced techniques; low staff morale; loss of key staff.	HR	Cardiac physiologists working additional hours to avoid National Target breeches for New referrals. SAC (some slots available on same day as O/P consultant visit) for Planned referrals not performed prior to OP appointment. Clinicians also able to re refer and change planned referral to New referral if Echo not performed prior to OP appointment. All new referrals attract 5 wk target. Waiting list initiative implemented (only outside of department standard working hours). Locum staff employed to support with the planned workload.	Major	Likely	16	Recruit 1.0 WTE BSE Cardiac Physiologists - 30/06/2015.	1	MCA

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
2423	RRC	Respiratory Medicine	Outstanding clinic letters and inability to act on results impacting on patient safety in respiratory services	30/09/2014	31/05/2015	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	Likely	16	Ensure named IM&T support for ICE implementation - complete Employ personal user voice recognition software to fill ICE templates - 30/4/15 Recruitment of two WTE secretary - complete. Recruitment of two WTE Audio Typists - Complete. Stress Risk assessment to be carried out - 31/5/15.	6	AGIB

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
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	31/05/2015	29/10/2014	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. (11/02/2015, several recent SI's highlighted) 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. 10/02/2015 update - Recent SI's related to CAHMS have been raised on the agenda of the Mental Health Urgent Care Board. LLR System Urgent Care Board has agreed that they will commission an external independent investigation into the 3 recent Patient Safety Serious Incidents (SIs) relating to vulnerable children under the care of the CAMHs services. This process will follow the methodology set out for NHS organisations. Terms of reference agreed by John Adler. Urgent review across all agencies regarding people being detained in place of safety. Protocol being developed for management of younger people. Recent reports have been shared with the TDA UHL representation (JE) on the Health Economy Partnership Group There is a detailed action plan that links into the concordat that UHL has signed up to to improve things for MH patients in crisis in response to CQC visit in 2014.	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 - 31/05/15. Training to be available for ED staff with regard to management of aggressive patients, to include breakaway techniques - Completed, Conflict resolution training now completed via E learning Roll out of Mental Health Study Day for ED staff during 2014/15 - Complete. Develop plans in line with Government's "Mandate" to ensure no one in crisis will be turned away by - 31/05/15. 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 - completed. Violence Risk Assessment &Training needs analysis to be completed to identify appropriate training needs- 31/05/2015 Urgent review of MH pathway, particularly time in ED - 31/0/2015 Development of protocol for management of younger people - 30/06/2015 An external independent investigation into incidents relating to vulnerable children under the care of the CAMHs services by LLR - 30/06/2015	6	JE

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2466	Emergency and Specialist Medicine	Rheumatology	Risk of Patient Harm due to delays in timely review of results and Monitoring in Rheumatolgy	03/12/2014	31/07/2015	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 - 31/08/15 Every patient on DMARD to be on DAWN system and monitored in real time - 31/07/15.	1	GST
2191	Musculoskeletal and Specialist Surgery	Ophthalmology	Follow up backlogs and capacity issues in Ophthalmology	12/06/2013	31/05/2015	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 - 31/05/15. Implement clinic utilisation work - 31/05/15 Continued review of Newmedica - 31/05/15	8	DTR

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2504	Musculoskeletal and Specialist Surgery	Trauma Orthopaedics	Patients will wait for an unacceptable length of time for trauma surgery resulting in poor outcomes and patient satisfaction	12/03/2015	30/04/2015	Causes: increased spinal activity; workload exceeds capacity; underutilised theatre capacity; insufficient capacity at the weekend; inadequate junior doctor numbers; insufficient Orthogeriatrician input across 7 days; absence / under- provision of senior anaesthetic ward pre-assessment. Consequences: Patient safety and patient experience; financial loss through increased LoS; inability to take advantage of increased tariff from #NOF BPT; increased morbidity; risk to reputation; risk to CT training programme; litigation risk.	Patients	Weekly monitoring of performance against BPT criteria Monitoring of morbidity at M&M meetings LiA Event taken place to identify problem areas and potential solutions Action plan in place and monitored monthly Trauma Coordinator role implemented Increased Orthogeriatrician Input Mandatory reporting to CQRG Trauma unit meeting reinstated	Major	Likely	16	Creation of escalation and response process to meet peaks in trauma demand - 30/0415. Scoping and implementation of a more responsive data capture and scheduling database - 30/04/15. Complete LiA cycle and subsequent action plan - 30/04/15. Formulation of capacity plan across the region to make plans for increased spinal activity - 30/06/15. Employment of further staff to support the service across 7 days as per the recent business case - 31/12/15. Employment and training of further TNPs to bolster junior doctor gaps and facilitate more stable CT training - 30/04/18.	8	MMCM

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
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	22/12/2006	02/04/2015	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 02.05.2015; Full implementation of LIMS 31.05.15; Full implementation Blood Track 31.10.15.	4	KJON

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
2487	Clinical Support and Imaging	Medical Physics	Maintaining the quality of the Nuclear Medicine service for PET, Cardiac MPI and general diagnostics	30/05/2015	06/01/2015	The lead clinician in Nuclear Medicine is on long term sick leave. He is the only PET ARSAC certificate holder in the Trust and the clinical lead for the service. The locum covering cardiac MPI is the only other experienced ARSAC certificate holder for MPI studies. His contract ends in Jan 2015. There are other ARSAC certificate holders who cover general Nucelar Medicine and paediatric work. Their time commitment to Nuclear Medicine is severely limited. There is only one Consultant Radiologist currently entitled to report PET images under the national contract. A second is experienced and has retained competence but requires some training and revalidation. There are a number of Consultant Radiologists who report MPI's and general Nuclear Medicine but none elgibile or interested in gaining ARSAC certification The consequences are severe. An ARSAC certificate holder for PET can be "borrowed" under the existing contract but the new contract will require a certificate holder within the Trust. This puts the plans for fixed PETCT at risk Loss of MPI expertise will have a major impact on the service and on Imaging and MR throughput. Pressures on the consultant body to provide a comprehensive imaging service are high. The risks are that PET and MPI scanning are suspended, impacting on patients and business.	Quality	Imaging rotas re-arranged to increase reporting sessions from other Radiologists Consultants nominated as interim clinical leads - carol Newland and Yvonne Rees Take action to provide clinician cover for ARSAC, reporting and clinical supervision - 30/12/14 completed Undertake clinical review - 30/12/14 completed Produce business case - 1/3/15 - completed	Major	Likely	16	Appoint new clinician - 1/6/15	6	DPE

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2378	Clinical Support and Imaging	Pharmacy	Pharmacy workforce capacity	19/06/2014	30/05/2015	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	Implement recruitment and retention criteria at key grades and monitor impact - 31/05/15 Explore potential for overseas recruitment - 30/05/15 Ensure exit interviews completed for all staff and review outcome - 31/05/15 Recruit additional band 6 pharmacists - 31/05/15 Increase band 4 technician training capacity - 30/09/15 Recruit externally at 8a - 31/05/15	8	CELL
1926	Clinical Support and Imaging	Ultrasound	Risk to Trust operations and patient safety due to insufficient staffing to manage the ultrasound referrals	10/04/2012	30/06/2015	Causes: Unfilled vacancies, out of hours inpatient lists and an increase in scanning time for nuchal screening Consequences: Patients waiting much longer for Imaging tests May affect ED 4 hour targets Negative effect on internal standard turnaround times for inpatients Further effect is to contribute towards Trust bed pressures; increased patient stays and breaches of targets (ED targets.) Radiology staff over stretched due to covering extra overtime continuously to meet targets and internal wait. Unsustainable service. Cost pressure from the use of agency staff and overtime payments	Patients	Staff volunteer to do overtime/extra duties . Agency and bank staff are being used to cover sessions	Major	Likely	16	Recruit to vacancies - 30/06/2015	6	JGI

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
2384	Women's and Children's	Maternity	There is an increased risk in the incidence of babies being born with HIE (moderate & severe) within UHL	24/06/2014	30/04/2015	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 30/04/15. Review of Consultant working patterns and extension of presence on the DS and MAU due 30/04/15. 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 30/04/15.	8	ACURR

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2153	Women's and Children's	Paediatrics	Shortfall in the number of qualified nurses in Children's Hospital including ECMO staffing and Capacity	05/03/2013	30/04/2015	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	Major	Likely	16	Continue to recruit to remaining 5wte vacancies - due 30/4/2015 Completion of a period of perceptorship for newly qualified nurses - due 30/4/2015 Completion of a period of perceptorship for new international qualified nurses - due 30/6/15	8	EA

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2237	Medical Directorate		Risk of results of outpatient diagnostic tests not being reviewed or acted upon resulting in patient harm.	07/10/2013	31/10/2015	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

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2338	Medical Directorate		There is a risk of patients not receiving medication and patients receiving the incorrect medication due to an unstable homecare	01/05/2014	31/05/2015	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	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	review of RPS stds across region - 30/4/2015 review against Hackett - due 31/5/2015 appt of homecare administrator post - 31/5/2015	9	CELL

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2093	Medical Directorate	R&D	Athena Swan - potential Biomedical Research Unit funding issues.	31/08/2015	08/08/2014	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. New high level process has been introduced at University of Leicester to drive and supervise the application.	Major	Likely	16	Add Athena Swan to every agenda at Leicester & Loughborough Universities attended by UHL R&D Personnel	4	CMAL

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2247	Nursing		There are significant numbers of RN vacancies in UHL leading to a deterioration in service/ adverse effect on financial position	30/10/2013	30/06/2015	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. - 30/10/16 Utilise other roles to liberate nursing time - 30/04/17	12	CRIB

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2325	Nursing		Risk to patient/staff safety due to security staff not assisting with restraint	03/04/2014	30/04/2015	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	Development and delivery of training programme in Physical Skills for clinical staff - 30/04/15	6	DLO

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
1693	Operations		Risk of inaccuracies in clinical coding	02/08/2011	30/06/2015	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). This has risen again to 8,000 in January due to Christmas Bank holidays, lack of agency coders and mandatory training for coders. When the backlog was reduced casenotes delivered to the coding offices, can be coded within 24 hours and work is underway again to reduce the backlog back to this level. Backlog reduction has increased coverage of coding from notes (rather than other electronic sources) and reduced the unnecessary movement of notes between departments. 4 Trainee coders commenced in Jan15 and have commenced comprehensive training in February (minimum of 21 days). 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 but is failing to function correctly. The benefits of Medicode are being re-evaluated with a view to ensuring a comprehensive IT support model is developed. When upgraded, Medicode will provide an audit functionality to facilitate regular audit of coding. In the short term an in-house audit tool has been developed by the Head of Information and routine randomised audit has commenced. Lead clinicians identified to move coding closer to the clinician. "Codebreaker" system has been developed by Respiratory Medicine (enabling clinicians to record diagnostic coding in real time) and implementation has the support of the coding department. A trust Clinical Coding policy is under development. Scorecard redevelopment to demonstrate improvements and benchmark against other Trusts. 3 year refresher training to be in place and funded recurrently	Major	Likely	16	Minimise backlog of coding, monitoring coding quality, appointing to substantive posts to reduce reliance on agency coders - 30/06/15	8	JRO

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2316	Operations	Business Continuity	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

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2318	Operations	Business Continuity	Blocked drains causing leaks and localized flooding of sewage	17/03/2014	30/06/2015	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 30/06/15. NHS Horizons to identify additional measures to reduce blockages - Nigel Bond 30/06/15	2	PWA

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
2328	ITAPS	Anaesthesia	Risk of inadvertent wrong route administration of anaesthetic medicines during epidural and regional anaesthesia.	30/11/2016 16/04/2014	Causes Continued use of Luer fitting syringes, needles etc increases the risk of anaesthetic medicines being administered via the wrong route. Distractions during anaesthetic procedure. Consequences Permanent injury on irreversible health effects. Death of patient Adverse publicity affecting reputation of the Trust and its staff Litigation leading to medical negligence claim	Patients	Labelling of syringes to indicate content Two people to check drugs during 'drawing up' procedure wherever possible. Training	Extreme	Possible	15	Use of Non-Luer syringes for all LA injections(following introduction of ISO standard) - 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
1196	Clinical Support and Imaging		No comprehensive out of hours on call rota and PM cover for consultant Paediatric radiologists	30/06/2015 29/06/2009	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	2	RG

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2380	Clinical Support and Imaging		Imaging - Risk of breach of Same Sex Accommodation Legislation	23/06/2014	30/04/2015	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:- due 30/04/15 * Explore options around redesigning the cubicles and waiting area in the MRI and CT zone. LGH Action Plan:- due 30/04/15. 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.	3	JHA

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2496	Clinical Support and Imaging	Blood Transfusion	Risks associated with implementation of an Electronic Blood Tracking and Traceability Management System within MHRA timescales	12/03/2015	30/06/2015	Causes: The training of clinical, laboratory and all other UHL staff in the use of system is inadequate leading to delay in implementation and the fate of the blood not being stored electronically. The procurement of an Electronic Blood Tracking and Traceability Management System which is not fit for purpose. The inability of the system to maintain and retain data storage (eg ward based data) for the minimum legal time. There is inadequate supplier, IT and laboratory support for a system that needs to run 24/7/365. Consequences: Having to ensure paper systems are maintained with associated costs. Not reaching 100% compliance in relation to traceability. Loss of opportunity to comply with additional recent transfusion recommendations eg positive patient ID on transfusion sampling. Loss of opportunity for patient safety improvements through the security of electronic monitoring and tracking of the vein to vein transfusion process. Lack of economies in patient blood component administration by only needing a single practitioner to transfuse a component augmented by electronic checking.	Statutory	1.Blood Transfusion Electronic Tracking Group Members and meeting - held fortnightly and consisting of multi-team specialists to address all aspects of procurement and implementation of the system 2.Business case for the Electronic Tracking System completed. Capital and Revenue Funds (PQQ) allocated for the purchase of the system - completed June 2014 3.Timeline and action plan for implementation of the Electronic Tracking System - active 4.Procurement process for the 'expressions of interest' for the Electronic system actioned and review of the expressions of interest presently being reviewed by Group Members 5.Defined specification of required Electronic system completed in preparation for the procurement process 6.Completion of scoring mechanism for system functionality and 'fit for purpose' being completed by Group members 7.IT specification for the non-functionality of the Electronic system requirements - members of the group collating system interfacing with UHL IT systems, data storage, training and equipment needs 8.Appointment of a project manager to support the implementation and dissemination of the Electronic Tracking system to service areas/users within UHL	Moderate	Almost certain	15	Purchase and implementation of a Electronic Blood tracking and Tractability System to an agreed schedule - October 2015	4	KJON

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
2426	Clinical Support and Imaging	Dietetics	Compromised safety for patients with complex nutritional requirements	28/10/2014	31/03/2015	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

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
2278	Women's and Children's	Family Planning	Risk that the Leicester Fertility Centre could have its licence for the provision of treatment and services withdrawn	17/12/2013	30/04/2015	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 30/04/2015 Overhaul of specimen request, collection and delivery procedures - due 30/04/2015	6	DMARS

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2402	Nursing		Inappropriate Decontamination practise within UHL may result in harm to patients and staff	19/08/2014	31/05/2015	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 - 31/05/15 Review all education and training for staff involved in reprocessing reusable medical equipment - 31/05/15 Review the use of equipment and the appropriateness of their current placement according to national guidance - 31/05/15	3	LCOL

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
1551	Nursing	Safety	Failure to manage Category C documents on UHL Document Management system (Insite)	14/03/2011	30/06/2015	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

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
2501	Clinical Support and Imaging	Physiotherapy	The Proposal to relocate the Womens Health Physiotherapy Service to the LGH and to review the ward cover on LRI/LGH sites	26/05/2014	31/05/2015	Causes- Moving the Womens Health Physiotherapy Service from a two site service to a one site service (LGH) and changes to service provision. The team will cease to provide routine postnatal ward cover and will develop postnatal classes and an SOS service for women with continence and musculoskeletal conditions. Consequences- The possibility that some patients at LRI may not be treated because there are no Womens Health staff on the LRI site. The types of patient would be antenatal and postnatal patients on the delivery suite with chest problems, orthopaedic outliers on the Gynae Assessment Unit, Antenatal patients admitted with musculoskeletal problems and surgical mobility patients.	Patients	The controls that would be put in place would be: - Patients with respiratory problems and those with mobility concerns would be assessed and treated by the respiratory/surgical physiotherapy teams who are based at LRI - Orthopeadic outliers would be seen by the Trauma Physiotherapy Team - Antenatal patients who could be discharged (aprox 4 patients a month) would be given an urgent outpatient appointment (within 5 working days) - Antenatal patients who could not be discharged until they were seen by a Physiotherapist would be assessed by a member of the Womens Health Physiotherapy team as this staff member would travel to the LRI to see them. - The numbers of any of these patients are very small and can vary according to the time of year (e.g. Orthopeadic outliers)	Moderate	Almost certain	15	To liaise with Womens Patient Advisor - 28/08/15. To liaise with medical staff within the maternity unit - 28/08/15. To decide if the proposal is achievable - 28/08/15. To discuss and get approval at COG - 28/08/15. To liaise with other teams to understand the level of support they can give - 28/08/15. To decide if the proposal is achievable - 28/08/15.	2	LCOO

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: 7 May 2015

COMMITTEE: Quality Assurance Committee

CHAIRMAN: Dr S Dauncey, QAC Chair

DATE OF COMMITTEE MEETING: 26 March 2015

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

- **None.**

OTHER KEY ISSUES IDENTIFIED BY THE COMMITTEE FOR THE INFORMATION OF THE TRUST BOARD:

- **The Trust Board to note the two locations that had been incorporated within UHL's CQC registration (Minute 30/15/2 refers).**

DATE OF NEXT COMMITTEE MEETING: 30 April 2015

Dr S Dauncey
QAC Chairman
1 May 2015

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF A MEETING OF THE QUALITY ASSURANCE COMMITTEE HELD ON THURSDAY, 26 MARCH 2015 AT 1:00PM IN THE BOARD ROOM, VICTORIA BUILDING, LEICESTER ROYAL INFIRMARY

Present:
Dr S Dauncey – Non-Executive Director (Chair)
Mr J Adler – Chief Executive (until Minute 26/15/7 and including Minute 30/15/1)
Mr M Caple – Patient Adviser (non-voting member)
Mr P Panchal – Non-Executive Director
Ms C Ribbins – Acting Chief Nurse
Ms J Wilson – Non-Executive Director

In Attendance:
Ms E Broughton – Head of Midwifery (for Minutes 25/15/1 and 26/15/7)
Colonel Ret'd I Crowe – Non-Executive Director
Miss M Durbridge – Director of Safety and Risk
Mr M Hotson – Business Manager (for Minute 26/15/1)
Mrs S Hotson – Director of Clinical Quality
Mrs H Majeed – Trust Administrator
Ms E Meldrum – Assistant Chief Nurse (for Minutes 26/15/2 and 26/15/3)
Ms L Tebbutt – Head of Performance and Quality Assurance (for Minute 26/15/1)

RESOLVED ITEMS **ACTION**

23/15 APOLOGIES

Apologies for absence were received from Mr A Furlong, Deputy Medical Director, Dr K Harris, Medical Director, Ms C O'Brien, Chief Nurse and Quality Officer, East Leicestershire CCG, Mr K Singh, Trust Chairman, Mr M Traynor, Non-Executive Director and Mr M Williams, Non-Executive Director.

24/15 MINUTES

Resolved – that the Minutes of the Quality Assurance Committee meeting held on 26 February 2015 (paper A refers) be confirmed as a correct record.

25/15 MATTERS ARISING REPORT

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

(i) Minute 76/14 (QAC draft work programme) – the Chairs of the Quality Assurance Committee (QAC), Integrated Finance Performance and Investment Committee (IFPIC) and Audit Committee were scheduled to have a discussion in May 2015 re. the work programme for all these Committee alongside the Board Intelligence work and a formal work programme for the QAC was expected to be available by June 2015;

(ii) Minute 16/15/3a – the Acting Chief Nurse undertook to confirm to the Trust Administrator, the date of the Trust Board meeting when the patient story relating to a multiple cancelled cancer operation would be presented. The matters arising log to be updated accordingly, and **ACN/TA**

(iii) Minute 103/14/1 (item referred from the Finance and Performance Committee on 24 September 2014) – (re. arrangements for monitoring small clinical teams) – it was noted that this matter would be actioned through the CMG quality and safety reviews and any issues would be reported to the Executive Quality Board by exception. Therefore, it was considered complete **TA**

and could be removed from the matters arising log.

Resolved – that the matters arising report (paper B refers) and the actions outlined above be noted and undertaken by those staff members identified.

25/15/1 Update on Puerperal Sepsis

Further to Minute 77/14/1 of 24 September 2014, Ms E Broughton, Head of Midwifery attended the meeting to present paper C, an update on the action plan following the CQC Puerperal Sepsis alert in August 2013. Actions 1d and 1e of the action plan remained outstanding, although the process for clinical coding of sepsis going forward was expected to be more robust and independent of individual clinical case review with regular reporting through the Women's and Children's CMG dashboard. In respect of action 1d 'benchmark coding practice against another organisation', members were advised that colleagues in the Women's CMG were scheduled to meet colleagues in Sheffield Teaching Hospitals NHS FT to take this action forward. The Head of Midwifery was confident that the planned improvement processes were appropriate to prevent a CQC re-alert. A further update was requested to be provided at the QAC meeting in September 2015. **HM**

Resolved – that an update on the puerperal sepsis action plan (including feedback from the visit to Sheffield Teaching Hospitals NHS FT) be provided to the QAC in September 2015. **HM**

26/15 QUALITY

26/15/1 Interserve Estates and Facilities Contract Quality Performance Report (Quarterly)

Mr M Hotson, Business Manager and Ms L Tebbutt, Performance and Quality Assurance Manager attended the meeting to present paper D, performance in respect of the quality aspects of the Interserve contract for the 12 month period leading up to December 2014 for the top ten quality KPIs.

Due to the reporting cycles, the figures provided in paper D outlined performance prior to December 2014 and therefore did not include the recent concerns raised in respect of cleaning and catering services.

The Chief Executive noted that Interserve were undertaking further service transformations particularly in relation to cleaning and catering services where the levels of resources were planned to be reduced and queried whether contractual requirements allowed the Trust to decline any of the proposed changes if they proved unacceptable – in response, the Business Manager confirmed that a letter had been sent to Interserve colleagues to this effect. The Chief Executive requested that a copy of this letter be forwarded to him. **BM**

The Acting Chief Nurse reported that at the Infection Prevention Assurance Committee (IPAC) meeting on 25 March 2015, concerns had been particularly raised in respect of the cleaning standards and the reduction in staff to undertake cleaning. Responding to a query, it was noted that a report on the recent audit of cleaning, catering and portering services would be presented to IFPIC in April 2015.

The Patient Adviser expressed concern that an Interserve representative chaired the Food Forum and suggested that it should be chaired by a member of UHL staff. In response, the Acting Chief Nurse advised that at the IPAC meeting on 25 March 2015 it had been agreed that a monthly Operational Group (comprising Cleaning Forum, Food Forum etc) would be established and chaired by the Interim Director of Estates and Facilities.

The Head of Performance and Quality Assurance provided a brief update on the

unannounced PLACE visits which had taken place in March 2015 highlighting that the Trust's scores had decreased in comparison to the previous visit.

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

(B) the Business Manager be requested to forward a copy to the Chief Executive of the letter sent recently to Interserve regarding the Trust's right to decline any of the proposed changes arising via service transformation if they prove unacceptable. **BM**

26/15/2 National Care Certificate

Ms E Meldrum, Assistant Chief Nurse attended the meeting to present paper E, which outlined the background and content of the National Care Certificate, a training and assessment programme for health and social care support workers in England which had been launched nationally in February 2015 and was due to commence in UHL in April 2015. The National Care Certificate would be rolled out across UHL from 1 April 2015 starting with all new Health Care Assistants commencing their employment in the Trust.

Resolved – that the contents of this report be received and noted.

26/15/3 Revalidation for Nurses and Midwives

Ms E Meldrum, Assistant Chief Nurse presented paper F, which provided an update on the work taking place in UHL regarding revalidation for Nurses and Midwives, following the revised Nursing and Midwifery Code (NMC) published in January 2015.

Members were advised that all registered nurses and midwives in clinical practice, education or management roles would need to comply with the requirements of revalidation to maintain registration. As of January 2015, revalidation was being piloted nationally across a range of healthcare and education providers including individuals, small groups of registrants and nursing agencies. Revalidation would replace the NMC post registration education and practice standards from April 2016.

Members were advised that with almost 5000 nurses working in UHL there would be challenges to the rollout particularly for the 300 bank only nurses who, because of the transient nature of their employment, might struggle to gain third party feedback and confirmation of their practice.

Responding to a query from the Patient Adviser, it was noted that the Trust was currently implementing a revised appraisal process that would support the pay progression policy which would also assist in ensuring that appraisals were undertaken in a timely manner.

Resolved – that the contents of this report be received and noted.

26/15/4 Month 11 – Quality and Performance Update

The Acting Chief Nurse presented paper G, which provided an overview of the February 2015 Quality and Performance (Q&P) report. Particular note was made in respect of improvement in C Diff, Maternity Friends and Family Test and Fractured Neck of Femur performance.

Members expressed concern that the Medical Director/Deputy Medical Director were not present at the meeting. A query was raised regarding whether the Associate Medical Director should also be an attendee at the Quality Assurance Committee – in response, the Chief Executive suggested that Mr A Furlong, Deputy Medical Director could take a decision on this matter when he was in post as the Interim Medical Director in April **DMD**

2015.

In response to a further query, the Acting Chief Nurse and the Director of Safety and Risk undertook to liaise outwith the meeting regarding an apparent discrepancy between the SUI figures set out in the Q&P report and the Patient Safety report, respectively **ACN/ DSR**

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

(B) the Deputy Medical Director be requested to consider whether the Associate Medical Director should be an attendee at the Quality Assurance Committee, and **DMD**

(C) the Acting Chief Nurse and the Director of Safety and Risk be requested to liaise outwith the meeting regarding an apparent discrepancy between the SUI figures set out in the Q&P report and the Patient Safety report, respectively and provide an update to the Quality Assurance Committee, as appropriate. **ACN/ DSR**

26/15/5 Nursing Acuity Report – Overview Regarding Review findings and resource implications for the Trust

The Acting Chief Nurse reported verbally advising that the Surgical Assessment Unit in the CHUGGS CMG required additional resources as there had been an error in the initial calculation of the ward establishments. The CMG would be supported with additional investment.

Resolved – that the verbal update be noted.

26/15/6 Nursing Report

The Chief Nurse presented paper H, which detailed information in respect of the latest nurse staffing in post figures, real time staffing, the current recruitment position, premium pay and nursing dashboard. She provided a brief update on some potential issues in respect of a specific ward advising that any wards put on "special measures" would be included within the quarterly nursing report.

Resolved – that the contents of this report be received and noted.

26/15/7 Midwifery Staffing Report

The Head of Midwifery presented paper I, a report which detailed the outcome of a review of maternity staffing in relation to the birth rate plus staffing ratio. A 90:10 skill mix with midwives and band 3 maternity support workers/nursery nurses had been achieved. Maternity staffing would be reviewed further in light of the recently published NICE guidance. 34% of midwives worked in the community but given that UHL midwives cared for an extra 1500 women who did not deliver in UHL, this percentage appeared appropriate. There were higher than average sickness rates, maternity leave and attrition rates particularly on one hospital site.

The Acting Chief Nurse commended the Women's and Children's CMG for the significant improvement recently in the Maternity Friends and Family Test score.

In response to a query regarding temporary transfers of activity when one maternity unit (i.e. LRI/LGH) was closed due to capacity issues, it was confirmed that this information was appropriately collated and monitored.

Resolved – that the contents of this report be received and noted.

26/15/8 Patient Experience Triangulation Report

The Acting Chief Nurse presented paper J which detailed the variety of patient feedback

via formal complaints, verbal complaints, GP concerns, NHS Choices, Patient Opinion, Patient surveys (electronic and paper formats), Message to Matron, Message through a Volunteer and the feedback from staff in the Friends and Family Test surveys. This data had been formally triangulated, building from quarter one with the projection that comparisons from each quarter could occur formally from quarter three. The top three themes overall remained waiting times for appointments, in clinic and Emergency Department and these three issues accounted for the top issue in five of the seven CMGs.

In response to a query on how the information gathered from feedback was being responded to, it was noted that this was discussed at CMG Board meetings and further action was taken through those fora. In discussion on whether assurance needed to be sought directly from CMGs on actions taken in response to such feedback, members were advised that the Chairs of the Quality Assurance Committee, Integrated Finance Performance and Investment Committee and Audit Committee were scheduled to have a discussion in May 2015 re. the work programme for all these Committees and they would ensure that the themes from the triangulation would be included in the work programme, as appropriate.

Responding to a query from the Director of Safety and Risk regarding complaints information to be presented to the Trust Board, a variety of views were expressed. In conclusion, it was agreed that any information that needed to be brought to the attention of the Trust Board could be done so through the minutes of the Quality Assurance Committee which were presented to the Trust Board on a monthly basis.

The Acting Chief Nurse advised that 500 places had been secured through the Leicester Hospitals Charity for staff to attend a theatre production called 'Inside Out of Mind' – this was in respect of caring for dementia patients. The Patient Adviser undertook to provide feedback to the Committee on his views of the production which he was scheduled to attend on 27 March 2015. **PA**

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

(B) the Patient Adviser be requested to provide feedback on the theatre production called 'Inside Out of Mind' at the QAC meeting on 30 April 2015. **PA**

26/15/9 <u>Friends and Family Test Scores – January 2015</u>

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

26/15/10 <u>Draft Quality Account 2014-15</u>

The Director of Clinical Quality presented paper L, which detailed the Draft Quality Account 2014-15, and requested that members provided feedback on the draft Quality Account noting that certain content was mandatory in nature and could, therefore, not be re-worded. It was noted that the Draft Quality Account would be issued to stakeholders imminently for comments to be received back within one month.

Further to a detailed discussion on whether a section for comments from Patient Advisers should be included within the Quality Account, it was agreed that a section describing the role of Patient Advisers should be included instead. **DCQ**

In relation to the cancer target section, Ms J Wilson, Non-Executive Director suggested that the narrative regarding joint workstreams with the CCG (from the exception report (i.e. Cancer Waiting Time Performance) to the Quality and Performance report) be included. **DCQ**

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

(B) the Director of Clinical Quality be requested to include the following within the Quality Account 2014-15 document:- **DCQ**
(i) a section describing the role of Patient Advisers, and
(ii) narrative regarding joint workstreams with the CCG (from the exception report (i.e. Cancer Waiting Time Performance) to the Quality and Performance report).

26/15/11 Quality Commitment

The Director of Clinical Quality presented paper M which proposed priorities for improvement for 2015-16 (appendix 2 refers), these would be included in the Trust's 2014-15 Quality Account and the Trusts Strategic Objectives/Priorities for 2015-16.

In discussion on the Quality Commitment, the following points were raised in particular:- **DCQ**

(i) consideration be given to changing the colours used in Appendix 2 – the Director of Clinical Quality undertook to action this;
(ii) in response to a query re. whether '2015-16' needed to be included within the title of the document, members advised that this was not necessary;
(iii) a comment was made that the 'Experience' section was mainly focused on 'End of Life' – however, members did not agree any changes, and
(iv) a suggestion whether the 'care for older people' needed to be re-worded to 'older people with frailty' – the Director of Clinical Quality undertook to discuss this suggestion with the Acting Chief Nurse outside the meeting. **DCQ**

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

(B) the Director of Clinical Quality be requested to take forward the actions listed in points (i) and (iv) above. **DCQ**

26/15/12 CQUINs and Quality Schedule Monthly Report

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

26/15/13 CQC Guidance – Regulation for Service Providers and Managers

The Director of Clinical Quality advised that paper O was the new guidance published by the CQC which would come into effect from 1 April 2015 and would replace the CQC's guidance about 'Compliance: Essential standards of quality and safety and its 28 outcomes'. Respective leads/experts would be asked to review the Trust's position against these standards at the CMG Quality and Safety Board meetings.

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

27/15 SAFETY

27/15/1 Safer Staffing Performance Indicator Development

The Acting Chief Nurse presented paper P, a letter from the NHS Trust Development Authority (TDA) which benchmarked the Trust's nurse staffing arrangements. In order to do this, the TDA had chosen the following indicators:-

(i) question in patient survey re. nurse staffing;
(ii) question in staff survey re. nurse staffing;
(iii) appraisal data from ESR;
(iv) mandatory training information from ESR, and
(v) 'hard truths' staffing % reported every month on NHS Choices.

UHL was denoted as a Trust performing at 'expected levels across all indicators'.

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

27/15/2 Patient Safety Report

The Director of Safety and Risk presented paper Q, which provided a monthly update on internal safety issues, serious incidents, external safety news and developments.

The issue in respect of the use and functionality of the Nerve Centre Task Allocation system was highlighted in particular. This system had been introduced into the Trust in February 2013 to aid medical staff with timely and effective prioritisation of clinical tasks. Over the months, since its introduction the number and type of tasks had increased significantly. The Director of Safety and Risk advised that these issues had been highlighted to Mr A Furlong, Deputy Medical Director and work was underway to resolve the issues.

The Committee also noted that the NHSLA had approved the Trust's recent bid to support safety work at UHL.

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

27/15/3 Statutory Duty of Candour

Resolved – that the contents of paper R and the need for all CMG staff to be conversant with the expectations of Regulation 20: Duty of Candour be noted.

27/15/4 Learning from Claims and Inquests

The Director of Safety and Risk presented paper S and advised that most issues identified during the claims and inquests process had been incorporated within safety work streams of the Quality Commitment actions/KPIs. However, in respect of the emerging issues that had arisen through this process – the Acting Chief Nurse, Director of Clinical Quality, Director of Safety and Risk and the Medical Director would be discussing the workstreams that would need to be put in place to resolve the issues. An update on this would be provided to QAC in June 2015. **DSR**

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

(B) the Director of Safety and Risk be requested to provide an update to QAC in June 2015 regarding the workstreams that had been and would be put in place to resolve the emerging issues that had arisen through the learning from claims and inquests process. **DSR**

27/15/5 Report from the Acting Chief Nurse

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

28/15 ITEMS FOR THE ATTENTION OF QAC FROM EQB

28/15/1 EQB Meeting of 3 February 2015 – Items for the attention of QAC

Resolved – that the action notes of the 3 February 2015 Executive Quality Board meeting (paper U refers) be received and noted.

28/15/2 EQB Meeting of 3 March 2015 – Items for the attention of QAC

Resolved – that there were no items for the attention of QAC from the EQB meeting on 3 March 2015.

29/15 MINUTES FOR INFORMATION

29/15/1 Executive Performance Board

Resolved – that the action notes of the 24 February 2015 Executive Performance Board meeting (paper V refers) be received and noted.

30/15 ANY OTHER BUSINESS

30/15/1 Report by the Chief Executive

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

30/15/2 CQC Registration Update

The Director of Clinical Quality advised verbally that applications had been made to add two more locations to UHL's CQC registration - firstly, the National Centre for Sports and Exercise Medicine (East Midlands) and secondly, Syston Health Centre where surgical procedures would be undertaken as part of the Alliance contract. The Committee Chair undertook to highlight this information to the members of the Trust Board. **Chair**

Resolved – (A) the verbal update be noted, and

(B) the Committee Chair be requested to inform the Trust Board in respect of the two locations that had been incorporated within UHL's CQC registration. **Chair**

30/15/3 Medical Director, Mr P Panchal, Non-Executive Director and Mr M Williams, Non-Executive Director

The Committee Chair thanked Dr K Harris, Medical Director, Mr P Panchal, Non-Executive Director and Mr M Williams, Non-Executive Director for their contributions to the QAC noting that this would be their last meetings of the Committee.

Resolved – that the position be noted.

31/15 DATE OF NEXT MEETING

Resolved – that the next meeting of the Quality Assurance Committee be held on Thursday, 30 April 2015 from 1.00pm until 4.00pm in the Board Room, Victoria Building, LRI.

The meeting closed at 4:37pm.

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

Voting Members

Name	*Possible*	*Actual*	*% attendance*	*Name*	*Possible*	*Actual*	*% attendance*
J Adler	12	10	83%	*R Overfield*	11	9	81%
S Dauncey (Chair)	12	11	91%	*P Panchal*	12	8	67%
K Harris	12	7	58%	*J Wilson*	12	10	83%
K Jenkins	1	0	0%	*D Wynford-Thomas*	11	3	27%
				C Ribbins	1	1	100%

Non-Voting Members

Name	*Possible*	*Actual*	*% attendance*	*Name*	*Possible*	*Actual*	*% attendance*
M Caple	12	10	83%	*K Singh*	6	5	83%
I Crowe	6	4	66%	*M Traynor*	6	2	33%
R Moore	2	0	0%	*M Williams*	6	2	33%
*C O'Brien – East Leicestershire/Rutland CCG**	12	6	50%				

Hina Majeed
Trust Administrator

University Hospitals of Leicester NHS
NHS Trust

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT BY TRUST BOARD COMMITTEE TO TRUST BOARD

DATE OF TRUST BOARD MEETING: 7 May 2015

COMMITTEE: Integrated Finance, Performance and Investment Committee

CHAIR: Ms J Wilson, Non-Executive Director

DATE OF COMMITTEE MEETING: 26 March 2015

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

- **Emergency Floor – final full business case (Minute 24/15);**
- **Draft Financial Plan 2015-16 (Minute 25/15), and**
- **Working Capital Strategy 2015-16 (Minute 26/15).**

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

- **none**

DATE OF NEXT COMMITTEE MEETING: 30 April 2015

Ms J Wilson

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF A MEETING OF THE INTEGRATED FINANCE, PERFORMANCE AND INVESTMENT COMMITTEE (IFPIC), HELD ON THURSDAY 26 MARCH 2015 AT 9AM IN THE BOARD ROOM, VICTORIA BUILDING, LEICESTER ROYAL INFIRMARY

Voting Members Present:
Ms J Wilson – Non-Executive Director (Committee Chair and Acting Trust Chair)
Mr J Adler – Chief Executive
Colonel (Retired) I Crowe – Non-Executive Director
Mr R Mitchell – Chief Operating Officer (excluding Minutes 27/15 to 29/15)
Dr S Dauncey – Non-Executive Director
Mr P Traynor – Director of Finance

In Attendance:
Mr C Allsager – Clinical Director, ITAPS (for Minute 30/15/1)
Ms L Bentley – Head of Financial Management and Planning (from Minute 30/15/3)
Mr P Gowdridge – Head of Strategic Finance (for Minute 24/15)
Ms G Harris – Deputy Head of Operations, ITAPS (for Minute 30/15/1)
Mr D Kerr – Interim Director of Estates and Facilities
Ms M MacLellan-Smith – Ernst Young (for Minute 31/15/2)
Mr W Monaghan – Director of Performance and Information
Mrs K Rayns – Acting Senior Trust Administrator
Ms K Shields – Director of Strategy
Mr N Sone – Financial Controller (for Minute 26/15)
Mr M Williams – Non-Executive Director

RECOMMENDED ITEMS **ACTION**

24/15 EMERGENCY FLOOR – FINAL FULL BUSINESS CASE

Further to the Finance and Performance Committee's consideration of the Trust's draft Emergency Floor full business case (Minute 134/14 of 18 December 2014 refers), paper E provided the final full business case and sought the Committee's endorsement prior to submission to the Trust Board on 2 April 2015 and the TDA National Capital Investment Group on 22 April 2015 for final approval. Mr P Gowdridge, Head of Strategic Finance attended the meeting for the discussion on this item and to respond to any queries raised by the Committee.

IFPIC members commented that the business case was well-made and that the recommendations arising from the gateway review had been appropriately incorporated into this final business case. As requested by the TDA, the business case had now been modified to assume the use of Interest Bearing Debt (IBD) instead of Public Dividend Capital (PDC) and this would have an additional revenue impact of £200,000 per annum. However, PDC would remain the Trust's preferred funding option and the eventual funding route would be subject to further discussions with the Independent Trust Financing Facility (ITFF) once the TDA had approved the business case. The Director of Finance provided some contextual information regarding the increasing use of IBD within the wider NHS and he highlighted the potential cumulative impact of such additional costs upon UHL's capital programme and cash management arrangements.

The Committee noted that a letter of support was currently being prepared by the Leicester City Clinical Commissioning Group (on behalf of the 3 LLR CCGs) and that this would be appended to the Trust Board version of the business case.

Responding to a query regarding the derogations for non-HBN compliant room sizes, the

Interim Director of Estates and Facilities reported verbally on the different operating models and their impact upon the size of some treatment rooms. He provided assurance that the maximum variation from the HBN guidance would be 20% and that patient safety considerations had been taken into account for the relevant models of care. He also provided assurance that the project would be strictly managed within the guaranteed maximum price (GMP) and that room sizes would not be increased between the planning and building phases.

Particular discussion took place regarding emergency capacity modelling, activity trends and the future alignment between UHL's Emergency Department and the LRI Urgent Care Centre (UCC). It was agreed that the Trust Board submission would be amended to clarify the patient quality and organisational efficiency benefits of UHL being involved in the provision of the UCC service. The Chief Executive noted an opportunity to discuss the future UCC service provision at a forthcoming Board to Board meeting between UHL and the 3 CCGs on 9 April 2015. **CE**

In respect of the benefits realisation arrangements, it was agreed that relevant benefit "owners" would be nominated for each theme and that performance would be monitored through the Trust's existing budget setting, workforce modelling and financial controls mechanisms. The Director of Strategy advised that a "lessons learned" report on the development of the Emergency Floor business case (and the scale of management resources required) would be presented to a future IFPIC meeting. **DS**

The Committee commended the robust PPI and stakeholder engagement activity and the positive outcome of the Gateway 3 review, recognising the significant contribution made by Ms N Topham, Project Director, Site Reconfiguration in this respect.

<u>Recommended</u> – that (A) the Emergency Floor final full business case be supported for Trust Board approval on 2 April 2015, subject to inclusion of the CCG letter of support and clarity being provided regarding the potential benefits of UHL being involved in the UCC service, **DS**

(B) consideration be given to discussing the future service provision for the LRI Urgent Care Centre at the 9 April 2015 Board to Board meeting between UHL and the 3 LLR CCGs, and **CE**

(C) a report on the lessons learned from the development of the Emergency Floor business case be presented to a future IFPIC meeting. **DS**

25/15 DRAFT FINANCIAL PLAN 2015-16

The Director of Finance introduced paper H providing an update on the progress of UHL's financial plan for 2015-16, and highlighting the current position with commissioning negotiations, income and expenditure assumptions, the draft capital programme, cash requirements, key risks and next steps. He advised that the final plan would be presented to the Committee on 30 April 2015, subject to the conclusion of the ongoing 2015-16 contractual negotiations. **DF**

Dr S Dauncey, Non-Executive Director and Chair of the Quality Assurance Committee commented upon the positive nature of the contractual negotiations and discussion took place regarding the mutual benefits of a less transactional focus, subject to agreement being reached with the TDA regarding the proposed risk sharing arrangements between UHL and the 3 LLR CCGs. The Director of Finance agreed to circulate copies of correspondence between UHL and the CCGs to Trust Board members outside the meeting to sight them to the positive nature of the dialogue that had been taking place. **DF**

IFPIC members also considered the prioritisation process for additional CMG and Directorate cost pressures, and the actions that would be required by other parts of the

LLR health economy to support UHL's delivery of the 2015-16 deficit control total. In respect of section 7.1.4, the Committee Chair sought additional assurance regarding any terms and conditions that might be applied to the contract to mitigate against any changes in planned activity levels from presenting an unacceptable financial risk to the Trust. The Chief Operating Officer highlighted opportunities to segment the overall volume of the contract into elective and non-elective activity and the scope for Commissioners to agree to fund 100% of any RTT and cancer activity required to deliver a fully compliant position. He agreed to liaise with the Director of Finance further on these suggestions outside the meeting.

Recommended – that (A) the draft 2015-16 financial plan be endorsed and recommended for Trust Board approval on 2 April 2015, **DF**

(B) the final 2015-16 financial plan be presented to the IFPIC meeting on 30 April 2015, **DF**

(C) the Director of Finance be requested to circulate copies of correspondence between UHL and its Commissioners in respect of the contractual discussions to Trust Board members for information (outside the meeting), and **DF**

(D) the Chief Operating Officer and the Director of Finance be requested to liaise further outside the meeting regarding technical aspects of the 2015-16 contract (eg potential segmentation between elective and non-elective activity). **COO/ DF**

26/15 WORKING CAPITAL STRATEGY 2015-16

The Financial Controller attended the meeting to introduce a revised version of paper I (which had been circulated in advance of the meeting), seeking the Committee's endorsement of the UHL Working Capital Strategy for 2015-16. He particularly drew members' attention to the Trust's annual external financing requirements to meet its working capital objectives (as set out in section 6.1 of the Strategy) and the 5 new financing facilities now available from the Department of Health Independent Trust Financing Facility (ITFF).

The Financial Controller invited the Committee to endorse the terms of the proposed application for interim Revolving Working Capital (RWC) support, noting that the deadline for submission to the Department of Health would be Monday 30 March 2015 and that the next full Trust Board meeting would be held on Thursday 2 April 2015.

In discussion on the report and the proposed RWC application, IFPIC members:-

(a) sought and received additional information regarding current and future performance against the 30 day Better Payment Practice Code (BPPC) target and the on-line card facility for making payments to the Trust;
(b) received assurance in respect of the Trust's cash management monitoring and reporting regime, noting that satisfactory external audit and internal audit reviews of these processes had been undertaken recently;
(c) agreed that a formal report on the Trust's cash position would be provided to the Committee on a quarterly basis, with an additional focus being maintained through the monthly financial performance reports; **DF**
(d) considered whether the Trust's Standing Orders and Standing Financial Instructions provided sufficient powers to this Committee to endorse the Strategy and the application for RWC support. In response, it was noted that such emergency powers were available to the Chief Executive and the Acting Trust Chair, having consulted at least 2 Non-Executive Directors, and
(e) requested the Financial Controller to circulate a briefing note to all Committee members (following the meeting) confirming the RWC approvals process to maintain an appropriate audit trail. **FC**

Recommended – that (A) the UHL Working Capital Strategy for 2015-16 be endorsed by the Integrated Finance, Performance and Investment Committee (as presented in revised paper I) and the interim Revolving Capital Support Facility (Schedule 1: Conditions Precedent) be endorsed by the Committee as follows:- **DF**

- **the terms of the interim revolving working capital support facility be approved;**
- **the Director of Finance be nominated to execute the agreement;**
- **the Director of Finance be nominated to manage the agreement;**
- **compliance with additional terms and conditions be confirmed;**

(B) the Trust Board be requested to formally ratify the Working Capital Strategy 2015-16, and the above agreements at the 2 April 2015 Trust Board meeting, and **DF**

(C) a briefing note on the above approvals processes be circulated to all IFPIC members to maintain an appropriate audit trail. **FC**

RESOLVED ITEMS

27/15 APOLOGIES AND WELCOME

Apologies for absence were received from Mr G Smith, Patient Adviser, Mr K Singh, Trust Chairman and Mr M Traynor, Non-Executive Director. The Chair welcomed Mr D Kerr, Interim Director of Estates and Facilities to his first IFPIC meeting.

28/15 MINUTES

Papers A and A1 provided the Minutes of the Integrated Finance, Performance and Investment Committee meeting held on 26 March 2015.

Resolved – that the Minutes of the 26 March 2015 IFPIC meeting (papers A and A1) be confirmed as correct records.

29/15 MATTERS ARISING PROGRESS REPORT

The Committee Chair confirmed that the matters arising report provided at paper B detailed the status of all outstanding matters arising from previous Finance and Performance Committee and Integrated Finance, Performance and Investment Committee meetings.

In respect of Minutes 126/14/4 (a) and (b) of 26 November 2014 – the Director of Finance expressed his disappointment that the expected reports on the Empath business case and future governance arrangements had been deferred from today's agenda and he provided assurance that the Empath management team would be attending the 30 April IFPIC meeting to report on these issues. In discussion on the reasons for the delays, members noted the need for both UHL and NUH to increase their focus on supporting the Empath business case and clarifying their support to the TDA. The Director of Strategy queried whether the delays had arisen as a result of the Empath model concept or the operational management arrangements. In response, it was noted that the concept was generally sound (although there was currently no lead provider) but some mixed messages were emerging from the 2 host Trusts which might have affected progress. The Director of Finance agreed to follow up these concerns outside the meeting. **DF**

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

30/15 STRATEGIC MATTERS

30/15/1 CMG Presentation – Intensive Therapy, Anaesthetics, Pain and Sleep (ITAPS)

Paper C provided an overview of the ITAPS CMG's operational and financial performance, significant achievements in the last 6 months, risks, CIP performance, workforce indicators, proposed strategic changes in 2015-16 and key commitments for the next 12 months.

Before the CMG representatives attended the meeting, the Director of Performance and Information briefed the Committee on the CMG's recent progress with improving performance, eg sleep study provision and reductions in the number of operations cancelled for non-clinical reasons. The Chief Operating Officer reported on progress with the theatres cross-cutting CIP theme, noting that theatre capacity plans had been signed off and agreement had been reached in relation to implementation of the theatres trading model, which would provide greater transparency of theatre staffing costs. He also stressed the importance of the alignment of services and capacity under the ITU reconfiguration workstream. The Director of Finance confirmed that the CMG was close to meeting its 2014-15 financial control total, advising that the main area of variation related to additional RTT activity, where clarity had been provided about the cost of the additional theatre sessions. The CMG's financial plans for 2015-16 were robust and improved links with the other (service user) CMGs were in place.

Mr C Allsager, Clinical Director, ITAPS and Ms G Harris, Deputy Head of Operations, ITAPS attended the meeting at this point and they were invited to highlight the CMG's top 2 or 3 achievements and any areas of additional support that might be required from the Trust Board. In response, the CMG reported on the following issues:-

(a) development of the relatively new CMG management team (over the last 8-10 months) and the aim to achieve high quality patient care within a framework of financial efficiency;
(b) robust performance against the friends and family patient feedback targets;
(c) continued reductions in RTT waiting times;
(d) 2 out of the 3 "excellent" scores attained by the Trust at the last CQC inspection had related to services provided by the ITAPS CMG;
(e) compliance with statutory and mandatory training – ITAPS was currently the best-performing CMG in this respect;
(f) plans in place to mitigate the CMG's financial challenges on a sustainable and recurrent basis;
(g) additional support required with the Theatres cross-cutting CIP theme and the ITU reconfiguration process;
(h) progress with addressing recruitment challenges and the continuing workstream being undertaken in liaison with Ms C Free, Associate Medical Director to address risks relating to identified niche areas where some recruitment issues were causing concern;
(i) a month 11 adverse movement against the financial plan for 2014-15 was attributable to an overspend on Consultants' pay expenditure and unmet theatres CIP schemes arising from the additional RTT activity, and
(j) additional 2015-16 CIP plans were being identified to offset the impact of unmet theatre efficiency schemes. Agreement had been reached with the CMGs regarding the re-sizing of their theatre capacity (with the aim of increasing the number of mid-week sessions and reducing high-cost weekend sessions).

In discussion on the presentation and the issues raised, the Committee:-

(1) queried what would make the most difference to the CMG's 2015-16 financial and operational performance, noting in response that the theatre trading model had now been agreed by all parties and that this would be supported by improved theatre information flows and robust governance arrangements through the Theatres Board;
(2) requested that an update on the cross-cutting theatres CIP scheme be provided to the Committee in July 2015; **COO**

(3) sought and received additional information regarding the arrangements for "left shift" of pain service activity into the Alliance;
(4) queried whether there were any additional risks arising from the transfer of the adult ECMO service into the ITAPS CMG, noting in response that work was continuing to develop the clinical pathways and that the financial implications and budget alignment arrangements were still being worked through. The Clinical Director commented upon national changes for the ECMO service and opportunities for growth in the Trust's market share;
(5) noted the clinical and technical differences between the adult and paediatric ECMO services and received assurance that the CMG was working closely with the Women's and Children's CMG regarding any co-dependencies between the 2 services (eg dual skilled nursing teams);
(6) queried the arrangements within the 2015-16 specialised commissioning contract in respect of additional ECMO activity and whether any marginal rates would be incurred for activity undertaken above the baseline;
(7) received assurance that robust arrangements were being developed as part of the ITU reconfiguration scheme (with input from the ECMO retrievals team) in the event that any patients on the LGH site unexpectedly developed complications requiring stabilisation on site and transferring to an ITU facility on the LRI or GH sites, and
(8) discussed the impact of ITU bed availability and equipment failure upon theatre lists under the new theatre trading model and the scope to smooth elective bookings to support the Trust's emergency flow. The Clinical Director noted the additional decant space that would be provided by the new theatre recovery unit and confirmed that this would have the added benefit of reducing cancelled operations.

The Committee Chair thanked the CMG team for their presentation, recognising the innovative work that was taking place in respect of theatres resources and Consultant job planning. She highlighted opportunities for the whole Trust to learn from the processes followed and the CMG team left the meeting. Following their departure, IFPIC members commented upon the improved operational grip demonstrated by the new CMG management team confirming that the CMG was in a much better position that it had been 12 months previously.

<u>Resolved</u> – that (A) the ITAPS CMG presentation and subsequent discussion be noted, and

(B) a progress report on the Theatres cross-cutting CIP scheme be presented to the 30 July 2015 IFPIC meeting. **COO**

30/15/2 <u>University of Leicester Embedded Space at UHL</u>

Further to Minute 140/14/2 of 18 December 2014, the Interim Director of Estates and Facilities introduced paper D, providing a progress report on the work taking place with the University of Leicester (UoL) to agree a schedule of UHL accommodation occupied by UoL and an appropriate charging mechanism or seek repatriation of the premises by UHL.

IFPIC members were assured that the process would be completed within the next 2 months and that the final agreed schedule would be linked with the Trust's 5 Year Strategy and the Better Care Together Strategy. As a minimum, it was expected that agreements would be put in place to cover UHL's baseline costs via a re-charging mechanism for those areas where UoL expressed a desire to continue occupancy. The quantum of agreed re-charges was estimated to fall in the region of £0.5 to £1m and there did not appear to be any reciprocal arrangements relating to UoL's premises.

It was agreed that the agreed schedule of accommodation and the proposed recharging mechanism would be presented to the 28 May 2015 IFPIC meeting for the Committee's approval. Discussion took place regarding the lack of suitable accommodation for storage and staff rooms within some of UHL's clinical areas and opportunities to repatriate any **IDEF**

unused research offices as clinical space.

Resolved – that (A) the update on UoL embedded space at UHL and the arrangements for development of an appropriate charging mechanism (paper D) be received and noted, and

(B) the Interim Director of Estates and Facilities be requested to present the confirmed schedule of UoL occupied premises and the proposed charging mechanism to the 28 May 2015 IFPIC meeting. **IDEF**

30/15/3 Report by the Director of Facilities

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

31/15 FINANCE

31/15/1 Month 11 Financial Performance 2014-15

The Director of Finance introduced papers F and F1 providing an update on UHL's performance against the key financial duties surrounding delivery of the planned deficit, achievement of the External Financing Limit (EFL) and achievement of the Capital Resource Limit (CRL), as submitted for consideration by the 24 March 2015 Executive Performance Board and the 2 April 2015 Trust Board meetings. He confirmed that the Trust was still on track to deliver its forecast control total for the 2014-15 financial year. He reported on the progress of local 2015-16 negotiations with the CCGs and advised that the specialised commissioning contract had now been agreed. CIP performance remained strong: plans for 2015-16 were well advanced and integrated CIP planning processes were well-embedded within the CMGs.

In respect of the Capital Programme for 2014-15, a summary of the lessons learned had been included in paper J (minute 31/15/3 below refers). However, the Capital Monitoring and Investment Committee had received assurance that each of the 3 capital groups (monitoring expenditure on estates, medical equipment and IT) would each deliver their year-end control totals, despite a degree of slippage in some schemes. The Committee Chair invited the Interim Director of Estates and Facilities to report on the estates backlog maintenance programme, recognising the challenges that existed in respect of decant ward accommodation to support the ward refurbishment programme. In response, he briefed the Committee on the arrangements for breaking down the capital programme into statutory compliance, business critical, back-office functions and rolling refurbishments and noted the need to link this with the Trust's 5 year strategy, the Better Care Together Programme, site reconfiguration plans and the space utilisation workstream. He also noted the need to provide decant accommodation to support the Trust's programme of deep cleaning wards. Finally, the Committee commented upon the scope to redevelop some "front of house" areas to improve patient and public perception of the Trust.

Pay expenditure trends continued to cause concern as the Trust moved into the 2015-16 financial year and a wide-range of action was being implemented to control premium pay expenditure in the short term and drive improved longer term efficiency through the cross-cutting workforce CIP theme. The Committee Chair sought assurance regarding the Trust's ability to reduce temporary staffing costs in a timely manner following substantive recruitment to vacant posts, noting in response that nursing agency expenditure was reducing although a cost pressure had been highlighted in respect of bank nursing costs. From the medical staffing perspective, significant gaps existed within several rotas and Dr P Rabey, Deputy Medical Director was leading a workstream to strengthen medical productivity and job planning.

Responding to a Non-Executive Director query, the Director of Finance advised that non-

pay expenditure variances were mainly attributable to clinical activity above the planned levels (eg RTT backlog clearance). However, UHL had recently appointed Mr B Shaw as the new Head of Procurement and consideration was now being given to development of a fifth cross-cutting CIP theme relating to procurement for 2015-16.

Resolved – that the briefings on UHL's Month 11 financial performance (papers F and F1) and the subsequent discussion be noted.

31/15/2 Cost Improvement Programmes for 2014-15 and 2015-16

Ms E MacLellan-Smith, Ernst Young, attended the meeting to present paper G, providing the monthly update on CIP performance for 2014-15 and the development of CIP plans for 2015-16. The total value of schemes on the Programme Management Tracking Tool (PMTT) at month 11 was £47.99m with a risk adjusted value of at £47.82m. The Trust was forecast to over-deliver against the £45m 2014-15 CIP target by between £2.5m and £3m.

In respect of the £41m 2015-16 CIP target, the Trust had already identified £34.95m (which equated to 85% of the target). Paper G1 set out the proposed arrangements for delivering the current £6.1m CIP shortfall based on the existing plans for 2015-16. The Chief Operating Officer highlighted opportunities to deliver significant cost improvements through the 4 cross-cutting CIP themes during 2015-16, by reducing reliance upon additional theatre sessions, reducing bed capacity, improving outpatient productivity and workforce productivity and efficiency savings.

The Executive Strategy Board had supported all of the proposed schemes listed in paper G1 on 24 March 2015, with the exception of the final scheme on page 3 of the report (relating to reductions in administrative and clerical staffing hours). These schemes were now being progressed by the relevant leads with support from the embedded CIP Managers within each CMG. The Committee Chair requested that the embedded CMG CIP Managers be invited to attend IFPIC meetings for their respective CMG presentations. **COO**

The Chief Operating Officer reported on the differing challenges being experienced by the 2 worst performing CMGs, providing assurance that their respective RAG ratings were improving on a daily basis. Members noted that the Outpatients Project had been nominated for a Health Service Journal Award and that the Trust's strong CIP performance was considered to be quite unusual within the NHS more generally. The Chief Operating Officer commented upon the scope to increase UHL's 2015-16 CIP target to take account of identified cost pressures.

Finally, the Committee agreed to review the cross-cutting CIP theme relating to workforce issues on 30 April 2015 (instead of the outpatients theme agreed previously). **DF**

Resolved – that (A) the Cost Improvement Programme updates (papers G and G1) and the subsequent discussion be received and noted,

(B) the Chief Operating Officer be requested to arrange for the CMG CIP Managers to attend the IFPIC meetings for their respective CMG performance presentations, and **COO**

(C) a review of the Workforce cross-cutting CIP scheme be presented to the IFPIC meeting on 30 April 2015 (instead of the previously agreed Outpatients theme). **DF**

31/15/3 2014-15 Financial Management and Planning Lessons Learned

Further to Minute 57/14/3 of 28 May 2014, the Director of Finance introduced paper J, setting out the key lessons learned from the 2014-15 financial management and planning processes and highlighting further actions to enhance the robustness of UHL's financial management and planning for future financial years. He particularly noted the scope to improve business case governance and the arrangements for monitoring the actual

outcomes of business cases against the expected outcomes, via a formal reporting mechanism to this Committee. A financial awareness session was planned to be held for Trust Board members on 30 April 2015, following the IFPIC and QAC meetings being held earlier on that day. **DF**

<u>Resolved</u> – that (A) the report on lessons learned from the 2014-15 financial management and planning process (paper J) be received and noted,

(B) the actions identified in appendix 1 to paper J to support improved financial robustness be endorsed, and **DF**

(C) a financial awareness session for Trust Board members be held on 30 April 2015. **DF**

32/15 PERFORMANCE

32/15/1 <u>Month 11 Quality and Performance Report</u>

The Committee supported a suggestion that the operational performance and financial performance items be alternated within the running order on the agenda each month. **TA**

Paper K provided an overview of UHL's quality, patient experience, operational targets, and HR performance against national, regional and local indicators for the month ending 28 February 2015. Particular discussion took place regarding the performance metrics for admitted RTT, ambulance handovers, cancer performance, cancelled operations, choose and book slot availability and delayed transfers of care (DTOCS). A recent improvement in DTOC performance was partly attributed to a change in the classification criterion.

In respect of admitted RTT, the Trust's performance against the 92% target for incomplete pathways stood at 96.2% in February 2015, which was ranked the second highest performance amongst UHL's recognised peer group Trusts and within the upper quartile of all hospitals in England. UHL's overall admitted RTT backlog was currently just below 600 cases and work was continuing to reduce this to a more sustainable position (eg 550 cases). It was likely that the Alliance activity would be non-compliant for April 2015 and this might significantly challenge UHL's ability to deliver compliant performance in April 2015 (as planned).

The Chief Operating Officer reported on outline proposals to strengthen the performance management arrangements between UHL and the Alliance (subject to approval at the Alliance Leadership Board meeting during the first week of April 2015). Members noted that a substantive Alliance Director had now been appointed and there was some scope to develop a more proactive approach to validation of patient pathways and access to UHL clinicians through the Alliance contract without hindering the existing level of autonomy within the service. The Chief Operating Officer was requested to escalate any barriers or areas of concern regarding the performance management of the Alliance contract to the Chief Executive without delay. **COO**

The Director of Performance and Information summarised progress in respect of the following key areas:-

- Diagnostics – performance had been achieved in February 2015 and was likely to be achieved in March 2015;
- Cancer 2 week waits – the majority of the internal UHL components had been addressed and performance was much improved. However, the rate-limiting factor appeared to be patient choice and their preparedness for entering the cancer exclusion pathways. Non-Executive Director members were requested to consider raising this issue at a forthcoming meeting between UHL and CCG Non-Executive Directors and Lay Members as a means of increasing CCG support in this area; **Chair/ NEDs**
- Cancer 31 day – the Urology service had been recognised as the most improved

specialty due to their significant progress in reducing backlogs. Compliant performance was forecast to be delivered in April 2015, and

- Cancer 62 day – confirmation was provided that all Cancer Lead Clinicians, Heads of Operations and Clinical Directors had signed up to their respective tumour site trajectories. A compliant position might be achieved (temporarily) in March 2015 but sustainable compliance was not likely to be achieved until July 2015.

The Committee Chair sought and received assurance from the Chief Operating Officer regarding the Trust's preparations for sustaining performance over the forthcoming Easter bank holiday period, noting that the key areas of focus related to (1) UHL's staffing rotas, (2) additional health economy support and (3) access to GP surgeries. Further discussion on these matters was due to take place at the Urgent Care Board meeting later that day.

IFPIC members commended the introduction of a new section on page 8 of paper K, which set out the months in which the respective key performance standards were expected to become compliant, together with a RAG rating and commentary for each standard. The Committee Chair invited members to consider whether the existing mechanism for providing performance exception reports was working effectively and this was confirmed.

Resolved – that (A) the month 11 Quality and Performance report (paper K) and the subsequent discussion be received and noted, and

(B) the Chief Operating Officer be requested to escalate any concerns regarding performance management arrangements within the Alliance contract to the Chief Executive, and **COO**

(C) the Committee Chair and the Non-Executive Director members present be requested to consider raising the issue of patient preparedness for cancer exclusion pathways at a forthcoming meeting between UHL and CCG Non-Executive Directors and Lay Members. **Chair/ NEDs**

33/15 SCRUTINY AND INFORMATION

33/15/1 Executive Performance Board

Resolved – that the notes of the 24 February 2015 Executive Performance Board meeting (paper L) be received and noted.

33/15/2 Revenue Investment Committee

Resolved – that (A) the notes of the 13 February 2015 Revenue Investment Committee meeting be received and noted as paper M, and

(B) the notes of the 13 March 2015 Revenue and Investment Committee meeting be presented to the 30 April 2015 IFPIC meeting.

33/15/3 Capital Monitoring and Investment Committee

Resolved – that (A) the notes of the 13 February 2015 Capital Monitoring and Investment Committee meeting be received and noted as paper M, and

(B) the notes of the 13 March 2015 Capital Monitoring and Investment Committee meeting be presented to the 30 April 2015 IFPIC meeting.

33/15/4 Tariff arrangements for 2015-16

Resolved – that confirmation of UHL's selected tariff arrangements for 2015-16 NHS activity be received and noted as paper O.

33/15/5 Updated IFPIC Calendar of Business

Paper P provided the Committee's updated calendar of business for the period 1 January 2015 to 31 March 2016. Subject to the additional items agreed during the course of this meeting, the Committee approved the report and agreed that the calendar of business would be presented to the Committee on a monthly basis as a standing agenda item.

Resolved – that the Trust Administrator be requested to update the IFPIC Calendar of Business to reflect the additional items agreed during the course of this meeting and present the updated calendar of business as a standing agenda item to all future IFPIC meetings. **TA**

34/15 ANY OTHER BUSINESS

Resolved – that no other items of business were noted.

35/15 ITEMS TO BE HIGHLIGHTED TO THE TRUST BOARD

Resolved – that (A) a summary of the business considered at this meeting be provided to the Trust Board meeting on 2 April 2015, and **TA/ Chair**

(B) the recommendations contained in Minutes 24/15, 25/15 and 26/15 be highlighted for the Board's approval.

36/15 DATE OF NEXT MEETING

Resolved – that the next meeting of the Integrated Finance, Performance and Investment Committee be held on Thursday 30 April 2015 from 9am – 12noon in the Board Room, Victoria Building, Leicester Royal Infirmary.

The meeting closed at 12noon

Kate Rayns,
Acting Senior Trust Administrator

Attendance Record 2014-15

Voting Members:

Name	Possible	Actual	% attendance	Name	Possible	Actual	% attendance
J Wilson (Chair from 29.10.14)	12	11	92%	R Mitchell	12	11	92%
R Kilner (Chair up to 24.9.14)	6	6	100%	P Panchal	5	1	20%
J Adler	12	11	92%	S Sheppard	4	4	100%
I Crowe	12	11	92%	M Traynor	5	4	80%
S Dauncey	5	4	80%	P Traynor (from 26.11.14)	5	5	100%
P Hollinshead	3	3	100%				

Non-Voting Members:

Name	Possible	Actual	% attendance	Name	Possible	Actual	% attendance
D Kerr (from 26.3.15)	1	1	100%	K Shields	5	4	80%
K Singh	5	4	80%	M Williams	5	3	60%
G Smith	12	11	92%	D Wynford-Thomas (up to 28.2.15)	4	0	0%

Trust Board Paper Q

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT BY TRUST BOARD COMMITTEE TO TRUST BOARD

DATE OF TRUST BOARD MEETING:	**7 May 2015**

COMMITTEE:	**Charitable Funds Committee**
CHAIRMAN:	**Mr K Singh, Trust Chairman**
DATE OF COMMITTEE MEETING:	**2 April 2015**

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

The Trust Board are invited to endorse all recommendations.

OTHER KEY ISSUES IDENTIFIED BY THE COMMITTEE FOR NOTING BY THE PUBLIC TRUST BOARD:

- **None**

DATE OF NEXT COMMITTEE MEETING: 4 June 2015.

K Singh, Trust Chairman
1 May 2015

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF THE CHARITABLE FUNDS COMMITTEE MEETING HELD ON THURSDAY 2 APRIL 2015 AT 2PM IN SEMINAR ROOMS 2 AND 3, CLINICAL EDUCATION CENTRE, GLENFIELD HOSPITAL

Present: Mr K Singh – Trust Chairman (Chair)
Mr I Crowe – Non-Executive Director
Ms C Ribbins – Acting Chief Nurse (from Minute 18/15 to 24/15 inclusive)
Mr M Traynor – Non-Executive Director

In Attendance: M T Diggle – Head of Fundraising
Mrs H Majeed – Trust Administrator
Mr R Moore – Non-Executive Director
Mr N Sone – Charity Finance Lead
Mr S Ward – Director of Corporate and Legal Affairs
Mr M Wightman – Director of Marketing and Communications
Ms J Wilson – Non-Executive Director
Ms J Woolley – Assistant Financial Accountant

RECOMMENDED ITEMS **ACTION**

16/15 ITEMS FOR APPROVAL

Paper F outlined the grant applications received since the January 2015 Charitable Funds Committee meeting, noting that all bids received had been pre-reviewed as per current guidelines. The Charity Finance Lead considered that all applications fell within the scope of the funds, were affordable, and had been appropriately authorised by the fund advisers. Applications totalling £180,275 had been approved by the Charity Finance Lead through the scheme of delegation (they did not, therefore, require additional Charitable Funds Committee approval), and were detailed in appendix 1 of paper F. Appendix 2 outlined three applications which had been rejected by the Charity Finance Lead. Appendix 3 detailed transfers between funds requested by the relevant fund managers in order to facilitate grant applications (in accordance with the Transfer of Unrestricted Funds Policy agreed by the Committee).

Members expressed concern that some of the applications did not have sufficient information on which informed decisions could be taken. The Charity Finance Lead advised that, in future, all applications would have a cover sheet listing a number of questions which the applicant would be required to complete and the Finance team would review the application and, if appropriate, would recommend it to the Charitable Funds Committee, for approval. He undertook to circulate the cover sheet outwith the meeting, for approval, so that it could be accompany applications submitted to the June 2015 meeting and subsequent meetings of the Committee. **CFL**

The Committee undertook detailed consideration of the following new applications for funding (as detailed in appendices 4 – 19 inclusive):

(i) application 5243 (appendix 4 refers) was an application for £16,104 for conversion of a shower room into a wet room in ward 15 at Glenfield Hospital. The Committee approved the application as the cardio-respiratory patient benefit fund was being used for this purpose;

(ii) application 5383 (appendix 5 refers), was an application for £27,554 for Bariatric CTG machines in the Maternity Unit at LGH and LRI. The Committee noted that the Medical Equipment Executive had approved this equipment. The Committee were interested to know the grading of this equipment in the medical equipment priority list. The Charity Finance Lead was requested to source this information and forward it to the Committee Chair. Further to this, the Committee Chair would circulate this information to the Charitable Funds Committee members to seek their views. The Committee Chair would confirm to the Charity Finance Lead outwith the meeting re. whether the application had **CFL** **Chair**

been approved/rejected;

(iii) application 5394 (appendix 6 refers) – £18,385.14 for the extension and refurbishment of Ultrasound Room 3 in the Breast Care Centre – this was approved;

(iv) application 5398 (appendix 7 refers) was an application for £20,760 for a Criticool machine and fixings for a Neonatal ambulance – this was approved;

(v) application 5424 (appendix 8 refers) was an application for £9,882 for physiotherapy and occupational therapy equipment – this was approved. However, concern was expressed regarding the provision of annual maintenance costs for this equipment. It was suggested that as part of the application process, CMGs should be asked to confirm whether they had maintenance costs set aside for equipment purchased through charitable funds. However, one view was that such equipment should be maintained as part of the annual equipment maintenance programme. Members suggested that the Interim Director of Estates and Facilities be requested to attend the June 2015 Charitable Funds Committee to provide an update on this matter and on whether retrospective audits could be undertaken to ensure that the equipment purchased through charitable funds remained fit for purpose and available for use. Responding to a query, it was noted that equipment purchased through charitable funds were included on the Trust's asset register; **IDEF**

(vi) application 5426 (appendix 9 refers) was an application for £170,485 for salary costs for three individuals to take forward renal research. The Committee requested details to be submitted regarding the added value the funding would provide in taking forward the research. The funding would require Director of Research and Development and Medical Director approval. The Committee agreed that the applicant be asked to outline the consequences if only 75%, 50% or none of the funding requested was approved. The application was not approved but deferred pending such clarification. The Charity Finance Lead was requested to forward these details to the Committee Chair. Further to this, the Committee Chair would circulate this information to the Charitable Funds Committee members to seek their views. The Committee Chair would confirm to the Charity Finance Lead outwith the meeting whether the application had been approved/rejected; **CFL** **Chair**

(vii) application 5448 (appendix 10 refers) was an application for £28,000 for a laser for neonatal eye surgery – the application was approved as it was being funded through the Women's and Children's patient benefit fund. The Committee requested that the grading of this equipment in the medical equipment priority list be confirmed. It was suggested that the cover sheet for future applications included 'utilisation levels' noting that in this case a similar laser was already in place in emergency theatres; **CFL** **CFL**

(viii) application 5449 (appendix 11 refers) was an application for £16,700 for a Chemidoc touch imaging system for use by the Renal Research Group – the application was approved;

(ix) application 5458 (appendix 12 refers) was an application for £49,522 for an automated tissue processor to be used in the Breast Care Centre – the application was not approved and CMG representatives were requested to attend the Charitable Funds Committee in June 2015 to provide further details; **CFL**

(x) application 5462 (appendix 13 refers) was an application for £327,494 to cover salary costs for Meaningful Activity Coordinator posts – the application was not approved noting that an alternative option for the posts to be funded through the CMG/Directorate budgets. The Committee noted that these posts were very valued and funding needed to be identified. The Director of Corporate and Legal Affairs undertook to highlight this matter to the Chief Executive and Acting Chief Nurse; **CFL** **DCLA**

(xi) application 5474 (appendix 14 refers) was an application for £1,535 for training for a healthcare scientist in Jamaica – there was lack of support for this application and therefore it was rejected; **CFL**

(xii) application 5327 (appendix 15 refers) was an application for £10,000 for a diabetic screening DVD and easy read leaflets – this application was rejected and the CMG was requested to instead use the services provided by the Medical Illustration Team for this purpose;

(xiii) application 5332 (appendix 16 refers) was an application for £1,800 for three patient TV systems in AICU at Glenfield Hospital – this was approved;

(xiv) application 5345 (appendix 17 refers) was an application for £1,500 for a carers engagement event – this was approved;

(xv) application 5346 (appendix 18) was an application for £4,500 for room hire and facilities for a patient experience celebration event – the application was deferred and further information was requested. Members requested details regarding the cost per head, target audience and objectives of the event. The Charity Finance Lead was requested to include 'cost per head' on the covering proforma for applications, and **CFL**

(xvi) application 5241 (appendix 19) was an application for a contribution of £29,000 towards the cost of 2 EUS scopes from the Brown Dog Fundraising Group – this was approved.

In general discussion on the bids presented, the Charity Finance Lead was requested to provide an update to the Charitable Funds Committee in June 2015 on the different funding pots (i.e. patient benefit fund, research fund etc.) available and their current income levels. **CFL**

<u>Recommended</u> – that (A) the contents of this report and its appendices be received and noted;

(B) applications 5243, 5394, 5398, 5424, 5449, 5332, 5345 be approved and 5448 and 5241 be recommended onto the Trust Board for formal approval (due to their value being over the Charitable Funds Committee's delegated authorisation limit of £25,000); **Chair**

(C) the Interim Director of Estates and Facilities be invited to attend the Charitable Funds Committee in June 2015 to provide an update on the annual maintenance of equipment and the need to ensure that the equipment was still fit for purpose noting that these had been purchased through charitable funds; **CFL/ IDEF**

(D) applications 5383, 5426, 5458 and 5346 not be approved, with the applicants to be notified of the outcome of their application by the Charitable Funds Assistant, and the nominated staff members (full details of which are as above – please see points (ii), (vi), (ix), and (xv)) now to seek additional information in respect of these applications before they could be re-submitted for consideration at future meetings of the Charitable Funds Committee; **CFL**

(E) applications 5462, 5474 and 5327 not be approved, with the applicants to be notified of the outcome of their application by the Charitable Funds Assistant; **CFL**

(F) the Director of Corporate and Legal Affairs be requested to raise the matter with the Chief Executive and Acting Chief Nurse in respect of application 5462 (as detailed in point (x) above); **DCLA**

(G) the Charity Finance Lead be requested to circulate the cover sheet that would accompany future 'items for approval' reports to the Charitable Funds Committee members outwith the meeting, for approval, and **CFL**

(H) the Charity Finance Lead be requested to provide an update to the Charitable Funds Committee in June 2015 on the different funding pots (i.e. patient benefit fund, research fund etc.) available and the current income in those. **CFL**

<u>RESOLVED ITEMS</u>

17/15 APOLOGIES FOR ABSENCE

Apologies for absence were received from Mr C Sutton, Chairman of the Medical Equipment Executive and Mr P Traynor, Director of Finance.

18/15 DECLARATION OF INTERESTS

Mr M Traynor, Non-Executive Director declared an interest in the item entitled 'Establishing a Public Lottery' (Minute 26/15 below refers), however due to time constraints this item was deferred.

19/15 MINUTES

Resolved – that the Minutes of the 19 January 2015 Charitable Funds Committee meeting be confirmed as a correct record.

20/15 MATTERS ARISING FROM THE MINUTES

Members reviewed the matters arising report at paper B, which covered both the immediately preceding and earlier Charitable Funds Committee meetings. Specific discussion took place in respect of the following items, noting that all items currently designated as a '5' rating (complete) would be removed from the log.

(a) Minute 03/15a of 19 January 2015 and Minute 56/14a of 17 November 2014 – the Charity Finance Lead confirmed that the Director of Finance had held a meeting with the External Auditors regarding the audit of the Leicester Hospitals Charity accounts. These items be removed from the log; **TA**

(b) Minute 03/15h of 19 January 2015 – the Committee Chair undertook to liaise with Mr P Panchal, former Non-Executive Director outwith the meeting regarding contacts for Leicester Community groups. This item be removed from the log; **Chair**

(c) Minute 06/15c of 19 January 2015 (re. future size and structure of UHL's charitable funds) – it was noted that a LiA approach was being taken and the initial aim through this process was for a discussion with the fund holders in respect of the governance arrangements of the existing established funds within CMGs. Further to this, discussions would be held regarding the criteria for the use of charitable funds. Responding to a query, it was noted that an approved strategy did not exist for the use of charitable funds and the Charity did not currently have an annual or medium term expenditure plan. Further to a detailed discussion on this matter, it was agreed that a report be presented to the Charitable Funds Committee in June 2015 regarding the overall objects of the Charity and the structure of the Charity's funds (i.e. size of the charitable funds and how much of it had already been allocated and how much of it currently remained for use). This report to also include an update on future spending plans listing the criteria for which funds could/could not be used and the pattern of the funds (i.e. had there been an increase/decrease). Ms J Wilson, Non-Executive Director noted the need for a mechanism to be in place to ensure donors' wishes to be observed and that the funds were used for the purpose for which they were donated. Members also noted that the Committee had previously considered the possibility of 'externalising' the Charity, however this had not been taken forward because the DoH would not support this due to the smaller size of Leicester Hospitals Charity. The Committee Chair suggested that the paper mentioned above also include an update on the pros and cons in 'externalising' the Charity, and **CFL/HF CFC 4.6.15**

(d) Minutes 61/14 and 61/14a (Charitable Funds Investment Portfolio) of 17 November 2015 – it was agreed that these items be removed from the matters arising log and the Committee Chair undertook to highlight to the Chief Executive the need for Executive Team oversight of UHL's charitable funds investment management arrangements. **Chair**

Resolved – that the discussion above and any associated actions, be noted and progressed by the appropriate lead. **Named leads**

21/15 UPDATE FROM CHARITABLE FUNDS INVESTMENT MANAGERS

Paper C detailed the quarter 4 (2014-15) report from Cazenove Capital Management (investment managers for Leicester Hospitals Charity).

The Committee Chair noted that Cazenove had been the Trust's charitable funds investment managers since 2009 and queried when the market had last been tested via competitive tenders for such services – in response, it was noted that the existing contract with Cazenove was for a period of three years and had been further extended to two years. The Committee Chair requested that a report be presented to the Charitable Funds Committee in June 2015 regarding the proposals for the future appointment of investment managers taking into account the need for maximising returns. The Charity Finance Lead commented that normal practice would be to appoint an independent expert to undertake an assessment of the investment managers, however consideration would need to be given to value for money aspects given that the size of the fund was modest. **CFL**

Mr R Moore, Non-Executive Director stressed the need for updating the Trust's investment policy for the Charity. It was suggested that good practice / ideas from other NHS Charities or large charitable funds organisations be sought. **CFL/HF**

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

(B) a report be presented to the Charitable Funds Committee in June 2015 regarding the proposals for the future appointment of investment managers taking into account the need for maximising returns, and **CFL**

(C) the Charity Finance Lead be requested submit a report to the June 2015 meeting of the Charitable Funds Committee to enable the Committee to consider updating the Charity's Investment Policy. **CFL/HF**

22/15 INSURANCE POLICIES

Paper D sought the Committee's retrospective approval to fund the following insurance policies from General Purpose funds as the policies currently funded by the Committee had expired on 31 March 2015:

- Directors and Officers Liability – this was designed to protect charitable trustees and covered losses arising from claims brought against the Officials and the Charitable Trust (2015-16 cost £5,777), and
- Group Personal Accident – this was designed to protect members of the Trust's Flying Squad and call out teams who sustained accidental bodily injury resulting in death or disablement. The Trust was not permitted to utilise exchequer funds for this purpose (HSC1999/021 refers) and use of charitable funds for this purpose had been adopted since the inception of UHL (2015-16 cost £9,652.93).

The Committee approved the funding of the above policies through charitable funds for 2015-16.

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

(B) use of charitable funds for the Directors' and Officers' Liability and Group Personal Accident insurance policies described above be approved.

23/15 FINANCE AND GOVERNANCE REPORT

Paper E detailed the financial position of the Charity for the period ending 28 February 2015 and also provided an update on the general purposes charitable fund. Members expressed concern over some of the outstanding commitments highlighting that the reason for charitable funds being used was not always clear. The Director of Marketing and Communications advised that rigid criteria would not apply in certain cases, noting that if charitable funds were not used for that purpose then the idea/initiative would not go forward particularly citing the example of 'Above Bed Patient Name Boards' and 'Meaningful Activity Coordinator Posts'. Assurance was required that if charitable funds were not available to take forward these initiatives then mainstream funding would be available, however, the Director of Marketing and Communications highlighted that this

assurance was currently not available.

In discussion on appendix 2 (annual events to take place in 2015-16 amounting to £109,000 previously supported from General Purposes funds), a variety of views were expressed in respect of whether these events required charitable funding or could instead be funded through CMG/Directorate budgets. Members suggested that it would be appropriate if charitable funds were used to pump prime such events (e.g. for up to two to three years) and then these should become mainstream and not require charitable funds on an annual basis. It was suggested that for each of the events listed in appendix 2, the lead who had made the initial request be identified and be requested to provide an update for the rationale for the use of charitable funds for that event. A report on this matter be presented to the Committee in June 2015, where a decision would be taken on whether or not it would be appropriate to use charitable funds for that purpose. **CFL**

The Committee Chair requested that the 'Finance and Governance Report' to the June 2015 Charitable Funds Committee include: - ongoing commitments (split by capital and revenue), one-off capital commitments, well being at work initiatives and total available balances. **CFL**

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

(B) the Charity Finance Lead be requested to contact the Leads who had made the initial request for the events listed in appendix 2 of paper E and request them to provide an update for the rationale for the use of charitable funds for that event, with a report on this matter being presented to the Charitable Funds Committee in June 2015, where a decision would be taken on whether or not it would be appropriate to use charitable funds for that purpose, and **CFL**

(C) the Finance and Governance Report to be submitted to the Charitable Funds Committee in June 2015 include:- ongoing commitments (split by capital and revenue), one-off capital commitments, well being at work initiatives and total available balances. **CFL**

24/15 FUNDRAISING UPDATE REPORT

Paper G detailed the recent fundraising and promotional activities undertaken by the Charity. The Head of Fundraising advised that the fundraising team had recruited a number of new members of staff and the team were currently focussing on a number of smaller appeals. Further to approval by the Charitable Funds Committee in January 2015 to change the payroll giving benefiting charity from Health Action Leicester for Ethiopia (HALE) to Leicester Hospitals Charity and LOROS, plans were in place to re-launch Pennies from Heaven on 1 May 2015.

<u>Resolved</u> – that the contents of paper G be received and noted.

25/15 ESTABLISHING A PUBLIC LOTTERY

<u>Resolved</u> – that due to time constraints, this report be deferred to the Charitable Funds Committee in June 2015. **TA**

26/15 POTENTIAL FUNDRAISING SCHEME FOR THE CHILDREN'S HOSPITAL

The Director of Marketing and Communications provided a verbal update on a potential fundraising scheme for the Children's Hospital.

<u>Resolved</u> – that (A) the verbal update be noted, and

(B) the Director of Marketing and Communications be requested to provide an update at the next Committee meeting on the potential fundraising scheme for the Children's Hospital further to the initial scoping meeting with the Women's and Children's CMG. **DMC**

27/15 ANY OTHER BUSINESS

27/15/1 Review of Policies in respect of Celebrities/Visitors

The Head of Fundraising advised verbally that further to the findings from the Savile Enquiry, NHS Charities had been requested to review areas of governance. Therefore, he would be reviewing the current policies in relation to celebrities and visitors and other related areas and put measures in place to strengthen the governance arrangements, as appropriate. An update on this issue would be provided to the Charitable Funds Committee in August 2015. The Committee Chair requested that a checklist of the areas that needed to be reviewed be provided to the June 2015 meeting of the Committee. **HF**

In discussion, the Director of Corporate and Legal Affairs advised that the Acting Chief Nurse was working on the recommendations from the recently published NHS report relating to the relationship of Savile with the NHS. He suggested that the Head of Fundraising liaise with the Acting Chief Nurse in respect of this matter.

Resolved – that (A) the verbal update be noted, and

(B) the Head of Fundraising be requested to:-
(i) provide a checklist to the June 2015 Charitable Funds Committee on the areas/policies that required review following the findings from the Savile Enquiry, and **HF**
(ii) provide an update to the August 2015 Charitable Funds Committee re. the review of current policies in relation to celebrities and visitors and other related areas and measures put in place to strengthen the governance arrangements.

28/15 DATE OF NEXT MEETING

Resolved – that the next Charitable Funds Committee be held on Thursday, 4 June 2015 from 2pm to 4pm in the C J Bond Room, Clinical Education Centre at Leicester Royal Infirmary.

The meeting closed at 4:15pm.

Cumulative Record of Members' Attendance (2015-16 to date):

Voting Members

Name	*Possible*	*Actual*	*% attendance*	*Name*	*Possible*	*Actual*	*% attendance*
I Crowe	1	1	100%	*M Traynor*	1	1	100%
C Ribbins	1	1	100%	*P Traynor*	1	0	0%
K Singh (Chair)	1	1	100%				

Non-Voting Members

Name	*Possible*	*Actual*	*% attendance*	*Name*	*Possible*	*Actual*	*% attendance*
S Dauncey	1	0	0%	*R Moore*	1	1	100%
J Wilson	1	1	100%				

Hina Majeed, **Trust Administrator**

University Hospitals of Leicester NHS
NHS Trust

Agenda Item: Trust Board Paper R

Trust Board – 7th May 2015

On-going Funding for Meaningful Activities Services

DIRECTOR:	Carole Ribbins, Acting Chief Nurse
AUTHOR:	Heather Leatham, Assistant Chief Nurse
DATE:	7 May 2015
PURPOSE:	**Introduction** The Trust currently has a Meaningful Activities Service consisting of three permanently funded posts and seven charitable funds supported posts. This service has been running for two years and is highly successful with the benefits for patients and staff being celebrated internally and externally to the Trust. The role's effectiveness significantly contributes in supporting teams in: reduction of falls, increasing flow of discharge, prompting dementia screening, improving wellbeing and reduction of challenging behaviour, increasing nutritional intake and hydration, improving carer/family involvement in completing Patient Profiles, improving safeguarding and unsafe wandering, detecting pain, prevention of pressure ulcers, reduction in the use of anti-psychotic medication. Over the last twelve months the Meaningful Activity Service have supported 730 patients (and their carers where relevant) through activity. **On- Going Funding** In August 2015 the charitable funding that supports seven of these posts finishes and therefore on–going funding is required. The service will require funding for 12 months to allow retention of trained staff: Posts: 12 months 6 x Midpoint band 3 with on costs: £127,596 1 x Midpoint band 6 with on costs: £36,151 TOTAL: £163,747 **The Charitable Funds Committee / Trust Board are asked to**: • Receive and note this report • Support the above proposal for the on-going funding of the Meaningful Activities Service.
PREVIOUSLY CONSIDERED BY:	Executive Workforce Board
Objective(s) to which issue relates *	[x] 1. Safe, high quality, patient-centred healthcare [ ] 2. An effective, joined up emergency care system [ ] 3. Responsive services which people choose to use (secondary, specialised and tertiary care) [ ] 4. Integrated care in partnership with others (secondary, specialised and tertiary care) [ ] 5. Enhanced reputation in research, innovation and clinical education

	[x] 6. Delivering services through a caring, professional, passionate and valued workforce [ ] 7. A clinically and financially sustainable NHS Foundation Trust [ ] 8. Enabled by excellent IM&T
Please explain any Patient and Public Involvement actions taken or to be taken in relation to this matter:	The Meaningful Activities Service has been evaluated by carers and the public with exceptionally positive feedback provided.
Please explain the results of any Equality Impact assessment undertaken in relation to this matter:	This proposal did not require an equality impact assessment
OrganisationalRisk Register/Board Assurance Framework *	[ ] **Organisational Risk Register** [ ] **Board Assurance Framework** [X] **Not Featured**
ACTION REQUIRED *	For decision [X] For assurance [ ] For information [ ]

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

***** tick applicable box

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

Report To: Charitable Funds Committee / Trust Board

Report From: Carole Ribbins, Acting Chief Nurse

Report By: Lara Wealthall, Dementia Sister
Heather Leatham, Assistant Chief Nurse

Date: 7 May 2015

Subject: On-going Funding for Meaningful Activities Services

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1. INTRODUCTION

Approximately one in four older people in acute hospitals suffer from dementia. People with dementia are vulnerable to illness, accidents and falls, all of which extend their stay in hospital. Meaningful activity improves the wellbeing of people with dementia and promote a closer working relationship with carers.

The Trust currently has a Meaningful Activities Service consisting of three permanently funded posts and seven charitable funds supported posts. This service has been running for two years and is highly successful with the benefits for patients and staff being celebrated internally and externally to the Trust.

The currently seven Charitable Funded posts will cease in August 2015. Through the Trust's financial prioritisation process a paper to continue this service was submitted and not financially supported. Therefore the service seeks financial support from the Charitable Funds Committee for the next year.

2. CURRENT POSITION

Meaningful Activities have been identified as a way to improve the experience and wellbeing of people with dementia and their carers. In the last twelve months, Meaningful Activity Facilitators have been appointed and will cover ten wards across two sites including an on-call service for challenging situations within the wards.

3. IMPACT OF THESE ROLES

Nationally it is clearly acknowledged that the introduction of Meaningful Activities for patients suffering from dementia can have a marked positive effect.

The role's effectiveness significantly contributes in supporting teams in:

- Reduction of falls
- Increasing flow of discharge
- Prompting dementia screening
- Improving wellbeing and reduction of challenging behaviour
- Increasing nutritional intake and hydration
- Improving carer/family involvement in completing Patient Profiles
- Improving safeguarding and unsafe wandering

- Detecting pain
- Prevention of pressure ulcers
- Reduction in the use of anti-psychotic medication.

This role is an enormous support for medical, multi-disciplinary and nursing teams. Local patient and carer feedback has been overwhelmingly positive.

4. OUTCOME MEASURES

4.1 ACTIVITY

Over a twelve month period, the Meaningful Activity Service have supported 730 patients (and their carers where relevant) through activity.

Figure 1 – Summary of activities undertaken

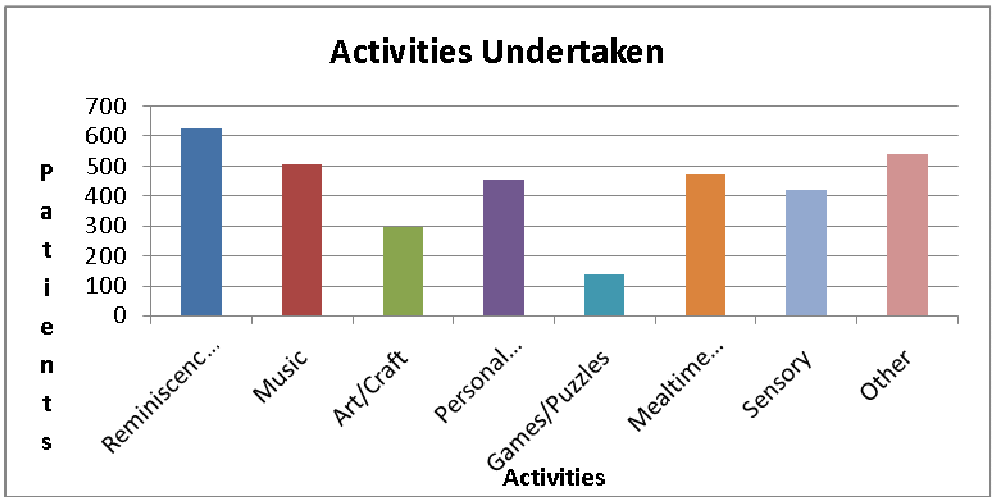
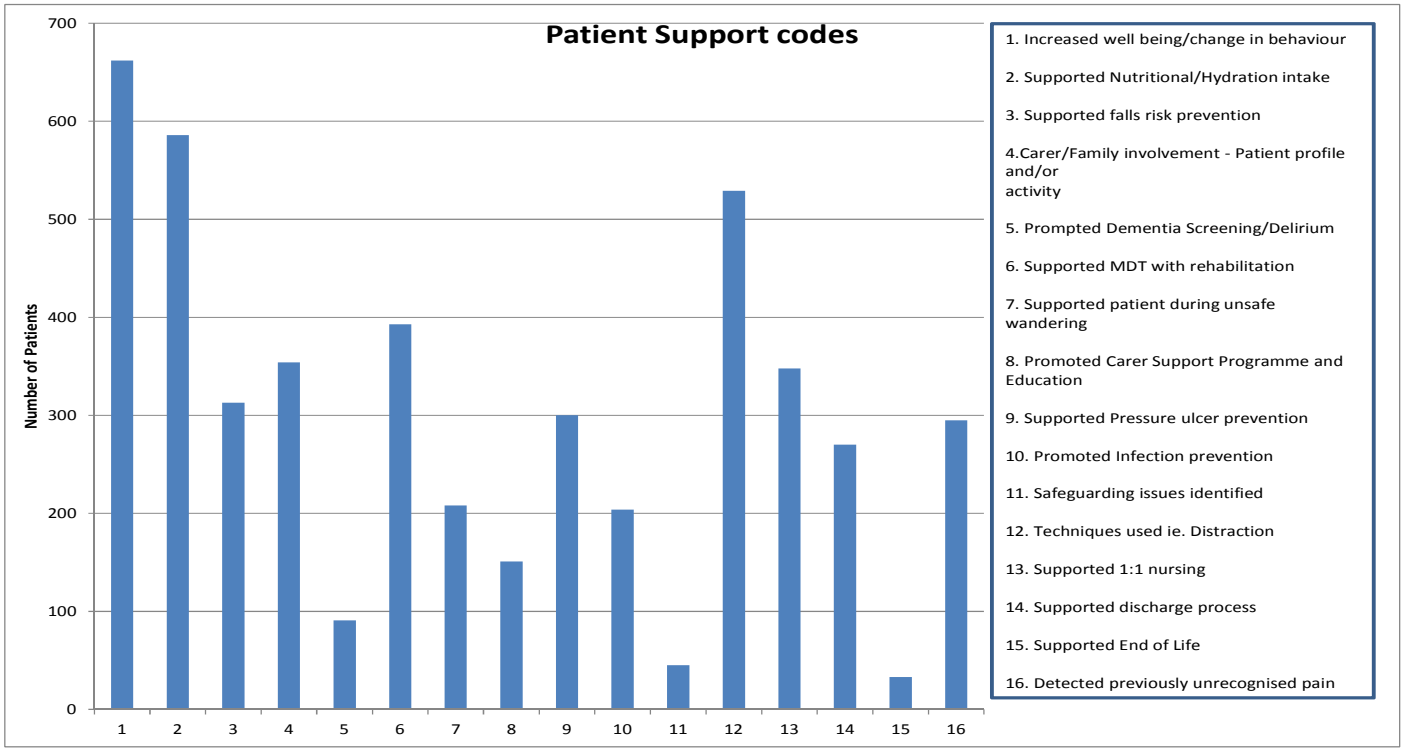


Figure 2 - Impact of Meaningful Activity Role



4.2 KEY OUTCOMES

- Over 80% of patients were either assisted or prompted with their nutritional intake during or as part of an activity.

- For 662 patients, a positive change in wellbeing and behaviour was noted after being involved with meaningful activity.

- 354 carers were actively involved with activities.

- For 529 patients, techniques such as distraction, mirroring and orientation through visual prompts were used to achieve change in behaviour and reduction in agitation and aggression.

- Support was provided to 58 patients with other complex behaviour such as learning disabilities, depression and neurological, cognitive impaired conditions.

- 295patients were made more comfortable through the detection of pain.

- 43% of all patients referred to the Meaningful Activity Service were identified as high risk of falls.

4.3 CARER AND PATIENT FEEDBACK

Improving carer involvement is evident in particular with completion of the patient profile. Locally, a Meaningful Activity Survey has been given to carers and family members to review the service. A total of 130 responded to the questionnaire, of which:

- 96% thought that their family member's experience in hospital had been improved by the Meaningful Activities Service.
- 96% thought that appropriate activities were provided.
- 82% were 'extremely likely' and the other 18% 'likely' to recommend the Meaningful Activities Service to others.

Common themes from free text comments from carer feedback highlighted; they have seen a 'significant improvement' in the patient's well-being; that patients are 'feeling the benefits of having a Meaningful Activity Facilitator involved in the patients care.

In addition, staff have also reported the Meaningful Activity Service is having a positive effect on other patients on wards, who do not have dementia. This is due to Facilitators focusing on activities which distract people with dementia who are challenging towards other patients on their wards.

4.4 COST EFFECTIVENESS

Qualitative data is suggesting the service is reducing costs (both human and financial) associated with malnutrition, dehydration, falls and fractures, delirium, 'patient vulnerability' (i.e. reduced incidences of wandering) and decreasing length of stay in hospital.

5. PROPOSAL

Secure permanent funding for the seven posts as outlined below to allow the continued provision of Meaningful Activities Facilities to cover ten wards including designated older peoples wards within UHL. The team also support the application of Meaningful Activities in

other relevant areas such as the Discharge Lounge, Emergency Department and admission facilities. The team are also fostering 'Forget Me Not' volunteers to allow the service to reach more patients and host 'Forget Me Not' afternoon events across the Trust.

5.1 FINANCIAL SUPPORT REQUIRED

The service will require funding for 1**2 months to allow on-going retention of trained staff:**

Posts	12 months
6 x Midpoint band 3 with on costs	£127,596
1 x Midpoint band 6 with on costs	£36,151
TOTAL	£163,747

6. RECOMMENDATIONS

The Charitable Funds Committee / Trust Board are asked to:

- Receive and note this report.
- Support the above proposal for the on-going funding of the Meaningful Activities Service.

Trust Board Paper S

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

Trust Board Bulletin – 7 May 2015

The following reports are attached to this Bulletin as items for noting, and are circulated to UHL Trust Board members and recipients of public Trust Board papers accordingly:-

- **Annual Updated Declarations of Interest** – Lead contact point Mr S Ward, Director of Corporate and Legal Affairs (0116 258 8721) – **paper 1;**

- **NHS Trust Over-Sight Self Certification return for the period ended 28 February (as submitted to the NTDA on 31 March 2015)** – Lead contact point Mr S Ward, Director of Corporate and Legal Affairs (0116 258 8721) – **paper 2**, and

- **Quarterly Sealings Report** – Lead contact point Mr S Ward, Director of Corporate and Legal Affairs (0116 258 8721) – **paper 3.**

It is intended that these papers will not be discussed at the formal Trust Board meeting on 7 May 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.

Annual Update of Trust Board declarations of interest – 2015-16

NAME	POSITION	INTEREST(S) DECLARED
Mr K Singh	Trust Chairman	Trustee – Joseph Rowntree Foundation, Trustee – Joseph Rowntree Housing Trust, Council Member of Justice, family member working in locum position with Lakeside Consortium, Northamptonshire.
Mr R Moore	Non-Executive Director	Director of the following companies: Momentum Advisers Ltd, Momentum 002 Ltd (trading as Soccer City), Momentum 003 Ltd (trading as Lutterworth Soccer Centre), Momentum 004 Ltd, 555 Fussball Projekt GmBH (Germany), SoccerWorld China Ltd (Hong Kong), SoccerWorld Shanghai Ltd (China), Peppercorn Serviced Offices Ltd, EAI 555 Ltd.
Mr M Traynor (updated)	Non-Executive Director	Partner – Traynor Consulting & Training LLP, Non-Executive Chairman – The Forest Experience Ltd, Non-Executive Chairman – King Richard III Visitor Centre Trust Ltd, Non-Executive Director – Leicestershire Promotions Ltd, Trustee – The National Forest Charitable Trust Ltd, Trustee – Leicestershire Rural Community Council Ltd, Trustee – Menphys, Member – HM Govt's Regulatory Policy Committee. ***Resigned as a Trustee/Director of LOROS Ltd on 23 April 2015.***
Dr R Palin	LLR CCG Representative	GP, Partner at Bushloe Surgery, Wigston, Vice Chair, East Leicestershire and Rutland CCG, Clinical Director for Prisons, Leicestershire Partnership NHS Trust.
Ms K Shields	Director of Strategy	None to declare
Mr M Wightman	Director of Marketing and Communications	None to declare

NHS Trust Oversight Self-Certification

In accordance with the Accountability Framework, the Trust is required to complete self certifications in relation to the Foundation Trust application process. A copy of the performance self-certification submitted in March 2015 (February 2015 position) is attached.

Stephen Ward
Director of Corporate and Legal Affairs

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: * 31/03/2015 Reporting Year: * 2014/15

Select the Month *

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

NB: The next report produced will be for **January 2014/15**

Next Page 1 of 16

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

Prev Next Page 3 of 16

16% Complete

NHS TRUST DEVELOPMENT AUTHORITY

tda Trust Development Authority
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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

Prev Next Page 4 of 16

22% Complete

NHS 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

Prev Next Page 5 of 16

28% Complete

NHS TRUST DEVELOPMENT AUTHORITY

Quality. Delivery. Sustainability.

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

Prev Next Page 6 of 16

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

Prev Next Page 7 of 16

40% Complete

NHS TRUST DEVELOPMENT AUTHORITY

Trust Development Authority
Quality. Delivery. Sustainability.

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

Prev Next Page 8 of 16

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

Prev Next Page 9 of 16

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

Prev Next Page 10 of 16

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

Prev Next Page 11 of 16

64% Complete

NHS TRUST DEVELOPMENT AUTHORITY

BOARD STATEMENTS:

For GOVERNANCE, that

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

10. GOVERNANCE
Indicate compliance. *

Risk

Timescale for compliance: *

31/07/2015

RESPONSE:

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

The 26 March 2015 UHL NHS Trust Integrated Finance, Performance and Investment Committee 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 anticipated compliance dates are shown against relevant indicators:-

S2a MRSA bacteraemias (March 2015); R1 ED 4-hour waits (April 2015); R3 RTT waiting times (admitted) (May 2015); R9 Cancer-2-week wait for symptomatic breast patients (February 2015); R10 Cancer 31-day wait for first treatment (April 2015); R12 Cancer 31-day wait for second or subsequent treatment: surgery (February 2015); R13 Cancer 31-day wait for second or subsequent treatment: radiotherapy (February 2015); R14 Cancer 62-day wait for first treatment from GP referral (July 2015); R15 Cancer 62-day wait for first treatment from Consultant referral (July 2015), and R17 Cancelled patients not rebooked within 28 days (April 2015).

NHS TRUST DEVELOPMENT AUTHORITY

Quality. Delivery. Sustainability.

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

Prev Next Page 13 of 16

76% Complete

NHS TRUST DEVELOPMENT AUTHORITY

Quality. Delivery. Sustainability.

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

Prev Next Page 14 of 16

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

Prev Next Page 15 of 16

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

Prev Submit Page 16 of 16

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **7 MAY 2015**

REPORT BY: **DIRECTOR OF CORPORATE AND LEGAL AFFAIRS**

SUBJECT: **SEALING OF DOCUMENTS**

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1. The Trust's Standing Orders (Standing Order 12) set out the approved arrangements for custody of the Trust's seal and the sealing of documents.

2. Appended to this report is a table setting out details of the Trust sealings for the 2014-15 financial year to date (by quarter).

3. The Trust Board is invited to receive and note this information.

4. Reports on Trust sealings will continue to be submitted to the Trust Board on a quarterly basis.

Stephen Ward
Director of Corporate and Legal Affairs

List of Trust Sealings for Quarter 4, 2014/15

Date of Sealing	Nature of Document	Date of Authority and Minute Reference	Sealed by	Remarks
26/01/15	Deed of Variation of Contract between (1) UHL and (2) Asteral (Leicester 2) Limited and (3) Asteral Holdings Limited, dated 30 October 2014.	Trust Board – 24/04/15 Minute 105/14	Chairman/ Assistant Director – Head of Legal Services	Originals handed to Helen Seth. 26.1.15.
26/01/15	Funders Direct Agreement between (1) UHL, (2) Asteral (Leicester 2) Limited, (3) Asteral Limited (as ~Agent) (4) Asteral Limited (as Security Trustee, dated 14 October 2014.	Trust Board – 22/12/14 Minute 331/14	Chairman/ Assistant Director – Head of Legal Services	Originals handed to Helen Seth. 26.1.15.
26/01/15	Guarantor Deed of Novation between (1) UHL, (2) Asteral (Leicester 2) Limited, (3) Asteral Holdings (COOP MES) Limited (4) Brook Henderson Group Limited (5) Asteral Limited (as Security Trusts) (6) Asteral Holidings Limited (as Successor Gurantor).	Trust Board – 22/12/14 Minute 331/14	Chairman/ Assistant Director – Head of Legal Services	Originals handed to Helen Seth. 26.1.15.
26/01/15	Deed of Undertaking between (1) Asteral Limited (2) Asteral (Leicester 2) Limited (3) UHL dated 14 October 2014.	Trust Board – 22/12/14 Minute 331/14	Chairman/ Assistant Director – Head of Legal Services	Originals handed to Helen Seth. 26.1.15.
23/02/15	Deed of Surrender between (1) UHL and (2) Lloyds Pharmacy Limited relating to Rooms at LRI	Trust Board – 27/03/14 Minute 77/14	Chairman/ Assistant Director – Head of Legal Services	Originals handed to A.Middleton 23.2.15.
23/02/15	Lease of Property at LRI between (1) UHL and (2) Lloyds Pharmacy Limited.	Trust Board – 27/03/14 Minute 77/14	Chairman/ Assistant Director – Head of Legal Services	Originals handed to A.Middleton 23.2.15.