

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

**MINUTES OF A MEETING OF THE TRUST BOARD, HELD ON THURSDAY 5 MAY 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 (from part of note 117/11/1)
Mrs K Jenkins – Non-Executive Director
Mr R Kilner – Non-Executive Director
Mr M Lowe-Lauri – Chief Executive (from part of note 117/11/1)
Mr P Panchal – Non-Executive Director
Mr I Reid – Non-Executive Director
Mr A Seddon – Director of Finance and Procurement (from note 114/11c)
Mr D Tracy – Non-Executive Director
Ms J Wilson – Non-Executive Director
Professor D Wynford-Thomas – Non-Executive Director

In attendance:

Ms W Lane – Associate Director, Acute Commissioning, NHS Warwickshire (observing)
Mrs K Rayns – 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

112/11 APOLOGIES

No apologies for absence were received.

113/11 DECLARATIONS OF INTERESTS

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

114/11 CHAIRMAN'S ANNOUNCEMENTS

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

- (a) a fire that had occurred at Leicester Royal Infirmary in the early hours of that morning and which the Chief Executive would include in his briefing report (Minute 118/11 below refers). The Chairman recorded the Trust's appreciation to the fire service, all UHL staff involved in the evacuation process and the other healthcare agencies that had assisted the Trust at this difficult time;
- (b) the successful completion of the London Marathon by Ms J Wilson, Non-Executive Director. The Chairman expressed gratitude (on behalf of the Trust Board) for raising in excess of £2,025 towards the Lord Mayor's Forget-Me-Not Appeal;
- (c) the Chief Executive's selection for participation in the NHS Future Forum, established as part of the national pause to review the underlying principles and effectiveness of the plans for reforming the NHS as set out in the current Health Bill,
- (d) positive feedback received following UHL's Board-to-Board meeting with NHS East Midlands held on 8 April 2011;

- (e) the continuing development of UHL’s draft Integrated Business Plan which was still considered as work in progress, but he recognised the ultimate aim of presenting key elements of the finalised document in the public arena, and
- (f) his thanks to Leicester City Manager, Mr Sven-Goran Eriksson, for supporting the “Hold on to our Hearts” campaign, through his visit to Glenfield Hospital on 27 April 2011.

115/11 MINUTES

Resolved – that the Minutes of the meeting held on 7 April 2011 be confirmed as a correct record.

116/11 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’. The Trust Board noted the following issues from the matters arising report:-

- (a) Minute 91/11 – the Chief Operating Officer/Chief Nurse was requested to provide an update to the next meeting on the consideration of holding nurse staffing agencies to appropriate account for adhering to the Vital tool;
- (b) Minute 98/11 – the Chief Operating Officer/Chief Nurse was requested to provide an update to the next meeting on the consideration of additional sources of patient feedback for inclusion in the patient experience dashboard, and
- (c) Minute 52/11 of 24 March 2011 – the Director of Strategy briefed the Board in respect of developments relating to the national paediatric cardiac surgery consultation “Safe and Sustainable”, noting that in-depth reviews of patient flows and business case submissions were currently taking place for each of the centres and that these findings were due to be presented to the Review Committee in June 2011.

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Resolved – that the matters arising report and associated actions above, be noted as appropriate.

117/11 PATIENT EXPERIENCE

117/11/1 Interface Geriatrics Project – Update

Further to Minute 26/11 of 3 February 2011, the Medical Director provided a verbal update in respect of the multi-faceted developments taking place as part of UHL’s contribution to the Interface Geriatrics Project (part of the wider LLR emergency care transformational change programme). He particularly highlighted the following developments which had demonstrated improvements in patient quality, improved discharge rates from admissions units and reduced admissions through the Emergency Department (ED):-

- FOPAL (Frail Older Person’s Advice and Liaison service) – five days per week
- Emergency Frailty Unit – seven days per week

The Medical Director recognised the significant input by Dr S Conway, Senior Lecturer/Geriatrician, in respect of these initiatives and he undertook to arrange for the Trust Administrator to circulate some informative presentation slides with the Minutes of this meeting. As expected, neither of these initiatives had yet impacted upon patient length of stay rates, but if the pilot results were extrapolated over a one year period, there was a

potential to reduce inappropriate admissions amongst this patient group by 700 per year, whilst maintaining high standards of patient safety and quality.

Resolved – that (A) the verbal update by the Medical Director in respect of the Interface Geriatrics Project be received and noted, and

(B) the Medical Director be requested to provide the Trust Administrator with a copy of the above mentioned presentations slides for circulation with the Minutes of this meeting.

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118/11 CHIEF EXECUTIVE'S MONTHLY REPORT – MAY 2011

The Chief Executive provided a verbal report in respect of the fire that had broken out on Ward 8 at Leicester Royal Infirmary at 00.20 hours on Thursday 5 May 2011. An immediate evacuation of the affected ward had taken place and five other wards were subsequently evacuated as a precautionary measure against the effects of smoke. Extensive damage had been caused to Ward 8 during the fire and the area was currently sealed off to allow incident investigation work to take place. He advised that a 40 year old male patient had been arrested in connection with this incident. All patients from the affected ward had been relocated to other wards and the hospital was in the process of returning to normal service. The Chief Executive particularly expressed his gratitude to all staff and agencies involved in the emergency response, noting that very positive feedback had been received from the police, fire service and from the affected patients themselves. He confirmed that the Chief Operating Officer/Chief Nurse would be leading a comprehensive incident review exercise, as appropriate for an incident of this severity.

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In his monthly report for May 2011 the Chief Executive highlighted the continuing challenges to meet Emergency Department (ED) targets and containing MRSA bacteraemia cases below the threshold of 9 for the 2011-12 financial year. Paper C also updated the Trust Board following UHL's Board-to-Board meeting with NHS East Midlands held on 8 April 2011. The Chief Executive quoted the following statement of feedback, provided in a letter from Professor D Chiddick, Acting Chairman, NHS East Midlands: *"In summary, you have demonstrated that you are a strong, cohesive Board with a leading edge approach to your collective development"*. Finally, the Chief Executive briefed members on his membership of the NHS Future Forum and his intention to facilitate local engagement events within UHL and the wider LLR health economy using existing network links to gather a wide range of views.

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

(B) the Chief Operating Officer/Chief Nurse be requested to lead a comprehensive review exercise in respect of the fire at Leicester Royal Infirmary and communicate the findings as appropriate.

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119/11 QUALITY, FINANCE, AND PERFORMANCE

119/11/1 LLR Urgent and Emergency Care System Improvement Programme – Update

Copies of paper D, prepared by the Joint Chief Executive NHSLCR/LC, were circulated at the meeting. The paper updated the Trust Board in respect of progress of the urgent and emergency care system improvement programme for LLR. The Chief Operating Officer/Chief Nurse apologised on behalf of the Joint Chief Executive NHSLCR/LC for the late submission of this paper, due (in part) to the absence of appropriate targets within the

single performance framework appended to the report (paper D1 refers) and she noted that further work on the development of these targets would be required prior to the next iteration of the report. The Chief Operating Officer/Chief Nurse particularly drew members' attention to the following issues:-

- (a) the Clinicians Delivering Change (CDC) workstream being led by Professor A Rashid, PCT Medical Director;
- (b) the Senior Operational Group (SOG) workstreams being led by Mrs C Griffiths, Joint Chief Executive NHSLCR/LC, which included older people's pathways and improving discharge processes. The responsibilities of health and social care agencies were highlighted alongside UHL's responsibilities;
- (c) issues surrounding the reconfiguration of UHL's ED footprint, including:-
 - consideration of the likely impact upon other UHL services that might require to be relocated;
 - the development of a procurement tendering exercise, with a view to awarding a contract in August/September 2011 for a contract period which might span the 2011-12 and 2012-13 financial years;
 - the application process for transformational funding and the associated deadline of 10 May 2011 for submissions;
 - project management arrangements and additional resources;
- (d) significant progress in respect of developing the ED workforce and recruitment to identified roles (as detailed in section 3.3.2 of paper D);
- (e) the success of the pilot schemes for bed bureau admissions in Medicine and Surgery and the aspiration to continue the arrangements;
- (f) the early implementation of ambulatory care pathways for abdominal pain and pulmonary embolism (PE) and plans to bring forward the timescale for the chest pain ambulatory care pathway, and
- (g) the process to be followed in order to appoint an appropriate Emergency Care Network (ECN) performance management role.

In discussion on this report, the Trust Board noted:-

- (i) in response to a query by Professor D Wynford-Thomas, Non-Executive Director, the Chief Operating Officer/Chief Nurse advised that workforce expansions were not directly commensurate with the planned expansion of the ED footprint, as alternative workforce models were in the process of being adopted with different skill mixes and opportunities for more flexible solutions. She confirmed that these changes were being subjected to appropriate internal and external scrutiny. The Medical Director also noted that patients would be seen in more efficient ways once the re-modelled ED became fully operational;
- (ii) concern expressed by Professor D Wynford-Thomas, Non-Executive Director, that the ED footprint might become too big, in the event of any significant reduction in patient demand. In response the Chief Operating Officer/Chief Nurse advised that emergency activity modelling had not indicated such a reduction in activity. Furthermore, current building regulations now dictated increased space in patient treatment cubicles to allow appropriate access to both sides of the patient simultaneously;
- (iii) Mr D Tracy, Non-Executive Director, noted that every GP practice was being monitored against targets to reduce ED attendance and queried whether any sanctions would be applied – in response the Chief Executive advised of the different approaches by NHSLC and NHSLCR towards incentives and performance management measures to encourage appropriate referral patterns. He undertook to follow-up this query through the Emergency Care Network, as appropriate;

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- (iv) Mr R Kilner, Non-Executive Director, welcomed the joined up approach to producing a single emergency care performance report, but commented that it felt like a slight backward step in terms of the availability of certain data. The Chief Operating Officer/Chief Nurse highlighted where some of the given examples of data were provided within the appended spreadsheet, but she conceded that the report was still under development and a little more sophistication would be required;
- (v) Mrs K Jenkins, Non-Executive Director queried when the performance report would be fully populated (particularly a progress update on the 11 point action plan) and noted in response that the report for June 2011 would be more developed in this respect;
- (vi) responding to a query raised by Mr P Panchal, Non-Executive Director, the Director of Finance and Procurement briefed the Board on the degree of optimism that transformational funding might be made available to support the required expansion to the ED footprint. However, he couched his comments by highlighting the profile and phasing of UHL's capital plan and ability to fund major capital projects without compromising the Trust's liquidity rating, and
- (vii) Mr I Reid, Non-Executive Director, noted that much of the ED remodelling work would be scheduled to take place during the winter period and he queried the potential impact on the existing ED facilities during that time. The Chief Operating Officer/Chief Nurse acknowledged the potential level of disruption to the service, but provided assurance regarding a segmented approach to decanting services and the preparation of other areas to receive those services for a temporary period. Each aspect of the scheme would have dedicated SRO management support put in place to oversee the transition.

The Chairman summarised the discussion, confirming that the Board had welcomed and supported the opportunities provided by the integrated LLR emergency care reporting mechanism, subject to appropriate population and additional routine data being provided in future iterations of the report. He highlighted the significant financial modelling that was still required and the operational challenges associated with the proposed expansion of UHL's Emergency Department.

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

(B) the Chief Executive be requested to seek confirmation from NHSLCR/LC in respect of any incentives or sanctions to encourage appropriate referral patterns by GP practices, and

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(C) the Board continue to receive monthly update reports, on the LLR urgent and emergency care system (subject to the continuing development of the performance framework reporting mechanism).

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119/11/2 Month 12 Quality and Performance Report

Paper E comprised the quality, finance and performance report for month 12 (month ending 31 March 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. Appendix B to paper E provided further technical guidance in respect of the 2011-12 NHS Performance Framework Indicators including the associated thresholds, weightings and monitoring periods. To support this information, appendix A set out the indicators and weightings for the DoH Performance Framework and FT Compliance Framework.

The commentary accompanying the month 12 report identified key issues from each Lead Executive Director and the following points were now noted by exception:-

- (a) the wider dialogue being implemented through the Communications Team and “The 100” meetings to remind staff of their responsibilities and accountability to comply with measures aimed at reducing the number of MRSA bacteraemias within the Trust, including use of the new “grab bags” for blood cultures and strict compliance with all infection prevention policies;
- (b) achievement of the 100% target for same sex patient accommodation, including intensivists areas, for March 2011 (noting that this performance for May 2011 might have been compromised due to the impact of the fire evacuation procedure);
- (c) improved theatre utilisation performance whilst recognising the need to further increase the run hours (currently standing at 91.5%);
- (d) a revised statistical measure for referral to treatment (RTT) and a reduction in the threshold from 27.7 weeks to 23 weeks, compounded by the fact that missing one month’s performance would result in losing that performance measure for the whole quarter. Outline plans were being developed with Commissioners and community healthcare providers to manage an additional 600 patients within the next 10 weeks to meet this challenging target, but UHL was not considered to be an outlier in this respect when compared to similar sized Trusts. The Chief Operating Officer/Chief Nurse undertook to map out the project plans by specialty and share these with the Board for assurance purposes. All patients would be treated in accordance with their choice and in order of their position on the waiting list, unless there was a clinical reason for priority;
- (e) the appointment of Mrs D Mitchell as Head of Transformational Programmes on a one year fixed term secondment basis, the arrangements being progressed to back-fill the Divisional Manager post for Planned Care, and the transfer of Mr M Natrass from Cardio-Respiratory CBU Manager to Cancer Services CBU Manager;
- (f) fractured neck of femur performance for patients receiving surgery within 36 hours of being fit for surgery had improved to 75%. As Chair of the Fractured Neck of Femur Steering Group, the Director of Research and Development was exploring the safety and quality benefits for developing a dedicated ward to treat this cohort of patients and plans would be submitted for consideration by the Executive Team during May 2011;
- (g) the Medical Director provided an update on the implementation plans for an electronic system to record and recall patient VTE risk assessments within 24 hours of admission in order to address UHL’s non-achievement of the 90% target;
- (h) in respect of reducing re-admissions, the Trust had now appointed a specific Senior Responsible Officer (SRO) and work would be commencing in earnest to address the complex range of contributory factors affecting this financial and patient quality related issue;
- (i) patient safety performance continued to improve with a reduction in patient falls and 14 consecutive months with no ‘never events’. However, the Quality and Performance Management Group and the Governance and Risk Management Committee continued to review an unwelcome increase in the number of complaints related to outlying patients, discharge and attitudes of staff;
- (j) staff appraisal rates appeared to have reached a plateau recently (standing at 90%) and further improvement was being sought through the implementation of an agreed action plan in response to the National Staff Attitude and Opinion Survey and local staff polling;
- (k) sickness absence stood at 4% for March 2011 and 3.7% cumulatively for the year 2010-11 – to address this a new set of actions had been agreed in conjunction with Occupational Health and these would be presented to the Executive Team for approval

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during May 2011. The Director of Human Resources undertook to agree an appropriate approach with the respective chairs of the Finance and Performance Committee and the Workforce and Organisational Development Committee;

- (l) information relating to the month 12 financial position, including:-
- delivery of the forecast £1m year-end surplus (subject to audit and prior to impairment);
 - year-end accounts filed with the DoH ahead of the statutory deadline;
 - a negative income and expenditure run-rate for month 12, reflecting current high levels of patient activity and requiring the application of tighter controls to bring financial performance back on track;
 - achievement of the cash flow external financing and capital resource limits, and
 - an overall Financial Risk Rating (FRR) score of 2, which was not considered an acceptable base case as an aspirant Foundation Trust. Members noted the key importance of improving the Trust's income and expenditure surplus and liquidity ratio for 2011-12.

In discussion on the month 12 report, the Trust Board noted:-

- (1) a query from Ms J Wilson, Non-Executive Director, regarding any potential adverse impact of RTT waiting list initiatives upon patients, in response to which the Chief Operating Officer/Chief Nurse provided assurance that the majority of the additional activity would be day case surgery provided in parallel to usual activity and there would not be any requirement to cancel and re-schedule large groups of patients;
- (2) a query from the Director of Strategy regarding the impact of the reclassification of emergency activity by hospital site, particularly in respect of Acute emergency admissions to Glenfield Hospital. The Chief Operating Officer/Chief Nurse indicated that under the new rules, Glenfield Hospital data would no longer be amalgamated with LRI data for the purposes of emergency admissions. However, the scope to include Urgent Care Centre (UCC) attendances with LRI data was being explored due to their site co-location, but this would be subject to the resolution of potential information governance issues regarding the provision of patient related information;
- (3) a suggestion from Mr D Tracy, Non-Executive Director, that the Trust might seek external support to address high levels of sickness absence, noting that 2% was considered normal within private industry. In response, the Director of Human Resources noted favourable sickness pay and conditions in the NHS, compared to some private industries which did not pay employees for their first 3 days of sickness and had no arrangements to provide employees with 6 months sick leave on full pay and 6 months on half pay. However, she undertook to consider this option and build any recommendations into the proposals as appropriate;
- (4) Mr R Kilner, Non-Executive Director, requested further analysis be undertaken of the Trust's pay costs per head in relation to the reported headcount reductions (as described on page 10 of paper E). The Director of Finance and Procurement reported on the revised process to keep account of the time element of bank and agency staff usage and the Chief Operating Officer/Chief Nurse provided additional contextual information regarding changes in skill mix, additional research and development workload and temporary pay protection arrangements, noting that the Finance and Performance Committee had already requested a review of this information;
- (5) Mrs K Jenkins, Non-Executive Director, highlighted a red RAG rated performance indicator on page 4 of paper E related to inpatient polling (83.8% score for patients rating the care received) and sought confirmation of the actions planned to address improvements in this area of patient experience. In response the Chief Operating Officer/Chief Nurse detailed some of the challenges experienced within the Acute Care Division over the last three months. Appropriate action plans were being developed to

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- provide assurance to the Governance and Risk Management Committee in this respect and these would also be shared with Mrs K Jenkins, Non-Executive Director outside the meeting, and
- (6) the Director of Strategy noted that patients rating the care they received might be a subjective question and she queried whether local media coverage, or comments from friends and relatives, might have influenced such scores. The Director of Communications and External Relations confirmed that anecdotal evidence might impact upon a patient's perception of their care but overall benchmarking work had demonstrated that UHL still had some scope for improvement in the area of patient satisfaction.
- Resolved – that (A) the quality finance and performance report for month 12 (month ending 31 March 2011) be noted;**
- (B) the Chief Operating Officer/Chief Nurse be requested to share an overview of the project plans to address RTT performance by specialty with Trust Board members for assurance purposes outside the meeting;**
- (C) the Medical Director/Director of Research and Development be requested to present proposals to the Executive Team for improving performance related to the care of fractured neck of femur patients;**
- (D) the Director of Human Resources be requested to present proposals to the Executive Team in respect of additional actions to reduce staff sickness absence and to agree an approach to monitoring arrangements with the respective chairs of the Finance and Performance Committee and the Workforce and Organisational Development Committee;**
- (E) the Chief Operating Officer/Chief Nurse and the Director of Finance and Procurement be requested to present further analyses of the Trust's pay costs and headcount reductions to the Finance and Performance Committee, and**
- (F) the Chief Operating Officer/Chief Nurse be requested to present action plans to improve patient experience polling results to the Governance and Risk Management Committee, and share these with Mrs K Jenkins, Non-Executive Director, outside the meeting.**

119/11/3 Finance and Performance Committee

Resolved – that the Minutes of the Finance and Performance Committee meeting held on 27 April 2011 (discussion subjects as listed on the covering sheet at paper F) be submitted to the Trust Board on 2 June 2011.

120/11 **STRATEGY**

120/11/1 FT/IB/LTFM Monthly Update

The Director of Strategy introduced the FT application and strategic business planning process progress report as at 29 April 2011 (paper G refers). Members particularly noted the overview and timeline for the Historical Due Diligence (HDD1) process, which would commence on 9 May 2011 and conclude on 30 May 2011, when Ernst and Young would be issuing their final assessment report to Monitor. Consideration took place of the current draft status of UHL's developing Integrated Business Plan (IBP) and members recognised

that feedback from the HDD1 process would inform the final version of this document. The Director of Strategy highlighted the requirement to ensure that wherever possible the IBP was consistent with the direction of travel and read across accurately to Divisional and CBU business plans, including CIPs and service developments.

The Director of Finance and Procurement provided a verbal update in respect of the Finance workstream, noting that the financial modelling had now been refreshed to the 2011-12 baseline, and recent revision had been incorporated into the Finance and Risk chapters of the IBP to reflect revised guidance from Monitor.

The Director of Corporate and Legal Affairs updated the Board in respect of the current status of the Governance and Risk workstream, advising that arrangements for membership, the Council of Governors and quality governance would be built in as they developed. He particularly highlighted the requirement for effective Board engagement as a Foundation Trust within the self-certification process.

The Director of Communications and External Relations detailed progress against the separate internal and external communications processes to increase engagement in the Trust's FT application. Internally, staff engagement had not yet progressed beyond 25%, but there was optimism that a video launch of the Medical Director and the Divisional Director, Planned Care, presenting UHL's Strategic Plan "From Good to Great" would help to increase engagement, alongside the use of a poster campaign encouraging staff to see the changes happening within the Trust and to become a part of them. From an external engagement perspective, discussion during the afternoon's Board development session was expected to inform the communications agenda surrounding the perception and development of the role of FT Governor.

Mr P Panchal, Non-Executive Director, sought an update in respect of the regular Friday afternoon FT engagement sessions with "The 100" and Ms J Wilson, Non-Executive Director enquired how "The 100" were being held to account for cascading the important communications messages to their staff. In response, the Director of Communications and External Relations described the orientation of these sessions, noting that each week a separate theme was selected and interactive discussion featured strongly throughout each session. A more prescriptive approach was being developed towards staff engagement and this was being monitored regularly by the Executive Team. The Chief Executive confirmed that the whole of the Executive Team (including the Divisional Directors) was committed to improving and developing the staff engagement process.

Resolved – that the FT/IBP/LTFM monthly update and subsequent discussion be noted.

121/11 RISK

121/11/1 UHL Risk Management Strategy

Paper H provided an overview of the consultation process undertaken as part of the annual review of UHL's Risk Management Strategy and a summary of the revisions made to reflect changes in the Trust's organisational structure. Copies of the revised Risk Management Strategy for 2011-12 and Risk Reporting Framework were provided at appendices 1 and 2 respectively. The Medical Director highlighted the following further amendments required to these documents:-

- under the roles and responsibilities of Corporate Directors on page 7, the Director of

Safety and Risk held responsibility for maintaining the Trust's assurance framework and the post of Director of Clinical Education had been replaced by an Associate Medical Director post with a responsibility for clinical education, and

- the Executive Team was not a sub-committee of the Trust Board (as suggested on page 2 of appendix 2).

In discussion on this item, the Trust Board expressed a preference to continue to receive copies of the integrated Strategic Risk Register and Board Assurance Framework (SRR/BAF) on a monthly basis and considered the arrangements for the Governance and Risk Management Committee, the Finance and Performance Committee and the Audit Committee to review the SRR/BAF. It was agreed that the outcome of the HDD1 process would be used to inform the assurance arrangements for these Committees to ensure that any particular concerns were escalated appropriately.

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In response to a query from Mr D Tracy, Non-Executive Director, members considered the Trust's aspiration to achieve NHSLA Acute Risk Management Standards compliance at level 3. The Chief Operating Officer/Chief Nurse and the Chief Executive provided an insight into the granular level of detail required to attain level 3 and the ability to evidence that such processes had been embedded within an organisation for 12 months. The Director of Corporate and Legal Affairs advised that the Trust's assessment to retain level 2 compliance would take place in December 2011.

Mrs K Jenkins, Non-Executive Director, sought and received information regarding the purpose and workings of the Policy and Guideline Committee, a sub-Committee of the Executive Team, established to review and monitor the content, format and consultation arrangements in respect of new and revised Trust policies. The Chief Executive extended an invitation to any Board members to attend a meeting of this Committee if they would find this helpful.

Resolved – that (A) the UHL Risk Management Strategy 2011-12 be agreed, subject to the amendments noted above;

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(B) SRR/BAF reports continue to be submitted to the Trust Board on a monthly basis, and

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(C) when next presenting the SRR/BAF to Trust Board (on 7 July 2011 – please see Minute 121/11/2(A) below), the Medical Director be requested to confirm the assurance arrangements and escalation process for highlighting specific risks to the Governance and Risk Management Committee, the Finance and Performance Committee and the Audit Committee.

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121/11/2 Strategic Risk Register/Board Assurance Framework (SRR/BAF)

Paper I briefly summarised the process for reviewing the format and content of the SRR/BAF. Members noted that the first version of the revised report would be presented to the Board on 7 July 2011 and monthly Trust Board reports would resume thereafter. The Medical Director was requested to ensure that any material changes in risk be highlighted to the Trust Board on an exception basis during the interim period.

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Resolved – that (A) the revised format integrated SRR/BAF be presented to the Trust Board on 7 July 2011, and

(B) the Medical Director be requested to inform the Trust Board of any material

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changes in risk (on an exception basis) during the interim period.

122/11 REPORTS FROM BOARD COMMITTEES

122/11/1 Audit Committee

As Chair of the Audit Committee, Mrs K Jenkins, Non-Executive Director highlighted recent revisions to the Trust's corporate governance policies. These were endorsed by the Trust Board.

Resolved – that (A) the Minutes of the Audit Committee meeting held on 12 April 2011 be received, and the recommendations and decisions therein be endorsed and noted respectively, and

(B) the Director of Corporate and Legal Affairs be requested to publish the revised corporate governance documentation, accordingly.

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122/11/2 Governance and Risk Management Committee (GRMC)

Resolved – that the Minutes of the Governance and Risk Management Committee meeting held on 28 April 2011 (discussion subjects as listed on the covering sheet at paper F) be submitted to the Trust Board on 2 June 2011.

122/11/3 UHL Research and Development Committee

Resolved – that the Minutes of the UHL Research and Development Committee meeting held on 11 April 2011 be received, and the recommendations and decisions therein be endorsed and noted respectively.

122/11/4 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 the next meeting due to be held on 22 June 2011 was currently being rescheduled.

Resolved – that the next meeting of the Workforce and Organisational Development Committee due to be held on 22 June 2011 be rescheduled and members advised of the revised arrangements as appropriate.

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123/11 CORPORATE TRUSTEE BUSINESS

123/11/1 Charitable Funds Committee

Resolved – that the next meeting of the Charitable Funds Committee due to be held on 6 May 2011 be re-scheduled and members advised of the revised arrangements as appropriate.

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124/11 TRUST BOARD BULLETIN

Resolved – the report on Trust Sealings 2010-11 circulated with the 5 May 2011 Trust Board Bulletin be noted.

125/11 QUESTIONS FROM THE PUBLIC RELATING TO BUSINESS TRANSACTED AT THIS

MEETING

The following query was received regarding the business transacted at the meeting:-

- (1) whether the Trust would be able to achieve the required RTT reductions within the 10 week timescale (Minute 119/11/2(d) refers), noting the possible effect of summer holidays and what the likely impact would be if this was not achieved. In response the Chief Operating Officer/Chief Nurse advised that the majority of the additional activity was being timetabled to take place before the end of July 2011 to avoid the peak of the summer holiday season. Progress would be monitored closely and a view on the project's achievability would be taken in due course.

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

126/11 DATE OF NEXT MEETING

Resolved – that the next Trust Board meeting be held on Thursday 2 June 2011 at 10am in Rooms A & B, Clinical Education Centre, Leicester General Hospital site.

127/11 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 128/11 – 136/11), having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.

128/11 DECLARATION OF INTERESTS

No interests were declared.

129/11 CONFIDENTIAL MINUTES

Resolved – that the confidential Minutes of the Trust Board meeting held on 7 April 2011 be confirmed as a correct record.

130/11 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.

131/11 REPORT 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).

132/11 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.

133/11 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.

134/11 REPORTS FROM REPORTING COMMITTEES

134/11/1 Finance and Performance Committee

Resolved – that the confidential Minutes of the Finance and Performance Committee meeting held on 27 April 2011 be submitted to the 2 June 2011 Trust Board meeting.

135/11 ANY OTHER BUSINESS

135/11/1 Report by the Chief Executive

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.

135/11/2 Report by the Director of Human Resources

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.

135/11/3 Report by the Director of Corporate and Legal Affairs

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

136/11 EVALUATION OF THE MEETING

The Chairman introduced a new process for gathering real-time evaluation at UHL's Board meetings. Starting at a random member and proceeding in turn around the room, he invited everybody present to contribute to the evaluation process. The following comments and suggestions were received:-

- (a) the volume of business on that day's meeting agenda was considered more realistic and achievable than previous recent meetings and the meeting had kept to time reasonably well. Greater emphasis on forward agenda planning might be required in order to smooth out any peaks in the volume of business for future meetings;
- (b) when considering Board reports, it would be helpful to know which other UHL Committees had also considered the proposals as this would inform members of the level of scrutiny proposals had been subjected to. The Director of Corporate and Legal Affairs undertook to consider adapting the Trust Board reporting proforma to capture this information;
- (c) papers submitted late or tabled at the meeting were difficult to absorb within the timescale and these required additional meeting time to review;

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- (d) some members had unavoidably arrived late to the meeting (due to the earlier hospital fire incident) but progress was soon brought back on schedule;
- (e) the issues surrounding the Urgent and Emergency Care System Improvement Programme were quite complex and care was required to ensure that the right performance metrics were included and that clarity was provided regarding any key proposals or decisions required;
- (f) additional support might be required to embed the implications of the indicators and weightings for the new DoH Performance Framework and FT Compliance Framework. The Chief Operating Officer/Chief Nurse undertook to explore the scope to provide additional background material to support members' comprehension in this respect;
- (g) the depth of discussion of the draft IBP had been less detailed than some members had anticipated;
- (h) more focus was required regarding any red rated performance indicators within the Quality, Finance and Performance Report. A response to a query regarding improving patient experience did not appear to have been well-prepared. The Chief Operating Officer/Chief Nurse advised that patient experience action plans had been considered in detail by the GRMC recently and consideration would be given to showcasing this work at a future Board meeting;
- (i) some of the speakers were hard to hear at times and had a tendency to "tail off" at the end of their report. It was agreed that if a speaker was considered to be speaking too quietly, other members would point their index finger towards the ceiling to encourage more volume;
- (j) it would be considered helpful if speakers could add more contextual information when stating figures within their reports;
- (k) some excellent challenges had been presented by Non-Executive Directors towards Executive Directors, but limited examples had been evidenced of Executive to Executive challenge. Opportunities for Executive Directors to challenge other Executive Directors usually took place through informal discussion and/or the weekly Executive Team meeting forum;
- (l) significant variances had occurred in the indicative discussion timings on the agenda and the actual duration of each discussion. Members suggested that the purpose and value of including these timings on the agenda be further reviewed;
- (m) the IBP had highlighted a few issues which Non-Executive Directors had not previously been aware of. The Director of Strategy noted this comment with a view to improving the arrangements for appropriate Non-Executive Director engagement;
- (n) there had been no noticeable difference in members' behaviours (or the interaction between members) during the public and private sections of the meeting and positive engagement had been evidenced during both sessions.

COO/
CN

COO/
CN

Resolved – that (A) the Chief Operating Officer/Chief Nurse be requested to explore the scope for providing additional supporting information in relation to the impact of the new indicators and weightings for the DoH Performance Framework and FT Compliance Framework, and

COO/
CN

(B) the Director of Corporate and Legal Affairs be requested to consider adapting the Trust Board covering proforma to capture details of any prior consideration by other Committees.

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The meeting closed at 2.26pm

Kate Rayns
Trust Administrator



**University of
Leicester**

Leicester Medical School

**Frail older people
- current developments**

Simon Conroy
Senior Lecturer/Geriatician

Primary care

Prevention

- Falls prevention
- Care home focus
 - CGA on admission?
 - Pharmacist reviews (STOPP/START)
 - (Advance) care planning

Locality based

- Community hospital
- Matrons
- Intermediate care
- Hospital at home/admission avoidance
- Community geriatrician

Interface geriatrician

SPA

ISAR

or fall

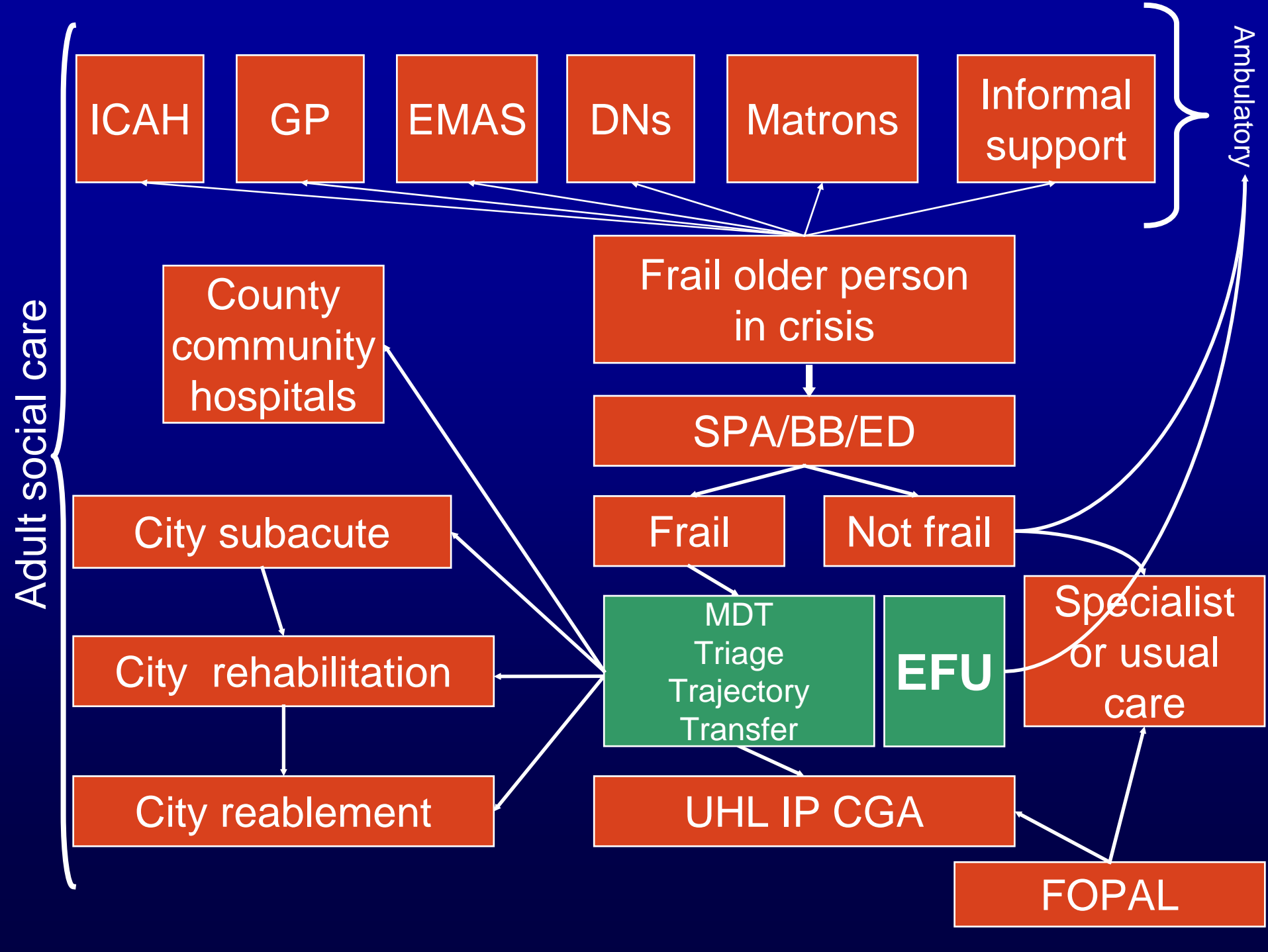
CGA

AMU

CGA

Necessary conditions

- Single point of access
- Communication
- Education
- Teamwork
- Shared goals
- Continuity of care
- Patient centred services
- Financial levers
- Positive attitude towards older people



Adult social care

Ambulatory

- ICAH
- GP
- EMAS
- DNs
- Matrons
- Informal support

County community hospitals

Frail older person in crisis

SPA/BB/ED

Frail

Not frail

City subacute

City rehabilitation

City reablement

MDT
Triage
Trajectory
Transfer

EFU

UHL IP CGA

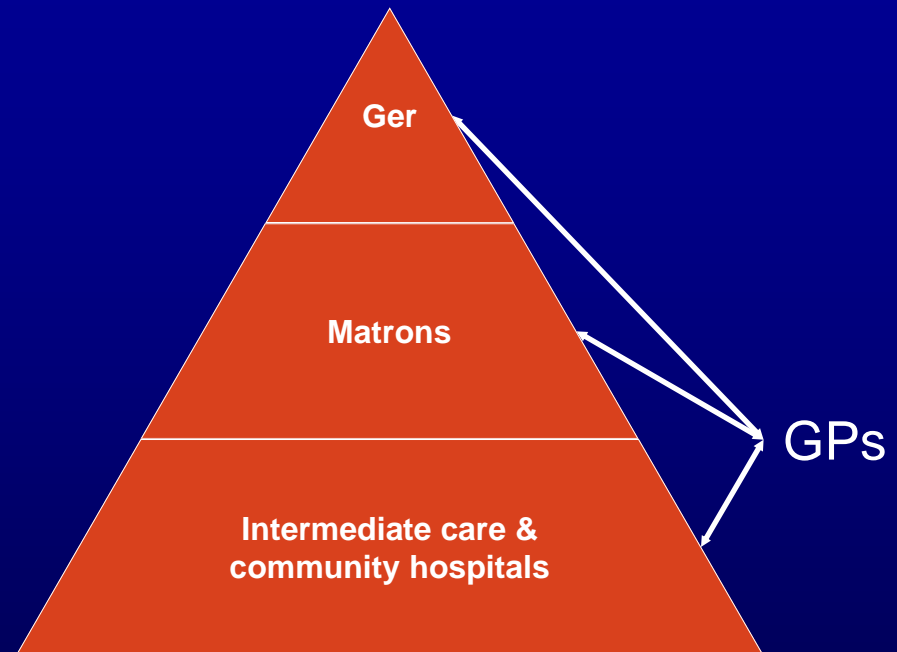
FOPAL

Specialist or usual care

Multiagency working

- Community hospitals
- Community matrons
- Intermediate care
- Social care
- Care homes
- Mental health
- Public support

- **Different ways of working**



Shared definition of target population
Single point of access
e-communication
Education & training

Key UHL developments

- Emergency frailty unit (EFU)
 - Located in EDU
 - Consultant geriatrician & team 7/7
- Frail Older Peoples' Advice & Liaison Service (FOPAL)
 - Located in AMU
 - Consultant geriatrician & team 5/7

FOPAL - aims

- To improve the quality of care and decision making for frail older people attending the acute medical unit
- To deliver multidisciplinary assessment from nurses, therapists and geriatricians in the acute medical unit
- Objectives
 - To increase AMU discharge rate from 8% to 10%
 - To reduce LoS for admitted patients by 0.5 days

Initial findings – first four months

- 551/3173 AMU patients (17%) referred to FOPAL January-April 2011
- 187 seen (6% of all AMU patients, 34% of those referred)
- Seeing frail older people
 - mean age 85, 69% female
 - median ISAR 3, median Barthel 60/100
 - mean AMT 4/10 (60% has AMT <5)
 - median comorbidities 4
 - mean medications 7

Destinations

	AMU recommendation	FOPAL recommendation	Actual destination
N	165	164	163
Home	13 (8%)	87 (53%)	59 (36%)
IP UHL	140 (85%)	56 (34%)	94 (58%)
Community bed	7 (4%)	18 (11%)	7 (4%)
Other	5 (3%)	3 (2%)	3 (2%)

Performance against objectives - FOPAL

Objectives

- To increase AMU discharge rate from 8% to 10%
- To reduce LoS for admitted patients by 0.5 days

Performance

- AMU discharge rate increased from to 53% *in those seen by FOPAL*
- LoS for admitted patients 10 days (mainly because only sickest being admitted now)

EFU - aims

- To improve the quality of care and decision making for frail older people attending the Emergency Department
- To deliver multidisciplinary assessment from nurses, therapists and geriatricians in the Emergency Department – operationalised as the EFU
- Objectives
 - To reduce the ED conversion rate for FOP from 90% to 80%
 - To reduce the LoS for admitted patients by 0.5 days

Older people – 85+

		Pre-EFU	Post-EFU
n		1227	176
LoS	(days)	0.44	0.52
LoS	(hours)	10.6	12.5
Destination	Home	51%	63%
	UHL	39%	25%
	Intermediate care	8%	7%
	Other	2%	2%

EFU Summary

- Overall length of stay has increased by one hour, by two hours for those aged 85+
- Overall 13% decrease in admissions to UHL (32% vs. 19%); similar for older people (39% vs. 25%)
- Overall, for every seven patients seen with an average additional one hour LoS, one patient is discharged home instead of being admitted

Performance against objectives

Objectives

- To reduce the ED conversion rate for FOP from 90% to 80%
- To reduce the LoS for admitted patients by 0.5 days

Performance

- EFU conversion rate reduced from 39% to 25%
- LoS in EFU increased by 2 hours
- System-wide data awaited

Overall performance against objectives – frail older people

	Objective	Relative impact	Performance	Relative impact
ED conversion rate	90% down to 80%	12% reduction	39% down to 25%	36% reduction
AMU discharge rate	8% to 10%	25% increase	8% to 53%	660% increase in those seen
Length of stay if admitted	9 days down to 8 days	12% reduction	FOPAL only – no change	No change

Projections - frail older people

- We said...
 - We will prevent 440 admissions per year and reduce LoS in those admitted by 1 day, saving £600,000
- Projecting current results over one year, we will:
 - Prevent 2 admissions per day from EFU (730 per year)
 - Prevent 1 admission per day from AMU (260 per year)

Projected cost savings

	Projected	Actual	Bed-days	Cost
Admissions to AMU from ED avoided	1040	730	770 AMU	$770 \times \text{£}227 = \text{£}175,000$
			770 base ward	$770 \times \text{£}106 = \text{£}81,620$
Admissions from AMU to base ward avoided	32	260	$260 \times 11 = 2860$ base ward	$2860 \times \text{£}106 = \text{£}303,160$

Total projected saving: £559,780 vs. planned £383,000

Comparison against 'Interface Geriatrics - the development of a service to improve care for frail older patients across LLR, Version 11 29.3.10 Helen Mather, Simon Conroy'

Community

- Subacute geriatric clinics about to start
- City and county –wide falls services
- Coverage of 50% of community hospitals
- Increased locality working

Summary

- Geriatric medicine is responding to the challenges
- What more can we do together?