Paper A

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF A MEETING OF THE TRUST BOARD, HELD ON THURSDAY 7 APRIL 2011 AT 10AM IN ROOMS 1A & 1B, GWENDOLEN HOUSE, LEICESTER GENERAL HOSPITAL SITE

Present:
Mr M Hindle – Trust Chairman
Ms K Bradley – Director of Human Resources
Dr K Harris – Medical Director
Mrs S Hinchliffe – Chief Operating Officer/Chief Nurse
Mrs K Jenkins – Non-Executive Director (up to and including Minute 99/11)
Mr R Kilner – Non-Executive Director
Mr M Lowe-Lauri – Chief Executive
Mr P Panchal – Non-Executive Director
Mr I Reid – Non-Executive Director
Mr A Seddon – Director of Finance and Procurement
Mr D Tracy – Non-Executive Director
Ms J Wilson – Non-Executive Director
Professor D Wynford-Thomas – Non-Executive Director

In attendance:
Mr P Cleaver – Risk and Assurance Manager (for Minute 94/11)
Mr T Diggle – Head of Fundraising (for Minute 107/11)
Miss M Durbridge – Director of Safety and Risk (for Minute 94/11)
Mrs P Kaur – Deputy Finance and Performance Manager, Women's and Children's Division (for Minute 107/11)
Ms H Killer – CBU Manager and Lead Nurse, Children's CBU (for Minute 107/11)
Dr F Miall – Consultant Haematologist (for Minute 107/11)
Mr R Pinsent – Director of Facilities (for Minute 105/11/1 and 105/11/2)
Dr A Rashid – PCT Medical Director (for Minute 92/11/1)
Dr E Ross – Consultant Paediatric Oncologist (for Minute 107/11)
Dr N Rudd – Consultant Haematologist (for Minute 107/11)
Ms H Stokes – Senior Trust Administrator
Dr A Tierney – Director of Strategy
Mr S Ward – Director of Corporate and Legal Affairs
Mr M Wightman – Director of Communications and External Relations

ACTION

85/11 APOLOGIES

No apologies for absence were received.

86/11 DECLARATIONS OF INTERESTS

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

87/11 CHAIRMAN'S ANNOUNCEMENTS

The Chairman drew the Trust Board's attention to the following issues:-

(a) the PCTs' decision that the Urgent Care Centre (UCC) situated adjacent to the Emergency Department (ED) at the LRI would now be run by George Eliot Hospital, Nuneaton for a 12-month period. Although disappointed by this decision, UHL

would ensure positive relations continued with the UCC over the next 12 months, to maintain appropriate integration with the ED;

(b) the very significant opportunities and challenges for UHL in 2011-12. Although confident that UHL would achieve Foundation status by its target authorisation date of 1 April 2012, the Chairman emphasised that patient care and quality of service remained the Trust's driving priorities during that period;

(c) the ongoing national consultation on the future of paediatric cardiac surgery in England, and the significant public support being mobilised locally in favour of the Glenfield Hospital facility;

(d) his recognition of, and thanks to (on behalf of the Trust Board) all UHL staff and Executive Directors for UHL's significant achievements in 2010-11, including:- UHL's new £10m neonatal unit; the ECMO unit's contribution during the swine flu outbreak; continued progress on research and development, including the November 2010 opening by the Secretary of State for Health of the £5m cardiorespiratory Biomedical Research Unit (a UHL-University of Leicester collaborative project); creation of a 24/7 stroke unit at the LRI; new orthopaedic theatres at the Leicester General Hospital; housing of the first cord blood collection bank outside London; robotic arm mapping procedures for heart patients, and the achievement of a £31m cost improvement programme without impacting adversely on quality of care, and

(e) UHL's welcome to 69 new staff joining the Trust as of 1 April 2011 through the Transforming Community Services (TCS) process. Appropriate steps were being taken to incorporate the new services and their staff into UHL.

88/11 MINUTES

Resolved – that the Minutes of the meetings held on 3 March 2011 and 24 March 2011 be confirmed as correct records.

89/11 MATTERS ARISING FROM THE MINUTES

As previously requested, the Chairman noted that the report at paper B detailed the status of any previous matters arising marked as 'work in progress' or 'under consideration'.

90/11 CHIEF EXECUTIVE'S MONTHLY REPORT – APRIL 2011

In his monthly report for April 2011 the Chief Executive highlighted the continuing efforts to transform emergency and urgent care in Leicester, Leicestershire and Rutland (Minute 92/11/1 below also refers), and UHL's actions to improve patient care and experience generally, with particular regard to the care of the elderly (Minute 91/11 below also refers). With regard to the Safe and Sustainable review of paediatric cardiac surgery services in England and Wales, the Chief Executive noted a recent very good consultation event organised by Leicester Links. Paper C also updated the Trust Board on quality governance developments, and on the publication of national reports on public services pensions and the review of fair pay in the public sector. These were key reports (from Lord Hutton and Mr Will Hutton, respectively) and the Chief Executive advised that he would update a future Trust Board accordingly once the Government's response was published. **CE**

Resolved – that (A) the Chief Executive's monthly report for April 2011 be noted, and

(B) the Chief Executive be requested to provide an update on the Hutton reports (public services pensions and the review of fair pay in the public sector) to a future Trust Board meeting, following the Government's response. **CE**

91/11 PATIENT EXPERIENCE

91/11/1 Care and Compassion – Older People's Care within UHL (and accompanying patient story)

Further to Minute 53/11/1.1 of 3 March 2011, paper D provided an overview of the Parliamentary and Health Service Ombudsman (PHSO) report "Care and Compassion", and highlighted the actions taken (at both Acute Care Division and Trust-wide levels) to improve the care of older people within UHL. Key specific initiatives included:-

(i) roll-out of the (previously-reported) 'Vital' tool across older people's care wards;
(ii) clear badged identification of the Nurse in Charge;
(iii) introduction of hourly ward rounds on older people's wards, which was also being rolled-out across the Acute Care Division;
(iv) increasing the number of volunteers and focusing their duties to the needs of patients on the older people's wards;
(v) ensuring daily rounds by the Matron/Ward Sister during visiting times;
(vi) holding Ward Sisters and ward staff to account where performance was not up to an acceptable standard;
(vii) maintaining a regular review of patient acuity and the associated nurse staff levels required across older people's wards;
(viii) introduction of a dashboard of data to assess each ward's performance (in terms of quality and overall patient experience);
(ix) expanding the existing UHL annual staff awards by launching the quarterly 'Caring at its Best' awards linked to the Trust's values, and
(x) development of an internal and external communications campaign to support the patient experience approach and underline UHL's values.

In discussion on the actions detailed in paper D, the Trust Board noted:-

(a) a query from Professor D Wynford-Thomas, Non-Executive Director, as to what other activities might not be being undertaken in order to accommodate these new tasks. In response, the Chief Operating Officer/Chief Nurse advised that the patient care centred actions should already be being done, and she noted evidence that hourly ward rounds saved time overall through reducing falls/incontinence/pain and improvements to patient care and experience;

(b) (in response to a query from Ms J Wilson, Non-Executive Director) that UHL bank staff would also be required to undertake the Vital tool. Although the Trust was aiming to reduce its use of agency staff, the Chief Operating Officer/Chief Nurse confirmed that agencies were obliged to comply with Trust policies and procedures and would receive a copy of the Vital tool accordingly. Ms Wilson asked that agencies be held to specific account on this issue; **COO/ CN**

(c) the experience of the Acute Care Division Head of Nursing (as now expressed) in terms of the benefits to date of the initiatives. Hourly nursing rounds were having a fundamental impact and had already noticeably reduced patients' needs to use their call bells;

(d) a query from Mr R Kilner, Non-Executive Director, as to whether the Vital tool would be applied to medical staff. Although not currently planned, the Chief Operating Officer/Chief Nurse agreed to discuss this further with the Medical Director; **COO/ CN**

(e) the intention for all registered general nurses to have been covered by the programme

initiatives by Summer 2011;

(f) queries from Mr P Panchal, Non-Executive Director, as to when the initiatives would be evaluated and also rolled out more widely and the extent to which demographic/cultural issues would be taken into account in such an evaluation. In response, the Chief Operating Officer/Chief Nurse outlined the factors which would be used to inform the evaluation (including complaints, metrics, staff turnover, patient feedback) – although demographic issues had not been a primary focus to date, the Chief Executive noted that further cultural events were planned, and

(g) (in response to a query) UHL's role as one of four national pilots for the latest acuity and dependency tool. The acuity of patients was felt to be rising generally. In further discussion, the Chief Operating Officer/Chief Nurse advised that the decision on whether to call in additional bank/agency ward staff resulted from the Nurse in Charge's clinical judgement.

In respect of paper D1, the Trust Board then viewed a short DVD illustrating how the initiatives were working in practice on the wards, and outlining patient feedback to the changes. The Trust Chairman commented that UHL had been very open in publicly discussing previous instances where care had not been of an acceptable standard – this was a key issue for the Trust Board which would now receive a quarterly patient experience report from the Chief Operating Officer/Chief Nurse and monitor performance against stated objectives accordingly. The patient stories presented to the Trust Board would be structured around Divisional initiatives and developments (timetable as detailed in paper D1). **COO/ CN**

Although supporting the overall proposed approach to patient stories, Mr D Tracy Non-Executive Director and Chair of the Governance and Risk Management Committee, commented on the need to ensure that all patient experience was captured, without inadvertently selecting out any particular category of patient. He also commented on the power of hearing the stories in the patients'/relatives' own words. Mr P Panchal, Non-Executive Director, suggested it might be useful to link with external organisations (thus raising Trust Board awareness of UHL patients' experiences as relayed to such organisations). **COO/ CN**

<u>Resolved</u> – that (A) the initiatives to improve older people's (and patients more generally) care within UHL be endorsed as detailed in paper D;

(B) in respect of the Vital tool, the Chief Operating Officer/Chief Nurse be requested to:- **COO/ CN**

(1) consider how best to hold nursing agencies to account to ensure that their staff adhered to UHL's policies and procedures including the Vital tool;
(2) discuss potentially extending the Vital tool to medical staff, with the Medical Director;

(C) the Chief Operating Officer/Chief Nurse be requested to provide a patient experience update to the Trust Board on a quarterly basis, including appropriate performance management aspects, and **COO/ CN**

(D) the proposal that future patient stories be structured around Divisional initiatives and developments be supported (timetable as per paper D1), noting the need to:- **COO/ CN**
(1) ensure that certain sectors of patients were not inadvertently selected out of the patient story process, and

(2) consider how to ensure appropriate Trust Board awareness of UHL patient experiences as relayed to external organisations.

92/11 QUALITY, FINANCE, AND PERFORMANCE

92/11/1 LLR Urgent and Emergency Care System Improvement Programme

Paper E prepared jointly by the Joint Chief Executive NHSLCR/LC and UHL's Chief Operating Officer/Chief Nurse, updated the Trust Board on the development of the urgent and emergency care system improvement programme for LLR. Dr A Rashid, PCT Medical Director, attended for the discussion on this item. In introducing this item the Chief Executive reiterated that UHL would continue to work to maintain the appropriate relationship between the UCC and the ED, and advised that UHL's views on the UCC situation had been made clear through the emergency care network. He was confident that the need for a systems approach to improving urgent and emergency care in LLR was now well recognised, although implementation of improvements was the key issue.

Dr A Rashid, PCT Medical Director, thanked the Trust Board for inviting him for this discussion. In respect of the UCC, he thanked UHL's Medical Director for his role in fostering UHL clinicians' engagement. Dr Rashid outlined a number of factors behind the current increased demand for urgent care – these factors were largely rooted in 2004-05 and included the changes at that time to GP out-of-hours care, the end of domiciliary visits by Consultants, reduced communication between GPs and Consultants, European Working Time Directive issues, and a rise in public expectations. Dr Rashid noted that the Emergency Care Network had been set up in 2011 to find a solution to the LLR emergency and urgent care system challenges, and he outlined the remit of the two groups chaired (respectively) by the Joint Chief Executive NHSLCR/LC and himself. He confirmed that primary care was aware of its own responsibilities for the system improvement required, and outlined a number of initiatives currently underway accordingly:-

(i) a campaign to improve GP accessibility for patients;
(ii) bench-marking all GP practices in terms of their usage of ED – action plans would be developed to address any particularly high-use practices;
(iii) an opt back in to the GP responsibility for providing an out-of-hours services, as of 1 April 2011;
(iv) a requirement for all care home patients to have care plans;
(v) increasing levels of community nurse support to avoid unnecessary hospital admissions;
(vi) a "choose well" public education campaign on how to access urgent care. A pilot was also running in terms of unregistered patients, aiming to reduce the level of people not currently registered with a GP;
(vii) establishment of a stable GP presence in ED, with 5 GPs recently appointed and due to come into post within the next 4 months. It was hoped also to increase the number of GPs to 7;
(viii) increasing use of GP referral to next day clinics and theatre spots to reduce unnecessary admissions;
(ix) improved GP communication with acute clinical colleagues – all GP practices now had the 'red phone' system in place to contact Consultants and Dr Rashid thanked UHL's Medical Director for his role in facilitating this, and
(x) work with EMAS to divert patients back to their GPs (where appropriate) rather than going to ED. This was currently being piloted in NW Leicestershire.

A clinicians' group was also working to review the LRI ED physical footprint, and positive

discussions had taken place with the Children's Hospital clinicians in terms of closer working with Children's ED. Additional ED Consultant and nursing staff posts had also been agreed. Plans were also in hand to enable ED access to GP medical records within the next 10 weeks, and the PCT Medical Director advised that appropriate mental health input to ED was also under review.

In discussion on paper E and the comments from the PCT Medical Director, the UHL Trust Board noted:-

(a) the positive impact of the collaborative approach to developing a system-wide solution. There was also significant collaborative engagement on – and commitment to addressing – outflow issues, through the group chaired by the Joint Chief Executive NHSLCR/LC;

(b) comments from Mr D Tracy and Mr R Kilner, Non-Executive Directors, that the 2010-11 PCT demand management plans had not come to fruition, with numbers continuing to increase. Although acknowledging the long-term nature of some of the plans, they noted the need for the initiatives outlined above to yield results. Mrs K Jenkins, Non-Executive Director also queried the timescale for results from the PCT initiatives outlined above. Although the PCT Medical Director considered that measurable success would be evident by winter 2011, he also noted that certain improvements were dependent on footprint change and commented on the higher costs of NHS building projects (compared to residential). He hoped to reach agreement with GP colleagues on the ED footprint investment required, with procurement then expected to take 6-9 months. The Chief Executive noted the need for realism about the size of any likely capital build;

(c) advice from the Chief Executive that due to time constraints, plans should not rely solely on demand management reductions;

(d) concerns expressed by Mr D Tracy, Non-Executive Director, regarding a lack of precision about the available budget. He also noted the need to cost and prioritise any proposed remedial actions in the context of the very challenging CIP for 2011-12 and recognising the need for appropriate value-for-money. The Director of Finance and Procurement confirmed that addressing the LLR emergency care system was a recognised priority for all organisations involved – from UHL's perspective, schemes to address this issue would therefore be exempt from the usual requirement fully to identify pay-back prior to any investment. The Director of Finance and Procurement further noted the need for agreement of a clinical model to resolve the emergency care system within LLR and the importance of an integrated community-wide approach;

(e) a query from Mr R Kilner, Non-Executive Director as to whether the new management arrangements for the UCC served to increase risk in any way, noting increased attendances. In response, the PCT Medical Director reiterated his previous comments on patient expectations and advised that in 12 months' time the PCT wished to see an LLR emergency system characterised by improved primary-secondary care communications and reduced unnecessary hospital admissions;

(f) (in response to a query from Mr I Reid, Non-Executive Director and Finance and Performance Committee Chair) confirmation from the PCT Medical Director that all organisations' Boards would be reviewing the same metrics/performance indicators when measuring progress on this issue (agreed dashboard being used). It was

also confirmed that Leicestershire Partnership NHS Trust (LPT) was appropriately involved in the discussions;

(g) a query as to what primary care plans were in place to deflect acute admissions over the forthcoming Bank Holiday period. The PCT Medical Director reiterated that GPs were now responsible for the provision of an out-of-hours service, with an appropriate level of responsible management expected over that period. Although the UCC was fully staffed over the Bank Holiday period, GP practices were not. The PCT Medical Director agreed to try and encourage GP colleagues to open over the Bank Holiday period, although reiterating that he could not force such a change in light of the national contract. The Chief Executive noted that outflow issues were also challenging over Bank Holidays and advised that UHL's Executive Team would be reviewing UHL's own readiness for the late April/early May 2011holiday period; **EDs**

(h) the key importance of patient access to and communication with, their GPs – this was recognised by the PCT, and

(i) comments from the Chief Executive that although good progress could be made, the situation was unlikely to be fully resolved in one year.

The Trust Chairman thanked the PCT Medical Director for attending the Trust Board meeting, and welcomed the opportunity to see the outlined initiatives come to fruition.

Resolved – that (A) the update on the LLR urgent and emergency care system improvement programme be noted, and

(B) the Executive Team be requested to review UHL's internal readiness for potential peak activity over the Easter and early May 2011 Bank Holiday period. **EDs**

92/11/2 Emergency Care Transformation

Paper E1 from the Chief Operating Officer/Chief Nurse advised the Trust Board of February 2011 performance on emergency care and of progress to date on the emergency care transformation. There had been 68 rebeds in February 2011, and the Trust continued to maintain two private crews to support the delivery of patient discharges and to ameliorate the risk of further rebeds at times of peak activity. Paper E1 also advised of progress in appointing additional ED Advanced Practitioners and Physicians' Assistants, noted the establishment of the emergency frailty unit on 24 January 2011, and outlined findings from the March 2011 ED patient survey (appendix 1).

In response to a query from Mr R Kilner, Non-Executive Director, the Chief Operating Officer/Chief Nurse confirmed that a PTS (patient transport service) was not yet in place with EMAS. In response to a query from Ms J Wilson, Non-Executive Director, the Chief Operating Officer/Chief Nurse advised of discussions with LPT regarding mental health support for frequent attenders at ED (as appropriate) – alcohol/drug liaison services were also involved for relevant patients.

The Trust Chairman thanked ED staff for their continuing efforts and noted that a further update on emergency care transformation would be provided to the May 2011 Trust Board. **COO/ CN**

Resolved – that a further update on the emergency care transformation be provided to the Trust Board on 5 May 2011. **COO/ CN**

92/11/3 Month 11 Quality and Performance Report

Paper F comprised the quality, finance and performance report for month 11 (month ending 28 February 2011), which included red/amber/green (RAG) performance ratings and covered quality, HR, finance, commissioning and operational standards. Individual Divisional performance was detailed in the accompanying heatmap. The commentary accompanying the month 11 report identified key issues from each Lead Executive Director, and the following points were now noted by exception:-

(a) any future changes to the report (as a result of updated guidance on the 2011-12 NHS Operating Framework) would be asterisked for ease of reference;
(b) UHL compliance with TIA requirements was now at its highest ever level (77%);
(c) further information on cancer 2-week wait issues was detailed in the Trust Board Bulletin (paper 1);
(d) the Trust's wish to see theatre opening hours extended;
(e) an increase in the cost per bed in February 2011, due partly to the shorter number of working days in that month. A more detailed explanation and clarity on the number of UHL beds would be provided to the April 2011 Finance and Performance Committee meeting; **COO/ CN/ DFP**
(f) UHL's current appeals against specific repeat patient MRSA bacteraemias, and the impact (if successful) on the Trust's 2010-11 MRSA figures;
(g) continued good performance on elective and emergency mortality rates, with UHL rates well below the NHS average;
(h) good performance on discharge letters, which would shortly be rolled out. Work was underway to understand the increase in the number of complaints relating to discharge;
(i) the need for appropriate caution against over-reliance on e-recording of VTE risk assessments, until the system was totally embedded, and
(j) information relating to the month 11 financial position, including:-
    - disappointing rise in pay costs, which was being explored more fully by the Director of Finance and Procurement;
    - the agreement of a year-end settlement with Commissioners;
    - a good position in terms of UHL's working capital;
    - the significant impairment forecast in relation to the neonatal unit new build;
    - continued overperformance on the 2010-11 cost improvement programme, with £27.7m delivered against a planned £27.3m, and
    - the Director of Finance and Procurement's continued expectation of achieving UHL's forecast £1m surplus at year-end.

In discussion on the month 11 report, the Trust Board noted:-

(1) a query from Mr R Kilner, Non-Executive Director, regarding potential significant CQUIN penalties, which were noted to be non-recoverable;
(2) a query from Mrs K Jenkins, Non-Executive Director, regarding the Trust's understanding of the root causes of the rise in complaints. In his capacity as GRMC Chair, Mr D Tracy Non-Executive Director confirmed that the GRMC received detailed assurances on complaints – the Medical Director advised that a weekly meeting also took place to explore complaint themes. The Director of Corporate and Legal Affairs noted that the Deloitte review of UHL's quality governance had identified a need to refresh the Trust's approach to learning from complaints – this would be pursued through the Quality and Performance Management Group; **MD**
(3) a request from Mr D Tracy, Non-Executive Director and GRMC Chair, that the April 2011 GRMC be provided with further assurance on patient safety, given that six out **MD**

of ten indicators were red rated, and

(4) a query from Mr R Kilner, Non-Executive Director, on how to improve sickness absence management, noting the worsening rates from 2010 levels. This issue had been discussed at the 23 March 2011 Workforce and Organisational Development Committee, and work was in hand accordingly to learn from areas of good practice. Stretch targets were also being considered.

Resolved – that (A) the quality finance and performance report for month 11 (month ending 28 February 2011) be noted;

(B) in the month 12 report for receipt at the 5 May 2011 Trust Board, the Chief Operating Officer/Chief Nurse be requested to asterisk any changes arising from recent further technical guidance on the NHS Operating Framework 2011-12; **COO/ CN**

(C) through the month 12 report, the Chief Operating Officer/Chief Nurse be requested to advise the 27 April 2011 Finance and Performance Committee regarding UHL's actual bed numbers and cost per bed, and **COO/ CN**

(D) the Medical Director be requested to:- **MD**
(1) (through the QPMG) review how best to refresh UHL's approach to understanding and learning from its complaints, and
(2) provide assurance to the April 2011 GRMC on patient safety.

92/11/4 Finance and Performance Committee

Resolved – that the Minutes of the Finance and Performance Committee meeting held on 24 February 2011 be received, and the recommendations and decisions therein be endorsed and noted respectively.

93/11 STRATEGY

93/11/1 Annual Operational Plan 2011-12

Further to Minute 76/11 of 24 March 2011, members considered the further updated UHL annual operational plan for 2011-12 (paper H). The plan was presented for conditional Trust Board approval subject to:-

(1) finalisation of detailed CIP planning;
(2) availability of targeted turnaround support to reinforce delivery of the CIP plans by the Divisional Management Teams;
(3) completion of clinical risk assessments of the CIP schemes, and
(4) finalisation of the formal acute contract with LLR Commissioners consistent with the terms in the agreed Heads of Agreement.

It was noted that updates on the annual operational plan would be provided to the Trust Board on a quarterly basis. **DS/ DFP**

At the Chairman's request, Non-Executive Directors confirmed that they were happy with the revised format and content of the 2011-12 annual operational plan. In response to a query from Professor D Wynford-Thomas, Non-Executive Director, the Director of Strategy advised that the nursing initiatives detailed in Minute 91/11/1 above would be reflected in the Trust's 2011-16 Integrated Business Plan. The Trust Board then discussed the financial section of the annual operational plan (which included the 2011-12 capital programme) in particular detail, noting:- **DS**

(a) that Heads of Agreement had now been reached with Commissioners. The Director of Finance and Procurement considered that a fair and reasonable deal had been reached in terms of 2011-12, although further discussion was still required on the detail below that topline agreement, prior to finalisation of the formal acute contract;

(b) that work continued on the 2011-12 cost improvement programme, with an approximate further £6m to be identified. Clinical risk assessments of the schemes were underway within the Clinical Business Units (CBUs), although some phasing information was now available for Trust Board members. The £38m CIP target for 2011-12 was extremely challenging, and UHL was determined to achieve it in a safe and sustainable way. All schemes were assessed on their impact on quality and patient experience and then RAG rated. The Chief Operating Officer/Chief Nurse also outlined progress on recruitment to the SRO posts for the corporate/cross-cutting CIP projects. CBUs had also been asked to look ahead to 2012-13 CIPs, as required for HDD1;

(c) the summary of movements from 2010-11, as detailed on page 15 of the annual operational plan. This showed a modest 2010-11 surplus of £1.3m and the Director of Finance and Procurement emphasised the need to move away from non-recurrent income solutions. He also reiterated that the 2011-12 plan did not assume any benefits from reducing readmissions, as discussed on 24 March 2011;

(d) comments from Mr R Kilner, Non-Executive Director, regarding the benefits of having stretch targets in place, in terms of removing costs;

(e) a query from Mrs K Jenkins, Non-Executive Director, regarding stage of development of any business cases for the use of the non-recurrent transformational funding referred to in the annual operational plan. As noted in paper H, it had been agreed that all organisations would receive a proportionate share of health economy transformational funds, and the Director of Finance and Procurement acknowledged the need to use these funds in a genuinely and visibly transformational way, and

(f) a query from Mr D Tracy, Non-Executive Director and GRMC Chair, as to how the Trust Board would gain assurance on the clinical risk assessment of the CIP plans. The Chief Operating Officer/Chief Nurse noted that CBU ownership of that risk assessment was key, and she noted that a list was also kept of any CIP schemes declined following that risk assessment. Although the assessments were ongoing, she considered that a first cut report to date could be provided to the 28 April 2011 GRMC meeting. **MD/ COO/ CN**

<u>Resolved</u> – that (A) noting the 4 areas of further work detailed below, the UHL annual operational plan 2011-12 (including the 2011-12 capital programme) be given conditional approval as requested, subject to:- **ALL**
(1) finalisation of detailed CIP planning;
(2) availability of targeted turnaround support to reinforce delivery of the CIP plans by the Divisional Management Teams;
(3) completion of clinical risk assessments of the CIP schemes;
(4) finalisation of the formal acute contract with LLR Commissioners consistent with the terms in the agreed Heads of Agreement, and

(B) the Director of Finance and Procurement and the Director of Strategy be **DFP/**

requested to provide quarterly updates to the Trust Board regarding the implementation of, and progress against the key milestones within, UHL's annual operational plan for 2011-12; **DS**

(C) the Director of Strategy be requested to ensure that the nursing initiatives outlined to improve care of the elderly are appropriately reflected in the final iteration of the IBP, and **DS**

(D) the Medical Director and the Chief Operating Officer/Chief Nurse be requested to provide assurance on the process used to risk assess the impact of the CIPs on patient safety and quality of care, to the April 2011 GRMC. **MD/ COO/ CN**

93/11/2 Commissioning for Quality Innovation (CQUIN) Schemes and Quality Schedules 2011-12

Paper I outlined the indicators for the 2011-12 CQUIN schemes and quality schedules for both the Primary Care Trust and the East Midlands Specialised Commissioning Group, covering nearly 200 indicators with a corporate and Divisional lead (plus Senior Responsible Officer) identified for each. All indicators were subject to performance measures and CQUIN indicators would also incur financial penalties if thresholds were not achieved. Quarterly RAG rated performance reports would be provided to the GRMC, and the Chief Operating Officer/Chief Nurse commented that delivering the 2011-12 CQUIN would be a very significant task. In discussion, Mr R Kilner, Non-Executive Director suggested that it would be helpful for the Finance and Performance Committee to monitor the financial elements of the 2011-12 CQUIN, recognising that the quality aspects were the remit of the GRMC. The Chief Executive also noted the need for appropriate UHL linkage with the FT Network on a national approach to managing any potential Commissioner clawback of CQUIN monies. **MD/ COO/ CN** **DCLA**

Resolved – that (A) the update on 2011-12 CQUIN schemes and quality schedules be noted;

(B) the Chief Operating Officer/Chief Nurse and the Medical Director be requested to: (1) provide quarterly updates on the 2011-2 CQUIN to the Governance and Risk Management Committee; (2) report on the financial elements (and any associated risks) of CQUIN performance, to the Finance and Performance Committee, and **COO/ CN/ MD**

(C) the Director of Corporate and Legal Affairs be requested to link appropriately with the FT Network regarding potential national Commissioner issues re: CQUIN monies. **DCLA**

93/11/3 FT/IB/LTFM Monthly Update

The Director of Strategy introduced the FT application and strategic business planning process progress report as of the period ending 31 March 2011 (paper J). The NHS East Midlands review to inform the signing of the Tripartite Formal Agreement had been completed, and the agreement had been signed by UHL on 31 March 2011. As detailed in paper J, Pricewaterhouse Coopers (PwC) had identified a number of areas for the Trust to address as part of its FT application process, and these would be progressed as would any issues emerging from Deloitte's quality governance review of UHL.

The Director of Strategy confirmed that HDD1 would now start on 9 May 2011, in line with Trust plans. UHL recognised the likely very significant work involved. In discussion, the

Trust Chairman queried whether the Trust's Strategy team was appropriately resourced for the task – in response, the Director of Strategy advised that additional support would be welcomed at Divisional level, and it was agreed to raise this at UHL's Board-to-Board with NHS East Midlands on 8 April 2011. **CE/ DS**

In discussion, Mr R Kilner, Non-Executive Director requested that the outcome of the KPMG draft IBP review be circulated to Trust Board members. He also suggested that the communications workstream should be split into internal and external threads, and considered that there was further work needed on UHL's internal communication with staff on "From Good to Great". The Director of Communications and External Relations recognised this point and outlined a number of measures planned accordingly. **DS/ DFP** **DCER**

Resolved – that (A) the FT/IBP/LTFM monthly update be noted;

(B) the Director of Strategy and the Chief Executive be requested to raise the need for potential additional Divisional-level support, at the 8 April 2011 Board-to-Board with NHS East Midlands; **DS/CE**

(C) the Director of Strategy be requested to liaise with the Director of Finance and Procurement in circulating the KPMG draft IBP review to Trust Board members, for information, and **DS/ DFP**

(D) the Director of Communications and External Relations be requested to separate the internal and external communication strands within the FT communications workstream, noting the need for further work on internal cascading of (eg) "From Good to Great". **DCER**

94/11 STRATEGIC RISK REGISTER/BOARD ASSURANCE FRAMEWORK

Paper K detailed the final 2010-11 iteration of the integrated strategic risk register/Board Assurance Framework (SRR/BAF), noting that its format was likely to change from May 2011 onwards. A summary of the changes from the March 2011 iteration was detailed in appendix 2. Noting that each risk would then have been reviewed twice, the Trust Board discussed three specific risks in detail as follows:-

(a) risks 16 and 17 *inability to maintain competence of staff* and *inadequate organisational development* – the Medical Director noted significant progress in the Consultant appraisal and revalidation processes, and the Director of Human Resources confirmed that the 2010 staff opinion and attitude survey had been discussed in detail at the 23 March 2011 Workforce and Organisational Development Committee meeting. An action plan was now in place in respect of staff development, which would be shared with the Trust Board at the start of May 2011, and **DHR**

(b) risk 20 *failure to comply with The Health and Social Care Act 2008 (Hygiene Code*) – the Chief Operating Officer/Chief Nurse confirmed UHL's compliance with the Hygiene Code, noting that all required measures were in place. It was clarified that the order of this risk on the risk register reflected its linkages to UHL's objectives.

Resolved – that (A) the updated integrated SRR/BAF be noted, ahead of the new format likely to be in place from May 2011, and

(B) the action plan in respect of staff development be circulated to Trust Board **DHR**

members at the start of May 2011.

95/11 REPORTS FROM BOARD COMMITTEES

95/11/1 Audit Committee

Resolved – that the Minutes of the Audit Committee meeting scheduled for 12 April 2011 be submitted to the Trust Board on 5 May 2011. **STA**

95/11/2 Governance and Risk Management Committee (GRMC)

Resolved – that the Minutes of the GRMC meeting held on 24 February 2011 be received, and the recommendations and decisions therein be endorsed and noted respectively.

95/11/3 UHL Research and Development Committee

As Chair of the Research and Development Committee, the Trust Chairman noted the proposed additional (non-voting, co-opted) membership of Professor R Baker, LNR CLAHRC Programme Director and Professor N Samani, Consultant Paediatric Cardiologist. These additions were endorsed by the Trust Board.

Resolved – that the Minutes of the UHL Research and Development Committee meeting held on 7 March 2011 be received, and the recommendations and decisions therein be endorsed and noted respectively.

95/11/4 Workforce and Organisational Development Committee (WODC)

In her capacity as Chair of the Workforce and Organisational Development Committee, Ms J Wilson, Non-Executive Director advised that lengthy discussions had taken place at the 23 March 2011 WODC regarding the 3% sickness assumption in the 2011-12 annual operational plan and the 2011-16 Integrated Business Plan. A further update on sickness absence issues was scheduled for the June 2011 WODC meeting.

Resolved – that the Minutes of the Workforce and Organisational Development Committee meeting held on 23 March 2011 be received, and the recommendations and decisions therein be endorsed and noted respectively.

96/11 CORPORATE TRUSTEE BUSINESS

96/11/1 Charitable Funds Committee

Resolved – that the Minutes of the Charitable Funds Committee meeting held on 4 March 2011 be received, and the recommendations and decisions therein be endorsed and noted respectively by the Trust Board (in its capacity as Corporate Trustee).

97/11 TRUST BOARD BULLETIN

Resolved – the following papers circulated with the 7 April 2011 Trust Board Bulletin be noted:-
(A) update on cancer 2-week waits;
(B) 2011-12 declarations of Trust Board members' interests (list available on line), and
(C) report on Leicestershire County Council Health and Wellbeing Board.

98/11 QUESTIONS FROM THE PUBLIC RELATING TO BUSINESS TRANSACTED AT THIS MEETING

The following queries/comments were received regarding the business transacted at the meeting:-

(1) a query as to whether it would be possible for the Trust to include additional sources of patient feedback when building up its picture of patient experience through the dashboard (Minute 91/11 above refers). These other sources could include PILS concerns, messages to Matron, patient opinion and NHS choices, verbal complaints, and touchscreen data. The Chief Operating Officer/Chief Nurse agreed to consider this accordingly; **COO/ CN**
(2) a query as to how to ensure an appropriate focus of Trust Board time and attention, given the volume of business being transacted. The Trust Chair advised that he intended to reinstate UHL's previous practice of Board evaluation of each meeting. He also confirmed that the business on the Trust Board agenda (and its public/private split) was carefully reviewed in advance;
(3) concern voiced over the speed with which George Eliot Hospital had been agreed to take over the UCC, although noting that due diligence had been undertaken, and
(4) a concern over the lack of contract in place with EMAS for patient transport services, and a query as to whether UHL was being reimbursed for the cost of the private crews (Minute 92/11/2 above refers). The Chief Operating Officer/Chief Nurse confirmed that UHL did submit bills to EMAS for the additional expenditure incurred, and the Director of Finance and Procurement agreed that the current position was unsustainable in the longer-term. The potential NHS East Midlands role was noted.

Resolved – that the comments above and any related actions, be noted. **EDs**

99/11 DATE OF NEXT MEETING

Resolved – that the next Trust Board meeting be held on Thursday 5 May 2011 at 10am in Rooms 1A & 1B, Gwendolen House, Leicester General Hospital site.

100/11 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 101/11 – 111/11/2), having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.

101/11 DECLARATION OF INTERESTS

Professor D Wynford-Thomas, UHL Non-Executive Director, declared an interest in Minute 105/11/2 below – this was agreed not to be a prejudicial interest and he remained present

for the discussion. Members of the Trust's Charitable Funds Committee also declared their positions in respect of Minute 107/11 below.

102/11 CONFIDENTIAL MINUTES

Resolved – that the confidential Minutes of the Trust Board meetings held on 3 and 24 March 2011 be confirmed as correct records.

103/11 MATTERS ARISING REPORT

Resolved – that the consideration of the confidential matters arising report 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.

104/11 REPORT BY THE MEDICAL DIRECTOR

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

105/11 REPORTS BY THE DIRECTOR OF STRATEGY

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

106/11 REPORTS BY THE DIRECTOR OF HUMAN RESOURCES

Resolved – that this Minute be classed as confidential and taken in private accordingly, on the grounds of commercial interests and on the grounds of personal information (data protection).

107/11 JOINT REPORT BY THE CHIEF OPERATING OFFICER/CHIEF NURSE AND THE DIRECTOR OF FINANCE AND PROCUREMENT

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

108/11 CONFIDENTIAL TRUST BOARD BULLETIN

Resolved – that the report from the Chief Operating Officer/Chief Nurse attached to the confidential Trust Board Bulletin, be noted for information.

109/11 REPORTS FROM REPORTING COMMITTEES

109/11/1 Finance and Performance Committee

Resolved – that the confidential Minutes of the Finance and Performance Committee meeting held on 24 February 2011 be received, and the recommendations and decisions therein be endorsed and noted, respectively.

109/11/2 Governance and Risk Management Committee (GRMC)

Resolved – that the confidential Minutes of the GRMC meeting held on 24 February 2011 be received, and the recommendations and decisions therein be endorsed and noted, respectively.

110/11 CORPORATE TRUSTEE BUSINESS

110/11/1 Charitable Funds Committee

Resolved – that the confidential Minutes of the Charitable Funds Committee meeting held on 4 March 2011 be received, and the recommendations and decisions therein be endorsed and noted, respectively.

111/11 ANY OTHER BUSINESS

111/11/1 Report by the Chief Operating Officer/Chief Nurse

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.

111/11/2 NHS East Midlands Board-to-Board 8 April 2011

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.

The meeting closed at 4pm

Helen Stokes
Senior Trust Administrator