UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

TRUST BOARD

MEETING TO BE HELD ON THURSDAY 5 MARCH 2015 FROM 9AM IN THE C J BOND ROOM, CLINICAL EDUCATION CENTRE, LEICESTER ROYAL INFIRMARY

Public meeting commences at 9am

AGENDA

Please take papers as read

Item no.	Item	Paper ref:	Lead	Discussion time
1.	**APOLOGIES AND WELCOME**	**-**	**Chairman**	
	To receive any apologies for absence. To welcome Mr R Moore, Non-Executive Director (Designate), Dr R Palin, LLR CCG Representative, and Ms C Ribbins, Acting Chief Nurse.			-
2.	**DECLARATIONS OF INTERESTS**	**-**	**Chairman**	
	Members of the Trust Board and other persons attending are asked to declare any interests they may have in the business on the public agenda (Standing Order 7 refers). Unless the Trust Board agrees otherwise in the case of a non-prejudicial interest, the person concerned shall withdraw from the meeting room and play no part in the relevant discussion or decision.			-
3.	**MINUTES**			
	Minutes of the 5 February 2015 Trust Board meeting. *For approval*	**A**	**Chairman**	-
4.	**MATTERS ARISING**			
	Action log from the 5 February 2015 meeting. *For approval*	**B**	**Chairman**	9am – 9.05am
5.	**CHAIRMAN'S MONTHLY REPORT – MARCH 2015** *For noting*	**C**	**Chairman**	9.05am – 9.10am
6.	**CHIEF EXECUTIVE'S MONTHLY REPORT – MARCH 2015** *For noting*	**D**	**Chief Executive**	9.10am – 9.15am
7.	**KEY ISSUES FOR DECISION/DISCUSSION**			
7.1	**PATIENT STORY** *For discussion*	**E**	**Acting Chief Nurse**	9.15am – 9.35am
7.2	**LEARNING LESSONS TO IMPROVE CARE – QUARTERLY UPDATE** *For discussion and assurance*	**F**	**Medical Director**	9.35am – 9.45am

7.3	**INSTITUTE OF FRAIL ELDERLY MEDICINE – PROPOSED PARTNERSHIP WITH DE MONTFORT UNIVERSITY** *For approval* Dr S Oldroyd, Dean – Faculty of Health and Life Sciences, De Montfort University to attend for this item.	**G**	**Medical Director**	9.45am – 10am
7.4	**PATIENT AND PUBLIC INVOLVEMENT AND ENGAGEMENT STRATEGY** *For approval*	**H**	**Director of Marketing and Communications**	10am – 10.15am
8.	**QUALITY AND PERFORMANCE**			
8.1	**QUALITY AND PERFORMANCE REPORT – MONTH 10** The Chief Executive to introduce his monthly overview of quality and performance and the relevant Lead Executive Directors to be invited to comment on their respective sections of the detailed report. *For discussion and assurance*	**I**	**Chief Executive and Lead Executive Directors**	10.15am – 10.30am
8.2	**2014-15 MONTH 10 FINANCIAL POSITION** *For discussion and assurance*	**J**	**Director of Finance**	10.30am – 10.40am
8.3	**APPROVAL OF 2014-15 CAPITAL LOAN** *For approval*	**J1**	**Director of Finance**	10.40am – 10.45am
8.4	**EMERGENCY CARE PERFORMANCE REPORT** *For discussion and assurance*	**K**	**Chief Operating Officer**	10.45am – 10.55am
9.	**WORKFORCE**			
9.1	**ORGANISATIONAL DEVELOPMENT STRATEGY – QUARTERLY UPDATE** *For discussion and assurance*	**L**	**Acting Director of Human Resources**	10.55am – 11.10am
10.	**GOVERNANCE**			
10.1	**BOARD ASSURANCE FRAMEWORK** *For discussion and assurance*	**M**	**Medical Director**	11.10am – 11.25am
11.	**REPORTS FROM BOARD COMMITTEES**			
11.1	**QUALITY ASSURANCE COMMITTEE (QAC)** To receive the Minutes of the 29 January 2015 meeting for noting and endorsement of any recommendations. The QAC Chair to present a summary of the key issues considered at the 26 February 2015 meeting and to note that the formal Minutes of this meeting will be presented to the Trust Board on 2 April 2015.	**N & N1**	**QAC Chair**	11.25am – 11.30am
11.2	**INTEGRATED FINANCE, PERFORMANCE AND INVESTMENT COMMITTEE (IFPIC)** To receive the Minutes of the 29 January 2015 meeting for noting and endorsement of any recommendations. The IFPIC Chair to present a summary of the key issues considered at the 26 February 2015 meeting and to note that the formal Minutes of this meeting will be presented to the Trust Board on 2 April 2015.	**O & O1**	**IFPIC Chair**	11.30am – 11.35am

12.	**CORPORATE TRUSTEE BUSINESS**			
12.1	**CHARITABLE FUNDS COMMITTEE** To receive the Minutes of the inquorate meeting held on 19 January 2015 for approval and endorsement of any recommendations.	**P**	**CFC Chair**	11.35am – 11.40am
13.	**TRUST BOARD BULLETIN – FEBRUARY 2015**	**Q**	**-**	-
14.	**QUESTIONS FROM THE PUBLIC RELATING TO BUSINESS TRANSACTED AT THIS MEETING**		**Chairman**	11.40am – 11.55am
15.	**ANY OTHER BUSINESS**		**Chairman**	11.55am – 12noon
16.	**DATE OF NEXT MEETING**			
	The next Trust Board meeting will be held on Thursday 2 April 2015 from 10am in Seminar Rooms 2 and 3, Clinical Education Centre, Glenfield Hospital site.			
17.	**EXCLUSION OF THE PRESS AND PUBLIC** It is recommended that, pursuant to the Public Bodies (Admission to Meetings) Act 1960, the press and members of the public be excluded from the following items of business, having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest (items 18-24).			
10 minute comfort break 12noon – 12.10pm				
18.	**DECLARATIONS OF INTERESTS** Members of the Trust Board and other persons attending are asked to declare any interests they may have in the business on the agenda (Standing Order 7 refers). Unless the Trust Board agrees otherwise in the case of a non-prejudicial interest, the person concerned shall withdraw from the meeting room and play no part in the relevant discussion or decision.			
19.	**CONFIDENTIAL MINUTES** To receive the confidential Minutes of the 5 February 2015 Trust Board meeting. *For approval*	**R**	**Chairman**	-
20.	**MATTERS ARISING** Confidential action log from the 5 February 2015 Trust Board meeting. *For approval*	**S**	**Chairman**	12.10pm – 12.15pm
21.	**REPORTS FROM THE INTERIM DIRECTOR OF ESTATES AND FACILITIES** *For approval* *Commercial in confidence*	**T**	**Interim Director of Estates and Facilities**	12.15pm – 12.20pm
22.	**REPORT FROM THE DIRECTOR OF CORPORATE AND LEGAL AFFAIRS** *For assurance Personal data and prejudicial to the conduct of public affairs.*	**U**	**Director of Corporate and Legal Affairs**	12.20pm – 12.25pm
23.	**REPORTS FROM BOARD COMMITTEES**			

23.1	**INTEGRATED FINANCE, PERFORMANCE AND INVESTMENT COMMITTEE** To receive the confidential Minutes of the 29 January 2015 meeting and a summary of the confidential issues considered at the 26 February 2015 meeting (Minutes of the latter meeting will be presented to the 2 April 2015 Trust Board meeting). *Prejudicial to the conduct of public affairs*	**V & V1**	**IFPIC Chair**	12.25pm – 12.30pm
23.2	**REMUNERATION COMMITTEE** To receive the confidential Minutes of the 29 January 2015 meeting for noting. *Personal data and prejudicial to the conduct of public affairs*	**W**	**Chairman**	12.30pm – 12.35pm
24.	**ANY OTHER BUSINESS**	**-**	**Chairman**	12.35pm – 12.40pm

Kate Rayns
Acting Senior Trust Administrator

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF A MEETING OF THE TRUST BOARD, HELD ON THURSDAY 5 FEBRUARY 2015 AT 9AM IN SEMINAR ROOMS A & B, CLINICAL EDUCATION CENTRE, LEICESTER GENERAL HOSPITAL

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

In attendance:
Professor S Carr – Associate Medical Director, Clinical Education (for Minute 28/15/1)
Ms J Gilmore – Imaging Service Manager, Clinical Support and Imaging CMG (for Minute 37/15)
Mr D Henson – LLR Healthwatch Representative (up to and including Minute 32/15)
Mr D Kerr – Interim Director of Estates and Facilities
Ms S Khalid – Clinical Director, Clinical Support and Imaging CMG (for Minute 37/15)
Ms H Leatham – Assistant Chief Nurse (for Minute 25/15/1)
Mrs K Rayns – Acting Senior Trust Administrator
Ms C Ribbins – Deputy Chief Nurse
Ms K Shields – Director of Strategy
Ms E Stevens – Acting Director of Human Resources
Dr M VanWattinghen – Consultant Radiologist, Clinical Support and Imaging CMG (for Minute 37/15)
Mr S Ward – Director of Corporate and Legal Affairs (from part of Minute 23/15)
Mr M Wightman – Director of Marketing and Communications

ACTION

18/15 APOLOGIES

There were no apologies for absence.

19/15 DECLARATIONS OF INTERESTS IN THE PUBLIC BUSINESS

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

20/15 CHAIRMAN'S ANNOUNCEMENTS

The Chairman welcomed Ms C Ribbins, Deputy Chief Nurse and Mr D Kerr, Interim Director of Estates and Facilities to the meeting and highlighted the following issues:-

(a) the recent appointment of Mr R Moore as a Non-Executive Director with effect from 1 April 2015. The Board also endorsed the proposal to appoint Mr Moore as a Non-Executive Director Designate with immediate effect until the commencement of his substantive appointment;
(b) that this would be the last UHL Trust Board meeting for Ms R Overfield, Chief Nurse before she left the Trust at the end of February 2015 to take up her new role with the NHS Trust Development Authority (TDA). He thanked Ms Overfield for her contribution

to the Trust's nursing services, and

(c) that this would also be the last UHL Board meeting for Professor D Wynford-Thomas before he stood down from his role as the nominated University of Leicester Non-Executive Director at the end of February 2015. He thanked Professor Wynford-Thomas for his support, noting the importance of this role as a bridge between the Trust and the University, and

(d) the Trust's support of the "Hello my name is …" campaign.

Resolved – that the Trust Board endorse the proposal to appoint Mr R Moore as a Non-Executive Director Designate with immediate effect until his substantive Non-Executive Director appointment commences on 1 April 2015. **DCLA**

21/15 MINUTES

Resolved – that the Minutes of the 8 January 2015 Trust Board (paper A) be confirmed as a correct record and signed by the Trust Chairman accordingly. **CHAIR**

22/15 MATTERS ARISING FROM THE MINUTES

Paper B detailed the status of previous matters arising and the expected timescales for resolution. The Board received updated information on the following items:-

(a) item 2 (Minute 6/15/2 of 8 January 2015) – the final emergency floor full business case was provisionally scheduled for Trust Board consideration on 5 March 2015, pending feedback from the TDA on the outline business case;

(b) item 4 (Minute 6/15/3(b) of 8 January 2015) – the Chief Executive confirmed that UHL was working with the CCGs to determine whether there was any evidence of GP over-referring and the Medical Director advised that the results of an ongoing practice and patient level audit on referral pathways would be available within the next month. The Chief Operating Officer commented upon work taking place in order to reduce patient DNA (did not attend) rates and review referral patterns. The Director of Marketing and Communications provided feedback from an Executive Team demonstration of some new software which might be able to provide more time-sensitive data on referrals from primary care in future, and

(c) item 5 (Minute 6/15/3(c) of 8 January 2015) – the Director of Marketing and Communications reported on the Urgent Care Board winter resilience planning workstream which was looking at avoiding attendances at A&E, noting that an opportunity for GPs to write to their most "at risk" patients advising them of early warning signs relating to their condition was under consideration by the CCGs.

Resolved – that (A) the update on outstanding matters arising and the timescales for resolution be noted, and

(B) the Chairman to be kept informed of any developments in respect of items (b) and (c) above to inform his monthly meetings with the CCG Chairs. **CE**

23/15 CHAIRMAN'S MONTHLY REPORT – FEBRUARY 2015

The Chairman introduced paper C, providing a summary of current environmental themes and specific issues arising from this month's Trust Board reports. He particularly drew members' attention to the following points:-

(a) his thanks to all staff for their hard work in supporting emergency performance in the context of challenging national and local activity levels;

(b) the size of the Trust as an employer and the importance of encouraging staff input in

terms of innovation (eg the robotic surgery programme and Listening into Action Programme);
(c) the intended focus on patients at UHL's Trust Board meetings, as evidenced by the real life patient story scenarios which featured near the beginning of the agenda each month, and
(d) the report on the reconfiguration of the Trust's Intensive Care Unit (ICU) services, including the potential relocation of ICU services on the LGH site to the LRI site (Minute 25/15/2 below refers).

Resolved – that the position be noted.

24/15 CHIEF EXECUTIVE'S MONTHLY REPORT – FEBRUARY 2015

The Chief Executive introduced his monthly update report (paper D refers), noting that substantive reports on emergency care performance and the Trust's month 9 financial position featured later in the agenda. He briefed the Board on the following issues:-

(a) satisfactory progress in respect of the Emergency Floor business case and the intentional overlap between the approvals processes for the outline and full business cases. A recent independent Gateway Review had provided an amber-green delivery/competence rating with no significant urgent recommendations being highlighted. A small number of non-urgent recommendations had been made which included clarification of the benefits realisation and commissioning arrangements. CCG colleagues had indicated (informally) that they would be in a position to support the final business case;
(b) a quality improvement partnership opportunity being explored by the NHS Trust Development Authority with the Virginia Mason Hospital in Seattle, USA, which would be subject to the appropriate approvals and UHL being one of the Trusts selected to participate;
(c) the percentage of formal objections raised during the 2015-16 tariff consultation process (71%), noting that 50% was the threshold for a further consultation process to be instigated. The most controversial element of the proposed tariff had related to the potential impact upon specialised services. Consequently a degree of uncertainty now surrounded the 2015-16 financial outlook, pending the development of a holding position and revised proposals, and
(d) assurance that the recruitment processes were all underway for the posts of (1) Director of Estates and Facilities, (2) Medical Director, (3) Chief Nurse and (4) Director of Human Resources and Organisational Development, and that the final round of interviews was scheduled for April 2015.

Responding to a query raised by Col (Ret'd) I Crowe, Non-Executive Director, the Chief Executive advised that no feedback had yet been received from the TDA following submission of UHL's business case for the procurement of an Electronic Patient Record (EPR) solution. The Gateway Review for this scheme was due to take place mid-March 2015.

In discussion on the Emergency Floor Gateway Review, it was agreed that a summary of the findings would be circulated to Board members via the Integrated Finance, Performance and Investment Committee. **DS**

Resolved – that (A) the position be noted, and

(B) a summary of the findings arising from the Emergency Floor Gateway Review be circulated to Board members via the Integrated Finance, Performance and Investment Committee. **DS**

25/15 KEY ISSUES FOR DECISION/DISCUSSION

25/15/1 Patient Story – Emergency Admission through the Emergency Department

Ms H Leatham, Assistant Chief Nurse attended the meeting to introduce paper D and to show a short DVD detailing the negative experiences of a male patient who had been diagnosed as suffering from pneumonia and had been admitted to the Trust through the Emergency Department. The patient's wife (who was also his carer) provided the video feedback but the family had declined an invitation to attend the Board meeting for this discussion. During the showing of the DVD and the subsequent discussion, Board members noted that:-

(a) there was a long wait in ED to be assessed and only 1 family member was allowed to remain with the patient during that time;
(b) there appeared to be a lack of continuity and handover arrangements between staff, as multiple case histories were taken and the patient was almost sent for a second chest x-ray in error;
(c) the patient (who had recently been diagnosed as suffering from dementia) had been moved 3 times during his admission including a stay on the Medical Assessment Unit and an outlying Orthopaedic ward due to a shortage of medical beds. These moves had increased his levels of anxiety and stress and security arrangements had been required to prevent him from wandering, which (in turn) had made the patient feel like a prisoner on the ward;
(d) the family had commended the efforts of staff who they felt were extremely busy, but they had commented upon the scope to (i) improve communications with patients' family members, (ii) reduce the number of internal transfers, and (iii) increase the level of family involvement within care pathways;
(e) in response to the issues outlined in the patient story, Board members noted that a draft Carers' Charter (appendix 1) had been developed which set out to identify patient carers on the wards, assess their needs and ensure open channels of communication regarding patient progress and discharge planning. The policy for outlying patients with a confirmed diagnosis of dementia or cognitive behaviour related issues had been amended and the Datix incident report form revised to take account of such incidents and the position was being closely monitored. Arrangements to provide carers with drinks and meals on the wards were also being explored. Appendix 2 provided the new patient profile form, which clearly identified a space for comments from patients' friends, family and carers.

Board members commented upon the patient story and raised questions on the related training processes, the arrangements for ensuring that the right information ended up on each patient's file and how the Trust could seek assurance that such incidents would not occur again. In response, it was noted that a carers' engagement event had been held recently and the Trust continued to work through the action plan arising from this event. Monthly carers' surveys continued to demonstrate an improving trend. One of the key issues was to simplify the process for clinical staff to identify when patients' carers wished to be actively involved in planning care. The Chief Executive commended the actions taken in response to this negative patient story, noting the connection between high emergency activity levels and outlying patients. He particularly welcomed the initiative to provide carers with food and drinks whilst they were present on the wards and he offered his support to the Assistant Chief Nurse in the event that she encountered any barriers in this respect.

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

25/15/2 The Proposed Move of Level 3 Intensive Care off the LGH Site and its Impact upon Other Services

The Director of Strategy introduced paper F, outlining the operational and safety issues likely to impact upon the Leicester General Hospital intensive care service within the next 12

months, and seeking Trust Board approval to consolidate UHL's intensive care services into 2 units based on the Leicester Royal Infirmary and Glenfield Hospital sites. She briefed Board members on the contributory factors arising from the removal of training designation for the LGH service and the planned retirement of a further Consultant which would result in the clinical rota for the level 3 intensive care service becoming unsustainable. Previous attempts to recruit substantive staff to strengthen the intensive care rota had been unsuccessful; this was largely due to the reduced patient acuity on the LGH site and a national shortage of experienced nursing and medical staff.

The report detailed the proposed governance arrangements, project framework, timeline, risks, benefits and consultation and engagement arrangements and the accompanying appendices provided the bed numbers, activity data, communications plan and associated entries on the Trust's risk register.

In discussion on the proposals, Trust Board members:-

(a) sought and received confirmation that there was no other feasible solution for the future of this service, as it was proving impossible to recruit to the clinical posts and noted the impact upon other supporting services (such as Imaging);
(b) highlighted the complex nature of service-level reconfiguration plans and associated opportunities to improve theatre and bed utilisation and implement 6 or 7 day operating schedules in parallel;
(c) noted that reports on this subject had been presented to the Joint Staff Consultation and Negotiation Committee (JSCNC) and the Local Negotiating Committee (LNC) and a number of staff engagement listening events had been held;
(d) requested that a further report be provided to the Trust Board in April 2015 to provide feedback on the formal consultation requirements, once this dialogue had been held with the local Health Overview and Scrutiny bodies; **DS**
(e) requested additional assurance regarding the arrangements for transferring any LGH patients requiring level 3 intensive care to a suitable facility in a timely manner and queried how this would be audited going forwards;
(f) received additional information from the Director of Marketing and Communications on the recruitment process for a dedicated communications and engagement specialist to support the Trust's 5 year plan, reconfiguration programme and the Better Care Together Programme. Until that appointment had been made, the Director of Marketing and Communications was leading on this work. In response to a further query, the Chief Executive and the Director of Marketing and Communications agreed to explore the use of additional interim communications resources (if this was likely to be helpful); **CE/DMC**
(g) considered the scale of any additional investment required for theatres at the LRI and GH sites, noting that the laminar flow theatre facilities on the LGH site would continue to be used as Orthopaedics was not one of the specialties affected by this change;
(h) queried whether there was any scope to increase the flexibility of ITU facilities to improve patients' privacy and dignity by providing single sex accommodation, and
(i) noted the Medical Director's comment that under UHL's original reconfiguration proposals, no provision had been made for level 3 ITU facilities on the LGH site.

<u>Resolved</u> – that (A) the operational and safety issues surrounding future provision of level 3 intensive care services on the LGH site be noted;

(B) the proposal to consolidate UHL's intensive care services into 2 units on the LRI and GH sites be endorsed, subject to confirmation of the formal consultation requirements at the April 2014 Trust Board meeting; **DS**

(C) the Chief Executive and the Director of Marketing and Communications be requested to explore the use of additional interim communications resources (if appropriate), and **CE/DMC**

(D) regular reports on the implementation arrangements be provided to the Executive Strategy Board and the Integrated Finance, Performance and Investment Committee for assurance purposes. **DS**

26/15 QUALITY AND PERFORMANCE

26/15/1 Quality and Performance Report – Month 9 (December 2014)

Paper G provided an overview of the Trust's quality and operational performance and detailed performance against key UHL and TDA metrics. Escalation reports were appended to the report detailing any areas of underperformance. Members welcomed the recent introduction of the accompanying Chief Executive's highlight report, providing a summary of the key issues for the Board's attention.

The Chief Executive drew members' attention to the impact of recent emergency activity pressures and the associated deteriorating trend in certain quality metrics. In respect of Referral to Treatment (RTT) performance, 2 of the 3 main metrics were now compliant and a revised trajectory had been agreed with the CCGs and NHS England to deliver compliant admitted RTT performance by the end of April 2015. The Chief Executive's main concern related to cancer performance, where limited progress appeared to have been achieved in respect of 3 key performance indicators.

The Chief Operating Officer provided assurance that the Trust continued to focus upon the longest waiting RTT patients (both admitted and non-admitted) and the total number of UHL patients who were waiting over 18 weeks had now reached an all-time low. He also expressed confidence that cancer performance would improve within the next month, as a result of recent progress with 2 week wait and 31 day performance. The biggest concern for cancer services continued to be 62 day performance and an additional focus was being provided by Mr W Monaghan, the Trust's new Director of Performance and Information. In response to a query, the Chief Operating Officer offered to meet with the LLR Healthwatch Representative outside the meeting to brief him on the key factors affecting UHL's recent cancer performance. **COO**

Responding to a Non-Executive Director observation that 3 of the performance exception reports related to research study recruitment, the Medical Director highlighted the Board's responsibility as host of the Local Clinical Research Network (LCRN) and advised that regular LCRN performance reports were presented to the Trust Board for assurance purposes. He further advised that such exception reports would be triggered at key points within the year and he suggested that the Board might like to challenge whether these trigger points were appropriate when the next LCRN performance report was discussed. The Director of Corporate and Legal Affairs agreed to check when the next such report was due for Trust Board consideration. **DCLA**

Dr S Dauncey, Non-Executive Director and Chair of the Quality Assurance Committee (QAC) introduced a summary of the key issues considered at the 29 January 2015 QAC meeting (paper H1 refers) and confirmed that the Minutes of that meeting would be presented to the 5 March 2015 Trust Board meeting. She noted the short (half day) turnaround time for producing the briefing notes following the QAC and IFPIC meetings and the Board commended the Trust Administration team for their work.

Ms J Wilson, Non-Executive Director and Chair of the Integrated Finance, Performance and Investment Committee (IFPIC) presented paper H2, providing a summary of the issues discussed at the 29 January 2015 IFPIC meeting, noting that a confidential recommendation would be considered in the private section of today's Trust Board meeting due to commercial interests. She commended the work of the Director of Finance and his team in concluding the negotiations in respect of the 2014-15 year end position and highlighted a presentation received from the Musculo-skeletal and Specialist Surgery CMG in respect of

the challenges surrounding RTT performance in the context of increased referrals. The Minutes of the 29 January 2015 IFPIC meeting would be presented to the Trust Board in March 2015.

Resolved – that (A) the month 9 Quality and Performance report be received and noted as paper G;

(B) the Chief Operating Officer be requested to brief the LLR Healthwatch Representative on the factors affecting UHL's cancer performance outside the meeting (if required), and **COO**

(C) the Director of Corporate and Legal Affairs be requested to ascertain the date when the next LCRN report was scheduled to be submitted to the Trust Board. **DCLA**

26/15/2 2014-15 Financial Position – Month 9 (December 2014)

The Director of Finance presented paper I, updating the Board on performance against the Trust's key financial duties and providing further commentary on the month 9 financial performance by CMG and Corporate Directorates, and the associated risks and assumptions. He noted an in-month adverse movement to plan (£0.3m worse than forecast), but provided assurance that the year-end forecast deficit of £40.7m would still be delivered, subject to the CMGs and Directorates delivering their control totals. A summary of any lessons learned from the 2014-15 financial forecasting and outturn performance would be presented to the Integrated Finance, Performance and Investment Committee in March 2015.

Agreement had now been reached in respect of the 2014-15 contract with CCGs and the specialised commissioning contract negotiations were almost complete. Performance against the Trust's cost improvement programme remained strong. The Chairman highlighted the significance of the Trust's financial deficit and members noted the importance of delivering the planned position going forwards (despite the severe operational pressures) and the Trust's aim to build a track record for consistent financial planning and delivery.

The Director of Finance briefed the Board on the outcome of the consultation process for the 2015-16 national contract and national tariff, noting that widespread concerns had been expressed regarding the proposed risk share arrangements for specialised commissioning. Whilst there was not expected to be any additional funding made available, it was hoped that the revised version (once developed) would contain a fairer solution to avoid any perverse incentives in terms of patients' treatment. In the meantime (with effect from 1 April 2015) a draft outline proposal had been put forward to continue using the existing 2014-15 tariff. A suggestion had also been made to reduce non-tariff related funding (eg CQUIN payments) to compensate for the lack of a tariff deflator.

Col (Ret'd) I Crowe, Non-Executive Director sought and received additional information regarding the potential impact of the specialised services reduction and the benefits of emergency care threshold adjustments, noting that the negative movement in specialised services income would far outweigh the income adjustments for emergency activity. In addition, the Director of Strategy expressed concern that the proposed payment mechanism for specialised services (if it went ahead) might lead to some Trusts rationing access to healthcare on the basis of financial quantum.

Resolved – that the month 9 financial performance report (paper I) and the subsequent discussion be received and noted.

26/15/3 Emergency Care Performance Report

The Chief Operating Officer introduced paper J providing the Trust Board with the regular monthly update on UHL's emergency care performance and progress against the Leicester, Leicestershire and Rutland (LLR) Improvement Plan. The LLR Improvement Plan continued to be reviewed weekly by the Urgent Care Board and the main workstreams were focused upon the following 3 areas:-

- *discharge* – there was some evidence of improvement in terms of the volume of discharges and the ratio between discharges and admissions. The Chief Operating Officer recorded formal thanks to staff from the Leicestershire Partnership Trust (LPT) who had been supporting timely UHL discharge processes from the LRI and GH sites;
- *internal processes* – progress continued to be made and there was evidence of improved patient flows and reduced ED occupancy, and
- *attendances and admissions* – the Urgent Care Centre continued to see and treat high volumes of low acuity attendances, but concern was expressed that the level of UHL admissions was still higher than expected for the time of the year (eg 6,600 projected adult emergency admissions for January 2015 compared to 6,442 in January 2014).

Overall, UHL's performance against the 95% 4 hour target was improving, with the whole of January 2015 being in excess of 90% and the latter half of the month being above 95%. There had been a couple of challenging days, but performance had recovered and work continued to fully understand the drivers for these "dips". Nationally, the Trust appeared to have been performing better than some peer group Trusts in the last 2 months. In conclusion, the Chief Operation Officer highlighted the following factors which he felt were making the biggest contribution to improved emergency care performance:-

(1) support from external partners in terms of discharge;
(2) on-site senior management presence which had strengthened the arrangements for 7 day working and increased the weekend management structure;
(3) the huge efforts on the part of staff which had led to a cumulative improvement;
(4) the quality of management support for the programme of change and the strong clinical engagement in these plans, and
(5) the personal impact of Dr I Lawrence, Clinical Director for the Emergency and Specialist Medicine, during the first 5 weeks of his appointment.

In discussion on this report, Non-Executive Director members queried whether any additional resources might help to bolster the position and when the next iteration of the LLR emergency care dashboard would be available. In response, the Chief Operating Officer noted that the cultural improvements and the required reduction in admission rates were not directly attributed to additional resources. He briefed the Board on the arrangements for the Urgent Care Board to identify the key metrics for a more concise health economy wide dashboard, suggesting that this would be complete within the next month and would then be shared with Board members on a quarterly basis. **COO**

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

(B) the revised LLR Emergency Care Dashboard be circulated to Trust Board members on a quarterly basis. **COO**

27/15 GOVERNANCE

27/15/1 <u>Fit and Proper Persons Test</u>

Further to Minute 324/14/1 of 22 December 2014, the Acting Director of Human Resources introduced paper K providing a briefing on the proposed arrangements for meeting the new requirements to ensure that all Directors employed by the Trust were fit and proper for their role. She particularly drew members' attention to paragraph 2.5 on page 2 of the report,

which set out the categories of persons who were prevented from holding office. Based on advice received from the TDA, the term "Director" was being interpreted as those Directors who reported directly to the Chief Executive or who regularly attended Trust Board meetings. Appendix 1 detailed the evidence and assurance to be sought in respect of each standard; appendix 2 provided the proposed pre-employment checklist, and appendix 3 set out the draft annual declaration form.

During a detailed discussion on the draft annual declaration form, the Trust Board:-

(a) sought clarity regarding the wording of paragraph 9, item (l) [relating to staff who had been dismissed from any paid employment with a health service body] and queried whether this would include voluntary resignations prior to any impending disciplinary procedures, or compromise agreements. The Acting Director of Human Resources suggested that such circumstances would usually come to light as part of the pre-employment references, but she agreed to seek additional clarity on whether such individuals would be barred from employment; **ADHR**
(b) queried whether the wording of paragraph 9, item (g) [relating to convictions and sentence of imprisonment in the British Islands] would also be extended to convictions on non-British territory. Professor D Wynford-Thomas, Non-Executive Director noted that section 1.1 of appendix 1 included a clause relating to convictions elsewhere of any offence which, if committed in any part of the UK, would constitute an offence;
(c) commented that there appeared to be no reference to political restrictions in the draft declaration form, and received assurance that any political issues were covered under other provisions, although there would be some scope to include this in the declaration (if required);
(d) recognised that the annual declaration wording was not perfect but agreed that it should be taken in the spirit of the requirements;
(e) noted that the CQC had issued some further interim guidance and that a more substantive report would be presented to a future Trust Board meeting on the final implementation arrangements, and
(f) requested the Director of Corporate and Legal Affairs to feedback the Board's comments and queries to the CQC for their consideration. **DCLA**

<u>Resolved</u> – that (A) the report on the arrangements for implementation of the Fit and Proper Persons Test be received and noted as paper K,

(B) the Director of Corporate and Legal Affairs be requested to feedback the Trust Board's comments and queries to the CQC, and **DCLA**

(C) the Acting Director of Human Resources be requested to report on the final implementation arrangements to a future Trust Board meeting. **ADHR**

27/15/2 <u>Board Assurance Framework (BAF)</u>

The Chief Nurse introduced paper L detailing UHL's Board Assurance Framework as at 31 December 2014 and notifying the Trust Board of 3 new high risks opened during December 2014 (as detailed in appendix 3). Board members particularly noted the key points set out in paragraph 2.2, points (a) to (e) relating to individual risk scores and gaps in assurance. As requested under paragraph 2.3, the Trust Board undertook a detailed review of the 5 risks linked to the strategic objective *"a clinically and financially sustainable NHS Foundation Trust",* incorporating principal risks 18 to 22 inclusive:-

(a) ***principal risk 18 (lack of effective leadership capacity and capability)*** – the Acting Director of Human Resources confirmed that this risk had recently been updated with additional control measures and good progress was being maintained. The Chairman and the Chief Executive noted the importance of developing the 360° feedback tool and the Medical Director advised that this was a mandatory element of the medical appraisal

and revalidation processes. The current (9) and target (6) risk scores were confirmed as appropriate;

(b) ***principal risk 19 (failure to deliver financial strategy [including cost improvement programme])*** – the Chairman noted that the Trust was beginning to develop a "firm grip" on its financial performance and that work was taking place to refresh the 5 year strategy and its links with the Better Care Together Programme and the re-configuration programme. The current (15) and target (10) risk scores were confirmed as appropriate;

(c) ***principal risk 20 (failure to deliver internal efficiency and productivity improvements)*** – the narrative had not yet been updated due to the Chief Operating Officer being away on annual leave prior to the circulation of reports for this meeting. He reported verbally on progress of appointments to the 8 cost improvement management positions, cross cutting CIP themes, and advised that plans for the workforce cross-cutting theme (led by the Director of Finance) would be available in March 2015. The current (16) and target (6) risk scores were confirmed as appropriate, although members suggested that the current scores for risk 19 (score 15) and risk 20 (score 16) should be aligned;

(d) ***principal risk 21 (failure to maintain effective relationships with key stakeholders)*** – all of the actions to address gaps in assurance were noted to have been completed, but the Director of Marketing and Communications noted the need to update the narrative to reflect the implementation of the revised Patient and Public Engagement Strategy which was due to be presented to the Trust Board on 5 March 2015, and

(e) ***principal risk 22 (failure to deliver service and site reconfiguration programme and maintain the estate effectively)*** – the Director of Strategy noted an opportunity to update the narrative to reflect recent progress with the reconfiguration programme and cross cutting cost improvement themes. Members queried whether the current risk score (10) was high enough and it was agreed that this would be reviewed at the next Board meeting on 5 March 2015.

Section 3 of the report detailed outline proposals for re-development of the BAF for the 2015-16 financial year. However, the Chief Executive advised that following consideration by the Executive Team, some alternative proposals had been developed which focused upon a monthly review of key annual priorities (instead of strategic objectives). Mr M Williams, Non-Executive Director commented upon this development in the light of some recent guidance another Trust had received from Monitor on this subject. However, further discussion on these proposals was scheduled for the Trust Board thinking day on 12 February 2015. **CN**

<u>Resolved</u> – that (A) the December 2014 Board Assurance Framework (BAF) be received and noted as presented in paper L, and

(B) further discussion on the proposed BAF refresh be held at the Trust Board thinking day on 12 February 2015. **CN**

28/15 EDUCATION

28/15/1 <u>Quarterly Update on Medical Education Issues</u>

Further to Minute 260/14/1 of 25 September 2014, the Associate Medical Director for Clinical Education attended the meeting to present paper M, briefing Board members on key medical education issues in UHL, and highlighting the following points:-

- positive comments arising from the Level 2 multi-professional Health Education East Midlands (HEEM) quality review visit in October 2015;
- progress with the development of the new library facilities (in the old Odames ward) which was due to be opened in February 2015;
- potential redistribution of training posts, and
- work taking place with the Director of Finance to strengthen the accountability

arrangements for medical education funding.

The Trust Board sought and received additional information regarding Information Management and Technology support during induction days, and the timescale for further development of the IT Strategy for Medical Education. The Trust's strategy for simulation facilities was currently under development, and proposals were due to be presented to the Executive Workforce Board in March 2015.

The Chief Nurse highlighted the need to improve education facilities for nursing staff, noting that the HEEM visit was a multi-professional visit. The Chairman suggested that it would be helpful to hold a future Trust Board thinking day in respect of workforce development and training issues and that representatives from the University of Leicester, De Montfort University and Loughborough University would be invited to attend. **CHAIR/ DCLA**

Noting that a planned HEEM visit relating to Obstetrics and Gynaecology education had recently been postponed, the Chief Executive sought and received a verbal update on the key issues which related to split site working and members noted that an interim visit would now be arranged (possibly in October 2015). The Director of Strategy noted the links with the development of the business case for UHL's maternity services and provided assurance that this was being monitored through the Trust's reconfiguration programme.

Resolved – that (A) the quarterly update on clinical education be received and noted, and

(B) consideration be given to scheduling a future Trust Board thinking day on workforce development and training issues. **CHAIR/ DCLA**

29/15 REPORTS FROM BOARD COMMITTEES

29/15/1 Audit Committee

Mr M Williams, Interim Non-Executive Director and Audit Committee Chair introduced paper N, providing the Minutes of the 8 January 2015 Audit Committee meeting. He particularly commented upon the robust risk management arrangements within the Clinical Support and Imaging CMG and the further work required in respect of strengthening the EMPATH governance arrangements.

Resolved – that the Minutes of the Audit Committee meeting held on 8 January 2015 be received and noted.

30/15 CORPORATE TRUSTEE BUSINESS

30/15/1 Charitable Funds Committee

Resolved – that the Minutes of the Charitable Funds Committee meeting held on 19 January 2015 be submitted to the 5 March 2015 Trust Board meeting.

31/15 TRUST BOARD BULLETIN – FEBRUARY 2015

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

- **NHS Trust Over-Sight Self Certification return for the period ended 31 December 2014.**

32/15 QUESTIONS AND COMMENTS FROM THE PRESS AND PUBLIC RELATING TO BUSINESS TRANSACTED AT THIS MEETING

The following questions and comments were received:-

(1) a query regarding the training provided to staff in respect of dementia care. The Chief Nurse outlined the key training requirements arising from the Dementia Strategy and associated work plan, providing assurance that a wide range of training was available and that this was being rolled out throughout the Trust (according to the nature of individual staff roles). In addition, she noted that De Montfort University had developed a dementia training model for nursing staff and that medical staff were also able to access this course;
(2) a question regarding the high patient throughput in the Emergency Department and ward 33 and whether any plans were in place to ensure that staff had sufficient time to document the care needs of patients with dementia. In response, the Deputy Chief Nurse advised that staff from the ED and ward 33 had been involved in the interactive training sessions recently held at the Curve Theatre and these areas were also piloting the Carers' Charter. It was noted that the process of clearly documenting patients' needs at an early stage tended to save staff time in the longer term;
(3) a query regarding the flexibility of the Carers' Charter in seeking carers' support for patients who might develop deliria following treatment in Intensive Care Units, noting that this might occur in approximately 80% of cases. The Deputy Chief Nurse confirmed that 1 of the 7 workstreams associated with dementia related to deliria and pain management and that staff were being trained to recognise non-verbal communications in this respect, and
(4) a question regarding the proposed expansion of Intensive Care bed capacity and whether the Trust would be able to recruit to any additional posts. In response, the Director of Strategy briefed members on the vision to develop world class ICU facilities which would help to support clinical recruitment. The Chief Nurse noted the intention to continue local and international nurse recruitment workstreams in parallel for the ICU service, alongside increased commissioning for local nurse training and the development of new roles (eg advanced practitioners).

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

33/15 EXCLUSION OF THE PRESS AND PUBLIC

Resolved – that, pursuant to the Public Bodies (Admission to Meetings) Act 1960, the press and members of the public be excluded during consideration of the following items of business (Minutes 34/15 – 41/15), having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.

34/15 DECLARATIONS OF INTERESTS IN THE CONFIDENTIAL BUSINESS

Professor D Wynford-Thomas, Non-Executive Director declared a non-prejudicial interest in the confidential item of business discussed under Minute 38/15 below.

35/15 CONFIDENTIAL MINUTES

Resolved – that the confidential Minutes of the 8 January 2015 Trust Board be confirmed as a correct record and signed accordingly by the Trust Chairman. **CHAIR**

36/15 CONFIDENTIAL MATTERS ARISING REPORT

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

37/15 REPORT FROM THE CHIEF EXECUTIVE

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

38/15 REPORT FROM THE INTERIM DIRECTOR OF ESTATES AND FACILITIES

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

39/15 REPORTS FROM BOARD COMMITTEES

39/15/1 Integrated Finance, Performance and Investment Committee

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

39/15/2 Remuneration Committee

Resolved – that (A) the confidential Minutes of the 22 December 2015 Remuneration Committee be received and noted, and

(B) the Minutes of the 29 January 2015 Remuneration Committee be presented to the 5 March 2015 Trust Board.

40/15 ANY OTHER BUSINESS

40/15/1 Report by the Director of Finance

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

41/15 DATE OF NEXT MEETING

Resolved – that the next Trust Board meeting be held on Thursday 5 March 2015 from 9am in the C J Bond Room, Clinical Education Centre, Leicester Royal Infirmary.

The meeting closed at 12.35pm

Kate Rayns
Acting Senior Trust Administrator

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

Voting Members:

Name	Possible	Actual	% attendance	Name	Possible	Actual	% attendance
K Singh (Chair from 1.10.14)	5	5	100	R Mitchell	12	11	92
R Kilner (Acting Chair from 26.9.13 to 30.9.14)	7	7	100	R Overfield	12	12	100
J Adler	12	10	83	P Panchal	12	12	100
I Crowe	12	11	92	M Traynor (from 1.10.14)	5	5	100
S Dauncey	12	11	92	P Traynor (from 27.11.14)	4	4	100
K Harris	12	11	92	M Williams	5	5	100
K Jenkins (until 30.6.14)	3	3	100	J Wilson	12	10	83
				D Wynford-Thomas	12	5	42

Non-Voting Members:

Name	Possible	Actual	% attendance	Name	Possible	Actual	% attendance
T Bentley*	9	7	78	K Shields*	12	12	100
K Bradley*	9	9	100	S Ward*	12	12	100
D Henson*	8	8	100	M Wightman*	12	12	100

University Hospitals of Leicester NHS Trust

Progress of actions arising from the Trust Board meeting held on Thursday, 5 February 2015

Item No	Minute Ref:	Action	Lead	By When	Progress Update	RAG status*
1	24/15	***Emergency Floor Gateway Review*** Summary report to be circulated to Trust Board members via the Integrated Finance, Performance and Investment Committee agenda.	DS	IFPIC 26.3.15	Provisionally scheduled on the IFPIC agenda for 26 March 2015.	4
2	25/15/2 (b)	***Level 3 Intensive Care Service on the LGH Site*** Formal consultation requirements to be confirmed at the 2 April 2015 Trust Board meeting.	DS	TB 2.4.15	Provisionally scheduled on the 2 April 2015 Trust Board agenda.	4
3	25/15/2 (c)	Chief Executive and Director of Marketing and Communications to explore the use of additional interim communications resources (if appropriate).	CE/DMC	TB 2.4.15	Verbal update to be provided to the 5 March 2015 Trust Board meeting.	4
4	25/15/2 (d)	Regular updates on the implementation arrangements to be provided to the Executive Strategy Board and the Integrated Finance, Performance and Investment Committee.	DS	TBA	Verbal update to be provided to the 5 March 2015 Trust Board meeting.	4
5	26/15/1 (b)	***Quality and Performance Report – month 9*** Chief Operating Officer to brief the LLR Healthwatch Representative on the factors affecting UHL's cancer performance outside the meeting (if required).	COO	TBA	Briefing to be provided outside the meeting (if required).	4
6	26/15/1 (c)	Director of Corporate and Legal Affairs to ascertain when the next LCRN report was scheduled to be submitted to the Trust Board.	DCLA	TB 5.3.15	The next LCRN update is provisionally scheduled for the 2 April 2015 Board meeting.	4
7	26/15/3	***Emergency Care Performance*** The revised LLR Emergency Care Dashboard to be circulated to Trust Board members on a quarterly basis.	COO	TBA	To be appended to the 5 March 2015 Emergency Care Report (if available).	4
8	27/15/1 (b)	***Fit and Proper Persons Test*** Director of Corporate and Legal Affairs to feedback the Trust Board's comments and queries to the CQC.	DCLA	TBA	Complete.	5
9	27/15/1 (c)	Acting Director of Human Resources to report on the final arrangements for implementation of the fit and proper persons test to a future Trust Board meeting.	ADHR	TBA	Discussions held between the NTDA and NHS Employers. An Annual Declaration Form template will be produced.	5

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

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

Item No	Minute Ref:	Action	Lead	By When	Progress Update	RAG status*
10	27/15/2	***Board Assurance Framework*** Further discussion on the development of the BAF for 2015-16 to be held at the Trust Board thinking day on 12 February 2015.	CN	TBTD 12.2.15	Complete.	5

Matters arising from previous Trust Board meetings

Item No	Minute Ref:	Action	Lead	By When	Progress Update	RAG status*
8 January 2015						
11	6/15/2	***Emergency Floor Business Case*** Draft business case to be update to reflect any TDA feedback and presented to the next available Trust Board meeting for final approval.	DS	TB ~~5.2.15 or 5.3.15~~ 2.4.15	Provisionally re-scheduled for the 2 April 2015 Trust Board, pending TDA feedback.	4
12	6/15/3 (b)	Executive Team to consider whether sufficient robust evidence was available regarding any GP over-referrals and whether any processes could be implemented to disincentivise such behaviours.	CE	As appropriate	Chief Executive to update Chairman on any developments to inform his monthly meetings with CCG Chairs.	4
13	6/15/3 (c)	Director of Marketing and Communications to meet with the Chairman and the Chief Executive to agree the extent of any additional communications workstreams in relation to ED attendances.	DMC	As appropriate	Chief Executive to update Chairman on any developments to inform his monthly meetings with CCG Chairs.	4
22 December 2014						
14	320/14/3	***Delivering the 5 Year Strategy*** Director of Strategy to provide regular progress reports to the Trust Board on delivering the 5 Year Strategy.	DS	TBA	Reports to be scheduled on the Board agenda. Frequency to be agreed in consultation with the Director of Strategy.	4
15	324/14/1 (a)	***Duty of Candour/Fit and Proper Persons Test*** Chief Nurse to report on the arrangements for meeting the requirements of the duty of candour at the 29 January 2015 QAC meeting.	CN	QAC ~~29.1.15~~ 26.3.15	Report provisionally scheduled on the 3 March 2015 EQB agenda and the 26 March 2015 QAC agenda.	3
16	324/14/2	***Board and Board Committee Governance*** Trust Chairman to write to the CCG Chairs consulting them on the arrangements for joint CCG representation on UHL Board Committees and inviting appropriate nominations.	Chair	TBA	Complete.	5

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

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

University Hospitals of Leicester NHS
NHS Trust

Agenda Item: Paper C

TRUST BOARD – 5th MARCH 2015

Chairman's Monthly Report

DIRECTOR:	Chairman
AUTHOR:	Chairman
DATE:	26th February 2015
PURPOSE:	**(concise description of the purpose, including any recommendations)** To brief the Board monthly on the Chairman's perspective.
PREVIOUSLY CONSIDERED BY:	**(name of Committee)** N/A
Objective(s) to which issue relates *	√ 1. Safe, high quality, patient-centred healthcare √ 2. An effective, joined up emergency care system √ 3. Responsive services which people choose to use (secondary, specialised and tertiary care) √ 4. Integrated care in partnership with others (secondary, specialised and tertiary care) √ 5. Enhanced reputation in research, innovation and clinical education √ 6. Delivering services through a caring, professional, passionate and valued workforce √ 7. A clinically and financially sustainable NHS Foundation Trust √ 8. Enabled by excellent IM&T
Please explain any Patient and Public Involvement actions taken or to be taken in relation to this matter:	As stated in the report.
Please explain the results of any Equality Impact assessment undertaken in relation to this matter:	N/A
Organisational Risk Register/ Board Assurance Framework *	☐ **Organisational Risk Register** ☐ **Board Assurance Framework** ☑ **Not Featured**
ACTION REQUIRED *	For decision ☐ For assurance ☐ For information ☑

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

* tick applicable box

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **5 MARCH 2015**

REPORT BY: **CHAIRMAN**

SUBJECT: **CHAIRMAN'S MONTHLY REPORT**

Introduction

In my report to the Trust Board last month I signalled that in future Board meetings I would draw attention (briefly) to two issues that were on my mind and also identify two specific items on the agenda in respect of which some questions which had occurred to me.

Key Considerations

All of us are aware that we are part of an aging society which will have implications for NHS expenditure and the shape of future services. This of course is a national issue but we also need to reflect on the key future challenges, opportunities and vision for the future of the aging population and the aging experience across Leicester, Leicestershire and Rutland. Given the diversity of our communities we also need to ensure this dimension is at the forefront of our thinking and planning for the future. If we don't we will not be responding to the different needs within our communities.

Much has been said and written about the need to ensure there is a constant patient focus embedded throughout the NHS. This poses the question in my mind how do we understand the patient and carer experience and where there is a user perception that this has been less than ideal then how do we respond? I appreciate that there is a wide spectrum between complaints about perceived discourtesy at one end and the investigations that focus on serious issues relating to safety and quality at the other but the common thread has to be a willingness to investigate thoroughly, promptly and transparently. The NHS obtains information about patient experiences in many different ways and it is not always clear to external observers how these insights are brought together. A recent report of the Health Ombudsman reviewing a sample of internal investigations by health bodies concluded that nearly half were deficient either in information gathering, analysis or transparency. There are of course other service focused organisations in the private sector who appear to take on customer comments in real time and link this to their service provision. Could the NHS emulate this?

The two items listed below are part of this month's Trust Board agenda.

The report on Patient and Public Involvement and Engagement Strategy raises the following questions in my mind:

To what extent are we seeking to engage across the different communities as a whole and not just those that are the most articulate or have traditionally featured in consultation processes?

How do we distinguish between communicating with external stakeholders and listening to them in our discussions about engagement?

How do we measure success in this area assuming we make a distinction between outcomes and activity?

The report on Institute of Frail Elderly Medicine - proposed partnership with De Montfort University raises the following questions in my mind:

Are any of the general points and questions that I have identified above relevant?

How do we measure success in terms of this potential partnership between academics and practitioners and are there any risks attached?

Given this is a forward looking initiative how will we seek to embed the research outcomes in terms of our learning?

Karamjit Singh CBE
Chairman, UHL Trust

University Hospitals of Leicester NHS
NHS Trust

Agenda Item: Paper D

TRUST BOARD – 5th MARCH 2015

MONTHLY UPDATE REPORT – MARCH 2015

DIRECTOR:	CHIEF EXECUTIVE
AUTHOR:	DIRECTOR OF CORPORATE AND LEGAL AFFAIRS
DATE:	25TH FEBRUARY 2015
PURPOSE:	**(concise description of the purpose, including any recommendations)** To brief the Trust Board on key issues and identify changes or issues in the external environment.
PREVIOUSLY CONSIDERED BY:	**(name of Committee)** N/A
Objective(s) to which issue relates *	[√] 1. Safe, high quality, patient-centred healthcare [√] 2. An effective, joined up emergency care system [ ] 3. Responsive services which people choose to use (secondary, specialised and tertiary care) [ ] 4. Integrated care in partnership with others (secondary, specialised and tertiary care) [ ] 5. Enhanced reputation in research, innovation and clinical education [√] 6. Delivering services through a caring, professional, passionate and valued workforce [√] 7. A clinically and financially sustainable NHS Foundation Trust [ ] 8. Enabled by excellent IM&T
Please explain any Patient and Public Involvement actions taken or to be taken in relation to this matter:	N/A
Please explain the results of any Equality Impact assessment undertaken in relation to this matter:	N/A
Organisational Risk Register/ Board Assurance Framework *	[ ] **Organisational Risk Register** [ ] **Board Assurance Framework** [√] **Not Featured**
ACTION REQUIRED *	For decision [ ] For assurance [ ] For information [√]

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♦ We focus on what matters most ♦ We are one team and we are best when we work together
♦ We are passionate and creative in our work

* tick applicable box

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **5 MARCH 2015**

REPORT BY: **CHIEF EXECUTIVE**

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

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1. The Chief Executive submits a written report to each Board meeting detailing the key Trust issues and identifying important changes or issues in the external environment.

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

(a) emergency care performance;

(b) the Trust's month 10 financial position;

(c) the Emergency Floor Full Business Case;

(d) recent developments relating to the national tariff 2015/16;

(e) the 'Freedom to Speak Up report, an independent review into creating an open and honest reporting culture in the NHS, published by Sir Robert Francis QC in February 2015;

(f) Mutuals in Health pathfinder project; and

(g) Greater Manchester health and social care reform.

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

John Adler
Chief Executive

25th February 2015

Agenda Item: Paper E

TRUST BOARD – 5th March 2015

Patient Experience Story- "We are only baby-sitting you"

DIRECTOR:	Carole Ribbins, Acting Chief Nurse
AUTHOR:	Michaela Thompson, Patient Experience Sister Heather Leatham, Assistant Chief Nurse Kelly Richardson, Ward Sister Christopher Sutton, Head of Service, Consultant Surgeon
DATE:	5th March 2015
PURPOSE:	Introduction To describe the negative experience of care a patient received following admission with acute pain to ward 22 at the Leicester Royal Infirmary and how services have listened and responded to patient feedback resulting in improvements on the same ward. A patient's story will be shared with Trust Board on a video clip to illustrate the patient's perception that they were spoken to in an unprofessional/uncaring manner and that their requirement to see the chronic pain team caused delays in discharge. Following this and other feedback the multidisciplinary team have spent a number of months adapting and changing processes and ways of working to improve the experience of care for patients. The team's success is illustrated in the second video clip. Friends & Family Test From November 2014 the Friends and Family Test has been reported on NHS choices as a percentage. Ward 22 results are displayed as a percentage for January 2015. **Would recommend this ward**: 90% **Wouldn't recommend this ward**: 5% First Patient's Experience of Care This patient story identifies: • The perception that a nurse did not believe them regarding her pain relief after being transferred from another ward • How members of the medical team used the terminology of 'baby sitting' when patients were waiting review by the pain management team • The experience of care on ward 22 was found to be uncaring and unprofessional In response to this patient feedback the medical and nursing notes were examined in detail to elicit the 'root cause' from patient's perception of experience of care. It is considered that this patient's experience of care reflected the interpersonal relationships with specific members of staff.

Prior to the present Ward Sister arrival, ward 22 underwent a period of change and movement in leadership; it was at this point the negative patient experience of care occurred.

Nursing Staff Improvements

Following the appointment of Kelly Richardson, Ward Sister, a review of the ward's performance was undertaken the main element of which was to examine in detail all the feedback from patients, their families and carers and from this information the key areas for improvement identified.

Over the last six months the Ward Sister has demonstrated outstanding resilience courage and determination to improve the experience of care for patients on ward 22 by:

1. Leading work on the complexity of pain management/perception of pain
2. Performance managed staff as appropriate which has resulted in changes in the team
3. Improving team work and communication with all members of qualified and unqualified staff.
4. Improving how welcoming and friendly staff are on the ward by sharing positive feedback and directly addressing poor attitude
5. Increasing staff awareness of the experience of care for patients is addressed through staff meetings
6. All comments regarding an individual's behaviour or attitude are managed immediately highlighting expectations of staff
7. Effective sickness absence management has reduced sickness levels
8. Ensuring housekeepers work with catering staff to ensure patients are offered all choices from the menu and assisted through the red tray system
9. Staffing ratio's increased per shift and to cover a seven day service
10. By end of April will have recruited to all present seven vacancies

Medical Staff Improvements

Mr Sutton, who is the Head of service for Ward 22 has worked with the medical team to ensure the following:

1. Avoid terminology which is not respectful
2. Liaise with the Ward Sister and to address patient feedback relating to the doctors
3. This patient story was shown to some of the gastroenterology team
4. Ensure all staff are aware of the appropriate referral to the pain team via ICM system
5. Clearer referral pathway being reviewed and disseminated towards the team

Challenges remain on ward 22 due to the nature of the speciality and many patients having chronic pain, some for many years and may have several admissions because of their debilitating pain.

The second video clip shows a positive experience of care recently received, demonstrating evaluation of improvements made. All patient feedback is scrutinised every week and here are some further examples of what patients have said anonymously:

"Cannot fault the treatment I have received since I have been here. I have been very well looked after"

"I had the best care and kindness and patient could have better then a

	private nursing hospital" *"It's a lovely ward. Clean + friendly staff"* *"Staff were very happy and polite at all times and kept me informed along the way"* *"Staff were very kind and helpful"* *"The staff were kind and helpful towards me and my Carer / mum"* *"Very competent and caring staff"* <u>Recommendations:</u> The Trust Board is asked to: • Receive and listen to the patient's story
PREVIOUSLY CONSIDERED BY:	**(name of Committee)**
Objective(s) to which issue relates *	[Y] 1. Safe, high quality, patient-centred healthcare [ ] 2. An effective, joined up emergency care system [Y] 3. Responsive services which people choose to use (secondary, specialised and tertiary care) [ ] 4. Integrated care in partnership with others (secondary, specialised and tertiary care) [ ] 5. Enhanced reputation in research, innovation and clinical education [Y] 6. Delivering services through a caring, professional, passionate and valued workforce [ ] 7. A clinically and financially sustainable NHS Foundation Trust [ ] 8. Enabled by excellent IM&T
Please explain any Patient and Public Involvement actions taken or to be taken in relation to this matter:	This paper provides assurance that ward 22 and the wider multi-disciplinary team are listening and acting upon patient feedback to improve patient's experience of care. Patients are encouraged to share their stories of care within the Trust.
Please explain the results of any Equality Impact assessment undertaken in relation to this matter:	An equality impact assessment was not required in relation to this patient story.
Strategic Risk Register/ Board Assurance Framework *	[ ] **Strategic Risk Register** [ ] **Board Assurance Framework** [x] **Not Featured**
ACTION REQUIRED *	For decision [ ] For assurance [x] For information [X]

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♦ We focus on what matters most ♦ We are one team and we are best when we work together
♦ We are passionate and creative in our work

* tick applicable box

University Hospitals of Leicester NHS
NHS Trust

Agenda Item: Trust Board Paper F

TRUST BOARD – 5 MARCH 2015

Learning the Lessons to Improve Care
Quarterly Progress Update to Boards and Governing Bodies

DIRECTOR:	Kevin Harris
AUTHOR:	Caroline Trevithick and Claire Saul
DATE:	5 March 2015
PURPOSE:	To provide an update on the work undertaken in the last reporting period, and priority areas for the next quarter
PREVIOUSLY CONSIDERED BY:	Trust Board on 30.10.14
Objective(s) to which issue relates *	✓ 1. Safe, high quality, patient-centred healthcare ✓ 2. An effective, joined up emergency care system ✓ 3. Responsive services which people choose to use (secondary, specialised and tertiary care) ✓ 4. Integrated care in partnership with others (secondary, specialised and tertiary care) ☐ 5. Enhanced reputation in research, innovation and clinical education ✓ 6. Delivering services through a caring, professional, passionate and valued workforce ☐ 7. A clinically and financially sustainable NHS Foundation Trust ✓ 8. Enabled by excellent IM&T
Please explain any Patient and Public Involvement actions taken or to be taken in relation to this matter:	Please refer to the engagement, listening and action section of the attached progress report (section 2.3) and also Section 2 of the attached updated Joint Action Plan (patient and staff engagement, listening and action). These sections outline progress to date and future plans
Please explain the results of any Equality Impact assessment undertaken in relation to this matter:	• The Trust and the CCGs will work to support the NHS in fulfilling its obligations under the Equality Act 2010, and to promote services which are non-discriminatory on the grounds of any protected characteristics. • The Trust and the CCGs will work with providers, service users and communities of interest to ensure if any issues relating to equality of service within this report are identified and addressed.
Organisational Risk Register/ Board Assurance Framework *	☐ **Organisational Risk Register** ☒ **Board Assurance Framework** ☐ **Not Featured**
ACTION REQUIRED *	For decision ☐ For assurance ☒ For information ☒

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

* tick applicable box

EXECUTIVE SUMMARY (to include the purpose of the paper):

1. In the summer of 2014 the Leicester, Leicestershire and Rutland provider organisations (University Hospitals of Leicester, and Leicestershire Partnership Trust) and 3 Clinical Commissioning Groups published the Learning Lessons to Improve Care report. The report detailed the findings of a clinical audit commissioned by health organisations in Leicester, Leicestershire and Rutland to examine the quality care of patients, and the action plan to address the areas of improvement identified.

2. This is the second progress update since publication, outlining action implemented to date and priority areas for the next quarter.

3. Key headlines are:

- The Learning Lessons to Improve Care (LLtIC) Clinical Taskforce is now integrated into the Better Care Together (BCT) Governance structure
- The Clinical Taskforce has revised its Terms of Reference to clarify three key functions: Assurance, Implementation, Facilitating Solutions & Action
- Progress has been made in all of the five workstreams. This is outlined in Section 2 of the report
- Planned activity in the next quarter is outlined in section 3 and includes holding a development workshop with Better Care Together colleagues to ensure complete alignment between the programmes, with the Lessons Learned as a 'golden thread' throughout Better Care Together
- An Outcomes Framework is being developed in the next quarter
- The 2nd Clinical Summit will be held in March 2015

1.0 INTRODUCTION

1.1 This is the second progress update since the Learning Lessons to Improve Care (LLtIC) report was published in July 2014. This paper:

- Highlights key activity since the last progress report in November 2014
- Outlines planned activity during the next quarter

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

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

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

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

2.0 Key activity during last quarter

2.1 General progress

- An interim Project Manager is in place to develop a range of outputs, including a Governance and Project Management Framework, an updated joint action plan, a draft Outcomes Framework and arrangements for the next review

- The Learning Lessons to Improve Care (LLtIC) Clinical Taskforce has further clarified its role and place in the system through confirming the inter-dependencies with Better Care Together (BCT) and revising its Terms of Reference. The purpose of the LLtIC work programme is to provide assurance that patient issues identified from the Learning Lessons to Improve Care Audit are being addressed across the whole health economy. The Terms of Reference have been revised to reflect three key functions:

    - Assurance: Where something is happening elsewhere
    - Implementation: When something isn't happening elsewhere
    - Facilitating Solutions & Action: Making action happen on the ground

  While the LLtIC Clinical Taskforce is developing mechanisms for assurance and monitoring of action plans, there are already good examples of how organisations are getting on and demonstrating good progress, and these are included in this progress report.

2.2 Clinical Leadership Workstream

- Learning the Lessons to Improve Care Clinical Leadership has been integrated with Better Care Together Clinical Leadership through the establishment of the BCT Clinical Leadership Group
- A phased approach to the work programme has been agreed, along with the associated Governance and Project Management Framework (Appendix 1 – Programme Timeline)
- Initial feedback from first Clinical Summit analysed to inform action planning
- Next Clinical Summit March 2015
- First draft of the updated joint action plan has been produced (Appendix 2). Responsibility for monitoring this plan and supporting plans is with the LLtIC Clinical Taskforce

2.3 Engagement, Listening and Action Workstream

- Thematic analysis of Listening into Action events with Professionals, Patients and the Public underway
- Produced Communication & Engagement Plan

2.4 Care across Interfaces Workstream

- Agreed that this is a workstream to which the Clinical Taskforce can particularly add value
- Facilitated action to address issues raised by clinicians that span primary and secondary care
- Increased data sharing being progressed

2.5 Emergency Care Workstream

- Linked this workstream with the work being undertaken as a result of the LLR Urgent Care Review and associated action plan

2.6 End of Life Workstream

- An End of Life Task and Finish Group was established in response to the findings of the Quality Review. The purpose was to effect swift change and action to ensure that standards of End of Life Care were improved and the LLR Health Community could work in a more collaborative way for the benefit of patients. Short term achievements were outlined in the first progress report. Longer term actions are captured in the Joint Action Plan.

3.0 Planned activity next quarter

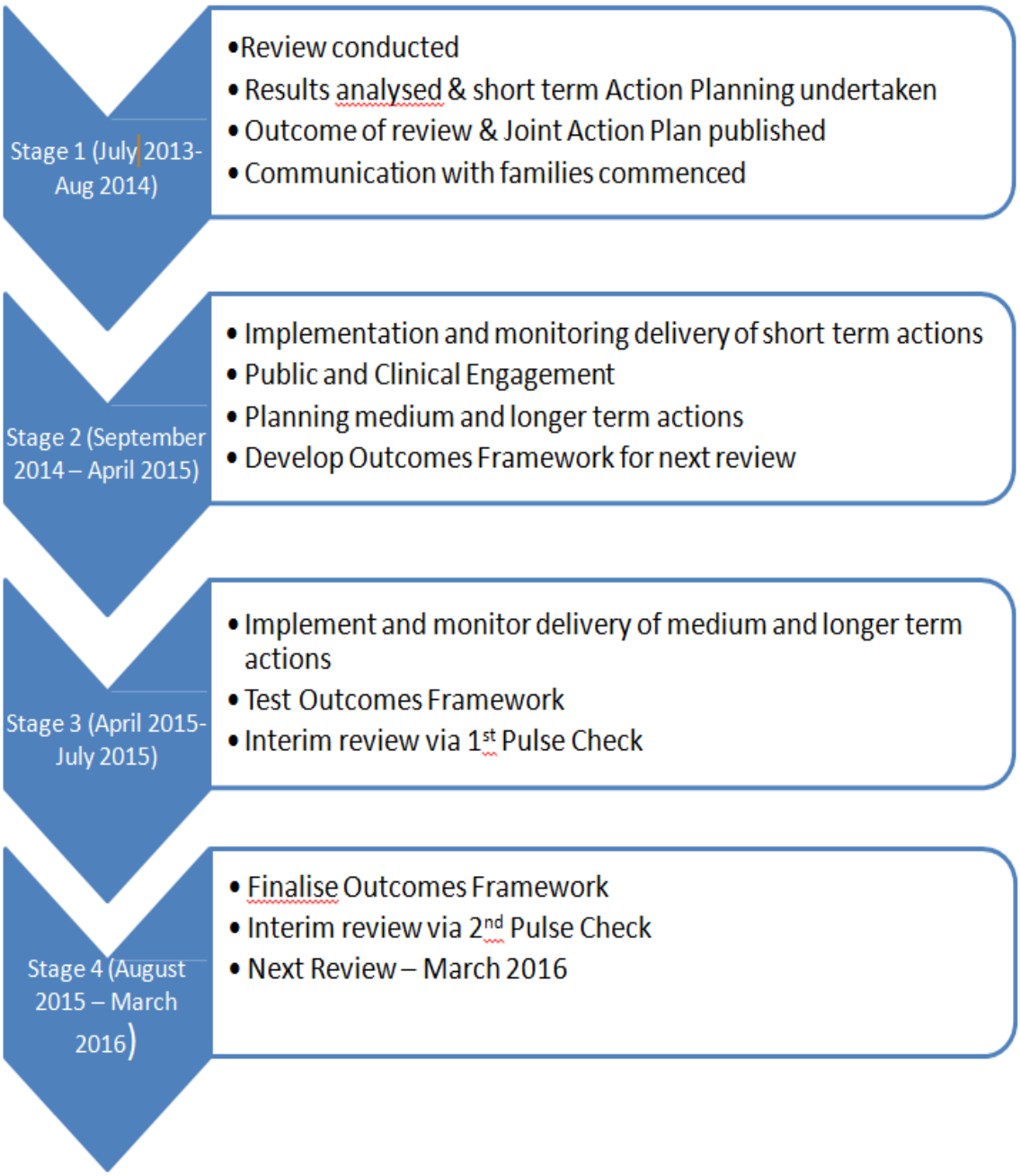
During the first quarter, short term actions were planned, implemented and monitored and medium and long term actions were shared. During the second quarter, the Governance & Project Management arrangements, along with the inter-dependencies with Better Care Together have been confirmed and aligned. During the next quarter, further progress is expected towards embedding the progress monitoring arrangements and developing the Outcomes Framework, particularly:

- Development workshop to be held between LLtIC Clinical Taskforce and Better Care Together leads to ensure complete alignment, with the Lessons from the Quality Review as a golden thread throughout Better Care Together
- Develop draft Outcomes Framework and arrangements for pulse check
- Receive and publish the report on themes identified from the LiA engagement events and incorporate into ongoing action plans
- Monitor and report on progress through Clinical Taskforce in line with new project management arrangements for the three new workstreams: The 12 System Themes, the 8 Challenges to Quality Improvement and the 5 themes in the Joint Action Plan
- First report to BCT Clinical Leadership Group in March 2015
- Host 2nd Clinical Summit in March 2015
- Website to be established
- Develop Business Case for ongoing support to the programme

4.0 Attachments:

App1 - Programme Timeline
App2 – Draft updated Joint Action Plan
App 3 – The 8 Challenges to Quality Improvement

Appendix1 – Programme Timeline



Leicester, Leicestershire and Rutland Quality Review Joint Action Plan

Supporting Plan

Purpose of plan: To provide assurance that patient issues identified from the Learning Lessons to Improve Care (LLtIC) audit are being addressed across the whole health community

Joint Action Plan Theme	Overarching Actions	Underpinning short term action (Completed)	Underpinning medium term/long term action (Planned)	Timescale
1. System wide clinical leadership to ensure that patient care issues are addressed across the health community	1.1-LLR clinical leaders commit to establish a system wide clinical leader task force. This will:	1.1 Establish LLtIC Clinical Taskforce to include membership from UHL, LPT, 3 CCGs, LMC, PH and Healthwatch 1.1 Agree role and remit of Clinical Taskforce and establish short term action plan 1.1 Integrate LLtIC Clinical Taskforce with Better Care Together Programme through - Clinical Leadership Group (CLG) as part of the BCT Governance structure -Confirming the place of the Clinical	1.1 Further actions to be the remit of the BCT Clinical Leadership Group	1.1 – Set up complete. Ongoing role for Leadership

		Taskforce within the BCT Governance structure; reporting into the Clinical Leadership Group **1.1 Agreeing the link between LLtIC and the BCT Clinical and Enabling Workstreams** **1.1 Ensuring link to Contracting Teams** **1.1 Working in the best interests of patients to address the key themes and lessons from the quality review has required organisations to work together. A number of examples of the benefit of this work are highlighted below to collectively improve and transform end of life care**		
	1.2-Monitor progress against the key themes identified within the quality review	**1.2 Clinical Taskforce monitors progress against the action plan and links to Contracts and Quality monitoring as appropriate** **1.2 First Quarterly Progress update (Q1) supplied to November 2014 Boards**	**1.2 Newly established BCT Clinical Leadership Group will oversee system wide programmes of work as agreed with Chief Officers e.g the LLtIC programme and plan** **1.2 Clinical Taskforce to receive highlight and exception reports from workstreams and to facilitate restorative action to address deviations from plan** **1.2 Commitment through LLtIC Clinical Taskforce, to provide progress updates to all partner Boards quarterly. March, June, September & December 2015**	**Ongoing from March-May 2015** **Routinely from March-May 2015** **Quarterly**

	1.3-Ensure there is collaborative system wide action taken to improve quality and safety	**1.3 Thematic analysis of initial review findings undertaken, to inform individual organisation and joint action plans** **1.3 Action plans developed within organisations to address the top twelve themes identified in the review**	**1.3Consider, via the Clinical Taskforce, whether any further action is required within and across organisations which will contribute to addressing the issues identified in the LLtIC review** **1.3 In order to assess this, a Joint Workshop will be held between the LLtIC Clinical Taskforce and Better Care Together Leads, with the aim of ensuring that the issues identified in the review are being addressed. Attendance to include Clinical Taskforce members, BCT Clinical and Enabling Workstream Leads, BCT PMO Leads**	**March-May 2015** **March – May 2015**
	1.4-Commission a further independent review/evaluation	**1.4 Agree to undertake another review/evaluation**	**1.4 Agree review/evaluation methodology, to incorporate ongoing pulse checks** **1.4 Develop an Outcomes Monitoring Framework, against which to conduct the next review and measure improvement:** **-Design and agree questions/metrics/KPIs** **-Establish information/data requirements** **- Agree baseline** **- Conduct review** **- Analyse and report** **1.4 Scope methodology for further review in March 2016**	**March – May 2015** **March – May 2015** **June – Aug 2015 onwards. Review March 16**

			1.4 Commission technical expertise as required **1.4 Monitor SHMI regularly**	**March – Aug 2015** **Routinely**
	1.5-Oversee and receive ongoing patient feedback on LLR services	**1.5 See 2.2 below**	**1.5 LLTIC Clinical Taskforce will ensure ongoing opportunities for patient feedback, through listening events, pulse checks and the Outcomes Framework indicators, and linking with contract monitoring and patient safety**	**Routinely**
	1.6-We have a strategic plan to deliver optimum care across the health community – *Better Care Together*	**1.6 We have worked together to develop a 5 year strategy for our health services across LLR which aims to deliver best practice care pathways to people within LLR**	**1.6 Further Communication and Engagement events will be undertaken** **1.6 Implementation of BCT Strategy over five years** **1.6 LLtIC Clinical Taskforce will ensure that the themes identified in the LLtIC review are a golden thread** **1.6 Learning from the Outcomes Framework, Pulse Checks and Listening events to inform planning and implementation**	**Routinely** **Ongoing** **March – May 2015 and ongoing** **Ongoing**

2. Patient and staff engagement, listening and action	**2.1-GP feedback systems on any quality care issues related in place across LLR**	**2.1 Feedback from first Clinical Summit informed planning for second Clinical Summit**	**2.1 Group to be established for purposes of communication and education, across primary and secondary care**	**March – May 2015**
	2.2-Listening events across LLR for patients, the public and staff	**2.2 Listening into Action events undertaken in Autumn 2014 – Clinical Summit and four public events. Thematic analysis in progress**	**2.2 Cascade results of analysis and incorporate into further iterations of the action plan(s)** **2.2Commission website and feedback mechanisms/social media links** **2.2 Ongoing engagement with patients, public and stakeholders** **2.2 Pulse check as part of ongoing review process**	**March – May 2015** **March – May 2015** **Ongoing** **March – Aug 2015 and ongoing**
	2.3-Adopt and promote specific patient campaigns across LLR	**2.3 Campaigns have been rolled out including patient postcards**	**2.3 Review implementation of 'Hello My Name Is' and consider LLR wide roll out**	**Ongoing**
3. Effective care across interfaces between providers of health services	**3.1- Electronic transfer of information e.g. patient discharge summaries from secondary care to primary care i.e. from hospitals to GPs**	**3.1 Some progress has been made on electronic transfer of information**	**3.1 Sharing of data/care plans across health and social care in order to ensure holistic model of care for older people and those with multiple LTCs**	**Ongoing**
	3.2-Review quality of patient discharge and referral documentation	**3.2 Revised template available from February**	**3.2 Continuous improvement in the quality of patient discharge letters happening via the Discharge Letters Clinical Problem**	**Ongoing**

			Solving Group (CPSG)	
	3.3-Increased data sharing & monitoring across organisations to address current or potential gaps	3.3 Increased data sharing being progressed	3.3 Receive update from BCT Workstream Lead	March – May 2015
	3.4-Development and implementation of ambulatory care pathways (ambulatory care is where conditions can often be treated without the need for an overnight hospital stay)	3.4 Included in BCT Urgent Care Workstream	3.4 Receive update from BCT Workstream Lead	March – May 2015
	3.5 -LLR wide sign up and commitment to National 'sign up to safety' campaign	3.5 All partner organisations are signed up		Set up complete, work ongoing
	3.6 -Introduction of individual care plans following identification of risk stratification (risk stratification is a clinical evaluation used to determine a person's risks when suffering a	3.6 Care plans in place for over 75s. Risk stratification rolled out through CCGs		Ongoing

	particular condition) and Multi-Disciplinary Team planning for older people shared with health and social care providers			
4. Transforming emergency care in our wards, hospitals and communities	4.1-Emergency Care pathway review 4.2-Development of a community based comprehensive older peoples assessment service and support 4.3-LLR-wide review of support which would allow older people to remain in their usual place of residence, including a falls support service 4.4-Well-developed joint referral guidelines e.g. 2 week wait, Stroke/TIA, Urology with haematuria, acute retention of urine	4 Review completed and action plan produced	4 LLtIC Clinical Taskforce to support Implementation of action plan 4 LLtIC Clinical Taskforce to ensure lessons learned from the LLtIC review are a golden thread 4 Hold workshop described in 1.3 above between LLtIC Clinical Taskforce and Better Care Together Leads	March – May 2015 and ongoing

5. Transforming end of life care (EoL)	**5.1-LLR EoL Care working group is established to develop unified approach to EoL care across all LLR healthcare organisations and includes:** **5.2-Standardisation of EoL care plans & process for sharing key information across organisations** **5.3-Implementation of a joint EoL care pathway across LLR** **5.4-Design and implement training and development for GPs/Nurses/Care Homes on EoL care planning & DNAR orders** **5.5-Revision of guidelines & teaching of best practice for DNAR status**	**5 An EoL Task and Finish group was established in response to the findings of the Quality Review. The purpose was to effect swift change and action to ensure that the standards of EoL care were improved and the LLR Health Community could work in a more collaborative way for the benefit of patients. Achievements include:** • **Unified approach to Do Not Attempt Cardio Pulmonary Rehabilitation (DNA CPR)** • **A single DNACPR form in use across Leicester, Leicestershire and Rutland and available electronically for GPs and EMAS** • **Unified Advance Care Planning** • **Green bags and wallets in place to ensure all staff are aware of care plans** • **Anticipatory drugs** • **Location agreed to ensure all staff are aware of preferred location** • **Community access identified** • **Timely access to wheelchair provision for end of life patients** • **Standardising leaflets and terminology**	**5 EoL Workstream established in Better Care Together Programme. To be part of the joint workshop outlined in 1.3 above**	**March – May 2015 and ongoing**

	5.6-Rapid discharge for EoL patients to named GP. Where DNAR orders in place flagged prominently on discharge summaries **5.7-'Electronic patient record' in fast track development to share EoL/discharge and patient management plans seamlessly across all organisations**			

Appendix 3 – The 8 System Challenges

Challenge 1 – Convincing People that the Problem is Theirs

Challenge 2 – Convincing People that by Working Together a Solution can be Found

Challenge 3 – Getting Data Collection and Monitoring Systems Right

Challenge 4 – Making Changes that are Achievable and Sustainable

Challenge 5 – Shifting Organisational Context and Culture

Challenge 6 – Leadership, Oversight and Co-ordination

Challenge 7 – Maintaining Momentum

Challenge 8 – Considering the Side Effects of Change

Adapted from Dixon-Woods M, McNicol S, Martin G. (2012) *Overcoming challenges to improving quality. Lessons from the Health Foundation's improvement programme evaluations and relevant literature* (available at http://www.health.org.uk/public/cms/75/76/313/3357/overcoming%20challenges.pdf?realName=HGHuMk.pdf).

University Hospitals of Leicester NHS
NHS Trust

Agenda Item: Trust Board Paper G

TRUST BOARD – 5 MARCH 2015

ESTABLISHING THE *LEICESTER INSTITUTE OF HEALTH FOR OLDER PEOPLE*

DIRECTOR:	Kevin Harris – Medical Director
AUTHORS:	• Kevin Harris. Medical Director ,University Hospitals of Leicester NHS Trust • Simon Oldroyd. PVC/Dean Faculty of Health and Life Sciences, DMU • Satheesh Kumar. Medical Director, Leicestershire Partnership NHS Trust • Tony Donavan. Executive Director, Age UK Leicester Shire & Rutland
DATE:	5th March 2015
PURPOSE:	To seek Trust Board support for the establishment of an "Institute of Health for Older People" in Leicester utilising the expertise and resource from 2 local healthcare providers (UHL and LPT), DeMontfort University and Age UK (LLR).
PREVIOUSLY CONSIDERED BY:	
Objective(s) to which issue relates *	☑ 1. Safe, high quality, patient-centred healthcare ☑ 2. An effective, joined up emergency care system ☑ 3. Responsive services which people choose to use (secondary, specialised and tertiary care) ☑ 4. Integrated care in partnership with others (secondary, specialised and tertiary care) ☑ 5. Enhanced reputation in research, innovation and clinical education ☑ 6. Delivering services through a caring, professional, passionate and valued workforce ☐ 7. A clinically and financially sustainable NHS Foundation Trust ☐ 8. Enabled by excellent IM&T
Please explain any Patient and Public Involvement actions taken or to be taken in relation to this matter:	This project is supported by Age UK (LLR). Age UK is the country's largest charity dedicated to helping everyone make the most of later life.
Please explain the results of any Equality Impact assessment undertaken in relation to this matter:	• The Institute will be committed to ensure obligations under the Equality Act 2010 are fulfilled, and to ensure services are non-discriminatory on the grounds of any protected characteristics. • The Institute will work with providers, service users and communities of interest to ensure if any issues relating to equality of service within this report are identified and addressed.
Organisational Risk Register/ Board Assurance Framework *	☐ **Organisational Risk Register** ☐ **Board Assurance Framework** ☐ **Not Featured**
ACTION REQUIRED *	For decision [x] For assurance [ ] For information [ ]

♦ We treat people how we would like to be treated ♦ We do what we say we are going to do
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♦ We are passionate and creative in our work

***** tick applicable box

ESTABLISHING THE *LEICESTER INSTITUTE OF HEALTH FOR OLDER PEOPLE*

A CULTURAL PARTNERSHIP TO IMPROVE PERSON CENTRED CARE FOR OLDER PEOPLE IN LEICESTER LEICESTERSHIRE & RUTLAND

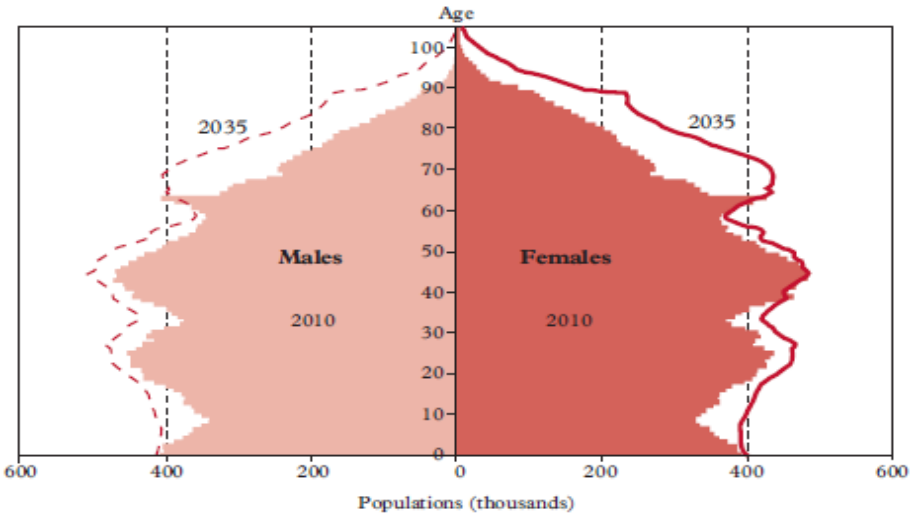
Authors:

- Kevin Harris. Medical Director ,University Hospitals of Leicester NHS Trust
- Simon Oldroyd. PVC/Dean Faculty of Health and Life Sciences, DMU
- Satheesh Kumar. Medical Director, Leicestershire Partnership NHS Trust
- Tony Donavan. Executive Director, Age UK Leicester Shire & Rutland

Introduction and Context

The changing demographic of our nation is well documented. The increase in the older population is shown in the 'Christmas tree' diagram below, with the biggest increase in profile amongst those people aged 70-90.

Estimated and projected age structure of the United Kingdom population, mid-2010 and mid-2035[55]



Within the UK there will be:

- 51% more people aged 65 and over in England in 2030 compared to 2010
- 101% more people aged 85 and over in England in 2030 compared to 2012. This compares to an overall growth in the population of only 12%.
- Over 50% more people with three or more long-term conditions in England by 2018 compared to 2008
- Over 80% more people aged 65 and over with dementia (moderate or severe cognitive impairment) in England and Wales by 2030 compared to 2010.
- The proportion of people of state pension age will increase by 28% between 2010 and 2035 and outnumber children by 2.6 million. Over the same time, the number of employed people for every pensioner would decrease from 3.16 to 2.87 (without changes in state pension age, this would have been 2.17)

The number of people aged over 90 who went to hospital by ambulance rose by 81 per cent – up from 165,910 in 2009-10 to 300,370 in 2013. However, the King's Fund has pointed out that "*The model of acute care is unsuited to patients with complex needs. The physical environment, working practices and care processes of acute hospitals geared to the model of acute medical care presuppose that the main task of the hospital is treatment and cure. However, care pathways and*

performance targets for waiting times and access to elective procedures are either irrelevant or actively obstructive to high-quality care for patients with complex conditions".

A model of care centred around hospitals, or only healthcare for that matter, has been decried as it represents a narrow view of people and the role that healthcare plays in contributing towards their health. A transformation towards care wrapped around the needs of the individual is vitally important to support complex health and social requirements as individuals' age and this change needs to happen at scale and pace.

Promoting the health of older people requires a number of cultural issues to be addressed. There is a tendency to discuss the ageing population in pejorative terms ("bedblockers"), which is often underpinned by the assumption that with age comes frailty. This is not necessarily the case. Self-reporting shows that the majority of people aged over 80 are satisfied or very satisfied with their health. At the same time we know that for a cohort of older patients there is an increased likelihood that whilst they will live for longer than ever before they do so with one or more long term illness. The most important amongst these will be dementia (increase of 40% over the next 12 years and of 156% over the next 38 years) and cancer (55% increase by 2030). Issues at end of life are also fast emerging as a big challenge. By 2033 the Midlands and East of England is predicted to have the highest percentage of 85s and over and 36.2% of deaths are in this age group.

The House of Lords Select Committee on ageing pointed out that *"The National Health Service will have to transform to deal with very large increases in demand for and costs of health and social care. Overall, the quality of healthcare for older people is not good enough now, and older people should be concerned about the quality of care that they may receive in the near future. England has an inappropriate model of health and social care to cope with a changing pattern of ill health from an ageing population".*

LLR has over 200,000 older people with 13% of the City and 23% of the County being old. This impacts on use of health and social care resources and the threats posed by national policy, funding cuts and staff disengagement combined with competition in an internal market, add to the challenges of addressing complex organisational transitions and maintaining quality care to an increasing group of frail older people with complex care needs. A number of individual organisations within the Leicester, Leicestershire and Rutland (LLR) Healthcare Economy are already undertaking different initiatives to address this need and it is a key priority for local Clinical Commissioning Groups as well as for the LLR "Better Care Together" program. The UHL Board has previously approved "A Strategic Direction for Frail and Older People's Services" as presented by Mark Wightman in May 2014.

However, to meet the challenge of this scale will require a more fundamental change in the ways that both public and private sector services for older people are designed. In particular improving the heath of older people will need to encompass acute, social, primary, voluntary sector and mental health care, with care pathways designed around the needs of the individual. The planning framework needs to move away from just decreasing healthcare utilisation to increasing community participation. The focus needs to shift from setting up or discontinuation of services towards delivering person centred outcomes that address the totality of needs for the older individual and not just on health and social care.

There is an urgent need to establish within LLR an integrated collaborative multidisciplinary approach to the needs of older people, which is underpinned by a strong evidence based focus on person centred outcomes and experience. This would need to be supported by a redesigned workforce that addresses capacity and capability when it comes to managing older peoples issues.

Proposal

The 2 local healthcare providers (UHL and LPT), DeMontfort University and Age UK propose that an "Institute of Health for Older People" is established in Leicester utilising the expertise and resource from the individual institutions to ensure the LLR community is optimally equipped to meet the challenge to provide evidence based integrated care to the population of LLR.

The vision of the Institute would be to promote active aging (defined by WHO/EU as "*the process of optimising opportunities for health, participation and security in order to enhance quality of life as people age. Active ageing applies to both individuals and groups. It allows people to realise their potential for physical, social, and mental well-being throughout their lives and to participate in society according to their needs, desires and capacities, while providing them with adequate protection, security and care when they require assistance*")

An initiative that brings together healthcare organisations to undergo cultural transformation to deliver the "Triple Ai"m and support the community in active ageing, has the potential to actively contribute towards greater societal productivity for all members. The work programmes would not only address simple processes such as decreasing admission rates and length of stay in hospitals but also supporting more reablement and independent living with community programmes for wider participation. This would also include active engagement of the community in end of life programmes.

The potential scope for such an Institute is very large. However initially the partners would work to develop a strong leadership for the Institute who would agree and implement a focused work programme on improving care for older people through key collaborations with local partners. The aim would be to develop a learning community that would actively participate to improve quality care for older people through person centred, shared models of improvement in health and well-being. The Institute would initially take a virtual form building on established strengths and expertise of the partners (for example see 5) but this would rapidly evolve to ensure there was a robust governance structure and in the fullness of time, a physical identity.

The Institute will require strong leadership and it is proposed this is provided jointly by medical and non medical senior clinicians ideally at tenured Professorial level complemented by "Board level" support from the NHS partners. Patients and older people would be members of the leadership team at every level – including authoritarian leadership of the Institute and within leadership teams to support innovation and improvement.

The exact work program needs to be defined and agreed by the partners but it is envisaged that the following themes will be important aspects of the Institute's work:

- The development of innovative approaches to improving outcomes in frail older people that seek to transition the interfaces between primary/secondary care, health/social care and physical/mental health that can be shown to be effective and efficient are required
- The development of solutions which focus on knowledge generation (new models of care), quality improvement (working smarter) and knowledge transfer (spreading good practice)
- Quality improvement (all the activities carried out by professionals, older people, carers and society to learn continuously and improve health outcomes)
- The development of competencies which promote older people focused care and develop teaching programs for these competencies

- The establishment of tenured posts that can drive academic developments in gerontology and geriatrics; these should be subject to a five year review of benefit and evidence of sustainable grant income
- Supporting future growth through PhD opportunities, Academic Clinical Fellows/Lecturers
- The development of income streams from undergraduate education, grants, collaborations with industry and spin off businesses.

Leadership of the Institute will be supported by the establishment of tenured posts (initially two posts at professorial level – one medical, one non-medical) that can drive academic developments; these should be subject to a five year review of benefit and evidence of sustainable grant income.

The proposal has already been considered by the Board of Governors of DMU who have provided their support for the proposal. In particular they have committed to

- Funding of one of the professorial posts (non-medical)
- Contributing expertise from the faculty of Health and Life Science regarding the nursing of older people, psychology research and expertise in health psychology, gerontology and active ageing (independence of people with mild cognitive impairment).
- Contributing expertise/research from the faculty of Art Design and Humanities regarding design concepts for older people
- Providing ongoing strong leadership of the institute and support from their Board of Governors

The Medical Director of LPT has indicated executive level support for the proposal and will be seeking full support from their board in due course.

Age UK have also committed to supporting the work of the institute.

Although the proposal comes from the four institutions, the intention would be for the Institute to develop strong links with other partners to further its key objectives. Examples of partners could include:

1. Health and Social Care from both Leicester City Council, Leicestershire County Council and Rutland County Council . In June 2014 report to the Adult Social Care Scrutiny Commission, Leicester identified that being an "age friendly city" was one of its strategic aim.
2. Other HEIs
    a. the University of Leicester Medical School would be a key partner to ensure a multidisciplinary approach to care can be developed. Professor Nick London Associate Dean of Leicester Medical School has indicated his support for the proposal.
    b. Loughborough University who have recognised expertise in enhancing productive and healthy environments for the older workforce; regenerative medicine
3. The AHSN: the care of frail older people is one of the major priorities of the East Midlands AHSN
4. Biomedical Research Units -
5. The Leicester Improvement, Innovation and Patient Safety unit (LIIPS)
6. Health Education East Midlands: care of the elderly is a specific theme within the East Midlands Educational priorities

7. Patient and public groups
8. Local Clinical Commissioning Groups
9. Private providers of care (nursing homes) and relevant healthcare industry

Benefits of the Institute and Markers of Success

The establishment of an Institute of Health for Older People provides a unique opportunity to embed world class, whole-system service development within LLR.

Key benefits would include:

- Being recognised as a National centre of excellence in the health needs of older people
- Being recognised as the place to do research into older peoples heath
- Acting as a focus for inward investment from the healthcare industry
- Being recognised as the centre of excellence for education and training in the health care needs of older people
- Improving the local economy's ability to recruit and retain the very best expertise in this field
- Delivering metrics (includes the Active Ageing Index and outcome indicators for frail older people) that demonstrate improvement in experience of ageing in older people in LLR and improved systemic and organisational attitude towards ageing and older people

The institute will effectively develop a "brand" in this field. Thus far no healthcare economy in the country has sought to position itself as excellent in the care of older people. The reason would not be to attract more patients, if anything the opposite. Rather the Institute would attract talent and research funding, positioning the local economy as the leader in the care of older people and in doing so would ensure services of excellence for our local aging population.

Conclusion

The Board is asked to:

1. Indicate its support for the proposal
2. Ask the Executive to provide ongoing support from UHL to allow the creation of the Institute. This may include:
    a. Providing staff resource (time) to allow the objectives of the Institute to be defined and the agreed joint objectives of the Institute to be taken forward.
    b. Providing co-funding to enable the establishment of medical leadership for the Institute at Consultant/Professorial level
    c. Funding posts to work within UHL where such posts facilitate the objectives of the Institute as well as meet UHL priorities.
    d. Ask for a progress report in 3 months

University Hospitals of Leicester NHS
NHS Trust

Agenda Item: Trust Board Paper H

TRUST BOARD – 5 MARCH 2015

NEW PPI AND ENGAGEMENT STRATEGY

DIRECTOR:	Mark Wightman, Director of Marketing and Communications
AUTHOR:	Karl Mayes PPI and Membership Manager
DATE:	
PURPOSE:	**To seek Board endorsement for the Trust's new PPI and Community Engagement Strategy and plan.**
PREVIOUSLY CONSIDERED BY:	**The subject has been previously discussed and refined at two Trust Board development sessions and a CMG engagement event.**
Objective(s) to which issue relates *	☑ 1. Safe, high quality, patient-centred healthcare ☐ 2. An effective, joined up emergency care system ☑ 3. Responsive services which people choose to use (secondary, specialised and tertiary care) ☐ 4. Integrated care in partnership with others (secondary, specialised and tertiary care) ☐ 5. Enhanced reputation in research, innovation and clinical education ☐ 6. Delivering services through a caring, professional, passionate and valued workforce ☐ 7. A clinically and financially sustainable NHS Foundation Trust ☐ 8. Enabled by excellent IM&T
Please explain any Patient and Public Involvement actions taken or to be taken in relation to this matter:	The strategy and plan has been through a number of iterations which have been discussed with the Trust's Patient Advisors.
Please explain the results of any Equality Impact assessment undertaken in relation to this matter:	The strategy has been discussed with the Trust's Equalities lead. There will be a requirement that as the strategy and plan are operationalised that the individual pieces of PPI activity will be subject, where appropriate to EIA.
Organisational Risk Register/ Board Assurance Framework *	☐ **Organisational Risk Register** ☒ **Board Assurance Framework** ☐ **Not Featured**
ACTION REQUIRED *	For decision ☒ For assurance ☐ For information ☐

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

* tick applicable box

Executive summary:

The revised strategy and accompanying plan seek to take our engagement activity to the next level where it is seen as core business to the Trust, the CMGs and to any individual leading service change and development. In one sense and despite the establishment of KPIs to monitor improvements, 'success' will come at the point when we hear people say, "Sorry not sure we can discuss this now, we don't have a patient representative with us".

The key interventions detailed in the strategy which will deliver this ambition can be summarised as:

- CMG ownership of the PPI agenda
- Adopting a Listening into Action approach to PPI: Involvement into Action
- The creation of Patient Partners
- A single engagement forum for Patient Advisors and Trust members
- Creation of E–Advisors
- Formal requirements to involve patients in business planning
- Patient Involvement in sub committees of the Board
- Community Engagement
- Reward and Recognition
- Trust Board templates

The essence of the strategy is that whilst the Trust at a corporate level, essentially managed through the Communications and Engagement team with particular support from the CEX, does a reasonable job of engaging with the most influential stakeholders, (e.g. Councils, CCGs, Healthwatch, MPs etc). The business of engagement is not hardwired into the routine of our CMGs. Hence, it is often the case that a request from the CMGs for support with engagement activity or more rarely the co-production of service change comes too late in the process. To address this the strategy positions PPI as a core element of the business planning cycle for CMGs.

The second element of the strategy is to recognise that whilst our engagement with key stakeholders is reasonable our community outreach and understanding of the diverse needs of our local population lags some way behind. So, the strategy then outlines our new approach to community engagement and some of the tactics we will use to make sure that the seldom heard voices increasingly have a greater say in the development of our services.

Finally, to take this from conceptual to concrete the strategy is supported by a three year plan and as such the Board is requested to both discuss and support the strategy and endorse the plan.

ENDS

University Hospitals of Leicester NHS Trust

Stakeholder Engagement and Patient and Public Involvement (PPI) Strategy

March 2015

"Patients and their carers should be present, powerful and involved at every level"
Keogh Review report (2013)

Purpose

This document describes how University Hospitals of Leicester NHS Trust will engage and involve the public, patients and its stakeholders in the planning, provision and evaluation of its services. As such its core purpose is to;

- Outline the mechanisms by which the Trust communicates and engages with its stakeholders.
- Outline the ways in which the Trust involves its patients and the wider community in its service development
- Set out the Trust's plans to achieve high quality stakeholder, patient and public involvement over the next 3 years.

In October 2014 the Trust Board approved the UHL Five Year Development Support Plan (see Appendix 1.). The section on Patient and Public Involvement and Stakeholder Engagement outlined the present risks and set out the interventions required. This strategy provides a delivery plan for that paper. The development of this strategy also benefited from a Board Development session in January 2015 and prior engagement with CMGs, PPI leads and the Trust's Patient Advisors.

Strategic outcomes

- Patient and public involvement activity is an integral and valued element of mainstream work, which leads to identifiable improvements in services and facilities and a better experience for patients.
- Changes to services and facilities meet the needs of our diverse service users
- Staff at all levels understand the importance and benefits of actively involving patients and the wider public.
- Well informed staff select an appropriate method of patient and public involvement according to the specific context.
- Evaluation of patient and public involvement informs future developments.
- Resources for PPI are assessed and steps taken to secure them.

Responsibilities

The Trust Board is ultimately responsible for ensuring that the Trust meets its legal and policy obligations to deliver the Patient and Public Involvement agenda. The Trust Board is responsible for ensuring that Patient and Public Involvement is

included in its own work and that it has been included appropriately in work submitted for Board endorsement or approval.

Directors are accountable to the Chief Executive for the delivery of Patient and Public Involvement in their areas of responsibility, through the performance review process.

Clinical Management Groups (CMGs) are central to involving patients and public. They are responsible for implementing patient and public involvement in their service areas and facilities.

Matrons/Senior Nurses have a responsibility for patient and public involvement written into their Job Descriptions. However since patient and public involvement covers all areas, not only nursing, other members of the CMG management team share the responsibility for ensuring appropriate involvement.

Introduction

Involving patients and the wider public is not a soft, optional activity. The Trust has a statutory duty to do so; a duty strongly reinforced by the recommendations of the Francis, Keogh and Berwick reports among others. These reports call clearly for "real" patient and public involvement and a cultural change across the NHS to ensure greater openness, transparency and a duty of candour to patients. The Keogh Review (ambition 3), for example, presses for patients to be equal partners in the design and assessment of NHS services, with the patient voice at the centre of the planning, management and evaluation of hospital services.

Expectations regarding PPI have grown considerably over the last decade. Today's patients are better informed, have greater choice and are less likely to accept being passive recipients of care in a system they have no influence over. This cultural shift is reflected in the proliferation of fora within which patients and the wider public are connecting with healthcare organisations (e.g. The Trust's Patient Advisor group and public membership, NHS Citizens, Expert Patients, Healthwatch, the Mercury Patients' panel partner organisation memberships, PPGs etc.).

While there is much to celebrate in terms of our engagement to date with our patients, stakeholders and the wider public, there is a good deal more that we can do to ensure the voices of patients, carers and the local population are at the centre of our everyday business. In particular the Trust has a patchy track record of involving patients in its business and service development. Where patients are involved at all it is usually towards the end of the process, at a point where they have little opportunity to influence. In short, we sometimes start too late for PPI to be credible.

There is a clear benefit to involving patients from the earliest discussions and throughout the planning process. Indeed, where patients witness and are involved in discussions which appraise options and consider clinical and financial constraints they are far better placed to understand and endorse the final outcomes.

This strategy aims to raise the profile of PPI within the organisation and move us towards a situation where involving patients is the norm. A move to link PPI with the Listening into Action programme aims to make the involvement process more accessible to our staff and also to patients and patient representatives who may be interested in getting involved. In particular the strategy aims to strengthen and support a commitment to patient involvement from our CMGs.

Listening to patients or involving them?

There is a distinction between *listening* to patients and *involving* them in the development and evaluation of their hospital services. Although the Trust has invested increasing time and resource in to collecting patient feedback, opportunities for patient *involvement* remain few and far between. There are several reasons why this might be the case, ranging from a fear of public challenge and a misunderstanding of the agenda to a shortfall in both the human and financial resources required to build and sustain meaningful involvement. Whatever the reasons, the Trust is still some way off the oft quoted aspiration for patient involvement; "no decision about us, without us" (Equity & Excellence: Liberating the NHS, 2010).

We want our strategy to go beyond being a framework for how we receive and act upon feedback, because we believe the voice of patients should be at the centre of our organisation. Patient feedback provides an important and useful barometer by which the Trust may gauge patient experience and identify key areas for improvement. However, once identified, it is most often the case that actions to address these areas for improvement are determined exclusively by our staff, without the direct *involvement* of patients and the wider public. The diagram below (fig.1) reflects the common response to patient feedback within the Trust.

In many respects the collection of patient feedback is too readily taken as a proxy for patient involvement. This serves to keep "real" involvement at arms length from our strategic activity and the development and evaluation of our services. We are missing opportunities to explore and "co-design" services that best meet the needs of people using them.

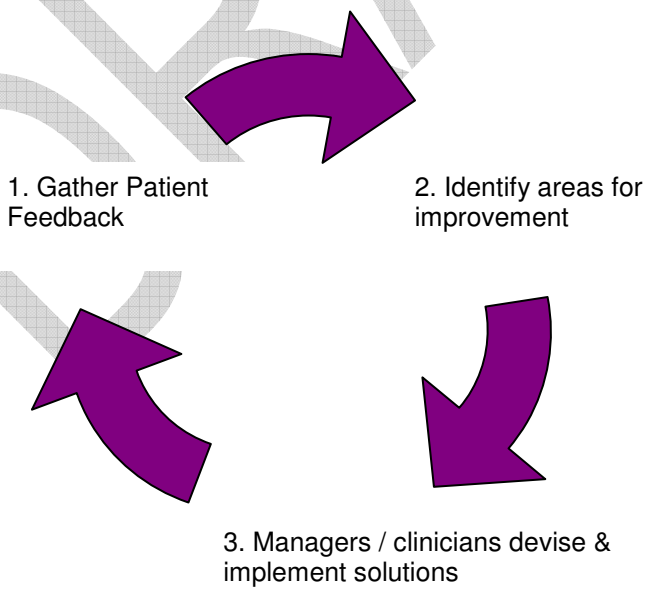


Figure 1. Common pattern of action on patient feedback within the Trust

To be effective, PPI cannot be carried out as a discrete set of activities which bear little relation to our core activity: rather it needs to be embedded throughout the

planning and delivery of our services. Involvement should be the *means by which* we approach this activity. In other words, PPI should not be an additional, "bolt – on" practice that exists separately to where we expend most of our professional energy.

Aim of the strategy

The broad aim of this strategy is to ensure that patients and the public are involved and have a strong voice in our core business and strategic and service development. It seeks to link PPI activity directly to our core business. In terms of service development the strategy seeks to move from the diagram (fig. 1) presented above to the diagram below (fig. 2.) which sees patient feedback as a trigger to involve patients and the public in service redesign.

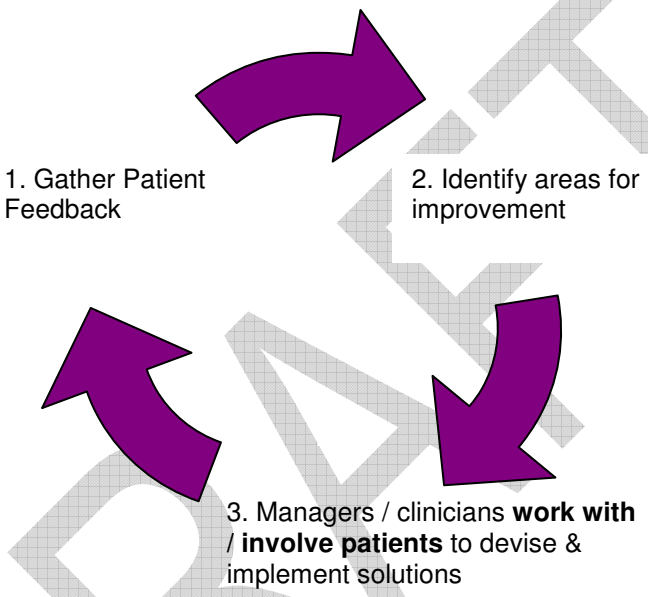


Figure 2. Simple model of involvement

Vision and Principles

To achieve meaningful involvement of patients and the wider public the Trust will honour the following commitments;

Early involvement
Patient engagement (where it is considered at all) is still frequently undertaken at haste, towards the end of a project. As such, it is little more than a box ticking exercise. If patients are to be meaningfully involved this needs to happen as early as possible and throughout the life of the project. Rather than presenting a *fait accompli* for endorsement, we should be co-designing from the start.

Ownership of PPI by CMGs
For PPI to be meaningful and effective it is vital that CMGs treat it as core business. As such they must adequately resource involvement and actively create opportunities for patients and the public to work alongside them as they develop their services.

Empowering patients to get involved

If we wish to see enthusiastic, committed patients who remain engaged with the Trust we will need to support them (through training, development and covering expenses) and ensure that we demonstrate how their involvement has changed our thinking and impacted on service development.

Involvement in strategic planning
Patients are arguably more readily engaged on their day to day experience of our services. However, patient involvement is often absent in the large scale strategic planning of the organisation. At a time of significant change for the local health community there is a clear imperative to involve patients in the planning of future services. Such involvement is a prerequisite for public transparency.

Involvement of people with direct experience of our services
Across the UK PPI fora are populated by what we might term "semi professional engagers". These are individuals who devote a great deal of time to their involvement with health services and as a result gain a nuanced and detailed understanding of the local health economy. Such individuals are invaluable and are well placed to both challenge and to act as a "critical friend". However, we need to find a balance between such involvement and that of the "ordinary" patient who has a direct and recent experience of our services. As such we must identify ways in which we can recruit and support such patients and provide a range of opportunities for them to get involved.

Managing expectations
Well supported participants in PPI will be clear about what they can influence and what they cannot. Moreover they will understand the important clinical, political and financial drivers that may influence the Trust's decision making.

What is Patient and Public Involvement (PPI)?

Patient and Public Involvement (PPI) refers to the active participation of patients, carers, community representatives and the public in the design, delivery and evaluation of health services.

It may be helpful to think of patient and public involvement as one element of a continuum of engagement activities. One end of the continuum represents simple information giving, while placing decision making directly in the hands of patients is at the other end of the scale. The term "engagement" covers a range of activity characterised by the degree of influence patients and the public may have. The diagram below (fig. 3) provides a summary of the range and nature of public and patient engagement. Activities that "involve" patients in various degrees are indicated by the shaded areas of the diagram.

Goal	Commitment to the public	Tools (examples)
Empowerment Supporting patients / the public while placing decision making in their hands	We will provide support and information to you and implement what you decide	Working with Voluntary sector / health interest groups, citizens juries
Collaboration Working in partnership with patients / the public through every aspect of the project including development of alternatives & identification of the preferred solution	We will work together through each step of the process, seeking your advice and innovation & incorporating this in to decisions to the maximum extent possible	Project boards, advisory committees, participatory decision making, patient representatives
Involvement Working directly with patients / the public throughout the process. Ensuring concerns and aspirations are understood & considered	We will work with you to ensure your concerns & aspirations are directly reflected in our activity. We will provide feedback on how public views have influenced our decisions	Focus groups, workshops, project groups, expert patients,
Consultation Obtaining public feedback, acknowledging concerns and suggestions. Providing feedback on how public opinion shaped the decision	We will listen to your views & acknowledge your concerns & aspirations. We will provide feedback on how public views have influenced our decisions	Feedback forms, surveys, social media, public meetings
Information Providing clear information on services and how they are being developed. (Newsletters, web sites etc.)	We will keep you informed, providing accurate and accessible information	Fact sheets, local media, social media, newsletters, web sites, Open days

Fig. 3. Levels of Patient and Public Involvement (Adapted from Arnstein's "Ladder of Participation" 1969)

As noted above, all of these activities fall under the general heading of "engagement" and different approaches will suit different activities. For example, if the Trust installs new equipment to speed up the way in which it can dispense medicines it may be appropriate simply to inform the public (e.g. through communications with our membership and through local media). However, if a care pathway is being redeveloped the project would clearly benefit from the involvement of people who use, will use, or have used the service. Indeed, the Trust has a legal obligation to involve the public in such circumstances.

In practice, patients and the public can become involved in decisions about healthcare and health services at a number of different levels, ranging from the

involvement of individual patients and carers in treatment decisions to large scale consultations on national policy.

Benefits of PPI

Involving patients and the public in our service development and delivery brings many benefits; both to the Trust and to the people who use our services. Indeed, in the private sector it would be almost inconceivable to develop products and services without actively seeking the insight of customers. Market research, Mystery Shoppers, customer surveys and focus groups etc are fundamental to successful businesses and reduce risk, minimise dissatisfaction and avoid costly mistakes. In short, any organisation that seeks assurance that it is developing services in a way that is right for the people that use them will involve them in the process.

Among the many benefits of PPI it can;

- Improve the planning and development of services
- Improve patient satisfaction
- Increase confidence in Hospital care
- Encourage public endorsement of strategic decisions
- Increase public understanding of the complexities of healthcare provision
- Improve decision making by incorporating the perspective of patients
- Encourage a sense of shared ownership
- Avoid conflicts by identifying and addressing critical issues early on
- Build better relationships and communication between hospital staff and service users
- Facilitate better health and more appropriate use of services
- Promote openness and accountability
- Contribute to the development of fairer and more accessible services
- Empower communities to have a say in the delivery of services
- Improve how we respond to people's needs and values
- Encourage more informed and active patients
- Build Trust and legitimacy
- Build relationships between the Trust and local communities
- Reduce complaints

Why is Stakeholder Engagement important?

The Trust is keen to build stronger and more productive relationships with its stakeholders to understand their needs and ensure that hospital services are optimised for our local population. Stakeholder engagement is essentially about building a dialogue with interested parties, providing timely information and gaining endorsement for projects and initiatives. It is also a means by which we can minimise negative and maximise positive environmental and social impacts. In other words, effective and honest stakeholder engagement is the hallmark of an organisation that is run responsibly. It entails a willingness to listen; to discuss issues of interest to stakeholders and crucially a willingness to change what the Trust aims to achieve and how it operates as a result of its engagement.

Robust and successful stakeholder engagement will:-

- Ensure the Trust is more responsive to the needs of its users and local population
- Improve the hospital experience of patients and carers
- Improve communications and feedback with stakeholders
- Gain buy in to Trust strategies by stakeholders
- Ensure support for key strategic business developments
- Support the Trust to gain influence to achieve its organisational objectives
- Increase leverage and influence within health and social care markets
- Support the Trust to compete effectively & improve financial stability
- Improve the Trust's reputation

Legal requirements

Notwithstanding the many and obvious benefits of stakeholder, patient and public engagement, the Trust also has a statutory requirement or duty to consult and involve the public. Specifically, under section 242 of the Health Act (2006) we are obliged to ensure that users of our services are involved / consulted in -

a. the planning of the provision of services,
b. the development and consideration of proposals for changes in the way those services are provided, and
c. decisions we make which affect the operation of those services.

This is particularly important if the implementation of a proposal will have an impact on -

a. the manner in which the services are delivered to users of those services,

or

b. the range of health services available to those users.

Management of current PPI and stakeholder engagement

Within the Marketing and Communications directorate the Trust has a clear team structure with which to coordinate stakeholder engagement and PPI. Led by the Director of Marketing and Communications. The Communications team includes a PPI and Membership manager and a Head of Services for GPs. So, for example, the key relationships and communications products / channels with the three Healthwatch organisations, the two Overview & Scrutiny Committees, the Patient Advisors, Trust Members, the Mercury Patients Panel and local MPs are managed through this team, with support from key individuals including the Chairman and Chief Executive. A full stakeholder analysis and communications plan may be found in appendix 2 of this document.

The Trust's PPI and Membership Manager is responsible for engagement and involvement programmes across the Trust, providing support and advice at all organisational levels. Corporate engagement is managed through the PPI and Membership office, drawing on a range of sources including the Trust's Patient Advisor group, its public membership and Members' Engagement Forum, Healthwatch and other patient and public representative groups.

Patient Advisors

Since 2001 the Trust has supported a group of Patient Advisors. Patient Advisors are members of the public who provide a lay perspective on various groups Boards and Committees within the organisation. They are also involved in patient surveying and act as a consultation group. We currently have 12 active Patient Advisors, each of which is allocated to a CMG. Their annual work plan is coordinated by the CMG PPI leads.

PPI in CMGs

To manage PPI within the Trust each Clinical Management Group (CMG) has nominated a lead senior member of staff. These "PPI leads", supported by the PPI manager, take responsibility for locally coordinating and monitoring patient involvement. In practice, the majority of our PPI leads are senior nurses. The Trust also attaches Patient Advisors to each of the CMGs.

Within CMGs there is a range of activity already taking place to involve and include patients and the wider public. Not only are our patient advisors involved in many contexts, we are working with support groups (e.g. in cancer services), visiting schools to explore the patient experience in our children's hospital, running patient experience days (e.g. the Urology and Thoracic surgery teams) and working with carers to understand how we can improve their experience. Across the Trust there is a good deal of PPI activity going on, although this is not always above the radar or even recognised by staff as PPI. Closer monitoring by CMG managers would enable a fuller account to be given by the Trust.

Trust membership

The Trust now has a public membership of 15,252 people across the LLR region. Although its Foundation Trust application was suspended, there is still a significant advantage to having such a large membership. Currently members receive a bi monthly magazine with news from the Trust. There are also regularly approached to attend events and engagement opportunities and form the population from which such roles as Patient Advisor are recruited. Members also attend a monthly "Leicester's Marvellous Medicine" talk, usually delivered by one the Trust's consultants. It is clear that there are many who wish to become more involved with the Trust and there is certainly scope to create more opportunities for this to happen.

Patient Involvement Patient Experience and Equality Assurance Committee (PIPEEAC)

In December 2013 the Trust established a new assurance committee which monitors CMG performance on Patient Involvement, Patient Experience and Equality. The committee was set up to recognise the close links between these three agendas. CMGs are required to report quarterly to the committee across a range of metrics. CMG leads now attend PIPEEAC meetings along with patient representatives.

Members' Engagement Forum

Public involvement is also facilitated through the Trust's new Members' Engagement Forum which meets quarterly and is chaired by the Trust's Chairman, supported by

the DoM&C and attended by a minimum of two directors and two non executive Directors. This forum was formerly known as the Prospective Governors group and was renamed following a discussion with the group on the receding prospect of an FT application by the Trust. The Forum is one of the key means by which the Trust Board may engage with our public members. However, attendance has diminished recently since the focus moved away from governorship.

Healthwatch

Previously the Trust had established good working relationships with its Local Involvement Networks (LINks). Since April 2013 these organisations ceased to exist. They were replaced by Healthwatch Leicester, Healthwatch Leicestershire and Healthwatch Rutland.

Our engagement with Healthwatch is good. Representatives from each of the Healthwatch organisations meet with our Chief Executive and the DoM&C on a quarterly basis to discuss issues that have been raised through their memberships and engagement. A Healthwatch representative also sits on our Trust Board as a participating observer. The PPI and Membership Manager is also in regular contact with Healthwatch representatives and acts as a point of contact for the Trust.

In January 2015 Healthwatch Leicestershire conducted four informal visits to departments at the Leicester Royal Infirmary. Early feedback was good and a report will be issued in due course. Healthwatch have also undertaken two “Enter & View” visits recently (one covering the care of older people and another in response to the CQC comments on the YDU).

The New Strategy

This strategy aims to build upon what is already happening within the Trust and to strengthen PPI in our strategic initiatives and within CMGs. We aim to raise the profile and significance of PPI activity throughout the Trust, increase the opportunities to get involved and emphasise the responsibility of CMGs to involve patients in the shaping and development of their services.

Recommendations in the following areas will help us to achieve these aspirations;

- CMG ownership of the PPI agenda
- Adopting a Listening into Action approach to PPI: Involvement into Action
- Patient Partners
- A single engagement forum for Patient Advisors and Trust members
- Creation of E–Advisors
- Formal requirements to involve patients in business planning
- Patient Involvement in sub committees of the Board
- Community Engagement
- Reward and Recognition
- Trust Board templates
- Promoting PPI
- Better communication with our volunteers

Linking PPI to the Trust’s planning cycle

The diagram below illustrates how we will link PPI to the Trust's annual planning cycle. At the centre is our engagement strategy and intention to create a culture of engagement. Around this, the four stages of our strategic planning cycle flow from a period of analysis and planning, on to pathway design and then procurement and implementation / evaluation.

The outer circle of the diagram illustrates some of the range of patient and public groups and methodologies that are appropriate to each stage. Thus, during our analysis and planning stage we will seek to understand the views, needs and aspirations of our local communities and public representatives. We will work with patients, families and carers to "co-design" service pathways and then consult on our plans and involve patients in the development of business cases. We will also ensure that the patient voice is central to the evaluation of services.

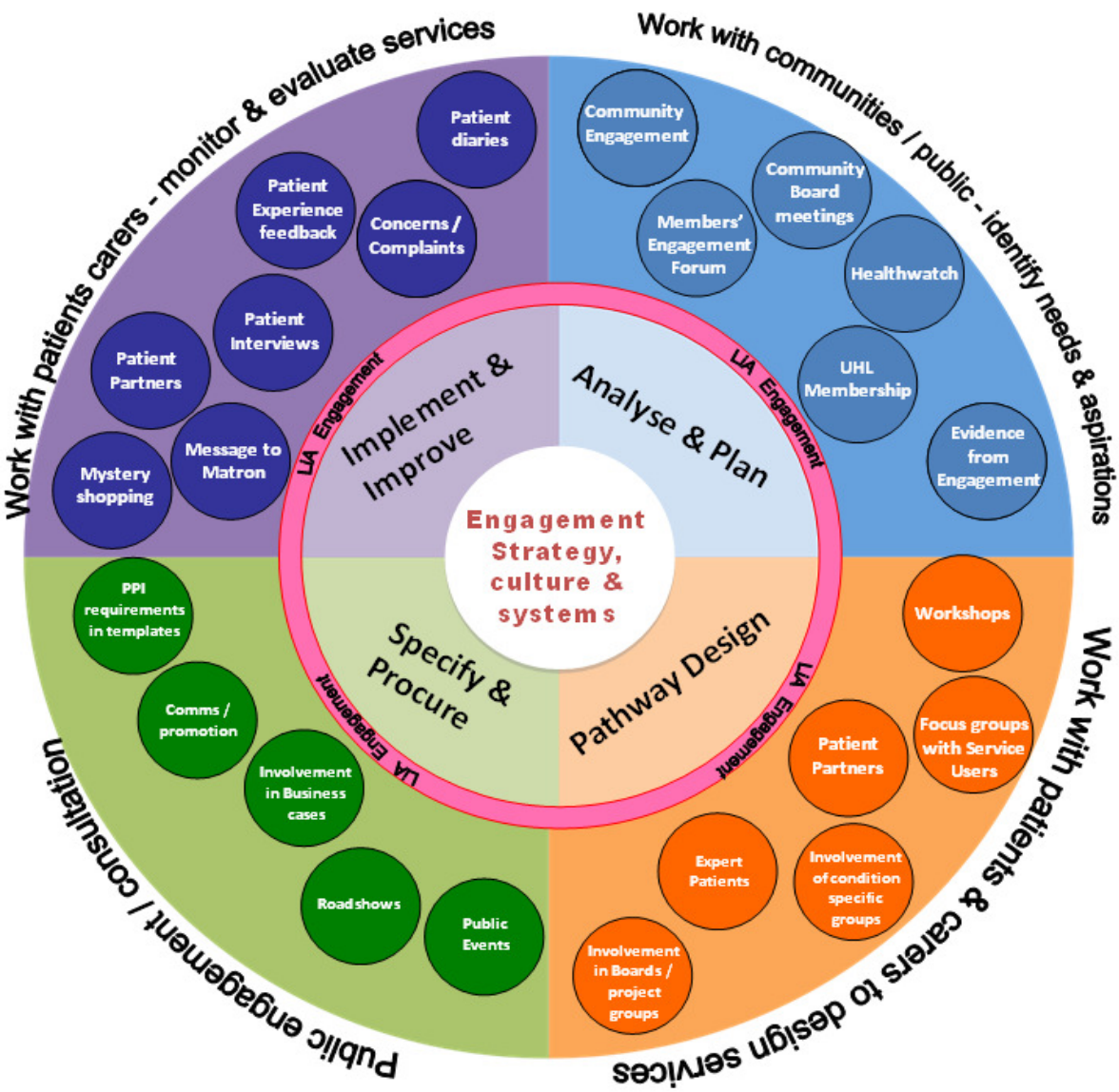


Fig. 4. Diagram illustrating how PPI will inform the annual planning cycle

CMG ownership of the PPI agenda

If we are to generate a step change in patient and public involvement then CMGs must take a central role. Indeed, PPI in the organisation will succeed or fail commensurate with the level of time and commitment given to it by CMGs.

As things stand, the resource for PPI at CMG level is, in most cases, their Head of Nursing. Although all of our Heads of Nursing understand the value of PPI they have many other demands on their time and as a consequence they can struggle to devote sufficient attention to patient involvement or to their Patient Advisors. Similarly, in the crowded CMG Board agendas there is rarely mention or monitoring of PPI activity.

Given our statutory duty and increasing national attention to PPI, CMGs will need to integrate PPI in to their activity as a matter of core business. Moreover, such activity must be adequately resourced. We propose the following measures to support and monitor PPI in CMGs;

- A standing agenda item on PPI at CMG Board meetings
- CMGs to be reviewed on their performance on PPI at the CMG confirm and Challenge meetings.
- Training and support for CMGs to improve their PPI capabilities
- A review of KPIs relating to PPI in the PIPEEAC quarterly reporting template
- PPI leads in each CMG required to nominate delegates to coordinate PPI at service level

The CMG management team are collectively responsible for developing their CMG's approach, identifying priorities and for the production of an annual plan for involving patients and public. The plan will include milestones and measurable targets.

In particular CMGs will:

- Support patients and carers to provide feedback on the services provided.
- Indicate how the patient perspective has been or will be sought in individual business cases or bids for funding including identifying any resources needed to do this.
- Identify which CMG member will be responsible for leading, co-ordinating or facilitating patient and public involvement within the Team.
- Identify one or more people working within the CMG and support and resource them to develop expertise so that they become a local source of guidance and advice on patient and public involvement.
- Document the decisions taken as to whether/how to involve users, the processes undertaken, the views expressed, the service improvements implemented and the evaluation mechanisms used to review the patient experience.

Adopting a Listening into Action approach to PPI: Involvement into Action

Over the last two years the Trust has successfully introduced the Listening into Action (LiA) programme. This has significantly improved staff engagement in innovation and change projects across the organisation. The relatively uncomplicated

and staged methodology of LiA brings clarity to project management and encourages staff to adopt the approach.

Given the profile of LiA and building on its aspiration to become the *modus operandi* of the Trust we will adapt the format to manage elements of patient and public involvement in the Trust. While the LiA methodology will not suit all instances of patient and public involvement it does lend itself to a number of common projects and initiatives. In particular it is well suited to the service development, business planning and evaluation processes.

"Involvement into Action" will set out a step by step methodology by which staff leading on service development and change can ensure that PPI begins early and continues throughout the life of the project. The prescribed process will need to have flexibility to accommodate a range of projects and will be fully worked up with the support of the Trust's LiA team who are keen to support the venture.
In year one we will train and support PPI leads to roll out this process in their CMGs. This will be jointly managed by the PPI and membership Manager and the LiA team. Evaluation of activity will be captured in the PIPEEAC quarterly reporting templates.

Patient Partners

To support CMGs in their day to day activity we will re-brand and expand the numbers of Patient Advisors in the Trust. By Patient Advisors' own admission the title "Patient Advisor" is not always readily understood by Trust staff or patients. We will, therefore, effect a change of name for this group to "Patient Partners". This terminology is inspired by a model use din America, as examined by our Interim Medical Director on a recent visit. The change of name also indicates the Trust's intention to work more closely with patients to co-design and evaluate its services. It will also serve to clarify the nature of the role.

The Patient Partner role outline will be modelled on that of the Patient Advisor's. As such, they will work with CMGs in a variety of contexts to act as a patient / public voice. Patient Partners would constitute a PPI resource for CMGs and get involved in such areas as;

- Service development
- Service evaluation
- Strategic planning
- Patient surveying
- Boards and committees
- Audits (e.g. environmental)
- Focus groups
- Team meetings
- Patient information development

We will increase the numbers of Patient Partners active within the Trust. We currently have 12 Patient Advisors, each of whom is attached to a CMG. In year one we will recruit Patient Partners to bring this number up to twenty. In year two we will conduct a trial, in which two CMGs will begin working with greater numbers of Patient Partners. This will encourage patient involvement across the spread of services within each CMG. Pending evaluation, this model will then be rolled out to the remaining CMGs in year three.

The Patient Partner group will be managed centrally and recruitment will take place through the PPI & Membership Manager, as will induction and training of new and existing Patient Partners. However, they will be coordinated at service / CMG level. This would include administrative support to manage placements and coordinate work plans etc. Coordination would need to be adequate at service level to ensure that Patient Partners are guided and supported in their involvement with the Trust. Indeed, without a clear commitment from each CMG to embrace Patient Partners the model would not be sustainable.

The involvement at service level of significant numbers of Patient Partners would bring the Trust closer to a "Co-production" model of PPI with an ambition that no service in the organisation would be without their involvement.

As an integral part of their duties, Patient Partners will be expected to attend the Patient Partnership Forum (see below).

A single engagement forum for Patient Advisors and Trust members

Both Patient Advisors and the Members' Engagement Forum have recently sought to clarify their relationship to the Trust Board. For the Members' Engagement Forum this is now enshrined in a Terms of Reference. As things stand, the Members' Engagement Forum has a more formal relationship to the Trust Board, despite its relatively recent creation.

There is a sufficient degree of overlap between the Patient Advisor and Members' Engagement group to warrant rationalising the groups to create a single, more focused point of engagement for the Trust (and for members of each group). This will create a more influential PPI forum for the Trust and enhance patient and public links to the Trust Board. Given the proposal to re-brand and increase the numbers of Patient Advisors, the forum may be best known as the "Patient Partnership Forum". Membership of this forum will remain open to encourage new participants to get involved. Its activity will be promoted to our wider membership and through our community engagement and communications channels.

Patient Partners will be asked to submit an agenda item for each meeting. This will allow issues raised by the group to be aired in a wider public arena. The Trust will field relevant members of staff to cover this item.

The Trust Board's current commitment to the forum will remain as it is with the meetings chaired by the Trust Chairman and attendance by a minimum of two directors and two non executive directors.

The existing Patient Advisors Support Group meeting will continue (as the Patient Partners' Support Group) but will focus on training and development for Patient Partners and administrative matters. Engagement on strategic and service issues will take place in the Patient Partnership Forum as noted above.

E–Advisors

In recognition of the fact that many people now prefer to interact online and to provide new avenues by which we may enter in to dialogue with our public members we will establish an "E-Advisor role". E–Advisors will be asked to volunteer to review information and participate in discussions online about a wide variety of our services.

As such, they will respond to surveys, review patient information and comment on service developments and matters of strategic significance.

One of the key advantages of this initiative is that it will make it easier for working people to engage with the Trust: a population we have, for obvious reasons, struggled to engage.

The E–Advisor role will be promoted thorough the Trust's membership and to public members of partner organisations (LPT, EMAS, CCGs etc). E-Advisors will be asked to specify particular areas of interest and will be "flagged" on the Trust's Membership database. As such, we will be in a position to contact E-Advisors as a discrete group and by service interest. E- Advisors will be required to register as a member for the Trust in order to participate.

The growth of E-Advisors will constitute an excellent PPI resource and opportunities to engage in this manner will be promoted to CMGs. In year one we will aim to recruit at least 50 E-Advisors. The scheme will be reviewed after one year.

Our approach to Community Engagement

With reference to the stakeholder mapping diagram (fig. 5 NB Full stakeholder map and comms plan on request), the Trust spends most of its engagement time and effort concentrating on those stakeholders with the highest interest and influence (in the top right of the diagram). As such we have regular contact with MPs, our Patient Advisors, Healthwatch and the Mercury Patients' Panel etc. However, we engage far less with the majority of our service users, their families and communities who are located in the bottom left quadrant of our stakeholder diagram. To remedy this we will take steps to improve the relationships we have with faith and community groups and with geographical and interest communities across the LLR region.

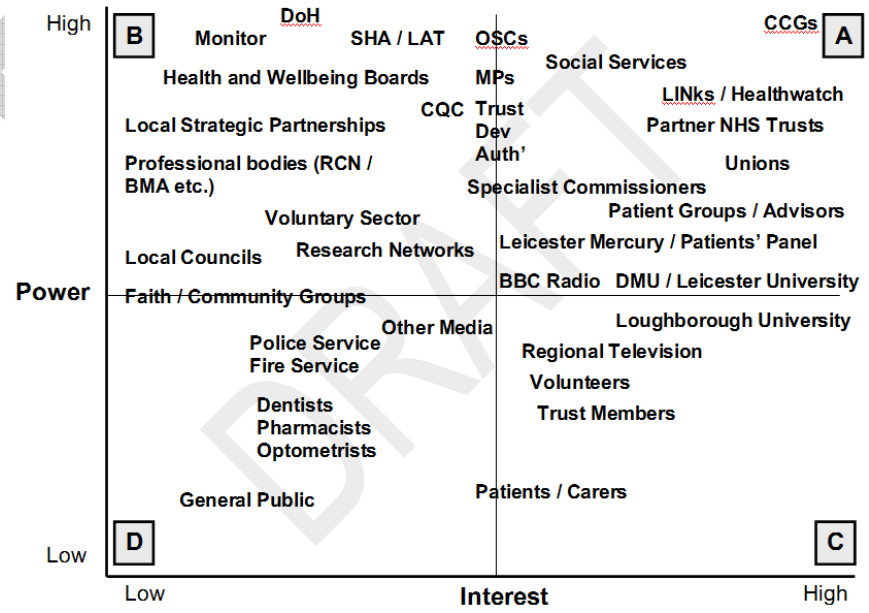


Fig. 5. Matrix analysis of UHL stakeholders

The diversity of our local population is well documented. Within the city of Leicester, people from Black and Minority Ethnic (BME) communities comprise almost 50% of the population and within the county the BME population is higher than the national average. People from all of our local communities are users of our services. As such, it is imperative that PPI activity conducted by the Trust is inclusive. This extends, of course, not only to people from BME backgrounds but also to people with disabilities, faith groups, Lesbian Gay Bisexual and Transgender (LGBT) service users, rural residents, people from disadvantaged communities and other communities that are less often engaged and consulted.

Engaging and involving such a diverse population will require different approaches and may also call for extra resource (e.g. interpreters, accessible formats for information etc.). However, given that we provide acute care for the whole population and that "seldom heard" groups often experience poorer health and social circumstances, it is particularly important that we make the effort to engage and involve them.

While we already have (as noted above) a number of ways in which patients and the public may become involved in the development of our services, some groups and communities will not readily put themselves forward as participants. There are a number of reasons for this including a lack of awareness of such opportunities, skepticism regarding large public sector organizations, barriers to participation (e.g. language and disability access issues), geographical distance and a perception that PPI activity is dominated by the "usual suspects" and is not for them.

A commitment to inclusive PPI must therefore come with a strong commitment to community engagement; both to create dialogue with communities where they live and socialise and to raise awareness of the Trust's PPI opportunities and encourage wider participation (continuing the dialogue).

Community Engagement objectives

- Create a meaningful dialogue between the Trust and local communities
- Encourage and empower communities to become involved in the development of new policies and service changes
- Improve the experience of communities when receiving our services

To ensure our community engagement is effective we will;

- Take time to develop relationships
- Support people to get involved
- Recognise and respond to access needs
- Engage with a purpose
- Pay particular attention to "seldom heard" groups

A phased approach

For community engagement to be meaningful we must avoid "engaging for the sake of engaging". However, it is equally important that we do not take staff with little experience of engagement (and armed with complex plans and strategies) out to

groups who are unused to being consulted and involved in our plans. If we are to embed community engagement in to the work of the organisation a phased approach is needed; particularly when undertaking outreach work with excluded or overlooked groups.

Bearing in mind that community engagement will be an ongoing process with the objective of developing a dialogue between the Trust and the communities that use its services, responsibility will be shared between the PPI & Membership office and CMGs. The PPI & Membership office will undertake to identify and establish contact with local groups and communities, providing initial outreach to build trust, raise awareness of opportunities to get involved and identify key issues. Supported by the PPI & Membership office, CMGs will field staff to engage on both community priorities and on service developments. As a deeper engagement is established CMGs will take greater ownership of the relationship.

Community mapping

The PPI and Membership Manager will ensure that a comprehensive and up to date community database is maintained. This will entail a community mapping exercise in which community influencers and "gatekeepers" are identified. The database will also include voluntary and community sector groups, "grassroots" community groups, health and condition specific groups, religious organisations, community development workers, specialist bodies (the Race Equality Council, disability groups etc) and community social groups.

Good community engagement requires health professionals to have a working knowledge of a particular community's needs, aspirations and wider underlying issues. As such, the PPI and Membership Manager, through engagement with local groups and with the support of the Equality team will develop a series of community profiles which will act as a resource for staff and encourage a degree of empathy with groups they engage with. The development of these profiles will be ongoing and they will be made available on the Trust's Intranet. The profiles will provide basic demographic data as well as information on religion, language and known health issues.

Community Board meetings

We will place a greater emphasis on understanding particular communities and their circumstances, particularly as this relates to health and access to our services. As such, we propose to continue to hold Trust Board meetings in community venues. As with previous community Board meetings, a slot during the meeting will be devoted to dialogue with a particular group or organisation. Holding meetings in community settings also has the advantage of making the public Board sessions more accessible to our local population. We will encourage public attendance by promoting the meeting through our media and communications channels. We will aim to hold three such meetings each year.

Making the most of Trust Board members' connections

A number of Trust Board members will be involved in groups, communities or networks which could provide excellent communications and engagement channels. Be they related to business, philanthropy, culture or simply social we could harness these connections to engage on matters of health and strategic importance. As such we will ask Trust Board and the wider senior management team to consider any

networks they are connected to which might provide opportunities to engage. Moreover we will ask them to explore the extent to which they might act as an ambassador for the Trust, understanding the expectations and concerns of the group. Of course, in many cases this already happens. However, it would be useful for the Trust to be sighted on such activity to help understand the breadth of engagement on key issues and to identify gaps.

We will identify opportunities for Board members to hold "mini surgeries" with community groups. This will be run along the lines of a drop - in listening event which will create opportunities for participants to provide feedback and air concerns about their experience of our services. This would involve, for example, a Director and Non Executive Director spending a couple of hours listening to individuals' experience of our services and gaining a greater appreciation of what it feels like to be a patient from the target community.

Partnership with PPGs: "Surgeries within Mini surgeries"

The majority of General Practices in LLR now have Patient Participation Groups (PPGs). It is a given that members of these groups will also have experience of our hospital services and, by virtue of their membership to the PPG, have a declared interest in health care. We wish to tap in to this network of engaged and interested local people to identify opportunities to engage across LLR localities.

As PPGs are organised locally by practice we will approach these groups to propose engagement events which will be opened out to the local community. As with all community engagement we will seek to strike a balance between topics that respond to the groups interests and concerns and issues on which the Trust is seeking engagement. This would also be an opportunity to facilitate the "mini-surgery" model noted above. PPG groups will be encouraged to jointly host the events with the Trust and to promote them through their membership and networks and wider to the local population. Our Communications team will also support the promotion of these opportunities.

We will work with CCG colleagues and PPG group chairs to develop a programme of activity which will establish opportunities to engage in localities across the LLR region. Working with PPGs will also provide the Trust with the added advantage of collaboration with other patient and public involvement networks.

Health Promotion

Engagement works best if both parties benefit from the exchange. While the Trust clearly benefits form understanding the perspective of community groups and gaining their involvement in our services, there is arguably less perceived benefit for communities participating in this activity. Indeed, community groups are often surprised when NHS organisations turn up at events and meetings but are not offering any health service or benefit.

To maximise the utility of our community engagement we will therefore work with CMGs to release clinical staff to provide health checks, dietary advice, smoking cessation, perinatal health advice and basic life support skills etc. In terms of encouraging communities to take a more proactive approach to health this can only

be of benefit. Such a move also equalises the exchange, encourages people to become more active partners in their health and encourages participation in community engagement events.

Reward and Recognition

In order to raise the profile of PPI within the Trust and to recognise good practice and a commitment to the agenda we will recognise and reward services who have made a significant contribution to patient involvement. We propose to establish a PPI award as part of our Caring at its Best award programme. We will also run a "spotlight" feature on the PPI pages of our Intranet and in our Member and staff magazine.

Trust Board templates

Papers submitted to Trust Board already carry a cover sheet which asks the author(s) to identify the implications for PPI that exist for that particular piece of work. Board submissions are rarely challenged on this aspect and yet much of what goes to Board does have a potentially significant impact on patients and the wider public and should be subject to PPI. To strengthen the monitoring of Board submissions the wording on this section of the cover sheet will be reviewed to incorporate a checklist which will make more transparent whether or not a submission should have been developed with the involvement of patients before coming to Board.

Better communication with our volunteers

The Trust supports approximately 1000 volunteers who are engaged in a wide range of support activity within the Trust. By definition, our volunteers are "active citizens" who come with a unique perspective and close knowledge of our services. As members, volunteers are offered regular invitations to get more involved with the Trust. However, more could be done to harness the views and participation of this group. The PPI and Membership Manager will work with the Trust's Volunteer Services Manager to explore the most effective means of tapping in to the volunteer community.

Resource

A last, but important point raised in this strategy is the resourcing of PPI activity within the Trust and community engagement externally. Over the last two years we have seen a marked improvement in levels of staff engagement (and all the benefits this entails). This is thanks both to the introduction of the Listening into Action programme and the clear support it has from the top of the organisation.

The resource to manage both our public Membership and the PPI agenda is currently one 8a WTE with administrative support (One Band 3 WTE). While the improvements indicated above will rest largely on CMGs they will need supporting with training and support materials as well as for the roll out of the Involvement into Action process. The expansion of a Patient Partner model will also require adequate resource to recruit, induct, develop and manage the group; as will a commitment to increase our community engagement. In some cases, for example, we may be required to hire a venue if we wish to engage with communities or hold Board meetings in particular localities. We will also need to meet the modest cost of refreshments for some events

(not least as a small incentive to participate) alongside funding (in some cases) interpreting and easy access literature formats.

To support the central PPI function, community engagement and to support CMGs in a renewed focus on PPI it is proposed that a Band 5 officer post will be created to work with the PPI and Membership Manager. The key areas of work will be;

- Supporting and developing Patient Partners
- Supporting the implementation of the LiA / Co-design process
- Assisting the Community Engagement programme
- PPI training, promotion and development

Summary & Recommendations:

The revised strategy and accompanying plan seek to take our engagement activity to the next level where it is seen as core business to the Trust, the CMGs and to any individual leading service change and development. In one sense and despite the establishment of KPIs to monitor improvements 'success' will come at the point when we hear people say, Sorry not sure we can discuss this now, we don't have a patient representative with us'.

The Trust Board is invited to discuss the strategy and approve the plan for immediate implementation.

ENDS

Plan

Below is the three year plan to deliver this strategy. Year one aims to establish the key elements of the strategy. These will be reviewed and rolled over in the following years. Developments are indicated in years two and three of the action plan.

	Priority	Actions	Target date	Responsibility
		Year 1: 2015 / 16		
1.	**CMG ownership of PPI**	• Standing agenda item on PPI at CMG Board meetings • PPI performance reviewed at Confirm & Challenge meetings • CMGs to nominate delegates to coordinate PPI at service level • Develop training and support programme for CMGs • Roll out to CMGs • Review of KPIs in quarterly CMG (PIPEEAC) reporting template • Review of PPI section on Trust Board templates • Patient Partner sits on CMG Board	September 2015 September 2015 September 2015 August 2015 September 2015 April 2015 July 2015 September 2015	CMG GMs Trust Board CMG GMs PPI & M Manager PPI & M Manager PPI & M Manager PPI & M Manager CMG GMs
2.	**Developing the "Involvement in to Action" process**	• Engage Listening in to Action team / Patient Partners & develop co – design process and supporting materials • Develop "train the trainer" programme for CMG PPI leads • Roll out training to CMG PPI leads • Recruit first cohort of Involvement in to Action teams	September 2015 September 2015 October 2015 February 2016	PPI & M Manager + LiA team
3.	**Patient Partners**	• Review and develop Patient Partner role outline • Develop branding and promote Patient Partner role internally / externally • Agree recruitment / contract process for Patient Partners • Develop induction And training programme for Patient Partners • Recruit to bring Patient Partner group to 20 members	July 2015 August 2015 / ongoing April 2015 July 2015 December 2015	PPI & M Manager PPI & M Manager HR/PPI & M Manager PPI & M Manager PPI & M Manager
4.	**Establish Patient Partnership Forum**	• Establish and promote quarterly Forum meetings • Patient Partner group to contribute agenda item for each meeting • Review of Patient Partner meetings to focus on development and support / administration	April 2015 / ongoing April 2015 / ongoing June 2015	PPI & M Manager Patient Partners Patient Partners / PPI & M Manager
5.	**Create E- Advisor role**	• Develop role and "rules of engagement" for E-Advisors • Brand and promote the role (internally to CMGs + externally)	October 2015 January 2016 / ongoing	PPI & M Manager

		• Recruit >50 E-Advisors	April 2016	
6.	**Community Engagement**	• Develop / maintain community stakeholder database • Establish programme of "outreach" community engagement • Three Trust Board meetings to be held in community venues • Trial of "Mini surgery" events with community groups (minimum of four) • Establish partnerships with PPGs (minimum four engagement opportunities) • Develop standards / toolkit for Community engagement	March 2015 / ongoing September 2015 / ongoing March 2016 March 2016 March 2016 March 2016	PPI & M Manager PPI & M Manager Trust Board NEDs / Directors PPI & M Manager PPI & M Manager
Year 2: 2016 / 17				
7.	**CMG ownership of PPI**	• Train CMG PPI leads and Patient Partners to deliver PPI support to CMGs • Introduce PPI Annual report with submissions from each CMG • Review of KPIs in quarterly CMG (PIPEEAC) reporting template to increase challenge	June 2016 / ongoing March 2017	PPI & M Manager Director Comms / Marketing PPI & M Manager
8.	**"Involvement in to Action"**	• Evaluate progress of first cohort • Recruit second cohort of teams to adopt "involvement in to Action" • Report on progress included in PPI Annual Report	March 2017	PPI & M Manager + LiA team
9.	**Patient Partners**	• Identify CMG to pilot expanded Patient Partner model • CMG to identify lead officer responsible for Patient Partner coordination • Training and support for pilot areas • Recruit Patient Partners to work with the pilot CMG (numbers will depend upon CMG services) • Monitor and evaluate pilot	April 2016 April 2016 April 2016 / ongoing April – July 2016 March 2017	PPI & M Manager CMG GM PPI & M Manager PPI & M Manager PPI & M Manager CMG GM
10.	**Patient Partnership Forum**	• Promotion and monitoring of Forum effectiveness • Review format and frequency of meetings	Ongoing April 2016	PPI & M Manager
11.	**E-Advisors**	• Review effectiveness of role • Pending successful evaluation, recruit > 100 E – Advisors	June 2016 March 2017	PPI & M Manager
12.	**Community Engagement**	• Evaluation of year one / priority setting for year two • Increase training and support on engagement methods / facilitation skills / using the toolkit • Develop health promotion training package to allow CMGs take a more active role in community engagement	April 2016 Ongoing February 2017	PPI & M Manager PPI & M Manager PPI & M Manager / CMG GMs

		• Promote examples of good community engagement • Community Profiles cover > 20 local community groups • Maintain record of community engagement	Ongoing March 2017 ongoing	PPI & M Manager PPI & M Manager PPI & M Manager
Year 3: 2017 / 18				
13.	**CMG ownership of PPI**	• CMGs with support from Patient Partners foster and support patient / carer led groups	March 2018	CMG GMs
14.	**Patient Partners**	• Pending successful evaluation of CMG pilot, roll out Patient Partner model to two further CMGs • Training and support for new areas • Recruit Patient Partners to work with the two CMGs • Monitor and evaluate	 April 2017 April 2017 / ongoing April – July 2017 March 2018	PPI & M Manager CMG GMs PPI & M Manager PPI & M Manager / CMG GMs
15.	**Community Engagement**	• Minimum of six Health promotion training sessions to community groups delivered by clinical staff • Evidence of Patient Partners recruited through community engagement	March 2018 March 2018	PPI & M Manager / CMG GMs PPI & M Manager

Appendix 1. University Hospitals of Leicester: Development Support Plan (Patient & Public Involvement)

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

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

University Hospitals of Leicester NHS
NHS Trust

Agenda Item: Trust Board Paper I

TRUST BOARD – 5th MARCH 2015

QUALITY AND PERFORMANCE REPORT – JANUARY 2015

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

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

* tick applicable box

CHIEF EXECUTIVE'S ISSUES TO HIGHLIGHT REPORT

Exception reports are automatically triggered when pre-set national or local thresholds are met. The issues that I wish to particularly highlight/comment on for January are as follows:

Clostridium Difficile (page 10)
In January we were back on trajectory for our national targets and we remain on course to deliver the national target. NHS England have recently released 15/16 trajectories for Acute Trusts with the UHL's trajectory confirmed as 61. There remain significant discussions with Interserve on the quality of cleaning. This continues to be managed as part of the contract process.

Never Events (page 11)
The Never Event reported in January was one of the two cases reported in the December Q&P and is not a new Never Event. Follow up of these events will take place at both EQB and QAC, so as to minimise the chances of a recurrence.

Maternal Deaths (page 12)
There was an unexpected indirect maternal death in January reported to the Coroner, but an inquest was not required. A decision was made by the CCG that an RCA investigation was not required as there were no omissions or mismanagement in care that led to the indirect maternal death.

Fractured Neck of Femur (page 17)
It is disappointing that we are not seeing any improvement in this key quality metric with performance below trajectory for the last 6 months. The Listening into Action group is now underway.

RTT Admitted (page 19)
It is encouraging to see that RTT backlog (18+ week waiters) continues to improve and that we are delivering 2 out of the 3 RTT targets. Backlog trajectories for both admitted and non-admitted patients have been signed off with the TDA and commissioners. Risks and mitigation plans are included in the exception report with delivery of admitted performance still expected April 2015.

Diagnostic waits (page 20)
Performance was very disappointing for a second month with a further deterioration in performance to 5%.Areas that contributed to this poor performance include MRI, Endoscopy, and Sleep studies due to insufficient capacity plus Dexa Scans due to a system failure. Action has been taken to resolve these issues and the good news is that the February position is looking much better with performance expected to be below the threshold of 1%.

Cancer (page 21)
It's encouraging to see that the two week wait standard was met in December. We still have work to do on the 31 day target (which is failing due to Urology) but this is now improving. A recovery plan for 62 day target has been submitted to the CCGs with the plan to recover monthly performance in July and cumulative performance by September.

John Adler
Chief Executive

Caring at its best

University Hospitals of Leicester NHS
NHS Trust

Quality and Performance Report

January 2015

One team shared values

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UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **5th MARCH 2015**

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

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

1.0 Introduction

The following report provides an overview of the January 2015 Quality & Performance report highlighting NTDA/UHL key metrics and escalation reports where required.

2.0 Performance Summary

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

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

	KPI Ref	Indicators	Board Director	Lead Director/Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	13/14 Outturn	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	YTD
Safe	S1a	Clostridium Difficile	RO	DJ	FYE = 81	NTDA	Red / ER for Non compliance with cumulative target	66	10	0	4	4	6	5	7	2	5	7	7	11	7	61
	S1b	Clostridium Difficile (Local Target)	RO	DJ	FYE = 50	UHL	Red >5 per month, ER when YTD red	66	10	0	4	4	6	5	7	2	5	7	7	11	7	61
	S2a	MRSA Bacteraemias (All)	RO	DJ	0	NTDA	Red = >0 ER = 2 consecutive mths >0	3	0	0	0	0	0	0	0	0	1	1	0	2	0	4
	S2b	MRSA Bacteraemias (Avoidable)	RO	DJ	0	UHL	Red = >0 ER = 2 consecutive mths >0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	S3	Never Events	RO	MD	0	NTDA	Red = >0 in mth ER = in mth >0	3	0	1	0	0	0	0	0	0	0	1	0	1	1	3
	S4	Serious Incidents	RO	MD	tbc	NTDA	tbc	60	3	4	5	4	6	3	7	2	3	4	2	4	3	38
	S5	Proportion of reported safety incidents that are harmful	RO	MD	tbc	NTDA	tbc	2.8%	2.3%			1.7%			2.2%			1.4%				1.8%
	S6	Overdue CAS alerts	RO	MD	0	NTDA	Red = >0 in mth ER = in mth >0	2	0	0	0	2	2	2	3	0	0	0	0	0	0	9
	S7	RIDDOR - Serious Staff Injuries	RO	MD	FYE = <47	UHL	Red / ER = non compliance with cumulative target	47	7	2	5	3	5	1	2	2	1	2	2	1	0	19
	S8	Safety Thermometer % of harm free care (all)	RO	EM	tbc	NTDA	Red = <92% ER = in mth <92%	93.6%	93.8%	94.8%	93.6%	94.6%	94.7%	94.2%	94.9%	94.4%	93.9%	94.9%	93.3%	94.1%	95.0%	94.4%
	S9	% of all adults who have had VTE risk assessment on adm to hosp	KH	SH	95% or above	NTDA	Red = <95% ER = in mth <95%	95.3%	95.6%	95.0%	95.6%	95.7%	95.9%	95.9%	96.3%	95.5%	96.2%	95.4%	95.5%	95.0%	96.3%	95.8%
	S10	Medication errors causing serious harm	RO	MD	0	NTDA	Red = >0 in mth ER = in mth >0	New NTDA Indicator - Definition to be confirmed														
	S11	All falls reported per 1000 bed stays for patients >65years	RO	EM	<7.1	QC	Red >= YTD >8.4 ER = 2 consecutive reds	7.1	6.6	7.0	6.9	7.0	7.5	7.1	7.3	7.3	5.9	6.4	7.5	6.9	7.1	7.0
	S12	Avoidable Pressure Ulcers - Grade 4	RO	EM	0	QS	Red / ER = Non compliance with monthly target	1	0	0	0	0	0	0	0	0	0	0	0	1	0	1
	S13	Avoidable Pressure Ulcers - Grade 3	RO	EM	<8 a month	QS	Red / ER = Non compliance with monthly target	71	7	3	6	5	5	5	5	6	6	4	6	7	5	54
	S14	Avoidable Pressure Ulcers - Grade 2	RO	EM	<10 a month	QS	Red / ER = Non compliance with monthly target	120	10	8	9	6	6	6	7	9	4	8	13	11	7	77
	S15	Compliance with the SEPSIS6 Care Bundle	RO	MD	All 6 >75% by Q4	QC	Red/ER = Non compliance with Quarterly target	27.0%	27.0%			47.0%			>=60%			Audit underway				47.0%
	S16	Nutrition and Hydration Metrics - Fluid Balance and Nutritional Assessment	RO	MD	Q2 80%, Q3 85%, Q4 90%	QC	Red >2% below threshold ER = 2 mths red					≥71%	≥77%	≥75%	Action Planning	≥74%	≥85%	≥84%	≥88%	≥86%		≥86%
	S17	Maternal Deaths	KH	IS	0	UHL	Red / ER = Non compliance with monthly target	3	1	2	0	0	0	0	0	0	0	0	0	0	1	1

	KPI Ref	Indicators	Board Director	Lead Director/Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	13/14 Outturn	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	YTD
Caring	C1a	Inpatient Friends and Family Test - Score	RO	CR	72 (Eng Avge - Mar 14)	NTDA	Red if <3SD. ER if <3SD or 3 mths deteriorating performance	68.8	71.8	69.0	69.9	69.6	71.0	74.5	73.8	73.8	76.1	71.1	70.3	72.1	70.8	72.2
	C1b	Inpatient Friends and Family Test - Score (Local Target)	RO	CR	75	UHL	Red/ ER =<=69.9 Green >74.9	68.8	71.8	69.0	69.9	69.6	71.0	74.5	73.8	73.8	76.1	71.1	70.3	72.1	70.8	72.2
	C2a	A&E Friends and Family Test - Score	RO	CR	54 (Eng Avge - Mar 14)	NTDA	Red if <3SD. ER if <3SD or 3 mths deteriorating performance	58.5	67.6	58.7	65.5	69.4	66.0	71.4	71.7	56.3	66.1	71.1	72.3	72.8	72.4	68.9
	C2b	A&E Friends and Family Test - Score (Local Target)	RO	CR	75	UHL	Red/ ER =<=64.9 Green >74.9	58.5	67.6	58.7	65.5	69.4	66.0	71.4	71.7	56.3	66.1	71.1	72.3	72.8	72.4	68.9
	C3	Outpatients Friends and Family Test - Score	RO	CR	75	UHL	Red / ER =<=64.9	New Indicator											58.7	69.5	75.9	72.8
	C4	Daycase Friends and Family Test - Score	RO	CR	75	UHL	Red / ER =<=69.9	New Indicator				79.0	80.2	79.7	77.5	74.3	81.7	80.1	80.9	74.9	78.5	78.7
	C5	Maternity Friends and Family Test - Score	RO	CR	75	UHL	Red/ ER =<=61.9	64.3	67.3	62.1	66.7	61.2	63.5	69.5	69.7	67.3	63.0	64.1	67.7	63.8	74.5	66.5
	C6	Complaints Rate per 100 bed days	RO	MD	tbc	NTDA	tbc		0.3	0.5	0.4	0.4	0.3	0.3	0.4	0.4	0.4	0.4	0.4	0.3	0.3	0.4
	C7	Complaints Re-Opened Rate	RO	MD	<9%	UHL	Red = >10% ER = 3 mths Red or any month >15%	New Indicator for 14/15				8%	5%	8%	11%	10%	9%	11%	11%	10%	17%	10%
	C8	Single Sex Accommodation Breaches (patients affected)	RO	CR	0	NTDA	Red = >0 ER = in mth >0	2	0	0	0	4	3	0	0	0	0	0	5	0	1	13
	C9	Improvements in the FFT scores for Older People (65+ year)	RO	CR	75	QC	Red / ER = End of Yr Targets non recoverable.	New Indicators for 14/15				73.7	73.2	75.7	76.1	78.5	83.0	76.4	72.9	76.7	76.6	76.2
	C10	Responsiveness and Involvement Care (Average score)	RO	CR	0.8 improvement	QC	tbc					87.6	87.5	87.5	87.8	88.1	88.4	87.4	87.9	87.8	88.5	88.1
	C10a	Q15. When you used the call button, was the amount of time it took for staff to respond generally:	RO	CR	FYE 89.7	QC	Red = <87.9 ER = Red or 3 mths deterioration					88.9	89.3	88.8	89.0	88.9	90.0	88.4	88.6	89.2	88.7	89.0
	C10b	Q16. If you needed help from staff getting to the bathroom or toilet or using a bedpan, did you get help in an acceptable amount of time?	RO	CR	FYE 92.9	QC	Red = <91.1 ER = Red or 3 mths deterioration					92.1	91.9	91.2	91.7	91.9	92.4	92.2	92.4	92.1	92.7	92.3
	C10c	Q11. Were you involved as much as you wanted in decisions about your care and treatment?	RO	CR	FYE 85.5	QC	Red = <83.6 ER = Red or 3 mths deterioration					84.6	84.3	84.9	84.9	85.6	85.2	84.6	85.1	84.8	86.1	85.3

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Well Led	W1	Inpatient Friends and Family Test - Coverage	RO	CR	30% - Q4. 40% Mar 15	NTDA / CQUIN	Red = Non compliance with monthly target ER = 2 consecutive mths non compliance	24.3%	24.5%	28.2%	28.8%	36.8%	38.1%	32.6%	30.8%	28.9%	33.4%	36.3%	36.0%	31.9%	34.6%	33.8%
	W2	A&E Friends and Family Test - Coverage	RO	CR	15% Q1-Q3 20% for Q4	NTDA	Red = Non compliance with monthly target ER = 2 consecutive mths non compliance	14.9%	15.6%	18.4%	16.1%	15.2%	17.8%	14.9%	10.2%	16.1%	19.1%	15.9%	14.0%	18.7%	25.3%	16.7%
	W3	Outpatients Friends and Family Test - Valid responses	RO	CR	tbc	UHL	tbc	New Indicator available from October 2014			271	175	286	1,879	1,535	785	927	1,255	1,506	1,053	1,259	10,660
	W4	Maternity Friends and Family Test - Coverage	RO	CR	tbc	UHL	tbc	25.2%	20.9%	23.7%	23.9%	27.2%	36.4%	25.2%	29.2%	29.9%	18.7%	15.8%	21.7%	22.1%	25.8%	25.2%
	W5	Friends & Family staff survey: % of staff who would recommend the trust as place to work	ES	ES	tbc	NTDA	tbc	New NTDA Indicator - Definition to be confirmed				53.6%			53.7%			Q3 staff FFT not completed as National Survey carried out				53.7%
	W6	Friends & Family staff survey: % of staff who would recommend the trust as place to receive treatment	ES	ES	tbc	NTDA	tbc	New NTDA Indicator - Definition to be confirmed				68.3%			67.2%			Q3 staff FFT not completed as National Survey carried out				67.2%
	W7	Data quality of trust returns to HSCIC	KS	JR	tbc	NTDA	tbc	New NTDA Indicator - Definition to be confirmed														
	W8	Turnover Rate	ES	ES	<10.5%	UHL	Red = 11% or above ER = Red for 3 Consecutive Mths	10.0%	10.6%	10.4%	10.0%	9.9%	10.0%	10.2%	10.0%	10.5%	10.3%	10.8%	10.7%	10.3%	10.1%	10.1%
	W9	Sickness absence	ES	ES	> 3.0%	UHL	Red = >3.5% ER = 3 consecutive mths >3.5%	3.4%	3.8%	3.7%	3.5%	3.4%	3.3%	3.3%	3.4%	3.4%	3.7%	4.0%	4.0%	4.8%		3.7%
	W10	Total trust vacancy rate	ES	ES	tbc	NTDA	tbc	New NTDA Indicator - Definition to be confirmed														
	W11	Temporary costs and overtime as a % of total paybill	ES	ES	tbc	NTDA	tbc	New Indicator for 14/15				9.4%	9.4%	8.1%	8.5%	8.9%	8.5%	9.5%	9.0%	9.8%	10.5%	9.2%
	W12	% of Staff with Annual Appraisal	ES	ES	95%	UHL	Red = <90% ER = 3 consecutive mths <90%	91.3%	91.9%	92.3%	91.3%	91.8%	91.0%	90.6%	89.6%	88.6%	89.7%	91.8%	92.3%	92.5%	90.9%	90.9%
	W13	Statutory and Mandatory Training	ES	ES	Jun 80%, Sep 85%, Dec 90%, Mar 95%	UHL	Red / ER for Non compliance with Quarterly incremental target	76%	69%	72%	76%	78%	79%	79%	80%	83%	85%	86%	87%	89%	89%	89%
	W14	% Corporate Induction attendance	ES	ES	95.0%	UHL	Red = <90% ER = 3 consecutive mths <90%	94.5%	93%	89%	95%	96%	94%	92%	96%	98%	98%	98%	98%	100%	99%	99%

	KPI Ref	Indicators	Board Director	Lead Director/Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	13/14 Outturn	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	YTD
Effective	E1	Mortality - Published SHMI	KH	PR	Within Expected	NTDA	Higher than Expected		107 (Jul12-Jun13)			106 (Oct12-Sept13)			106 (Jan13-Dec13)			105 (Apr13-Mar14)			105 (Jul13-Jun14)	105 (Jul13-Jun14)
	E2	Mortality - Rolling 12 mths SHMI (as reported in HED)	KH	PR	100 or below	QC	Red = >expected ER = >Expected or 3 consecutive mths increasing SHMI >100	105	107	106	105	104	105	105	104	103	102	Awaiting HED Update				102
	E3	Mortality HSMR (DFI Quarterly)	KH	PR	Within Expected	NTDA	Red = >expected ER = >Expected or 3 consecutive increasing mths >100	88	83			92			87			86	Awaiting HED Update			89
	E4	Mortality - Rolling 12 mths HSMR (Rebased Monthly as reported in HED)	KH	PR	100 or below	QC	Red = >expected ER = >Expected or 3 consecutive increasing mths >100	99	100	100	99	97	98	98	97	96	96	96	Awaiting HED Update			96
	E5	Mortality - Monthly HSMR (Rebased Monthly as reported in HED)	KH	PR	100 or below	QC	Red = >expected ER = >Expected or 3 consecutive increasing mths >100	91	89	103	91	83	110	107	87	99	98	92	Awaiting HED Update			97
	E6	Mortality - Rolling 12 mths HSMR Emergency Weekday Admissions - (HED) OVERALL Rebased Monthly	KH	PR	Within Expected	NTDA	Red = >expected ER = >Expected or 3 consecutive increasing mths >100	100	101	101	100	99	99	100	98	97	97	96	Awaiting HED Update			96
	E7	Mortality - Monthly HSMR Emergency Weekday Admissions - (HED) OVERALL Rebased Monthly	KH	PR	Within Expected	NTDA	Red = >expected ER = >Expected or 3 consecutive increasing mths >100	100	93	102	94	88	100	111	86	91	99	90	Awaiting HED Update			95
	E8	Mortality - rolling 12 mths HSMR Emergency Weekend Admissions - (HED) OVERALL Rebased Monthly	KH	PR	Within Expected	NTDA	Red = >expected ER = >Expected or 3 consecutive increasing mths >100	99	101	102	99	95	98	97	97	97	97	98	Awaiting HED Update			98
	E9	Mortality - Monthly HSMR Emergency Weekend Admissions - (HED) OVERALL Rebased Monthly	KH	PR	Within Expected	NTDA	Red = >expected ER = >Expected or 3 consecutive increasing mths >100	99	84	106	82	69	137	94	94	122	99	106	Awaiting HED Update			103
	E10	Deaths in low risk conditions (Risk Score)	KH	PR	Within Expected	NTDA	Red = >expected ER = >Expected or 3 consecutive increasing mths >100	94	164	35	63	63	80	103	78	62	57	92	Awaiting HED Update			77
	E11	Emergency 30 Day Readmissions (No Exclusions)	KH	PR	Within Expected	NTDA	Higher than Expected	7.9%	8.7%	9.0%	8.8%	8.8%	8.8%	8.6%	8.4%	8.9%	8.4%	8.7%	8.9%	9.1%		8.7%
	E12	No. of # Neck of femurs operated on 0-35 hrs - Based on Admissions	KH	RP	72% or above	QS	Red = <72% ER = 2 consecutive mths <72%	65.2%	68.2%	73.7%	54.7%	56.9%	40.6%	60.3%	76.9%	59.0%	68.6%	69.6%	59.4%	57.3%	57.9%	60.9%
	E13	Stroke - 90% of Stay on a Stroke Unit	RM	CF	80% or above	QS	Red = <80% ER = 2 consecutive mths <80%	83.2%	89.3%	83.7%	83.5%	92.9%	80.3%	87.1%	78.1%	84.5%	83.2%	70.4%	72.1%	75.2%		80.0%
	E14	Stroke - TIA Clinic within 24 Hours (Suspected High Risk TIA)	RM	CF	60% or above	QS	Red = <60% ER = 2 consecutive mths <60%	64.2%	60.5%	40.7%	77.9%	79.7%	58.8%	71.3%	62.8%	65.5%	72.7%	67.8%	69.0%	83.5%	80.6%	71.4%
	E15	Communication - ED, Discharge and Outpatient Letters - Compliance with standards	KH	SJ	90% or above	QS	Red = <80% ER = Qrtly ER if <90% and deterioration	New Indicator for 14/15								60% (InPt)	83% (ED)	Policy out for consultation				83% (ED)
	E16	Published Consultant Level Outcomes	KH	SH	>0 outside expected	QC	Red = >0 Quarterly ER = >0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	E17	Non compliance with 14/15 published NICE guidance	KH	SH	0	QC	Red = in mth >0 ER = 2 consecutive mths Red	New Indicator for 14/15				0	0	0	0	0	0	0	0	0	0	0

Responsive

KPI Ref	Indicators	Board Director	Lead Director/Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	13/14 Outturn	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	YTD
R1	ED 4 Hour Waits UHL + UCC (Sit Rep)	RM	CF	95% or above	NTDA	Red = <95% ER via ED TB report	88.4%	93.6%	83.5%	89.3%	86.9%	83.4%	91.3%	92.5%	90.9%	91.5%	90.1%	88.5%	83.0%	90.2%	88.8%
R2	12 hour trolley waits in A&E	RM	CF	0	NTDA	Red = >0 ER via ED TB report	5	0	0	0	0	1	1	0	0	0	1	0	0	1	4
R3	RTT Waiting Times - Admitted	RM	CC	90% or above	NTDA	Red /ER = <90%	76.7%	81.8%	79.1%	76.7%	78.9%	79.4%	79.0%	80.9%	82.2%	81.6%	84.4%	85.5%	86.9%	85.0%	85.0%
R4	RTT Waiting Times - Non Admitted	RM	CC	95% or above	NTDA	Red /ER = <95%	93.9%	93.4%	93.5%	93.9%	94.3%	94.4%	95.0%	94.9%	95.6%	94.6%	94.9%	95.2%	96.0%	95.4%	95.4%
R5	RTT - Incomplete 92% in 18 Weeks	RM	CC	92% or above	NTDA	Red /ER = <92%	92.1%	92.0%	92.6%	92.1%	93.9%	93.6%	94.0%	93.2%	94.0%	94.3%	94.8%	95.0%	95.1%	95.2%	95.2%
R6	RTT 52 Weeks+ Wait (Incompletes)	RM	CC	0	NTDA	Red /ER = >0	0	1	0	0	0	0	0	15	1	3	3	2	0	0	0
R7	6 Week - Diagnostic Test Waiting Times	RM	SK	1% or below	NTDA	Red /ER = >1%	1.9%	5.3%	1.9%	1.9%	0.8%	0.9%	0.8%	0.7%	1.0%	1.0%	0.7%	1.8%	2.2%	5.0%	5.0%
R8	Two week wait for an urgent GP referral for suspected cancer to date first seen for all suspected cancers	RM	MM	93% or above	NTDA	Red = <93% ER = Red for 2 consecutive mths	94.8%	95.3%	95.9%	95.3%	88.5%	94.7%	93.5%	92.2%	92.0%	90.6%	92.0%	92.5%	93.0%		92.1%
R9	Two Week Wait for Symptomatic Breast Patients (Cancer Not initially Suspected)	RM	MM	93% or above	NTDA	Red = <93% ER = Red for 2 consecutive mths	94.0%	96.8%	93.4%	94.3%	80.0%	95.0%	98.9%	94.9%	94.4%	95.2%	98.6%	100.0%	93.0%		94.7%
R10	31-Day (Diagnosis To Treatment) Wait For First Treatment: All Cancers	RM	MM	96% or above	NTDA	Red = <96% ER = Red for 2 consecutive mths	98.1%	97.2%	98.5%	98.2%	97.2%	92.9%	93.6%	94.4%	97.9%	91.9%	95.9%	92.5%	95.2%		94.6%
R11	31-Day Wait For Second Or Subsequent Treatment: Anti Cancer Drug Treatments	RM	MM	98% or above	NTDA	Red = <98% ER = Red for 2 consecutive mths	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.8%	100.0%	97.1%	100.0%	96.7%		99.2%
R12	31-Day Wait For Second Or Subsequent Treatment: Surgery	RM	MM	94% or above	NTDA	Red = <94% ER = Red for 2 consecutive mths	96.0%	94.8%	96.4%	98.6%	95.2%	97.0%	90.8%	90.1%	87.8%	94.0%	81.9%	82.4%	80.3%		88.7%
R13	31-Day Wait For Second Or Subsequent Treatment: Radiotherapy Treatments	RM	MM	94% or above	NTDA	Red = <94% ER = Red for 2 consecutive mths	98.2%	94.8%	96.3%	99.1%	97.3%	95.6%	93.9%	97.3%	99.0%	96.5%	96.0%	94.7%	95.5%		96.2%
R14	62-Day (Urgent GP Referral To Treatment) Wait For First Treatment: All Cancers	RM	MM	85% or above	NTDA	Red = <85% ER = Red in mth or YTD	86.7%	89.1%	89.1%	92.4%	92.7%	88.5%	73.1%	85.6%	78.8%	75.5%	80.4%	77.0%	84.8%		81.6%
R15	62-Day Wait For First Treatment From Consultant Screening Service Referral: All Cancers	RM	MM	90% or above	NTDA	Red = <90% ER = Red for 2 consecutive mths	95.6%	97.1%	95.1%	91.7%	91.1%	67.4%	73.9%	73.0%	100.0%	87.5%	75.0%	94.4%	93.8%		84.2%
R16	Urgent Operations Cancelled Twice	RM	PW	0	NTDA	Red = >0 ER = >0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
R17	Cancelled patients not offered a date within 28 days of the cancellations UHL	RM	PW	0	NTDA	Red = >2 ER = >0	85	9	2	8	10	3	1	1	1	2	2	1	3	4	28
R18	Cancelled patients not offered a date within 28 days of the cancellations ALLIANCE	RM	PW	0	NTDA	Red = >2 ER = >0	New Indicator for 14/15				0	0	0	0	6	0	0	1	1	2	10
R19	% Operations cancelled for non-clinical reasons on or after the day of admission UHL	RM	PW	0.8% or below	Contract	Red = >0.9% ER = >0.8%	1.6%	1.6%	2.1%	1.5%	1.1%	0.8%	1.1%	0.7%	0.6%	0.8%	0.8%	1.2%	1.1%	0.8%	0.9%
R20	% Operations cancelled for non-clinical reasons on or after the day of admission ALLIANCE	RM	PW	0.8% or below	Contract	Red = >0.9% ER = >0.8%	1.6%	1.6%	2.1%	1.5%	0.6%	0.6%	0.3%	2.7%	0.0%	0.9%	1.0%	0.0%	0.8%	1.4%	0.8%
R21	% Operations cancelled for non-clinical reasons on or after the day of admission UHL + ALLIANCE	RM	PW	0.8% or below	Contract	Red = >0.9% ER = >0.8%	New Indicator for 14/15				1.1%	0.8%	1.0%	0.9%	0.6%	0.8%	0.8%	1.1%	1.1%	0.8%	0.9%
R22	No of Operations cancelled for non-clinical reasons on or after the day of admission UHL + ALLIANCE	RM	PW	N/A	UHL	tbc	1739	152	178	139	106	77	98	94	55	90	94	108	102	74	898
R23	Delayed transfers of care	RM	PW	3.5% or below	NTDA	Red = >3.5% ER = Red for 3 consecutive mths	4.1%	4.6%	4.3%	3.8%	4.4%	4.2%	4.0%	3.9%	3.9%	4.5%	4.6%	5.2%	3.9%	3.2%	4.2%
R24	Choose and Book Slot Unavailability	RM	CC	4% or below	Contract	Red = >4% ER = Red for 3 consecutive mths	13%	10%	16%	19%	22%	25%	26%	25%	26%	25%	20%	17%	16%	12%	21%
R25	Ambulance Handover >60 Mins (CAD)	RM	CF	0	Contract	Red = >0 ER = Red for 3 consecutive mths	868	52	207	111	173	253	88	71	50	106	253	343	460	353	2,150
R26	Ambulance Handover >30 Mins and <60 mins (CAD)	RM	CF	0	Contract	Red = >0 ER = Red for 3 consecutive mths	7,075	573	818	601	720	951	671	591	805	736	1,147	1,364	1,170	1,167	9,322

Research

KPI Ref	Indicators	Board Director	Lead Director/Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	Sep-14	Oct-10	Nov-10	Dec-10	Jan-11	YTD
RS1	Number of participants recruited in a reporting year into NIHR CRN Portfolio studies	KH	DR	England 650,000 East Midlands 50,000	NIHR CRN	Red / ER = <90%	92%	93%	94%	93%	91%	91%
RS2a	A: Proportion of commercial contract studies achieving their recruitment target during their planned recruitment period.	KH	DR	England 80% East Midlands 80%	NIHR CRN	Red / ER = <60%	67%	64%	68%	54%	56%	56%
RS2b	B: Proportion of non-commercial studies achieving their recruitment target during their planned recruitment period	KH	DR	England 80% East Midlands 80%	NIHR CRN	Red / ER = <60%	81.0%	81.0%	73%	77%	77%	77%
RS3a	A: Number of new commercial contract studies entering the NIHR CRN Portfolio	KH	DR	600	NIHR CRN	tbc						
RS3b	B: Number of new commercial contract studies entering the NIHR CRN Portfolio as a percentage of the total commercial MHRA CTA approvals for Phase II-IV studies	KH	DR	75%	NIHR CRN	Red <75%						
RS4	Proportion of eligible studies obtaining all NHS Permissions within 30 calendar days (from receipt of a valid complete application by NIHR CRN)	KH	DR	80%	NIHR CRN	Red <80%	90.0%	89.0%	84.0%	82.0%	83.0%	82.0%
RS5a	A: Proportion of commercial contract studies achieving first participant recruited within 70 calendar days of NHS services receiving a valid research application or First Network Site Initiation Visit	KH	DR	80%	NIHR CRN	Red <80%						
RS5b	B: Proportion of non-commercial studies achieving first participant recruited within 70 calendar days of NHS services receiving a valid research application	KH	DR	80%	NIHR CRN	Red <80%						
RS6a	A: Proportion of NHS Trusts recruiting each year into NIHR CRN Portfolio studies	KH	DR	England 99% East Midlands 99%	NIHR CRN	Red <99%	81.0%	81.0%	81.0%	88.0%	88.0%	88.0%
RS6b	B: Proportion of NHS Trusts recruiting each year into NIHR CRN Portfolio commercial contract studies	KH	DR	England 70% East Midlands 70%	NIHR CRN	Red <70%	56.0%	56.0%	56.0%	56.0%	56.0%	56.0%
RS6c	B: Proportion of General Medical Practices recruiting each year into NIHR CRN Portfolio studies	KH	DR	England 25% East Midlands 25%	NIHR CRN	Red <25%	45.0%	45.0%	51.0%	63.0%	54.0%	54.0%
RS7	Number of participants recruited into Dementias and Neurodegeneration (DeNDRoN) studies on the NIHR CRN Portfolio	KH	DR	England 13500 East Midlands 510	NIHR CRN	Red <510 Q4	325	438	448	532	624	624
RS8	Deliver robust financial management using appropriate tools - % of financial returns completed on time	KH	DR	England 100% East Midlands 100%	NIHR CRN	Red <100%	100% *Q2	100.0%				100% *Q2

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	KPI Ref	Indicators	Board Director	Lead Director/Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	YTD
Estates and Facilities	E&F1	Percentage of statutory inspection and testing completed in the Contract Month measured against the PPM schedule.	AC	GL	100%	Contract KPI	Red = ≤ 98%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	E&F2	Percentage of non-statutory PPM completed in the Contract Month measured against the PPM schedule	AC	GL	100%	Contract KPI	Red = ≤ 80%	91.5%	81.2%	95.6%	80.5%	86.6%	87.1%
	E&F3	Percentage of Estates Urgent requests achieving rectification time	AC	LT	95%	Contract KPI	Red = ≤ 75%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	E&F4	Percentage of scheduled Portering tasks completed in the Contract Month	AC	LT	99%	Contract KPI	Red = ≤ 98%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	E&F5	Number of Emergency Portering requests achieving response time	AC	LT	100%	Contract KPI	Red = >2	0	0	0	0	0	0
	E&F6	Number of Urgent Portering requests achieving response time	AC	LT	95%	Contract KPI	Red = ≤ 95%	95.1%	96.2%	97.3%	97.2%	97.2%	96.6%
	E&F7	Percentage of Cleaning audits in clinical areas achieving NCS audit scores for cleaning above 90%	AC	LT	100%	Contract KPI	Red = ≤ 98%	100.0%	99.1%	100.0%	100.0%	100.0%	99.8%
	E&F8	Percentage of Cleaning Rapid Response requests achieving rectification time	AC	LT	92%	Contract KPI	Red = ≤ 80%	99.6%	89.9%	93.3%	90.5%	91.1%	92.9%
	E&F9	Percentage of meals delivered to wards in time for the designated meal service as per agreed schedules	AC	LT	97%	Contract KPI	Red = ≤ 95%	99.4%	99.5%	100.0%	100.0%	98.9%	99.6%
	E&F10	Overall percentage score for monthly patients satisfaction survey for catering service	AC	LT	85%	Contract KPI	Red = ≤ 75%	96.7%	97.3%	97.3%	96.7%	93.8%	96.4%

S1b – CDIFF local target

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly)	Latest month performance	YTD performance	Forecast performance for next reporting period
The cases of CDT have been the subject of Root Cause Analysis and there are no discernible factors that link these cases to date.	Action plans that have resulted from the RCA should be presented to the CMG Infection Prevention Groups and should follow the RCA process flow chart as described in the Infection Prevention Toolkit In line with the 'updated guidance in the diagnosis and reporting of Clostridium difficile' the cases have been sent to Commissioning Group that has been established to review each case individually. The comments from this group will be received within seven working days. This process commenced in October and sample positive cases that are the subject of RCA will be sent monthly for review. A thematic review of CDT cases will be undertaken with the results presented to the March EQB and CQRG meetings now and not February in line with request from commissioners	4	7	61	N/A

	Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
Traj 14/15	7	8	5	7	6	7	7	7	6	7	7	7	81
Internal Traj 14/15	4	5	4	5	4	4	4	4	4	4	4	4	50
Actual Infections 14/15	4	6	5	7	2	5	7	7	11	7			61

Expected date to meet standard / target	TBA
Revised date to meet standard	TBA
Lead Director / Lead Officer	Elizabeth Collins - Lead Nurse Infection Prevention & Control

S3 Never events

<table>
<tr><th colspan="2"></th><th>Target</th><th>Jan 14</th><th>YTD</th><th>Forecast</th></tr>
<tr><th>What is causing underperformance?</th><th>What actions have been taken to improve performance?</th><td>NIL</td><td>1</td><td>3</td><td>3</td></tr>
<tr>
<td>A patient was listed for surgery at Melton Hospital by a Podiatric Surgeon to straighten the 3rd toe on her right foot.

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

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

The patient was brought into the theatre and the WHO checklist completed whilst the Surgeon was scrubbing up. He was not fully engaged in the check and the Podiatry Assistant was not present in Theatre to participate in the checks. Surgery was undertaken on the 2nd toe.</td>
<td>1. Change in practice: marking extending to digit implemented immediately.
2. Messages regarding WHO checklist reinforced at meeting on 6 January 2015 with teams involved.
3. Podiatry Assistant must be present in theatre when WHO checklist completed.</td>
<td colspan="4">2013/14 Performance by Quarter
<table><tr><th>13/14 Q1</th><th>13/14 Q2</th><th>13/14 Q3</th><th>13/14 Q4</th></tr><tr><td>0</td><td>0</td><td>1</td><td>2</td></tr></table>
Three Never Events will trigger UHL as 'red' on this indicator for 2014/15.

<table><tr><td>Expected date to meet standard</td><td>N/A</td></tr><tr><td>Revised date to meet standard</td><td>-</td></tr><tr><td>Lead Director</td><td>Moira Durbridge, Director of Safety and Risk</td></tr></table></td>
</tr>
</table>

Commentary:

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

2. In relation to UHL performance:

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

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

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

S17 – Maternal Deaths

INDICATOR:

Reason for Breach/Exception Report	Actions that have been taken or are planned to prevent recurrent, where applicable	Target	Latest performance	YTD performance	Forecast performance for next reporting period
A lady was admitted to ED late January via ambulance with sudden onset of right sided weakness, vomiting and increasing blood pressure. A diagnosis of a catastrophic left hypertensive bleed with compression of the ventricles was made. Following discussion with QMC, surgery was ruled out. The lady deteriorated and died on ITU the next day. On admission to ED there was a suspicion that she may be pregnant – a scan later confirmed a pregnancy of approximately 19 weeks. The lady's husband was unaware that she was pregnant.	This unexpected maternal death was reported to the Coroner, but an inquest is not required. The CCG and NHS England were informed. Confirmation was received that the patient had not been seen by her GP in over 6 months. As per CCG guidance this had to be escalated as a maternal death. A decision was made by the CCG that an RCA investigation was not required as there were no omissions or mismanagement in care that led to the indirect maternal death.	**0**	**1**	**1**	**0**

Deliveries and Maternal Deaths per Financial Year

Financial Year	Deliveries	Maternal Deaths
2012/13	10,694	1
2013/14	10,230	3
2014/15 YTD (16/2/15)	9,347	1

Expected date to meet standard / target	N/A
Lead Director / Lead Officer	Ian Scudamore, Clinical Director Elaine Broughton, Head of Midwifery

C7 - Complaints Re-opened

	Target	Jan 15	Forecast
What is causing underperformance? / What actions have been taken to improve performance?	<9%	17%	

157 Formal complaints were received in January 2015 and **26 (17%)** were re-opened. The thresholds for an exception are >10% of complaints re-opened 3 months in a row or any month over 15%.

In January 7 of the complaints which re-opened were first received prior to October 2014. The following table outlines when the remaining were first received.

First Received	No. Re-opened
October '14	3
November '14	7
December '14	8
Jan '15	1

For the same period last year 16% were re-opened which does reflect a seasonal trend with fewer re-opening in December.

5 of the re-opened complaints had been previously re-opened and required either a further response or a local resolution meeting therefore a review of the processes will take place to consider only re-opening complaints once whilst trying to achieve local resolution.

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

	Received	Re-opened	% Reopened
CHUGGS	23	3	13%
RRC	15	2	13%
ESM	42	9	21%
ITAPS	5	1	20%
MSS	32	7	22%
CSI	10	1	10%
W&C	20	1	5%
The Alliance	3	0	0%
Corporate	7	1	14%
Totals:	**157**	**25**	**16%**

1) Greater scrutiny of the complaint and response prior to re-opening to establish if anything further can be contributed. Also if new concerns are raised then a new complaint to be logged instead of re-opening the original concerns

2) Complaints only to be re-opened once whilst trying to achieve local resolution even where 2 responses and a local resolution meeting are required.

3) Those CMGs with a high number of complaints re-opening to review the final responses and consider if these were fit for purpose.

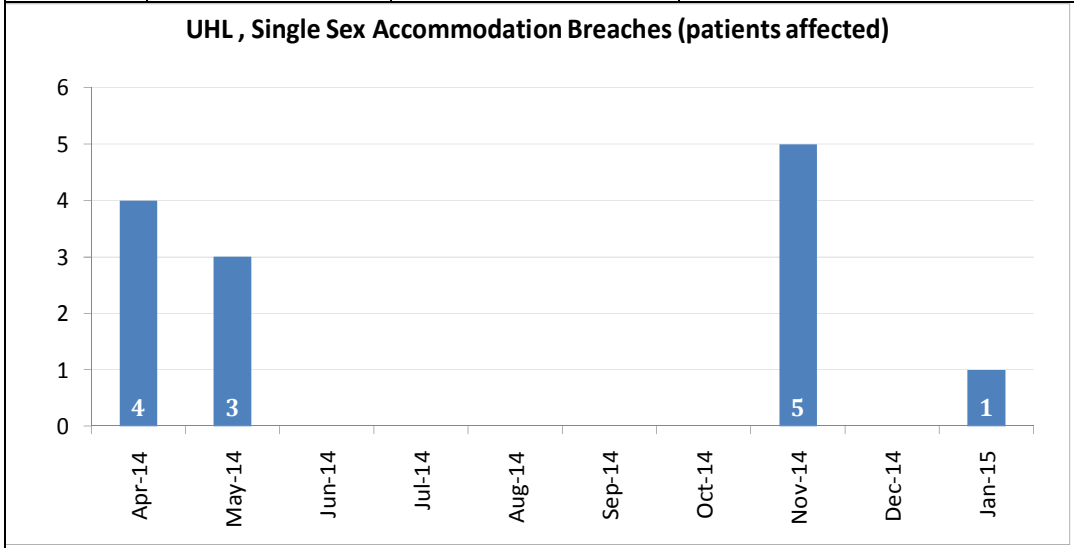
Previous Months performance

	Oct 14	Nov 14	Dec 14	Jan 15
No. of Formal Complaints Received	197	162	147	157
No. of Complaints Re-opened	23	17	14	26
% re-opening	12%	10%	10%	17%

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

C8 - Single sex accommodation breaches

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest month performance	YTD performance	Forecast performance for next reporting period
During January 2015 the Same-Sex policy was not adhered too, effecting one patient on one occasion. This occurred in the HDU bay on ward 26 at the Glenfield Hospital, the causes were: Sudden change in demand for high dependency facilities. Night staff successfully focusing upon the needs of a deteriorating patient and not successfully finding a solution to the resulting same sex accommodation breach. Limited communication regarding bed availability . .	Meetings have been held with Nursing and Duty Management leads, this information has then been cascaded to the clinical staff. A Route Cause Analysis has been completed, addressing learning needs and looking at preventing future breaches.	**0**	**1**	**13**	**0**



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

W9 Sickness absence

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest month	YTD performance	Forecast performance for next reporting period
1. Sickness absence is reported a month in arrears. 2. There has been an increase in sickness absence from July 2014 of 1.39%. 3. Sickness levels for December 2014 are the same as those first reported for December 2013 - 4.7%. 4. Sickness absence reporting highlights an adjustment of around 0.5% due to late closures. It is therefore expected the December 2014 sickness absence rate will be adjusted in the coming months. 5. In the last two years December 2012 to December 2014 we have seen: a. A reduction in staff taking sickness absence (December 2012 – 67.2%, December 2014 – 65.6%) b. An increase in staff taking sickness absence in excess of 28 days (December 2012 – 7.6%, December 2014 – 8.28%) 6. Feedback from Clinical Management Group and Directorates Leads indicates that the increased sickness absence is due to :- a. Increased operational pressures / activity b. Seasonal variations c. Inaccurate data – delays in closing absences d. Management changes / handovers e. Vacancies and other absences reducing management time f. Service pressures delaying sickness absence management	1. Improved data through weekly SMART (Sickness Monitoring and Reporting Team) reports forwarded to lead managers highlighting open absences, closed absences and triggers (3 episodes / more than 10 days / 2 working weeks) 2. Discussion at CMG / Directorate Boards and across services / areas with specific actions confirmed 3. Circulation of breakdown of CMG performance by cost centre covering monthly and cumulative sickness absence. 4. Making it Happen Reviews, to discuss and agree actions for the management and support of open absences, 'triggers' and complex cases with line managers. 5. 6 monthly CMG Sickness Performance Reviews / Case reviews with Occupational Health and Senior and independent HR colleagues. 6. Sickness Absence training continues for line managers, and a new programme has been introduced for those administering the sickness absence paperwork. **Further Actions:** 7. In addition to the corporate sickness absence training, local training is facilitated for CMG's / Directorates in response to specific needs – management of long term absence, documentation etc. 8. Local actions to address high sickness absence include CMG Management Team 'Hot Spot' meetings, Staff Engagement events to reduce sickness absence and improve the management of sickness absence. 9. Improvement plans including timescales are discussed and agreed at CMG / Directorate level to reduce sickness absence and increase performance in the management of sickness absence. 10. Specific staff support and targeted management of stress related absences.	**UHL Stretch target 3% (previous SHA target 3.4%)**	**4.8%**	**3.7% (average)**	**3.50% average (April 2015)**

Trust Performance

Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14
3.4%	3.3%	3.3%	3.4%	3.4%	3.7%	4.0%	4.0%	4.8%

Expected date to meet standard / target	Monthly Target
Revised date to meet standard	April 2015
Lead Director / Lead Officer	Emma Stevens, Acting Director of Human Resources Kalwant Khaira, CMG HR Lead (HR Sickness Absence Lead)

W13 – Statutory and Mandatory Training

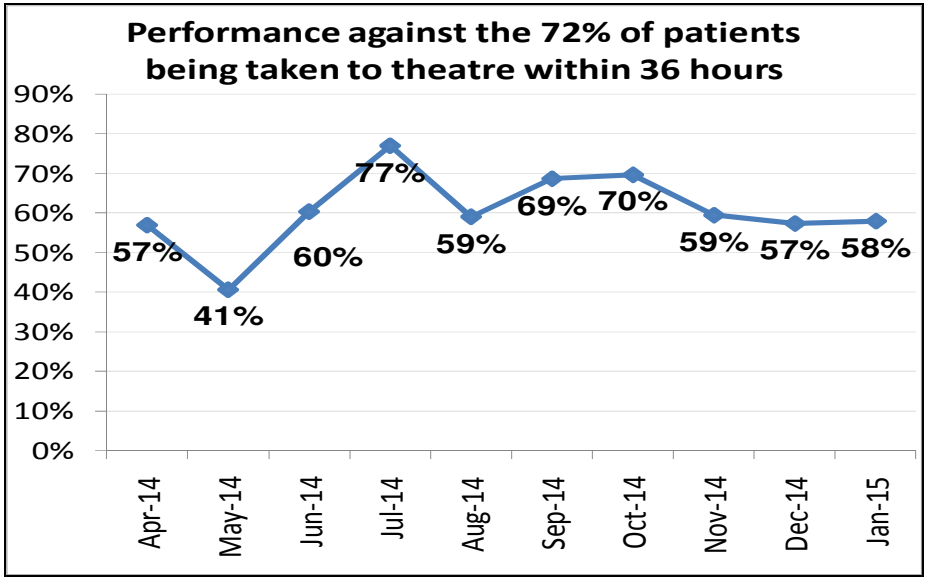
What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest performance	YTD performance	Forecast performance for next reporting period
We note that Statutory and mandatory Training is underperforming for the second month in a row. This minimal underperformance (by approx. 1%) results primarily from a reduction in attendance at face to face training sessions and completion of eLearning during December and January 2015 given service demands and pressures. We recognise that attendance at face to face training relies on staff being covered to attend, particularly in clinical areas and therefore generally completion rates for fire, resuscitation and manual handling training are lower than previous months. The underperformance is also partly due to the expiry of certain eLearning courses that were massively subscribed to in January 2014 due to targeted campaign such as Information Governance. Therefore the number of staff that are out of date for this programme in January 2015 are significant.	1,200 team leaders (as recorded on the eUHL System) with access to the 'Team Builder' function have been contacted directly and requested to focus upon key training including Information Governance Training. The Core Training Team has liaised with the Moving & Handling team to improve engagement and clarity regarding attendance and access to their training sessions. All Subject Matter Experts are being contacted to identify and share across the group successful strategies. A new guide to 'Checking your Required Training' will be distributed to all staff during February to improve compliance levels and increase awareness of the targets and the necessity of training completion. Automated Reminder emails will be generated by the eUHL system before courses expire. This has been in development since September and should be up and running before the end of February 2015.	31st March, 2015 – 95%	6th Feb, 2015 – 89%	89%	95% at end of Quarter 4 / Year End

CMG / Corporate Directorates	Fire Training	Moving & Handling	Infection Prevention	Equality & Diversity	InformationGover'ce	Safeguard Children	Conflict Resolution	Safeguard Adults	Health & Safety	Resus - BLS Equivalent	Average
CHUGS	84%	84%	88%	94%	85%	94%	93%	93%	92%	85%	89%
CSI	90%	92%	92%	96%	89%	95%	95%	92%	95%	82%	92%
ESM	87%	86%	85%	92%	83%	93%	91%	91%	89%	84%	88%
ITAPS	88%	94%	89%	96%	87%	96%	95%	95%	93%	88%	92%
MSS	82%	83%	81%	93%	85%	94%	92%	92%	91%	82%	88%
RCC	82%	86%	87%	94%	87%	92%	91%	90%	91%	84%	88%
W&C	83%	82%	79%	92%	85%	95%	91%	88%	88%	84%	87%
The Alliance	94%	90%	92%	93%	92%	94%	91%	92%	93%	42%	87%
Corporate	82%	88%	82%	95%	86%	96%	92%	92%	89%	79%	88%
Total compliance by subject	85%	87%	86%	94%	86%	94%	92%	91%	91%	83%	89%

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

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

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest month performance	YTD performance	Forecast performance for next reporting period
All of the issues set out in previous reports continue in the service and are exacerbated at times of heightened activity. The acceptance of out of area elective and emergency spinal work is having a detrimental effect on the main trauma capacity as spinal patients are medically prioritised over 'other' trauma which has a knock on effect on #NOF capacity. With this additional demand the current theatre capacity for trauma is insufficient and patients have to wait longer than usual whilst short notice additional operating sessions are arranged. Work continues within the spinal network with regards to spinal capacity across the region and how UHL fits into the future plans.	An action plan from the recent preoperative LiA listening event is being written up. The 4 main work streams are: • ED Admissions • Medical Work Up • Theatre Scheduling • Theatre Productivity Project teams are set up to look at each of the work streams in detail and produce their individual action plans for delivery of improvement within the LiA timescales. The LiA sponsor group continue to meet weekly to push actions forward and assess progress. A meeting took place with the CCG to discuss which aspect of the Trauma service should be included in the quality schedule. It was agreed that time to theatre is the most significant and achievement of this would almost guarantee success in the remaining indicators. Realistically this will not be achieved until all of the LiA work is complete and embedded. The date given for achievement was the end of Q3 2015/16	72%	58%	61%	62%



Performance by Quarter

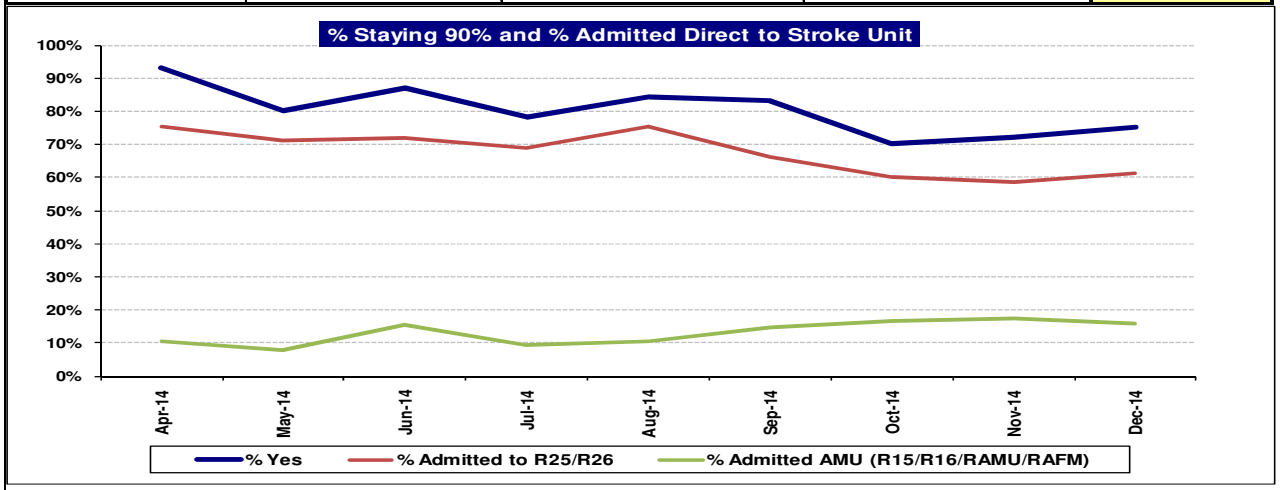
13/14 FYE	14/15 Q1	14/15 Q2	14/15 Q3	14/15 Q4
65%	52%	68%	62%	

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

E13 – Stroke - 90% of Stay on a Stroke Unit

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest performance	YTD performance	Forecast performance for next reporting period
A recent audit performed by Dr Rachel Marsh has highlighted a number of issues (see full report Appendix 1) Main issues: Lack of stroke beds at times of high in flow in terms of both stroke patients and all admissions Insufficient access to therapy services leading to longer lengths of stay Delays in transfers of care Social care delays Diagnostic confusion at first presentation. Referral delays Clarification of reporting rules and exceptions including surgical wards and ITU.	**Actions taken thus far:** Support from executive leads including the CE to ring fence beds. Daily list of patients awaiting rehabilitation beds emailed to bed bureau and bed managers to support better 'out flow'. Monthly audit of notes to confirm presence of stroke where 90% not achieved Recruitment of fixed term occupational therapist to cover maternity leave Improvement in Trust performance has had an effect on Stroke performance in January early cut. **Actions planned:** Introduce daily record of any non-stroke patients on the stroke unit and reason Monthly audit of coding plus reason for patients not achieving 90% stay Develop a business plan with therapy services to increase physiotherapy and occupational therapists Review of LPT contract to increase Speech and Language therapists Escalate delays in transfers of care. Ensure the stroke bed policy is robustly enforced and re-issue the policy via senior management. Review bed usage across the stroke unit to ensure capacity is maximised. Review exclusion criteria regarding 90% stay including ITU and surgical stays.	**80%**	**75.2%**	**80.0%**	**80.0%**

Month	No	Ave Spell LOS (No)	Yes	Ave Spell LOS (Yes)	Total	Overall Ave LOS	% Yes
Apr-14	6	12.3	79	13.3	85	13.2	92.9%
May-14	15	7.7	61	12.2	76	11.3	80.3%
Jun-14	11	7.2	74	13.6	85	12.7	87.1%
Jul-14	21	12.3	75	14.9	96	14.3	78.1%
Aug-14	15	6.9	82	15.2	97	13.9	84.5%
Sep-14	17	12.0	84	15.3	101	14.8	83.2%
Oct-14	32	11.6	76	10.1	108	10.5	70.4%
Nov-14	29	9.9	75	15.7	104	14.0	72.1%
Dec-14	25	17.2	76	15.6	101	16.0	75.2%
2014/15	**171**	**11.1**	**682**	**14.1**	**853**	**13.4**	**80.0%**

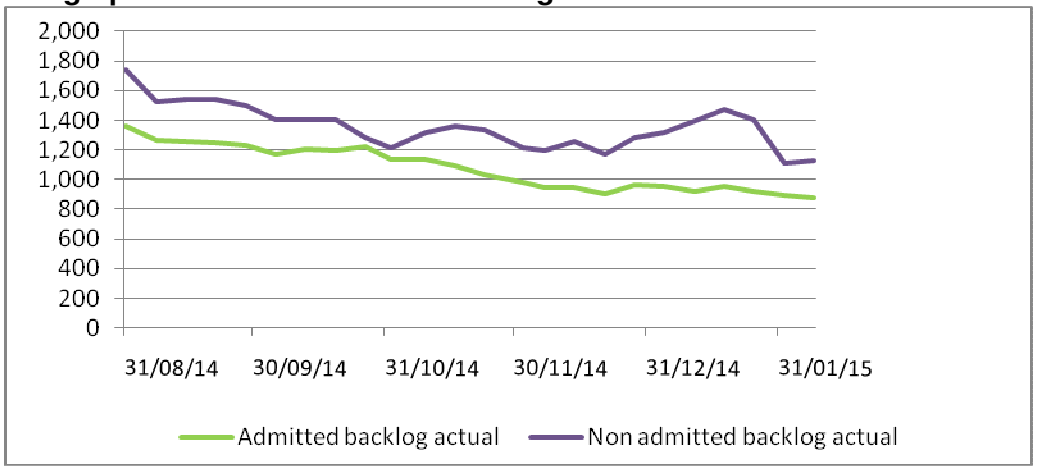


Expected date to meet standard / target	January 2015.
Lead Director / Lead Officer	Dr Ian Lawrence, Clinical Director for ESM / Dr Rachel Marsh, Head of Stroke Services

R3 – RTT Waiting Time - Admitted

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest performance	YTD performance	Forecast performance for next reporting period
The admitted backlog is too high to deliver sustained performance of the admitted target. Reduction in the size of the backlog has been significant but the progress in the next 2 months has to be accelerated in key specialties. **By key speciality:** -Ophthalmology, continues to perform well. • General surgery, backlog continues to reduce as planned. • Urology the backlog has not reduced and is a significant cause of concern. • Max fax backlog has reduced but the paediatric element has been hampered by lack of paediatric elective capacity as have both paediatric surgery and urology • Gynaecology, has seen a steady reduction in the backlog this needs to accelerate in March. • Orthopaedics, backlog has remained static. It is a significant risk due to the unstainable non admitted backlog position	The Trust is achieving 2 of the 3 RTT standards: Non admitted performance is 95.4% against a target of 95%. Incomplete performance 95.2% against a target of 92%. The revised weekly access meeting is working well as is the predictive ability of ensuring delivery. The TDA has requested a reduction in the total backlog of 370 patients. The Trust is on track to deliver this through: • Additional activity at weekends until the end of March • Urology additional in house and independent sector activity has started. • Additional weekend work across the paediatric specialities has also started • Additional work in house but also with the local independent sector. Over 500 patients sent to the IS. There are also 75 patients sent from Orthopaedics • Orthopaedics remains the greatest risk to the Trust RTT performance. Weekend working continues, additional outsourcing to the local Independent sector for elective activity has also started.	90% treated within 18 weeks	85% (UHL and Alliance)	85%	86%

The graph below illustrates the backlog reduction at Trust level



Risks

Orthopaedics and Urology remain the biggest risks to the Trust overall performance. The TDA agreed backlog by the end of Febraury is no more than 814. As at the end of January this stood at 915. Agreement has been reached with both the TDA and commissioners that backlog reduction should continue with the clear aim of admitted achievement during April 2015.

Mitigation

All key speciality plans being reviewed by Director of Performance and Information.
Urology on weekly meetings.
Orthoapedics on daily reproting of key improvement metric.
Re modelling of anticipated performance.
Ongoing additional activity in key specialities.
Additional outsourcing of activity in January to March, supported by TDA additional funding.
Weekly CCG RTT meetings.

Expected date to meet standard / target	April 2015
Lead Director / Lead Officer	W Monaghan, Director of Performance and Information C Carr, Head of Performance

R7 – Diagnostic Waiting Times

<table>
<tr><th>What is causing underperformance?</th><th>What actions have been taken to improve performance?</th><th>Standard</th><th>January 2015</th><th>YTD performance</th><th>Forecast performance for next reporting period</th></tr>
<tr><td rowspan="5">The Trust is measured on the waiting times of the top 15 diagnostic modalities, these are reported at the end of each month. These modalities cross all CMGs

Factors that have caused this under performance are:

Imaging (accounting for 74% of breaches)
- Cardiac CT and MRI, there remains insufficient capacity – this is ongoing issue and these are supervised scans so need consultant radiologist availability.
- MSK MRI , these are consultant specific test
- Utrasound. Agency dependent solution due to national shortage stopped for two weeks within December due to Christmas – This provided a special cause within January.

Dexa (accounting for 18%of breaches)
- During November there was a system failure resulting in the breaching of the standard. No alternative capacity available.

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

Sleep studies (16 breaches)
- Capacity issues with Paediatric provision.

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

Collectively these have caused a breach of the standard a total of 431 patients waiting over 6 weeks.</td><td rowspan="5">Weekly diagnostic PTL meeting established to review future performance cross CMG and develop shared learning of a multi CMG provision.

Control totals established to help focus delivery with additional capacity where there is risk of breaching encouraged, in addition to dating patients in date order

February performance on track for 1% deliver currently, with further validation to follow.

Trajectory is for future months to deliver nearer to 0.8% performance.

Cardiac CT and MRI
Additional sessions being carried out by cardiologists during December to February. Radiographer led scanning to be implemented February (CT) and April (MR).
InHealth mobile unit on-site 13 days February/March

MSK imaging capacity
New MSK radiologist has started, with locum continuing to help manage backlog.

Dexa
Scanner now repaired. Contingency plan between Imaging and Rheumatology implemented.
Recovery plan implemented within January, benefits to be seen within February return. Currently tracking <0.8% delivery for next submission.

Endoscopy
Additional endoscopy work is being carried out by Medinet on UHL site from mid January. Recovery plan implemented within January, benefits to be seen within February return. Currently tracking <0.8% delivery for next submission.

All other modalities
Pro-active PTL management, additional capacity.</td><td><1% over 6 weeks</td><td>UHL and Alliance combined 5.0%</td><td>5.0%</td><td>1%</td></tr>
<tr><td colspan="4">Risks:

There remain risks to achievement of this standard due to the instability of a number of diagnostic modalities which collectively make up this standard although increased visibility and forward planning within nascent PTL meetings will mitigate against this.

Capacity pressures within MR and paediatric sleep studies/endoscopy remain a challenge.</td></tr>
<tr><td colspan="2">Expected date to meet standard / target</td><td colspan="2">November 2014</td></tr>
<tr><td colspan="2">Revised date to meet standard</td><td colspan="2">February 2015</td></tr>
<tr><td colspan="2">Lead Director / Lead Officer</td><td colspan="2">Will Monaghan, Director of Performance and Information
Suzanne Khalid, CSI CMG Director
Matthew Archer, CSI Head of Operations</td></tr>
</table>

R8-15 Cancer Waiting Times Performance

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest month performance December	Performance to date 2014/15	Forecast performance for January
R8 There has been an annualised increase of 18% in 2WW suspected cancer referrals in 2014/15 to date This is likely to continue to grow This has not been matched by increased provision of carved out availability, nor sufficient response to individual cancer type awareness campaigns **R10, 12, 14, 15** The system for the integration of complex cancer pathways remains in place (**R14, R15**) Access to cancer diagnostics remains good. The delivery of timely treatments (**R10, R12**) lies within the gift of services for surgery, and the oncology department for chemotherapy and radiotherapy. Chemotherapy and radiotherapy treatments have remained timely for the most part. The issue is adequate access to surgical capacity. There is no shortage of overall surgical capacity, the poor performance results from the failure to appropriately prioritise cancer pathways in the face of competing priorities.	The Cancer Centre has taken the following actions to further strengthen the support offered to the CMGs in delivering cancer performance; All 2WW referrals processed within 24 hours of receipt since December 2014 Revision to Monday CAB meetings to ensure that patient level management may be expedited whilst reducing the time commitment of the meeting Cancer tracking reaching earlier into pathways to flag delays to services empowered to expedite "next steps" maximising opportunities for host services to deliver treatment dates within breach. These corporate actions are facilitating. Delivery of cancer performance will continue to depend upon CMGs prioritising cancer patient pathways in recognition of their complexity and the tight time lines compared with other elective care standards. The Cancer Centre and Director of Performance will meet with the CMGs to review how best they can be supported in the delivery of these standards. Business Case for the administrative staff required to deliver the enhanced support to services for their cancer pathways taken to Revenue Investment Committee on 13.02.2015	**R8 2WW 93%**	93%	92.1%	92.3%
		R10 31 day 1st 96%	95.2%	94.6%	88.9%
		R12 31 day sub (Surgery) 94%	80.3%	88.7%	86.7%
		R14 62 day RTT 85%	84.8%	81.6%	75.4%
		R15 62 screening 90%	93.8%	84.2%	81.3%

Performance by Quarter

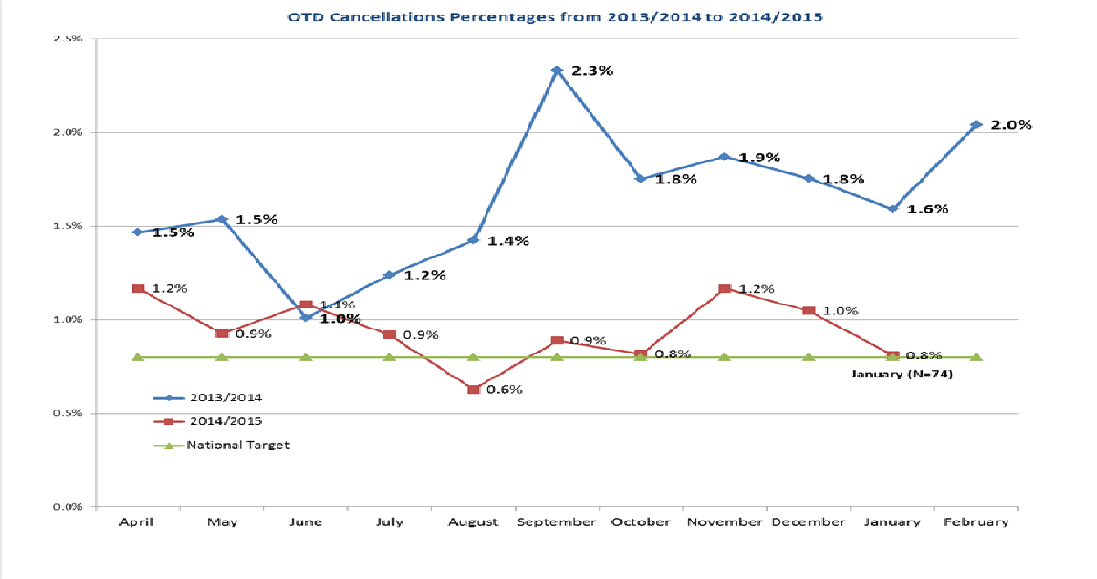
	13/14 FYE	14/15 Q1	14/15 Q2	14/15 Q3	14/15 Q4
R8	94.8%	92.2%	91.6%	92.5%	
R10	98.1%	94.6%	94.6%	94.6%	
R12	96.0%	94.2%	90.5%	81.5%	
R14	86.7%	84.1%	79.9%	80.8%	
R15	95.6%	78%	85%	89.2%	

Expected date to meet standard / target	R8 – Recovered December R10,12 – Recovery expected M12 2014/15 R14,15 – Recovery expected M6 2015/16
Revised date to meet standard	Subject to modelling – details in next report
Lead Director / Lead Officer	Will Monaghan, Director of Performance and Information Matt Metcalfe, Consultant Hepatobiliary and Pancreatic Surgeon

R16-R22 - cancelled operations

INDICATOR: The cancelled operations target comprises of three components:
1. The % of cancelled operations for non-clinical reasons On The Day(OTD) of admission
2.The number of patients cancelled who are offered another date within 28 days of the cancellation
3. The number of urgent operations cancelled for a second time.

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly) 1)On day=0.8% 2) 28 day = 0 3)urgent second time=0	Latest month performance – Jan 15	YTD performance (inc Alliance)	Forecast performance for next reporting period
This month UHL is compliant with the 0.8% target. This target has not been achieved in winter since 2010. Last year January UHL had 151 cancellations (1.6%). There were 78 fewer cancellations this January. The OTD cancellation reasons remain similar to last month. 21 out of 74 were patients cancelled due to HDU/ITU bed unavailability. Emergency admissions to the LRI critical care unit increased significantly this year compared to the last three years adding pressures to OTD cancellations and 28 days breaches in January. There were four, 28 day breaches due to ITU/HDU pressures or complex procedures requiring specific medical input.	A number of work streams have started aimed at reducing OTD cancellations including a LIA project. A successful LIA event was completed with participation of 48 staff in all three sites. Lots of useful feedback and a number of new ideas were provided by the staff to reduce cancellations. The LIA team are working to implement the changes suggested. <u>Risks to delivery of recovery plan</u> HDU and ITU bed availability due emergency pressures are still a high significant risk to OTD cancellations and 28 day breaches. The situation has been monitored on a daily basis to try to prevent OTD cancellations. Plans are in discussion to improve the patient booking processes and maintain a realistic number of bookings who will require critical care post operatively.	1) 0.8% 2) 0 3) 0	1) 0.8 % 2) 6 3) 0	1) 0.9% 2) 39 3) 0	1) 0.9% 2) 3 3) 0



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

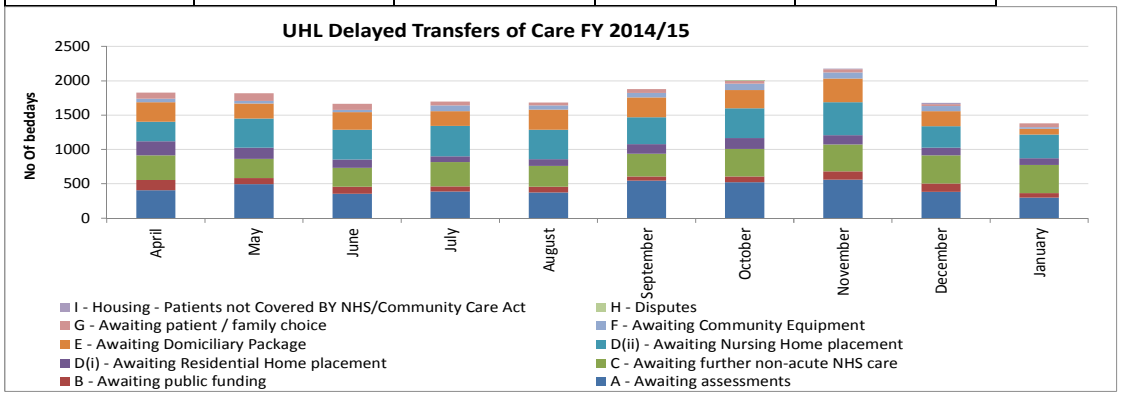
R23 Delayed Transfers of Care

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest month performance	YTD performance	Forecast performance for next reporting period
There has been an decrease in delays due to DTOC in December and January. There remains concern about the availability of packages of care in the County Local Authority. Interim placements in care homes are offered to patients but are not always accepted. There continue to be a number of DTOCs due to slow discharges to care homes. A large number of patients remain delayed whilst waiting for community hospital beds. There are robust mechanisms for transferring patients as soon as possible, but mixed sex and location issues remain issues that delay discharge	The ICRS and ICS teams continue to attend wards to identify patients that they could take directly in to their home based services. This has been particularly successful with the City services and lessons learnt are being discusses with county colleagues There is on-going emphasis regarding therapists reducing the required package of care to try to ensure faster discharge which appear to have had some success. Local Authority staff have been asked to ensure that patients are not offered choice about accepting an interim placement, which appears to have had some success in discharging patients. Ward Two at the LGH has been closed. Good working around discharging directly from wards rather than transferring patients to Ward 2 who were know DTOCS has been instrumental in closing this facility.	3.5%	3.2%	4.2%	4.5%

Row Labels	A - Awaiting assessments	B - Awaiting public funding	C - Awaiting further non-acute NHS care	D(i) - Awaiting Residential Home placement	D(ii) - Awaiting Nursing Home placement	E - Awaiting Domiciliary Package	F - Awaiting Community Equipment	G - Awaiting patient / family choice	H - Disputes	I - Housing - Patients not Covered BY NHS/Community Care Act	Grand Total
April	407	148	356	207	285	285	55	87			1830
May	494	90	277	166	425	218	34	113			1817
June	353	103	277	122	433	253	36	89			1666
July	387	77	353	82	444	215	85	54			1697
August	371	87	302	98	430	294	61	41			1684
September	546	57	333	141	394	286	65	57			1879
October	520	84	402	159	434	266	95	40	4	3	2007
November	561	119	392	134	484	343	88	46		9	2176
December	384	120	408	113	312	222	74	26		21	1680
January	298	65	410	98	345	87	22	53			1378

Performance by Quarter

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



Expected date to meet standard / target	TBA
Revised date to meet standard	TBA
Lead Director / Lead Officer	Richard Mitchell, Chief Operating Officer, Phil Walmsley, ITAPS Head of Operations

R24 Choose and Book

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

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

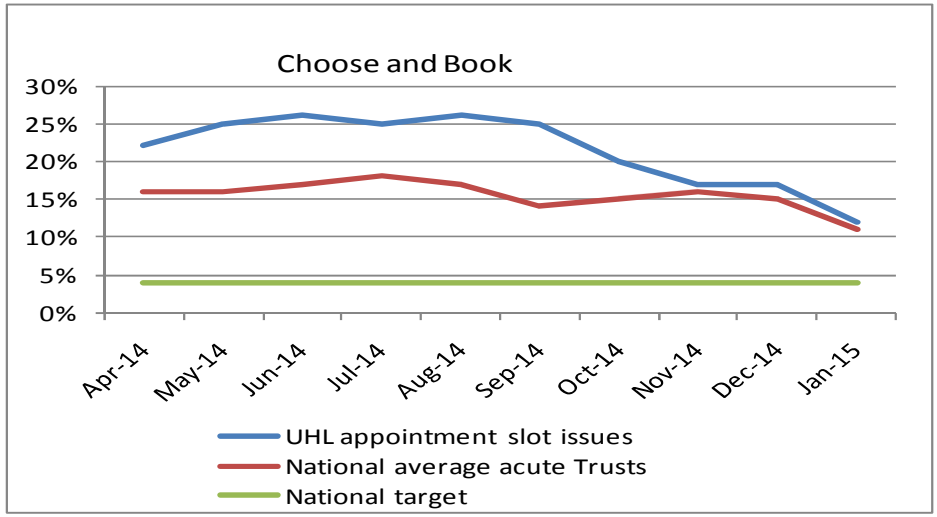
The two most significant factors causing underperformance are:

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

The issues are notably: General Surgery and orthopaedics and Urology.</td><td rowspan="4">Capacity

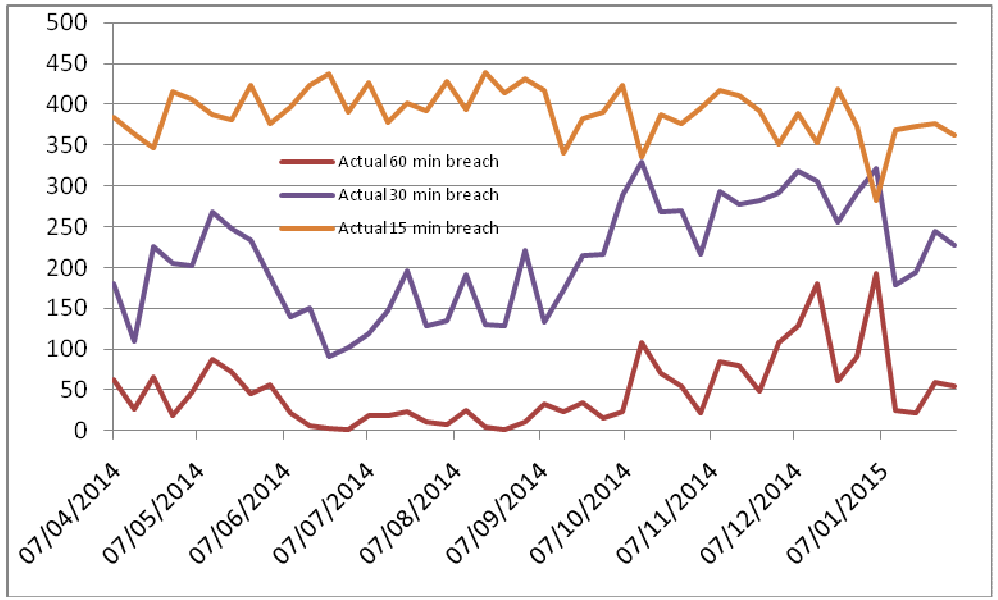
Additional capacity in key specialties is part of the RTT recovery plans.

Training and education

The comprehensive training and education of relevant staff in key specialties continues, to ensure that choose and book is correctly set up and that supporting administrative purposes are fit for purpose.
A speciality level ‘score card’ to highlight areas required for improvement is being distributed weekly to CMGs. This highlights areas for concern and actions required.</td><td><4%</td><td>12%</td><td>21%</td><td>15%</td></tr>
<tr><td colspan="4"> 
</td></tr>
<tr><td>Expected date to meet standard / target</td><td colspan="3">January 2015</td></tr>
<tr><td>Revised date to meet standard</td><td colspan="3">March 2015</td></tr>
<tr><td>Lead Director / Lead Officer</td><td colspan="3">Will Monaghan, Director of Performance and Information
Charlie Carr, Head of Performance</td></tr>
</table>

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

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest month performance	YTD performance	Forecast performance for next reporting period
Difficulties in accessing medical beds continue to lead to a backlog in the assessment area of ED. This delays movement out of the assessment area and delays handover. January's performance improved due to consistently having beds in AMU so improving flow out of the ED. It should be noted that the overall attendances in January via ambulance have gone down by 27 compared to December	A further meeting took place with EMAS in January. There are a series of actions that are being progressed to manage delays in handover. Key ones include visibility of patients on 'the stack' for ED to highlight a likely problem. This allows ED to try an pre-empt delays in handover. To review clinical in put in to 111 calls to try to avoid unnecessary attendances Clarification on communication process for when there is build-up of delays in ED	0 delays over 30 minutes	> 60 min 6% 30-60 min – 24% 15-30 min – 33%	> 60 min 3% 30-60 min – 17% 15-30 min – 36%	



Expected date to meet standard / target	
Revised date to meet standard	
Lead Director / Lead Officer	Richard Mitchell, Chief Operating Officer, Phil Walmsley, ITAPS Head of Operations

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

<table>
<tr><th>What is causing underperformance?</th><th>What actions have been taken to improve performance?</th><th>Target (mthly / end of year)</th><th>Latest month performance</th><th>YTD performance</th><th>Forecast performance for next reporting period</th></tr>
<tr><td rowspan="5">East Midlands is currently 6th of the 15 LCRNs for this metric with no LCRN currently achieving the 80% target, highest is currently 65%

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

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

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

3. Meetings with key research teams to discuss the importance of target setting and aligning the approach across the region so the target is reflective of the contract figure.

4. 6 to 8 weekly performance meetings with delivery managers have been introduced to address this issue from the start of December.

5. Collation of local information to report on the actual figure to take account for the lag in National reporting.</td><td>80%</td><td>56%</td><td>56%</td><td>56%</td></tr>
<tr><td colspan="4" rowspan="4"></td></tr>
<tr><td>Expected date to meet standard / target</td><td colspan="2">April 2015</td></tr>
<tr><td>Revised date to meet standard</td><td colspan="2">May 2015</td></tr>
<tr><td>Lead Director / Lead Officer</td><td colspan="2">Daniel Kumar, Industry Delivery Manager, CRN: East Midlands</td></tr>
</table>

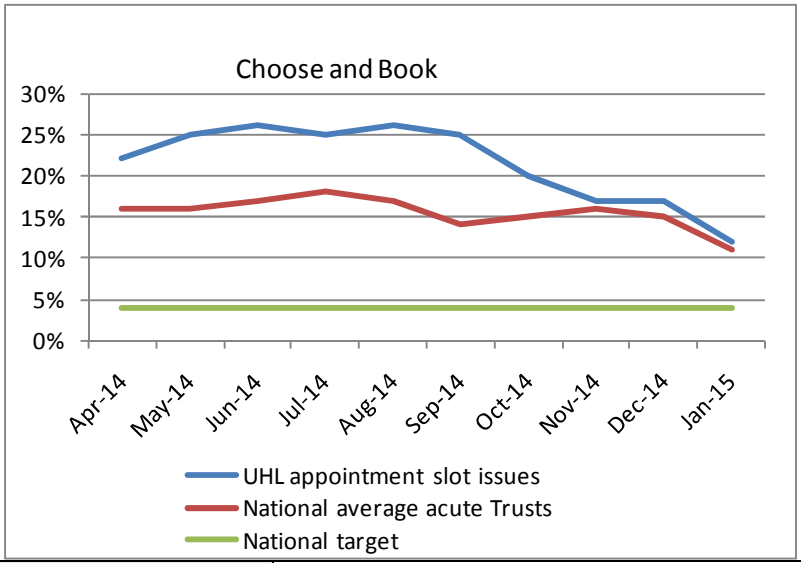
RS6A : Proportion of NHS Trusts recruiting each year into non-commercial NIHR CRN Portfolio studies

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

Expected date to meet standard / target	It is unlikely we will make the 99% target due to the nature of the services provided by LCHS. We may reach 94% by April 2015.
Revised date to meet standard	
Lead Director / Lead Officer	Elizabeth Moss, Chief Operating Officer CRN: East Midlands

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

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest month performance	YTD performance	Forecast performance for next reporting period
There are 16 Trusts within the East Midlands region, with 9 Trusts currently recruiting to commercial studies. The seven who have not reported any recruitment are: • East Midlands Ambulance Service NHS Trust (EMAS) • Derbyshire Community Health Services NHS Foundation Trust (DCHS) • Lincolnshire Community Health Services (LCHS) • Leicestershire Partnership NHS Trust (LePT) • Lincolnshire Partnership NHS Trust (LiPT) • Nottinghamshire Healthcare NHS Foundation Trust (NHFT) • Derbyshire Healthcare NHS Foundation Trust (DHFT)	1. **EMAS**: Currently no open commercial studies nationally run by ambulance services on the NIHR portfolio, therefore unlikely that EMAS will open a commercial study this financial year. Industry team currently reviewing studies previously run at other ambulance services across the country to gain insight. Meeting with Trust and RDM for Division 6 to discuss this month 2. **DCHS**: due to the nature of research within this Trust, they are unlikely to be involved in commercial research, Have met with Trust and a preliminary plan is in place to take this forward. 3. **LCHS**: due to the nature of research within this Trust, they are unlikely to be involved in commercial research. Met on the 18th December and a preliminary plan is in place to take this forward. 4. **LePT**: Selected for one study, due to open by the end of 2014. One study also being taken forward with sponsor and awaiting confirmation if selected 5. **LiPT**: have been involved in commercial research in the past and the site is actively seeking commercial opportunities 6. **NHFT**: One trial initiated at the end of November 2014, 2nd UK site to open 7. **DHFT**: One trial recently opened to recruitment closed early prior to recruitment. 2 studies in the pipeline.	**70%**	**56% (red)**	**56% (red)**	**56%**



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

2014/15 NTDA METRICS AND WEIGHTINGS

Responsiveness Domain

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

Effectiveness Domain

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

Safe Domain

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

Caring Domain

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

Well Led Domain

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

CQC – Intelligent Monitoring Report

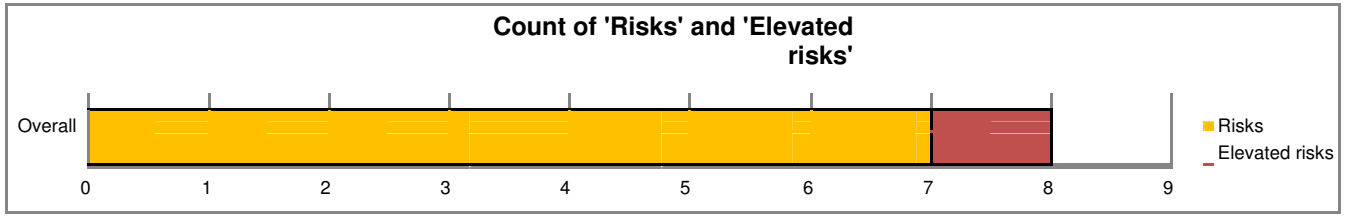
The latest CQC Intelligent Monitoring Report (IMR) was published on the CQC website on the 3rd December 2014.

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

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

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

The next publication date is May 2015.



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

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

Quality Schedule and CQUIN Schemes

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

Ref	Indicator Title	Q1 RAG	Q2 RAG	Q3 RAG	Q4 Predicted RAG	Commentary
	QUALITY SCHEDULE					
PS01	Infection Prevention and Control Reduction. - C Diff	G	A	tbc	G	Q2 Amber RAG remains as Multi Drug Resistant data not submitted. Monthly reporting of C Diff. Threshold for 14/15 is 81. UHL is aiming to achieve a reduction on last year's total of 66 and has given itself a Target of 50 . 61 cases as at end of January which is below the NTDA trajectory but above UHL's own threshold. Q3 RAG to be confirmed at the March CQRG
PS02	HCAI Monitoring - MRSA	0	1	2	G	1 in October and 2 in December. All reviews to date confirm these were unavoidable. None reported in January.
PS03	Patient Safety – SIs, Never Events	G	G	2 tbc	1 G	Q3 & Q4 Red RAG for Never Events. (relating to 'wrong sized hip prosthesis, retained Swab ties and wrong site surgery Q3 Patient Safety Report due to be presented to the March CQRG. Number of incidents reported continues to rise. But there has been a reduction in number that resulted harm.
PS04	Duty of Candour	0	0	0	0	No breaches to date.
PS05	Complaints and user feedback Management (excluding patient surveys).	A	A	G	G	Complaints responses performance improved and achieved for December. Q3 RAG to be confirmed at the March CQRG.
PS06	Risk Assurance and CAS Alerts	A	A	G	G	Amber RAG for Q2 relates to overdue CAS alerts for July. All risk reviews back on track for Q3. No overdue CAS alerts and all risk reviews and actions on Track
PS07	Safeguarding – Adults and Children	G	G	G	G	Assurance documentation due to be sent to CCG Safeguarding leads for their review ahead of their observational visit to the Trust.
PS08	Reduction in Pressure Ulcer incidence.	G	G	R	G	Monthly thresholds met for G3 HAPUs. Above the monthly trajectory for Grade 2 HAPUs in both Nov (13) and Dec (11) and Grade 4. Within trajectory for both G2 and G3 for Jan and No Grade 4.
PS09	Medicines Management Optimisation	A	G	A	G	Commissioners noted improvement in Controlled Drugs audit report and also Medicines Code but thresholds not fully achieved. Progress made with developing LLR Medicines Optimisation Strategy.
PS10	Medication Errors	G	G	G	G	Increased reporting of errors and actions being taken.
PS11	Venous Thromboembolism (VTE) and RCAs of Hospital Acquired Thrombosis	95.7%	96.1%	G	G	Preliminary data suggested Dec performance below 95% for VTE risk assessment but case note review confirmed actual performance above 95% and Q3 performance overall = 95.6%. RCAs in progress for Q3 Hospital Acquired Thrombosis. RAG

Ref	Indicator Title	Q1 RAG	Q2 RAG	Q3 RAG	Q4 Predicted RAG	Commentary
PS12	Nutrition and Hydration	G	>80%	>85%	tbc	Work programme on track for nutrition, some delays with hydration actions. Threshold achieved for all measures across all CMGs with exception of ESM for 'Protected Mealtimes'.
PE1	Same Sex Accommodation Compliance and Annual Estates Monitoring	2	0	2	0	2 breaches in Q3. No breaches to date for Q4
PE2	Patient Experience, Equality and Listening to and Learning from Feedback.	G	G	tbc	G	Good progress made with triangulation of data. Waiting time main area for improvement. RAG tbc at March CQRG
PE3	Improving Patient Experience of Hospital Care (NPS)	N/A	N/A	N/A	tbc	Not due to be reported until March 15. RAG dependent upon results in the National Patient Survey.
PE4	Equality and Human Rights	G	G	G	G	Progress reported to the September CQRG with further information provided in October – relating to actions being taken to capture BME data
CE01	Communication – Content (ED, Discharge & Outpatient Letters)	A	A	tbc	G	Clinical Problem Solving Group held to agree key priorities. Letters policy finalised launched end of Jan 15. RAG tbc at March CQRG
CE02	Intra-operative Fluid Management	G	>80%	<80%	G	Performance deteriorated during Oct/Nov. 80% achieved for December. Remedial actions in place to maintain.
CE03	Clinical Effectiveness Assurance – NICE and Clinical Audit	A	A	G	G	Responses for NICE Clinical Guideline / Quality Standards documents on track and actions being taken where audits behind schedule
CE04	Women's Service Dashboard	A	A	tbc	tbc	Amber RAG for Q2 relates to increase in C Section Rate. Q3 RAG to be confirmed at the March CQRG
CE05	Children's Service Dashboard	A	A	tbc	tbc	Q2 Amber RAG relates to SpR training Q3 RAG to be confirmed at the March CQRG
CE06	Patient Reported and Clinical Outcomes (PROMs and Everyone Counts)	A	A	tbc	G	Groin Hernia PROMs improved, although still below the national average. Consultant Outcomes published and all consultants in line with national average. Q3 RAG to be confirmed at the March CQRG.
CE07	#NOF - Dashboard	51%	67.9%	62.1%	57.9	72% threshold not met for any month in Q3. Mainly relates to peaks in activity and spinal patients. Performance deteriorated for Jan. L*i*A programme in place and business case submitted to support increased theatre capacity.
CE08a	Stroke monitoring	G	G	A G	G	Red for '90% stay on Stroke Unit not achieved for Oct or for November TIA Clinic thresholds exceeded and improvements made for other Stroke indicators (time to Scan, admission to stroke unit, thrombolysis). SSNAP data for Q3 to be confirmed.
CE08 b	TIA monitoring	76%	67%	73.4%	80.6%	Threshold achieve for each month for high risk patients and performance improved for low risk patients being seen within 7 days.

Ref	Indicator Title	Q1 RAG	Q2 RAG	Q3 RAG	Q4 Predicted RAG	Commentary
CE09	Mortality (SHMI, HSMR)	A	A	A	A	Latest published SHMI = 105 (104.7) and is slowly reducing but is still above 100.
CE10	Making Every Contact Count (MECC)	A	G	tbc	G	Referrals to STOP and ALW continue. 'Healthy Eating and Physical Activity publicity campaign due to commence in General Surgery and Sleep Clinics. Q3 RAG to be confirmed at March CQRG.
AS01	Cost Improvement Programme (CIP) Assurance	A	G	tbc	G	Q3 RAG revised upon review of additional assurance.
AS02	Ward Healthcheck (Nursing Establishment, Clinical Measures Scorecard)	G	G	G	G	Recruitment of additional nurses continues. Not all wards meeting 'Nurse to bed Ratio' but actions in place. Support being provided to those wards not meeting thresholds in the Clinical Measures Scorecard.
AS03	Staffing governance	A	A	A	A	Internal thresholds not met for Appraisal, Sickness and Corporate Induction or Turnover although improvement noticed. Medical Staffing Strategy submitted.
AS04	Involving employees in improving standards of care. (Whistleblowing)	G	G	G	G	Actions taken to address concerns raised.
AS05	Staff Satisfaction	G	G	G	G	
AS06	External Visits and Commissioner Quality Visits	G	G	G	G	Actions in response to Reviews being taken.
AS07	CQC Registration	A	G	A	G	2 Actions in response to CQC visit findings behind schedule – remedial actions being taken.
	NATIONAL CQUINS					
Nat 1.1a	F&FT 1a - Staff	G	G	G	G	Implemented during Q1/2. No Staff F&FT survey undertaken in Q3 as National Staff Survey.
Nat 1.1b	F&FT 1b - OutPt & Day Case	G	G	G	G	F&FT already happening in Day Case and has started in Outpatients.
Nat 1.2	F&FT 1.2 - Increased participation - ED	16.%	15.1%	16.2%	25.3%	Performance dropped significantly in November but up to 18.7% in December and YTD rate of 15.8% . Need to achieve 20% for Q4 to meet CQUIN requirements.
Nat 1.3	F&FT 1.3 - Inpt increase in March	35.8%	31%	34.7%	34.6%	Improvement in January and still on track to achieve Q4 30% threshold but need to further improve to achieve 40% for March 15 for additional CQUIN monies.
Nat 2.1	ST 2.1 - ST data submission	G	G	G	G	Data collection continues for all 4 harms.
Nat 2.2	ST 2.2 - LLR strategy	G	G	tbc	G	UHL contributing to the LLR Pressure Ulcer group and workstreams. Q3 RAG to be confirmed upon receipt of LLR Group minutes.

Ref	Indicator Title	Q1 RAG	Q2 RAG	Q3 RAG	Q4 Predicted RAG	Commentary
Nat 3.1	Dementia 3.1 - FAIR	G	G	G	G	90% thresholds met for all parts of the Dementia FAIR CQUIN.
Nat 3.2	Dementia 3.2 - Training & Leadership	G	N/A	N/A	G	Nicky Morgan is new Clinical Lead Dementia Training Programme reviewed and revised. Q4 RAG dependent on evidence of increased staff attending training.
Nat 3.3	Dementia 3.3 - Carers	G	G	G	G	Surveys carried out and evidence of actions being taken
	LOCAL CQUINS					
Loc 1	Urgent Care 1 (Discharge)	G	G	G	tbc	Although no improvement in 'discharges before 11am/1pm' in Q3, Commissioners' noted increased capacity issues and work undertaken in Q3.
Loc 2	Urgent Care 2 (Consultant Assessment)	G	G	A	tbc	65% threshold exceeded for AMU but not achieved in other assessment areas. Audit data not felt to accurately reflect practice. Q4 audit to have increased clinical input to ensure accuracy but unlikely to achieve the 75% threshold across all areas.
Loc 3	Improving End of Life Care (AMBER)	G	G	G	G	New facilitators in post and Q3 threshold achieved.
Loc 4	Quality Mark	G	G	G	A	Quality Mark achieved for 6 out of the 8 wards to date. Although remaining 2 wards on track to achieve the QM, will be outside the agreed timescale for Q4.
Loc 5	Pneumonia	A	G	G	G	Q3 threshold achieved for all aspects of CQUIN scheme.
Loc 6	Think Glucose	G	G	G	G	Think Glucose programme on track.
Loc 7	Sepsis Care pathway	≥47%	≥60%	A	G	Not all 6 aspects of the Sepsis6 Care Bundle thresholds achieved in Q3. Remedial actions in place for Q4.
Loc 8	Heart Failure	≥49.5 %	≥63%	≥65%	tbc	Q3 65% threshold achieve and actions on track. Q4 RAG dependent upon achievement of 75% threshold.
Loc 9	Medication Safety Thermometer	G	G	G	G	All wards submitting data.
	SPECIALISED CQUINS*					
SS1	National Quality Dashboards	G	G	G	G	Dashboards now open for data submission at end of Q3

Ref	Indicator Title	Q1 RAG	Q2 RAG	Q3 RAG	Q4 Predicted RAG	Commentary
SS2	Breast Feeding in Neonates	61%	66%	tbc	G	Threshold not fully achieved for Q3 with remedial actions in place.
SS3	Clinical Utilisation Review of Critical Care	N/A*	G	G	G	CCMDS and ICNARC data now being collected for all satellite HDUs.
SS4	Acuity Recording	N/A*	G	G	G	Acuity recording in place for all areas. Q4 RAG dependent upon being able to demonstrate effective use of Acuity data.
SS5	Critical Care Standards - Disch	N/A*	G	tbc	G	Reduction in delays but increase in out of hours transfers during December – related to increased activity in Critical Care.
SS6	Critical Care Outreach Team	N/A*	G	tbc	G	Q3 threshold not fully achieved. Remedial actions in place.
SS7	Consultant Assessment	G	G	tbc	tbc	Links to the CCG CQUIN.
SS8	Highly Specialised Services Collaborative Workshop	G	G	G	G	Q3 threshold is to provide update regarding participation in Clinical Benchmarking for both ECMO and PCO.

University Hospitals of Leicester NHS
NHS Trust

Agenda Item: Trust Board Paper J

TRUST BOARD MEETING – 5th MARCH 2015

2014/15 FINANCIAL POSITION TO MONTH 10 (JANUARY)

DIRECTOR:	Paul Traynor - Director of Finance
AUTHOR:	Paul Traynor - Director of Finance
DATE:	5th March 2015
PURPOSE:	This paper provides the Trust Board with an update on performance against the key financial duties: • Delivery against the planned deficit • Achieving the External Financing Limit (EFL) • Achieving the Capital Resource Limit (CRL) The paper also provides further commentary on the key risks
PREVIOUSLY CONSIDERED BY:	Not applicable
Objective(s) to which issue relates *	☐ 1. Safe, high quality, patient-centred healthcare ☐ 2. An effective, joined up emergency care system ☐ 3. Responsive services which people choose to use (secondary, specialised and tertiary care) ☐ 4. Integrated care in partnership with others (secondary, specialised and tertiary care) ☐ 5. Enhanced reputation in research, innovation and clinical education ☐ 6. Delivering services through a caring, professional, passionate and valued workforce ☑ 7. A clinically and financially sustainable NHS Foundation Trust ☐ 8. Enabled by excellent IM&T
Please explain any Patient and Public Involvement actions taken or to be taken in relation to this matter:	Considered but not relevant to this paper
Please explain the results of any Equality Impact assessment undertaken in relation to this matter:	Considered but not relevant to this paper
Organisational Risk Register/ Board Assurance Framework *	☑ **Organisational Risk Register** ☑ **Board Assurance Framework** ☐ **Not Featured**
ACTION REQUIRED *	For decision ☐ For assurance ☑ For information ☐

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

* tick applicable box

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **5TH MARCH 2015**

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

SUBJECT: **2014/15 FINANCIAL POSITION TO MONTH 10 (JANUARY)**

1. INTRODUCTION AND CONTEXT

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

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

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

1.3 The paper also provides detail on the forecast outturn for 2014/15.

2. KEY FINANCIAL DUTIES

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

Financial Duty	YTD Plan £'Ms	YTD Actual £'Ms	RAG	Forecast Plan £'Ms	Forecast Actual £'Ms	RAG
Delivering the Planned Deficit	(31.8)	(33.9)	A	(40.7)	(40.7)	G
Achieving the EFL	46.8	26.4	A	50.3	50.3	G
Achieving the Capital Resource Limit	38.3	26.7	A	46.2	46.2	G

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

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

Key issues

- In month favourable movement to plan of £0.4m, which is £0.1m better than forecast
- YTD adverse movement to plan of £2.1m
- Agreement has been reached with local CCGs and NHSE regarding 2014/15 income, removing significant risk to the forecast
- Pay is adverse to plan by £0.4m and £2m higher than the beginning of the year. Medical pay is a particular area of pressure
- Year end forecast of £40.7m can be delivered. CMGs and Directorates must deliver to control totals to ensure this

3. FINANCIAL POSITION (MONTH 10 – JANUARY)

3.1. The Month 10 results may be summarised as follows and as detailed in Appendix 1:

	January 2015			April - January 2015		
	Plan £m	Actual £m	Var (Adv) / Fav £m	Plan £m	Actual £m	Var (Adv) / Fav £m
Income						
Patient income	59.3	60.9	1.6	585.8	586.2	0.4
Teaching, R&D	6.6	6.4	(0.2)	67.7	67.2	(0.5)
Other operating Income	3.1	3.2	0.1	30.9	31.9	1.0
Total Income	**68.9**	**70.5**	**1.6**	**684.4**	**685.3**	**0.9**
Operating expenditure						
Pay	42.2	42.6	(0.4)	413.7	411.3	2.3
Non-pay	27.3	27.7	(0.5)	266.0	270.9	(5.0)
Total Operating Expenditure	**69.5**	**70.4**	**(0.9)**	**679.6**	**682.2**	**(2.6)**
EBITDA	**(0.5)**	**0.1**	**0.7**	**4.8**	**3.1**	**(1.7)**
Net interest	0.0	0.0	0.0	0.1	0.0	0.0
Depreciation	(2.7)	(2.7)	0.0	(27.9)	(27.9)	0.0
Impairment	-	-	-	(1.4)	(4.4)	(3.0)
PDC dividend payable	(0.8)	(1.0)	(0.2)	(8.8)	(9.2)	(0.4)
Net deficit	**(4.1)**	**(3.6)**	**0.5**	**(33.2)**	**(38.3)**	**(5.1)**
EBITDA %		**0.2%**			**0.5%**	
Less Impairments	-	(0.0)	(0.0)	1.4	4.4	3.0
RETAINED SURPLUS / (DEFICIT)	**(4.1)**	**(3.6)**	**0.4**	**(31.8)**	**(33.9)**	**(2.1)**

3.2 In the month of January, the Trust delivered a deficit of £3.6m against a planned deficit of £4.1m, a favourable variance of £0.4m. This was £0.1m better than forecast.

3.3 Year to date, the deficit at the end of January is £33.9m, £2.1m worse than the £31.8m planned deficit.

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

Income

Patient care income is £1.6m favourable to plan in month following the release of operational resilience monies and the finalisation of year end settlements with LLR CCGs and NHSE. Agreement has been reached with both NHSE and LLR CCGs that ensure income at

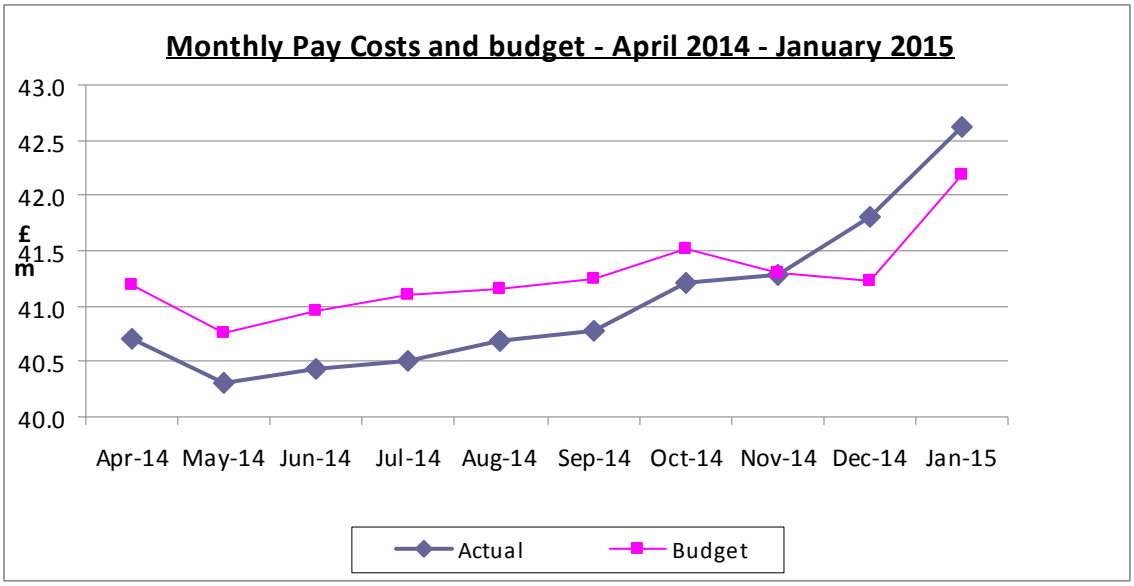
forecasted levels for the remainder of the year. These settlements ensure that there can be no further challenges on coding or activity as well as ensuring no further adverse impact from penalties.

Elective and daycase activity were £1.4m worse than plan in month and penalties £0.8m, offset by emergency activity being £0.5m better than plan and outpatients being £0.2m better than plan. The receipt of operational resilience funding and the agreement with commissioners as detailed above has offset this adverse variance, meaning a £1.6m positive variance to plan.

Pay

Pay costs are £0.4m adverse to plan in January and £2.3m favourable to plan year to date. This is the second month that pay costs have been adverse to plan, with costs now £2m higher than the beginning of the year.

The total paybill compared to budget since April 2014 can be seen in the chart below. This removes VSS costs paid in year and shows the sharp upward trend in cost since November with spend now in excess of budget.



The variance to plan by staff group can be seen in the table below, including all premium costs. Medical pay spend remains the only staff group overspending. This overspend is increasing compared to earlier in the year. In addition, nurse recruitment means nurse underspends are reducing placing further pressures on the paybill.

	In Month £000s			YTD £000s			WTE		
Pay Type	Plan	Actual	Better / (worse)	Plan	Actual	Better / (worse)	Plan	Actual	Better / (worse)
Non Clinical	5,991	5,875	117	59,529	58,483	1,046	2,418	2,415	3
Other Clinical	5,292	5,127	165	53,251	50,354	2,897	1,710	1,613	97
Medical & Dental	14,227	15,036	(809)	138,922	142,296	(3,374)	1,744	1,730	14
Nursing & Midwifery	16,680	16,584	96	161,956	160,192	1,764	5,657	5,373	284
Total	**42,190**	**42,622**	**(431)**	**413,658**	**411,326**	**2,332**	**11,529**	**11,132**	**397**

Further analysis of the current spend shows that the value of vacancies is £1.3m in January across all staff groups, however the cost of each WTE that is in post is higher than planned and a total cost of £1.7m. It is this price variance that is driving the adverse variance to plan.

In January 2015, premium pay spend was at it's highest at £4.7m, 11% of the paybill. This increasing premium cost, despite a decrease in the number of vacancies in the Trust, is driving the increasing cost and overspend

Non Pay

Operating non pay spend is £0.5m adverse to plan in January and £5.0m adverse to plan YTD.

In month overspends relate to clinical supplies and service costs, including £0.2m of high cost devices.

Year to date, the key drivers of the overspend relate to consumables £4.8m, security £0.8m, printing and postage £1.0m, consultancy £0.5m, international nurse recruitment costs £0.3m, offset with phased release of reserves and supplier discounts of £2.2m.

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

Cost Improvement Programme

Appendix 2 shows CIP performance in January by CMG and Corporate Directorate against the 2014/15 CIP plan. This currently shows an over-delivery against the target YTD of £2.1m.

The year end forecast reflects identified schemes of £48m against a target of £45m. Development of schemes for 2015/16 is underway against a target of £40.7m.

4. FORECAST OUTTURN

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

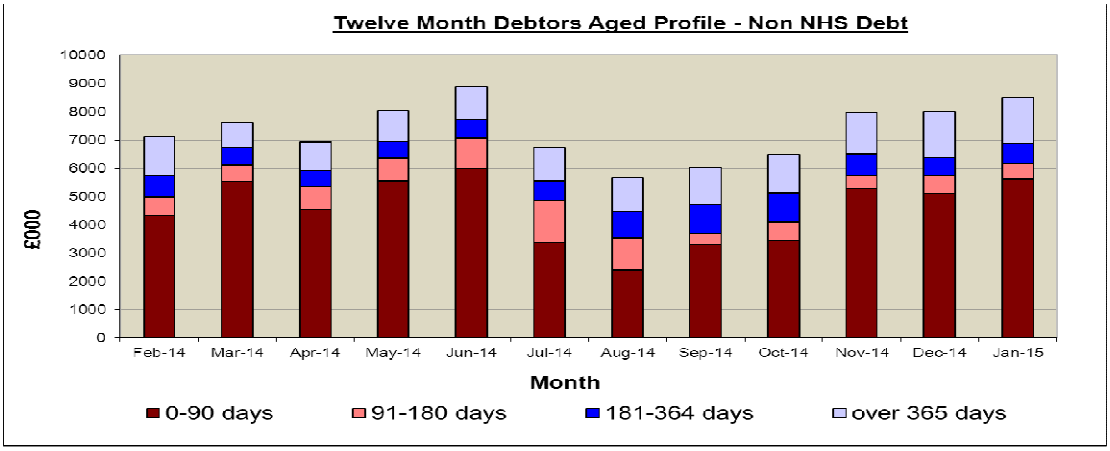
	Year End Forecast		
	Plan £m	Forecast £m	Var (Adv) / Fav £m
Income			
Patient income	701.7	705.8	4.1
Teaching, R&D	81.4	80.6	(0.8)
Other operating Income	37.7	38.5	0.8
Total Income	**820.8**	**824.8**	**4.0**
Operating expenditure			
Pay	499.7	496.8	2.9
Non-pay	319.2	327.8	(8.6)
Total Operating Expenditure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

4.2 Control totals have been agreed for each CMG and Directorate and these need to be delivered in order to ensure delivery of the planned deficit. The agreement with commissioners on income for 2014/15 removes income risk and means focus should be on expenditure control. Measurement of forecasts and resolution of issues is ongoing where needed.

4.3 Overall, the Trust's planned forecast of £40.7m is now likely subject to expenditure control following the agreement of income levels.

5. BALANCE SHEET AND CASHFLOW

5.1 The effect of the Trust's financial position on its balance sheet is provided in Appendix 3. The retained earnings reserve has reduced by the Trust's deficit for the year to date. The level of non-NHS debt has fluctuated across the year as shown in the following table:



5.2 The overall level of non-NHS debt at the end of January increased to £8.5m from £7.9m in December. Total debt over 90 days is £2.9m and this has remained constant from December.

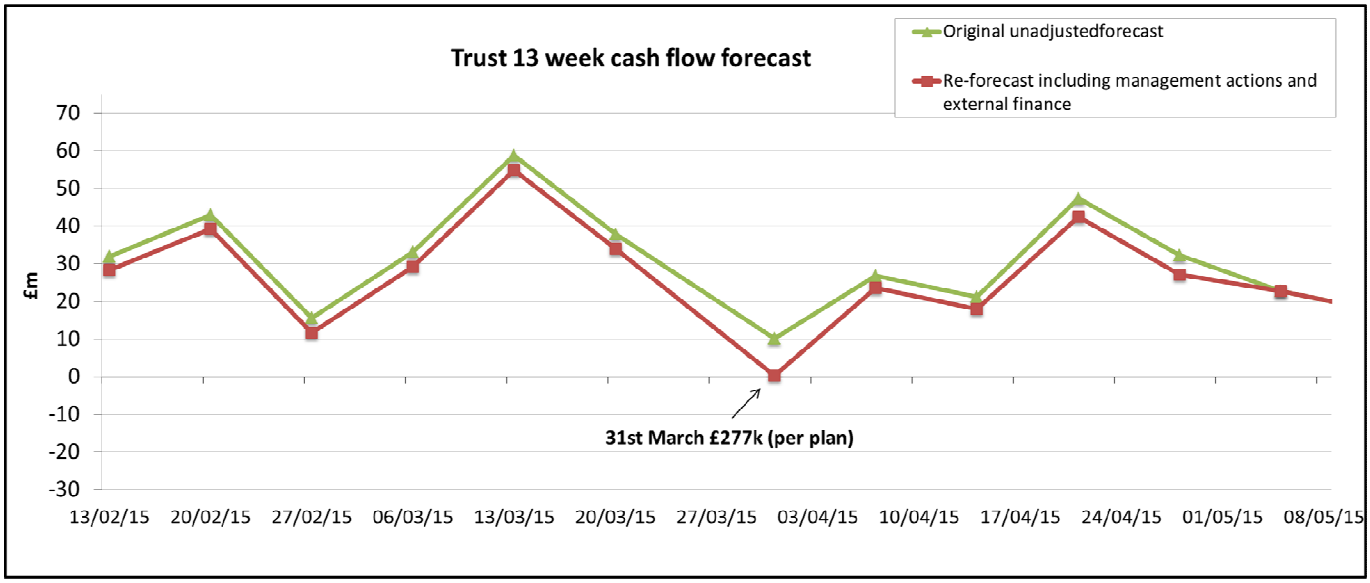
5.3 The proportion of total debt over 90 days has reduced from 36% to 34%. £1.7m of this debt relates to overseas patients where we expect a low recovery rate of approximately 25%. All overseas patient debt over 90 days old is provided for in full within the Trust's bad debt provision. A write-off of aged debt will be undertaken and reported to the Audit Committee on 5th March 2015.

5.4 The Better Payments Practice Code (BPPC) performance for end of December YTD, shown in the table below, shows a slight deterioration from 70% to 69% in terms of invoices paid within 30 days by value.

	By Volume Number	By Value £000s
Current Month YTD		
Total bills paid in the year	119,465	546,998
Total bills paid within target	60,247	375,460
Percentage of bills paid within target	**50%**	**69%**
Prior month YTD		
Total bills paid in the year	110,479	497,698
Total bills paid within target	55,054	346,044
Percentage of bills paid within target	**50%**	**70%**

5.5 The Trust's cashflow forecast is consistent with the income and expenditure position. The cash balance at the end of January was £17.3m which is £16.8m above plan of £0.5m.

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



5.7 We have had a total of £58m financing approved for 2014/15 by the Independent Trust Financing Facility (ITFF) split between:

- £46m revenue financing (£40.7m to cover our deficit and £5.3m to improve liquidity)
- £12m capital financing

5.8 We have received £46m of temporary borrowing in the year to date and this has enabled us to maintain sufficient cash whilst we awaited confirmation from the Department of Health (DoH) as to whether our £58m financing would take the form of PDC or a loan. The DoH has now confirmed that we will receive the £46m revenue financing as permanent PDC and the £12m capital financing will be a loan repayable over the economic life of the assets that are being funded.

5.9 We will receive the £46m revenue PDC on 2nd March 2015 and this will be used to repay the equivalent temporary borrowing on the same day. We are planning to draw down the £12m capital loan on 16th March 2015 and a separate paper has been presented to the Board outlining the process for approving the loan application. This is in accordance with our agreed final plan for 2014/15

5.10 We expect to have a backlog of authorised and unpaid invoices of £8.5m at the 31st March 2015. We will apply for temporary borrowing to be received in early April 2015 to enable us to make these payments and minimise the potential impact on our suppliers.

5.11 We will also not achieve the BPPC target of 95% for 2014/15 as the value of the approved funding will enable us to achieve 72% against the BPPC by value. We are currently on course to achieve this as the YTD performance is currently 69% as shown in Section 5.4.

6. CAPITAL

6.1 The total capital expenditure at the end of January 2015 was £26.9m. This is an underspend of £6.7m against the year to date plan of £33.6m and we have therefore achieved 80% of planned spend. The capital plan and expenditure can be seen in Appendix 4.

6.2 At the end of December, there was a total of £12.0m of outstanding orders. The combined position is that we have spent or committed £38.9m, or 84% of the annual plan which is also 116% of the year to date plan.

6.3 The table below details the capital plan at the start of the year compared with the revised plan at the end of January as well as forecast expenditure. We reduced our external capital funding requirement by £4.3m following advice from the NTDA. After a detailed review of schemes, forecast spend has reduced from £55.0m to £46.5m, which matches the full year plan.

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

Revised and original capital plan and forecast spend

	Original plan	Revised plan	Movement
	£000's	£000's	£000's
Capital Resource Limit	34,207	34,207	-
Plus Donations	300	300	-
Plus Anticipated PDC	16,322	12,000	(4,322)
TOTAL Funding	**50,829**	**46,507**	**(4,322)**
Forecast Spend	(54,932)	(46,507)	8,425
Over Commitment	**(4,103)**	**-**	**4,103**

7. RISKS

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

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

  Mitigation: Agreement of income with local CCGs and NHSE reduces this risk significantly and allows focus on expenditure control

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

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

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

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

Mitigation: RTT plan performance managed through fortnightly meeting with CCG/NTDA and IST to review robustness of the plan. Additional costs to weekend theatre sessions have been identified within the forecast and embedded in proposed control totals. In addition, further funding has been made available to support the clearance of the backlog

- **CIP Delivery**

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

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

- **Liquidity**

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

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

- **Unforeseen Events**

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

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

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

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

  Mitigation: The Trust has reviewed the contract and has further contractual claims to more than negate the counter claims. Further legal advice will be sought to confirm the value and timescales for resolution

8. CONCLUSION

8.1. The Trust, at the end of Month 10, has an adverse position of £2.1m against the planned deficit of £31.8m but is forecasting the delivery of all its financial duties at year end.

9. NEXT STEPS AND RECOMMENDATIONS

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

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

Paul Traynor
Director of Finance
5th March 2015

Appendix 1

	January 2015			April - January 2015		
	Plan £ 000	Actual £ 000	Variance (Adv) / Fav £ 000	Plan £ 000	Actual £ 000	Variance (Adv) / Fav £ 000
Elective	6,292	5,478	(815)	61,538	**59,113**	(2,425)
Day Case	5,042	4,481	(561)	50,695	**48,622**	(2,072)
Emergency (incl MRET)	14,939	15,454	515	146,937	**147,376**	439
Outpatient	8,752	8,973	220	87,965	**87,129**	(836)
Penalties	(292)	(1,078)	(787)	(2,917)	**(6,941)**	(4,024)
Non NHS Patient Care	483	495	12	4,694	**5,233**	539
Resilience Funding	0	2,085	2,085		**4,574**	4,574
Other	24,065	25,025	960	236,912	**241,124**	4,212
Patient Care Income	**59,282**	**60,912**	**1,630**	**585,824**	**586,230**	**406**
Teaching, R&D income	6,558	6,405	(153)	67,665	**67,192**	(473)
Other operating Income	3,084	3,183	99	30,940	**31,922**	982
Total Income	**68,924**	**70,500**	**1,576**	**684,429**	**685,344**	**915**
Pay Expenditure	**42,190**	42,622	**(432)**	**413,658**	**411,326**	**2,332**
Non Pay Expenditure	**27,277**	27,733	**(456)**	**265,966**	**270,917**	**(4,951)**
Total Operating Expenditure	**69,467**	**70,355**	**(888)**	**679,624**	**682,243**	**(2,619)**
EBITDA	**(543)**	**145**	**688**	**4,805**	**3,101**	**(1,704)**
Interest Receivable	8	8	0	80	**69**	(11)
Interest Payable	0	(3)	(3)	0	**(29)**	(29)
Depreciation & Amortisation	(2,691)	(2,686)	5	(27,878)	**(27,859)**	19
Impairment	0	0	0	(1,445)	**(4,447)**	(3,002)
Surplus / (Deficit) Before Dividend and Disposal of Fixed Assets	**(3,226)**	**(2,536)**	**690**	**(24,438)**	**(29,165)**	**(4,727)**
Profit / (Loss) on Disposal of Fixed Assets	(1)	1	2	(12)	**0**	12
Dividend Payable on PDC	(827)	(1,040)	(213)	(8,776)	(9,175)	(399)
Net Surplus / (Deficit)	**(4,054)**	**(3,575)**	**479**	**(33,226)**	**(38,340)**	**(5,114)**
Less Impairments	0	(48)	(48)	1,445	4,447	3,002
RETAINED SURPLUS / (DEFICIT)	**(4,054)**	**(3,623)**	**431**	**(31,781)**	**(33,893)**	**(2,112)**

Financial Performance by CMG & Corporate Directorate

I&E and CIP – to January 2015

	Year to Date					
	I&E			CIP		
CMG / Directorate	YTD Budget £000s	YTD Actual £000s	Variance £000s	YTD Plan £000s	YTD Actual £000s	Variance £000s
CMGs:						
C.H.U.G.S	36,924	37,338	414	4,359	4,482	123
Clinical Support & Imaging	-30,248	-30,247	1	4,621	4,709	88
Emergency & Specialist Med	14,790	16,473	1,683	5,554	6,324	770
I.T.A.P.S	-36,112	-38,203	-2,091	3,561	3,204	-357
Musculo & Specialist Surgery	33,871	29,478	-4,394	4,165	4,152	-13
Renal, Respiratory & Cardiac	26,874	26,362	-512	4,906	5,208	302
Womens & Childrens	37,123	37,244	120	5,300	5,381	81
	83,222	**78,443**	**-4,779**	**32,466**	**33,460**	**994**
Corporate:						
Communications & Ext Relations	-604	-569	35	57	57	0
Corporate & Legal	-2,870	-2,895	-25	72	94	22
Corporate Medical	-1,488	-1,394	94	79	86	7
Facilities	-32,721	-32,197	524	3,669	4,261	592
Finance & Procurement	-5,733	-5,302	432	275	489	214
Human Resources	-4,760	-4,505	255	179	303	124
Im&T	-8,263	-8,072	192	48	63	15
Nursing	-17,715	-17,377	337	280	344	64
Operations	-7,890	-8,106	-216	128	206	78
Strategic Devt	-802	-536	267	168	184	16
	-82,846	**-80,952**	**1,895**	**4,955**	**6,087**	**1,132**
Other:						
Alliance Elective Care	10	10	0			
R&D	4	161	158			
Central	-32,163	-31,513	650	4	0	-4
	-32,150	**-31,342**	**808**			
Total	**-31,774**	**-33,850**	**-2,076**	**37,425**	**39,547**	**2,123**

Appendix 3

Balance Sheet

	Mar-14 £000's Actual	Apr-14 £000's Actual	May-14 £000's Actual	Jun-14 £000's Actual	Jul-14 £000's Actual	Aug-14 £000's Actual	Sep-14 £000's Actual	Oct-14 £000's Actual	Nov-14 £000's Actual	Dec-14 £000's Actual	Jan-15 £000's Actual	Mar-15 £000's Forecast
Non Current Assets												
Property, plant and equipment	362,465	360,188	359,769	358,289	359,152	359,238	359,534	361,704	399,441	396,190	402,003	380,902
Intangible assets	8,019	7,788	7,555	7,338	7,109	6,877	6,636	6,408	6,180	6,452	6,217	5,327
Trade and other receivables	3,123	3,311	3,152	3,115	3,002	3,004	3,043	3,065	3,087	3,163	3,132	2,503
TOTAL NON CURRENT ASSETS	**373,607**	**371,287**	**370,476**	**368,742**	**369,263**	**369,119**	**369,213**	**371,177**	**408,708**	**405,805**	**411,352**	**388,732**
Current Assets												
Inventories	13,937	13,711	14,633	14,627	15,390	14,894	14,579	15,215	15,040	15,009	14,692	14,200
Trade and other receivables	49,892	44,492	44,580	51,192	47,903	38,966	32,335	36,344	36,383	32,211	33,094	46,932
Cash and cash equivalents	515	13,850	5,838	13,662	14,954	8,430	7,560	3,205	9,931	9,846	17,252	277
TOTAL CURRENT ASSETS	**64,344**	**72,053**	**65,051**	**79,481**	**78,247**	**62,290**	**54,474**	**54,764**	**61,354**	**57,066**	**65,038**	**61,409**
Current Liabilities												
Trade and other payables	(109,135)	(102,381)	(100,604)	(100,725)	(100,661)	(88,023)	(86,892)	(91,232)	(102,723)	(85,350)	(96,781)	(92,743)
Dividend payable	0	(1,025)	(1,894)	(2,763)	(3,632)	(4,540)	0	0	(2,080)	(3,120)	(4,160)	0
Borrowings	(6,590)	(6,590)	(6,590)	(6,590)	(6,590)	(6,590)	(2,919)	(2,919)	(3,753)	(4,170)	(4,170)	(2,800)
Provisions for liabilities and charges	(1,585)	(1,585)	(1,585)	(1,585)	(1,585)	(1,585)	(1,585)	(1,585)	(1,585)	(512)	(1,585)	(426)
TOTAL CURRENT LIABILITIES	**(117,310)**	**(111,581)**	**(110,673)**	**(111,663)**	**(112,468)**	**(100,738)**	**(91,396)**	**(95,736)**	**(110,141)**	**(93,152)**	**(106,696)**	**(95,969)**
NET CURRENT ASSETS (LIABILITIES)	**(52,966)**	**(39,528)**	**(45,622)**	**(32,182)**	**(34,221)**	**(38,448)**	**(36,922)**	**(40,972)**	**(48,787)**	**(36,086)**	**(41,658)**	**(34,560)**
TOTAL ASSETS LESS CURRENT LIABILITIES	**320,641**	**331,759**	**324,854**	**336,560**	**335,042**	**330,671**	**332,291**	**330,205**	**359,921**	**369,719**	**369,694**	**354,172**
Non Current Liabilities												
Borrowings	(5,890)	(5,794)	(5,785)	(5,730)	(5,676)	(5,683)	(9,179)	(9,186)	(8,075)	(7,663)	(7,668)	(9,356)
Other Liabilities	0	0	0	0	0	0	0	0	0	0	0	0
Provisions for liabilities and charges	(2,070)	(2,048)	(2,022)	(2,006)	(1,830)	(1,207)	(1,171)	(1,156)	(1,110)	(2,194)	(1,069)	(1,873)
TOTAL NON CURRENT LIABILITIES	**(7,960)**	**(7,842)**	**(7,807)**	**(7,736)**	**(7,506)**	**(6,890)**	**(10,350)**	**(10,342)**	**(9,185)**	**(9,857)**	**(8,737)**	**(11,229)**
TOTAL ASSETS EMPLOYED	**312,681**	**323,917**	**317,047**	**328,824**	**327,536**	**323,781**	**321,941**	**319,863**	**350,736**	**359,862**	**360,957**	**342,943**
Public dividend capital	282,625	298,125	298,125	311,625	311,625	311,625	311,625	311,625	311,625	329,837	329,725	353,602
Revaluation reserve	64,598	64,598	64,598	64,598	64,598	64,598	64,598	64,598	104,278	99,785	104,230	64,628
Retained earnings	(34,542)	(38,806)	(45,676)	(47,399)	(48,687)	(52,442)	(54,282)	(56,360)	(65,167)	(69,760)	(72,998)	(75,287)
TOTAL TAXPAYERS EQUITY	**312,681**	**323,917**	**317,047**	**328,824**	**327,536**	**323,781**	**321,941**	**319,863**	**350,736**	**359,862**	**360,957**	**342,943**

Capital Plan

January 2015	Annual Budget £'000	Actual Spend £'000	Outstanding Commitments £'000	Total £'000	Variance £'000	Full Year Forecast Outurn £'000	Variance £'000
CHUGGS CMG							
Endoscopy GH	309	177	0	177	132	197	112
Lithotripter Machine	430	430	0	430	(0)	430	0
Sub-total: CHUGGS CMG	**739**	**607**	**0**	**607**	**132**	**627**	**112**
CSI CMG							
Aseptic Suite	400	181	214	395	5	200	200
MES Installation Costs	1,302	1,357	130	1,487	(185)	1,675	(373)
Sub-total: CSI CMG	**1,702**	**1,538**	**344**	**1,882**	**(180)**	**1,875**	**(173)**
Women's and Children's CMG							
Maternity Interim Development	1,000	827	12	839	161	900	100
Bereavement Facilities	62	113	0	113	(51)	162	(100)
Life Studies Centre	650	2	48	50	600	50	600
Sub-total: Women's & Children's CMG	**1,712**	**941**	**60**	**1,001**	**711**	**1,112**	**600**
Renal, Respiratory & Cardiac CMG							
Renal Home Dialysis Expansion	708	142	0	142	566	528	180
Sub-total: Renal, Respiratory & Cardiac CMG	**708**	**142**	**0**	**142**	**566**	**528**	**180**
Emergency & Specialist Medicine CMG							
Brain Injury Unit (BIU) Works	47	46	0	46	1	46	1
Equipment: 8th Resus Bay	40	42	0	42	(2)	42	(2)
DVT Clinic Air Conditioning	30	14	0	14	16	14	16
Sub-total: Emergency & Specialist Medicine CMG	**117**	**101**	**0**	**101**	**16**	**102**	**15**
ITAPS CMG							
da Vinci Robot equipment	103	223	0	223	(120)	223	(120)
GH Theatre 6 Equipment	177	145	0	145	32	145	32
Sub-total: ITAPS CMG	**280**	**368**	**0**	**368**	**(88)**	**368**	**(88)**
Corporate / Other Schemes							
Stock Management Project	6	5	0	5	1	5	1
Medical Equipment Executive	3,237	2,333	387	2,720	517	3,237	0
LiA Schemes	250	82	25	107	143	250	0
Odames Library	1,500	1,217	190	1,406	94	1,500	0
Safecare Module	66	77	0	77	(11)	77	(11)
Other Developments	0	244	29	273	(273)	273	(273)
Donations	300	280	0	280	20	300	0
Sub-total: Corporate / Other Schemes	**5,359**	**4,238**	**630**	**4,868**	**491**	**5,642**	**(283)**
IM&T Schemes							
IM&T Sub Group Budget	2,000	1,054	438	1,492	508	2,000	0
Safer Hospitals Technology Fund	1,150	290	27	316	834	1,150	0
EDRM System	3,300	705	604	1,310	1,990	3,300	0
EPR Programme	3,100	1,358	13	1,370	1,730	3,100	0
LRI Managed Print	412	74	351	425	(12)	412	0
Unified Comms	1,850	135	0	135	1,715	850	1,000
Sub-total: IM&T Schemes	**11,812**	**3,616**	**1,432**	**5,048**	**6,765**	**10,812**	**1,000**
Facilities / NHS Horizons Schemes							
Facilities Backlog Budget	5,500	1,392	1,174	2,566	2,934	5,500	0
Accommodation Refurbishment	52	10	12	22	30	22	30
CHP Units LRI & GH	800	626	2	628	172	800	0
Multi-Storey Car Park (MSCP)	250	121	187	308	(58)	250	0
Sub-total: Facilities / NHS Horizons Schemes	**6,602**	**2,149**	**1,374**	**3,215**	**3,137**	**6,572**	**30**
Reconfiguration Schemes							
Theatre Recovery LRI	2,785	1,176	223	1,399	1,386	2,350	435
Interim ITU LRI	590	377	151	528	62	528	62
Ward 4 LGH	1,000	856	29	885	115	885	115
Additional Beds (GH & LRI)	2,000	42	378	420	1,580	1,700	300
Feasibility Studies	100	(10)	0	(10)	110	20	80
Sub-total: Reconfiguration Schemes	**6,475**	**2,441**	**781**	**3,222**	**3,253**	**5,483**	**992**
Over Commitment	(5,321)					(2,036)	(3,285)
Total Schemes funded via internal sources	**30,185**	**16,141**	**4,621**	**20,763**	**14,744**	**31,085**	**(900)**
Schemes to be funded via external loan / PDC							
ED Enabling Schemes							
Modular Wards LRI	3,700	4,730	500	5,230	(1,530)	3,700	0
Clinic 1 & 2 Works	814	75	34	109	705	814	0
Old Cancer Centre Conversion	1,050	1,141	8	1,149	(99)	1,050	0
Oliver Ward Conversion	1,260	1,718	53	1,771	(511)	1,260	0
Clinical Genetics	158	68	8	76	82	158	0
Chapel Relocation	315	102	16	118	197	315	0
Victoria Main Reception	525	85	26	111	414	525	0
Sub-total: ED Enabling schemes	**7,822**	**7,920**	**644**	**8,564**	**(742)**	**7,822**	**0**
Emergency Floor	6,000	2,754	5,070	7,824	(1,824)	6,400	(400)
GGH Vascular Surgery	2,500	124	1,650	1,774	726	1,200	1,300
Sub-total: External Loans	**16,322**	**10,798**	**7,364**	**18,161**	**(1,839)**	**15,422**	**900**
Total Capital Plan	**46,507**	**26,939**	**11,985**	**38,924**	**12,904**	**46,507**	**0**

University Hospitals of Leicester NHS
NHS Trust

Agenda Item: Trust Board Paper J1

TRUST BOARD MEETING – 5th MARCH 2015

APPROVAL OF 2014-15 CAPITAL LOAN APPLICATION

DIRECTOR:	Paul Traynor - Director of Finance
AUTHOR:	Nick Sone – Financial Controller
DATE:	5th March 2015
PURPOSE:	The paper provides details of the Trust's £12m capital loan for 2014-15 and outlines the requirement for the Board to approve the Loan Agreement. The paper requests that the Board approves the terms of the loan as set out in the Loan Agreement and authorises the Director of Finance to sign the Loan Agreement on behalf of the Board.
PREVIOUSLY CONSIDERED BY:	Not applicable
Objective(s) to which issue relates *	☐ 1. Safe, high quality, patient-centred healthcare ☐ 2. An effective, joined up emergency care system ☐ 3. Responsive services which people choose to use (secondary, specialised and tertiary care) ☐ 4. Integrated care in partnership with others (secondary, specialised and tertiary care) ☐ 5. Enhanced reputation in research, innovation and clinical education ☐ 6. Delivering services through a caring, professional, passionate and valued workforce ☑ 7. A clinically and financially sustainable NHS Foundation Trust ☐ 8. Enabled by excellent IM&T
Please explain any Patient and Public Involvement actions taken or to be taken in relation to this matter:	Considered but not relevant to this paper
Please explain the results of any Equality Impact assessment undertaken in relation to this matter:	Considered but not relevant to this paper
Organisational Risk Register/ Board Assurance Framework *	☑ **Organisational Risk Register** ☑ **Board Assurance Framework** ☐ **Not Featured**
ACTION REQUIRED *	For decision ☑ For assurance ☐ For information ☐

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

* tick applicable box

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **5 MARCH 2015**

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

SUBJECT: **APPROVAL OF 2014-15 CAPITAL LOAN APPLICATION**

1. INTRODUCTION AND CONTEXT

1.1. This paper provides details of the Trust's £12m capital loan for 2014-15 and outlines the requirement for the Board to approve the Loan Agreement.

1.2 In accordance with our agreed final plan for 2014-15 we have had a total of £58m financing approved for 2014-15 by the Independent Trust Financing Facility (ITFF) split between £46m revenue financing (£40.7m to cover our deficit and £5.3m to improve liquidity); and £12m capital financing. The Department of Health has confirmed that we will receive the £46m revenue PDC on the 2nd March and we will use this to repay equivalent temporary borrowing on the same day.

1.3 The £12m approved capital financing will take the form of a loan repayable over the economic life of the assets that are being funded. The affordability of this loan has been assessed as part of the original ITFF application and we will incorporate all future repayments and interest charges into our medium and long term plans.

1.4 We are planning to draw down the £12m capital loan on the 16th March and have received the Loan Agreement, which is attached as Appendix 1.

2. LOAN DETAILS AND APPROVAL PROCESS

2.1 The loan will run for 22 years from the drawdown date of the 16th March 2015 to the final repayment date of the 18 March 2037. Instalments will be payable each year in September and March and the interest rate for the loan will be 2.27%. Further details, including the detailed loan terms and conditions are included within the Loan Agreement.

2.2 Schedule 1 of the Loan Agreement requires us to provide a resolution from the Board approving the terms of the loan and authorising a specified person (in this case the Director of Finance) to execute the loan documents on the Board's behalf.

3 RECOMMENDATIONS

3.1 The Board is asked to:

- **approve** the terms of the loan as set out in the Loan Agreement; and
- **authorise** the Director of Finance to sign the Loan Agreement on behalf of the Board.

Paul Traynor
Director of Finance
5th March 2015

DATED 2015

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST
(as Borrower)

and

THE SECRETARY OF STATE FOR HEALTH
(as Lender)

£12,000,000

SINGLE CURRENCY INTERIM CAPITAL SUPPORT FACILITY AGREEMENT

REF NO : ITFF/ISCIL/RWE/2014-10-21/A

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THIS AGREEMENT is dated 2015 and made between:

(1) **UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST** of**,** (the **"Borrower" which expression shall include any successors in title or permitted transferees or assignees**); and

(2) **THE SECRETARY OF STATE FOR HEALTH** as lender (the **"Lender" which expression shall include any successors in title or permitted transferees or assignees**).

IT IS AGREED as follows:

1. DEFINITIONS AND INTERPRETATION

1.1 Definitions

In this Agreement:

"Account" means the Borrower's account held with the Government Banking Service.

"Act" means the National Health Service Act 2006 as amended from time to time.

"Additional Terms and Conditions" means the terms and conditions set out in Schedule 8.

"Agreed Purpose" means capital expenditure in respect of the Property as set out in Schedule 3.

"Anticipated Drawdown Schedule" means the anticipated drawdown schedule set out in Schedule 4.

"Authorisation" means an authorisation, consent, approval, resolution, licence, exemption, filing, notarisation or registration.

"Available Facility" means the Facility Amount less:

(A) all outstanding Loans; and

(B) in relation to any proposed Utilisation, the amount of any Loan that is due to be made on or before the proposed Utilisation Date.

"Availability Period" means the period from and including the date of this Agreement to and including 31/03/2015 or such later date as the Parties may agree.

"Business Day" means a day (other than a Saturday or Sunday) on which banks are open for general banking business in London.

"Cashflow Forecast" means the Borrower's current rolling cashflow forecast in a form to be agreed with the Lender from time to time (and as prepared on behalf of the Borrower's Board). The forecast must include all utilisations, proposed utilisations and repayments under any agreement with the Lender for the relevant period.

"Compliance Certificate" means a certificate in form and substance satisfactory to the Lender.

"Compliance Framework" means the relevant Supervisory Body's frameworks for monitoring and assessing risks to NHS Bodies' compliance with their governance and continuity of services licence conditions and for triggering further investigation.

"Dangerous Substance" means any natural or artificial substance (whether in a solid or liquid form or in the form of a gas or vapour and whether alone or in combination with any such other substance) capable of causing harm to the Environment or damaging the

Environment or public health or welfare including any noxious, hazardous, toxic, dangerous, special or controlled waste or other polluting substance or matter.

"Default" means an Event of Default or any event or circumstance specified in Clause 18 (*Events of Default*) which would (with the expiry of a grace period, the giving of notice, the making of any determination under the Finance Documents or any combination of any of the foregoing) be an Event of Default.

"Default Rate" means the higher of the interest rate specified in Clause 8.1 (*Calculation of interest*) and the rate determined by the Lender from time to time which is the then current rate charged on late payments of loans made from the National Loans Fund and calculated by reference to a temporary loan for the relevant period.

"Environment" means the natural and man-made environment and all or any of the following media namely air (including air within buildings and air within other natural or man-made structures above or below ground), water (including water under or within land or in drains or sewers and inland waters), land and any living organisms (including humans) or systems supported by those media.

"Environmental Claim" means any claim alleging liability whether civil or criminal and whether actual or potential arising out of or resulting from the presence at on or under property owned or occupied by the Borrower or presence in or escape or release into the environment of any Dangerous Substance from any such property or in circumstances attributable to the operation of the Borrower's activities or any breach of any applicable Environmental Law or any applicable Environmental Licence.

"Environmental Law" means all statutes, instruments, regulations, orders and ordinances (including European Union legislation, regulations, directives, decisions and judgements applicable to the United Kingdom) being in force from time to time and directly enforceable in the United Kingdom relating to pollution, prevention thereof or protection of human health or the conditions of the Environment or the use, disposal, generation, storage, transportation, treatment, dumping, release, deposit, burial, emission or disposal of any Dangerous Substance.

"Environmental Licence" shall mean any permit, licence, authorisation, consent or other approval required by any Environmental Law or the Planning (Hazardous Substances) Act 1990.

"Event of Default" means any event or circumstance specified as such in Clause 18 (*Events of Default*).

"Facility" means the term loan facility made available under this Agreement as described in Clause 2 (*The Facility*).

"Facility Amount" means £12,000,000 at the date of this Agreement and thereafter that amount to the extent not cancelled, reduced or transferred by the Lender or the Borrower (as the case may be) under this Agreement.

"Final Repayment Date" means 18/03/2037.

"Finance Documents" means:

(A) this Agreement; and

(B) any other document designated as such by the Lender and the Borrower.

"Financial Indebtedness" means any indebtedness for or in respect of:

(A) moneys borrowed;

(B) any amount raised by acceptance under any acceptance credit facility;

(C) any amount raised pursuant to any note purchase facility or the issue of bonds, notes, debentures, loan stock or any similar instrument;

(D) the amount of any liability in respect of any lease or hire purchase contract which would, in accordance with any applicable Audit Code for NHS Bodies, any applicable Manual for Accounts for NHS Bodies and Annual Report Guidance for NHS Bodies, be treated as a finance or capital lease;

(E) receivables sold or discounted (other than any receivables to the extent they are sold on a non-recourse basis);

(F) any amount raised under any other transaction (including any forward sale or purchase agreement) having the commercial effect of a borrowing;

(G) any derivative transaction entered into in connection with protection against or benefit from fluctuation in any rate or price (and, when calculating the value of any derivative transaction, only the marked to market value shall be taken into account);

(H) any counter-indemnity obligation in respect of a guarantee, indemnity, bond, standby or documentary letter of credit or any other instrument issued by a bank or financial institution; and

(I) the amount of any liability in respect of any guarantee or indemnity for any of the items referred to in paragraphs (A) to (H) above.

"Government Banking Service" means the body established in April 2008 being the banking shared service provider to government and the wider public sector incorporating the Office of HM Paymaster General (OPG).

"Interest Payment Date" means the last day of an Interest Period.

"Interest Period" means, in relation to a Loan, the period determined in accordance with Clause 9 (*Interest Periods*) and, in relation to an Unpaid Sum, each period determined in accordance with Clause 8.3 *(Default interest).*

"**Interest Rate**" means the National Loan Fund EIP rate prevailing on the date of this Agreement for the term of the Facility. The term being the period between the date of this Agreement and the Final Repayment Date inclusive. For the avoidance of doubt the rate is percent per annum.

"Licence" means the licence issued by Monitor to any person who provides a health care service for the purposes of the NHS.

"Loan" means a loan made or to be made under the Facility or the principal amount outstanding for the time being of that loan.

"Material Adverse Effect" means a material adverse effect on:

(A) the business or financial condition of the Borrower;

(B) the ability of the Borrower to perform any of its material obligations under any Finance Document;

(C) the validity or enforceability of any Finance Document; or

(D) any right or remedy of the Lender in respect of a Finance Document.

"**Monitor**" means the independent regulator for NHS Foundation Trusts or any successor body to that organisation

"Month" means a period starting on one day in a calendar month and ending on the numerically corresponding day in the next calendar month, except that:

(A) (subject to paragraph (C) below) if the numerically corresponding day is not a Business Day, that period shall end on the next Business Day in that calendar month in which that period is to end if there is one, or if there is not, on the immediately preceding Business Day;

(B) if there is no numerically corresponding day in the calendar month in which that period is to end, that period shall end on the last Business Day in that calendar month; and

(C) if a period begins on the last Business Day of a calendar month, that period shall end on the last Business Day in the calendar month in which that period is to end,

provided that the above rules will only apply to the last Month of any period.

"National Loans Fund" means the government's main borrowing account set up under the National Loans Act 1968.

"NHS Bodies" means either an NHS Trust or an NHS Foundation Trust , or any successor body to that organisation**.**

"NHS Trust Development Authority" means the body responsible for monitoring the performance of NHS Trusts and providing assurance of clinical quality, governance and risk in NHS Trusts, or any successor body to that organisation;

"Original Financial Statements" means a certified copy of the audited financial statements of the Borrower for the financial year ended 2013-14.

"Participating Member State" means any member state of the European Communities that adopts or has adopted the euro as its lawful currency in accordance with legislation of the European Community relating to Economic and Monetary Union.

"Party" means a party to this Agreement.

"Permitted Security" means:

(A) normal title retention arrangements arising in favour of suppliers of goods acquired by the Borrower in the ordinary course of its business or arising under conditional sale or hiring agreements in respect of goods acquired by the Borrower in the ordinary course of its business;

(B) liens arising by way of operation of law in the ordinary course of business so long as the amounts in respect of which such liens arise are not overdue for payment;

(C) any existing Security listed in Schedule 7;

(D) any Security created or outstanding with the prior written consent of the Lender; and

(E) any other Security securing in aggregate not more than £150,000 at any time.

"Prepayment Amount" means the amount in respect of all or any part of the Loan which is prepaid which represents the Present Value of the relevant Repayment Instalment and interest that would have been paid if the Repayment Schedule had been complied with. For this purpose "Present Value" is calculated by discounting the future payments at a rate of discount equal to the rate of interest applicable to new loans from the National Loans Fund of a similar

type to the Loan and with a life equal to the remaining term of the Loan (or part thereof) being prepaid, prevailing on the Business Day on which the Lender receives notice of the prepayment.

"Property" means any building or facility needed to deliver the Agreed Purpose.

"Supervisory Body" means either the NHS Trust Development Authority and/or Monitor.

"Relevant Consents" means any authorisation, consent, approval, resolution, licence, exemption, filing, notarisation or registration of whatsoever nature necessary or appropriate to be obtained for the purpose of entering into and performing the Borrower's obligations under the Finance Documents.

"Relevant Percentage" means in respect of each Repayment Date, the percentage figure set opposite such Repayment Date in the Repayment Schedule.

"Relevant Quarter Period" means the quarter period in which a Utilisation is contemplated in accordance with the Anticipated Drawdown Schedule or as may otherwise be agreed by the Parties in writing from time to time.

"Repayment Dates" means the repayment dates set out in the Repayment Schedule.

"Repayment Instalment" means each instalment for the repayment of the Loan referred to in Clause 6.2.

"Repayment Schedule" means the repayment schedule set out in Schedule 6.

"Repeating Representations" means each of the representations set out in Clause 14 (*Representations*) other than those under Clauses 14.9, 14.10, 14.12.2 and 14.16.2.

"Security" means a mortgage, charge, pledge, lien or other security interest securing any obligation of any person or any other agreement or arrangement having a similar effect.

"Tax" means any tax, levy, impost, duty or other charge or withholding of a similar nature (including any penalty or interest payable in connection with any failure to pay or any delay in paying any of the same).

"Tax Deduction" means a deduction or withholding for or on account of Tax from a payment under a Finance Document.

"Test Date" means the Utilisation Date and each Interest Payment Date.

"Unpaid Sum" means any sum due and payable but unpaid by the Borrower under the Finance Documents.

"Utilisation" means a utilisation of the Facility.

"Utilisation Date" means the date of a Utilisation, being the date on which a drawing is to be made under the Facility.

"Utilisation Request" means a notice substantially in the form set out in Schedule 2 (*Utilisation Request*).

"VAT" means value added tax as provided for in the Value Added Tax Act 1994 and other tax of a similar nature, whether imposed in the UK or elsewhere.

1.2 **Construction**

1.2.1 Unless a contrary indication appears, any reference in any Finance Document to:

(A) the **"Lender"**, the **"Borrower"** the **"Supervisory Body"** or any **"Party"** shall be construed so as to include its successors in title, permitted assigns and permitted transferees;

(B) **"assets"** includes present and future properties, revenues and rights of every description;

(C) a **"Finance Document"** or any other agreement or instrument is a reference to that Finance Document or other agreement or instrument as amended or novated;

(D) **"indebtedness"** shall be construed so as to include any obligation (whether incurred as principal or as surety) for the payment or repayment of money, whether present or future, actual or contingent;

(E) a **"person"** includes any person, firm, company, corporation, government, state or agency of a state or any association, trust or partnership (whether or not having separate legal personality) or two or more of the foregoing;

(F) a **"regulation"** includes any regulation, rule, official directive, request or guideline (whether or not having the force of law) of any governmental, intergovernmental or supranational body, agency, department or regulatory, self-regulatory or other authority or organisation;

(G) **"repay"** (or any derivative form thereof) shall, subject to any contrary indication, be construed to include **"prepay"** (or, as the case may be, the corresponding derivative form thereof);

(H) a provision of law is a reference to that provision as amended or re-enacted;

(I) a time of day is a reference to London time; and

(J) the word **"including"** is without limitation.

1.2.2 Section, Clause and Schedule headings are for ease of reference only.

1.2.3 Unless a contrary indication appears, a term used in any other Finance Document or in any notice given under or in connection with any Finance Document has the same meaning in that Finance Document or notice as in this Agreement.

1.2.4 A Default (other than an Event of Default) is **"continuing"** if it has not been remedied or waived and an Event of Default is **"continuing"** if it has not been waived or remedied to the satisfaction of the Lender.

1.3 **Third party rights**

1.3.1 Except as provided in a Finance Document, the terms of a Finance Document may be enforced only by a party to it and the operation of the Contracts (Rights of Third Parties) Act 1999 is excluded.

1.3.2 Notwithstanding any provision of any Finance Document, the Parties to a Finance Document do not require the consent of any third party to rescind or vary any Finance Document at any time.

2. THE FACILITY

2.1 Subject to the terms of this Agreement, the Lender makes available to the Borrower a sterling term loan facility in an aggregate amount equal to the Facility Amount.

2.2 The Facility shall be utilised by the Borrower for the purposes of and/or in connection with its functions as an NHS Body.

3. PURPOSE

3.1 Purpose

The Borrower shall apply all Loans towards financing or refinancing the Agreed Purpose and any applicable non-recoverable VAT in respect thereof.

3.2 Pending application

Without prejudice to Clause 3.1 *(Purpose)*, pending application of the proceeds of any Loan towards financing or refinancing the Agreed Purpose, the Borrower must deposit such proceeds in the Account.

3.3 Monitoring

The Lender is not bound to monitor or verify the application of any amount borrowed pursuant to this Agreement.

4. CONDITIONS OF UTILISATION

4.1 Initial conditions precedent

The Borrower may not deliver the first Utilisation Request unless the Lender has received all of the documents and other evidence listed in Schedule 1 (*Conditions precedent*) in form and substance satisfactory to the Lender or to the extent it has not received the same, it has waived receipt of the same. The Lender shall notify the Borrower promptly upon being so satisfied.

4.2 Further conditions precedent

The Lender will only be obliged to comply with a Utilisation Request if on the date of the Utilisation Request and on the proposed Utilisation Date:

4.2.1 No Event of Default might reasonably be expected to result from the making of an Utilisation other than those of which the Lender and Borrower are aware; and

4.2.2 the Repeating Representations to be made by the Borrower with reference to the facts and circumstances then subsisting are true in all material respects.

5. UTILISATION

5.1 Utilisation

5.1.1 Subject to the terms of this Agreement, the Borrower may utilise the Facility in the amounts agreed and during the Relevant Quarter Periods agreed by the Parties in writing from time to time. On the date of this Agreement, the Parties anticipate Utilisations being made on the dates and in the amounts set out in the Anticipated Drawdown Schedule.

5.2 Delivery of a Utilisation Request

The Borrower may utilise the Facility by delivery to the Lender of a duly completed Utilisation Request not later than 11.00 a.m. five Business Days before the proposed Utilisation Date unless otherwise agreed.

5.2.1 The Borrower may only issue one Utilisation Request per Month unless otherwise agreed.

5.3 **Completion of a Utilisation Request**

The Utilisation Request is irrevocable and will not be regarded as having been duly completed unless:

(A) the proposed Utilisation Date is a Business Day within the Availability Period; and

(B) the currency and amount of the Utilisation comply with Clause 5.4 (*Currency and amount*).

(C) an appropriate Cashflow Forecast is received covering the period for which the Payment is being made

5.4 **Currency and amount**

5.4.1 The currency specified in the Utilisation Request must be sterling.

5.4.2 The amount of each proposed Utilisation must be an amount which is not more than the planned expenditure to support achievement of the agreed purpose as demonstrated by the Cashflow Forecast.

5.4.3 The amount of each proposed Loan must be an amount which is not more than the Available Facility and which is a minimum of £150,000 or, if less, the Available Facility.

5.5 **Payment to the Account**

The Lender shall pay each Loan:

5.5.1 by way of credit to the Account and so that, unless and until the Lender shall notify the Borrower to the contrary, the Lender hereby consents to the withdrawal by the Borrower from the Account of any amount equal to the relevant Loan provided that any sums so withdrawn are applied by the Borrower for the purposes for which the relevant Loan was made;

5.5.2 if the Lender so agrees or requires, on behalf of the Borrower directly to the person to whom the relevant payment is due as specified in the relevant Utilisation Request; or

5.5.3 in such other manner as shall be agreed between the Lender and the Borrower.

6. PAYMENTS AND REPAYMENT

6.1 **Payments**

6.1.1 The Borrower shall make all payments payable under the Finance Documents without any Tax Deductions, unless a Tax Deduction is required by law.

6.1.2 The Borrower shall promptly upon becoming aware that it must make a Tax Deduction (or that there is any change in the rate or the basis of a Tax Deduction) notify the Lender accordingly.

6.1.3 If a Tax Deduction is required by law to be made by the Borrower, the amount of the payment due from the Borrower shall be increased to an amount which (after making any Tax Deduction) leaves an amount equal to the payment which would have been due if no Tax Deduction had been required.

6.1.4 If the Borrower is required to make a Tax Deduction, the Borrower shall make that Tax Deduction and any payment required in connection with that Tax Deduction within the time allowed and in the minimum amount required by law.

6.1.5 Within thirty days of making either a Tax Deduction or any payment required in connection with that Tax Deduction, the Borrower shall deliver to the Lender evidence reasonably satisfactory to the Lender that the Tax Deduction has been made or (as applicable) any appropriate payment paid to the relevant taxing authority.

6.2 **Repayment**

The Borrower shall repay:

6.2.1 each Loan by instalments equal to the Relevant Percentage of all Loans which have been made on each Repayment Date in accordance with the Repayment Schedule; and

6.2.2 each Loan and all other amounts outstanding under the Finance Documents in full on the Final Repayment Date.

6.3 **Reborrowing**

The Borrower may not reborrow any part of the Facility which is repaid or prepaid.

7. PREPAYMENT AND CANCELLATION

7.1 **Illegality**

If it becomes unlawful in any applicable jurisdiction for the Lender to perform any of its obligations as contemplated by this Agreement or to fund or maintain all or any part of the Loans:

7.1.1 the Lender shall promptly notify the Borrower upon becoming aware of that event;

7.1.2 upon the Lender notifying the Borrower, the Available Facility will be immediately cancelled; and

7.1.3 the Borrower shall repay such Loans on the last day of the Interest Period for Loans occurring after the Lender has notified the Borrower or, if earlier, the date specified by the Lender in the notice delivered to the Borrower (being no earlier than the last day of any applicable grace period permitted by law).

7.2 **Voluntary cancellation**

The Borrower may, if it gives the Lender not less than seven days' (or such shorter period as the Lender may agree) and not more than fourteen days' prior notice, cancel the whole or any part (being a minimum amount of £100,000) of the Facility Amount.

7.3 **Voluntary prepayment of Loans**

The Borrower may, if it gives the Lender not less than seven days' (or such shorter period as the Lender may agree) and not more than fourteen days' prior notice, prepay the whole or any part of any Loan (but, if in part, being an amount that reduces the amount of the Loan by a minimum amount of £250,000).

7.4 **Restrictions**

7.4.1 Any notice of cancellation or prepayment given by any Party under this Clause 7 shall be irrevocable and, unless a contrary indication appears in this Agreement, shall

specify the date or dates upon which the relevant cancellation or prepayment is to be made and the amount of that cancellation or prepayment.

7.4.2 Any prepayment under this Agreement shall be made together with accrued interest on the amount prepaid without premium or penalty and applied against the outstanding Repayment Instalments in inverse order of maturity.

7.4.3 The Borrower shall not repay or prepay all or any part of the Loan or cancel all or any part of the Available Facility except at the times and in the manner expressly provided for in this Agreement.

7.4.4 No amount of the Available Facility cancelled under this Agreement may be subsequently reinstated.

7.5 **Automatic Cancellation**

At the end of the Availability Period the undrawn part of the Available Facility will be cancelled.

8. INTEREST

8.1 **Calculation of interest**

The rate of interest on each Loan for each Interest Period is the Interest Rate.

8.2 **Payment of interest**

The Borrower shall pay accrued interest on each Loan on the last day of each Interest Period.

8.3 **Default interest**

8.3.1 If the Borrower fails to pay any amount payable by it under a Finance Document on its due date, interest shall accrue on Unpaid Sums from the due date up to the date of actual payment (both before and after judgment) at the Default Rate. Any interest accruing under this Clause 8.3 shall be immediately payable by the Borrower on demand by the Lender.

8.3.2 Default interest (if unpaid) arising on an overdue amount will be compounded with the overdue amount at the end of each Interest Period applicable to that overdue amount but will remain immediately due and payable.

9. INTEREST PERIODS

9.1 **Interest Payment Dates**

The Interest Period for each Loan shall be six Months, provided that any Interest Period which begins during another Interest Period shall end at the same time as that other Interest Period (and, where two or more such Interest Periods expire on the same day, the Loans to which those Interest Periods relate shall thereafter constitute and be referred to as one Loan).

9.2 **Shortening Interest Periods**

If an Interest Period would otherwise overrun the relevant Repayment Date, it shall be shortened so that it ends on the relevant Repayment Date.

9.2A **Payment Start Date**

Each Interest Period for a Loan shall start on the Utilisation Date or (if already made) on the last day of its preceding Interest Period.

9.3 **Non-Business Days**

If an Interest Period would otherwise end on a day which is not a Business Day, that Interest Period will instead end on the next Business Day in that calendar month (if there is one) or the preceding Business Day (if there is not).

9.4 **Consolidation of Loans**

If two or more Interest Periods end on the same date, those Loans will be consolidated into and be treated as a single Loan on the last day of the Interest Period.

10. PREPAYMENT AMOUNT

10.1.1 If all or any part of the Loans are subject to a voluntary prepayment pursuant to Clause 7.3 (*Voluntary prepayment of Loans*), the Borrower shall pay to the Lender on the relevant prepayment date the Prepayment Amount in respect of the same.

10.1.2 For as long as the Secretary of State for Health remains the Lender, the Lender will consider waiving the Prepayment Amount in cases where the Borrower can demonstrate to the Lender's satisfaction that the voluntary prepayment results from the Borrower's proper use of genuine surplus funds resulting from a sale of assets or trading activities.

11. INDEMNITIES

11.1 **Currency indemnity**

11.1.1 If any sum due from the Borrower under the Finance Documents (a **"Sum"**), or any order, judgment or award given or made in relation to a Sum, has to be converted from the currency (the **"First Currency"**) in which that Sum is payable into another currency (the **"Second Currency"**) for the purpose of:

(A) making or filing a claim or proof against the Borrower;

(B) obtaining or enforcing an order, judgment or award in relation to any litigation or arbitration proceedings,

the Borrower shall as an independent obligation, within five Business Days of demand, indemnify the Lender against any cost, loss or liability arising out of or as a result of the conversion including any discrepancy between (A) the rate of exchange used to convert that Sum from the First Currency into the Second Currency and (B) the rate or rates of exchange available to that person at the time of its receipt of that Sum.

11.1.2 The Borrower waives any right it may have in any jurisdiction to pay any amount under the Finance Documents in a currency or currency unit other than that in which it is expressed to be payable.

11.2 **Other indemnities**

The Borrower shall, within five Business Days of demand, indemnify the Lender against any cost, loss or liability incurred by the Lender as a result of:

11.2.1 the occurrence of any Event of Default;

11.2.2 a failure by the Borrower to pay any amount due under a Finance Document on its due date;

11.2.3 funding, or making arrangements to fund, all or any part of the Loans requested by the Borrower in a Utilisation Request but not made by reason of the operation of any

one or more of the provisions of this Agreement (other than by reason of default or negligence by the Lender alone); or

11.2.4 the Loans (or part of the Loans) not being prepaid in accordance with a notice of prepayment given by the Borrower.

11.3 **Indemnity to the Lender**

The Borrower shall promptly indemnify the Lender against any cost, loss or liability incurred by the Lender (acting reasonably) as a result of:

11.3.1 investigating any event which it reasonably believes is a Default; or

11.3.2 acting or relying on any notice, request or instruction which it reasonably believes to be genuine, correct and appropriately authorised.

11.4 **Environmental indemnity**

The Borrower shall promptly indemnify the Lender within five Business Days of demand in respect of any judgments, liabilities, claims, fees, costs and expenses (including fees and disbursements of any legal, environmental consultants or other professional advisers) suffered or incurred by the Lender as a consequence of the breach of or any liability imposed under any Environmental Law with respect to the Borrower or its property (including the occupation or use of such property).

12. MITIGATION BY THE LENDER

12.1 **Mitigation**

12.1.1 The Lender shall, in consultation with the Borrower, take all reasonable steps to mitigate any circumstances which arise and which would result in any amount becoming payable under or pursuant to, or cancelled pursuant to Clause 7.1 (Illegality) including transferring its rights and obligations under the Finance Documents to another entity owned or supported by the Lender.

12.1.2 Clause 12.1.1 does not in any way limit the obligations of the Borrower under the Finance Documents.

12.2 **Limitation of liability**

12.2.1 The Borrower shall indemnify the Lender for all costs and expenses reasonably incurred by the Lender as a result of steps taken by it under Clause 12.1 (Mitigation).

12.2.2 The Lender is not obliged to take any steps under Clause 12.1 (Mitigation) if, in its opinion (acting reasonably), to do so might be prejudicial to it.

13. COSTS AND EXPENSES

13.1 **Enforcement costs**

The Borrower shall, within three Business Days of demand, pay to the Lender the amount of all costs and expenses (including legal fees) incurred by the Lender in connection with the enforcement of, or the preservation of any rights under, any Finance Document.

14. REPRESENTATIONS

The Borrower makes the representations and warranties set out in this Clause 14 to the Lender on the date of this Agreement.

14.1 **Status**

14.1.1 It is an NHS Body.

14.1.2 It is duly authorised as an NHS Body in accordance with the provisions of the Act and, except as previously disclosed in writing to the Lender, such authorisation has not been varied, amended or revoked since the date it was granted.

14.1.3 It has the power to own its assets and carry on its business as it is being conducted.

14.2 **Binding obligations**

The obligations expressed to be assumed by it in each Finance Document are legal, valid, binding and enforceable obligations.

14.3 **Non-conflict with other obligations**

The entry into and performance by it of, and the transactions contemplated by, the Finance Documents to which it is party do not and will not conflict with:

14.3.1 any law or regulation applicable to it;

14.3.2 its constitutional documents; or

14.3.3 any agreement or instrument binding upon it or any of its assets.

14.4 **Power and authority**

It has the power to enter into, exercise its rights under, perform and deliver, and has taken all necessary action to authorise its entry into, performance and delivery of, the Finance Documents to which it is a party and the transactions contemplated by those Finance Documents.

14.5 **Validity and admissibility in evidence**

All Authorisations required:

14.5.1 to enable it lawfully to enter into, exercise its rights and comply with its obligations in the Finance Documents to which it is a party; and

14.5.2 to make the Finance Documents to which it is a party admissible in evidence in its jurisdiction of incorporation,

have been obtained or effected and are in full force and effect.

14.6 **Relevant Consents**

14.6.1 All Relevant Consents which it is necessary or appropriate for the Borrower to hold have been obtained and effected and are in full force and effect.

14.6.2 There exists no reason known to it, having made all reasonable enquiries, why any Relevant Consent might be withdrawn, suspended, cancelled, varied, surrendered or revoked.

14.6.3 All Relevant Consents and other consents, permissions and approvals have been or are being complied with.

14.7 **Title to Property**

The Borrower is the sole legal and beneficial owner of the Property.

14.8 **Governing law and enforcement**

14.8.1 The choice of English law as the governing law of the Finance Documents will be recognised and enforced by the courts of England and Wales.

14.8.2 Any judgment obtained in England in relation to a Finance Document will be recognised and enforced by the courts of England and Wales.

14.9 **Deduction of Tax**

It is not required to make any deduction for or on account of Tax from any payment it may make under any Finance Document.

14.10 **No filing or stamp taxes**

It is not necessary that the Finance Documents be filed, recorded or enrolled with any court or other authority in any jurisdiction or that any stamp, registration or similar tax be paid on or in relation to the Finance Documents or the transactions contemplated by the Finance Documents.

14.11 **No default**

14.11.1 No Event of Default might reasonably be expected to result from the making of an Utilisation other than those of which the Lender and Borrower are aware.

14.11.2 No other event which constitutes a default under any other agreement or instrument which is binding on it or to which its assets are subject which might have a Material Adverse Effect might reasonably be expected to result from the making of an Utilisation other than those of which the Lender and Borrower are aware.

14.12 **No misleading information**

14.12.1 All factual information provided by or on behalf of the Borrower in connection with the Borrower or any Finance Document was true and accurate in all material respects as at the date it was provided or as at the date (if any) at which it is stated.

14.12.2 Any financial projections provided to the Lender by or on behalf of the Borrower have been prepared on the basis of recent historical information and on the basis of reasonable assumptions.

14.12.3 Nothing has occurred or been omitted and no information has been given or withheld that results in the information referred to in Clause 14.12.1 being untrue or misleading in any material respect.

14.13 **Financial statements**

14.13.1 Its financial statements most recently delivered to the Lender (being on the date of this Agreement, the Original Financial Statements) were prepared in accordance with any applicable Audit Code for NHS Bodies, any applicable Manual for Accounts for NHS Bodies and Annual Report Guidance for NHS Bodies and/or any other guidance with which NHS Bodies are (or in the case of the Original Financial Statements were) required to comply.

14.13.2 Its financial statements most recently delivered to the Lender (being on the date of this Agreement, the Original Financial Statements) fairly represent its financial condition and operations during the relevant financial year.

14.13.3 There has been no material adverse change in the business or financial condition of the Borrower since the date to which its financial statements most recently delivered to the Lender were made up.

14.14 **Ranking**

Its payment obligations under the Finance Documents rank at least pari passu with the claims of all its other unsecured and unsubordinated creditors, except for obligations mandatorily preferred by law.

14.15 **No proceedings pending or threatened**

No litigation, arbitration or administrative proceedings of or before any court, arbitral body or agency which, if adversely determined, might reasonably be expected to have a Material Adverse Effect have (to the best of its knowledge and belief) been started or threatened against it.

14.16 **Environmental Matters**

14.16.1 It is and has been in full compliance with all applicable Environmental Laws and there are, to the best of its knowledge and belief after reasonable enquiry, no circumstances that may prevent or interfere with such full compliance in the future, in each case to the extent necessary to avoid a Material Adverse Effect and the Borrower has not other than in the ordinary course of its activities placed or allowed to be placed on any part of its property any Dangerous Substance and where such Dangerous Substance has been so placed, it is kept, stored, handled, treated and transported safely and prudently so as not to pose a risk of harm to the Environment.

14.16.2 It is and has been, in compliance in all material respects with the terms of all Environmental Licences necessary for the ownership and operation of its activities as presently owned and operated and as presently proposed to be owned and operated.

14.16.3 It is not aware, having made reasonable enquiries, of any Environmental Claim.

14.17 **Repetition**

The Repeating Representations are deemed to be made by the Borrower by reference to the facts and circumstances then existing on the date of each Utilisation Request and on the first day of each Interest Period.

15. INFORMATION UNDERTAKINGS

The undertakings in this Clause 15 remain in force from the date of this Agreement for so long as any amount is outstanding under the Finance Documents or any part of the Facility is available for utilisation.

15.1 **Financial statements**

The Borrower shall supply to the Lender its audited financial statements for each financial year and its financial statements for each financial half year (including any monitoring returns sent to the appropriate Supervisory Body), in each case when such statements are provided to the appropriate Supervisory Body.

15.2 **Compliance Certificate**

15.2.1 The Borrower shall supply to the Lender, with each set of financial statements delivered pursuant to Clause 15.1 (Financial statements), a Compliance Certificate setting out (in reasonable detail) computations as to compliance with Clause 17

(Financial covenants) as at the date as at which those financial statements were drawn up.

15.2.2 Each Compliance Certificate shall be signed by two directors of the Borrower.

15.3 **Requirements as to financial statements**

15.3.1 Each set of financial statements delivered by the Borrower pursuant to Clause 15.1 (Financial statements) shall be certified by a director of the Borrower, acting on the instructions of the board of directors of the Borrower, as fairly representing its financial condition as at the date as at which those financial statements were drawn up.

15.3.2 The Borrower shall procure that each set of financial statements delivered pursuant to Clause 15.1 (Financial statements) is prepared in accordance with any applicable Audit Code for NHS Bodies and any applicable Manual for Accounts for NHS Bodies and Annual Report Guidance for NHS Bodies or in the case of the Original Financial Statements in accordance with such guidelines with which NHS Bodies are required to comply.

15.4 **Information: miscellaneous**

The Borrower shall supply to the Lender:

15.4.1 copies or details of all material communications between the Borrower and the relevant Supervisory Body, including all official notices received by the Borrower promptly after the same are made or received and, upon the Lender's request, any or all other documents, information and returns sent by it to the relevant Supervisory Body;

15.4.2 copies or details of all material communications between the Borrower and its members or its creditors (or in each case any class thereof), including all official notices received by the Borrower promptly after the same are made or received and upon the Lender's request any and all other documents dispatched by it to its members or its creditors (or in each case any class thereof), promptly after they are sent to such members or creditors;

15.4.3 details of any breaches by the Borrower of the Compliance Framework and/or any replacement to such frameworks used by the relevant Supervisory Body to assess governance and financial risk at NHS Bodies;

15.4.4 details of any breaches by the Borrower of the Licence or the terms of their Licence;

15.4.5 details of any other financial assistance or guarantee requested or received from the Secretary of State for Health other than in the ordinary course of business promptly after the same are requested or received;

15.4.6 upon the Lender's request, information regarding the application of the proceeds of the Facility;

15.4.7 promptly upon becoming aware of them, the details of any litigation, arbitration and/or administrative proceedings which are current, threatened or pending against the Borrower which would reasonably be expected to have a Material Adverse Effect;

15.4.8 promptly, such further information regarding the financial condition, business and operations of the Borrower as the Lender may reasonably request to the extent the same are relevant to the Borrower's obligations under this Agreement or otherwise significant in the assessment of the Borrower's financial performance and further to the extent that the disclosure of information will not cause the Borrower to be in

breach of any obligation of confidence owed to any third party or any relevant data protection legislation; and

15.4.9 any change in the status of the Borrower after the date of this Agreement

15.5 **Notification of default**

15.5.1 The Borrower shall notify the Lender of any Default (and the steps being taken to remedy it) promptly upon becoming aware of its occurrence.

15.5.2 Promptly upon a request by the Lender, the Borrower shall supply a certificate signed by two of its directors (acting on the instructions of the board of directors of the Borrower) on its behalf certifying that no Default is continuing (or if a Default is continuing, specifying the Default and the steps, if any, being taken to remedy it).

15.6 **Other information**

The Borrower shall promptly upon request by the Lender supply, or procure the supply of, such documentation and other evidence as is reasonably requested by the Lender (for itself or on behalf of a prospective transferee) in order for the Lender (or such prospective transferee) to carry out and be satisfied with the results of all necessary money laundering and identification checks in relation to any person that it is required to carry out pursuant to the transactions contemplated by the Finance Documents.

16. GENERAL UNDERTAKINGS

The undertakings in this Clause 16 remain in force from the date of this Agreement for so long as any amount is outstanding under the Finance Documents or any part of the Facility is available for utilisation.

16.1 **Authorisations**

The Borrower shall promptly:

16.1.1 obtain, comply with and do all that is necessary to maintain in full force and effect; and

16.1.2 supply certified copies to the Lender of any Authorisation required under any law or regulation of its jurisdiction of incorporation to enable it to perform its obligations under the Finance Documents and to ensure the legality, validity, enforceability or admissibility in evidence in England of any Finance Document.

16.2 **Compliance with laws**

The Borrower shall comply in all respects with all laws to which it may be subject, if failure so to comply would materially impair its ability to perform its obligations under the Finance Documents and shall exercise its powers and perform its functions in accordance with its constitutional documents.

16.3 **Negative pledge**

16.3.1 The Borrower shall not without the prior written consent of the Lender (such consent not to be unreasonably withheld or delayed) create or permit to subsist any Security over any of its assets save for any Permitted Security.

16.3.2 The Borrower shall not:

(A) sell, transfer or otherwise dispose of any of its assets on terms whereby they are or may be leased to or re-acquired by it;

(B) sell, transfer or otherwise dispose of any of its receivables on recourse terms;

(C) enter into any arrangement under which money or the benefit of a bank or other account may be applied, set-off or made subject to a combination of accounts; or

(D) enter into any other preferential arrangement having a similar effect,

in circumstances where the arrangement or transaction is entered into primarily as a method of raising Financial Indebtedness or of financing the acquisition of an asset.

16.4 **Disposals**

16.4.1 The Borrower shall not in a single transaction or a series of transactions (whether related or not) and whether voluntary or involuntary sell, lease, transfer or otherwise dispose of any material asset without the prior written consent of the Lender.

16.4.2 Clause 16.4.1 does not apply to any sale, lease, transfer or other disposal where the higher of the market value or consideration receivable does not (in aggregate) in any financial year exceed 10% of the total net assets of the Borrower as at the end of the most recent financial year end for which audited financial statements have been published

16.5 **Merger**

Without prejudice to Clause 16.4 (disposals) the Borrower shall not, without the prior written consent of the Lender, enter into nor apply to the relevant Supervisory Body (including pursuant to Section 56 of the Act) to enter into any amalgamation, demerger, merger or corporate reconstruction.

16.6 **Guarantees**

The Borrower will not, without the prior written consent of the Lender, give or permit to exist any guarantee or indemnity by it of any obligation of any person, nor permit or suffer any person to give any security for or guarantee or indemnity of any of its obligations except for guarantees and indemnities:

16.6.1 made in the ordinary course of the Borrower's business as an NHS Body ; and

16.6.2 which when aggregated with any loans, credit or financial accommodation made pursuant to Clause 16.7 (*Loans*) do not exceed £1,000,000 (or its equivalent in any other currency or currencies) in aggregate in any financial year.

16.7 **Loans**

The Borrower will not make any investment in nor make any loan or provide any other form of credit or financial accommodation to, any person except for investments, loans, credit or financial accommodation:

16.7.1 made in the ordinary course of the Borrower's business as an NHS Body ;

16.7.2 made in accordance with any investment policy or guidance issued by the relevant Supervisory Body; and

16.7.3 which when aggregated with any guarantees or indemnities given or existing under Clause 16.6 (*Guarantees*) do not exceed £1,000,000 (or its equivalent in any other currency or currencies) in aggregate in any financial year.

16.8 **Consents**

The Borrower must ensure that all Relevant Consents and all statutory requirements, as are necessary to enable it to perform its obligations under the Finance Documents to which it is a party, are duly obtained and maintained in full force and effect or, as the case may be, complied with.

16.9 **Activities**

The Borrower will not engage in any activities other than activities which enable it to carry on its principal purpose better, if to do so may, in the Lender's opinion, have a Material Adverse Effect.

16.10 **Environmental**

The Borrower shall:

16.10.1 obtain, maintain and comply in all material respects with all necessary Environmental Licences in relation to its activities and its property and comply with all Environmental Laws to the extent necessary to avoid a Material Adverse Effect;

16.10.2 promptly upon becoming aware notify the Lender of:

(A) any Environmental Claim current or to its knowledge threatened;

(B) any circumstances likely to result in an Environmental Claim; or

(C) any suspension, revocation or notification of any Environmental Licence;

16.10.3 indemnify the Lender against any loss or liability which:

(A) the Lender incurs as a result of any actual or alleged breach of any Environmental Law by any person; and

(B) which would not have arisen if a Finance Document had not been entered into; and

16.10.4 take all reasonable steps to ensure that all occupiers of the Borrower's property carry on their activities on the property in a prudent manner and keep them secure so as not to cause or knowingly permit material harm or damage to the Environment (including nuisance or pollution) or the significant risk thereof.

16.11 **Constitution**

The Borrower will not amend or seek to amend the terms of its authorisation as an NHS Body or the terms of its constitution without the prior written consent of the Lender, in each case if to do so would be reasonably likely to have a Material Adverse Effect.

16.12 **The relevant Supervisory Body**

The Borrower will comply promptly with all directions and notices received from the relevant Supervisory Body to the extent failure to do so might have a Material Adverse Effect and will, upon the Lender's request, provide reasonable evidence that it has so complied.

16.13 **Additional Terms and Conditions**

The Borrower will comply promptly with the Additional Terms and Conditions.

17. COMPLIANCE FRAMEWORK

17.1 Compliance

The Borrower shall ensure at all times that it complies with its Licence, the Compliance Framework and/or any replacement to such frameworks used by the relevant Supervisory Body to assess governance and financial risk at NHS Bodies.

17.2 Advance Notification

Without prejudice to the Borrower's obligations under Clause 17.1 (*Compliance*), if the Borrower becomes aware at any time on or after the first anniversary of the date of signing of the Agreement that it is or is likely to breach any of the frameworks referred to in Clause 17.1, it shall immediately notify the Lender of the details of the impending breach.

18. EVENTS OF DEFAULT

Each of the events or circumstances set out in this Clause 18 is an Event of Default.

18.1 Non-payment

The Borrower does not pay on the due date any amount payable pursuant to a Finance Document at the place at and in the currency in which it is expressed to be payable unless:

18.1.1 its failure to pay is caused by administrative or technical error; and

18.1.2 payment is made within two Business Days of its due date.

18.2 Financial Covenants and Negative Pledge

Any requirement of Clause 17 (*Financial Covenants*) or Clause 16.3 (*Negative Pledge*) is not satisfied.

18.3 Other obligations

18.3.1 The Borrower does not comply with any term of:

(A) Clause 15.5 (*Notification of default*); or

(B) Clause 16 (*General Undertakings*).

18.3.2 The Borrower does not comply with any term of any Finance Document (other than those referred to in Clause 18.1 (*Non-payment*), Clause 18.2 (*Financial Covenants and Negative Pledge*) and Clause 18.3.1(*Other obligations*) unless the failure to comply is capable of remedy and is remedied within ten Business Days of the earlier of the Lender giving notice or the Borrower becoming aware of the failure to comply.

18.4 Misrepresentation

Any representation or statement made or deemed to be made by the Borrower in any Finance Document or any other document delivered by or on behalf of the Borrower under or in connection with any Finance Document is or proves to have been incorrect or misleading in any material respect when made or deemed to be made.

18.5 Cross default

18.5.1 Any Financial Indebtedness of the Borrower is not paid when due nor within any originally applicable grace period.

18.5.2 Any Financial Indebtedness of the Borrower is declared to be or otherwise becomes due and payable prior to its specified maturity as a result of an event of default (however described).

18.5.3 Any commitment for any Financial Indebtedness of the Borrower is cancelled or suspended by a creditor of the Borrower as a result of an event of default (however described).

18.5.4 Any creditor of the Borrower becomes entitled to declare any Financial Indebtedness of the Borrower due and payable prior to its specified maturity as a result of an event of default (however described).

18.5.5 No Event of Default will occur under this Clause 18.5 if the aggregate amount of Financial Indebtedness or commitment for Financial Indebtedness falling within Clauses 18.5.1 to 18.5.4 is less than £250,000 (or its equivalent in any other currency or currencies).

except that for as long as the Secretary of State for Health remains the Lender, the provisions of Clause 18.5 relate to Financial Indebtedness owed to any party but do not apply to amounts owed to other NHS bodies in the normal course of business where a claim has arisen which is being disputed in good faith or where the Borrower has a valid and contractual right of setoff.

18.6 **Insolvency**

18.6.1 The Borrower is unable or admits inability to pay its debts as they fall due, suspends making payments on any of its debts or, by reason of actual or anticipated financial difficulties, commences negotiations with one or more of its creditors with a view to rescheduling any of its indebtedness.

18.6.2 A moratorium is declared in respect of any indebtedness of the Borrower.

18.7 **Insolvency proceedings**

Any corporate action, legal proceedings or other procedure or step is taken:

18.7.1 in relation to a composition, assignment or arrangement with any creditor of the Borrower; or

18.7.2 in relation to the appointment of a liquidator, receiver, administrator, administrative receiver, compulsory manager or other similar officer in respect of the Borrower or any of its assets; or

18.7.3 in relation to the enforcement of any Security over any assets of the Borrower,

or any analogous action, proceedings, procedure or step is taken in any jurisdiction.

18.8 **Appointment of a Trust Special Administrator**

An order, made by The Secretary of State, authorising the appointment of a Trust Special Administrator or a valid application to the court for a Health Special Administration Order by Monitor as defined by the Act.

18.9 **Creditors' process**

Any expropriation, attachment, sequestration, distress or execution affects any asset or assets of the Borrower having an aggregate value of £250,000 and is not discharged within ten Business Days.

18.10 **Repudiation**

The Borrower or any other party to a Finance Document repudiates any of the Finance Documents or does or causes to be done any act or thing evidencing an intention to repudiate any Finance Document.

18.11 **Cessation of Business**

Other than with the prior written approval of the Lender, the Borrower ceases, or threatens to cease, to carry on all or a substantial part of its business or operations.

18.12 **Unlawfulness**

It is or becomes unlawful for the Borrower or any other party to a Finance Document to perform any of its obligations under any Finance Document.

18.13 **Material adverse change**

Any event or circumstance or series of events or circumstances occurs which, in the reasonable opinion of the Lender, has or is reasonably likely to have a Material Adverse Effect.

18.14 **Additional Terms and Conditions**

In the reasonable opinion of the Lender, the Borrower fails to make reasonable efforts to comply with the Additional Terms and Conditions.

18.15 **Acceleration**

On and at any time after the occurrence of an Event of Default which is continuing the Lender may by notice to the Borrower:

18.15.1 cancel the Facility whereupon it shall immediately be cancelled; and/or

18.15.2 declare that all or part of the Loans, together with accrued interest, and all other amounts accrued or outstanding under the Finance Documents be immediately due and payable, whereupon they shall become immediately due and payable; and/or

18.15.3 declare that all or part of the Loans be payable on demand, whereupon they shall immediately become payable on demand by the Lender.

19. ASSIGNMENTS AND TRANSFERS

19.1 **Assignments and transfers by the Lender**

Subject to this Clause 19, the Lender may:

19.1.1 assign any of its rights; or

19.1.2 transfer by novation any of its rights and obligations,

to another entity owned or supported by the Lender or to a bank or a financial institution or to a trust, fund or other entity which is regularly engaged in or established for the purpose of making, purchasing or investing in loans, securities or other financial assets (the **"New Lender"**).

19.2 **Conditions of assignment or transfer**

19.2.1 The consent of the Borrower is required for an assignment or transfer by the Lender, unless:

(A) the assignment or transfer is to an entity owned or supported by the Lender; or

(B) a Default is continuing.

19.2.2 The consent of the Borrower to an assignment or transfer must not be unreasonably withheld or delayed. The Borrower will be deemed to have given its consent twenty Business Days after the Lender has requested it unless consent is expressly refused (and reasons for such refusal are given) by the Borrower within that time.

provided that nothing in this Clause shall restrict the rights of the Secretary of State for Health to effect a statutory transfer.

19.3 **Disclosure of information**

The Lender may disclose to any person:

19.3.1 to (or through) whom the Lender assigns or transfers (or may potentially assign or transfer) all or any of its rights and obligations under the Finance Documents;

19.3.2 with (or through) whom the Lender enters into (or may potentially enter into) any transaction under which payments are to be made by reference to, any Finance Document or the Borrower;

19.3.3 to whom, and to the extent that, information is required to be disclosed by any applicable law or regulation;

19.3.4 which are investors or potential investors in any of its rights and obligations under the Finance Documents and only to the extent required in relation to such rights and obligations;

19.3.5 which is a governmental, banking, taxation or other regulatory authority and only to the extent information is required to be disclosed to such authority,

any information about the Borrower and/or the Finance Documents as the Lender shall consider appropriate if, in relation to Clauses 19.3.1, 19.3.2 and 19.3.4 the person to whom the information is to be given has agreed to keep such information confidential on terms of this Clause 19.3 provided always that the Lender shall comply with any relevant data protection legislation.

19.4 **Assignment and transfer by the Borrower**

The Borrower may not assign any of its rights or transfer any of its rights or obligations under the Finance Documents.

20. ROLE OF THE LENDER

20.1 **Rights and discretions of the Lender**

20.1.1 The Lender may rely on:

(A) any representation, notice or document believed by it to be genuine, correct and appropriately authorised; and

(B) any statement made by a director, authorised signatory or authorised employee of any person regarding any matters which may reasonably be assumed to be within his knowledge or within his power to verify.

20.1.2 The Lender may engage, pay for and rely on the advice or services of any lawyers, accountants, surveyors or other experts.

20.1.3 The Lender may act in relation to the Finance Documents through its personnel and agents.

20.1.4 Notwithstanding any other provision of any Finance Document to the contrary, the Lender is not obliged to do or omit to do anything if it would or might in its reasonable opinion constitute a breach of any law or a breach of a fiduciary duty or duty of confidentiality.

20.2 **Exclusion of liability**

20.2.1 Without limiting Clause 20.2.2, the Lender will not be liable for any omission or any act taken by it under or in connection with any Finance Document, unless directly caused by its gross negligence or wilful misconduct.

20.2.2 The Borrower may not take any proceedings against any officer, employee or agent of the Lender in respect of any claim it might have against the Lender or in respect of any act or omission of any kind by that officer, employee or agent in relation to any Finance Document and any officer, employee or agent of the Lender may rely on this Clause. Any third party referred to in this Clause 20.2.2 may enjoy the benefit of or enforce the terms of this Clause in accordance with the provisions of the Contracts (Rights of Third Parties) Act 1999.

20.2.3 The Lender will not be liable for any delay (or any related consequences) in crediting an account with an amount required under the Finance Documents to be paid by the Lender if the Lender has taken all necessary steps as soon as reasonably practicable to comply with the regulations or operating procedures of any recognised clearing or settlement system used by the Lender for that purpose.

20.2.4 The Lender shall not be liable:

(A) for any failure by the Borrower to give notice to any third party or to register, file or record (or any defect in such registration, filing or recording) any Finance Document; or

(B) for any failure by the Borrower to obtain any licence, consent or other authority required in connection with any of the Finance Documents; or

(C) For any other omission or action taken by it in connection with any Finance Document unless directly caused by its gross negligence or wilful misconduct.

21. PAYMENT MECHANICS

21.1 **Payments**

21.1.1 The Borrower shall receive notification 10 working days prior to each payment required under a Finance Document, the Borrower shall make the same available to the Lender (unless a contrary indication appears in a Finance Document) for value on the due date at the time and in such funds specified by the Lender as being customary at the time for settlement of transactions in the relevant currency in the place of payment.

21.1.2 Payment shall be collected through Direct Debit from a Borrower's account with the Government Banking Service.

21.2 **Distributions to the Borrower**

The Lender may (with the consent of the Borrower or in accordance with Clause 22 (*Set-off*)) apply any amount received by it for the Borrower in or towards payment (on the date and in

the currency and funds of receipt) of any amount due from the Borrower under the Finance Documents or in or towards purchase of any amount of any currency to be so applied.

21.3 **Partial payments**

If the Lender receives a payment that is insufficient to discharge all the amounts then due and payable by the Borrower under the Finance Documents, the Lender shall apply that payment towards the obligations of the Borrower in such order and in such manner as the Lender may at its discretion decide.

21.4 **No set-off**

All payments to be made by the Borrower under the Finance Documents shall be calculated and be made without (and free and clear of any deduction for) set-off or counterclaim.

21.5 **Business Days**

21.5.1 Any payment which is due to be made on a day that is not a Business Day shall be made on the next Business Day in the same calendar month (if there is one) or the preceding Business Day (if there is not).

21.5.2 During any extension of the due date for payment of any principal or Unpaid Sum under this Agreement, interest is payable on the principal or Unpaid Sum at the rate payable on the original due date.

21.6 **Currency of account**

21.6.1 Subject to Clauses 21.6.2 to 21.6.5, sterling is the currency of account and payment for any sum due from the Borrower under any Finance Document.

21.6.2 A repayment of the Loan or Unpaid Sum or a part of the Loan or Unpaid Sum shall be made in the currency in which the Loan or Unpaid Sum is denominated on its due date.

21.6.3 Each payment of interest shall be made in the currency in which the sum in respect of which the interest is payable was denominated when that interest accrued.

21.6.4 Each payment in respect of costs, expenses or Taxes shall be made in the currency in which the costs, expenses or Taxes are incurred.

21.6.5 Any amount expressed to be payable in a currency other than sterling shall be paid in that other currency.

21.7 **Change of currency**

21.7.1 Unless otherwise prohibited by law, if more than one currency or currency unit are at the same time recognised by the central bank of any country as the lawful currency of that country, then:

(A) any reference in the Finance Documents to, and any obligations arising under the Finance Documents in, the currency of that country shall be translated into, or paid in, the currency or currency unit of that country designated by the Lender (after consultation with the Borrower); and

(B) any translation from one currency or currency unit to another shall be at the official rate of exchange recognised by the central bank for the conversion of that currency or currency unit into the other, rounded up or down by the Lender (acting reasonably).

21.7.2 If a change in any currency of a country occurs, this Agreement will, to the extent the Lender (acting reasonably and after consultation with the Borrower) specifies to be necessary, be amended to comply with any generally accepted conventions and market practice in the London interbank market and otherwise to reflect the change in currency.

22. SET-OFF

The Lender may set off any matured obligation due from the Borrower under the Finance Documents against any matured obligation owed by the Lender to the Borrower, regardless of the place of payment, booking branch or currency of either obligation. If the obligations are in different currencies, the Lender may convert either obligation at a market rate of exchange in its usual course of business for the purpose of the set-off.

23. NOTICES

23.1 Communications in writing

Any communication to be made under or in connection with the Finance Documents shall be made in writing and, unless otherwise stated, may be given in person, by post, fax or by electronic communication.

23.2 Addresses

The address and fax number (and the department or officer, if any, for whose attention the communication is to be made) of each Party for any communication or document to be made or delivered under or in connection with the Finance Documents is:

23.2.1 in the case of the Borrower, that identified with its name below; and

23.2.2 in the case of the Lender, that identified with its name below,

or any substitute address, email address, fax number or department or officer as the Borrower may notify to the Lender by not less than five Business Days' written notice.

23.3 Delivery

23.3.1 Any communication or document made or delivered by one person to another under or in connection with the Finance Documents will only be effective:

(A) if by way of fax, when received in legible form; or

(B) if by way of letter, when it has been left at the relevant address or five Business Days after being deposited in the post postage prepaid in an envelope addressed to it at that address,

and, if a particular department or officer is specified as part of its address details provided under Clause 23.2 (*Addresses*), if addressed to that department or officer.

23.3.2 Any communication or document to be made or delivered to the Lender will be effective only when actually received by the Lender and then only if it is expressly marked for the attention of the department or officer identified with the Lender's signature below (or any substitute department or officer as the Lender shall specify for this purpose).

23.4 Electronic communication

23.4.1 Any communication to be made between the Borrower and the Lender under or in connection with this Agreement and any other Finance Document may be made by electronic mail or other electronic means, if the Borrower and the Lender:

(A) agree that, unless and until notified to the contrary, this is to be an accepted form of communication;

(B) notify each other in writing of their electronic mail address and/or any other information required to enable the sending and receipt of information by that means; and

(C) notify each other of any change to their address or any other such information supplied by them.

23.4.2 Any electronic communication made between the Borrower and the Lender will be effective only when actually received in readable form and only if it is addressed in such a manner as the Borrower and the Lender, as the case may be, specify for this purpose.

24. CALCULATIONS AND CERTIFICATES

24.1 Accounts

In any litigation or arbitration proceedings arising out of or in connection with a Finance Document, the entries made in the accounts maintained by the Lender are *prima facie* evidence of the matters to which they relate.

24.2 Certificates and Determinations

Any certification or determination by the Lender of a rate or amount under any Finance Document is, in the absence of manifest error, conclusive evidence of the matters to which it relates.

24.3 Day count convention

Any interest, commission or fee accruing under a Finance Document will accrue from day to day and is calculated on the basis of the actual number of days elapsed and a year of 365 days or, in any case where the practice in the London interbank market differs, in accordance with that market practice.

25. PARTIAL INVALIDITY

If, at any time, any provision of the Finance Documents is or becomes illegal, invalid or unenforceable in any respect under any law of any jurisdiction, neither the legality, validity or enforceability of the remaining provisions nor the legality, validity or enforceability of such provision under the law of any other jurisdiction will in any way be affected or impaired.

26. REMEDIES AND WAIVERS

No failure to exercise, nor any delay in exercising, on the part of the Lender, any right or remedy under the Finance Documents shall operate as a waiver, nor shall any single or partial exercise of any right or remedy prevent any further or other exercise or the exercise of any other right or remedy. The rights and remedies provided in this Agreement are cumulative and not exclusive of any rights or remedies provided by law.

27. AMENDMENTS AND WAIVERS

Any term of the Finance Documents may only be amended or waived in writing.

28. COUNTERPARTS

Each Finance Document may be executed in any number of counterparts, and this has the same effect as if the signatures on the counterparts were on a single copy of the Finance Document.

29. GOVERNING LAW

This Agreement shall be governed by and construed in accordance with English law.

30. DISPUTE RESOLUTION

The Parties agree that all disputes arising out of or in connection with this Agreement will be settled in accordance with the terms of Schedule 5.

This Agreement has been entered into on the date stated at the beginning of this Agreement.

SCHEDULE 1: CONDITIONS PRECEDENT

1. Authorisations

1.1 A copy of a resolution of the board of directors of the Borrower:

(A) approving the terms of, and the transactions contemplated by, the Finance Documents to which it is a party and resolving that it execute the Finance Documents to which it is a party;

(B) authorising a specified person or persons to execute the Finance Documents to which it is a party on its behalf; and

(C) authorising a specified person or persons, on its behalf, to sign and/or despatch all documents and notices (including, if relevant, any Utilisation Request and) to be signed and/or despatched by it under or in connection with the Finance Documents to which it is a party.

(D) Confirming the Borrower's undertaking to comply with the Additional Terms and Conditions

1.2 A certificate of an authorised signatory of the Borrower certifying that each copy document relating to it specified in this Schedule 1 and provided to the Lender is correct, complete and in full force and effect as at a date no earlier than the date of this Agreement.

2. Financial Information

Updated financial statements of the Borrower unless otherwise available.

3. Finance Documents

3.1 This Agreement (original).

3.2 The original or certified copy (as the Lender shall require) of any Finance Document not listed above.

4. General

4.1 A copy of any other Authorisation or other document, opinion or assurance which the Lender considers to be necessary or desirable in connection with the entry into and performance of the transactions contemplated by any Finance Document or for the validity and enforceability of any Finance Document.

4.2 Evidence that the fees, costs and expenses then due from the Borrower pursuant to Clause 13 (*Costs and expenses*) have been paid or will be paid by the first Utilisation Date.

SCHEDULE 2: UTILISATION REQUEST

From:[ ]

To: The Secretary of State for Health

Dated:

Dear Sirs

[ ] – £
dated [ ] (the "Agreement")

1. We refer to the Agreement. This is a Utilisation Request. Terms defined in the Agreement have the same meaning in this Utilisation Request unless given a different meaning in this Utilisation Request.

2. We wish to borrow a Loan on the following terms:

Proposed Utilisation Date:	[ ] (or, if that is not a Business Day, the next Business Day)
Amount:	[ ] or, if less, the Available Facility
Payment Instructions:	[*Relevant account to be specified here*]

3. We confirm that each condition specified in Clause 4.2 (Further conditions precedent) is satisfied on the date of this Utilisation Request.

4. We represent and warrant that the Loan will be applied solely towards capital expenditure in respect of Agreed Purpose.

5. This Utilisation Request is irrevocable.

Yours faithfully

……
authorised signatory for and on behalf of the Board of Directors
[ ]

SCHEDULE 3: AGREED PURPOSE

Essential capital expenditure in 2014-15.

SCHEDULE 4: ANTICIPATED DRAWDOWN SCHEDULE

£000	Q1	Q2	Q3	Q4	TOTAL
2014-15	0	0	0	12,000	**12,000**
TOTAL					**12,000**

SCHEDULE 5: DISPUTE RESOLUTION

1. NEGOTIATION

If any claim, dispute or difference of whatsoever nature arising out of or in connection with this Agreement ("**Dispute(s)**") arises, the Parties will attempt in good faith to settle it by negotiation. Each Party will nominate at least one management representative ("**Authorised Representative**") who shall attend and participate in the negotiation with authority to negotiate a solution on behalf of the Party so represented.

2. MEDIATION

It shall be a condition precedent to the commencement of reference to arbitration that the Parties have sought to have the dispute resolved amicably by mediation as provided by this paragraph 2.

2.1 Initiation of Mediation Proceeding

(A) If the Parties are unable to settle the Dispute(s) by negotiation in accordance with paragraph 1 within 15 days, either Party may by written notice upon the other initiate mediation under this paragraph 2. The notice initiating mediation shall describe generally the nature of the Dispute.

(B) Each Party's Authorised Representative nominated in accordance with paragraph 1 shall attend and participate in the mediation with authority to negotiate a settlement on behalf of the Party so represented.

2.2 Appointment of Mediator

(A) The Parties shall appoint, by agreement, a neutral third person to act as a mediator (the "Mediator") to assist them in resolving the Dispute. If the Parties are unable to agree on the identity of the Mediator within 10 days after notice initiating mediation either party may request the Centre for Effective Dispute Resolution ("CEDR Solve") to appoint a Mediator.

(B) The Parties will agree the terms of appointment of the Mediator and such appointment shall be subject to the Parties entering into a formal written agreement with the Mediator regulating all the terms and conditions including payment of fees in respect of the appointment. If the Parties are unable to agree the terms of appointment of the Mediator within 10 days after notice initiating mediation either Party may request CEDR Solve to decide the terms of appointment of the Mediator

(C) If the appointed Mediator is or becomes unable or unwilling to act, either Party may within 10 days of the Mediator being or becoming unable or unwilling to act follow the process at paragraph 2.3 to appoint a replacement Mediator and paragraph 2.4 to settle the terms of the appointment of the replacement Mediator.

2.3 Determination of Procedure

The Parties shall, with the assistance of the Mediator, seek to agree the mediation procedure. In default of such agreement, the Mediator shall act in accordance with CEDR Solve's Model Mediation Procedure and Agreement. The Parties shall within 10 days of the appointment of the Mediator, meet (or talk to) the Mediator in order to agree a programme for the exchange of any relevant information and the structure to be adopted for the mediation.

2.4 Without Prejudice/Confidentiality

All rights of the Parties in respect of the Dispute(s) are and shall remain fully reserved and the entire mediation including all documents produced or to which reference is made, discussions and oral presentations shall be strictly confidential to the Parties and shall be conducted on the same basis as "without prejudice" negotiations, privileged, inadmissible, not subject to disclosure in any other proceedings whatever and shall not constitute any waiver of privilege whether between the Parties or between either of them and a third party. Nothing in this paragraph 2.4 shall make any document privileged, inadmissible or not subject to disclosure which would have been discloseable in any reference to arbitration commenced pursuant to paragraph 3.

2.5 **Resolution of Dispute**

If any settlement agreement is reached with the assistance of the Mediator which resolves the Dispute, such agreement shall be set out in a written settlement agreement and executed by both parties' Authorised Representatives and shall not be legally binding unless and until both parties have observed and complied with the requirements of this paragraph 2.5. Once the settlement agreement is legally binding, it may be enforced by either party taking action in the High Court.

2.6 **Failure to Resolve Dispute**

In the event that the Dispute(s) has not been resolved to the satisfaction of either Party within 30 days after the appointment of the Mediator either party may refer the Dispute to arbitration in accordance with paragraph 3.

2.7 **Costs**

Unless the Parties otherwise agree, the fees and expenses of the Mediator and all other costs of the mediation shall be borne equally by the Parties and each Party shall bear their own respective costs incurred in the mediation regardless of the outcome of the mediation.

3. **ARBITRATION**

3.1 If the Parties are unable to settle the Dispute(s) by mediation in accordance with paragraph 2 within 30 days, the Dispute(s) shall be referred to and finally determined by arbitration before an Arbitral Tribunal composed of a single Arbitrator.

3.2 Any reference of a Dispute to arbitration shall be determined in accordance with the provisions of the Arbitration Act 1996 and in accordance with such arbitration rules as the Parties may agree within 20 days after notice initiating arbitration or, in default of agreement, in accordance with the Rules of the London Court of International Arbitration which Rules are deemed to be incorporated by reference into this clause.

3.3 London shall be the seat of the arbitration.

3.4 Reference of a Dispute to arbitration shall be commenced by notice in writing from one Party to the other Party served in accordance with the provisions of Clause 23 (Notices).

3.5 The Arbitral Tribunal shall be appointed as follows.

(A) Within 14 days of receipt of any notice referring a Dispute to arbitration the Parties shall agree the identity of the person to act as Arbitrator. In default of agreement or in the event the person so identified is unable or unwilling to act, either party shall be entitled to request the President for the time being of the Chartered Institute of

Arbitrators to appoint an Arbitrator for the Dispute and the parties shall accept the person so appointed.

(B) If the Arbitrator becomes unwilling or unable to act, the procedure for the appointment of a replacement Arbitrator shall be in accordance with the provisions of paragraph 3.5(A).

3.6 The language of the arbitration shall be English.

SCHEDULE 6: REPAYMENT SCHEDULE

Repayment Date	Relevant Percentage
18 September 2015	2.27%
18 March 2016	2.27%
18 September 2016	2.27%
18 March 2017	2.27%
18 September 2017	2.27%
18 March 2018	2.27%
18 September 2018	2.27%
18 March 2019	2.27%
18 September 2019	2.27%
18 March 2020	2.27%
18 September 2020	2.27%
18 March 2021	2.27%
18 September 2021	2.27%
18 March 2022	2.27%
18 September 2022	2.27%
18 March 2023	2.27%
18 September 2023	2.27%
18 March 2024	2.27%
18 September 2024	2.27%
18 March 2025	2.27%
18 September 2025	2.27%
18 March 2026	2.27%
18 September 2026	2.27%
18 March 2027	2.27%
18 September 2027	2.27%
18 March 2028	2.27%
18 September 2028	2.27%
18 March 2029	2.27%
18 September 2029	2.27%
18 March 2030	2.27%
18 September 2030	2.27%
18 March 2031	2.27%
18 September 2031	2.27%
18 March 2032	2.27%
18 September 2032	2.27%
18 March 2033	2.27%
18 September 2033	2.27%
18 March 2034	2.27%
18 September 2034	2.27%
18 March 2035	2.27%
18 September 2035	2.27%
18 March 2036	2.27%
18 September 2036	2.27%
18 March 2037	2.39%

SCHEDULE 7: PERMITTED SECURITY – EXISTING SECURITY

NONE

SCHEDULE 8: ADDITIONAL TERMS AND CONDITIONS

NONE

SIGNATORIES

Borrower

For and on behalf of UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

By:

Name:

Position:

Address: Headquarters
Level 3, Balmoral Building
Leicester Royal Infirmary
Infirmary Square
Leicester
Leicestershire
LE1 5WW

Email: paul.traynor@uhl-tr.nhs.uk

Attention: Paul Traynor

Lender

The Secretary of State for Health

By:

Name:

Address: Department of Health,
4th Floor,
Skipton House,
80 London Road,
London SE1 6LH

Email: dhloanscentralinbox@dh.gsi.gov.uk

Agenda Item: Trust Board Paper K

TRUST BOARD – 5 March 2015

Emergency Care Performance Report

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

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

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

- Performance in January 2015 was 90.2%.
- As detailed in the attached report admissions remain very high.
- There has been recent progress on delayed transfers of care.

Key points

As discussed in previous trust boards, the following remain key risks:

1. Communications- Attendances and admissions remain high. It is felt that an LLR communications message directly to GPs, care homes, nursing home and carers of patients restating the importance of choosing wisely and acknowledging where the risks currently are, may gain more traction than the current plan.
2. There remains an urgent requirement to spot purchase nursing home and care home beds to alleviate some of the pressure within UHL and LPT, whilst noting concerns about opening additional nursing and care home beds at short notice
3. Surge capacity – we continue to see increasing rates of admissions and we have no surge capacity
4. Progress has been made with short notice cancellations but risks remain around; EMAS capacity, overcrowding in ED/ CDU, handover delays in ED and overstretched nursing and medical capacity.
5. Plans have not been agreed yet for the spend of investment monies for emergency admissions and readmissions in 2015- 16.
6. We need to unite the deliverability of the urgent care agenda and Better Care Together.

Conclusion

To achieve sustainable improvement requires all parts of the health economy to improve. The fragile nature of the pathway means that slow adoption of improvements in one part of the health economy will hinder the overall improvement. We need to be ambitious for the level of improvement we require of each other.

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

Only improving the rate of discharge does not consistute a sustainable plan.

Recommendations

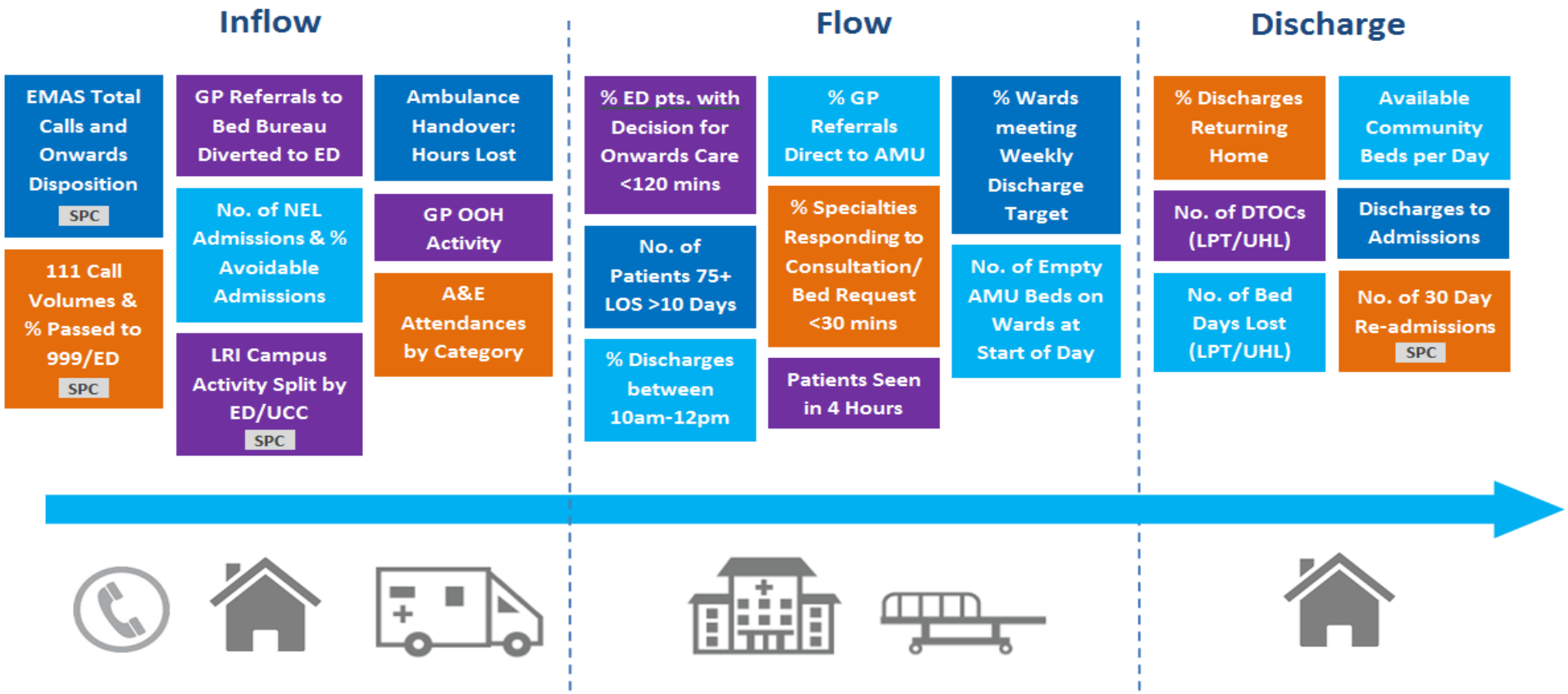
The Trust Board is recommended to:

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

Urgent Care Board - Dashboard

Updated Monday 23rd February 2015

Arden&GEM



Data Quality

Low Data counts for UHL Admissions and Discharges (last 2 weeks - reported to UHL Info Team).

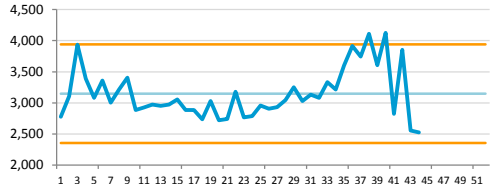
All Metrics are shown Weekly with the Year Running from 1st April 2014

Urgent Care Board - Dashboard

Updated Monday 23rd February 2015

INFLOW

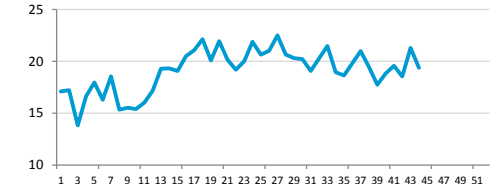
111 Total Calls



Current Wk
2,527

2014/15 AVG
3,148

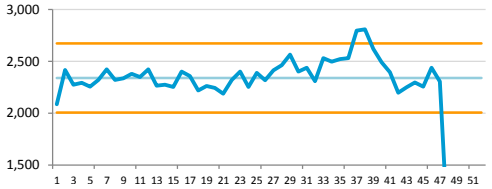
% of 111 Calls sent to 999/ED



Current Wk
19.4%

2014/15 AVG
19.1%

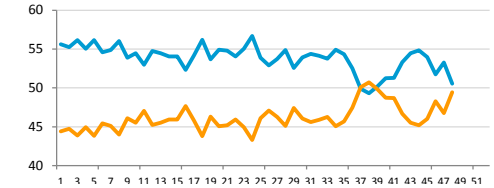
EMAS Calls



Current Wk
781

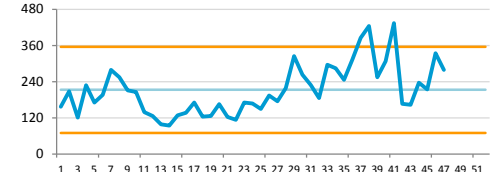
2014/15 AVG
2,341

EMAS Disposition



	Conveyed	Non Conveyed
Current Wk	50.5%	49.5%
2014/15 AVG	53.8%	46.2%

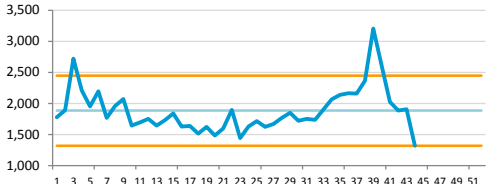
EMAS Ambulance Handover: Hours Lost



Current Wk
278

2014/15 AVG
212

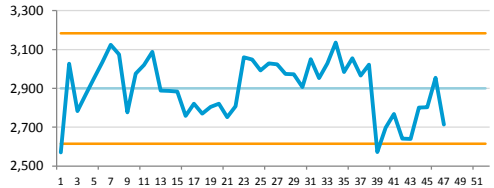
GP OOH Activity



Current Wk
1,318

2014/15 AVG
1,884

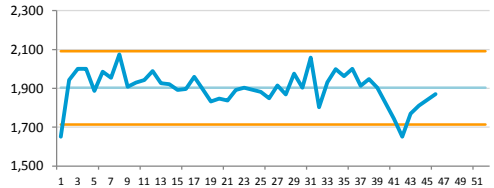
ED: LRI Attendances



Current Wk
2,713

2014/15 AVG
2,899

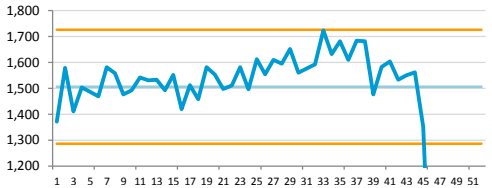
ED: UCC Attendances



Current Wk
1,870

2014/15 AVG
1,903

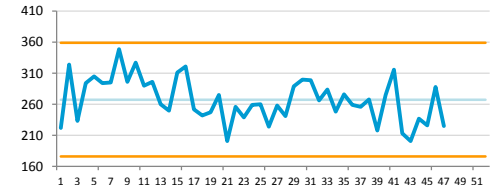
UHL Emergency Admissions



Current Wk
588

2014/15 AVG
1,506

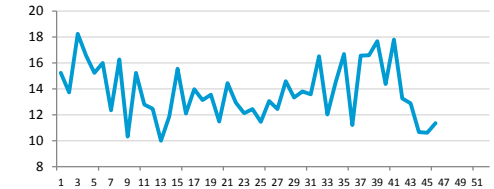
GP Referrals to Bed Bureau that are Diverted to ED



Current Wk
225

2014/15 AVG
267

% of UHL Emergency Admissions that were Avoidable



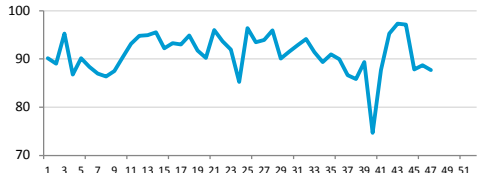
Current Wk
11.4%

2014/15 AVG
13.8%

All Metrics are shown Weekly with the Year Running from 1st April 2014

FLOW

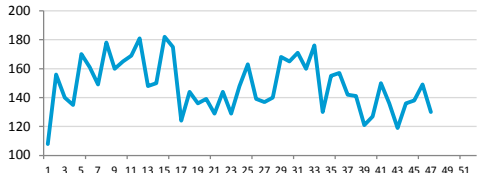
% of UHL and UCC Attendances seen within 4 Hours



Current Wk **87.7%**

2014/15 AVG **91.1%**

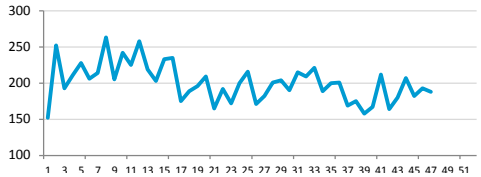
UHL ED with Decision about Onward Care within 120 mins (Actual)



Current Wk **130**

2014/15 AVG **148**

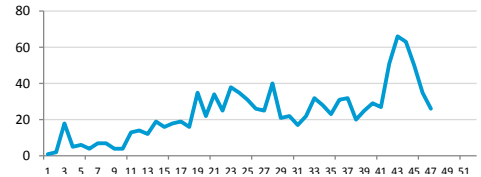
UHL Ward Response to ED/Bed Requests within 30 mins (Actual)



Current Wk **188**

2014/15 AVG **201**

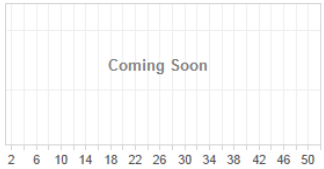
UHL GP Referrals Direct to AMU (Actual)



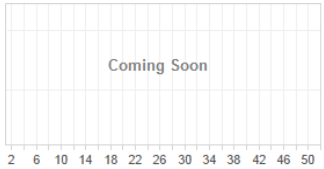
Current Wk **26**

2014/15 AVG **24**

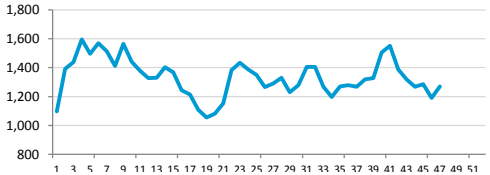
UHL Empty Beds at Start of Day on AMU Ward



% of UHL Wards Achieving Targeted Weekly Discharges



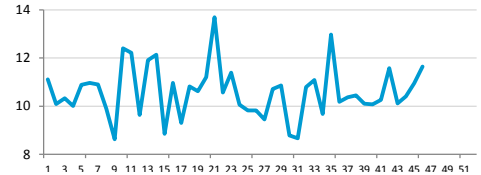
Aged 75+ with Length of Stay >10 days at UHL



Current Wk **1,271**

2014/15 AVG **1,333**

% of Discharges between 10am and 12pm at UHL



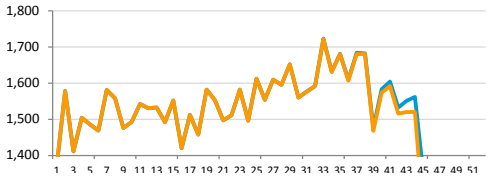
Current Wk **11.6%**

2014/15 AVG **10.6%**

All Metrics are shown Weekly with the Year Running from 1st April 2014

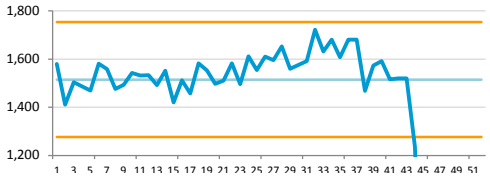
DISCHARGES

UHL Discharges against Admissions



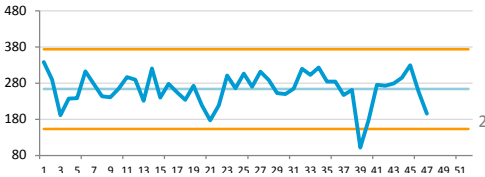
	ADM	DIS
Current Wk	588	305
2014/15 AVG	1,506	1,515

UHL Discharges



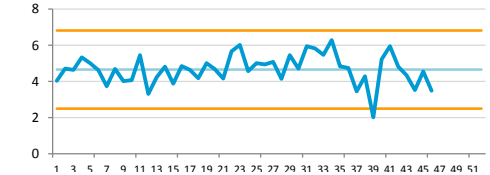
Current Wk: **305**
2014/15 AVG: **1,515**

LPT Discharges



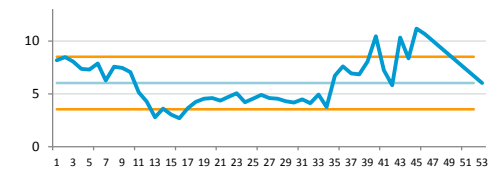
Current Wk: **196**
2014/15 AVG: **264**

UHL Delayed Transfers of Care



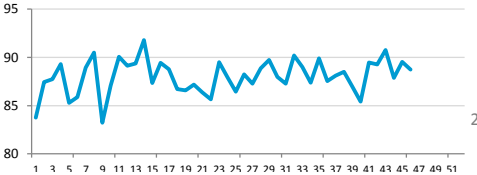
Current Wk: **3.5**
2014/15 AVG: **4.7**

LPT Delayed Transfers of Care



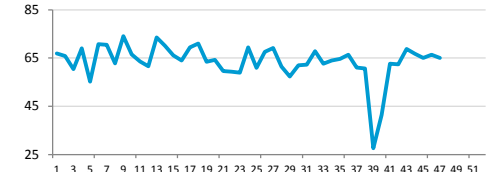
Current Wk: **10.6**
2014/15 AVG: **10.6**

% of UHL Discharged to Admitting Address



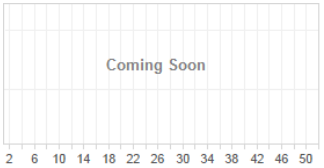
Current Wk: **88.7%**
2014/15 AVG: **88.0%**

% of LPT Discharged to Admitting Address

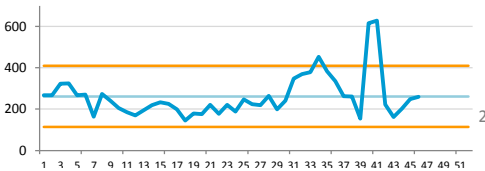


Current Wk: **65.0%**
2014/15 AVG: **63.6%**

Average Beds Available in Community

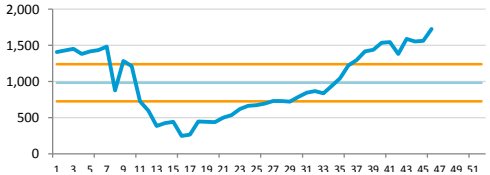


UHL Delayed Transfers of Care - Bed Days Lost



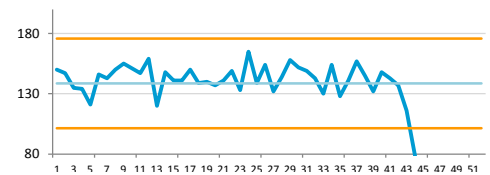
Current Wk: **259**
2014/15 AVG: **261**

LPT Delayed Transfers of Care - Bed Days Lost



Current Wk: **1,725**
2014/15 AVG: **984**

30 Day Readmission Rate



Current Wk: **27**
2014/15 AVG: **139**

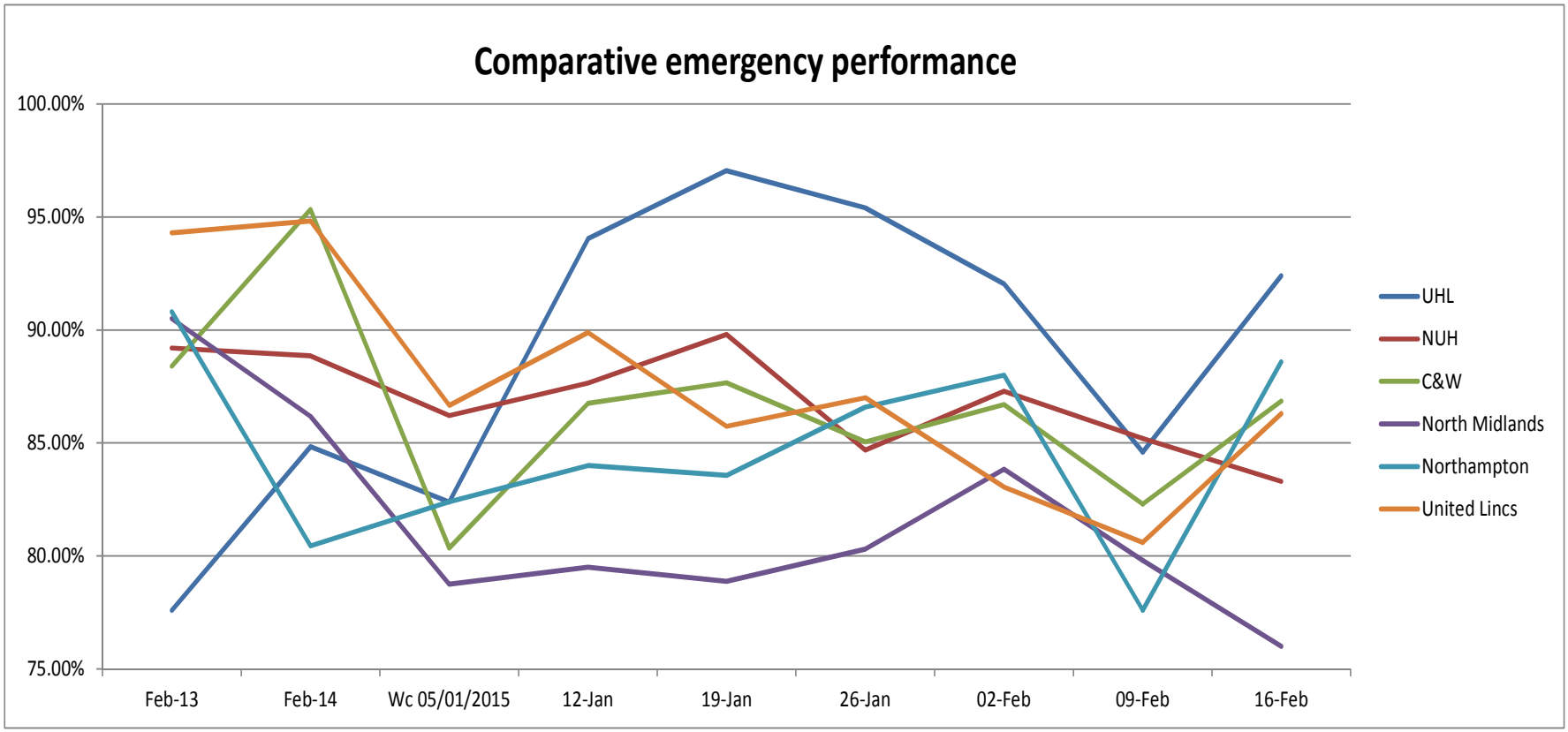
All Metrics are shown Weekly with the Year Running from 1st April 2014

Paper K1

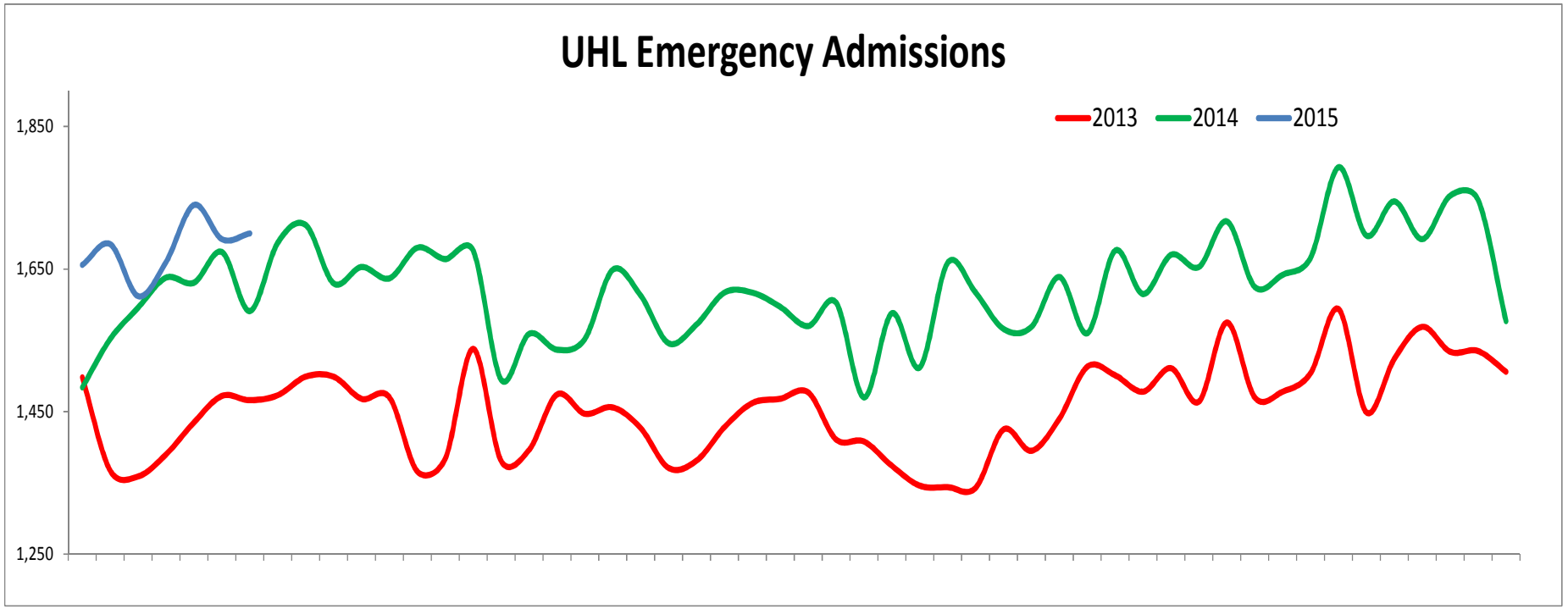
UHL emergency performance

Trust Board

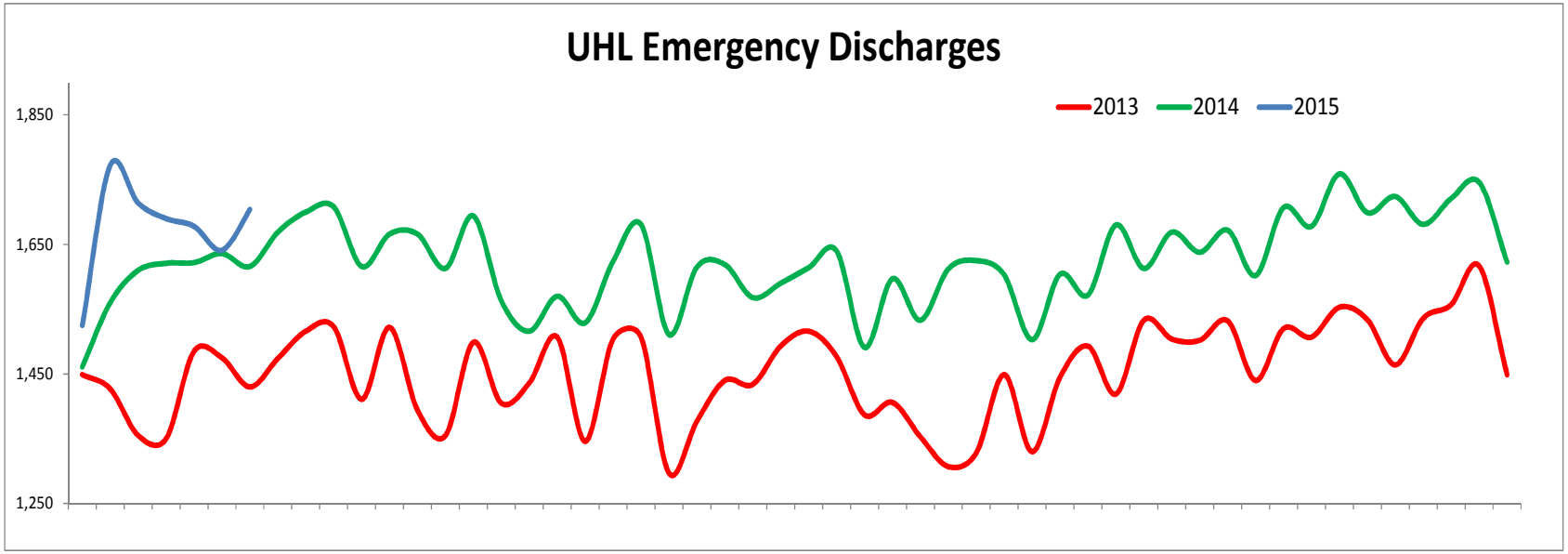
5 March 2015



- Feb 2013 – worst in the NHS
- 85% Feb 2014 – 130/140
- 89% Feb 2015 – 72/140
- Strongest performance against peer group and only Trust whose performance has improved

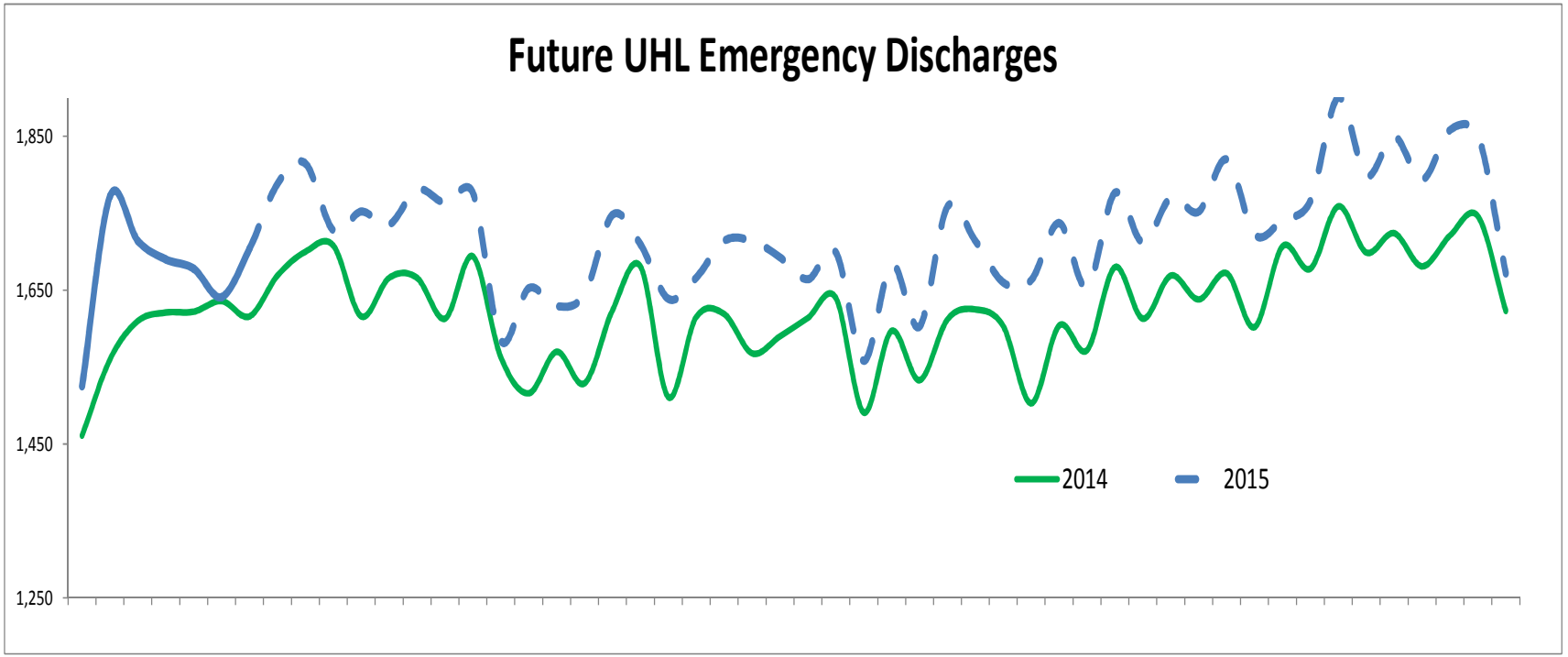


- Admissions are increasing year on year
- 51 weeks out of 52 in 2014 had higher admissions than corresponding week year before
- So far admissions in 2015 are higher still – this is a huge risk

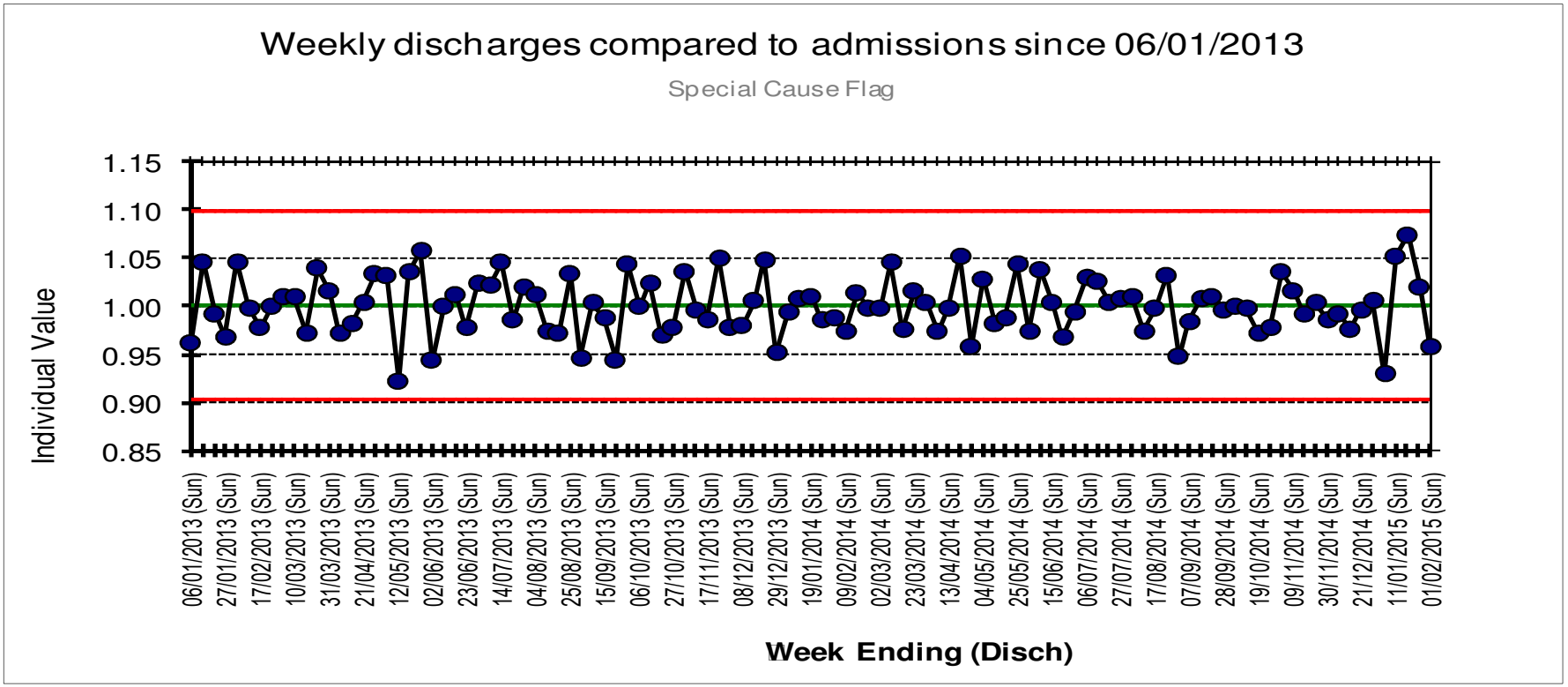


- Discharges are increasing year on year
- 52/52 weeks in 2014/15 had higher discharges than corresponding week year before

ESM LRI Month	% Occupancy (Incl Short Stay)
Dec-14	93.9%
Nov-14	93.9%
Oct-14	94.6%
Sep-14	93.4%
Aug-14	93.5%
Jul-14	92.7%
Jun-14	94.1%
May-14	95.2%
Apr-14	95.1%
Mar-14	96.2%
Feb-14	97.3%
Jan-14	95.6%
Dec-13	94.8%

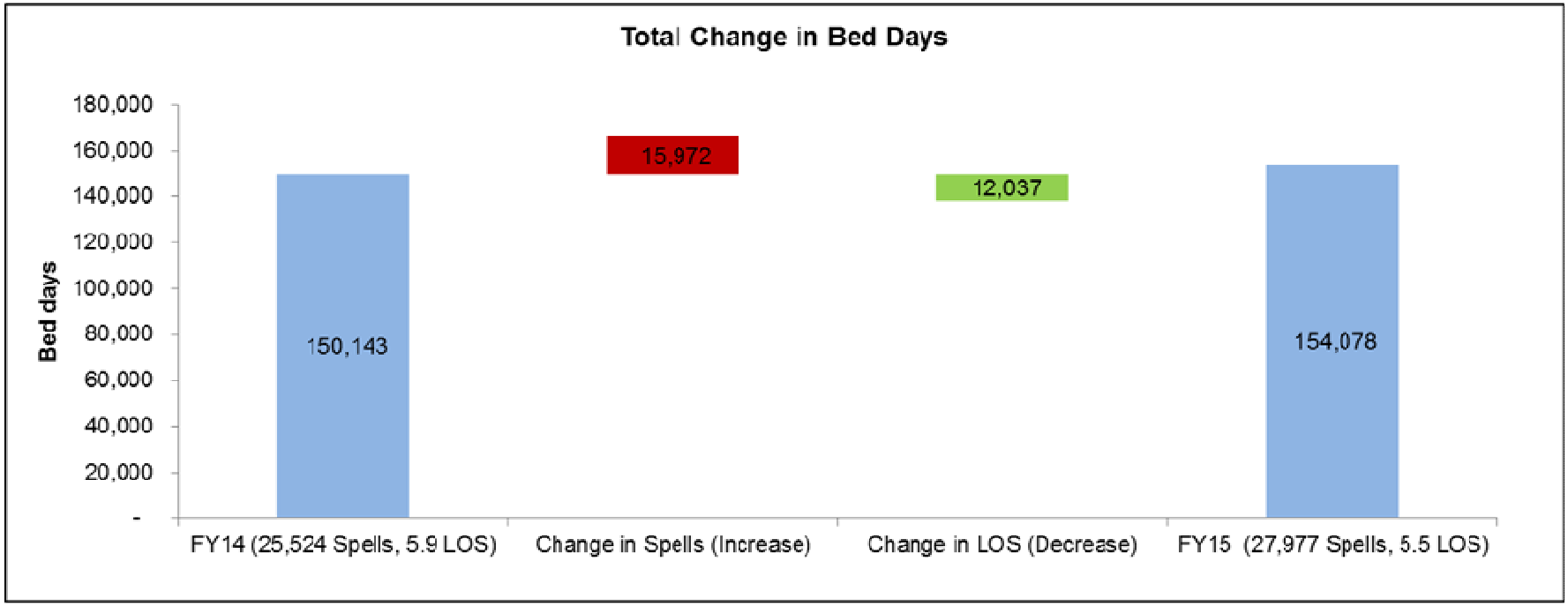


- To keep up with admissions in 2015-16, we will have to discharge more patients than we have ever done before

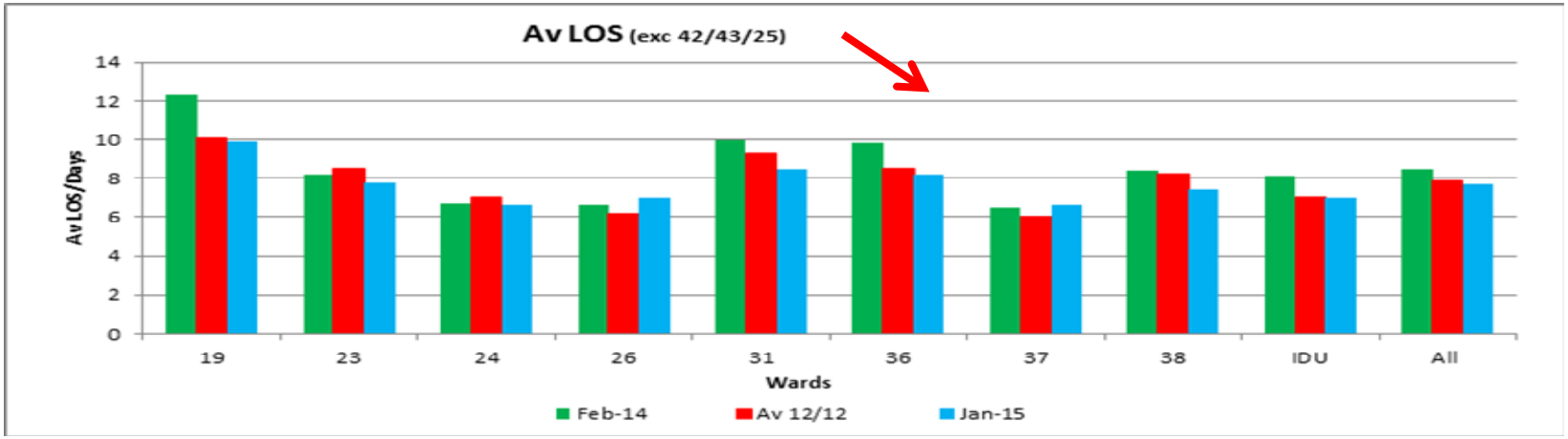


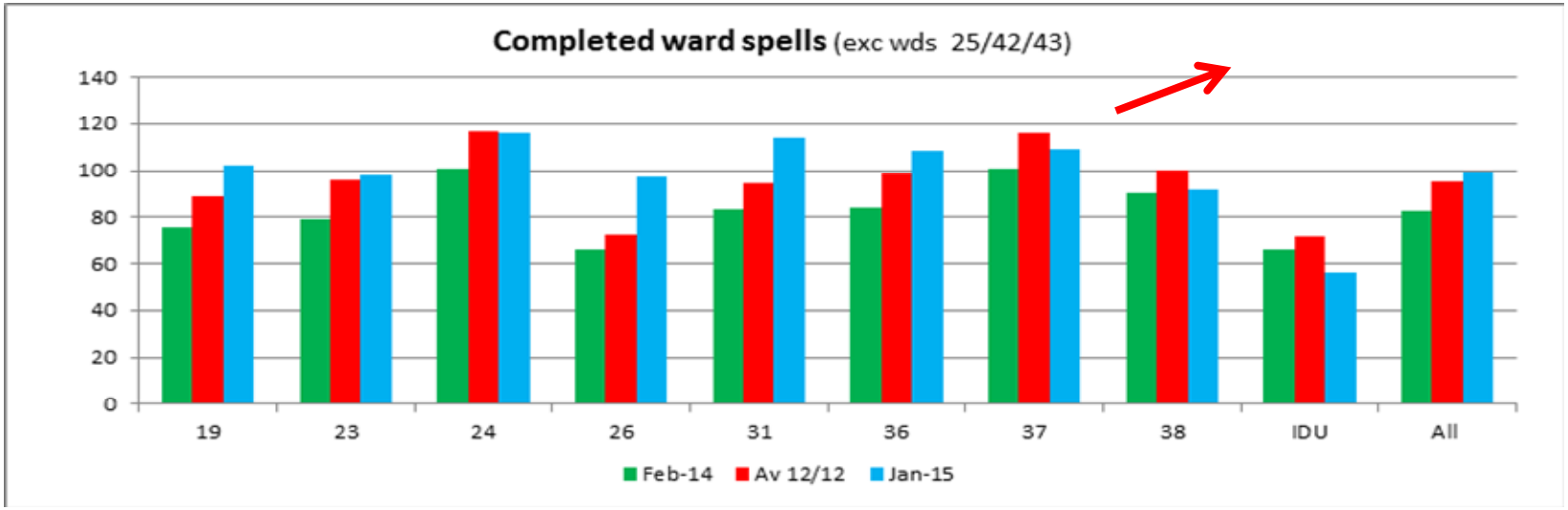
- No change in admission v discharge ratio
- This is what is hammering us because we haven't been able to consistently get bed occupancy down – ED and CDU need meaningful flow
- Fragile because of volume of demand

Rank (Atts)	Org Code	Org Name	Average Daily Atts
1	R1H	BARTS HEALTH NHS TRUST	1,210
2	RW6	PENNINE ACUTE HOSPITALS NHS TRUST	873
3	RW3	CENTRAL MANCHESTER UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	815
4	RYJ	IMPERIAL COLLEGE HEALTHCARE NHS TRUST	763
5	RXP	COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST	748
6	RYQ	SOUTH LONDON HEALTHCARE NHS TRUST	742
7	RF4	BARKING, HAVERING AND REDBRIDGE UNIVERSITY HOSPITALS NHS TRUST	686
8	RR1	HEART OF ENGLAND NHS FOUNDATION TRUST	640
9	RXF	MID YORKSHIRE HOSPITALS NHS TRUST	608
10	RR8	LEEDS TEACHING HOSPITALS NHS TRUST	606
11	RV8	NORTH WEST LONDON HOSPITALS NHS TRUST	593
12	**RWE**	**UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST**	**593**
13	RXK	SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST	528
14	RE9	SOUTH TYNESIDE NHS FOUNDATION TRUST	523
15	RVV	EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST	521
16	RX1	NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	514
17	RTD	THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	497
18	RKB	UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST	479
19	RJ1	GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	476
20	RXR	EAST LANCASHIRE HOSPITALS NHS TRUST	470



- In 2013/14 - 25,524 medical admissions at LRI, with a LOS of 5.9
  = 150,143 bed days
- In 2014/15 - 27,977 medical admissions at LRI (despite much improved use of AMC which understates improvement), with a LOS of 5.5 (-7%)
  = 154,078 bed days
- LOS reduction = 12,037 bed days (33 beds)
- Increase in admissions = 15,972 (43 beds)
- Lots of hard work, no net gain





- LOS on 8/ 10 wards has reduced
- Throughput on 9/10 wards has improved

Next steps

- Admission avoidance – noting improvement in AMC, what more can UHL/ LLR do? Until this is sorted, we don't have a sustainable solution
- Weekend admissions are 20% lower – why?

	2013- 2015	Winter 2014-15
Mon	15.14%	15.26%
Tues	15.36%	15.48%
Wed	14.98%	14.95%
Thurs	15.07%	14.63%
Fri	15.27%	15.21%
Sat	12.32%	12.43%
Sun	11.85%	12.03%

- Discharge – reduce variation - but what are the limits to LOS and throughput improvement noting BCT in Q2?
- LLR capacity plan with agreed bed occupancy
- Winter and emergency monies agreement
- Additional LLR partner support for discharge

University Hospitals of Leicester NHS
NHS Trust

Agenda Item: Trust Board Paper L

TRUST BOARD – 5 MARCH 2015

[UHL Organisational Development Quarterly Update Report]

DIRECTOR:	Emma Stevens, Acting Director of Human Resources
AUTHORS:	Bina Kotecha, Assistant Director of Learning and Organisational Development Helen Mancini, Organisational Development Specialist
DATE:	5 March 2015
PURPOSE:	This report highlights progress with implementing the Trust's Organisational Development Plan (2014-16), led through five substantial work streams. The Trust Board is asked to note and comment on progress with implementing the Organisational Development Plan.
PREVIOUSLY CONSIDERED BY:	N/A
Objective(s) to which issue relates *	☐ 1. Safe, high quality, patient-centred healthcare ☐ 2. An effective, joined up emergency care system ☐ 3. Responsive services which people choose to use (secondary, specialised and tertiary care) ☐ 4. Integrated care in partnership with others (secondary, specialised and tertiary care) ☐ 5. Enhanced reputation in research, innovation and clinical education ☑ 6. Delivering services through a caring, professional, passionate and valued workforce ☐ 7. A clinically and financially sustainable NHS Foundation Trust ☐ 8. Enabled by excellent IM&T
Please explain any Patient and Public Involvement actions taken or to be taken in relation to this matter:	Patient representative involvement ensured in all key development activity
Please explain the results of any Equality Impact assessment undertaken in relation to this matter:	Priorities have been assessed against the nine protected characteristics under the Equality Act 2010.
Organisational Risk Register/ Board Assurance Framework *	☐ **Organisational Risk Register** ☑ **Board Assurance Framework** ☐ **Not Featured**
ACTION REQUIRED *	For decision ☐ For assurance ☑ For information ☐

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

***** tick applicable box

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **5 MARCH 2015**

REPORT FROM: **EMMA STEVENS, ACTING DIRECTOR OF HUMAN RESOURCES**

REPORT BY: **BINA KOTECHA, ASSISTANT DIRECTOR OF LEARNING AND OD AND HELEN MANCINI, OD SPECIALIST**

SUBJECT: **ORGANISATIONAL DEVELOPMENT PLAN UPDATE**

---

1. INTRODUCTION

1.1 To deliver our vision of 'Caring at its Best' and to facilitate the necessary change we have set out an ambitious Organisational Development (OD) Plan for UHL. Our priorities are led through five work streams which were approved by the Trust Board and Executive Workforce Board in June 2014.

1.2 Against each work stream we have set out:-

- What will be different?
- What we will do to make it different?
- How we will know if we are successful?

1.3 These work streams have been aligned to UHL values, vision and strategic objectives particularly our objective to support the development of a professional, passionate and valued workforce.

1.4 This report highlights progress with implementing the Trust's Organisational Development Plan providing a brief summary of progress against each of the work streams over the previous quarter and key next steps.

1.5 On-going development and refinement to the Organisational Health Dashboard, have taken place, reflecting Trust Board feedback from the December 2014 meeting

and ensuring alignment to the Trust's Organisational Development Plan in monitoring the impact of delivery.

1.6 Our latest Learning into Action Newsletter (March Edition) will be circulated to the Trust Board and outlines the range of our impressive 'Learning into Action' successes and events including achievement of the Learning and Performance Institute's 'Learning Team of the Year Award', Assistant Practitioner development activity, salary maxing benefits and well-being initiatives.

2. LIVE OUR VALUES

2.1 Caring at its Best Awards

Quarterly Caring at its Best Awards will be presented during March 2015, in the workplace by Senior Leaders, to staff and teams that exemplify the Trust's values. In addition we have agreed that the next Annual Award Ceremony will take place on 24 September 2015. The Trust Board are invited to attend this prestigious event.

2.2 Values Based Recruitment

All application forms have a mandatory standard values based question. A bank of values based questions have been developed for the consultant interview process. Further work is being progressed over the next quarter to evaluate current processes and increase robustness in the recruitment and selection of senior posts within the Trust as highlighted within the Trust's Board Assurance Framework.

2.3 Fit and Proper Person Regulations (2015*)*

All Executive and Non-Executive Director posts (and equivalent) conform to the Fit and Proper Person Regulations (2015) through robust self-declaration, appropriate searches and reference process. In addition the application and interview process will include values based questions.

2.4 Pay Progression Policy

The Pay Progression Policy has been developed. A key criteria for incremental progression requires staff to demonstrate Trust values and behaviours as part of the appraisal process. Appraisal documentation has been updated to reflect this change.

2.5 Brand Development

The 'work for us' website development is underway and will showcase our 'Employer Brand' by April 2015

3. IMPROVE TWO WAY ENGAGEMENT AND EMPOWER OUR PEOPLE

3.1 Mutuals in Health Pathfinder Programme

Hempsons, Albion and Stepping Out (HASO) partners have been working with UHL as part of the Mutuals in Health (MiH) Pathfinder Programme since the beginning of 2015 to explore how UHL can benefit from the aspects of mutualisation.

HASO facilitated a Trust Board Thinking Session on MiH Pathfinder Programme on 12 February 2015.

The Trust Board are invited to attend the MiH Pathfinder Programme Closing Workshop on the 25 March and will be provided with the opportunity to comment on the draft Feasibility Report prior to sign-off.

3.2 Listening into Action (LiA)*:*

The annual Organisational Pulse Check will be carried out in March 2015 via global emails to all UHL staff. Also in March, a 'Pass it On' Newsletter will be distributed to share success stories from each of the LiA work strands. Activity within each of the work streams is summarised below:

3.2.1 *Classic LiA*

Wave 4 Pioneering Teams commenced in November 2014 with 12 new teams starting their LiA journeys. A Pass It On event is scheduled for May 2015 for these teams to share their successes and lessons learned.

3.2.2 *Thematic LiA*

LiA Admin & Clerical work stream started in January 2015. Nominated leads from across Clinical Management Groups (CMG) attended the first session. The aim is to focus on improving working lives of this group of staff and address issues within the CMG supported by the LiA Team.

3.2.3 *Management of Change (MoC) LiA*

We continue to support service managers to undertake LiA Engagement events prior any MoC. Activity is captured on the Organisational Health Dashboard.

3.2.4 *Enabling LiA*

The Alliance is now implementing LiA in line with the first year of activities in UHL. They have held their Listening events, set up a Steering Group, commenced 2 Enabling Our People Schemes and have launched a campaign during February 2015 to seek Pioneering Teams to start adopting LiA at a local level.

3.2.5 *Nursing into Action (NiA)*

Four sets have started LiA to improve the quality of services and experience on their wards and departments. The first set completed on 11 March 2015 with a poster presentation of their achievements to the Deputy Chief Nurse.

A Nursing Conference which will include a celebration of Nursing into Action is currently being planned for April 2015.

3.3 Salary Maxing

Total Reward Statements are regularly promoted and accessed by staff.

The 'Salary Maxing' Take IT Home scheme has been successful and we have seen an increase in uptake of both 'UHL's Childcare Vouchers' and 'Salary Maxing' Car Scheme.

In terms of next steps, 'Salary Maxing' Cycles and 'Salary Maxing' Take IT Home will be available during March 2015 for employee applications. Also in March 2015 we will be holding our annual Staff Benefits Fair. This was very successful last year with approximately 1,100 UHL staff attendance.

3.4 Health and Wellbeing

3.4.1 *Public Health Responsibility Deal Health Pledges*

Public Health responsibility Deal Health Pledges H8 for young person's commencing work, has been completed and is due to be pledged with the feedback from the success of the apprenticeship programme.

3.4.2 *Emotional Resilience*

UHL has successful secured LLR wide funding from Health Education East Midlands (HEEM) to deliver Emotional Resilience training to 240 new starters. In addition, line managers training is being reviewed to encompass Stress Management training.

3.4.3 *Mindfulness at Work Programme*

UHL have secured funding from HEEM to design and deliver a bespoke Mindfulness at Work Programme in partnership with Barbara Reid Mindfulness Teacher and Supervisor.

3.5 Medical Engagement

3.5.1 *The Doctors in Training Committee (DiTC)*

The Doctors in Training Committee have appointed a new Chair and Vice Chair, to replace the outgoing post holders who are rotating out of UHL. The new post holders will be initially focusing on membership and confirming the efficient cascade of information to all Junior Doctors.

3.5.2 *New Consultant Forum*

The next New Consultant Forum is planned for 19th March 2015. HM Coroner will be presenting and the second session will be utilised as a focus group for the Mutuals in Health Pathfinder Programme.

3.5.3 *Clinical Senate*

The Clinical Senate on 25th February 2015, focussed on the Mutuals in Health Pathfinder Programme. UHL Consultants, Trust Board, GP's and Commissioners are all invited to the Annual Conference organised by the Clinical Senate which will be held in December.

4.0 STRENGTHEN LEADERSHIP

4.1 Accountability into Action

The Accountability into Action Development Plan was approved by the Executive Workforce Board in December 2014 targeting UHL CMG senior leadership teams (at phase 1). The training will take place over the next quarter and commence with Influencer, followed by Crucial Conversations and finally Crucial Accountability.

There are twenty five places available which have been offered out and accepted by each of the CMGs.

4.2 Knowing your Business e-learning Modules

Eight 'Knowing the Business e-learning modules, as listed below, were commissioned via LiA Capital spend following the outcomes highlighted from both the Leadership into Action and Clinical Coding LiA's. Modules are being developed in partnership with OCB Media and are due to be completed in April 2015. The eight e-learning modules are:-

1) Referral To Treatment (RTT)
2) Basic Finance
3) CIP
4) Procurement
5) Clinical Coding
6) Appraisal
7) Electronic handover – (Patient Safety)
8) Making the most of meetings

4.3 Trust Board Development

The Trust Board has embarked on a programme of work (supported by external consultants appointed by the Trust) to improve Board and Board committee reporting. The aims of this work are to:-

- align the Board agenda to the priorities of the Trust and the things that matter most;
- stimulate more forward-looking and strategic conversations in the Board Room;
- reduce duplication and the size of the Board pack whilst increasing visibility and insight; and
- embed the tools, skills and capability to deliver high quality reports and executive summaries that work for the Board.

The Trust Board has held a workshop to explore these issues and final recommendations are to be presented to the Board through a 'Thinking Day'.

4.4 Medical Leadership Development

The most recent Medical Leadership Programme took place on 10th and 11th February 2015 with 12 Medical Leaders attending. Two more three day programmes will be arranged with Momentum during 2015 and four additional coaching days.

4.5 Consultant Appraiser Top-Up Training

Professor Furness (Revalidation Lead UHL) and the Learning and OD Specialist have held three Consultant Appraiser top-up Training sessions attended by Ninety Seven Consultant Appraisers.

4.6 Multi-Professional Mentoring Programme

The follow-up day for the second cohort of the Multi-professional Mentoring Programme led by UHL and Health Education East Midlands (HEEM), will take place on 6th March 2015. The next cohort will attend the programme on 25 and 26 March 2015. Further collaborative work is planned this quarter with HEEM and Nottingham University Hospital NHS Trust. Mentors have requested a 'Performance Coaching Workshop' in September 2015, plus a quarterly Mentoring Forum which is planned for July 2015. The next steps will be to develop internal capacity to deliver future programmes and to develop a spectrum of support for staff.

4.7 External Leadership Development

UHL staff continue to access a range of Leadership Development Programme through the Regional and National NHS Leadership Academy. These programmes are promoted primarily via the Trust's Senior Leadership community and key programme successes are captured in the Trust's Learning into Action Newsletter and shared at our annual Leadership Showcase Event (2015 date to be confirmed).

5.0 ENHANCE WORKPLACE LEARNING AND DEVELOPMENT

5.1 New Roles

The new roles group has been established and participants have been engaged in the development of education pathways for new roles to deliver new models of care, these include assistant and advanced practitioners. UHL will also be a pilot site for hosting US trained Physician Associates to facilitate embedding the principles and practices of such roles in the UK workforce.

Building on the success of the internship programme, the Trust is developing a local UHL Trainee Management scheme to build the managerial capacity to deliver our strategic direction.

5.2 Improvements in Medical Education

CMG Education Leads have been appointed for the majority of CMG's. This group meet with the Director of Medical Education on a bi-monthly basis. The CMG Education leads are expected to attend their CMG management meetings and raise educational issues.

5.3 Appraisal Training

From April 2015 the appraisal documentation and system will change for all staff employed on Agenda for Change Terms and Conditions. To update appraisers / line managers on the changes we have been providing 1.5 hour update sessions (in lecture theatre format) since January 2015 covering the key elements i.e.:-

- Equity and fairness;
- Shift from automatic reward for length of service to awarding for performance and delivery;

- Measurement which is based on performance strength comprising of delivery and approach; and
- Rewarding in line with Trust values and associated behaviours.

In improving appraisal quality a range resources have been developed to support staff including and Appraisal Toolkit and Frequently Asked Questions document.

A report on the 360 Feedback Tool and options available to the Trust will be presented to the Executive Workforce Board on 17 March 2015.

5.3. Non-Medical Education

Health Education East Midlands (HEEM) report into non-medical education has confirmed the quality of education and support for learners is exemplary.

A collaborative agreement between De Montfort University (DMU) and the Nursing Directorate was confirmed at a Validation Event in December 2014. This agreement will support the delivery of 'in-house' degree level education for nurses in UHL for the next 3 years.

5.4 NHS Talent Management ™ Tool

Introduction of NHS Talent Management (TM) Tool and roll out is planned for June 2015. This tool is aligned to the NHS Healthcare Leadership Model (2014). A more robust TM framework will capture talent data and put in place effective action plans to manage talent, at both strategic and operational levels.

6.0 QUALITY IMPROVEMENT AND INNOVATION

6.1 UHL Measure to Improvement Workshops

A "Measure to Improve" workshop was successfully delivered in January 2015, and positively evaluated by attendees. This focused on developing knowledge, skills and attitude in how data is used effectively to drive improvement. A repeat workshop is planned for May due to the level of interest and feedback received.

6.2 Leicester Innovation Improvement and Patient Safety Unit (LIIPS)

LIIPS is collaboration between academia and the NHS with the aim is to connect and share expertise, knowledge and support in service improvement across Leicestershire. A number of local NHS and academic organisations are actively involved in LIIPS including:-

- East Leicestershire and Rutland CCG
- Leicestershire Partnership Trust
- Leicester City CCG
- University Hospitals of Leicester
- West Leicestershire CCG
- De Montfort University
- Loughborough University
- University of Leicester

The governance structure consists of a Steering group, Core Development Group and three Working Groups. The working groups include Education and Training, Research and Evaluation and Service Improvement and will focus on improvement, innovation and patient safety.

6.3 Research and Development (R&D)

UHL is recognised nationally and Internationally for its contribution and cutting edge research and innovation. Key actions for R&D include:

- LIFE Project; contractual issues being addressed; staffing structure are being developed
- 100k Genome project application has been successful and further partnership working with consortium partners and NHS England on project initiation will continue.

6.4 East Midlands Streamlining Programme

UHL has signed up to the East Midlands Streamlining Programme in October 2014 for which the vision is: “All Trusts across our region working together to provide a consistent and efficient way of operating within our Human Resources functions.”

The work streams that have been identified include:-

1. Recruitment
2. Occupational Health
3. Mandatory & Statutory Training
4. Medical Staffing
5. In addition Electronic Staff Records (ESR) underpins each of the above

A UHL Task & Finish Group has been set up to oversee the implementation of each of the work stream objectives, identify any interdependencies between work streams, ensuring UHL governance, risk & resources are appropriately identified and managed.

7.0 RECOMMENDATION

The Trust Board is asked to note and comment on progress with implementing the priorities of the Trust’s Organisational Development plan, led through five work streams as set out in this report.

University Hospitals of Leicester NHS
NHS Trust
Caring at its best

Learning into Action Newsletter

3rd Edition, March 2015

Our future depends on it

Dear colleagues

Once again this newsletter highlights the enormous number of exciting events and initiatives going on across the organisation and how linking with external partners helps to improve learning, recruitment and benefits for all our staff across UHL.

We have celebrated and recognised many achievements and successes over recent months including the **Mary Seacole Programme Graduation** and the **Learning and Performance Institute's 'Learning Team of the Year' outstanding achievement**. It has been great to hear of the successes of our **Bowel Cancel Screening Team** and learn about the new national **Bowel Scope Development Programme** that will help save many lives. Also it's great to hear that we have launched our new **Assistant Practitioner Development Programme** and I wish our Health Care Assistants well on their development journey.

On a final note please 'do the right thing' for yourself, your colleagues and our patients and find the time to keep on top of your **Statutory and Mandatory training**. We have made great strides this year but need to ensure there is a concerted effort over March to achieve our 95% target.

Well done to all

John Adler
Chief Executive

Learning & Performance Institute

UHL Learning Team of the Year Award Winners

The learning and development community's top organisations and outstanding individuals gathered together in London on 5th February 2015 to celebrate the 19th annual Learning Awards. Our Learning and Organisational Development Team and Listening into Action Team were finalists under the Learning Team of the Year Category and selected as the best of the best and won with the Learning Team of the Year Silver Award.

A stellar showcase of Learning and Development (L&D) excellence was present at the annual Learning Awards, which celebrates and honours excellence in the learning and development industry. Devised and hosted exclusively by the Learning & Performance Institute, the Learning Awards is recognised as the L&D sector's premier awards ceremony.

With a record number of submissions from individuals and organisations from across the globe, the winners were selected from a competitive field of entrants, all of whom demonstrated exceptional vision and depth in providing learning solutions with a proven business impact. Popular British television and radio presenter, Claudia Winkleman, hosted the event, which took place at the 5-star Dorchester Hotel, on London's Park Lane. The ceremony was filled with international figureheads from the global learning community, who joined the awards finalists to celebrate outstanding success across 14 award categories.

Learning Team of the Year – Sponsored by CEB
Gold Winner: Virgin Holidays
Silver: University Hospitals Leicester
Bronze: Dell

"Very many congratulations to the team – a great achievement up against such competition."
John Adler, Chief Executive

The Award Ceremony was attended by Bina Kotecha, Michelle Cloney, Kate Bradley & Helen Mancini

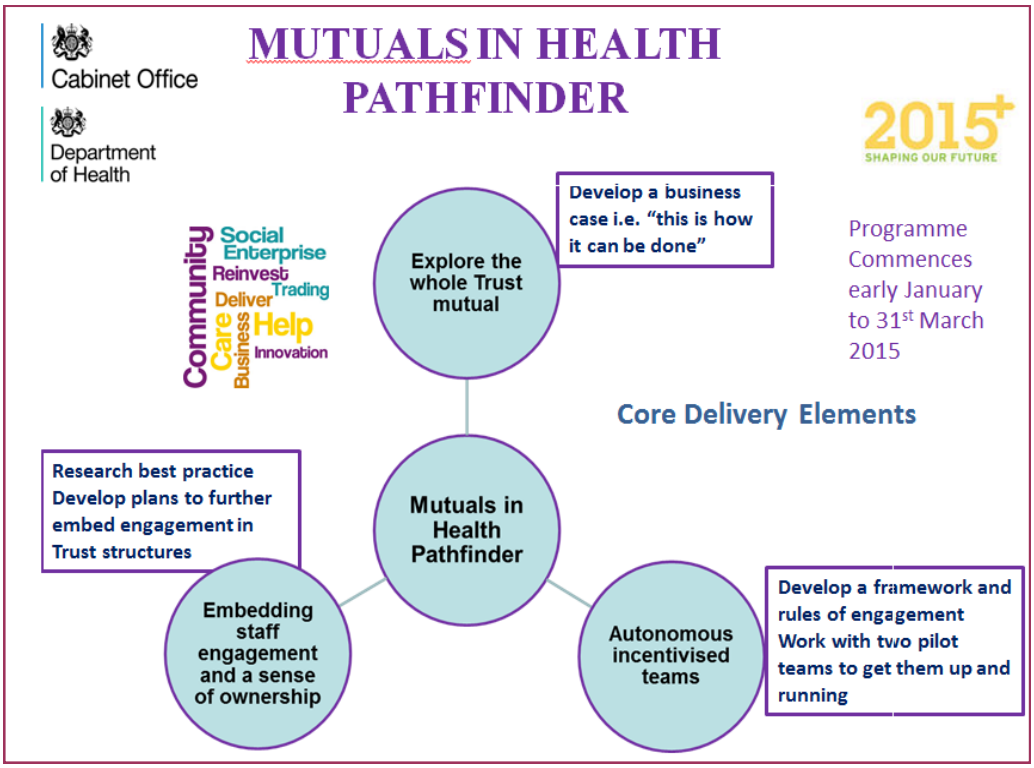
MutualsHealth Pathfinder

Raising the Bar on Staff Engagement - Building on Listening into Action

Cabinet Office

Department of Health

As you may know, we have been selected as a **'Mutuals in Health (MiH) Pathfinder'** along with a further 6 NHS Organisations, with the scope and vision of our programme comprising three main elements as shown in the diagram below:-



As part of the MiH Pathfinder Programme we have been provided with bespoke technical, legal and consultancy support funded by Cabinet Office and the Department of Health.

The programme of work commenced with a kick off meeting in January 2015, following which we are undergoing a three month intensive period of work which will conclude by 31st March 2015.

Our partners Hempsons, Albion and Stepping Out have held a range of development and engagement workshops in taking forward this programme. A report will be produced, based on the conclusions and lessons learnt from the 7 Pathfinders and will make recommendations to the Government by May 2015.

As part of the pilot team work, we are working with Elective Orthopaedics, Trauma and Theatres and exploring how we can get them up and running as an Autonomous, Incentivised Team with the support of our partners. We will update you on progress in the next edition .

For further information contact Bina Kotecha, Assistant Director of Learning and OD at bina.kotecha@uhl-tr.nhs.uk

NEW PROGRAMMES COMING UP

Mindfulness Taster Workshop:
24th May 2015

Buddying (Welcoming) Workshop:
14th May 2015

Leadership Development:
Multi-Professional Three Day Egan Skilled Helper Mentoring Programme for senior leaders

Dates June and October 2015
For the above programmes contact:-
lauren.copland@uhl-tr.nhs.uk to book a place
helen.mancini@uhl-tr.nhs.uk for more information

Good to Great PG Certificate in Leadership:
Now recruiting for June 2015
Contact minaxi.mardania@uhl-tr.nhs.uk
For further advise on development programmes contact our Directions Service: thedirectionsservice@uhl-tr.nhs.uk

Statutory & Mandatory
TRAINING UHL
Excellence in Training
Excellence in Care

Please take the time to check your required training page and complete any out of date training asap.

Statutory and Mandatory training needs one final push to make sure that the Trust reaches 95% by the end of March 2015.

If you have any queries please email:
edward.thurlow@uhl-tr.nhs.uk

The East Midlands Leadership Academy

Inclusive Leadership for a Purpose

Congratulations to students on the **Mary Seacole Programme.** This years UHL graduates were all invited to the Award Ceremony on the 23rd January. We offer our congratulations to:

- **Attilio Lotto,** Consultant, Congenital Cardiac Surgery
- **Gavin Bennett,** Senior Category Manager, Finance & Procurement
- **Neelam Potdar,** Consultant, Gynaecology & Subspecialist Reproductive Medicine
- **Sarah Ritchie,** Sister, Cardiology
- **Jessica Kennedy,** Senior Radiographer
- **Nicholas Bland,** Duty Manager, Operations
- **Robert Burd,** Consultant, Dermatology

To find out what about the all the Programmes the EMLA have available, visit-
www.leadershipeastmidlands.nhs.uk

Apprenticeships

Good for our Business

In November seven young people joined the Trust as **Customer Service Apprentices.**

They work across the 3 sites in various departments and they will follow a programme which includes study days supported by our UHL's HR Vocational Training Team. During their programme they will gain the skills required to deliver excellent customer service and demonstrate the Trust values. Study days cover a range of topics such as Customer Service, Managing and Developing your own Performance, Understanding Employer Organisations, Products and Services, Communication and Handling Information.

In the workplace their managers, mentors and UHL's Vocational Assessors observe and verify their competency ensuring they meet the QCF national standards.

Lauren Bettany said '*I feel very settled in the job already, I am enjoying the role and feel welcomed by the team. I have enjoyed meeting new people and hope to have a career at UHL'.*

Her manager Lauren Copland stated *'Lauren is gaining experience and confidence in the workplace, being given time off for study days to learn off the job and being paid.'*

Apprentices at UHL have a 12 month contract to complete their qualification. They are not guaranteed job at the end but most previous Apprentices have progressed onto a substantive position as their mangers feel they have become an integral part of the team.

We see it as growing our own future workforce with the skills, experience and values we need

For more information, visit ***www.apprenticeships.org.uk***

Lauren Bettany, Jordan Slack, Amina Hansrot, Ambreen Anwary, Nicole Allen, Nehal Dipac and Anneqa Hafezi

SystmOne

ONEPATIENTONERECORD

Training now available

What is SystmOne?

SystmOne is a clinical application widely used across the community which allows health care professionals, GPs, Child Health Services, Community Services etc. to record patient information.

UHL have been given access to the EPR (Electronic Patient Record) Core module, the enhanced component will allow hospital staff VIEW ONLY access to relevant information which will help improve the care of patients admitted to hospital.

Only records of patients who have a SystmOne GP record and are recorded as a CURRENT IN-PATIENT at UHL can be accessed and viewed

The benefits

SystmOne now provides hospital clinicians with controlled access to GP records. This will give significant improvements in clinical efficiency and patient safety. Trust clinicians will be able to access details of drug treatments, long term conditions, allergies and safeguarding regimes.

Providing access to records via SystmOne saves time for both hospital and GP staff, and improves efficiency and speed of response in the interests of patient safety.

Training and Access

Following the successful training and roll-out to pharmacy staff **our IT Training Team have produced an ELearning module for clinicians. Access to SystmOne is** via your RA (Registration Authority Card)

Fore more details visit *http://insite.xuhl-tr.nhs.uk/homepage/working-life/education--training/it-training/systmone*

Are you protected against FLU??

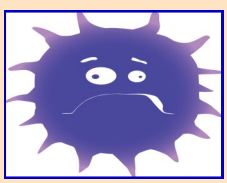
The Occupational Health Service in conjunction with our peer vaccinator colleagues based in the clinical areas have given at total of 5,199 flu vaccinations to UHL staff and a further 450 flu vaccinations to Interserve colleagues.

This has meant more frontline staff than ever before have been vaccinated with a total from 1/10/2014-31/12/2014 of 60.5% compared to 54% in total for the whole season finishing in February last year. This uptake compares favourably with other NHS Trusts in the East Midlands region.

There is still vaccine available for those who wish to have it – please contact your site based Occupational Health Department

	Total	%
Doctors	713	39.60%
Nurses	1805	49%
AHP	486	99%
HCSW	643	96.50%
Non clinical staff	552	

A breakdown in staff groups compared to the total number employed



In the spotlight - 'New' Assistant Practitioner Role

The introduction of the Level 5 Assistant Practioner Programme commenced February 2015 with a small pilot group. The role of **Assistant Practitioner,** is being introduced and bridges the gap between the traditional healthcare assistant and registered nurse.

The Chief Nurse, Rachel Overfield, is a strong advocate for the Assistant Practitioner role. She says, *"Assistant Practitioners bring an important addition to the teams in front-line care and a very important role at UHL and with our local communities. It is essential that we embrace roles such as the Assistant Practitioner into our workforce. It offers a real career opportunity for existing band 2 and 3 staff who perhaps don't aspire to degree based courses; it offers teams a very stable element of folks who are likely to stay with us for many years; it gives a large pool of potential candidates at a time when we are struggling to fill band 5 posts and, if done properly, is safe and effective. I have seen these roles introduced into many areas in hospitals including wards and I am confident that it is the right thing to do."*

Rachael, Jenny, Sarah, Melanie, Suzanne

Our first group of learners gave us their comments,

- *"Before we studied to take on the extended role as an Assistant Practitioner we were stuck in a position as a healthcare assistant,"*
- *"At that time there was nowhere to go to advance".*
- *"I believe the Assistant Practitioner role is great for patients. It brings a good continuity in care and my hope is that patients get better care because of it."*
- *"It's a really patient focused role,"*
- *"Now when I am caring for patients I will have the underlying knowledge not just to carry out certain tests or treatment but to be able to explain why we are doing them. That can be so reassuring for a patient who might be frightened or anxious. I know there are so many excellent healthcare assistants at our hospitals and I'd encourage them not to sit back. If they can make the commitment, then training as an Assistant Practitioner has great rewards."*

Programme Contact:
sharon.baines@uhl-tr.nhs.uk

The Bowel Cancer Screening Programme (BCSP) was launched in Leicester in 2006 and In Feb 2014 -UHL became an independent screening centre. This screening programme is led by Specialist Screening Practitioners (SSP's), registered nurses who have completed extra training at John Moores University in Liverpool.

After a successful 6 months, the BCSP Team joined the 2nd wave of a new national programme – Bowel Scope. This programme was launched nationally and could potentially save 1 in 300 lives a year - one life saved every 2 weeks! This gave us the opportunity to think how we could develop a new career pathway for non-registered nurses.

Nationally the BCSP Team created some core competencies for the Assistant Screening Practitioner (ASP) but locally we felt the ASP's needed more education and support so working with Sharon Baines, Learning and Development Specialist we are in the process of writing a Foundation Degree (level 5 programme).

We put together a very comprehensive pre-interview assessment and are very pleased to say we successfully recruited to all 3 of our newly created Assistant Screening Practitioners posts. The candidates commenced at the beginning of this year (the first Band 4 nurses to commence on the new career pathway) and they enrolled onto the Foundation Degree in February 2015.

Jenny and Rachael - two of the ASP's said,

"We are both excited and looking forward to developing this new role as the program grows and more GP's 'Go Live' with the Bowel Scope Programme. We are looking forward to starting our level 5 course work, which in time will hopefully see us recognised in our role as Assistant Practitioners."

"As the role develops it is expected that we will become invaluable to the SSP's it gives us the perfect opportunity to set the standards and build a working relationship with the patients. We both believe the role of the ASP is the way forward for the NHS and we are both privileged to be amongst the first in the Trust to take on this role."

The Bowel Cancer Screening Team feels very privileged to be the pioneers for the Trust with this new career pathway for non-registered nurses – this is a very exciting time for the profession and we have aspirations for Leicester to become the training centre for all ASP's in the future.

Karen Emery, Programme Manager,
Bowel Cancer Screening

SALARY MAXING UPDATE

Staff Benefits Fair

Ahoy there!
Did you attend the Staff Benefits Fair and hunt for treasure at the start of March?
Once again we had a great turn out, with colleagues taking the opportunity to check out and take advantage of the extensive offerings available from UHL!
If you haven't done so already, take a few minutes to have a look at the superb range of Salary Exchange schemes that UHL has to offer.
>>> Visit InSite/SalaryMaxing
Look out for the photographs in the next edition!

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Stop Press! Total Rewards Statements now launches from the *'Salary Maxing'* Benefits Portal!

Many of our staff have already accessed their **Total Reward Statement** (`***TRS***`) and are impressed with what the Trust has to offer. Now it's even easier to access your personalised information about the true value of your NHS employment package, including details about your remuneration together with any other benefits provided to you through the Trust.

NHS Total Reward Statements *Totally about you*

>>> Find out more and gain access by visiting InSite/TotalRewardStatements
You'll be surprised!

****

'Salary Maxing' Car Scheme now available through the `*Salary Maxing*` Benefits Portal!

The ***'Salary Maxing'* Car Scheme** is now available through our exclusive `***Salary Maxing***` **Benefits Portal** making it even easier to access!
Registering with the `***Salary Maxing***` **Benefits Portal** will enable you to access a wealth of information about the ***'Salary Maxing'* Car Scheme** including details of the extensive range of cars available to you, vehicle comparisons and quotations. You can even request your new car online!
The `***Salary Maxing***` **Benefits Portal** also gives you easy access to our other superb Salary Exchange Schemes such as `***Park and Save'***, ***'Salary Maxing'* Cycles, *'Salary Maxing'* Take IT, Home, *'Salary Maxing'* for Accommodation and *'UHL's Childcare Voucher Scheme'.***
Don't forget you can gain access from home, from anywhere, www.UHLSalaryMaxing.NHS.UK
It really is worth a look!

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Salary Maxing Electric Vehicle Feedback

We've now received feedback from colleagues who took up the opportunity to test drive our `***Salary Maxing***` **Electric Vehicle.** Reported as "good as a city commuting vehicle", feedback on the vehicle also includes comments on driving experience, mileage range and accessibility to charging points.
A range of drivers took our `***Salary Maxing***` **Electric Vehicle** on it's travels including Midwives, Accountants, Physiotherapists, Administrators and Project staff, here's what they had to say...

"Thank you so much for the opportunity to drive the Nissan Leaf electric car. It has been an eye opening experience into the growing world of electric vehicles."
"The Leaf itself is comfortable and very easy to drive. Its quietness of running takes a bit of getting used to but it becomes the norm so quickly that getting back into my normal car made me realise how noisy driving is. All in all, a great experience!
In Leicester city and on the M1 the points are well placed and generally easily accessible. Rarely is there another vehicle on a station so access and use also wasn't a problem."
"The vehicle's performance was very good overall. In ECO modes it did feel a bit heavy and acceleration was sluggish but the power use was lower than in normal mode where performance was very lively, with extremely good acceleration but the trade-off is in power use and I found anything out of ECO mode drained power very quickly."
"The Nissan Leaf is a lovely car to drive, comfortable and spacious. I loved the reversing camera."
We've said good bye now to our `***Salary Maxing***` **Electric Vehicle** - many thanks to Nissan, Tusker, Knowles and Plugged in Midlands for supporting the trial over the six months.

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Our Annual Election Window

If you are in our Staff Accommodation at Leicester General or Glenfield Hospitals or using the staff car parks at any of our three main sites but paying from your Net pay you could change to Salary Exchange every March!
Between 1st and 31st March every year anybody

- Accessing staff car parking but not in `***Park and Save***`
- Using our Staff Accommodation but not in ***'Salary Maxing' for Accommodation***

can change to using Salary Exchange (subject to employment checks) and pay a reduced amount of Tax, National Insurance and, where appropriate, Pension contributions because they will be calculated after your Accommodation / Car Parking
Everything can be done online!
Visit **InSite/SalaryMaxing**

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NHS Pension Scheme Changes

2015 / 1995 / 2008 NHS Pension Schemes *Securing tomorrow, today*

The NHS Pension Scheme is changing - Ensure you are up to speed and establish if it affects you.

Visit InSite/Payroll

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well-being@work
be healthy, have fun

FREE HYPNOTHERAPY SESSIONS
A THREE WEEK WEIGHT LOSS PROGRAMME

You MUST attend all three sessions and bring along a pillow or cushion.

Join John Peakman, Qualified Clinical Hypnotherapist

VENUE
Education Centre, LRI

DATES
Thursday 16th, 23rd & 30th April 2015

HOW TO BOOK
Visit InSite, Wellbeing at Work page and use the on-line booking

FREE LAUGHTER YOGA THERAPY

Join Kirti Sharma and let go of your inhibitions and enjoy the experience physically, psychologically and spiritually

VENUE
Available at all three sites

DATES
Thursday 16th April LGH
Thursday 14th May LRI
Thursday 18th June GH

HOW TO BOOK
Visit InSite, Wellbeing at Work page and use the on-line booking

FREE HEALTHY EATING COOKERY CLASSES
A FOUR WEEK PROGRAMME

(UHL Lotto Members Only)

You MUST attend all four sessions

Learn how to cool wholesome and healthy meals for all the family.

VENUE
Leicester College

DATES
Tuesday 10th, 17th, 24th & 31st March

HOW TO BOOK
Visit InSite, Wellbeing at Work page and use the on-line booking

FREE POOL NIGHT

(UHL Staff Only)

Do you enjoy playing pool, come and join the pool knockout competition & Food will be provide

Prize for the Winner

VENUE
Rileys, Grange lane, close to the LRI

DATE
Friday 20th March

HOW TO BOOK
Visit InSite, Wellbeing at Work page and use the on-line booking

If you have any queries please contact Marcella Burgess at Wellbeing@uhl-tr.nhs.uk

It is acknowledged that service needs are paramount, however, the Trust's Executive Team supports all Well Being activities and encourages as many staff as possible to be involved. As such operational managers wherever possible are obliged to facilitate this by considering requests from staff in relation to off duty rotas and flexible working hours to support staffs' involvement.

UHL staff are in a unique position that we are able to provide Well Being events for our staff using income from the Staff Lottery. Staff lottery income can only be used for the benefit of Staff, so join today! See Insite for more details.

University Hospitals of Leicester NHS
NHS Trust

Agenda Item: Trust Board Paper M

TRUST BOARD – 5th MARCH 2015

UHL RISK REPORT INCORPORATING THE BOARD ASSURANCE FRAMEWORK 2014/15

DIRECTOR:	KEVIN HARRIS – MEDICAL DIRECTOR
AUTHOR:	PETER CLEAVER – RISK AND ASSURANCE MANAGER
DATE:	5TH MARCH 2015
PURPOSE:	This report provides the Trust Board (TB) with:- a) A copy of the UHL BAF and action tracker as of 31ST January 2015. b) Notification of any new extreme or high risks opened during January 2015. Taking into account the contents of this report and its appendices the TB is invited to: • review and comment upon this iteration of the BAF, as it deems appropriate: • note the actions identified within the framework to address any gaps in either controls or assurances (or both); • identify any areas which it feels that the Trust's controls are inadequate and do not, therefore, effectively manage the principal risks to the organisation achieving its objectives; • 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; • 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; • note the revised timescale for the production of the UHL 2015/16 BAF.
PREVIOUSLY CONSIDERED BY:	**UHL Executive team**
Objective(s) to which issue relates *	[x] 1. Safe, high quality, patient-centred healthcare [√] 2. An effective, joined up emergency care system [√] 3. Responsive services which people choose to use (secondary, specialised and tertiary care) [√] 4. Integrated care in partnership with others (secondary, specialised and tertiary care) [√] 5. Enhanced reputation in research, innovation and clinical education

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

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

* tick applicable box

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **5th MARCH 2015**

REPORT BY: **KEVIN HARRIS – MEDICAL DIRECTOR**

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

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1. INTRODUCTION

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

a) A copy of the UHL BAF and action tracker as of 31st January 2015.

b) Notification of any new extreme or high risks opened during January 2015.

2. BAF POSITION AS OF 31ST JANUARY 2015

2.1 A copy of the 2014/15 BAF is attached at appendix one with changes since the previous version highlighted in red text. A copy of the BAF action tracker is attached at appendix two with changes also highlighted in red for ease of reference. The TB is asked to note the following points:

a. Principal risks one, seven, 21, 22, and 23; all previously listed actions have been taken and there are no further gaps in control/assurance and therefore the TB is asked to consider whether these risks have now reached their target score or, alternatively, identify any additional gaps and mitigating actions to be included.

b. Principal risks 11 and 24 have reached their target score and the TB is asked to consider if they feel the controls are effective and, if so, whether these risks can be accepted as treated.

c. The TB is asked to note the extension to timescales for completion for action numbers 8.7, 13.1, 13.2, 13.6, 15.4, 15.10, and 16.3 and their subsequent move to an amber RAG rating within the action tracker.

2.2 The following strategic objective is submitted to this TB for discussion and review:

- *'Enabled by excellent IM&T'* (incorporating principal risks 23 and 24).

3. DEVELOPMENT OF THE UHL 2015/16 BAF

3.1 Work has commenced with the following elements being completed:

- Strategic objectives revised and objective owners identified.
- Draft key priorities for 2015/16 identified
- Draft strategic objectives, key priorities and principal risks discussed at ESB on 10th February, TB 'Thinking Day' on 12th February and 'Clinical Senate' meeting on 26th February.

3.2 Further changes are now required to the priorities and risks with some unable to be confirmed until the UHL 'Quality Commitment' priorities have been agreed at the Executive Quality Board (EQB) and Quality Assurance Committee (QAC) in March. With this in mind, and taking into account a slightly extended timescale for finalising the Annual Operating Plan (AOP), it would appear reasonable to propose a date of May 2015 for the 2015/16 BAF to be completed.

4. EXTREME AND HIGH RISK REPORT.

4.1 Two new high risks have opened during January 2015 as described below. The details of these risks are included at appendix three for information.

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Risk ID	Risk Title	Risk Score	CMG/ Directorate
2487	Maintaining the quality of the Nuclear Medicine service for PET, Cardiac MPI and general diagnostics	16	CSI
2488	Risk of vacancies on resident on call rotas being unfilled resulting in increased use of locums and Consultants acting down	20	ITAPS

5. RECOMMENDATIONS

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

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

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

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

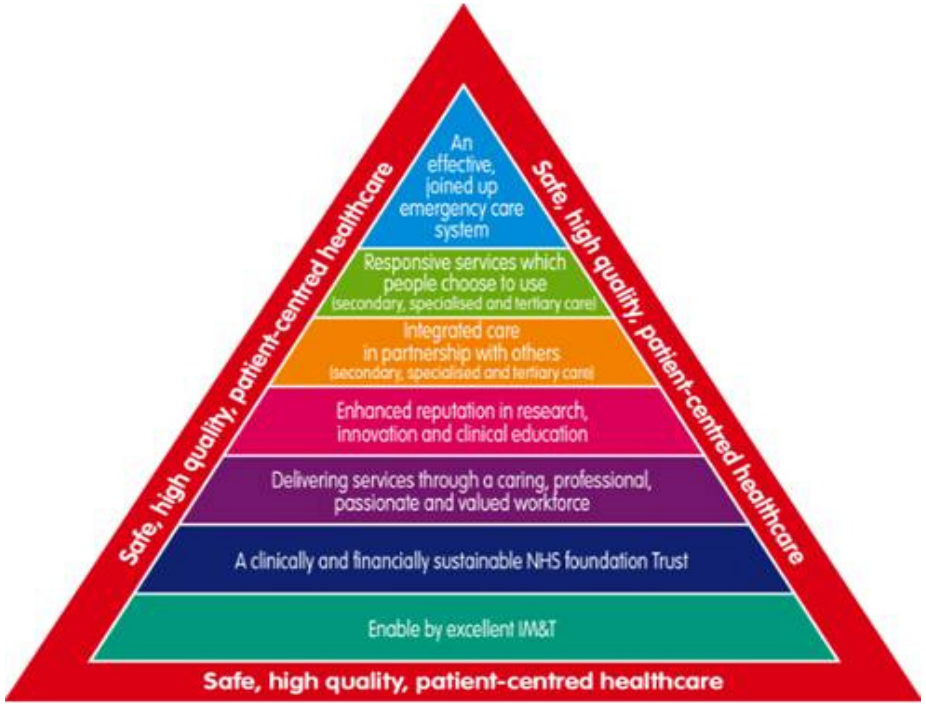
(d) identify any gaps in assurances about the effectiveness of the controls in place to manage the principal risks and consider the nature of, and timescale for, any further assurances to be obtained;

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

(f) note the revised timescale for the production of the UHL 2015/16 BAF.

Peter Cleaver,
Risk and Assurance Manager,
26 February 2015.

UHL BOARD ASSURANCE FRAMEWORK 2014/15



UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

STRATEGIC OBJECTIVES

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

PERIOD: JANUARY 2015

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

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

BAF Consequence and Likelihood Descriptors:

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 2	Failure to implement LLR emergency care improvement plan.	**Overall level of risk to the achievement of the objective**	**Current score 4 x 5 = 20**	**Target score 3 x 2 = 6**
Executive Risk Lead(s)	Chief Operating Officer			
Link to strategic objectives	An effective joined up emergency care system			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Establishment of emergency care delivery and improvement group with named sub groups	Meetings are minuted with actions circulated each week. Trust Board emergency care report references the LLR steering group actions.	(C) Emergency admissions are not reducing (C) Discharges are not increasing and delayed discharge rate has not changed	Review effectiveness of specific LLR improvement actions to deliver a reduction in admissions and increase in discharges (2.4)	LLR MD review Feb 2015
Appointment of Dr Ian Sturgess to work across the health economy	Weekly meetings between Dr Sturgess, UHL CEO and UHL COO. Dr Sturgess attends Trust Board.	(C) IS's time with the health economy finishes in mid-November 2014	Arrangements for IS to return for a two week period (2.5)	Mar 2015 RM
Allocation of winter monies	Allocation of winter monies is regularly discussed in the LLR steering group	None	N/A	

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 5	Failure to deliver RTT improvement plan.	**Overall level of risk to the achievement of the objective**	**Current score 4x4=16**	**Target score 3 x 2 = 6**
Executive Risk Lead(s)	Chief Operating Officer			
Link to strategic objectives	Responsive services which people choose to use (secondary, specialised and tertiary care)			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Weekly RTT meeting with commissioners to monitor overall compliance with plan	Trust Board receives a monthly report detailing performance against plan	(c) There is a revised admitted trajectory which is awaiting agreement with TDA and CCG. UHL is in line with the revised trajectory.	Action plans to be developed in key specialities to regain trajectory for admitted RTT(5.1)	April 2015 COO
Weekly meeting with key specialities to monitor detailed compliance with plan	Trust Board receives a monthly report detailing performance against plan	(c) There is a revised admitted trajectory which is awaiting agreement with TDA and CCG. UHL is in line with the revised trajectory.	As above 5.1	As above COO
Intensive support team back in at UHL (July 2014) to help check plan is correct	IST report including recommendations to be presented to Trust Board	(c) Recommendations from IST report not yet implemented.	Act on findings from recently published IST report (5.2)	Mar 2015 COO

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
(i) Regional partnerships: UHL is actively engaging with partners with a view to: • establishing a Leicestershire Northamptonshire and Rutland partnership for the specialised service infrastructure in partnership with Northampton General Hospital and Kettering General Hospital • establishing a provider collaboration across the East Midland's as a whole • Developing an engagement strategy for the delivery of the long term vision for and East Midlands network for both acute and specialised services	Minutes of the April 2014 Trust Board meeting: o Paper presented to the April 2014 UHL Trust Board meeting, setting out the Trust's approach to regional partnerships Project Initiation Document (PID): o Developed as part of UHL's Delivering Care at its Best (DC@IB) o Reviewed at the June 2014 Executive Strategy Board (ESB) meeting o Updates (DC@IB Highlight Report reviewed at ESB meetings	(c) Lack of Programme Plan	Programme Plan to be developed (8.3)	Apr 2015 DS
(ii) Academic and commercial partnerships. (iii) Local partnerships	Project Initiation Document (PID): o Developed as part of UHL's Delivering Care at its Best (DC@IB) o Reviewed at the August 2014 Executive Strategy Board (ESB) meeting o Updates (DC@IB Highlight Report reviewed at ESB meetings	(c) Lack of PID for local partnerships	PID for Local Partnerships to be developed by the Head of Local Partnerships (8.7)	Feb 2015 DS
Specialised Services specifications: CMGs addressing Specialised Service derogation plans	Plans issued to CMGs in February 2014. Follow up meetings being convened for w/c 14th July 2014to identify progress to date.			

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 12	Failure to retain BRU status.	**Overall level of risk to the achievement of the objective**	**Current score 3 x 3 = 9**	**Target score 3 x 2 = 6**
Executive Risk Lead(s)	Medical Director			
Link to strategic objectives	Enhanced reputation in research, innovation and clinical education			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Maintaining relationships with key partners to support joint NIHR/ BRU infrastructure	Joint BRU Board (bimonthly) Annual Report Feedback from NIHR for each BRU (annual) UHL R&D Executive (monthly) R&D Report to Trust Board (quarterly)	(c) Requirement to replace senior staff and increase critical mass of senior academic staff in each of the three BRUs.	BRUs to re-consider theme structures for renewal, identifying potential new theme leads. (12.1) BRUs to identify potential recruits and work with UoL/LU to structure recruitment packages. (12.2) UHL to use RCF to pump prime appointments if possible and LU planning new academic appointments to support lifestyle BRU. (12.3)	Jun 2015 MD June 2015 MD Jun 2015 MD
	Athena Swan Silver Status by University of Leicester and Loughborough University. (The Athena Swan charter applies to higher	(c) Athena Swan Silver not yet achieved by UoL and Loughborough	UoL and LU to ensure successful applications for	Mar2016 MD

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Medical Education Strategy	Department of Clinical Education (DCE) Business Plan and risk register are discussed at regular DCE Team Meetings and information given to the Trust Board quarterly Medical Education issues championed by Trust Chairman Bi-monthly UHL Medical Education Committee meetings (including CMG representation) Oversight by Executive Workforce Board Appointment processes for educational roles established KPI are measured using the: • UHL Education Quality Dashboard • CMG Education Leads and stakeholder meetings • GMC Trainee Survey results • UHL trainee survey • Health Education East Midlands Accreditation visits Trainee Survey results • UHL trainee survey Health Education East Midlands	(c) Transparent and accountable management of postgraduate medical training tariff is not yet established (c) Transparent and accountable management of SIFT funding not yet identified in CMGs (proposal prepared for EWB) (c) Job Planning for Level 2 (SPA) Educational Roles not written into job descriptions (c) Appraisal not performed for Educational Roles	To work with Finance and CMGs to ensure transparency and accountability of undergraduate and postgraduate medical training tariffs (13.1) Ensure appropriate Consultant Job descriptions include job planning (13.2) Disseminate agreed appraisal methodology to CMG s (13.4)	Jul 2015 MD Apr 2015 MD Feb 2015 MD

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 14	Lack of effective partnerships with universities.	**Overall level of risk to the achievement of the objective**	**Current score 3 x 3=9**	**Target score 3 x 2= 6**
Executive Risk Lead(s)	Medical Director			
Link to strategic objectives	Enhanced reputation in research, innovation and clinical education			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Maintaining relationships with key academic partners Developing relationships with key academic partners. Existing well established partners: • University of Leicester • Loughborough University	Minutes of joint UHL/UoL Strategy meetings Minutes of Joint BRU Board Minutes of NCSEM Management Board	(c) New relationships need to be developed and nurtured with the new VC and President for UHL. New Dean of Medical School expected 2015.	LU strategy to be discussed at joint BRU board. (14.2) UHL membership of NCSEM management board (14.3) Meeting with LU VC, UHL MD, UHL DRD and BRU Director to discuss strategy (14.4) Develop regular meeting with DMU (14.5)	Mar 2015 Mar 2015 Jun 2015 Jun 2015
Developing partnerships; • De Montfort University • University of Nottingham • University College London (Life Study) • Cambridge University (100k project)	100k genome and Life study reports to ESB monthly. Joint meetings held with R&D team for NUH - reported through R&D Exec minutes to ESB. EM CLAHRC Management Board reports via R&D Exec to ESB	(c) Contacts with DMU could be developed more closely		

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
UHL Workforce Plan (by staff group) including an integrated approach to workforce planning with LPT.	Reduction in number of 'hotspots' for staff shortages across UHL reported as part of workforce plan update. Executive Workforce Board will consider progress in relation to the overarching workforce plan through highlight report from CMG action plans.	(c) Workforce planning difficult to forecast more than a year ahead as changes are often dependent on transformation activities outside UHL (e.g. social services/ community services and primary care and broad based planning assumptions around demographics and activity). (c) Difficulty in recruiting to hotspots as frequently reflect a national shortage occupation (e.g. nurses)	Develop Innovative approaches to recruitment and retention to address shortages. (15.4) Develop new roles that address competency and skill gaps in service delivery areas (15.9)	Jun 2015 DHR Mar 2015 DHR

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

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

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

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Year 2 Listening into Action (LiA) Plan (2014 to 2015) including five work streams: Year 3 Listening into Action (LiA) Plan (2015 to 2016) to be developed in March 2015 for next 12 months. To include continued work with five work streams: Work stream One: **Classic LiA** • Two waves of Pioneering teams to commence (with 12 teams per wave) using LiA to address changes at a ward/department/pathway level	Quarterly reports to Executive Workforce Board (EWB) and Trust Board Updates provided to LiA Sponsor group on success measures per team and reports on Pulse Check improvements Annual Pulse Check Survey to be conducted March 2015 Update reports provided to JSCNC meetings	(a) Lack of triangulation of LiA Pulse Check Survey results with National Staff Opinion Survey and Friends and Family Test for Staff		
Work stream Two: **Thematic LiA** • Supporting senior leaders to host Thematic LiA activities. These activities will respond to emerging priorities within Executive Directors' portfolios. Each Thematic event will be hosted and led by a member of the Executive Team or delegated lead.	Quarterly reports to Executive Workforce Board (EWB) and Trust Board Updates provided to LiA Sponsor group on each thematic activity Update reports provided to JSCNC meetings			
Work stream Three: **Management of Change LiA** • LiA Engagement Events held as a precursor to change projects associated with service transformation and / or HR Management of Change (MoC) initiatives.	Quarterly reports to Executive Workforce Board (EWB) and Trust Board Updates provided to LiA Sponsor group on each thematic activity Update reports provided to JSCNC meetings			

Work stream Four: **Enabling LiA** • Provide support to delivering UHL strategic priorities (Caring At its Best), where employee engagement is required.	Quarterly reports to Executive Workforce Board (EWB) and Trust Board Updates provided to LiA Sponsor group on each thematic activity Update reports provided to JSCNC meetings	(C) Resource requirements in terms of people and physical resources difficult to anticipate from LiA activity linked to Caring at its Best engagement events		
Work stream Five: **Nursing into Action (NiA)** • Support all nurse led Wards or Departments to host a listening event aimed at improving quality of care provided to patients and implement any associated actions.	Quarterly reports to Executive Workforce Board (EWB) and Trust Board Updates provided to LiA Sponsor group every 6 months on success measures per set and reports on Pulse Check improvements Update reports provided to JSCNC meetings Monthly updates to Nursing Executive Team (NET) meetings via Heads of Nursing per CMG	(c) Lack of a clear system for sharing lessons learned and success outcomes from each of the NiA Ward / Department areas to maximise spread of learning and sharing best practice.	Success outcomes to be shared with nursing workforce via new annual Nursing Conference – first one scheduled for April 2015. (17.10)	Mar 2016 DHR/ Chief Nurse
Annual National Staff Opinion and Attitude Survey	Annual Survey report presented to EWB and Trust Board Analysis of results in comparison to previous year's results and to other similar organisations presented to EWB and Trust Board annually Updates on CMG / Corporate actions taken to address improvements to National Survey presented to EWB Staff sickness levels may also provide an indicator of staff satisfaction and performance and are reported monthly to Board via Quality and Performance report Results of National staff survey and local patient polling reported to Board on a six monthly basis. Improving staff satisfaction position.	(a) Lack of triangulation of National Staff Survey results with local Pulse Check Results (Work stream One: Classic LiA / Work stream Five: NiA) and other indicators of staff engagement such as Friends and Family Test for Staff	Workshop on 2014 survey results priorities and actions with CEO & DHR on 27 January2015 leading to 2015 / 16 engagement plan for the Trust – to be shared via appropriate management forums and CE Briefing (March & April 2015). TB paper on March Trust Board And ET Paper for March 2015. (17.11)	Mar 2016 DHR
Friends and Family Test for NHS Staff	Quarterly survey results for Quarter 1, 2 and 4 to be submitted to NHS England for external publication:	(a) Survey completion criteria variable		

	Submission commencing 28 July 2014 for quarter 1 with NHS England publication commencing September 2014 Local results of response rates to be CQUIN Target for 2014/15 – to conduct survey in Quarter 1 (achieved)	between NHS organisations per quarter. (a) Survey to include 'NHS Workers' and not restricted to UHL staff therefore creating difficulty in comparisons between organisations as unable to identify % response rates. (c) No guidance available regarding how NHS England will present the data published in September 2014, i.e. same format at FFT for Patients or format for National Staff Opinion and Attitude Survey. (a) Lack of triangulation of Friends and Family Test for Staff results with local Pulse Check Results (Work stream One: Classic LiA / Work stream Five: NiA) and other indicators of staff engagement such as National Staff Survey	Workshop outputs to lead to 2015/16 engagement plan for the Trust – to be shared via appropriate management forums and CE Briefing (March & April 2015). TB and ET Paper for March 2015. (17.13)	Mar 2016 DHR
Workforce Sickness Absence levels	Attendance management policy and procedures available to staff and managers. Compliance reports via Workforce Informatics Manager sent to CMGs monthly to support management of individual cases.	(a) Lack of triangulation between the use of premium rate staff to support non-compliance with UHL	Annual performance target set with CMG breakdown available per month	Mar 2016

	ESR recording of attendance. Monthly reports available to CMGs / Corporate Divisions HR CMG Teams support front line managers to manage staff in line with policy Sickness levels reported via CE Briefings per month Sickness levels incorporated into Organisational Health Dashboard monthly reporting via EWB quarterly meetings and available to CMG HR Leads via SharePoint Sickness absence rates reported to UHL Leadership Community via CE Briefings per month	target for 2014/15 sickness absence rates, with increasing levels of sickness reported for some CMGs / staff groups	for CMG Board Meetings. (17.15) Workforce KPIs included in Quarterly CMG Workforce meetings from January 2015 – to be attended by HR CMG Leads and Workforce Development Manager (17.16) Premium spend / pay group to be established in February 2015 as part of the CIP Workforce Charter to review use of premium pay and reasons for use – to support CMGs to identify links to, for example, sickness absence, recruitment, & increased activities during 2015/16 (17.17)	Mar 2016 /17
Mutuals in Health Pathfinder Programme	Submitted application to Cabinet Office (CO) and Department of Health (DH) to participate in the programme as one of the Trusts nationally. Selected to participate in the Pathfinder	a) Due to tight timeframes for delivery of the Feasibility Report	Feasibility Report (by 31 March 2015 with Trust Board approval. To be	Mar 2015 DHR

	Programme – 1st January 2015 – 31 March 2015 Mutuals Programme Board established – January 2015 chaired by CEO. Programme Lead identified (Assistant Director of OD & Learning) to work with the assigned external partners (Hempsons, Stepping Out & Albion) Monthly update reports to Executive Team. Progress Report to be presented to EWB in March 2015 Programme of work relates to delivery of 3 pillars identified for UHL – 1. Exploring organisational forms with whole Trust 2. Autonomous Incentivised Teams – elective orthopaedics & trauma team 3. Improving engagement within UHL Production of a Feasibility Report (Business Case) to DH/CO by 31 March 2014 Attendance at national workshops to learn from other Trusts – knowledge transfer. Organise internal workshops on each of the 3 pillars and encourage appropriate attendance by CMG Managers and nominated staff. Pathfinder Programme Risk Register to be managed by external partners with CO/DH.	(FBC) will the Trust Board and Executive Team be fully signed up to the final produced report and proposals for transferability of lessons learned to UHL service and workforce models.	presented to TB in March and EWB in March 2015 (17.18)	

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Leadership into Action Strategy (2014:16) including six work streams: 'Providing Coaching and Mentoring' by developing an internal coaching and mentoring network, with associated framework and guidance which will be piloted in agreed areas (targeting clinicians at phase 1).	Quarterly Reports to Executive Workforce Board (EWB) as part of Organisational Development Plan and Learning, Education and Development Update as set out in Risk 16.			
'Shadowing and Buddying' by creating shadowing opportunities and devising a buddy system for new clinicians or those appointed into new roles.	Quarterly Reports to Executive Workforce Board as part of Organisational Development Plan and Learning, Education and Development Update as set out in Risk 16.	(c) Buddying / Shadowing System Requires Development	System being developed in partnership with HEEM and Assistant Medical Director to ensure support provided to newly appointed Consultants at initial phase (18.3)	Apr 2015 DHR
'Improving local communications and 360 degree feedback' by developing and implementing a 360 Degree feedback Tool for all leaders and developing nurse leaders to facilitate Listening Events in all ward and clinical department areas as set out in Risk 17.	Quarterly Reports to Executive Workforce Board as part of Organisational Development Plan and Learning, Education and Development Update as set out in Risk 16. Updates provided to LiA Sponsor group every 6 months on success measures Monthly updates to Nursing Executive Team (NET) meetings via Heads of Nursing per CMG	(a) 360 Feedback Tool not yet developed	Present update on Learner Management System developments and NHS Healthcare Leadership Model Resources to support the provision of 360 Feedback (18.4)	Feb 2015

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

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

	Escalation meeting between CEOs/CCG Accountable Officers			
Securing capital funding by linking to Strategy, Strategic Outline Case (SOC) and Health Systems Review and Service Strategy	Regular reporting to F&P Committee, Executive Board and Trust Board	(c) Lack of clear strategy for reconfiguration of services.	Production of Business Cases to support Reconfiguration and Service Strategy (19.10)	On-going action - Review monthly DF
Obtaining sufficient cash resources by agreeing short term borrowing requirements with TDA	Monthly reporting of cash flow to F&P Committee and Trust Board	(c) Lack of service strategy to deliver recurrent balance	Agreement of long-term loans as an outcome of submission of SOC/ business cases (19.11)	On-going action – Review March 2015 DF

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
CIP performance management including CIP s as part of integrated performance management	Monthly reports to F&P committee and Trust Board. Formal sign-off documents with CMGs as part of agreement of IBPs	c) Not all PMO posts have been recruited to	Recruit substantive staff to vacant posts (20.2)	Feb 2015 COO
Cross cutting themes are established.	Executive Lead identified. Monthly reports to F&P committee and Trust Board			

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

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

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Governance in place to manage the procurement of the solution	EPR project board with executive and Non-Executive members. Standard boards in place to manage IBM; Commercial board, transformation board and the joint governance board. UHL reports progress to the CCG IM&T Strategy Board	EPR Board now needs to be re-shaped from procurement to delivery		
Clinical acceptability of the final solution	Clinical sign-off of the specification. Clinical representation on the leadership of the project. The creation of a clinically led (Medical Director) EPR Board which oversees the management of the programme. Highlight reports on objective achievement go through to the Joint Governance Board, chaired by the CEO. The main themes and progress are discussed at the IM&T clinical advisory group.			
Transition from procurement to delivery is a tightly controlled activity	EPR board has a view of the timeline. Trust Board and ESB have had an outline view of the delivery timelines.	EPR Board now needs to be re-shaped from procurement to delivery		

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 24	Failure to implement the IM&T strategy and key projects effectively *Note: Projects are defined, in IM&T, as those pieces of work, which require five or more days of IM&T activity.*	**Overall level of risk to the achievement of the objective**	**Current score 3x3 = 9**	**Target score 3 x 3 = 9**
Executive Risk Lead(s)	Chief Information Officer			
Link to strategic objectives	Enabled by excellent IM&T			

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

Appendix two

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

Monitoring body (Internal and/or External):	UHL Executive Team
Reason for action plan:	Board Assurance Framework
Date of this review	**January 2015**
Frequency of review:	Monthly
Date of last review:	December 2014

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

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

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

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

8.7	PID for Local Partnerships to be developed by the Head of Local Partnerships	DS		~~December 2014~~ February 2015	A local partnership PID is currently under development and it will be presented to the February UHL BCT Board for review and comment.	3
9	**Failure to implement network arrangements with partners.**					
	Actions, 8.1, 8.2, 8.3 and 8.5 refer to risk 9. Action 7.3 refer to risk 7, therefore refer above for progress				See risks 7 & 8	
10	**Failure to develop effective partnership with primary care and LPT.**					
11	**Failure to meet NIHR performance targets.**					
12	**Failure to retain BRU status.**					
12.1	BRUs to re-consider theme structures for renewal, identifying potential new theme leads. (12.1)	MD	DR&D	June 2015	Awaiting National Guidance on structure required for future bids	4
12.2	BRUs to identify potential recruits and work with UoL/LU to structure recruitment packages.	MD	DR&D	June 2015		4
12.3	UHL to use RCF to pump prime appointments if possible and LU planning new academic appointments to support lifestyle BRU.	MD	DR&D	June 2015		4
12.4	UoL and LU to ensure successful applications for Silver swan status and. Individual medical school depts will need to separately apply for Athena Swan Silver status.	MD	DR&D	March 2016	VC and President has re-constituted group leading Medical School Bid with appointment of new project manager.	4
12.5	Special meeting of Joint BRU Board: planning to secure BRU funding at the next NIHR competition. Further meetings planned.	MD	DR&D	March 2015		4
13	**Failure to provide consistently high standards of medical education.**					

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

13.1	To work with Finance and CMGs to ensure transparency and accountability of undergraduate and postgraduate medical training tariffs *(reworded October 2014)*	MD	AMD (CE)	~~October 2014~~ July 2015	SIFT and MADEL has now been identified in CMG budgets. A more extensive piece of work is now required for the Clinical Education Dept to work with CMG teams to define expenditure. Timescale for completion extended to reflect this	3
13.2	Ensure appropriate Consultant Job descriptions include job planning	MD	AMD (CE)	April 2015	Not all job plans have yet been submitted. This is not under the control of the Clinical Education department. Timescale for completion extended to reflect this	3
13.3	Develop appraisal methodology for educational roles	MD	AMD (CE)	January 2015	**Complete.**	5
13.4	Disseminate approved appraisal methodology to CMGs.	MD	AMD (CE)	~~December~~ February 2015	Date changed as appraisal methodology will not be developed until January 2015 (see action 13.3)	3
13.5	Work to relocate anomalous budgets to HR as other Foundation doctor contracts	MD	AMD (CE)	~~January~~ April 2015	Budgets will be relocated at the beginning of 2015/16 financial year to avoid potential confusion of transferring part year budgets. Deadline changed to reflect this.	3
13.6	Develop more robust system of appointment and appraisal of disparate roles by separating College Tutor roles in order to be able to appoint and appraise as College Tutors	MD	AMD (CE)	April 2015	We have a role description agreed between UHL and HEEM – problem is unlike other Trusts UHL does not support College Tutor roles. A paper is being prepared for submission to the April UHL Executive team to address this issue. Timescale for completion extended to reflect this	3
14	**Lack of effective partnerships with universities.**					
14.1	UHL CE to meet with VC in near future.	CEO		March 2015	**Complete.**	5
14.2	LU strategy to be discussed at joint BRU board.	MD	DR&D	March 2015		4

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

14.3	UHL membership of NCSEM management board	MD	DR&D	March 2015	Currently MD and DR&I attending	4
14.4	Meeting with LU VC, UHL MD, UHL DRD and BRU Director to discuss strategy	MD	DR&D	June 2015	Invitation sent to LU VC	4
14.5	Develop regular meeting with DMU	MD	DR&D	June 2015	Regular meetings established at Exec level – relevant subgroups established	4
15	**Failure to adequately plan the workforce needs of the Trust.**					
15.4	Develop Innovative approaches to recruitment and retention to address shortages.	DHR		June 2015	Medical Workforce Strategy to be updated following feedback from HEEM quality visit and the Clinical Senate. This will be incorporated into an overarching Workforce Board Thinking Session in May or June to look at the workforce risks and workforce transformation agenda in totality. Timescale for completion extended to reflect this Services are developing a portfolio to reflect provision in better attracting consultant to services	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

15.6	Delivering our Employer Brand group to share best practice and development social media techniques to promote opportunities at UHL	DHR		March 2015	We will be using Twitter and other social media techniques to attract staff to UHL. The Twitter account is now live and requires a suitable logo. A guide is being produced for recruiting managers on social media options for promoting their vacancies. Service areas are to provide an overview of the future of their services for use when advertising consultant posts. Scheme to promote managerial and leadership posts to existing NHS MTS scheme graduates to be developed and in place for March 2015. Scheme will include a unique offer in terms of development in order to attract high calibre applicants.	4
15.8	Consultant recruitment review team to develop professional assessment centre approach to recruitment utilising outputs to produce a development programme	DHR		April 2015	Consultant recruitment process has been improved to incorporate unseen presentations. This started in January 2015 and will be evaluated	4

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

15.9	Develop new roles that address competency and skill gaps in service delivery areas	DHR		March 2015	UHL New Roles Group with the remit of delivering new roles in Assistant Practitioner, Advanced Practitioner and Physician Assistant. The first cohort of assistant practitioners is planned for March 2015 focused on ITU and HDU areas and the Advanced Practitioner role is underway in ED to be spread into priority recruitment hotspots areas HEEM Funding of £250k has been approved to enable LLR providers to introduce US Physicians Assistants into the workforce. For UHL this means improved capacity of 20-30 Associates to support medical staff.	4
15.10	Refine the workforce elements of the Operational Planning cycle to ensure robust workforce plans to support organisational transformation, activity and finance	DHR		April 2015	Template defined which analyses the workforce implications of both CIP and growth schemes and describes workforce improvement. Schemes to be triangulated with finance and activity and confirmed through Executive dialogue. Final submission of workforce plan will be March 31 2015. The first confirm and challenge of these plans has taken place with CMGs. These plans have also been challenged to ensure they deliver quality standards. Final submission of these plans is scheduled for April 2015. Timescale for completion extended to reflect this	3

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

15.11	Development of Cross Cutting Programme to support focus on workforce efficiency, productivity and development	DOF and DHR		February 2015 established and on-going work programme through 2015/16	4 work streams covering medical, nursing, premium spend and 3-5 year planning with specified actions and deliverables for improving pay governance and efficiency. First meeting to take place 11 February to agree deliverables and terms of reference.	4
16	**Inability to recruit and retain staff with appropriate skills.**					
16.2	eUHL system updates required to meet Trust needs	DHR		March 2015	Awaiting confirmation of tender waiving process. Developing Business Case to secure Capital Funds	4
16.3	Robust ELearning policy and procedures to be developed to reflect P&GC approach	DHR		February 2015	The E-learning policy and procedures will form part of the Core Training Policy. Policy submitted to Policy and Guidelines Committee (PGC). Currently awaiting PGC feedback. Deadline extended to reflect this.	3
17	**Failure to improve levels of staff engagement**					
17.7	Listening into Action activity within CMGs / Corporate Divisions to be one of the reported Performance Indicators within the Organisational Health Dashboard	DHR		March 2016	**Complete**	5
17.8	CMG HR Leads to notify LiA Team of any listening events – proforma developed to capture activities and to be reported in Organisational Health Dashboard.	DHR		March 2016	**Complete**	5
17.9	LiA to be rolled out within Alliance utilising Alliance Management Team to support the implementation and to report activity via LiA Sponsor Group	DHR		March 2016	**Complete**	5
17.10	Success outcomes to be shared with nursing workforce via new annual Nursing Conference –scheduled for April 2015.	DHR/ CN		March 2016	Nursing Conference being planned.	4

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

17.11	Workshop on 2014 survey results priorities and actions with CEO & DHR on 27 January 2015 leading to 2015 / 16 engagement plan for the Trust – to be shared via appropriate management forums and CE Briefing (March & April 2015). TB paper on March Trust Board And ET Paper for March 2015.	DHR		March 2016	Clear plans currently in development to identify priority areas for action during 2015/16. Scheduled meetings and papers for Trust Board and Executive Team identified in March / April 2015	4
17.12	Workshop on 2014 survey results priorities and actions with CEO & DHR on 27 January 2015. (17.12)	DHR		March 2015	**Complete.** Workshop held with follow up meeting currently being arranged for March 2015	5
17.13	Workshop outputs to lead to 2015/16 engagement plan for the Trust – to be shared via appropriate management forums and CE Briefing (March & April 2015). TB and ET Paper for March 2015.	DHR		March 2016	Awaiting the outputs from the second workshop (TBC – March 2015)	4
17.14	Organisational Health Dashboard quarterly via EWB / monthly reports available via SharePoint	DHR		March 2016	**Complete**	5
17.15	Annual performance target set with CMG breakdown available per month for CMG Board Meetings.	DHR		March 2016	To be discussed at March EWB meeting	4
17.16	Workforce KPIs included in Quarterly CMG Workforce meetings from January 2015 – to be attended by HR CMG Leads and Workforce Development Manager	DHR		March 2016	HR Leads identified to attend Workforce KPI Quarterly meetings.	4
17.17	Premium spend / pay group to be established in February 2015 as part of the CIP Workforce Charter to review use of premium pay and reasons for use – to support CMGs to identify links to, for example, sickness absence, recruitment, & increased activities during 2015/16.	DHR		March 2016/17	First meeting scheduled for February 2015. Awaiting date of Workforce Charter Programme Board.	4

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

17.18	Feasibility Report by 31 March 2015 with Trust Board approval. To be presented to TB in March and EWB in March 2015	DHR		March 2015	Paper to be presented to Executive Team February 2015. Update to be provided on Mutuals in Health pathfinder Programme at EWB and TB in March 2015	4
18	**Lack of effective leadership capacity and capability**					
18.3	'Shadowing and Buddying' System being developed in partnership with HEEM and Assistant Medical Director to ensure support provided to newly appointed Consultants at initial phase (18.3)	DHR		April 2015	Consultant Forum in place and key development identified to support the newly appointed consultants Mentoring framework being devised in consultation with Medical Director	4
18.4	Present update on Learner Management System developments and NHS Healthcare Leadership Model Resources to support the provision of 360 Feedback	DHR		February 2015	Report to be presented to Executive Team on 24 February setting out 360 Degree Feedback System options and associated costing	4
18.5	Support national and regional Talent Management and Succession Planning Projects by National NHS Leadership Academy , EMLA and NHS Employers	DHR		March 2015	UHL staff nominated to access National Leadership Academy Programme based on talent conversations. Report on talent profile of Senior Leadership Community to be presented to Executive Workforce Board during March 2015	4
18.6	Board Coach (on appointment) to facilitate Board Development Session	DHR		~~October 2014~~ February 2015	Board development session completed on 16/10/14. Board Coach identified subject to agreement with the Trust Chairman. Awaiting decision and deadline extended to reflect this	4

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

18.7	Update of UHL Leadership Qualities and Behaviours to reflect Board Development, UHL 5 Year Plan and new NHS Healthcare Leadership Model	DHR/ CE		January 2015	As above, at the initial phase the Trust Board will discuss and agree : (a) the overall leadership model the Board and Executive Team are seeking to build; and (b) The Board culture that it is seeking to shape and exemplify. Paper to be presented on national NHS Leadership Model to Executive Team during February 2015	4
19	**Failure to deliver financial strategy (including CIP).**					
19.2	Production of a financial strategy to accelerate the recovery programme (action reworded and timescale amended by DF to more accurately portray required action)	DF		~~August Review September 2014~~ February 2015	Amending the consolidated capital investment Program. Refreshed financial strategy to be presented to TB and TDA during February 2015. Timescale reflected to reflect this.	4
19.10	Business Cases to support Reconfiguration and Service Strategy	DF		~~July Review September 2014~~ On-going as per individual business case timeline	BCT SOC approved by UHL and all LLR partners. SOC submitted to TDA and NHS England and are awaiting approval. Individual business cases will be submitted to the Trust Board and TDA as per the overall reconfiguration strategy	4
19.11	Agreement of long-term loans as an outcome of submission of SOC/ business cases	DF		~~June August~~ On-going action – review March 2015	Trust received a £29m cash loan in line with the Plan and trajectory submitted to the TDA. Application for further loans (via SOC/business cases)to be submitted as necessary	4
20	**Failure to deliver internal efficiency and productivity improvements.**					
20.1	Simplify cross cutting themes to workforce, beds, outpatients and theatres	COO		~~August 2014~~ February 2015	**Complete.** In place with each CCT meeting monthly	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

20.2	Recruit substantive staff to vacant posts to ensure continuity of function of PMO	COO		February 2015	On track. One vacancy out of eight remains	4
21	**Failure to maintain effective relationships with key stakeholders**					
22	**Failure to deliver service and site reconfiguration programme and maintain the estate effectively**.					
23	**Failure to effectively implement EPR programme**					
23.7	Review governance arrangements and alignment with other major programmes	CIO		Jan 2015	**Complete.** Draft governance structure ready and needs approval by the EPR Board	5
24	**Failure to implement the IM&T strategy and key projects**					

Key

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

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

Appendix 3

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2488	ITAPS		Risk of vacancies on resident on call rotas being unfilled resulting in increased use of locums and Consultant acting down	28/02/2015	14/01/2015	Causes: We are currently running with 11 junior doctor vacancies across the on call rotas on all three sites This is due to failure to recruit, maternity leave and sick leave. The options for filling these gaps are 1)□Use of internal locums but due to the number of gaps it is often difficult to find an internal locum who is available. 2)□Use of appropriate external locum via locum bookers but these are also often not available. 3)□Use of consultants acting down 4)□As a last resort the non-resident consultant on call becomes resident and the rota is run with one less person available. Consequences: Increase in Consultant Acting Down payments - Increased risk of on-call consultants becoming resident which will impact on elective activity the following day - Increased risk of trainee/consultant sick leave due to workload Increased risk of clinical incidents due to the use of external locums who are unfamiliar with UHL Decreased ability to manage emergency situations if there are less people available on call	Business	Locum Bookers contacted for available doctors Internal Trainees approached for extra shifts Ongoing recruitment in process Cross site cover explored	Major	Almost certain	20	Continue pro-active recruitment to specialty doctor jobs - 31/8/15 Expand fellowship jobs to support the rotas - 31/8/15 Recruit ICM trainees - 31/8/15 Plan to recruit non trainees to a level to ensure that all rotas are fully filled - 31/8/15 Robust escalation process understood and adhered to - 31/3/15 Monthly recruitment update at Board meeting - 28/2/15 Ensure core members attend recruitment meetings - 31/8/15	12	MTI

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2487	Clinical Support and Imaging	Medical Physics	Maintaining the quality of the Nuclear Medicine service for PET, Cardiac MPI and general diagnostics	28/02/2015	06/01/2015	The lead clinician in Nuclear Medicine is on long term sick leave. He is the only PET ARSAC certificate holder in the Trust and the clinical lead for the service. The locum covering cardiac MPI is the only other experienced ARSAC certificate holder for MPI studies. His contract ends in Jan 2015. There are other ARSAC certificate holders who cover general Nucelar Medicine and paediatric work. Their time commitment to Nuclear Medicine is severely limited. There is only one Consultant Radiologist currently entitled to report PET images under the national contract. A second is experienced and has retained competence but requires some training and revalidation. There are a number of Consultant Radiologists who report MPI's and general Nuclear Medicine but none elgibile or interested in gaining ARSAC certification The consequences are severe. An ARSAC certificate holder for PET can be "borrowed" under the existing contract but the new contract will require a certificate holder within the Trust. This puts the plans for fixed PETCT at risk Loss of MPI expertise will have a major impact on the service and on Imaging and MR throughput. Pressures on the consultant body to provide a comprehensive imaging service are high. The risks are that PET and MPI scanning are suspended, impacting on patients and business.	Quality	Imaging rotas re-arranged to increase reporting sessions from other Radiologists Consultants nominated as interim clinical leads - carol Newland and Yvonne Rees Take action to provide clinician cover for ARSAC, reporting and clinical supervision - 30/12/14 completed Undertake clinical review - 30/12/14 completed	Major	Likely	16	Produce business case - 30/3/15 Appoint new clinician - 1/6/15	6	DPE

University Hospitals of Leicester NHS
NHS Trust

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT BY TRUST BOARD COMMITTEE TO TRUST BOARD

DATE OF TRUST BOARD MEETING: 5 March 2015

COMMITTEE: Quality Assurance Committee

CHAIRMAN: Dr S Dauncey, QAC Chair

DATE OF COMMITTEE MEETING: 29 January 2015

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

- **None.**

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

- **Minute 7/15/3 (CQC Registration Update).**

DATE OF NEXT COMMITTEE MEETING: 26 February 2015

Dr S Dauncey
QAC Chairman
12 February 2015

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF A MEETING OF THE QUALITY ASSURANCE COMMITTEE HELD ON THURSDAY, 29 JANUARY 2015 AT 1:00PM IN THE BOARD ROOM, VICTORIA BUILDING, LEICESTER ROYAL INFIRMARY

Present:
Dr S Dauncey – Non-Executive Director (Chair)
Mr J Adler – Chief Executive
Mr M Caple – Patient Adviser (non-voting member)
Dr K Harris – Medical Director
Ms C O'Brien – Chief Nurse and Quality Officer, East Leicestershire CCG (non-voting member)
Ms R Overfield – Chief Nurse
Mr P Panchal – Non-Executive Director
Ms J Wilson – Non-Executive Director

In Attendance:
Mr T Bourne – Consultant Anaesthetist (for Minute 3/15/3)
Miss M Durbridge – Director of Safety and Risk
Ms J Halborg – Head of Nursing, ITAPS CMG (for Minute 3/15/3)
Mrs S Hotson – Director of Clinical Quality
Mrs H Majeed – Trust Administrator
Mr K Singh – Trust Chairman (up to and including Minute 4/15/1)
Mr M Traynor – Non-Executive Director
Mr M Williams – Non-Executive Director

RESOLVED ITEMS **ACTION**

1/15 APOLOGIES

Apologies for absence were received from Mr I Crowe, Non-Executive Director, Ms C Ribbins, Deputy Chief Nurse and Professor D Wynford-Thomas, Non-Executive Director and Dean of the University of Leicester Medical School.

2/15 MINUTES

Resolved – that the Minutes of the Quality Assurance Committee meeting held on 15 December 2014 (papers A and A1 refer) be confirmed as correct records.

3/15 MATTERS ARISING REPORT

3/15/1 Matters Arising Report

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

(i) Minute 109/14/2 (TTO error rates) – the Medical Director advised that he met with the Chief Pharmacist on a regular basis to discuss these issues. A report on this matter was scheduled to be presented to the EQB in February 2015 and QAC in April 2015 as noted on the matters arising report;
(ii) Minute 76/14 (regarding the draft QAC work programme) – discussions remained in progress – the QAC Chair would be meeting with the Deputy Chief Nurse and Director of Clinical Quality in early March 2015 to finalise the work programme. The Chief Executive commented that this interconnected with the Board Intelligence programme;
(iii) Minute 77/14/4 and 79/14/2 (Patient Safety and Complaints Annual Reports 2013-14) – the Director of Safety and Risk advised that due to staff shortages in the Graphics Team, there had been a delay in the production of

these reports. They were expected to be available for the QAC meeting in February 2015 as noted on the matters arising report, and

(iv) Minute 78/14/5 (re. appropriate messaging of nursing workforce indicators, once national benchmarking/RAG ratings were available) – in discussion, it was agreed that this action was no longer required and therefore could be removed from the matters arising log. **TA**

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

3/15/2 Draft NICE Guidance – Safe Staffing for A&E

The Chief Executive advised that NICE had recently published draft guidance in respect of safe staffing for A&E and the Trust would now be undertaking the following work:-

(i) comparing the current staffing levels in the Emergency Department with the draft guidance, and
(ii) comparing the workforce model in the Emergency floor business case with the draft guidance.

Resolved – that the position be noted.

3/15/3 Electronic Prescribing and Medicines Administration (EPMA) Update

Mr T Bourne, Consultant Anaesthetist and Ms J Halborg, Head of Nursing, ITAPS attended the meeting to present paper C, an update on the EPMA project. Members noted that the Executive Quality Board (EQB) on 3 February 2015 would take a decision regarding the options put forward by the EPMA Board following an option appraisal in respect of the future of the system.

In summary, members were advised that although the EPMA system had been 'live' for up to three years in the Trust, the use of the system was not fully integrated into patient care and was widely perceived as being slow and unreliable. Whilst there was support for an electronic prescribing system in general, there was only limited support for the current system. Support for the system was strongest amongst band 5 nurses and weakest amongst medical staff, particularly amongst senior medical staff.

The options arising from the option appraisal were as follows:-

(i) stop rollout and consolidate the position;
(ii) defer rollout and have a period of consolidation of practice on existing live wards;
(iii) proceed with rollout in Surgery, and
(iv) cease use of Medchart.

Members were advised that the ePMA Board did not recommend option 4 above and this was included for completeness. The Consultant Anaesthetist noted that the Electronic Patient Record (EPR) was expected to be in place in 2016 and the prescribing system would need to be converted in order to ensure that it was compatible with EPR. UHL colleagues had visited another Trust with regard to the use of EPMA within theatres and ITU, however a number of reservations as to its use in these environments had been noted. Concern was expressed in respect of the miniscule resources that had been made available to rollout EPMA in comparison to the resources that had been provided for the rollout of Electronic Document Records Management. The EPMA Board's preferred option was stopping rollout and focussing resources on ensuring that ePMA was used effectively within the current 'live' areas. Members of the Quality Assurance Committee supported this option.

In response to queries from Non-Executive Directors, it was noted that UHL was the first Trust to use EPMA in the UK. Despite assurance being provided by the company which

had provided this software, a number of issues had come to light when the system was being rolled out within the Trust. The Chief Executive noted that the EQB would focus on actions that needed to be taken to mitigate any risks. Ms J Wilson, Non-Executive Director suggested that an update on learning lessons from post investment reviews be presented to Integrated Finance, Performance and Investment Committee (IFPIC), as appropriate. **CE** **CA**

Resolved – that (A) the contents of paper C be received and noted;

(B) the EQB to take a decision at its meeting on 3 February 2015 regarding the options put forward by the EPMA Board following an option appraisal in respect of the future of the EPMA system including a focus on actions that needed to be taken to mitigate any risks, and **CE**

(C) consideration be given to including an EPMA post investment review on the Integrated Finance, Performance and Investment Committee's calendar of business. **CA**

3/15/4 Update on Renal Transplant Unit

The Medical Director presented paper D, which provided an update on Professor C Rudge's visit to evaluate progress of actions that had been put in place following his visit to the Trust's Renal Transplant Unit in April and July 2014. Members were advised that Professor Rudge's impression from discussion and observations was that there had been a significant improvement and that the unit was safe to remain open. In response to a query from Dr S Dauncey, QAC Chair in respect of one of the recommendations, the Medical Director highlighted the potential for the Renal Transplant Unit to be led by a Physician.

In response to a suggestion from Mr P Panchal, Non-Executive Director, members were of the view that the CMG's recommendations be accepted, the external review process be closed and the EQB be requested to report to QAC if there were any further issues.

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

4/15 SAFETY

4/15/1 Patient Safety Report

The Director of Safety and Risk presented paper E, which provided a monthly update on internal safety issues and serious incidents and external safety news and developments. In her presentation of the report, the Director of Safety and Risk particularly highlighted some significant safety concerns in December 2014 relating to the emergency care system, however members noted that performance had improved since.

Members particularly noted section 2.8 of paper E which highlighted that 655 out of 1032 policies on the Trust's Sharepoint system had a lapsed review date as of 19 December 2014. 484 of these were clinical guidelines and the highest proportion was within the Women's and Children's CMG. The Director of Safety and Risk highlighted that one of the common themes arising from patient safety incidents between October and December 2014 was in relation to lack of/deviation from policies and guidelines. She advised that this issue was being progressed by the Policy and Guideline Committee. In discussion, members noted that the main issue was in relation to the Sharepoint system not initiating appropriate reminders to policy authors informing them that their policy required a review (it was noted that this facility had been lost since the upgrade of Sharepoint). The Director of Clinical Quality advised that a business case had been developed as there was need for additional resources to resolve this issue. The Chief Nurse noted the need for a systematic approach highlighting that this issue was not 'unusual'. Responding to a query from the Chief Nurse and Quality Officer, East

Leicestershire CCG regarding the Trust's procedures to track actions arising from serious incidents and noting that the policy and guideline issue had not yet been resolved and this was one of the themes arising from incidents, the Director of Safety and Risk advised that the monitoring of actions was undertaken at the Adverse Events Committee.

Mr M Williams, Non-Executive Director queried the scope for the Policy and Guideline Committee (PGC) to take a more proactive view in progressing the policy review – in response, the Director of Safety and Risk highlighted the accountability of policy authors in ensuring that the policy was updated and received by the PGC for review. The Patient Adviser suggested that this issue be delegated to CMGs, however the Chief Nurse advised that some of the policies were corporate and therefore Trust-wide. The Chief Nurse provided assurance that the wider issue of policy review mechanism was currently under discussion with the PGC.

The report provided a summary of the initial work of the new East Midlands Patient Safety Collaborative including their agreed priorities for 2015-16. UHL was contributing to three of these work-streams. A brief update on SUIs, patient safety incidents, CAS and RCAs was also provided.

In response to a query from Mr M Williams, Non-Executive Director in respect of any 'duty of candour' issues, the Director of Safety and Risk advised that the legislation had changed in respect of reporting incidents and a discussion was required in respect of this. The QAC Chair advised that 'Statutory Duty of Candour' would now be a standing item on QAC agendas starting from February/March 2015 noting that a report on this matter was scheduled to be presented to EQB in February/March 2015. **DSR**

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

(B) 'Statutory Duty of Candour' be scheduled as a standing item on QAC agendas with effect from February/March 2015. **DSR/TA**

4/15/2 <u>Complaints Engagement Events Update Report and Action Plan</u>

Paper F provided an update on the progress made following the Complaints Engagement Event in June 2014. The primary focus of this event was to listen to the experiences of users, learn and take actions to improve the complaints service and processes.

One of the actions following this event was to explore an external evaluation process of UHL's complaints process (the action plan was detailed in appendix 1 of paper F). The Director of Safety and Risk and her team, HealthWatch, POhWER and Patient Adviser representatives had considered the establishment of an Independent Complaints Review Panel. Appendix 2 outlined the terms of reference of this panel and a draft template for use in reviewing individual cases. A pilot review panel had met on 13 January 2015 to test the processes and consider any amendments. The Director of Safety and Risk and the Patient Adviser highlighted that this was a useful experience and that a first full review panel was planned for March 2015.

In response to a query from Ms J Wilson, Non-Executive Director in respect of the action in the action plan re. 'Support staff to deal with concerns at source - Develop tools, guidance and training' – the Director of Safety and Risk advised that an e-learning package was being developed and would be piloted and rolled out. However, a rollout programme would need to be agreed by the Executive Quality Board. The Director of Safety and Risk undertook to discuss this matter at the EQB and provide an update to QAC in April 2015. **DSR**

Mr P Panchal, Non-Executive suggested some changes to the terms of reference of the Independent Complaints Review Panel which were in relation to the provision of support

to panel members and clarity regarding how the cases were chosen. It was also suggested that the Review Panel should attend the Trust Board in October 2015 to present a patient story in respect of a complaint that had been reviewed. **DSR** **DSR**

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

(B) the Director of Safety and Risk be requested to discuss at the EQB re. the roll out programme for the e-learning package to support staff to deal with complaints/concerns at source and provide an update to QAC in April 2015; **DSR**

(C) the Director of Safety and Risk be requested to update the terms of reference of the Independent Complaints Review Panel which were in relation to the provision of support to panel members to review complaints and clarity regarding how the cases were chosen, and **DSR**

(D) the Director of Safety and Risk be requested to invite members of the Independent Complaints Review Panel to attend the Trust Board in October 2015 to present a patient story in respect of a complaint that had been reviewed by them. **DSR**

5/15 QUALITY

5/15/1 CQC Should Dos

The Director of Clinical Quality presented paper G, which provided an update on the CQC 'should do' actions that remained non-compliant. Although the majority of actions were either 'complete' or 'on track', two actions had been rated 'amber':-

(i) 'action was required in respect of 'improving facilities for teenagers within hospital' – the QAC provided some suggestions to take forward this action, and
(ii) 'having different medication systems in different hospitals made tracking patients' medications difficult at times' – members noted that the issues re. EPMA would negate the planned actions and therefore would need to be reassessed.

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

05/15/2 Claims and Inquests Reports including an update on Regulation 28 letters

The Chief Nurse presented paper H, highlighting that two regulation 28 letters had been received in quarter 3 (2014-15) and the actions taken following these had been detailed in the appendices of paper H. The Director of Safety and Risk confirmed that Regulation 28 letters were scrutinised appropriately by the Adverse Events Group.

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

05/15/3 Nursing Report

The Chief Nurse presented paper I, which detailed information in respect of the latest nursing staffing in post figures, the current recruitment position, premium pay, nursing dashboard and the mitigation of workforce gaps.

In discussion on this item, members:

(i) noted that an overtime premium had been agreed in the short-term for paediatric trained nurses in order to mitigate some staffing issues in that area;
(ii) noted that there were 330 vacancies in November 2014;

(iii) noted the nursing clinical dashboard – two wards had triggered a concern for October 2014 and action plans had been developed to resolve the issues;
(iv) queried whether a process was in place to monitor the number of overtime hours undertaken by nurses – it was noted that for bank and substantive staff, triggers were in place if working time regulation hours were exceeded;
(v) noted that there had been nursing acuity changes in the CHUGGS CMG and that a bid for additional funding would be submitted.

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

05/15/4 Months 8 and 9 – Quality and Performance Update

The Chief Nurse presented papers J and J1, which provided an overview of the November and October 2014 Quality and Performance reports.

In discussion on this item, members noted that :

(i) there had not been any improvement in the fractured neck of femur performance. This pathway was now the subject of a Listening into Action team approach;
(ii) there had been an avoidable grade 4 pressure ulcer in December 2014 as well as an increase in avoidable grade 2 ulcers. However, the position was now improving;
(iii) there had been deterioration in ED 4 hour performance in December 2014, and
(iv) there had been 2 never events and the Medical Director provided a brief update on these.

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

5/15/5 Statutory Duty of Candour

Resolved – that 'Statutory Duty of Candour' be scheduled as a standing item on QAC agendas starting from February/March 2015 (Minute 4/15/1 above refers).

6/15 ITEMS FOR THE ATTENTION OF QAC FROM EQB

6/15/1 EQB Meeting of 2 December 2014 – Items for the attention of QAC

Resolved – that the action notes of the 2 December 2014 Executive Quality Board meeting (paper K refers) be received and noted.

6/15/2 EQB Meeting of 6 January 2015 – Items for the attention of QAC

Resolved – that there were no items for the attention of QAC from the EQB meeting on 6 January 2015.

7/15 ITEMS FOR INFORMATION

7/15/1 Update on the process utilised by the NHSLA to determine the annual premium to be paid to the NHSLA by Trusts

Members received and noted the contents of paper L. The Director of Safety and Risk advised that the safety improvement plan and NHSLA bid to support the safety work at UHL would be submitted to the EQB and QAC in February 2015. The learning from inquests would be submitted to EQB and QAC in March 2015. **DSR**

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

(B) the Director of Safety and Risk be requested to submit:-

- **the safety improvement plan and NHSLA bid to support the safety work at UHL to the EQB and QAC in February 2015, and** **DSR**
- **the learning from inquests to EQB and QAC in March 2015.**

7/15/2 Complaints Briefing Report

Members noted the contents of paper M. The Director of Safety and Risk queried whether this report provided sufficient information noting that the CQC's expectation was that the Trust Board should receive a report on complaints. In discussion on this matter, it was suggested that this report should now feature as a substantive item on the QAC agenda and this would provide an opportunity for QAC to escalate any issues to the Trust Board as per the CQC's requirement. In discussion, members also noted that the 'Triangulation of Patient Experience' report was initially presented to the Trust Board but it was agreed that this report would be considered by the QAC instead of the Trust Board. It was suggested that when this report was next discussed, consideration be given in respect of whether this report would be best considered by the QAC or the Trust Board.

The Chief Nurse advised that initial discussions had been held with the Trust Chairman and the QAC Chair in respect of organising a briefing on the existing Quality Commitment to take place soon after the QAC meeting on 26 February 2015. Executive and Non-Executive Directors including the Deputy Chief Nurse, Director of Safety and Risk and Director of Clinical Quality would be invited to attend this session. **CN**

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

(B) the Chief Nurse be requested to organise a briefing on the existing Quality Commitment to take place soon after the QAC meeting on 26 February 2015. **CN**

7/15/3 CQC Registration Update

The Director of Clinical Quality introduced paper N and advised that UHL had hosted the Alliance activity and therefore registered this with the CQC. When the initial applications were made in April 2014, Rutland Memorial Hospital applied to be able to provide surgical activity. This was now deemed to be inappropriate. An application therefore had been made to this effect to remove from the registration certificate. She highlighted that the Trust Board needed to be notified of this.

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

8/15 MINUTES FOR INFORMATION

8/15/1 Executive Performance Board

Resolved – that the action notes of the 16 December 2014 Executive Performance Board meeting (paper O refers) be received and noted.

9/15 ANY OTHER BUSINESS

Resolved – that there were no items of any other business.

10/15 IDENTIFICATION OF ANY KEY ISSUES FOR THE ATTENTION OF THE TRUST BOARD

Resolved – that the QAC Chair be requested to bring the following issue to the attention of the Trust Board:

- **(i) Minute 7/15/3 (CQC Registration Update).**

11/15 DATE OF NEXT MEETING

<u>Resolved</u> – that the next meeting of the Quality Assurance Committee be held on Thursday, 26 February 2015 from 1.00pm until 4.00pm in the Board Room, Victoria Building, LRI.

<u>The meeting closed at 2.58pm.</u>

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

Name	*Possible*	*Actual*	*% attendance*	*Name*	*Possible*	*Actual*	*% attendance*
J Adler	10	8	80%	*R Overfield*	10	8	80%
S Dauncey (Chair)	10	9	90%	*P Panchal*	10	6	60%
K Harris	10	8	80%	*J Wilson*	10	9	90%
K Jenkins	1	0	0%	*D Wynford-Thomas*	10	3	30%

Non-Voting Members

Name	*Possible*	*Actual*	*% attendance*	*Name*	*Possible*	*Actual*	*% attendance*
M Caple	10	8	80%	*K Singh*	4	4	100%
I Crowe	4	3	75%	*M Traynor*	4	1	25%
*C O'Brien – East Leicestershire/Rutland CCG**	10	6	60%	*M Williams*	4	1	25%

Hina Majeed
Trust Administrator

University Hospitals of Leicester NHS
NHS Trust

Trust Board Paper N1

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT BY TRUST BOARD COMMITTEE TO TRUST BOARD

DATE OF TRUST BOARD MEETING: 5 March 2015

COMMITTEE: Quality Assurance Committee

CHAIR: Dr S Dauncey, Non-Executive Director

DATE OF MEETING: 26 February 2015

This report is provided for the Trust Board's information in the absence of the formal Minutes, which will be submitted to the Trust Board on 2 April 2015.

SPECIFIC RECOMMENDATIONS FOR THE TRUST BOARD:

- None

SPECIFIC DECISIONS:

- None

DISCUSSION AND ASSURANCE:

- **Patient Safety Report** – particularly noted internal safety information and data for January 2015. An update on external safety news and developments including Leicestershire Improvement, Innovation and Patient Safety Unit (LIIPS) and East Midlands Patient Safety Collaborative was provided. A brief discussion took place in respect of the themes arising from safety walkabouts, 3636 staff concerns reporting line and SUIs/never events;
- **Statutory Duty of Candour** – a brief verbal update on implications for UHL following the CQC's recent publication on 'Regulation 20: Duty of Candour' was provided. A written update on this matter would be presented to QAC in March 2015 and any exception reports would be provided to future QAC meetings;
- **Safety Improvement Plan and NHSLA Bid to Support the Safety Work at UHL** – members noted that the safety improvement plan and NHSLA bid to support the safety work at UHL was submitted to NHS England on 19 January 2015. A response to the bid was expected before end of March 2015. It was noted that the safety improvement plan was not separate from the Quality Commitment and was part of the "safety domain" within the Quality Commitment;
- **Nursing Acuity Report** – it was now a national requirement that Trusts were sighted to a bi-annual detailed review of staffing using evidence based tools to ensure appropriate deployment of staff etc. The first of these reviews was presented to QAC for assurance and noting of recommendations and actions;
- **Nursing Report** – a brief update on real time staffing, vacancies, premium pay and nursing clinical dashboard was provided. An update on midwifery staffing would be included in future iterations of this report;
- **Month 10 Quality and Performance Report** – particular note was made in respect of improvement in C Diff and safety thermometer performance, and deterioration in #NOF time to

theatre performance. In respect of the exception reports relating to 'research', it was noted that consideration needed to be given to the role of UHL and not just the East Midlands Network. Concern was expressed in respect of the co-ordination of the LiA workstream re. 'same day cancellation of operations', however, further to discussion it was noted that the appropriate leads had been informed and this would be monitored by the LiA Sponsor Group;

- **Quality Impact Assessment of CIP Schemes** – it was noted that there had been no significant identified harm to patients from the CIP programme at end of quarter 3 and there were a minimal number of risks identified which were being monitored. QAC members were re-assured by this.
- **CQUINs and Quality Schedule Monthly Report** – members were advised that '#NOF' and 'stroke' indicators had now been rated 'red'. A LiA workstream was now underway to resolve the #NOF performance. In respect of the 'stroke' indicator, the CMG was aware of the issues and a new model was being developed to create more capacity and flexibility around ring-fencing of beds for stroke patients;
- **External Visit Schedule** – a brief update on the external visits including the 'Trauma Peer Review' visit and the re-visit to review the cytology screening programme. It was suggested that the presentation of the report be improved to highlight imminent visits and ones of greater significance.
- **Patient Safety Annual Report and Complaints Annual Report** – received and noted;
- **Quality Commitment Report –** quarter 3 performance was noted and it was agreed that this report be scheduled as a substantive agenda item rather than an 'item for information';
- **Dementia Implementation Plan Update** – an update was provided on the Dementia Implementation Plan for quarter 3 of 2014-15 against the key performance indicators aligned to each of the eight work streams. It was noted that the majority of the 60 KPIs had been significantly completed. It was agreed that this report should also feature as a substantive agenda item rather than an 'item for information', and
- **Friends and Family Test Scores – December 2014** – the scores were as follows: - Inpatient – 72.1, Emergency Department – 72.8 and Maternity – 63.8.

DATE OF NEXT COMMITTEE MEETING: 26 March 2015

Dr S Dauncey – Committee Chair
27 February 2015

University Hospitals of Leicester NHS
NHS Trust

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT BY TRUST BOARD COMMITTEE TO TRUST BOARD

DATE OF TRUST BOARD MEETING: 5 March 2015

COMMITTEE: Integrated Finance, Performance and Investment Committee

CHAIR: Ms J Wilson, Non-Executive Director

DATE OF COMMITTEE MEETING: 29 January 2015

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

- **Confidential Minute 1/15 – report by the Chief Executive**

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

- **none**

DATE OF NEXT COMMITTEE MEETING: 26 February 2015

Ms J Wilson
27 February 2015

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF THE INAUGURAL MEETING OF THE INTEGRATED FINANCE, PERFORMANCE AND INVESTMENT COMMITTEE (IFPIC), HELD ON THURSDAY 29 JANUARY 2015 AT 9AM IN THE BOARD ROOM, VICTORIA BUILDING, LEICESTER ROYAL INFIRMARY

Voting Members Present:
Ms J Wilson – Non-Executive Director (Committee Chair)
Mr J Adler – Chief Executive
Colonel (Retired) I Crowe – Non-Executive Director
Dr S Dauncey – Non-Executive Director
Mr P Panchal – Non-Executive Director (from Minute 5/15/1)
Mr P Traynor – Director of Finance
Mr M Traynor – Non-Executive Director (from part of Minute 5/15/1)

In Attendance:
Ms L Bentley – Head of Financial Management and Planning
Ms J Fawcus – Head of Operations, CHUGGS (for Minute 5/15/1)
Ms L Gallagher – Workforce Development Manager (for Minute 5/15/2)
Ms J Gilmore – Imaging Service Manager, CSI (for Minute 1/15)
Mr M Hotson – Business Manager, LLR Facilities Management Consortium (for Minute 5/15/5)
Ms G Kenney – Head of Nursing, CHUGGS (for Minute 5/15/1)
Ms E MacLellan-Smith – Programme Director, CIP and Future Operating Model (for Minutes 5/15/4, 6/15/1 and 6/15/2)
Mr T Maton – Finance Lead, CSI (for Minute 1/15)
Mr W Monaghan – Director of Performance and Information
Mrs K Rayns – Acting Senior Trust Administrator
Mr D Rose – IM&T Infrastructure and Support Manager (for Minute 1/15)
Ms K Shields – Director of Strategy (excluding Minute 5/15/5 and part of Minute 1/15)
Mr K Singh – Trust Chairman (from part of Minute 5/15/1)
Mr G Smith – Patient Adviser
Ms S Taylor – Head of Operations, MSS (for Minute 7/15/2)
Dr M VanWattingen – Consultant Radiologist, CSI (for Minute 1/15)
Ms E Wilkes – Programme Director, 5 Year Strategy (for Minute 5/15/4)
Mr M Williams – Non-Executive Director

RECOMMENDED ITEM **ACTION**

1/15 REPORT BY THE CHIEF EXECUTIVE

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

RESOLVED ITEMS

2/15 APOLOGIES AND WELCOME

Apologies were received from Mr R Mitchell, Chief Operating Officer and Mr J Jameson, Clinical Director, CHUGGS. The Chair welcomed Mr W Monaghan, Director of Performance and Information to the meeting, noting that he would be attending future meetings in a non-voting capacity.

3/15 MINUTES

Papers A and A1 provided the Minutes of the final Finance and Performance Committee meeting held on 18 December 2014.

Resolved – that the Minutes of the 18 December 2014 Finance and Performance

Committee meeting be confirmed as correct records.

4/15 MATTERS ARISING PROGRESS REPORT

The Committee Chair confirmed that the matters arising report provided at paper B detailed the status of all outstanding matters arising from Finance and Performance Committee meetings and that the Integrated Finance, Performance and Investment Committee would continue to monitor their progress. Members received updated information in respect of the following items:-

(a) Minute 140/14(a) of 18 December 2014 – the Director of Finance confirmed that the additional resources agreed with IBM to support data warehouse performance were still in place and that the position was being monitored on a monthly basis. Assurance would be provided to the IFPIC through the quarterly IBM contract performance reports; **CIO**

(b) Minute 140/14/3 of 18 December 2014 – the Chief Executive had not yet received feedback from the Director of Estates and Facilities following his review of hospital reception opening hours and how these aligned with visiting times and clinic attendances. Noting the non-urgent nature of this action, it was agreed that an update would be provided to the March 2015 IFPIC meeting via the matters arising log and that this should include the interface with hospital volunteers; **CE/DEF**

(c) Minute 140/14/4(b) of 18 December 2014 – a briefing from the Trust's solicitors was expected to be received on 30 January 2015 and this would be shared with Board members as appropriate; **DF**

(d) Minute 122/14(a) of 26 November 2014 – the agreed actions relating to the Electronic Patient Record (EPR) business case were progressing according to plan;

(e) Minute 126/14 /4(a) of 26 November 2014 – in discussion on the delayed development of the Empath business case, the Chief Executive highlighted the delayed opportunity to realise the associated financial benefits of this scheme. The Director of Finance confirmed that the business case and the Governance "road map" were expected to be presented to the March 2015 IFPIC meeting; **DF**

(f) Minute 128/14/3(b) of 26 November 2014 – the Committee Chair confirmed that a financial awareness session was being factored later into the programme of Trust Board thinking days, but a date was yet to be agreed; **DCLA**

(g) Minutes TBC(1) and (11) of 29 October 2014 – a Trust Board thinking day was planned to be held in the first quarter of 2015-16 to discuss the wider issues surrounding the 5 year workforce plan and education matters. These actions would therefore be removed from the matters arising log for this Committee, and **TA**

(h) Minute 103/14/4 of 24 September 2014 – the Trust's arrangements for monitoring small clinical teams were being monitored by the Quality Assurance Committee and could be removed from the matters arising log for this Committee. **TA**

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

5/15 STRATEGIC MATTERS

5/15/1 <u>CMG Presentation – Cancer, Haematology, Urology, Gastroenterology and General Surgery (CHUGGS)</u>

The Head of Operations and the Head of Nursing from the CHUGGS Clinical Management

Group attended the meeting to present a summary of the CMG-level operational and financial performance. The presentation slides had been circulated in advance of the meeting (paper C refers) and these were taken as read. The CMG team was invited to focus on any key issues or particular concerns on the basis of exception and they responded by highlighting the following points:-

(a) ***Infection Prevention*** – following an increased incidence of Clostridium Difficile within the 2 Gastroenterology wards, a priority bid for ward refurbishment work was being developed in order to improve the environment on these wards. The CMG had also experienced 2 MRSA bacteraemias (1 avoidable and 1 non-avoidable) within the 2014-15 year to date;

(b) ***Referral to Treatment (RTT)*** – the RTT backlog within General Surgery was reducing well, but the increasing trend in referrals and activity levels was restricting the ability to reduce the backlog within Urology Services;

(c) ***Cancer Target Compliance*** – the Urology service remained an outlier which was attributed (in part) to the rise in referrals and some individual performance issues;

(d) ***Achievements*** – the robotic surgical programme and a Lithotripsy service for patients with kidney stones had been successfully implemented. Palliative care services had been expanded and length of stay within Oncology had reduced following the implementation of daily Consultant led ward rounds. The target radiotherapy IMRT rate had also been achieved;

(e) ***Risk Register*** – key risks included (1) the loss of JAG accreditation for the LGH Endoscopy unit, (2) a programme of investment required for radiotherapy, and (3) staffing levels on the Surgical Assessment Unit (SAU);

(f) ***Workforce*** – sickness absence rates and appraisal rates were steadily improving and international nurse recruitment had been successful. Significant progress had been made in respect of statutory and mandatory training and work was taking place with the Deanery to increase the focus on junior doctors' compliance;

(g) ***Finance*** – the CMG was likely to deliver their year end control total. CIP performance had been strong in 2014-15, but work continued to identify sufficient schemes to deliver the 2015-16 target, with the support of good clinical engagement, and

(h) ***Anti-Coagulation Service*** – the CMG had expressed an interest in disinvestment, but Commissioners had been unable to source an alternative provider and UHL had been requested to continue delivery of this service.

In discussion on the presentation and the issue raised, the Committee:-

(i) commented upon the staffing levels on SAU (following a recent walkaround visit) and noted that the CMG was currently progressing a bid for additional nurse acuity funding. The Corporate Nursing Directorate had supported this bid which reflected a genuine change in case mix over the last 18 months, with increasing numbers of intensive care discharges and elderly patients with complex co-morbidities;

(ii) queried whether any additional Corporate support was required to address cancer performance within Urology. In response, the Head of Operations commented on improved Consultant engagement and team working in respect of the robotics programme. Some additional Urology capacity had been created but this had not kept pace with the increasing trend in referrals. Dr S Dauncey, Non-Executive Director and Chair of the Quality Assurance Committee (QAC), commented on the scope for QAC to review Urology activity and capacity plans in light of recent health awareness campaigns and an increase in "worried well" patients coming forward for screening. In **QAC Chair**

addition, members noted that a wider post-investment review on the implementation of the DaVinci Robot was due to be undertaken at the 26 February 2015 IFPIC meeting;

(iii) sought and received additional information relating to friends and family test feedback and queried whether there was any correlation with complaints trends and telephone response rates. In response, it was noted that the Clinical Director, Head of Operations and Head of Nursing reviewed all patient complaints and that the telephone system on the LGH site had recently been upgraded. Some additional customer service and communications training had been arranged for administrative staff and additional appointment slots had been made available (which included some Saturday working).

(iv) received an update on the work planned to address the gap in identified CIP schemes for 2015-16. A CIP workshop had been held in the last week with good clinical engagement and weekly planning meetings were being held with Ernst Young support, and

(v) received assurance that the transfer of Endoscopy activity from the LGH site would not impact upon patient experience, privacy and dignity at the LRI and GH sites, noting that some activity would also be transferred to the Alliance premises (once these had been JAG accredited) and that additional evening and weekend sessions would be provided.

The Committee Chair thanked the CMG team for their presentation and suggested that a separate discussion be held outside the meeting to ascertain whether those performance issues highlighted which also had associated quality and safety implications would be monitored via the IFPIC or QAC agendas going forwards. **QAC & IFPIC Chairs**

<u>Resolved</u> – that (A) the CMG presentation and subsequent discussion be noted, and

(B) the IFPIC Chair and the QAC Chair be requested to liaise outside the meeting to determine whether the quality and safety aspects of the CMG's presentation would be monitored through the IFPIC or QAC agendas going forwards. **QAC & IFPIC Chairs**

5/15/2 <u>Workforce Plan Update</u>

Paper D provided an update on the development of the 2015-16 workforce plan (year 2 of the Trust's 5 year workforce plan) and described the role and purpose of the workforce cross-cutting CIP theme, which was being led by the Director of Finance (in the absence of a substantive Director of Human Resources). The Workforce Development Manager attended the meeting to introduce this item, noting the impact of technical operational planning guidance published by the NTDA on 23 December 2014. Under the new guidance, the Trust was required to provide greater transparency of workforce changes by occupational group and by the categories outlined in section 2.2 of paper D.

Appendix A set out the workforce project charter which detailed the key workstream activities surrounding (a) reconfiguration, (b) medical, (c) nursing, and (d) premium pay. Section 4 of the report focused upon the Medical Workforce Strategy and section 5 highlighted the supporting transformational activity (eg new role developments).

The Committee considered the wider implications of UHL's position as a major local employer in the context of falling unemployment, external market pressures and opportunities to influence training commissioning plans. The Trust Chairman highlighted a strategic requirement to plan workforce models in more innovative ways, noting that some self-funded nurse training courses were being offered in Lancashire.

Responding to a Non-Executive Director query, the Director of Finance advised that no provision had yet been made for any revised overhead costs (eg uniforms and back office

services) in line with proposed changes in the shape and size of UHL's workforce. However, any large scale savings would be linked to the relevant CMGs' cost improvement programme and captured accordingly on the programme management tracker.

The Committee Chair suggested that any strategic workforce issues be debated further at the Trust Board thinking day session planned for that purpose. Members noted that the Integrated Finance, Performance and Investment Committee would continue to monitor progress against all 4 of the cross-cutting CIP themes and that the next substantive update on the workforce plan would be presented to the 30 April 2015 meeting.

Resolved – that (A) the workforce plan update be received and noted as paper D, and

(B) the next iteration of the report be presented to the IFPIC in April 2015. **DHR/ WDM**

5/15/3 Update on the Transfer of UHL's Clinical Services to the Alliance

Paper E provided an update on progress of the Alliance Contract and the proposed clinical service transfers. In view of time pressures at this meeting, discussion on this item was deferred to the 26 February 2015 meeting.

Resolved – that a refreshed report on the transfer of UHL's clinical services to the Alliance be presented to the 26 February 2015 IFPIC meeting. **DS**

5/15/4 5 Year Strategy Enabling Workstreams

Ms E MacLellan-Smith and Ms E Wilkes, Programme Directors attended the meeting to brief the Committee on the programme of work underway to support the delivery of UHL's 5 year strategy, as detailed in paper F. The appended slides provided an overview of the governance structure and enabling workstreams. During discussion on this item, IFPIC members particularly noted:-

(a) the crucial nature of the ITU strategy and the LPT shift workstreams;
(b) that substantive appointments had been made to 6 of the 7 CIP posts. The Committee Chair sought and received additional assurance on the arrangements for building capability and transfer of skills within the CMGs and she requested that this detail be incorporated into future iterations of the supporting slides;
(c) Mr P Panchal, Non-Executive Director supported the programme of work but queried whether there was likely to be any duplication of effort between the various meetings and governance structures. In response, the Chief Executive confirmed that this framework had been structured in a coherent way so as to avoid such duplication. However, he noted the scope for further discussion on the finalised title/branding of this collective programme to emphasise the quality improvement aspects as well as the cross cutting CIP themes;
(d) Mr Panchal also suggested that it would be helpful to see the 5 year strategy governance structure in the context of the overall UHL governance structure. The Chief Executive advised that this information had been circulated previously as part of the supporting papers for the 22 December 2014 Trust Board meeting and the 15 January 2015 Trust Board development session. Further copies of these documents were available from Trust Administration upon request;
(e) Mr M Williams, Non-Executive Director sought additional information regarding the staff engagement and communications workstreams and where the biggest challenges lay. In response, it was noted that an advertisement had been placed for an additional communications and engagement resource to support this workstream. Once this post had been recruited to, the communications strategy would be developed further. The Director of Strategy suggested that the biggest challenge would be associated with the Trust's transition from planning phases to delivery phases;
(f) Colonel (Retired) I Crowe, Non-Executive Director commented upon the scope to use

IBM predictive analysis data more effectively within the enabling schemes, and

(g) finally members noted the importance of the patient and public involvement strategy and the need to dovetail UHL's engagement opportunities with those of the Better Care Together Programme.

Resolved – that update on the 5 year strategy enabling workstreams be received and noted as paper F.

5/15/5 Report by the Interim Director of Estates and Facilities

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

6/15 FINANCE

6/15/1 2014-15 Financial Position to Month 9

The Director of Finance introduced papers I and I1 providing an update on UHL's performance against the key financial duties surrounding delivery of the planned deficit, achievement of the External Financing Limit (EFL) and achievement of the Capital Resource Limit (CRL), as submitted for consideration by the 27 January 2015 Executive Performance Board and the 5 February 2015 Trust Board meetings. He advised that agreement had been reached with the local Clinical Commissioning Groups (CCGs) regarding the final 2014-15 income position and that the Trust was close to reaching a similar agreement with Specialised Commissioners. Clinical Management Groups and Corporate Directorates were being held to account to deliver their control totals to support delivery of the Trust's year-end forecast deficit of £40.7m.

In discussion on the Trust's financial performance, IFPIC members:-

(a) sought and received assurance regarding progress of the 2014-15 Capital Plan provided at appendix 5, noting that the Director of Finance chaired the Capital Monitoring and Investment Committee and that appropriate oversight was maintained in respect of the estates, medical equipment, IM&T and procurement elements of this plan and that there was a high degree of confidence that the forecast expenditure would be met;
(b) noted that a technical correction was required in respect of teaching and R&D income;
(c) queried whether there would be any scope to build in a larger financial contingency for 2015-16, noting the need to follow established guidance on this point;
(d) received assurance that the CMGs were appropriately sighted to the issues affecting UHL's financial performance, and
(e) requested the Director of Finance to present a report to the March 2015 IFPIC meeting outlining any lessons learned from the financial management and forecasting process in 2014-15. **DF**

Resolved – that (A) the briefings on UHL's Month 9 financial performance (papers I and I1) and the subsequent discussion be noted, and

(B) the Director of Finance be requested to report on any lessons learned from the 2014-15 forecasting process at the March 2015 IFPIC meeting. **DF**

6/15/2 Cost Improvement Programmes for 2014-15 and 2015-16

Ms E MacLellan-Smith, Programme Director, CIP and Future Operating Model attended the meeting to present paper J, providing the monthly update on CIP performance for 2014-15 and the development of CIP plans for 2015-16. She noted a continued strong position for 2014-15, despite the month 8 slippage of £300k in respect theatre productivity programme to manage additional 18 week RTT activity. Service reviews of the loss

making specialties continued and some good clinical engagement was being evidenced. 6 of the 7 CMG Transformation Manager posts had been appointed and some good NHS Management Team trainee candidates had been identified for the final post in ITAPS. A formal knowledge transfer and training programme was in place to support the transfer of skills into the CMGs.

In respect of the £41m CIP target for 2015-16, the CMGs continued to develop their high level plans into granular plans and convert the RAG-ratings to green and amber. The ITAPS and ESM CMGs were experiencing differing challenges with their CIP plans for 2015-16 but appropriate support was being provided as required.

In discussion on the report, IFPIC members noted the links between CIP planning and the future operational model and business structures. Assurance was provided that the CMGs were appropriately engaged in the development of the 4 cross cutting CIP themes, although the Outpatients theme was more advanced than the others and the Workforce scheme was yet to be fully embedded. A rolling process was in place for capturing any quality and safety implications arising from CIP schemes and an additional review stage by the Executive Quality Board had been included prior to submission to the Chief Nurse and the Medical Director for sign-off.

Resolved – that the Cost Improvement Programme update (paper J) and the subsequent discussion be noted.

6/15/3 Response to the National Contract and Tariff Guidance for 2015-16 and Next Steps

The Director of Finance introduced paper K, providing a briefing on the proposals relating to the NHS Standard Contract and Tariff Guidance. The report highlighted the key changes proposed and their potential impact upon the Trust's financial position. Formal objections had been raised with a particular focus on marginal rates for specialised services and the financial impact of the quality agenda not being properly reflected in the tariff uplift.

Resolved – that the briefing on the proposed National Contract and Tariff Guidance for 2015-16 (paper K) be received and noted.

6/15/4 Patient Level Information and Costing System (PLICS) and Service Level Reporting (SLR) Update

The Head of Financial Management and Planning introduced paper L, providing an update on the continued development of PLICS and SLR at UHL and taking the paper as read. She highlighted opportunities to further improve the availability of PLICS data and the need for further internal debate on the subjects of space utilisation, apportionment of overhead charges and nurse acuity/patient dependency data. An audited report on the Trust's reference cost position was expected in the next few weeks. In addition, the Director of Finance advised that UHL was due to participate in a Monitor pilot scheme in respect of costing information and technical engagement.

Resolved – that the briefing on PLICS and SLR (paper L) and the subsequent discussion be noted.

7/15 PERFORMANCE

7/15/1 Month 9 Quality and Performance Report

Paper M provided an overview of UHL's quality, patient experience, operational targets, and HR performance against national, regional and local indicators for the month ending 31 December 2014. The Chief Executive introduced this item, noting the inclusion (with effect from this month) of his new accompanying highlight report. Particular discussion

took place regarding the following issues:-

(a) non-admitted RTT performance remained strong, but the trajectory for admitted performance was disappointing in the specialties of Urology and Orthopaedics. A form of special measures had been implemented for the Urology service and an update on the Orthopaedics service would be provided later in the agenda (Minute 7/15/2 below refers). In response to national RTT pressures, it had been agreed that the Trust would treat an additional 360 cases in February 2015 and this would be achieved using a combination of in-house and independent sector activity. Good progress had been evidenced in the Ophthalmology and ENT services where compliant RTT performance had now been achieved, and

(b) cancer performance continued to cause concern in a number of the key indicators and there had been a significant number of cancelled operations in December 2014. The Director of Performance and Information provided a detailed breakdown of cancer performance and the trajectory for improvement, noting the impact of JAG accreditation in Endoscopy services and 31 day breaches in Urology. Tumour site action plans had been agreed by all parties.

IFPIC members requested additional clarity regarding the process for capturing any patient harm arising from delays in cancer treatments or cancellation of operations and it was agreed to escalate this matter for consideration at the next available Quality Assurance Committee meeting. **QAC Chair**

<u>Resolved</u> – that (A) the month 9 Quality and Performance report and the subsequent discussion be noted;

(B) the Quality Assurance Committee Chair be requested to schedule a discussion at the next available QAC meeting on the mechanism for monitoring any patient harm arising from delays in treatment or cancelled surgery. **QAC Chair**

7/15/2 <u>RTT Performance</u>

Further to Minute 7/15/1 point (a) above, Ms S Taylor, Head of Operations attended the meeting from the MSS CMG to provide an update on RTT performance within the Orthopaedics service (paper N refers).

Section 5 of the report detailed the range of additional actions and support being undertaken to deliver the revised action plan and achieve compliant RTT performance by the end of April 2015. Members noted that spinal surgery and recruitment of a replacement spinal surgeon remained the biggest challenge. Active discussions with a number of trainee spinal surgeons were underway but there remained a national shortage of surgeons in this sphere. In respect of independent sector and out of area referrals, a cautious approach was being adopted to management of patient expectations, given that not all of UHL's spinal patients would meet the criteria for being treated outside of UHL, nor would some patients be happy to travel a significant distance to other centres.

The Committee Chair queried whether there were any barriers to improving Orthopaedic RTT performance and noted in response that imaging reporting times had improved from 6 weeks to 4 weeks and that the MRI scanning van had been made available as required. The Director of Performance and Information noted the scope to implement a short term "fee for service" arrangement for additional spinal outpatient activity and he undertook to discuss this option with the Acting Director of Human Resources and the Director of Finance outside the meeting. **DPI**

<u>Resolved</u> – that (A) the update on RTT performance within the MSS CMG be received and noted, and

(B) the Director of Performance and Information be requested to liaise with the Acting Director of Human Resources and the Director of Finance outside the meeting regarding any opportunity to implement a "fee for service" arrangement for spinal surgeons. **DPI**

8/15 SCRUTINY AND INFORMATION

8/15/1 Executive Performance Board

Resolved – that the notes of the 16 December 2014 Executive Performance Board meeting (paper O) be received and noted.

8/15/2 Revenue Investment Committee

Resolved – that the notes of the 16 January 2015 Revenue Investment Committee meeting (paper P) be received and noted.

8/15/3 Capital Monitoring and Investment Committee

Resolved – that the notes of the 16 January 2015 Capital Monitoring and Investment Committee meeting (paper Q) be received and noted.

9/15 ANY OTHER BUSINESS

Resolved – that no other items of business were noted.

10/15 ITEMS TO BE HIGHLIGHTED TO THE TRUST BOARD

Resolved – that (A) a summary of the business considered at this meeting be provided to the Trust Board meeting on 5 February 2015, and **TA/ Chair**

(B) the recommendation contained in confidential Minute 1/15 be particularly highlighted for the Board's attention.

11/15 DATE OF NEXT MEETING

Resolved – that the next meeting of the Integrated Finance, Performance and Investment Committee be held on Thursday 26 February 2015 from 9am – 12noon in the Board Room, Victoria Building, Leicester Royal Infirmary.

The meeting closed at 12:08pm

Kate Rayns,
Acting Senior Trust Administrator

Attendance Record 2014-15

Voting Members:

Name	Possible	Actual	% attendance	Name	Possible	Actual	% attendance
J Wilson (Chair from 29.10.14)	10	9	90%	R Mitchell	10	9	90%
R Kilner (Chair up to 24.9.14)	6	6	100%	P Panchal	3	1	33%
J Adler	10	9	90%	S Sheppard	4	4	100%
I Crowe	10	9	90%	M Traynor	3	3	100%
S Dauncey	3	2	66%	P Traynor (from 26.11.14)	3	3	100%
P Hollinshead	3	3	100%				

Non-Voting Members:

Name	Possible	Actual	% attendance	Name	Possible	Actual	% attendance
K Singh	3	3	100%	M Williams	3	1	33%
G Smith	10	10	100%	D Wynford-Thomas	3	0	0%
K Shields	3	2	66%				

University Hospitals of Leicester NHS
NHS Trust

Trust Board Paper O1

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT BY TRUST BOARD COMMITTEE TO TRUST BOARD

DATE OF TRUST BOARD MEETING: 5 March 2015

COMMITTEE: Integrated Finance, Performance and Investment Committee

CHAIR: Ms J Wilson, Non-Executive Director

DATE OF MEETING: 26 February 2015

This report is provided for the Trust Board's information in the absence of the formal Minutes, which will be submitted to the Trust Board on 2 April 2015.

SPECIFIC RECOMMENDATIONS FOR THE TRUST BOARD:

- ***Draft Interim Annual Operational Plan*** – noting the requirement for providers to decide whether to opt for the enhanced tariff option or the default tariff rollover (by 4 March 2015), the Committee provided delegated authority to the Director of Finance and the Chief Executive to determine the best option for UHL following a meeting to be held on Monday 2 March 2015. A briefing note would then be circulated to Trust Board members on 3 March 2015 explaining the rationale behind the Trust's decision and the Trust Board would be invited to ratify the decision on 5 March 2015. The Director of Finance advised that the enhanced tariff model appeared to be the best and most likely option at the current time, but he was keeping an open mind until after the meeting on 2 March 2015.

SPECIFIC DECISIONS:

- ***Matter Arising (1) Empath*** – the Chief Executive and the Director of Finance to review progress in respect of the development of the Empath Business Case and provide a briefing on the outcome to the IFPIC on 26 March 2015;
- ***Matter Arising (2) Financial Awareness Session*** – consideration to be given to scheduling a financial awareness session for Non-Executive Directors after the IFPIC and QAC meetings on 26 March 2015 or 30 April 2015, and
- ***Capital Expenditure 2014-15 and Draft Capital Programme 2015-16*** – a further report to be presented to the 26 March 2015 IFPIC meeting to include plans for addressing backlog maintenance. Consideration to be given to inviting the Interim Director of Estates and Facilities to attend future IFPIC meetings, and
- ***Draft Financial Plan 2015-16*** – a further iteration to be presented to the 26 March 2015 IFPIC meeting prior to submission to the 2 April 2015 Trust Board for final approval. Consideration to be given to inclusion of any risks surrounding the Interserve contract and the projected outturn for emergency activity.

DISCUSSION AND ASSURANCE:

- ***Clinical Support and Imaging CMG Presentation*** – the following issues were highlighted:-
  - strong financial performance and CIP delivery for 2014-15,
  - excellent progress with identification of CIP schemes for 2015-16 and opportunities being explored to over-deliver against the 2015-16 CIP target and/or deliver an income and expenditure surplus for 2015-16;
  - the significant contributions that CSI made to support UHL's emergency care performance (eg

expanded pharmacy dispensing hours);
    - innovative workstreams within pharmacy and forensic imaging;
    - risks surrounding increased imaging activity, diagnostic capacity, demand management issues, workforce management of change processes and the volume of projects contributing to the Trust's 5 Year Strategy;
    - additional support that might be required in the form of commercial and marketing expertise to support innovation, including the potential development of a Commercial Strategy during the 2015-16 financial year;
    - workforce shortfalls (particularly in Pharmacy and Ultrasound services) and plans being taken forward to mitigate the position and reduce premium pay expenditure, and
    - the positive interaction between the CMG and their embedded EY resource and the arrangements for transferring these skills across to the CMG's newly appointed transformation lead;
- ***Quarterly review of the IM&T contract with IBM*** – including a particular focus on:-
    - Data Warehouse arrangements, where a revised plan was expected to be signed off by the end of the week to achieve an optimal and sustainable position;
    - financial and operational risks surrounding the ceasing of the DoH free SMS text delivery service for NHS Trusts;
    - opportunities to review the contractual KPIs and seek independent assurance that the Trust was still gaining appropriate value for money during the third year of the contract;
    - the "go live" date for Electronic Document Record Management (EDRM) in Paediatrics on 27 April 2015, and
    - examples of clinical innovation which were due to be showcased in the next 7 days at the Clinical Advisory Group;
- ***Update on the Alliance contract*** – including the appointment of the substantive Alliance Director and the proposal supported for the Revenue and Investment Committee to oversee the processes and business cases for all service shifts into the Alliance;
- ***Governance Process for EMRAD*** – the assurance provided by the Director of Finance following his in-depth review;
- ***Forward schedule of business cases for 2015-16*** – further work was taking place to define the shape of the business cases and the Committee's work programme would be updated accordingly and presented to the next IFPIC meeting;
- ***Month 10 financial performance*** – updates on the following issues to be included in the next iteration of the report:-
    - short term mitigation measures to reduce the run-rate on premium pay, and
    - clarification of an apparent overspend in respect of printing and postage charges;
- ***Cost Improvement Programme*** – continued good progress was noted and arrangements for processing any quality and safety impact assessments were being made through the quarterly extended quality and safety review meetings with the CMGs. A report articulating the key actions to be undertaken in respect of the 2015-16 CIP programme would be presented to the Executive Team in the next 2 weeks. It was agreed that a review of the Outpatients cross-cutting theme would be presented to the IFPIC on 30 April 2015;
- ***Month 10 Quality and Performance*** – discussion focused upon the Trust's improved RTT position, diagnostics performance and cancer 2 week wait and 31 day performance. The required standard for 62 day performance was expected to be achieved in July 2015;
- ***Clinical Letters*** – assurance was provided that the turnaround times for clinical letters production and the volumes of outstanding letters had reduced in all CMGs. There was still no automated process to capture the data, but work was continuing to address this. In addition, the Clinical Information Officers were working with primary care with a view to developing a direct email mechanism for clinical letters;
- ***Ambulance Handovers*** – the new RFID tagging equipment was expected to be implemented by 1 April 2015, at which point more accurate performance data would become available. However, ED occupancy and patient flows would remain the overriding factor in reducing delays in ambulance handovers.

DATE OF NEXT COMMITTEE MEETING: 26 March 2015

Ms J Wilson – Committee Chair 26 February 2015

Trust Board Paper P

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT BY TRUST BOARD COMMITTEE TO TRUST BOARD

DATE OF TRUST BOARD MEETING:	**5 March 2015**

COMMITTEE:	**Charitable Funds Committee**
CHAIRMAN:	**Mr P Panchal, Non-Executive Director**
DATE OF COMMITTEE MEETING:	**19 January 2015**

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

- **All items are recommended as the meeting was Inquorate.**

OTHER KEY ISSUES IDENTIFIED BY THE COMMITTEE FOR NOTING BY THE PUBLIC TRUST BOARD:

- **None**

DATE OF NEXT COMMITTEE MEETING: 2 April 2015.

P Panchal, Non-Executive Director
27 February 2015

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF AN INQUORATE* MEETING OF THE CHARITABLE FUNDS COMMITTEE HELD ON MONDAY 19 JANUARY 2015 AT 2PM IN TEACHING ROOM 2, CLINICAL EDUCATION CENTRE, LEICESTER ROYAL INFIRMARY

***** all items are therefore recommended***

Present: Mr P Panchal – Non-Executive Director (Chair)
Col (Ret'd) I Crowe – Non-Executive Director

In Attendance: M T Diggle – Head of Fundraising
Mr N Sone – Charity Finance Lead
Mrs A Hunte – Interim Trust Administrator
Mr S Ward – Director of Corporate and Legal Affairs
Mr M Wightman – Director of Marketing and Communications

RECOMMENDED ITEMS **ACTION**

01/15 APOLOGIES FOR ABSENCE

Apologies for absence were received from Mr P Traynor, Director of Finance; Mrs R Overfield, Chief Nurse; Dr S Dauncey, Non-Executive Director, and Mr M Traynor, Non-Executive Director.

02/15 MINUTES

Recommended – that the Minutes of the 17 November 2014 Charitable Funds meeting be confirmed as a correct record.

03/15 MATTERS ARISING FROM THE MINUTES

Members reviewed the matters arising report paper B, which covered both the immediately preceding and earlier Charitable Funds Committee meetings. Specific discussion took place in respect of the following items:-

The following actions be closed and removed from the log as they had either been completed or superseded:

- 17 November 2014 – Minutes 56/14, 57/14b, 57/14c, 57/14e, 60/14a, 57/14e, 60/14a, 63/14, 64/14, 70/14/2 **TA**
- 15 September 2014 – Minutes 47/14, 51/14, 54/14a, 55/14

The following matters were also progressed by the Committee as stated below:

(a) Minute 56/14a of 17 November 2014 – Charity Finance Lead to provide meeting date outwith the meeting; **CFL**

(b) Minute 57/14a of 17 November 2014 – to provide an update on applications 5212 & 5279 at the next Charitable Funds Committee on 2 April 2015; **CFL**

(c) Minute 57/14d of 17 November 2014 – to re submit application 5241 to the next Charitable Funds Committee meeting on 2 April 2015; **CFL**

(d) Minute 42/14 of 17 November 2014 – to present a report on the new approach to the size and structure of UHL's charitable funds (as now endorsed by the Committee) to the Executive Team to ensure CMG awareness and buy in; **CFL**

(e) Minute 60/14 of 17 November 2014 – the Charity Finance Lead provided a brief update advising that the funds were provided as a loan but the demonstration had only recently gone live. Therefore, it was too early to review any income, a report on the repayment of the loan to be presented at the next Charitable Funds Committee; **CFL**

(f) Minute 43/14c of 15 September 2014 – Bid 5088 (Women's and Children's CMG) – as no re-submission had been received by the Committee a further four weeks would be allowed and then the bid would be removed from the Matters Arising Log if no further updates received; **CFL**

(g) Minute 43/14d of 15 September 2014 – as no re-submission had been received by the Committee a further four weeks would be allowed and then the bid would be removed from the Matters Arising Log if no further updates received, and **CFL**

(h) Minute 54/14 15 September 2014 – to send contacts for Leicester Community groups to the Head of Fundraising outwith the meeting. **CFC CHAIR**

<u>Recommended</u> – that the discussion above any associated actions, be noted and progressed by the appropriate lead.

03/15 POLICY FOR ACCESS OF CHARITABLE FUNDS FOR TRAINING PURPOSES

Further to Minute 62/14 of 17 November 2015 paper C outlined a draft policy that detailed Leicester Hospitals Charity's proposed policy towards funding training for UHL staff. Members of the Charitable Funds Committee were invited to comment.

The Head of Fundraising advised that there was still more work to be done and he had sought collaboration on the policy from Ian Stephens of the Local Education Group today who had offered support with developing the policy. The Committee was supportive of the initial draft proposals.

In discussion, the Director of Marketing and Communication proposed that the fund be centrally managed. The Committee endorsed this approach in principle. It was agreed that the Director of Marketing and Communications liaise with the Head of Fundraising, Director of Corporate and Legal Affairs and Director of Finance and report back thereon to the next meeting of the Committee. **DMC**

<u>Recommended</u> – that the Director of Marketing and Communications be requested to liaise with Head of Fundraising, Director of Corporate and Legal Affairs and Director of Finance to progress the concept of a centrally managed fund and report back thereon to the next meeting of the Committee. **DMC**

04/15 FRAMEWORK FOR EXPENDITURE OF CHARITABLE FUNDS ON MEDICAL EQUIPMENT

Paper D provided the Committee with an update on progress along with a proposed Framework for Medical Equipment Expenditure through Charitable Funds for which approval from the Committee was sought.

The Charity Finance Lead advised that the current process was confusing, as it was unclear where the funds had been accessed from. The suggested framework in this report would make the process much clearer by identifying what the Trust could afford and whether the equipment was suitable for the Charity criteria. It would stop adhoc applications and provide the ability to prioritise equipment. Whilst the Committee supported the proposed framework in principle, it was recommended that the Charity Finance Lead consult further with the Director of Finance and the new Chairman of the Medical Equipment Executive to progress the Framework for Medical Equipment Expenditure through charitable funds. **CFL**

<u>Recommended</u> – the Charity Finance Lead be requested to consult further with the Director of Finance and the new Chairman of the Medical Equipment Executive to progress the framework for Medical Equipment Expenditure through Charitable Funds and report again on this matter to the next meeting of the Committee. **CFL**

5/15 UPDATE ON THE CHARITY'S FUNDS AND RESERVES

Further to Minute 63/14 of 17 November 2014 paper E updated members on progress in reviewing the structure of the Charity's funds and on the production of future spending plans. The overall thrust of the proposal was to further reduce the number of funds to 31 and to propose three simple categories of funds as listed in section 3.1 of the paper. The Committee endorsed the proposals as detailed in paper E, and emphasised the importance of dialogue with UHL Fund Managers to discuss the implications. It was agreed therefore that the Charity Finance Lead would consider a Communication Strategy in liaison with the Director of Marketing and Communications to ensure that UHL Fund Managers were informed. A further review of the Charity Funds and Reserves would be presented at the 2 April 2015 Charitable Funds Committee, to include detail on how the changes were being implemented and any feedback received from Fund Managers. It was also agreed to submit a report on the changes to the Executive Team prior to April 2015. **CFL** **CFL** **DF**

<u>Recommended</u> – that (A) the Charity Finance Lead be requested to consider a Communication Strategy in liaison with the Director of Marketing and Communications to ensure that UHL Fund Managers were informed of the changes now proposed and endorsed; **CFL**

(B) a further review of the Charity Funds and Reserves be presented at the 2 April 2015 Charitable Funds Committee to include detail on how the changes were being implemented and any feedback received from Fund Managers, and **CFL**

(C) the proposals re: the future size and structure of UHL's charitable funds be endorsed as outlined in paper E, and a report be presented accordingly to the Executive Team. **DF**

6/15 FINANCE AND GOVERNANCE REPORT

Paper F presented the financial position of Leicester Hospitals Charity for the period ending 31 December 2014 and updated members on the status of the General Purposes Fund.

<u>Recommended</u> – that the finance and governance report be received and noted.

7/15 NAMED FUND FOR NEONATAL UNIT

The Head of Fundraising gave a brief update and advised that the Director of Finance had now given his approval in this matter and the family had been updated.

<u>Recommended</u> – that the verbal update be noted

8/15 ITEMS FOR APPROVAL

Paper G outlined the grant applications received since the November 2014 Charitable Funds Committee meeting, noting that all bids received had been pre-reviewed as per current guidelines. The Charity Finance Lead considered that all applications fell within the scope of the funds, were affordable, and had been appropriately authorised by the fund advisers. Applications totalling £56,141 had been approved by the Charity Finance Lead through the scheme of delegation (they did not, therefore, require additional Charitable Funds Committee approval), and were detailed in appendix 1 of paper G.

The Committee then considered the applications presented for approval, as detailed in appendices 3-11 of paper G. The Committee's recommendations on the applications were as detailed below:-

(a) applications **<u>supported</u>** by the Charitable Funds Committee (for onwards approval by the Trust Board as Corporate Trustee):-

(i) **application 5345** (room hire and facilities for a carers event in line with the Carers

Charter) for £1,500 from P802 patients fund – the Committee was supportive of this application but advised that the funds should instead be sourced from the nursing charitable fund;
(ii) **application 5346** (room hire and facilities for a patient experience celebration event) for £4,500 from P802 patients fund – the Committee was supportive of this application but advised that the funds should instead be sourced from the nursing charitable fund. The Director of Marketing and Communications agreed to liaise with Ms H Leatham, Assistant Chief Nurse with a view to reviewing the structure of the event; **DMC**
(iii) **application 5356** (provision of wheelchairs for the Occupational/Physiotherapy departments for patients with complex needs) for £6,973 – the Committee supported the application but during a brief discussion the Chair raised a specific query in regards to the diminishing number of wheelchairs at the Trust and the need for tighter controls. The Director of Marketing and Communication agreed to liaise with Ms H Leatham, Assistant Chief Nurse in relation to this query, and **DMC**
(iv) **application 5364** (for the provision of a Biometric Access Locker System for the Chemotherapy Suite at the LRI) for £21,670.80 – the Committee supported the application.

(b) applications **not supported** by the Charitable Funds Committee:-
(i) **application 5240** (for the provision of an iPad to enable the theatre arrivals area at the LRI to carry out friends and family patient surveys relating to the outpatient service for high risk and difficult airway patients) for £871 – the Committee queried whether an IPad was the most appropriate and cost effective device and could not see the benefit;
(ii) **application 5331** (for upgrading works to the imaging patient waiting area at LGH) for £17,081 – consideration was deferred to the 2 April 2015 Charitable Funds Committee to enable checking of the costs, which the Committee considered expensive and with no breakdown of costs, and felt should be covered by the Capital Programme;
(iii) **application 5332** (for the provision of 3 patient TV systems for AICU at Glenfield Hospital) for £1,800 – the Committee felt that future sponsorship could support this activity and the content feed would need to be provided for all communities, and
(iv) **application 5363** (supply and fitting of window blinds to Main Workshop, Hot Desk Room and Library Decontamination Room at LGH) for £2,568.12 – the application was refused.

(c) applications **deferred** by the Charitable Funds Committee:-
(i) **application 5241** (for the provision of EUS scopes for the Hepatobiliary and Pancreatic surgery department at LGH) for £176,000 – there were currently insufficient funds in the General Purpose fund to fund this item and the Committee deferred this application.

Recommended – that subject to the comments above (A) applications 5345 (£1,500), 5346 (£4,500), 5356 (£6,973) and 5364 (£21,670.80) be supported and recommended to the Trust Board accordingly; **ALL**

(B) application 5345 – that the funds should be sourced from the nursing charitable fund; **CFL**

(C) application 5346 – that the funds be sourced from the nursing charitable fund and the Director of Marketing and Communications to liaise with Ms H Leatham, Assistant Chief Nurse with a view to reviewing the structure of the event; **CFL DMC**

(D) application 5356 – the Director of Marketing and Communication agreed to liaise with Ms H Leatham, Assistant Chief Nurse in relation to this matter; **DMC**

(E) the Charity Finance Lead feed back to the applicants in respect of applications 5240, 5331, 5332 and 5363, advising of the decision not to support them, and **CFL**

(F) application 5241 be deferred. **CFL**

9/15 WELL BEING AT WORK UPDATE

Paper H from the CMG Human Resources Lead provided an update on Well Being Activity

since May 2013 and sought approval for specific items as detailed below:-

(a) the annual schedule of prizes for the Staff Lottery shown in appendix 1 of paper H;
(b) a lump sum transfer to the well being fund of £34,900 from the current Staff Lottery surplus of £117,000;
(c) a permanent increase from 25% to 30% of staff lottery funds to be transferred to the Well Being Fund;
(d) meeting from charitable funds the costs associated with the proposed increase in the Well Being Coordinators hours from 22.5 per week to 37.5 per week;
(e) the current plans of Well Being activities and events with associated costs, as shown in appendix 2 of paper H, and
(f) the initial plan to improve cycling facilities on all UHL sites using surplus Staff Lottery surplus funds, pending a final plan and associated costs being submitted for approval by the Committee.

<u>Recommendations</u> – that approval be given to the proposed charitable expenditure on the well being at work initiatives set out in paper H, now submitted **CFC**

10/15 CHARITABLE GIVING – PENNIES FROM HEAVEN

Paper I presented by the Head of Fundraising sought approval from the Charitable Funds Committee to change the current payroll giving benefitting Charity HALE (Health Action Leicester and Ethiopia) to LOROS and Leicester Hospitals Charity. The Head of Fundraising advised that when the original proposal was approved by the Charitable Funds Committee in 2009 it was asked to support HALE for the first two years. Since then the benefitting Charity has not changed and neither had the staff participating which had stayed at 260 people. During a recent staff survey, staff were asked to vote on a preference for an alternative charity from a list of five charities LOROS had attracted most support with 61.5% and Leicester Hospitals Charity had come second with 47% choosing the Hospital Charity.

A discussion followed and members were supportive of the change in beneficiary but agreed that the current beneficiary HALE would need to be notified and the current members of staff participating would need to be notified also. The Head of Fundraising agreed to liaise with HALE and notify them of the change in beneficiary of the 'Pennies from Heaven Funds'. The Head of Fundraising undertook to contact all current participating staff to notify them personally of the change in beneficiaries to the 'Pennies from Heaven Fund'. **HoF**

<u>Recommended</u> – that (A) the Head of Fundraising be requested to liaise with HALE and notify them of the change in beneficiary of the payroll giving scheme, and **HoF**

(B) the Head of Fundraising be requested to contact all current participating staff to notify them personally of the change in beneficiaries of the payroll giving scheme. **HoF**

11/15 FUNDRAISING UPDATE REPORT

Paper J from the Head of Fundraising detailed recent fundraising and promotional activities by the Charity. The Head of Fundraising highlighted that the RVS (formerly WRVS) had pledged £340,000 and that the Charity had not yet received the £300,000 pledged by Thomas Cook Paediatric Care. The Head of Fundraising agreed to actively pursue both donations. Also, at the next Charitable Funds Committee on Thursday 2 April 2015 the Head of Fundraising would submit a report entitled 'Establishing a Public Lottery'. **HoF**

<u>Recommended</u> – that (A) the fundraising update be noted, and

(B) the Head of Fundraising be requested to submit a report entitled 'Establishing a Public Lottery' to the next Charitable Funds Committee meeting on Thursday 2 April 2015. **HoF**

12/15 INTERNAL AUDIT REVIEW OF CHARITABLE FUNDS

Paper K provided by the Director of Finance detailed the report findings and classifications arising from an Internal Audit review of Charitable Funds undertaken as part of the Internal Audit Plan for 2014/15.

Recommended – that the Internal Audit Review of Charitable Funds report be received and noted.

13/15 CONFIRMATION OF AUDITOR APPOINTMENT FROM 2015/16

Paper L confirmed the appointment of KPMG LLP as the external auditors for Leicester Hospitals Charity.

Recommended – that the confirmation of the Charity Auditor Appointment from 2015/16 report be noted.

14/15 ANY OTHER BUSINESS

The Director of Marketing and Communications undertook to submit a report to the next Charitable Funds Committee meeting on Thursday 2 April 2015 on a potential fundraising scheme for the Children's Hospital. **DMC**

Recommended – that the Director of Marketing and Communications be requested to submit a report to the next Charitable Funds Committee on Thursday 2 April 2015 on a potential fundraising scheme for the Children's Hospital. **DMC**

15/15 DATE OF NEXT MEETING AND MEETING DATES 2015

Recommended – that (A) the next Charitable Funds Committee be held on Monday 2 April 2015 from 2pm to 4pm in the Teaching Room 2 Clinical Education Centre at Leicester Royal Infirmary, and **TA**

(B) all other dates as listed in paper M be agreed for 2015. **ALL**

The meeting closed at 4:11pm

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

Name	Possible	Actual	% attendance
P Panchal (Chair)	5	5	100
I Crowe	3	2	66
P Burlingham *	3	1	33
T Diggle *	5	5	100
P Hollinshead*	3	1	33
K Jenkins	3	0	0
R Overfield	5	2	40
S Sheppard	1	1	100
N Sone *	5	5	100
P Spiers *	4	3	75
P Traynor	2	1	50
M Wightman*	5	4	80
S Ward *	5	4	80
R Kilner	2	1	50
J Wilson	2	1	50

* non-voting members

Angela Hunte - **Interim Trust Administrator**

Trust Board Paper Q

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

Trust Board Bulletin – 5 March 2015

The following report is attached to this Bulletin as an item for noting, and is circulated to UHL Trust Board members and recipients of public Trust Board papers accordingly:-

- **NHS Trust Over-Sight Self Certification return for the period ended 31 January 2015 (as submitted to the NTDA on 27 February 2015)** – Lead contact point Mr S Ward, Director of Corporate and Legal Affairs (0116 258 8721) – **paper 1.**

It is intended that these papers will not be discussed at the formal Trust Board meeting on 5 March 2015, unless members wish to raise specific points on the reports.

This approach was agreed by the Trust Board on 10 June 2004 (point 7 of paper Q). Any queries should be directed to the specified lead contact point in the first instance. In the event of any further outstanding issues, these may be raised at the Trust Board meeting with the prior agreement of the Chairman.

NHS Trust Oversight Self-Certification

In accordance with the Accountability Framework, the Trust is required to complete two self certifications in relation to the Foundation Trust application process. Copies of the self certifications submitted in February 2015 (January 2015 position) are attached as Appendices A and B.

Stephen Ward
Director of Corporate and Legal Affairs

NHS TRUST DEVELOPMENT AUTHORITY

tda Trust Development Authority
Quality. Delivery. Sustainability.

OVERSIGHT: Monthly self-certification requirements - Compliance Monitor

Monthly Data.

CONTACT INFORMATION:

Enter Your Name: * John Adler

Enter Your Email Address * john.adler@uhl-tr.nhs.uk

Full Telephone Number: * 01162588940 Tel Extension: 8940

SELF-CERTIFICATION DETAILS:

Select Your Trust: * University Hospitals Of Leicester NHS Trust

Submission Date: * 27/02/2015 Reporting Year: * 2014/15

NB: The next report produced will be for **January 2014/15**

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NHS TRUST DEVELOPMENT AUTHORITY

Select the Month *

- April
- May
- June
- July
- August
- September
- October
- November
- December
- January
- February
- March

COMPLIANCE WITH MONITOR LICENCE REQUIREMENTS FOR NHS TRUSTS:

1. **Condition G4** – Fit and proper persons as Governors and Directors (also applicable to those performing equivalent or similar functions).
2. **Condition G5** – Having regard to monitor Guidance.
3. **Condition G7** – Registration with the Care Quality Commission.
4. **Condition G8** – Patient eligibility and selection criteria.

5. **Condition P1** – Recording of information.
6. **Condition P2** – Provision of information.
7. **Condition P3** – Assurance report on submissions to Monitor.
8. **Condition P4** – Compliance with the National Tariff.
9. **Condition P5** – Constructive engagement concerning local tariff modifications.

10. **Condition C1** – The right of patients to make choices.
11. **Condition C2** – Competition oversight.

12. **Condition IC1** – Provision of integrated care.

Further guidance can be found in Monitor's response to the statutory consultation on the new NHS provider licence: The new NHS Provider Licence

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16% Complete

NHS TRUST DEVELOPMENT AUTHORITY

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COMPLIANCE WITH MONITOR LICENCE REQUIREMENTS FOR NHS TRUSTS:

		Comment where non-compliant or at risk of non-compliance
1. Condition G4 Fit and proper persons as Governors and Directors. *	Yes	
2. Condition G5 Having regard to monitor Guidance. *	Yes	
3. Condition G7 Registration with the Care Quality Commission. *	Yes	

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18% Complete

NHS TRUST DEVELOPMENT AUTHORITY

Quality. Delivery. Sustainability.

Comment where non-compliant or at risk of non-compliance

4. Condition G8
Patient eligibility and selection criteria. *

Yes

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39% Complete

NHS TRUST DEVELOPMENT AUTHORITY

Quality. Delivery. Sustainability.

Comment where non-compliant or at risk of non-compliance

5. Condition P1
Recording of information. *
Yes

6. Condition P2
Provision of information. *
Yes

7. Condition P3
Assurance report on submissions to Monitor. *
Yes

8. Condition P4
Compliance with the National Tariff. *
Yes

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45% Complete

NHS TRUST DEVELOPMENT AUTHORITY

Quality. Delivery. Sustainability.

Comment where non-compliant or at risk of non-compliance

9. Condition P5
Constructive engagement concerning local tariff modifications. *

Yes

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73% Complete

NHS TRUST DEVELOPMENT AUTHORITY

Quality. Delivery. Sustainability.

Comment where non-compliant or at risk of non-compliance

10. Condition C1
The right of patients to make choices. *
Yes

11. Condition C2
Competition oversight. *
Yes

12. Condition IC1
Provision of integrated care. *
Yes

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NHS TRUST DEVELOPMENT AUTHORITY

tda Trust Development Authority
Quality. Delivery. Sustainability.

OVERSIGHT: Monthly self-certification requirements - Board Statements
Monthly Data.

CONTACT INFORMATION:

Enter Your Name: * John Adler

Enter Your Email Address * john.adler@uhl-tr.nhs.uk

Full Telephone Number: * 01162588940 Tel Extension: 8940

SELF-CERTIFICATION DETAILS:

Select Your Trust: * University Hospitals Of Leicester NHS Trust

Submission Date: * 27/02/2015 Reporting Year: * 2014/15

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- April
- May
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- December
- January
- February
- March

NB: The next report produced will be for **January 2014/15**

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NHS TRUST DEVELOPMENT AUTHORITY

Quality. Delivery. Sustainability.

BOARD STATEMENTS:

CLINICAL QUALITY
FINANCE
GOVERNANCE

The NHS TDA's role is to ensure, on behalf of the Secretary of State, that aspirant FTs are ready to proceed for assessment by Monitor. As such, the processes outlined here replace those previously undertaken by both SHAs and the Department of Health.

In line with the recommendations of the Mid Staffordshire Public Inquiry, the achievement of FT status will only be possible for NHS Trusts that are delivering the key fundamentals of clinical quality, good patient experience, and national and local standards and targets, within the available financial envelope.

NHS TRUST DEVELOPMENT AUTHORITY

tda Trust Development Authority
Quality. Delivery. Sustainability.

BOARD STATEMENTS:

For CLINICAL QUALITY, that

1. The Board is satisfied that, to the best of its knowledge and using its own processes and having had regard to the TDA's oversight model (supported by Care Quality Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.

1. CLINICAL QUALITY
Indicate compliance. *

Yes

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16% Complete

NHS TRUST DEVELOPMENT AUTHORITY

BOARD STATEMENTS:

For CLINICAL QUALITY, that

2. The board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality Commission's registration requirements.

2. CLINICAL QUALITY
Indicate compliance. *

Yes

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22% Complete

NHS TRUST DEVELOPMENT AUTHORITY

Trust Development Authority
Quality. Delivery. Sustainability.

BOARD STATEMENTS:

For CLINICAL QUALITY, that

3. The board is satisfied that processes and procedures are in place to ensure all medical practitioners providing care on behalf of the trust have met the relevant registration and revalidation requirements.

3. CLINICAL QUALITY
Indicate compliance. *

Yes

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28% Complete

NHS TRUST DEVELOPMENT AUTHORITY

Trust Development Authority
Quality. Delivery. Sustainability.

BOARD STATEMENTS:

For FINANCE, that

4. The board is satisfied that the trust shall at all times remain a going concern, as defined by the most up to date accounting standards in force from time to time.

4. FINANCE
Indicate compliance. *

Yes

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34% Complete

NHS TRUST DEVELOPMENT AUTHORITY

Quality. Delivery. Sustainability.

BOARD STATEMENTS:

For GOVERNANCE, that

5. The board will ensure that the trust remains at all times compliant with the NTDA accountability framework and shows regard to the NHS Constitution at all times.

5. GOVERNANCE
Indicate compliance. *

Yes

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40% Complete

NHS TRUST DEVELOPMENT AUTHORITY

BOARD STATEMENTS:

For GOVERNANCE, that

6. All current key risks to compliance with the NTDA's Accountability Framework have been identified (raised either internally or by external audit and assessment bodies) and addressed – or there are appropriate action plans in place to address the issues in a timely manner.

6. GOVERNANCE
Indicate compliance. *

Yes

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46% Complete

NHS TRUST DEVELOPMENT AUTHORITY

BOARD STATEMENTS:

For GOVERNANCE, that

7. The board has considered all likely future risks to compliance with the NTDA Accountability Framework and has reviewed appropriate evidence regarding the level of severity, likelihood of a breach occurring and the plans for mitigation of these risks to ensure continued compliance.

7. GOVERNANCE
Indicate compliance. *

Yes

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52% Complete

NHS TRUST DEVELOPMENT AUTHORITY

BOARD STATEMENTS:

For GOVERNANCE, that

8. The necessary planning, performance management and corporate and clinical risk management processes and mitigation plans are in place to deliver the annual operating plan, including that all audit committee recommendations accepted by the board are implemented satisfactorily.

8. GOVERNANCE
Indicate compliance. *

Yes

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58% Complete

NHS TRUST DEVELOPMENT AUTHORITY

Quality. Delivery. Sustainability.

BOARD STATEMENTS:

For GOVERNANCE, that

9. An Annual Governance Statement is in place, and the trust is compliant with the risk management and assurance framework requirements that support the Statement pursuant to the most up to date guidance from HM Treasury (www.hm-treasury.gov.uk).

9. GOVERNANCE
Indicate compliance. *

Yes

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64% Complete

NHS TRUST DEVELOPMENT AUTHORITY

BOARD STATEMENTS:

For GOVERNANCE, that

10. The Board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets as set out in the NTDA oversight model; and a commitment to comply with all known targets going forward.

10. GOVERNANCE
Indicate compliance. *

Risk

Timescale for compliance: *

31/07/2015

RESPONSE:

Comment where non-compliant or at risk of non-compliance *

The 26 February 2015 UHL NHS Trust Integrated Finance, Performance and Investment Committee and Quality Assurance Committees received reports identifying the causes of underperformance on the following indicators, and endorsed the remedial actions being taken to achieve compliance. The individual anticipated compliance dates are shown against relevant indicators:-

S3 Never events (February 2015); C8 Single Sex Accommodation Breach (February 2015); R1 ED 4-hour waits (March 2015); R2 12 hour trolley waits in ED (February 2015); R3 RTT waiting times (admitted) (April 2015); R7 6 week Diagnostic test waiting times (February 2015); R9 Cancer-2-week wait for symptomatic breast patients (February 2015); R10 Cancer 31-day wait for first treatment (March 2015); R11 31-day wait for second or subsequent treatments: anticancer drug treatments (February 2015); R12 Cancer 31-day wait for second or subsequent treatment: surgery (April 2015); R14 Cancer 62-day wait for first treatment from GP referral (July 2015); R17 Cancelled patients not rebooked within 28 days (February 2015), and R23 DTOCs (March 2015).

NHS TRUST DEVELOPMENT AUTHORITY

Quality. Delivery. Sustainability.

BOARD STATEMENTS:

For GOVERNANCE, that

11. The trust has achieved a minimum of Level 2 performance against the requirements of the Information Governance Toolkit.

11. GOVERNANCE
Indicate compliance. *

Yes

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76% Complete

NHS TRUST DEVELOPMENT AUTHORITY

Quality. Delivery. Sustainability.

BOARD STATEMENTS:

For GOVERNANCE, that

12. The board will ensure that the trust will at all times operate effectively. This includes maintaining its register of interests, ensuring that there are no material conflicts of interest in the board of directors; and that all board positions are filled, or plans are in place to fill any vacancies.

12. GOVERNANCE
Indicate compliance. *

Yes

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82% Complete

NHS TRUST DEVELOPMENT AUTHORITY

Quality. Delivery. Sustainability.

BOARD STATEMENTS:

For GOVERNANCE, that

13. The board is satisfied that all executive and non-executive directors have the appropriate qualifications, experience and skills to discharge their functions effectively, including setting strategy, monitoring and managing performance and risks, and ensuring management capacity and capability.

13. GOVERNANCE
Indicate compliance. *

Yes

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88% Complete

NHS TRUST DEVELOPMENT AUTHORITY

BOARD STATEMENTS:

For GOVERNANCE, that

14. The board is satisfied that: the management team has the capacity, capability and experience necessary to deliver the annual operating plan; and the management structure in place is adequate to deliver the annual operating plan.

14. GOVERNANCE
Indicate compliance. *

Yes

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