UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

TRUST BOARD

MEETING TO BE HELD ON THURSDAY 27 FEBRUARY 2014 FROM 9.30AM IN THE C J BOND ROOM, CLINICAL EDUCATION CENTRE, LEICESTER ROYAL INFIRMARY

Public meeting commences at 12.30pm

AGENDA

Please take papers as read

Item no.	Item	Paper ref:	Lead	Discussion time
1.	**EXCLUSION OF THE PRESS AND PUBLIC** It is recommended that, pursuant to the Public Bodies (Admission to Meetings) Act 1960, the press and members of the public be excluded from the following items of business, having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest (items 1-16).			-
2.	**APOLOGIES AND WELCOME** To receive apologies for absence from Professor D Wynford-Thomas, Non-Executive Director, Mr A Seddon, Director of Finance and Business Services and Mrs K Shields, Director of Strategy. Mrs H Seth, Head of Planning and Business Development will attend in the absence of the Director of Strategy.	**-**	**Acting Chairman**	9.30 – 9.32am
3.	**DECLARATIONS OF INTERESTS** Members of the Trust Board and other persons attending are asked to declare any interests they may have in the business on the agenda (Standing Order 7 refers). Unless the Trust Board agrees otherwise in the case of a non-prejudicial interest, the person concerned shall withdraw from the meeting room and play no part in the relevant discussion or decision.			-
4.	**ACTING CHAIRMAN'S AND CHIEF EXECUTIVE'S OPENING COMMENTS**	**-**	**Acting Chairman and Chief Executive**	9.32 – 9.40am
5.	**CONFIDENTIAL MINUTES** Confidential Minutes of the 30 January 2014 Trust Board meeting. *For approval*	**A**	**Acting Chairman**	9.40 – 9.42am
6.	**MATTERS ARISING** Confidential action log from the 30 January 2014 Trust Board. *For approval*	**B (to follow)**	**Acting Chairman**	9.42 – 9.50am
7.	**REPORT BY THE CHIEF EXECUTIVE** *Commercial interests and prejudicial to the conduct of public affairs*	**C**	**Chief Executive**	9.50 – 10.15am
8.	**REPORTS BY THE MEDICAL DIRECTOR** *Personal information and prejudicial to the conduct of public affairs*	**verbal**	**Medical Director**	10.15 – 10.35am
9.	**REPORTS BY THE DIRECTOR OF HUMAN RESOURCES** *Personal information, commercial interests, and prejudicial*	**D & D1**	**Director of Human Resources**	10.35 – 10.45am

	to the conduct of public affairs			
10.	**REPORTS BY THE DIRECTOR OF STRATEGY** *Commercial interests*	**E**	**Head of Planning and Business Development**	10.45 – 10.55am
11.	**REPORT BY THE CHIEF EXECUTIVE** *Prejudicial to the conduct of public affairs*	**F** **(to follow)**	**Chief Executive**	10.55 – 11.25am
12.	**REPORT BY THE CHIEF NURSE** *Personal information*	**G**	**Chief Nurse**	11.25 – 11.45am
13.	**REPORT BY THE DIRECTOR OF CORPORATE AND LEGAL AFFAIRS** *Personal information and prejudicial to the conduct of public affairs*	**verbal report**	**Director of Corporate and Legal Affairs**	11.45 – 11.50am
14.	**REPORTS FROM BOARD COMMITTEES**			11.50 – 11.55am
14.1	**QUALITY ASSURANCE COMMITTEE** Confidential Minutes of the 29 January 2014 meeting for noting. *Prejudicial to the conduct of public affairs*	**H**	**Quality Assurance Committee Chair**	
14.2	**REMUNERATION COMMITTEE** Confidential Minutes of the 30 January 2014 meeting for noting. *Personal information and prejudicial to the conduct of public affairs*	**I**	**Acting Chairman**	
15.	**PRIVATE TRUST BOARD BULLETIN FEBRUARY 2014** *No items for noting.*	**-**		-
16.	**CORPORATE TRUSTEE BUSINESS**	**-**		11.55 – 11.56am
16.1	**CHARITABLE FUNDS COMMITTEE** Confidential Minutes of the 3 February 2014 Charitable Funds Committee meeting for noting and endorsement of recommendations. P*rejudicial to the conduct of public affairs*	**additional paper 1**	**Charitable Funds Committee Chair**	
17.	**ANY OTHER BUSINESS**	**-**	**Acting Chairman**	11.56 – 12noon
Lunch break from 12noon to 12.30pm prior to commencing the public section of the meeting				
18.	**DECLARATION OF INTERESTS**	**-**	**Acting Chairman**	-
	Members of the Trust Board and other persons attending are asked to declare any interests they may have in the business on the public agenda (Standing Order 7 refers). Unless the Trust Board agrees otherwise in the case of a non-prejudicial interest, the person concerned shall withdraw from the meeting room and play no part in the relevant discussion or decision.			
19.	**ACTING CHAIRMAN'S AND CHIEF EXECUTIVE'S OPENING COMMENTS**	**-**	**Acting Chairman/ Chief Executive**	12.30 – 12.35pm
20.	**MINUTES**			
	Minutes of the 30 January 2014 Trust Board meeting. *For approval*	**J**	**Acting Chairman**	12.35 – 12.37pm
21.	**MATTERS ARISING**			

	Action log from the 30 January 2014 meeting. *For approval*	**K** **(to follow)**	**Acting Chairman**	12.37 – 12.45pm
22.	**REPORTS BY THE CHIEF EXECUTIVE**			
22.1	**MONTHLY UPDATE REPORT – FEBRUARY 2014** *For discussion and assurance*	**L**	**Chief Executive**	12.45 – 12.55pm
22.2	**IM&T DATA CENTRE** *For discussion and assurance*	**M**	**Chief Executive**	12.55 – 1.10pm
22.3	**ELECTRONIC DOCUMENTS RECORDS MANAGEMENT UPDATE** *For discussion and assurance*	**N**	**Chief Executive**	1.10 – 1.20pm
23.	**CLINICAL QUALITY AND SAFETY**			
23.1	**PATIENT EXPERIENCE** *For discussion and assurance*	**O**	**Chief Nurse**	1.20 – 1.45pm
24.	**QUALITY AND PERFORMANCE** *For assurance*			
24.1	**MONTH 10 QUALITY, FINANCE AND PERFORMANCE REPORT** *For assurance* ***Consideration of this item will be structured as follows:-*** **Quality** (a) The **Non-Executive Director Chair** of the **Quality Assurance Committee** will be invited to comment verbally on the month 10 position, as considered at the meeting held on 26 February 2014 (the Minutes of which will be presented to the 27 March 2014 Trust Board); (b) **Lead Executive Directors** will then be invited to comment on their respective sections of the month 10 report, specifically:- • **Chief Nurse** – patient safety and quality, quality commitment, patient experience. A never event is reported at paper P1; • **Medical Director** – mortality rates; **Finance and Performance** (c) **Acting Chair** to comment verbally on the month 10 position, as considered at the **Finance and Performance Committee** meeting held on 26 February 2014 (the Minutes of which will be presented to the 27 March 2014 Trust Board). (d) **Lead Executive Directors** will then be invited to comment on their respective sections of the month 10 report, specifically:- • **Chief Operating Officer** – operational performance and exception reports; • **Director of Human Resources** – staff appraisal, sickness absence and statutory and mandatory training compliance;	**P** **P1**	**Quality Assurance Committee Chair** **Chief Nurse** **Medical Director** **Acting Chair** **Chief Operating Officer** **Director of Human Resources**	1.45 – 2.10pm

	• **Chief Executive** – information management and technology performance, and • **Interim Director of Financial Strategy** – month 10 financial position.		**Chief Executive** **Interim Director of Financial Strategy**	
24.2	**REFERRAL TO TREATMENT (RTT) PERFORMANCE** *For discussion and assurance*	**Q** **(to follow)**	**Chief Operating Officer**	2.10 – 2.20pm
24.3	**EMERGENCY CARE PERFORMANCE AND RECOVERY PLAN** *For discussion and assurance*	**R** **(to follow)**	**Chief Operating Officer**	2.20 – 2.35pm
24.4	**FACILITIES MANAGEMENT PERFORMANCE** *For discussion and assurance*	**S** **(to follow)**	**Chief Nurse**	2.35 – 3pm
24.5	**NHS TRUST OVER-SIGHT SELF CERTIFICATION** *For discussion and approval*	**T**	**Director of Corporate and Legal Affairs**	3 – 3.05pm
25.	**STRATEGY AND FORWARD PLANNING**			
25.1	**UPDATE ON DRAFT OPERATIONAL PLANS 2014-15 AND 2015-16** *For discussion and ratification*	**U**	**Head of Planning and Business Development**	3.05 – 3.20pm
25.2	**FUTURE APPROACH TO IMPROVEMENT, TRANSFORMATION AND FINANCIAL RECOVERY**	**V** **(to follow)**	**Chief Executive**	3.20 - 3.45pm
26.	**HUMAN RESOURCES**			
26.1	**STAFF ATTITUDE AND OPINION SURVEY** *For discussion. Please note that the national Staff Attitude Survey report is embargoed until 25 February 2014 and will therefore be published after that date*	**W** **(to follow)**	**Director of Human Resources**	3.45 – 4pm
27.	**RISK**			
27.1	**BOARD ASSURANCE FRAMEWORK – UPDATE** *For discussion and assurance*	**X**	**Chief Nurse**	4 – 4.10pm
28.	**REPORTS FROM BOARD COMMITTEES**			4.10- 4.13pm
28.1	**FINANCE AND PERFORMANCE COMMITTEE** Minutes of the 29 January 2014 meeting for noting and endorsement of any recommendations.	**Y**	**Acting Chairman**	
28.2	**QUALITY ASSURANCE COMMITTEE** Minutes of the 29 January 2014 meeting for noting and endorsement of any recommendations.	**Z**	**Quality Assurance Committee Chair**	-
29.	**CORPORATE TRUSTEE BUSINESS**			4.13 – 4.15pm
29.1	**CHARITABLE FUNDS COMMITTEE** Minutes of the 3 February 2014 meeting for noting and endorsement of any recommendations. For approval.	**AA**	**Interim Director of Financial Strategy /Charitable Funds Committee Chairman**	
30.	**TRUST BOARD BULLETIN – FEBRUARY 2014** No items received		**-**	-
31	**QUESTIONS FROM THE PUBLIC RELATING TO BUSINESS TRANSACTED AT THIS MEETING**	**-**	**Acting Chairman**	4.15 – 4.35pm

32.	**ANY OTHER BUSINESS**	**-**	**Acting Chairman**	4.35 - – 4.40pm
33.	**DATE OF NEXT MEETING**			
	The next Trust Board meeting will be held on **Thursday 27 March 2014** from **9.30am** at **Voluntary Action LeicesterShire, 9 Newarke Street, Leicester, LE1 5S**	**-**		

Helen Stokes
Senior Trust Administrator

J

Paper J

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF A MEETING OF THE TRUST BOARD, HELD ON THURSDAY 30 JANUARY 2014 AT 9.30AM IN SEMINAR ROOMS 2 AND 3, CLINICAL EDUCATION CENTRE, GLENFIELD HOSPITAL

Present:
Mr R Kilner – Acting Trust Chairman
Mr J Adler – Chief Executive
Colonel (Retired) I Crowe – Non-Executive Director
Dr S Dauncey – Non-Executive Director
Dr K Harris – Medical Director
Ms K Jenkins – Non-Executive Director
Mr R Mitchell – Chief Operating Officer
Ms R Overfield – Chief Nurse
Mr P Panchal – Non-Executive Director
Professor D Wynford-Thomas – Non-Executive Director

In attendance:
Dr T Bentley – Leicester City CCG (from Minute 17/14)
Ms K Bradley – Director of Human Resources
Professor N Brunskill – Director of Research and Development (for Minute 28/14/1)
Professor S Carr – Associate Medical Director, Clinical Education (for Minute 27/14/1)
Mr A Chatten – Managing Director, NHS Horizons (for Minute 8/14/1)
Mr E Charlesworth – Healthwatch Representative (from Minute 17/14)
Mr P Cleaver – Risk and Assurance Manager (for part of Minute 26/14/1)
Ms L Douglas-Pannett – Specialty Registrar in Public Health (for part of Minute 7/14/1)
Miss M Durbridge – Director of Safety and Risk (for Minute 8/14/2)
Mr P Hollinshead – Interim Director of Financial Strategy
Dr R Hsu – Senior Teaching Fellow in Epidemiology and Public Health (for part of Minute 7/14/1)
Ms H Leatham – Head of Nursing (for Minute 22/14/1)
Mrs K Rayns – Trust Administrator
Ms H Seth – Head of Planning and Business Development (for Minutes 9/14/1 and 9/14/2)
Ms K Shields – Director of Strategy (from part of Minute 10/14/2)
Ms L Stevens – Clinical Nurse Specialist (for Minute 22/14/1)
Mr S Ward – Director of Corporate and Legal Affairs
Mr M Wightman – Director of Marketing and Communications

ACTION

1/14 EXCLUSION OF THE PRESS AND PUBLIC

Resolved – that, pursuant to the Public Bodies (Admission to Meetings) Act 1960, the press and members of the public be excluded during consideration of the following items of business (Minutes 1/14 – 16/14), having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.

2/14 APOLOGIES AND WELCOME

Apologies for absence were received from Mr A Seddon, Director of Finance and Business Services, Ms J Wilson, Non-Executive Director and Professor D Wynford-Thomas, Non-Executive Director. The Chairman welcomed Dr S Dauncey, Non-Executive Director and Mr P Hollinshead, Interim Director of Financial Strategy to the meeting.

3/14 DECLARATIONS OF INTERESTS IN THE CONFIDENTIAL BUSINESS

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

4/14 ACTING CHAIRMAN'S AND CHIEF EXECUTIVE'S OPENING COMMENTS

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

5/14 CONFIDENTIAL MINUTES

Resolved – that (A) the confidential Minutes of the Trust Board meetings held on 13 and 20 December 2013 be confirmed as correct records, and

(B) the notes of the 16 January 2014 Trust Board Development Session be submitted to the 27 February 2014 Trust Board meeting for approval. **DCLA/ TA**

6/14 CONFIDENTIAL MATTERS ARISING REPORT

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

7/14 REPORTS BY THE MEDICAL DIRECTOR

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

8/14 REPORTS BY THE CHIEF NURSE

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

9/14 REPORTS BY THE DIRECTOR OF STRATEGY

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

10/14 REPORTS BY THE INTERIM DIRECTOR OF FINANCIAL STRATEGY

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

11/14 REPORTS BY THE DIRECTOR OF HUMAN RESOURCES

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

12/14 REPORT BY THE ACTING CHAIRMAN AND THE DIRECTOR OF CORPORATE AND LEGAL AFFAIRS

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

13/14 REPORT BY THE DIRECTOR OF CORPORATE AND LEGAL AFFAIRS

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

14/14 REPORTS FROM BOARD COMMITTEES

14/14/1 Finance and Performance Committee

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

14/14/2 Quality Assurance Committee

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

14/14/3 Remuneration Committee

Resolved – that (A) the confidential Minutes of the Remuneration Committee meeting held on 10 January 2014 (paper K refers) be received and noted, and

(B) the Minutes of the meeting held on 30 January 2014 be presented to the 27 February 2014 Trust Board meeting. **DCLA**

15/14 PRIVATE TRUST BOARD BULLETIN – JANUARY 2014

Resolved – that the Trust Board Bulletin report containing details of a life study in Leicester (paper L) be received for information.

16/14 MEETING EVALUATION

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

17/14 DECLARATIONS OF INTERESTS IN THE PUBLIC BUSINESS

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

18/14 ACTING CHAIRMAN'S OPENING COMMENTS

The Acting Chairman welcomed the attendance of Mr P Hollinshead, Interim Director of Financial Strategy at this meeting, in the absence of the Director of Finance and Business Services who was taking a period of special leave. He announced the resignation of Mr I Sadd, Non-Executive Director who had taken up a full time Director of Finance role and he welcomed Dr S Dauncey who had stepped down from her position as UHL Non-Executive Director in June 2013 for family reasons and had kindly agreed to re-join the Trust as an Interim Non-Executive Director for a period of 6 months. The Trust Board supported the **DCLA**

appointment of Ms Dauncey, Non-Executive Director to the Quality Assurance Committee and Colonel (Retired) I Crowe, Non-Executive Director to the Audit Committee with immediate effect.

The Acting Chairman drew members' attention to the positive informal feedback at the conclusion of the CQC inspection and congratulated the relevant UHL teams and partner agencies on improvements in Emergency Department 4 hour performance as a result of 2 "Super Weekends" held earlier that month.

Resolved – that (A) the verbal information provided by the Acting Chairman be received and noted, and

(B) the appointment of Dr S Dauncey, Non-Executive Director to the membership of the Quality Assurance Committee and Colonel (Retired) I Crowe, Non-Executive Director to the membership of the Audit Committee, be approved. **DCLA**

19/14 MINUTES

Paper M provided the Minutes of the Trust Board meeting held on 20 December 2013 and members commented in respect of the following Minutes:-

- 340/13/2 – Colonel (Retired) I Crowe, Non-Executive Director referred to the discussion on UHL's Reward and Recognition Strategy and requested that this Minute be revised to include an action for the Director of Human Resources to develop a formalised process (possibly through the Remuneration Committee) to ensure that the Trust submitted 2 or 3 nominations for national honours each year; **DHR**
- 341/13/1 – the Director of Finance and Business Services had reported on comments received to the effect that UHL's cost control could have been better. Board members noted that he had also made these comments himself in local radio and television interviews, and
- 341/13/1 – Dr T Bentley, CCG Representative expressed disappointment that this Minute had been truncated and his comments relating to tariff arrangements had been omitted. The Trust Administrator was requested to refer back to her notes and provide some additional wording for inclusion in the Minutes (to be agreed by the Chairman). **TA/ CHAIR MAN**

Resolved – that, subject to the amendments noted above to Minutes 340/13/2 and 341/13/1, the Minutes of the Trust Board meeting held on 20 December 2013 (paper M) be confirmed as a correct record. **TA/ CHAIR MAN**

20/14 MATTERS ARISING FROM THE MINUTES

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

(a) item 9 – Minute 303/13/2 of 28 November 2013 – the Chief Executive reported verbally on the approvals process for UHL's new Emergency Floor and the associated enabling works, noting that the Trust Development Authority (TDA) had approved the Strategic Outline Case. The Outline Business Case had been considered by the TDA and no fundamental issues had been raised. UHL would be responding to a number of queries raised by the TDA in the next few days, but they had confirmed that the first stage of the enabling works relating to the provision of a modular ward block could proceed. The Chief Executive had written to the TDA seeking agreement to proceed with 6 or 7 other enabling schemes to be funded from UHL's Capital Programme and these were due to be considered by the TDA's Capital Committee. In the meantime, discussions were planned between the Interim Director of Financial Strategy and the TDA regarding access to national capital funding for the Emergency Floor and further consultation and

engagement with health economy partners was planned as part of the Full Business Case submission;

(b) item 10 – Minute 304/13/1 of 28 November 2013 – the Chief Nurse confirmed that the patient information packs relating to community based rehabilitation facilities were now available on the relevant wards;

(c) item 11 – Minute 308/13/1 of 28 November 2013 – the Executive Team would be reviewing progress with the Trust's emergency preparedness, resilience and response arrangements on 18 February 2014;

(d) item 12 – Minute 308/13/2 of 28 November 2013 – the Director of Marketing and Communications advised that further analysis of the reputation audit results had been delayed as a result of additional work for the CQC inspection. He confirmed that the analysis to differentiate between feedback provided by healthcare professionals and the wider stakeholder group would be shared with Board members once it was available;

(e) item 13 – Minute 309/13/1 of 28 November 2013 – an update on progress against outstanding Internal Audit recommendations was due to be presented to the February 2014 meeting of the Audit Committee;

(f) item 14 – Minute 311/13(1) of 28 November 2013 – the Director of Strategy reported that there had been no evidence of any impact of large scale immigration from Romania and Bulgaria since the border controls with these countries had changed on 1 January 2014. It was agreed that this item would be removed from the progress log;

(g) item 15 – Minute 311/13(2) of 28 November 2013 – the Director of Corporate and Legal Affairs advised that additional concerns had been raised by Mr M Woods on 17 December 2013 (and these had been circulated to all Board members as requested), but the Trust was awaiting feedback from a meeting between Mr Woods and the family involved, to determine whether the family wanted to raise their concerns on a formal basis. An update on this issue would be provided to the 27 February 2014 meeting;

(h) item 16 – Minute 227/13/1 of 31 October 2013 – the Chief Nurse had communicated with the National Lead for Dementia Care regarding UHL's meaningful activities programme for dementia patients and a related staff awards nomination had been made;

(i) item 17 – Minute 227/13/5 of 31 October 2013 – the Director of Human Resources advised that (subject to some minor amendments to the terms of reference and membership) the first meeting of the Executive Workforce Board would be held in April 2014, and

(j) item 18 – Minute 252/13/1 of 26 September 2013 – the Chief Nurse advised that the ongoing monitoring arrangements for risk 4 on the Board Assurance Framework would be agreed at the February 2014 Audit Committee meeting and it was agreed to remove this item from the Trust Board progress log.

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

21/14 REPORTS BY THE CHIEF EXECUTIVE

21/14/1 Monthly Update Report – January 2014

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

(a) significant concerns regarding the Trust's financial deficit and arrangements in place to ensure that the Clinical Management Groups delivered their forecast year-end plans, without exceeding any deficit trajectories;

(b) improvements in emergency care performance had exceeded expectations arising from the "Super Weekends" and the 4 hour performance continued to progress in a positive direction;

(c) an exception report on Referral Time to Treatment (RTT) featured later in the agenda

and this had been reviewed by the Finance and Performance Committee. Funding had been agreed through collaborative discussions with Commissioners for additional capacity to be provided in the 2014-15 financial year to provide additional capacity which would reduce the backlogs;

(d) formal feedback from the CQC was expected to confirm that the Trust had a range of issues requiring resolution, however evidence had been presented to demonstrate that the Trust was committed to tackling these and that good relationships were being maintained throughout the process. No immediate rectifications were required and no warning notices had been issued. A draft report would be provided to the Trust for checking factual accuracy by 25 February 2014 and then a Quality Summit would be held on 26 March 2014 prior to publication of the final report and an action plan at the end of March 2014. The CQC inspection team had congratulated the Trust on the quality of the logistical planning for the visit and the timely response to requests for additional information, and

(e) feedback from the launch event for the LLR 5 Year Health and Social Care Strategy held on 29 January 2014: the event had been well attended and had been met with an apparent lack of scepticism. The next key stage would be for each health economy partner organisation to sign up to the goals and enabling strategies and a series of workshops were being arranged to support the 5 main workstreams. He noted the crucial importance of delivering high impact outputs as opposed to niche areas. Regular progress reports would be provided to the Trust Board.

Resolved – that the Chief Executive's monthly update report for January 2014 be received and noted.

21/14/2 Children's Services Board Level Leadership

In accordance with good practice, the Chief Executive introduced paper P, confirming the appointment of the Director of Strategy as the Board level lead for Children's Services. He also advised that the Director of Strategy would be chairing the new Children's Board which was due to hold its inaugural meeting soon.

Resolved – that the appointment of the Director of Strategy as Trust Board lead for Children's Services be approved. **DS**

22/14 CLINICAL QUALITY AND SAFETY

22/14/1 Patient Experience – Acupuncture Service

The Chief Nurse introduced Ms H Leatham, Head of Nursing and Ms L Stevens, Clinical Nurse Specialist who had attended the meeting to present paper Q, providing the Board with a flavour of patient experience feedback relating to the acupuncture treatment service provided at UHL. A short video was shown, providing highlights from interviews with 4 service users, who all spoke positively about the benefits of the treatment. In discussion following the video, Board members:-

(a) noted that between 60% and 70% of patients felt some benefits from the treatment and that these benefits included pain relief, improved sleep, reductions in analgesia, reduced symptoms of depression, avoidance of surgery, and improved mobility. The only negative comments received had related to the length of waiting lists (up to 5 months) and unavailability of more frequent treatments;

(b) queried whether the service needed to be based in an Acute Care hospital setting and noted in response that this service could equally be delivered from a community hospital, GP surgery or within patients' own homes;

(c) noted that the Trust did not provide an acupressure service, as research had demonstrated that this treatment was not as beneficial as acupuncture;

(d) noted that approximately 800 of the Trust's younger (or more agile) patients had

received training in order to carry out their own self-treatment;

(e) commended the performance of this service which treated 4,500 patients per year and generated annual income of £135,000;

(f) sought and received additional information regarding the clinic model and the length of time for each treatment;

(g) considered the training required to become a qualified acupuncture practitioner and maintain accreditation status, and what the training requirements for Ms L Stevens to become an accredited trainer;

(h) requested the Director of Strategy to review the scope for further service development in liaison with Commissioners. **DoS**

Resolved – that (A) the video and discussion on patient experience within the Acupuncture Service be received and noted, and

(B) Ms L Stevens, Clinical Nurse Specialist be requested to contact the governing body to ascertain the training needs and qualifications required in order to undertake an acupuncture training role, and **CN/CNS**

(C) the Director of Strategy be requested to liaise with Commissioners to explore the scope for further service development. **DoS**

22/14/2 Supporting Carers of People with Dementia

The Chief Nurse introduced paper R, briefing the Trust Board on the results of the dementia carers surveys conducted through monthly rotational audits and re-audits within each of the CMGs. The report had previously been considered by the Executive Quality Board and members noted the ongoing achievement of National CQUIN compliance. The report also highlighted key themes identified to further improve the support offered to carers through strengthening communications, dissemination of information and greater involvement of carers and families in the discharge planning process.

The Healthwatch representative noted that there were significant patient and public involvement implications associated with this workstream, despite these not being indicated on the cover sheet. Ms K Jenkins, Non-Executive Director recorded her support for this workstream and queried the arrangements for working with the wider health economy in view of the multiple agencies that had contact with this patient group. The Chief Nurse advised that such arrangements had been implemented under the dementia strategy and other frail elderly work strands. Dr T Bentley, CCG representative agreed to arrange for joint working in respect of dementia care to be highlighted within the appropriate LLR 5 Year Strategy workstream. **TB, CCG**

Responding to a wider query raised by Mr P Panchal, Non-Executive Director, on the subject of UHL's relationships with carers of patients, the Chief Nurse advised that a Carers' Strategy was under development and that this would be presented to the Executive Quality Board for consideration in April 2014. The Acting Chairman noted the scope to raise Board-level awareness of dementia care issues through the Trust Board development programme. **CN** **DCLA**

Resolved – that (A) the progress report on supporting carers of patients with dementia (paper R) be received and noted;

(B) the CCG Representative be requested to arrange for dementia care joint working to be highlighted within the relevant LLR 5 Year Strategy workstream; **TB, CCG**

(C) proposals for a UHL Carers' Strategy be presented to the Executive Quality Board in April 2014, and **CN**

(D) consideration be given to raising awareness of dementia related issues through **DCLA**

the Trust Board development programme.

23/14 HUMAN RESOURCES

23/14/1 Local Clinical Excellence Awards Scheme 2013

The Director of Human Resources introduced paper S, informing the Trust Board of the outcome of the Clinical Excellence Awards (CEA) scheme for 2013 and summarising the spread of awards by Clinical Management Group and the equality and diversity background of applicants. The CEA scheme was considered to be a sub-set of the Trust's reward and recognition workstream and members noted the intention to reward hardworking and committed staff in respect of high quality service delivery, in addition to research, training and management achievements.

Discussion took place regarding reductions in the baseline funding for 2013 and potential changes to the Consultant contract which might impact on future years' schemes. The Chief Executive noted the minimum investment allocation of £266,721 and requested the Director of Human Resources to confirm the actual financial allocation. Board members recognised the engagement work ongoing within the CMGs to encourage all eligible staff (including part time staff) to apply and encourage their peers to self-nominate across all 5 of the domains. **DHR**

Resolved – that (A) the Clinical Excellence Awards for 2013 (paper S) be noted, and

(B) the Director of Human Resources be requested to confirm the final financial allocation for 2013 (outside the meeting). **DHR**

24/14 QUALITY AND PERFORMANCE

24/14/1 Month 9 Quality, Finance and Performance Report

Paper T, the quality and performance report for month 9 (month ending 31 December 2013) advised of red/amber/green (RAG) performance ratings for the Trust, and set out performance exception reports in the accompanying appendices. The Acting Chairman briefed Trust Board members on the following issues, as considered at the 29 January 2014 Quality Assurance Committee meeting:-

- a review of the Quality Commitment which was also due to be considered at the April 2014 Trust Board development session;
- the development of an additional critical safety action surrounding the management of sepsis, and
- improvements in the critical safety action performance relating to acting upon results linked to the process for electronic receipt and acknowledgement of test results and a material improvement in the timeliness of emergency surgery.

The Chief Nurse reported on the Trust's performance in respect of Friends and Family Test results, infection prevention, and pressure ulcer damage. In respect of pressure ulcer prevalence, the CQC intelligent monitoring data had highlighted UHL's data as being above the national average, but when variations in the local population demographics were taken into account, assurance was provided that UHL was not an outlier. However, some scope for additional work to improve rates for patients over 70 had been recognised.

The Medical Director briefed the Board on developments led by the Chief Medical Information Officers (CMIOs) to support the implementation of ICE software across the Trust to improve the timeliness of discharge letters. Section 4.2 of paper T outlined the Trust's mortality data including an update on the expected changes to SHMI data which the Trust was now able to analyse using the Hospital Evaluation Dataset (HED) and which would be reported in detail to the next Mortality Review Committee. The Medical Director confirmed

good progress with VTE assessments, fractured neck of femur performance and advised that no never events had occurred during December 2013.

Dr T Bentley, CCG representative commented upon the Trust's IT systems for requesting and reporting on diagnostic tests and highlighted opportunities to work with the Trust to expand access to Systm1 for UHL clinicians, subject to appropriate consent. The Acting Chairman advised that the Trust Board was expected to consider a number of IM&T related issues at its February 2014 meeting. Dr S Dauncey, Non-Executive Director complimented the Trust on improvements in its quality and operational performance data over the last 6 months, particularly noting the consistent 100% compliance with theatres WHO checklist.

Colonel (Retired) I Crowe, Non-Executive Director queried who was leading the implementation of the data quality diamond and recommended that a clear prioritisation process be identified for the implementation and that all segments of the diamond be RAG-rated. It was noted that Ms S Priestnall, Information Manager was leading this workstream, and the Director of Strategy agreed to liaise with Mr J Roberts, Assistant Director of Information to progress this accordingly. The Medical Director advised that care was needed in the presentation of the diamond to ensure that the information was legible (given the size of the diamond). **DoS**

The Acting Chairman then reported on the following items of business, as considered by the Finance and Performance Committee on 29 January 2014:-

- a presentation by Dr P Rabey, Deputy Medical Director in respect of improving medical productivity through the Consultant job planning process. Significant opportunities had been noted to increase efficiency and effectiveness, which in turn could create additional clinical capacity, and
- the positive progress being made in recruitment to vacant nursing posts and the high calibre of the nurses recruited from overseas.

The Chief Operating Officer referred to the operational performance table provided on page 24 of paper T, and drew members' attention to the following issues :-

(i) recovery plans for RTT performance had been agreed across the specialties of ENT, orthopaedics, ophthalmology and general surgery, but it was expected that full compliance with the 90% and 95% targets for admitted and non-admitted performance (respectively) would not be achieved for a further 7 or 8 months. An exception report was provided at appendix 4, advising of a 52 week breach for an incomplete pathway in ophthalmology. The patient involved had travelled overseas, but the pathway had not been paused and treatment would be offered upon return to the UK;

(ii) the exception report provided at appendix 5 advised of non-compliant diagnostic imaging 6 week wait performance for December 2013 (performance stood at 1.4% against the threshold of 1%);

(iii) cancelled operations performance had been reviewed by the Finance and Performance Committee with further workstreams being identified for the Chief Operating Officer to progress with the ITAPS Clinical Management Group;

(iv) cancer performance for 2 week symptomatic breast patients was non-compliant for November 2013 (reported 1 month in arrears) due to some elements of patient choice. December 2013 performance had been met;

(v) the percentage of stroke patients spending 90% of their stay on a stroke ward in November 2013 (reported 1 month in arrears) stood at 78% against a target of 80%, This was being reviewed in light of the Executive Team's agreement to ring-fence a small number of stroke beds. Confirmation was provided that performance for December 2013 had been met, and

(vi) arrangements for reducing delayed transfers of care continued to be progressed as part of the work to improve discharge processes.

The Chief Executive reported that (in the absence of the Director of Finance and Business Services) he had assumed accountability for the IM&T workstreams and he introduced sections 10.4 and 10.5 of paper T highlighting IM&T operational performance for the month of December 2013. It was agreed that the Chief Executive would liaise with the Chief Information Officer and the Chief Medical Information Officers to review progress against the key transformation schemes, although there were no particular concerns about the progress of any of these. Colonel (Retired) I Crowe, Non-Executive Director observed an ongoing issue with multiple clinical log-ins and requested that the technical solution for single clinical sign-on be progressed as a priority. **CE**

Section 9 of paper T provided an update on performance of the Facilities Management contract provided by Interserve and contract managed by NHS Horizons. The Chief Nurse presented this section advising that performance against estates and portering KPIs had been impacted by a failure in the electronic management system and Interserve had been tasked with resolving this issue. Performance against cleaning KPIs was showing a gradual improvement and further assurance would be provided to the Trust Board on 27 February 2014. The Acting Chairman also advised that a robust contractual review would be undertaken on the 12 month anniversary of the contract award. **CN**

The Director of Human Resources drew members' attention to section 7 of paper T, covering appraisals, sickness, staff turnover, statutory and mandatory training and corporate induction. Particular discussion took place regarding improvements in statutory and mandatory training compliance. IT system issues were noted which related to the number of e-learners accessing the system at the same time and the facility to provide "team builder" reports. The Acting Chairman encouraged all Trust Board members to undertake their statutory and mandatory e-learning modules. Corporate induction sessions were due to become weekly sessions with effect from April 2014. **ALL**

The Interim Director of Financial Strategy presented the month 9 financial performance, focusing on the Trust's statutory duties in respect of:-

(1) income and expenditure position – noting a year to date deficit of £28.5m and risks and issues surrounding delivery of the year-end controls total within the context of variances within the CMGs' financial performance. He reported on the limited flexibility of central management options to effect a small tolerance either side of the forecast £39.8m deficit;
(2) capital resource limit – the Trust had spent £17.7m of the planned £39.8m as at the end of December 2013, and the year end position was expected to be in the region of £33m to £34m. This was seen as a lost opportunity to some extent and revised internal management arrangements were due to be implemented going forward, and
(3) external financing limit – DoH controls for non-Foundation Trusts meant that the UHL was required to have funds of at least £16.9m in the bank at the financial year end. The Trust's current balance stood at £3.9m and advice was being sought from the TDA in respect of the process and timescale for securing a short-term loan.

In discussion on the Trust's financial performance, Mr E Charlesworth, Healthwatch representative requested that careful consideration be given to future public messaging arrangements surrounding the deficit position and he queried the scope to benchmark UHL's financial performance with that of other Trusts to set the national context. The Interim Director of Financial Strategy agreed to explore the possibility of including such contextual information in future reports. **IDFS**

Ms K Jenkins, Non-Executive Director sought additional clarity with reference to the following sub-sections of paper T:-

- section 11.2.1 on page 41 – noting that the Trust had forecast an in-month deficit of £6.2m, but delivered a net deficit of £8.2m, she queried the reasons for this variance.

The Interim Director of Financial Strategy undertook to provide a breakdown of such variances within subsequent iterations of the financial performance report, including greater transparency relating to any deployment of central reserves; **IDFS**

- section 11.4.4 on page 44 – following the Internal Audit review of bank and agency non-contractual payments she queried whether the Executive Team had yet agreed a timescale for implementation of the Internal Audit recommendations. The Chief Executive and the Chief Nurse provided their views that implementation of the recommendations surrounding improved expenditure controls and back-filling of positions was not likely to materially reduce the current levels of expenditure on non-contracted staffing, as there was currently no other means of filling the gaps in staffing rotas. The Director of Strategy commented upon opportunities to ensure that existing staffing levels were appropriately distributed (via the e-rostering system) prior to resorting to agency usage. The Chief Nurse also noted the scope for the Audit Committee to review medical locum expenditure at a future meeting; **KJ, AC Chair**
- section 11.4.9 on page 46 – noting a cost pressure of £1.2m for consultancy costs, she requested a breakdown of this expenditure for the February 2014 meeting. Within the same section, a cost pressure of £1.1m was noted for imaging and laboratory non-pay consumables and it was agreed that this would be reviewed by the Finance and Performance Committee on 26 February 2014; **IDFS** **RK, FPC Chair**

Following the above discussion, the Acting Chairman highlighted a helpful report on the nursing workforce which had been presented to the Finance and Performance Committee and the Quality Assurance Committee on 29 January 2014 and he requested the Trust Administrator to circulate copies of this report to all Board members for information.

The Chief Executive briefed the Trust Board on the mechanism for centralised discretionary expenditure controls and recruitment approvals. With the exception of nursing posts, all new and replacement posts were being reviewed and appropriately challenged. Non-stock requisitions over the value of £100 were being scrutinised and all suppliers had been informed that purchase orders were required for all goods and services ordered. The Chief Operating Officer provided assurance that patient care activity assumptions were being monitored closely, alongside theatre plans and medical locum expenditure in order to maximise the Trust's financial position.

<u>Resolved</u> – that (A) the quality and performance report for month 9 (month ending 31 December 2013) be noted;

(B) the Director of Strategy be requested to liaise with the Assistant Director of Information to prioritise the development of RAG-rated quality diamonds; **DoS**

(C) the Chief Executive be requested to review progress with the IM&T transformation schemes to determine whether reports would be available for consideration by the Trust Board in February 2014; **CE**

(D) the trajectory for improving key Facilities Management KPIs be provided to the Trust Board in February 2014; **CN**

(E) all Trust Board members to review their Statutory and Mandatory training profile and complete any courses or e-learning modules as required; **ALL**

(F) the Interim Director of Financial Strategy be requested to undertake the following actions:- **IDFS**

- **(i) consider including national contextual information in future financial performance reports;**
- **(ii) provide a breakdown of any in-month variances to the planned income and expenditure position, and**
- **(iii) provide a breakdown of the £1.2m cost pressure relating to consultancy costs;**

(G) consideration be given to an Audit Committee review of medical agency staffing costs, and **AC Chair**

(H) a reported £1.1m cost pressure in respect of imaging and laboratory consumables be reviewed in depth by the Finance and Performance Committee on 26 February 2014. **FPC Chair**

24/14/2 Emergency Care Performance and Recovery Plan

Further to Minute 341/13/2 of 20 December 2014, the Chief Operating Officer introduced paper U, briefing members on recent performance against the 4 hour emergency care target and the continued focus on delivering sustainable improvements. Detailed performance data relating to the 2 super weekends (held on 4-5 and 11-12 January 2014) was appended to paper U. In-month performance was noted to have improved from 88.5% in November 2013 to 90.5% in December 2013 and the year to date performance now stood at 88.56%. Month to date performance for January 2014 stood at 93.43%. Graph 4 on page 2 of paper U showed ED performance for the first 23 days of January 2014 compared to the same period of 2013 and graph 5 illustrated a pleasing reduction in performance variation. The Chief Operating Officer noted the 4 main focus areas being progressed were:- (1) discharge processes, (2) command and control site meetings, (3) non-admitted breaches, and (4) super weekends and plans to normalise key behaviours.

Ms K Jenkins, Non-Executive Director noted the positive effect of the super weekends and queried what had made the difference. In response, the Chief Operating Officer reported on the arrangements to replicate mid-week working combined with the effect of less elective activity, additional portering staff, access to CT scanners, pharmacy services and breach chasers. At the following day's Emergency Care Action Team meeting, consideration would be given as to which actions had made the most difference and which would be continued. The Chief Operating Officer also paid credit to the support provided by Dr D Briggs, Managing Director, East Leicestershire and Rutland CCG and Ms R Bilsborough, Divisional Director, Leicestershire Partnership NHS Trust.

Mr P Panchal, Non-Executive Director had recently visited the discharge lounge at the LRI site and he queried whether there were any medium or long term plans to increase discharge lounge capacity. In response, the Chief Operating Officer and the Chief Nurse advised that discharge lounges were currently a necessary step in the patient discharge journey whilst they were awaiting transport or take home medication. Ideally, they would not be required in future, but whilst they were required, some positive steps were being taken to address privacy and dignity issues and to improve the patient experience in these areas generally.

In conclusion, the Chief Operating Officer summarised the improving position noting the expectation that the Trust would be delivering sustainable compliant performance by the end of quarter 1 2014-15. Ms K Jenkins, Non-Executive Director queried whether performance penalties were still being deducted for non-compliance and noted in response that a year-end agreement had been reached with Commissioners in this respect. Members commended the achievements to date, noting that an audit of basic care interventions and quality measures had evidenced significant improvements within the ED.

Resolved – that the report on Emergency Care Performance be received and noted.

24/14/3 NHS Trust Over-Sight Self Certifications

The Director of Corporate and Legal Affairs introduced UHL's self certification returns for December 2013 (paper V refers), inviting any comments or questions on this report. The Acting Chairman highlighted the need for clarity (within section 4) regarding funding sources **DCLA/**

and the basis that the Trust was considered to be a going concern. The Interim Director of Financial Strategy advised that he would be preparing a report to the Audit Committee on this particular point. **CE**

The December 2013 self certification against Monitor Licensing Requirements (appendix A), and Trust Board Statements (appendix B) were endorsed for signature by the Chief Executive and submission to the TDA accordingly.

Resolved – that the NHS Trust Over-Sight Self Certification returns for December 2013 be approved for signature by the Chief Executive, and submitted to the TDA as required. **CE**

25/14 STRATEGY AND FORWARD PLANNING

25/14/1 Annual Operational Plan 2013-14 Quarter 3 Progress Report

Paper W provided a high level overview of UHL's performance against the 2013-14 Annual Operational Plan objectives for the period October 2013 to December 2013. Appendix 1 to paper W provided a RAG-rated progress report against each individual workstream. The Director of Strategy noted that many of the key issues covered by the report had been discussed earlier in the agenda and she invited any questions on the report.

Resolved – that the quarter 3 progress report on the 2013-14 Annual Operational Plan be received and noted.

25/14/2 Update on Draft Annual Operational Plans 2014-15 and 2015-16

The Director of Strategy presented paper X, seeking the Trust Board's ratification of the first cut operational plan for 2014 to 2016, as approved by the Acting Chairman and the Chief Executive and submitted to the TDA on 13 January 2014. Members noted that the TDA planning guidance required the Trust to submit a detailed planning checklist and statement of compliance or non-compliance against a wide range of parameters. This detailed documentation (Annex A to E) had not been circulated with paper X but was available for review upon request.

Board members discussed the key messages surrounding UHL's financial deficit and system wide responses which would be triangulated with the responses from CCGs, Nottingham University Hospitals NHS Trust, Northampton General Hospital, Kettering General Hospital and the Provider Alliance for the LLR Elective Care Bundle. The Director of Strategy reported on the arrangements for patient and public engagement and plans for strengthening operational grip, capital planning and workforce plans. A further interim submission would be presented at the 13 February 2014 Trust Board development session prior to submission to the TDA on 14 February 2014.

The Acting Chairman sought and received assurance that appropriate clinical engagement was driving the development of service based strategies. Mr P Panchal, Non-Executive Director requested that relationships with the voluntary sector and patient carers be factored in to subsequent submissions. The Director of Marketing and Communications reported on early discussions with the Leicester City CCG, Social Services and Age UK surrounding the development of "loneliness prescriptions", whereby healthcare professionals would be encouraged to identify isolated patients in need of additional support and arrange for them to be offered professional or voluntary assistance (where required).

Resolved – that (A) the first draft submission of UHL's Annual Operational Plans for 2014-16 be endorsed, and **DS**

(B) the second draft submission be presented to the Trust Board development **DS**

session on 13 February 2014 for approval prior to submission to the TDA on 14 February 2014.

25/14/3 Quarterly Review of the Improvement and Innovation Framework

The expected report on the Improvement and Innovation Framework had been withdrawn.

Resolved – that the quarterly review of the Improvement and Innovation Framework be deferred to the 27 February 2014 Trust Board meeting. **DoS**

26/14 RISK

26/14/1 Board Assurance Framework (BAF) Update

The Chief Nurse presented the latest iteration of UHL's BAF (paper Y). Mr P Cleaver, Risk and Assurance Manager attended the meeting for this item. The Acting Chairman noted that it had been some time since the last detailed review of the whole BAF and he requested the Director of Corporate and Legal Affairs to build such a review into the Trust Board development programme. Discussion took place regarding the optimum timing for this and Ms K Jenkins, Non-Executive Director and Audit Committee Chair noted the importance of ensuring that the Board was content with the content of the BAF and the allocated risk ratings prior to the development of the 2014-15 Internal Audit plan. The Chief Executive and the Acting Chairman suggested that the BAF be reviewed after submission of the Annual Operational Plan and the CQC summit at the end of March 2014. **DCLA**

In respect of the 3 risks selected for detailed consideration at today's meeting, the Trust Board noted the following information:-

- risk 8 – failure to achieve and sustain quality standards – it was agreed that the Chief Nurse and the Medical Director would review the scoring of this risk through the Executive Quality Board, alongside the outputs from the CQC inspection, once the formal feedback was available; **CN/MD**
- risk 9 – failure to achieve and sustain high standards of operational performance – the Chief Operating Officer undertook to update the mitigating actions now that RTT recovery plans had been signed off by Commissioners. However, it was not intended to downgrade the existing risk scoring (4 x 5 = 20) at the present time, and **COO**
- risk 10 – inadequate reconfiguration of buildings and services – the Director of Strategy noted the need to re-score this risk rating upon completion of the work to triangulate UHL's reconfiguration plans with those of the CCGs. **DoS**

In discussion on the remainder of the report, the Trust Board:-

(i) noted the key changes to the BAF (as outlined in section 2.4 of paper Y);
(ii) highlighted the need to review the Improvement and Innovation Framework at the next Trust Board meeting and the particular relevance of this workstream to risk 4 (ineffective organisational transformation); **DoS**
(iii) agreed that the risk rating for risk 12 (failure to exploit the potential of IM&T) seemed to have been under-scored (3 x 3 = 9) and this would require further review at the 27 February 2014 Trust Board meeting;
(iv) suggested that it would be helpful to receive updated criteria for gauging the current and target risk ratings alongside some up-to-date examples of extreme risks. The Risk and Assurance Manager agreed to append this information to the February 2014 iteration of the BAF; **RAM**
(v) commented upon section 3 of the paper Y showing the new extreme and high risks noting that the detailed risk summaries were provided in appendix 5. The Risk and Assurance Manager advised that since producing this report, appropriate updates had been received in respect of the outstanding actions highlight in red within appendix 5;

(vi) considered the overall length of the BAF report and highlighted opportunities to draw key points to the Board's attention through the use of an additional column providing an opinion as to whether adequate action plans/assurance had been provided by the risk owner, and **RAM**

(vii) agreed that the governance structures relating to the BAF as highlighted within the Assurance and Response Framework would be tested and re-confirmed by the Trust Board when this document was reviewed in March 2014. **DCLA**

Resolved – that (A) the Board Assurance Framework (presented as paper Y) and the associated actions listed above be noted. **EDs**

27/14 MEDICAL EDUCATION

27/14/1 Quarterly Update on Medical Education

The Medical Director introduced Professor S Carr, Associate Medical Director for Clinical Education who had attended the meeting to present paper Z. Taking the paper as read, Professor Carr highlighted recent key achievements and ongoing challenges relating to medical education at UHL. Members particularly noted progress with appointing Medical Education Leads in each CMG and the focus on accountability for evidencing expenditure against SIFT funding (to include any "hidden" costs such as cancellation of a clinic to facilitate student examinations and the associated impact upon waiting lists and operational performance).

The Acting Chairman noted the need to align the income and expenditure position for medical education to ensure that there was no cross-subsidisation and the Interim Director of Financial Strategy reported on the associated risks and opportunities. Noting that engagement with the CMGs was improving in respect of medical education, the Acting Chairman requested the Chief Operating Officer to include this item on the agenda for review at the monthly CMG Performance Management meetings. **COO**

The Chief Executive noted the need to mainstream the reporting arrangements for both medical education and research and development performance and he sought an update on the development of the reporting dashboard. Professor Carr advised that a pilot dashboard was currently being trialled and she provided assurance that the dashboard would be rolled out within all CMGs by 1 April 2014.

The Chief Executive sought and received verbal feedback arising from recent inspections and suggested that this would be a useful addition to the quarterly reports going forwards. Members noted that following the Deanery's follow-up inspection, 2 rotas were still RAG-rated as red, the ED visit had gone well, a renal follow-up visit had highlighted no particular issues and the ophthalmology visit had confirmed good progress towards addressing the issues raised previously. It was agreed that feedback from inspections and visits from external agencies would be included as a standing item in each quarterly update. **AMD**

Resolved – that (A) the quarterly update report on Medical Education be received and noted, and

(B) the Chief Operating Officer be requested to include medical education on the agenda for the CMG performance management meetings, and **COO**

(C) feedback from inspections and external visits be included in future iterations of the report. **AMD**

28/14 RESEARCH AND DEVELOPMENT

28/14/1 Quarterly Update on Research and Development

The Medical Director introduced Professor N Brunskill, Director of Research and Development who had attended the meeting to present paper AA, the quarterly update on research and development at UHL. Taking the report as read, Professor Brunskill highlighted progress with appointment of the R&D leads and deputy leads within each CMG, and arrangements to appoint leads within the spheres of nursing and allied healthcare professional groups. Recruitment to portfolio studies continued to exceed trajectory and the median time for the Trust to approve studies stood at 1 day (against the national target of 30 days). The Trust's research management team had been requested to share good practice with other Trusts in respect of this performance.

Section 3.5 of paper AA outlined the hosted research institutions and advised that UHL had been selected as a Cancer Research UK Centre. Current challenges were set out in section 4 of the report. These included maintaining and developing relationships with a range of academic and industry partners and approvals for recruitment to existing posts. Section 5 provided the Leicestershire, Northamptonshire and Rutland Comprehensive Local Research Network (CLRN) report as required by the NIHR to qualify for the appropriate funding.

Responding to a query raised by Dr S Dauncey, Non-Executive Director, the Medical Director reported on the historical issues relating to appointments to academic posts and the arrangements being progressed to redress the balance between Trust funding and University of Leicester funding. The Chief Executive noted progress towards achieving parity at a Trust-wide level, but he noted the need to refresh the CMG-level budgets in this respect. He agreed to liaise with the Interim Director of Financial Strategy on this point outside the meeting. **CE/IDFS**

Trust Board members raised some detailed queries surrounding UHL's Biomedical Research Units, Olympic legacy funding, the Academic Health Sciences Network. The Acting Chairman noted that UHL was an important partner within a wide range of organisations and it would be helpful to see the joined up strategy for research and development. The Medical Director suggested that a Trust Board development session might be useful and he offered to help structure such a session (if required). **DCLA/MD**

Finally, the Director of Strategy raised a query on the calculation of excess treatment costs in respect of clinical trials in accordance with the NHS commissioning annual prioritisation process. The Director of Research and Development provided an example of some diabetes research whereby a study was conducted which involved provision of special standing workstations for the study group. It was agreed that the Director of Strategy would update the Interim Director of Financial Strategy on this matter outside the meeting. **DoS**

<u>Resolved</u> – that (A) the quarterly update on Research and Development be received and noted;

(B) the Chief Executive be requested to brief the Interim Director of Financial Strategy on the apportionment of medical staffing costs between UHL and the UoL; **CE/IDFS**

(C) consideration be given to presenting UHL's research and development strategy to a Trust Board development session, and **DCLA/MD**

(D) the Director of Strategy be requested to update the Interim Director of Financial Strategy on the arrangements for processing excess treatment costs outside the meeting. **DoS**

29/14 REPORTS FROM BOARD COMMITTEES

29/14/1 <u>Finance and Performance Committee</u>

Resolved – that the Minutes of the 18 December 2013 Finance and Performance Committee meeting (paper BB) be received and noted.

29/14/2 Quality Assurance Committee

Resolved – that the Minutes of the 17 December 2013 Quality Assurance Committee meeting (paper CC) be received and noted.

30/14 CORPORATE TRUSTEE BUSINESS

30/14/1 Final Accounts and Annual Report 2012-13 for Leicester Hospitals Charity

The Interim Director of Financial Strategy introduced paper DD, providing the Leicester Hospitals Charity Final Annual Accounts, Annual Report and Letter of Representation for the year 2012-13 and seeking Trust Board approval (as Corporate Trustee). Members noted that in the absence of a Charitable Funds Committee meeting before the Charity Commission's 31 January 2014 deadline, the detailed Accounts and Annual Report had been circulated to all Committee members by email for their approval on 21 January 2014.

The Director of Corporate and Legal Affairs highlighted recent challenges experienced in ensuring that meetings of the Charitable Funds Committee were quorate. He sought the Trust Board's approval to revising the membership and terms of reference for this Committee to the effect that, at the Committee Chairman's discretion, any voting member of the Trust Board could be invited to attend the meetings and that their attendance would count towards the quoracy of the meeting. **DCLA**

Resolved – that (A) the Annual Accounts and Annual Report for Leicester Hospitals Charity be endorsed;

(B) the Interim Director of Financial Strategy and the Chief Executive be requested to sign the relevant certificates and arrange for submission to the Charity Commission before the 31 January 2014 deadline, and **IDFS/CE**

(C) the above amendment to the membership and terms of reference for the Charitable Funds Committee be approved. **DCLA**

31/14 TRUST BOARD BULLETIN – JANUARY 2014

Resolved – that the Trust Board Bulletin report containing the quarterly update on sealing of documents (paper EE) be received for information.

32/14 QUESTIONS AND COMMENTS FROM THE PUBLIC RELATING TO BUSINESS TRANSACTED AT THIS MEETING

The Acting Chairman invited any comments or queries relating to items of business on the Trust Board meeting agenda and a member of staff commented upon a lack of awareness of the Clinical Excellence Awards Scheme. In response, the Director of Human Resources noted the need for additional information sessions on these awards and agreed to liaise with the CMGs to arrange this within each speciality. **DHR**

Resolved – that the comment above be noted and the Director of Human Resources be requested to liaise with the CMGs to arrange for information sessions on the CEA scheme to be held within each specialty. **DHR**

33/14 ANY OTHER BUSINESS

33/14/1 Report by the Medical Director

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

33/14/2 Urgent Care Centre Tender

Mr E Charlesworth, Healthwatch representative raised a query relating to the tender for the Urgent Care Centre service currently provided by the George Eliot Hospital NHS Trust. The Chief Executive confirmed that UHL was aware of the re-procurement exercise currently being undertaken to maintain continuity of service. In the longer term, options were under consideration in order to potentially repatriate this activity or incorporate some collaboration with the service provider as part of the new emergency floor redesign.

Resolved – that the information be noted.

33/14/3 ED Performance

Mr P Panchal, Non-Executive Director noted the positive progress in respect of ED performance recently but he queried the arrangements to factor in the impact of any severe weather conditions within the improvement trajectory. In response, the Chief Operating Officer advised that he would not expect bad weather to significantly impact upon progress, providing that the existing focus on admissions and discharge rates was sustained.

Resolved – that the information be noted.

33/14/4 Ms H Stokes – Senior Trust Administrator

The Acting Chairman noted that the Senior Trust Administrator would be returning to work in February 2014 following her period of maternity leave and that she would resume servicing the Trust Board meetings. He thanked Mrs K Rayns, Trust Administrator for servicing the Board meetings in her absence.

Resolved – that the information be noted.

34/14 MEETING EVALUATION

The Acting Chairman invited members to evaluate the public section of the meeting and provide their comments accordingly. The following comments and observations were raised:-

(1) the Chief Operating Officer queried what more the Board could do to engage with the public and increase attendance at Board meetings. The Director of Marketing and Communications reported on the arrangements to hold selected Board meetings in a range of external stakeholder venues commencing in March 2013. These sessions would have built in opportunities for stakeholder engagement and would be well advertised in advance;
(2) Ms K Jenkins, Non-Executive Director highlighted opportunities to make Trust Board meeting more interactive, she queried the scope to adapt the language used to make them more "digestible" and suggested that it would be helpful if the agreed resolutions and actions could be summarised following each agenda item;
(3) Mr P Panchal, Non-Executive Director commented on time pressures during the meetings, suggesting that Board members' ability to raise questions was sometimes hampered. He also agreed to speak to the Director of Marketing and Communications **PP,**

outside the meeting regarding community access to Board meeting and the relevance of any external venues selected; **NED**

(4) Dr T Bentley, CCG representative commended the Board's progress in implementing the "paper-lite" approach to meetings, with all the documents being provided in an easily accessible electronic format. Mr P Panchal, Non-Executive Director echoed this comment but suggested that arrangements for re-charging electronic devices during the meeting were required (avoiding the need for extension cables and the inherent risks of creating tripping hazards); **TA**

(5) the Acting Chairman accepted the comments relating to time pressures and queried whether the Board should hold longer meetings or conduct less business at each meeting. He proposed that the agenda timings be circulated 10 days prior to each meeting, to assist members to escalate any concerns in advance; **DCLA**

(6) the Chief Operating Officer noted the reactive nature of the Trust Board agenda over the last 12 months and commented upon the scope to focus on more strategic issues. He also noted the opportunity to create a more continuous narrative on key issues through the Minutes of the meetings, and

(7) members also considered the following issues in respect of Trust Board meeting development:-

- scope to reflect the CQC inspection framework within the agenda planning;
- opportunities to track the number of decisions/approvals arising from each item;
- whether the Trust Board was predominantly expected to be a decision making forum or an assurance forum, and
- opportunities to reference the Trust's strategic objectives within the reporting template.

Resolved – that the above comments be noted.

35/14 DATE OF NEXT MEETING

Resolved – that the next Trust Board meeting be held on Thursday 27 February 2014 in the C J Bond room, Clinical Education Centre, Leicester Royal Infirmary.

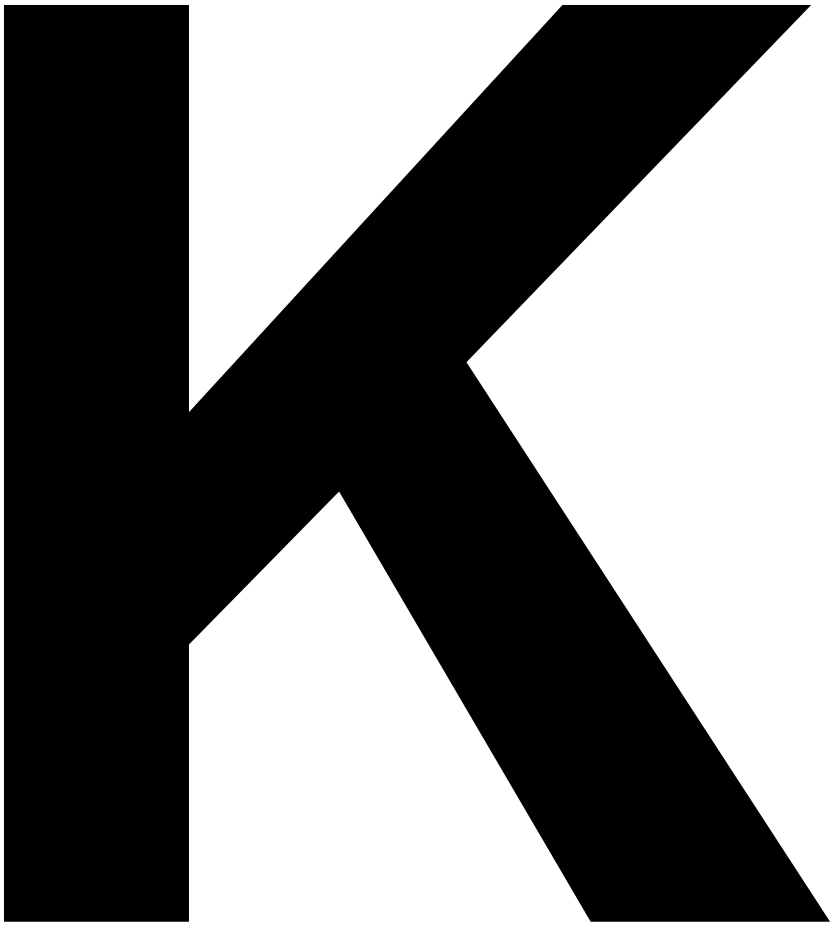
The meeting closed at 3.56pm

Kate Rayns,
Trust Administrator

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

Name	Possible	Actual	% attendance	Name	Possible	Actual	% attendance
R Kilner (Acting Chair from 26.9.13)	12	12	100	R Overfield	6	5	83
J Adler	12	11	92	P Panchal	12	10	83
T Bentley*	10	6	60	I Reid	4	4	100
K Bradley*	12	10	83	C Ribbins	4	4	100
I Crowe	8	7	88	I Sadd	4	3	75
S Dauncey	2	2	100	A Seddon	11	11	100
K Harris	12	12	100	K Shields*	4	4	100
S Hinchliffe	2	2	100	J Tozer*	3	2	66
M Hindle (Chair up to 26.9.13)	7	7	100	S Ward*	12	12	100
P Hollinshead*	1	1	100	M Wightman*	12	11	92
K Jenkins	12	11	92	J Wilson	12	10	83
R Mitchell	8	8	100	D Wynford-Thomas	12	5	42

* non-voting members



University Hospitals of Leicester NHS Trust

Trust Board Paper K

Progress of actions arising from the Trust Board meeting held on Thursday 30 January 2014

Item No	Minute Reference	Action	Lead	By When	Progress Update	RAG status*
1	19/14	Amendments to Minutes 340/13/2 and 341/13/1 of the 20 December 2013 Trust Board meeting to be agreed.	TA/Chairman	27.2.14	Suggested amendments made to Minutes 340/13/2 and 341/13/1 and the additional wording agreed for insertion within Minute 341/13/1 is provided in appendix 1 below.	5
2	22/14/1	Acupuncture Service developments to be pursued outside the meeting relating to training roles and commissioning negotiations.	CN/DoS	27.3.14	DoS to provide an update for the March 2014 Trust Board actions log.	4
3	22/14/2 (B)	CCG Representative to arrange for dementia care joint working to be highlighted within the relevant LLR 5 year strategy workstream.	T Bentley	27.2.14	**Verbal update to be provided to the Board on 27 February 2014.**	4
4	22/14/2 (C)	Proposals for a UHL Carers' Strategy to be presented to the Executive Quality Board in April 2014.	CN	2.4.14	Provisionally scheduled on the Executive Quality Board agenda.	4
5	22/14/2 (D)	Consideration to be given to raising awareness of dementia related issues through the Board development programme.	DCLA	27.3.14	Under discussion between the Acting Chairman and the Director of Corporate and Legal Affairs.	4
6	23/14/1	Director of Human Resources to confirm the final financial allocation for the 2013 Clinical Excellence Awards outside the meeting.	DHR	27.2.14	Information to be provided to the Chief Executive outside the meeting.	4
7	24/14/1 (B)	Director of Strategy to liaise with the Assistant Director of Information to prioritise the development of 'quality diamonds'.	DoS	27.3.14	DoS to provide an update for the March 2014 Trust Board actions log.	4
8	24/14/1 (E)	All Trust Board members to review their Statutory and Mandatory Training Profiles and complete any required training.	All	27.2.14	To be progressed outside the meeting and monitored accordingly.	4
9	24/14/1 (F)	Interim Director of Financial Strategy to incorporate agreed amendments into the regular financial reporting mechanism.	IDFS	27.2.14	**To receive a verbal update on 27 February 2014.**	4
10	24/14/1 (G)	Consideration to be given to the Audit Committee undertaking a review of medical agency expenditure.	AC Chair	7.3.14	Review of bank and agency expenditure provisionally scheduled on the 7 March 2014 Audit Committee agenda.	4
11	24/14/1 (H)	Cost pressures in respect of imaging and laboratory consumables	FPC Chair	~~26.2.14~~	Attendance by the Clinical Support and	3

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

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

Item No	Minute Reference	Action	Lead	By When	Progress Update	RAG status*
		to be reviewed in depth by the Finance and Performance Committee.		26.3.14	Imaging CMG has been deferred to March 2014 Finance and Performance Committee with the agreement of the Chairman.	

Matters arising from previous Trust Board meetings

Item No	Minute Reference	Action	Lead	By When	Progress Update	RAG Status*
20 December 2013						
12	337/13 (g)	Acting Chairman to provide feedback on proposals to strengthen the governance arrangements for the Better Care Together Programme.	Acting Chair	27.2.14	**Update to be provided by 27 February 2014 Trust Board.**	4
13	340/13/1	Update on talent management and leadership development to be incorporated into the Quarter 4 update on workforce and OD.	DHR	27.3.14	To be included in the report scheduled for the 27 March 2014 Board meeting.	4
14	342/13/3	Trust Board development time to be allocated for discussion of issues relating to the UHL Travel Plan.	DCLA	31.3.14	Under discussion between the Acting Chairman and the Director of Corporate and Legal Affairs.	4
15	344/13/1	Equality and Diversity report to feature earlier in the agenda in July 2014 and consideration be given to holding a Board development session on equality and diversity.	DCLA	31.7.14	Under discussion between the Acting Chairman and the Director of Corporate and Legal Affairs.	4

Additional wording for insertion within Trust Board Minute 341/13/1 of 20 December 2013

Dr T Bentley, CCG representative commented upon the factors affecting UHL's financial position which still required to be addressed, noting that tariff based payments (including A&E attendances) were set nationally, and that the Leicester City CCG did not enact MRET penalties. The 2 County CCGs were using their share of MRET deductions to re-invest in community health services, in order to relieve the pressure on UHL's Emergency Department. In previous years, the Primary Care Trusts had provided end-of-year financial support to UHL, but for the 2013-14 financial year, the CCGs had no such funds available due to expenditure on community health schemes. He recorded the CCGs' intention to support UHL to improve urgent care delivery through initiatives such as the super weekends. He looked forward to seeing a change in culture and expressed confidence that the Acting Chairman and the Chief Executive would address these issues accordingly.

** 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***

To:	**Trust Board**
From:	**CHIEF EXECUTIVE**
Date:	**27 February 2014**
CQC regulation:	N/A

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

Author/Responsible Director: Director of Corporate and Legal Affairs

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

The Report is provided to the Committee for:

Decision		Discussion	√
Assurance	√	Endorsement	

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

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

Previously considered at another corporate UHL Committee? No

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

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

Assurance Implications: N/A

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

Stakeholder Engagement Implications: N/A

Equality Impact: N/A

Information exempt from Disclosure: None

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **27 FEBRUARY 2014**

REPORT BY: **CHIEF EXECUTIVE**

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

---

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

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

(a) the Trust's financial position as at month 10 2013/14;

(b) emergency care performance;

(c) Referral Time to Treatment performance;

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

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

John Adler
Chief Executive

14 February 2014

To:	**Trust Board**
From:	**John Clarke, Chief Information Officer**
Date:	**27 February 2014**
CQC regulation:	

Title:	**Update on UHL IT infrastructure**

Author/Responsible Director: John Clarke, Chief Information Officer

Purpose of the Report:

This report highlights the work undertaken by UHL and IBM to stabilise the current IT infrastructure and to improve the user experience going forward

The Report is provided to the Board for:

Decision		Discussion	X
Assurance	X	Endorsement	

Summary / Key Points:

Investment has been made in the core infrastructure to ensure we have modern dependable systems on which to build opportunities for change.

We have received significant new central funding to help accelerate our plans to free clinical staff from a PC and embracing a more mobile approach. We have invested in leading edge technology and have won awards and accolades for our proof of concept projects.

There has been a planned delay in the data centre project so we can properly align this with our future strategic needs. We are currently working on this with IBM and NTT and aiming for this to be resolved in June 2014.

Through 2013, we have made significant improvements to our base infrastructure. We have also been successful in bidding for additional external funding support (capital) totalling £4.15m; Safer Wards £2.8m, ePMA £0.7m and Nursing Technology £.65m

The additional funding will help us accelerate our solutions and create an exciting mix of new technologies. At the end of 2014, we will have a modern mobile approach to technology, allowing us to safely blend personal devices alongside corporate devices to maximise both our new telecommunications options as well as the new mobile clinical solutions.

Recommendations:

The Board is asked to discuss/note the

1. The steps taken in 2013/14 with regard to both the quality and support of our infrastructure.

2. The significant effort of colleagues from clinical, financial and IM&T in supporting the development and presentation of bids for funding from the various IT streams held centrally to which we have be extraordinarily successful

3. To note the initial plan for 2014/15 to ensure we will be taking significant steps forward; to revolutionise access to our systems, both within UHL and from outside UHL.

Previously considered at another corporate UHL Committee?

The UHL/IBM working groups

Board Assurance Framework:	**Performance KPIs year to date:**
Yes, part of business continuity	All KPIs for IT infrastructure have been met.

Resource Implications (eg Financial, HR):

This forms part of the IM&T capital plan. Further business cases will be produced to support the printing changes at LRI and LGH.

Assurance Implications: Yes – IG, Security and audit actions

Patient and Public Involvement (PPI) Implications: No

Stakeholder Engagement Implications: Yes, working with partners to share infrastructure

Equality Impact: N/A

Information exempt from Disclosure: No

Requirement for further review? Yes

Updates will be included in the standard Trust Board reporting cycle for IM&T.
There will be the data centre and storage strategy, including a data retention plan that will be ready in June 2014

IT Infrastructure Update

John Clarke
Chief Information Officer

Introduction

This paper provides an update on the key issues surrounding the IT infrastructure at UHL.

The focus for 2013/14 has been around stabilising our current infrastructure. Significant upgrades have happened to key clinical systems, clinical mobility, and investments have been made to we deliver these over a stable network and desktop environment.

The focus for 2014/15 is to increase our mobile capability and deliver an environment that is conducive to creating change opportunities from the use of predictable and sustainable technology.

In 2013/14 we delivered, alongside IBM, improvements in our infrastructure

- 24x7 helpdesk support & improved SLAs
- Improved mobile (corporate) access to UHL resources (email, calendars, dashboards, ED Portal etc)
- Virtual Desktop Proof of Concept (POC) (350 concurrent Users)
- Unified Communications POC
- Hospital 24x7 workflow support
- Clinical Handover POC
- Replacement archive storage
- Cardio PACS Solution
- Anywhere Printing at GH
- Successful bids for funding support (capital)
    - Safer Wards £2.8m
    - ePMA £0.7m
    - Nursing Technology £.65m

In 2014/15 we will be focusing on using the new technology we will have in place to mitigate the current pain points for UHL staff when using our technology

- Desktop Transformation
- Upgrade of the wireless network
    - Free Public Wireless
    - Removal of significant Wireless black spots
    - Extension of Mobile Phone (EE) coverage to black spots
- Increased availability of Mobile Devices
    - The ability to use your own (Bring Your Own Device)
    - The expansion of Apple iOS devices to support the increasing range of mobile clinical solutions

- Increased Availability of Mobile Applications
  - Clinical Handover
  - Nursing solution
  - Unified Communications
- Single-sign-on
- Anywhere printing at LRI and GH (subject to suitable project orders)

Anywhere Connectivity

The “anywhere Connectivity” programme is made up of a suite of projects that is focused on vastly improving the user experience for clinicians and other staff. Key feedback from the Clinical Advisory Group identified both the quality of the Desktops, especially the log on time, the use of smartcards, the amount of passwords required and the availability of sufficient equipment as a key risk.

Desktop Transformation

The desktop transformation programmes objective is to move the reliance away from the desktop and provide this from within the datacentre. We currently have this as a proof of concept which was successful. WE are now building the operational environment and it will be available from April 2014.

The main advantage is how the user interact with the system; a user can remove a smartcard (ours not NPfIT) move to any other machine and log back in (<5 secs) and be back to where were they removed the card. This has key advantages of the current system which limits the use of the computers, limited by the capability to support multiple users, as well has having a significant positive impact on information governance

Single-Sign-On Technology

A key request from the clinical teams was to reduce the number of passwords that they need to use. We currently have 800 users of the single-sign-on system and we have purchased the required licences to cover all clinical staff. We will be re-launching the sign up process, mindful of the risk assessment, to new users in April 2014. An additional benefit of this approach is that users can re-set their own passwords by utilising additional information such as secret questions/answers.

Printing Transformation

We are currently deploying the new printing project at Glenfield. This programme replaces the current printer stock and provides a reliable professional service going forward. There will be one print queue and all users will be able to receive their prints from any of the new printers by means of their smart card. The audits have been completed for the LRI and GH and we are currently awaiting the proposal from IBM to extend the programme to these sites.

Mobile Working

In 2013/14 we invested in mobile clinical solutions; in the main this was through the NerveCenter solution. We will be continuing to improve this solution, the next go-live is the clinical handover tool. The Clinical Handover’s proof of concept project won UHL a national award in 2013 for digital innovation and demonstrated the real advantage of clinically led IT programmes.

We have received additional funding from the Department of Health Safer Wards programme to help us develop both the infrastructure to support mobile working. This will allow us to accelerate our plans and provide a series of opportunities to improve our services.

We have been also successful in securing funding for nursing technology which will further develop the NerveCenter solution to provide a mobile solution to support processes such as nursing observation collection.

Unified Communications

We have been running a pilot in 2013/14 to test the infrastructure and software that will allow use connected devices (tablets, phones, PCs) to communicate across the trust. Part of the funding from the DH Safer Wards funding was to extend this provision across more users. This technology will be available in Q1 2014/15 and will allow users to use there devices as a telephone, instant messaging and video conferencing.

Data Centre

Part of the contract with IBM was the creation of a new modern Data Centre to host the new applications that we will be implementing in UHL. This was a pre-requisite for both EDRM and EPR programmes. However as we are pursuing a proof of concept with EDRM we can wait until the choice of EPR vendor is known. This will allow UHL to tailor the data centre approach to the EPR requirements. The was a small risk that if we had placed this order before the EPR vendor was known we could potentially dis-advantage certain bidder who could not use the original solution or would de-value the investment.

We have designed the optimum data centre solution, based on current known information, and any variance through the EPR programme will reduce the costs. The likely EPR choice will be known in Q1 2014/14 and therefore we will be able to finalise the designs.

Wireless

Over the past few years UHL has made significant investment in it's wireless technology. There is good coverage in clinical areas but there are some known black spots. Some of the access points are close to 7 years old and are obsolete. In 2014 there is a programme, funded from the DH money, to replace some of these and focusing on delivering the mobile applications and unified comms technologies.

As part of the wireless project we will be upgrading the RFID technology we use for tracking high value items in the trust.

Data Storage

We have a key risk in how we manage Data Storage at UHL. We have made a significant investment 5 years ago in storage technology which is now proving expensive to maintain. This is exasperated by the exponential rise in storage requirements. The new imaging modalities have increased of requirements to 4.5Tb of new storage a month. Our storage is almost full; our current cost of

storage, including archives, is c6k/Tb of data so imaging alone is accounting for £27k/Month if we were to continue with our current provider.

There is a project, with IBM and UHL, currently looking at the storage strategy. This has a linkage to the Data Centre project but we will be able to deploy the new storage at UHL if needed. At the same time we are looking at the data retention policy, and its enforcement, at UHL with a view to reducing the current storage

East Midlands PACS Procurement

UHL invest £50k in the EMRad project to look at the collective procurement of a new PACS solution. Our current contract runs until June 2016. The other Trusts in the East Midlands have a more pressing need than UHL to start their migration to a new supplier due to their current implementation. The procurement is looking to create a framework contract and is looking to be completed in June/July 2014. We are not bound to take the solution but significant savings have been identified as well as improved opportunities to work with images across all trusts who take the solution.

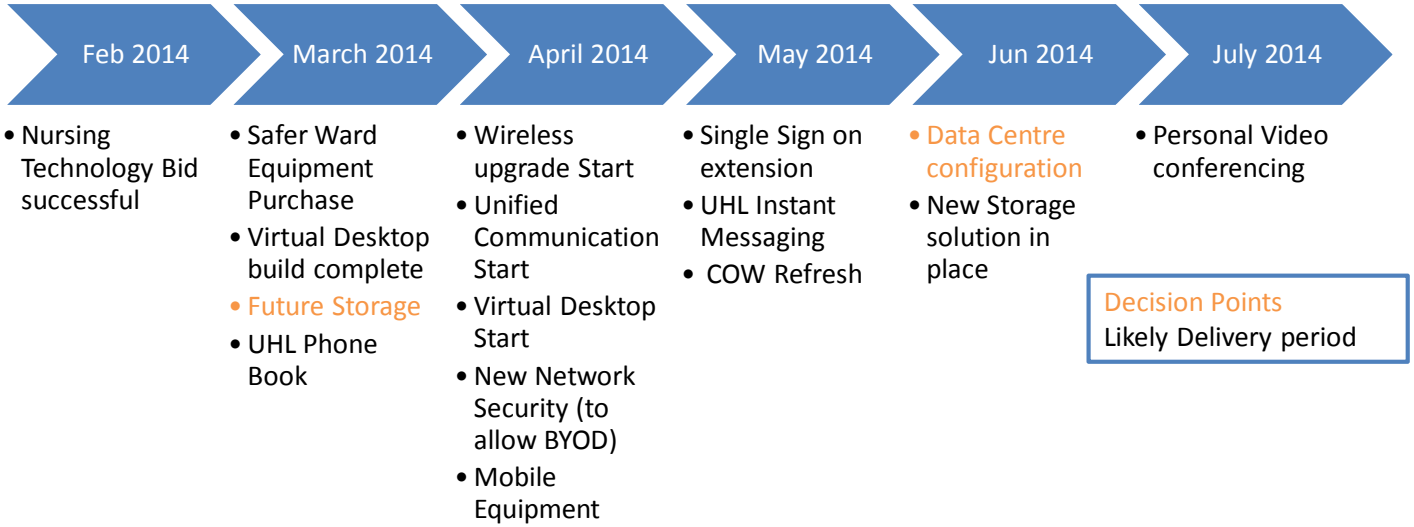
Conclusion

We have taken incremental steps forward in 2013/14 with regard to both the quality and support of our infrastructure.

In 2014/15 we will be taking significant steps forward; we will revolutionise access to our systems, both within UHL and from outside UHL. We will be able to support significant developments of mobile computing. We are continuing to develop, alongside IBM, strategic relationships with key vendors to take advantage of our new infrastructure.

Appendix 1 – Outline Plan

Infrastructure 6 month Timeline



Significant future work 2014/15

Email Replacement
PACS Replacement Procurement (Jun 2016)
Replacement of ICM and roll out to outpatients

N

To:	**Trust Board**
From:	**John Clarke, Chief Information Officer**
Date:	**27 February 2014**
CQC regulation:	

Title:	**Electronic Document and Records Management Update**

Author/Responsible Director: John Clarke, Chief Information Officer

Purpose of the Report:

To provide an overview of the EDRM Trial Implementation and seek clarification on the next steps for the Business Case for the Full Implementation.

The Report is provided to the Board for:

Decision		Discussion	X
Assurance	X	Endorsement	

Summary / Key Points:

The full business case was presented to the Trust Board in November 2013. After due consideration it was decided to proceed with a proving stage to test both the deployment methodology and the deliverable benefits.

We have reached agreement between UHL and IBM to proceed with the 16 week EDRM Trial Implementation project this paper provides an overview of the scope of the project, the timeline, the anticipated benefits and potential next steps around how this could evolve into the wider implementation across the Trust as a whole.

Pilot Areas

The two pilot areas are clinical genetics and MSK. Clinical Genetics was chosen because of a pressing need for this technology within its service, the closed nature of the service and the clear demonstrable clinical commitment to making the POC work. MSK was chosen to test the workflow element of the solution to enable it to manage its referrals within the service and several key clinicians have volunteered to be part of the work.

The clinical champions for each department, Dr Pradeep Vesudevan from Clinical Genetics and Kevin Boyd and Sally Le-Good from MSK, are engaged with the process and have been involved in defining the benefits that the trial will bring to their areas.

The project will implement the trial EDRM Solution in the two departments concurrently over a period of 8 weeks. This will be followed by a further 8 week evaluation period which will validate the benefits of the EDRM Solution compared to those anticipated at the outset.

Next Steps

Work has started, on the 17th of February, to take the POC forward and IBM resources are at UHL starting the implementation programme.

To proceed to a full roll out we will need to submit the relevant business cases to the NTDA. With this in mind the Business Case for the Full Implementation was prepared using the Five Case Model and is ready to start the approvals process.
Recommendations: The Board is asked to discuss/note the 1. The nature and makeup of the proof of concept and its governance. 2. The decision to take the outline business case, as previously presented to the Trust Board, to the NTDA in parallel with the POC.
Previously considered at another corporate UHL Committee? UHL/IBM joint Governance Group EDRM Project Group

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

Resource Implications (eg Financial, HR): Yes – costs of the POC
Assurance Implications: Yes
Patient and Public Involvement (PPI) Implications: Yes - As part of the POC we will be working with clinical genetics to identify any issues and concerns.
Stakeholder Engagement Implications: Yes – The POC will be used to build engagement with key stakeholders
Equality Impact: N/A
Information exempt from Disclosure: No
Requirement for further review? Yes

Background

A decision was taken at the Trust Board in November to scope a piece of work to look at the potential for undertaking a pilot or trial implementation of the EDRM solution being proposed for the hospital as a whole.

A number of options were put forward for consideration with the final candidate areas being agreed as being the Clinical Genetics and Musculoskeletal Departments due to their size and the nature of the challenges they are facing.

A subsequent Business Case was prepared for the Trial Implementation which was discussed and agreed from a business, financial and technical perspective and the contract for this piece of work was signed at the beginning of February.

The project commenced on the 17th February and the purpose of this report is to provide an overview of the scope, activities, timelines, and anticipated benefits etc for your information.

The next step, for the approval of the Business Case for the Full Implementation that was circulated to the JGB and Trust Board in November, is to issue the OBC to the NTDA. This will be done in parallel of the pilot to ensure that there is a limited gap at the end of the POC for the Trust to undertake the full implementation.

Scope of the Trial Implementation

The scope of the project is for UHL, in partnership with IBM through the Managed Business Partnership (MBP), to undertake a trial implementation of the proposed EDRM Solution in two areas of the Trust: the Clinical Genetics and Musculoskeletal (MSK) departments.

The clinical champions for each department, Dr Pradeep Vesudevan from Clinical Genetics and Kevin Boyd and Sally Le-Good from MSK, are already engaged with the process and have been involved in defining the benefits that the trial will bring to their areas.

Clinical Genetics Scope

The Clinical Genetics department currently have around twenty thousand (20,000) sets of family notes dating back to the 1980's which are stored onsite in the Clinical Genetics offices. It is outpatient based, seeing around 3,000 patients per year.

The proposal is that the Clinical Genetics Specialty Case Notes will be scanned in a one off back-scanning exercise and loaded into the EDRM Solution where they will be indexed according to the family ("pedigree") number and surname. This is in line with the proposal for the full implementation where only case notes logged on TrackIt will be scanned on demand. All other notes held in the various specialty departments will be scanned in total as a one-off exercise.

Ongoing paper produced by the Clinical Genetics department will be scanned within the department and stored in the EDRM Solution. Existing photographs and clinic letters will be loaded into the EDRM Solution and stored with the scanned notes so that the EDRM record contains all of the relevant information for the clinicians. Optical Character Recognition (OCR) will be applied to the scanned notes to allow clinicians to search their entire corpus of information to discover more links between

conditions or families that would not be possible using the current paper-based process.

The benefits of the EDRM solution for Clinical Genetics include:

- Proving the solution in an outpatient environment.
- Proving that the selected EDRM Solution will function in a UHL clinical department that will make full use of the EDRM search and navigation function to significantly speed up clinical access and decision-making whilst maintaining strict security controls.
- Bringing together disparate files and sources of information into a single record so that the clinicians have all the information to hand when dealing with patients.
- Freeing up of space occupied by numerous paper files that can be re-purposed as clinical rooms and will therefore increase the capacity within the Clinical Genetics department, allowing them to see more patients and reduce waiting times for referrals, once the space has been re-purposed.

Musculoskeletal Scope

The Musculoskeletal (MSK) department currently have issues with managing their GP referral letter process. The current process is heavily paper-based and it can take up to three (3) weeks for a consultant to respond to a GP referral letter for various reasons, including getting access to the paper referral letter or letters getting lost or going missing. The paper-based process also has issues where a consultant is on leave and their GP referrals cannot be easily retrieved for processing by someone else. The paper-based process is contributing to breaches in the RTT targets and fines are being incurred by the Trust as a consequence.

Implementing the EDRM Solution and using the workflow capability of the EDRM Solution in the MSK department will enable GP referral letters to be scanned in and distributed electronically to consultants. This will allow consultants to read and respond to the GP referral letters from any computer that has had WinDIP installed on it, rather than having to find the paper letter. This will speed up the process and reduce the manual effort required. Other benefits to MSK include:

- Better visibility of the progress of referrals, enabling bottlenecks to be identified and resolved quickly.
- Freeing up of administrative time for other tasks within the department.
- Less likelihood of referral letters getting lost or misplaced.

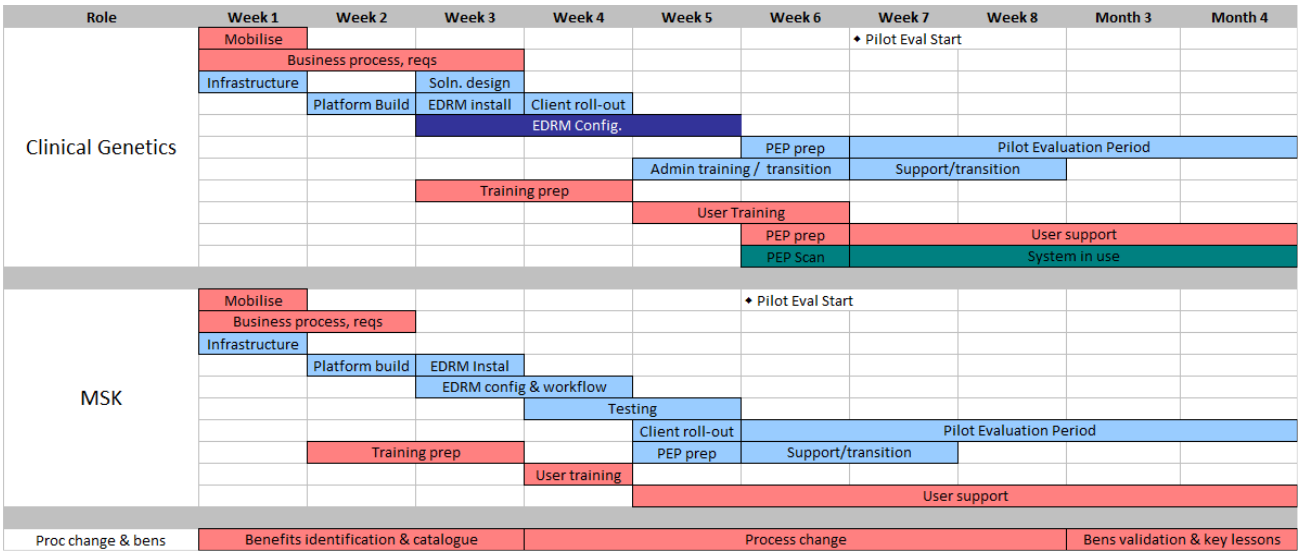
In addition to addressing these real business needs in both departments, implementing the EDRM Solution brings other benefits:

- It establishes the EDRM platform within the Trust that can be expanded to meet other business needs.
- It enables Trust staff to get used to and see the benefits of an electronic way of working.
- It acts as a “showcase” for the EDRM Solution across the Trust in preparation for the full roll-out of the EDRM for Core Case Notes and other Specialty areas.

Timeline

The project will implement the trial EDRM Solution in the two departments concurrently over a period of 8 weeks. This will be followed by a further 8 week evaluation period which will validate the benefits of the EDRM Solution compared to those anticipated at the outset.

The outline plan for completing this project is as follows.



At the end of the project evaluation period there will be a decision point. This will include a review of the effectiveness of the trial implementation, taking into account the experience of the clinicians who have been using the system in each department as well as examining how well the EDRM solution has met its objectives:

- Has the technical solution been deployed successfully into the departments ?
- Are the clinicians using the solution ?
- Are the benefits capable of being realised ?

The options for the Trust at this point are:

- Continue with the use of the EDRM solution in both departments.
- Decommission the EDRM trial implementation, revert back to the paper-based processes in both departments and return the scanned notes to the Clinical Genetics department.

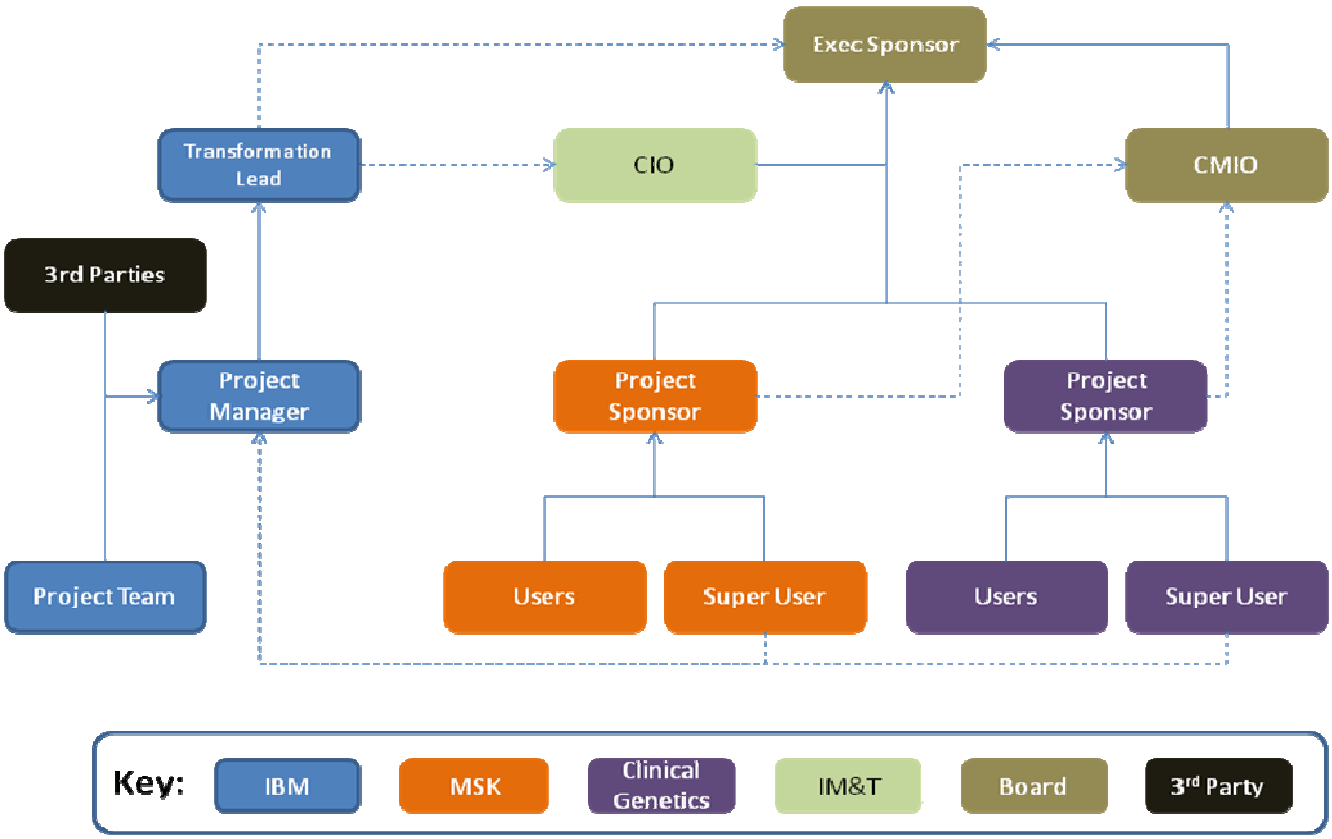
Governance

Weekly Project Meetings with the Department Champions will be run to report progress and raise any issue or concerns. The Project Manager will produce a weekly report that will be issued ahead of the meeting as a basis for the discussion.

In addition to this fortnightly Project Steering Board meetings will be arranged to discuss progress and issues on the work being carried out under this, plus any other relevant Project Orders. Trust attendees at this meeting will include the CIO, CMIOs

and the Project Sponsors for each area supported by any additional resources as required.

The organisation chart is show in the diagram below.



Implications for the Full Implementation

Carrying out the trial implementation will mean the following benefits for the wider implementation of EDRM within the Trust:

Inform

- Brings electronic ways of working to outpatient activity, validating efficiency benefits, process change impacts and improving confidence in the technical implementation.
- Applies practical information governance to electronic patient records within a highly confidential area of the hospital.
- Provides the opportunity to measure tangible and intangible benefits, including staff efficiency, clinical adoption, patient experience and safety.
- Surfaces the clinical and cultural adoption issues and potential mitigation that can in turn be fed into the full implementation approach.
- Tests the key solution components – 3rd party scanning services and EDRM platform with real workload and live operation.

Reuse

- Starts the Specialty adoption – creates a potential re-usable adoption model and platform that can be applied in other specialties to accelerate the implementation, where they have similar outpatient processes. This could

save in the order of 10-15% of the planned duration for the latter Specialty roll out.
- Although not targeted at the main Core Notes, the trial implementation creates some reusable assets that will need to be extended for the full implementation, such as configuration and training elements, which could save time in the wider implementation.
-

Reduce

- Investment in licensing for the trial implementation will be removed from the full implementation license costs.
- Creates a baseline design and configuration that can be extended for the full implementation.
- Creates training template / assets and a re-usable approach that can be enhanced to support the full roll out.
- Creates a change and communications template that can be extended to the full rollout.
- Although the trial implementation is focused on a single Speciality and MSK referrals it is anticipated that this could lead to a potential reduction of between 3 - 5% of the effort for the full implementation, based on current scope.

Next Steps for Full Business Case

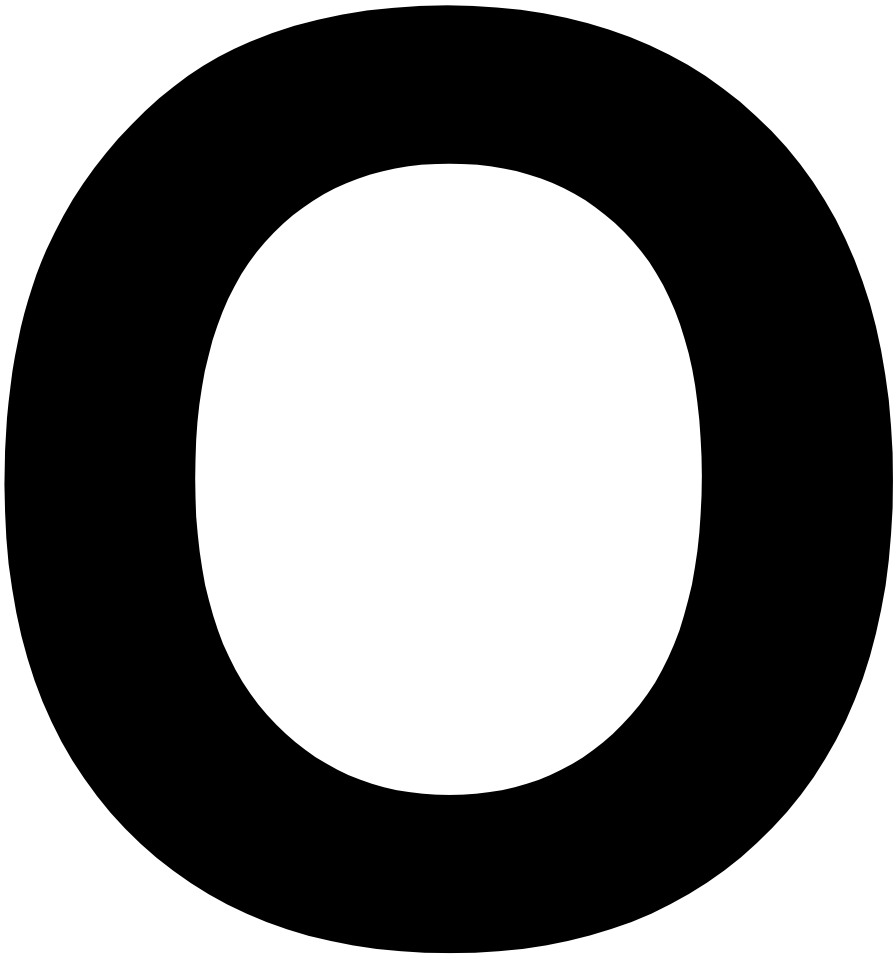
A Business Case for the Full Implementation was prepared at the end of last year, using the Five Case Model, and circulated to the JGB and Trust Board in November. A question remains as to how this should be taken forward while the Trial Implementation is underway for which there are essentially two options:

1. Submit the Business Case for the Full Implementation to the NTDA as soon as possible in order to commence discussions, refining if necessary as the Trial Implementation progresses.

2. Wait for the Trial Implementation to finish i.e. June 2014 and then take the decision about whether or not to submit the Business Case to the NTDA.

The decision from the project team is that, as we need to do an OBC followed by FBC, we are better off starting the process ASAP as we will be able to inform the FBC better as we get the information through the pilot work. If we wait for the pilot to complete, we will have a “dead period” after the pilot when we are seeking authority to proceed.

John Clarke
Chief information Officer



To:	Trust Board
From:	Rachel Overfield, Chief Nurse
Date:	27th February 2014
CQC regulation:	Outcome 1,4,17

Title:	Patient Experience Story – Maternity Care

Author/Responsible Director:
Marian Parrish, Ward Sister
Joan Morrissey, Senior Midwife
Michaela Thompson, Patient Experience Sister

Purpose of the Report: To describe for Trust Board the experience of care for a mother following the delivery of her baby in Ward 30 Leicester General Hospital

The Report is provided to the Board for:

Decision		Discussion	X
Assurance		Endorsement	

Summary / Key Points:

Introduction

From February 2014 the Maternity Friends and Family Test results are available to the public via the NHS choice website and the Trust public website. This means that women seeking information about Leicester's Hospitals as a care provider for their journey through pregnancy, birth and after their baby is born can compare us with other Trusts to see if previous mothers would recommend the maternity services.

The Friends and Family Test is a high level metric that allows the public to view feedback from patients about specific services and also focuses improvement activity. Supplementary questions are also asked with the Friends and Family Test to provide information about why this score has been given. The Friends and Family Test is collected via a range of mediums and is used to measure from the patients perspective if the trusts is providing 'Caring at its Best' and applying the Trust values.

Friends and Family Test in Leicester's Maternity Services

When reviewing patient feedback from maternity services in Leicester's Hospitals, many women are generally telling us, as one patient states "I'm very happy with overall care and services I have received" (data from December 2013 Friends and Family Test).

In January 2014, 702 (20.9%) patients completed the Friends and Family Test in Maternity. Of these:

Promoters	Passives	Detractors	Don't Know
487	192	18	5

The Maternity teams are learning from the feedback and celebrating/reinforcing aspects of care that the patients positively evaluate and identifying the reasons why patients are detractors and changing/improving services in line with this feedback.

Experience of Care on Ward 30 Leicester General Hospital

A woman who gave birth on ward 30 Leicester General Hospital in November 2013 is captured on DVD and provides details of some areas of concerns from her experience:

- The patient thought the staff were wonderful but that there were just not enough of them.
- Not being offered anything to eat or drink for a long period
- Handover of care

Improvements Made in Line With This Feedback

There have been a number of developments and improvements in response to feedback on ward 30, Leicester General Hospital and these are highlighted below:

- A review of the establishment in 2012 increased the numbers of midwives from 66 WTE in 2012 to 78, this was to take into account the new Maternity Assessment Unit, Labour ward and the Antenatal/Postnatal ward. Qualified midwives either rotate throughout these areas or remain core and can request which they prefer. There has been a decline in birth rates in the past two years however the complexity of the women we care for has increased so the decline is not significant in the clinical areas and would only equate to two deliveries a day across both sites. At present there are five midwife vacancies and interviews are on the 19th February. In 2013 there have been two extra ward clerk posts, a band 7 across site for low risk care, developing the Band 3 maternity support worker roles and an extra housekeeper post on the LGH site.
- Matron rounds to ensure increased communication of needs from women and increased awareness of prioritising work load and informing patients after handover.
- Baby Feeding Logs are awaiting ratification then will be introduced.
- New house keeper role secured and vacancy filled. Training given on how to order out of hours snack boxes and to ensure toast, cake and fruit are always available 24/7.
- The information leaflet welcoming women to the ward has been updated to highlight the availability of food and refreshments and the Baby Feeding Logs.
- The 6C's is being promoted and ensuring all staff are incorporating the culture of enhancing patient experience.
- Exploring extending visiting times, whilst not compromising care and safety of the women and their babies.

Recommendations:
The Trust Board is asked to:

- Receive and listen to the patient's story
- Support the improvements instigated in response to this feedback.

Previously considered at another corporate UHL Committee? No

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

Resource Implications (eg Financial, HR): None

Assurance Implications: This paper provides assurance that the maternity clinical teams are listening and acting upon patient feedback to improve patients experience of care.

Patient and Public Involvement (PPI) Implications: Patient encouraged to share their stories of care within the trust.

Stakeholder Engagement Implications: None

Equality Impact: None

Information exempt from Disclosure: N/A
Requirement for further review? No requirement for further review or further review to share their stories of care clinical teams are listening and acting upon patient feebdback to improve pati

P

	TRUST BOARD
From:	Rachel Overfield, Kevin Harris, Richard Mitchell Kate Bradley Peter Hollinshead
Date:	**27th February 2014**
CQC regulation	All

Title:	**Quality & Performance Report**

Author/Responsible Director: R Overfield, Chief Nurse
K. Harris, Medical Director
R, Mitchell, Chief Operating Officer
K. Bradley, Director of Human Resources
P Hollinshead, Interim Director of Financial Strategy

Purpose of the Report:
To provide members with an overview of UHL quality, operational performance against national and local indicators and Finance for the month of January.

The Report is provided to the Board for:

Decision		Discussion	√
Assurance	√	Endorsement	

Summary / Key Points:

Successes

- Theatres – 100% WHO compliant for the last 12 months.
- 62 day cancer – performance for December was 89.4% and year to date performance now delivering 85.5%,
- The percentage of stoke patients spending 90% of their stay on a stroke ward year to date position is 82.1%.
- Friends and Family Test - performance for December is 71.8%.

Areas to watch:-

- Diagnostic waiting times– the 1% threshold was missed in January
- C&B – performance similar to this time last year and target is still not delivered.
- VTE - The VTE risk assessment within 24 hours of admission was 94.2% in January against a 95% threshold. A full investigation for the reasons the January performance below the threshold of 95% is being undertaken.

Exceptions/Contractual Queries:-

- Pressure Ulcers – recovery action plan signed off and revised trajectory agreed
- C Difficile – 62 reported year to date against a year to date target of 57.
- ED 4hr target - Performance for emergency care 4hr wait in January was 93.6%. Actions relating to the emergency care performance are included in the ED exception report.
- Cancelled Operations – contract query has been raised by the commissioners due

to consistent failure of the threshold. At the end of January a remedial action was submitted and is awaiting commissioner sign off.

- RTT admitted and non-admitted – Commissioners have agreed to a significant financial investment during 2014-15 to reduce waiting times in key challenged specialties. A recovery action plan has been submitted and is awaiting sign off by commissioners.

Finance key issues:-

- The Trust will not deliver its planned surplus and is forecasting a deficit position of £39.8m, and as such will not meet its breakeven duty
- The Trust has formally written to the NTDA to amend the EFL to enable the deficit to be cash managed
- The Capital Resource Limit will be achieved but further focus on the management of the programme is required

Recommendations: Members to note and receive the report	
Strategic Risk Register	**Performance KPIs year to date** CQC/NTDA
Resource Implications (eg Financial, HR) N/A	
Assurance Implications Underachieved targets will impact on the NTDA escalation level, CQC Intelligent Monitoring and the FT application	
Patient and Public Involvement (PPI) Implications Underachievement of targets potentially has a negative impact on patient experience and Trust reputation	
Equality Impact N/A	
Information exempt from Disclosure N/A	
Requirement for further review? Monthly review	

University Hospitals of Leicester NHS
NHS Trust

Caring at its best

Quality and Performance – January 2014

Trust Board

Thursday 27th February 2014

One team shared values

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **27th FEBRUARY 2014**

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

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

1.0 INTRODUCTION

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

2.0 2013/14 NTDA Oversight and Escalation Level

2.1 NTDA 2013/14 Indicators

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

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

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

Outcome Measures	Target	2012/13	Apr-13	May-13	Jun-13	Qtr1	Jul-13	Aug-13	Sep-13	Qtr2	Oct-13	Nov-13	Dec-13	Qtr 3	Jan-14	YTD
30 day emergency readmissions	7.0%	7.8%	7.5%	7.8%	7.7%	7.7%	7.5%	7.6%	7.8%	7.6%	7.9%	7.8%	8.0%	7.9%		7.7%
Avoidable Incidence of MRSA	0	2	0	0	0	0	0	0	1	1	0	0	0	0	0	1
Incidence of C. Difficile	67	94	6	7	2	15	6	5	9	20	6	6	5	17	10	62
Incidence of MSSA		46	5	2	5	12	1	4	3	8	1	1	1	3	3	26
Safety Thermometer Harm free care		94.1%*	92.1%	93.7%	93.6%		93.8%	93.5%	93.1%		94.7%	93.9%	94.0%		93.8%	
Never events	0	6	1	0	0	1	0	0	1	1	0	0	0	0	0	2
C-sections rates*	25%	23.9%	23.8%	26.1%	26.1%	25.3%	25.0%	25.2%	24.6%	24.9%	25.6%	27.5%	25.2%	26.1%	23.9%	25.3%
Maternal deaths	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Avoidable Pressure Ulcers (Grade 3 and 4)	0	98	11	3	8	22	7	8	5	20	4	4	5	13	7	62
VTE risk assessment	95%	94.5%	94.1%	94.5%	93.1%	93.9%	95.9%	95.2%	95.4%	95.3%	95.5%	96.7%	96.1%	96.1%	94.2%	95.1%
Open Central Alert System (CAS) Alerts		13	14	9	15		36	10	10		14	15	12		11	
WHO surgical checklist compliance	100%	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

*target revised to 25%

Quality Governance Indicators	Target	2012/13	Apr-13	May-13	Jun-13	Qtr1	Jul-13	Aug-13	Sep-13	Qtr2	Oct-13	Nov-13	Dec-13	Qtr 3	Jan-14	YTD
Patient satisfaction (friends and family)		64.5	66.4	73.9	64.9		66.0	69.6	67.6		66.2	70.3	68.7		71.8	68.6
Sickness/absence rate	3.0%	3.4%	3.3%	3.1%	3.0%	3.2%	3.2%	3.1%	3.1%	3.1%	3.3%	3.5%	3.9%	3.6%	4.5%*	3.4%
Proportion temporary staff – clinical and non-clinical (WTE for Bank, Overtime and Agency)			5.6%	5.9%	5.6%		5.6%	5.5%	5.3%		6.0%	6.1%	6.0%		5.0%	
Staff turnover (excluding Junior Doctors and Facilities)	10.0%	9.0%	8.8%	8.9%	9.2%		9.5%	9.3%	9.7%		9.6%	9.7%	10.2%		10.6%	
Mixed sex accommodation breaches	0	7	0	0	0	0	0	0	0	0	0	2	0	2	0	2
% staff appraised	95%	90.1%	90.9%	90.2%	90.7%		92.4%	92.7%	91.9%		91.0%	91.8%	92.4%		91.9%	91.9%
Statutory and Mandatory Training	75%		45%	46%	46%		48%	49%	55%		58%	60%	65%		69%	
% Corporate Induction attendance rate	95%		87%	82%	95%		90%	94%	94%		91%	87%	89%		93%	90%

*provisional data

2.2 UHL NTDA Escalation Level

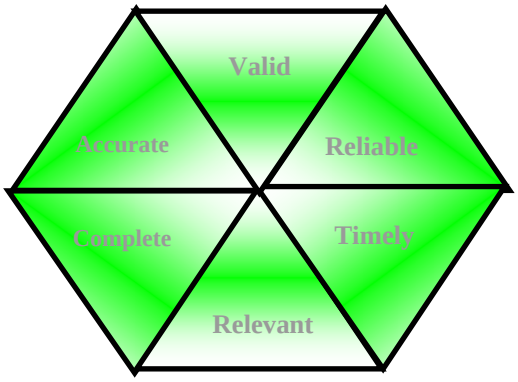
The Accountability Framework sets out five different categories by which Trust's are defined, depending on key quality, delivery and finance standards.

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

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

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

3.0 DATA QUALITY DIAMOND



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

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

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

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

4.0 QUALITY AND PATIENT SAFETY – KEVIN HARRIS/RACHEL OVERFIELD

4.1 Quality Commitment

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

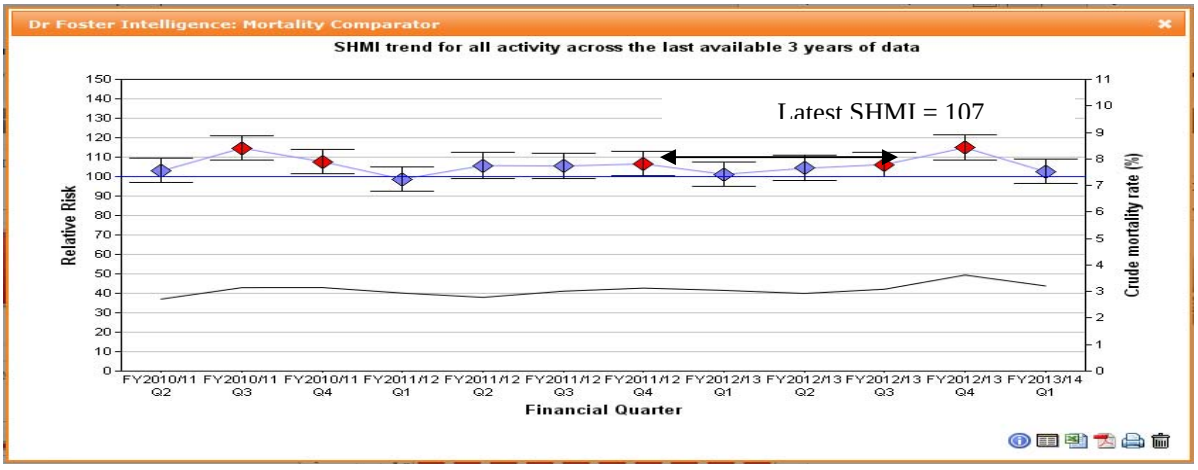
4.2 Mortality Rates

Mth | Qtr 1 | Qtr2 | Qtr3 | YTD

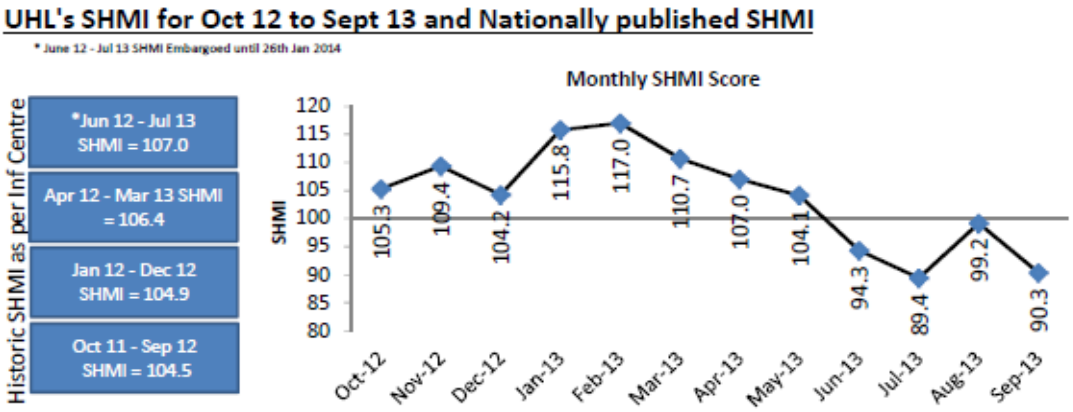
SUMMARY HOSPITAL MORTALITY INDEX (SHMI)

The latest SHMI by the Health and Social Care Information Centre (HSCIC) was published at the end of January and covers the 12 month period July 12 to June 13. As anticipated UHL's SHMI has gone up from 106 to 107 however, it remains in Band 2 (ie within expected). This slight increase was anticipated as the latest 'rolling 12 month' period includes April 13 where we saw an increase in both UHL's crude and risk adjusted mortality. Whilst the

As can be seen from the Quarterly SHMI chart below, Jul 12 to Jun 13 will also include the increased SHMI period for January to March 13 whilst losing the lower SHMI of April to June 2012.



As advised previously, UHL is able to use the Hospital Evaluation Dataset tool (HED) to internally monitor our SHMI on a monthly basis. UHL's SHMI for the months May to October 2013 is predicted to be closer to 100 (see below). However, due to the published SHMI being based on a '12 month rolling figure', the trust's published SHMI is likely to remain above 100 until the Jan to April 13 period is not included.



HOSPITAL STANDARDISED MORTALITY RATIO (HSMR)

Previous Q&P reports have presented UHL's 'in hospital' risk adjusted mortality (HSMR) using the Dr Foster tool. However, Dr Fosters do not rebase their HSMR until the end of each financial year and UHL's HSMR has gone up each time.

The HED tool also includes HSMR and this is rebased monthly and it has therefore been agreed that UHL's monthly HSMR will now be reported using the HED data.

UHL's HSMR for 2013 (Jan to Nov) is 100.3 and for Sept to Nov has been below 100.

	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	YTD
Mortality HSMR - (HED) OVERALL Rebased Monthly	101.4	98.6	104.7	109.8	101.6	98.2	104.6	103.6	95	93.7	96.26	tbc	100.3

UHL's crude mortality rates are also monitored as these are available for the more recent time periods. As can be seen from the table below, whilst there is 'month on month' variation, the overall rate for 13/14 (Apr 13 to Jan 14) is slightly lower than in 12/13.

HOSPITAL STANDARDISED MORTALITY RATIO (HSMR)

	Month	Jan-13	Feb-13	Mar-13	FY 2012/13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	FYTD 2013/14
ALL SPELLS	No of Patients Disch/Died	18,579	17,321	18,439	**221,146**	17,870	18,692	17,734	19,135	17,890	18,199	19,673	18,683	17,898	19,527	185,301
	No of in-hospital deaths	313	275	288	**3,177**	277	254	229	229	233	218	253	251	267	245	2,456
	Crude Mortality Rate	1.70%	1.60%	1.60%	**1.40%**	1.60%	1.40%	1.30%	1.20%	1.30%	1.20%	1.30%	1.30%	1.50%	1.30%	1.30%

DR FOSTER MORTALITY

In the recently published Dr Foster Hospital Guide, UHL was reported as having a 'higher than expected' mortality rate in 12/13 for patients who died with 'low risk diagnosis groups'. (such as, chest pain, abdominal pain, abdominal hernia, speech disorder). Whilst this 'alert' was subsequently found to be an error, UHL has seen a higher than expected number of deaths for the time period October to December 2012.

All of these deaths have been reviewed and, for the majority of patients, their death was expected and appropriate care was given.

4.3 Patient Safety

Mth | Qtr 1 | Qtr2 | Qtr3 | YTD

In January a total of 20 new Serious Untoward Incidents (SUIs) were escalated within the Trust, the highest number for 3 years. 12 of these were patient safety incidents, 7 were Hospital Acquired Pressure Ulcers and 1 was a Healthcare Acquired Infection. 3 of the Patient Safety SUIs relate to Women's and Children's Services, 3 relate to the Cardiac, Respiratory and Renal CMG and 6 relate to Emergency and Specialist Medicine. No Never Events were reported in the Trust in January. Three patient safety root causes analysis (RCA) investigation reports were completed and signed off last month, the actions and learning of which have been shared internally. These will be further reviewed at the Trust's 'Learning from Experience Group'.

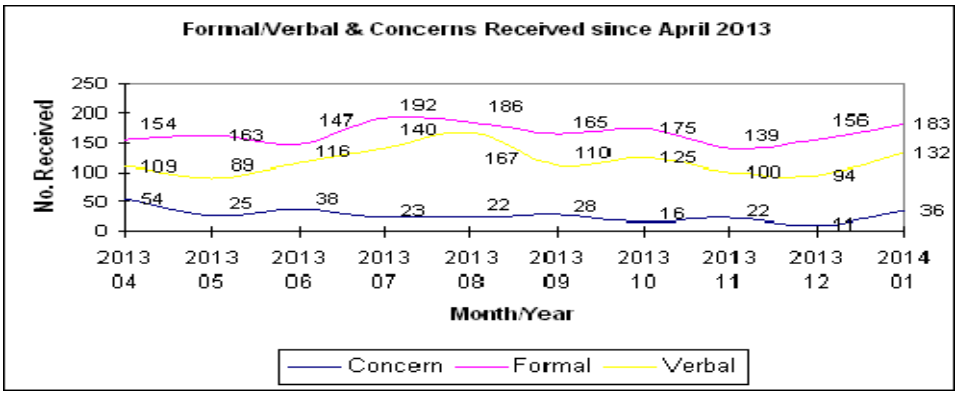
In January only one call was made to the 3636 Staff Concerns Reporting Line (possibly as many staff engagement events had been held ahead of the CQC inspection). This concern was fully investigated by a director and actions have been reported to the Executive Quality Board. A high level of compliance with deadlines for external CAS (Central Alerting System) alerts has been maintained - 100% for quarter three and 99% over a rolling 12 months.

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

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

Pleasingly, complaints relating to nursing care have reduced and complaints regarding staff attitude have dropped to the lowest level for over twelve months. Complaints performance has also improved a little last month.

Below is a trend graph which shows complaints activity over the past 10 months.



4.4 Critical Safety Actions

Mth | Qtr 1 | Qtr2 | Qtr3 | YTD

The aim of the 'Critical safety actions' (CSAs) programme is to see a reduction in avoidable mortality and morbidity. The key indicator being focused upon by commissioners is a reduction in Serious Untoward Incidents related to the CSAs.

1. **Improving Clinical Handover**.

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

Actions:-

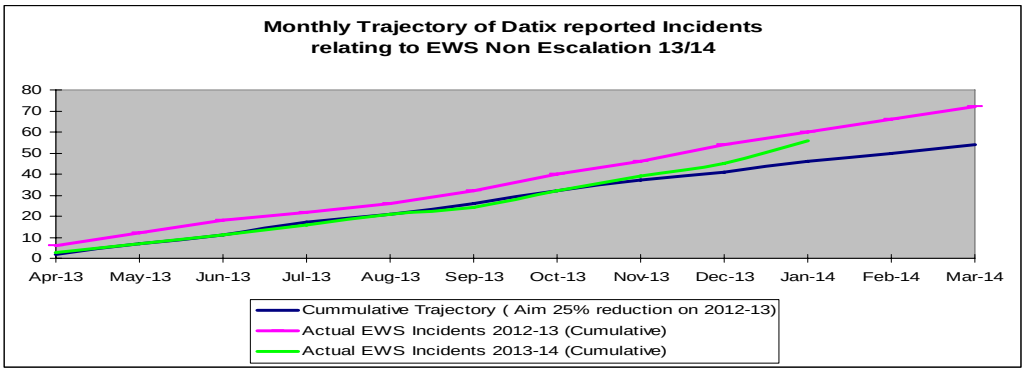
- The Nerve Centre handover project steering group is now meeting fortnightly to agree implementation plan. Plan to commence roll out in January has been delayed as work on 24/7 server upgrade and addition of handover module was not undertaken. This was mainly due to this work not being escalated to a 'live' project with IBM during handover period.
- Plans are being made to roll out to nursing staff first across the Trust and then follow on with medical staff once mobile devices are available.

2. Relentless attention to Early Warning Score triggers and actions

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

Actions:-

- EWS Datix reported incidents related to non escalation are still being monitored this year. The internal aim is to reduce these by 25% against 2012-13 figures. Looking at the graph below it is unlikely that we will now achieve a 25% reduction but we should still achieve a reduction in EWS incidents related to non escalation. To end of January 14 we have seen a 7% reduction to same point last year. Since last year there has been 2 new EWS chart implemented, one for post natal babies and a revised PEWS chart in Childrens This has meant the implementation of 2 new charts with one being additional to those in use last year.



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

% of red calls within response time <30 minutes

Site	October 13	November 13	December 13
GH	100%	100%	97%
LGH	98%	97%	98%
LRI	97%	98%	96%

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

- A case note review to validate data for the medical documentation of the review of patients with escalated EWS via 24/7 system out of hours took place for the LRI and GH sites in December, and the LGH site in January

undertaking one site per week. Results showed that not one site had a documented review for every escalated EWS out of hours, the actual results were:

Site	Number of EWS>4 red calls escalated	Number of EWS>4 calls with a documented medical review
GH	**16 (100%)**	**15 (94%)**
LRI	**39 (100%)**	**32 (82%)**
LGH	**32 (100%)**	**28 (87.5%)**

Where there is no documented review it must be assumed that the patient did not receive a medical review. A meeting will now take place in February with the EWS medical lead, the outreach lead and the 5CSA lead to discuss these results and identify actions to improve this position and agree timeframe for a further validation exercise.

3. Acting on Results

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

Actions:-

- Have received signed off processes for managing diagnostic tests for 70% of specialities now.
- CMG deputy directors have been very supportive of this work and have been working to ensure their specialities agree their processes.

4. Senior Clinical Review, Ward Rounds and Notation

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

Actions:-

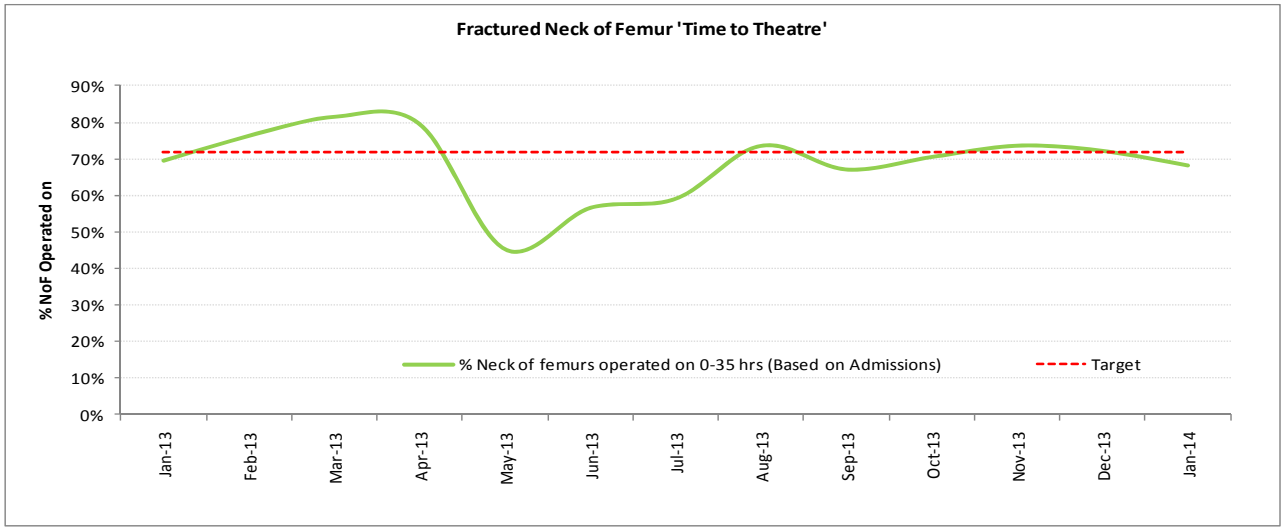
- All documentation finalised by the end of January for a revised February implementation and print changeover process.
- Negotiations taking place to secure ward round simulation sessions as a pilot in medicine to inform and scope for future ongoing training programme.

The Q3 CSA CQUIN visit to observe compliance had been confirmed for 14th February 2014. They have now been postponed due to lack of availability from CCG GP to attend visit. New date to be confirmed but areas for visit have been agreed as follows:

- Handover **– Nurse and doctor handover on cardiac ward GH**
- Ward Round **– Ward 16 respiratory GH**
- Acting on Results **– General surgery LRI inpatients and Max fax LRI outpatients**
- EWS **– Kinmonth unit**

4.5 Fractured Neck of Femur 'Time to Theatre'

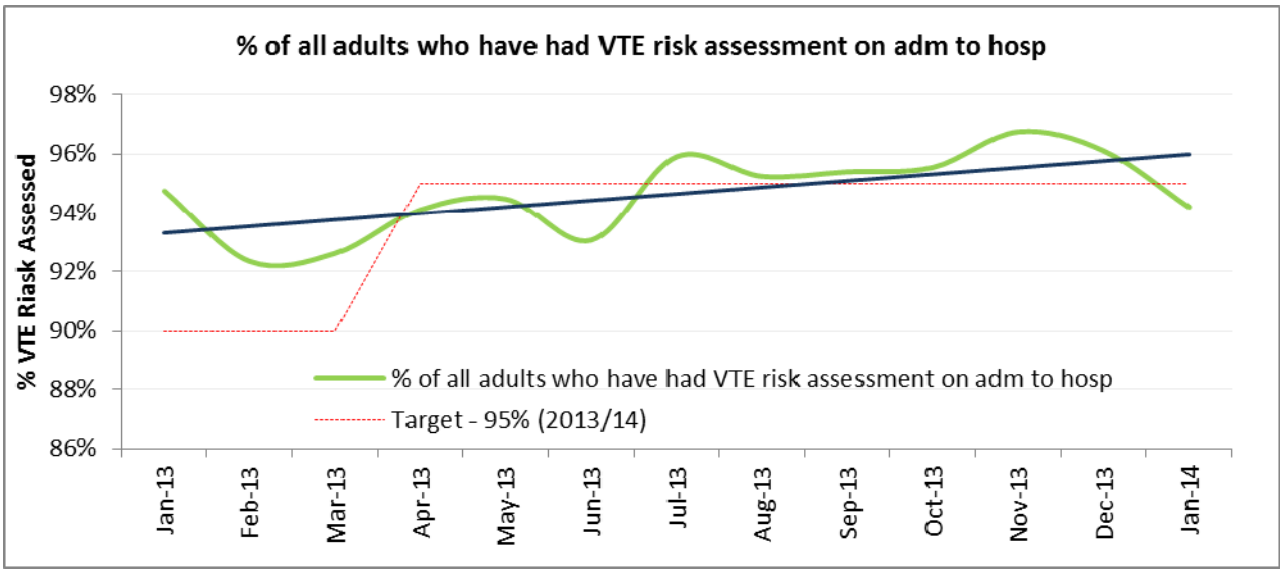
Mth | Qtr 1 | Qtr2 | Qtr3 | YTD



The percentage of patients admitted with fractured neck of femur during January who were operated on within 36hrs was 68.2% (45 out of 66 #NOF patients) against a target of 72%.

4.6 Venous Thrombo-embolism (VTE) Risk Assessment

Mth | Qtr 1 | Qtr 2 | Qtr 3 | YTD



The 95% threshold for VTE risk assessment within 24 hours of admission has not been achieved for January at 94.2%. However, the year to date performance is being achieved at 95.1%. A full investigation for the reasons the January performance below the threshold of 95% is being undertaken.

4.7 Quality Schedule and CQUIN Schemes

Specialised Services Commissioners have confirmed that UHL met the Quarter 3 thresholds for all CQUINs. CCG Commissioners have agreed to full payment for all but two of the National and Local CQUINs. Further review is required for the 'Safety Thermometer – CAUTI CQUIN' as some of the action plan timescales have not been met. Clarification has also been requested in respect of the Local 'Pneumonia CQUIN'. As both schemes have demonstrated improvements in outcomes for Quarter 3, it is anticipated that full payment will be achieved following this review.

In respect of the Quality Schedule indicators, there were 39 indicators due for reporting and of these 32 were given a Green RAG. Four indicators were given a Red RAG and a further three Amber.

The Red RAGs were for:

PR1.2 - Intraoperative Fluid Management (IOFM). The percentage of procedures having IOFM appears to have dropped since Q1. However, further audit work is underway to confirm whether this is a data issue. The supply of equipment to support IOFM suggests there is a higher usage than what is being recorded on the theatre database (ORMIS).

PE2a – Complaint Response Times. Response times for Complaints averaged at 87% for Q3 in respect of complaints due for a response within 25 days (Threshold is 95%). Performance has improved for January and is believed to be on track for the end of Q4.

IP2b – Compliance with the High Impact Interventions (Peripheral Lines and Urinary Catheters). Performance for Q3 was below the 90% for several CMGs. Following discussion at the Trust's Infection Prevention Assurance Committee, a different approach to ensuring compliance with the HIIs has been agreed, involving quarerly review of all patients with a peripheral or central line insitu. This process will be incorporated into the Safety Thermometer Audit Day.

PS2b – Compliance with Central Alerts – The actions relating to the NPASA "Right Patient Right Blood" have not been completed.

The Amber RAGs were for:

WF1 – Workforce – due to performance being below the trust's internally set threshold for mandatory training.

CE1 – Maternity Dashboard – due to the increased percentage of women having a Caesarean Section during Quarter 3. A full audit is currently underway to confirm that the RCOG guidelines are being followed.

CE6 – Mortality Dashboard – due to the SHMI being above 100.

In respect of the 14/15 Quality Schedule and CQUIN Schemes, contract negotiation discussions continue with the Commissioning Quality Leads. Internally details of proposed indicators have been discussed with the relevant leads and CMGs.

The aim has been to reduce the number of Quality Schedule indicators and also that these should reflect internally agreed work programmes (i.e. Infection Prevention, Medicines Optimisation)

In respect of the CQUIN programme, there are two current national CQUINs which will continue into 14/15 – Dementia and Friends & Family Test, although the latter has extended scope. The patient F&FT is to be implemented in both Outpatients and Day Case and there will also be a Staff F&FT.

In respect of the CCG commissioners, there are currently 7 local schemes that have been put forward by UHL, most of which are a continuation of previous CQUINs (MECC, Community Acquired Pneumonia Care Bundle, AMBER Care Bundle, Heart Failure Care Bundle, Quality Mark Charter. The other 2 are new schemes; Medication Safety Thermometer and Sepsis Care Bundle.

Commissioners have advised they would also like two CQUIN schemes around Urgent Care and the 'Seven Day Working' Plan, further details are to be discussed on 21st February.

Specialised Services have met with UHL to discuss potential CQUIN schemes they would like for 14/15. 'Breast feeding for babies discharged from the neonatal unit' and 'Utilisation Review of Critical Care Beds' are currently being considered. There will also be the continuation of the 'Quality Dashboards for each area of Specialised Services commissioned.

Both the Quality Schedule and CQUIN indicators for 14/15 are expected to be finalised by the end of February.

Schedule Ref	Indicator Title and Detail	Q3 RAG
IP1a	MRSA bacteraemias	G
IP1b	C Diff Numbers	G
IP1c	MRSA screens (Emergency & Elective admissions)	G
IP1d	MSSA bacteraemias	G
IP1e	E Coli bacteraemias	G
IP2a	Surgical Wound Surveillance - Caesarean Section	G
IP2b	Improved compliance with Surgical Wound, Peripheral Canula and Urinary Cathether HIIs across UHL	R
PS1b	Never Events	G
PS2a	Risk register - Board Assurance Framework report	G
PS2b	Central Alerting System Patient Safety Alerts and Rapid Response Reports (NPSA PSA and RRR)	R
PS3	Safe Guarding for Adults and Children	G
PS4	Ward Health Check Proactive oversight and scrutiny of ward level data to ensure safety care delivery	G
PS6	Eliminating "avoidable" Grade 2, 3 and 4 Hospital Acquired Pressure Ulcers	G
WF1	Organisational Development Plan Update and Workforce Metrics	A
MM1d	Antipsychotic drugs are prescribed in line with the EM SHA prescribing guideline	G
MM1e	Non compliance with Traffic Light Policy	G
MM1f	Compliance with LLR Formulary for prescribing	G
MM1g	Medication errors causing serious harm	G
PE1a	SSA Breaches Monthly Compliance	G
PE2a	Number of Formal Written Complaints and Rates against Activity	G
PE2b	Response to complainants within agreed timescales	R
PE3a	Progress in respect of Quality Commitment of the Patient Centred Care Priorities for 2013:	G
PE4	ED service experience.	G
PE5	Improve staff engagement	G
PE6	Implementation of the Trust's Equality high level plan.	G
CE1	Maternity Dashboard	A
CE2	Children's Services Dashboard	G
CE3a	PROMS Participation for patients undergoing Groin Hernia Surgery Varicose Vein Repair	G
CE5a)	Improve performance with the Stroke Dashboard Indicators	G

Schedule Ref	Indicator Title and Detail	Q3 RAG
CE6	Mortality Dashboard to include: SHMI HSMR	A
CE7a	Compliance with NICE Technology Appraisals published in 13/14	G
CE7b	Compliance with all NICE Guidance published in 13/14	G
CE7c	Clinical Audit 13/14 programme progress	G
CE8	Francis Report and 'Transforming Care' Recommendations	G
CE9	National Quality Dashboard	G
CE10	Consultant level survival rates as stated on the 'Everyone Counts' document	G
PR1.1	Use of Digital First to reduce inappropriate face-to-face contacts	G
PR1.2	Use of IntraOperative Fluid Management	R
PR1.3	Carers of patients with dementia receive advice	G
Nat 1.2	Implementation of Friends and Family Test: 1.2 Increased Response Rate	G
Nat 2.1	2.1. To collect data on the following three elements of the NHS Safety Thermometer: pressure ulcers, falls and urinary tract infection in patients with a catheter	G
Nat 2.2a	2. 2a Reduction in the prevalence of CAUTI	TBC
Nat 2.2b	2. 2b Reduction in the prevalence of Falls	G
Nat 3	3.1a .Patients aged 75 and over admitted as an emergency are screened for dementia within 72 hrs of admission, 3.1b. Where screening is positive patients are assessed 3.1c Where risk assessment suggests dementia, patients are referred to their GP	G
Nat 3	3.2 Training of staff – Category A, B C	
Nat 3	3.3. Ensuring carers of people with dementia feel adequately supported	G
Nat 4	Reduce avoidable death,disability and chronic ill health from Venous thromboembolism(VTE) 1. VTE risk assessment	G
Nat 4	2. VTE RCAs	G
Loc 1.1	MECC - Increase in number of referrals to Smoking Cessation Services (STOP), Alcohol Liaison, Healthy Eating	G
Loc 2	Implementation of the AMBER care bundle to ensure patients and carers will receive the highest possible standards of end of life care	G
Loc 3	Improve care pathway and discharge for patients with Pneumonia a) Admission directly to respiratory ward (Glenfield site) and piloting of 'pneumonia virtual clinic for patients admitted to LRI') b) Improving care pathway and discharge for patients with Pneumonia - Implementation of Pneumonia Care Bundle	TBC
Loc 4	Improving care pathway and discharge for patients with Heart Failure - Implementation of Care Bundle and discharge Check List and piloting of 'virtual ward'	G
Loc 5	Critical Safety Actions: Clinical Handover, Acting on Results, Senior Clinical Review, Ward Round and Notation standards and Early Warning Scores (EWS)	G
Loc 6	Implementation of DoH Quality Mark with specific focus on Dignity Aspects	G
SS1	Implementation of Specialised Service Quality Dashboards	G
SS2	Bone Marrow Transplant (BMT) – Donor	G

Schedule Ref	Indicator Title and Detail	Q3 RAG
	acquisition measures	
SS3	Fetal Medicine – Rapidity of obtaining a tertiary level fetal medicine opinion	G
SS4	Increase use of Haemtrack for monitoring clotting factor requirements	G
SS5	Discharge planning is important in improving the efficiency of units and engaging parents in the care of their infants thereby improving carer satisfaction of NICU services.	G
SS6	Radiotherapy – Improving the proportion of radical Intensity modulated radiotherapy (excluding breast and brain) with level 2 imaging – image guided radiotherapy (IGRT)	G
SS7	Acute Kidney Injury	G
SS8	PICU - . To prevent and reduce unplanned readmissions to PICU within 48 hours	G

4.8 Theatres – 100% WHO compliance

Mth | Qtr 1 | Qtr2 | Qtr3 | YTD

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

4.9 C-sections rate

Mth | Qtr 1 | Qtr2 | Qtr3 | YTD

The C-section rate for January is 23.9% against a target of 25%

4.10 Safety Thermometer

Areas to note for the January Safety Thermometer:-

- Harm free care remains at 93.8%
- The increase in newly acquired harms increased slightly and is likely to have been caused by an increase in the prevalence of newly acquired pressure ulcers
- There was a small increase in the prevalence of falls with a harm.
- There has been an increase in the number of VTEs for a fifth month in succession. However, data analysis confirms that not all the VTEs are hospital acquired thrombosis (HAT).

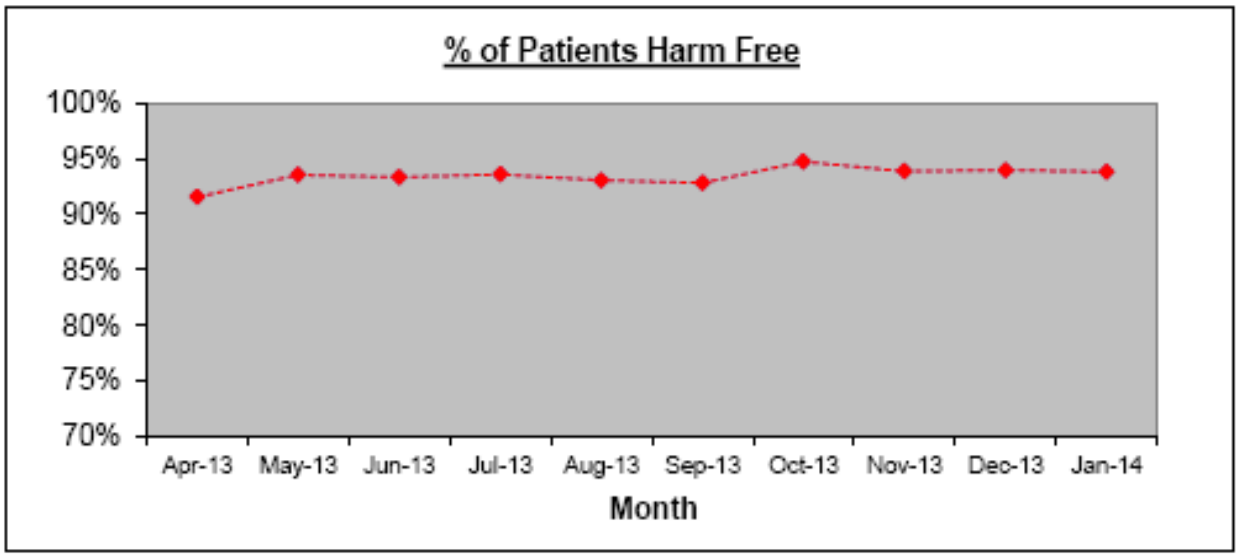
ANALYSIS OF SAFETY THERMOMETER DATA - April 2103 to Jan 2014

		Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14
	Number of patients on ward	1672	1686	1650	1514	1496	1579	1596	1662	1558	1616
All Harms	Total No of Harms - Old (Community) and Newly Acquired (UHL)	150	117	113	100	108	121	85	102	102	104
	No of patients with no Harms	1531	1577	1540	1417	1392	1466	1512	1560	1464	1516
	% Harm Free	91.57%	93.53%	93.33%	93.59%	93.05%	92.84%	94.74%	93.86%	93.97%	93.81%
New	Total No of Newly Acquired (UHL) Harms	73	58	56	49	59	46	42	40	41	46
Harms	No of Patients with no Newly Acquired Harms	1600	1631	1596	1466	1438	1535	1555	1622	1519	1572
	% of UHL Patients with No Newly Acquired Harms	95.69%	96.74%	96.73%	96.83%	96.12%	97.21%	97.43%	97.59%	97.50%	97.28%
Harm One	No of Patients with an OLD or NEWLY Acquired Grade 2, 3 or 4 PU	92	75	73	66	67	87	54	74	62	69
	No of Newly Acquired Grade 2, 3 or 4 PUs	26	27	26	19	25	16	19	17	13	21
Harm Two	No of Patients with falls in a care setting in previous 72 hrs resulting in harm	14	8	8	5	3	3	2	3	3	5
	No of patients with falls in UHL in previous 72 hrs resulting in harm	3	3	4	5	2	2	2	1	3	5
Harm Three	No of Patients with Urinary Catheter and Urine Infection (prior to or post admission)	36	27	27	25	31	25	22	15	24	14
	Number of New Catheter Associated UTIs	25	16	17	21	24	21	14	10	12	4
Harm Four	Newly Acquired community or hospital acquired VTE (DVT, PE or Other)	8	7	5	4	7	6	7	10	13	16
	Hospital Acquired Thrombosis (HAT)						2	1	6	7	4

Amendments to the Falls and VTE rows have been made

1) Number of falls in a care setting in previous 72 hours has been sub-divided into Falls in UHL.
2) Number of Newly Acquired community or hospital acquired VTE (DVT, PE or Other) has been sub-divided into Hospital Acquired Thrombosis (HAT) separating those patients admitted to UHL in the previous 72 hours with a VTE i.e. community acquired and those that have developed a VTE in UHL

Chart One – UHL Percentage of Harm Free Care April to January 2014



DETAILED ANALYSIS OF FOUR HARMS

a) Falls

In January 2014, UHL reported five patients who hospital fall resulted in a harm. All five falls occurred within UHL and all harms sustained were level 2. The injuries sustained were either bruising or a laceration to the head or face. The falls in January 2014 are an increase on the falls that occurred in December 2013 where only 3 falls were reported but it is felt that the increase is a fluctuation due to the small figures we are reporting.

b) Pressure Ulcers

The increase in prevalence of pressure ulcers does correlate with the number of avoidable ulcers in January 2014.

c) VTE

There appears to have been an increase for the fifth month in succession in the prevalence of VTE harms for the month of January 2014. However, data analysis confirms that not all the VTEs reported are hospital acquired, the majority appear to community acquired. As per safety thermometer guidance, new VTE harms must include those patients who were admitted, diagnosed with a VTE and commenced treatment in a 72 period prior to the Safety Thermometer data collection period. i.e. community acquired VTE. This information will now be included within future reports.

d) CAUTI

There has been a decrease in the number of CAUTIs reported in January 2014. A significant amount of educational interventions has been undertaken since September 2013 in relation to the promotion of continence across the Trust following the appointment of a second Continence Nurse Specialist funded via CQUIN monies. It is too early to suggest this additional support has contributed to a reduction in catheter associated UTIs but it is a promising start.

Pressure Ulcer Prevalence

There has been a slight increase in the prevalence of new pressure ulcer harms for all patients and those over 70 years of age in January 2014 compared to previous months. One other peer organisation has also experienced this increase.

Chart Two – New Pressure Ulcers (all Patients) from Nov 2012 to Jan 2014

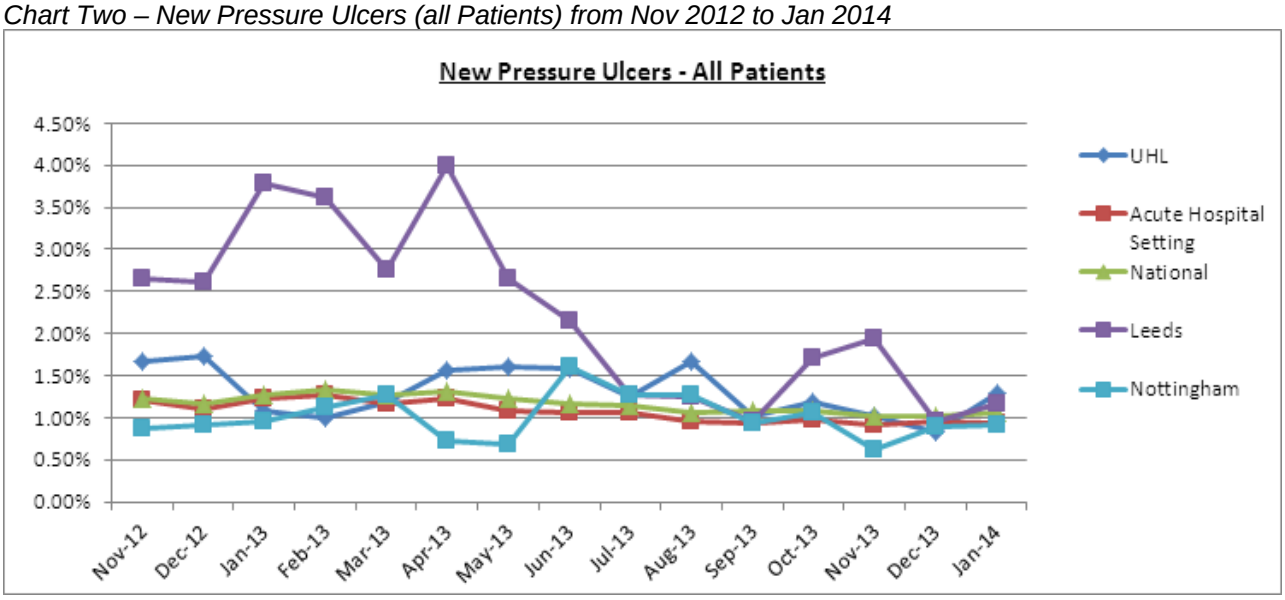
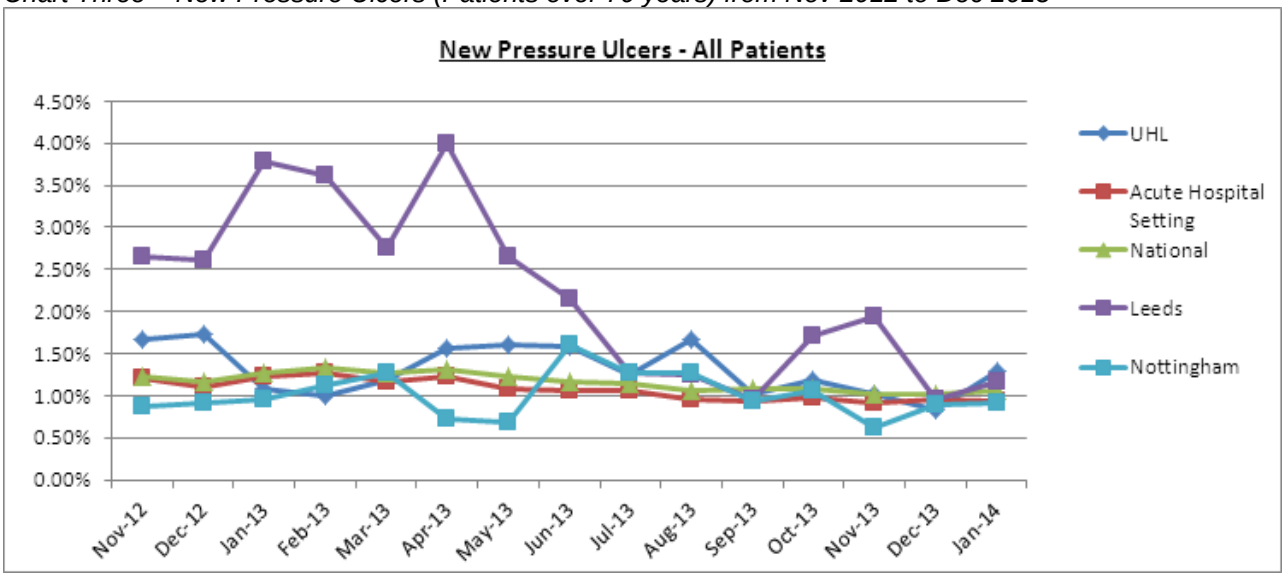


Chart Three – New Pressure Ulcers (Patients over 70 years) from Nov 2012 to Dec 2013



Falls Prevalence

Charts four and five confirm a slight increase in the prevalence of falls with harm for UHL in January 2014. However, there has been no change in UHL's position in comparison to other acute hospital settings.

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

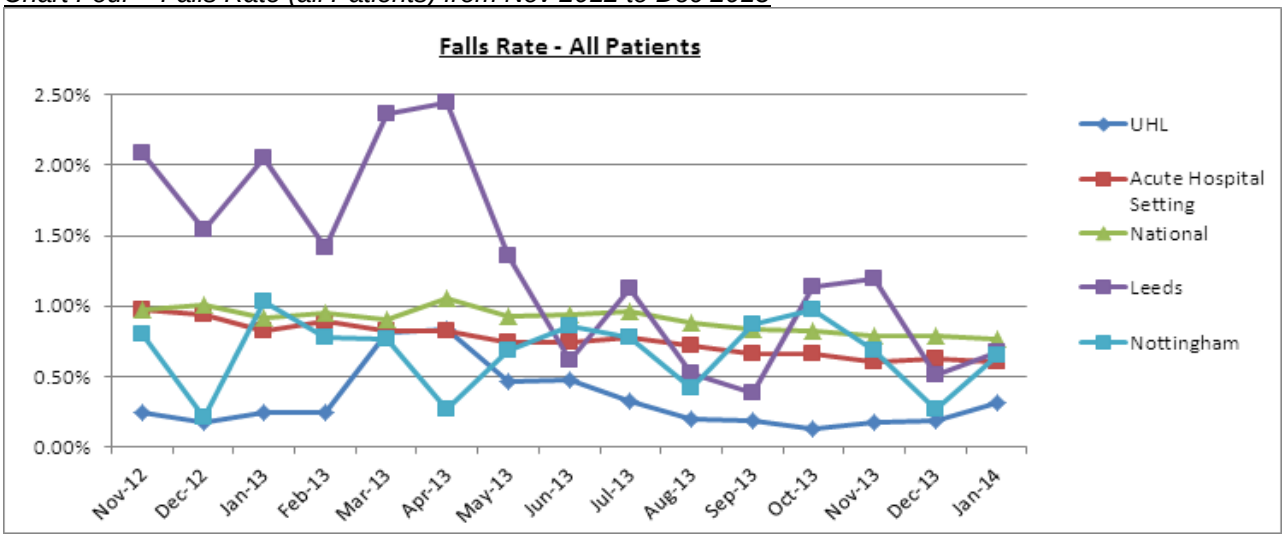
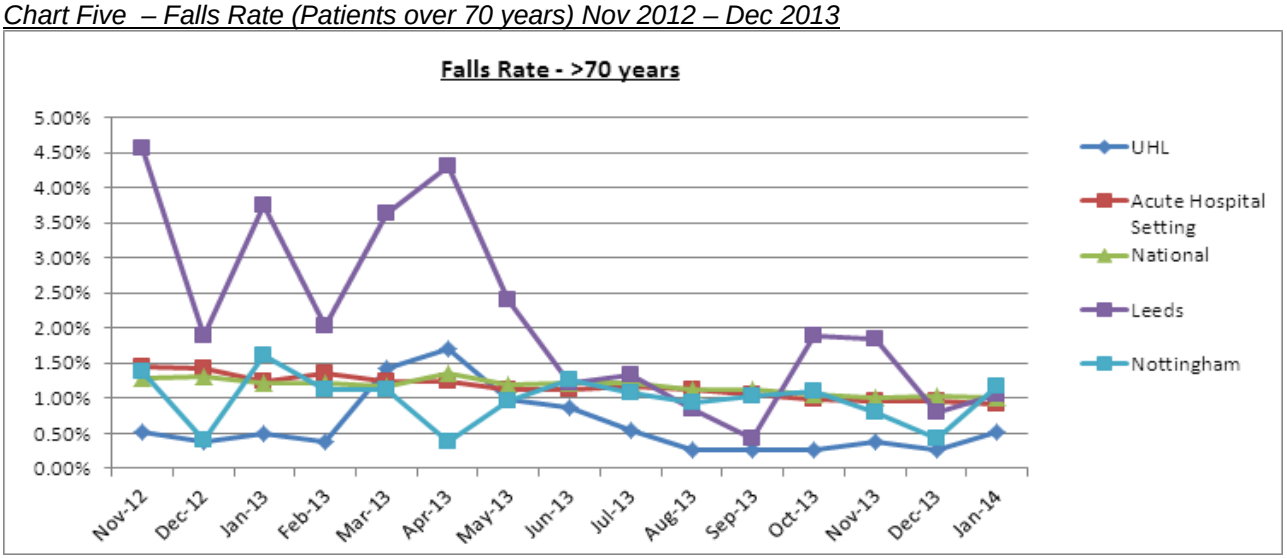
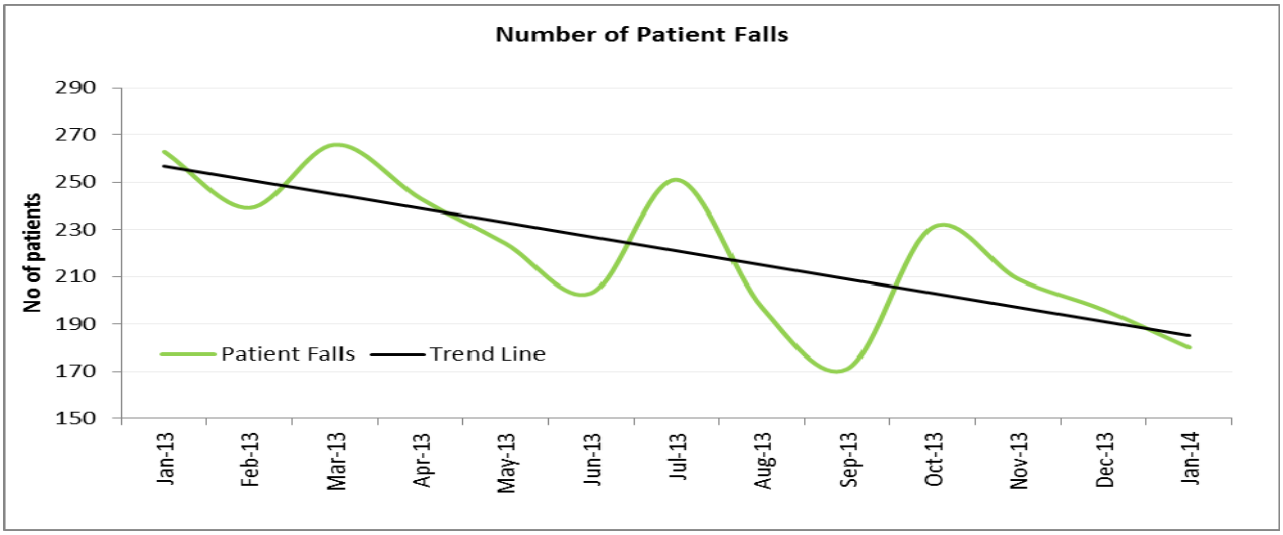


Chart Five – Falls Rate (Patients over 70 years) Nov 2012 – Dec 2013



Patient Falls



Falls incidence for January 2013 was 180 this may be subject to change in February due to outstanding Datix incidents being closed by ward managers.

The number of falls reported on Datix for January 2014 has seen a further decrease from the number of falls reported in December 2013

Pressure Ulcer Incidence

Mth	Qtr 1	Qtr 2	Qtr 3	YTD

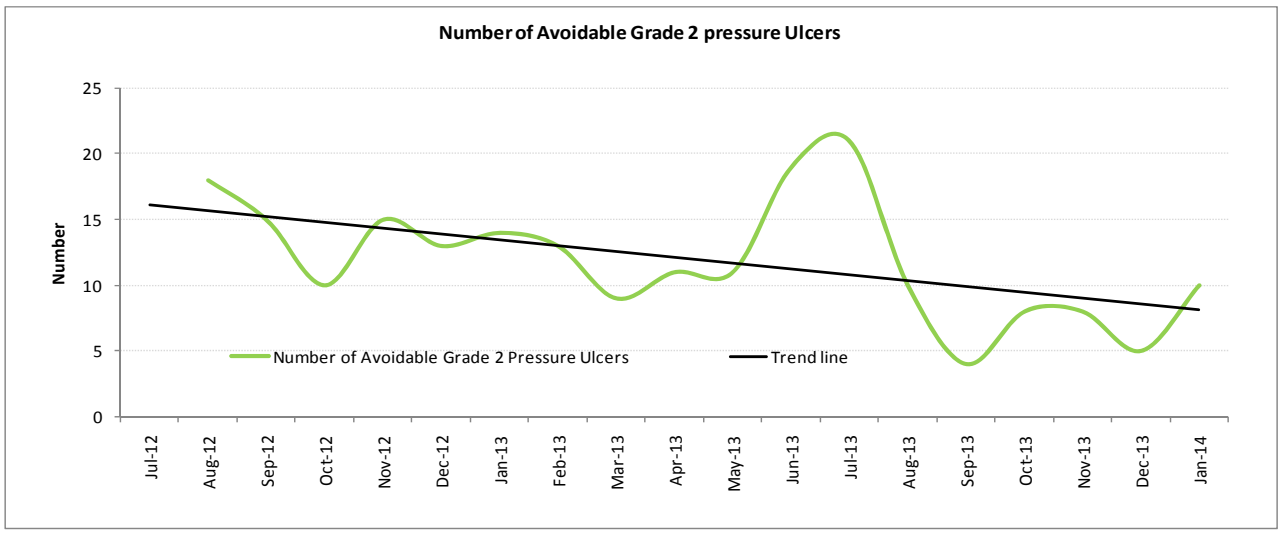
The number of avoidable grade 3 pressure ulcers for January 2014 was seven Grade 3 ulcers (within threshold) and ten grade 2 ulcers (which is one over threshold).

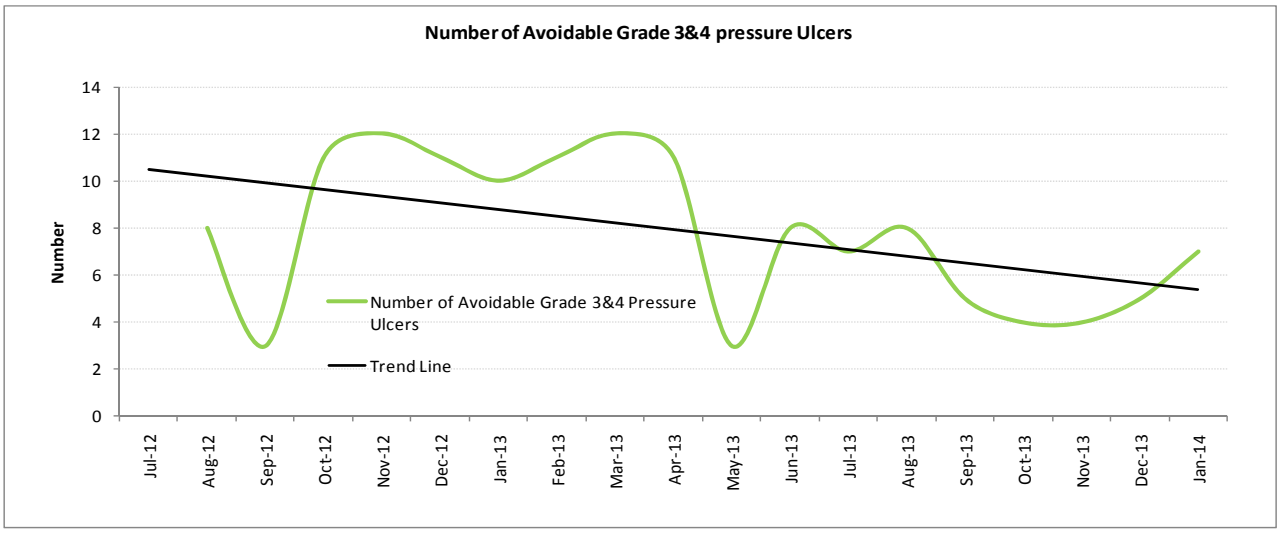
For the month of January 2014, UHL has not maintained the reduction thresholds for avoidable pressure ulcers and so the Trust will receive a £50,000 penalty.

The main themes highlighted for those areas reporting avoidable ulcers include:

- Gaps in repositioning or long periods sitting out of bed
- No heel protection
- Poor documentation and assessment on admission
- Delays in implementing pressure ulcer preventative measures

Heads of Nursing have been asked to undertake a review of the areas reporting avoidable ulcers and to report to the Chief Nurse actions taken.





5.0 PATIENT EXPERIENCE – RACHEL OVERFIELD

5.1 Infection Prevention

a) MRSA

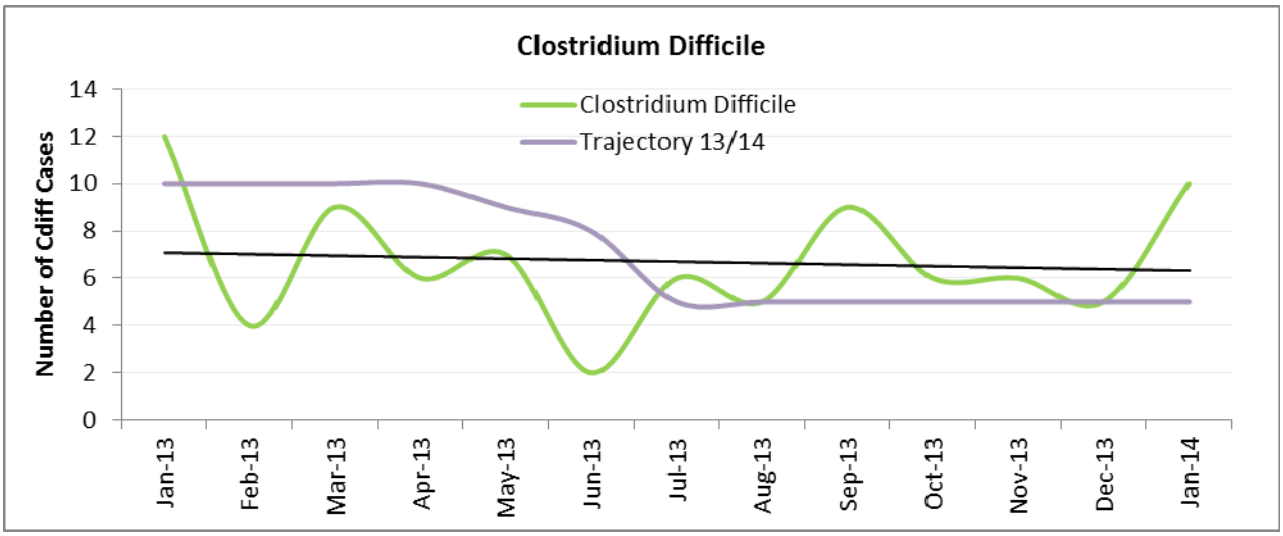
Mth	Qtr 1	Qtr 2	Qtr 3	YTD

There were no avoidable MRSA cases reported in January.

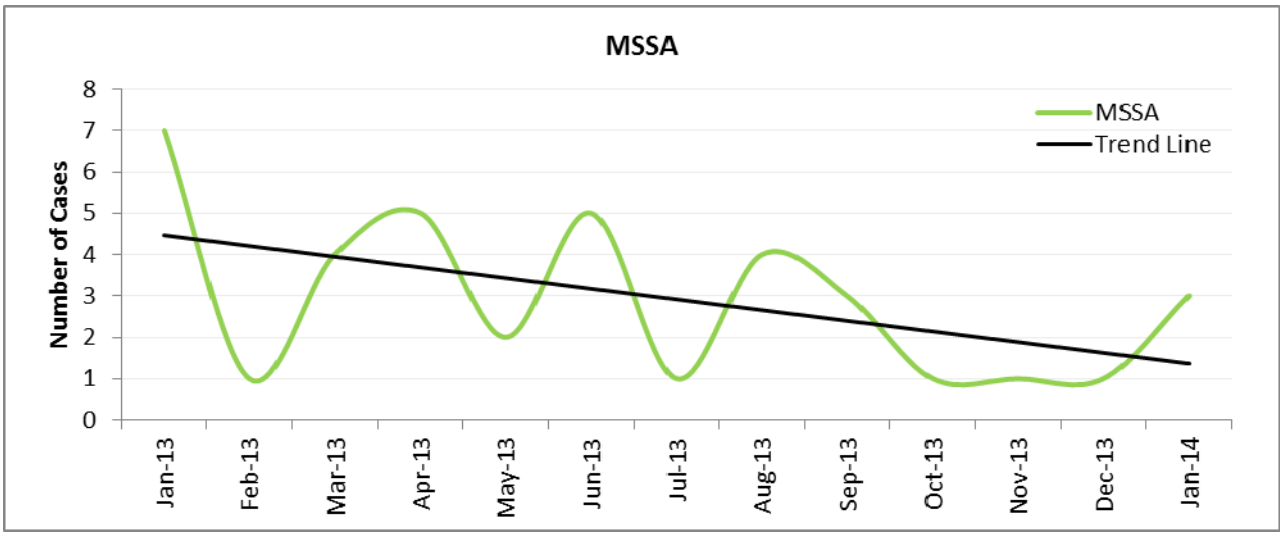
b) CDT

Mth	Qtr 1	Qtr 2	Qtr 3	YTD

The year to date position is 62 cases against a year to date target of 57 with a full year target of 67.



c) The number of MSSA cases reported in January was 3, with a year to date figure of 26.



5.2 Patient Experience

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

In January 2014, 4,024 Patient Experience Surveys were returned this is broken down to:

- 2,414 paper inpatient/day case surveys
- 943 electronic surveys
- 526 ED paper surveys
- 141 maternity paper surveys

Share Your Experience – Electronic Feedback Platform

In January 2014, a total of 943 electronic surveys were completed via email, touch screen, our Leicester's Hospitals web site or handheld devices.

A total of 150 emails were sent to patients inviting them to complete a survey. The table below shows how this breaks down across the trust:

Share Your Experience Survey	Email	Touch Screen	Hand held	QR scan/Web		Total Surveys		Emails sent
Carers Survey	0	0	0	2		2		0
& ED Care	0	13	0	0		13		0
A&E Department	0	93	18	6		117		0
Eye Casualty	0	22	248	0		270		0
Glenfield CDU	0	23	3	0		26		0
Glenfield Radiology	17	0	0	0		17		43
IP and Childrens IP	0	0	0	11		11		0
Maternity Survey	0	0	311	2		313		0
Neonatal Unit	0	0	0	13		13		0
Outpatient Survey	38	4	96	3		141		108
Windsor Eye Clinic	0	1	19	0		20		0
Total	**55**	**156**	**695**	**37**		**943**		**150**

Treated with Respect and Dignity

Mth | Qtr 1 | Qtr2 | Qtr3 | YTD

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

This new threshold scheme will be refreshed on a quarterly basis. A green score at trust level will mean that a new high score (based on the previous 12 months) and an improvement has been achieved. Conversely a red score will mean a new low score has been given by patients. The amber score has been replaced by blue and reflects 'an expected score' as scores will not be outside this blue range unless there is a significant improvement / deterioration.

Friends and Family Test

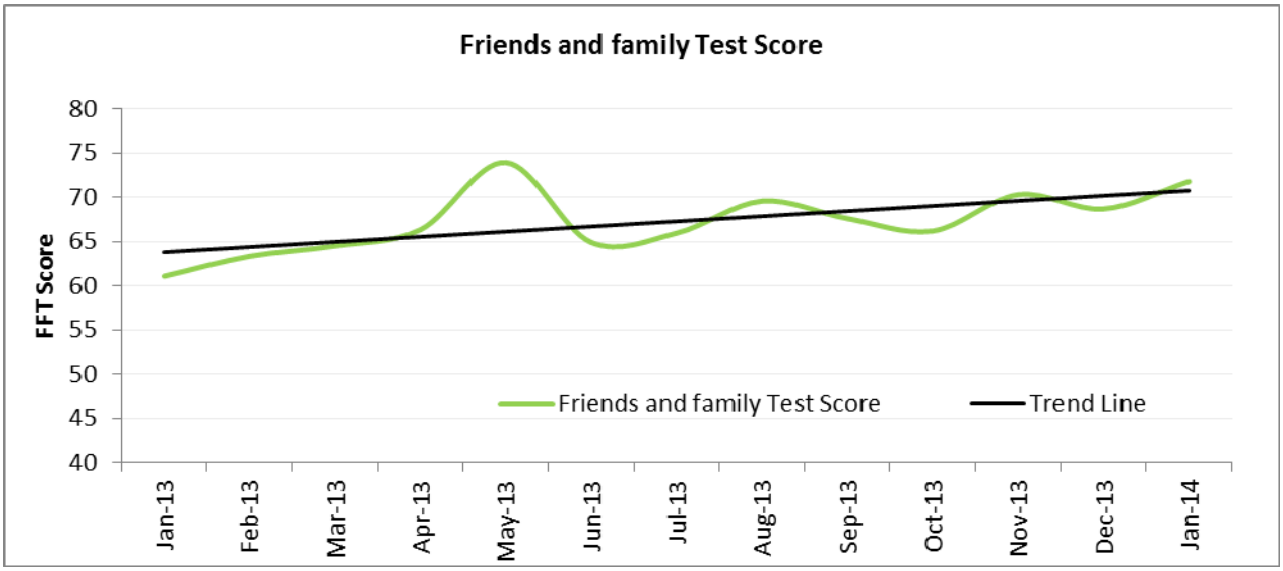
Inpatient

The inpatient surveys include the Friends and Family Test question; **How likely are you to recommend this ward to friends and family if they needed similar care or treatment?'** Of all the surveys received in January, 1,765 surveys included a response to this question and were considered inpatient activity (excluding day case / outpatients) and therefore were included in the Friends and Family Test score for NHS England.

Overall there were 7,197 patients in the relevant areas within the month of January 2014. The Trust easily met the 15% target achieving coverage of **24.5%.**

The Friends & Family Test responses broken down to:

Extremely likely:	1,334
Likely:	351
Neither likely nor unlikely:	52
Unlikely	12
Extremely unlikely	8
Don't know:	8
Overall Friends & Family Test Score	**71.8**



December 2013 Data Published Nationally

The National Table reports the scores and responses for 170 Trusts

If we filter out the Private and Single Speciality Trusts, and those that achieved less than 20% footfall, the UHL score of **69** ranks 78th out of **121** Trusts.

The overall National Inpatient Score (not including independent sector Trusts) was **71**.

Friends and Family Test Scores by CMG

Renal, Respiratory and Cardiac, and Musculoskeletal and Specialist Surgery, both showed improvements in their FFT score compared to December performance. For Renal, Respiratory and Cardiac the increase of 7 percentage points was due to an increase in promoters of 5 percentage points, and a decrease in both the number of passive and detractor responses. For Musculoskeletal and Specialist Surgery the improvement came from a decrease in detractors of 3 percentage points compared to December, and a small increase in the number of promoters of 2 percentage points.

With over 600 responses (35%) coming from Renal, Respiratory and Cardiac this CMG has been the main driver of the improved score for UHL this month.

Emergency and Specialist Medicine and CHUGS showed small decreases in their FFT score this month but performance was largely consistent with December performance.

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

Women's and Children's had more responses this month, but their FFT performance fell slightly compared to December. Although the number of detractors decreased, more respondents chose to be 'passive' rather than a 'promoter' in January.

	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Point Change in FFT Score (Dec - Jan 14)
UHL Trust Level Totals	**66.4**	**73.9**	**64.9**	**66.0**	**69.6**	**67.6**	**66.2**	**70.3**	**68.7**	**71.8**	**3.1**
Renal, Respiratory and Cardiac	70	76	73	80	80	79	70	78	74	81	**7.4**
Emergency and Specialist Medicine	64	72	57	62	63	68	63	68	73	72	**-0.7**
CHUGS	59	70	57	53	61	53	58	59	56	54	**-2.8**
Musculoskeletal and Specialist Surgery	72	75	73	66	68	69	69	70	66	71	**4.9**
Women's and Children's	78	80	74	68	76	77	70	76	76	73	**-2.6**
Emergency Department	43	47	61	57	60	58	59	59	67	68	**0.2**

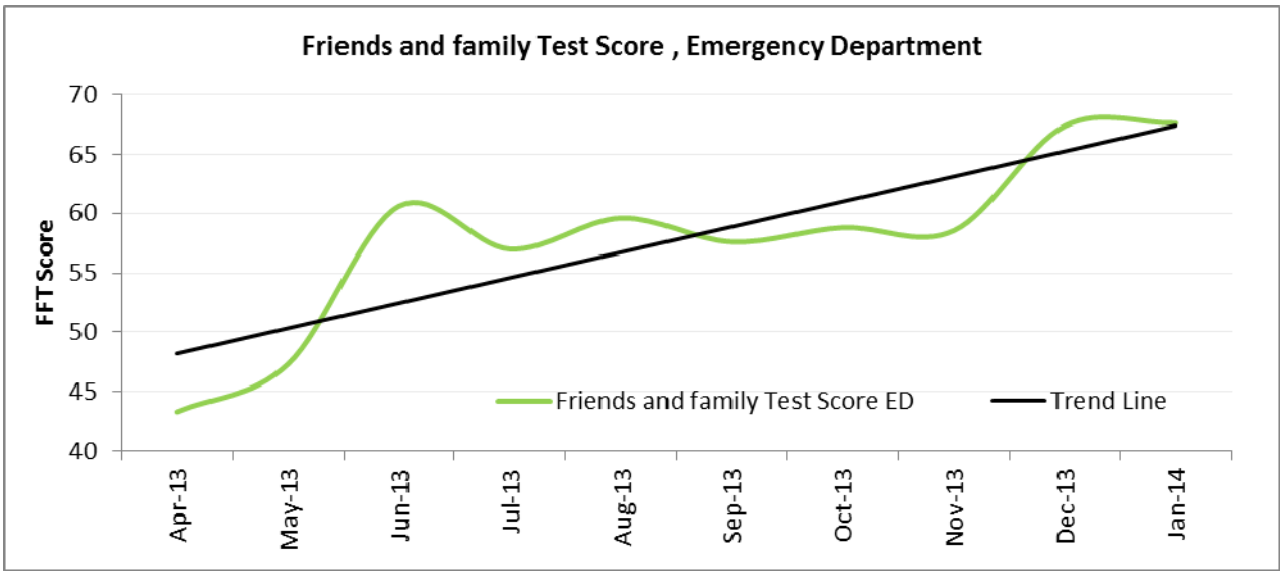
<u>Emergency Department & Eye Casualty</u>

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

Overall there were 5,887 patients who were seen in A&E and then discharged home within the month of January 2014. The Trust surveyed 918 eligible patients meeting **15.6%** of the footfall. The Friends & Family test responses break down to:

Extremely likely:	658
Likely:	206
Neither likely nor unlikely:	17
Unlikely	11
Extremely unlikely	16
Don't know:	10

Overall Friends & Family Test Score **67.6**



Breakdown by department	No. of responses	FFT Score	Total no. of patients eligible to respond
Emergency Dept Majors	156	57.5	1,397
Emergency Dept Minors	378	63.7	2,267
Emergency Dept – not stated	27	69.2	-
Emergency Decisions Unit	98	57.9	858
Eye Casualty	259	82.6	1,365

December 2013 Data Published Nationally

The National Table reports the scores and responses for 143 Trusts

If we filter out the Trusts that achieved less than 20% footfall, then we are left with 35 Trusts. However our UHL score of **67** does not feature among these as the 20% footfall was not achieved.

The overall National Accident & Emergency Score was **56**.

Maternity Services

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

Overall there were 3,363 patients in total who were eligible within the month of January 2014. The Trust surveyed 702 eligible patients meeting **20.9%** of the footfall. The Friends & Family test responses break down to:

Extremely likely:	487
Likely:	192
Neither likely nor unlikely:	11
Unlikely	6
Extremely unlikely	1
Don't know:	5

Overall Maternity Friends & Family Test Score 67.3

Breakdown by maternity journey stage	No. of responses	FFT Score	Total no. of patients eligible to respond
Antenatal following 36 week appointment	109	70.1	907
Labour Ward/Birthing centre following delivery	274	69.5	860
Postnatal Ward at discharge	246	62.6	636
Postnatal community – 10 days after birth	73	70.8	960

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

December 2013 Data Published Nationally

Maternity

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

Antenatal

The average Friend and Family Test score for England (excluding independent sector providers) was **63**.

If we filter out the Trusts that are single speciality or achieved less than 20% footfall, then we are left with 129 Trusts. However our UHL Score of **61** does not feature among these as the 20% footfall was not achieved.

Birth

The average Friend and Family Test score for England (excluding independent sector providers) was **75**.

With single speciality and Trusts that achieved less than a 20% footfall excluded, the UHL Friends and Family Test score of **66** for December ranks the Trust 41st out of the remaining 54 Trusts.

Postnatal Ward

The average Friend and Family Test score for England (excluding independent sector providers) was **66**.

With single speciality and Trusts that achieved less than a 20% footfall excluded, the UHL Friends and Family Test score of **63** for December ranks the Trust 48th out of the remaining 67 Trusts.

Postnatal Community Provision

The average Friend and Family Test score for England (excluding independent sector providers) was **74**.

If we filter out the Trusts that are single speciality or achieved less than 20% footfall, then we are left with 24 Trusts. However our UHL Score of **64** does not feature among these as the 20% footfall was not achieved.

5.3 Nursing workforce

5.3.1 Vacancies

The sum of budgeted wtes in January 2013 is reported as	4,888 wte
The sum of nurses in post in January 2014 is reported as	4,326 wte
The sum of nurses waiting to start in January 2014 is reported as	332 wte
The sum of nurses waiting to leave in January 2014 is reported as	63 wte
Therefore the sum of total reported vacancies for January 2014 is	293 wte

CMG	Felt RN Vacant	Felt HCA Vacant	Total
CHUGS	67	30.74	**97.74**
CSI	0	0	**0**
ED & SM	201.95	21.46	**223.41**
ITAPs	48.74	16.34	**65.08**
MSK & SS	34.66	8.00	**42.66**
RRC	35.16	21.64	**56.8**
W & C	51.26	24.6	**75.86**
Total	**438.77**	**122.78**	**562**

5.3.2 Real Time Staffing

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

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

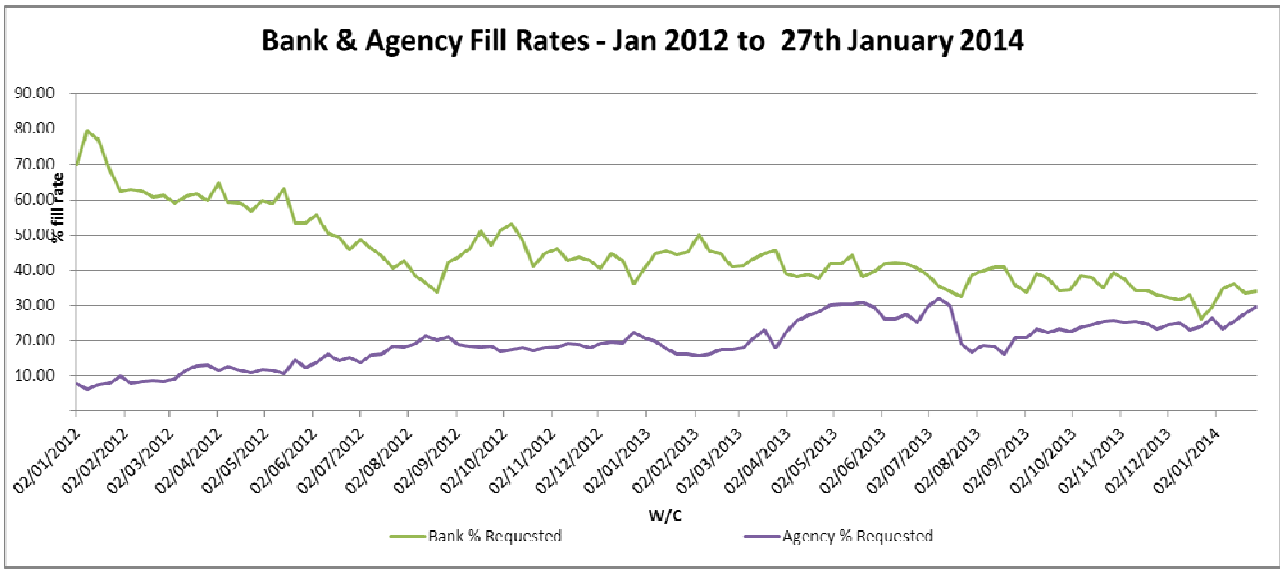
For the same time period, approximately 20 shifts per week were overstaffed.

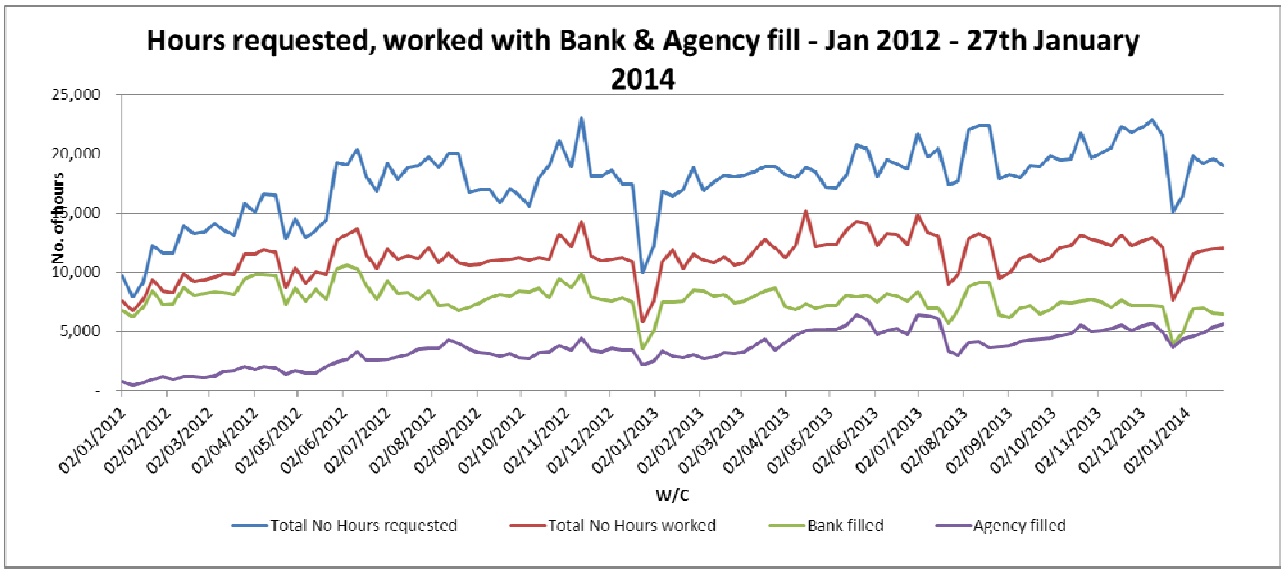
200 shifts per week on average required wider CMG intervention to make wards safe.

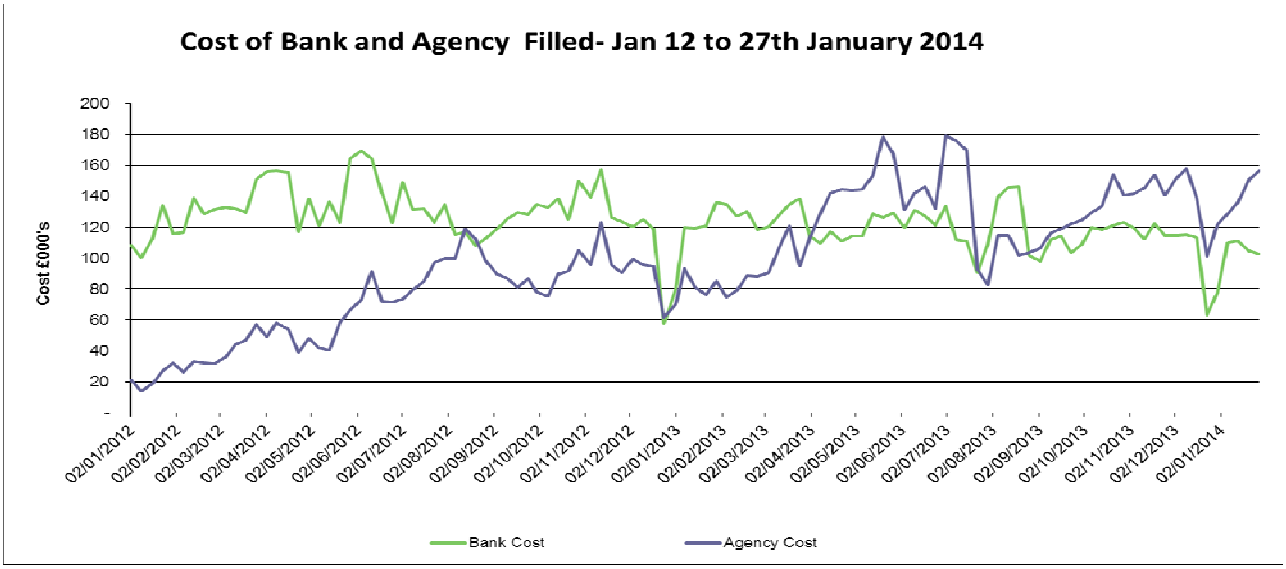
We are continuing to refine the use of this tool, especially around the 'unmanaged' shifts and our corporate response in these situations.

5.3.3 Bank and Agency

Bank and agency information is shown in the following graphs.


Bank & Agency Fill Rates - Jan 2012 to 27th January 2014
% fill rate
90.00
80.00
70.00
60.00
50.00
40.00
30.00
20.00
10.00
02/01/2012
02/02/2012
02/03/2012
02/04/2012
02/05/2012
02/06/2012
02/07/2012
02/08/2012
02/09/2012
02/10/2012
02/11/2012
02/12/2012
02/01/2013
02/02/2013
02/03/2013
02/04/2013
02/05/2013
02/06/2013
02/07/2013
02/08/2013
02/09/2013
02/10/2013
02/11/2013
02/12/2013
02/01/2014
w/c
Bank % Requested
Agency % Requested


Hours requested, worked with Bank & Agency fill - Jan 2012 - 27th January 2014
No. of Hours
25,000
20,000
15,000
10,000
5,000
-
02/01/2012
02/02/2012
02/03/2012
02/04/2012
02/05/2012
02/06/2012
02/07/2012
02/08/2012
02/09/2012
02/10/2012
02/11/2012
02/12/2012
02/01/2013
02/02/2013
02/03/2013
02/04/2013
02/05/2013
02/06/2013
02/07/2013
02/08/2013
02/09/2013
02/10/2013
02/11/2013
02/12/2013
02/01/2014
w/c
Total No Hours requested
Total No Hours worked
Bank filled
Agency filled


Cost of Bank and Agency Filled- Jan 12 to 27th January 2014
Cost £000's
200
180
160
140
120
100
80
60
40
20
-
02/01/2012
02/02/2012
02/03/2012
02/04/2012
02/05/2012
02/06/2012
02/07/2012
02/08/2012
02/09/2012
02/10/2012
02/11/2012
02/12/2012
02/01/2013
02/02/2013
02/03/2013
02/04/2013
02/05/2013
02/06/2013
02/07/2013
02/08/2013
02/09/2013
02/10/2013
02/11/2013
02/12/2013
02/01/2014
Bank Cost
Agency Cost

5.4 Ward Performance and Ward Alerting Concerns

The dashboard (Appendix 2) represents December/January data. The dashboard suggests that the following wards are showing early signs of deterioration/challenge and need observation by the CMG leadership:

LRI	LGH	GH
5	15	15
7	28 *	28
15		32
16		33
17		CDU
18		
19 *		
22		
24		
29 *		
30 *		
32		
33		
36		
39		

Ward marked with * have been previously highlighted for CMG or targeted additional support which is ongoing. If next month, these wards continue to show no sign of improvement, we will consider a 'special measures' approach.

Other 'alerting' wards will be subject to a discussion at Nursing Executive Team on 26 February 2014 with action agreed. At this stage it is likely to be targeted CMG support or wait to see if trend continues next month. Many of these wards are struggling with vacancies and so we hope that the additional nurses that have joined the Trust in recent weeks will impact positively over coming weeks.

Ward Reviews

The quarterly results (for Q3) are attached and based on reviews undertaken in January. Acknowledging that we still have some differences in thresholds between Heads of Nursing, there are some wards that flag on the ward review tool as well as the dashboard:

LRI	GH
19	15
24	CDU
	32
	33

There are a number of wards that scored no green ratings, ie all amber. This would suggest that some concentrated effort is required around the ward systems, processes and leadership:

LRI	LGH
34	2
25	
26	
31	
Kinmonth	
8	

This will also be subject to discussion at Nursing Executive Team.

The Heads of Nursing report that there is still an absence of information/evidence for all indicators at ward level and more work needs to be done to ensure ward staff see data that is available about the care they deliver.

The Heads of Nursing however report that Ward Managers and Matrons were on the whole, better prepared for the round of reviews.

5.4 Same Sex Accommodation

Mth	Qtr 1	Qtr 2	Qtr 3	YTD

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

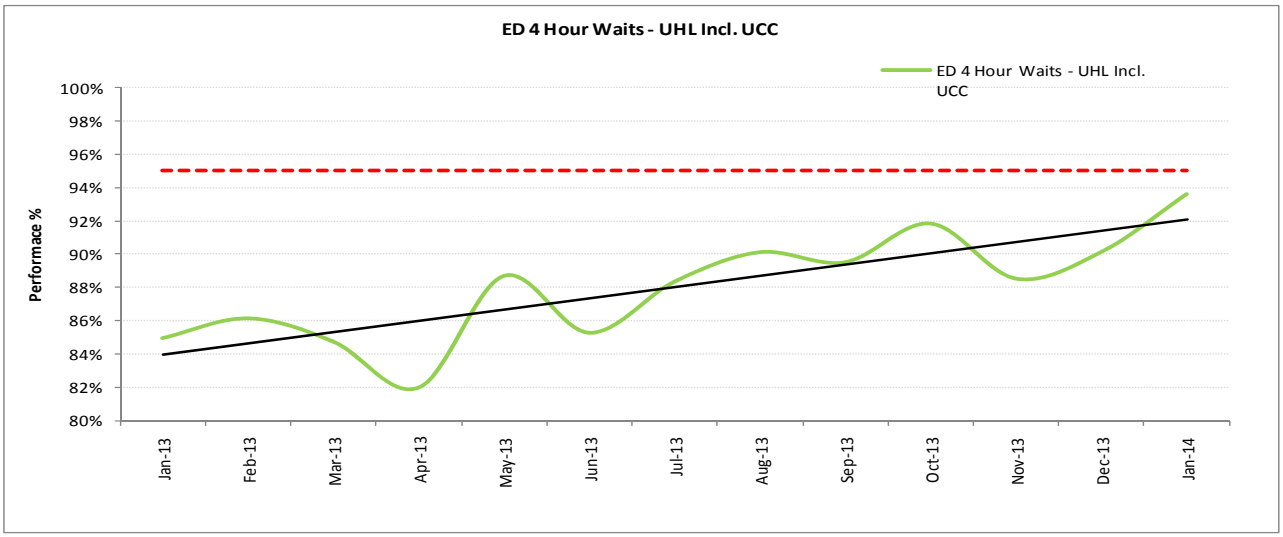
6 OPERATIONAL PERFORMANCE – RICHARD MITCHELL

Outcome Measures

Performance Indicator	Target	Jan-13	Feb-13	Mar-13	Q4	Apr-13	May-13	Jun-13	Q1 2013	Jul-13	Aug-13	Sep-13	Q2 2013	Oct-13	Nov-13	Dec-13	Q3 2013	Jan-14	YTD
A&E - Total Time in A&E (UHL+UCC)	95%	84.9%	86.1%	84.7%	85.2%	82.0%	88.7%	85.3%	85.3%	88.3%	90.1%	89.5%	89.3%	91.8%	88.5%	90.1%	90.2%	93.6%	88.7%
RTT waiting times – admitted	90%	92.2%	91.9%	91.3%		88.2%	91.3%	85.6%		89.1%	85.7%	81.8%		83.5%	83.2%	82.0%		81.8%	
RTT waiting times – non-admitted	95%	97.3%	97.0%	97.0%		97.0%	95.9%	96.0%		96.4%	95.5%	92.0%		92.8%	91.9%	92.8%		93.4%	
RTT - incomplete 92% in 18 weeks	92%	93.4%	93.5%	92.6%		92.9%	93.4%	93.8%		93.1%	92.9%	93.8%		92.8%	92.4%	91.8%		92.0%	
RTT - 52+ week waits	0	0	0	0		0	0	0		0	0	0		0	0	1		1	2
Diagnostic Test Waiting Times	<1%	0.7%	1.0%	0.5%		1.6%	0.6%	0.6%		0.6%	0.8%	0.7%		1.0%	0.8%	1.4%		5.3%	
Cancelled operations re-booked within 28 days	100%	97.1%	92.3%	94.2%	94.6%	90.4%	91.0%	86.4%	89.8%	99.1%	96.0%	98.6%	98.0%	94.2%	97.7%	94.3%	95.5%	94.3%	94.8%
Cancelled operations on the day (%)	0.8%	1.6%	1.6%	1.6%	1.6%	1.5%	1.5%	1.0%	1.3%	1.2%	1.4%	2.3%	1.6%	1.7%	1.8%	1.7%	1.8%	1.5%	1.6%
Cancelled operations on the day (vol)		137	130	137	404	125	135	85	345	117	124	212	453	171	172	141	484	141	1423
Urgent operation being cancelled for the second time	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2 week wait - all cancers	93%	89.8%	95.9%	95.2%	93.7%	93.0%	95.2%	94.8%	94.4%	94.2%	94.6%	93.0%	94.0%	94.9%	95.7%	94.9%	95.2%		94.5%
2 week wait - for symptomatic breast patients	93%	93.6%	93.1%	95.4%	94.0%	94.0%	94.8%	93.2%	94.1%	93.6%	92.0%	95.2%	93.8%	93.0%	91.3%	95.5%	93.3%		93.7%
31-day for first treatment	96%	96.6%	97.6%	98.8%	97.6%	97.5%	97.0%	99.0%	97.8%	98.3%	99.7%	99.1%	99.0%	98.9%	96.2%	97.4%	97.6%		98.1%
31-day for subsequent treatment - drugs	98%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%
31-day wait for subsequent treatment - surgery	94%	94.6%	94.1%	92.7%	94.0%	97.2%	94.4%	97.5%	96.4%	100.0%	98.4%	88.6%	95.9%	96.4%	97.1%	92.3%	95.3%		95.8%
31-day wait subsequent treatment - radiotherapy	94%	99.1%	98.9%	99.1%	99.0%	100.0%	97.8%	99.1%	98.8%	100.0%	100.0%	97.7%	99.4%	97.5%	98.5%	98.1%	98.0%		98.7%
62-day wait for treatment	85%	79.5%	75.4%	81.5%	78.8%	80.9%	80.3%	85.9%	82.3%	85.8%	88.2%	87.4%	87.1%	86.4%	85.7%	89.4%	87.1%		85.5%
62-day wait for screening	90%	91.7%	95.7%	95.8%	94.4%	98.6%	94.3%	95.0%	95.9%	90.6%	97.2%	96.2%	94.1%	100.0%	97.0%	96.6%	97.9%		96.1%
Stroke - 90% of Stay on a Stroke Unit	80%	77.8%	81.4%	82.3%	80.6%	77.4%	80.7%	78.7%	78.5%	87.1%	88.6%	89.1%	88.3%	83.5%	78.0%	80.2%	80.6%		82.1%
Stroke - TIA Clinic within 24 Hours (Suspected TIA)	60%	60.8%	85.1%	77.0%	73.1%	51.1%	69.2%	72.0%	63.9%	60.5%	73.6%	64.6%	66.0%	62.4%	76.8%	65.7%	68.4%	60.5%	65.4%
Choose and Book Slot Unavailability	4%	5%	10%	9%		7%	9%	13%		15%	14%	11%		16%	17%	14%		9%	
Delayed transfers of care	3.5%	2.8%	2.7%	3.7%	3.0%	3.7%	3.9%	3.1%	3.6%	3.6%	3.1%	3.9%	3.5%	3.1%	4.6%	2.8%	3.5%	3.7%	3.5%

6.3 Emergency Care 4hr Wait Performance

Mth | Qtr 1 | Qtr 2 | Qtr 3 | YTD



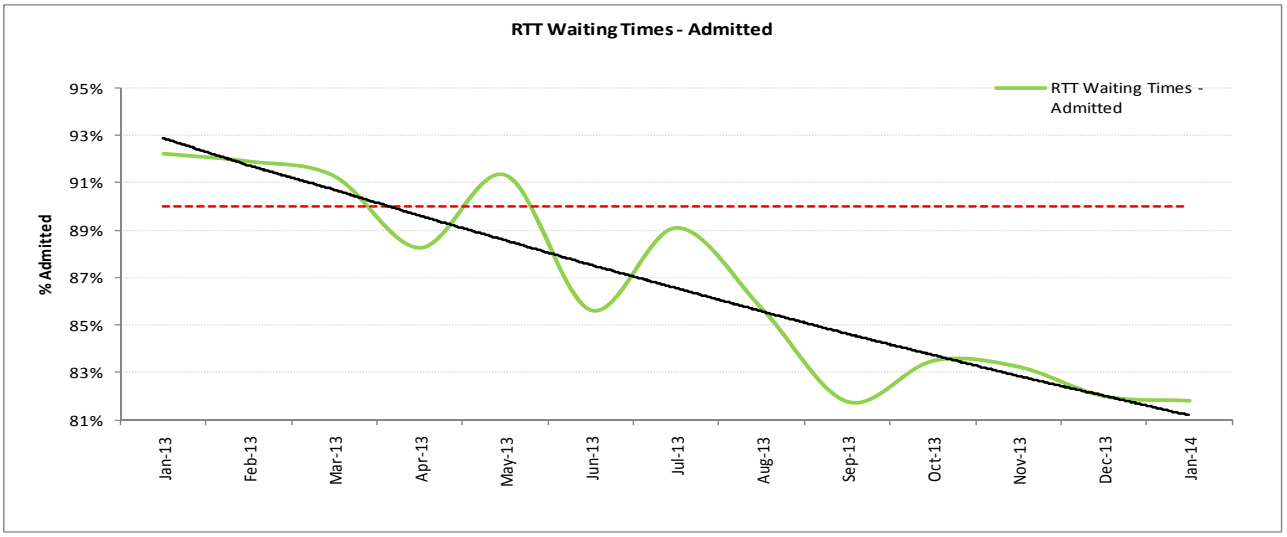
Performance for emergency care 4hr wait in January was 93.6%. Actions relating to the emergency care performance are included in the ED exception report.

UHL was ranked 106 out of 144 Trusts with Type 1 Emergency Departments in England for the four weeks up to 2nd February 2013. Over the same period 74 out of 144 Acute Trusts delivered the 95% target.

6.4 RTT – 18 week performance

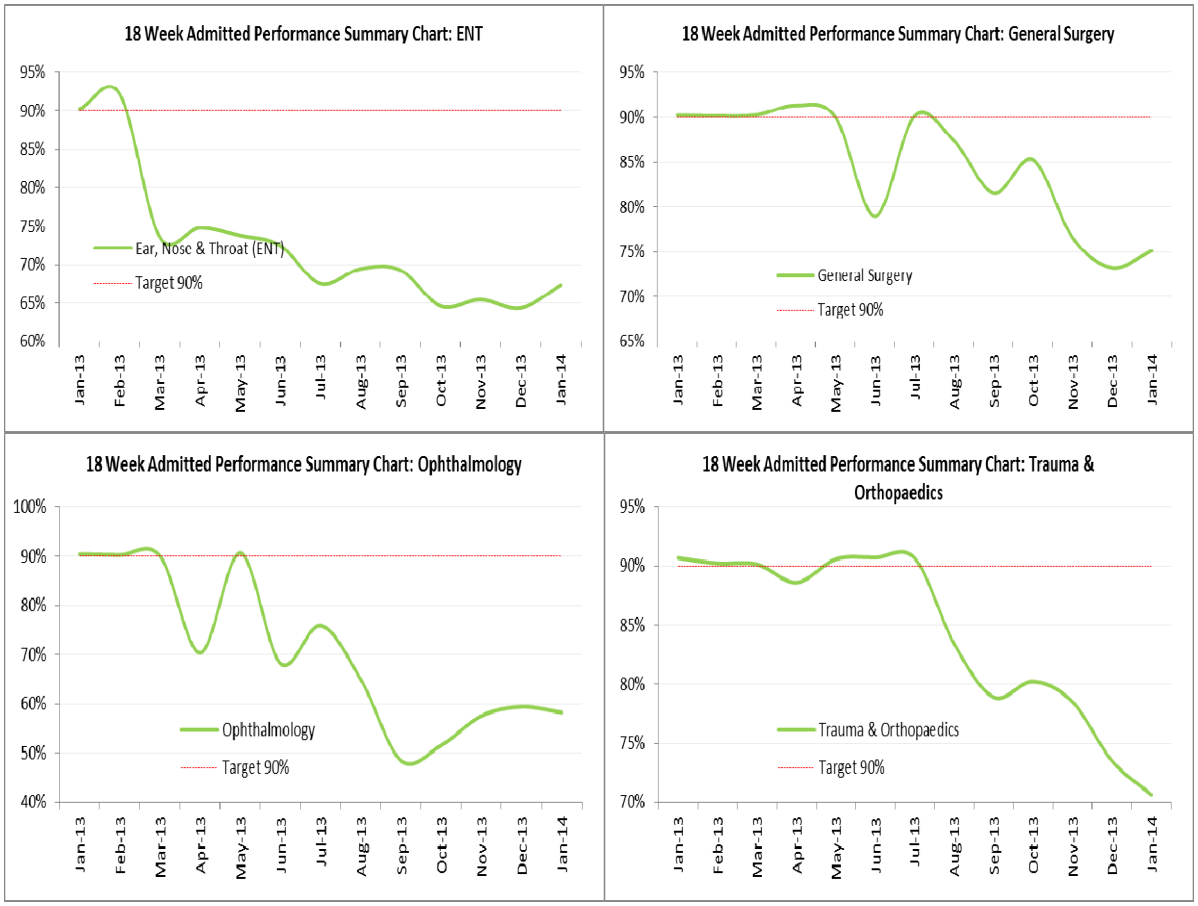
a) RTT Admitted performance

Mth | Qtr 1 | Qtr 2 | Qtr 3 | YTD

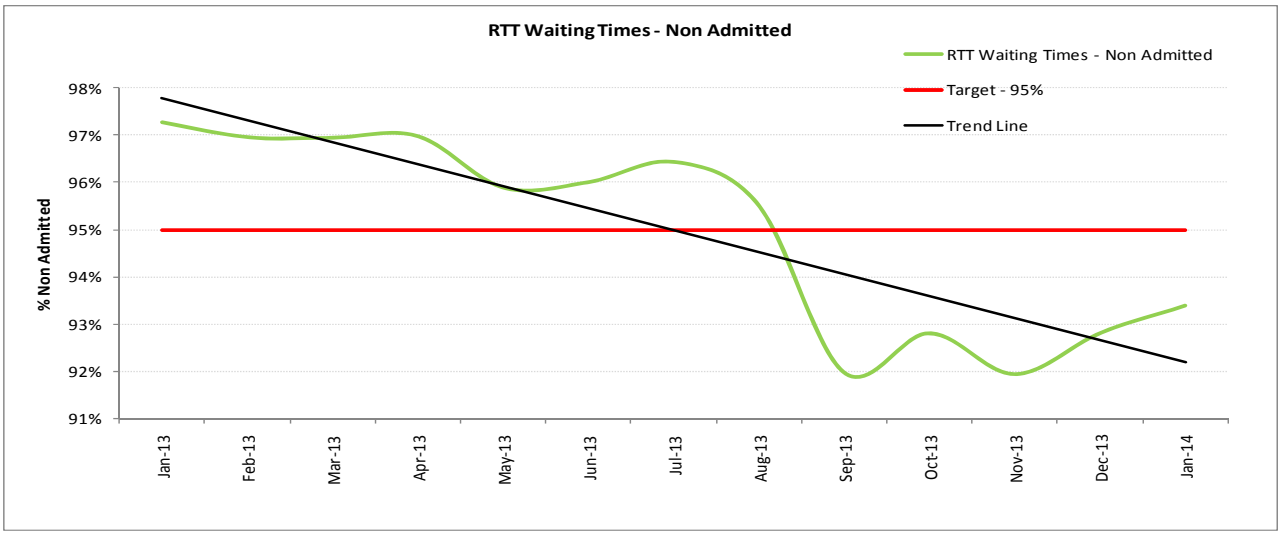


RTT admitted performance for January was 81.8% with significant speciality level failures in ENT, General Surgery, Ophthalmology and Orthopaedics. A recovery action plan has been submitted to commissioners for referral to treatment, final sign off is awaited.

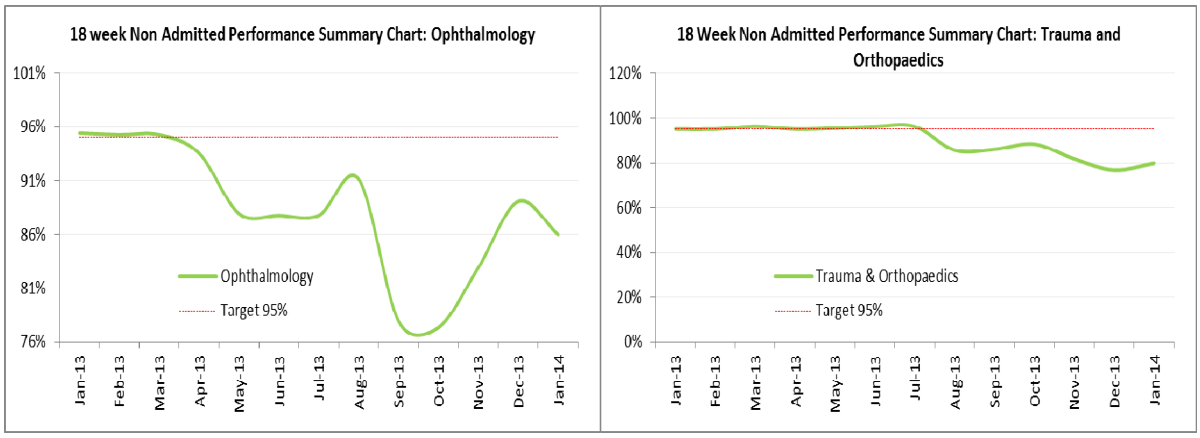
Commissioners have agreed to a significant financial investment during 2014-15 to reduce waiting times in key challenged specialties.It is anticipated that recovery of the Trust level admitted position will be in November 2014.



b) RTT Non Admitted performance

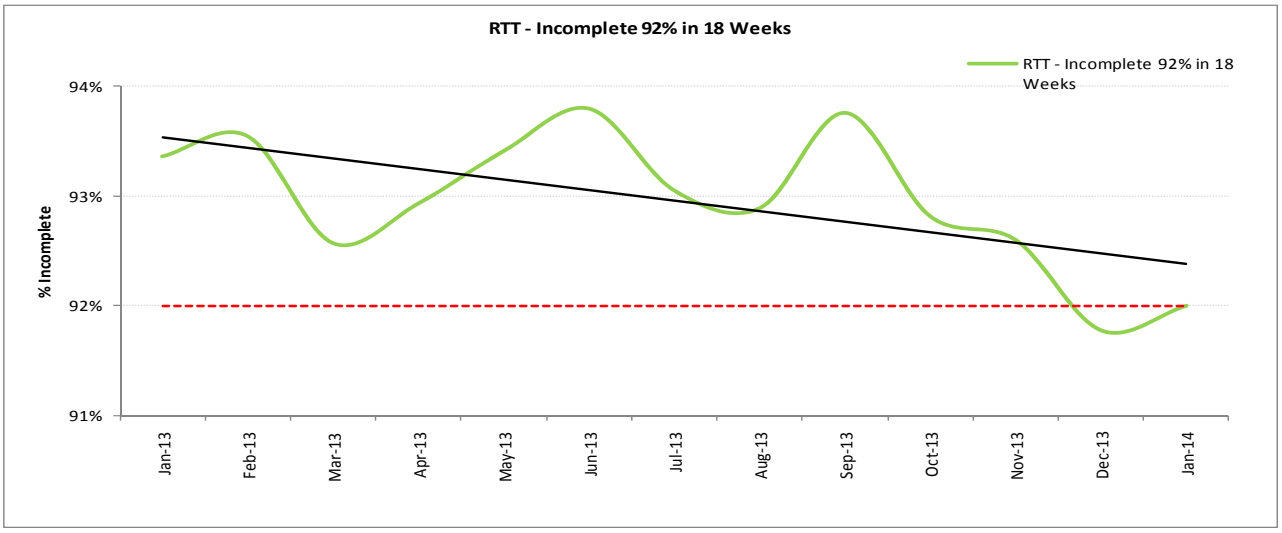


Non-admitted performance during January was 93.4%, with the significant specialty level failures in Orthopaedics and Ophthalmology. Commissioners have agreed to a significant financial investment during 2014-15 to reduce waiting times in key challenged specialties.It is anticipated that recovery of the Trust level non admitted position will be in August 2014.



c) RTT Incomplete Pathways

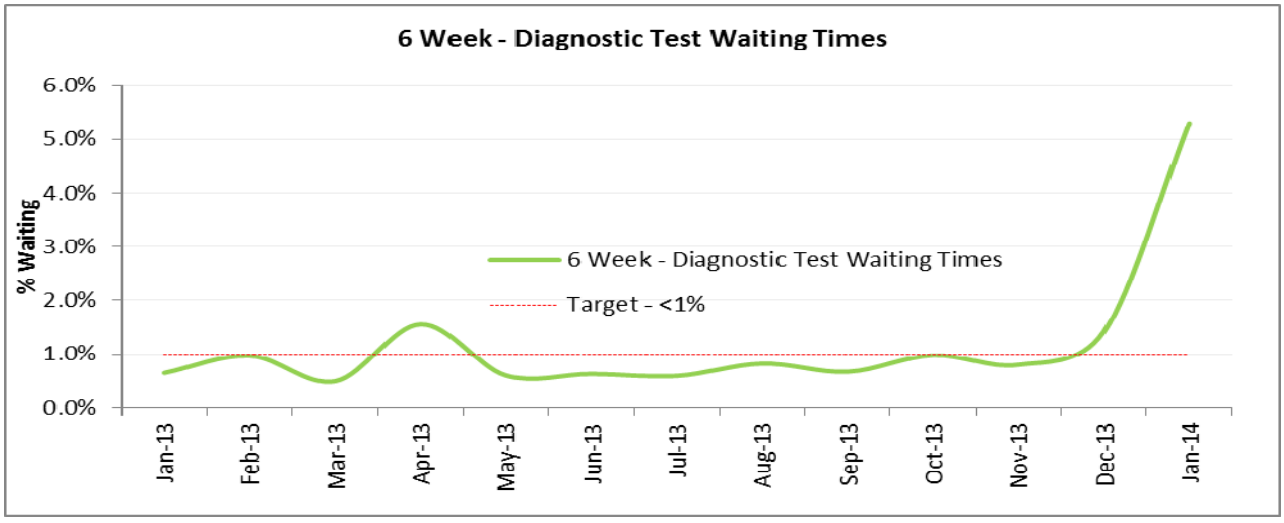
Mth | Qtr 1 | Qtr2 | Qtr3 | YTD



RTT incomplete (i.e. 18+ week backlog) performance achieved the target at 92.0%. In numerical terms the total number of patients waiting 18+ weeks for treatment (admitted and non-admitted) at the end of January was 3,194 down 96 from December (3,290)

6.5 Diagnostic Waiting Times

Mth | Qtr 1 | Qtr2 | Qtr3 | YTD



At the end of January 5.3% of patients were waiting for diagnostic tests longer than 6 weeks. Further details are included in the diagnostic exception report – Appendix 3.

6.6 Cancer Targets

a) Two Week Wait

Mth	Qtr 1	Qtr2	Qtr3	YTD

December performance for the 2 week to be seen for an urgent GP referral for suspected cancer was achieved at 94.9% (national performance 95.5%).

Mth	Qtr 1	Qtr2	Qtr3	YTD

Performance for the 2 week symptomatic breast patients (cancer not initially suspected) was achieved at 95.5% (national performance 95.6%).

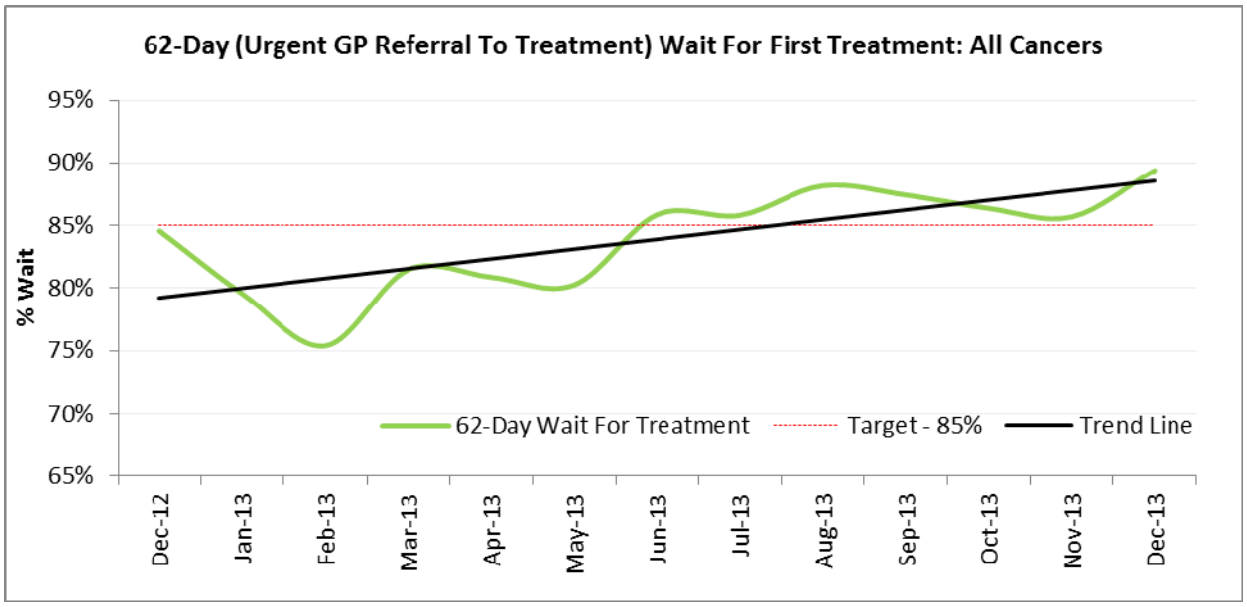
b) 31 Day Target

Mth	Qtr 1	Qtr2	Qtr3	YTD

Three out of the four 31 day cancer targets have been achieved in December (latest reported month). The 31 day subsequent surgery target was missed as a result of 2 too many patients waiting over 31 days for treatment.

c) 62 Day Target

Mth	Qtr 1	Qtr2	Qtr3	YTD



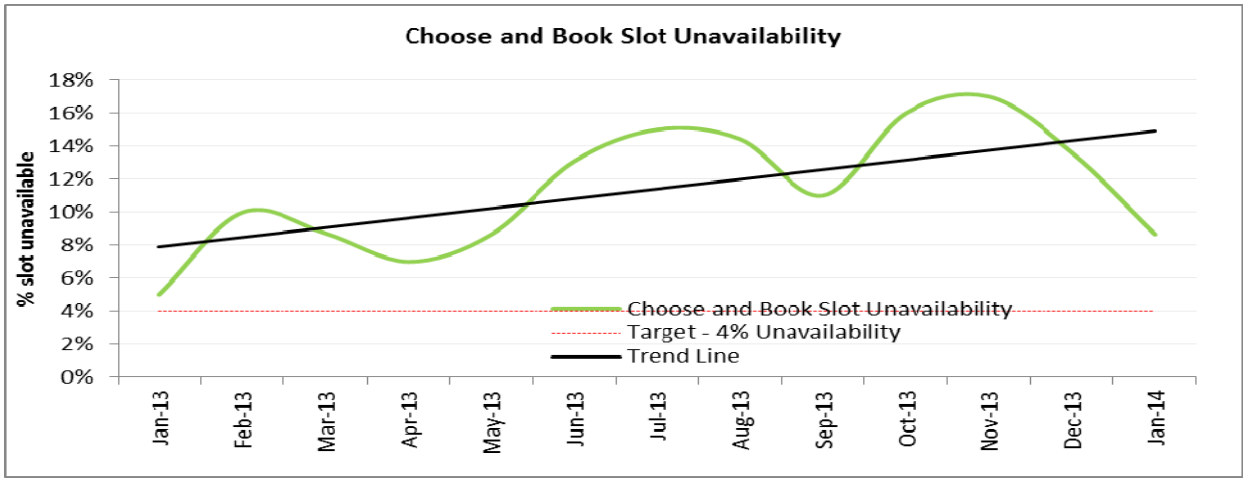
The 62 day urgent referral to treatment cancer performance in December was 89.4% (national performance 86.8%) against a target of 85%. The year to date position is now also being delivered at 85.5%.

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

The key points to note as at end January are:-

- Current volume over 62 days =32 patients
- Waits > 100 days = 5 all in Urology
- Longest wait 154 days – complex pathway

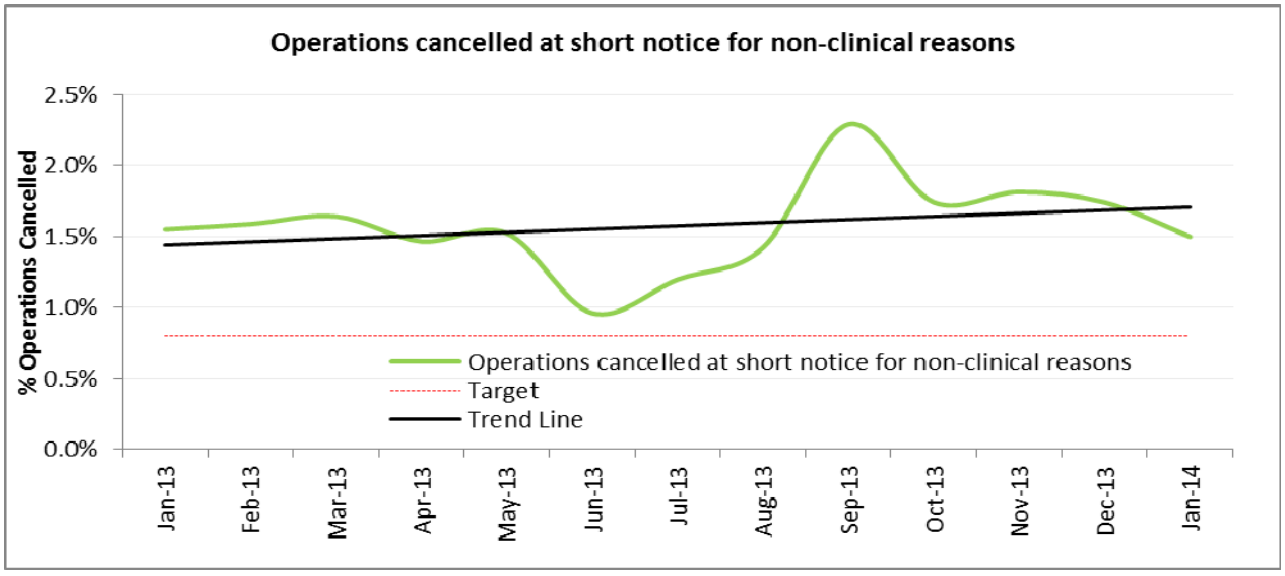
6.7 Choose and Book slot availability



Choose and book slot availability performance for January is 10% with the national average at 7%. Resolution of slot unavailability requires a reduction in waiting times for 1st outpatient appointments in key specialties and prospectively. For ENT and Orthopaedics, this forms part of the 18 week remedial action plan. Neurology is in the process of recruiting additional Clinical staff to increase capacity.

6.8 Short Notice Cancelled Operations

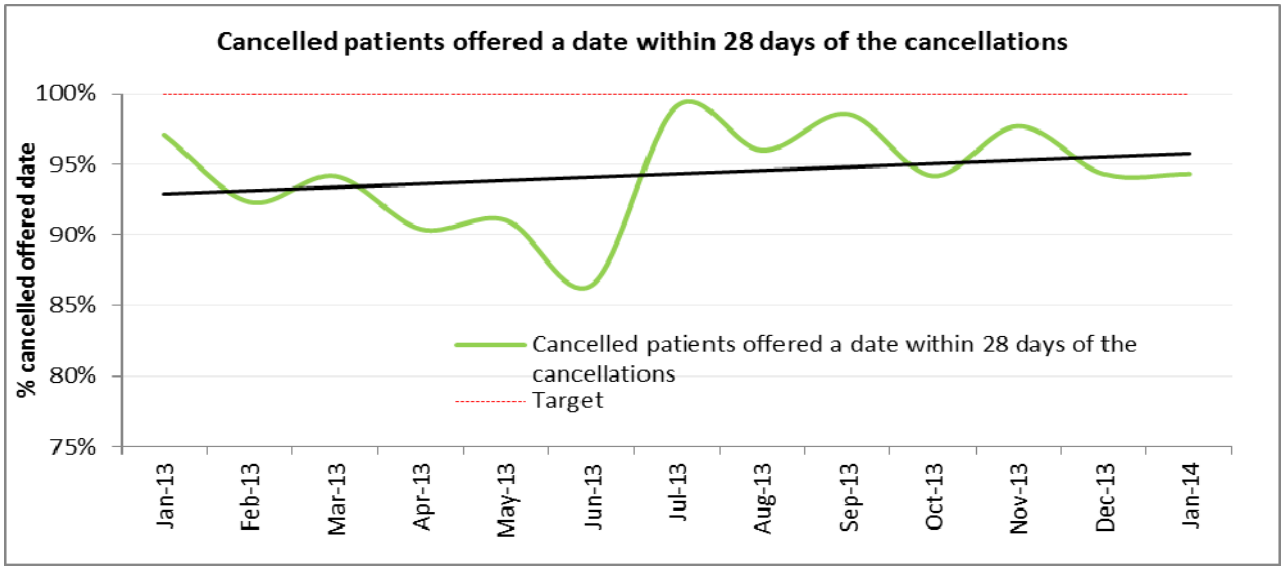
Mth	Qtr 1	Qtr 2	Qtr 3	YTD



The percentage of operations cancelled on/after the day activity for non-clinical reasons during January is 1.5% against a target of 0.8%. The year to date performance is 1.6%. A remedial action plan has been submitted to commissioners and this is awaiting final sign off, this is attached as Appendix 4.

Cancelled patients offered a date within 28 days

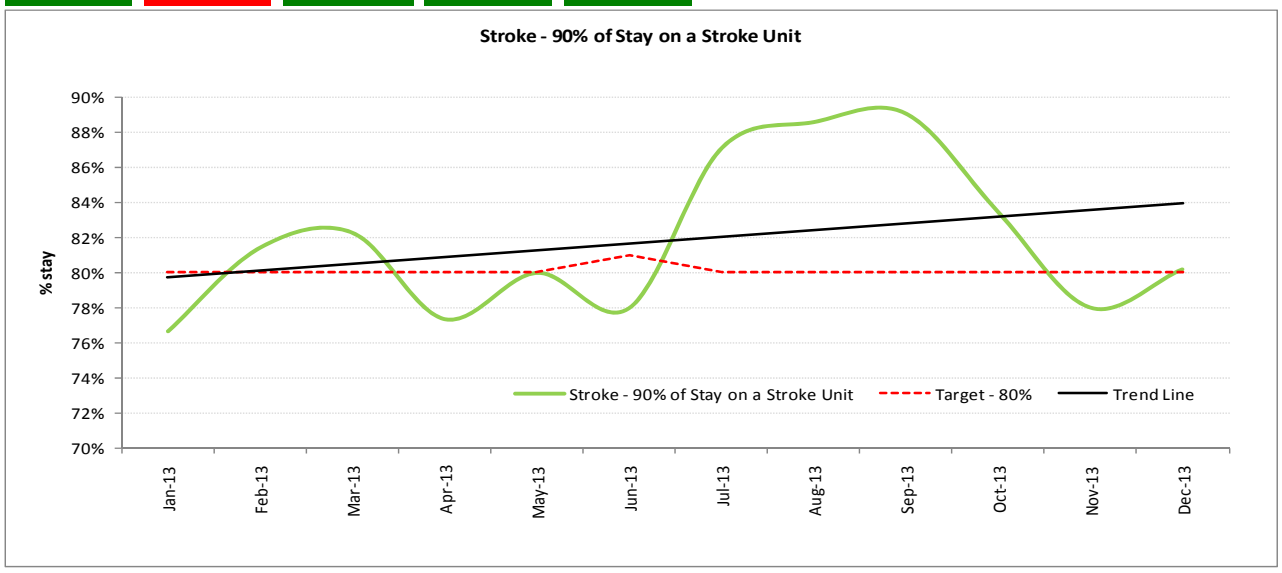
Mth | Qtr 1 | Qtr 2 | Qtr 3 | YTD



The threshold has been amended from 95% to 100% to reflect that every breach of this standard is subject to a financial penalty. The number of patients breaching this standard in January was 8 with 94.3% offered a date within 28 days of the cancellation. A remedial action plan has been submitted to commissioners and this is awaiting final sign off. A remedial action plan has been submitted to commissioners and this is awaiting final sign off, this is attached as Appendix 4.

6.9 Stroke % stay on stroke ward

Mth | Qtr 1 | Qtr 2 | Qtr 3 | YTD

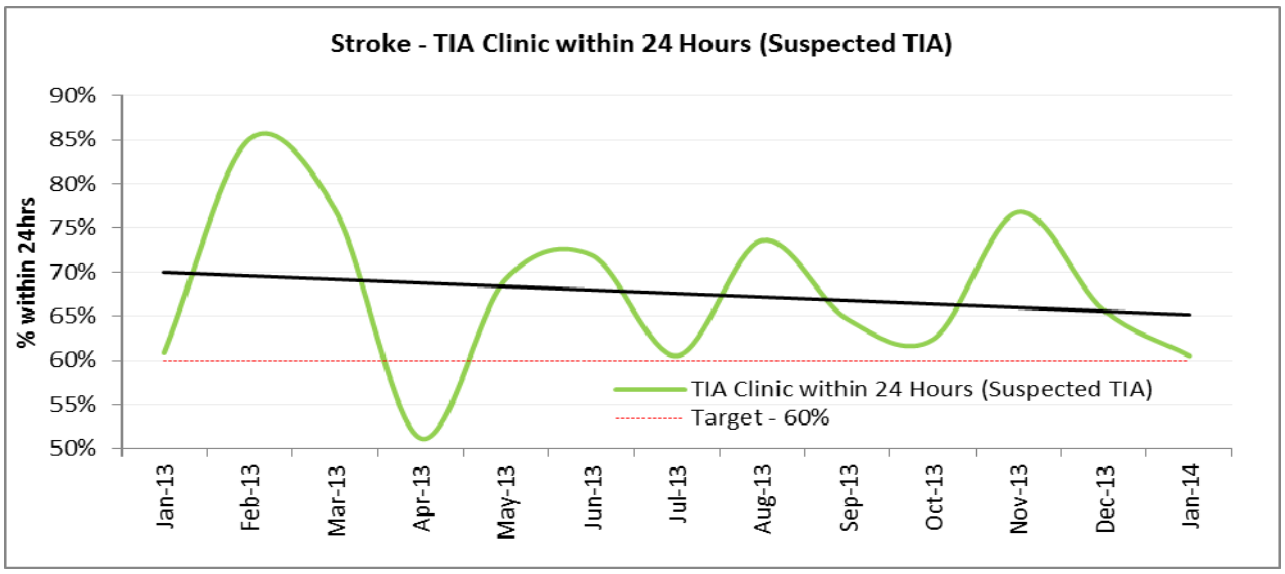


The percentage of stoke patients spending 90% of their stay on a stroke ward in December (reported one month in arrears) is 80% against a target of 80%. The year to date position is 82.1%.

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

6.10 Stroke TIA

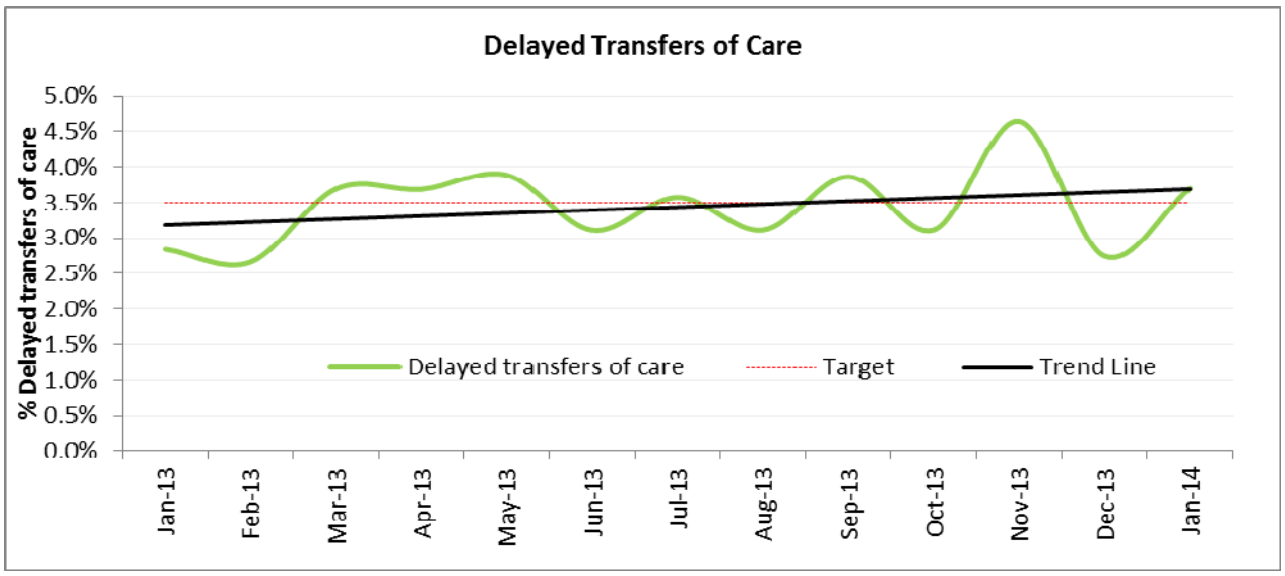
Mth | Qtr 1 | Qtr2 | Qtr3 | YTD



The percentage of high risk suspected TIAs receiving relevant investigations and treatment within 24 hours of referral receipt is 60.5% against a national target of 60.0%. The year to date performance is 65.4%.

6.11 Delayed Transfers of Care

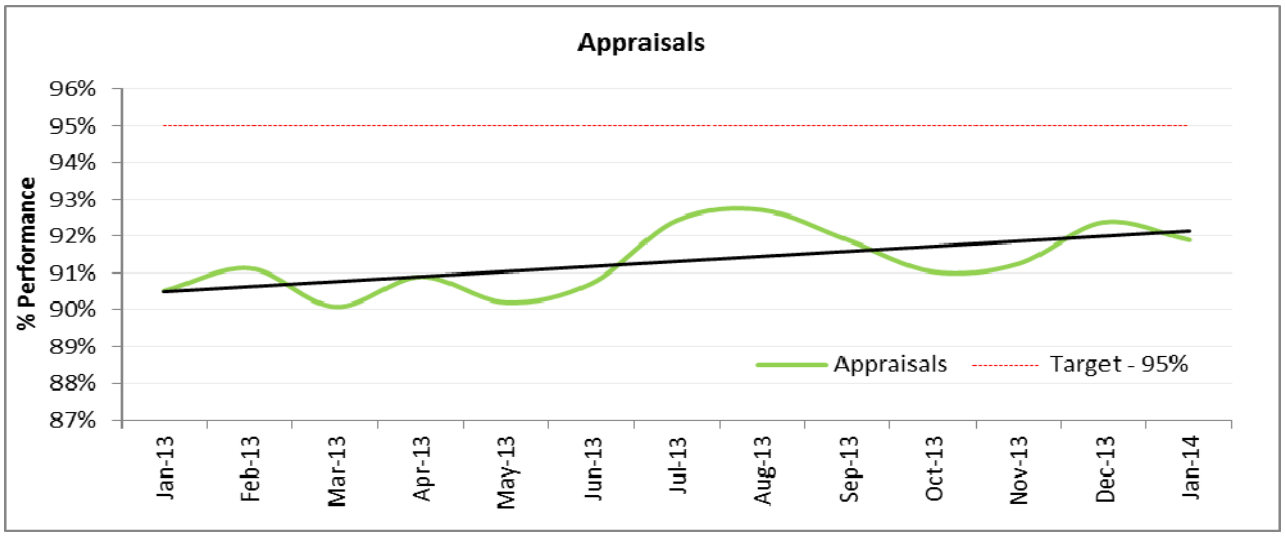
The January delayed transfer of care position was 3.7% with a year to date position of 3.5% equalling the target threshold of 3.5%.



7 HUMAN RESOURCES – KATE BRADLEY

7.1 Appraisal

Mth | Qtr 1 | Qtr 2 | Qtr 3 | YTD



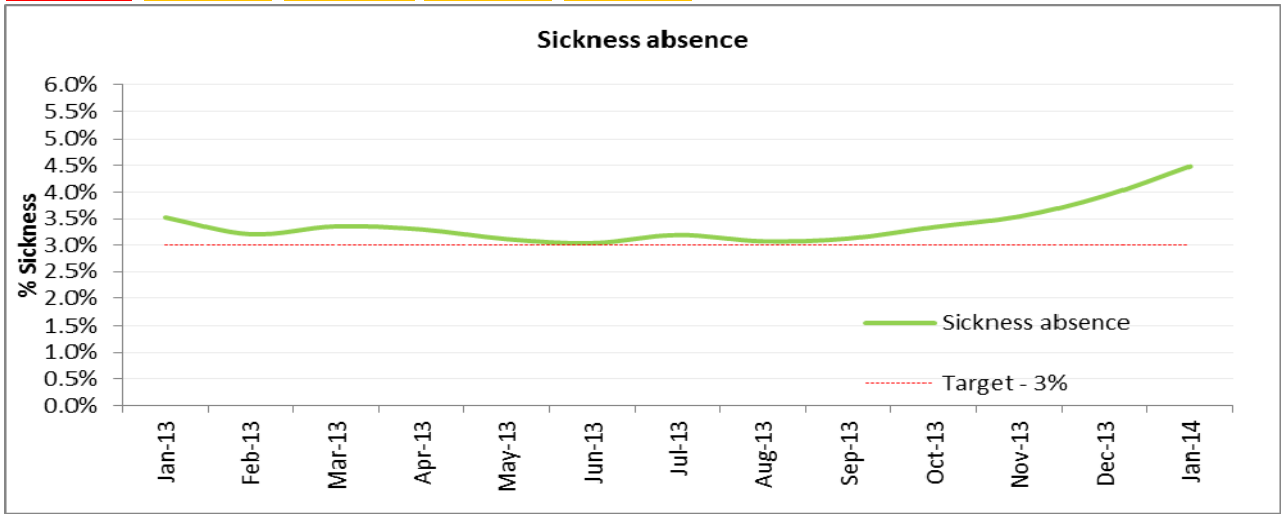
There continues to be considerable appraisal activity over the last month, we recognise that there has been a slight reduction in overall appraisal performance at the end of January.The appraisal rate for January is skewed due to TUPE transfer of some staff groups, for example IM+T. A number of Clinical and Corporate areas continue to meet the 95% target.

Appraisal performance and quality remains high on the CMG business agenda and a commitment to achieve 95%. All areas are encouraged to work to a 10 or 11 month cycle. Appraisals and statutory / mandatory training are also discussed at monthly CMG/Service Performance Meetings.

Work continues with IBM, IM&T & OCB Media in developing the new e-appraisal system to improve reporting functionality and programme access.

7.2 Sickness

Mth | Qtr 1 | Qtr 2 | Qtr 3 | YTD



The sickness rate for January is 4.48% and the December figure has now adjusted to 3.93% to reflect closure of absences. The overall cumulative sickness figure remains at

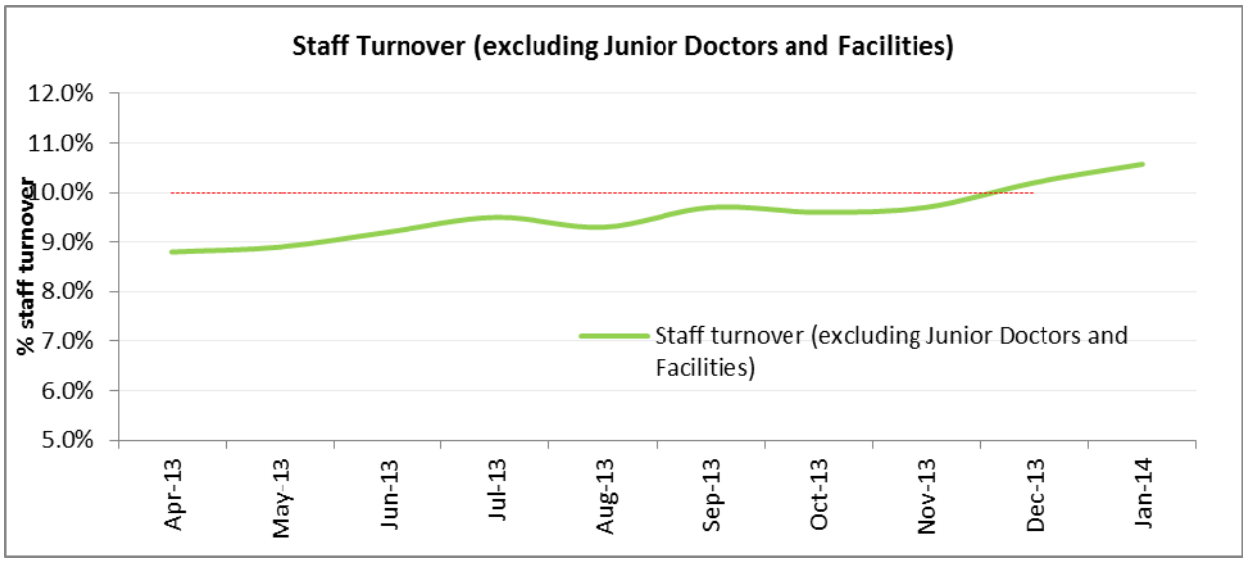
3.4%. This is equal to the previous SHA's target of 3.4% but slightly above the Trust stretch target of 3%. Given the large retrospective adjustments in sickness figures as a result of the closure of absences, sickness reporting will be undertaken one month in arrears in future Quality and Performance Reports.

The Health and Social Care Information Centre has recently published sickness absence rates for the period July to September 2013. These statistics show an average sickness rate of 3.66% for this period compared to 3.12% for UHL for same period. In September 2013 UHL was the highest performing acute Trust in the East Midlands with rates ranging from 3.12% to 4.83%.

The UHL Health and Wellbeing Steering Group met on 31 January 2014 and agreed to focus will be on developing pregnancy workshops to support wellbeing during pregnancy, implementation of the revised sickness absence training programmes and further rollout of Emotional Resilience Training.

7.3 Staff Turnover

Mth | Qtr 1 | Qtr 2 | Qtr 3 | YTD



The cumulative Trust turnover figure (excluding junior doctors and facilities staff who have Tupe'd from the Trust) has increased slightly from 10.2% to 10.57%. The latest figure includes the TUPE transfer of 27 IM &T staff to IBM on 30 November 2013 and the transfer of 65 sexual health services staff to Staffordshire and Stoke on Trent Partnership NHS Trust and therefore skews the overall turnover figures.

7.4 Statutory and Mandatory Training

Mth | Qtr 1 | Qtr2 | Qtr3 | YTD

As a Trust in January 2014, we were reporting against nine core subjects in relation to Statutory and Mandatory Training. These were Fire Safety Training, Moving & Handling, Hand Hygiene, Equality & Diversity, Information Governance, Safeguarding Children, Conflict Resolution, Safeguarding Adults and Resuscitation (BLS Equivalent). From 1st February, 2014 we will be incorporating Hand Hygiene with Infection Prevention Training. There are two Infection Prevention modules, clinical and non-clinical, and these contain the relevant Hand Hygiene information.

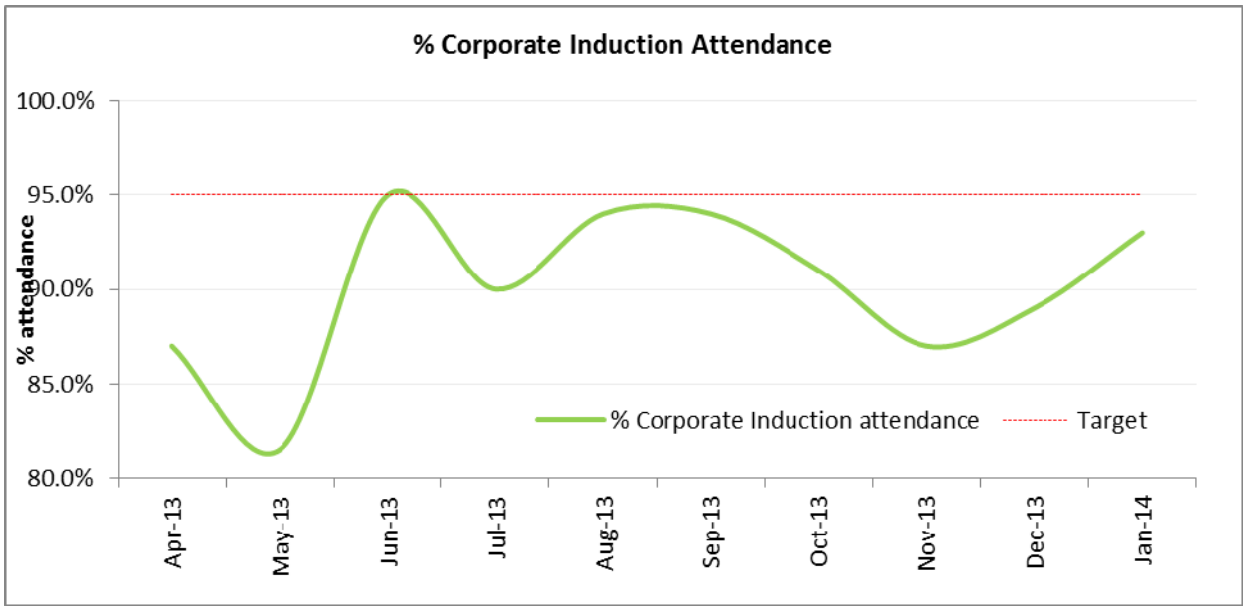
In the period between January 8th and January 31st staff compliance against Statutory and Mandatory Training has increased from 65% to 69% across these nine core areas, despite the seasonal pressures. A plan to restructure eUHL, has been completed to capture performance by Clinical Management Group and Corporate Directorates.

There are now a total of 9 new eLearning packages live on eUHL, the release of the final package has been delayed until February, due to updates being applied to eUHL to improve performance and to update associated training records. The final module to be released will see the total number of Statutory and Mandatory subjects rise to a total of 10. This last package is Health and Safety and will be a requirement of all staff every 3 years.

We continue to communicate progress, essential training requirements and follow up on non-compliance at an individual and CMG/Directorate level. During February a final version of the 'UHL Statutory and Mandatory Training Guide' will be released.

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

7.5 Corporate Induction



Performance has improved between December and January, over the last month the Corporate Induction attendance rate has increased to 93%.

Success is attributed to a number of aspects, mainly improved internal processes, encouragement and focus placed on induction and communication associated with induction completion.

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

8 2013/14 CONTRACTUAL QUERY STATUS

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

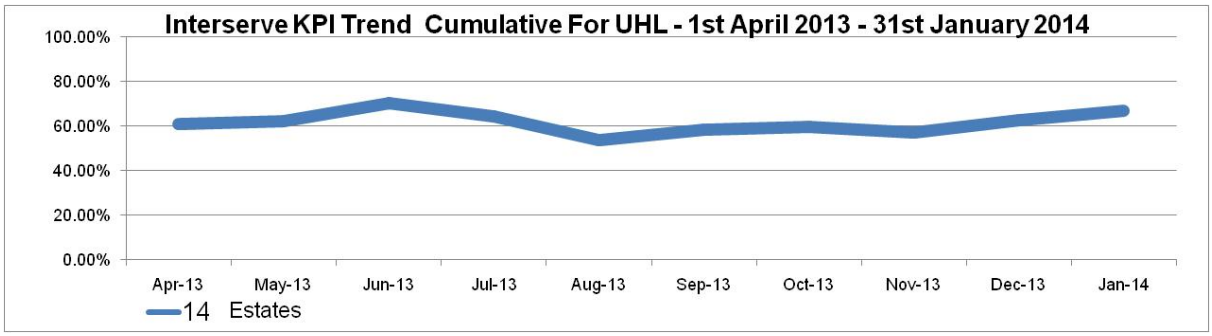
9 UHL - FACILITIES MANAGEMENT– RACHEL OVERFIELD

This report covers a review of overall performance on the Facilities Management (FM) service delivery provided by Interserve FM (IFM) and contract managed by NHS Horizons up to and including month 11 of the contract.
The FM contract providing 14 different services to the Trust is underpinned by 83 Key Performance Indicators (KPIs) and the summary information and trend analysis below details a snapshot of 6 key Indicators over the last eleven month.

9.1 Key Performance Indicators

KPI 14 – Estates

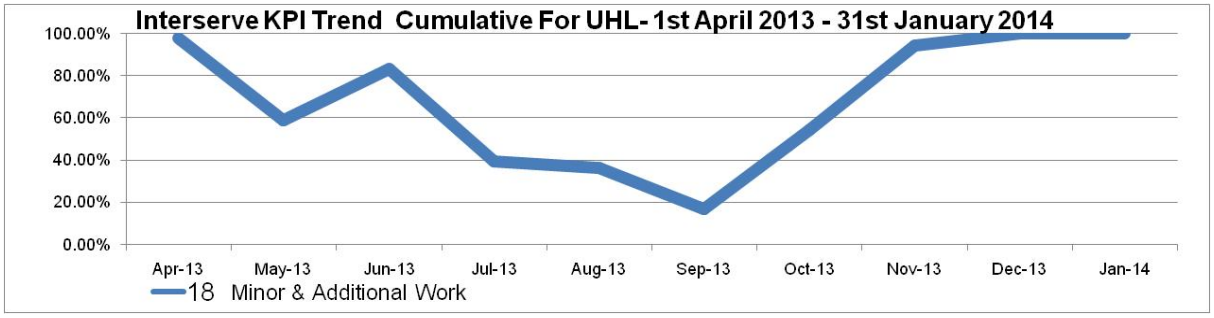
Percentage of routine requests achieving response time



KPI 14 This KPI measures the response by estates for routine requests. This has previously been an inconsistent level of performance however a steady improvement is evidenced over the last three months. Since November the percentage achieved has improved from 57% to 66.95% and recent moves to 24/7 cover over all 3 acute sites and recruitment to vacant posts appear to be having a positive impact. There are still on-going issues to be resolved with electronic working however it is hoped that this improvement can be sustained going forward.

KPI 18 – Minor & Additional Work

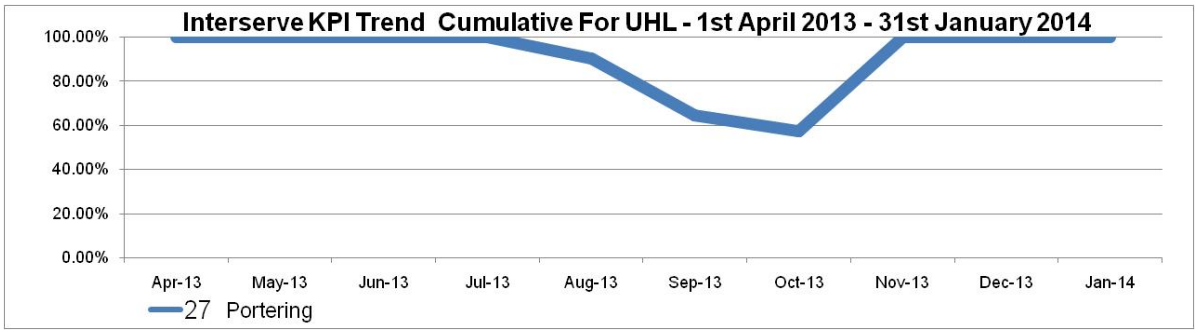
Percentage of Minor works quoted and priced within 10 working days



KPI 18 The evidence for January indicates that the 100% target has been maintained. There has been an improved response time since Interserve has been using Interserve Construction for quotations. The protocols for approval within UHL have been complied with since its introduction in December, 2013.

KPI 27 – Portering

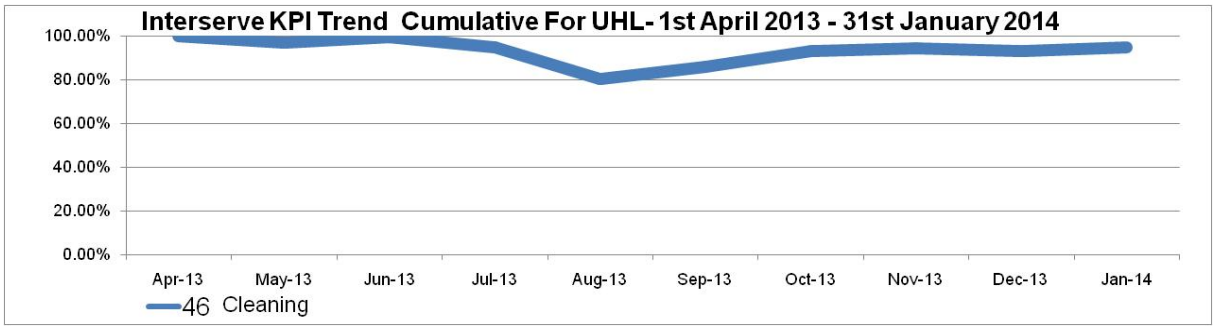
Percentage of emergency portering tasks achieving response time



KPI 27 IFM has maintained their 100% achievement of response times for January 2014.

KPI 46 - Cleaning

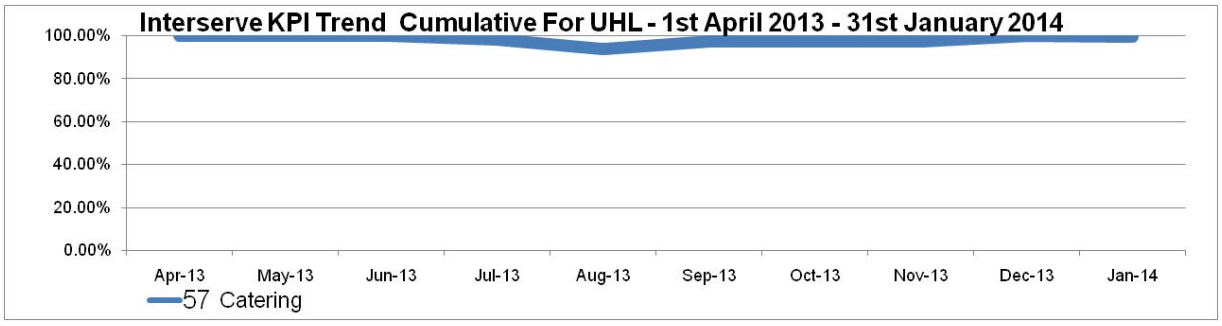
Percentage of audits in clinical areas achieving National Specification for cleaning audit scores for cleaning above 90%



KPI 46 This KPI shows a slight improvement for January with a percentage average of 94.87%. There is further improvement required in several areas. IFM have recruited additional staffing to cover the public areas and public toilets at the LRI and once this service is further embedded it is envisaged that further improved results will be seen in the coming months.

KPI 57 - Catering

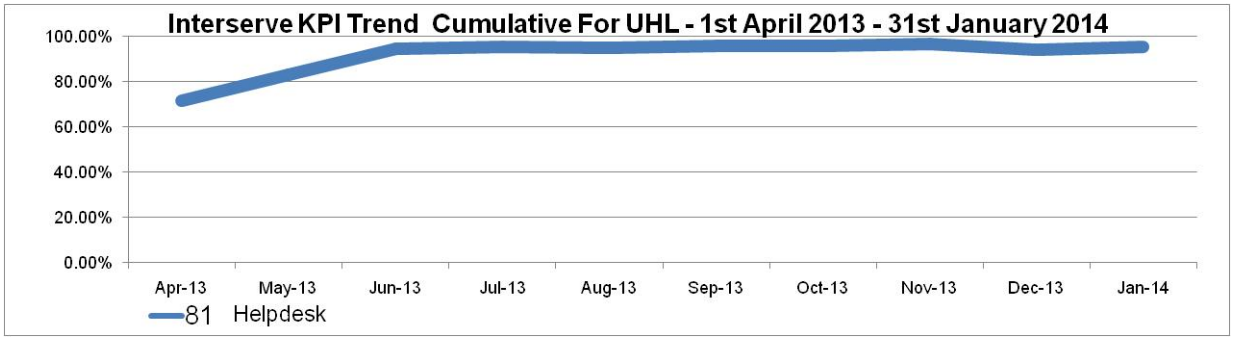
Percentage of meals delivered to wards in time for the designated meal service as per agreed schedules



KPI 57 The result for this KPI in January shows a slight reduction from last month 99.46% compared to 99.95% in December. Whilst this is a high percentage figure there are still areas, particularly at the LRI, where late meal deliveries are being experienced.

KPI 81 -Helpdesk

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



KPI 81 An improvement is shown in the results for January with 95.34% of calls being answered. There is also an overall improvement in feedback from customers in relation to this KPI which is positive.

9.2 GENERAL SUMMARY

The recorded performance for January, when measured against the 14 services and 83 KPI's shows a consistent levelling out of services with some small improvements in specific areas when compared to previous months. Interserve have confirmed that additional recruitment specifically focussed on cleaning and estates is in progress and should lead to further improvements within those services.
Electronic works and management systems are still yet to be fully established across the UHL and once these are fully operational should lead to improved performance relating to response and rectification times.

10 IM&T Service Delivery Review

10.1 Highlights

- Successful upgrade to the GOOD mobile Technology service
- Successful upgrade to the Dictate IT system
- Successful Chemocare system upgrade
- IS027001 audit completed
- Projects & Programmes – Communications with CMGs completed
- Technical testing has completed the critical applications list, but still has actions to address known Clinicom HISS / Patient Centre and ICM issues.
- Xerox devices delivered to Glenfield in readiness for start of rollout, now re-planned to 3rd Feb in order to implement learning from LiA

10.2 IT Service Review

There were 8977 (6795 previous month) incidents were logged during December, out of which 6473 (4823 previous month) were resolved. Incidents logged via X8000, email and self-service.

There were 6351 telephone calls to X8000

1589 (1208 previous month) incidents were closed on first contact

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

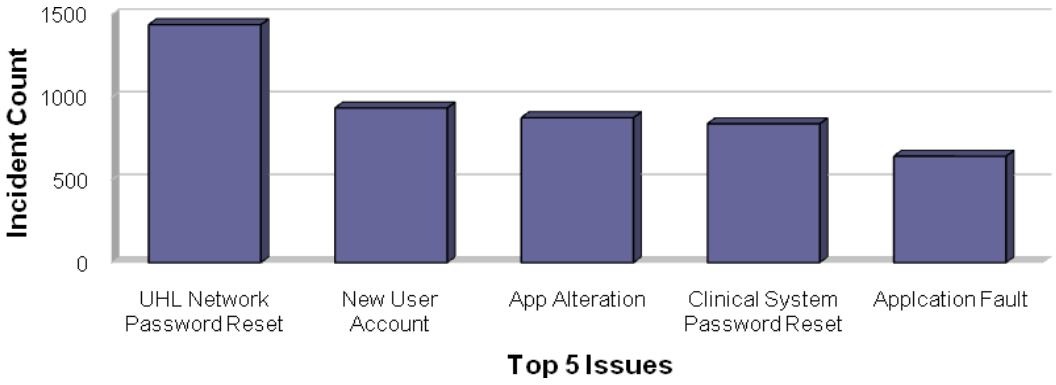
Number of official complaints relating to service has dropped to 1 in month (3 in previous month)

There were 812 (635 previous month) incidents logged out of hours via the 24/7 service desk function

10.3 Future Action

- Continuing to provide drop in training sessions in Glenfield every Tuesday and Thursday, including RA availability for smartcard updates
- Communications sessions on-going with wards and departments and successful LiA event held on 23/01 in Glenfield
-

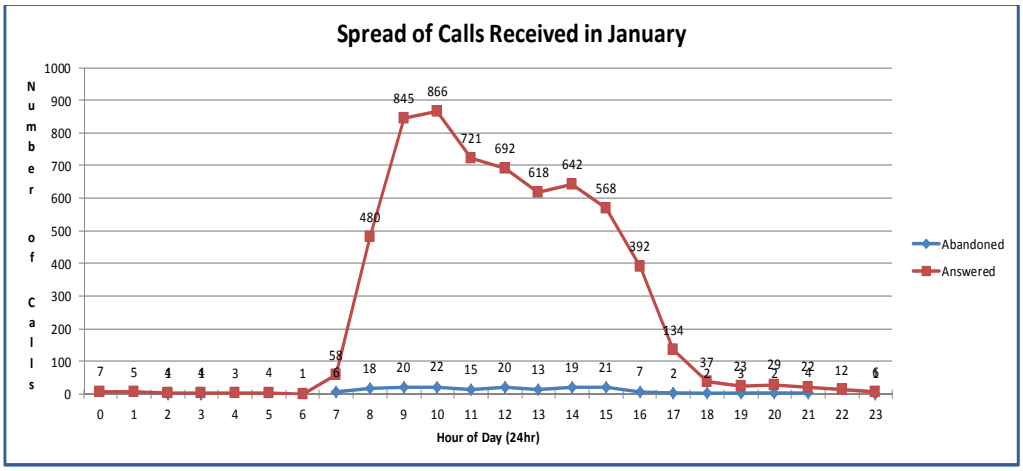
10.4 IM&T Service Desk top 5 issues



10.5 IM&T January Heatmap

Telephone	Metric	
	Total Calls Answer	6173
	Total Calls Abando	177
	Total Calls Receive	6350
	Answered in 30sec	93.82%

NOTE	Incident Logging
	SD Request email - email to sdrequest@uhl-tr.nhs.uk
	SelfService Portal - LANDesk web portal for end user
	Service Desk - call to x8000
	SS/WebDesk - Resolving Analysts logged own incident



Incident Logging Route

	SD Request email		Self Service Portal		Service Desk		SS/WebDesk		Total Logged
	Logged	%	Logged	%	Logged	%	Logged	%	
January 2013	1191	21.45%	536	9.65%	3295	59.34%	531	9.56%	5553
February 2013	1018	20.28%	496	9.88%	2974	59.25%	531	10.58%	5019
March 2013	956	21.60%	362	8.18%	2587	58.46%	520	11.75%	4425
April 2013	1215	21.47%	504	8.91%	3300	58.32%	639	11.29%	5658
May 2013	1076	21.11%	479	9.40%	3087	60.55%	456	8.94%	5098
June 2013	1113	23.13%	733	15.24%	2580	53.63%	385	8.00%	4811
July 2013	1391	23.69%	637	10.85%	3093	52.68%	750	12.77%	5871
August 2013	1731	23.43%	377	5.10%	3780	51.17%	1499	20.29%	7387
September 2013	1587	21.78%	446	6.12%	3802	52.18%	1451	19.91%	7286
October 2013	1723	22.42%	678	8.82%	4111	53.49%	1174	15.27%	7686
November 2013	1907	25.43%	614	8.19%	3931	52.43%	1046	13.95%	7498
December 2013	1834	26.99%	529	7.79%	3642	53.60%	790	11.63%	6795
January 2014	2668	29.72%	766	8.53%	4626	51.53%	917	10.21%	8977

Incidents Resolved when Logged

	AD Password Reset	Contact/ Technical Query	Total	% of Total Logged
January 2013	1164	732	1896	34%
February 2013	878	834	1712	34%
March 2013	672	700	1372	31%
April 2013	1104	940	2044	36%
May 2013	902	570	1472	29%
June 2013	791	659	1450	30%
July 2013	1192	1388	2580	44%
August 2013	1598	2744	4342	59%
September 2013	1568	2412	3980	55%
October 2013	1502	2060	3562	46%
November 2013	1304	1812	3116	42%
December 2013	1086	1330	2416	36%
January 2014	1570	1597	3167	35%

NOTE

Incidents resolved when logged.

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

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

11 FINANCE – PETER HOLLINSHEAD

11.1 Introduction

11.1.1 This purpose of this report is to provide the Trust Board and Finance & Performance Committee with an update on performance against the Trust's key financial duties as follows:

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

11.1.2 The paper also provides further commentary on the year-end forecast based on the Month 10 results, key risks and the main financial statements.

11.2 Key Financial Duties

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

Financial Duty	YTD Plan £'Ms	YTD Actual £'Ms	Forecast Plan £'Ms	Forecast Actual £'Ms	RAG
Delivering the Planned Surplus	4.1	(31.0)	3.7	(39.8)	R
Achieving the EFL *	n/a	n/a	(1.4)	(1.4)	R
Achieving the Capital Resource Limit	25.9	18.9	41.8	33.0	G

Key Issues

- The Trust will not deliver its planned surplus and is forecasting a deficit position of £39.8m, and as such will not meet its breakeven duty
- The Trust has formally written to the NTDA to amend the EFL to enable the deficit to be cash managed

- The Capital Resource Limit will be achieved but further focus on the management of the programme is required

11.3 Year to Date Financial Position and Month 10 Results

11.3.1 The Month 10 results and year-to-date performance may be summarised:

	January 2014			April - January 2014		
	Plan £m	Actual £m	Var (Adv) / Fav £m	Plan £m	Actual £m	Var (Adv) / Fav £m
Income						
Patient income	49.5	56.0	6.4	530.1	547.3	17.2
Teaching, R&D	6.1	4.4	(1.8)	62.6	60.3	(2.3)
Other operating Income	3.2	3.5	0.3	31.9	32.9	1.0
Total Income	**58.9**	**63.9**	**5.0**	**624.5**	**640.4**	**15.9**
Operating expenditure						
Pay	37.2	39.8	(2.6)	373.3	392.7	(19.4)
Non-pay	23.2	22.8	0.4	230.3	242.3	(12.0)
Reserves	(6.3)	-	(6.3)	(19.9)	-	(19.9)
Total Operating Expenditure	**54.1**	**62.6**	**(8.5)**	**583.8**	**635.0**	**(51.3)**
EBITDA	**4.8**	**1.3**	**(3.5)**	**40.8**	**5.4**	**(35.4)**
Net interest	0.0	0.0	(0.0)	0.0	0.0	0.0
Depreciation	(2.7)	(2.8)	0.1	(27.1)	(27.1)	(0.0)
PDC dividend payable	(1.0)	(0.9)	(0.0)	(9.6)	(9.3)	0.3
Net deficit	**1.1**	**(2.5)**	**(3.4)**	**4.1**	**(31.0)**	**(35.1)**
EBITDA %		**2.0%**			**0.8%**	

11.3.2 The Trust is reporting:

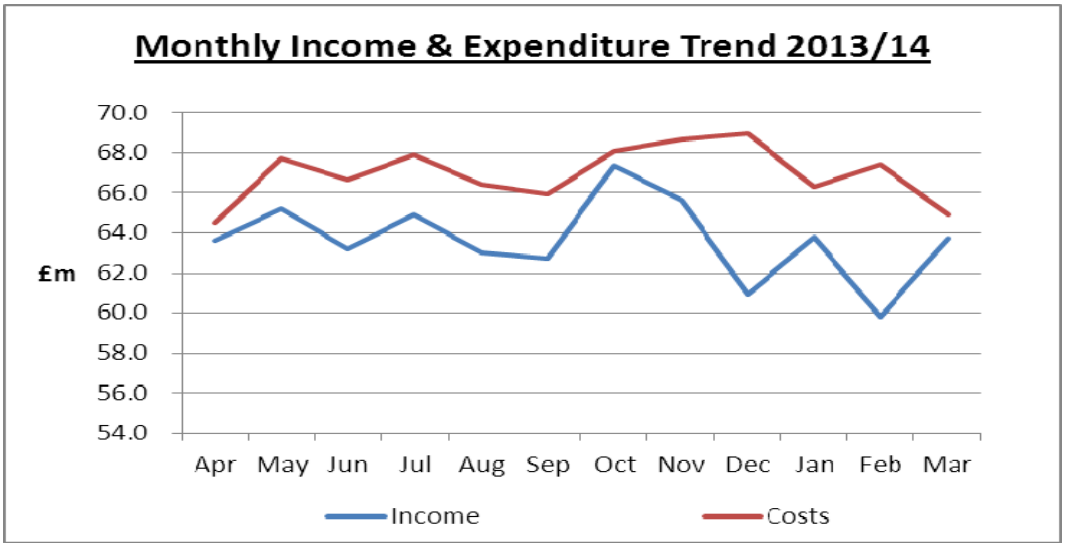
- A deficit at the end of January 2014 of £31.0m, which is £35.1m adverse to the planned surplus of £4.1m
- In month position is a £2.5m deficit, £3.4m adverse to the Plan
- The forecast for January was a deficit of £2.3m; therefore the January actuals reflect a £0.2m adverse position to forecast

11.4 Year End Forecast

11.4.1 The revised base-case forecast, taking account of the Month 10 results, is consistent with the agreed year end control total at £39.8m deficit. This is summarised in the following table:

	Year End Forecast		
	Plan £m	Forecast £m	Var (Adv) / Fav £m
Income			
Patient income	634.0	654.1	20.1
Teaching, R&D	75.0	70.8	(4.2)
Other operating Income	38.2	39.0	0.8
Total Income	**747.1**	**763.9**	**16.8**
Operating expenditure			
Pay	447.6	473.1	(25.5)
Non-pay	275.7	287.5	(11.8)
Reserves	(24.0)	-	(24.0)
Total Operating Expenditure	**699.4**	**760.6**	**(61.2)**
EBITDA	**47.8**	**3.3**	**(44.5)**
Net interest	0.0	-	0.0
Depreciation	(32.5)	(32.3)	0.2
PDC dividend payable	(11.6)	(10.8)	0.8
Net deficit	**3.7**	**(39.8)**	**(43.5)**
EBITDA %		**0.4%**	

11.4.2 The following chart highlights, graphically, the monthly trends of both income and expenditure to the year end:



11.4.3 Whilst this forecast maintains delivery of the year end control total, there have been some movements within the respective CMGs and Corporate Directorates. This is shown in detail in the Financial Appendix 1.

11.4.4 There have been material movements with the 2 CMGs, Musculo-Skeletal & Specialist Surgery and ITAPS, plus IM&T. These 3 areas total almost a £5m deterioration from the Month 7 control total. The positions have been escalated through the performance management review process.

11.4.5 The IM&T adverse movement, relates to staff TUPE transferring to our Managed Business Partner.

A more detailed financial analysis of CMG and Corporate performance is provided through the Executive Performance Board financial report.

11.4.6 The risks and opportunities within the year end forecast are shown in the following table to provide a risk range:

	Risk	Downside £000	Likely Year End £000	Upside £000
Month Gross 10 Re-forecast (I&E deficit)		**(44,731)**	**(44,731)**	**(44,731)**
Risks & Opportunities				
Additional Education & Training income	G	300	300	300
Theatre Tray Stock Count	A	0	1,500	2,500
Reduction in Contingency	A	0	800	1,200
PDC Dividend revised Calculation	G	0	400	600
Depreciation	A	0	300	300
Corporate Forecast Improvement	A	0	500	700
CMG Forecast Improvement	A	0	500	700
Winter	G	0	600	750
Sum of upside / downside issues		**300**	**4,900**	**7,050**
Revised Year End Forecast (I&E deficit)		**(44,431)**	**(39,831)**	**(37,681)**

11.4.7 The key financial risks are as follows:

- Winter pressures beyond the levels planned resulting in premium costs and the loss of elective income

  Mitigation: The Trust is closely monitoring the impact providing additional resource as required. The position will be escalated with CCGs through the contract management process

- CCG income assumptions

  Whilst activity and income assumptions are aligned between the Trust and Commissioners, there is a 'subject to affordability' clause within the CCG position

  Mitigation: Contract settlement sought with Specialised Commissioning and local CCG

- Unforeseen events

  The Trust has very little flexibility and a minimal contingency to manage unforeseen financial pressures and as such these risks will impact on the bottom line position

- Liquidity

  The projected £39.8m deficit creates liquidity issues for which an EFL adjustment has been requested (see Section 11.6)

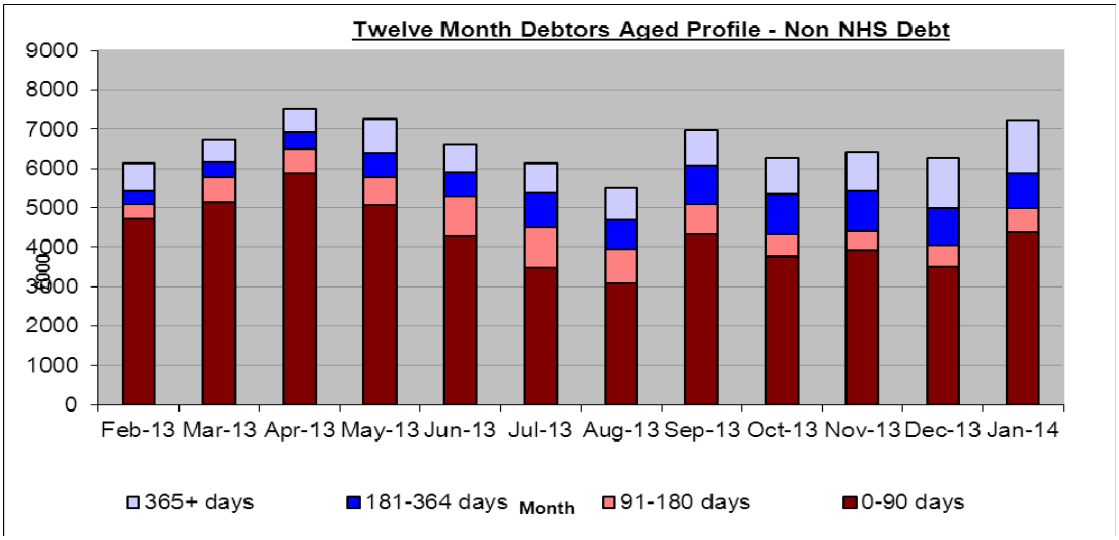
  Mitigation: Contingency plan will be considered by the Finance and Performance Committee.

11.5 Balance Sheet

11.5.1 The effect of the Trust's financial position on its balance sheet is provided in Financial Appendix 2.

11.5.2 The retained earnings reserve will reduce by the Trust's £39.8m deficit. This is matched by the reduction of £20.0m cash and increase in Trade and Other Payables of £22.3m; as well as smaller movements on other current and non-current assets and liabilities.

11.5.3 The level of non-NHS debt has fluctuated across the year as shown in the following table:



11.5.4 The overall level of non-NHS debt at Month 10 was similar to the April 2013 position although the proportion of debt over 365 days has increased from £583k (8%) at the end of March 2013 to £1,378k (19%) in Month 10. This is primarily due to the ageing of overseas visitors' debt.

11.5.5 The Trust will be undertaking a debt write-off exercise by the year end which will reduce the level of outstanding aged debt. All debts to be written off have been provided for 100% in the Trust's bad debt provision and there will be no impact on the financial position as a result of these write-offs.

11.5.6 NHS debt is £14.2m at the end of Month 10. This is inflated by approximately £7m mainly due to several legacy debts totalling £2.6m carried forward from the demised PCTs; and outstanding winter pressures monies of £4.5m. These debts are expected to be received by the year end and the level of NHS debt will then reduce to a more normalised position of around £7m.

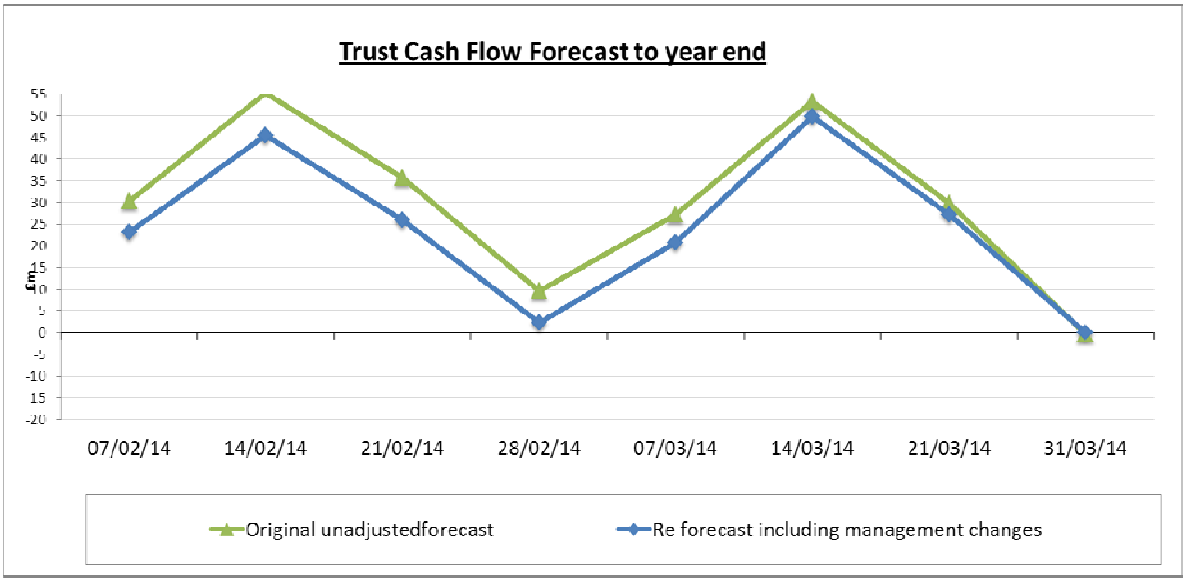
11.6 Cash Flow Forecast

11.6.1 The Trust's cash flow is provided in Financial Appendix 3.

11.6.2 The Trust's current cashflow forecast is aligned to the forecast year end deficit of £39.8m. This indicates a deliberate year end cash balance of zero against a Plan balance of £19m. The forecast is shown on the graph overleaf and includes the following assumptions:

- Capital cash payments will total £31m for the full year

- The current balance of £13m extended creditor payments will be reduced to less than £5m by the year end
- All suppliers will remain on 30 day payment terms (apart from specific exceptions)
- The current level of NHS debt will reduce by £7.0m



11.6.2 The Trust set an initial plan for 2013/14 to achieve a year end cash balance of £17.3m (2012/13 - £19.98m) based on a retained Income & Expenditure (I&E) surplus of £3.7m. This level of planned cash equates to an External Financing Limit of (£1.4m), which is a statutory financial duty that the Trust must achieve. Failure to achieve the planned level of cash means that we will not achieve our EFL.

Year End Cash Forecast

11.6.3 To achieve the planned level of cash without external support, the Trust will need to maintain a backlog of unpaid and overdue creditor invoices totalling at least £26.90m, which approximates to one month of creditor payments over and above the Trust's standard 30 day payment terms. There are considerable operational risks to the Trust of maintaining such a high level of unpaid invoices, such as key suppliers putting the account on stop and not maintaining a continuity of supplies essential to patient care.

11.6.4 The Trust is not in a position to apply for a longer term loan given the current timescales and lack of certainty concerning its granting. Equally, temporary borrowing repayable by 31 March 2014 would not solve the in-year liquidity problem.

11.6.5 The Trust has therefore formally requested from the NTDA that our EFL is reset from (£1.4m) to £19m. This will enable us to reduce our year end cash balance to zero and minimise the level of backlog invoices whilst still achieving the EFL. We are currently awaiting approval for this adjustment.

11.6.6 The Trust will apply for temporary borrowing to be received on 1 April 2014 which will ensure an adequate level of cash in the first quarter of 2014/15 until a longer term financing solution is secured.

11.7 Capital

11.7.1 The capital position at end of January 2014 is £19.2m against the annual plan of £40.1m. Financial Appendix 4 shows the monthly capital programme by scheme.

11.7.2 The yearend forecast is now £33.5m. Key deliverables to meet this forecast are CHP Units (£2.1m), Facilities Backlog (£3.7m), Medical Equipment (£1.1m), IM&T (£1.4m) and ED Floor (£1.1m).

11.7.3 External funding bids of £2m, £0.75m and £0.16m have been awarded this month around successful IM&T, maternity and safer ward bids. The majority of this funding is required to be spent by the end of the year and is within the cash position.

11.7.4 The inaugural Capital Group is meeting on 21 February 2014 to develop a process to improve the Trust's management of the capital resource.

11.8 Next Steps and Recommendations

11.8.1 The Trust Board and Finance & Performance Committee is **recommended** to:

- **Note** the contents of this report
- **Confirm** the year end forecast of a deficit of £39.8m, and the risks and opportunities within this (Section 11.4.7)
- **Note** the submission to reset the EFL (Section 11.6.3)
- **Note** performance against the capital plan (Section 11.7)

Financial Appendices below

FOT Position as at Month 10

Financial Appendix 1

		Income			Pay			Non Pay			TOTAL			M7 FOT	
Division	CMG's	Budget £000s	Actual £000s	'Variance £000s	Budget £000s	Actual £000s	'Variance £000s	Budget £000s	Actual £000s	'Variance £000s	Budget £000s	Actual £000s	'Variance £000s	'Variance £000s	Change in forecast M7 vs M10
Clinical CMG's	C.H.U.G.S	120,465	123,830	3,364	45,500	46,670	(1,170)	35,817	40,617	(4,800)	39,148	36,543	(2,605)	(2,062)	(543)
	Clinical Support & Imaging	31,084	33,089	2,004	67,030	69,957	(2,927)	2,574	5,009	(2,435)	(38,519)	(41,878)	(3,359)	(3,395)	37
	Emergency & Specialist Med	105,808	118,431	12,622	63,868	74,780	(10,913)	30,011	32,456	(2,446)	11,930	11,194	(736)	(735)	(1)
	I.T.A.P.S	27,738	28,110	372	49,526	54,899	(5,373)	19,551	19,692	(141)	(41,339)	(46,481)	(5,143)	(3,472)	(1,670)
	Musculo & Specialist Surgery	96,134	96,610	476	43,571	45,584	(2,013)	18,415	19,517	(1,101)	34,148	31,510	(2,638)	(533)	(2,105)
	Renal, Respiratory & Cardiac	129,797	131,642	1,845	56,033	58,518	(2,485)	41,881	45,482	(3,602)	31,884	27,642	(4,242)	(4,242)	(0)
	Womens & Childrens	141,043	141,770	726	74,589	74,547	42	29,481	30,132	(651)	36,973	37,091	118	117	0
Clinical CMG's Total		**652,070**	**673,481**	**21,411**	**400,116**	**424,955**	**(24,839)**	**177,730**	**192,906**	**(15,176)**	**74,225**	**55,621**	**(18,605)**	**(14,321)**	**(4,283)**
Corporate Total		**17,443**	**18,967**	**1,524**	**34,640**	**35,072**	**(433)**	**81,166**	**82,105**	**(939)**	**(98,363)**	**(98,211)**	**153**	**(397)**	**550**
Research & Development Total		**29,241**	**27,017**	**(2,224)**	**12,857**	**12,810**	**46**	**16,385**	**14,137**	**2,247**	**(0)**	**70**	**70**	**191**	**(121)**
Central Division Total		**48,530**	**44,449**	**(4,080)**	**0**	**246**	**(246)**	**20,683**	**41,513**	**(20,830)**	**27,846**	**2,691**	**(25,156)**	**(28,963)**	**3,808**
Grand Total		**747,284**	**763,914**	**16,631**	**447,612**	**473,083**	**(25,471)**	**295,964**	**330,661**	**(34,697)**	**3,708**	**(39,830)**	**(43,538)**	**(43,491)**	**(47)**

Financial Appendix 2

Balance Sheet

	Mar-13 £000's Actual	Apr-13 £000's Actual	May-13 £000's Actual	Jun-13 £000's Actual	Jul-13 £000's Actual	Aug-13 £000's Actual	Sep-13 £000's Actual	Oct-13 £000's Actual	Nov-13 £000's Actual	Dec-13 £000's Actual	Jan-14 £000's Actual	Mar-14 £000's Forecast
Non Current Assets												
Property, plant and equipment	354,680	353,855	353,723	352,327	352,803	353,255	352,521	352,993	353,114	352,703	352,189	354,046
Intangible assets	5,318	5,160	5,012	4,940	4,795	4,650	4,627	4,419	4,273	4,328	4,179	4,910
Trade and other receivables	3,125	3,183	3,181	3,252	3,302	3,291	3,331	3,268	3,191	3,218	3,223	3,200
TOTAL NON CURRENT ASSETS	**363,123**	**362,198**	**361,916**	**360,519**	**360,900**	**361,196**	**360,479**	**360,680**	**360,578**	**360,249**	**359,591**	**362,156**
Current Assets												
Inventories	13,064	13,869	13,257	13,778	13,861	13,776	14,499	14,176	14,155	14,558	14,133	14,200
Trade and other receivables	44,616	42,408	42,628	35,756	40,713	44,182	46,674	42,210	49,634	50,922	50,734	47,950
Other Assets	40	40	40	40	40	40	40	40	40	40	40	40
Cash and cash equivalents	19,986	19,957	14,257	19,129	15,343	7,203	4,484	5,335	2,933	6,876	4,986	0
TOTAL CURRENT ASSETS	**77,706**	**76,274**	**70,182**	**68,703**	**69,957**	**65,201**	**65,697**	**61,761**	**66,762**	**72,396**	**69,893**	**62,190**
Current Liabilities												
Trade and other payables	(75,559)	(73,056)	(67,971)	(68,079)	(71,026)	(69,123)	(77,327)	(81,916)	(88,794)	(93,069)	(91,182)	(95,903)
Dividend payable	0	(964)	(1,928)	(2,892)	(3,856)	(4,820)	0	(964)	(1,928)	(2,892)	(3,856)	0
Borrowings	(2,726)	(2,800)	(2,800)	(2,800)	(2,800)	(2,800)	(2,800)	(2,800)	(2,800)	(2,727)	(2,800)	(3,000)
Provisions for liabilities and charges	(1,906)	(1,906)	(1,906)	(1,906)	(1,906)	(1,906)	(1,342)	(1,342)	(1,342)	(2,244)	(2,244)	(2,200)
TOTAL CURRENT LIABILITIES	**(80,191)**	**(78,726)**	**(74,605)**	**(75,677)**	**(79,588)**	**(78,649)**	**(81,469)**	**(87,022)**	**(94,864)**	**(100,932)**	**(100,082)**	**(101,103)**
NET CURRENT ASSETS (LIABILITIES)	**(2,485)**	**(2,452)**	**(4,423)**	**(6,974)**	**(9,631)**	**(13,448)**	**(15,772)**	**(25,261)**	**(28,102)**	**(28,536)**	**(30,189)**	**(38,913)**
TOTAL ASSETS LESS CURRENT LIABILITIES	**360,638**	**359,746**	**357,493**	**353,545**	**351,269**	**347,748**	**344,707**	**335,419**	**332,476**	**331,713**	**329,402**	**323,243**
Non Current Liabilities												
Borrowings	(10,906)	(10,958)	(11,190)	(10,809)	(11,522)	(11,484)	(11,159)	(10,797)	(10,410)	(10,887)	(11,103)	(11,575)
Other Liabilities	0	0	0	0	0	0	0	0	0	0	0	0
Provisions for liabilities and charges	(2,407)	(2,454)	(2,488)	(2,404)	(2,315)	(2,312)	(2,986)	(2,910)	(2,870)	(2,004)	(1,984)	(2,000)
TOTAL NON CURRENT LIABILITIES	**(13,313)**	**(13,412)**	**(13,678)**	**(13,213)**	**(13,837)**	**(13,796)**	**(14,145)**	**(13,707)**	**(13,280)**	**(12,891)**	**(13,087)**	**(13,575)**
TOTAL ASSETS EMPLOYED	**347,325**	**346,334**	**343,815**	**340,332**	**337,432**	**333,952**	**330,562**	**321,712**	**319,196**	**318,822**	**316,315**	**309,668**
Public dividend capital	277,733	277,733	277,733	277,733	277,733	277,733	277,733	277,733	277,733	277,733	277,733	279,880
Revaluation reserve	64,628	64,626	64,628	64,632	64,632	64,628	64,628	64,628	64,628	64,628	64,628	64,628
Retained earnings	4,960	3,975	1,454	(2,033)	(4,933)	(8,409)	(11,799)	(20,649)	(23,165)	(23,539)	(26,046)	(34,840)
TOTAL TAXPAYERS EQUITY	**347,325**	**346,334**	**343,815**	**340,332**	**337,432**	**333,952**	**330,562**	**321,712**	**319,196**	**318,822**	**316,315**	**309,668**

Cash Flow for the period ended 31st January 2014	2013/14 Apr - Jan Plan £ 000	2013/14 Apr - Jan Actual £ 000	2013/14 Apr - Jan Variance £ 000
CASH FLOWS FROM OPERATING ACTIVITIES			
Operating surplus before Depreciation and Amortisation	41,126	5,393	(35,733)
Donated assets received credited to revenue and non cash	(250)	(300)	(50)
Interest paid	(704)	(842)	(138)
Movements in Working Capital:			
- Inventories (Inc)/Dec	-	(1,069)	(1,069)
- Trade and Other Receivables (Inc)/Dec	-	(6,216)	(6,216)
- Trade and Other Payables Inc/(Dec)	-	19,503	19,503
- Provisions Inc/(Dec)	(1,780)	(85)	1,695
PDC Dividends paid	(5,500)	(5,454)	46
Other non-cash movements	(273)	825	1,098
Net Cash Inflow / (Outflow) from Operating Activities	**32,619**	**11,755**	**(20,864)**
CASH FLOWS FROM INVESTING ACTIVITIES			
Interest Received	80	84	4
Payments for Property, Plant and Equipment	(26,192)	(22,845)	3,347
Capital element of finance leases	(3,850)	(3,994)	(144)
Net Cash Inflow / (Outflow) from Investing Activities	**(29,962)**	**(26,755)**	**3,207**
CASH FLOWS FROM FINANCING ACTIVITIES			
New PDC	-	-	-
Net Cash Inflow / (Outflow) from Financing	**-**	**-**	**-**
Opening cash	19,986	19,986	-
Increase / (Decrease) in Cash	2,657	(15,000)	**(17,657)**
Closing cash	**22,643**	**4,986**	**(17,657)**

Rolling 12 month cashflow forecast - February 2014 to January 2015	2013/14 February Forecast £ 000	2013/14 March Forecast £ 000	2014-15 April Forecast £ 000	2014-15 May Forecast £ 000	2014-15 June Forecast £ 000	2014-15 July Forecast £ 000	2014/15 August Forecast £ 000	2014/15 September Forecast £ 000	2014/15 October Forecast £ 000	2014/15 November Forecast £ 001	2014/15 December Forecast £ 000	2014/15 January Forecast £ 000
CASH FLOWS FROM OPERATING ACTIVITIES												
Operating surplus before Depreciation and Amortisation	1,279	3,366	2,098	5,468	2,098	5,468	5,468	2,971	6,341	4,719	3,658	5,321
Donated assets received credited to revenue and non cash	(25)	(26)	(26)	(26)	(26)	(26)	(26)	(26)	(26)	(26)	(25)	(25)
Interest paid	(79)	(78)	(82)	(82)	(81)	(81)	(80)	(80)	(79)	(78)	(77)	(77)
Movements in Working Capital:										-		
- Inventories (Inc)/Dec										-		
- Trade and Other Receivables (Inc)/Dec	1,654	3,150	(2,869)	(10)	41	9	8	41	(11)	24	2,000	3,000
- Trade and Other Payables Inc/(Dec)	(5,012)	(688)	(83)	(83)	(83)	(83)	(83)	(83)	(83)	(83)	(2,500)	(2,500)
- Provisions Inc/(Dec)	(8)	(8)	(8)	(8)	(8)	(8)	(8)	(8)	(8)	(8)	(8)	(8)
PDC Dividends paid	-	(5,454)	-	-	-	-	-	(5,615)	-	-	-	-
Other non-cash movements	-	-	-	-	-	(21)	-	-	-	-	-	-
Net Cash Inflow / (Outflow) from Operating Activities	**(2,191)**	**262**	**(970)**	**5,259**	**1,941**	**5,258**	**5,279**	**(2,800)**	**6,134**	**4,548**	**3,047**	**5,711**
CASH FLOWS FROM INVESTING ACTIVITIES												
Interest Received	8	8	6	6	6	6	7	7	7	7	8	8
Payments for Property, Plant and Equipment	(2,251)	(2,169)	(2,294)	(2,295)	(2,294)	(2,295)	(2,294)	(2,295)	(2,294)	(2,295)	(2,251)	(2,252)
Capital element of finance leases	(400)	(400)	(391)	(391)	(391)	(391)	(391)	(391)	(391)	(391)	(400)	(400)
Net Cash Inflow / (Outflow) from Investing Activities	**(2,643)**	**(2,561)**	**(2,679)**	**(2,680)**	**(2,679)**	**(2,680)**	**(2,678)**	**(2,679)**	**(2,678)**	**(2,679)**	**(2,644)**	**(2,644)**
CASH FLOWS FROM FINANCING ACTIVITIES												
New PDC	2,147	-	-	-	-	-	-	-	-	-	-	-
Net Cash Inflow / (Outflow) from Financing	**2,147**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Opening cash	**4,986**	**2,299**	**(0)**	**(3,649)**	**(1,070)**	**(1,808)**	**770**	**3,371**	**(2,108)**	**1,348**	**4,986**	**4,986**
Increase / (Decrease) in Cash	(2,687)	(2,299)	(3,649)	2,579	(738)	2,578	2,601	(5,479)	3,456	1,869	404	3,067
Closing cash	**2,299**	**(0)**	**(3,649)**	**(1,070)**	**(1,808)**	**770**	**3,371**	**(2,108)**	**1,348**	**3,217**	**5,389**	**8,053**

Financial Appendix 4

University Hospitals of Leicester NHS Trust
Capital Expenditure Report for the Period 1st April 2013 to 31st March 2014

	Capital Plan 2013/14	YTD Spend 13/14	Expenditure Profile												Forecast Out Turn	Variance
			Actual										Forecast			
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar		
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£'000's
Recurrent Budgets																
IM&T	4,425	2,954	69	226	290	203	475	93	754	54	38	753	500	971	4,425	0
Medical Equipment	4,187	3,045	264	7	209	119	386	347	904	431	103	275	202	941	4,187	0
Facilities Sub Group	6,000	2,251	286	204	193	388	261	143	67	328	240	141	700	3,049	6,000	0
Divisional Discretionary Capital	381	352	150	65	9	10	16	12	55	4	16	14	29	0	381	0
MES Installation Costs	2,500	1,829	38	178	343	455	40	403	32	92	243	5	200	271	2,300	200
Total Recurrent Budgets	**17,493**	**10,431**	**807**	**680**	**1,045**	**1,174**	**1,179**	**998**	**1,812**	**909**	**639**	**1,187**	**1,631**	**5,231**	**17,293**	**200**
Reconfiguration Schemes																
Emergency Floor	3,500	1,374	134	7	14	79	79	130	312	575	34	12	500	626	2,500	1,000
Theatres Assessment Area (TAA)	1,580	1,333	4	10	27	30	491	172	82	164	188	164	247	0	1,580	0
Advanced Recovery LRI & LGH	514	161	63	(7)	55	11	7	(6)	18	8	5	7	70	69	300	214
GGH Vascular Surgery	650	43	0	0	0	0	0	0	24	4	25	(11)	50	257	350	300
Vascular Enabling	200	2	0	0	0	0	0	0	0	0	0	2	10	88	100	100
Daycase / OPD Hub	328	0	0	0	0	0	0	0	0	0	0	0	0	0	0	328
Ward 4 LGH / H Block Isolation	283	4	0	0	0	0	0	0	1	0	0	2	10	86	100	183
Modular Wards	500	0	0	0	0	0	0	0	0	0	0	0	0	100	100	400
Brandon Unit Refurb: OPD 1-4	100	90	0	0	0	0	5	4	1	95	0	(16)	0	0	90	10
ITU	140	0	0	0	0	0	0	0	0	0	0	0	0	0	0	140
Poppies Conversion	300	28	0	0	0	0	0	0	0	28	0	0	100	172	300	0
Surgical Assessment Unit	150	3	0	0	0	0	0	0	0	0	1	2	20	0	23	127
Endoscopy GH	100	3	0	0	0	0	0	0	0	1	0	2	7	0	10	90
Feasibility Studies	100	23	0	0	0	0	0	0	35	(3)	(9)	0	0	11	34	66
Total Reconfiguration	**8,445**	**3,063**	**201**	**10**	**96**	**121**	**582**	**300**	**472**	**873**	**244**	**165**	**1,014**	**1,410**	**5,487**	**2,958**
Corporate / Other Schemes																
Osborne Ventilation	650	442	0	0	0	0	13	(1)	18	199	151	61	100	108	650	0
Endoscopy LRI	165	152	0	80	(1)	24	5	28	16	1	0	0	0	0	152	13
Maternity Interim Development	3,000	2,161	3	18	9	273	388	332	190	334	324	290	311	301	2,773	227
Aseptic Suite	650	18	7	0	1	0	0	2	5	1	0	1	150	300	468	182
Diabetes BRU	750	769	0	62	125	128	141	37	105	121	21	29	0	206	975	(225)
Respiratory BRU	730	807	3	809	(245)	190	9	(46)	10	1	75	(0)	0	0	807	(77)
Stock Management System	2,800	201	0	0	0	0	0	0	3	185	13	0	0	0	201	2,599
LIA Schemes	500	12	0	0	0	0	0	0	0	0	0	12	100	231	343	157
CMG Contingency	147	6	0	0	0	0	0	0	0	0	0	6	35	106	147	0
CHP Units	2,147	13	0	0	0	0	0	0	11	5	(2)	(2)	0	2,134	2,147	0
EDRM System	1,639	388	0	0	0	0	212	218	278	(42)	0	(278)	278	334	1,000	639
Donations	300	300	0	42	11	0	61	0	36	51	68	29	108	25	433	(133)
Other Developments	729	505	32	81	80	36	8	(9)	68	112	33	64	50	75	630	99
	14,207	**5,773**	**45**	**1,093**	**(20)**	**650**	**837**	**561**	**739**	**970**	**684**	**214**	**1,132**	**3,820**	**10,725**	**3,482**
Total Capital Programme	**40,145**	**19,268**	**1,054**	**1,783**	**1,121**	**1,945**	**2,598**	**1,858**	**3,024**	**2,752**	**1,567**	**1,566**	**3,777**	**10,460**	**33,505**	**6,640**

Friends & Families Test

What is the Friends & Family test?

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

Patients can choose from one of the following answers:

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

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

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

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

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

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

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

University Hospitals of Leicester NHS
NHS Trust

Caring at its best

FRIENDS AND FAMILY TEST : August'13 - January'14

									JANUARY SCORE BREAKDOWN				
			Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Total Responses	Promoters	Passives	Detractors	Score
GLENFIELD HOSPITAL	GH WD 15	F15	100	82	91	73	70	85	20	17	3	0	85
	GH WD 16 Respiratory Unit	F16	68	80	80	87	100	83	29	24	5	0	83
	GH WD 20	F20	79	-	59	56	79	62	26	16	10	0	62
	GH WD 23A	F23A	-	80	55	82	0	89	27	24	3	0	89
	GH WD 24	F24	-	95	96	100	88	86	36	31	5	0	86
	GH WD 24	F24	-	95	96	100	88	86	36	31	5	0	86
	GH WD 25E Digestive Diseases	F25E	85	88	96	90	-	93	42	40	1	1	93
	GH WD 26	F26	94	93	87	80	94	91	35	32	3	0	91
	GH WD 27	F27	90	67	54	74	25	96	25	24	1	0	96
	GH WD 28	F28	96	76	89	80	87	68	34	25	7	2	68
	GH WD 29	F29	75	68	74	90	88	82	27	24	1	2	82
	GH WD 30	F30	94	0	95	94	0	0	0	0	0	0	0
	GH WD 31	F31	94	88	90	95	87	100	21	21	0	0	100
	GH WD 32	F32	87	81	74	79	84	96	22	21	1	0	96
	GH WD 33	F33	73	76	77	79	76	83	41	34	7	0	83
	GH WD 33A	F33A	84	67	80	87	95	95	19	18	1	0	95
	GH WD Clinical Decisions Unit	FCDU	58	50	44	65	28	66	104	78	17	9	66
	GH WD Coronary Care Unit	FCCU	90	91	100	89	79	94	62	58	4	0	94
	GH WD GICU Gen Intensive	FITU	93	100	89	96	-	92	40	37	1	1	92
	GH WD Paed ITU	FPIC	100	75	100	100	88	100	10	10	0	0	100

University Hospitals of Leicester NHS
NHS Trust

Caring at its best

FRIENDS AND FAMILY TEST : August'13 - January'14

									JANUARY SCORE BREAKDOWN				
			Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Total Responses	Promoters	Passives	Detractors	Score
LEICESTER GENERAL HOSPITAL	LGH WD 1	G1	-	-	78	84	0	0	0	0	0	0	0
	LGH WD 10	G10	70	50	56	70	100	70	10	7	3	0	70
	LGH WD 11	G11	80	89	88	88	-	83	36	31	4	1	83
	LGH WD 14	G14	85	61	78	46	74	88	43	38	5	0	88
	LGH WD 15N Nephrology	G15N	-	38	60	86	0	100	7	7	0	0	100
	LGH WD 16	G16	71	50	94	70	74	83	23	19	4	0	83
	LGH WD 17 Transplant	G17	84	88	86	79	82	78	24	19	3	1	78
	LGH WD 18	G18	93	71	81	85	81	69	29	22	5	2	69
	LGH WD 18	G18	93	71	81	85	81	69	29	22	5	2	69
	LGH WD 2	G2	-	87	57	46	63	0	0	0	0	0	0
	LGH WD 22	G22	50	79	46	42	52	45	20	13	3	4	45
	LGH WD 26 SAU	G26	48	46	52	60	67	71	21	17	2	2	71
	LGH WD 27	G27	64	55	58	60	33	50	18	11	5	2	50
	LGH WD 28 Urology	G28	100	24	51	60	68	65	40	30	6	4	65
	LGH WD 3	G3	70	43	100	80	40	50	2	1	1	0	50
	LGH WD 31	G31	73	83	89	79	76	80	51	43	6	2	80
	LGH WD Brain Injury Unit	GBIU	-	100	100	50	0	33	3	1	2	0	33
	LGH WD Crit Care Med	GDCM	90	56	70	89	81	90	10	9	1	0	90
	LGH WD Surg Acute Care	GSAC	100	79	100	100	0	0	0	0	0	0	0
	LGH WD Young Disabled	GYDU	100	100	50	0	67	0	0	0	0	0	0

University Hospitals of Leicester NHS
NHS Trust

Caring at its best

FRIENDS AND FAMILY TEST : August'13 - January'14

									JANUARY SCORE BREAKDOWN				
			Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Total Responses	Promoters	Passives	Detractors	Score
LEICESTER ROYAL INFIRMARY	LRI WD 10 Bal L4	R10	77	62	83	68	0	0	0	0	0	0	0
	LRI WD 11 Bal L4	R11	68	74	77	48	0	0	0	0	0	0	0
	LRI WD 12 Bal L4	R12	84	67	79	100	-	75	28	22	5	1	75
	LRI WD 14 Bal L4	R14	95	0	100	96	0	0	0	0	0	0	0
	LRI WD 15 AMU Bal L5	R15	65	56	53	67	73	58	86	57	19	8	58
	LRI WD 17 Bal L5	R17	48	74	44	0	50	30	10	3	7	0	30
	LRI WD 18 Bal L5	R18	-100	57	48	0	65	0	0	0	0	0	0
	LRI WD 19 Bal L6	R19	35	59	44	63	53	41	17	9	6	2	41
	LRI WD 21 Bal L6	R21	89	100	91	82	64	100	22	22	0	0	100
	LRI WD 22 Bal 6	R22	44	38	63	58	42	17	29	11	12	6	17
	LRI WD 24 Win L3	R24	52	38	25	18	28	62	22	14	6	1	62
	LRI WD 25 Win L3	R25	69	88	73	85	80	90	20	18	2	0	90
	LRI WD 26 Win L3	R26	65	0	69	86	71	95	20	19	1	0	95
	LRI WD 27 Win L4	R27	100	75	100	100	0	100	4	4	0	0	100
	LRI WD 28 Windsor Level 4	R28	-	0	82	62	0	0	0	0	0	0	0
	LRI WD 29 Win L4	R29	70	65	75	67	75	71	21	16	4	1	71
	LRI WD 31 Win L5	R31	48	23	72	40	65	90	20	17	2	0	90
	LRI WD 32 Win L5	R32	48	58	54	69	64	86	7	6	1	0	86
	LRI WD 33 Win L5	R33	75	58	81	77	81	79	38	31	6	1	79
	LRI WD 34 Windsor Level 5	R34	58	55	55	70	68	81	21	18	2	1	81
	LRI WD 36 Win L6	R36	50	60	57	63	95	84	20	16	3	0	84
	LRI WD 37 Win L6	R37	71	81	52	100	0	72	43	33	8	2	72
	LRI WD 38 Win L6	R38	85	100	82	92	86	96	23	22	1	0	96
	LRI WD 39 Osb L1	R39	72	88	81	76	44	70	27	20	6	1	70
	LRI WD 40 Osb L1	R40	-	71	56	61	72	63	30	19	11	0	63
	LRI WD 41 Osb L2	R41	73	50	75	86	83	56	16	9	7	0	56
	LRI WD 7 Bal L3	R07	64	61	75	61	59	48	60	31	27	2	48
	LRI WD 8 SAU Bal L3	RSAU	52	56	14	40	44	39	44	24	13	7	39
	LRI WD Bone Marrow	RBMT	67	33	25	86	100	0	0	0	0	0	0
	LRI WD Chemo Suite Osb L1	RCHM	86	88	92	72	83	78	24	19	3	1	78

University Hospitals of Leicester NHS
NHS Trust

Caring at its best

FRIENDS AND FAMILY TEST : August'13 - January'14

			Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	JANUARY SCORE BREAKDOWN				
									Total Responses	Promoters	Passives	Detractors	Score
	LRI WD Childrens Admissions	RCAU	-	-	53	61	0	76	18	13	4	0	76
	LRI WD Endoscopy Win L2	REND	64	100	81	70	85	83	46	38	8	0	83
	LRI WD Fielding John Vic L1	RFJW	67	86	81	82	83	85	20	17	3	0	85
	LRI WD GAU Ken L1	RGAU	82	65	53	71	0	70	152	110	38	4	70
	LRI WD IDU Infectious Diseases	RIDU	68	48	67	25	73	71	14	10	4	0	71
	LRI WD ITU Bal L2	RITU	95	87	80	78	82	83	24	20	4	0	83
	LRI WD Kinmonth Unit Bal L3	RKIN	57	89	74	76	73	81	21	17	4	0	81
	LRI WD Ophthalmic Suite Bal L6	ROPS	79	0	80	87	0	0	0	0	0	0	0
	LRI WD Osborne Assess Unit	ROND	84	88	73	76	85	56	25	16	7	2	56
	LRI WD Osborne Day Care Unit	RHAD	79	68	80	90	78	86	21	18	3	0	86
	LRI WD Paed ITU	RCIC	100	100	100	100	100	100	6	5	0	0	100

University Hospitals of Leicester NHS
NHS Trust

Caring at its best

FRIENDS AND FAMILY TEST : August'13 - January'14

								DECEMBER SCORE BREAKDOWN				
		Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Total Responses	Promoters	Passives	Detractors	Score
EMERGENCY DEPARTMENT	ED - Majors	47	23	48	59	64	58	156	101	39	13	58
	ED - Minors	65	31	66	62	69	64	378	258	98	19	64
	ED - (not stated)	72	65	69	69	69	69	27	18	8	0	69
	Eye Casualty	54	44	50	51	69	83	259	219	35	5	83
	Emergency Decisions Unit	69	81	57	61	65	58	98	62	26	7	58

MONTHLY CLINICAL MEASURES DASHBOARD: January '14

																					NURSING METRICS											
		Budgeted Qualified %	Total vacancies %	Total vacancies (WTE)	Current appraisal Rate % (rolling 12 months)	Sickness Absence %	Friends & Family score	No. of complaints	Safety Thermometer - No new harms %	Hand Hygiene %	Pressure Ulcers - Grade 2 (avoidable)	Pressure Ulcers - Grade 3 (avoidable)	Pressure Ulcers - Grade 4 (avoidable)	No. MRSA Bacteraemias (post 48 hrs)	MRSA Screening - Non elective %	MRSA Screening - Elective %	No. of C Diff cases (post 48 hrs)	No. of falls	No. of patient safety SUI's (severe)	No. Patient safety incidents (moderate)	No. Patient safety incidents (low)	No. of medication errors	Continence	Controlled Medicines	Discharge	Falls Assessment	Infection Prevention & Control	Medicine Prescribing & Administration	Nutritional Assessment	Pain Management	Patient Dignity	Patient Observations	Pressure Area Care	Resuscitation Equipment
	GREEN THRESHOLD	> = 60%	0 - 4.9%	< = 5	> = 95%	< = 3%	> = 75.0	< = 1	> = 95%	> = 90%	0	0	0	0	> = 100%	> = 100%	0	0	0	0	0	0											
	AMBER THRESHOLD	-	5 - 10 %	-	-	3.1% - 3.9%	-	2	-	-	-	-	-	-	-	-	-	1 - 3	-	1	1 - 4	-	RED: < 80 AMBER: 80 - 90 GREEN: >90										
	RED THRESHOLD	< 60%	> 10%	> 5	< 95%	> = 4%	< 75.0	> 2	< 95%	< 90%	> = 1	> = 1	> = 1	> = 1	< 100%	< 100%	> = 1	> = 4	> = 1	> 1	> = 5	> = 1											
GLENFIELD HOSPITAL	F15	↔ 60%	↓ 7.5%	↓ 2.97	↑ 98%	↓ 7.9%	↑ 85.0	↔ 0	↓ 92%	↓ 87%	↔ 0	↓ 0	↔ 0	↔ 0	-	-	↑ 1	↑ 5	↔ 0	↔ 0	↓ 3	↑ 1	↑ 100	↔ 100	↓ 67	↑ 100	↑ 88	↔ 100	↑ 94	↑ 89	↓ 88	↓ 56	↑ 100	↔ 100
	F16	↔ 63%	↓ 4.8%	↑ 1.74	↓ 65%	↑ 5.1%	↓ 82.8	↑ 1	↑ 97%	↑ 90%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↓ 0	↓ 1	↔ 0	↔ 0	↔ 2	↔ 0	↑ 93	↑ 100	↑ 71	↓ 83	↑ 94	↓ 97	↑ 86	↓ 72	↑ 88	↓ 69	↑ 97	↔ 100
	F17	↔ 75%	↓ 3.6%	↓ 1.44	↑ 60%	↓ 5.4%	↑ 74.3	↓ 1	↑ 97%	↑ 90%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↑ 3	↔ 0	↓ 0	↓ 1	↔ 0	↑ 100	↔ 100	↓ 48	↔ 100	↑ 100	↓ 94	↑ 89	↑ 78	↑ 94	↓ 39	↓ 80	↔ 100
	F17H	↔ 75%	↓ 3.6%	↓ 1.44	↑ 60%	↓ 5.4%	-	↔ 0	-	0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	-	-	-	-	-	-	-	-	-	-	-	-
	F20	-	-	-	-	-	↓ 61.5	↔ 0	↔ 93%	0%	↔ 0	↓ 0	↔ 0	↔ 0	-	-	↔ 0	↓ 0	↔ 0	↔ 0	↓ 1	↑ 1	↑ 100	↔ 100	↑ 100	↔ 100	↔ 100	↔ 100	↔ 100	↔ 100	↑ 91	↓ 94	↔ 100	↑ 100
	F23A	↔ 45%	↓ -62.3%	↓ -9.38	↑ 89%	↑ 7.8%	↑ 88.9	↔ 0	-	0%	↔ 0	↔ 0	↔ 0	↔ 0	-	↔ >= 100%	↔ 0	↓ 1	↔ 0	↔ 0	↓ 0	↔ 0	↔ 100	↔ 100	↑ 100	↑ 100	↑ 98	↑ 97	↓ 93	↓ 97	↓ 96	↑ 97	↓ 92	↔ 100
	F24	↔ 0%	↓ 0.0%	↓ 0.00	↑ 95%	↓ 0.0%	↓ 86.1	↓ 0	100%	↓ 87%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↑ 4	↔ 0	↑ 1	↑ 3	↔ 0	↔ 100	↑ 100	↑ 100	↑ 93	↑ 96	↓ 94	↑ 100	↓ 83	↑ 100	↓ 94	↔ 100	↑ 100
	F26	↔ 77%	↓ 1.3%	↓ 0.39	↑ 100%	↑ 9.0%	↓ 91.4	↑ 1	↔ 100%	↓ 70%	↔ 0	↔ 0	↔ 0	↔ 0	↑ >= 100%	↑ >= 100%	↔ 0	↓ 0	↔ 0	↔ 0	↓ 0	↔ 0	↔ 100	↔ 100	↔ 100	↔ 100	↔ 100	↑ 100	↔ 100	↔ 100	↔ 100	↔ 100	↔ 100	↔ 100
	F26H	↔ 77%	↓ 1.3%	↓ 0.39	↑ 100%	↑ 9.0%	-	↔ 0	-	0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	-	-	-	-	-	-	-	-	-	-	-	-
	F27	↔ 62%	↑ 7.9%	↑ 2.48	↔ 100%	↓ 3.1%	↑ 96.0	↑ 1	↔ 100%	↑ 90%	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	-	↔ 0	↔ 3	↔ 0	↔ 0	↑ 4	↔ 0	↔ 100	↔ 100	↓ 81	↔ 100	↔ 100	↓ 89	↓ 94	↔ 100	↓ 79	↑ 94	↔ 100	↔ 100
	F28	↔ 60%	↓ 10.4%	↓ 3.60	↑ 94%	↑ 4.3%	↓ 67.6	↓ 1	↔ 100%	94%	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	-	↔ 0	↑ 1	↑ 1	↑ 1	↑ 2	↑ 3	↔ 100	↔ 100	↓ 86	↓ 67	↓ 92	↔ 100	↓ 78	↓ 94	↓ 88	↓ 89	↔ 100	↔ 100
	F29	↔ 61%	↑ 10.2%	↑ 3.10	↓ 80%	↑ 6.3%	↓ 81.5	↔ 0	↑ 100%	↔ 100%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↓ 0	↔ 0	↔ 0	↓ 1	↑ 1	↑ 100	↔ 100	↑ 100	↑ 100	↑ 100	↔ 100	↑ 100	↑ 100	↓ 93	↑ 96	↔ 100	↔ 100
	F30	↔ 86%	↑ -3.2%	↑ -0.60	↑ 76%	↓ 0.1%	↔ 0.0	↔ 0	↔ 100%	0%	↔ 0	↔ 0	↔ 0	↔ 0	-	↔ >= 100%	↔ 0	↔ 0	↔ 0	↔ 0	↑ 4	↔ 1	↑ 100	↔ 100	↔ 100	↔ 100	↔ 100	↔ 100	↔ 100	↓ 95	↓ 96	↔ 100	↔ 100	↑ 100
	F31	↔ 77%	↑ 4.4%	↑ 1.94	↓ 94%	↓ 3.0%	↑ 100.0	↔ 0	↓ 95%	↑ 100%	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	↓ 98%	↔ 0	↓ 0	↔ 0	↔ 0	↓ 0	↑ 1	↔ 100	↔ 100	↔ 100	↔ 100	↑ 96	↑ 94	↔ 100	↔ 100	↓ 94	↑ 83	↓ 87	↔ 100
	F31H	↔ 77%	↑ 4.4%	↑ 1.94	↓ 94%	↓ 3.0%	-	↔ 0	-	0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	-	-	-	-	-	-	-	-	-	-	-	-
	F32	↔ 75%	↑ 27.5%	↑ 5.57	↓ 89%	↑ 7.5%	↑ 95.5	↑ 2	↔ 100%	↔ 100%	↔ 0	↔ 0	↔ 0	↔ 0	-	↔ >= 100%	↔ 0	↑ 1	↔ 0	↔ 0	↓ 0	↓ 0	↔ 100	↔ 100	↑ 100	↓ 73	↓ 67	↑ 83	↔ 100	↓ 89	↑ 94	↓ 72	↓ 93	↑ 100
	F33	↔ 70%	↑ 3.1%	↑ 1.04	↓ 90%	↑ 6.5%	↑ 82.9	↑ 1	↑ 100%	↑ 90%	↔ 0	↔ 0	↔ 0	↔ 0	-	↔ >= 100%	↓ 0	↔ 1	↑ 1	↑ 1	↑ 2	↓ 0	↔ 100	↔ 100	↓ 86	↓ 90	↑ 100	↓ 92	↑ 96	↑ 100	↑ 91	↓ 96	↑ 100	↔ 100
	F33A	↔ 64%	↓ 8.2%	↓ 2.16	↓ 79%	↓ 8.6%	↓ 94.7	↑ 1	↓ 90%	↔ 100%	↔ 0	↓ 0	↔ 0	↔ 0	-	-	↑ 1	↑ 6	↔ 0	↔ 0	↑ 4	↑ 1	↔ 100	↔ 100	↑ 90	↑ 100	↑ 92	↔ 100	↑ 100	↔ 100	↓ 91	↑ 100	↔ 100	↔ 100
	F34	-	-	-	-	-	↔ 0.0	↔ 0	↔ 100%	0%	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	↔ >= 100%	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	-	-	-	-	-	-	-	-	-	-	-	-
	FCCU	↔ 76%	↑ 6.4%	↑ 3.38	↓ 98%	↓ 4.4%	↑ 93.5	↓ 0	↔ 100%	↔ 100%	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	-	↔ 0	↑ 4	↔ 0	↓ 0	↑ 5	↓ 0	↔ 100	↔ 100	↑ 100	↔ 100	↔ 100	↔ 100	↔ 100	↔ 100	↔ 100	↔ 100	↔ 100	↔ 100
	FCDU	↔ 63%	↓ 5.5%	↓ 5.28	↑ 94%	↓ 4.1%	↑ 66.3	↔ 2	↓ 92%	49%	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	-	↔ 0	↑ 2	↔ 0	↓ 0	↑ 8	↓ 0	↑ 100	↔ 100	↑ 97	↔ 100	↑ 95	↔ 100	↔ 100	↑ 90	↑ 89	↓ 93	↔ 100	↔ 100
	FCHD	↔ 70%	↑ 3.1%	↑ 1.04	↓ 90%	↑ 6.5%	-	↔ 0	-	0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	-	-	-	-	-	-	-	-	-	-	-	-
	FCIC	-	-	-	-	-	-	↔ 0	-	0%	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	-	↑ 1	↓ 0	↔ 0	↔ 0	↑ 9	↑ 1	-	-	-	-	-	-	-	-	-	-	-	-
	FCID	-	-	-	↓ 94%	↓ 2.0%	-	↔ 0	-	0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	-	-	-	-	-	-	-	-	-	-	-	-
	FDIS	↔ 50%	↔ -8.9%	↔ -0.97	↓ 92%	↓ 0.9%	-	↑ 1	-	0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	-	-	-	-	-	-	-	-	-	-	-	-
	FITU	↔ 92%	↓ -2.9%	↓ -3.65	↓ 98%	↓ 5.4%	92.31	↔ 0	-	70%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	↓ 0	↔ 0	100	100	100	70	100	100	100	100	92	100	100	100
	FPIC	↔ 95%	↑ 12.8%	↑ 5.85	↑ 100%	↑ 6.3%	100.00	↔ 0	-	0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↑ 1	↑ 3	↓ 1	↑ 5	↔ 100	↔ 100	↔ 100	↔ 100	↔ 100	↑ 100	↔ 100	↔ 100	↑ 100	↔ 100	↔ 100	↔ 100
	FREC	↔ 92%	↑ 12.7%	↑ 3.26	↓ 78%	↓ 8.0%	-	↔ 0	-	0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	-	-	-	-	-	-	-	-	-	-	-	-
LEICESTER GENERAL HOSPITAL	G10	↔ 61%	↓ -9.3%	↓ -3.61	↓ 79%	↓ 4.3%	↓ 70.0	↔ 0	↔ 100%	↔ 100%	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	-	↔ 0	↔ 0	↔ 0	↔ 0	↓ 1	↔ 0	↔ 100	↔ 100	↓ 93	↔ 100	↔ 100	↔ 100	↔ 100	↔ 100	↑ 100	↓ 88	↔ 100	↔ 100
	G14	↔ 67%	↔ 2.3%	↔ 0.54	↔ 100%	↓ 0.3%	↑ 88.4	↓ 0	↓ 80%	90%	↔ 0	↑ 1	↔ 0	↔ 0	-	↔ >= 100%	↔ 0	↑ 6	↔ 0	↔ 0	↑ 4	↔ 0	↔ 100	↔ 100	↔ 94	↓ 96	↑ 100	↔ 100	↓ 93	↓ 97	↔ 100	↔ 93	↓ 92	↔ 100
	G15A	↔ 86%	↑ 16.3%	↑ 4.51	↔ 89%	↓ 2.8%	↑ 71.4	↔ 0	↔ 100%	↔ 100%	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	-	↔ 0	↑ 3	↔ 1	↔ 0	↑ 2	↔ 0	↔ 100	↔ 100	↓ 71	↔ 100	↑ 100	↔ 100	↔ 100	↑ 100	↑ 97	↑ 94	↔ 100	↔ 100
	G15N	↔ 63%	↔ 12.0%	↔ 3.83	↔ 100%	↑ 1.0%	↑ 100.0	↔ 0	↔ 100%	↔ 100%	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	-	↑ 1	↔ 1	↔ 0	↔ 0	↓ 1	↑ 1	↔ 100	↔ 100	↑ 62	↑ 100	↓ 96	↑ 100	↔ 100	↔ 100	↓ 97	↑ 89	↔ 100	↔ 100
	G16	↔ 65%	↔ 9.4%	↔ 2.11	↔ 100%	↑ 10.8%	↑ 82.6	↔ 0	↔ 100%	100%	↔ 0	↔ 0	↔ 0	↔ 0	-	↔ >= 100%	↔ 0	↑ 4	↔ 0	↔ 0	↑ 1	↔ 0	↔ 100	↔ 100	↓ 74	↑ 96	↑ 100	↓ 87	↔ 90	↑ 97	↑ 96	↔ 90	↑ 96	↔ 100
	G17	↔ 70%	↑ 13.9%	↑ 2.78	↔ 95%	↓ 1.8%	↓ 78.3	↔ 0	↔ 100%	↔ 100%	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	↓ 95%	↔ 0	↔ 1	↔ 0	↔ 0	↔ 1	↑ 1	↓ 60	↔ 100	↓ 36	↓ 70	↑ 91	↔ 100	↓ 88	↓ 71	↔ 100	↑ 96	↔ 100	↔ 100
	G18	↔ 59%	↑ 15.3%	↑ 4.11	↑ 100%	↓ 1.1%	↓ 69.0	↔ 0	↔ 100%	86%	↔ 0	↔ 0	↔ 0	↔ 0	-	↔ >= 100%	↔ 0	↑ 2	↔ 0	↔ 0	↔ 0	↓ 0	↔ 100	↔ 100	↔ 91	↓ 96	↑ 100	↔ 100	↔ 100	↔ 100	↑ 100	↔ 100	↔ 100	↔ 100
	G19	↔ 77%	↔ 38.0%	↔ 5.04	↔ 100%	↔ 0.0%	↔ 0.0	↑ 1	↔ 100%	100%	↔ 0	↔ 0	↔ 0	↔ 0	-	↔ >= 100%	↔ 0	↔ 0	↔ 0	↔ 0	↑ 1	↔ 0	↔ 100	↔ 100	↓ 97	↓ 92	↑ 100	↔ 100	↔ 100	↔ 100	↔ 100	↔ 100	↓ 96	↔ 100
	G2	↔ 60%	↓ 11.5%	↓ 3.19	↑ 85%	↔ 0.0%	↓ 0.0	↓ 0	↔ 100%	0%	↔ 0	↓ 0	↔ 0	↔ 0	-	-	↔ 0	↓ 0	↔ 0	↔ 0	↓ 4	↓ 0	100	100	100	96	100	93	97	80	100	100	100	100
	G20	↔ 62%	↔ 38.3%	↔ 6.46	↔ 100%	↑ 1.7%	↔ 0.0	↑ 2	-	0%	↔ 0	↔ 0	↔ 0	↔ 0	-	↔ >= 100%	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 100	↔ 0	↓ 86	↔ 100	↔ 100	↔ 100	↔ 100	↔ 100	↔ 100	↔ 100	↔ 100	↔ 100
	G22	↔ 62%	↔ 4.5%	↔ 1.19	↑ 95%	↑ 11.5%	↓ 45.0	↑ 1	↑ 100%	86%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 1	↔ 0	↔ 0	↓ 1	↔ 0	↑ 100	↔ 100	↓ 74	↑ 100	↔ 100	↓ 96	↔ 100	↔ 100	↑ 100	↔ 100	↔ 100	↔ 100
	G26	↔ 66%	↓ -1.4%	↓ -0.39	↔ 82%	↑ 11.4%	↑ 71.4	↑ 1	↔ 100%	0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↓ 2	↔ 0	↔ 0	↔ 2	↔ 1	↔ 100	↔ 100	↑ 51	↔ 100	↔ 100	↑ 100	↔ 100	↔ 100	↑ 100	↔ 100	↓ 93	↔ 100
	G27	↔ 61%	↑ 8.1%	↑ 1.97	↑ 96%	↑ 5.9%	↑ 50.0	↔ 0	↔ 100%	70%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↓ 1	↔ 0	↔ 0	↔ 0	↓ 0	↔ 100	↔ 100	↔ 100	↔ 100	↔ 100	↔ 100	↓ 94	↓ 96	↑ 91	↓ 94	↑ 90	↔ 100
	G28	↔ 62%	↑ 14.8%	↑ 5.23	↓ 81%	↑ 14.2%	↓ 65.0	↑ 2	↔ 100%	90%	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	-	↔ 0	↓ 0	↔ 0	↔ 0	↑ 3	↔ 0	65	100	89	100	88	100	100	83	91	100	100	100
	G3	↔ 60%	↓ 5.0%	↓ 1.37	↑ 96%	↓ 11.7%	↑ 50.0	↔ 0	↑ 100%	↑ 98%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 1	↔ 0	↔ 0	↓ 0	↔ 0	-	-	-	-	-	-	-	-	-	-	-	-
	G30	↓ 76%	↑ 2.2%	↑ 2.50	↓ 98%	↑ 5.9%	-	↔ 2	↔ 100%	0%	↔ 0	↔ 0	↔ 0	↔ 0	-	↔ >= 100%	↓ 0	↔ 0	↔ 0	↔ 0	↔ 1	↔ 1	-	-	-	-	-	-	-	-	-	-	-	-
	G31	↔ 61%	↑ 1.1%	↑ 0.31	↓ 91%	↓ 1.3%	↑ 80.4	↔ 0	↔ 100%	0%	↔ 0	↔ 0	↔ 0	↔ 0	-	↔ >= 100%	↔ 0	↑ 1	↔ 0	↔ 0	↑ 1	↔ 0	↔ 100	↔ 100	↔ 100	↔ 100	↓ 96	↔ 100	↔ 100	↔ 100	↔ 100	↔ 100	↔ 100	↔ 100
	GBIU	↔ 70%	↔ -3.9%	↔ -0.84	↓ 78%	↑ 18.0%	↑ 33.3	↔ 0	↓ 67%	0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	↑ 3	↔ 0	100	100	100	100	100	94	100	94	100	100	100	100
	GDCM	↔ 95%	↓ -1.6%	↓ -0.94	↓ 94%	↑ 7.5%	90.00	↔ 0	-	↓ 0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	↔ 1	↑ 1	-	-	-	-	-	-	-	-	-	-	-	-
	GSAC	↔ 68%	↑ 6.4%	↑ 1.06	↓ 94%	↑ 2.7%	↔ 0.0	↔ 0	-	0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↓ 0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 100	↔ 100	↔ 100	↓ 80	↔ 100	↔ 100	↔ 100	↔ 100	↓ 87	↓ 94	↔ 100	↔ 100
	GSM	↑ 100%	↔ 0.0%	↔ 0.00	↔ 100%	↔ 0.0%	-	↔ 0	-	0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	-	-	-	-	-	-	-	-	-	-	-	-
	GUEA	↔ 58%	↑ 16.3%	↑ 6.25	↑ 88%	↓ 2.0%	↑ 42.9	↑ 1	-	0%	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	↔ >= 100%	↔ 0	↔ 0	↔ 0	↑ 1	↑ 5	↔ 0	↓ 40	↔ 100	↓ 91	↔ 100	↓ 89	↔ 100	↓ 97	↓ 87	↑ 91	↓ 93	↑ 92	↔ 100
	GYDU	↔ 60%	↔ 2.1%	↔ 0.41	↑ 74%	↑ 14.0%	↓ 0.0	↔ 0	↔ 100%	0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↑ 6	↑ 1	↔ 0	↑ 3	↔ 0	100	100	100	100	100	100	100	89	100	100	87	100

MONTHLY CLINICAL MEASURES DASHBOARD: January '14

																				NURSING METRICS											
		Budgeted Qualified %	Total vacancies %	Total vacancies (WTE)	Current appraisal Rate % (rolling 12 months)	Sickness Absence %	Friends & Family score	No. of complaints	Safety Thermometer - No new harms %	Hand Hygiene %	Pressure Ulcers - Grade 2 (avoidable)	Pressure Ulcers - Grade 3 (avoidable)	Pressure Ulcers - Grade 4 (avoidable)	No. MRSA Bacteraemias (post 48 hrs)	MRSA Screening - Non elective %	MRSA Screening - Elective %	No. of C Diff cases (post 48 hrs)	No. of falls	No. of patient safety SUI's (severe)	No. Patient safety incidents (moderate)	No. Patient safety incidents (low)	No. of medication errors	Continence	Controlled Medicines	Discharge	Falls Assessment	Infection Prevention & Control	Medicine Prescribing & Administration	Nutritional Assessment	Pain Management	Patient Dignity	Patient Observations	Pressure Area Care	Resuscitation Equipment
	GREEN THRESHOLD	> = 60%	0 - 4.9%	< = 5	> = 95%	< = 3%	> = 75.0	< = 1	> = 95%	> = 90%	0	0	0	0	> = 100%	> = 100%	0	0	0	0	0	0											
LEICESTER ROYAL INFIRMARY	R01	-	-	-	↓ 90%	↑ 8.5%	-	↔ 0	-	0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↑ 1	↓ 0	↔ 0	-	-	-	-	-	-	-	-	-	-	-
	R05	↔ 60%	↓ 5.3%	↓ 2.13	↓ 63%	↑ 11.5%	-	↔ 0	-	100%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	↑ 5	↔ 100	↔ 100	100	-	↓ 95	↔ 100	↔ 100	↔ 100	↔ 100	↔ 100	↔ 100
	R06	↔ 63%	↓ 0.5%	↓ 0.22	↓ 86%	↑ 9.6%	-	↑ 1	-	↑ 96%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	↓ 1	↔ 2	↔ 100	↔ 100	100	-	↔ 100	↓ 96	↓ 67	↓ 80	↔ 100	↑ 100	↔ 100	↔ 100
	R07	↔ 58%	↑ 12.3%	↑ 4.27	↑ 100%	↑ 10.1%	↓ 48.3	↓ 0	-	100%	↔ 0	↑ 1	↔ 0	↔ 0	>= 100%	↔ >= 100%	↔ 0	↓ 0	↔ 0	↔ 0	↔ 2	↑ 5	↔ 100	↔ 100	↔ 100	↓ 97	↔ 100	↓ 97	↓ 86	↔ 100	↔ 100	↓ 97	↔ 100	↔ 100
	R10	↔ 69%	↓ 13.0%	↓ 3.58	↑ 100%	↑ 5.9%	↔ 0.0	↑ 2	↔ 100%	100%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	↔ 1	↑ 2	↔ 100	↔ 100	↓ 92	↔ 100	↔ 100	↓ 94	↓ 86	↑ 100	↓ 97	↔ 100	↔ 100	↔ 100
	R11	↔ 70%	↓ 6.1%	↓ 2.18	↑ 95%	↓ 4.2%	↔ 0.0	↓ 1	↔ 100%	7700%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↓ 0	↑ 3	↑ 1	↔ 100	↔ 100	↓ 42	↔ 100	↔ 100	↓ 94	↔ 100	↔ 100	↓ 94	↔ 100	↔ 100	↔ 100
	R12	↔ 83%	↓ 4.8%	↓ 1.38	↓ 79%	↓ 1.6%	75.00	↓ 0	↓ 91%	100%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↓ 0	↓ 2	↓ 1	↔ 100	↔ 100	↓ 96	↔ 100	↔ 100	↔ 100	↔ 100	↔ 100	↓ 97	↔ 100	↔ 100	↔ 100
	R12A	↔ 83%	↓ 4.8%	↓ 1.38	↓ 79%	↓ 1.6%	-	↔ 0	-	0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	-	-	-	-	-	-	-	-	-	-	-
	R14	↔ 70%	↑ 11.3%	↑ 3.06	↑ 97%	↓ 3.6%	↔ 0.0	↔ 0	↔ 100%	100%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 1	↔ 0	↔ 0	↓ 1	↓ 0	↔ 100	↔ 100	↓ 57	↓ 92	↔ 100	↓ 90	↓ 91	↔ 100	↓ 73	↔ 100	↓ 88	↔ 100
	R15	↔ 60%	↓ 10.9%	↓ 12.58	↑ 96%	↑ 5.1%	↓ 58.3	↔ 1	↔ 100%	0%	↔ 0	↓ 1	↔ 0	↔ 0	>= 100%	-	↔ 0	↑ 4	↔ 0	↓ 1	↓ 6	↓ 0	↑ 100	↔ 100	↔ 100	↑ 96	↑ 90	↔ 100	↔ 100	↓ 93	↓ 98	↑ 100	↑ 100	↔ 100
	R16	↔ 60%	↓ 10.9%	↓ 12.58	↑ 96%	↑ 5.1%	-	↔ 1	90%	0%	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	-	↔ 0	↓ 1	↔ 0	↓ 1	↑ 7	↑ 3	-	-	-	-	-	-	-	-	-	-	-	-
	R17	↔ 57%	↓ -1.6%	↓ -0.69	↑ 100%	↓ 4.5%	↓ 30.0	↑ 2	↑ 93%	↓ 80%	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	0.88	↔ 0	↔ 5	↔ 0	↓ 0	↑ 4	↑ 3	↑ 100	↔ 100	↑ 80	↓ 96	↓ 95	↔ 100	↓ 93	↓ 87	↓ 87	↓ 90	↔ 96	↔ 100
	R18	↔ 55%	↑ 7.4%	↑ 3.14	↔ 100%	↓ 5.2%	↓ 0.0	↓ 0	↓ 93%	↓ 90%	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	↔ >= 100%	↔ 0	↑ 5	↔ 0	↑ 3	↓ 2	↑ 1	↔ 100	↔ 100	↔ 80	↑ 100	↓ 95	↓ 97	↑ 97	↓ 87	↓ 93	↓ 93	↓ 96	↔ 100
	R19	↔ 60%	↓ 8.8%	↓ 3.73	↓ 84%	↓ 5.6%	↓ 41.2	↑ 1	↓ 87%	↓ 90%	↔ 0	↓ 0	↔ 0	↔ 0	-	-	↔ 1	↔ 4	↔ 0	↓ 0	↑ 3	↓ 0	↔ 100	↑ 100	↓ 83	↓ 68	↑ 95	↔ 100	↓ 63	↔ 100	↑ 96	↓ 90	↔ 100	↔ 100
	R21	↔ 61%	↑ 0.4%	↑ 0.14	↑ 97%	↓ 2.2%	↑ 100.0	↔ 1	↑ 96%	95%	↔ 0	↔ 0	↔ 0	↔ 0	-	↔ >= 100%	↔ 0	↓ 4	↔ 0	↓ 0	↓ 4	↔ 0	↑ 100	↔ 100	↑ 97	↓ 64	↓ 98	↔ 100	↑ 90	↑ 100	↔ 100	↓ 97	↓ 64	↔ 100
	R22	63.3%	↓ -2.8%	↓ -1.01	↓ 95%	↓ 5.7%	↓ 17.2	↔ 1	↓ 93%	86%	↔ 0	↔ 0	↔ 0	↔ 0	-	↓ 92%	↔ 0	↓ 0	↔ 0	↔ 0	↑ 2	↑ 4	↑ 100	↔ 100	↓ 48	↔ 100	↓ 94	↔ 100	↑ 100	↓ 89	↔ 100	↑ 100	↔ 100	↔ 100
	R23	↔ 60%	↓ 10.2%	↓ 4.03	↔ 93%	↓ 2.4%	↓ 47.1	↑ 1	↑ 96%	↑ 92%	↔ 0	↓ 0	↔ 0	↔ 0	-	-	↔ 0	↓ 4	↔ 0	↓ 0	↑ 3	↑ 1	↓ 96	↔ 100	↓ 86	↓ 92	↔ 100	↔ 100	↔ 100	↓ 77	↓ 87	↑ 93	↔ 100	↔ 100
	R24	↔ 60%	↓ 29.3%	↓ 11.33	↑ 71%	↑ 12.7%	↑ 61.9	↓ 0	↓ 96%	85%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↑ 1	↓ 6	↔ 0	↔ 0	↑ 8	↓ 0	100	100	93	100	97	100	75	100	91	83	100	100
	R25	↔ 69%	↓ -6.2%	↓ -3.55	↑ 97%	↑ 7.8%	↑ 90.0	↔ 1	↓ 89%	0%	↔ 0	↑ 1	↔ 0	↔ 0	>= 100%	-	↔ 0	↓ 3	↑ 1	↑ 1	↑ 7	↔ 2	↔ 100	↔ 100	↑ 86	↓ 92	↔ 100	↔ 100	↔ 100	↔ 100	↔ 100	↑ 100	↔ 100	↔ 100
	R26	↔ 69%	↓ -6.2%	↓ -3.55	↑ 97%	↑ 7.8%	↑ 95.0	↓ 0	↑ 100%	↑ 82%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↑ 3	↔ 0	↔ 0	↑ 4	↔ 0	↔ 100	↔ 100	↑ 100	↔ 88	↔ 100	↔ 100	↑ 100	↓ 73	↓ 96	↔ 100	↔ 100	↔ 100
	R27	↔ 80%	↔ 13.8%	↔ 3.95	↓ 89%	↑ 7.2%	↑ 100.0	↔ 0	↔ 100%	0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↑ 1	↑ 1	↓ 0	↔ 0	↑ 1	↔ 1	↔ 100	↔ 100	↓ 33	↔ 100	↔ 100	↓ 83	↓ 91	↔ 100	↓ 73	↓ 93	↔ 100	↔ 100
	R27A	↔ 80%	↔ 13.8%	↔ 3.95	↓ 89%	↑ 7.2%	-	↔ 0	-	0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	-	-	-	-	-	-	-	-	-	-	-	-
	R28	↔ 74%	↑ 14.3%	↑ 3.73	↑ 96%	↓ 5.0%	↔ 0.0	↓ 0	↔ 100%	81%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↑ 2	↑ 2	↑ 4	↔ 100	↔ 100	↑ 63	↑ 96	↑ 100	↑ 93	↓ 86	↓ 83	↑ 96	↓ 88	↔ 100	↑ 100
	R29	↔ 60%	↑ 17.0%	↑ 6.27	↔ 100%	↓ 8.3%	↓ 71.4	↓ 0	↑ 100%	0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↑ 5	↔ 0	↑ 2	↓ 0	↑ 2	↔ 100	↔ 100	↓ 67	↔ 100	↑ 92	↑ 100	↓ 86	↓ 86	↓ 76	↑ 86	↔ 100	↔ 100
	R30	↔ 60%	↓ 16.0%	↓ 6.32	↓ 85%	↑ 12.4%	↔ 0.0	↔ 1	↔ 100%	0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↓ 4	↔ 0	↑ 1	↑ 5	↔ 0	↑ 100	↔ 100	↑ 43	↑ 80	↑ 98	↑ 100	↑ 100	↓ 50	↑ 98	↓ 89	↑ 100	↓ 0
	R30H	↔ 60%	↓ 16.0%	↓ 6.32	↓ 85%	↑ 12.4%	-	↔ 0	-	0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	-	-	-	-	-	-	-	-	-	-	-	-
	R31	↔ 60%	↓ 9.7%	↓ 4.10	↓ 98%	↓ 2.5%	↑ 89.5	↓ 1	↓ 93%	100%	↔ 0	↑ 1	↔ 0	↔ 0	-	-	↔ 0	↑ 3	↔ 0	↑ 3	↑ 4	↑ 2	↔ 100	↔ 100	↔ 94	↑ 100	↑ 100	↔ 100	↑ 100	↑ 97	↑ 98	↓ 90	↔ 100	↔ 100
	R32	↔ 56%	↔ 2.6%	↔ 0.99	↔ 100%	↑ 3.3%	↑ 85.7	↔ 0	↔ 100%	0%	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	-	↔ 0	↑ 10	↔ 0	↑ 1	↓ 2	↑ 2	↑ 100	↔ 100	↓ 74	↔ 100	↔ 100	↔ 100	↓ 97	↓ 93	↓ 93	↓ 85	↓ 90	↔ 100
	R33	↔ 57%	↑ 9.2%	↑ 4.43	↑ 100%	↑ 5.8%	↓ 78.9	↔ 3	↔ 100%	↓ 0%	↔ 0	↓ 0	↔ 0	↔ 0	>= 100%	-	↔ 0	↑ 5	↔ 0	↔ 0	↑ 6	↑ 3	↔ 100	↔ 100	↑ 100	↓ 60	↔ 95	↔ 100	↑ 100	↓ 93	↔ 100	↑ 100	↔ 100	↔ 100
	R34	↔ 60%	↑ 100.0%	↑ 32.91	↑ 100%	↓ 4.7%	↑ 81.0	↓ 0	↔ 100%	↓ 0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↓ 1	↔ 0	↓ 0	↓ 2	↔ 0	↑ 96	↔ 100	↔ 100	↑ 100	↑ 100	↔ 100	↑ 100	↓ 97	↑ 100	↔ 97	↑ 100	↔ 100
	R36	↔ 60%	↓ 10.1%	↓ 3.97	↑ 100%	↑ 3.9%	↓ 84.2	↓ 0	↑ 100%	↑ 83%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↑ 7	↔ 0	↔ 0	↔ 3	↔ 0	↔ 100	↔ 100	↑ 86	↔ 92	↑ 100	↑ 97	↑ 97	↑ 100	↓ 89	↑ 77	↑ 100	↔ 100
	R37	↔ 60%	↓ 11.2%	↓ 4.12	↓ 97%	↓ 3.3%	↑ 72.1	↑ 2	↑ 96%	↓ 80%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↓ 1	↑ 1	↓ 0	↑ 5	↔ 0	↔ 100	↔ 100	↓ 91	↑ 100	↑ 98	↑ 97	↑ 100	↑ 100	↑ 100	↓ 80	↔ 100	↓ 0
	R38	↔ 60%	↑ 13.4%	↑ 4.88	↑ 100%	↓ 8.5%	↑ 95.7	↔ 1	↑ 100%	↓ 94%	↔ 0	↓ 0	↔ 0	↔ 0	-	-	↔ 0	↓ 4	↓ 0	↓ 1	↑ 4	↔ 0	↔ 100	↔ 100	↑ 97	↔ 100	↑ 98	↔ 100	↓ 83	↔ 100	↓ 89	↓ 73	↔ 100	↔ 100
	R39	↔ 66%	↑ 16.0%	↑ 3.90	↑ 96%	↓ 0.0%	↑ 70.4	↔ 0	↓ 89%	↔ 100%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↑ 1	↑ 4	↔ 0	↔ 0	↔ 1	↔ 0	↓ 80	↔ 100	↑ 71	↔ 100	↔ 100	↔ 100	↔ 100	↓ 90	↑ 91	↓ 93	↔ 100	↔ 100
	R40	↔ 72%	↑ 3.3%	↑ 0.80	↓ 81%	↓ 1.2%	↓ 63.3	↔ 0	↓ 95%	↑ 90%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↓ 1	↔ 0	↓ 0	↑ 6	↔ 2	↓ 60	↔ 100	↓ 0	↓ 80	↑ 98	↔ 100	↓ 60	↓ 57	↓ 75	↓ 83	↓ 80	↔ 100
	RACB	↔ 57%	↑ 9.2%	↑ 4.43	↑ 100%	↑ 5.8%	-	↔ 0	-	0%	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	-	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	-	-	-	-	-	-	-	-	-	-	-	-
	RAMB	↔ 100%	↔ 0.0%	↔ 0.00	↔ 100%	↑ 66.7%	-	↔ 0	-	0%	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	-	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	-	-	-	-	-	-	-	-	-	-	-	-
	RBMT	↔ 97%	↔ 2.0%	↔ 0.30	↔ 100%	↑ 2.4%	↓ 0.0	↔ 0	-	↔ 100%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↓ 0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 100	↔ 100	↑ 91	↔ 100	↑ 98	↔ 100	↔ 100	↔ 100	↔ 100	↓ 93	↔ 100	↔ 100
	RCAU	↔ 69%	↑ 14.7%	↑ 3.83	↑ 100%	↓ 6.6%	↑ 76.5	↑ 1	-	94%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↓ 0	↔ 1	↑ 1	↔ 0	↔ 100	↔ 100	↓ 25	↔ 100	↔ 100	↓ 97	↓ 93	↔ 100	↓ 92	↔ 100	↔ 100	↔ 100
	RCIC	↔ 95%	↑ 12.8%	↑ 5.85	↑ 100%	↑ 6.3%	100.00	↔ 0	-	100%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 1	↓ 1	↑ 3	↔ 100	↔ 100	↓ 95	↔ 100	↓ 89	↔ 100	↔ 100	↔ 100	↓ 96	↔ 100	↔ 100	↔ 100
	REDU	↔ 67%	↑ 21.0%	↑ 5.90	↓ 96%	↓ 4.3%	-	↓ 5	↔ 100%	↓ 70%	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	-	↔ 0	↑ 5	↔ 0	↓ 0	↑ 7	↓ 1	↔ 100	↔ 100	↔ 100	↔ 100	↓ 93	↔ 100	↓ 97	↓ 90	↓ 98	↔ 100	↔ 100	↔ 100
	REFU	-	-	-	-	-	-	↓ 0	-	0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	-	-	-	-	-	-	-	-	-	-	-	-
	RFJW	↔ 60%	↔ 12.5%	↔ 4.00	↔ 100%	↑ 2.4%	↑ 85.0	↔ 0	↓ 95%	↑ 100%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↑ 5	↔ 0	↔ 0	↓ 3	↔ 0	↔ 100	↔ 100	↓ 83	↔ 100	↔ 100	↓ 93	↔ 100	↓ 90	↓ 93	↓ 83	↔ 100	↔ 100
	RGAU	↔ 69%	↑ 8.6%	↑ 2.41	↔ 97%	↓ 3.4%	↑ 69.7	↓ 0	↔ 100%	0%	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	↔ >= 100%	↔ 0	↔ 0	↔ 0	↔ 0	↓ 1	↓ 0	100	100	100	100	100	100	100	100	100	100	100	100
	RIDU	↔ 60%	↔ -9.0%	↔ -2.13	↔ 96%	↑ 10.9%	↓ 71.4	↔ 0	↓ 89%	↑ 100%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↑ 2	↑ 1	↑ 1	↓ 1	↑ 2	↓ 96	↔ 100	↔ 91	↑ 100	↔ 100	↔ 100	↑ 100	↑ 80	↑ 100	↓ 93	↑ 100	↔ 100
	RITU	↔ 89%	↑ -9.7%	↑ -9.83	↓ 93%	↓ 5.7%	83.33	↔ 0	↑ 100%	↑ 95%	↔ 0	↓ 0	↔ 0	↔ 0	>= 100%	-	↑ 1	↔ 1	↔ 0	↓ 0	↓ 3	↔ 0	100	100	100	100	100	94	86	86	92	86	100	100
	RKIN	↔ 65%	↑ 9.6%	↑ 2.43	↑ 92%	↑ 5.9%	↑ 81.0	↔ 0	-	100%	↔ 0	↔ 0	↔ 0	↔ 0	0.70	>= 100%	↑ 1	↓ 1	↔ 0	↔ 0	↓ 2	↔ 0	↓ 90	↑ 100	↓ 93	↑ 100	↔ 100	↑ 100	↑ 100	↑ 100	↔ 100	↑ 94	↑ 100	↔ 100
	RODA	↔ 72%	↑ 12.9%	↑ 4.30	↓ 93%	↓ 4.7%	-	↓ 0	-	0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 2	↔ 0	↔ 0	↑ 3	↑ 1	-	-	-	-	-	-	-	-	-	-	-	-
	ROMO	↔ 62%	↑ 6.1%	↑ 1.96	↑ 89%	↓ 0.7%	-	↔ 0	-	90%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	-	-	-	-	-	-	-	-	-	-	-	-
	ROND	↔ 67%	↓ 3.7%	↓ 0.45	↓ 83%	↑ 0.9%	↓ 56.0	↔ 0	-	↑ 100%	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	-	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	-	-	-	-	-	-	-	-	-	-	-	-
	RPAC	↔ 83%	↑ 10.9%	↑ 4.50	↔ 100%	↓ 2.9%	-	↔ 0	-	0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	-	-	-	-	-	-	-	-	-	-	-	-
	RPSS	-	-	-	-	-	-	↔ 0	-	0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	-	-	-	-	-	-	-	-	-	-	-	-
	RSAU	56.3%	↑ 8.3%	↑ 3.73	↑ 79%	↓ 2.1%	↓ 38.6	↓ 0	-	90%	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	-	↔ 0	↔ 0	↔ 0	↓ 0	↓ 7	↑ 2	↔ 100	↔ 100	↑ 50	↑ 87	↑ 96	↔ 100	↑ 72	↑ 100	↔ 100	↓ 86	↑ 100	↔ 100
	RSCB	↔ 90%	↓ 8.1%	↓ 7.34	↓ 89%	↓ 1.0%	-	↔ 0	-	0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↑ 1	↑ 1	↓ 2	↑ 8	-	-	-	-	-	-	-	-	-	-	-	-

University Hospitals of Leicester NHS Trust

CMG	Ward/Department	Objective 1: Matrons and Ward Sisters are responsible for ensuring the patient environment is clean	Objective 2: Matrons and Ward Managers will ensure all patients will have their essential care needs	Objective 3: Matrons and Ward Sisters are responsible for ensuring nursing care is delivered with	Objective 4: Matrons and Ward Sisters ensure systems are in place to maximise patient experience by	Objective 5: Matrons and Ward sisters will ensure the needs of the vulnerable person are recognised	Objective 6: Matrons and Ward Sisters will ensure harm free care is delivered.	Objective 7: Matrons and Ward Sisters will make effective use of all resource and is able to
Emergency and Specialist Medicine	Emergency Department							
	EDU							
	Ward 15/16 Assessment Area							
	Ward 33 Elderly Frailty Unit							
	Ward 34 (was 37)							
	FJW LRI							
	Ward 19 LRI							
	Ward 23 LRI							
	Ward 24 LRI							
	Ward 25 LRI							
	Ward 26 LRI							
	Ward 31 LRI							
	Ward IDU LRI							
	Ward 36 LRI							
	Ward 37 LRI							
	Ward 38 LRI							
	Ward 1 LGH							
	Ward 2 LGH							
	Ward 3 LGH							
	Ward BIU LGH							
	Ward YDU LGH							
Musculo Skeletal and Specialist Surgery	Ward 19 LGH							
	Ward 16 LGH							
	Ward 18 LGH							
	Ward 14 LGH							
	Ward 21 LRI							
	Ward 17 LRI							
	Ward 18 LRI							
	Ward 32 LRI							
	Ward 7 LRI							
	Kinmonth LRI							
	Ward 24 GGH							
CHUGS	Ward 30 LRI							
	BMTU LRI							
	Osborne Assessment Unit LRI							
	SACU LGH							
	Ward 8 SAU LRI							
	Ward 22 LGH							
	Ward 22 LRI							
	Ward 23 LGH							
	Ward 26 LGH							
	Ward 27 LGH							
	Ward 28 LGH							
	Ward 29 LGH							
	Ward 29 LRI							
	Ward 41 LRI							
	Ward 39 LRI							
	Ward 40 LRI							
GH	Ward 24 GH							
	Ward 15 GH							
	Ward 10 LGH							
	Ward 17 GH							
	Ward 26 GH							
	Ward 31/34 GH							
	Ward 32 GH							
	CDU/20 GH							
	Ward 23a GH - surgery							
	Ward 17 LGH							
	Ward 28 GH							
	Ward 15N LGH							
	Ward 15A LGH							
	Ward 33a GH							
	Ward 27 GH							
	Ward 33 GH							
	CCU GH							
	Ward 16 GH							
	Ward 29 GH							
Women's and Children's	Ward 10 LRI							
	Ward 11 LRI							
	Ward 12 LRI							
	Ward 14 LRI							
	Ward 27 LRI							
	Ward 28 LRI							
	CICU LRI							
	CAU LRI							
	Ward 30 GH							
	PICU GH							
	NNU LGH							
	Delivery Suite LGH							
	Ward 30 LGH							
	Ward 31 LGH							
	Ward 11 LGH							
	Ward 5 LRI							
	Ward 6 LRI							
	Delivery Suite LRI							
	NNU LRI							
	GAU LRI							
	St Mary's							

Appendix 3

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

OPERATIONAL PERFORMANCE EXCEPTION REPORT

REPORT TO:	**TRUST BOARD**
DATE:	**27 February 2014**
REPORT BY:	**Richard Mitchell, Chief Operating Officer**
AUTHOR:	**Carl Ratcliff, Manager, Imaging & Medical Physics**
CMG GENERAL MANAGER:	**Nigel Kee**
SUBJECT:	**Diagnostic Imaging 6 week waits**

Introduction

Imaging failed to meet the diagnostic 6 week target for January 2014 with performance exceeding 6% of breaches. The impact on the Trust performance is that it failed the 1% threshold, with performance of 5.34% over 6 weeks.

Investigation

The breaches relate to MRI lost capacity over the Christmas period and loss of equipment over the first week of January due to the MRI replacement programme. This was also highlighted in last month's report where we failed the target by 1.6%.

Conclusion and Resolution

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

In January we failed the target by 6% again due to the replacement programme and the inability to source additional external activity to resolve the demand / capacity gap.

A mobile MRI van has been sourced in February and March to deliver the remedial additional activity. We are therefore forecasting a 2% breach for February (worst case) with performance forecast to be back within target (<1%) by March 2014.
This anticipated improved performance in Imaging by the end of March is expected to recover the Trust's overall position.

Details of senior responsible officer

CMG SRO: Nigel Kee

Appendix 4

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

OPERATIONAL PERFORMANCE EXCEPTION REPORT

REPORT TO:	**TRUST BOARD**
DATE:	**27 February 2014**
REPORT BY:	**Richard Mitchell, Chief Operating Officer**
AUTHOR:	**Charlie Carr, Head of Performance Improvement**
CMG GENERAL MANAGER:	**Monica Harris**
SUBJECT:	**Short notice cancelled operations**

Introduction

The cancelled operations target comprises of three components:

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

Trust performance in January:-

1. *The percentage of operations cancelled on/after the day* for non-clinical reasons during January was 1.5% against a target of 0.8%. The year to date performance is 1.6%.
2. *The % of patients cancelled who are offered another date within 28 days of the cancellation.* The number of patients breaching this standard in January was 8 with 94.3% offered a date within 28 days of the cancellation.
3. *The number of urgent operations cancelled for a second time* , Zero

A remedial action plan against the two standards that the Trust is failing has been submitted to commissioners in response to a contract query notice and this is awaiting final sign off by commissioners. This is attached as Appendix A

The recovery trajectory submitted to commissioners anticipates that standard 1) will be recovered by August 2014 and that standard 2) will be recovered by May 2014.

Details of senior responsible officer

CMG SRO: M Harris

Corporate Ops: C Carr

	Updated 14/2 2014		**Cancelled operations recovery plan**						
	Issue	**Priority 1= High**	**Actions**	**Responsible Officer (s)**	**Due Date**	**Evidence**	**New or pre-existing action**	**Status**	**RAG**
1	**Lack of theatre time / List over run**	3	a) Establish a project team to look at reasons for late starts - develop an action plan in response to findings	GH	15.3.14	Meeting notes/ plan	New	Cancelled ops operational group 1st meeting 24 th Feb	4
		3	b) Review of frequent overrun commenced and will be rolled out through weekly activity reviews	DT	16.2.14	Reduction in overuns	Refreshed	Complex agenda – resolution relies on many other things Changed reporting to increase awareness. Process is embedding. Regular/frequent overuns reviewed through theatre activity with team leaders and service managers	5
		3	c) Monitoring of any late starts and agreed escalation in place (transformational)	MT	16.2.14 ongoing	Reduction in late starts	Refreshed	Monitoring in place	5
		2	d) Speciality Confirm and challenge with each speciality to manage late starts – these will involve all specialities on a monthly basis. (transformational)	MH	30.11.13	Reduction in late starts	New	Already started – these are ongoing and are repeated every 6 weeks approx	5
		1	e) Weekly reporting of activity (transformational)	AM	23.11.13	Weekly reports	New	completed , reports go to each speciality	5
		2	f) Internal theatre escalation to authorise a cancellation on the day , see also Cancelled operations policy and escallation process	MH	23.11.13	Reduced cancelled ops	New	in place but reinforcing process	5
		3	g) Establish a system to respond within 24 hrs to the CMG to issues and problems on lists for that day(transformational)	KD/ DT	2.12.13	na	In progress	Daily data collection in progress - not yet reported into CMG	3
		1	h) Develop a robust escalation process to	MH /	31.1.14	Reduced	New	Re instate , re enforce	5

			prevent on the day cancellations – Trust wide	PW/CC		cancelled ops		cancellation policy	
		1	i) Operationalise and embed cancelled operations Trust wide policy	GH/ PW/CC	31.3.14 and ongoing	Reduced cancelled ops	New	Policy re issued to Trust , MH to present at Cross CMG meeting	4
		1	j) Develop a team leader score card to performance manage system to hold teams to account(transformational)	DT	25.1.14	Reduced cancelled ops	New	Draft in discussion. Test 25 Feb 14. go live 1 March 14	3
2	**Patient delayed due to admission of a higher priority patient**	3	a) Review of emergency list policy to ensure it supports effective running of the session b) Review the advantages of combining of all emergency lists as a means to improve access(transformational) c) Review the advantages of combining of all emergency lists as a means to improve access(transformational)	DT/MH/ PR	15.12.13	Improved access to emergency lists	Pre-existing	Review of emergency sessions on Monday and Friday to prevent backlog of emergencies building up – discussions with specialities with regards to loading these lists pre weekend. In Jan 1 additional list per week converterd to emergency. Completed 5 additional sessions per week embedded. Full compliance achieved.	5
3	**Lack of Theatre equipment**	3	a) Issues escalated to Synergy and equipment lead	EF	On-going	Issues raised	Pre-existing	Good performance from synergy. UHL performance included in Team Leader scorecard	5
		3	b) pre-plan to ensure equipment available – to ensure all lists are loaded onto -ORMIS >2 weeks	DT/KD	13-Jan	Pre booking monitored weekly	New	Progress been made - Score card being developed to monitor performance (see 1j). Escalation of ORMIS performance undertaken through weekly activity meetings	5
		3	c) 48hour requests for equipment so synergy can manage expectations	KD	13.1.13 and ongoing	Issues raised	New	Cessation of fast track without Matron authorisation	5

		3	d) Evaluate upgrade of Ormis	MH	14.2.14	na	New	Meeting with Ormis planned mid Feb	4
			e) Take forward actions from evaluation of Ormis upgrade options	MH/LW	TBC	TBC	New	Laura Wilcox leading review of theatre systems	1
4	**Lack of Anaesthetic staff/Lack of theatre staff (non-medical)**	1	a) New scheduling system (CLW) to be rolled out which will enable increased visability of Clinical Pa's	DT	28.11.13	na	New	CLW rolled out better transparency of where PAs are being allocated - completed	5
		3	b) Incremental move to six week planning of capacity: - 2weeks -3 weeks -4 weeks -5 weeks -6 weeks	MT	14.1.13 31.3.14 31.5.14 31.7.14 31.9.14	weekly theatre meetings	New	Currently at 2 weeks , feb 14	4
		2	c) Review waiting list payments	PS	ongoing	Finance reports	New	Daily monitoring of WLI. Job paln review in progress. WL payments in line with corporate workforce plan developed	4
		3	d) Matrons to undertake Floor Control to release Band 7 to clinical team if possible	Matrons /Floor Control	On-going	na	New	Floor walker daily update complete	5
		2	e) Cancel any non-critical management duties.	Matrons /Floor Control	On-going	na	New	Daily review	5
		1	f) Active recruitment program nationally for theatre staff -advert date -interview dates -appointment dates	JH	On-going	numbers appointed	New	Recruitment underway and progressing well - international recruitment - some are starting in Feb and some March - we have had Jan starters - we are going after more international recruits and GB adverts - not sure date for next set	4

								of interviews - possibly May/June. Recruitment applies to the now position and does not include future developments as we are not sure of the inpact as yet	
		1	g) Retention review – to encourage staff to stay, plan to reduce turnover to below national average which is 6%	JH	13.1.13 and ongoing	% turnover	New	Working with HR to establish recruitment and retention strategy. Current turnover = 7.5%	5
5	**Ward bed unavailable**	1	a) Review of urology day-case to transfer where possible patients to an OPD with procedure out of Daycase	CMG team	Novemb er	na	New	Discussions undertaken and action being taken to transfer cases to OPD with procedure	5
		2	b) Review number of day case beds	MH	16.12.1 3	na	New	Ongoing , linked to 23 hr unit -	5
		1	c) Review the ability to establish a 23 hour facility at: - the LGH site in March 2014 - LRI for specialist surgery , date TBC	MH / LG	31.12.1 3 - 31.3.14 -TBC	opening of 23 hr facility, reduced cancellati ons	New	23hr – general surgery facility aimed to be open march 14 awaiting confirmation of specialist surgery	4
		1	d) Confirm arrangements for outsourcing to IS , elective surgery	CC	31.12.1 3	IS waiting list report	New	Cases being transferred – further work underway to increase numbers. ENT . Ophthalmology. Orthopaedics. General surgery	5

		2	e) Previous day, review of capacity to allow earlier cancellations	PW/GH	16.12.13	Reduced cancelled on day	New	Embedding practice via daily bed meetings	5
		2	f) Data accuracy to ensure reasons are correct	MT	30.11.13	na	New	daily report to floor coordinators of any incomplete data	5
		1	g) Clinical lead for day surgery	PS	31.1.14	na	New	Advertised role, appointed to post for each site but no identified overall lead as yet	2
		1	h) Develop a robust escalation process to prevent on the day cancellations – corporate	MH / PW	31.1.14	Reduced cancelled on day	New	Re instate , re enforce cancellation policy	5
			i) Cross CMG weekly planing meeting to assess capacity based on emergency flows	GH	1.4.14	Reduced cancelled on day	New	Capacity meeting to be operationalised when admission destination is confirmed	1
			j) Identify admission destination and intended management at POA	GH	1.4.14	Reduced cancelled on day	New	Meetings set up with operational teams within service	4
			k) Develop predicting modelling tool to determine likely empty beds on daily basis , taking into accound EDD (estimated discharge dates) to plan admission numbers	MH / PW /CC	30.4.14	Reduced cancelled on day	New		1
			J) maximise day ward access at LRI , in line with BADS guidance and patient population	GH / Speck	1.4.14	Reduced cancelled on day	New		1
6	**Lack of surgeon**	1	a) Aligning job plans with theatre sessions (transformational)	CMG team	13.2.14	reduced cancellations duelack to surgeon	New	Work underway. Workforce plan completed and job plan review in progress	4

		2	b) Review surgeon availability for emergency lists (transformational) see section 2	CMG team	13.2.14 ongoing	reduced cancellations duelack to surgeon	New	Completed - 5 additional sessions	5
7	**HDU / critical care bed unavailable**	1	a) Flexible staffing across all three sites	JH	Dec-13	reduced cancellations in this category	completed	Flexible staffing established	5
		1	b) Service requirements for CC beds to be reviewed on the Thursday capacity meeting	MT	Nov-13	reduced cancellations in this category	New	Being included as part of the agenda – need to embed process to 6-4-2 - completed	5
		2	c) Electronic planner reflecting elective demand	PV	Nov-13	reduced cancellations in this category	New	In place - completed	5
		1	d) PACU on LRI site to be completed in 2014 increasing capacity	KD	Sep-14	reduced cancellations in this category	New	On track with project plan	4
		1	e) Daily review of level one beds in CC to prioritise their moves	PW / DM	Nov-13	reduced cancellations in this category	on-going	In place	5
		2	f) Improvement in access to timely high risk anaeshetic assessment to ensure appropriate booking of HDU beds	Speck / GH	1.3.14	reduced cancellations in this category	New	Currently reviewing existing service	4
8	**Cancellation and Re booking within 28 days (max) of cancellation**	1	a) Institute new Trust standard of requirement to contact patient within 48 hrs of cancellation and rebook TCI date within 21 days, and associated escallation process	CC / SP	31.1.14	Patients booked within 21 days	New	Cancelled ops flow chart revised, includes local standard and process to rebook within 21 days.	5
		1	b) daily cancelled operations patient level report to be e mailed via automated route to service and operational managers , highlighting 21 day re book date	CC/ SL	31.1.14 and ongoing	Patients booked within 21 days	New	process now live	5
		1	c) Weekly monitoring of performance against Trust 21 day / national 28 day standard, capturing of reasons for failure against the standard	CC / SP	31.1.14 and ongoing	Patients booked within 21 days	New	process now live	5

9	**Monitoring arrangements**	1	a) Implement CMG level reporting of reasons for breaching of 28 day standard -	MH / CC	15.3.14	Patient level report	New	1st reports will be on Feb data, by mid March	1
		1	b) Root case analysis by speciality of previous months breaches of 28 day standard - monthly report to CPM	MH / CC	15.3.14	Patient level report	New	1st reports will be on Feb data, by mid March	1
		1	c) Agree reporting and performance monitoring arrangements with Commissioners for (d) and e below	MH / CC	28.2.14	na	New	Agree at meeting with Commissioners 10 February 2014. Requirement will be for reporting at specialty level for both indicators. However breach consequences will only be applied at Trust level.	5
		1	d) Agree trajectory for recovery of 28 day standard (of less than or = to no more than 3 breaches per quarter).	MH / CC	31.1.14		New	Absolute numbers required at Trust level to enable a fixed proportionate penalty to be applied against monthly milestones with agreed tolerance levels	5
		1	e) Agree trajectory for recovery of cancelled ops on the day standard.	MH / CC	31.1.14		New	Absolute numbers required at Trust level to enable a fixed proportionate penalty to be applied against monthly milestones with agreed tolerance levels	5

UHL Statutory and Mandatory Training Compliance at 18 February 2014

CMG / Corporate Directorate	Fire Training	Moving & Handling	Infection Prevention	Equality & Diversity	Information Governance	Safeguard Children	Conflict Resolution	Safeguard Adults	Resus - BLS Equivalent	Average Compliance
CHUGS	66%	67%	67%	61%	72%	74%	53%	67%	71%	66%
CSI	76%	88%	83%	80%	84%	87%	69%	78%	69%	79%
Emergency & Speciality Medicine	65%	69%	71%	63%	63%	71%	47%	55%	55%	62%
ITAPS	72%	83%	86%	78%	80%	85%	66%	79%	69%	78%
Musculoskeletal & Specialist Surgery	66%	75%	76%	72%	75%	80%	66%	71%	71%	72%
Renal, Respiratory & Cardiac	71%	74%	81%	75%	75%	81%	67%	72%	64%	73%
Women's and Childrens	74%	77%	75%	70%	71%	91%	57%	51%	74%	71%
Corporate Directorates	73%	76%	79%	76%	74%	79%	62%	67%	60%	72%
Total compliance by subject	71%	77%	77%	72%	74%	82%	61%	67%	67%	
UHL staff are this compliant with their mandatory & statutory training from the key 9 subjects										72%
Performance Against Trajectory (Set at 70% at 28th Feb 14)									2% ahead	

Compliance Levels below 60%
Compliance Levels 60% to 75%
Compliance Levels at or exceeding target

Statutory & Mandatory
TRAINING FOR UHL
Excellence in Training
Excellence in Care

To:	**Trust Board**
From:	**Chief Nurse**
Date:	**27th February 2014**
CQC regulation:	Outcome 16

Title:	**Never Event**

Author/Responsible Director: Director of Safety and Risk

Purpose of the Report:

This report is to advise the Board of a Never Event which was escalated on the 21st February 2014.

The Report is provided to the Board for:

Decision		Discussion	x
Assurance	x	Endorsement	

Summary / Key Points:

- A thirty year old lady underwent an instrumental delivery on the 25th December 2013 and was discharged home the following day. On the 14th February 2014 the lady was admitted to the Maternity Assessment Unit and a medium sized vaginal swab was removed. This incident constitutes a Never Event – "Unintended retention of a foreign object in a patient following vaginal birth".

Recommendations:

The Trust Board is requested to note this report and the immediate actions that have been put in place following this Never Event.

Previously considered at another corporate UHL Committee?

Strategic Risk Register:	**Performance KPIs year to date:** Red compliance – three Never Events reported in 2013/14.

Resource Implications (eg Financial, HR):
Patient episode payment will be withheld in line with the Never Events Framework Regulations.

Assurance Implications:
Immediate actions to avoid a repetition have been implemented.

Patient and Public Involvement (PPI) Implications:

Stakeholder Engagement Implications:

As above.

Equality Impact:
Information exempt from Disclosure: Patient identifiable details
Requirement for further review? Through Executive Quality Board and Quality Assurance Committee.

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **27TH FEBRUARY 2014**

REPORT BY: **CHIEF NURSE**

SUBJECT: **NEVER EVENT**

---

1. INTRODUCTION

1.1 This report provides details of a Never Event which occurred within the Women's and Children's CMG and was escalated internally and to Commissioners on the 21st February 2014.

1.2 Never Events are incidents that have the potential to cause severe harm or death and are largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. Never Events are governed by the "Never Events Policy Framework" document available at:-

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213046/never-events-policy-framework-update-to-policy.pdf

2. DETAILS OF INCIDENT

2.1 A thirty year old lady underwent an instrumental delivery at the Leicester General Hospital on the 25th December 2013. During the delivery an episiotomy was performed by the Specialist Registrar (SpR). Once the delivery was complete, the SpR prepared the patient for suturing and repair of the episiotomy.

The Registrar started the suturing but was then called to theatre to assist with an emergency Caesarean section. The Registrar asked the midwife to take over and continue with the repair.

The patient was transferred to the post natal ward and subsequently discharged in to the care of the community midwives the following day. The lady visited her GP five weeks post delivery and on the 14th February 2014 was admitted to the Maternity Assessment Unit (MAU) at the LRI. A medical review was undertaken and a speculum examination performed. During this procedure a medium sized swab was removed from the vagina. The patient was admitted to the ward and intravenous (IV) antibiotics were commenced. The patient was discharged home two days later with follow up planned.

3. IMMEDIATE ACTIONS TAKEN

3.1 The following actions have been taken as a result of this incident:-

- Patient was informed and apologies provided.

- A formal memo has been sent out to all Medical and Midwifery staff reminding them to have all swabs and needles checked prior to commencing a procedure and to document this count on the white boards which are provided in all delivery rooms. Once the procedure is completed, a second member of staff must attend to confirm the swab/needle count is correct. This must be documented in the patient's medical records.
- A full RCA report will be commenced.
- Statements from all staff requested.
- The Never Event has been escalated to the Commissioners.

4. RECOMMENDATIONS

4.1 The Trust Board is requested to note this report and the immediate actions that have been put in place following this Never Event.

Moira Durbridge
Director of Safety and Risk
February 2014

To:	**Trust Board**
From:	**Richard Mitchell, Chief Operating Officer**
Date:	**27 February 2014**
CQC regulation:	**As applicable**

Title:	RTT Improvement Report

Author: Richard Mitchell, Chief Operating Officer

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

The Report is provided to the Board for:

Decision		Discussion	
Assurance	√	Endorsement	

Summary / Key Points:

- Reasons for RTT deterioration are well known
- Improvement plan will be agreed with the CCGs on 25 February 2014
- There are four challenged specialities; ophthalmology, ENT, orthopaedics and general surgery.
- Admitted compliant performance is expected in November 2014
- Non-admitted compliant performance is expected in August 2014
- Patients are being checked to ensure there has been no deterioration in their conditions linked to waits longer than 18 weeks.

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

Previously considered at another UHL corporate Committee N/A

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

Resource Implications (eg Financial, HR)
Yes

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

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

Equality Impact
N/A

Information exempt from Disclosure
N/A

Requirement for further review
Monthly

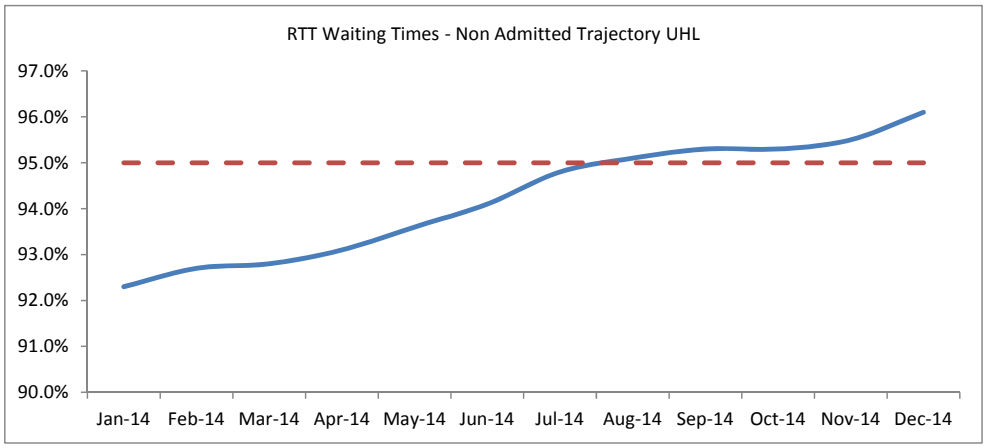
REPORT TO:	**Trust Board**
REPORT FROM:	**Richard Mitchell, Chief Operating Officer**
REPORT SUBJECT:	**RTT Improvement Report**
REPORT DATE:	**27 February 2014**

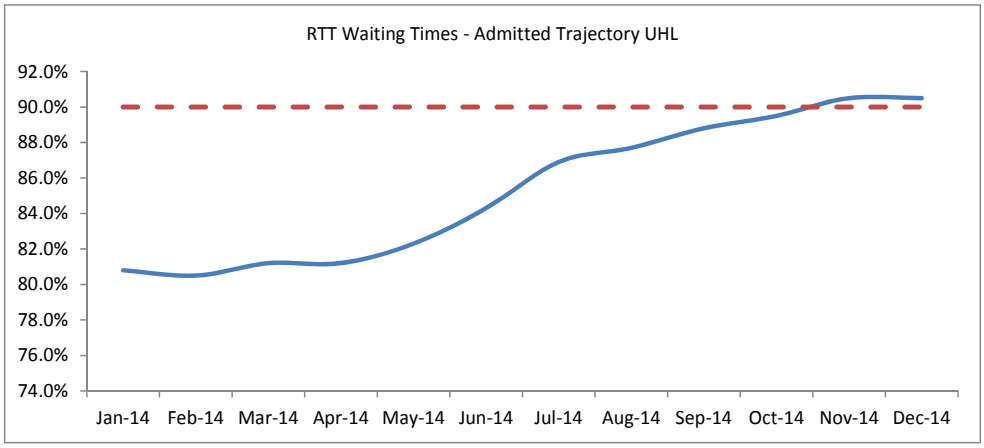
Introduction

The reasons for UHL's deterioration in RTT performance are well documented. On 25 February 2014, at the monthly 'Acute Contract Performance' meeting, UHL and Leicester City CCG will formally sign off the agreed plan to regain sustainably compliant performance. The high level trajectories are detailed below and attached. Trust level compliant non admitted performance is expected in August 2014 and trust level compliant admitted performance is expected in November 2014. The high level risks to the plan are detailed below.

Performance overview

UHL's RTT performance is mainly challenged in four specialities; ENT, ophthalmology, orthopaedics and general surgery. The specialities have put in place detailed plans to reduce their non-recurrent backlog and make permanent changes to increase their recurrent capacity. These plans have been submitted to the CCGs. Plans to increase outpatient capacity, theatre capacity and bed capacity have been shared. CCGs have committed non-recurrent and recurrent funding for this week and the aim to safely deliver the work at the lowest unit price. The graphs below detail the expected rate of improvement and the attached goes into greater detail.





Patients who have waited longer than 18 weeks for treatment are being checked to ensure they have had no deterioration in their condition linked to their long waits.

Risks

As detailed in the UHL response to the 2014-15 contract offer, the improvement 'plan will be carefully monitored including a full audit and re-population of the model after six months. If the volume of activity changes, the Trust may need to revisit the model and funding requirement. As all activity delivered is funded at tariff, this will jointly change our respective income and expenditure assumptions. As you will be aware, our elective capacity is often encroached by emergency activity. Therefore if emergency activity levels rise significantly above planned levels, this is likely to compromise our ability to deliver the RTT plan and this caveat will need to be included as we formalise this agreement.'

The key risks are:

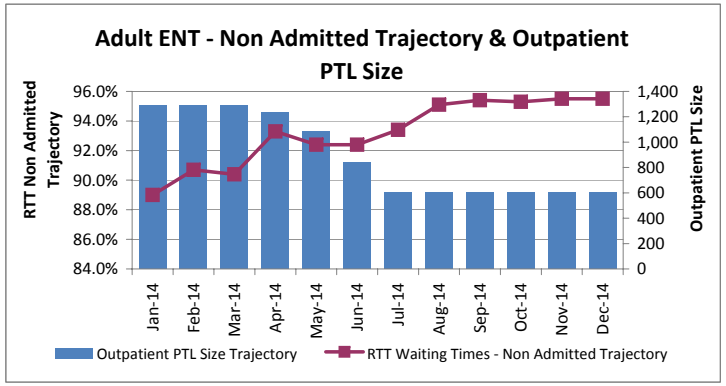
- Ability to deliver agreed capacity improvements including theatre, bed and outpatient space and staffing resources within agreed timelines
- Changes to emergency demand.

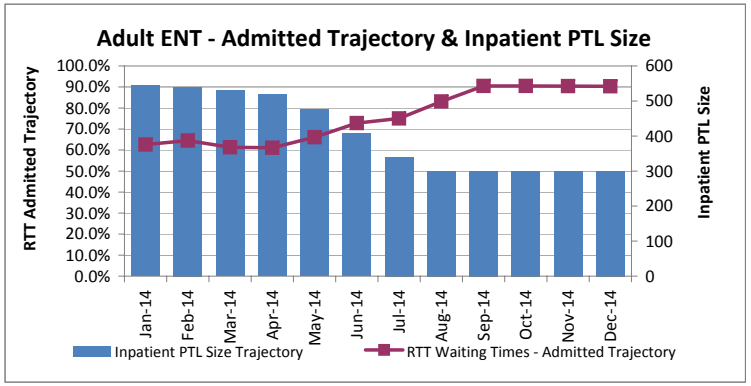
Recommendations
The board are asked to:

- Note the contents of the report
- Acknowledge the improvement trajectory
- Acknowledge the key risks.

Adult ENT

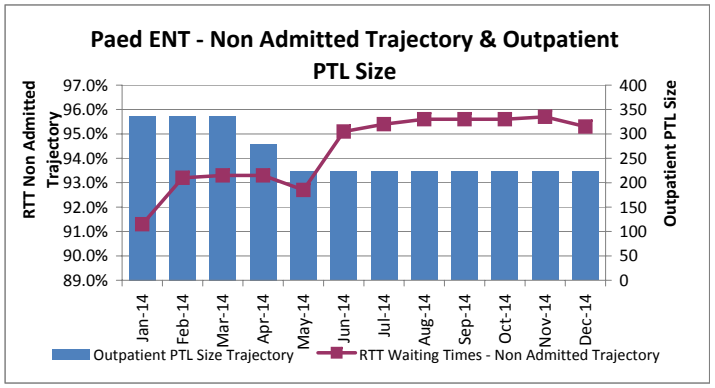
	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14
Outpatient PTL Size Trajectory	1,286	1,286	1,286	1,236	1,081	843	605	605	605	605	605	605
RTT Waiting Times - Non Admitted Trajectory	89.0%	90.7%	90.4%	93.3%	92.4%	92.4%	93.4%	95.1%	95.4%	95.3%	95.5%	95.5%
Inpatient PTL Size Trajectory	545	540	529	518	475	408	340	300	300	300	300	300
RTT Waiting Times - Admitted Trajectory	62.6%	64.5%	61.3%	61.1%	66.1%	72.8%	75.0%	83.1%	90.5%	90.5%	90.4%	90.3%

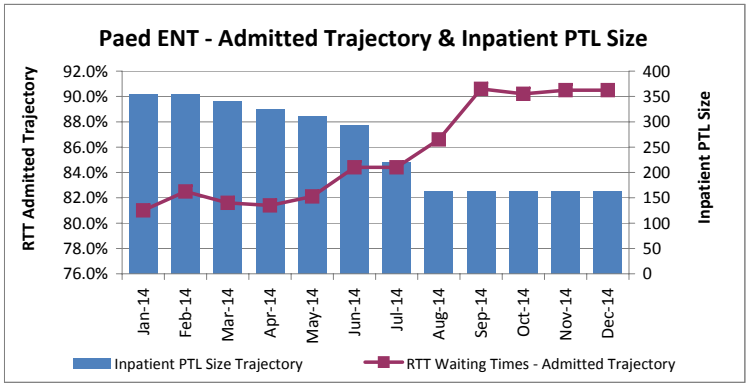




Paed ENT

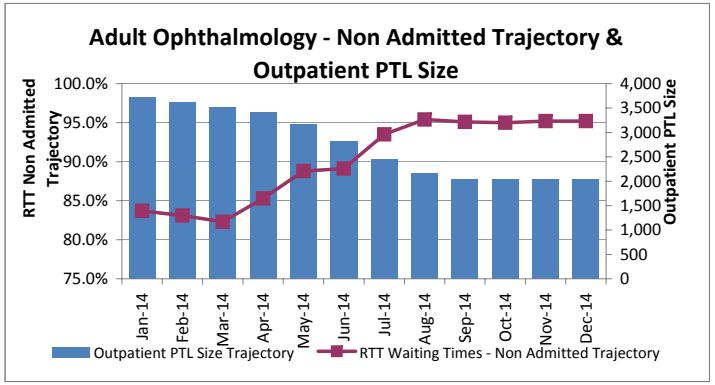
	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14
Outpatient PTL Size Trajectory	337	337	337	280	223	223	223	223	223	223	223	223
RTT Waiting Times - Non Admitted Trajectory	91.3%	93.2%	93.3%	93.3%	92.7%	95.1%	95.4%	95.6%	95.6%	95.6%	95.7%	95.3%
Inpatient PTL Size Trajectory	354	354	340	325	311	293	221	163	163	163	163	163
RTT Waiting Times - Admitted Trajectory	81.0%	82.5%	81.6%	81.4%	82.1%	84.4%	84.4%	86.6%	90.6%	90.2%	90.5%	90.5%

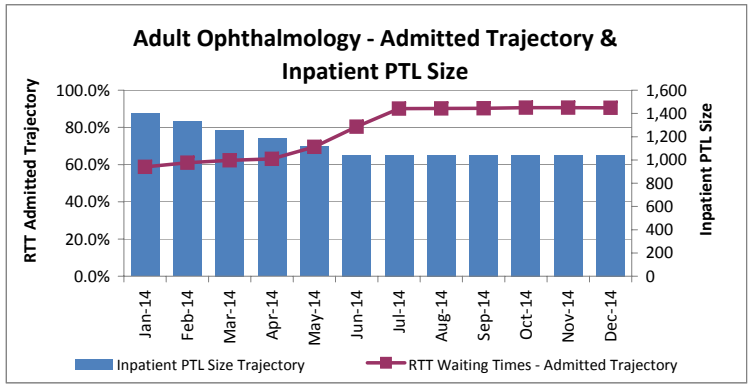




Adult Ophthalmology

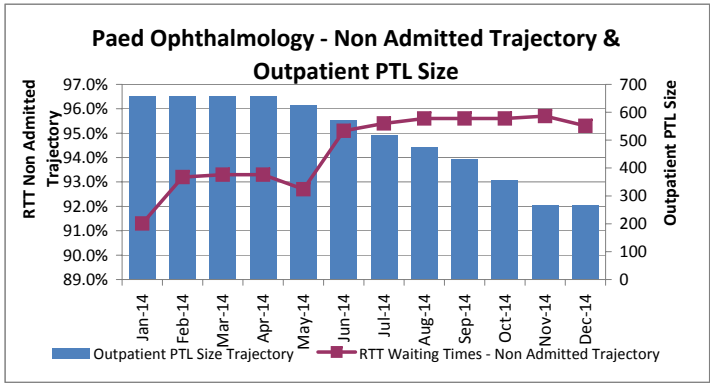
	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14
Outpatient PTL Size Trajectory	3,726	3,619	3,513	3,406	3,167	2,812	2,457	2,173	2,031	2,031	2,031	2,031
RTT Waiting Times - Non Admitted Trajectory	83.7%	83.1%	82.3%	85.3%	88.8%	89.1%	93.5%	95.4%	95.1%	95.0%	95.2%	95.2%
Inpatient PTL Size Trajectory	1,402	1,330	1,258	1,186	1,114	1,042	1,042	1,042	1,042	1,042	1,042	1,042
RTT Waiting Times - Admitted Trajectory	58.8%	61.0%	62.3%	63.1%	69.5%	80.4%	90.1%	90.2%	90.3%	90.6%	90.6%	90.5%

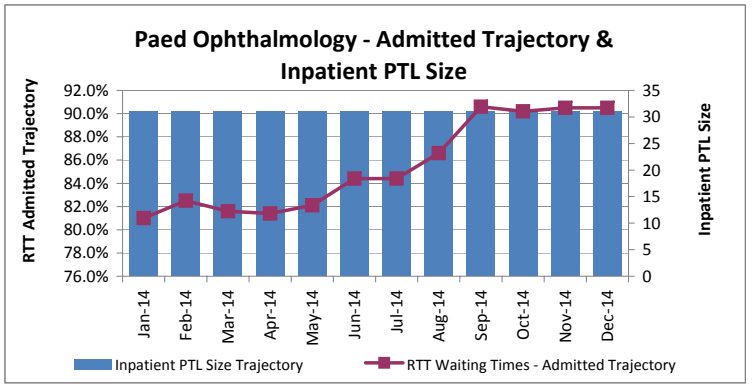




Paed Ophthalmology

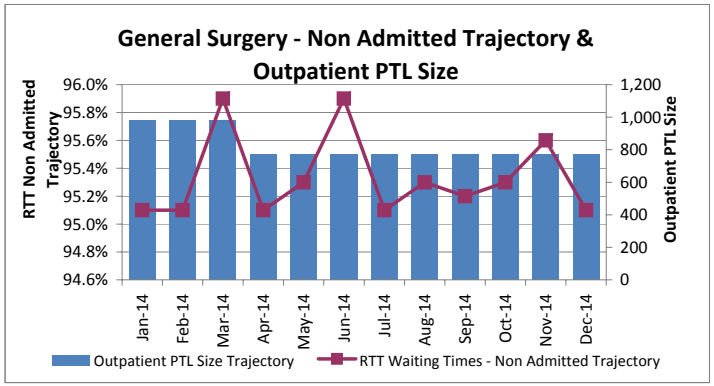
	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14
Outpatient PTL Size Trajectory	657	657	657	657	625	571	517	474	431	355	269	269
RTT Waiting Times - Non Admitted Trajectory	91.3%	93.2%	93.3%	93.3%	92.7%	95.1%	95.4%	95.6%	95.6%	95.6%	95.7%	95.3%
Inpatient PTL Size Trajectory	31	31	31	31	31	31	31	31	31	31	31	31
RTT Waiting Times - Admitted Trajectory	81.0%	82.5%	81.6%	81.4%	82.1%	84.4%	84.4%	86.6%	90.6%	90.2%	90.5%	90.5%

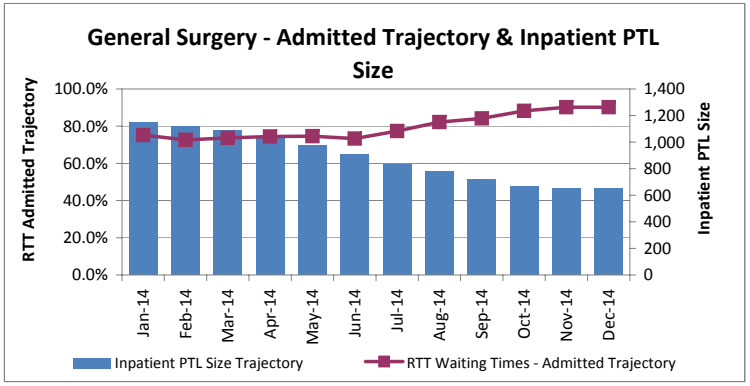




General Surgery

	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14
Outpatient PTL Size Trajectory	983	983	983	773	773	773	773	773	773	773	773	773
RTT Waiting Times - Non Admitted Trajectory	95.1%	95.1%	95.9%	95.1%	95.3%	95.9%	95.1%	95.3%	95.2%	95.3%	95.6%	95.1%
Inpatient PTL Size Trajectory	1,148	1,118	1,087	1,031	975	904	834	778	721	665	651	651
RTT Waiting Times - Admitted Trajectory	75.2%	72.6%	73.7%	74.4%	74.6%	73.3%	77.4%	82.2%	84.2%	88.2%	90.2%	90.2%

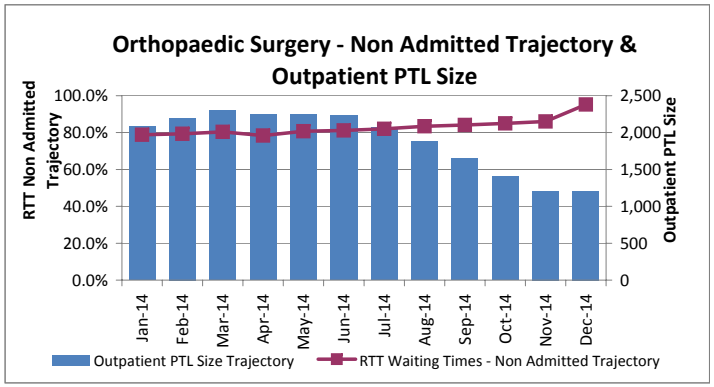


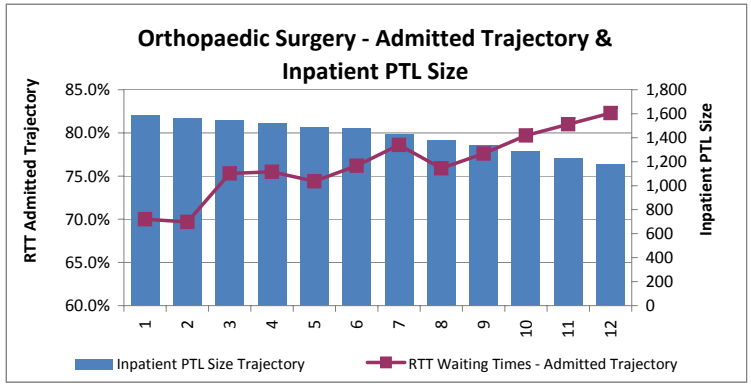


Orthopaedic Surgery

	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14
Outpatient PTL Size Trajectory	2,080	2,197	2,299	2,241	2,241	2,230	2,073	1,879	1,653	1,403	1,208	1,208
RTT Waiting Times - Non Admitted Trajectory	78.8%	79.3%	80.4%	78.4%	80.7%	81.2%	82.0%	83.4%	84.1%	85.0%	86.0%	95.2%
Inpatient PTL Size Trajectory	1,587	1,565	1,542	1,518	1,491	1,476	1,431	1,383	1,336	1,288	1,229	1,181
RTT Waiting Times - Admitted Trajectory	70.0%	69.7%	75.3%	75.5%	74.4%	76.2%	78.6%	75.9%	77.6%	79.7%	81.0%	82.3%

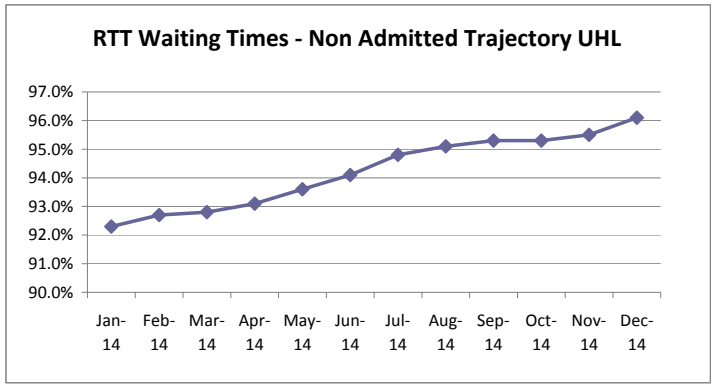
Note: Based on current plans admitted performance will not be achieved until Mar-15

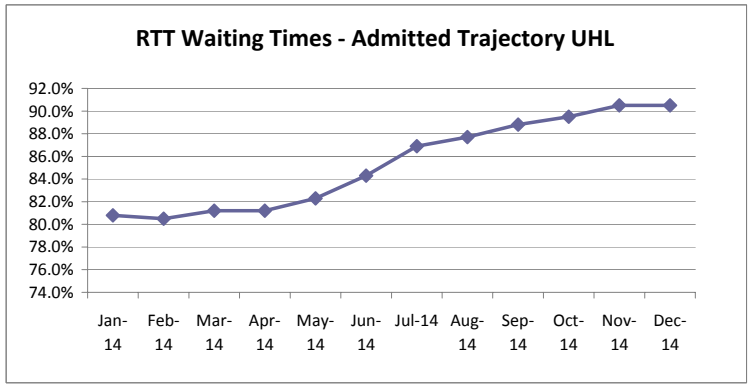


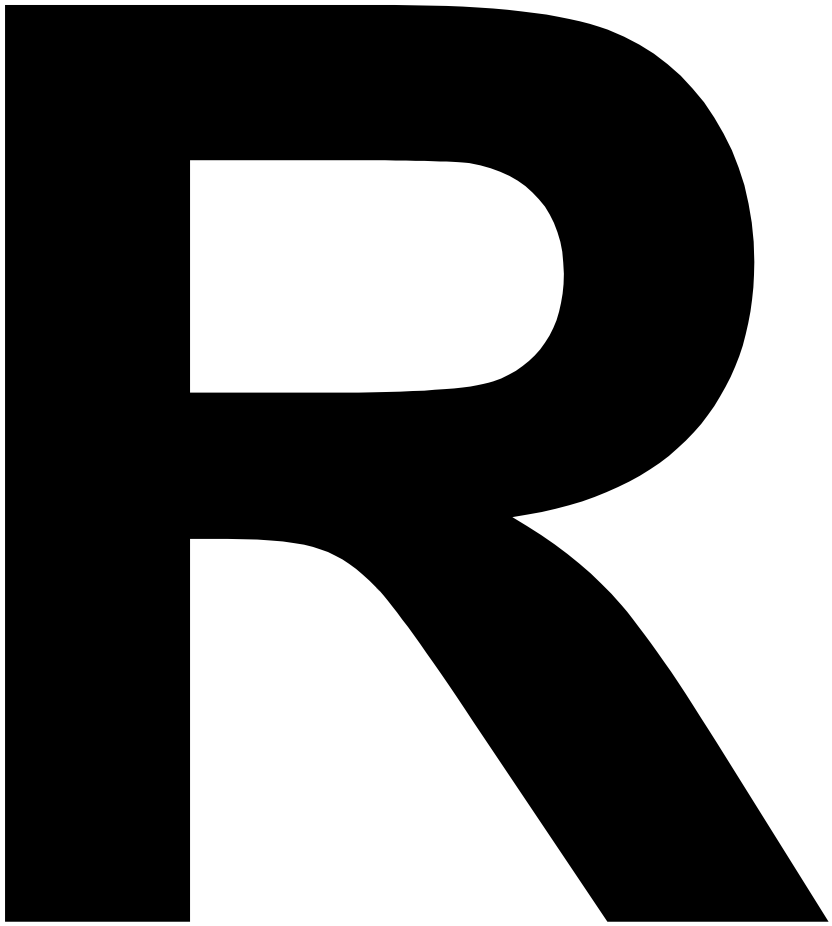


UHL Admitted & Non Admitted Trajectories

	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14
RTT Waiting Times - Non Admitted Trajectory	92.3%	92.7%	92.8%	93.1%	93.6%	94.1%	94.8%	95.1%	95.3%	95.3%	95.5%	96.1%
RTT Waiting Times - Admitted Trajectory	80.8%	80.5%	81.2%	81.2%	82.3%	84.3%	86.9%	87.7%	88.8%	89.5%	90.5%	90.5%







To:	**Trust Board**
From:	**Richard Mitchell, Chief Operating Officer**
Date:	**27 February 2014**
CQC regulation:	**As applicable**

Title:	Emergency Department Performance Report

Author: Richard Mitchell, Chief Operating Officer

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

The Report is provided to the Board for:

Decision		Discussion	
Assurance	√	Endorsement	

Summary / Key Points:

- Performance in December was 93.6%
- Performance year to date is 88.46%
- Performance has deteriorated over the last three weeks for four main reasons:
- Increase in admissions and a fixed bed base
- Increase in delayed transfers of care despite weekend discharges remaining high
- Reduction in community capacity
- Deterioration in internal processes primarily because of the sustained pressure caused by the above
- The UHL process is not broken.

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

Previously considered at another UHL corporate Committee N/A

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

Resource Implications (eg Financial, HR)
Yes

Assurance Implications
The 95% (4hr) target and ED quality indicators.

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

Equality Impact
N/A

Information exempt from Disclosure
N/A

Requirement for further review
Monthly

REPORT TO:	**Trust Board**
REPORT FROM:	**Richard Mitchell, Chief Operating Officer**
REPORT SUBJECT:	**Emergency Care Performance Report**
REPORT DATE:	**27 February 2014**

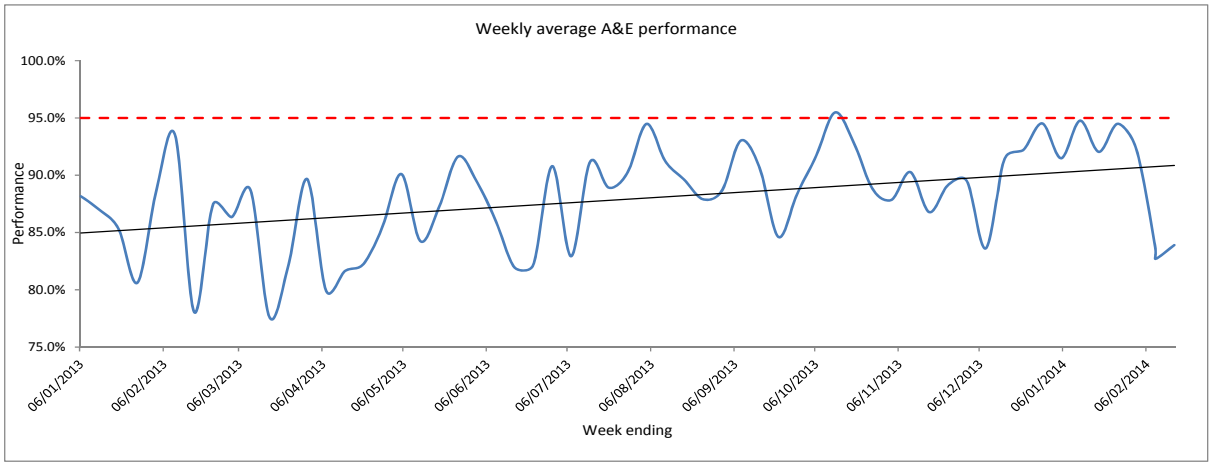
Introduction

Performance in January 2014 was 93.6% which was the best performing month for the last 15 months. This was because of the actions taken over the last six months including; twice daily discharge meetings, command and control leadership through the site meetings, the focus on non-admitted breaches and 'super weekends'. Performance has deteriorated since the end of February primarily because of a significant increase in emergency admissions and LLR's inability to increase the UHL discharge rate.

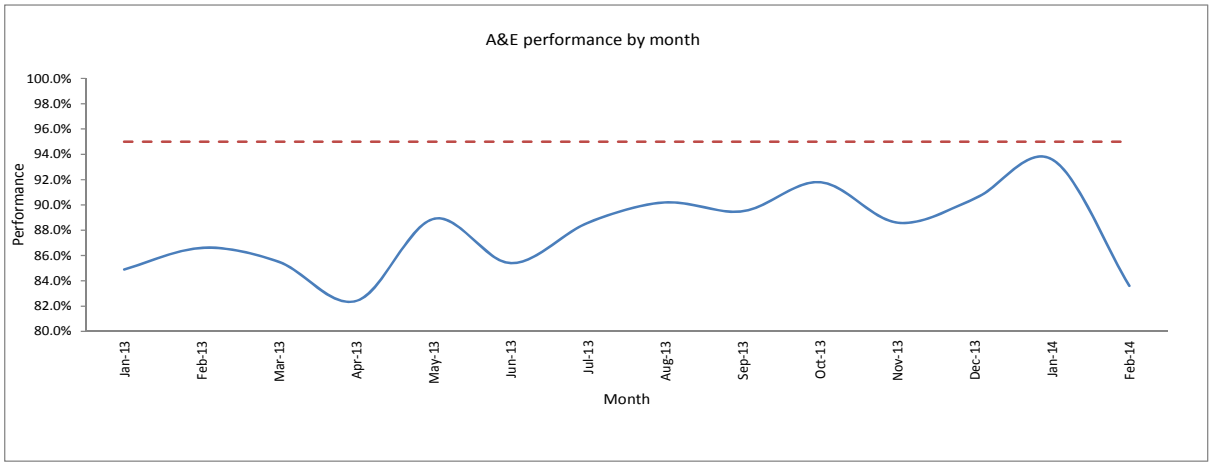
Performance overview

Performance in January was good, when compared to previous months at UHL and neighbouring acute trusts. 93.6% of patients were treated, admitted or discharges within four hours (graph one). There were 12 days of performance above 95%, two weeks above 94% including one week at 94.8% and by the end of January there had been eight consecutive weeks above 90%. Performance at this level was particularly pleasing because the month of January is often the most challenged month of the year.

However, performance in February has dramatically deteriorated, with no days above 95% and only one day above 90%. Year to date performance is 88.46%.



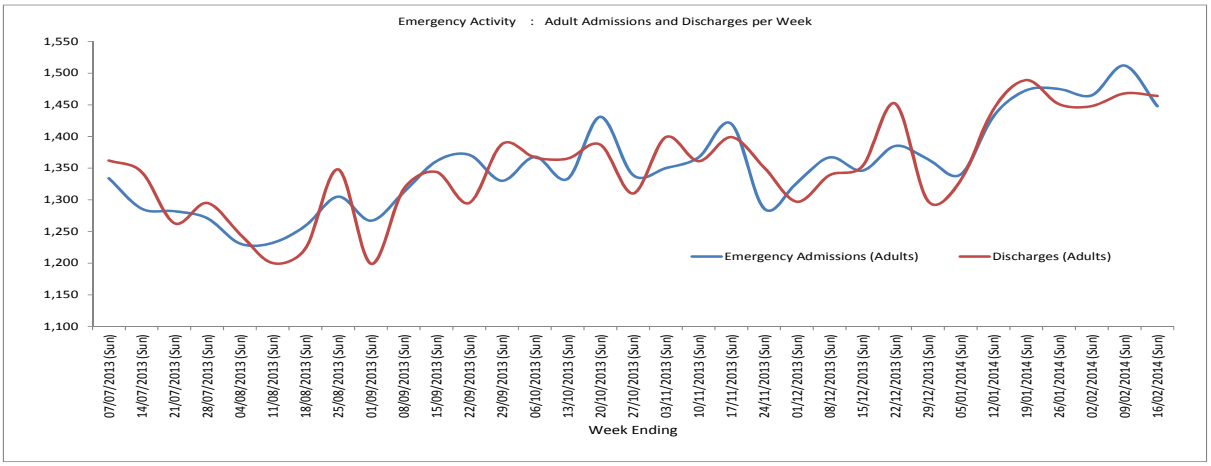
(graph one)



(graph two)

Reasons for deterioration in performance

Increasing admissions - Admissions have recently been very high. UHL's bed shortage is clearly documented and when we have increased levels of admissions, we quickly become unable to cope. Over the first six weeks of 2014 compared to 2013, we have 26.7 more beds full of patients per day with a length of stay of between two and 15 days. When short stay attendances (LOS less than two days) are included, this increase widens to 35.5 days. The increase in short stay admissions may well be because we opened up 16 more short stay beds and are caring for patients more effectively in them, when in the past they would have gone to a base ward.



(graph three)

High DTOCs - The number of patients with a delayed transfer of care has increased over the last couple of months. In early January, 3.5% of UHL bed's had DTOC patients in them. This has increased to 4.7% (66 patients) last week, an increase of nearly a ward's worth of patients. One of the problems is that community capacity has now got a higher number of patients who should be cared for in another location. Community capacity last Wednesday (19 Feb) had 15 patients who were solely awaiting a package of care, 15 patients who were awaiting placement either self-funded or social funded and 10 patients who were waiting for a continuing healthcare placement. Super weekend work and the focus on weekend discharge has continued throughout February although the level of ED performance has deteriorated. Last weekend (15-16 Feb), 291 patients were discharged from UHL with 312 discharged the weekend before. The second super weekend, when we had exceptional performance, discharged 304 patients. Weekend discharge rates have not changed.

Community capacity - CCGs have taken the decision to reduce community capacity which reduces our ability to discharge patients, hindering flow. For most of last week, UHL had 24 unfunded beds open and we cancelled the majority of elective and daycase work.

Internal process - Internal processes are not as good as they were previously. Since the morning of Friday 31 January, we have not had a day when we had continuous flow out of ED. Occupancy in ED has been very high with up to 17 ambulances waiting outside and in the evenings over 100 patients waiting in ED. With this level of sustained pressure, it is inevitable that process will suffer.

Actions

We continue to work closely with CCGs and external providers to deliver compliant performance. The level of performance over the last three weeks has been very disappointing and many difficult decisions to open additional capacity within UHL have been taken. The UHL process is not broken and we proved for a prolonged period of time that we can deliver many days of strong performance and weekly performance touching 95%. Many staff at UHL have been working most weekends in January and February to keep the super weekend effect going and discharges over the weekends

remain high. There are a number of factors outside of UHL that we need LLR support to resolve. Within UHL, we must continue to ensure that when possible we keep flow going and maintain a positive, focussed effort to providing a better level of emergency care for our patients.

Recommendations
The Board is asked to:

- Note the contents of the report
- Acknowledge the reasons for why performance has deteriorated
- Support the actions being taken to improve performance

S

Trust Board Paper S

To:	**Trust Board**
From:	**Rachel Overfield**
Date:	**27 February 2014**
CQC regulation:	

Title:	**Review of the performance of the Interserve Facilities Management Contract April to November 2013**

Author/Responsible Director:

Andrew Chatten Managing Director of NHS Horizons / Rachel Overfield Chief Nurse

Purpose of the Report:

To provide UHL Trust Board with a performance review of the contract with Interserve Facilities Management (IFM) over the first nine months of operation. To show performance levels across all operational services and the effectiveness of the framework in delivering capital solutions to development of the Trust estate.

The Report is provided to the Board for:

Decision		Discussion	
Assurance	X	Endorsement	

Summary / Key Points:

1. NHS Horizons

1.1. NHS Horizons is UHL's retained informed client. It consists of 20 individuals, employed by UHL, from a range of technical backgrounds to manage the interests of UHL and the patient experience in delivering estates and facilities services via the contract with IFM. The team is focused upon the following areas, statutory compliance, risk management, property and premises, capital projects and performance management (monitoring and audit) across 14 facilities services inclusive of Estates, Catering, Cleaning and Portering. The Horizons team provide a similar management service as an informed client to Leicestershire Partnership NHS Trust and NHS Property Services under a service level agreement.

1.2. Overall governance is managed via a collaborative Board, which consists of a Chair Kate Shields, Director of Strategy and Directors to whom, the Managing Director of NHS Horizons and team are accountable to. The Directors consist of Executive leads from each NHS body in Leicester, Leicestershire and Rutland. For UHL the Executive lead is Rachel Overfield Chief Nurse.

2. Scope of the Review

2.1. The paper reviews performance of the contract with IFM from the 1 March 2013 to the 30 November 2013.

2.2. The review focuses upon the levels of performance across 14 service areas.

2.3. The contract with IFM provides for adherence to a detailed service specification, performance to which is measured by 82 key performance indicators (KPI's) across the 14 services.

2.4. These KPI's are populated on a real time basis by IFM and are subject to audit and review by NHS Horizons.

2.5. These KPI's are the basis for the performance review of the first 9 months operation of the contract with IFM.

3. Summary Of Key Findings

3.1. IFM successfully managed the mobilisation of this major contract with the TUPE transfer of 2000 staff in March 2013

3.2. Services operating on a 'Business as usual' basis between March and June 2013 were delivered successfully. This is where services continued to operate to previous operational structures and procedures.

3.3. It is noted that in the first 9 months of operation there have been no significant service failures across the 14 services being performed by IFM.

3.4. The reviews findings in the attached report, demonstrate that performance across all 82 service KPI's shows a gradual improvement in performance. The month of November showed a levelling off of trajectory. Notable concerns continue with regards to Cleaning and Estate KPI's necessitating a remedial plan from IFM against which progress is being tracked.

3.5. IFM have invested in the refurbishment of new restaurant facilities on the three UHL hospital sites. These were opened in August in 2013. There were public and staff concerns regarding pricing of food in the restaurants. These concerns have been largely alleviated by subsequent meal deal offers on menu's.

3.6. IFM introduced two new service changes to UHL between June and August 2013. These consisted of Microfibre cleaning and Steamplicity patient meals. These technologies and service methods were well known to the Trust having been introduced at the Glenfield Hospital some years before and having had a proven track record with resultant positive Patient

Environmental Action Team scores. Introduction at the General Hospital in early summer went reasonably well with few complaints.

3.7. Transformation of the Cleaning and Catering service changes at the Royal Infirmary in July and August 2013 at the LRI, led to some significant service problems which impacted upon the patient experience. A Remedial Action Plan has been implemented by IFM with to improve levels of service. This has largely been successfully executed with performance levels showing steady recovery over the August to November period.

3.8. There is concern to see delivery by IFM of a full functioning estates integrated works system to give assurance upon levels of planned maintenance, effective scheduling of works and assured outcomes. This includes strategic estates facets such as space utilisation. NHS Horizons are currently reviewing the performance of the Micad system, which IFM have introduced and which consist of data and drawings upon buildings and assets and informs decision making. Delivery of the Planet system is scheduled for June 2014. This system provides for live management of maintenance services.

3.9. Collaborative working between the UHL Director of Safety and Risk and NHS Horizons has ensured an integrated route for compliance and assurance reporting. This includes risk management and infrastructure safety. Third party assurance services are also used such as Hydrop for water safety.

3.10. In late 2013 two audit reports were commissioned by UHL. One by UHL internal auditors Price Waterhouse Coopers and one by Willis Group, a risk management organisation which reviewed the level of connectivity between the contract processes and the UHL core governance. No major non compliances were reported. Reported recommendations are being implemented and tracked by UHL.

3.11. NHS Horizons continue to undertake a large proportion of manual auditing of statutory compliance and safety performance. This includes high risk areas to the patient environment. The main areas of review include statutory maintenance where compliance levels at the Glenfield and General Hospitals have been corroborated as comprehensive but improvement is needed at the Royal Infirmary where a remedial plan has been put forward by IFM against which progress is being tracked.

4. Capital Scheme Support and Delivery

4.1. The framework agreement between UHL and IFM, enables UHL to commission capital projects with IFM without the need to progress projects via time consuming procurement processes. There is no exclusivity to IFM and as such use of the framework is subject to value for money tests.

4.2. The benefits of long term partnering contracts are well published within the construction industry and NHS as a major purchaser of construction services.(Latham 1996)

4.3. IFM have over the past nine months been involved with providing services from NEC/P21+ stage 0 to stage 3 (business case and design works) and stage 4 construction under the Lot 2 contract and minor work up to £100k under the Lot 1 contract. The majority of construction works to date have been priced and delivered with a transparent pricing structure to a Guaranteed Maximum Price (GMP) and this has allowed for a measurable basis for value for money assessments.

4.4. UHL has appointed a Major Projects Technical Director to lead the Capital Planning and Delivery team for UHL. This is in response to the significant programme planned such as the Emergency Floor scheme, works for which are planned to commence in August 2014.

4.5. The Capital Planning and Delivery team for UHL work with NHS Horizons to manage capital programmes and delivery of works. This includes on a scheme by scheme basis how to procure solutions either via the framework or by traditional procurement.

4.6. External professional quantity surveyors, Rider Levett Bucknall have been employed to provide professional cost advice on a scheme by scheme basis. These have shown that works cost are within the median range.

4.7. The performance of IFM in delivering capital solutions which deliver to cost, time and quality are under constant review. The Capital Planning and Delivery Team supported by NHS Horizons will continue to press IFM for optimum solutions and utilise alternate procurement routes subject to performance.

4.8. The UHL Strategic Outline Case for the reconfiguration of clinical services (SOC) is to be delivered in March 2014. This will enable UHL to consider the overall scope of capital development required over the next 5 years. In turn this will enable an assessment of the overall procurement strategy for delivery of works.

Recommendations:

That the Trust Board note the level of assurance provided from the review of the first 9 months of operation of the contract with IFM.

Previously considered at another corporate UHL Committee?

Subject to delegated responsibilities to the LLR Facilities Management Collaborative Board

Board Assurance Framework:	Performance KPIs year to date: As reported
Resource Implications (eg Financial, HR): Contracted savings to March 2020	
Assurance Implications: Significant relating to statutory compliance and the patient experience / care	
Patient and Public Involvement (PPI) Implications: Yes. UHL Patient surveys obtain views on FM issues such as food quality and cleanliness levels. NHS Horizons also conduct customer satisfaction surveys.	
Stakeholder Engagement Implications: UHL is host to the framework with IFM and hosts the collaborative and informed client function provided by NHS Horizons	
Equality Impact: contract requires the observance of all relevant UHL policies including all relevant UHL equality policies.	
Information exempt from Disclosure: commercial information is exempt from disclosure	
Requirement for further review? Ongoing	

University Hospitals of Leicester NHS Trust
Review of Performance of the Interserve Facilities Management Contract
April to November 2013

1.0 Introduction

1.1 The regular monthly performance reports considered in the public section of the Trusts Quality & Performance Sub Committee cover the main Key Performance Indicators (KPIs) most indicative of the key service deliverables. The purpose of this report is to provide a fuller summary of performance against all the KPIs in the contract.

1.2 The charts and tables presented in the Annex to this report contain considerable detailed information on all aspects of the performance of the contract so that the UHL Trust Board has the maximum level of detail available for it to review the contract over the first 9 month period of service delivery under the Interserve contract.

2.0 Performance Review Overview

2.1 NHS Horizons manage the contract on behalf of the UHL and has provided the following information for this report regarding performance from April to November 2013 (although the contract commenced on 1st March reliable performance data started in April).

2.2 There are currently 14 separate services delivered under lot 1 of the contract by Interserve (IFM), focussed upon both hard and soft FM. These services are monitored by 82 separate KPIs which form the basis of a Performance and Payment Mechanism. Performance levels in this 'Paymech' determine the potential financial deductions, which provide a commercial incentive to achieve and maintain good performance.

2.3 The table below summaries the 14 services, numbers of KPIs applicable to each.

FM Service	**No. of KPIs for each service**
Contract Management	6
Estates Management and Maintenance Service	9
Energy and Utilities Management Service	2
PM, Design and Technical Support Service	1
Pest Control Service	7
Portering Service	7
Parking Service	3
Security Service	9
Cleaning Service	11
Catering Service	11
Reception Service	2
Linen Service	3
Print & Reprographic Services	4
Switchboard & Helpdesk Service	7

3.0 Summary of Service Performance April – November 2013

3.1 The section below summarises the service performance by IFM over the first 9 months and also includes a trend graph for the main KPI within the service area.

4.0 Contract Management

4.1 This element covers performance on the formal reporting requirements of the contract including all KPIs, Staff induction and Health & Safety reports on a monthly basis.

4.2 Overall the reporting of the contact by IFM has performed well over the 9 months of the contract period.

4.3 The level of incident reporting including near misses has been timely and consistent.

4.4 Encouragingly the levels of incidents reported have been low and no serious incidents to IFM or Trust personnel or property has been experienced to date.

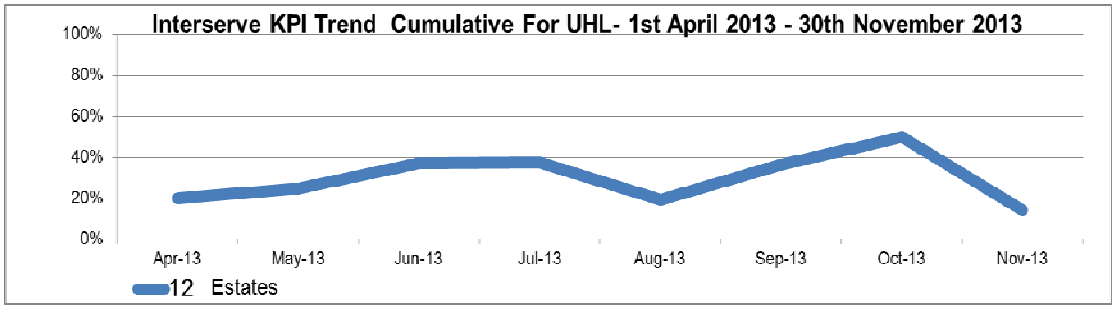
4.5 This service and the KPIs associated to it have generally exceeded the standard set.

4.6 A full description of all the KPS in this service area can be found in the Annex pages A-1 to A-2.

5.0 Estates & Maintenance

5.1 *KPI 12 - Estates*

Percentage of Urgent requests achieving response time within the 30 minutes Service Level Agreement time given



5.2 The Estates services have shown a very variable level of performance and have yet to achieve the required levels of delivery on a consistent basis.

5.3 Difficulties in the development of a fully functioning and populated electronic works management systems coupled with an initial reduced level of resources in key technical posts have been significant contributing factors.

5.4 Not being able to readily verify Planned Preventative Maintenance (PPM) easily through electronic records especially as regards statutory tasks has meant that detailed manual auditing undertaken by NHS Horizons has been necessary. This has identified a high degree of confidence regarding the LGH & GGH PPM completion rates. LRI systems and completion of both reactive and PPM activities requires substantial improvements to be implemented.

5.5 This service has been subject to corrective mechanisms within the contract and an on-going Interserve remedial action plan.

5.6 From a positive perspective IFM have confirmed as of January 14 that a targeted recruitment exercise has been successful in increasing the technical resources and has allowed them to now move to full 24 hour cover on all 3 sites.

5.7 A full description of the KPIs associated with this service and their performance can be seen at Annexe pages A-3 and A-4

6.0 Energy & Utilities

6.1 IFM carry out the full management of the trusts utilities services and maintenance of the supporting infrastructure. As part of this function monthly energy reports produced and full verification of utilities invoices is undertaken.

6.2 IFM in conjunction with both external and Trust support are developing further sustainability and energy management systems

6.3 Overall this service has performed well and has not been subject to any significant KPI shortcomings.

6.4 A full description of the KPI's associated with this service and their performance can be found in the Annexe pages A-5 to A-6

7.0 Project Management & Design

7.1 This service has had an inconsistent and poorly performing initial period. This is in part attributable to self-delivery of schemes by in house maintenance staff which due to operational pressures was not sustainable.

7.2 The single KPI related to this service is focussed on the production of quotations within required time frames. This has underperformed to date and has been subject to corrective action under the contract.

7.3 To support this service and filter out non-productive requests for minor works the Trust and IFM have introduced revised protocols including final approvals by the Chief Executive.
IFM have now restructured the service and appointed dedicated management resources and recognised new works providers in Interserve Construction (IC).

7.4 Following restructuring a steady increase in percentage of returns within timescales is now being observed for this service.

7.5 A full description of the KPI's associated with this service and their performance can be found in the Annexe pages A-5 to A-6

8.0 Pest Control

8.1 IFM appointed an external contractor to undertake this function and initial performance was inconsistent however over recent months this service has improved over the majority of KPIs associated to this element with these performing at the required standard.

8.2 A full description of the KPIs associated with this service and their performance can be found in the Annexe pages A-7 to A-8

9.0 Portering

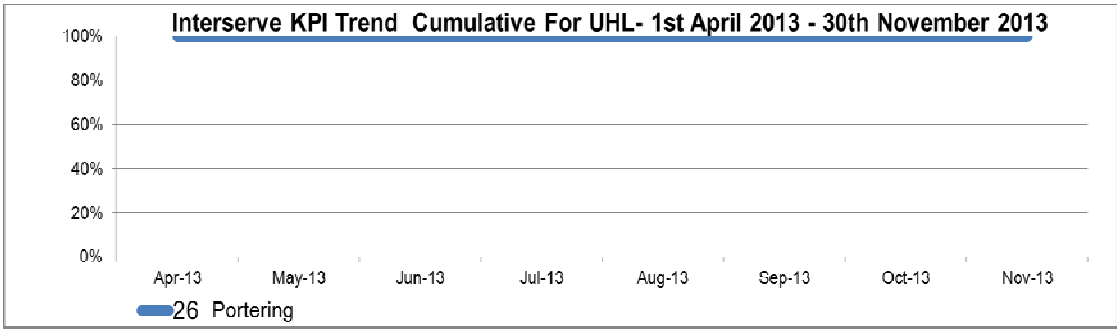
9.1 This service has seven KPIs measuring performance across a wide range of portering duties including:-

- Delivery and collection of linen
- Removal of waste to the waste compound
- Medical gas duties
- Postal services

9.2 The two KPIs reported on below are associated primarily to the movement of patients or specimens within the acute environment.

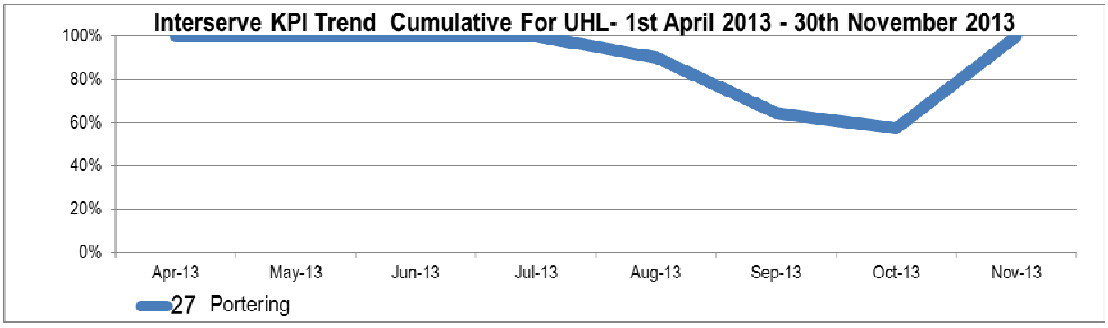
9.2.1 *KPI 26 – Portering*

Percentage of scheduled portering tasks completed in the contract month within 15 minutes of the Scheduled time



9.2.2 *KPI 27 – Portering*

Percentage of emergency portering tasks achieving response time



9.2.3 Recent performance has identified a dip in one element of portering responses which in part aligns to substantial increase in patient activity and demands upon this service; however scheduled portering tasks which constitute a major component of the service have remained consistent throughout.

9.2.4 This service has not been subject to transformation and remains configured on the whole across the acute units as per pre contract award. Portering is a service that under the original bid will subject staff to transformation and revised working patterns. IFM will agree transformational plans with the Authority prior to implementation.

9.2.5 As a further indicator of performance of the Portering Services a number of incidents continue to be recorded on the DATIX system particularly focussed at the LGH unit.

9.2.6 A full description of the KPIs associated with this service and their performance can be found in the Annexe pages A-9 to A-10

10.0 Parking Services

10.1 This service and associated KPIs are primarily focussed on the administration and management of staff and patient car parks. It includes for the provision of permits to staff, car park availability and continued access and safety patrols across all UHL facilities.

10.2 To date this service has performed well throughout all phases of the contract.

10.3 A full description of the KPI's associated with this service and their performance can be found in the Annexe pages A-11 to A-12

11.0 Security

11.1 This service with regards staff duties and resources has not been directly subject to transformation during the current reporting periods and continues to deliver security services generally in line with pre contract resources and procedures.

11.2 To date recorded performance has met the majority of the new KPI standards introduced by IFM at the commencement of the contract.

11.3 A full description of the KPI's associated with this service and their performance can be found in the Annexe pages A-13 to A-14

12.0 Cleaning

12.1 The cleaning services and model of delivery are those based on the existing methods previously undertaken at the Glenfield Hospital (GH) based on Chlor clean and Microfibre technology.

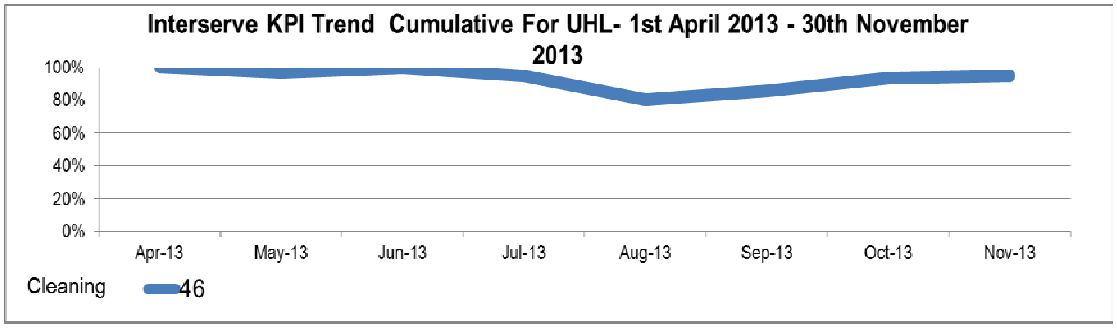
12.2 The initial introduction of this Microfibre model at the Leicester General Hospital (LGH) in March 13 was relatively successful. The later implementation at the LRI coupled

with staff experiencing Management of Change (MOC) procedures resulted in a tangible impact upon cleaning standards over the July to October at this hospital.

12.3 There are a number of KPIs that record performance against this service and the trend data below is representative of the main overall performance for scheduled cleaning.

12.4 *KPI 46 - Cleaning*

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



12.4.1 Recorded performance for KPI 46 started well but dipped around transformation of the service, but with evidence of improving results thereafter. At ward level the cleaning audits are undertaken jointly between clinical managers and designated IFM domestic auditors. In addition Cleaning services are subject to regular "dip tests" auditing via NHS Horizons and the Trusts Infection Prevention Team.

12.4.2 Cleaning is a key deliverable and critical service and has been subject to corrective action under the contract. It is underpinned by the on-going IFM remedial action plan which is being actively implemented with a focus on increasing cleaning hours to designated areas and the introduction of additional resources to establish an improved and consistent service.

12.4.3 A full description of the KPIs associated with this service and their performance can be found in the Annexe pages A-15 to A-16

13.0 Catering

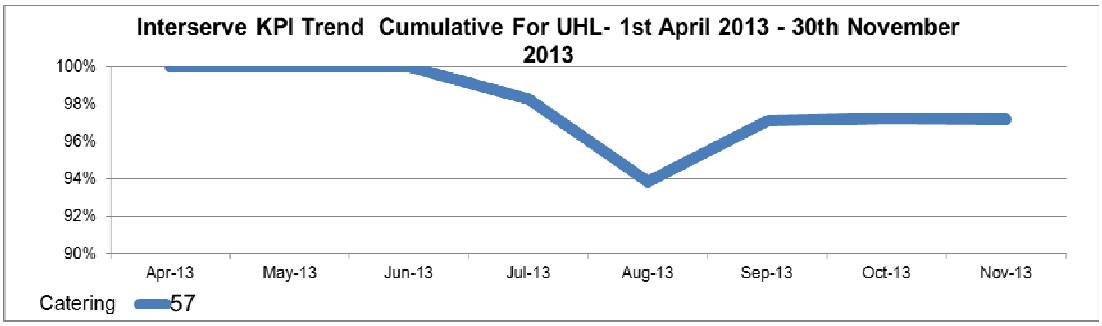
13.1 The patient catering services and model of delivery are those based on the existing methods previously in place at the Glenfield Hospital (GH) and based on utilising "steamplicity" with a wide selection of main meal hot choices. Dedicated specialised menus catering for both ethnic and dietary needs are also fully in place.

13.2 Initial transformation of these services in March 13 at the LGH was successfully achieved and with little impact upon the recorded levels of performance

13.3 Transformation of services at the LRI was problematic and mainly focussed not on the quality of the meals, but upon the timeliness of delivery to the patient. The KPI trend graph below records this element over the 9 month review period.

13.3.1 *KPI 57 - Catering*

Per*centage of meals delivered to wards in time for the designated meal service as per agreed schedules.*



13.3.2 Overall the quality and choice of patient meals has been well received across all 3 sites. The issue of timeliness of delivery and patient receiving their first choice of meals at the LRI was the major influence on performance during the latter phases of this review period.

13.3.3 The service has been subject to remedial action with a focus on improving the meal time delivery to patients. This is on-going and subject to monitoring through the Horizons Board.

13.3.4 A full description of the KPIs associated with this service and their performance can be found in the Annexe pages A-17 to A-18

14.0 Reception

14.1 Reception services have continued with Interserve generally in line with pre contract resources and to date there has not been any major transformation.

14.2 Overall the recorded levels of performance as measured by the two KPI's have not identified any issues or concerns regarding this service to date.

14.3 A full description of the KPIs associated with this service and their performance can be found in the Annexe pages A-19 to A-20

15.0 Linen Services

15.1 The management, stocking & delivery of all Linen services across the UHL is undertaken by Interserve.

15.2 The laundering and supply of all linen is undertaken within existing separate contracts with an external provider Berendsen (formally known as Sunlight laundries.)

15.3 This legacy contract is managed directly by NHS Horizons and includes for approving any variations and invoices accordingly. Regular linen audits of all hospital sites and external suppliers are carried out by NHS Horizons.

15.4 Initial delays in receiving and supplying staff uniforms were experienced but overall the service has performed well against the KPI's in place.

15.5 A full description of the KPI's associated with this service and their performance can be found in the Annexe pages A-21 to A22

16.0 Print & Reprographic Services.

16.1 This service is located at the LRI and has seen continued investment and improvement to equipment and facilities, and continues to perform well against the KPI's that record the performance of the print room and its services to the Trust.

16.2 A full description of the KPIs associated with this service and their performance can be found in the Annexe pages A-23 to A-24

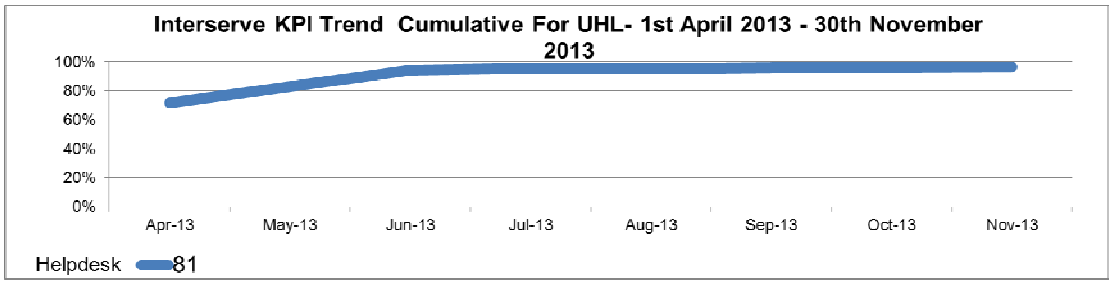
17.0-Switchboard & Helpdesk Services.

17.1 This service incorporates the Customer Service Centre (CSC).and the switchboard staff excluding the assets and infrastructure.

17.2 Initial recorded and on-going performance of this service has been inconsistent and the location and information technology infrastructure supporting the customer services centre has not been fully integrated and developed to meet IFM service delivery plans. This interdependence has and continues to impact on IFM's ability to fully meet the required KPIs within the contract.

17.2.1 *KPI 81 -Helpdesk*

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



17.2.2 KPI 81 started at a low percentage due to the change in how helpdesk calls across the services were handled at the start of the contract. Interserve have increased the percentage by staff training and recruitment over the last 9 months.

17.2.3 The CSC receives calls for all LLR Properties and FM services across LLR and initially helpdesk staff were unfamiliar with UHL procedures or categorisation of requests. This coupled with initial underestimation of the number of calls being received by the helpdesk across the LLR led to delays in responding to requests.

17.2.4 Over recent months the KPI data and user feedback have identified improvements to the CSC responses.

17.2.5 A full description of the KPIs associated with this service and their performance can be found in the Annexe pages A-25 to A-26

18.0 Patient Led Assessment of the Care Environment (PLACE)

18.1 NHS Horizons planned and implemented the PLACE programme for UHL during April, May and June 2013 submitting the results to the Health and Social Care Information Service in the required timeline.

18.2 The formal results for PLACE were received in September, 2013. GGH achieved a good cleanliness score but LGH and LRI scores indicated that there is work to be done to improve both cleanliness of some areas and the condition/maintenance of several areas. NHS Horizons submitted a report to the Trust Quality Assurance Committee and are liaising with both IFM and nursing colleagues to compile and implement action plans to address the issues noted.

19.0 Performance - General Summary

19.1 The above narrative and trend diagrams identify that the mobilisation of the contract and initial phases of service delivery from April to June by IFM were successful in maintaining and in some areas improving the standards and responses as regard service delivery.

19.2 This was followed by a period of transition generally covering the period July to September where in some cases performance dipped as new methodology and different ways of working coupled with staff changes were introduced and this particularly impacted upon services being delivered at the LRI.

19.2 The past three months (September – November 2013) have identified general improvements in performance by Interserve FM across the UHL underpinned by the IFM remedial action plans.

20.0 Statutory Compliance Report

20.1 Trust Governance

20.1.1 Collaborative working between NHS Horizons and UHL Health and Safety Compliance team has provided the structure and arrangements to support UHL's risk and governance requirements. Since the commencement of the contract and the reorganisation of the Trusts management and reporting structures formal reporting routes have been the established.

20.2 IFM Management Structure

20.2.1 To date IFM has not yet appointed their full Quality, Safety, Health, Environment (QSHE) establishment for the contract and much of the workload has resided with one 'interim' appointment covering the period up to November and beyond.

20.2.1 IFM assure the Trust that active recruitment is underway and confirmation of forthcoming appointments is on-going.

20.3 Electronic Evidence Files

20.3.1 To date Interserve are substantially behind the original plan regarding the introduction of electronic evidence files and have not fully implemented their Planet and Micad Facilities Management software which underpins this requirement.

20.3.2 Failure to establish these systems has impacted on NHS Horizons' resources and required manual validation of data and records, in order to provide UHL with the evidence required to meet their governance and assurance frameworks.

20.3.3 Statutory PPM delivery as measured by KPI7 has recorded partial compliance since May 2013. During the contract period NHS Horizons have manually verified IFM's monthly statutory PPM performance and found no misreporting to date.

20.4 Health and Safety Performance

20.4.1 During the contract period there has been no record of a serious IFM incident to either UHL personnel or property.

20.4.2 Evidence and data received indicates that IFM employs effective incident and near miss reporting procedures.

20.4.3 Incident recording in the categories of minor and non-injury reporting is indicating a decreasing trend.

20.4.4. Four RIDDOR incidents have been reported to date two of which were attributable to IFM.

20.5 Audit and Assurance Programme

20.5.1 NHS Horizons have implemented a formal audit programme to verify confidence in the status of statutory compliance across key areas.

20.5.2 Water management and asbestos management audits have been completed by NHS Horizons. Actions for UHL are mainly to complete an update of their policies and formally identifying responsible persons in their governance structure.

20.5.3 Audits and reviews to date have not identified any major or significant non-compliance regarding statutory requirements.

20.5.4 UHL are adapting to the new outsourced FM arrangements and are well advanced with their arrangements for the key risk areas of fire and water management.

20.6 Third Party Reviews

20.6.1 An independent review of management and governance across the LLR Facilities Management (FM) contract by Willis Ltd identified a number of opportunities to improve risk management and governance.

20.6.2 External specialist third party assurance is also provided via NHS Horizons and includes, environmental health, water management, and linen and waste expertise.

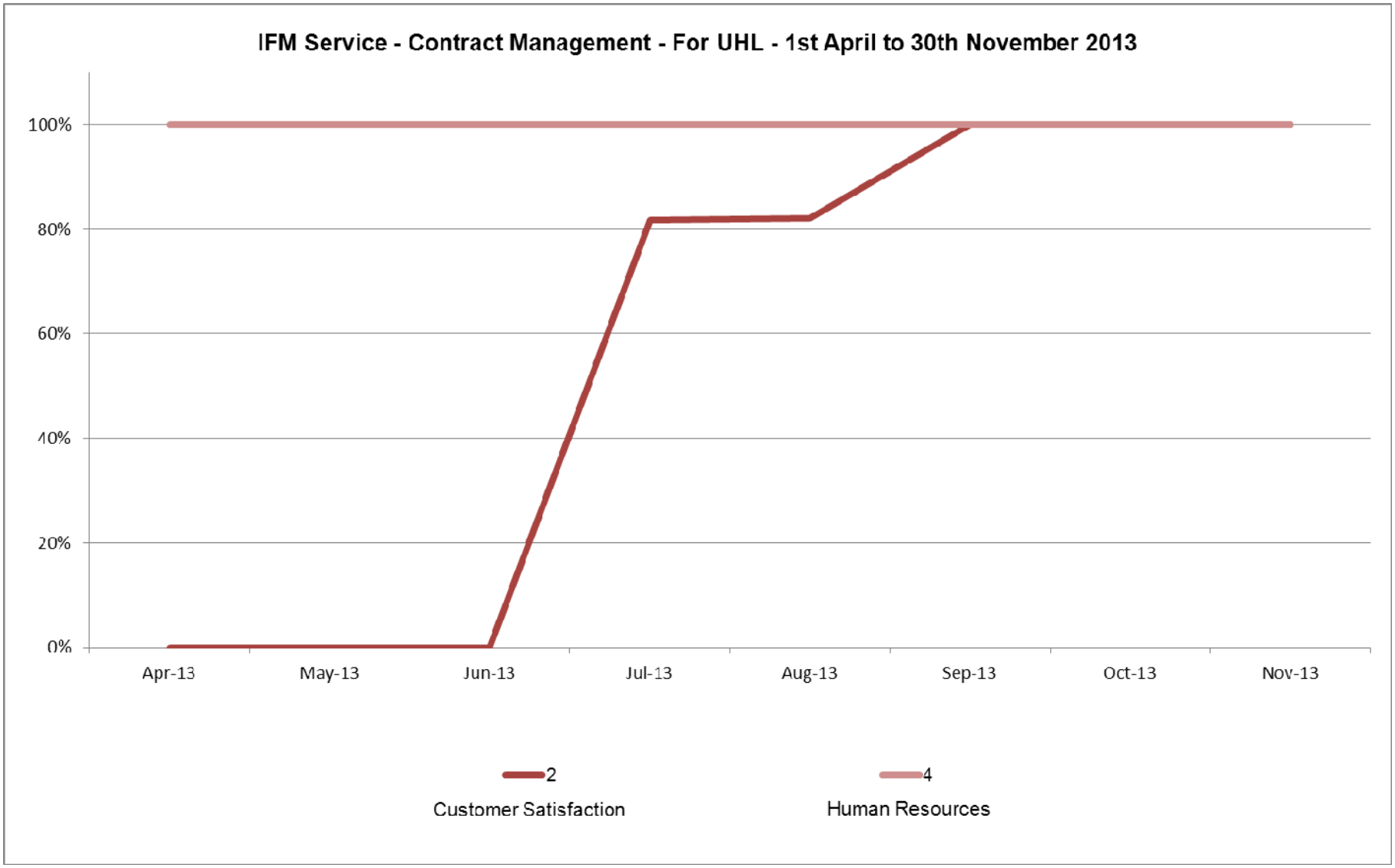
20.7 General Compliance Summary

20.7.1 Collaborative working between the UHL Director of Safety and Risk and NHS Horizons has provided an integrated route for compliance and assurance reporting from NHS Horizons into the Trust. The routes established fully support the risk and governance principles of the Trust. A flowchart to illustrate the risk and governance reporting process is attached at Annex B.

20.7.2 A formal statutory compliance audit programme for 2014 has been developed to provide the Trust with additional assurance across the outsourced Facilities Management Services. NHS Horizons will continue to monitor compliance and risk and alert the Trust if there are any significant issues. Further assurance will be available when Interserve fully implement their Planet and Micad Facilities management systems and provide access to live data and records to NHS Horizons.

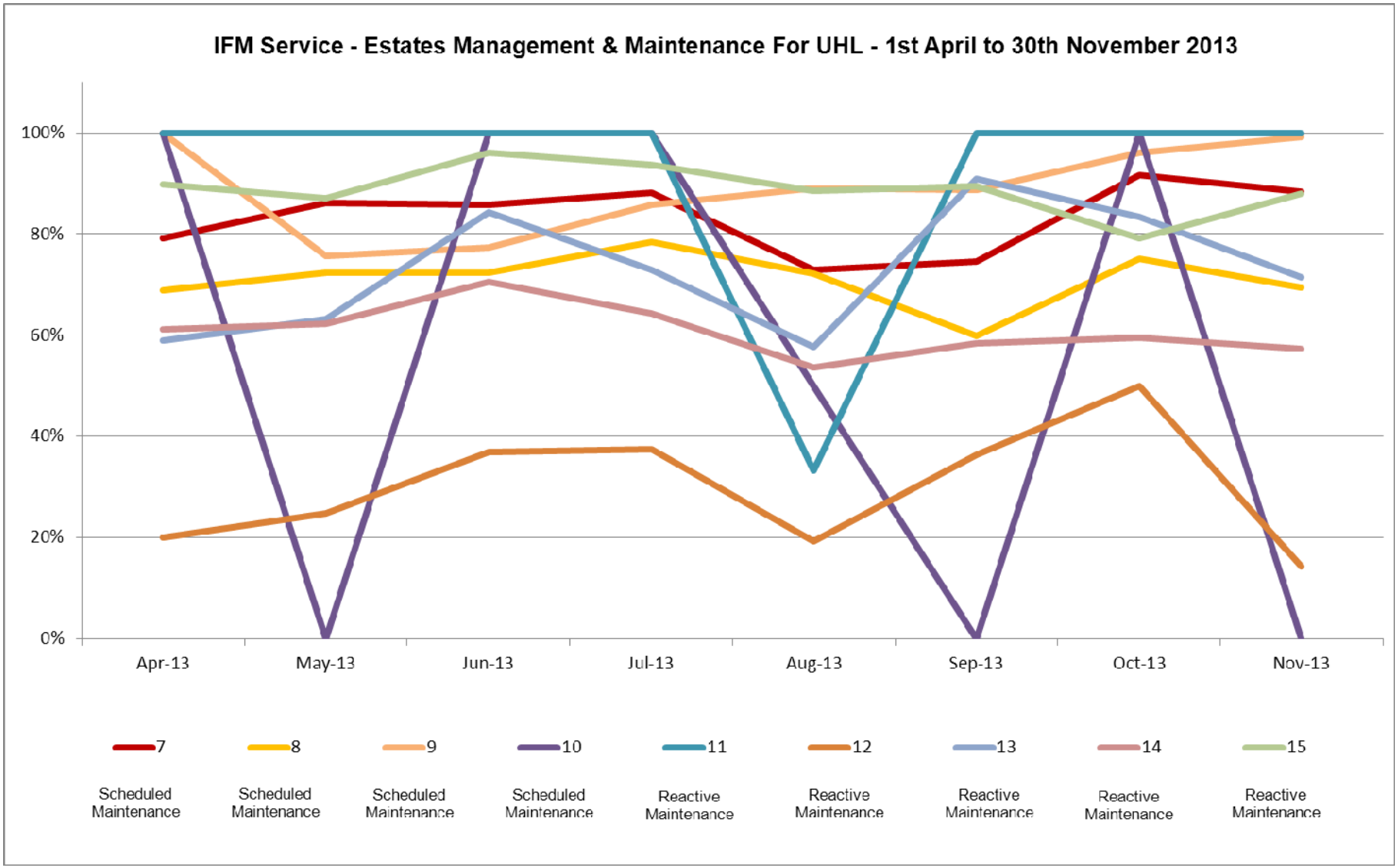
Contract Management Service

FM Service	KPI Reference	Description	Red	Amber	Green
Contract Management	1	Number of formal complaints not resolved to the satisfaction of the contracting authority within defined timescales within authority procedures	≥ 3	2	1
	2	Average score (%) of Customer Surveys returned in the Contract Month	≤ 80%	80% < X < 90%	≥ 90%
	3	Monthly Performance Report is accurate and received 10 business days after the end of the month Measurement note: A failure is recorded for each business day late per month	≥ 6	1 < X < 6	≤ 1
	4	Staff Induction - all new staff completed induction within 2 working days of commencing duties	≤ 95%	95% < X < 100%	100.00%
	5	Number of RIDDOR Injuries/accidents reported in the Contract Month that the cause is attributable to the Contractor.	> 3	1-3	0
	6	Number of actions not implemented within the agreed timescale with relation to non-RIDDOR Incidents reported in the Contract Month	> 3	1-3	0


IFM Service - Contract Management - For UHL - 1st April to 30th November 2013
100%
80%
60%
40%
20%
0%
Apr-13
May-13
Jun-13
Jul-13
Aug-13
Sep-13
Oct-13
Nov-13
2
Customer Satisfaction
4
Human Resources

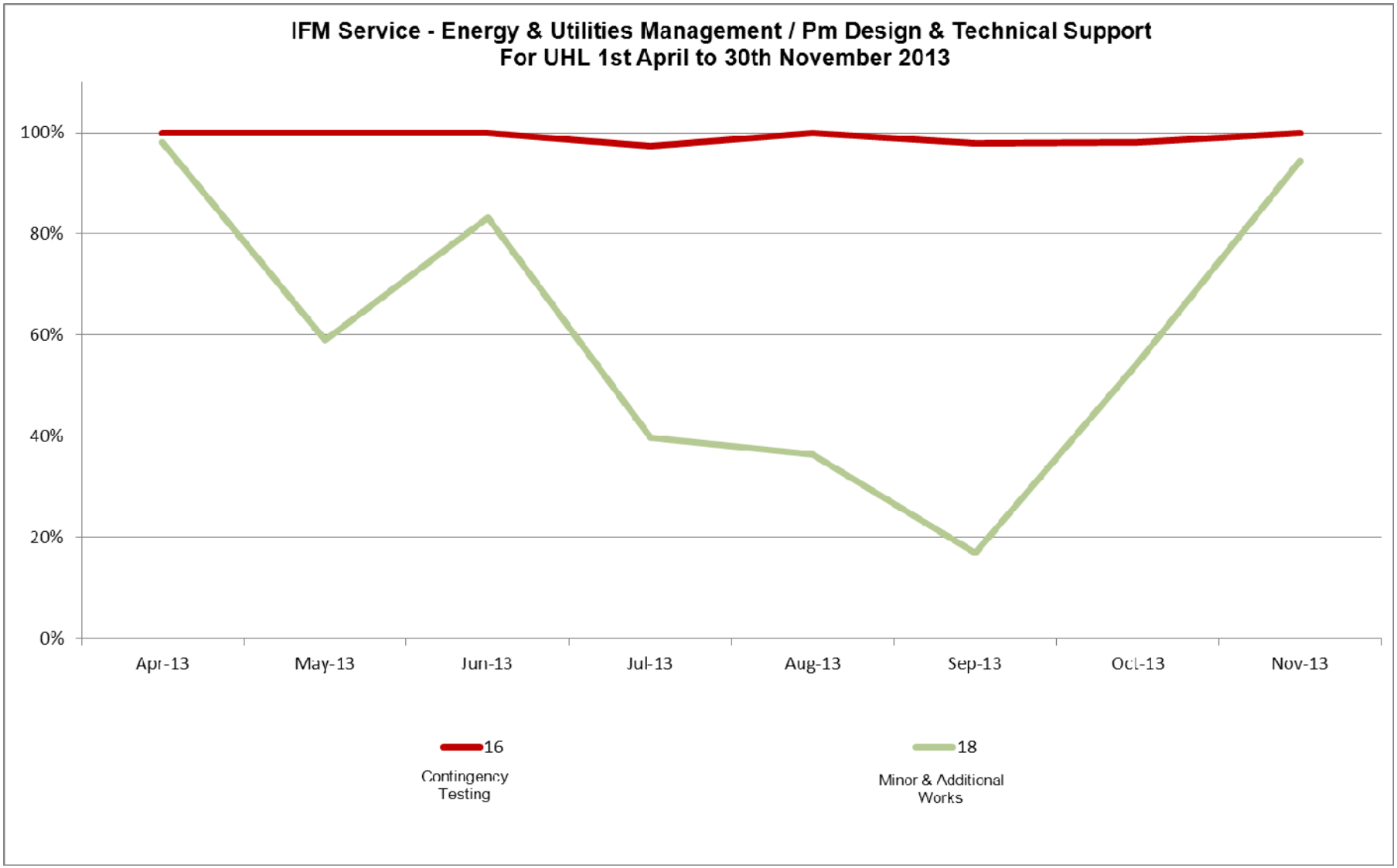
Estates Management & Maintenance Service

FM Service	KPI Reference	Description	Red	Amber	Green
Estates Management and Maintenance	7	Percentage of statutory inspection and testing completed in the Contract Month measured against the PPM schedule	≤ 98%	98% < X < 100%	100.0%
	8	Percentage of non-statutory PPM completed in the Contract Month measured against the PPM schedule	≤ 98%	98% < X < 100%	100.0%
	9	Percentage of plant and equipment receiving revalidation and calibration with the defined timescales	≤ 98%	98% < X < 100%	100.0%
	10	Percentage of Emergency requests achieving response time	≤ 98%	98% < X < 100%	100.0%
	11	Percentage of Emergency requests achieving rectification time	≤ 98%	98% < X < 100%	100.0%
	12	Percentage of Urgent requests achieving response time	≤ 96%	96% < X < 98%	≥ 98%
	13	Percentage of Urgent requests achieving rectification time	≤ 96%	96% < X ≤ 98%	≥ 98%
	14	Percentage of Routine requests achieving response time	≤ 92%	92% < X < 95%	≥ 95%
	15	Percentage of Routine requests achieving rectification time	≤ 92%	92% < X < 95%	≥ 95%


IFM Service - Estates Management & Maintenance For UHL - 1st April to 30th November 2013
100%
80%
60%
40%
20%
0%
Apr-13
May-13
Jun-13
Jul-13
Aug-13
Sep-13
Oct-13
Nov-13
7
Scheduled Maintenance
8
Scheduled Maintenance
9
Scheduled Maintenance
10
Scheduled Maintenance
11
Reactive Maintenance
12
Reactive Maintenance
13
Reactive Maintenance
14
Reactive Maintenance
15
Reactive Maintenance

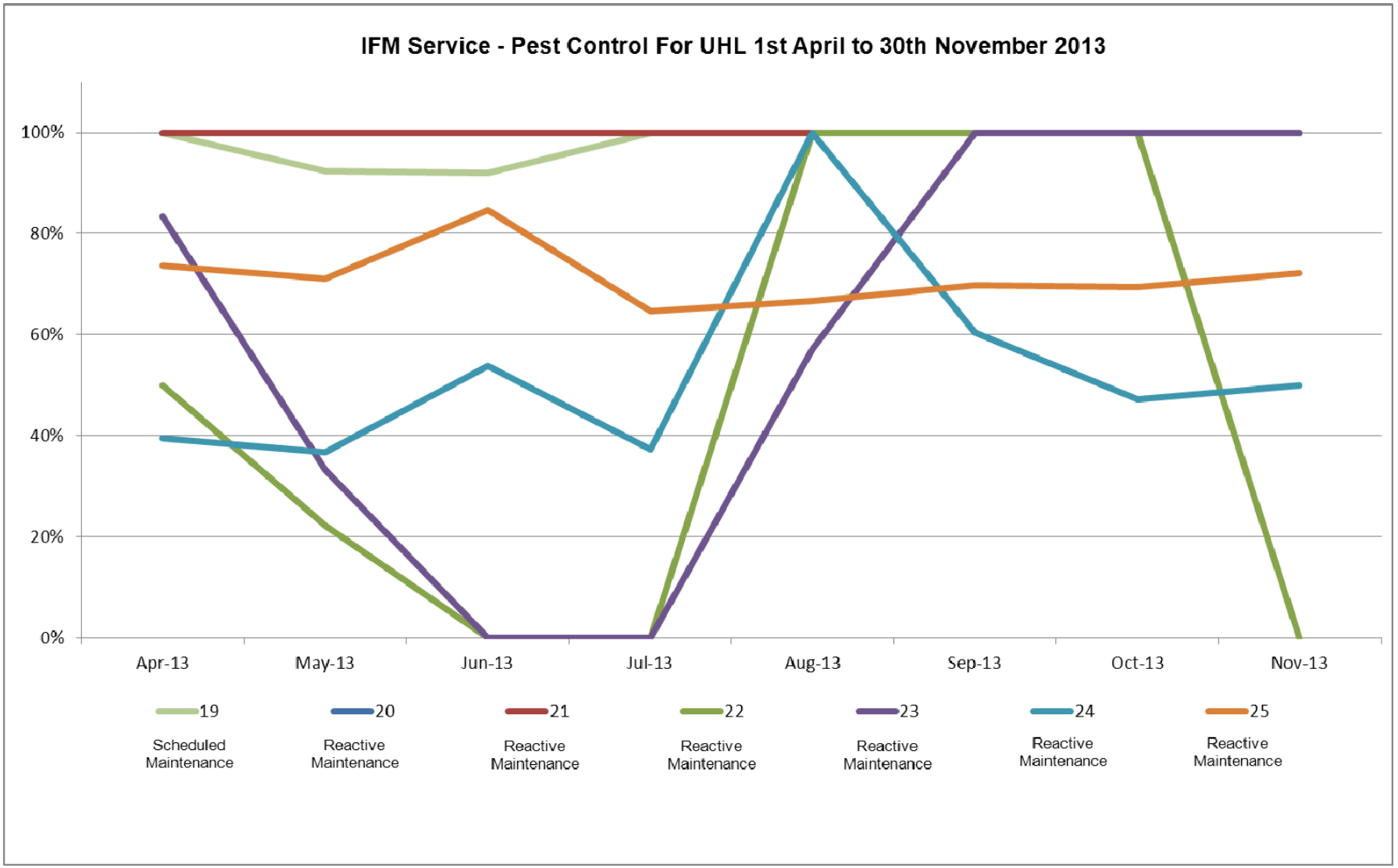
Energy & Utilities Management / PM Design & Technical Support Services

FM Service	KPI Reference	Description	Red	Amber	Green
Energy and Utillities Management	16	Percentage of successful tests completed in the Contract Month compared to those planned	≤ 98%	98% < X < 100%	100.0%
	17	Receipt of Monthly Utilities report (identifying consumption, cost and benchmark indicators to show performance against nationally and locally agreed standards) within 10 Business Days	≥ 6	1-5	0
PM, Design and Technical Support Service	18	Percentage of Minor Works and Additional Works Requests priced and returned in accordance with the agreed format, accuracy and timescale agreed by the Authority.	≤ 95%	95% < X <100%	100.0%


IFM Service - Energy & Utilities Management / Pm Design & Technical Support
For UHL 1st April to 30th November 2013
100%
80%
60%
40%
20%
0%
Apr-13
May-13
Jun-13
Jul-13
Aug-13
Sep-13
Oct-13
Nov-13
16
Contingency Testing
18
Minor & Additional Works

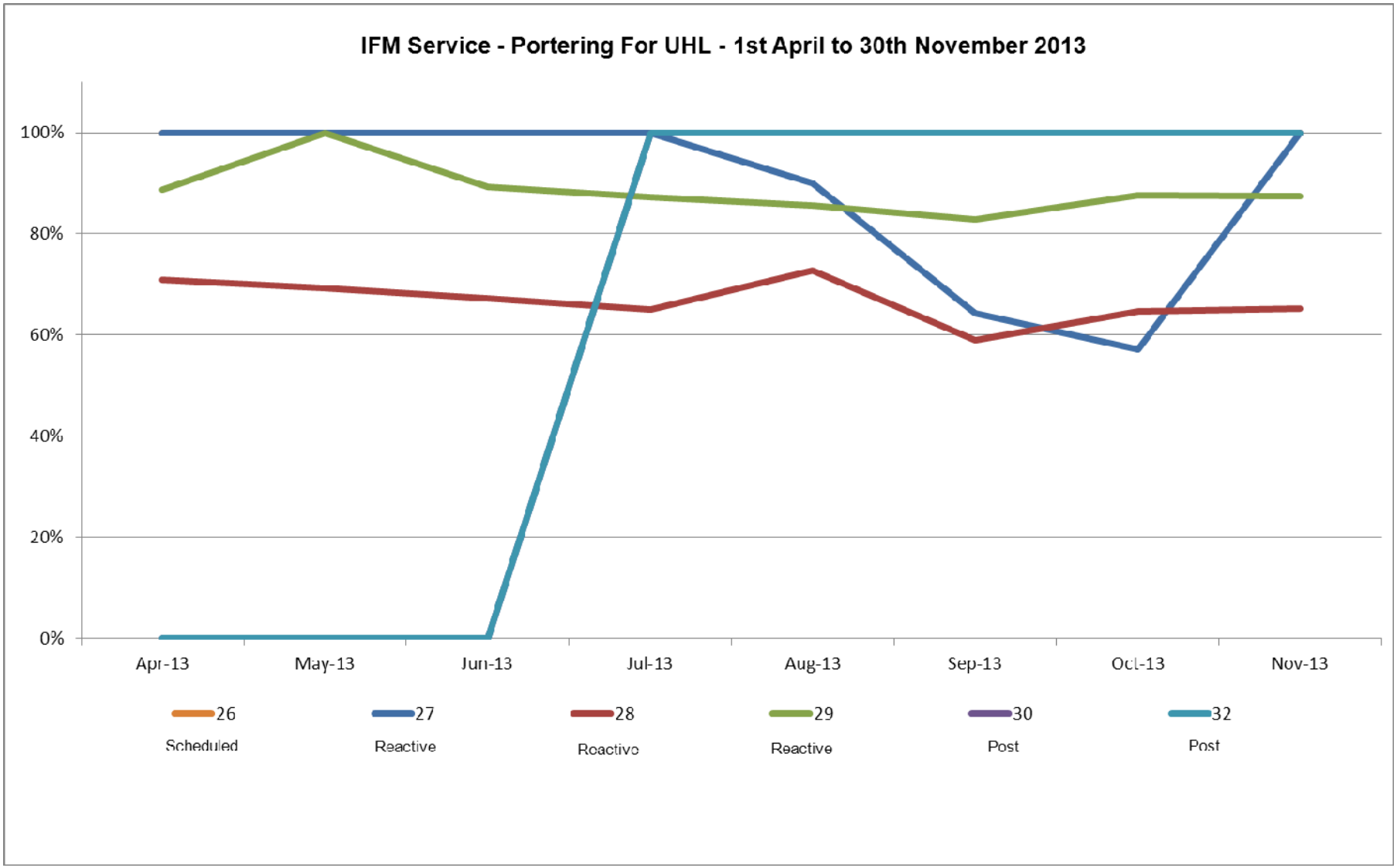
Pest Control Service

FM Service	KPI Reference	Description	Red	Amber	Green
Pest Control Service	19	Percentage of inspections and treatments completed in the Contract Month compared to PPM schedule	≤ 95%	95% < X < 100%	100.0%
	20	Percentage of Emergency requests achieving response time	≤ 98%	98% < X < 100%	100.0%
	21	Percentage of Emergency requests achieving rectification time	≤ 98%	98% < X < 100%	100.0%
	22	Percentage of Urgent requests achieving response time	≤ 95%	95% < X < 98%	≥ 98%
	23	Percentage of Urgent requests achieving rectification time	≤ 95%	95% < X < 98%	≥ 98%
	24	Percentage of Routine requests achieving response time	≤ 90%	90% < X < 95%	≥ 95%
	25	Percentage of Routine requests achieving rectification time	≤ 90%	90% < X < 95%	≥ 95%


IFM Service - Pest Control For UHL 1st April to 30th November 2013
100%
80%
60%
40%
20%
0%
Apr-13
May-13
Jun-13
Jul-13
Aug-13
Sep-13
Oct-13
Nov-13
19
Scheduled Maintenance
20
Reactive Maintenance
21
Reactive Maintenance
22
Reactive Maintenance
23
Reactive Maintenance
24
Reactive Maintenance
25
Reactive Maintenance

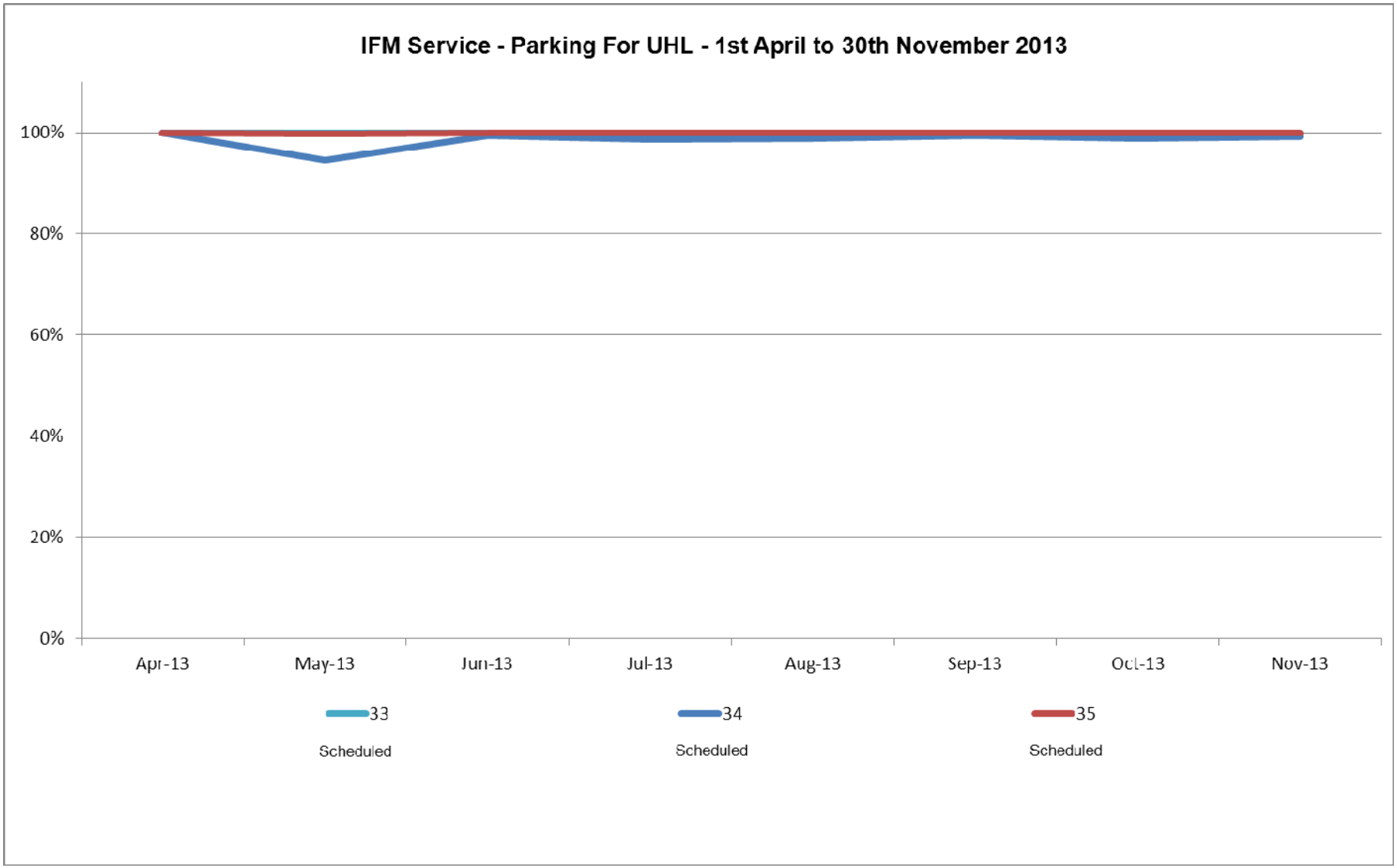
Portering Service

FM Service	KPI Reference	Description	Red	Amber	Green
Portering Service	26	Percentage of scheduled Portering tasks completed in the Contract Month	≤ 98%	98% < X < 99%	99%
	27	Percentage of Emergency Portering requests achieving response time	≤ 98%	98% < X < 100%	100.0%
	28	Percentage of Urgent Portering requests achieving response time	≤ 95%	95% < X < 98%	≥ 98%
	29	Percentage of Routine Portering requests achieving response time	≤ 90%	90% < X < 95%	≥ 95%
	30	Percentage of letters dispatched by post room based on standard measure of one mail sack	≤ 90%	90% < X < 95%	≥ 95%
	31	Number of complaints received regading late delivery of mail, recorded through CSC	≥3	>1 - <3	1
	32	Percentage of Special Delivery & Recorded Delivery items received, where the recipient is notified within 30 minutes of receipt of the item in Post room	≤ 90%	90% < X < 95%	≥ 95%


IFM Service - Portering For UHL - 1st April to 30th November 2013
100%
80%
60%
40%
20%
0%
Apr-13
May-13
Jun-13
Jul-13
Aug-13
Sep-13
Oct-13
Nov-13
26
Scheduled
27
Reactive
28
Reactive
29
Reactive
30
Post
32
Post

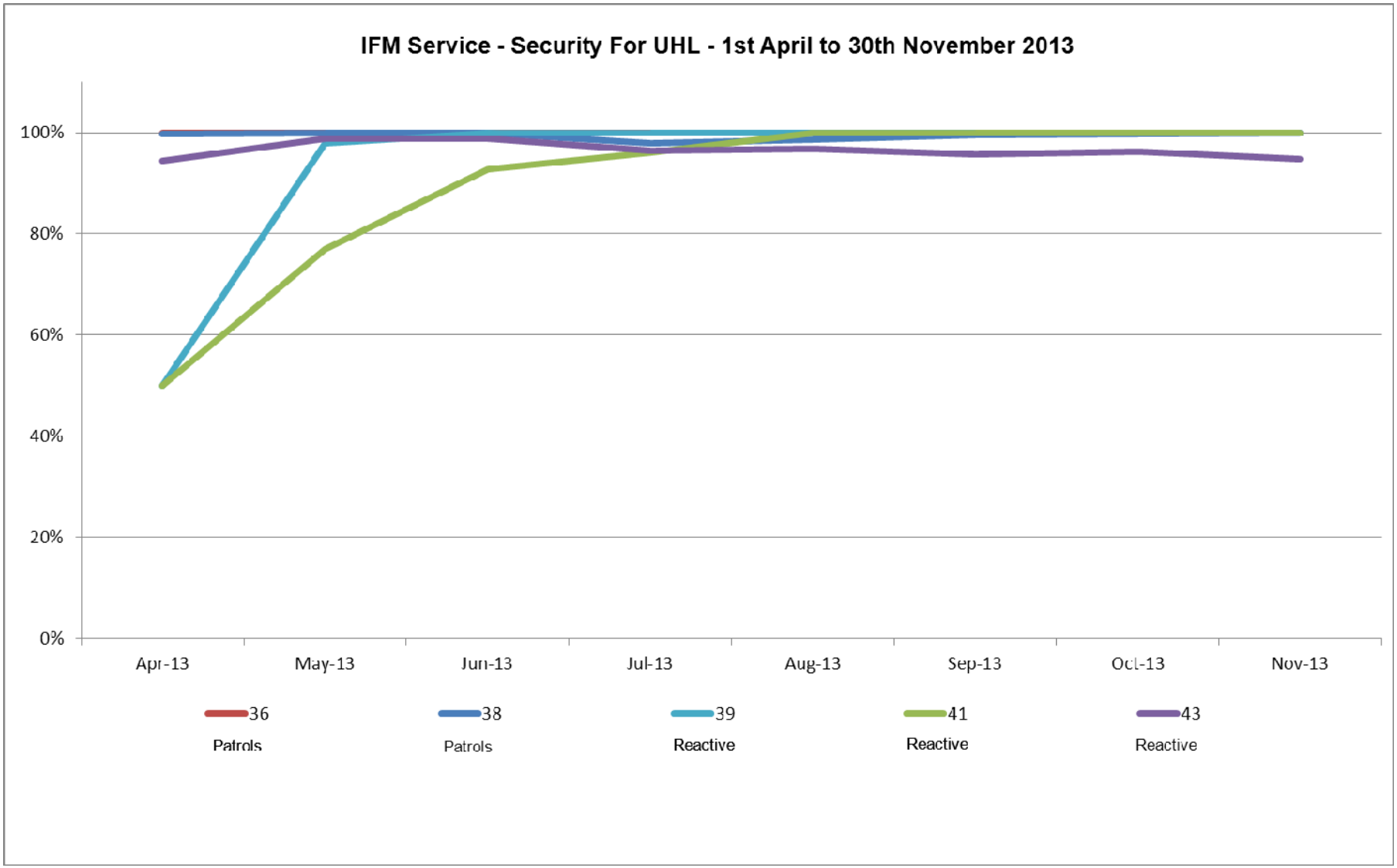
Parking Service

FM Service	KPI Reference	Description	Red	Amber	Green
Parking Service	33	Percentage of Trust authorised permits issued within 24 hours of request in accordance with Trust policy	≤ 98%	98% < X < 100%	100.0%
	34	Percentage of operational parking equipment available including spaces and payment machines compared to total number	≤ 95%	95% < X < 98%	≥ 98%
	35	Percentage of scheduled weekly patrols of car parks, completed as agreed with the Trust	≤ 95%	95% < X < 98%	≥ 98%


IFM Service - Parking For UHL - 1st April to 30th November 2013
100%
80%
60%
40%
20%
0%
Apr-13
May-13
Jun-13
Jul-13
Aug-13
Sep-13
Oct-13
Nov-13
33
Scheduled
34
Scheduled
35
Scheduled

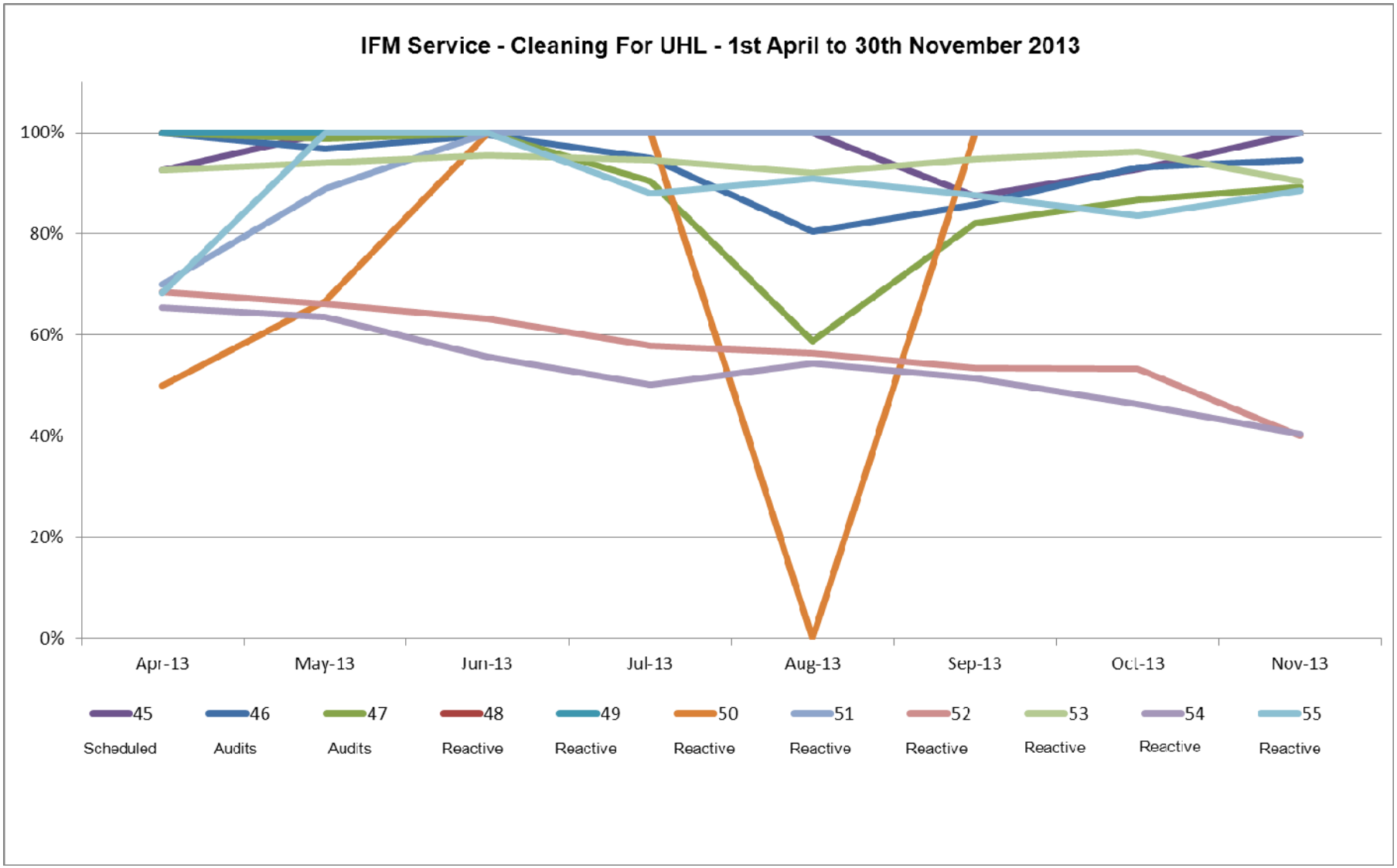
Security Service

FM Service	KPI Reference	Description	Red	Amber	Green
Security Service	36	Percentage of scheduled touch points activated by security patrols per calendar month	≤ 95%	95% < X < 98%	≥ 98%
	37	Number of action plans which result from security incidents, not delivered within the agreed timescale.	≥ 3	2	1
	38	Percentage of CCTV/Security equipment operational	≤ 95%	95% < X < 98%	≥ 98%
	39	Percentage of Emergency requests achieving response time	≤ 98%	98% < X < 100%	100.0%
	40	Number of Datex incidents received by the Trust where Emergency Security Events have not been resolved appropriately	>3	>0 - <3	0
	41	Percentage of Urgent requests achieving response time	≤ 95%	95% < X < 97%	≥ 97%
	42	Number of complaints received by the Trust where Urgent Security Events have not been resolved appropriately	≥3	>1 - <3	1
	43	Percentage of Routine requests achieving response time	≤ 95%	95% < X < 97%	≥ 97%
	44	Number of complaints received by the Trust where Routine Security Events have not been resolved appropriately	≥3	>1 - <3	1


IFM Service - Security For UHL - 1st April to 30th November 2013
100%
80%
60%
40%
20%
0%
Apr-13
May-13
Jun-13
Jul-13
Aug-13
Sep-13
Oct-13
Nov-13
36
Patrols
38
Patrols
39
Reactive
41
Reactive
43
Reactive

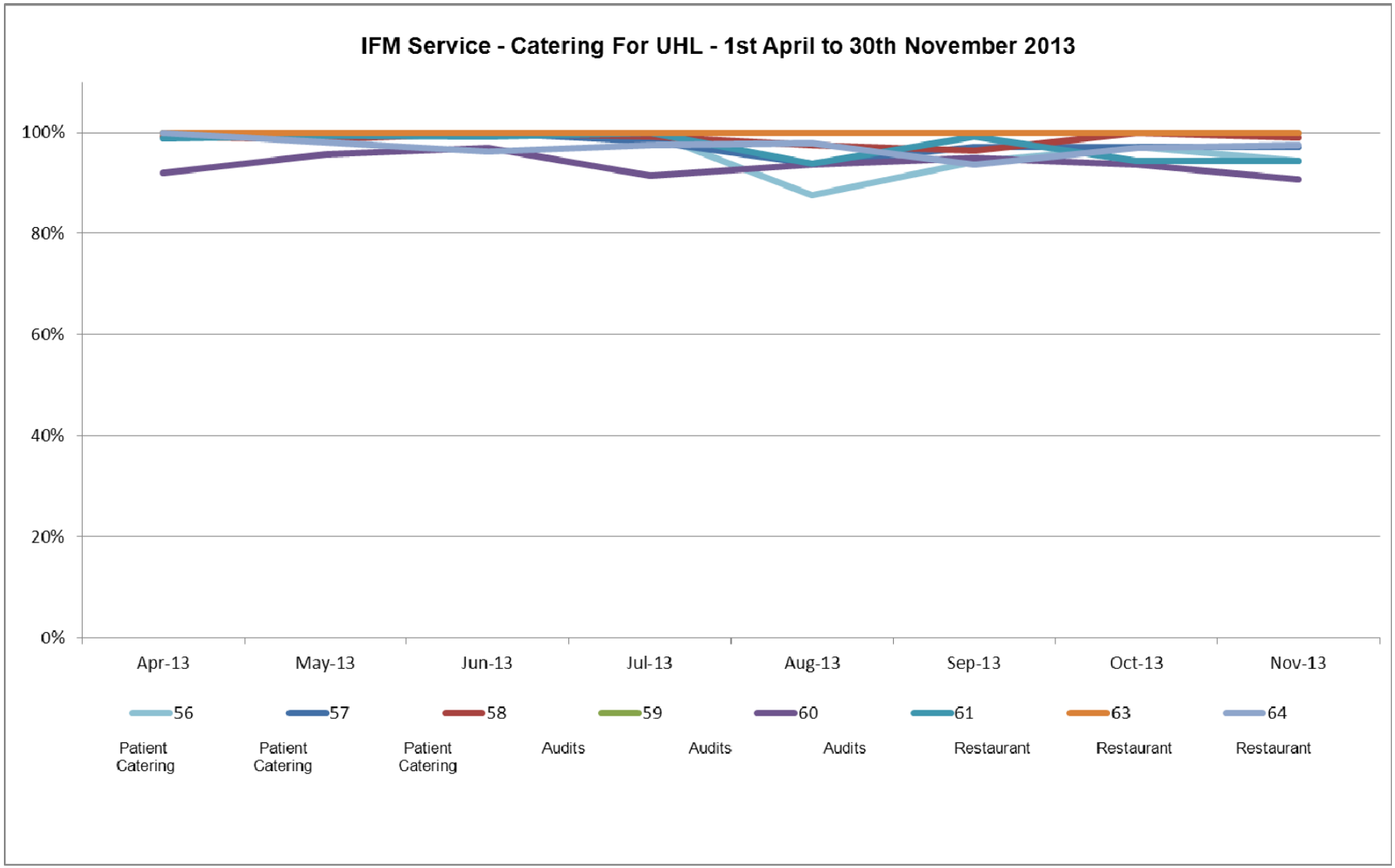
Cleaning Service

FM Service	KPI Reference	Description	Red	Amber	Green
Cleaning Service	45	Monthly percentage of Joint Audits undertaken against agreed schedules	≤ 98%	98% < X < 100%	100.0%
	46	Percentage of audits in clinical areas achieving NCS audit scores for cleaning above 90%	≤ 98%	98% < X < 100%	100.0%
	47	Percentage of audits in non clinical areas achieving NCS audit scores for cleaning above 90%	≤ 96%	96% < X < 98%	≥ 98%
	48	Percentage of Emergency requests achieving response time	≤ 98%	98% < X < 100%	100.0%
	49	Percentage of Emergency requests achieving rectification time	≤ 98%	98% < X < 100%	100.0%
	50	Percentage of Urgent requests achieving response time	≤ 95%	95% < X < 97%	≥ 97%
	51	Percentage of Urgent requests achieving rectification time	≤ 95%	95% < X < 97%	≥ 97%
	52	Percentage of Routine requests achieving response time	≤93%	93% < X < 95%	≥ 95%
	53	Percentage of Routine requests achieving rectification time	≤93%	93% < X < 95%	≥ 95%
	54	Percentage of Rapid Response requests achieving response time	≤ 90%	90% < X < 92%	≥ 92%
	55	Percentage of Rapid Response requests achieving rectification time	≤ 90%	90% < X < 92%	≥ 92%


IFM Service - Cleaning For UHL - 1st April to 30th November 2013
100%
80%
60%
40%
20%
0%
Apr-13
May-13
Jun-13
Jul-13
Aug-13
Sep-13
Oct-13
Nov-13
45 Scheduled
46 Audits
47 Audits
48 Reactive
49 Reactive
50 Reactive
51 Reactive
52 Reactive
53 Reactive
54 Reactive
55 Reactive

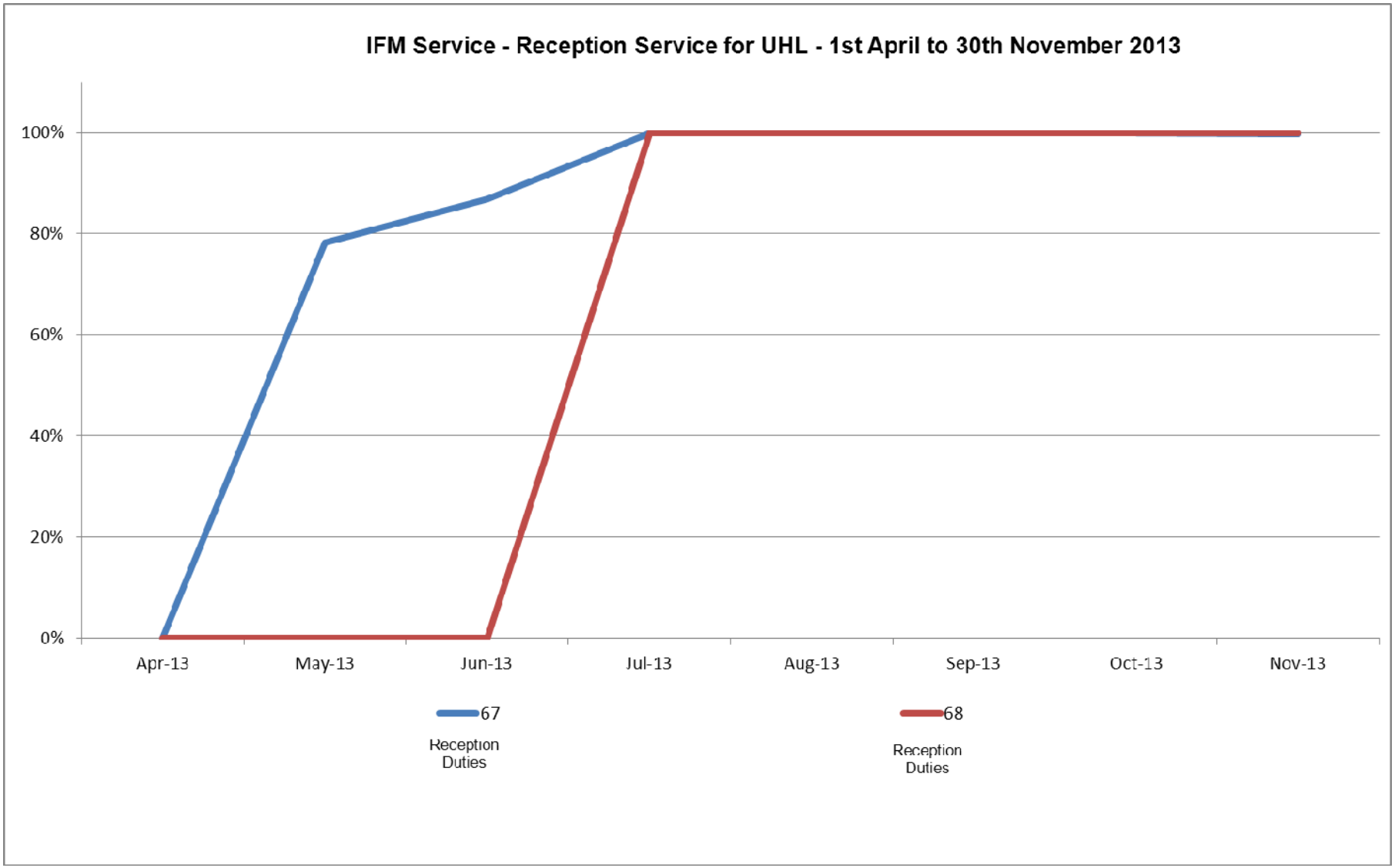
Catering Service

FM Service	KPI Reference	Description	Red	Amber	Green
Catering Service	56	Percentage of meals delivered to wards being served within 10 mins of arrival time as per agreed schedules	≤ 95%	95% < X < 97%	≥ 97%
	57	Percentage of meals delivered to wards in time for the designated meal service as per agreed schedules	≤ 95%	95% < X < 97%	≥ 97%
	58	Percentage of replacement meals snack boxes and lite bites provided within rectification time	≤ 90%	90% < X < 97%	≥ 97%
	59	Patient satisfaction surveys undertaken as per agreed monthly schedule.	≤ 92%	92% < X < 98%	≥ 98%
	60	Overall percentage score for monthly patients satisfaction survey for catering services.	≤ 75%	78% < X < 85%	≥ 85%
	61	Percentage of Meals provided as ordered received by patients.	≤ 90%	90% < X < 98%	≥ 98%
	62	% of Patient Catering Food Waste (excluding plate waste)	≥ 12%	12% > X > 10%	≤ 10%
	63	% of mystery shopper surveys completed against the agreed schedule.	≤ 97%	97% < X < 98%	≥ 98%
	64	Vending machines to be operational, and available for use, at all times when access to the building is available	≤ 97%	97% < X < 98%	≥ 98%
	65	Number of complaints regarding late delivery of hospitatlity in the month	≥3	>1 - <3	1
	66	Number of complaints regarding late collection of hospitality in the month	≥3	>1 - <3	1


IFM Service - Catering For UHL - 1st April to 30th November 2013
100%
80%
60%
40%
20%
0%
Apr-13
May-13
Jun-13
Jul-13
Aug-13
Sep-13
Oct-13
Nov-13
56
57
58
59
60
61
63
64
Patient Catering
Patient Catering
Patient Catering
Audits
Audits
Audits
Restaurant
Restaurant
Restaurant

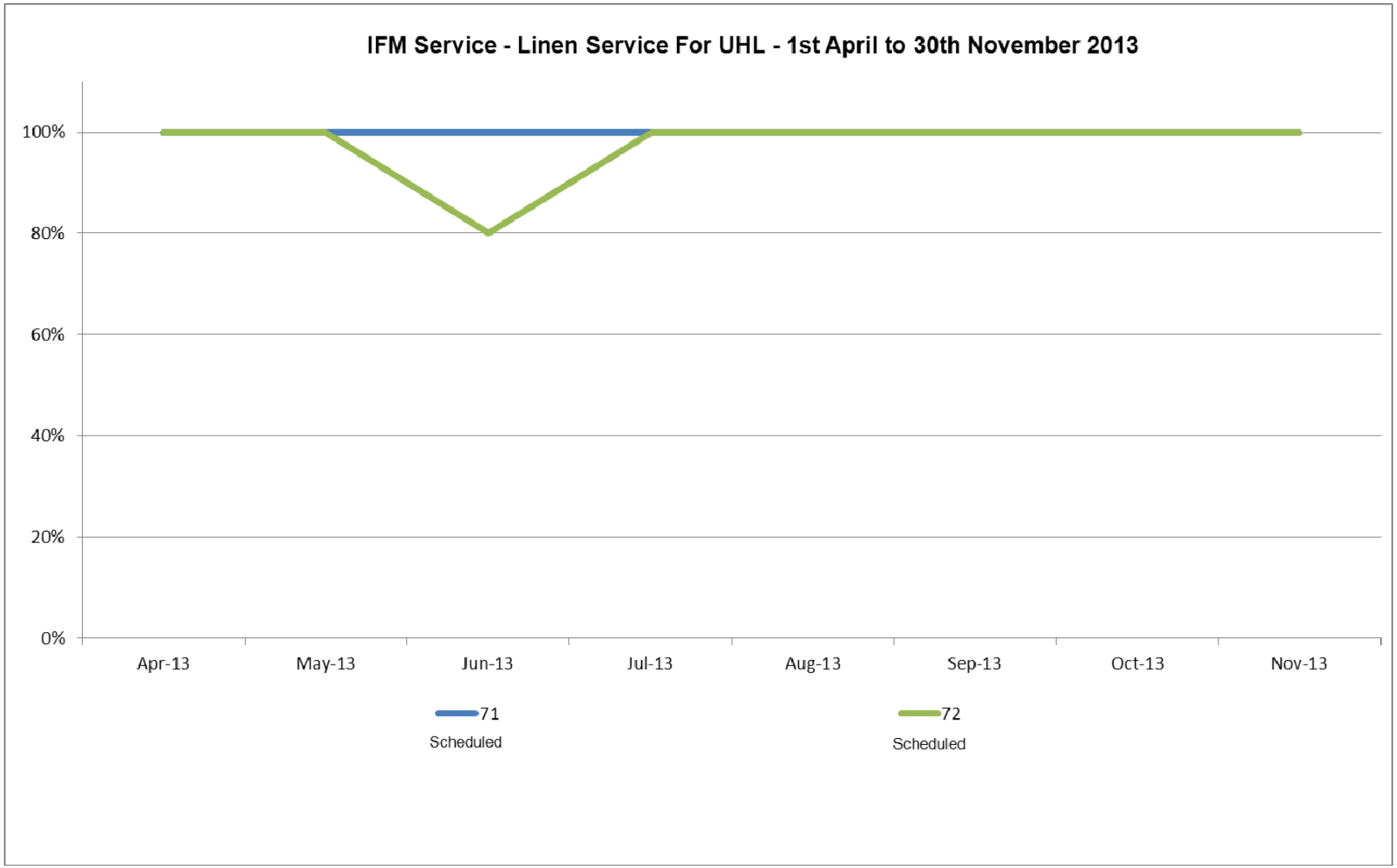
Reception Service

FM Service	KPI Reference	Description	Red	Amber	Green
Reception Service	67	Reception Staff in attendance in accordance with Rotas	≤ 95%	95% < X < 97%	≥ 97%
	68	%age of Mystery Shopper Reception surveys completed in the month against the schedule	≤ 93%	93% < X < 95%	≥ 95%


IFM Service - Reception Service for UHL - 1st April to 30th November 2013
100%
80%
60%
40%
20%
0%
Apr-13
May-13
Jun-13
Jul-13
Aug-13
Sep-13
Oct-13
Nov-13
67
Reception Duties
68
Reception Duties

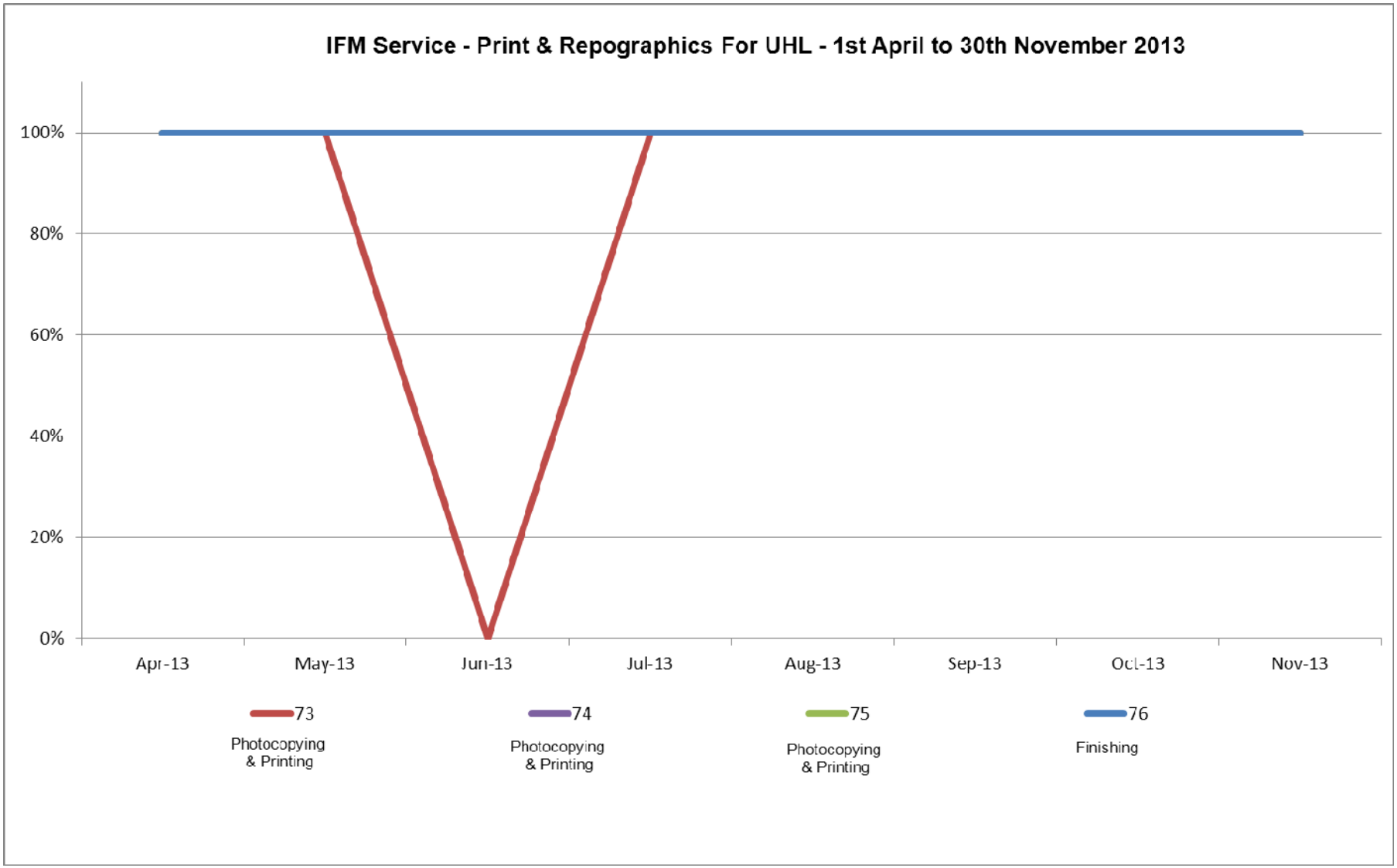
Linen Service

FM Service	KPI Reference	Description	Red	Amber	Green
Linen Service	70	Number of occurrences that stock levels of clean linen at wards and departments were below agreed levels	≥ 2.5%	2.5% > X > 1%	≤ 1%
	71	Linen delivery times achieved within agreed schedules.	≤ 96%	96% < X < 98%	≥ 98%
	72	Percentage of window and cubicle curtains replaced as per agreed schedule	≤ 96%	96% < X < 98%	≥ 98%


IFM Service - Linen Service For UHL - 1st April to 30th November 2013
100%
80%
60%
40%
20%
0%
Apr-13
May-13
Jun-13
Jul-13
Aug-13
Sep-13
Oct-13
Nov-13
71
Scheduled
72
Scheduled

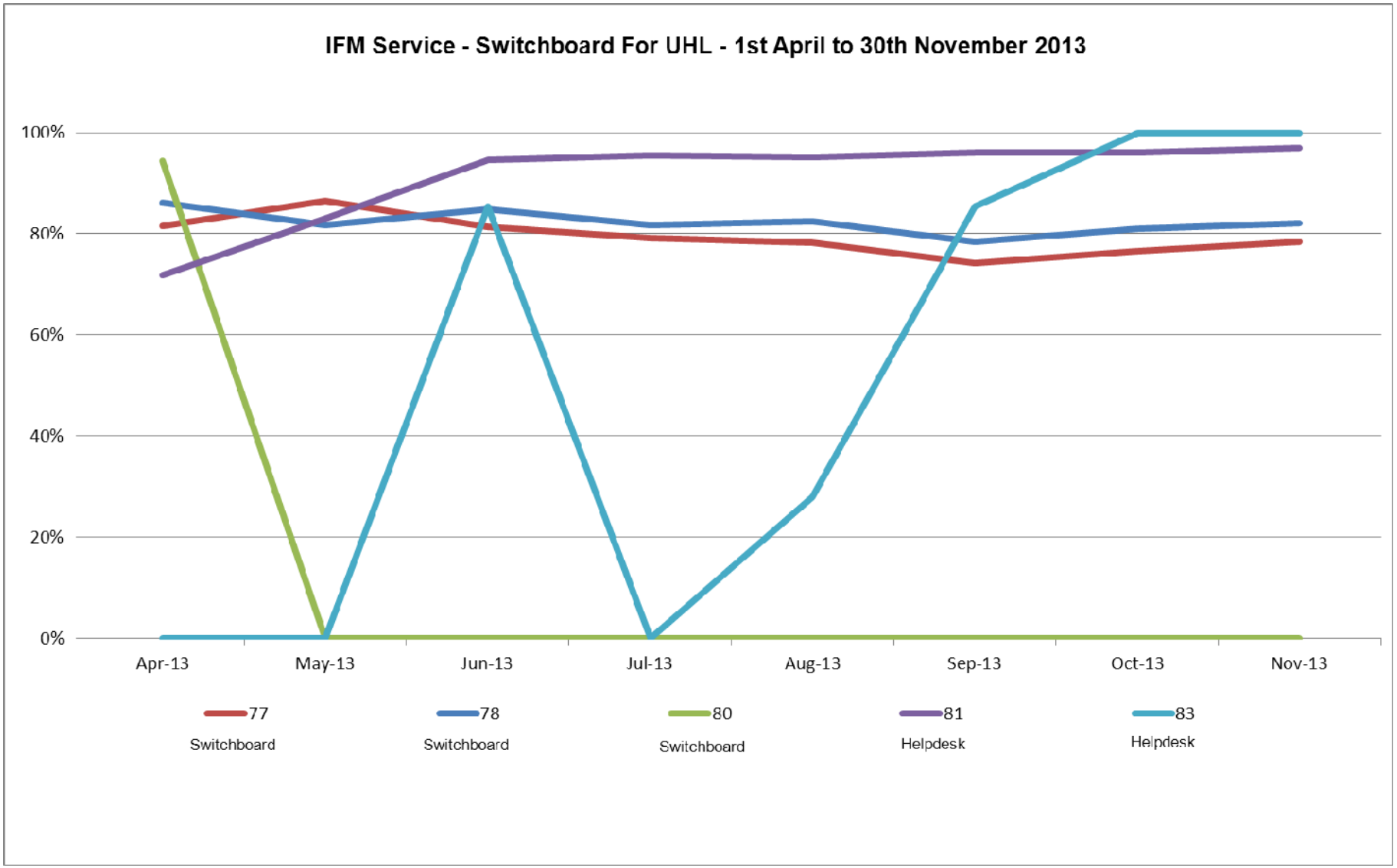
Print & Reprographics Service

FM Service	KPI Reference	Description	Red	Amber	Green
Print & Reprographics Service	73	Percentage of high volume photocopying requests completed within rectification times	≤ 96%	96% < X < 98%	≥ 98%
	74	Percentage of high volume printing requests completed within rectification times	≤ 96%	96% < X < 98%	≥ 98%
	75	Percentage of black & white and spot colour printing requests completed within rectification times	≤ 96%	96% < X < 98%	≥ 98%
	76	Percentage of photocopying and printing requests achieving required standard of finish per contract month	≤ 96%	96% < X < 98%	≥ 98%


IFM Service - Print & Repographics For UHL - 1st April to 30th November 2013
100%
80%
60%
40%
20%
0%
Apr-13
May-13
Jun-13
Jul-13
Aug-13
Sep-13
Oct-13
Nov-13
73
Photocopying & Printing
74
Photocopying & Printing
75
Photocopying & Printing
76
Finishing

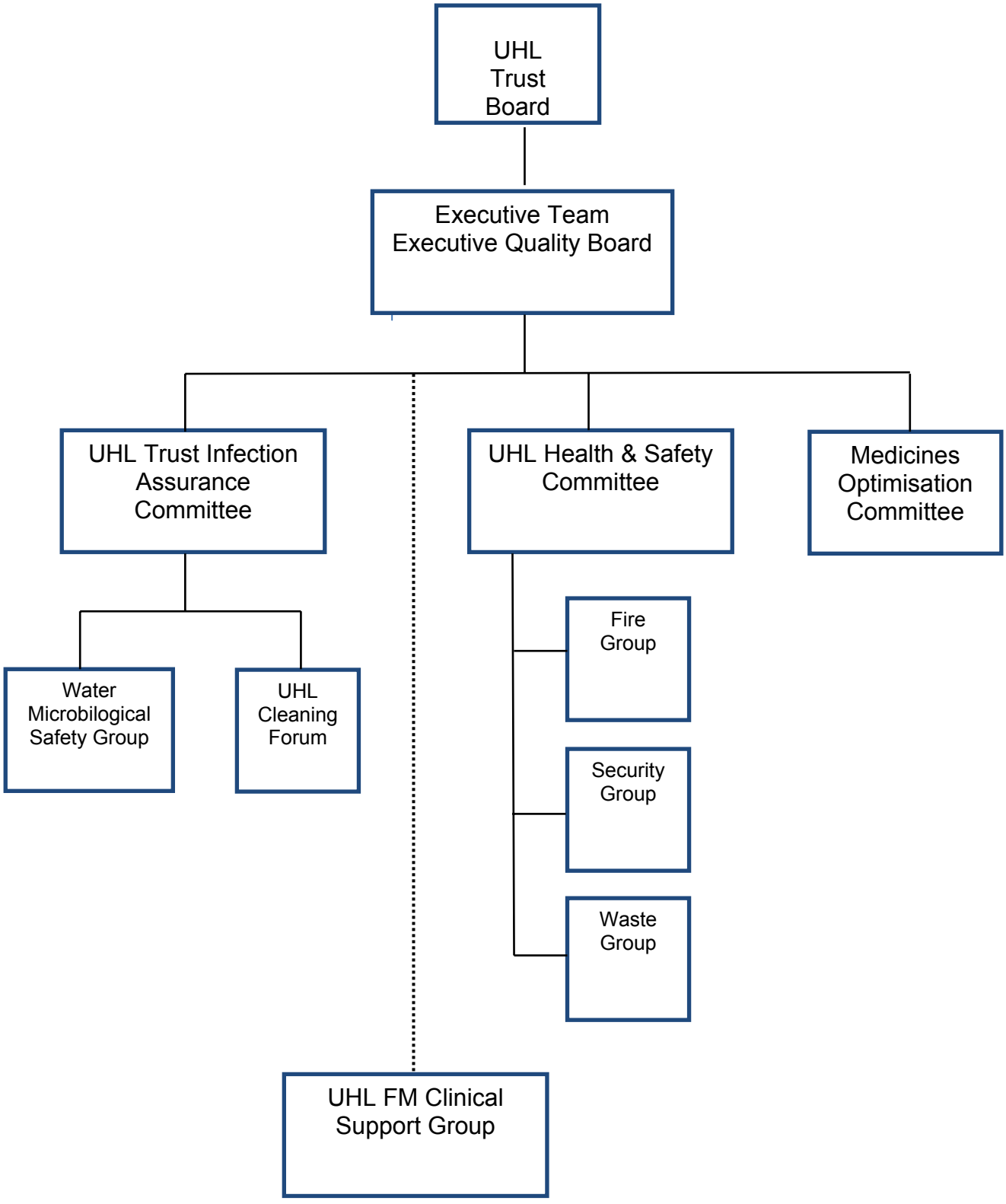
Switchboard & Helpdesk Service

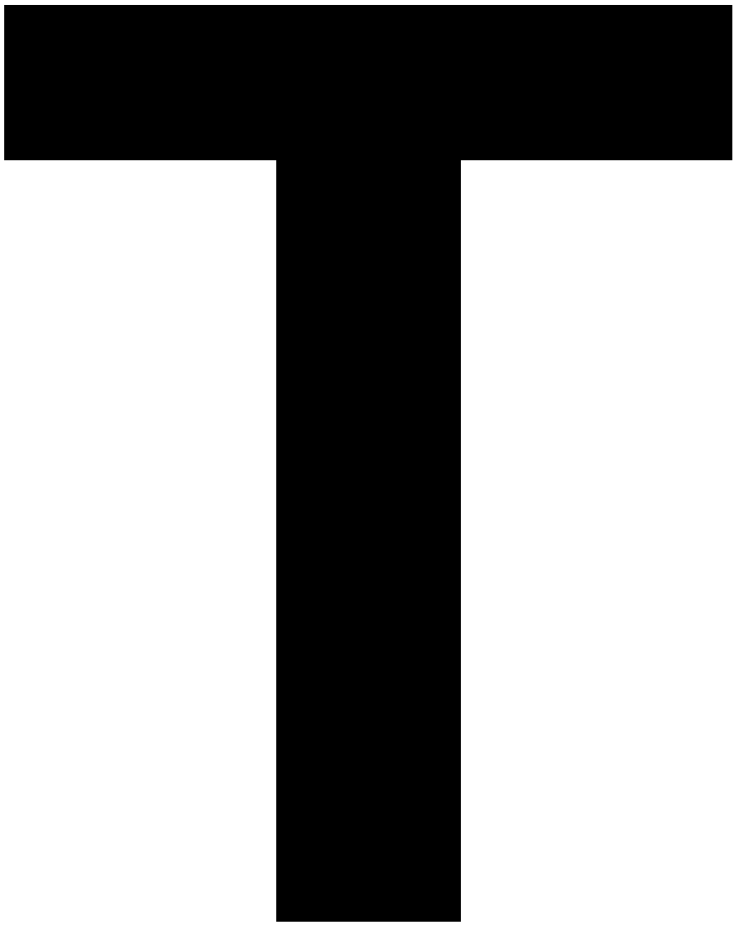
FM Service	KPI Reference	Description	Red	Amber	Green
Print & Reprographics Service	73	Percentage of high volume photocopying requests completed within rectification times	≤ 96%	96% < X < 98%	≥ 98%
	74	Percentage of high volume printing requests completed within rectification times	≤ 96%	96% < X < 98%	≥ 98%
	75	Percentage of black & white and spot colour printing requests completed within rectification times	≤ 96%	96% < X < 98%	≥ 98%
	76	Percentage of photocopying and printing requests achieving required standard of finish per contract month	≤ 96%	96% < X < 98%	≥ 98%


IFM Service - Switchboard For UHL - 1st April to 30th November 2013
100%
80%
60%
40%
20%
0%
Apr-13
May-13
Jun-13
Jul-13
Aug-13
Sep-13
Oct-13
Nov-13
77
Switchboard
78
Switchboard
80
Switchboard
81
Helpdesk
83
Helpdesk

Annex B

UHL TRUST GOVERNANCE STRUCTURE





University Hospitals of Leicester NHS
NHS Trust

Trust Board paper T

To:	Trust Board
From:	Stephen Ward, Director of Corporate & Legal Affairs
Date:	27th February 2014
CQC regulation:	N/A

Title:	NHS Trust oversight self certification

Author/Responsible Director: Helen Harrison, FT Programme Manager / Stephen Ward, Director of Corporate & Legal Affairs

Purpose of the Report:

At the beginning of April 2013, the NHS Trust Development Authority (NTDA) published a single set of systems, policies and processes governing all aspects of its interactions with NHS trusts in the form of '*Delivering High Quality Care for Patients: The Accountability Framework for NHS Trust Boards'.*

In accordance with the Accountability Framework, the Trust is required to complete two self certifications in relation to the Foundation Trust application process. Copies of the January 2014 self certifications are attached as Appendix A and B.

The Report is provided to the Board for:

Decision	X	Discussion	X
Assurance		Endorsement	

Summary / Key Points:

- Subject to discussion at the February 2014 Trust Board meeting on matters relating to operational and financial performance, it is proposed that the February 2014 self certifications against Monitor Licensing Requirements (Appendix A) and Trust Board Statements (Appendix B) be updated following the Trust Board meeting and submitted to the NHS Trust Development Authority accordingly

Recommendations:

The Trust Board is asked to provide the Director of Corporate and Legal Affairs with the delegated authority to agree a form of words with the Chief Executive in respect of the February 2014 self certifications to be updated following the Trust Board meeting and submitted to the NHS Trust Development Authority accordingly

Previously considered at another corporate UHL Committee? No

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

Resource Implications (eg Financial, HR): No

Assurance Implications: Yes

Patient and Public Involvement (PPI) Implications: No

Stakeholder Engagement Implications: No

Equality Impact: None

Information exempt from Disclosure: None

Requirement for further review? All future Trust oversight self certifications will be presented to the Trust Board for approval

NHS TRUST DEVELOPMENT AUTHORITY

OVERSIGHT: Monthly self-certification requirements - Compliance Monitor

Monthly Data.

CONTACT INFORMATION:

Enter Your Name: John Adler

Enter Your Email Address: john.adler@uhl-tr.nhs.uk

Full Telephone Number: 01162588940 Tel Extension: 8940

SELF-CERTIFICATION DETAILS:

Select Your Trust: University Hospitals Of Leicester NHS Trust

Submission Date: 31/01/2014 Reporting Year: 2013/14

Select the Month

- April
- May
- June
- July
- August
- September
- October
- November
- December
- January
- February
- March

COMPLIANCE WITH MONITOR LICENCE REQUIREMENTS FOR NHS TRUSTS:

1. **Condition G4** – Fit and proper persons as Governors and Directors (also applicable to those performing equivalent or similar functions).
2. **Condition G5** – Having regard to monitor Guidance.
3. **Condition G7** – Registration with the Care Quality Commission.
4. **Condition G8** – Patient eligibility and selection criteria.

5. **Condition P1** – Recording of information.
6. **Condition P2** – Provision of information.
7. **Condition P3** – Assurance report on submissions to Monitor.
8. **Condition P4** – Compliance with the National Tariff.
9. **Condition P5** – Constructive engagement concerning local tariff modifications.

10. **Condition C1** – The right of patients to make choices.
11. **Condition C2** – Competition oversight.

12. **Condition IC1** – Provision of integrated care.

Further guidance can be found in Monitor's response to the statutory consultation on the new NHS provider licence: The new NHS Provider Licence

COMPLIANCE WITH MONITOR LICENCE REQUIREMENTS FOR NHS TRUSTS:

		Comment where non-compliant or at risk of non-compliance
1. Condition G4 Fit and proper persons as Governors and Directors.	Yes	
Timescale for compliance:		
2. Condition G5 Having regard to monitor Guidance.	Yes	
Timescale for compliance:		
3. Condition G7 Registration with the Care Quality Commission.	Yes	
Timescale for compliance:		
		Comment where non-compliant or at risk of non-compliance
4. Condition G8 Patient eligibility and selection criteria.	Yes	
Timescale for compliance:		

		Comment where non-compliant or at risk of non-compliance
5. Condition P1 Recording of information.	Yes	
		Timescale for compliance:
6. Condition P2 Provision of information.	Yes	
		Timescale for compliance:
7. Condition P3 Assurance report on submissions to Monitor.	Yes	
		Timescale for compliance:
8. Condition P4 Compliance with the National Tariff.	Yes	
		Timescale for compliance:

		Comment where non-compliant or at risk of non-compliance
9. Condition P5 Constructive engagement concerning local tariff modifications.	Yes	
		Timescale for compliance:

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

10. Condition C1
The right of patients to make choices.

Yes

Timescale for compliance:

11. Condition C2
Competition oversight.

Yes

Timescale for compliance:

12. Condition IC1
Provision of integrated care.

Yes

Timescale for compliance:

Submit

NHS TRUST DEVELOPMENT AUTHORITY

OVERSIGHT: Monthly self-certification requirements - Board Statements

Monthly Data.

CONTACT INFORMATION:

Enter Your Name: John Adler

Enter Your Email Address: john.adler@uhl-tr.nhs.uk

Full Telephone Number: 01162588940 Tel Extension: 8940

SELF-CERTIFICATION DETAILS:

Select Your Trust: University Hospitals Of Leicester NHS Trust

Submission Date: 31/01/2014 Reporting Year: 2013/14

Select the Month

- April
- May
- June
- July
- August
- September
- October
- November
- December
- January
- February
- March

BOARD STATEMENTS:

CLINICAL QUALITY
FINANCE
GOVERNANCE

The NHS TDA's role is to ensure, on behalf of the Secretary of State, that aspirant FTs are ready to proceed for assessment by Monitor. As such, the processes outlined here replace those previously undertaken by both SHAs and the Department of Health.

In line with the recommendations of the Mid Staffordshire Public Inquiry, the achievement of FT status will only be possible for NHS Trusts that are delivering the key fundamentals of clinical quality, good patient experience, and national and local standards and targets, within the available financial envelope.

BOARD STATEMENTS:

For CLINICAL QUALITY, that

1. The Board is satisfied that, to the best of its knowledge and using its own processes and having had regard to the TDA's oversight model (supported by Care Quality Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.

1. CLINICAL QUALITY Indicate compliance.	Yes
Timescale for compliance:	
RESPONSE:	
Comment where non-compliant or at risk of non-compliance	

BOARD STATEMENTS:

For CLINICAL QUALITY, that

2. The board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality Commission's registration requirements.

2. CLINICAL QUALITY
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

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

BOARD STATEMENTS:

For CLINICAL QUALITY, that

3. The board is satisfied that processes and procedures are in place to ensure all medical practitioners providing care on behalf of the trust have met the relevant registration and revalidation requirements.

3. CLINICAL QUALITY
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

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

BOARD STATEMENTS:

For FINANCE, that

4. The board is satisfied that the trust shall at all times remain a going concern, as defined by the most up to date accounting standards in force from time to time.

4. FINANCE
Indicate compliance.

Risk

Timescale for compliance:

28/02/2013

RESPONSE:

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

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

BOARD STATEMENTS:

For GOVERNANCE, that

5. The board will ensure that the trust remains at all times compliant with the NTDA accountability framework and shows regard to the NHS Constitution at all times.

5. GOVERNANCE
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

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

BOARD STATEMENTS:

For GOVERNANCE, that

6. All current key risks to compliance with the NTDA's Accountability Framework have been identified (raised either internally or by external audit and assessment bodies) and addressed – or there are appropriate action plans in place to address the issues in a timely manner.

6. GOVERNANCE
Indicate compliance.

Risk

Timescale for compliance:

28/02/2013

RESPONSE:

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

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

BOARD STATEMENTS:

For GOVERNANCE, that

7. The board has considered all likely future risks to compliance with the NTDA Accountability Framework and has reviewed appropriate evidence regarding the level of severity, likelihood of a breach occurring and the plans for mitigation of these risks to ensure continued compliance.

7. GOVERNANCE
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

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

BOARD STATEMENTS:

For GOVERNANCE, that

8. The necessary planning, performance management and corporate and clinical risk management processes and mitigation plans are in place to deliver the annual operating plan, including that all audit committee recommendations accepted by the board are implemented satisfactorily.

8. GOVERNANCE
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

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

BOARD STATEMENTS:

For GOVERNANCE, that

9. An Annual Governance Statement is in place, and the trust is compliant with the risk management and assurance framework requirements that support the Statement pursuant to the most up to date guidance from HM Treasury (www.hm-treasury.gov.uk).

9. GOVERNANCE
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

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

BOARD STATEMENTS:

For GOVERNANCE, that

10. The Board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets as set out in the NTDA oversight model; and a commitment to comply with all known targets going forward.

10. GOVERNANCE
Indicate compliance.

No

Timescale for compliance:

01/04/2014

RESPONSE:

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

UHL is currently non compliant with the ED 4 hour wait target and the Referral to Treatment (RTT) - admitted and non-admitted targets. The Trust is working towards sustainable compliance with the ED target. An Emergency Care Improvement Hub has been established, which brings together partners from across health and social care. The formal agreement of a RTT plan by commissioners remains outstanding. An initial RTT action plan was submitted to commissioners on 14th August 2013 and revised plans were subsequently submitted on 11th September 2013 and 28th November 2013. A further recovery action plan is being finalised for submission to Commissioners by 31st January 2014.This plan includes the requirement for the following:
- Additional sessions in outpatients and electives in UHL
- The appointment of Locum and Substantive Consultant and Fellow posts
- Continued outsourcing to independent sector providers for ENT

BOARD STATEMENTS:

For GOVERNANCE, that

11. The trust has achieved a minimum of Level 2 performance against the requirements of the Information Governance Toolkit.

11. GOVERNANCE
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

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

BOARD STATEMENTS:

For GOVERNANCE, that

12. The board will ensure that the trust will at all times operate effectively. This includes maintaining its register of interests, ensuring that there are no material conflicts of interest in the board of directors; and that all board positions are filled, or plans are in place to fill any vacancies.

12. GOVERNANCE
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

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

BOARD STATEMENTS:

For GOVERNANCE, that

13. The board is satisfied that all executive and non-executive directors have the appropriate qualifications, experience and skills to discharge their functions effectively, including setting strategy, monitoring and managing performance and risks, and ensuring management capacity and capability.

13. GOVERNANCE
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

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

BOARD STATEMENTS:

For GOVERNANCE, that

14. The board is satisfied that: the management team has the capacity, capability and experience necessary to deliver the annual operating plan; and the management structure in place is adequate to deliver the annual operating plan.

14. GOVERNANCE
Indicate compliance.

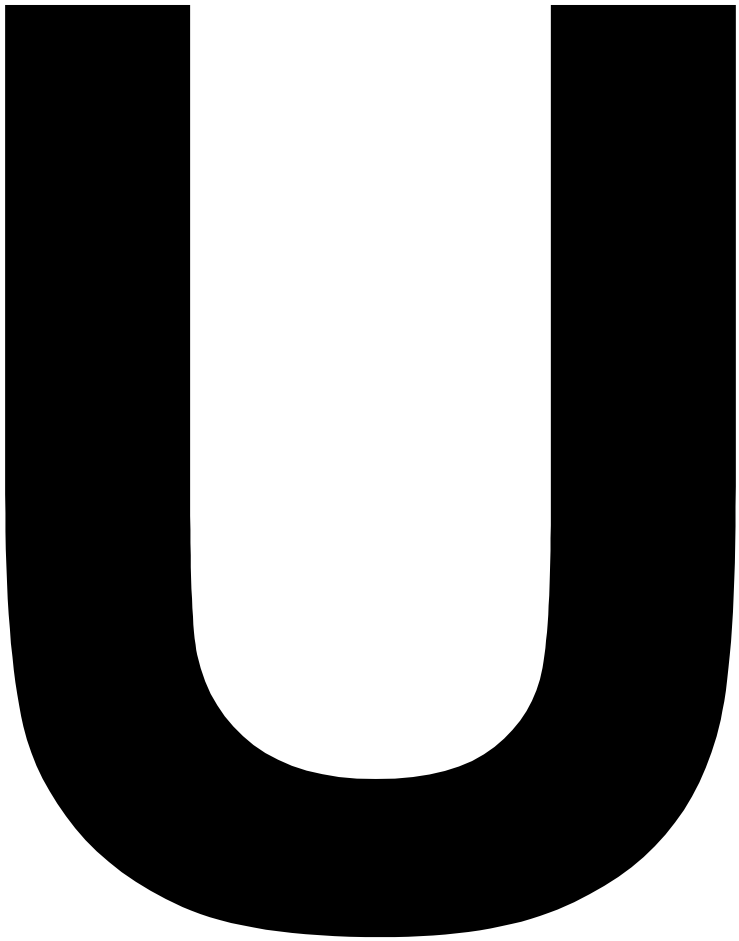
Yes

Timescale for compliance:

RESPONSE:

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

Submit



UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: Trust Board

REPORT FROM: Helen Seth, Head of Planning and Business Development

RE: Two Year Operational Plan (2014-2016)

DATE: 26 February 2014

---

1. PURPOSE

The purpose of this paper is to:

- Provide a brief overview of the national planning guidance for NHS Trusts *'Securing Sustainability: Planning Guidance for NHS Trust Boards 2014/15 to 2018/19'*
- Set out the planning timetable
- Summarise the key changes since the submission of our initial operational plan on 13 January 2014
- Highlight the external support that the Leicestershire health economy will benefit from in developing our 5 year plans
- Confirm next steps and timescales

2. NATIONAL PLANNING GUIDANCE

On 23 December 2013, the NTDA published guidance for NHS Trust Boards to help them plan the long term delivery of high quality services for patients. This planning guidance:

- Focuses on improving quality, patient safety, clinical and financial sustainability
- Covers the planning requirements for a two year operational plan and a five year strategy
- Is predicated on system wide transformation delivered in partnership

The guidance sets out the following planning timetable:

13th January 2014	Submit the **first draft initial operating plan** to the NTDA
5th March 2014	Submit the **first draft full** two year operating plan to the NTDA
4th April 2014	Submit the **final full** two year operating plan to the NTDA
20th June 2014	Submit the **final** five year Board-signed off and commissioner-aligned IBP & LTFM
30th September 2014	Submit development support plans to the NTDA

3. PROCESS AND PRODUCTS TO DATE

The planning process is iterative and will ultimately be underpinned by granular plans at service level. Active engagement of our CMGs and service teams in the Trust's planning process, the wider Leicester, Leicestershire and Rutland Health and Care Community including patients and the public will be critical to success. Key activities undertaken to inform the submission of first draft full plan are as follows:

- **13 January 2014**: First Initial Operating Plan submitted to the NTDA reflecting:

  a. High level revenue / capital and cash. Details of CIP programme, source and application of funds, exception reporting commentary

  b. 1 year Revenue Plan - (2014/15) plus 2013/14 FOT; Capital 5 years; Cash financing 5 years

  c. Workforce plan (1 year)

  d. Board statements (safe, effective, responsive, caring, well led, finance and QIPP) – 2 years

  e. Planning process – 2 and 5 years

4. KEY ACTIVITIES UNDERTAKEN TO INFORM THE SUBMISSION OF OUR FULL PLAN (FIRST DRAFT) ON 5 MARCH 2014 AND THE DEVELOPMENT OF THE LLR 5 YEAR STRATEGY

Following submission of our initial draft plan the Trust has been undertaking the following activities to inform the submission of our full plan (1st draft) which will reflect any changes required following contractual negotiation with our local CCGs or NHS England. Our first full plan will be submitted on 5 March 2014.

Key activities have included:

- **29 January 2014** – Stakeholder event launching the Leicester, Leicestershire and Rutland 5 year strategy programme

- **27 – 31 January 2014** – First round of financial planning meetings held by the Interim Director of Strategic Finance with the CMGs

- **30 January 2014:** High level overview of the Trust's initial draft operating plan presented at the January public Trust Board meeting

- **31 January 2014:** Feedback received from the NTDA on our initial plan with a request for further assurance on a number of key issues by 14 February 2014; The Trust's plan is rated by the NTDA as **'high risk'**

- **4 – 14 February:** Clinical teams support the LLR Clinical Workshops focusing on the high impact areas of: Respiratory, CVD, Cancer, Mental Health (substance misuse) and Dementia

- **13 February 2014:** Trust response to the key issues identified by the NTDA and the Trust strategic priorities presented at a Trust Board Development Session

- **14 February 2014:** UHL's response to the key issues identified submitted to the NTDA

- **7 – 26 February 2014:** CMG strategy workshops (covering 2 year plans and 5 year vision and strategy) including attendees from HR and finance

- **WB 24 February 2014:** 2nd round of Business (including finance) Planning meetings with CMGs and Corporate Directorates

- **26 February 2014:** UHL / NTDA assurance meeting

5. KEY CHANGES TO BE REFLECTED IN OUR FIRST DRAFT FULL PLAN

The output of the work outlined above will result in the following changes to the earlier submission:

4.1 FINANCE

The Financial Plan that will be submitted on the 5 March will reflect revenue, capital and cash, balance sheet and cash flow assumptions. Income will be reflected by commissioner by point of delivery. In addition an overview of our CIP programme will be reflected together with current assumptions of source and application of funds.

Key changes will include:

- **INCOME** - Feedback from the NTDA confirmed that the financial planning assumptions in our initial plan were prudent. Since that time we have received a contractual offer from our local CCGs (14 February) and are anticipating a contractual offer from NHS England (for nationally prescribed specialised services) by 21 February.

- As might be expected at this point there remains a significant difference in financial planning assumptions between the Trust and the CCGs however we are committed to working collaboratively to try and reach agreement. The Trust have formally responded to the offer received outlining:

    - those areas of broad agreement e.g. demographic growth and the plan for non-admitted and admitted elective activity
    - those areas where we agree with the direction of travel but need to understand further the scale and pace proposed and the effective management of transition e.g. QIPP
    - those areas of significant difference e.g. renegotiation of MRET

- Based on the outcome of further discussion the Trust will refine our previous income assumptions for our submission on 5 March. No numbers have been submitted in this paper as there still the subject to change.

- **NON-RECURRENT TRANSFORMATIONAL FUNDING –** A meeting will be held with commissioners on Monday 24 February to review options and proposals for the utilisation of the 2014/15 2.5% Non Recurrent Fund. The Trust has put forward options for consideration including funding transitional support and/or transformation schemes, for example mainstreaming the actions implemented during the recent 'super weekends' and actions to effectively manage demand during winter. The outcome of this process will help refine non-recurrent income assumptions made in the full plan submission. No income from this source was assumed in our initial plan submission.

- **EXPENDITURE** - The Interim Director of Strategic Finance has been undertaking financial/business planning meetings with each CMG. As a result an early estimate of the expenditure plans associated with activity levels assumed by the CMG and unavoidable cost pressures will be reflected in the plan submitted on 5 March. It will also reflect the current level of confidence in respect of Cost Improvement Programme (CIP) delivery.

- Formal Executive sign off of final CMG and Corporate directorate activity and workforce plans, CIPs and budgets is not scheduled to take place until the week commencing 21March 2014 and will not therefore be fully reflected in our submission on 5 March.

4.2 WORKFORCE

- The workforce impact of the activity assumptions put forward by the CMGs as part of the finance/business meetings will be reflected in the submission made on 5 March. It is important to note that at this time the activity plans will not reflect those of our commissioners particularly where commissioners have assumed a significant reduction due to QIPP as this is still subject to discussion and negotiation.

- In respect of workforce transformation and safe staffing, HR colleagues have been in attendance at the CMG planning workshops held throughout February 2014. They have emphasised the appropriate use of safe staffing tools across all disciplines (where available) and the need to capture future staffing models in order to inform education and training commissioning plans. The outputs from the workshops will be reflected in CMG operational plans and CIP schemes and as the level of detail evolves. Appropriate mechanisms will be put in place to prospectively evaluate staffing levels.

4.3 QUALITY

- A review of the Trust Quality Commitment is being undertaken in conjunction with the development of the Trust's Quality Account for 2014/15. A first draft

of the 2014/15 Quality Account will be presented to the Executive Quality Board on 5 March and will not therefore be reflected in the submission on 5 March.

- The draft report from the Care Quality Commission (CQC) inspection report is expected in early March 2014 and the post CQC inspection Quality Summit is scheduled to take place on 26 March 2014. Any implications for our operational plans will therefore be outlined in our final submission due to time constraints.

4.4 PERFORMANCE

- The Trust has agreed Referral to Treatment Time Plan for non-admitted and admitted activity which it believes will deliver the 95% and 90% performance target. The modelling that underpins this plan is predicated on specified activity assumptions and therefore requires action in both primary and secondary care to secure delivery.

5. EXTERNAL SUPPORT

Monitor, NHS England and the NTDA have agreed to fund a series of projects to help specific groups of commissioners and providers work together to develop integrated five-year plans that effectively address the particular local challenges they face. Eleven areas have been chosen on the basis that they will most benefit from external support. Potential suppliers are currently being invited to tender for this work. Successful suppliers will be appointed by the end of March and will begin a programme of work lasting around 10 weeks from April. Leicestershire is one of the selected economies who will be benefit from this support.

5. NEXT STEPS AND TIMESCALES

- **5 March 2014: first draft full** two year operating plan submitted to the NTDA
- **13 March 2014:** Present the **final full** two year plan at the March Trust Board Development Session
- **27 March 2014:** Trust Board approve the **final full** two year operating plan
- **4 April 2014:** Submit the **final full** two year operating plan to the NTDA

6. RECOMMENDATIONS

The Trust Board is asked to:

RECEIVE this report

ENDORSE the submission of the first draft full 2-year operational plan on 5 March which will reflect the principles outlined.

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: Trust Board

REPORT FROM: Helen Seth, Head of Planning and Business Development

RE: Two Year Operational Plan (2014-2016)

DATE: 26 February 2014

---

1. PURPOSE

The purpose of this paper is to:

- Provide a brief overview of the national planning guidance for NHS Trusts *'Securing Sustainability: Planning Guidance for NHS Trust Boards 2014/15 to 2018/19'*
- Set out the planning timetable
- Summarise the key changes since the submission of our initial operational plan on 13 January 2014
- Highlight the external support that the Leicestershire health economy will benefit from in developing our 5 year plans
- Confirm next steps and timescales

2. NATIONAL PLANNING GUIDANCE

On 23 December 2013, the NTDA published guidance for NHS Trust Boards to help them plan the long term delivery of high quality services for patients. This planning guidance:

- Focuses on improving quality, patient safety, clinical and financial sustainability
- Covers the planning requirements for a two year operational plan and a five year strategy
- Is predicated on system wide transformation delivered in partnership

The guidance sets out the following planning timetable:

13th January 2014	Submit the **first draft initial operating plan** to the NTDA
5th March 2014	Submit the **first draft full** two year operating plan to the NTDA
4th April 2014	Submit the **final full** two year operating plan to the NTDA
20th June 2014	Submit the **final** five year Board-signed off and commissioner-aligned IBP & LTFM
30th September 2014	Submit development support plans to the NTDA

3. PROCESS AND PRODUCTS TO DATE

The planning process is iterative and will ultimately be underpinned by granular plans at service level. Active engagement of our CMGs and service teams in the Trust's planning process, the wider Leicester, Leicestershire and Rutland Health and Care Community including patients and the public will be critical to success. Key activities undertaken to inform the submission of first draft full plan are as follows:

- **13 January 2014**: First Initial Operating Plan submitted to the NTDA reflecting:

  a. High level revenue / capital and cash. Details of CIP programme, source and application of funds, exception reporting commentary

  b. 1 year Revenue Plan - (2014/15) plus 2013/14 FOT; Capital 5 years; Cash financing 5 years

  c. Workforce plan (1 year)

  d. Board statements (safe, effective, responsive, caring, well led, finance and QIPP) – 2 years

  e. Planning process – 2 and 5 years

4. KEY ACTIVITIES UNDERTAKEN TO INFORM THE SUBMISSION OF OUR FULL PLAN (FIRST DRAFT) ON 5 MARCH 2014 AND THE DEVELOPMENT OF THE LLR 5 YEAR STRATEGY

Following submission of our initial draft plan the Trust has been undertaking the following activities to inform the submission of our full plan (1st draft) which will reflect any changes required following contractual negotiation with our local CCGs or NHS England. Our first full plan will be submitted on 5 March 2014.

Key activities have included:

- **29 January 2014** – Stakeholder event launching the Leicester, Leicestershire and Rutland 5 year strategy programme

- **27 – 31 January 2014** – First round of financial planning meetings held by the Interim Director of Strategic Finance with the CMGs

- **30 January 2014:** High level overview of the Trust's initial draft operating plan presented at the January public Trust Board meeting

- **31 January 2014:** Feedback received from the NTDA on our initial plan with a request for further assurance on a number of key issues by 14 February 2014; The Trust's plan is rated by the NTDA as **'high risk'**

- **4 – 14 February:** Clinical teams support the LLR Clinical Workshops focusing on the high impact areas of: Respiratory, CVD, Cancer, Mental Health (substance misuse) and Dementia

- **13 February 2014:** Trust response to the key issues identified by the NTDA and the Trust strategic priorities presented at a Trust Board Development Session

- **14 February 2014:** UHL's response to the key issues identified submitted to the NTDA

- **7 – 26 February 2014:** CMG strategy workshops (covering 2 year plans and 5 year vision and strategy) including attendees from HR and finance

- **WB 24 February 2014:** 2nd round of Business (including finance) Planning meetings with CMGs and Corporate Directorates

- **26 February 2014:** UHL / NTDA assurance meeting

5. KEY CHANGES TO BE REFLECTED IN OUR FIRST DRAFT FULL PLAN

The output of the work outlined above will result in the following changes to the earlier submission:

4.1 FINANCE

The Financial Plan that will be submitted on the 5 March will reflect revenue, capital and cash, balance sheet and cash flow assumptions. Income will be reflected by commissioner by point of delivery. In addition an overview of our CIP programme will be reflected together with current assumptions of source and application of funds.

Key changes will include:

- **INCOME** - Feedback from the NTDA confirmed that the financial planning assumptions in our initial plan were prudent. Since that time we have received a contractual offer from our local CCGs (14 February) and are anticipating a contractual offer from NHS England (for nationally prescribed specialised services) by 21 February.

- As might be expected at this point there remains a significant difference in financial planning assumptions between the Trust and the CCGs however we are committed to working collaboratively to try and reach agreement. The Trust have formally responded to the offer received outlining:

    - those areas of broad agreement e.g. demographic growth and the plan for non-admitted and admitted elective activity
    - those areas where we agree with the direction of travel but need to understand further the scale and pace proposed and the effective management of transition e.g. QIPP
    - those areas of significant difference e.g. renegotiation of MRET

- Based on the outcome of further discussion the Trust will refine our previous income assumptions for our submission on 5 March. No numbers have been submitted in this paper as there still the subject to change.

- **NON-RECURRENT TRANSFORMATIONAL FUNDING –** A meeting will be held with commissioners on Monday 24 February to review options and proposals for the utilisation of the 2014/15 2.5% Non Recurrent Fund. The Trust has put forward options for consideration including funding transitional support and/or transformation schemes, for example mainstreaming the actions implemented during the recent 'super weekends' and actions to effectively manage demand during winter. The outcome of this process will help refine non-recurrent income assumptions made in the full plan submission. No income from this source was assumed in our initial plan submission.

- **EXPENDITURE** - The Interim Director of Strategic Finance has been undertaking financial/business planning meetings with each CMG. As a result an early estimate of the expenditure plans associated with activity levels assumed by the CMG and unavoidable cost pressures will be reflected in the plan submitted on 5 March. It will also reflect the current level of confidence in respect of Cost Improvement Programme (CIP) delivery.

- Formal Executive sign off of final CMG and Corporate directorate activity and workforce plans, CIPs and budgets is not scheduled to take place until the week commencing 21March 2014 and will not therefore be fully reflected in our submission on 5 March.

4.2 WORKFORCE

- The workforce impact of the activity assumptions put forward by the CMGs as part of the finance/business meetings will be reflected in the submission made on 5 March. It is important to note that at this time the activity plans will not reflect those of our commissioners particularly where commissioners have assumed a significant reduction due to QIPP as this is still subject to discussion and negotiation.

- In respect of workforce transformation and safe staffing, HR colleagues have been in attendance at the CMG planning workshops held throughout February 2014. They have emphasised the appropriate use of safe staffing tools across all disciplines (where available) and the need to capture future staffing models in order to inform education and training commissioning plans. The outputs from the workshops will be reflected in CMG operational plans and CIP schemes and as the level of detail evolves. Appropriate mechanisms will be put in place to prospectively evaluate staffing levels.

4.3 QUALITY

- A review of the Trust Quality Commitment is being undertaken in conjunction with the development of the Trust's Quality Account for 2014/15. A first draft

of the 2014/15 Quality Account will be presented to the Executive Quality Board on 5 March and will not therefore be reflected in the submission on 5 March.

- The draft report from the Care Quality Commission (CQC) inspection report is expected in early March 2014 and the post CQC inspection Quality Summit is scheduled to take place on 26 March 2014. Any implications for our operational plans will therefore be outlined in our final submission due to time constraints.

4.4 PERFORMANCE

- The Trust has agreed Referral to Treatment Time Plan for non-admitted and admitted activity which it believes will deliver the 95% and 90% performance target. The modelling that underpins this plan is predicated on specified activity assumptions and therefore requires action in both primary and secondary care to secure delivery.

5. EXTERNAL SUPPORT

Monitor, NHS England and the NTDA have agreed to fund a series of projects to help specific groups of commissioners and providers work together to develop integrated five-year plans that effectively address the particular local challenges they face. Eleven areas have been chosen on the basis that they will most benefit from external support. Potential suppliers are currently being invited to tender for this work. Successful suppliers will be appointed by the end of March and will begin a programme of work lasting around 10 weeks from April. Leicestershire is one of the selected economies who will be benefit from this support.

5. NEXT STEPS AND TIMESCALES

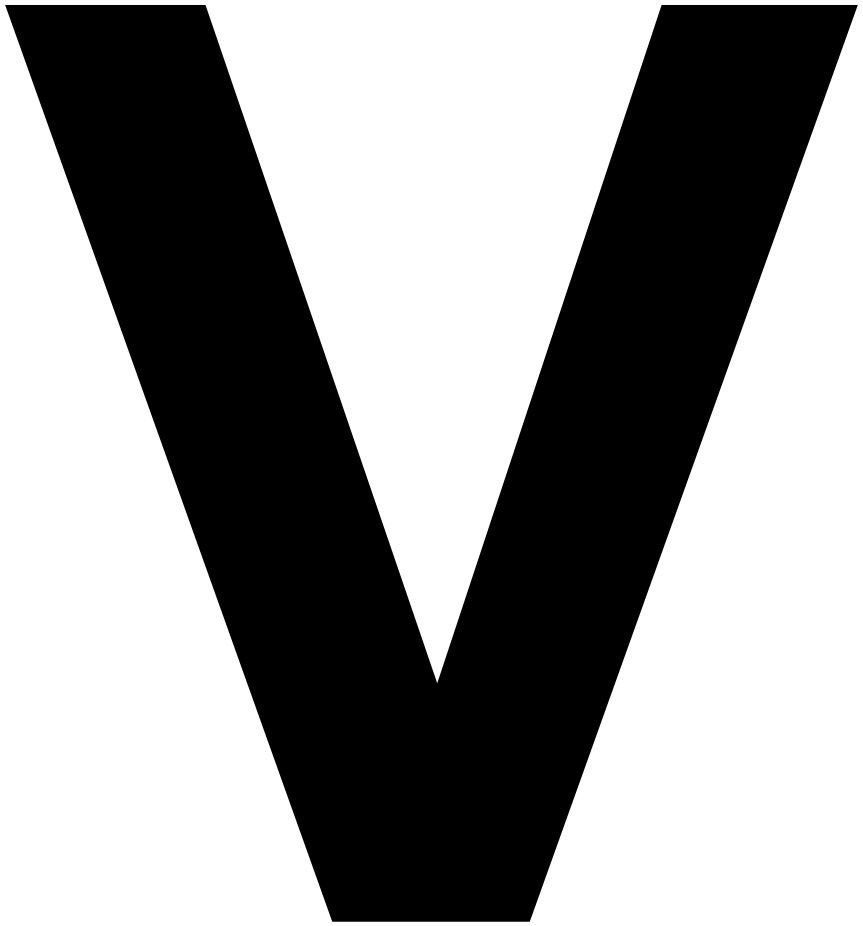
- **5 March 2014: first draft full** two year operating plan submitted to the NTDA
- **13 March 2014:** Present the **final full** two year plan at the March Trust Board Development Session
- **27 March 2014:** Trust Board approve the **final full** two year operating plan
- **4 April 2014:** Submit the **final full** two year operating plan to the NTDA

6. RECOMMENDATIONS

The Trust Board is asked to:

RECEIVE this report

ENDORSE the submission of the first draft full 2-year operational plan on 5 March which will reflect the principles outlined.



TRUST BOARD PAPER V

To:	Trust Board
From:	Chief Executive
Date:	27 February 2014
CQC regulation:	All

Title:	**FUTURE APPROACH TO IMPROVEMENT, TRANSFORMATION AND FINANCIAL RECOVERY**

Author/Responsible Director: Helen Seth/John Adler

Purpose of the Report:

- To outline some changes to the IIF to enable us to better support all of our improvement work across the Trust, including those activities focused on quality, safety, improving value for money, behaviour and culture.
- To propose a refocused approach aimed at increasing organisational capacity and capability so we can effectively identify quality and efficiency opportunities and deliver change in a timely fashion.
- To put forward a proposal for a whole-hospital continuous improvement programme that will bring together improvement plans for quality, productivity and financial sustainability within one overarching framework.

The Report is provided to the Board for:

Decision	X	Discussion	X
Assurance		Endorsement	

Summary / Key Points:

In June 2013 the Trust Board approved the development of the Improvement and Innovation Framework (IIF) supported through the adoption of appropriate improvement methodologies, on a scheme by scheme basis.

One of the programmes within the IIF is the cost improvement programme which has been successfully delivered for a number of years (98%+ 2013-14) however overall financial performance has slipped. Consecutive years of CIP delivery is inevitably reducing the opportunities for smaller scale savings and increasing the requirement for a bigger schemes thereby making delivery even more challenging.

The opportunity has been taken to review the operation of the current approach and to recommend a revised way forward, building on strengths and eliminating identified weaknesses.

Recommendations:

The Trust Board is asked to:

RECEIVE this report.

SUPPORT the re-branding of our improvement and innovation activities as “Being Better” and to note and comment on the proposed content and approach to the programme and its resourcing.	
Previously considered at another corporate UHL Committee? Executive Performance Board 25 February 2014	
Strategic Risk Register: Risk to effective transformation	**Performance KPIs year to date:**N/A
Resource Implications (eg Financial, HR): Internal and external	
Assurance Implications: Yes	
Patient and Public Involvement (PPI) Implications: By workstream	
Stakeholder Engagement Implications: Yes, especially whole system aspects	
Equality Impact: By workstream	
Information exempt from Disclosure: No	
Requirement for further review? Yes	

TRUST BOARD PAPER V

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: Trust Board

REPORT FROM: John Adler, Chief Executive

RE: **FUTURE APPROACH TO IMPROVEMENT, TRANSFORMATION AND FINANCIAL RECOVERY**

DATE: 27 February 2014

---

1. PURPOSE

The purpose of this paper is to:

- Outline changes to the Improvement and Innovation Framework to enable us to better support all of our improvement work across the Trust in the short and medium term, including those activities focused on quality, safety, improving value for money, behaviour and culture.

- Propose a refocused approach aimed at increasing organisational capacity and capability so we can effectively identify quality and efficiency opportunities and deliver change in a timely fashion.

- Put forward a proposal for a whole-hospital continuous improvement programme that will bring together improvement plans for quality, productivity and financial sustainability within one overarching framework.

2. HISTORICAL OVERVIEW

Across the Trust, there have been numerous different approaches to delivering improvement in quality and operational efficiency and effectiveness often generated incrementally to meet differing corporate, operational and external requirements.

In June 2013 the Trust Board approved the development of the Improvement and Innovation Framework (IIF). It became the operating model for UHL's organisational improvement (including cost improvement). It was agreed that "Improvement" would be linked back to the values of the Trust i.e. improving the way we do things in order to move towards our vision of delivering "Caring at its Best".

Projects and programmes were reviewed and clustered into themes to create seven pillars of improvement namely:

- Enabling Our People (Trust-wide improvements within Listening into Action)
- Quality
- Improving Patient Flow

- Delivering Best Value
- Better Care Together – Reconfiguration
- Better Care Together – Pathway re-design
- Workforce

The benefit of the framework was that it allowed all key improvement activities to be seen together, whilst not requiring them all to be managed within the same infrastructure or methodology.

Several improvement techniques/methodologies have been utilised to support specific projects/programmes that fall within the IIF:

Listening into Action (LiA) - LiA is an on-going approach rather than a programme or initiative which helps facilitate the cultural change that is needed in order to achieve a continuous quality improvement culture. Moving forward this will be a key enabler.

LEAN - LEAN is a service improvement technique based on process simplification and removing activities which have no added value (waste). It is a relevant technique for many, but not all, of the IIF programmes/projects.

Quality Improvement - The Trust's quality improvement capacity has increased following the return of Dr Jay Banerjee from a year-long Fellowship with the Institute for Healthcare Improvement in Boston, USA. To complement this, the Trust is currently exploring opportunities with local universities to work together with other key stakeholders across the health and social care community to explore how we can further enhance our capacity and capability in this area. The ambition would be to create an improvement and innovation centre which connects improvement experts, clinicians and researchers to drive the design and delivery of change programmes which improve health and healthcare. This is similar to models from centres of excellence in the USA and centres such as HAELO in Salford.

3. CASE FOR CHANGE - RATIONALE

UHL has successfully delivered cost improvement programmes (CIP) for a number of years. The CIP delivery for 2013-14 is forecast to be +98% of the agreed target. However the overall financial performance of UHL has declined due to a number of factors including our underlying deficit, increased unavoidable costs during the financial year and rising emergency demand. Consecutive years of CIP delivery inevitably reduces the opportunity for smaller scale savings and increases the need for larger scale solutions. This makes delivery of our 2014-2015 plans and our five-year plan even more challenging as we seek to return the Trust to surplus and ensure that we continue to provide safe, sustainable and responsive services which meet the needs of the local population.

To date the IIF cross cutting schemes have been supported by a small central team which is currently experiencing significant turnover. This together with the

context described above, has provided a timely opportunity to review whether the current structure and process are fit for purpose.

IIF Projects have been governed through a Project Management Office (PMO) structure. This has, however, lacked the rigour and grip necessary for a framework of this scale. Systems have been put in place to strengthen this, including an electronic project and programme software system but further development is required to make the PMO work more robustly.

Whilst the Trust has had the benefit of repeated external diagnostics we have often not followed through and performance managed delivery of the required change on time, to quality standards, primarily due to significant gaps in capacity and capability within our CMGs and corporate directorates and sufficient engagement to make the delivery of change happen. This is particularly evident where change is required across CMGs.

4. PROPOSED WAY FORWARD

STRUCTURE - The concept of a framework is sound. It is however essential that staff and stakeholders recognise that this is the vehicle by which we will coordinate operational and strategic activities to rise to the challenges we face and to ultimately deliver our vision of "Caring at its Best". To achieve this, our whole hospital, continuous quality and cost improvement activities, need to fundamentally redesign current ways of working, eliminate waste, reduce unwarranted variation, and improve quality. To keep up with the changing landscape, the framework needs to be dynamic but to have a clear branding.

It is now proposed that the "IIF" nomenclature is replaced by a more "user-friendly" branding – **"Being Better"**. It is felt that this branding will capture well the improvements that we are trying to secure on our journey towards "Caring at its Best". It is proposed that the core programmes within Being Better and the key enabling workstreams should be as shown in the table below:

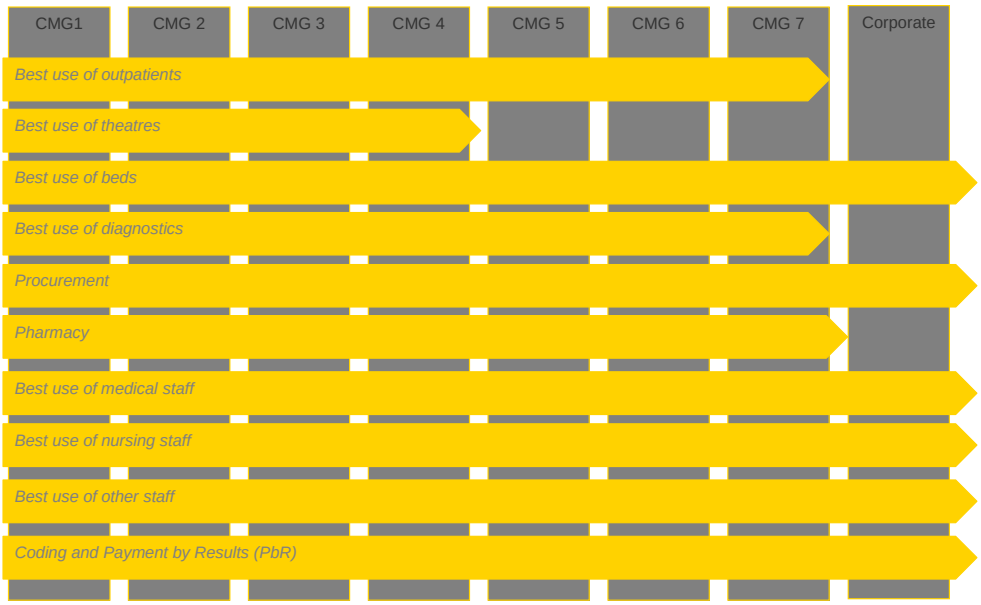
Core Programmes

Emergency Care/7 Day working	Reconfiguration	Quality Commitment	Best Use of Resources	Whole System Change
System improvement (internal)	2 year plan	Safety	Systems transformation	QIPP
System improvement (external)	3-7 year plan	Effectiveness	Speciality challenge	Better Care Fund
7 day working		Patient Experience	Business-as-usual CIPs	5 Year Strategy
			Coding	

Key Enablers

Listening into Action	IM&T	OD Plan	PMO Function & CIP tracking	Workforce development	Service Line Management

The “Best Use of Resources” section has been further broken down as shown in the schematic below:



RESOURCES – Change on this scale is unprecedented. It is therefore essential that we resource it appropriately and secure additional capacity and capability to work in partnership with our staff to deliver the desired change. All of our CMGs are in a different place, face different challenges and have different support requirements. We therefore need credible, tailored, capacity and capability that can flex according to demand. Given the need to move quickly and to resource at scale, external support will be required, but this will be embedded as part of CMG and corporate teams. This is the subject of a separate paper. It will also be necessary to identify on-going resource requirements once this interim resource is no longer present.

5. PROJECT MANAGEMENT OFFICE (PMO)

Adopting appropriate project management methodologies and having robust PMO governance arrangements will complement the above and ensure that at any time we know the status of all projects, we understand the interdependencies and risks we need to manage and we have a transparent means of testing whether the perceived benefits are realised.

6. GOVERNANCE

The IIF approach included a Board which oversees the programme as a whole at a high level as well as certain "governed" workstreams at a more detailed level. In addition CIP tracking has been carried out through the CIP Delivery Board and more recently the CMG Performance Meetings, as well as being overseen by the Executive Performance Board and Finance and Performance Committee. Whilst the CIP management elements have worked effectively, the IIF Board has not worked so well. As a result it is recommended that a different approach be utilised for Being Better as follows:

It is intended that Being Better is seen as an overarching concept rather than as a programme as such. As result, it will be described as part of the current refresh of the Trust's Strategic Direction and of the 2 year Operational Plan. At an overall level its progress will be monitored via the performance management of the Operational Plan and the tracking of annual priorities.

Individual components of Being Better will have specifically designed governance mechanisms. Some of these already exist e.g. the Emergency Care Action Team (for the emergency care/7 day working workstream) and the Executive Quality Board (for the Quality Commitment). A further paper will be produced which will set out all the governance arrangements in due course. It is proposed that CIP tracking arrangements continue essentially as now.

7. OUTPUTS

It will be important to clearly track the outputs of each element of Being Better. These outputs will generally fall into two categories:

- Outputs which can be defined through key performance indicators (e.g. falls rates, length of stay)
- Outputs which can be defined financially (i.e. CIP savings)

These will be tracked via the IBM programme management and PMTT tools respectively. Reports on delivery will be presented via the governance structures referenced in Section 6.

8. RECOMMENDATIONS

The Trust Board is asked to:

RECEIVE this report.

SUPPORT the re-branding of our improvement and innovation activities as "Being Better" and to note and comment on the proposed content and approach to the programme and its resourcing.

W

University Hospitals of Leicester NHS Trust

Trust Board paper W

To:	**Trust Board**
From:	Kate Bradley, Director of Human Resources
Date:	27 February 2014

Title:	**National NHS Staff Survey 2013 and LiA Pulse Check Report**

Author/Responsible Director: Kate Bradley, Director of Human Resources / Bina Kotecha Assistant Director of Learning and Organisational Development / Louise Gallagher, Workforce Development Manager

Purpose of the Report:
This paper advises the Trust Board of the annual national staff survey results based on the full comparison report compiled by the Care Quality Commission (CQC) and Listening into Action Pulse Check results. We also set out key next steps in continuing to improve the experience of staff at UHL.

The Report is provided to the Board for:

Decision		Discussion	X
Assurance	X	Endorsement	

Summary / Key Points:
We collect staff views and experiences of working at the Trust through the annual National Staff Survey and LiA Pulse Check to help improve the working lives of staff and the quality of care we provide. This analysis of results helps to identify if we are making sustainable change and to identify areas for improvement.

National Staff Survey
This report updates on the actions from the 2012 National Staff survey, 2013 National Survey Results, UHL local questions results (incorporated within the national survey) and Listening into Action Pulse Check results.

To facilitate the required level of organisational change from the 2012 national staff survey, we have set out an ambitious Organisational Development plan. The plan has been recently audited by PWC (Final report published in February 2014) and findings confirm that the Trust has implemented a strong OD Plan with clear alignment to the Strategic Direction of the Trust.

The National Staff Survey was open to all UHL staff between October and December 2013 and in total 3988 staff completed the survey giving an organisational response rate of 39%. This report details the responses from the 379 staff in the CQC random sample. Appendix One illustrates how the Trust has performed against the 15 questions which are specifically relevant to the Organisational Development Plan actions and provides a comparison with 79 other Acute Trusts who contract with Quality Health.

Overall National Staff Survey Key Findings indicate no change from the previous year with the exception of an increase in the number of staff having Equality and Diversity Training in 2013. We also note that change has not been sustained at the same pace as comparable organisations resulting in a downward trend in relation to overall rankings.

Staff engagement
A core theme within the full comparison report is the measurement of the 'Staff Engagement' score. The table below shows how UHL compares with other Acute Trusts on each of the three sub-dimensions of staff engagement, whether there has been a change since the 2011 and 2012 surveys and how the Trust's score compares to the average and best score for Acute Trusts. The Trust's overall 2013 score

for Staff Engagement is 3.68 (rated as below average ranking compared to average last year) and has increased from 3.66 in 2012. The 2013 national average score for Acute Trusts is 3.74.

2013 Overall Staff Engagement Scores					
	Trust Score 2011	Trust Score 2012	Trust Score 2013	National Average for Acute Trusts 2013	Best 2013 Acute Trusts
KF22 Percentage of staff able to contribute towards improvements at work	63%	70%	68%	68%	76%
KF24 Staff recommendation of the Trust as a place to work or receive treatment	3.24	3.46	3.53	3.68	4.25
KF25 Staff motivation at work	3.83	3.86	3.84	3.86	4.04

Findings based on the local questions provide reassurance in relation to senior manager communication and consistent demonstration of Trust values by immediate line managers and colleagues. Results show that the majority of respondents reported positively on receiving regular team briefings including the Chief Executive briefing and are positive about organisational communication about priorities and goals.

Listening into Action Pulse Check Survey

As illustrated in Appendix four and five UHL has completed 2 Pulse Check surveys since introducing Listening into Action (LiA) in April 2013. The first survey was undertaken in April 2013 at the start of the programme and the second survey was undertaken in January 2014. Survey Two responses are significantly more positive in 8 of 9 questions. It is worth noting that UHL has not only improved between surveys but is also reporting more positive scores in 13 of 15 questions when compared to the average scores of other NHS LiA organisations.

Continuing to Improve Staff Experience

We have set out key actions to continue to build on staff and team experiences including developing a high performing Board through implementing a tailored approach; providing team building development sessions for newly formed leadership teams; adopting an inclusive approach to strategic and business plan development and piloting new multi-professional development programmes such as 'Leading Across Boundaries'. We will continue to improve levels of staff engagement through embedding Listening into Action and other key engagement programmes including the Clinical Senate. In particular over 2014/15 we will be running Listening Events in every ward and clinical department and will focus on improving mechanisms for raising staff concerns/incidents placing emphasis on building resilience into the organisation.

Recommendations:

The Trust Board is asked to:

- Note the key messages from the analysis of the 2013 National Staff Survey, the results of UHL local questions and LiA Pulse Check results
- Support the key areas for development, which will be monitored through the Organisational Development Plan and Listening into Action Programme of Work

2013-2015 Strategic Risk Register	**Performance KPIs**
Risk 3	Appraisal, Training attendance' Sickness Absence and Turnover rate

Resource Implications (e.g. Financial, HR):

Allocation will be determined based on priorities identified by the Executive Workforce Board

The UHL Listening into Action Sponsor Group will progress action planning against key items (that correlate with the 'Pulse Check' survey) and integrate these into the UHL Listening into Action Framework adoption plan

Assurance Implications:

Forms part of the annual Care Quality Commission (CQC) standards monitoring process.

Patient and Public Involvement (PPI):

Results to be reviewed in conjunction with patient survey to provide public statement of Trust

performance.
Equality Impact: Part of the analysis examines if there are response differences between staff groups pertaining to the nine protected characteristics
Information exempt from Disclosure: No
Requirement for further review? Monitor progress through the UHL Organisational Development Plan (2013/15) by the Executive Workforce Board. Improvements against key survey items (identified within the Staff Pulse Check) will specifically be monitored over the next 12 months by the UHL Listening into Action Sponsor Group.

University Hospitals of Leicester NHS Trust

REPORT TO: **Trust Board**

DATE: **27 February 2014**

REPORT FROM: **Kate Bradley - Director of Human Resources**

REPORT BY: **Bina Kotecha Assistant Director of Learning and OD**

Louise Gallagher, Workforce Development Manager

SUBJECT: **NATIONAL NHS STAFF SURVEY RESULTS 2013 AND LISTENING INTO ACTON PULSE CHECK REPORT**

1.0 INTRODUCTION

This report updates on the actions from the 2012 National Staff survey, 2013 National Survey Results, UHL local questions results (incorporated within the national survey) and Listening into Action Pulse Check results.

The 11th National Staff Survey was conducted between September and December 2013. The survey is conducted on behalf of the Care Quality Commission (CQC) and the results form a key part of the Commission's assessment of the Trust in respect of its regulatory activities such as registration, the monitoring of on-going compliance and reviews. In January 2014, the Trust also conducted its second local Listening into Action Pulse Check Survey.

2.0 PURPOSE

2.1 The purpose of the National Staff Survey is to collect staff views about their experiences of working in their local NHS Trust. It provides Trusts with information about the views and experiences of its staff to help improve the working lives of staff and the quality of care for patients. Importantly, staff are asked a small number of key questions relating to their opinions regarding the standard of care provided at their place of work. The local Listening into Action Pulse Check Survey measures the impact of a new way of working and engaging with our staff and compliments the National Staff Survey by measuring 'real time' views and opinions.

3.0 PARTICIPATION

3.1 Analysis by the CQC of the survey results is undertaken through a self-completed questionnaire. This year all staff were given the opportunity to complete the survey through a combination of on line and paper based surveys and the Trust received 3988 responses (39% response rate). 379 of those responding formed part of the 850 CQC sample and the Trust had an official response rate of 46%.The majority of this report reflects the responses from these 379 respondents.

4.0 STRUCTURE

4.1 As illustrated in Appendix Two, the survey provides 28 Key Findings about working in the NHS derived from the responses to over 150 questions. The Key Findings are linked to, and provide information about progress against the four pledges to staff in the NHS Constitution together with two additional themes; Staff Satisfaction and Equality and Diversity. This year the Trust also asked a number of local questions relating to the cascade of information from Chief Executive Briefings and the demonstration of Trust values and behaviours by colleagues and managers.

5.0 ACTIONS ARISING FROM THE 2012 SURVEY

5.1 The results from the 2012 National Staff Survey saw a number of significant improvements in five areas including job satisfaction and staff recommendation of the Trust as a place to work or

receive treatment. The results from the survey were progressed through the implementation of the Organisational Development Plan which recognised that there was still significant work to do to move into the top quartile of Acute Trusts nationally.

5.1 To facilitate this required level of organisational change we set out an ambitious Organisational Development (OD) Plan (2013/15) for UHL. Our OD Plan priorities are led through six substantial work streams:-

- Live our Values;
- Improve Two-way Engagement;
- Enhance Workplace Learning
- Strengthen Leadership;
- Improve External Relationships and Workplace Partnerships; and
- Encourage Creativity and Innovation.

5.3 As shown in Appendix Three, for each work streamover 2013/14 we have implemented priorities that are designed to build on current strengths and address gaps to improve the organisational performance and culture of UHL. Quarterly progress updates have been provided to the Trust Board over 2013/14. The work streams have been aligned to UHL values and support building pride in our organisation.

5.4 A central enabler of delivering against the OD Plan has been adopting the 'Listening into Action (LiA)' approach across UHL. LiA has introduced a new and ambitious way of working and we have further empowered our staff to transform our hospitals to deliver "Caring at its best". As previously reported to the Board, key achievements of our first 12 Pioneering Teams and 10 Enabling our People (EoP) Schemes has raised the bar on the quality of care we provide to our patients, improving staff and patient experience (based on area specific results).

5.5 We have moved into Phase 4 of the LiA journey which means that we have started the process of 'embedding LiA as the way we do things at UHL'. A '*Pass It On* event' on the 6 November 2013 celebrated the successes of our first teams and used their stories to inspire the next wave of Pioneer Teams and EoP Schemes. As previously reported to the Board, there is strong evidence to support that this pioneering approach has seen positive improvements in staff and patient experience results and a positive shift in organisational culture and leadership.

5.6 This year local polling has been replaced by LiA Pulse Checks. The questions shown in Appendix Four demonstrate that the questions are not identical to the National Staff Surveybut do enable the Trust to track whether actions to improve staff engagement are working. As Listening into Action becomes more embedded in the organisation, the Trust anticipates improved National Staff Survey results.

6.0 2013 UHL RESULTS

6.1 Raw Data Results

6.1.1 As reported to the Executive Team in January 2013, generally the 'first cut' results of the 2013 national survey showed very little change from the results in 2012. There are a number of improvements in the results which are not captured in the CQC report which focuses on key findings. Examples of improvements from the detailed report include:

- A 3% increase in positive responses to the question: 'communication between senior management and staff is effective

- An 8% increase in positive responses to the question: the Trust's top priority is 'Care of Patients'
- A 6% increase in the percentage of staff receiving job relevant training, learning or development in the last 12 months.

6.1.2 There have equally been a number of slight deteriorations in results which include:

- A 4% decrease in staff knowing how to report fraud, malpractice or wrongdoing
- A 2% reduction in staff believing work is good for their health
- A 3% increase in staff agreeing that they have observed incidents/errors or near misses which could affect patients.

6.2 Key Findings Based on the 2013 CQC National Staff Survey Results

6.2.1 The CQC Key Findings Data (questions are grouped nationally into key areas, known as 'Key Findings') at Appendix Two clearly highlights that statistically with respect to twenty seven of the Key Findings the results at UHL have experienced 'no change'. We have seen an 'increase' against one Key Finding, with no areasof deterioration since the 2012 survey. The findings also highlight significant areas for review and action in a number of Key Findings.

6.2.2 The five Key Findings for which the Trust compares most favourably with other Acute Trusts are summarised below, also indicating changes since the 2011 and 2012 surveys and how the Trust's score compares to the average and best score for Acute Trusts:-

2013 TOP FIVE RANKING SCORES					
	Trust Score 2011	Trust Score 2012	Trust Score 2013	National Average for Acute Trusts 2013	Best 2013 Acute Trusts
KF26 Percentage of staff having equality and diversity training in the last 12 months	38%	57%	76%	60%	84%
KF5 Percentage of staff working extra hours (lower better)	63%	67%	65%	70%	60%
KF7 Percentage of staff appraised in the last 12 months	90%	94%	91%	84%	97%
KF6 Percentage of staff receiving staff relevant training, learning or development in the last 12 months	New question	79%	84%	81%	87%
KF18 Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months (lower better)	New question	26%	27%	29%	19%

6.2.3 The five Key Findings for which the Trust compares least favourably with other Acute Trusts are summarised below, also indicating changes since the 2011 and 2012 surveys and how the Trust's score compares to the average and best score for Acute Trusts:-

2013 BOTTOM FIVE RANKING SCORES					
	Trust Score 2011	Trust Score 2012	Trust Score 2013	National Average for Acute Trusts 2013	Best 2013 Acute Trusts
KF14 Percentage of staff reporting errors, near misses or incidents witnessed in the last month	96%	91%	87%	90%	97%
KF4 Effective team working	3.7	3.65	3.65	3.74	3.94
KF13 Percentage of staff witnessing potentially harmful errors, near misses or incidents in the last month (lower better)	32%	32%	37%	33%	18%
KF20 Percentage of staff feeling pressure in the last 3 months to	28%	32%	31%	28%	20%

attend work when feeling unwell (lower better)					
KF1 Percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver	70%	77%	75%	79%	86%

These are key areas of focus for review, discussion and action planning. It is essential that this review links to the 'Listening into Action', patient survey work (aligned to the UHL Quality Commitment) that is being undertaken and any actions arising from the January 2014 CQC Inspection.

6.2.4 Although the results do not demonstrate statistically significant improvements or deteriorations, the Trust has slipped in a number of overall rankings in comparison to other Acute Trusts. This would suggest that where UHL has made no or limited changes, other Trusts have improved their position.

Ranking	Number of Indicators 2012	Number of Indicators 2013
Best 20%	5	4
Above Average	9	3
Average	6	8
Below Average	6	7
Lowest 20%	2	6

6.2.5 Of those areas where the ranking has deteriorated, there are four areas of particular note. The effective team working score has fallen from below average to the lowest 20% with scores moving from 3.7 (2011), 3.69 (2012) to 3.65 in 2013. The percentage of staff saying hand washing facilities are always available has moved from 57% (2011) to 57% (2012) and 51% in 2013. The percentage of staff reporting errors, near misses or incidents witnessed in the last month has deteriorated from above average to the lowest 20% with scores moving from 96% (2011) to 91% (2012) to 87% in 2013. The percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver has moved from below average to the lowest 20% with scores moving from 70% (2011), 77% (2012) and 75% in 2013.

6.2.6 Although these changes are not considered to be statistically significant, the possible reason for these changes and suggested actions to improve the scores are outlined in section 7.0.

6.3 Results from UHL Local Questions

6.3.1 For the first time this year, the Trust included a number of local questions, the results of which are shown in Appendix Two. These show a particularly pleasing set of results which are indicative of the priorities identified in the Organisational Development Plan (see section 3.0). Significant investment has been made this year to improve senior management communication and as a result 72% of staff receive a regular team briefing which includes information from the Chief Executive briefing and 61% agree that the organisation communicates clearly with staff about priorities and goals.

6.3.2 This year also saw the launch of the local leadership behaviours framework and as a result the additional questions relating to the Trust values have seen positive outcomes. 66% agree that their managers exhibit the Trust values and behaviours and 69% agree that colleagues exhibit the Trust values and behaviours.

6.4 The Listening into Action Pulse Check

6.4.1 In addition to the National Staff Survey, the Trust has also undertook a second Listening into Action Pulse Check Survey in January 2014 following an initial pulse check survey in March 2013. This again presents a particularly pleasing set of results. Appendix Four demonstrates

that, in contrast to the limited number of statistically significant changes in the National CQC Staff Survey results, the Listening into Action (LiA) pulse check saw significant improvements.

6.4.2 The most significant improvements in this survey relate to improvements in the provision of high quality services, recognition of staff for the contribution that they make and clarity in relation to roles. Pulse checks will continue to operate across the Trust in order to monitor the LiA impact.

6.4.3 Appendix Five provides an overview of the response rates to Survey One and Survey Two and compares UHL to the average score of other NHS LiA Organisations. UHL has more positive scores in 13 of 15 questions when compared to the average scores of other NHS LiA organisations. The only question which is not scoring higher than the average scores of comparator LiA organisations is Question 1: 'I feel happy and supported working in my team/department/service' with a -0.76% less positive score at Survey Two.

6.4.4 Please note that Question 8 changed between surveys and has at this point only been asked in Survey Two (January 2014). UHL Question 8 has scored 46.11% with 49.8%scored by comparator NHS LiA organisations.

7.0 Building On and Improving Staff Experience

7.1 The results presented in this report are variable; taken collectively they indicate that the Trust's culture is moving in the right direction and that actions driven through the Organisational Development Plan are having a positive impact. At our recent Care Quality Commission Inspection (13-17 January 2014) we note that informal feedback from inspectors was very positive about the leadership of the Trust and cultural change.

7.2 We recognise that the scale and pace of organisational development in providing clear strategic direction, ensuring accountability and continuing to shape new cultures of quality, safety and stakeholder confidence requires strong leadership by a high performing Board. In 2014/15 we will work closely with 'Foresight Partnership' in implementing a tailored approach to developing a highly effective Board.

7.3 In September 2013, the Trust implemented a change programme to replace the Divisional structure with a structure comprising of seven Clinical Management Groups. This may have temporarily affected scores relating to teamwork and staff engagement given the recognised impact of organisational change. There have been a number of initiatives to support the development of teams and work has commenced on team building across the newly formed senior leadership teams, mapping out how teams will work together to achieve excellence. We are also adopting a more inclusive approach to strategic planning and business plan development. The intention is that this should support a multidisciplinary approach to service improvement and transformation.

7.4 Working in partnership with the regional Leadership Academy, we are participating in a pilot development programme titled 'Leading Across Boundaries' and have put together our first two clinically led multi-professional project teams to attend this development focussed on service and quality improvement (linked to Cancer Centre and Theatre Utilisation). Over 2014/15 we plan to expand on this approach to multi-professional team development focussing specifically on key Trust priorities including Emergency Care and seven day working.

7.5 A detailed overview of the results indicates generally lower scores from respondents from the Medical and Dental staff group. In 2013/14 there has been investment in providing further channels to engage and involve this staff group for example increased clinical leaders through the Clinical Management Group structure, the establishment of the Junior Doctors Committee and the Clinical Senate. It is anticipated this will impact on results for 2014. In addition we will continue to work in partnership with Momentum in providing Medical Leadership Development framed within the concept of task orientated thinking.

7.6 Listening into Action will continue to be embedded as a way of working as the Trust has already benefitted from significant improvements arising from the Enabling our People Schemes and Pioneering Project Teams. The majority of projects are directly focused on improvements in patient care, enabling and empowering staff to improve the patient experience.

7.7 The Trust's Reward and Recognition Strategy has recently been launched with an action plan focused on improving UHL as a place to work. This was developed during the autumn of 2013 and incorporated feedback from staff via two Listening Events.

7.8 The emotional resilience workshops delivered in partnership with Amica and Occupational Health have been very well evaluated in 2013 and sickness absence in the Trust for stress related illness for the past two quarters has reduced as a result of this training and other measures. Three further workshops are planned for 2014 hoping to reach around 200 staff. The workshops address the psychological elements of resilience with a focus on the management of stress and enhancing the development of resilient characteristics in the workplace.

7.9 There are a number of Key Findings scores which indicate the need to ensure that our Trust's policies on handling errors, near misses and incidents are transparent and effectively communicated to our staff. Particular emphasis will be placed on further developing a culture of transparency and openness. In progressing this over 2014/15 nursing leads are committed to running Listening Events in every ward and clinical department.

7.10 The Infection Prevention Team will undertake a detailed analysis of the findings relating to the availability of hand washing facilities in order to understand if this relates to specific areas of the Trust. In addition work will be undertaken in partnership with Interserve to ensure that focused attention is given to the replenishment of facilities.

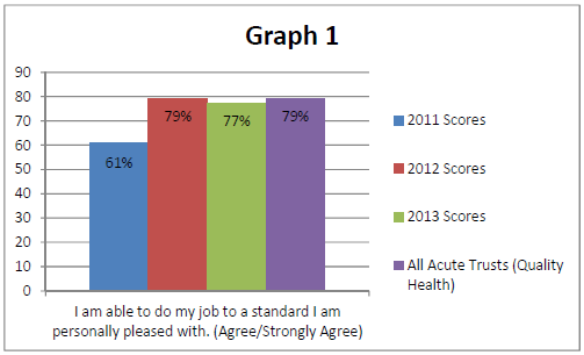
7.11 The Organisational Development (OD) Plan will be refreshed for 2014/15 as a result of the outcome of staff feedback and will incorporate relevant CQC Findings.

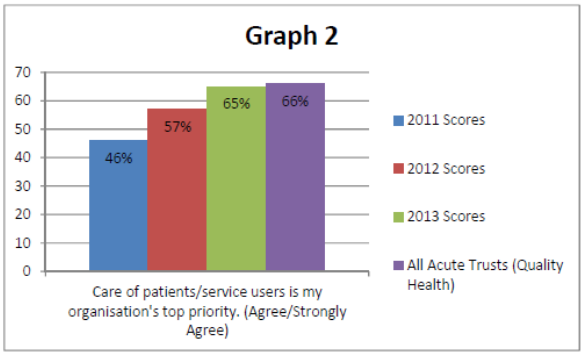
8.0 RECOMMENDATION

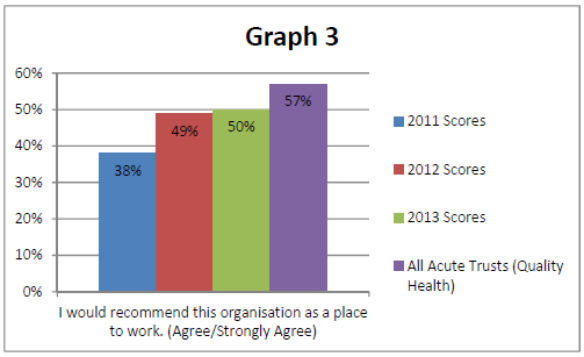
8.1 The Trust Board is asked to:-

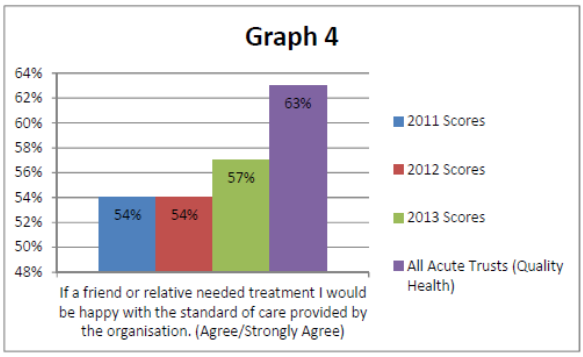
- Note the key messages from the analysis of the 2013 National Staff Survey results and Listening into Action Pulse Check results
- Support the key areas for development which will implemented through the Organisational Development Plan and Listening into Action Programme of Work.

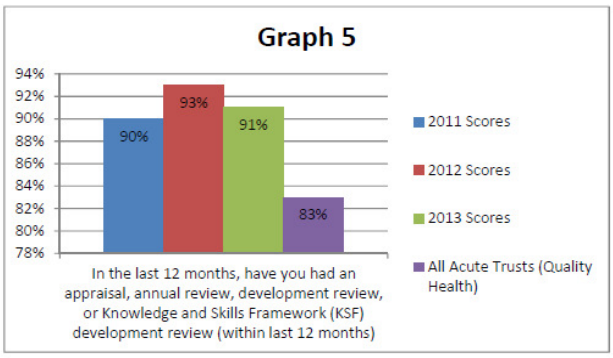
Appendix One: Raw Data National Staff Survey Results against the 15 questions relative to the Trust's OD Plan and former 8 Point Action Plan

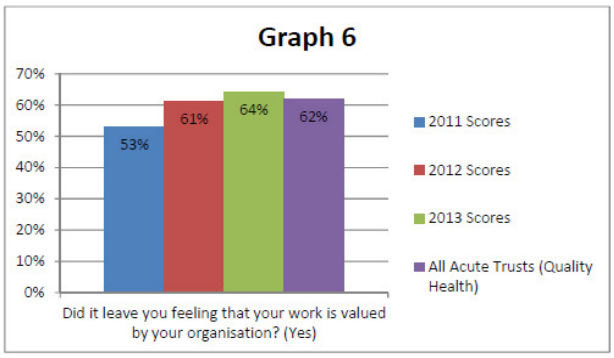


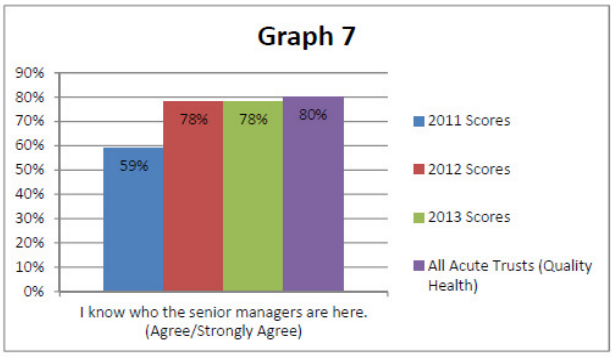


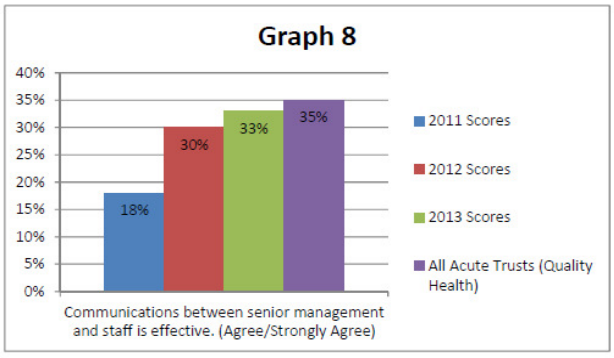




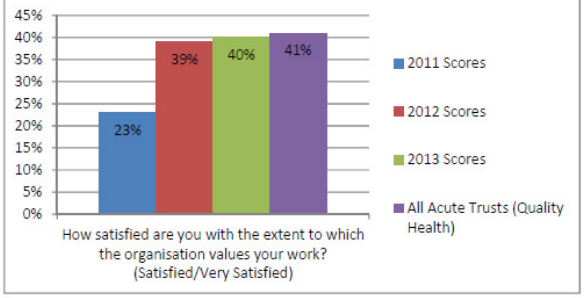




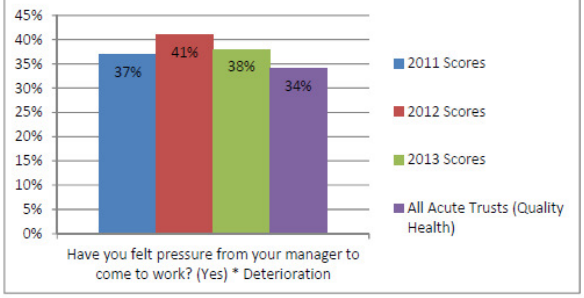




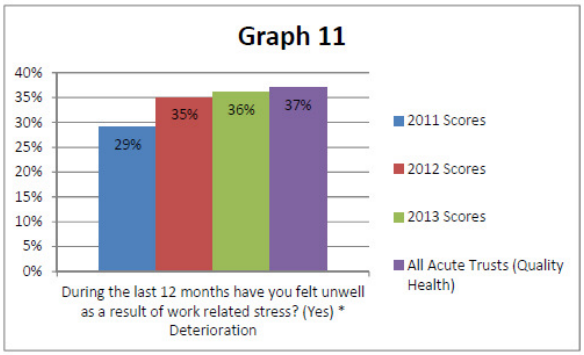
Graph 9



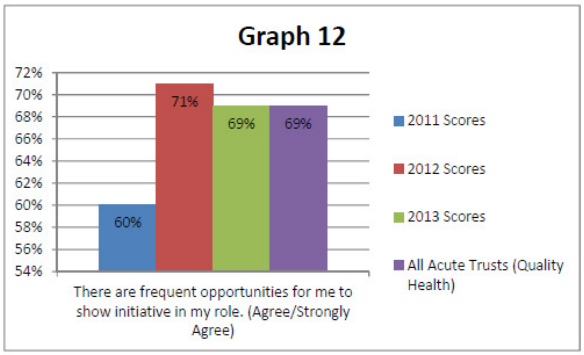
Graph 10



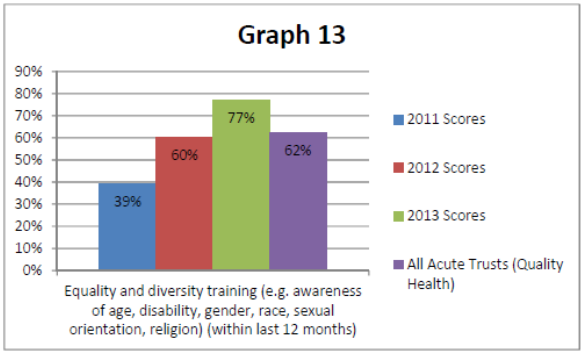
Graph 11



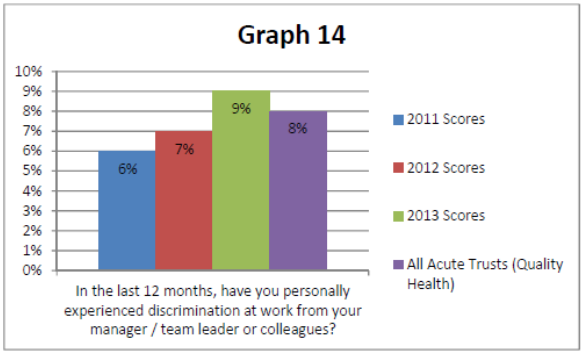
Graph 12



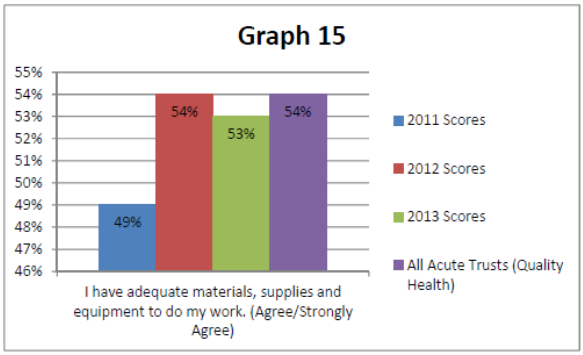
Graph 13



Graph 14



Graph 15



Appendix Two :CQC Published Key Findings and UHL Local Questions

3.3. Summary of all Key Findings for University Hospitals Of Leicester NHS Trust

KEY

✓ Green = Positive finding, e.g. in the best 20% of acute trusts, better than average, better than 2012.

! Red = Negative finding, e.g. in the worst 20% of acute trusts, worse than average, worse than 2012.

'Change since 2012 survey' indicates whether there has been a statistically significant change in the Key Finding since the 2012 survey.

-- Because of changes to the format of the survey questions this year, comparisons with the 2012 score are not possible.

* For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterix and in *italics*, the lower the score the better.

	Change since 2012 survey	Ranking, compared with all acute trusts in 2013
STAFF PLEDGE 1: To provide all staff with clear roles, responsibilities and rewarding jobs.		
KF1. % feeling satisfied with the quality of work and patient care they are able to deliver	• No change	! Lowest (worst) 20%
KF2. % agreeing that their role makes a difference to patients	• No change	• Average
* *KF3. Work pressure felt by staff*	• No change	! Above (worse than) average
KF4. Effective team working	• No change	! Lowest (worst) 20%
* *KF5. % working extra hours*	• No change	✓ Lowest (best) 20%
STAFF PLEDGE 2: To provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential.		
KF6. % receiving job-relevant training, learning or development in last 12 mths	• No change	✓ Highest (best) 20%
KF7. % appraised in last 12 mths	• No change	✓ Highest (best) 20%
KF8. % having well structured appraisals in last 12 mths	• No change	✓ Above (better than) average
KF9. Support from immediate managers	• No change	! Below (worse than) average
STAFF PLEDGE 3: To provide support and opportunities for staff to maintain their health, well-being and safety.		
Occupational health and safety		
KF10. % receiving health and safety training in last 12 mths	• No change	• Average
* *KF11. % suffering work-related stress in last 12 mths*	• No change	✓ Below (better than) average
Infection control and hygiene		
KF12. % saying hand washing materials are always available	• No change	! Lowest (worst) 20%
Errors and incidents		
* *KF13. % witnessing potentially harmful errors, near misses or incidents in last mth*	• No change	! Highest (worst) 20%
KF14. % reporting errors, near misses or incidents witnessed in the last mth	• No change	! Lowest (worst) 20%
KF15. Fairness and effectiveness of incident reporting procedures	• No change	• Average

	Change since 2012 survey	Ranking, compared with all acute trusts in 2013
Violence and harassment		
* *KF16. % experiencing physical violence from patients, relatives or the public in last 12 mths*	• No change	• Average
* *KF17. % experiencing physical violence from staff in last 12 mths*	• No change	• Average
* *KF18. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 mths*	• No change	✓ Below (better than) average
* *KF19. % experiencing harassment, bullying or abuse from staff in last 12 mths*	• No change	• Average
Health and well-being		
* *KF20. % feeling pressure in last 3 mths to attend work when feeling unwell*	• No change	! Highest (worst) 20%
STAFF PLEDGE 4: To engage staff in decisions that affect them, the services they provide and empower them to put forward ways to deliver better and safer services.		
KF21. % reporting good communication between senior management and staff	--	! Below (worse than) average
KF22. % able to contribute towards improvements at work	• No change	• Average
ADDITIONAL THEME: Staff satisfaction		
KF23. Staff job satisfaction	• No change	! Below (worse than) average
KF24. Staff recommendation of the trust as a place to work or receive treatment	• No change	! Below (worse than) average
KF25. Staff motivation at work	• No change	! Below (worse than) average
ADDITIONAL THEME: Equality and diversity		
KF26. % having equality and diversity training in last 12 mths	✓ Increase (better than 12)	✓ Highest (best) 20%
KF27. % believing the trust provides equal opportunities for career progression or promotion	• No change	• Average
* *KF28. % experiencing discrimination at work in last 12 mths*	• No change	! Above (worse than) average

University Hospitals of Leicester NHS Trust

LOCAL QUESTIONS	Total	2012	Total	2013
L01a. Do you have a regular team meeting/briefing which includes information from the Chief Executive Briefing?				
Yes I receive regular and timely updates from the Chief Executive Briefing	0	0%	2545	72%
Yes I receive updates from the Chief Executive Briefing that are irregular	0	0%	457	13%
No I do not receive information from the Chief Executive Briefing	0	0%	512	15%
Missing	840		474	
L02a. I feel that our organisation communicates clearly with staff about priorities and goals.				
Strongly agree	0	0%	360	10%
Agree	0	0%	1793	51%
Neither agree nor disagree	0	0%	950	27%
Disagree	0	0%	333	9%
Strongly disagree	0	0%	101	3%
Missing	840		474	
L02b. Day to day issues and frustrations that get in my way are quickly identified and resolved.				
Strongly agree	0	0%	125	4%
Agree	0	0%	607	17%
Neither agree nor disagree	0	0%	1124	32%
Disagree	0	0%	1191	34%
Strongly disagree	0	0%	443	13%
Missing	840		498	
L03. Thinking abour your line manager to what extent do you agree or disagree that they exhibit the Trust values and behaviours?				
Strongly agree	0	0%	711	20%
Agree	0	0%	1632	46%
Neither agree nor disagree	0	0%	833	24%
Disagree	0	0%	230	7%
Strongly disagree	0	0%	111	3%
Missing	840		471	
L04. Thinking abour your colleagues to what extent do you agree or disagree that they exhibit the Trust values and behaviours?				
Strongly agree	0	0%	535	15%
Agree	0	0%	1915	54%
Neither agree nor disagree	0	0%	838	24%
Disagree	0	0%	180	5%
Strongly disagree	0	0%	51	1%
Missing	840		469	

Appendix Three

UHL Organisational Development Plan (updated September 2013)

Caring at its best

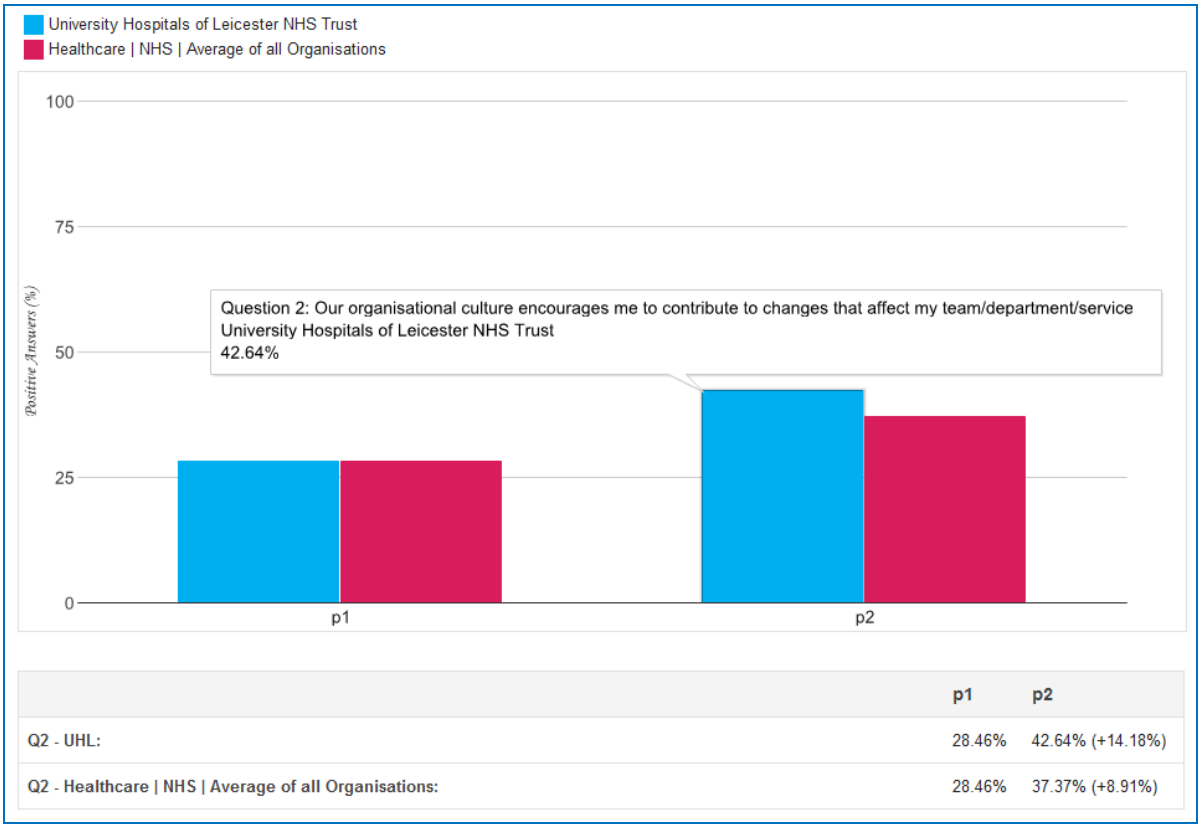
Six Work Streams	2013	2014-15	On-going Fundamentals
1. Live our Values	• **Implement Putting People First / Cultural Shift Programme** • Implement Values Based Recruitment	• Delivery of "Caring at its best" training Trust wide	• Embed Values within Systems and Processes • Continue 'Caring at its best' Awards
2. Improve Two-way Engagement	• Embed Listening into Action Framework (LiA) • Implement Medical Engagement Strategy Priorities	• Build on Health and Well Being and Resilience at Work Programmes	• Change Management • Achieve and maintain 'Excellent Employer' status
3. Strengthen Leadership	• **Devise and implement Leadership Qualities and Behaviours** • Board, Exec and Senior Leadership Development	• Embed Inclusive Talent Management	• Leadership Development • Skills development in Finance and Business Acumen • Talent Profile for Senior Leaders
4. Enhance Workplace Learning	• Statutory and Mandatory Training • **Implementation of Workforce Plans and Enhance Workplace Capacity**	• Build on training capacity and resources	• Improve Appraisal quality • Training, education and development for all staff • Recruitment and retention
5. Improve External Relationships and Workplace Partnerships	• Develop Patient and Public Involvement Strategy • Production of key guidance / toolkits	• Implement actions highlighted in PPI strategy	• Community Ambassador Programme • Representative Membership • Community Engagement and Representation
6. Encourage Creativity and Innovation	• **Develop an Improvement and Innovation Framework (IIF)** • **Develop and implement a plan for building improvement capacity**	• **Roll-out training, to enable a bottom-up approach towards improvement and innovation**	• Embedding Releasing Time to Care • Build on Research and Development • **Implementation of Improvement and Innovation Framework**

Appendix Four: Listening into Action Pulse Check Results

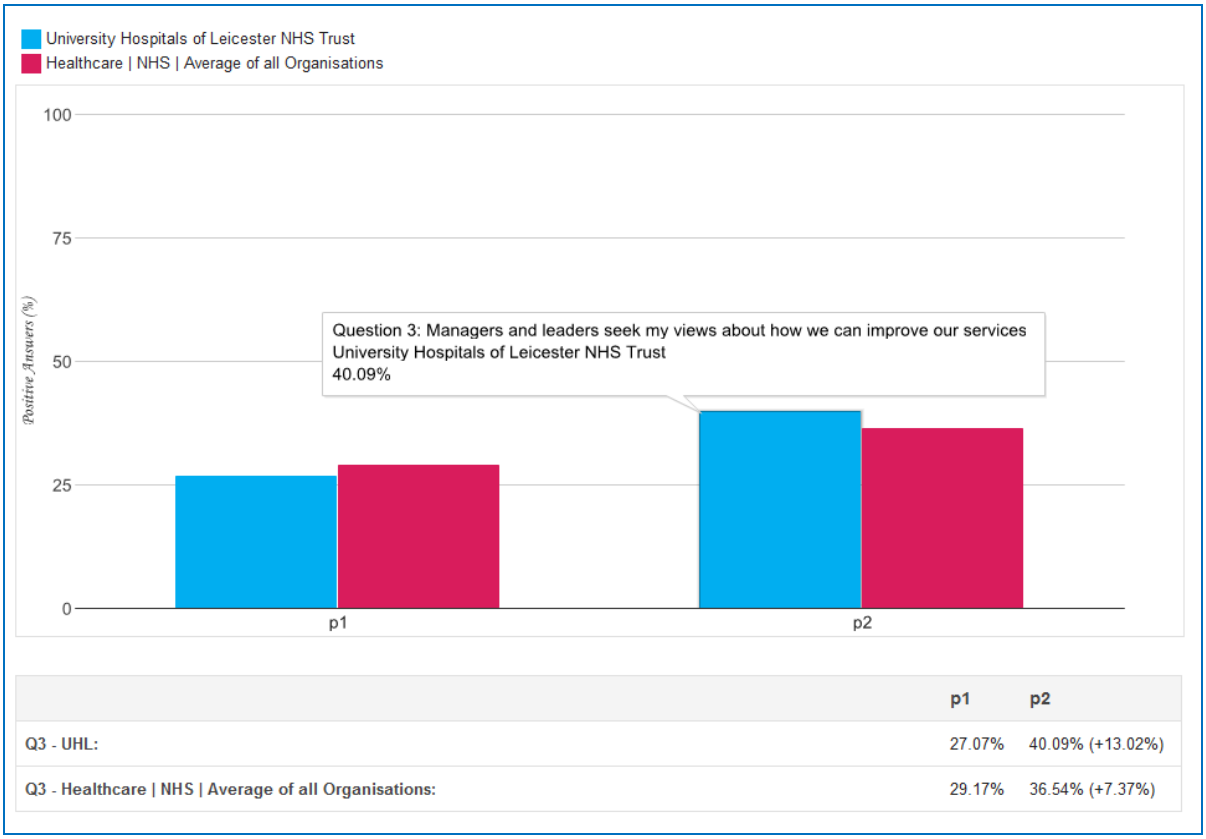
Pulse Check Questions	1st Pulse Check	2nd Pulse Check	Variance
I feel happy and supported working in my team/department/service	50.05%	49.82%	-0.23
Our organisational culture encourages me to contribute to changes that affect my team/department/service	28.46%	42.61%	+14.15
Managers and leaders seek my views about how we can improve our services	27.07%	40.08%	+13.01
Day-to-day issues and frustrations that get in our way are quickly identified and resolved	12.44%	25.59%	+13.15
I feel that our organisation communicates clearly with staff about its priorities and goals	28.25%	46.42%	+18.17
I believe we are providing high quality services to our patients/service users	30.09%	53.73%	+23.64
I feel valued for the contribution I make and the work I do	17.3%	43.1%	+25.8
I would recommend our Trust to my family and friends	-	46.19%	-
I understand how my role contributes to the wider organisational vision	41.28%	72.36%	+31.08
Communication between senior management and staff is effective	16.64%	36.24%	+19.6
I feel that the quality and safety of patient care is our organisation\'s top priority	-	52.85%	-
I feel able to prioritise patient care over other work	-	48.71%	-
Our organisational structures and processes support and enable me to do my job well	-	33.92%	-
Our work environment, facilities and systems enable me to do my job well	-	32.39%	-
This organisation supports me to develop and grow in my role	-	36.77%	-

Appendix Five: UHL Pulse Check Survey – Survey One & Two Comparison between UHL and all LiA Organisations

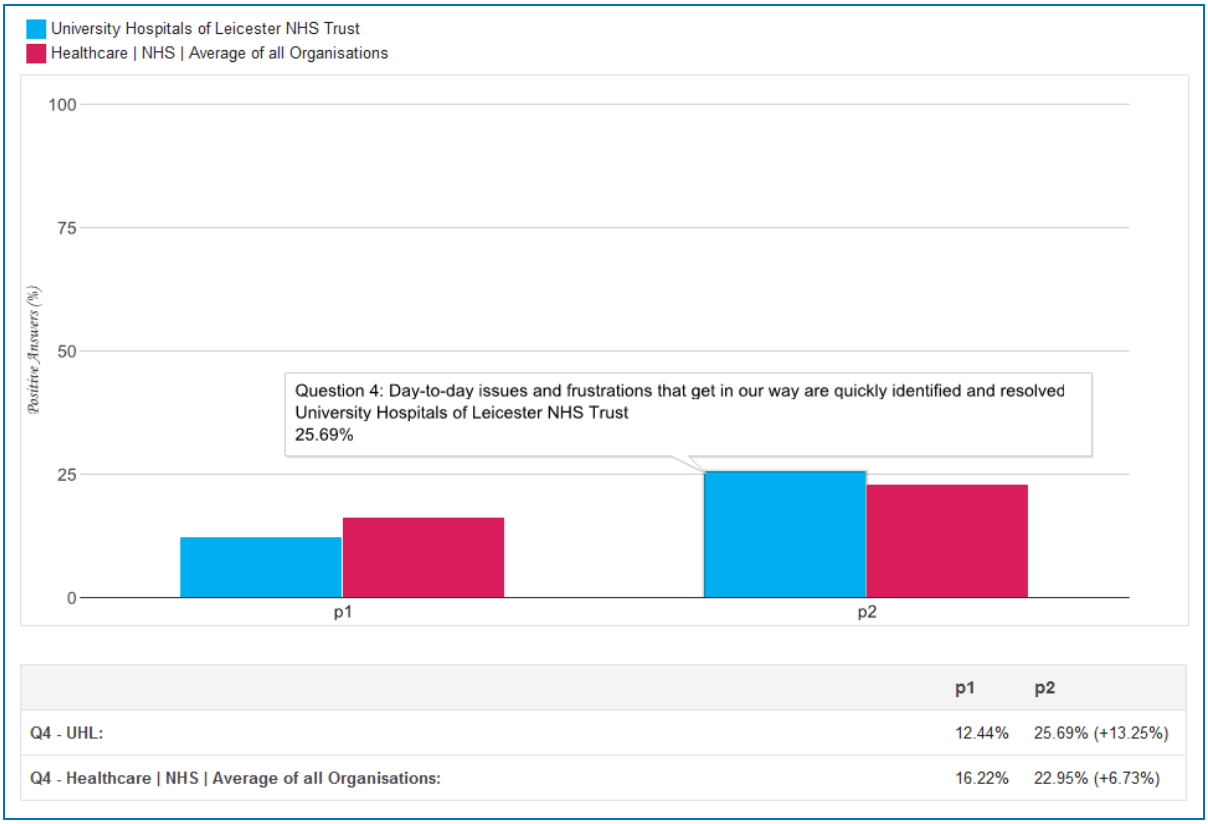
	p1	p2
Q1 - UHL:	50.05%	49.99% (-0.06%)
Q1 - Healthcare | NHS | Average of all Organisations:	50.05%	50.75% (+0.7%)



	p1	p2
Q2 - UHL:	28.46%	42.64% (+14.18%)
Q2 - Healthcare | NHS | Average of all Organisations:	28.46%	37.37% (+8.91%)

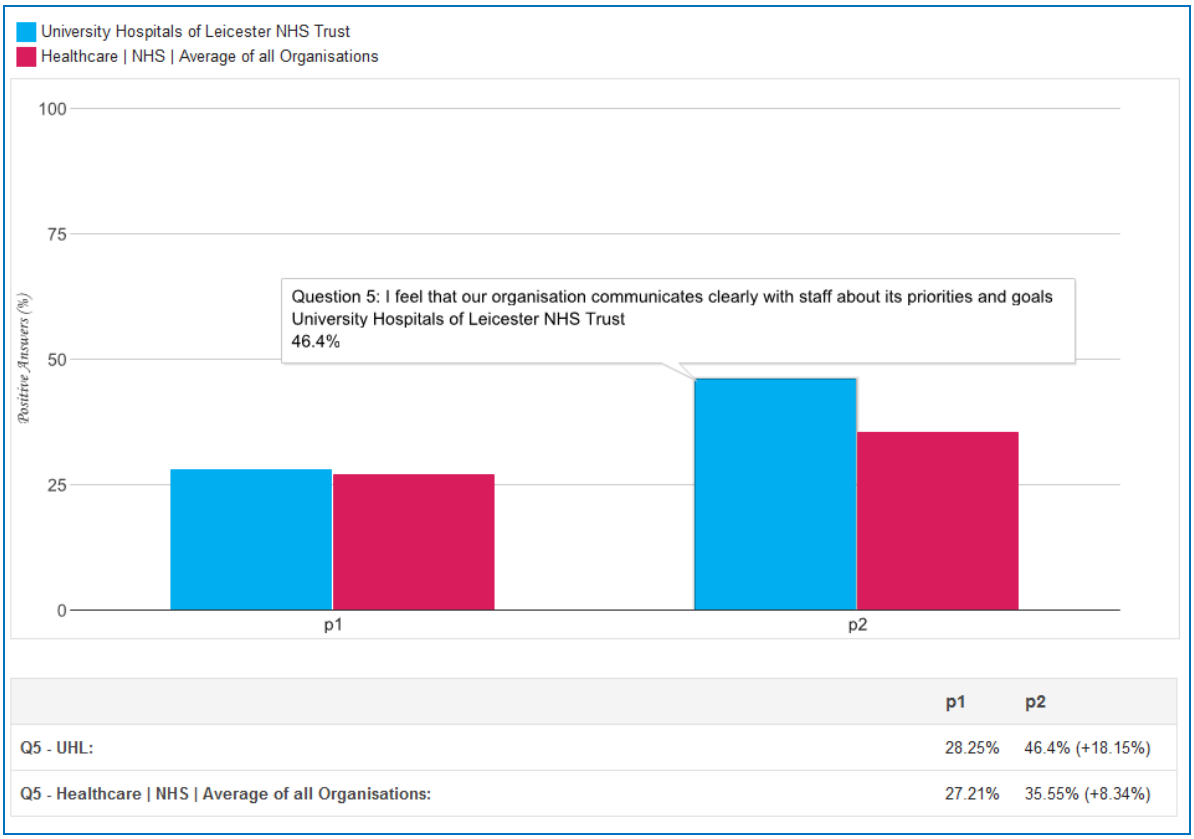


	p1	p2
Q3 - UHL:	27.07%	40.09% (+13.02%)
Q3 - Healthcare | NHS | Average of all Organisations:	29.17%	36.54% (+7.37%)

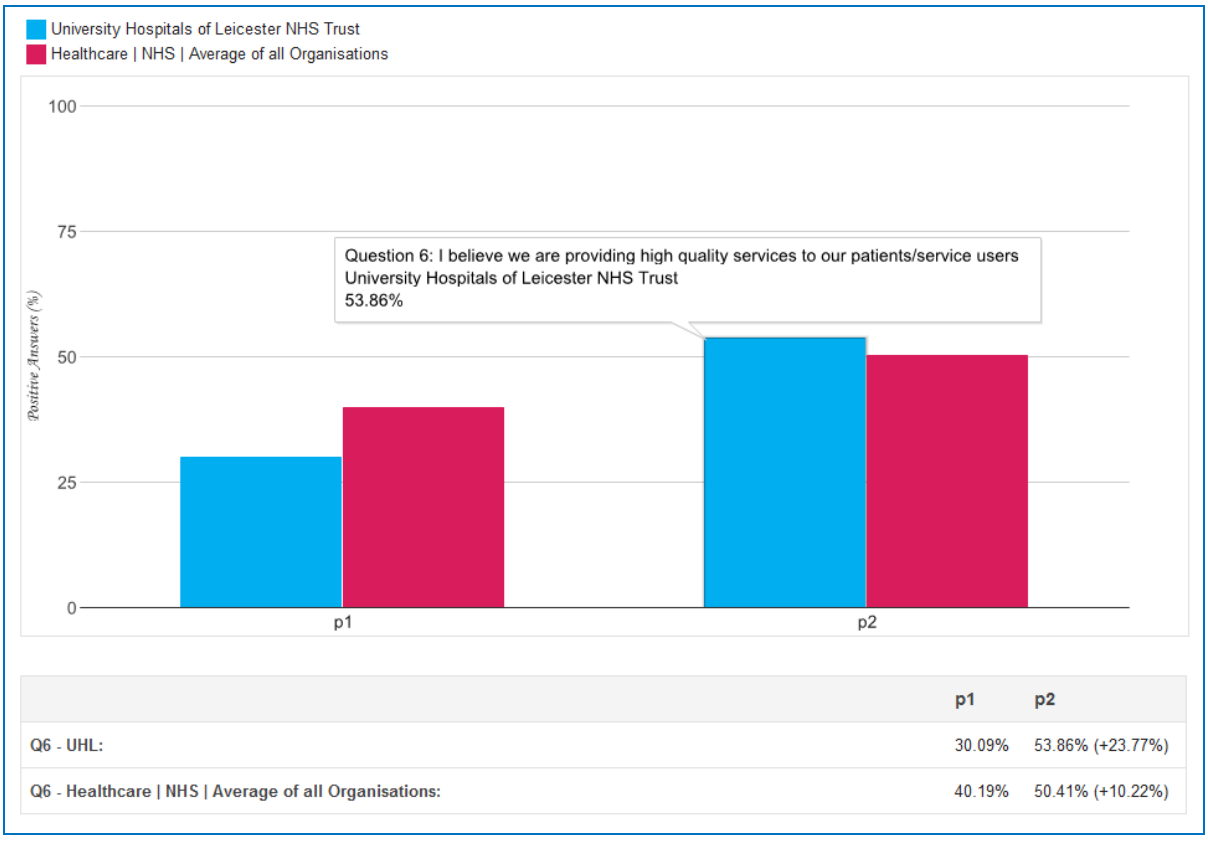


	p1	p2
Q4 - UHL:	12.44%	25.69% (+13.25%)
Q4 - Healthcare | NHS | Average of all Organisations:	16.22%	22.95% (+6.73%)

University Hospitals of Leicester NHS Trust

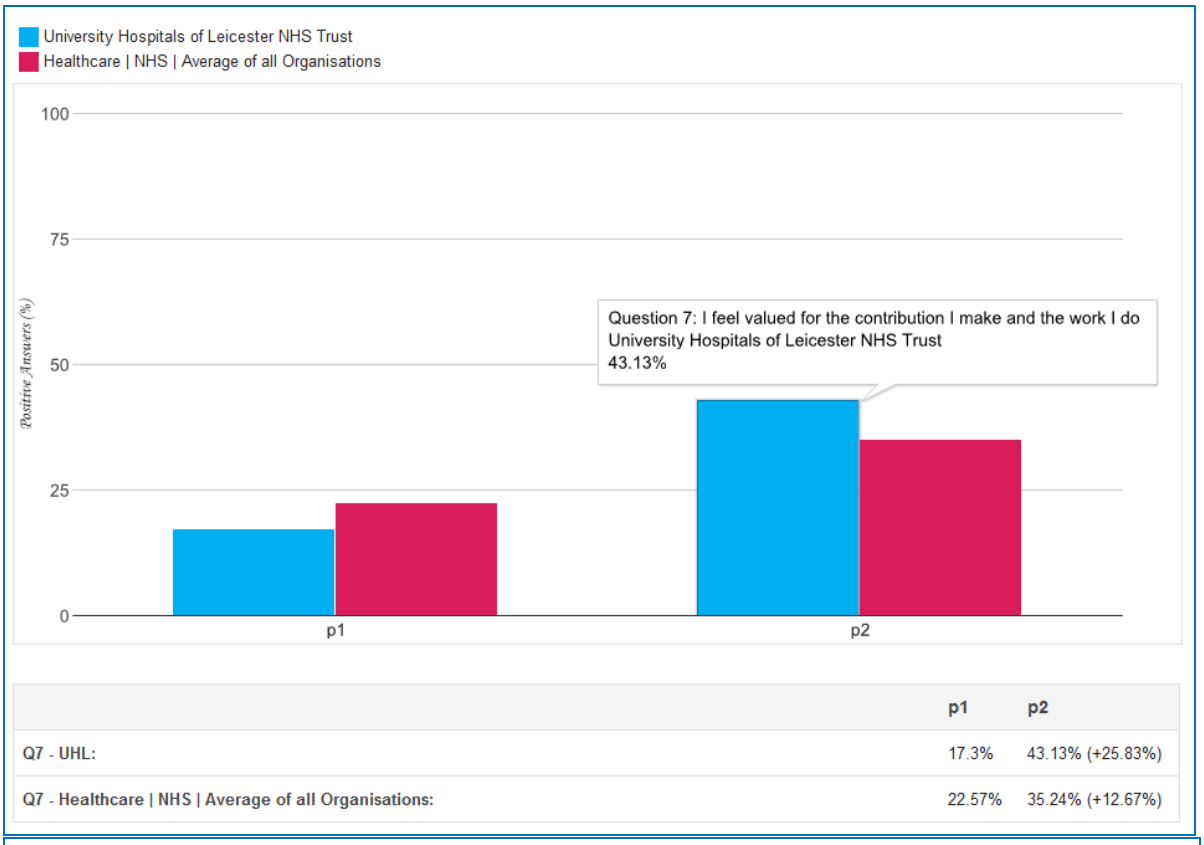


	p1	p2
Q5 - UHL:	28.25%	46.4% (+18.15%)
Q5 - Healthcare | NHS | Average of all Organisations:	27.21%	35.55% (+8.34%)

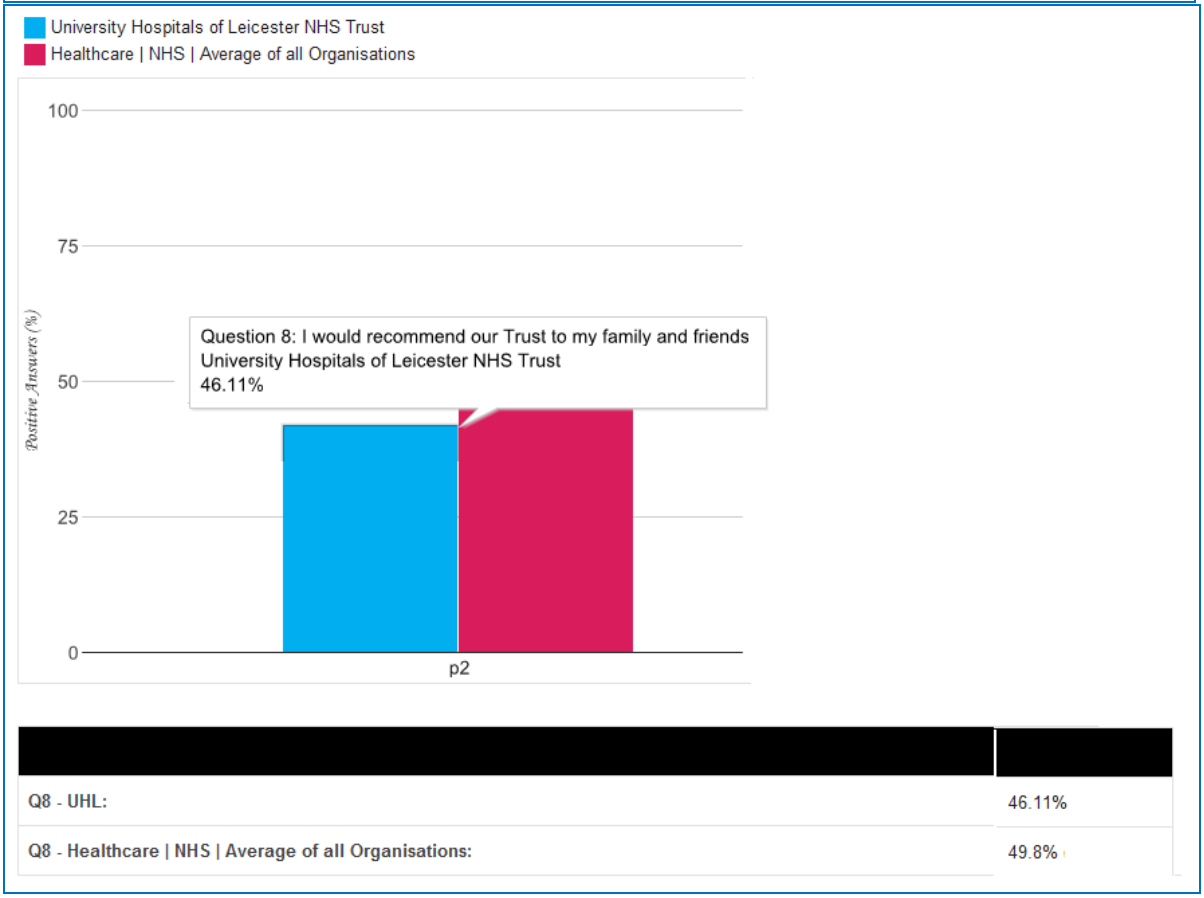


	p1	p2
Q6 - UHL:	30.09%	53.86% (+23.77%)
Q6 - Healthcare | NHS | Average of all Organisations:	40.19%	50.41% (+10.22%)

University Hospitals of Leicester NHS Trust

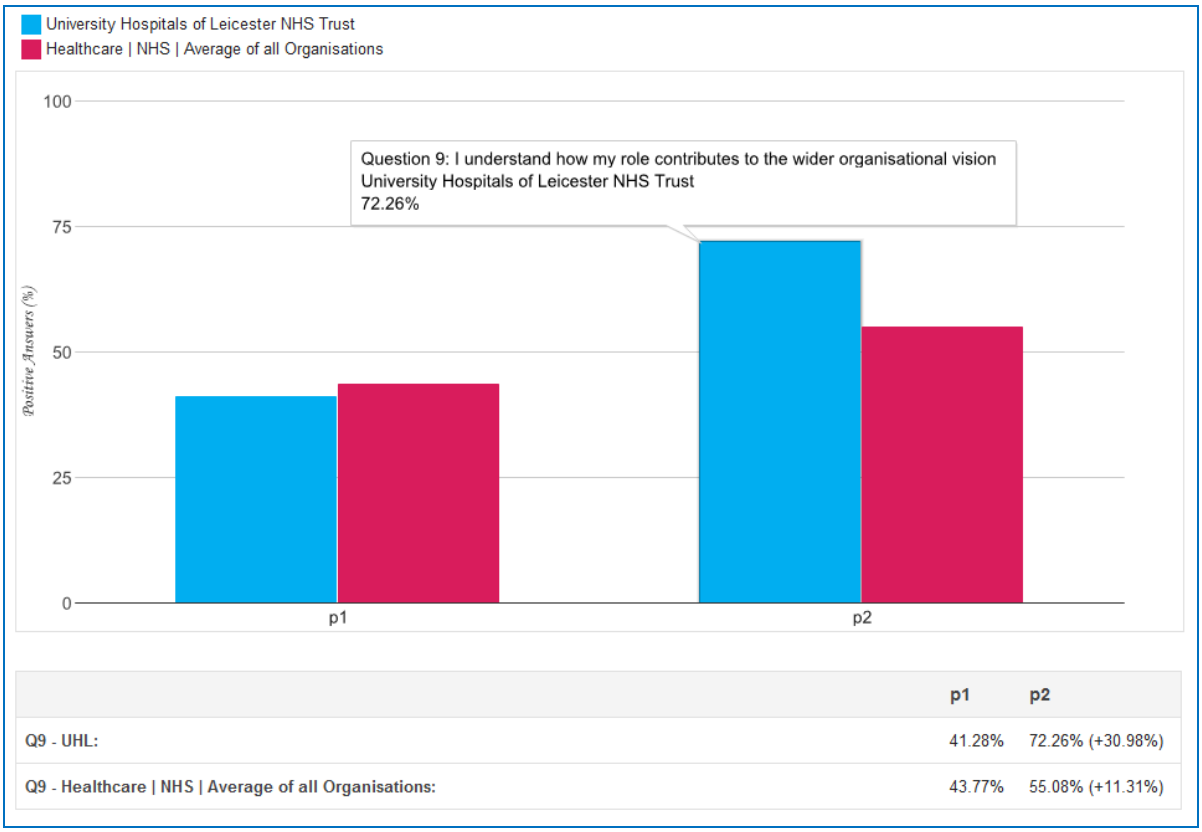


	p1	p2
Q7 - UHL:	17.3%	43.13% (+25.83%)
Q7 - Healthcare | NHS | Average of all Organisations:	22.57%	35.24% (+12.67%)

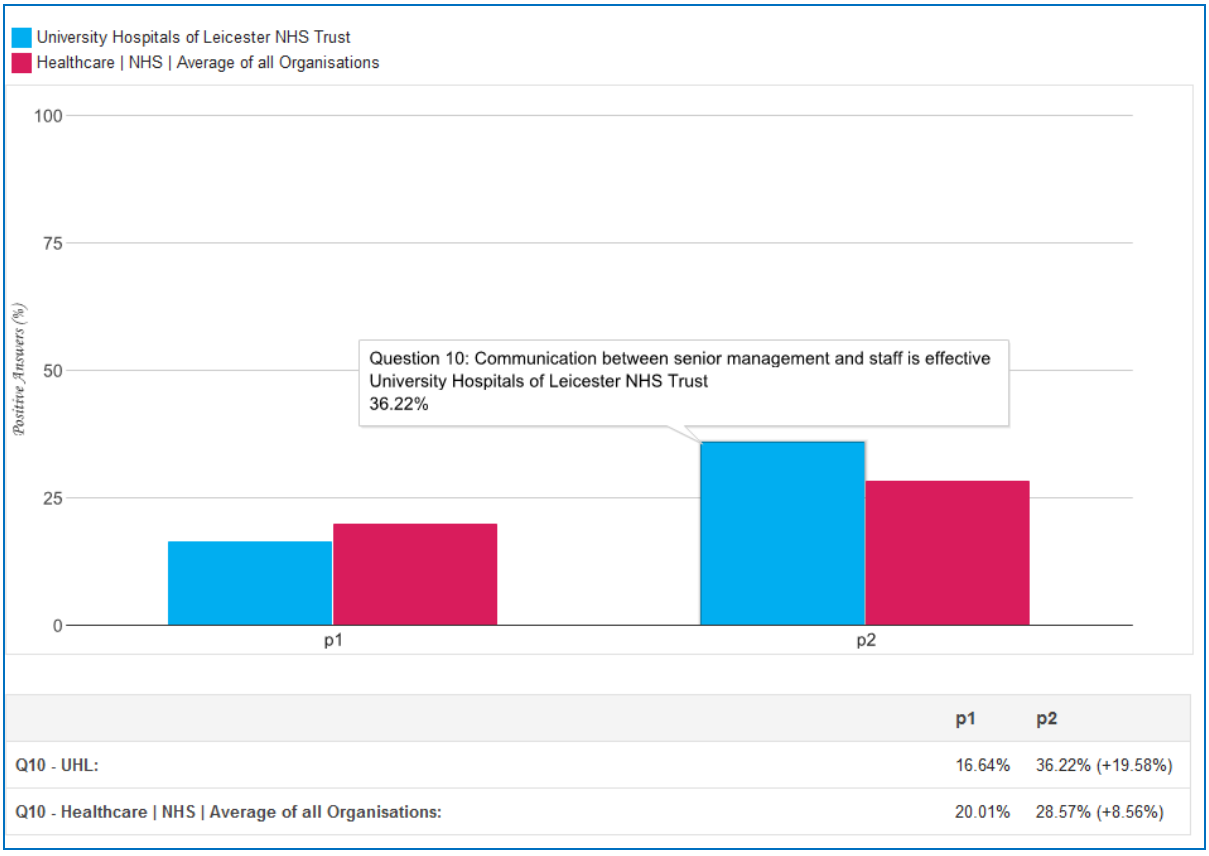


Q8 - UHL:	46.11%
Q8 - Healthcare | NHS | Average of all Organisations:	49.8%

University Hospitals of Leicester NHS Trust

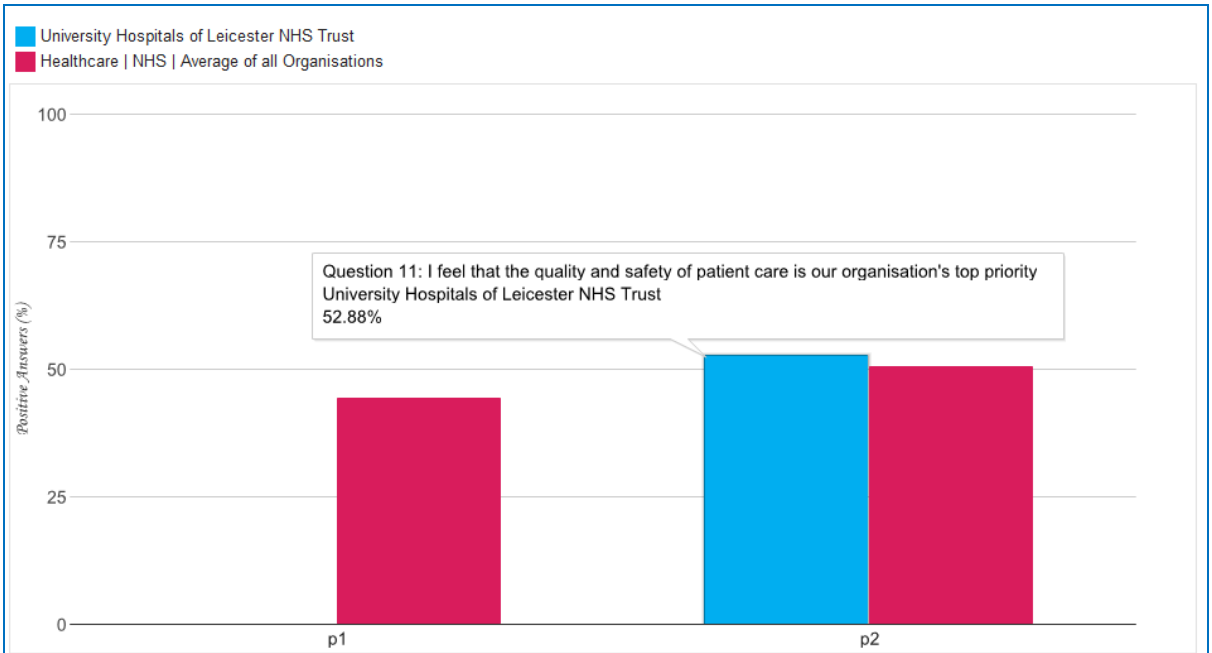


	p1	p2
Q9 - UHL:	41.28%	72.26% (+30.98%)
Q9 - Healthcare | NHS | Average of all Organisations:	43.77%	55.08% (+11.31%)

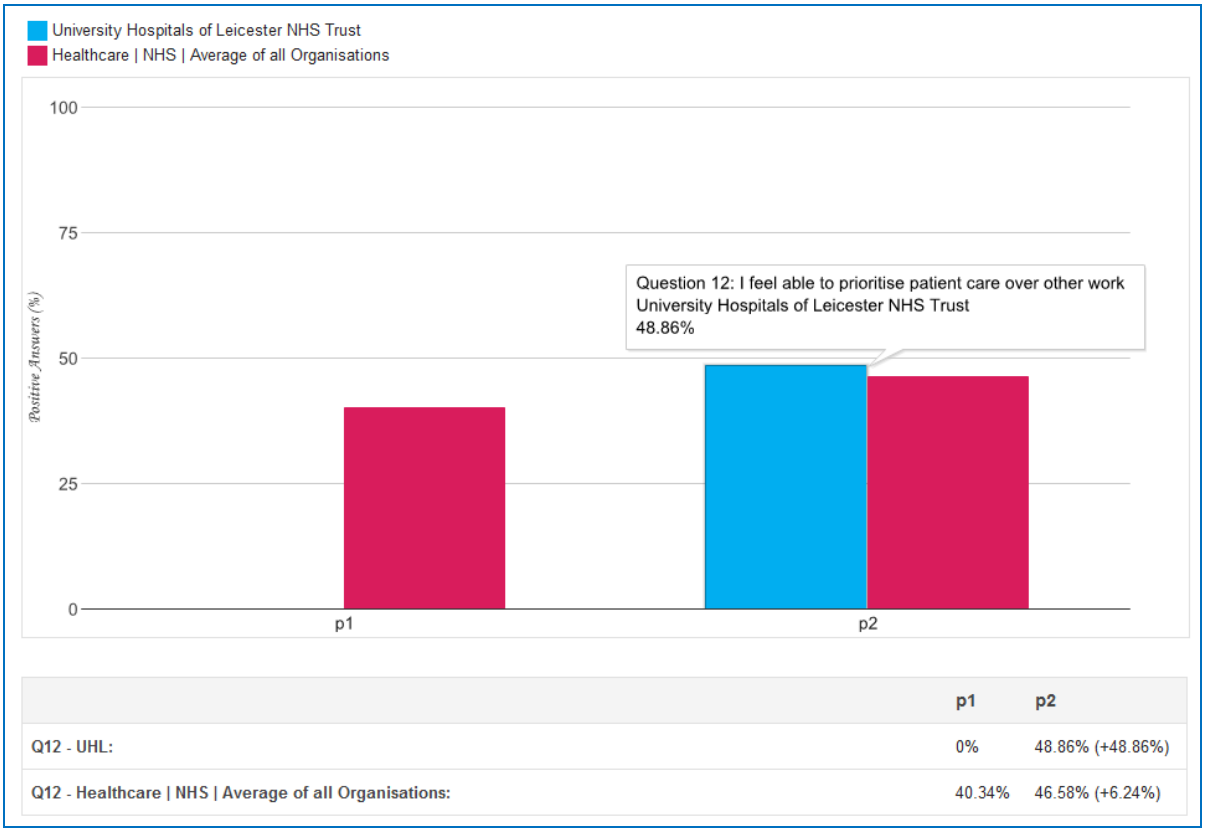


	p1	p2
Q10 - UHL:	16.64%	36.22% (+19.58%)
Q10 - Healthcare | NHS | Average of all Organisations:	20.01%	28.57% (+8.56%)

University Hospitals of Leicester NHS Trust

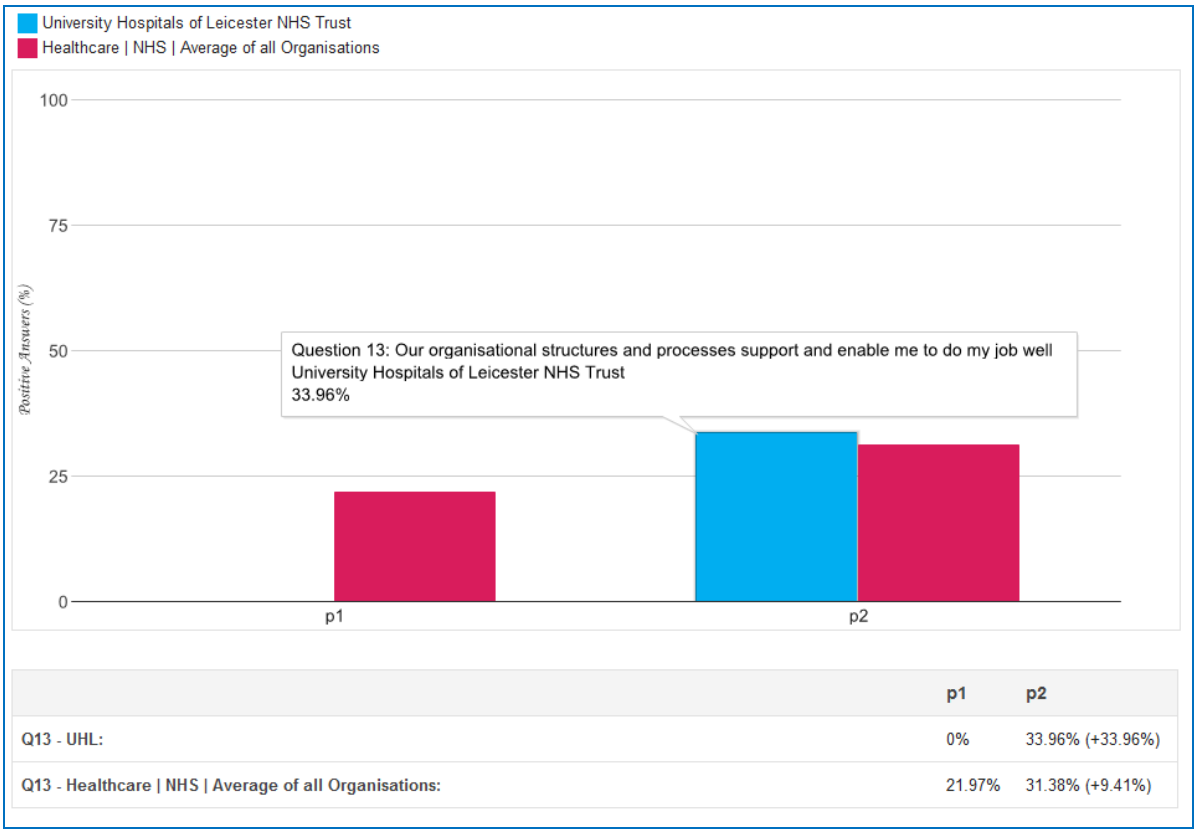


	p1	p2
Q11 - UHL:	0%	52.88% (+52.88%)
Q11 - Healthcare | NHS | Average of all Organisations:	44.48%	50.86% (+6.38%)

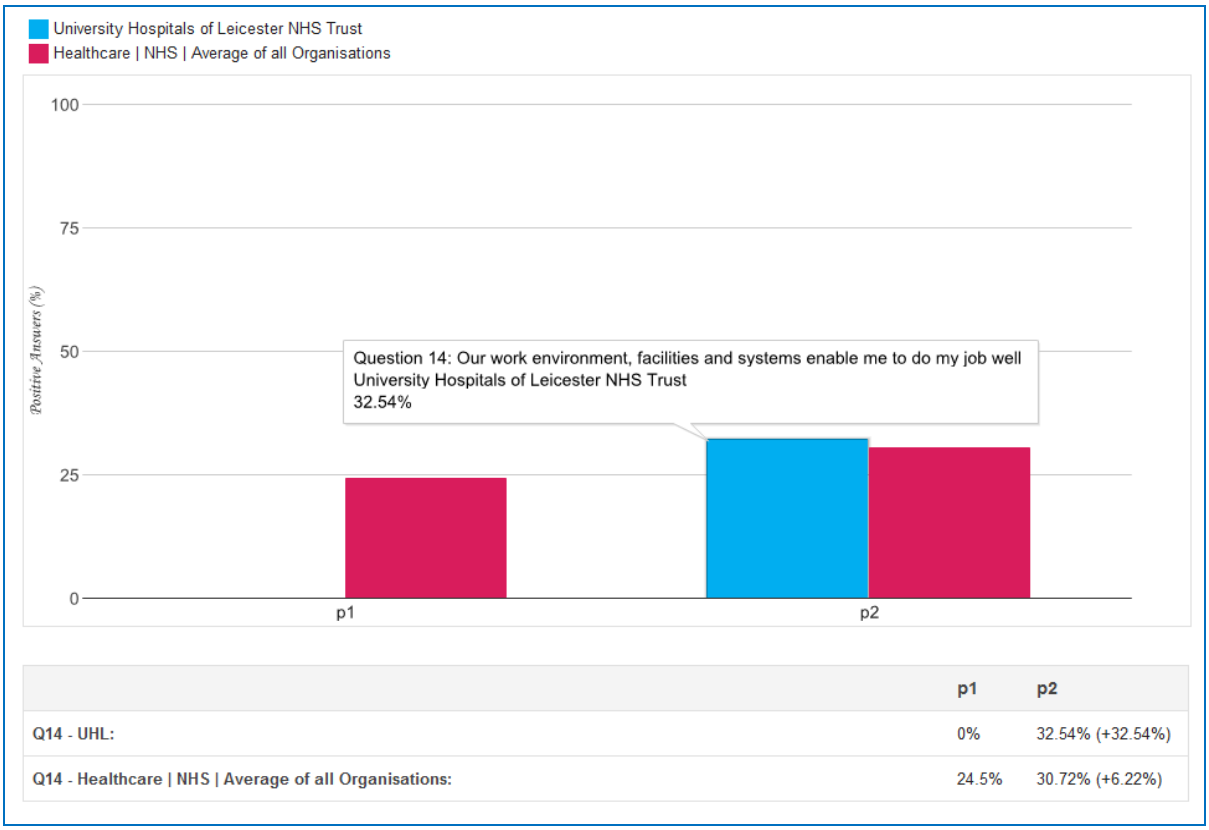


	p1	p2
Q12 - UHL:	0%	48.86% (+48.86%)
Q12 - Healthcare | NHS | Average of all Organisations:	40.34%	46.58% (+6.24%)

University Hospitals of Leicester NHS Trust

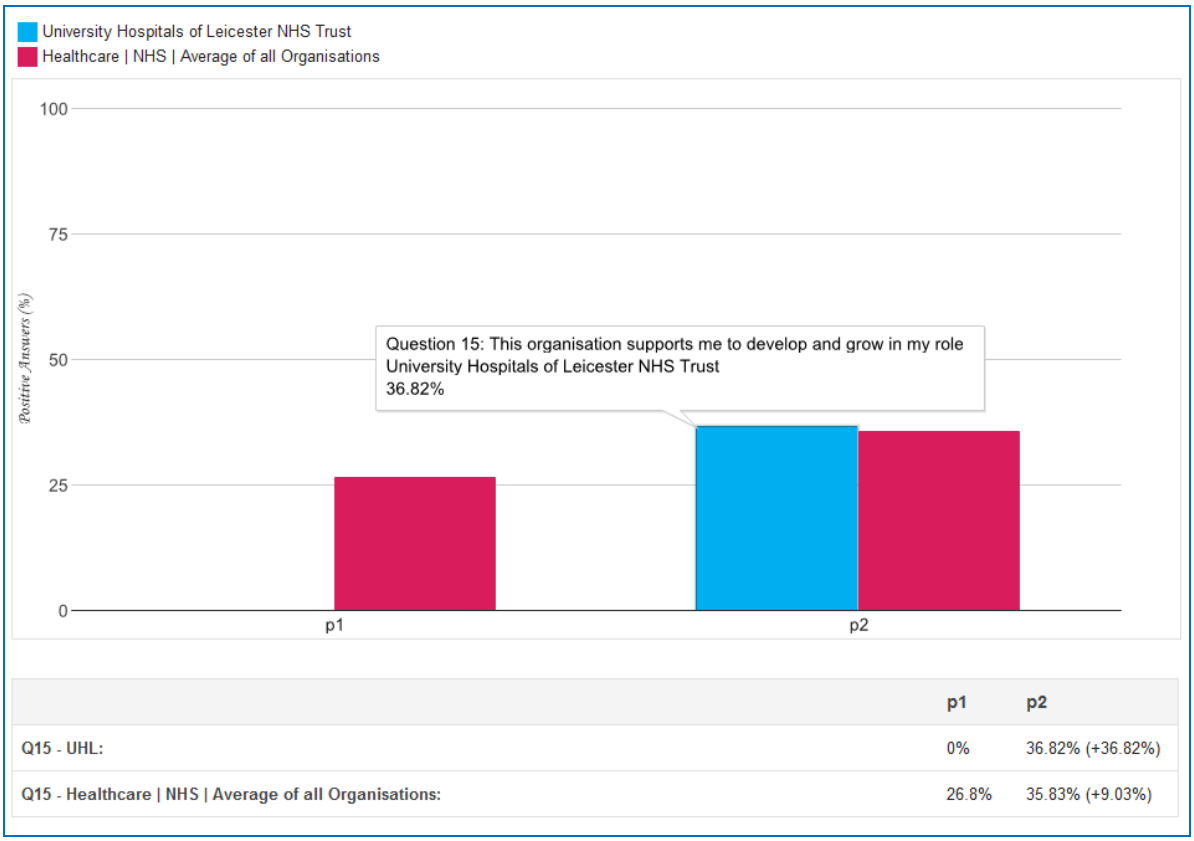


	p1	p2
Q13 - UHL:	0%	33.96% (+33.96%)
Q13 - Healthcare | NHS | Average of all Organisations:	21.97%	31.38% (+9.41%)

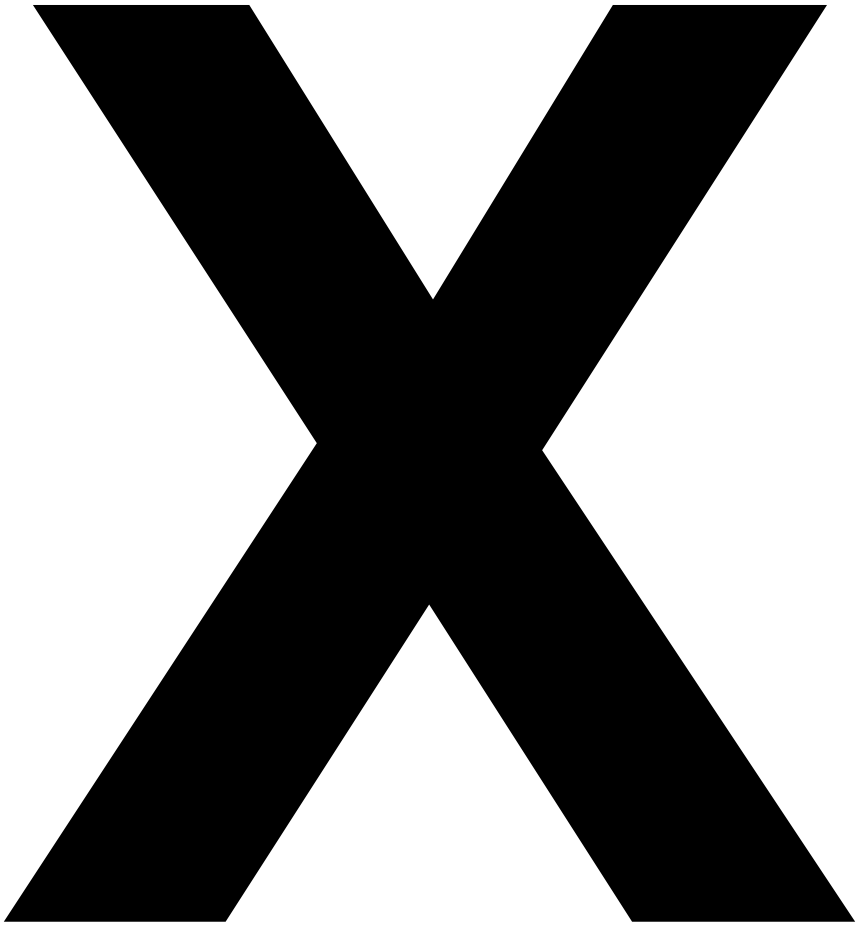


	p1	p2
Q14 - UHL:	0%	32.54% (+32.54%)
Q14 - Healthcare | NHS | Average of all Organisations:	24.5%	30.72% (+6.22%)

University Hospitals of Leicester NHS Trust



	p1	p2
Q15 - UHL:	0%	36.82% (+36.82%)
Q15 - Healthcare | NHS | Average of all Organisations:	26.8%	35.83% (+9.03%)



To:	**Trust Board**
From:	**Rachel Overfield - Chief Nurse**
Date:	**27 February 2014**
CQC regulation:	Outcome 16 – Assessing and Monitoring the Quality of Service Provision

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

Author/Responsible Director: Chief Nurse

Purpose of the Report:
The report provides the Board with an updated BAF and oversight of any new extreme and high risks opened within the Trust during the reporting period. The report includes:-

a) A copy of the BAF as of 31 January 2014.
b) An action tracker to monitor progress of BAF actions
c) New extreme and/ or high risks opened during the reporting period.

The Report is provided to the Board for:

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

Summary :

- Risk one requires significant revision and this entry will be updated by the IDFS and reported to the March TB.
- The contents of risk eight will be revised following discussions at the March 2014 EQB meeting and reported to the March TB.
- Actions 11.8 and 11.11 have moved to a red RAG rating due to the continued lack of response from 'Interserve'.
- There has been a reduction in risk score associated with risk number 12. This risk has now achieved its target score and the TB is asked to consider whether this risk can be closed.
- The following three BAF entries are suggested for review.
  Risk 11 – Loss of business continuity.
  Risk 12 – Failure to exploit the potential of IM&T.
  Risk 13 – Failure to enhance education and training culture.
- In response to a question raised at the previous TB meeting, risk scoring guidance is attached at appendix four. The guidance was developed by the National Patient Safety Agency for national use and is included on the UHL risk assessment form.
- Three new high risks have opened during January 2014.

Recommendations:
Taking into account the contents of this report and its appendices the Board are invited to:

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

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

(c) identify any areas which it feels that the Trust's controls are inadequate and do

not, therefore, effectively manage the principal risks to the organisation achieving its objectives;

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

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

(f) receive a verbal update in relation to action 10.6 from the Director of Strategy.

(g) endorse the closure of risk 12 as outlined in 2.3 (g) and consider whether there any further risks identified that may prevent the achievement of the strategic objectives that were associated with this risk. If closure is not endorsed then to consider what other actions are practicable to reduce the risk further.

Board Assurance Framework Yes	**Performance KPIs year to date** N/A
Resource Implications (eg Financial, HR) N/A	
Assurance Implications: Yes	
Patient and Public Involvement (PPI) Implications: Yes	
Equality Impact N/A	
Information exempt from Disclosure: No	
Requirement for further review? Yes. Monthly review by the Board	

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **27 FEBRUARY 2014**

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

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

---

1. INTRODUCTION

1.1 This report provides the Board with:-

a) A copy of the BAF as of 31 January 2014.
b) An action tracker to monitor progress of BAF actions.
c) Notification of any new extreme or high risks opened during the reporting period.

2. BAF POSITION AS OF 31 JANUARY 2014

2.1 A copy of the BAF is attached at appendix one with changes to narrative since the previous version shown in red text. A summary to show the movement of risk scores since the previous report is now included at page 3 of the BAF.

2.2 The progress of actions associated with the BAF is monitored by reference to the action tracker attached at appendix two. Actions completed prior to January 2014 have been removed from the tracker however a full audit trail of these is available by reference to previous documents.

2.3 The Board is asked to note the following points:

a. The Interim Director of Financial Strategy (IDFS) has advised that risk one requires significant revision as the risk has already materialised (i.e. a forecast deficit £39.8 million). This entry will be updated by the IDFS and reported to the TB at the end of March.

b. The Chief Nurse has advised that the contents of risk eight will be revised following discussions at the March 2014 EQB meeting.

c. Action 9.2 reworded to give greater emphasis on the reliance of the independent sector to help resolve referral to treatment (RTT) challenges within some specialties.

d. At the time of writing no update has been received for action 10.6 (due for completion in January 2014). The Director of Strategy is invited to provide the TB with a verbal update of progress.

e. Actions 11.8 and 11.11 have moved to a red RAG rating due to the continued lack of response from 'Interserve'.

f. New actions added to risk 11 (see actions 11.15, 11.16 and 11.17).

g. All actions associated with risk 12 have been completed and the current score has now reached the target score. Consideration should be given as to whether this risk can now be closed.

2.4 In order to provide an opportunity for more detailed scrutiny the following three BAF entries are suggested for review against the parameters listed in appendix three.

- Risk 11 – Loss of business continuity.
- Risk 12 – Failure to exploit the potential of IM&T.
- Risk 13 – Failure to enhance education and training culture.

2.5 In response to a question raised at the previous TB meeting, risk scoring guidance is attached at appendix four for information. The guidance was developed by the National Patient Safety Agency for national use and is included on the UHL risk assessment form. The TB is asked to note that the corporate risk team is currently updating the contents of the guidance to ensure relevance to UHL.

3 EXTREME AND HIGH RISK REPORT.

3.1 The TB is asked to note that three new high risks have opened during January 2014 as described below. The details of these risks are included at appendix five.

Risk ID	Risk Title	Risk Score	CMG/Corporate Directorate
2294	Risks to the clinical care of patients with CHD due to the shortfall of paediatric cardiac anaesthetists	20	Women's and Children's
2283	There is a risk of patient harm caused by failure of lifts in Kensington building	16	Women's and Children's
2275	There is a lack of robust clinical processes relating to Subcutaneous Methotrexate therapy due to staff shortages	15	Emergency Care and Specialist Medicine

4. RECOMMENDATIONS

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

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

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

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

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

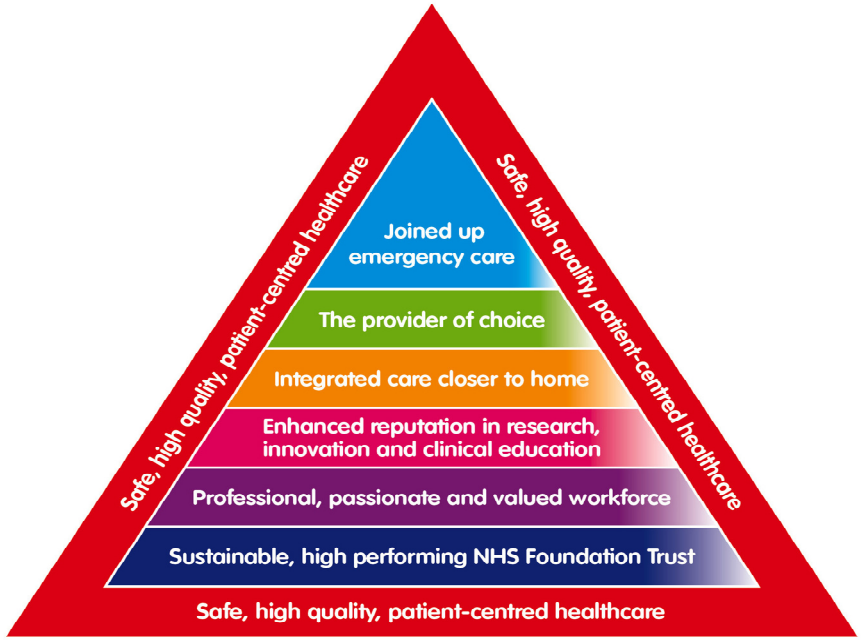
(e) identify any other actions which it feels need to be taken to address any 'significant control issues' to provide assurance on the Trust meeting its principal objectives;

(f) Receive a verbal update in relation to action 10.6 from the Director of Strategy.

(g) endorse the closure of risk 12 as outlined in 2.3 (g) and consider whether there are any further risks identified that may prevent the achievement of the strategic objectives that were associated with this risk. If closure is not endorsed then to consider what other actions are practicable to reduce the risk further.

Peter Cleaver,
Risk and Assurance Manager,
20 February 2014.

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK JANUARY 2014



UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK JANUARY 2014

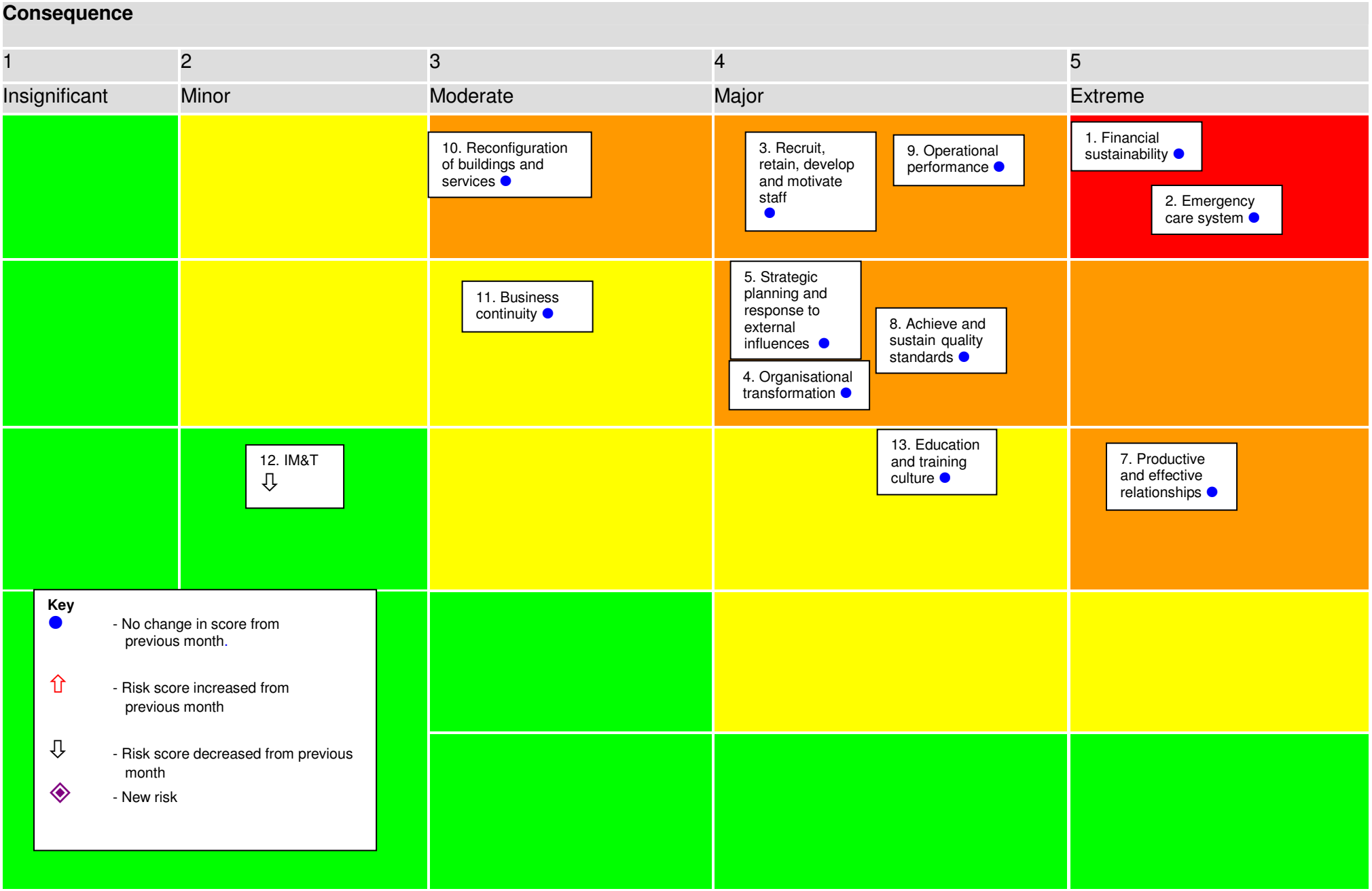
PERIOD: JANUARY 2014

RISK TITLE	STRATEGIC OBJECTIVE	CURRENT SCORE	TARGET SCORE
Risk 1 – Failure to achieve financial sustainability	g - To be a sustainable, high performing NHS Foundation Trust	25	12
Risk 2 – Failure to transform the emergency care system	b - To enable joined up emergency care	25	12
Risk 3 – Inability to recruit, retain, develop and motivate staff	f - To maintain a professional, passionate and valued workforce e - To enjoy an enhanced reputation in research, innovation and clinical education.	20	12
Risk 4 – Ineffective organisational transformation	a - To provide safe, high quality patient-centred health care c - To be the provider of choice d - To enable integrated care closer to home	16	12
Risk 5 – Ineffective strategic planning and response to external influences	a - To provide safe, high quality patient-centred health care c - To be the provider of choice g - To be a sustainable, high performing NHS Foundation Trust	16	12
Risk 6 – **Risk deleted from BAF following approval of Trust Board**	**Not applicable**	**N/A**	**N/A**
Risk 7 – Failure to maintain productive and effective relationships	c - To be the provider of choice d - To enable integrated care closer to home f - To maintain a professional, passionate and valued workforce	15	10
Risk 8 – Failure to achieve and sustain quality standards	a - To provide safe, high quality patient-centred health care c - To be the provider of choice	16	12
Risk 9 – Failure to achieve and sustain high standards of operational performance	a - To provide safe, high quality patient-centred health care	20	12
Risk 10 – Inadequate reconfiguration of buildings and services	a - To provide safe, high quality patient-centred health care	15	9
Risk 11– Loss of business continuity	g - To be a sustainable, high performing NHS Foundation Trust	12	6
Risk 12 – Failure to exploit the potential of IM&T	a - To provide safe, high quality patient-centred health care d - To enable integrated care closer to home	6	6
Risk 13 - Failure to enhance education and training culture	e – To enjoy an enhanced reputation in research, innovation and clinical education	12	6

STRATEGIC OBJECTIVES:-	
a - To provide safe, high quality patient-centred health care.	**e - To enjoy an enhanced reputation in research, innovation and clinical education.**
b - To enable joined up emergency care.	**f - To maintain a professional, passionate and valued workforce.**
c - To be the provider of choice.	**g - To be a sustainable, high performing NHS Foundation Trust.**

N.B. Action dates are end of month unless otherwise stated

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK JANUARY 2014



N.B. Action dates are end of month unless otherwise stated

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK JANUARY 2014

RISK NUMBER/ TITLE:	**RISK 1 – FAILURE TO ACHIEVE FINANCIAL SUSTAINABILITY**
LINK TO STRATEGIC OBJECTIVE(S)	**g. - To be a sustainable, high performing NHS Foundation Trust.**
EXECUTIVE LEAD:	Interim Director of Financial Strategy

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to achieve financial sustainability including:	Overarching financial governance processes including PLICS process and expenditure controls. Revised variance analysis and reporting metrics especially for the ETPB Self-assessment and SLM baseline exercise completed and project manager identified Finalised SLM Action plan Full information has now been received on UHL allocations from all the no-recurrent funding streams including transformation monies. This information is being incorporated into the financial forecasts.	5X5=25	Monthly /weekly financial reporting to Exec Team Performance Board, F&P Committee and Board. Cost centre reporting and monthly PLICS reporting. Monthly confirm and challenge processes at specialty and CMG level. Annual internal and external audit programmes. Monthly meetings with the NTDA and the CCG Contract Performance Meeting	(c) SLM programme not fully implemented	ESB will continue to meet every 6 weeks to ensure implementation of SLM across the Trust (expected Mar 2014) (1.19)	4x3=12	Mar 2014 IDFS
Failure to achieve CIP.	Strengthened CIP governance structure including appt of Head of CIP programme		Progress in delivery of CIPs is monitored by CIP Programme Board (meeting fortnightly) and reported to ET and Board.	(c) Under-delivery of CIP programme (£2.5m adverse to plan M9)			

Locum expenditure.	Workforce plan to identify effective methods to recruit to 'difficult to fill' areas Reinstatement of weekly workforce panel to approve all new posts. STAFFflow for medical locums saving £130k of every £1m expenditure Financial Recovery plans developed Non Contractual Payments are discussed at monthly CMG meetings Confirm and Challenge Meetings All CMGs (by specialty) have produced premium spend trajectories and associated plans until March 2014 Weekly Staff Bank data reports are issued for medical and nursing (qualified and unqualified) staff Action plan to increase bank staff capacity and drive down agency nurse expenditure.		The use of locum staff in 'difficult to fill' areas reported monthly to the Board via the Q&P report. A reduction in the use of locums would be an assurance of success in recruiting substantive staff to 'difficult to fill' areas. Increase in contracted staff numbers of medical and nursing professions of 252wte since Mar 12. Saving in excess of £0.6m 5 weeks after 'go live' date Monthly Q&P report to TB Monthly confirm and challenge meetings Non contractual payments (premium spend) are reported monthly to the Finance and Performance Committee A weekly report is presented to ET. Weekly meetings with HoNs and DHR to monitor progress.	(c) Further investigation required as to the increase in Consultant numbers by 41wte (7.7%)			
Loss of income due to tariff/tariff changes (including referral rate for emergency admissions – MRET)	Contract meetings with Commissioners Negotiations with Commissioners concluded at a transactional level. Ongoing discussions with commissioners about planned re-investment of the MRET deductions.		Monthly /weekly financial reporting to Finance and Performance (F&P) Committee and Board.	(c) Failing to manage marginal activity efficiently and effectively. This is being addressed via ongoing discussions with Commissioners			

Ineffective processes for Counting and Coding.	Clinical coding project. Clinical coding to be included as a 2nd wave LIA pioneering team to involve clinicians.		Ad-Hoc reports on annual counting and coding process. PbR clinical coding audit Jan 2013 (final report received 29 May 2013). IG toolkit audit (sample of 200 General Surgery episodes).	(c) Error rates in audit sample could be indicative of underlying process issues. (c) Error rates identified as: Primary diagnoses incorrect 8.0% › Secondary diagnoses incorrect 3.6%. › Primary procedure incorrect 6.4% › Secondary procedure incorrect 4.5%.			
Loss of liquidity.	Liquidity Plan.		Monthly /weekly financial reporting to F&P Committee and Board. Detailed cash management plans presented at August 2013 F&P committee.				
Lack of robust control over pay and non-pay expenditure.	Pay and Non-pay recovery action plan in place and monitored monthly. Catalogue control project.		Monthly /weekly financial reporting to F&P Committee and Board. Non-pay management plan presented at July F&P committee. Ongoing Monitoring via F&P Committee.				
Commissioner fines against performance targets.	Contract meetings with Commissioners and negotiations with Commissioners concluded at a transactional level. Plans and trajectories developed to reduce admission rates that are monitored at monthly C&C meetings.		Monthly /weekly monitoring of action plans, key performance target, and financial reporting to F&P Committee and Board.				
Use of readmission monies.	Contract meetings with Commissioners Negotiations with Commissioners concluded at a transactional level Ownership of readmissions work streams in divisions clarified.		Monthly /weekly financial reporting to F&P Committee and Board.				
Ineffective organisational transformation.	See risk 4		See risk 4.	See risk 4.	See risk 4.		See risk 4

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK JANUARY 2014

RISK NUMBER/ TITLE:	**RISK 2 – FAILURE TO TRANSFORM THE EMERGENCY CARE SYSTEM**
LINK TO STRATEGIC OBJECTIVE(S)	**b. - To enable joined up emergency care.**
EXECUTIVE LEAD:	Chief Operating Officer

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to transform emergency care system leading to demands on ED and admissions units continuing to exceed capacity.	Health Economy has submitted response plan to NHSE requirements for an Emergency Care system under the A&E Performance Gateway Reference 00062.	5x5=25	Once plan agreed with NTDA, it will be circulated to the Board.	No gaps	No actions	4x3=12	
	Emergency Care Action Team formed. Chaired by Chief executive to ensure Emergency Care Pathway Programme actions are being undertaken in line with NHSE action plan and any blockages to improvement removed. Development of action plan to address key issues.		Action Plan circulated to the Board on a monthly basis as part of the Report on the Emergency Access Target within the Quality and Performance Report.	Gaps described below	Actions described below		
	A new plan has been submitted detailing a clear trajectory for performance improvement and includes key themes from plan: Single front door.		Project plan developed by CCG project manager Risks from 'single front door' to be escalated via ECAT and raised with CCG Managing Director as required.	No gaps	No actions		
	ED assessment process is being operated.		Forms part of Quality Metrics for ED reported daily update and part of monthly board performance report.	No gaps	No actions		
	Recruitment campaign for continued recruitment of ED medical and nursing staff including fortnightly meetings with HR to highlight delays and solutions in the recruitment process.		Vacancy rates and bank/agency usage reported to Trust Board on a monthly basis. Recruitment plan being led by HR and monitored as part of ECAT.	(c) Difficulties are being encountered in filling vacancies within the emergency care pathway. Agency and bank requests continue to increase in response to increasing sickness rates, additional capacity, and vacancies. (c) Staffing vacancies for medical and nursing staff remain high.	Continue with substantive appts until funded establishment is achieved. (2.7)		Review Mar 2014 COO

	Formation of an EFU and AFU to meet increased demand of elderly patients.		'Time to see consultant' metric included in National ED quarterly indicator.	No gaps	No actions		
	Maintenance of AMU discharge rate above 40%.		Reported to Operational Board twice monthly and will be included in Emergency Care Update report in Q&P Report.	No gaps	No actions		
	New daily MDT Board Rounds on all medical wards and medical plans within 24hrs of admission.		Reported to Operational Board twice monthly and will be included in Emergency Care Update report in Q&P Report.	No gaps	No actions		
	EDDs to be available on all patients within 24 hours of admission. Review built in to daily discharge meetings to check accuracy of EDDs (from 2/09/13).		Monitored and reported to Operational Board twice monthly and will be included in Emergency Care Update report in Q&P report.	No gaps	No actions		
	Maintain winter capacity in place to allow new process to embed.		All winter capacity beds are to be kept open until the target is consistently met.	No gaps	No actions		
	DTOCs to be kept to a minimal level by increasing bed capacity. 24 Additional beds available from December 2013.		Forms part of the Report on Emergency Access in the Q&P Report.	No gaps	No actions		

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK JANUARY 2014

RISK NUMBER/ TITLE:	**RISK 3 – INABILITY TO RECRUIT, RETAIN, DEVELOP AND MOTIVATE STAFF**
LINK TO STRATEGIC OBJECTIVE(S))	**e. - To enjoy an enhanced reputation in research, innovation and clinical education** **f. - To maintain a professional, passionate and valued workforce**
EXECUTIVE LEAD:	Director of Human Resources

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Inability to recruit, retain, develop and motivate suitably qualified staff leading to inadequate organisational capacity and development.	Leadership and talent management programmes to identify and develop 'leaders' within UHL.	4x5=20	Development of UHL talent profiles.	No gaps identified.	No actions required.	4x3=12	
			Talent profile update reports to Remuneration Committee.	No gaps identified.	No actions required.		
	Substantial work program to strengthen leadership contained within OD Plan.			No gaps identified.	No actions required.		
	Organisational Development (OD) plan.		A central enabler of delivering against the OD Plan work streams will be adopting, 'Listening into Action' (LiA) and progress reports on the LiA will be presented to the Trust Board on a quarterly basis.	No gaps identified.	No actions required.		
	A central enabler of delivering against the OD Plan work streams will be adopting, 'Listening into Action (LiA). A Sponsor Group personally led by our Chief Executive and including, Executive Leads and other key clinical influencers has been established.		Progress reports on the LiA will be presented to the Trust Board on a quarterly basis.	No gaps identified. No gaps identified.	No actions required. No actions required.		
	Staff engagement action plan encompassing six integrated elements that shape and enable successful and measurable staff engagement.		Results of National staff survey and local patient polling reported to Board on a six monthly basis. Improving staff satisfaction position.	No gaps identified.	No actions required.		
			Staff sickness levels may also provide an indicator of staff satisfaction and performance. Staff sickness rate is 4.7% for M9.	No gaps identified	No actions required.		

	Appraisal and objective setting in line with UHL strategic direction. Local actions and appraisal performance recovery plans/ trajectories agreed with CMGs and Directorates Boards. Summary of quality findings communicated across the Trust; to identify how to improve the quality of the appraisal experience for the individual and the quality of appraisal meeting recording.		Appraisal rates reported monthly to Board via Quality and Performance report. Appraisal performance features on CMG / Directorate Board Meetings to monitor the implementation of agreed local actions. Month 9 appraisal rate = 92.4%.				
			Results of quality audits to ensure adequacy of appraisals reported to the Board via the quarterly workforce and OD report.	No gaps identified.	No actions required.		
			Appraisal Quality Assurance Findings reported to Trust Board via OD Update Report June 2013 Quality Assurance Framework to monitor appraisals on an annual cycle (next due March 2014).	No gaps identified.	No actions required.		
	Workforce plans to identify effective methods to recruit to 'difficult to fill areas). CMG and Directorates 2013/14 Workforce Plans. Active recruitment strategy including implementation of a dedicated nursing recruitment team. Programme of induction and adaptation for international pool of nurses.		Nursing Workforce Plan reported to the Board in September 2013 highlighting demand and initiatives to reduce gap between supply and demand. The use of locum staff in 'difficult to fill' areas is reported to the Board on a monthly basis via the Q&P report. Reduction in the use of such staff would be an assurance of our success in recruiting substantive staff.	(c) Risks with employing high number from an International Pool in terms of ensuring competence	Develop an employer brand and maximise use of social media (3.9).		April 2014 DHR
	Reward /recognition strategy and programmes (e.g. salary sacrifice, staff awards, etc). Recruitment and Retention Premia for ED medical and nursing staff.				Development of Pay Progression Policy for Agenda for Change staff (3.3).		Mar 2014 DHR
	UHL Branding – to attract a wider and more capable workforce. Includes development of recruitment literature and website, recruitment events, international recruitment. Recruitment progress is measured now there is a structured plan for bulk recruitment. Leads have been identified to develop and encourage the production of fresh and up to date recruitment material. Reporting and monitoring of posts with 5 or less applicants.		Evaluate recruitment events and numbers of applicants. Reports issued to Nursing Workforce Group (last report 4 Feb). Reporting will be to the Board via the quarterly workforce an OD report. Quarterly report to senior HR team and to Board via quarterly workforce and OD report.	(a) Better baselining of information to be able to measure improvement. (c) Lack of engagement in production of website material.			

	Statutory and mandatory training programme for 9 key subject areas in line with National Core Skills Framework.		Monthly monitoring of statutory and mandatory training uptake via reports to TB and ESB against 9 key subject areas (currently showing month on month improvements (65% at M9).	(c) Compliance against the 9 key subject areas is 62% (December 2013). (a) Potentially there may be inaccuracies of training data within the e-UHL system.	Ensure Statutory and Mandatory training is easy to access and complete with 75% compliance by reviewing delivery mode, access and increasing capacity to deliver against specific subject areas (3.5). Update e-UHL records to ensure accuracy of reporting on a real time basis (3.7).		Mar 2014 DHR Mar 2014 DHR

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK JANUARY 2014

RISK NUMBER/ TITLE:	**RISK 4 – INEFFECTIVE ORGANISATIONAL TRANSFORMATION**
LINK TO STRATEGIC OBJECTIVE(S)	**a. - To provide safe, high quality patient-centred health care.** **c. - To be the provider of choice.** **d. - To enable integrated care closer to home**
EXECUTIVE LEAD:	Director of Strategy

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to put in place a robust approach to organisational transformation, adequately linked to related initiatives and financial planning/outputs.	Development of Improvement and Innovation Framework (IIF). Outputs from this transformation programme will drive the implementation of the clinical strategy.	4x4=16	Monthly progress reports to Exec Strategy Board and F&P Committee. Approval of framework and operational arrangements due at Trust Board June 2013. Monitoring of overall Framework will be via IIF Board and F&P Ctte and monitoring of financial outputs (CIPs) will be via CIP Delivery Board, Exec Performance Board and F&P Committee. Delivery of whole hospital change programmes requires alignment with the whole local Health Economy change programme – currently described through the Better Care Together programme.	(c) Gaps are evident in the alignment of transformational process between UHL and principle partners – this is being raised through the Better Care Together Programme structures.	Review outputs from Chief Officers Group and strategic Planning Group to ensure gaps in current processes are being addressed (4.1).	4x3=12	Review Feb 2014 DS

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK JANUARY 2014

RISK NUMBER / TITLE	**RISK 5 - INEFFECTIVE STRATEGIC PLANNING AND RESPONSE TO EXTERNAL INFLUENCES**
LINK TO STRATEGIC OBJECTIVE(S)	**a. - To provide safe, high quality patient-centred health care.** **c. - To be the provider of choice.** **e. - To enjoy an enhanced reputation in research innovation and clinical education.** **g. - To be a sustainable, high performing NHS Foundation Trust**
EXECUTIVE LEAD:	Director of Strategy

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to put in place appropriate systems to horizon scan and respond appropriately to external drivers. Failure to proactively develop whole organisation and service line clinical strategies.	Appointment of Strategy Director.	4x4=16	Plan agreed by Remuneration Committee.	None identified.	Not applicable.	4x3=12	N/A
	Allocation of market intelligence responsibility to Director of Marketing and Communications. Co-ordinated approach to business intelligence gathering and response via Clinical Management Groups. Workshop 'hosted by the Director of Strategy 'delivering our strategic direction' held in November with all CMGs to set the external context within which we will need to develop a LLR Integrated 5-yaer plan, within which our 2-yaer operational plans will sit. CMG Strategy Leads now engaged in the BSST meetings to improve engagement, alignment and teamwork. ESB forward plan reflecting a 12 month programme aligned with: • the development of the IBP/LTFM • the reconfiguration programme • the development of the next AOP • The TB Development Programme The TB formal agenda		Agreed by Remuneration Committee. Weekly strategic planning meetings in place – cross CMG and corporate team attendance with delivery led through the Strategy Directorate. Development of a clear, clinically based 5 year strategic will provide assurance that strategic planning is taking place. Reports to ESB. Regular reports to TB reflecting progress of 12 month programme.	None identified. None identified. None identified.	Not applicable. Not applicable. Not applicable.		N/A

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK JANUARY 2014

RISK NUMBER/ TITLE:	**RISK 7– FAILURE TO MAINTAIN PRODUCTIVE AND EFFECTIVE RELATIONSHIPS**
LINK TO STRATEGIC OBJECTIVE(S)	**c. - To be the provider of choice.** **d. - To enable integrated care closer to home.** **f. – To maintain a professional, passionate and valued workforce.**
EXECUTIVE LEAD:	Director of Marketing and Communications

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to maintain productive relationships with external partners/ stakeholders leading to potential loss of activity and income, poor reputation and failure to retain/ reconfigure clinical services.	Stakeholder Engagement Strategy. Regular meetings with external stakeholders and Director of Communications and member of Executive Team to identify and resolve concerns. Regular stakeholder briefing provided by an e-newsletter to inform stakeholders of UHL news. Leicester, Leicestershire and Rutland (LLR) health and social care partners have committed to a collaborative programme of change ('Better Care Together').	5X3=15	Twice yearly GP surveys with results reported to UHL Executive Team. Latest survey results discussed at the April 2013 Board and showed increasing levels of satisfaction… a trend which has now continued for 18 months. Annual Reputation / Relationship survey to key professional and public stakeholders Nov 13.	(c) No external and 'dispassionate' professional view of stakeholder / relationship management activity.	Invite PWC (Trust's Auditors) to offer opinion on the plan / talk to a selection of stakeholders. (7.3)	5X2=10	Mar 2014 DCM

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK JANUARY 2014

RISK NUMBER/ TITLE:	**RISK 8 – FAILURE TO ACHIEVE AND SUSTAIN QUALITY STANDARDS**
LINK TO STRATEGIC OBJECTIVE(S)	**a. – To provide safe, high quality patient-centred health-care**
EXECUTIVE LEAD:	Chief Nurse (with Medical Director)

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to achieve and sustain quality standards leading to failure to reduce patient harm with subsequent deterioration in patient experience/ satisfaction/ outcomes, loss of reputation and deterioration of 'friends and family test' score.	Standardised M&M meetings in each speciality.	4x4=16	Routine analysis and monitoring of out of hours/weekend mortality at CMG Boards.	No gaps.	No action needed.	4x3=12	
	Systematic speciality review of "alerts" of deterioration to address cause and agree remedial action by Mortality Review Committee. Reports to Executive Quality Board, QAC, and by exception to ET and TB. All deaths in low risk groups identified. Working with DFI to ensure data has been recorded accurately.		Quality and Performance Report and National Quality dashboard presented to ET and TB. Currently SMHI "within expected" (i.e. 106). UHL now subscribes to the Hospital Evaluation Dataset (HED) which is similar to the Dr Foster Intelligence clinical benchmarking system but also includes a 'SHMI analysis tool'.	(a) UHL risk adjusted perinatal mortality rate above regional and national average.			
	Robust implementation of actions to achieve Quality Commitment (save 1000 extra lives in 3 years).		SHMI remains "within expected" (i.e. 106). Independent analysis of mortality review performed by Public Health. Results reported at November 2013 TB meeting.	No gaps identified.	No action needed.		
	Agreed patient centred care priorities for 2013-14: - Older people's care - Dementia care - Discharge Planning		Quality Action Group meets monthly. Achievement against key objectives and milestones report to Trust board on a monthly basis. A moderate improvement in the older people survey scores has been recorded.	No gaps identified.	No action needed.		
	Multi-professional training in older peoples care and dementia care in line with LLR dementia strategy.		Quality Action Group monitoring of training numbers and location.	No gaps identified.	No action needed.		

	Protected time for matrons and ward sisters to lead on key outcomes.		CMG/ specialty reporting on matron activity and implementation or supervisory practice.	(c) Present vacancy levels prevent adoption of supervisory practice.	Active recruitment to ward nursing establishment so releasing ward sister –for supervisory practice (8.5).		Sep 2014 CN
	To promote and support older peoples champions network and new dementia champions network.		Monthly monitoring of numbers and activity.	No gaps identified.	No action needed.		
	Targeted development activities for key performance indicators - answering call bells - assistance to toilet - involved in care - discharge information		Monthly monitoring and tracking of patient feedback results. Monthly monitoring of Friends and Family Test reported to the TB (68.7% at M9). England average 72%. Older Peoples Quality Outcomes: all scores increased from M7 to M8 Discharge: All scores except for the question on being informed of problems/dangers signals increased from M7 to M8.				
	Quality Commitment 2013 – 2016: • Save 1000 extra lives • Avoid 5000 harm events • Provide patient centred care so that we consistently achieve a 75 point patient recommendation score.		Quality Action Groups monitoring action plans and progress against annual priority improvements. A Quality Commitment dashboard has been developed to present updates to the TB on the 3 core metrics for tracking performance against our 3 goals. These metrics will be tracked up to 2015. Impressive drops in fall numbers have been observed in Datix reports and in the Safety Thermometer audit.				
	Relentless attention to 5 Critical Safety Actions (CSA) initiatives to lower mortality.		Q&P report to TB showing outcomes for 5 CSAs. 4CSAs form part of local CQUIN monitoring. There is a risk to Q3 CQUIN full compliance from the delay in implementing the ward round documentation for the Senior Clinical Review, Ward Rounds and Notation action. All the other actions have achieved full compliance for Q3 against agreed action plans.	(c) Lack of a unified IT system in relation to ordering and receiving results means that many differing processes are being used to acknowledge/respond to results. Potential risk of results not being acted upon in a timely fashion.	Implementation of Electronic Patient Record (EPR). (8.10)		2015 CIO

	NHS Safety thermometer utilised to measure the prevalence of harm and how many patients remain 'harm free' (Monthly point prevalence for '4 Harms'). Monthly meetings with operational/clinical and managerial leads for each harm in place.		Monthly outcome report of '4 Harms' is reported to Trust board via Q&P report. The percentage of Harm Free Care for M9was 94% reflecting a reduction in the number of patients with newly acquired harms. There are no areas of concern in relation to the prevalence of New Harms.	(a) There is some concern that the revised DH monitoring tool is still not an effective measure to produce accurate information. Local actions to resolve this are not practicable.			
RISK NUMBER/ TITLE:		**RISK 9 – FAILURE TO ACHIEVE AND MAINTAIN HIGH STANDARDS OF OPERATIONAL PERFORMANCE**					
LINK TO STRATEGIC OBJECTIVE(S)		**a. - To provide safe, high quality patient-centred health-care** **c. - To be the provider of choice.** **g. - To be a sustainable, high performing NHS Foundation Trust.**					
EXECUTIVE LEAD:		Chief Operating Officer					
Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to achieve and sustain operational targets leading to contractual penalties, patient dissatisfaction and poor reputation.	Referral to treatment (RTT) backlog plans (patients over 18 weeks) and operational performance of 90% (for admitted) and 95 % (for non-admitted). Further recovery plans submitted to Commissioners for external assurance on 31st January 2014. Anticipated sign off of recovery plans w/c 3rd Feb 2014 Use of independent sector for key specialties.	4x5=20	Key specialities in weekly performance meetings with COO to implement plans. Weekly patient level reporting meeting for all key specialties. Monthly Q&P report to Trust Board showing 18 week RTT performance. Daily RTT performance and prospective reports to inform decision making.	(c) Inadequate elective capacity. (c) Ongoing discussions with commissioners have failed to agree a clear recovery plan at this stage. (c) Capacity issues created by emergency demand causes cancellations of operations.	Agree recovery action plan with commissioners to recover Referral to Treatment Performance within required operational standards (9.11). Implementation of recovery action plan (including specialty level action plan / recovery trajectory at Trust and speciality level of RTT standards). (9.13) Re launch of cancelled operations policy (9.12).	4x3=12	Feb 2014 COO March 2015 COO Review Feb 2014 COO
	Transformational theatre project to improve theatre efficiency to 80 -90%.		Monthly theatre utilisation rates. Theatre Transformation monthly meeting. Transformation update to Board.	No gaps identified.	No actions required.		

	Emergency Care process redesign (phase 1) implemented 18 February 2013 to improve and sustain ED performance.		Monthly report to Trust Board in relation to Emergency Dept (ED) flow (including 4 hour breaches). 4 hour wait performance 90.1%	See risk number 2.	See risk number 2.		
	Cancer 62 day performance - Tumour site improvement trajectory agreed and each tumour site has developed action plans to achieve targets. Senior Cancer Manager appointed. Lead Cancer Clinician appointed. Action plan to resolve Imaging issues implemented.		Cancer action board established and weekly meetings with all tumour sites represented. Monthly trajectory agreed and Cancer action plan agreed with CCGs in June 2013 and reported and monitored at Executive Performance board. Chief Operating Officer receives reports from Cancer Manager and 62 day performance included within Monthly Q&P report to Trust Board. The ongoing management of cancer performance is carried out by a weekly cancer action board to provide operational assurance. Performance against 62 day standard has been achieved for the past 6 months. Commissioners have formally removed the contract perfomance notice in realtion to 62 day standard.	No gaps identified.	No actions required.		

RISK NUMBER/ TITLE:	**RISK 10 – INADEQUATE RECONFIGURATION OF BUILDINGS AND SERVICES**
LINK TO STRATEGIC OBJECTIVE(S)	**a. - To provide safe, high quality patient-centred health care**
EXECUTIVE LEAD:	Director of Strategy

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Inadequate reconfiguration of buildings and services leading to less effective use of estate and services.	Clinical Strategy.	3x5=15	Trust Board development session on development of approach to strategic planning and development of SOC. This outlined the methodology being used to ensure any changes in configuration are specifically designed to deliver optimum quality of care. Ongoing monitoring of service outcomes by MRC to ensure outcomes improve. Improvement in health outcomes and effective Infection Prevention and Control practices monitored by Executive Quality Board (Q+P report) with escalation to ET, QAC and TB as required.	(a) Service specific KPIs not yet identified for all services.	Iterative development of strategic plans with specialities. This is monitored by CMG and Executive Boards. Work continues with DS and CMGS to prioritise key areas for delivery within the clinical strategy. Further workshops planned for Jan/Feb 2014. (10.5)	3X3=9	March 2014 MD
	Estates Strategy including award of FM contract to private sector partner to deliver an Estates solution that will be a key enabler for our clinical strategy in relation to clinical adjacencies. Reconfiguration Programme working with clinicians to develop a 'preferred' way forwards' with regards to the alignment of the future estate with clinical strategy.		Facilities Management Collaborative (FMC) will monitor against agreed KPIs to provide assurance of successful outsourced service.	(c) Estates plans not fully developed to achieve the strategy. (c) The success of the plans will be dependent upon capital funding and successful approval by the NTDA.	Reconfiguration programme to develop a strategic outline case which will inform the future estate strategy (10.6) Secure capital funding. (10.3)		Jan 2014 DS Mar 2014 IDFS

	CMG service development strategies and plans to deliver key developments.		Progress of divisional development plans reported to Service Reconfiguration Board.	No gaps identified.	No actions required.		
	Service Reconfiguration Board.		Monthly ET Strategy session to provide oversight of reconfiguration.	No gaps identified.	No actions required.		
	Capital expenditure programme to fund developments.		Capital expenditure reports reported to the Board via F&P Committee.	No gaps identified.	No actions required.		
	Managed Business Partner for IM&T services to deliver IT that will be a key enabler for our clinical strategy. IM&T incorporated into Improvement and Innovation Framework.		IM&T Board in place.	No gaps identified.	No actions required.		

RISK NUMBER/ TITLE:	**RISK 11 – LOSS OF BUSINESS CONTINUITY**
LINK TO STRATEGIC OBJECTIVE(S))	**g. - To be a sustainable, high performing NHS Foundation Trust.**
EXECUTIVE LEAD:	Chief Operating Officer

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Inability to react /recover from events that threaten business continuity leading to sustained downtime and inability to provide full range of services.	Major incident/business continuity/ disaster recovery and Pandemic plans developed and tested for UHL/ wider health community. This includes UHL staff training in major incident planning/ coordination and multi agency involvement across Leicestershire to effectively manage and recover from any event threatening business continuity. Tailored training packages for service area based staff. All priority IT systems have disaster recovery testing completed as part of the change approvals for major upgrades or at least once per year if no upgrade is planned within a financial year. Contingency plans developed to manage loss of critical supplier and how we will monitor and respond to incidents affecting delivery of critical supplies.	3x4=12	Annual Emergency planning Report identifying good practice presented to the GRMC July 2012. Training Needs Analysis developed to identify training requirements for staff supported by appropriate training packages for Senior Managers on Call. External auditing and assurances to SHA, Business Continuity Self-Assessment, June 2010, completed by Richard Jarvis. Completion of the National Capabilities Survey, November 2013 completed by Aaron Vogel. Results included in the annual report on Emergency Planning and Business Continuity to the QAC. Audit by PwC Jan 2013. Completed Jan 2014. Documented evidence from key critical suppliers has been collected to ensure that contracts include business continuity arrangements.	(c) On-going continual training of staff to deal with an incident. (a) Do not consider realistic testing of different failure modes for critical IT systems to ensure IT Disaster Recovery arrangements will be effective during invocation. c) Not all the critical suppliers questioned provided responses. (c) contracts aren't assessed for their potential BC risk on the Trust.	Training and Exercising events to involve multiple specialties/CMGs to validate plans to ensure consistency and coordination (11.13). Finance and procurement staff to be trained how to assess the BC risk to a contract and utilise the tools developed. (11.14)	2x3=6	Aug 2014 COO Mar 2014 COO

	Emergency Planning Officer appointed to oversee the development of business continuity within the Trust.		Outcomes from PwC LLP audit identified that there is a programme management system in place through the Emergency Planning Officer to oversee. A year plan for Emergency Planning developed and updated annually. Production/updates of documents/plans relating to Emergency Planning and Business Continuity aligned with national guidance have begun. Including Business Impact Assessments for all specialties. Plan templates for specialties now include details/input from Interserve.	(c) Local plans for loss of critical services not completed due to change over of facilities provider. (c) Plans have not been provided by Interserve as to how they would respond or escalate issues to the Trust. (c) a number of plans are out of date and risk being inadequate for a response due to operational changes. (c)Call out system designed to notify staff of a major incident and activate the plan is not suitable.	Further work required to develop escalation plans and response plans for Interserve. (11.11) Review all the plans and identify priority for updating and work into 2014/2015 year plan (11.15) Review and consider options for an automated system to reduce time and resources required to initiate a staff call out (11.16).		Feb 2014 COO March 2014 COO April 2014 COO
	New policy to identify key roles within the Trust of those responsible for ensuring business continuity planning /learning lessons is undertaken.		Minutes/action plans from Emergency Planning and Business Continuity Committee. Any outstanding risks/issues will be raised through the COO.	No gaps identified.	No actions required.		
			New Policy on InSite Emergency Planning and Business Continuity Committee ensures that processes outlined in the Policy are followed, including the production of documents relating to business continuity within the service areas. Incidents within the Trust are investigated and debrief reports written, which include recommendations and actions to consider. Issues/lessons feed into the development of local plans and training and exercising events.	(c) Policy has not been reviewed as per the stated review date.	Policy and terms of reference require updating to reflect organisational restructuring (11.17).		Feb 2014 COO

			Head of Operations and Emergency Planning Officer are consulted on the implementation of new IM&T projects that will disrupt user's access to IM&T systems.	(c) Do not always consider the impact on business continuity and resilience when implementing new systems and processes. (c) End users aren't always consulted adequately prior to downtime of a system.	Further processes require development, particularly with the new Facilities and IM&T providers to ensure resilience is considered/ developed when implementing new systems, infrastructure and processes. (11.8)		Review Feb 2014 COO
				(a) Lack of coordination of plans between different service areas and across the specialties.	Training and Exercising events to involve multiple specialties/CMGs to validate plans to ensure consistency and coordination. (11.10)		Aug 2014 COO

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK JANUARY 2014

RISK NUMBER/ TITLE:	**RISK 12 FAILURE TO EXPLOIT THE POTENTIAL OF IM&T**
LINK TO STRATEGIC OBJECTIVE(S))	**a. - To provide safe, high quality patient-centred health care.** **d. - To enable integrated care closer to home**
EXECUTIVE LEAD:	Interim Director of Financial Strategy

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to integrate the IM&T programme into mainstream activities.	Managed Business Partner for IM&T services to deliver IT that will be a key enabler for our clinical strategy. IM&T now incorporated into Improvement and Innovation Framework.	3x2=6	IM&T Board in place. Quarterly reports to Trust Board	No gaps identified.	No actions required.	3x2=6	
	Engagement with the wider clinical communities (internal) including formal meetings of the newly created advisory groups/ clinical IT. Improved communications plan incorporating process for feedback of information.		CMIO(s) now in place, and active members of the IM&T meetings The joint governance board monitors the level of communications with the organisation.	No gaps identified.	No actions required.		
	Engagement with the wider clinical communities (External). UHL CMIOs are added as invitees to the meetings, as are the clinical (IM&T) leads from each of the CCGs.		UHL membership of the wider LLR IM&B board	No gaps identified.	No actions required.		

Benefits are not well defined or delivered	Appointment of IBM to assist in the development of an incentivised, benefit driven, programme of activities to get the most out of our existing and future IM&T investments. Initial engagement with key members of the TDA to ensure there is sufficient understanding of technology roadmap and their involvement. The development of a strategy to ensure we have a consistent approach to delivering benefits. Increased engagement and communications with departments to ensure that we capture requirements and communicate benefits. Standard benefits reporting methodology in line with trust expectations.		Minutes of the joint governance board, the transformation board and the service delivery board. Benefits are part of all the projects that are signed off by the relevant groups.				

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK JANUARY 2014

RISK NUMBER/ TITLE:	**RISK 13 – FAILURE TO ENHANCE MEDICAL EDUCATION AND TRAINING CULTURE**
LINK TO STRATEGIC OBJECTIVE(S)	**e - To enjoy an enhanced reputation in research, innovation and clinical education.**
EXECUTIVE LEAD:	Medical Director

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to implement and embed an effective medical training and education culture with subsequent critical reports from commissioners, loss of medical students and junior doctors, impact on reputation and potential loss of teaching status.	Medical Education Strategy and Action Plan.	4x3 = 12	Strategy approved by the Trust Board. Strategy monitored by Operations Manager and reviewed monthly in Full team Meetings. Favourable Deanery visit in relation to ED Drs training.	(c) Lack of engagement/awareness of the Strategy with CMGs.	Meetings to discuss strategy with CMGs (13.1).	3x2 = 6	Feb 2014 MD
	UHL Education Committee. 'Doctors in Training' Committee established. Education and Patient Safety.		Professor Carr reports to the Trust Board. Reports submitted to the Education Committee. Terms of reference and minutes of meetings.	(c) Attendance at the Committee could be improved. (c) Improved trainee representation on Trust wide committees. (c) Improve engagement with other patient safety activities/groups.	Relevance of the committee to be discussed at specialty/ CMG meetings (13.2). 'Build relationships with CMG Quality Leads. Establish links with LEG/QAC and QPMG. (13.4)		Feb 2014 MD Feb 2014 MD
	Quality Monitoring.		Quality dashboard for education and training (including feedback from GMC and LETB visits) monitored monthly by Operations Manager, Quality Manager and Education Committee. Education Quality Visits to specialties. Exit surveys for trainees. Monitor progress against the Education Strategy and GMC Training Survey results.	(a) Lack of engagement with specialties to share findings from the dashboards. (a) Do not currently ensure progress against strategic and national benchmarks. (c) Inadequate educational resources.	Attend CMG management meetings and liaise with specialties. (13.6) Monitor UHL position against other trusts nationally. (13.7) New Library/learning facilities to be developed at the LRI .(13.8)		Feb 2014 MD Review Feb 2014 MD Apr 2014 MD

	Educational project teams to lead on education transformation projects.		Project team meets monthly. Favourable outcome from Deanery visit in relation to ED Drs training.	(c) Implementation of the project within Acute Medicine needs to be improved.	Dr Hooper in post for Acute Medicine to implement project. (13.9)		Feb 2014 MD
	Financial Monitoring.		SIFT monitoring plan in place.	(c) Poor engagement with specialties in relation to implication of SIFT.	Need to engage with the specialties to help them understand the implication of SIFT and their funding streams. (13.10)		Feb 2014 MD

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

ACTION TRACKER FOR THE 2013/14 BOARD ASSURANCE FRAMEWORK (BAF)

Monitoring body (Internal and/or External):	Executive Team
Reason for action plan:	Board Assurance Framework
Date of this review	**January 2014**
Frequency of review:	Monthly
Date of last review:	December 2013

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
1	**Failure to achieve financial sustainability**					
1.19	ESB will continue to meet every 6 weeks to ensure implementation of SLM across the Trust (expected Mar 2014)	IDFS		March 2014	On track.	4
2	**Failure to transform the emergency care system**					
2.7	Continue with substantive appts until funded establishment within ED is achieved.	COO	HO	Review ~~Sept~~ ~~Nov 2013~~ ~~Jan 2014~~ March 2014	Still on track to recruit to funded establishment. International recruitment has been successful.	4
3	**Inability to recruit, retain, develop and motivate staff**					
3.1	Revise and re-launch UHL reward and recognition strategy.	DHR	DDHR	~~October 2013~~ January 2014	**Complete.** The Strategy was issued to CMGs via HR leads on 03.02.14	5
3.3	Development of Pay Progression Policy for Agenda for Change staff.	DHR	DDHR	~~October~~ ~~November~~ ~~December 2013~~ ~~February 2014~~ March 2014	Agreement on the content of the Pay progression policy was not reached in January 2014 at the JSCNC. A further meeting will be held on 28.02 with a view to reaching agreement which will be ratified by the Board and JSCNC in March 2014. The Listening event for Bands 8C and above will take place on 26.02.14. Timescale for action completion adjusted to reflect this.	3

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

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
3.5	Ensure Statutory and Mandatory training is easy to access and complete with 75% compliance by reviewing delivery mode, access and increasing capacity to deliver against specific subject areas.	DHR	ADLOD	March 2014	Performance improved to 69%. (4% ahead of trajectory). First seven newly designed e-learning packages have been completed:- All other e-learning packages available from the end of December 2013.	4
3.7	Update e-UHL records to ensure accuracy of reporting on a real time basis	DHR		March 2014	System functional. Any non-functional requirements undergoing review by IBM technical team. System performance issues have been resolved and work is underway in improving the interface between OCB Media and eUHL as required for accurately recording learner completion.	4
3.9	Develop an employer brand and maximise use of social media to describe benefits of working at UHL	DHR		April 2014	First meeting of task and finish group taken place. Use of Linked-In and staff good news stories to describe benefits of working at UHL. Group has expanded membership to broader range of staff groups. Action Plan in development, focused on three elements of employment cycle – attraction, retaining existing staff and understanding why individuals exit.	4

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

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
3.10	Programme of induction and adaptation in development with Nursing education leads, timetabled to ensure capacity to support recruitment programme.	DHR		April 2014	**Complete.** The first cohort of international nurses commenced in the Trust on the 20th January. The content and delivery of the induction programme has been positively received by the nurses. Second cohort commence 6th February Third Cohort beginning of May date to be confirmed	5
3.11	Implement targeted appraisal recovery plans for each cost centre	DHR		~~Dec 2013~~ Review January 2014	**Complete.** Appraisal recovery plans in place however the target of 95% has still not been achieved. Appraisal performance continues to feature on CMG / Directorate Board Meetings in monitoring the implementation of agreed local actions. HR CMG / Directorate Leads continue to work closely with areas in implementing targeted recovery	5
4	**Ineffective organisational transformation**					
4.1	Review outputs from Chief Officers Group and strategic Planning Group to ensure gaps in current processes are being addressed	DS		Review February 2014	On track	4
5	**Ineffective strategic planning and response to external influences**					
7	**Failure to maintain productive and effective relationships**					

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

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
7.3	Invite PWC (Trust's Auditors) to offer opinion on the plan / talk to a selection of stakeholders.	DMC		~~January 2014~~ March 2014	Meeting held to scope the work, however delays in sending the raw data to PWC have delayed this action. Timescale for completion adjusted to reflect this	3
8	**Failure to achieve and sustain quality standards**					
8.2	Women's CMG to work with Dr Foster and other trusts to better understand risk adjustment model related to the national quality dashboard.	MD		January 2014	**Complete.**	5
8.5	Active recruitment to ward nursing establishment so releasing ward sister for supervisory practice.	CN		September 2014	On going recruitment process in place and is likely to take 12 -18months. Deadline extended to reflect this.	4
8.10	Implementation of Electronic Patient Record (EPR)	CIO		2015	Currently developing the procurement strategy for the EPR solution	4
9	**Failure to achieve and sustain high standards of operational performance**					
9.2	Use of independent sector to deliver additional elective capacity to support challenged RTT specialities. *(Action reworded January 2014)*	COO	HO/CMGM Planned	~~November 2013~~ January 2014	**Complete.** Discussions with independent sector regarding sending elective surgical work to them. Paper written and presented to QAC and F&P. Local Independent sector transfers taking place for Ophthalmology , Orthopaedics, ENT to assist RTT recovery	5

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

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
9.11	Agree recovery action plan with commissioners to recover Referral to Treatment Performance within required operational standards	COO	Head of Performance Improvement	February 2014	Intensive Support Team model used to determine capacity gap. Continued failure to agree on a recovery plan that is deliverable and affordable. Met with CCGs 12 December, CCG to review UHL / IST modelling. Recovery plan re submitted 31st January 2014, waiting confirmation of acceptance of plan by commissioners w/c 3rd Feb 2014.	4
9.12	Re launch of cancelled operations policy	COO		Review February 2014	On track	4
9.13	Implementation of recovery action plan (including speciality level action plan / recovery trajectory at Trust and speciality level of RTT standards).	COO		March 2015	On track	4
10	**Inadequate reconfiguration of buildings and services**					
10.3	Secure capital funding to implement Estates Strategy.	IDFS		~~May 2013~~ ~~December 2013~~ March 2014	Work underway on capital planning around reconfiguration – SOC due for completion in March 2014 which will be the key vehicle to agree availability of capital funding.	3
10.5	Iterative development of strategic plans with specialities. This is monitored by CMG and Executive Boards. Work continues with DS and CMGS to prioritise key areas for delivery within the clinical strategy. Further workshops planned for Jan/Feb 2014. *(Action reworded December 2013 to incorporate action 10.1)*	MD		March 2014	On track	4

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

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
10.6	Reconfiguration programme to develop a strategic outline case which will inform the future estate strategy	DS		January 2014	No update received.	3
11	**Loss of business continuity**					
11.2	Determine an approach to delivering a physical testing of the IT Disaster Recovery arrangements which have been identified as a dependency for critical services. Include assessment of the benefits of realistic testing of arrangements against the potential disruption of testing to operations.	COO	CIO	~~September~~ Further review ~~December 2013~~ January 2014	**Complete.** Following an internal and external assessment, taking into account service disruption, all priority systems will have the disaster recovery testing completed as part of the change approvals for major upgrades or at least once per year if no upgrade is planned within a financial year. Systems that utilise generic virtual systems will benefit from these tests as it is applicable across all the infrastructure.	5
11.8	Further processes require development, particularly with the new Facilities and IM&T providers to ensure resilience is considered/ developed when implementing new systems, infrastructure and processes.	COO	EPO	~~July~~ ~~August~~ Review ~~October~~ ~~November 2013~~ ~~December 2013~~ February 2014	Work with IM&T has been completed. Delays are being encountered in developing agreed processes with Interserve. Briefed by NHS Horizons in terms of large capital projects. No progress with Interserve in terms of planned maintenance works. Lack of progress with Interserve escalated via NHS Horizons, however still no formal assurance from Interserve of the BCM policy/process/plans	2
11.10	Training and Exercising events to involve multiple CMGs/specialties to validate plans to ensure consistency and coordination.	COO	EPO	August 2014	BCM training and exercising programme has been developed.	4

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

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
11.11	Further work required to develop escalation plans and response plans for Interserve.	COO	EPO	~~October~~ ~~December 2013~~ February 2014	Draft escalation plan received and discussions held on 9.12.13. Was due to be implemented w/c 16th Dec. No update received from Interserve. Lack of response from Interserve escalated via NHS Horizons, however still no formal assurance from Interserve of the BCM policy/process/plans	2
11.13	Training and Exercising events to involve multiple CMGs/ specialties to validate plans to ensure consistency and coordination	COO	EPO	August 2014	On track	4
11.14	Finance and procurement staff to be trained how to assess the BC risk to a contract and utilise the tools developed.	COO	EPO	March 2014	On track	4
11.15	Review all the plans and identify priority for updating and work into 2014/2015 year plan	COO	EPO	March 2014	On track	4
11.16	Review and consider options for an automated system to reduce time and resources required to initiate a staff call out	COO	EPO	April 2014	On track	4
11.17	Policy and terms of reference require updating to reflect organisational restructuring	COO	EPO	Feb 2014	On track	4
12	**Failure to exploit the potential of IM&T**					

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

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
12.8	TDA approvals documentation to be completed	CIO		~~October 2013~~ Review Jan 2014	**Complete.** How we procure the EPR solution has a material effect on how or if we proceed with TDA approval. There will be a detailed paper to the February TB highlighting the timetable and requirements for the delivery of an EPR solution. TDA approvals process has been added to all projects which qualify. Assessments on project start up will now include a likelihood of requiring TDA approval to be added to the start-up documentation. CMGs and corporate leads have been taken through the new processes and provided comments and additional information. Over the next few months we will be working with the DH to design and implement an IT benefits reporting programme in line with two successful bids for IT transformation bids. When complete we will utilise this as our proforma.	5
13	**Failure to enhance education and training culture**					
13.1	To improve CMG engagement facilitate meetings to discuss Medical Education Strategy and Action Plans with CMGs.	MD	AMD	~~December 2013/January 2014~~ February 2014	Meetings now arranged for December13 /January 14/ February 14	3

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

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
13.2	Relevance of the UHL Education Committee to be discussed at CMG Meetings in an effort to improve attendance.	MD	AMD	~~December 2013/January 2014~~ February 2014	Meetings now arranged for December13 /January 14/ February 14	3
13.4	Build relationships with CBU Quality Leads and establish links with LEG/QAC and QPMG in an effort to improve engagement with other patient safety activities/groups.	MD	AMD	~~December 2013/January 2014~~ February 2014	Meetings now arranged for December13 /January 14/ February 14	3
13.6	Attend CMG management meetings and liaise with CMGs in an effort to improve engagement of CMGs.	MD	AMD	~~December 2013/January 2014~~ February 14	Meetings now arranged for December13 /January 14/ February 14	3
13.7	Monitor UHL position against other trusts nationally to ensure progress against strategic and national benchmarks.	MD	AMD	Review ~~October 2013~~ February 2014	Following further discussions with the LETB this data is not readily available. LETB to investigate how we can acquire this data.	2
13.8	New Library/learning facilities to be developed at the LRI to help resolve inadequate educational resources.	MD	AMD	~~October 2013~~ April 2014	A Project Manager is now in place. Odames Ward will be handed over on 1st February for work to start on 1st April 2014.	4
13.9	Dr Hooper in post for Acute Medicine to implement project and improve Acute Medicine progress.	MD	AMD	February 2014	On track.	4
13.10	Need to engage with the CMGs to help them understand the implication of SIFT and their funding streams.	MD	AMD	~~December 2013/January 2014~~ February 2014	Meetings now arranged for December13 /January 14/ February 14	3

Key

CEO	Chief Executive Officer
IDFBS	Interim Director of Financial Strategy

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

MD	Medical Director
AMD	Assistant Medical Director
COO	Chief Operating Officer
DHR	Director of Human Resources
DDHR	Deputy Director of Human Resources
DS	Director of Strategy
ADLOD	Asst Director of Learning and Organisational Development
DMC	Director of Marketing and Communications
CIO	Chief Information Officer
CMIO	Chief Medical Information Officer
EPO	Emergency Planning Officer
HPO	Head of Performance Improvement
HO	Head of Operations
CD	Clinical Director
CMGM	Clinical Management Group Manager
DDF&P	Deputy Director Finance and Procurement
FTPM	Foundation Trust Programme Manager
HTCIP	Head of Trust Cost Improvement Programme
ADI	Assistant Director of Information
FC	Financial Controller
ADP&S	Assistant Director of Procurement and Supplies
HoN	Head of Nursing
TT	Transformation Team
CN	Chief Nurse

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

Appendix three

University Hospitals of Leicester NHS Trust

AREAS OF SCRUTINY FOR THE UHL BOARD ASSURANCE FRAMEWORK (BAF)

1) Are the Trust's strategic objectives S.M.A.R.T? i.e. are they :-

- **S**pecific
- **M**easurable
- **A**chievable
- **R**ealistic
- **T**imescaled

2) Have the main risks to the achievement of the objectives been adequately identified?

3) Have the risk owners (i.e. Executive Team) been actively involved in populating the BAF?

4) Are there any omissions or inaccuracies in the list of key controls?

5) Have all relevant data sources been used to demonstrate assurance on controls and positive assurances?

6) Is the BAF dynamic? Is there evidence of regular updates to the content?

7) Has the correct 'action owner' been identified?

8) Are the assigned risk scores realistic?

9) Are the timescales for implementation of further actions to control risks realistic?

Risk Scoring Guidance:

How to use the consequence table

Choose the most appropriate domain for the risk from the left hand side of the table. Then work along the columns in the same row to assess the severity of the risk on the scale of '1' to '5' to determine the consequence score, which is the number given at the top of the column.

Consequence score (impact of cause / hazard) and example of descriptors					
Risk Subtype	1	2	3	4	5
	Insignificant	**Minor**	**Moderate**	**Major**	**Extreme**
PATIENTS (Consequence on the safety of patients physical/ psychological harm)	Minimal injury requiring no/minimal intervention or treatment.	Minor injury or illness, requiring minor intervention Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which Consequences on a small number of patients	Mismanagement of patient care with long-term effects Increase in length of hospital stay by >15 days	Incident leading to death Multiple permanent injuries or irreversible health effects An event which Consequences on a large number of patients
INJURY Consequence on the safety of staff or public physical/ psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for <3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days RIDDOR/agency reportable incident	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days	Incident leading to death Multiple permanent injuries or irreversible health effects
QUALITY Quality/ complaints/ audit	Peripheral element of treatment or service suboptimal Informal complaint/ inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/ service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards
HUMAN RESOURCES (Human resources/ organisational development/ staffing/ competence)	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
STATUTORY (Statutory duty/ inspections)	No or minimal Consequence or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report

				Critical report	
REPUTATION (Adverse publicity/ reputation)	Rumors Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
BUSINESS (Business objectives/ projects)	Insignificant cost increase/ scheduled slippage	<5 per cent over project budget Scheduled slippage	5–10 per cent over project budget Scheduled slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
ECONOMIC (Finance including claims)	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
TARGETS (Service/ business interruption)	Loss/interruption to service of >1 hour	Loss/interruption to service of >8 hours	Loss/interruption to service of >1 day	Loss/interruption to service of >1 week	Permanent loss of service or facility
ENVIRONMENT (Environmental Consequence)	Minimal or no Consequence on the environment	Minor Consequence on environment	Moderate Consequence on environment	Major Consequence on environment	Catastrophic Consequence on environment

How to assess likelihood:

When assessing 'likelihood' it is important to take into consideration the controls already in place. The likelihood score is a reflection of how likely it is that the risk described will occur with the current controls. Likelihood can be scored by considering:

- The frequency (i.e. how many times will the adverse consequence being assessed actually be realised?) or
- The probability (i.e. what is the chance the adverse consequence will occur in a given reference period?)

Likelihood and Risk score

The risk score is calculated by multiplying the consequence score by the likelihood score.

	← Consequence →				
Likelihood	**1**	**2**	**3**	**4**	**5**
↓	**Insignificant**	**Minor**	**Moderate**	**Major**	**Extreme**
1 Rare This will probably never happen/recur. Or Not expected to occur for years. Or Probability: <0.1%	**1**	**2**	**3**	**4**	**5**
2 Unlikely Do not expect it to happen/recur but it is possible it may do so. Or Expected to occur at least annually. Or Probability: 0.1-1%	**2**	**4**	**6**	**8**	**10**
3 Possible Might happen or recur occasionally. Or Expected to occur at least monthly. Or Probability: 1-10%	**3**	**6**	**9**	**12**	**15**
4 Likely Will probably happen/recur but it is not a	**4**	**8**	**12**	**16**	**20**

persisting issue. Or Expected to occur at least weekly. Or Probability: 10-50%					
5 Almost certain Will undoubtedly happen/recur, possibly frequently. Or Expected to occur at least daily. Probability: >50%	**5**	**10**	**15**	**20**	**25**

Appendix: Six

RISK ASSESSMENT ESCALATION STRUCTURE

CMG / Directorate Board

Corporate Risk Management Team provides monthly report to CMG / directorate Boards:
High risks and moderate risks

CMG / Direc Board Review Checklist:
The risk title is clear and descriptive;
The risk description lists the causes & consequences;
The documented control measures are actual controls currently in place (and not future actions);
The current risk rating is accurate;
The risk review date is in date;
All risks that can be treated have an associated action plan with explicit actions, a realistic and achievable timeframe and responsible person/s identified;
The risk manager details are correct.

Risk Assessor / Owner

Risk owner reviews the risk at a frequency based on the risk score.

Note: see Datix risk register user guide

Datix Risk Register

Risk assessment details transferred on to Datix risk register and risk assessment form scanned on to Datix risk register

APPROVED

CMG / Directorate Board

Risk assessment from specialty presented to CMG / directorate Board for approval

REJECTED: Feedback provided to Risk Owner / Assessor

Line Manager

Risk Assessment presented to line manager for sign off

REJECTED: Feedback provided to Risk Owner / Assessor

Risk Assessor
START PROCESS

Risk Assessment performed using UHL risk assessment form

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

NEW RISKS SCORING 15 OR ABOVE FOR THE PERIOD 1/1/14 - 31/1/14

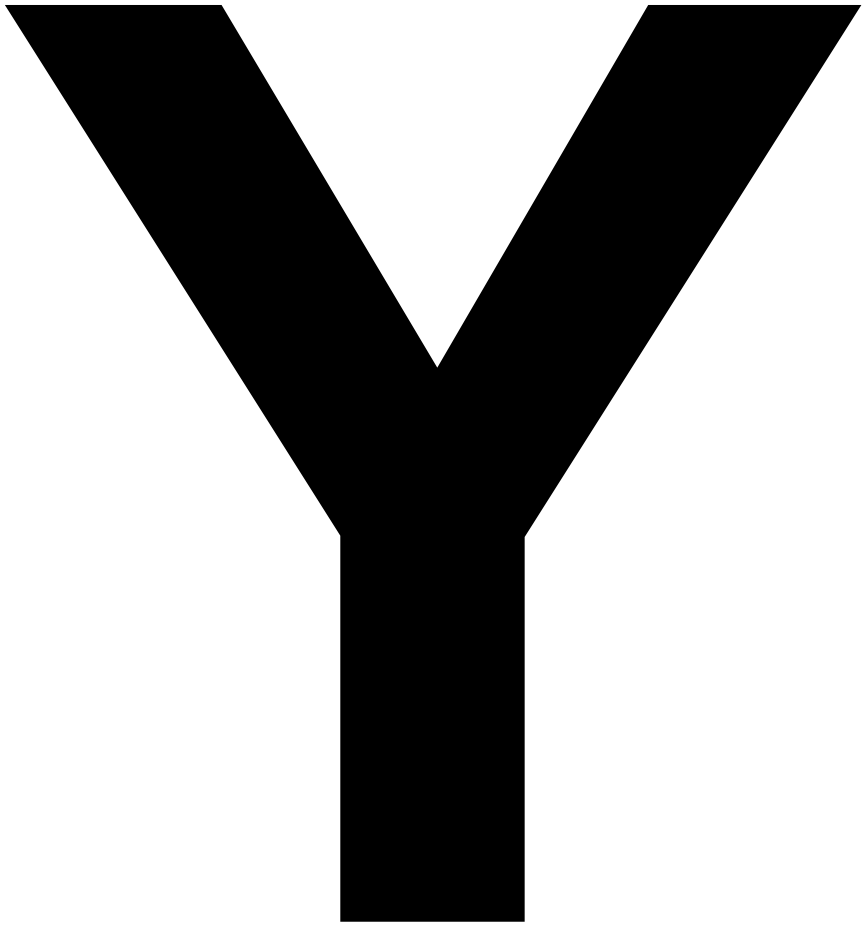
REPORT PRODUCED BY: UHL CORPORATE RISK MANAGEMENT TEAM

Key

Red	Extreme risk (risk score 25)
Orange	High risk (risk score 15 - 20)
Yellow	Moderate risk (risk score 8 - 12)
Green	Low risk (risk score below 8)

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2294	Women's and Children's	Paediatrics (Cardiorespiratory)	Risks to the clinical care of patients with CHD due to the shortfall of paediatric cardiac anaesthetists	29/01/2014	03/03/2014	Shortfall in availability of paediatric anaesthetists. Currently the consultant cardiac anaesthetists with paediatric/adult congential expertise are having to provide 1in 2 cover due to a number of absences.vacancies in the last 12 months. This has lead to unacceptable delays in surgery/interventional or diagnostic catheterisation with the potential for deterioration in the patients condition leading to higher risk intervention. Breaching of national and local waiting list targets Decreased patient/family satisfaction Increase in complaints Difficulty in recruiting and obtaining suitably trained locums due to a national shortage of expertise and training in this field	Patients	Use of Locums via agency	Major	Almost certain	20	Locum agency bookings to continue via agency - due 31/3/14 Explore sabbaticals for experienced congenital cardiac anaesthetists in Italy - due 28/2/14 Explore other options to cover adult congenital only lists with adult cardiac anaesthetists - due 28/2/14 National/International advert for replacement Anaesthetist - due 31/3/14	1	EA
2283	Women's and Children's	All	There is a risk of patient harm caused by failure of lifts in Kensington building	06/01/2014	06/03/2014	Kensington Building has 3 bed/passenger lifts and 1 passenger lift. Despite frequent attendance by lift engineers there is currently only 1 bed/passenger lift in working order. If this lift fails we will be unable to transport patients to, from and around the building including labouring women, obstetric emergencies, premature and sick neonates and emergency admissions to the GAU.	Patients	1. Lift currently working 2. Able to temporarily transfer activity to LGH should the need arise and therefore control admission to LRI if all lifts fail 3. Contract with Thyssen (lift engineers) provides 24/7 cover with 4 hour call out time. 4. Baby incubator to be kept on the Delivery Suite. 5. Delivery Pack placed in reception 6. Breakdowns escalated to NHS Horizons who are formulating business plan for replacement of passenger lift with a bed/passenger lift.	Major	Likely	16	Business plan to be formulated for replacement of passenger lift with a bed/passenger lift - due 31 March 2013.	2	EBROU

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2275	Emergency Care and Specialist Medicine	Rheumatology	There is a lack of robust clinical processes relating to Subcutaneous Methotrexate therapy due to staff shortages	02/01/2014	28/02/2014	**Causes** There is no dedicated person within rheumatology or pharmacy to generate the scripts for Subcutaneous Methotrexate (ScMTX). **Consequences** Patient safety - Patients often do not receive their drug on time, and as a result have worsening joint pains and in some cases have a flare of their arthritis. This can often result in an emergency out-patient clinic visit and sometimes can rarely even precipitate an emergency hospital admission. Quality - Increase in the amount of complaints being received with Service being considered sub-optimal by patients and GPs as well as hospital clinical staff. Human Resources - Late delivery of services for patients due to the lack of appropriate staffing resources. Increased workload to the Specialist Nursing team.	HR	Short-term resource has been assigned to clear the backlog ;A Junior Dr is supplying short-term overtime; admin resource has been assigned to the CNS team to release their time for other duties. Pharmacy Lead is pushing the recruitment into the pharmacy prescriber role.	Moderate	Almost certain	15	Review of Service Requirements for Rheumatology Specialist Nurses - capacity, establishment, admin support - including short term medical cover to support Junior doctor assisting with Scripts - technician identified for Specialist Nursing team 28/02/14 Pharmacy prescriber role to be filled - Lead pharmacy role for this service provision is crucial for this system to work efficiently 31/3/14	2	LDAL



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: 27 February 2014

COMMITTEE: Finance and Performance Committee

CHAIRMAN: Mr R Kilner, Non-Executive Director

DATE OF COMMITTEE MEETING: 29 January 2014

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

None

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

- Minute 5/14/1 – progress with recruitment to nursing vacancies;
- Minute 5/14/4 – medical productivity proposals, and
- Minute 7/14/3 – financial strategy.

DATE OF NEXT COMMITTEE MEETING: 26 February 2014

Mr R Kilner
21 February 2014

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF A MEETING OF THE FINANCE AND PERFORMANCE COMMITTEE, HELD ON WEDNESDAY 29 JANUARY 2014 AT 8.30AM IN SEMINAR ROOMS A & B, CLINICAL EDUCATION CENTRE, LEICESTER GENERAL HOSPITAL

Present:
Mr R Kilner – Acting Chairman (Committee Chair)
Mr J Adler – Chief Executive
Colonel (Retired) I Crowe – Non-Executive Director
Mr P Hollinshead – Interim Director of Financial
Mr R Mitchell – Chief Operating Officer
Mr G Smith – Patient Adviser (non-voting member)

In Attendance:
Dr M Ardron – Deputy Clinical Director, Emergency and Specialist Medicine CMG (for Minute 2/14 only)
Ms R Overfield – Chief Nurse (for Minute 5/14/1 only)
Dr P Rabey – Deputy Medical Director (for Minute 5/14/4 only)
Mrs K Rayns – Trust Administrator
Mr R Rughani – Interim Finance Lead, Emergency and Specialist Medicine CMG (for Minute 2/14 only)
Mr S Sheppard – Deputy Director of Finance
Ms G Staton – Head of Nursing, Emergency and Specialist Medicine CMG (for Minute 2/14 only)

ACTION

RESOLVED ITEMS

1/14 APOLOGIES AND WELCOME

Apologies for absence were received from Mr A Seddon, Director of Finance and Business Services and Ms J Wilson, Non-Executive Director. The Chairman welcomed Mr P Hollinshead, Interim Director of Financial Strategy to the meeting.

2/14 PRESENTATION BY THE EMERGENCY AND SPECIALIST MEDICINE CMG

The Deputy Clinical Director, the Head of Nursing and the Interim Finance Lead attended the meeting from the Emergency and Specialist Medicine CMG to present an overview of the CMG's financial and operational performance (as summarised within paper A). The Acting Chairman noted comments received on the format of the report template and it was agreed that the Chief Operating Officer would work with the Deputy Director of Finance to amend the template for future meetings. During the presentation, Finance and Performance Committee members particularly noted:- **COO/ DDF**

(a) that the CMG was expected to deliver its forecast year-end financial plan and that this was mainly attributed to reductions in non-contracted staffing costs as more of the vacant permanent positions were filled;
(b) improvements in ED performance as a result of the 2 super weekends. Further analysis was being undertaken to assess those actions which had delivered the most benefit and which could be continued to sustain the benefits. These were likely to include increased Consultant ward rounds at weekends and 7 day working on the base wards;
(c) that following a visit to Coventry and Warwickshire, an emergency care command cell structure had been implemented and this appeared to be working well;
(d) nursing recruitment was progressing well with 91 posts recruited to against the "felt" vacancy level of 183. The CMG anticipated that by June 2014, the position would be stabilised;
(e) an update on progress with medical recruitment where there were noted to be some challenges within the frail elderly and acute medicine services;

(f) RTT performance within Ophthalmology had been adversely affected by the cancellation of clinics when locum Consultants had left the Trust and their appointments had to be rescheduled, and
(g) progress against the top 4 quality and safety priorities (as outlined in paper A).

In discussion following the presentation, the Acting Chairman queried the scope to amend Consultant job plans by negotiation to include 1 of any additional sessions (over and above the regular 10 PAs) to be worked at the weekend. The Deputy Clinical Director confirmed that some Consultants already worked weekend sessions, but a small increase in establishment would be required to sustain a 7 day service. He added that any arrangements would have to be transparent and equitable for all staff.

The Acting Chairman queried the activity trends in respect of acute medicine and care of the frail elderly, noting in response the work that was ongoing by the CCGs to prevent inappropriate hospital admissions and expand the availability of quality end of life care within the community setting. The Chief Executive sought additional information regarding the scope to relocate urology, diabetes and endocrinology services into the community as outreach services. The Interim Director of Financial Strategy noted that the CMG's control total was challenging and he sought assurance that plans had been devolved to budget holder level and that all budget holders were being held to account to deliver the year-end forecast.

The Chief Executive reported on discussions with Ms F Wise, Interim Chief Executive at Kettering General Hospital regarding opportunities to pursue joint appointments in geriatric medicine and ED services and the CMG confirmed that Mr S Conboy would be the appropriate contact to pursue this discussion. It was also suggested that stroke medicine might be another area where joint appointments could be explored. **CE**

The Deputy Director of Finance commended the CMG's month 9 position and progress with identification of 2014-15 CIP schemes. He invited the CMG to identify any support required to strengthen engagement with the Patient Level Information Costing System (PLICS). The Interim Finance Lead noted the need to further review adverse trends in Service Level Reporting data and he undertook to discuss training needs with the Deputy Director of Finance outside the meeting.

Finally, the Deputy Clinical Director highlighted the clear plans in place to appoint to substantive medical staffing posts with the aim of reducing locum usage and increasing clinical effectiveness.

<u>Resolved</u> – that (A) the Emergency and Specialist Medicine CMG presentation be received and noted;

(B) the Chief Operating Officer be requested to liaise with the Deputy Director of Finance to amend the CMG reporting template; **COO/ DDF**

(C) the Chief Executive be requested to provide Dr Conboy's contact details to the Interim Chief Executive at Kettering General Hospital, and **CE**

(D) the Interim Finance Lead and the Deputy Director of Finance be requested to consider the CMG's training needs in relation to PLICS and SLR. **IFL/DDF**

4/14 MINUTES

<u>Resolved</u> – that the Minutes of the 18 December 2013 Finance and Performance Committee meeting (papers A and A1) be confirmed as a correct record.

3/14 MATTERS ARISING PROGRESS REPORT

The Committee Chairman confirmed that the matters arising report provided at paper C

detailed the status of all outstanding matters arising. Particular discussion took place in respect of the following items:-

(a) Minute 138/13/4 of 18 December 2013 – following the Emergency and Specialist Medicine CMG presentation earlier in the meeting, it had been agreed that the Chief Operating Officer and the Deputy Director of Finance would re-draft the CMG reporting template prior to the February 2014 presentation by Clinical Support and Imaging; **COO/ DDF**

(b) Minute 138/13/3 of 18 December 2013 – the Capital Projects Manager and the Head of Business Planning and Development would be invited to attend the 26 February 2014 meeting to report on the Managed Equipment Service (MES) programme; **TA**

(c) Minute 126/13/1(c) of 27 November 2013 – dates were being scheduled for the next round of Financial and Business Awareness Workshops and arrangements would be made for Colonel (Retired) I Crowe, Non-Executive Director to attend a workshop himself. The Trust Administrator was requested to remove this item from the progress log; **DDF**

(d) Minute 114/13/1(b) of 30 October 2013 – the Interim Director of Financial Strategy agreed to review progress relating to the development of a framework approach to reducing agency nursing rates; **IDFS**

(e) Minute 101/13/3 of 25 September 2013 – proposals for the Trust's residential accommodation stock were scheduled for presentation to the February 2014 Finance and Performance Committee meeting; **DHR**

(f) Minute 100/13/1.2 of 25 September 2013 – the expected update on Nurse Specialist workforce plan had not been included within the nursing workforce report but an update would be requested for the February meeting; and

(g) Minute 28/13/3 of 27 March 2013 – issues relating to delays with the 6 facet survey and implementation of the MICAD system had been escalated with a clear deadline being set for completion, after which the Trust would be approaching MICAD directly and re-charging Interserve with the expenditure. An update would be provided to the Committee in April 2014. **IDFS**

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

5/14 STRATEGIC MATTERS

5/14/1 <u>Nursing Workforce Update</u>

The Chief Nurse attended the meeting to present paper D, summarising the Trust's current position in respect of nursing establishment, vacancy rates, bank and agency usage and e-rostering. In discussion on the report, Finance and Performance Committee members noted the following points:-

(a) the Interim Director of Financial Strategy requested an update on progress with establishing a regional framework agreement for agency nurses. The Chief Nurse reported on the lack of networking mechanisms in the East Midlands and she agreed to explore opportunities to gain organisational learning from other regions (including Chesterfield and the West Midlands) and seek the latest position statement from the UHL procurement lead; **CN**

(b) Colonel (Retired) I Crowe, Non-Executive Director highlighted opportunities to escalate delays in resolving the functionality issues being experienced with e-rostering software. The Chief Nurse advised that 2 directors from Allocate Software had attended the Trust in the last 7 days and that an update on the outcomes from this meeting would be circulated to members outside the meeting. Responding to a further comment on the e-rostering system. the Chief Nurse confirmed that the Bank Office was part of the roll-out and that faxed requests were still required; **CN**

(c) the Chief Executive queried the arrangements for ongoing nurse recruitment to cover any natural turnover and he noted in response that normal levels of turnover would

be filled by the intake from local nursing schools, and

(d) opportunities to explore the scope to introduce a retention bonus for nurses who remained in post for 3 years (bearing in mind the cost of recruiting the international nurses).

Resolved – that the nursing workforce update report (paper D) be received and noted, and

(B) the Chief Nurse be requested to explore learning opportunities from other regions relating to nursing framework arrangements, and **CN**

(C) an update on resolution of e-rostering software functionality issues be circulated to Committee members outside the meeting. **CN**

5/14/2 Improvement and Innovation Framework Update

In the absence of the Director of Strategy, the Chief Executive presented paper E, briefing the Committee on proposals for development of a whole hospital improvement and sustainability programme. Members particularly noted that the key components of the Improvement and Innovation Framework would be retained within the new programme and that the links with quality improvement workstreams would be strengthened.

Discussion took place regarding the need to embed capacity within the CMGs and reduce the organisation's reliance upon a centralised team, although the centralised PMO function would be retained using the existing IBM software. The Acting Chairman queried the arrangements for leading the 8 main cross-cutting schemes (noting that Mr O Sudar, OPD Project Lead had recently left the Trust) and whether the Finance and Performance Committee would be reviewing progress against each of these schemes at future meetings. In response, it was confirmed that there would be no direct replacement appointment to lead the OPD project and that the Executive Team would be monitoring progress against the major CIP schemes. It was anticipated that the Finance and Performance Committee would review the overall CIP position, rather than progress with individual schemes.

Paper E1 was provided for members' information, highlighting the arrangements for building capacity and capability for change at UHL. The Acting Chairman sought and received additional information regarding the investment required (in terms of staff time and financial investment) and how success would be measured.

Resolved – that (A) the proposals for a Whole Hospital Improvement and Sustainability Programme and arrangements for building capacity and capability for change be received and noted, and

(B) a further report and project plan be presented to the February 2014 meeting. **DoS**

5/14/3 Update on Level 2 Implementation of Finance and Business Awareness Workshops

Further to Minute 126/13/1 of 18 December 2013, the Deputy Director of Finance provided a verbal update on progress of the workshops, noting that approximately 180 clinical staff had now received training and arrangements were being made to schedule further workshops to accommodate the waiting list of interested clinicians. He reported on developments underway to build and embed PLICS and Service Line Reporting within the CMG structures, through drop-in sessions and attendance at the cross-CMG meetings. Some helpful feedback on statistical anomalies had been raised through these sessions. Discussions were underway to include a business awareness session within the new Consultant induction sessions.

Dr S Agrawal, Associate Medical Director had attended a "lock-in" event on 7 January

2014 with 6 of the country's most influential Finance Directors with a view to leading a pilot scheme to support the development of a national financial strategy. Formal feedback from this event was still awaited.

Discussion took place regarding the next steps, which might include key commissioning negotiation themes, granular detail in respect of contracting, progression of SLR and SLM and the arrangements for linking these to medical productivity and job planning. The Deputy Director of Finance was requested to present a further progress update to the Committee in 3 months' time (April 2014).

Resolved – that the Deputy Director of Finance be requested to provide a progress report on financial and business awareness training to the April 2014 Finance and Performance Committee meeting.

5/14/4 Update on Progress of the Medical Productivity Workstream

Dr P Rabey, Deputy Medical Director attended the meeting to introduce paper F, briefing the Finance and Performance Committee on the proposed approach to improving medical productivity at UHL and summarising the current position in respect of each of the following workstreams:-

(a) Job Plan Framework – the LNC had approved the framework for pay progression, subject to clarity being provided relating to the definition of the 11th and 12th PA within relevant job plans. Clarity was provided that Consultants would be held to account in respect of their obligations relating to private practice;
(b) the Medical Staff Job Plan Assurance Group had been established to ensure consistency and equity across the Trust;
(c) Consultant Productivity Matrix to be implemented using the Hospital Evaluation Dataset (HED) software, and
(d) Medical Productivity Workstream – a review of waiting list initiatives and overtime payments was being undertaken to challenge whether additional recruitment or conversion to additional PAs would be a more efficient use of resources.

In discussion on the report, the Interim Director of Financial Strategy recorded his strong support of this workstream and queried the level of additional HR and financial support required to strengthen the implementation arrangements. The Chief Executive confirmed that the Executive Performance Board would oversee progress to ensure a properly disciplined approach within the national rules surrounding the Consultant contract. Members noted that a group of mediators would be trained for job plan mediation and to support the appeals process. Nominations for the mediator roles would be developed in conjunction with Dr K Blanchard, LNC Chair. The Acting Chairman noted that in addition to the financial benefits of the project, there were opportunities to make more effective use of clinical staff hours which might, in turn, increase clinical capacity. The Deputy Medical Director was requested to submit the overall project plan to the Finance and Performance Committee once this had been agreed. **DMD**

Resolved – that (A) the progress report on the Medial Productivity Improvement Plan be received and noted, and

COO/ DMD

(B) a detailed project plan be presented to the Committee when available.

5/14/5 Winter Plan 2013-14

The Chief Operating Officer presented paper G, updating the Finance and Performance Committee on the 2013-14 allocation of non-recurrent additional winter funding, noting that UHL's net expenditure was expected to reach approximately £9.4m by the end of the financial year. He provided assurance that all the expenditure was carefully monitored on a monthly basis to evidence where it had been spent. A schedule of the schemes and their respective quantum was appended to the report.

Within the 2013-14 winter plan, a number of recurrent schemes had been identified which would benefit from funding in 2014-15 (totalling £4.8m) although there was no guarantee that such funding would be made available. Discussion took place surrounding the additional bed capacity currently open for the winter period and the arrangements required to close these beds prior to additional costs being incurred in the new financial year. Confirmation was provided of the intention to close complete wards in the Spring of 2014, starting with Fielding Johnson on the LRI site and ward 2 on the LGH site. A focus would also be maintained on bed occupancy rates, reducing internal waits and reducing length of stay.

Resolved – that the briefing on Winter Plan 2013-14 performance be received and noted. **COO**

6/14 PERFORMANCE

6/14/1 Month 9 Quality, Finance and Performance Report

Paper H provided an overview of UHL's quality, patient experience, operational targets, HR and financial performance against national, regional and local indicators for the month ending 31 December 2013 and a high level overview of the Divisional Heatmap report. The Interim Director of Financial Strategy noted his preference to discuss the month 9 financial performance under Minute 7/14/3 below.

The Chief Operating Officer reported on the following aspects of UHL's operational performance, using the table on page 24 as his central point of reference:-

ED Performance – continued to improve with performance for December 2013 standing at 90.1% and performance for January 2014 to date standing at 93.26%. A range of actions continued to be implemented with a focus on delivering sustainable compliant performance;

RTT 18 Week Performance – improvement trajectories had now been agreed with Commissioners for the specialties of Orthopaedics, Ophthalmology, ENT and General Surgery and these would involve maximising productivity, increasing out-of-hours activity and use of the private sector. The TDA and the CCGs had expressed differing views regarding the timescale for the commencement of additional capacity plans. The exception report provided at appendix 4 advised of a 52 week breach for an incomplete patient pathway, due to patient choice. Under the process, the Trust could have legitimately paused this pathway;

Cancelled Operations and rebooking within 28 days – an improvement plan was provided at appendix 6, advising that cancellations for non-clinical reasons stood at 1.7% and that 94.3% of patients had been rebooked within the required 28 days. Assurance was provided that clinically urgent cases received appropriate priority;

Cancer Performance – the target for 2 week symptomatic breast cancer patients had not been met for November 2013 due to patient choice in a small number of cases. Performance was compliant for December 2013;

Stroke Performance – 2 stroke patients had missed the November target to spend 90% of their stay on a dedicated stroke ward and this was attributed to medical outliers within stroke beds. December performance was compliant. Discussion took place regarding the agreement in place to ring fence stroke beds and the Chief Operating Officer agreed to check whether this process had been followed, and **COO**

Choose and Book Slot Unavailability – progress was expected to be demonstrated once the additional RTT capacity commenced. In the meantime, clinic capacity continued to be challenged by increases in demand of between 10% and 12%.

The Acting Chairman queried the number of cancelled operations which were not attributed to capacity issues and what arrangements were being made to address the remaining causes such as missing case notes, lack of theatre equipment and lack of theatre time/list overruns. In response, the Chief Operating Officer advocated a cautious approach to this data noting the scope for some inaccuracies in reporting. He reported on a revised process for the ITAPS General Manager to be contacted in respect of all on the day theatre cancellations.

Resolved – that (A) the month 9 Quality, Finance and Performance report (paper H) and the subsequent discussion be received and noted, and

(B) the Chief Operating Officer be requested to check whether the process for ring fencing stroke beds had been followed in November 2013. **COO**

7/14 FINANCE

7/14/1 Delivery of Cost Improvement Programme (CIP) 2013-14 Update

The Chief Operating Officer introduced paper I, providing the December 2013 status report on the Cost Improvement Programme for 2013-14, consisting of 335 schemes with a total forecast delivery value of £37.1m against the £37.7m target, representing an in-month improvement of £310k. The RAG ratings for each scheme were presented in a table within section 1 of paper I. Members noted the arrangements in place for the Chief Operating Officer, the Interim Director of Financial Strategy and the Director of Strategy to become more involved in the forward planning of CIP schemes and that an update on the revised governance arrangements would be provided to the February 2014 meeting. **COO**

Resolved – that (A) the 2013-14 CIP update (paper I) be received and noted, and

(B) an update on the revised CIP governance arrangements be included in the February 2014 CIP report. **COO**

7/14/2 Update on Progress of 2014-15 Cost Improvement Plan Development

The Committee received a verbal progress report on the development of 2014-15 CIP schemes, noting that (subject to validation and clinical sign off) indicative savings of £45.5m had already been identified. Further work was underway to assess the schemes and identify the impact of any schemes rolling forward from 2013-14. Meetings were being scheduled with each CMG to challenge the pay, non-pay, income and workforce impact of each scheme and robust expectations had been set surrounding the submission of Project Initiation Documents with clear timescales and accountable lead officers. The Interim Director of Financial Strategy also highlighted the need to capture benefits such as reduced length of stay and improved day case utilisation rates.

In order to support the capability and capacity within CMGs, a range of measures were being explored, one of which might include the use of external consultants. Tenders had been invited for this work and these were due to be reviewed on 31 January 2014. Assurance was provided that any external resources would be embedded within the CMGs and a workshop was being arranged to take this forward.

Resolved – that the verbal update on 2014-15 CIP schemes be received and noted.

7/14/3 Financial Strategy

The Interim Director of Financial Strategy introduced paper J providing a briefing on the Trust's month 9 financial performance, the 2013-14 financial forecast and the financial plans for 2014-15 and 2015-16. Noting that the revised base-case forecast, taking into account the month 9 results, remained a deficit position of £39.8m (as set out in the table

on page 2 of paper J), the Interim Director of Financial Strategy outlined changes in the assumptions relating to education income, theatre stock count and contingency. Members queried the affordability of additional RTT activity within the current financial year and the potential impact of severe weather conditions upon emergency activity levels. Further enhancements to the existing expenditure controls had been introduced and the CMG and Corporate Directorate controls totals were being monitored closely.

Key actions for the remainder of the 2013-14 financial year included appropriate use of technical year end adjustments, maintaining CMG and Corporate performance management regimes (and escalation mechanisms where performance was off track) and agreeing the quantum of commissioning contracts for 2014-15. Particular attention was drawn to the Trust's statutory duties in respect of capital resource and external financing limits. The Trust had spent £19m against the capital plan for 2013-14 and might face criticism if the full £39.8m plan was not progressed appropriately. The current cash balance stood at £3.9m, but the Trust was expected to deliver a year-end cash balance of £16.9m. A case of need was under development to negotiate a year-end loan for this purpose.

Discussion took place regarding the potential quantum and timescale for securing a medium term loan or Public Dividend Capital (PDC) and the need for the Trust Board to be sighted to the whole income and expenditure profile, inclusive of longer term outline capital plans that were discussed at the Trust Board development session on 16 January 2014. It was agreed that proposals would be presented to the Trust Board development session on 13 February 2014. **IDFS**

The Chief Executive voiced his concerns regarding deteriorations in some of the CMG forecasts and re-iterated the importance of delivering these forecasts. Formal letters had been sent to the CMGs to this effect and the Chief Operating Officer confirmed that meetings had been held with the 4 worst performing CMGs to articulate the impact of not delivering the year-end forecasts. The Deputy Director of Finance advised that the benefits of theatre stock counts had not yet been built into the plans, pending agreement with Internal Audit regarding the mid-year timing of this adjustment.

Following the launch of the LLR 5 Year Strategy, the Interim Director of Financial Strategy advised that he would be chairing a working group of local Finance Directors to review the scale of the underlying deficit within the wider health economy and the development of whole health system response plans.

The Acting Chairman queried the arrangements for addressing the potential short fall in the 2013-14 capital programme and suggested that Mr R Kinnersley, Major Projects Technical Director be invited to brief the Committee on progress at the February 2014 Finance and Performance Committee meeting. The Acting Chairman also queried the arrangements for sighting the Trust Board and the Finance and Performance Committee to the 2014-15 Acute Contract negotiations, which were due to be signed off at the end of February 2014. The Interim Director of Financial Strategy reported on the particular challenges facing the contract negotiations advising that (given the Trust's reported deficit position) it would not be feasible to sign up to the previous historical model.

<u>Resolved</u> – that (A) the update on UHL's financial strategy and the subsequent discussion be noted;

(B) proposals for securing a medium term loan or PDC be presented to the Trust board development session on 13 February 2014, and

(C) an update on the Acute Contract negotiations be presented to the 26 February 2014 meeting.

8/14 SCRUTINY AND INFORMATION

8/14/1 Clinical Management Group (CMG) Performance Management Meetings

Resolved – that the action notes arising from the December 2013 CMG Performance management meetings (papers K to K6) be received and noted.

8/14/2 Executive Performance Board

Resolved – that the notes of the 17 December 2013 Executive Performance Board meeting (paper L) be received and noted.

8/14/3 Improvement and Innovation Framework Board

Resolved – that the notes of the 12 December 2013 Improvement and Innovation Framework Board meeting (paper M) be received and noted.

8/14/4 Quality Assurance Committee (QAC)

Resolved – that the Minutes of the 17 December 2013 QAC meeting (paper N) be received and noted.

9/14 ITEMS FOR DISCUSSION AT THE NEXT FINANCE AND PERFORMANCE COMMITTEE

Paper O provided a draft agenda for the 26 February 2014 meeting. The Trust Adminstrator was requested to update this with any additional items agreed at this meeting and circulate a revised version outside the meeting. **TA**

Resolved – that (A) the items for consideration at the Finance and Performance Committee meeting on 26 February 2013 (paper O) be noted, and

(B) the Trust Administrator be requested to update the draft agenda and recirculate it outside the meeting. **TA**

10/14 ANY OTHER BUSINESS

10/14/1 Stock Management System

Further to Minute 187/13/1 of the Trust Board meeting held on 25 July 2013, the Deputy Director of Finance advised that the TDA had now reviewed and approved the Outline Business Case. However, feedback had been provided that the Trust was required to include Public Dividend Capital (PDC) costs of £185k per year within the financial modelling. Committee members noted that the additional expenditure would not impact upon the affordability of the scheme and approved this amendment to the OBC. Discussion took place regarding potential amendments to the business case template going forwards to reflect consideration of the revenue consequences of any capital expenditure. **IDFS**

Resolved – that (A) the revised Stock Management System Outline Business Case (now reflecting additional expenditure of £185k per year for PDC costs) be approved, and **IDFS**

(B) the revenue consequences of any capital requirements be built into the UHL reporting template for future business case submissions. **IDFS/ DDF**

10/14/2 Public Perception of the Trust's Financial Position

The Patient Adviser reported on the public perception of reporting arrangements in announcing the Trust's financial deficit. He noted that public credibility concerns had arisen which might have been avoided with the aid of improved information handling. In

response, the Acting Chairman and the Chief Executive reported on the circumstances which had led to the information not being publicly shared at the Trust Board meeting in December 2013, pending the outcome of discussions with the wider health economy.

Resolved – that the information be noted.

11/14 ITEMS TO BE HIGHLIGHTED TO THE TRUST BOARD

Resolved – that the following issues be highlighted verbally to the Trust Board meeting on 30 January 2014:-

- Minute 5/14/1 – progress with recruitment to nursing vacancies;
- Minute 5/14/4 – medical productivity proposals, and
- Minute 7/14/3 – financial strategy.

12/14 DATE OF NEXT MEETING

Resolved – that the next Finance and Performance Committee be held on Wednesday 26 February 2014 from 8.30am – 11.30am in the Large Committee Room, Main Building, Leicester General Hospital.

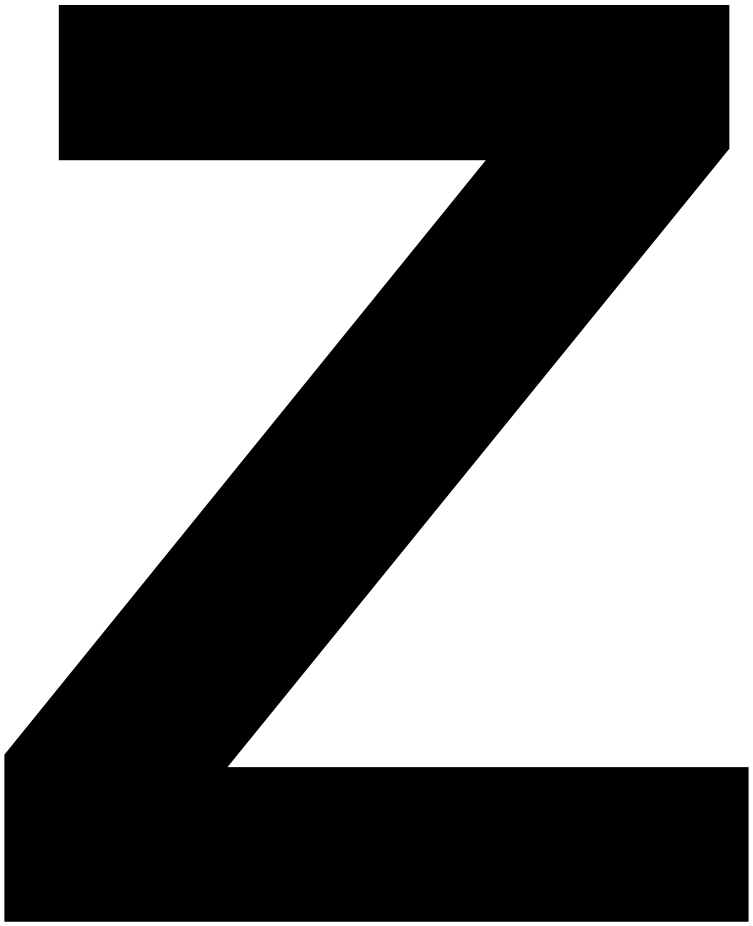
The meeting closed at 11.12am

Kate Rayns,
Trust Administrator

Attendance Record

Name	Possible	Actual	% attendance	Name	Possible	Actual	% attendance
R Kilner (Chair from 1.7.13)	10	10	100%	I Reid (Chair until 30.6.13)	3	3	100%
J Adler	10	8	80%	I Sadd	2	1	50%
I Crowe	7	7	100%	A Seddon	9	9	100%
R Mitchell	7	6	86%	G Smith *	10	9	90%
P Panchal	4	2	50%	J Tozer *	2	2	100%
				J Wilson	10	8	80%

* non-voting members



University Hospitals of Leicester NHS
NHS Trust

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT BY TRUST BOARD COMMITTEE TO TRUST BOARD

DATE OF TRUST BOARD MEETING: 27 February 2014

COMMITTEE: Quality Assurance Committee

CHAIRMAN: Ms J Wilson, Non-Executive Director

DATE OF COMMITTEE MEETING: 29 January 2014

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

- **None**

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

- **Quality Commitment – intention to review and reprioritise leading to discussion at the Trust Board Development session in April 2014 (Minute 04/14/3 refers);**
- **general IM&T issues (discussion under 05/14/1);**
- **Management of Sepsis becoming a part of the 5 Critical Safety Actions (Minute 05/14/3 refers);**
- **Challenge around the electronic system used to report test results (discussion under Minute 05/14/3 refers), and**
- **out of hours operating (Minute 05/14/9 refers).**

DATE OF NEXT COMMITTEE MEETING: 26 February 2014

Ms J Wilson
21 February 2014

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF A MEETING OF THE QUALITY ASSURANCE COMMITTEE HELD ON WEDNESDAY 29 JANUARY 2014 AT 12:30 PM IN THE SEMINAR ROOMS A&B, CLINICAL EDUCATION CENTRE, LEICESTER GENERAL HOSPITAL

Present:
Professor D Wynford-Thomas – Non-Executive Director and Dean of the University of Leicester Medical School (Acting Chair)
Mr J Adler – Chief Executive
Mr M Caple – Patient Adviser (non-voting member)
Ms C O'Brien – Chief Nurse and Quality Officer, East Leicestershire and Rutland CCG (non-voting member)
Ms R Overfield – Chief Nurse

In Attendance:
Ms R Broughton – Head of Outcomes and Effectiveness (for Minute 03/14/1)
Dr B Collett – Associate Medical Director, Clinical Effectiveness
Miss M Durbridge – Director of Safety and Risk
Mr A Furlong – Deputy Medical Director (on behalf of Medical Director)
Mrs S Hotson – Director of Clinical Quality
Mr R Kilner – Acting Trust Chairman/Non-Executive Director
Mrs H Majeed – Trust Administrator

RESOLVED ITEMS **ACTION**

01/14 APOLOGIES

Apologies for absence were received from Dr S Dauncey, Non-Executive Director; Dr K Harris, Medical Director; Ms K Jenkins, Non-Executive Director; Ms C Ribbins, Director of Nursing; Mr P Panchal, Non-Executive Director and Ms J Wilson, Non-Executive Director (Chair).

02/14 MINUTES

Resolved – that the Minutes of the meeting held on 17 December 2013 (papers A & A1 refer) be confirmed as a correct record.

03/14 MATTERS ARISING REPORT

Members reported on progress in respect of the following actions:-

(a) Minute 120/13/3 of 17 December 2013 – it was requested that an update on progress with statutory and mandatory compliance currently scheduled for QAC in June 2014 be brought forward to April 2014. **DHR**

(b) Minute 109/13/4 (ii) of 27 November 2013 – the Associate Medical Director confirmed that a meeting had taken place with the Clinical Audit Manager and a prioritisation scheme for clinical audits had been agreed. Reports presented to the Executive Quality Board would reflect this.

Resolved – that the matters arising report (paper B) and the actions above, be noted. **TA/DHR**

03/14/1 Quality Schedule / Quarter 3 (2013-14) CQUIN Update/ Draft Contractual Requirements 2014-15

Ms R Broughton, Head of Outcomes and Effectiveness attended to present paper C which detailed the anticipated RAG rating for Quality Schedule and CQUIN schemes' performance in quarter 3 (2013-14). She advised that good progress had been made against the quarter 3 thresholds for each of the CQUIN indicators and it was anticipated that all CQUIN schemes would be given a 'green' RAG rating. However, 2 Quality Schedule (QS) indicators ('Never Events' and ' Same Sex Accommodation') would be 'red' rated and there were 10 QS indicators which were at a risk of being rated 'amber'. All LLR indicators would be reviewed and the RAG ratings confirmed at the CQRG meeting on 20 February 2014.

Contract negotiations were underway with Commissioning Quality Leads with respect of the Quality Schedule and CQUIN schemes for 2014-15 and a final draft was expected to be completed by 14 February 2014.

Members were advised that the contract guidance suggested that there should be a small number of local quality schedule indicators. Early discussions had been held with Commissioners about the idea of having 'baskets' of indicators which would reflect the work programme associated with that basket and have one threshold and RAG rating set accordingly. The Acting Chair noted that if indicators were grouped together and one indicator met the threshold whilst the other did not, then there needed to be an appropriate way of flagging this – in response, it was noted that discussions were underway in respect of this matter.

The Chief Nurse and Quality Officer, East Leicestershire and Rutland CCG commented that the QS and CQUIN Schemes for 2014-15 would be more process measured rather than outcome focussed.

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

03/14/2 Update on CQC Inspection – January 2014

The Chief Nurse advised that 47 inspectors visited the Trust during week commencing 13 January 2014 to undertake the CQC inspection. They had given positive feedback about UHL's staff describing them as 'fantastic'. A draft report would be received on 25 February 2014. The Quality Summit had been scheduled to take place on 26 March 2014.

Resolved – that the verbal update be noted.

04/14 QUALITY

04/14/1 Update from the Executive Quality Board (EQB) held on 8 January 2014

The Chief Nurse advised that the EQB was focussing on re-scoping the leadership of EQB's sub groups, committee structures and terms of reference. She advised that a lengthy discussion took place at the January 2014 EQB in respect of refreshing and integrating the 5 Critical Safety Actions (CSAs) and the Quality Commitment in order that it had clear outcomes. In respect of the 5 CSAs, Mr R Kilner, Acting Trust Chairman noted the need for focus on the critical matters in order that work was not duplicated. In response, the Associate Medical Director advised that the work would now be undertaken by CMGs noting that some CMGs might require support. The Chief Nurse highlighted that performance management of CMGs in respect of quality and safety issues had not yet commenced but discussions had taken place to ensure that these meetings were appropriately scheduled.

Resolved – that the verbal update be noted.

04/14/2 Month 9 – Quality and Performance Update

Paper D provided an overview of the December 2013 quality and performance report highlighting key metrics and areas of escalation or further development where required.

The following issues were highlighted in particular:-

(a) C Diff – the number of C Diff cases had now exceeded the trajectory by 2 cases;

(b) as part of the recent CQC inspection, the CQC data pack highlighted that UHL's new pressure ulcer prevalence rate for all grades of pressure ulcers, for all patients (including those over 70 years of age) had been above the England average from March 2013 to November 2013. Although factually correct, the CQC compared UHL data to the national average that did not take into account Trust-to-Trust variation in the demographic make-up of the population;

(c) UHL's SHMI was within expected levels. The Mortality Review Group was scheduled on 30 January 2014 where the scorecard would be reviewed and if required the details of the scorecard would be presented to the Trust Board via the Q&P report;

(d) in response to a query in relation to the downward trend in respect of RTT performance – the Chief Executive confirmed that the Chief Operating Officer had had discussions with Commissioners and agreed a RTT recovery plan. This plan required some significant non-recurrent investment and some recurrent investment which would be discussed at the next Contracting meeting. It was anticipated that the Trust level recovery of the non-admitted standard would be achieved in quarter 2 of 2014-15 and admitted standard would be achieved in quarter 3 of 2014-15;

(e) the FFT score for the Emergency Department showed good improvement with score rising from 59 in November 2013 to 67 in December 2013, and

(f) the Acting Trust Chairman highlighted that the inpatient survey was a very lengthy document – the Chief Nurse undertook to review this at the Patient Experience Group. **CN**

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

(B) the inpatient survey document be reviewed at the Patient Experience Group to ensure that the length of this survey was reduced. **CN**

04/14/3 <u>Quality Commitment</u>

The Director of Clinical Quality presented paper E, which provided a summary on the background of the Quality Commitment programme including progress against the priorities identified for the first year of the programme. Progress had been made in at least one of the work streams for each of the goals identified, however these would need to be continued into 2014-15. Not all work streams had clearly defined targets and key performance indicators.

The Acting Trust Chairman noted that a number of work streams had been rated 'red' and sought assurance on how this would be taken forward – in response, the Chief Nurse noted the need for revised KPIs and robust action plans and advised that this would be discussed at the Executive Quality Board. **DCQ**

The Acting Trust Chairman requested that an update on Quality Commitment be scheduled on the agenda for the Trust Board Development session in April 2014. **CN/DCQ**

The Chief Executive noted the need for appropriate focus around this work stream and integration with the whole hospital modernisation programme.

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

(B) a discussion on the need for revised KPIs and robust action plans in respect of the 'red' rated work streams in the Quality Commitment be discussed at the March 2014 EQB, and **DCQ**

(B) an update on Quality Commitment be scheduled for discussion at the Trust Board Development session in April 2014. **CN/DCQ**

05/14 SAFETY

05/14/1 Patient Safety Report

The Director of Safety and Risk presented paper F, the patient safety report. She particularly highlighted the recent activity through the 3636 staff concerns reporting line. Each concern received was logged and sent through to the Director On Call to investigate and respond. In December 2013, 7 concerns were received, 3 of which were in respect of the low staffing levels in the Chemotherapy Suite. The Chief Executive requested that this issue be reviewed by the Executive Quality Board in January/February 2014. In respect of the IM&T issues raised via the staff concerns reporting line, it was noted that the Chief Executive would be taking it forward. In discussion, it was suggested that an update on the concerns received and the actions taken should be included in the Chief Executive's briefing. In response to a query from the Patient Adviser, the Director of Safety and Risk undertook to consider extending the 3636 concerns reporting line to the public. **CN** **DSR** **DSR**

A total of 7 SUIs (4 of which were patient safety incidents, 2 hospital acquired pressure ulcers and 1 health care acquired infection) were escalated in December 2013. Reference 2013/37745 was now classed as a SUI. Six SUIs had been closed in December 2013. The Learning from Experience Group would consider any Trust-wide learning from these SUIs and where further actions for improvement could be made. All SUIs were discussed at relevant CMG Quality and Safety Board and Mortality Committee meetings and CMGs were required to provide assurance that actions were being completed. The Chief Executive requested that a discussion be held at EQB in respect of the mandatory form of feedback for each grade of incident. **DSR**

In respect of incidents which CMGs did not classify as SUIs, the Chief Nurse and Quality Officer, East Leicestershire and Rutland CCG requested the need for a process to be developed to ensure that there was appropriate scrutiny/challenge at Executive level. **DSR**

The Director of Safety and Risk provided a brief update on the numbers and themes of complaints received within the Trust and a breakdown of complaints by ward and department relating to nursing care, medical care and attitude of staff (the three elements of complaints monitored within the Quality Schedule).

The Director of Safety and Risk expressed concern that a single action was outstanding to comply with the NPSA alert (re. Right Patient Right Blood). The alert required 100% of relevant staff to undertake an observed competency assessment. In discussion, it was agreed that this training needed to be made mandatory for clinical staff and it was noted that an e learning package was already in place. The Director of Safety and Risk undertook to discuss this with the Medical Director. **DSR**

Resolved – that (A) the contents of paper F be received and noted;

(B) the Chief Nurse to ensure that the issue in respect of low staffing levels in the Chemotherapy Suite was reviewed by the Executive Quality Board, and **CN**

(C) the Director of Safety and Risk be requested to:-

- **ensure that an update on the concerns received via the staff reporting line 3636 and the actions taken was included in the Chief Executive's briefing;** **DSR**
- **consider extending the 3636 concerns reporting line to the public;**
- **ensure that a discussion was held at EQB in respect of the mandatory form of feedback for each grade of incident;**

- **develop a process to ensure that there was appropriate scrutiny/challenge at Executive level in respect of incidents which CMGs did not classify as SUIs;**
- **liaise with the Medical Director in respect of making the transfusion competency assessment as mandatory training for clinical staff.**

05/14/2 Report from the Director of Safety and Risk

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

05/14/3 5 Critical Safety Actions Update

The Associate Medical Director presented paper H, a summary of progress made with the original 5 critical safety actions. Management of Sepsis had been identified as a new critical safety action in August 2013 and would replace 'Mortality and Morbidity' standards but was not subject to CQUIN monitoring for 2013-14.

In respect of 'Acting On Results' – it was noted that Deputy CMG Directors had been given the responsibility to define the process for each of the Specialties within each CMG and their team members would be required to act on results (this would apply to inpatients, outpatients and outlying hospitals).

In response to a query in relation to the 24/7 work to improve acting on results, the Associate Medical Director advised that consideration would be given to using the ICE system as some issues had been encountered with the current system (ICM). The Acting Chair requested that an update be provided to the March 2014 QAC in respect of which system would be used for test results. It was also noted that the Chief Medical Information Officers had been tasked to provide the strategy prior to the implementation of the Electronic Patient Record. **AMD**

In respect of the Specialties who had not yet documented their current handover process, it was noted that this had been escalated to the CMG Directors.

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

(B) an update on the electronic system that would be used for test results be provided at the QAC in March 2014. **AMD/TA**

05/14/4 Report from the Associate Medical Director

Resolved – that this item be classed as confidential and taken in private accordingly.

05/14/5 Nursing Workforce Report

Paper J provided an overview of the nursing workforce position for UHL. Vacancies for nursing and HCA posts across UHL ran currently at 334 WTE. The first cohort of internal nurses joined the Trust on 20 January 2014 and the second cohort was expected to commence on 10 February 2014. Work was underway to appoint an agency to recruit 20 international nurses per quarter. A significant number of clearing house students were expected to start in March 2014.

The Chief Nurse advised that from April/May 2014, there might be a reduction in agency spend, however this would be dependent on 20% of the current unfilled shift rate being filled.

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

05/14/6 Update on the actions in place following the NHS Trust Development Authority (NTDA)

Visit on 2 and 3 December 2013 to review Infection Prevention procedures

Paper K provided the action plan following the above visit. The Chief Nurse undertook to re-circulate the action plan with the progress updates included. **CN**

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

(B) the action plan with the progress updates included be circulated to QAC members. **CN**

05/14/7 Report from the Chief Nurse

Resolved – that this item be classed as confidential and taken in private accordingly.

05/14/8 Report from the Deputy Medical Director

Resolved – that this item be classed as confidential and taken in private accordingly.

05/14/9 Out of Hours Operating

The Deputy Medical Director advised verbally that the Trust collected data on performance against NCEPOD categories for emergency patients' retrospectively. An audit undertaken in November/December 2013 at the LRI indicated that the Trust was not achieving the target. Therefore it had been agreed to switch one elective theatre list to an emergency theatre list per day at the LRI. Further to this, another audit had been undertaken which showed that there had been significant improvement in performance.

A spreadsheet had been compiled to allow the monitoring of daily movement and the review of minimum and maximum times. An electronic scorecard would be developed in order to track performance. The Deputy Medical Director advised that the Trust's aspiration should be to undertake all emergency operations within 24 hours.

Resolved – that the verbal update be noted.

05/14/10 Report from the Deputy Medical Director

Resolved – that this item be classed as confidential and taken in private accordingly.

06/14 ITEMS FOR INFORMATION

06/14/1 QAC Work Plan

The Acting Chair requested that comments on the proposed cycle of business detailed in the work plan (paper N) be provided to the Committee Chair. An update on the QAC work plan would be scheduled on the agenda for the QAC in February 2014. **ALL** **TA**

Resolved – that an update on the QAC work plan be scheduled on the agenda for the February 2014 QAC. **TA**

06/14/2 Terms of Reference of the Mortality Review Group

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

06/14/3 Terms of Reference of the Infection Prevention Assurance Committee

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

07/14 MINUTES FOR INFORMATION

07/14/1 Finance and Performance Committee

Resolved – that the public Minutes of the Finance and Performance Committee meeting held on 18 December 2013 (paper Q refers) be received and noted.

07/14/2 Executive Quality Board

Resolved – that the action notes of the Executive Quality Board meeting held on 8 January 2014 (paper R refers) be received and noted.

08/14 ANY OTHER BUSINESS

08/14/1 Senior Information Risk Officer (SIRO)

Resolved – that the Director of Safety and Risk be requested to email the Chief Executive in respect of the details for the appointment of a SIRO. **DSR**

09/14 IDENTIFICATION OF ANY KEY ISSUES FOR THE ATTENTION OF THE TRUST BOARD

Resolved – that the following items be brought to the attention of the Trust Board in January 2014:-

- **Quality Commitment – intention to review and reprioritise leading to discussion at the Trust Board Development session in April 2014 (Minute 04/14/3 refers);**
- **general IM&T issues (discussion under 05/14/1);**
- **Management of Sepsis becoming a part of the 5 Critical Safety Actions (Minute 05/14/3 refers);**
- **Challenge around the electronic system used to report test results (discussion under Minute 05/14/3 refers);**
- **Discussion under Minute 05/14/4, and**
- **out of hours operating (Minute 05/14/9 refers).**

10/14 DATE OF NEXT MEETING

Resolved – that the next meeting be held on Wednesday, 26 February 2014 at 12:30pm in the Large Committee Room, Main Building, LGH.

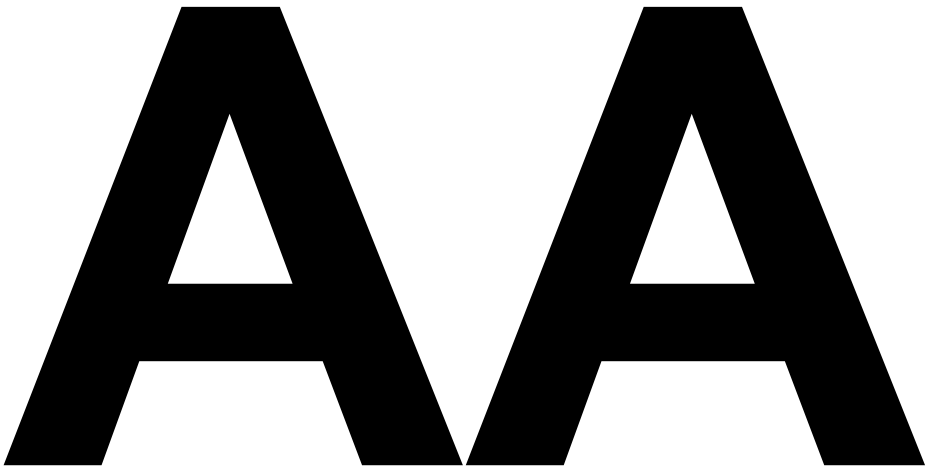
The meeting closed at 3:00pm.

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

Name	*Possible*	*Actual*	*% attendance*	*Name*	*Possible*	*Actual*	*% attendance*
J Adler	*10*	*6*	*60*	*R Overfield*	*5*	*4*	*80*
*M Caple**	*10*	*9*	*90*	*R Palin**	*4*	*3*	*75*
S Dauncey	*2*	*1*	*50*	*P Panchal*	*10*	*7*	*70*
K Harris	*10*	*7*	*70*	*C Ribbins ***	*4*	*3*	*75*
S Hinchliffe	*1*	*1*	*100*	*J Wilson (Chair)*	*10*	*9*	*90*
K Jenkins	*3*	*1*	*33*	*D Wynford-Thomas*	*10*	*7*	*70*
*C O'Brien – East Leicestershire/Rutland CCG**	*10*	*6*	*60*				

- *non-voting members*
- *** records attendance whilst Acting Chief Nurse*

Hina Majeed, **Trust Administrator**


AA

Trust Board Paper AA

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT BY TRUST BOARD COMMITTEE TO TRUST BOARD

DATE OF TRUST BOARD MEETING:	**27 February 2014**

COMMITTEE:	**Charitable Funds Committee**
CHAIRMAN:	**Mr P Panchal, Non-Executive Director**
DATE OF COMMITTEE MEETING:	**3 February 2014**

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

- **Items for Approval (Minute 01/04 refers) – specifically application numbers 4816, 4824 and 4844 due to their value being over the Charitable Fund Committee's delegated authorisation limit of £25,000.**

OTHER KEY ISSUES IDENTIFIED BY THE COMMITTEE FOR NOTING BY THE PUBLIC TRUST BOARD:

- **None**

DATE OF NEXT COMMITTEE MEETING: To be confirmed.

P Panchal, Non-Executive Director
21 February 2014

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF A MEETING OF THE CHARITABLE FUNDS COMMITTEE HELD ON MONDAY 3 FEBRUARY 2014 AT 11AM IN THE BOARD ROOM, VICTORIA BUILDING, LEICESTER ROYAL INFIRMARY

Present: Mr P Panchal – Non-Executive Director (Chair)
Mr P Hollinshead – Interim Director of Financial Strategy
Ms R Overfield – Chief Nurse

In Attendance: Mrs G Belton – Trust Administrator
Mr P Burlingham – Patient Adviser
Dr W Chung – Clinical Research Fellow (for Minute 01/04 – point (iii))
M T Diggle – Head of Fundraising
Ms J Foxon – Matron (for Minute 01/14 – point (ii))
Ms J Smith – Superintendent Radiographer (for Minute 01/04 – point (viii))
Mrs M Tuddenham – Charitable Funds Assistant
Mr M Wightman – Director of Marketing and Communications
Ms J Woolley – Assistant Financial Accountant

RECOMMENDED ITEMS **ACTION**

01/14 ITEMS FOR APPROVAL

The Assistant Financial Accountant presented paper 'G', which outlined grant applications received since the last Committee meeting.

Appendix 1 to the report detailed applications totalling £455,587 which had been approved by the Charity Finance Lead under the scheme of delegation, and which did not require approval by the Committee. Appendix 3 detailed those applications which had been rejected by the Charity Finance Lead. Appendix 2 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). It was noted that the reports continued to present information by the former Divisional / Directorate structure, rather than in the new Clinical Management Group (CMG) / Corporate Directorate structure, and that work would be required to align the relevant systems to the new CMG structure. It was agreed that the Director of Marketing and Strategy would discuss with the Charity Finance Lead the resource required in re-structuring the data so as to present this information by CMG. **DMC**

Section 2.6 of the report provided the details of an application approved by members outside the meeting, as per the required process for the seeking of urgent approval between formal Committee meetings, and related to the approval of £16,056 being utilised from the Forget-Me-Not Appeal to fund two Meaningful Activity Co-ordinators for a further six-month period in addition to the twelve months previously funded by the Charity.

The Committee undertook detailed consideration of the following new applications for funding (as detailed in appendices 4 – 18 inclusive):

(i) application 4496 (appendix 4 refers) was an application for £19,599 from the Women's and Children's Equipment Fund for the provision of computer workstations for use within the Neonatal Unit to allow for an increase in capacity of cots. This application had the approval of the CMG Deputy Clinical Director and General Manager, and sufficient funds were available to support the application. The Committee approved this application (noting also its relation to application 4550 (note (ii) below refers); **CFA**

(ii) application 4550 (appendix 5 refers), as presented by Ms J Foxon, Matron, was an application for £20,240 from the Women's and Children's Equipment Fund for the provision of eight Neopuff Resuscitation Devices for use within the Neonatal Unit to allow for an increase in the capacity of cots (and related to

application 4496, point (i) above refers). This application had the approval of the CMG Deputy Clinical Director and General Manager, and sufficient funds were available to support the application. The Committee approved this application, in light of its duty to utilise the funds raised by families for this specific purpose, on the basis that future replacements and on-going maintenance costs were met by the Trust. In light of the specific questions raised during the discussion on this application regarding the items that had been included or excluded from the original business case, and the particular process that had been followed, it was agreed that the Director of Marketing and Communications would feed back to the Women's and Children's Clinical Director and General Manager accordingly. It was further noted that more specific information was required on such future applications from across the Trust regarding issues relating to the maintenance of equipment; **CFA** **DMC**

(iii) application 4592 (appendix 6 refers), as presented by Dr Chung, Clinical Research Fellow, was an application for £42,024 for the provision of a Cytometer to aid research into the early detection of pancreatic cancer to be partially funded from the Pancreatic and Hepatobiliary research fund and the Marks and Spencer Pancreas Research Fund. The shortfall of approximately £20,000 was requested from general purpose charitable funds. Other potential funds within the Cancer and Haematology area had been identified however discussions had confirmed that these funds were earmarked for another purpose. Following discussion, the Committee did not approve this application at the current time on the basis that they would first wish to have evidence of the following: (a) confirmation that this application was supported by the CMG's Clinical Director (b) confirmation that this application was supported by the Trust's Medical Equipment Panel and (c) confirmation that this application was supported by the CMG's Research Lead / the Research and Development Executive. It was agreed that this decision would be fed back to the applicant by the Charitable Funds Assistant; **CFA**

(iv) application 4660 (appendix 7 refers) was an application for £14,617 from general purpose charitable funds to refurbish the Radio Fox studio including a new mixing desk. The radio station was a registered charity run by volunteers providing a radio station to the LRI and Glenfield Hospitals. Their limited income was insufficient to enable them to carry out a refit. Following discussion, the Committee did not approve this application at the current time on the basis that they considered that further information would be helpful, particularly in terms of the future strategy in respect of the two separate radio station services provided at the Trust (one at the Glenfield and LRI, and the other at the LGH). It was also considered that it would be helpful to seek feedback from patients on this issue, through the incorporation of a question into the patient surveys. It was agreed that the Head of Fundraising would make contact with the providers of Radio Fox and Radio Gwendolen for this purpose; **HoF**

(v) application 4670 (appendix 8 refers) which was an application for £16,841 from the Breast Care Centre fund for the provision of a perometer had been withdrawn, and this was noted by the Committee;

(vi) application 4675 (appendix 9 refers) was an application for £23,398 from the Renal Unit Patient Benefit Fund for the provision and installation of televisions for patients on Ward 15N at the Leicester General Hospital. This application had the approval of the CMG General Manager and there were sufficient funds within the Fund to support this. This application was approved by the Committee; **CFA**

(vii) application 4686 (appendix 10 refers) was an application for £10,500 from general purpose funds for additional high back chairs for the central outpatients department at the Leicester General Hospital to enhance patient experience. The Committee approved this application, albeit noting the requirement for a debate at a future point in time regarding the potential establishment of a central fund for bedside kit; **CFA/ CN**

(viii) application 4816 (appendix 11 refers), as presented by Ms J Smith, Superintendent Radiographer, was an application for £112,757 from the Breast Care Centre Fund for the provision of an ultrasound machine to enable the service to expand. This was to be funded by a patient legacy of £173,000. This

application had the approval of the Medical Equipment Panel and the CMG General Manager. The Committee approved this application; **CFA**

(ix) application 4824 (appendix 12 refers) was an application for £100,292 from the Oncology Equipment Fund for the provision of eight scalp cooling units for patients undergoing chemotherapy treatment. The funding for these had been donated by the Walk the Walk Charity specifically for this equipment. The application had the approval of the Medical Equipment Panel and the CMG Deputy General Manager. The Committee approved this application; **CFA**

(x) application 4836 (appendix 13 refers) was an application for £10,000 from general purpose charitable funds to refit the two junior doctor rooms in the Obstetrics and Gynaecology departments at the LRI and Leicester General Hospitals to ensure the facilities were functional for the staff. This application was approved in principle, subject to confirmation being sought by the Assistant Financial Accountant that this funding was not being utilised to comply with health and safety requirements, as this was a statutory function which should be met from exchequer funds; **AFA**

(xi) application 4837 (appendix 14 refers) was an application for £2,050 from general purpose charitable funds to purchase additional red dignity pegs. These had previously been funded by the charity and were a useful tool to ensure patients' privacy and dignity. This application had the support of the Director of Nursing and was approved by the Committee; **CFA**

(xii) application 4838 (appendix 15 refers) was an application for £831 from general purpose charitable funds to fund the translation of electronic patient surveys into Polish, Punjabi and Guajarati and had been requested by the Patient Experience Team in order to enable more patients to provide feedback about the Trust. The Committee approved this application, albeit noting that it would have been helpful if this additional requirement had been made explicit at the time at which the i-pads (for use by patients completing the electronic surveys) had been agreed for purchase; **CFA**

(xiii) application 4839 (appendix 16 refers) was an application for £20,000 from general purpose charitable funds to support a research study in which the Trust was a co-applicant to the EnRich project. This application had the approval of the Director of Nursing. The Committee did not approve this application at the current time as it was considered that further additional information was required. It was agreed that the Chief Nurse would provide confirmation of the additional information required for this application to be re-submitted to the Committee; **CN**

(xiv) application 4842 was an application for £4000 from general purpose charitable funds to fund stress resilience workshops for newly qualified nurses and midwives. The Committee did not approve this application at the current time as it was considered that further additional information was required. It was agreed that the Chief Nurse would provide confirmation of the additional information required, and **CN**

(xv) application 4844 (appendix 18 refers) was an application for £29,475 from the Foxtrot Restricted Fund for the provision of an Instron Biomechanical testing system for orthopaedic research. There were sufficient funds within the foxtrot fund to support this purchase, as raised by patients and their families at the Foxtrot Walk. This application had the support of the Clinical Director and was approved by the Committee. **CFA**

<u>Recommended</u> – that (A) the contents of this report (including the withdrawal of application 4670) and its appendices be received and noted,

(B) applications 4496, 4550, 4675, 4686, 4837 and 4838 be approved, with applications 4816, 4824 and 4844 being 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) application 4836 be approved subject to the specific action identified under point (x) to be undertaken by the Assistant Financial Accountant, **AFA**

(D) applications 4592, 4660, 4839 and 4842 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 (iv), (xiii), and (xiv)) 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, **HoF/CN**

(E) the Director of Marketing and Communications be requested to undertake the specific actions identified under paragraph two of this Minute and also point (ii) above, and **DMC**

(F) the Chief Nurse be requested to give consideration to progressing the establishment of a central fund for the purchase of bedside kit. **CN**

RESOLVED ITEMS **ACTION**

02/14 APOLOGIES

Apologies for absence were received from Ms K Jenkins, Non-Executive Director, Mr N Sone, Charity Finance Lead, Dr P Spiers, Chair of the Medical Equipment Executive and Mr S Ward, Director of Corporate and Legal Affairs.

03/14 MINUTES

Resolved – that the public and private Minutes of the meeting held on 13 September 2013 (paper A refers) be confirmed as a correct record.

04/14 MATTERS ARISING

04/14/1 Matters Arising Report

Members received and noted the contents of paper 'B', which detailed information in respect of outstanding matters arising from previous meetings. In view of the time that had elapsed since the last meeting of the Charitable Funds Committee (held in September 2013) it was agreed that the Committee Chairman and the Head of Fundraising would review the contents of this report outwith the meeting and report progress against all identified actions at the next meeting of the Committee. **Chair / HoF**

Specific discussion took place in respect of the following items:

(i) Minute 47/13 (Bereavement Room at the LGH, in particular the issue of staff training for patients experiencing miscarriage) – the Head of Fundraising advised that whilst the focus of the Leicester Baby Loss Appeal was on improvement of the environment in which to care for mothers giving birth to still-born babies, specific training had recently been undertaken by a number of midwives and there were other plans and initiatives underway within the service, and

(ii) Minute 48/13 (Finance and Governance Report) – the Interim Director of Financial Strategy advised that he was due to meet with KPMG the following day and would seek to expedite the reports referenced within paper B. **IDFS**

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

(B) the Committee Chairman and the Head of Fundraising be requested to review the contents of paper B outwith the meeting and report progress against all identified actions at the next meeting of the Charitable Funds Committee, and **Committee Chair / HoF**

(C) the Interim Director of Financial Strategy be requested to undertake the action highlighted under point (ii) above, and report back to the Committee accordingly. **IDFS**

05/14 FUNDRAISING UPDATE REPORT

The Head of Fundraising presented paper 'C', which detailed recent fundraising and promotional activities and noted future plans and fundraising events.

Specific discussion took place regarding the following points:

(i) members noted a specific issue raised in terms of equity of provision of the Staff Christmas Meals for UHL-employed staff compared to those who worked at the Trust but were employed by other organisations, and

(ii) the work that had commenced in respect of the Trust's new marketing and promotion strategy for legacies, including the outcome of a recent focus group that had been held, which would be used to inform a broader survey of supporters of Leicester Hospitals Charity and UHL Trust members. It was currently anticipated that the Legacy Strategy would be submitted for approval at the next meeting of the Charitable Funds Committee, along with the outcome of the planned survey (if available). Further discussion took place regarding this matter in terms of the importance of engaging with all of Leicester's diverse community groups, along with the potential to develop a partnership approach with a large organisation. It was agreed that the Committee Chairman would pass on details of relevant potential contacts to the Head of Fundraising for the purpose described. In response to a query raised, the Head of Fundraising confirmed that people leaving a legacy to the Trust were able to specify the area in which they wished the funds to be used.

HoF

Committee Chairman

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

(B) the Head of Fundraising be requested to present the Legacy Strategy to the next meeting for approval, along with the results of the planned survey (if available), and **HoF**

(C) the Committee Chairman be requested to undertake the action highlighted under point (ii) above. **Committee Chairman**

06/14 REPORT BY THE HEAD OF FUNDRAISING (1)

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

07/14 REPORT BY THE HEAD OF FUNDRAISING (2)

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

08/14 FINANCE AND GOVERNANCE REPORT

The Assistant Financial Accountant presented paper 'F', which provided an update on the financial position of the Charity for the period ending 31 December 2013, and also provided an update on the general purposes charitable fund.

The Interim Director of Financial Strategy requested that a report was submitted to a future meeting of the Charitable Funds Committee which detailed the following information:

(a) individual fund balances and movement over the last 24 months, and

(b) the status of any spending plans by fund. **CFL**

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

(B) the Charity Finance Lead be requested to submit a report to a future meeting of the Charitable Funds Committee which documented (a) individual fund balances

and movement over the last 24 months, and (b) the status of any spending plans by fund. **CFL**

09/14 ANY OTHER BUSINESS

09/14/1 Leicester and Leicestershire Secondary Schools Heartsafe Programme

The Head of Fundraising tabled a report in respect of the Leicester and Leicestershire Secondary Schools Heartsafe Programme which had been initiated by two local charities (The East Midlands Pacemaker Fund and the Joe Humphries Memorial Trust) with the aim of establishing and delivering a training programme to ensure all Year 10 pupils in Leicester and Leicestershire schools were given the opportunity to receive effective training in resuscitation skills. The initial two year programme would be hosted by the Trust. As the programme was being funded entirely out of donations and gifts there was a need to manage donations and any expenditure in a transparent and accountable manner. The creation of such a fund within Leicester Hospitals Charity would provide the appropriate level of accountability and any necessary administration, and was approved by the Committee.

Resolved – that the creation of a fund to manage donations to the Leicester and Leicestershire Heartsafe Programme be approved.

09/14/2 Charity Investment Managers

At the request of the Interim Director of Financial Strategy, it was agreed that the Charity Finance Lead would be requested to seek a report from the Charity's Investment Managers for submission to each meeting of the Charitable Funds Committee, with a request that the Charity Investment Managers attend a meeting of the Charitable Funds Committee on an annual basis (the latter aspect being the same arrangement as that previously in place). **CFL**

Resolved – that the Charity Finance Lead be requested to seek a report from the Charity's Investment Managers for submission to each meeting of the Charitable Funds Committee and request that they continue to attend a meeting of the Charitable Funds Committee on an annual basis. **CFL**

09/14/3 LiA Projects – Requests for Funding

The Head of Fundraising made reference to three projects which had arisen out of Listening into Action which had previously bid for capital funding. As these did not represent capital schemes, they were now seeking the use of charitable funds as an alternative source of funding. As members had not had the opportunity to review this information in detail, it was agreed that the Head of Fundraising would email members the relevant detail outwith the meeting and seek advice as to how best to progress this matter, potentially through submission of a bid to a future meeting of the Charitable Funds Committee. **HoF**

Resolved – that the Head of Fundraising be requested to email members the relevant information outwith the meeting and seek advice as to how best to progress this matter, potentially through submission of a bid to a future meeting of the Charitable Funds Committee. **HoF**

10/14 IDENTIFICATION OF KEY ISSUES THAT THE COMMITTEE WISHES TO DRAW TO THE ATTENTION OF THE TRUST BOARD

Resolved – that there were no specific issues that the Committee wished to draw to the attention of the Trust Board, other than the recommended item already highlighted for the attention of the Trust Board above (Minute 01/14 – Items for Approval refers).

11/14 CHARITABLE FUNDS COMMITTEE MEETING DATES 2014

It was agreed that the Trust Administrator would email members with potential dates for the Charitable Funds Committee to meet in 2014, in order that these could be confirmed and venues arranged accordingly.

Resolved – that the Trust Administrator be requested to undertake the action outlined above. **TA**

The meeting closed at 1.11pm.

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

Name	Possible	Actual	% attendance
P Burlingham *	3	3	100%
T Diggle *	3	3	100%
M Hindle	2	0	0%
P Hollinshead	1	1	100%
K Jenkins	3	1	33%
R Overfield	2	1	50%
P Panchal	3	3	100%
A Seddon	2	0	0%
N Sone *	3	2	67%
P Spiers *	2	1	50%
S Ward *	3	2	67%

* non-voting members

Gill Belton
Trust Administrator