Paper A

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF A MEETING OF THE TRUST BOARD, HELD ON THURSDAY 6 OCTOBER 2011 AT 9.30AM 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
Ms K Jenkins – Non-Executive Director
Mr R Kilner – Non-Executive Director (up to and including Minute 290/11)
Mr M Lowe-Lauri – Chief Executive
Mr P Panchal – Non-Executive Director (for Minutes 278/11 – 290/11 inclusive)
Mr I Reid – Non-Executive Director
Mr A Seddon – Director of Finance and Procurement (up to and including Minute 290/11)
Mr D Tracy – Non-Executive Director (up to and including Minute 291/11)
Ms J Wilson – Non-Executive Director (up to and including Minute 291/11)
Professor D Wynford-Thomas – Non-Executive Director (up to and including Minute 291/11)

In attendance:
Miss M Durbridge – Director of Safety and Risk (for Minute 279/11)
Ms C Ellis – PCT Cluster Chair (up to and including Minute 278/11/3)
Ms C Griffiths – PCT Cluster Chief Executive (for Minute 278/111)
Mr D Morgan – UHL Staff Side Chair (up to and including Minute 276/11)
Ms L Naylor – ED Project Manager (for Minute 278/11/1.3)
Miss 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
Mr D Yeomanson – Divisional Manager, Women's and Children's (for Minutes 278/11/5 and 278/11/6)

ACTION

271/11 APOLOGIES AND WELCOME

No apologies for absence were received. The Trust Chairman welcomed Ms C Griffiths, PCT Cluster Chief Executive and Ms C Ellis, PCT Cluster Chair, to the meeting.

272/11 DECLARATIONS OF INTERESTS

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

273/11 CHAIRMAN'S ANNOUNCEMENTS

The Chairman drew the Trust Board's attention to the following issues:-
(a) his welcome to Mr D Morgan, Staff Side Chair, who would be invited to make comments on the carparking proposals in Minute 276/11 below;
(b) the attendance of the PCT Cluster Chief Executive for the key discussions on LLR urgent care and winter planning issues in Minute 278/11/1 below. The Chairman noted the challenging winter experience of the previous two years and emphasised the need for a community-wide effort with diversion of appropriate patients away from the Emergency Department (ED). Appropriate and timely discharge processes were also key, as was the relationship with EMAS;
(c) the need for continued close monitoring of the Trust's 'stabilisation to transformation' financial recovery plan (Minute 278/11/3 refers);

(d) discussions on maternity/gynaecology service developments (Minute 268/11/5 refers), and
(e) the very positive nature of UHL's 2011 Annual Public Meeting, as held at the Leicester Royal Infirmary on Saturday 17 September 2011. The visits to clinical areas had been particularly well-received by public attendees. The Trust Chairman noted the Trust Board's thanks to all staff involved in making the 2011 UHL APM a success.

274/11 MINUTES

Resolved – that subject to amendment of Minute 251/11/3 as directed by the Director of Finance and Procurement, the Minutes of the meeting held on 1 September 2011 be confirmed as a correct record and recirculated to members accordingly for ease of reference. **STA**

275/11 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 250/11 of 1 September 2011 – it was confirmed that the implications of the public sector pension consultation exercise had been discussed at the 19 September 2011 Workforce and Organisational Development Committee;
(b) Minute 254/11 of 1 September 2011 – the Trust Chairman advised that the January 2012 Trust Board would receive a presentation on UHL R&D activity; **CE/ DRD**
(c) Minute 255/11 of 1 September 2011 – the September 2011 Audit Committee's discussions on the governance elements of the 2011-12 transformational cost improvement programme (CIP) schemes would captured in the Minutes of that meeting;
(d) Minute 228/11 of 4 August 2011 – the Director of Strategy advised that although the results of the LLR space utilisation survey were available, work was now underway to discuss their implications with the new Clinical Commissioning Groups (CCGs). An update was proposed for the January 2012 Trust Board (following workshops planned for October and November 2011), covering both the survey findings and potential resulting solutions. In response to a request, the Director of Strategy agreed to circulate the executive summary of the LLR space utilisation survey findings to Trust Board members for information, although noting the Chief Executive's comment that under-utilisation was already known. **DS** **DS**

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

276/11 CARPARKING CHARGES

Further to Minute 225/11/3 of 4 August 2011, paper C from the Director of Strategy advised the Trust Board of the outcome of the public engagement exercise on increasing staff/public carparking charges, and recommended the final charging model to be adopted accordingly. The Trust Chairman noted the presence of Mr D Morgan, Staff Side Chair, for this item and advised that exceptionally, Mr Morgan's comments would be taken after this discussion.

Approximately 1949 responses had been received to the public engagement exercise, 1014 of which were from UHL staff. Several key themes had emerged from the analysis of the responses and had helped to shape the resulting recommendations accordingly. The Director of Strategy reiterated that the current level of UHL subsidy for carparking (£301,000 per annum plus investment of £250,000 per annum) was not sustainable. The charging proposals in paper C (including the introduction of a staff salary sacrifice scheme on an opt-out basis)

could potentially generate £516k of additional income - this anticipated income along with the associated revised costs and income for the UHL Hospital Hopper would remove the £551,000 subsidy. The actual impact of the increased charges would be kept under appropriate review (including takeup of the salary sacrifice scheme). A majority of the public respondents supported increasing parking charges, with strong support also for better publicisation of the various saver packages available – the Director of Strategy would pursue this with the Trust's Communications Team. **DS/ DCER**

In summarising the main points of the proposals, the Director of Strategy noted a key change in that the first 30 minutes at the Leicester General and Glenfield Hospital sites would no longer be free of charge for the public. This change would mitigate the original steeper rise in some of the other time period bands (which had therefore also now changed), and also reflected that dropping-off was easier on those two sites than at the LRI (where that 30 minute drop-off period free of charge would be retained). However, the current provision of drop-off points on all three of UHL's sites was also being reviewed. **DS**

The revised proposals for staff carparking charges were detailed in appendix C of paper C. A flat rate would not be introduced, and two additional charging bands were being introduced at the top of the salary scale. As mentioned above, an opt-out salary sacrifice scheme was also being recommended for UHL staff – it was considered that this would benefit both staff and the Trust itself, and the Director of Strategy noted the significantly different take-up rates between opt-in and opt-out schemes. The Director of Strategy advised that Staff Side did not support the opt-out element of the salary sacrifice scheme, and she noted the need for clear and appropriate communication with staff on this issue. At this point, the Trust Chairman invited comments from the Staff Side Chair, who clarified that he would be speaking only in respect of the salary sacrifice elements of the proposals. **DS/ DCER**

The Staff Side Chair made the following key points:-

(1) his view that Staff Side's input to – and views upon – the proposals were significantly under-represented in paper C;
(2) the lengthy discussions held on salary sacrifice issues for the preceding 18-24 months through the Joint Staff Consultation and Negotiation Committee (JSCNC), involving both Staff Side and Management Side. He reiterated Staff Side's consistent agreement to an opt-in salary sacrifice scheme and noted Staff Side's view that Management Side's support for an opt-out basis related to the Trust's current financial position rather than to its benefits for all staff;
(3) not all staff would benefit from salary sacrifice, most notably any nearing retirement, going on maternity leave, or being made redundant;
(4) there had been insufficient detail in the engagement exercise for staff to make an informed decision on the salary sacrifice scheme, which he had raised accordingly with the Communications Team. The Staff Side Chair noted that 23% of staff respondents had replied 'don't know' to the two salary sacrifice questions. Given that 65.7% of staff respondents had favoured an opt-in basis for such a scheme, Staff Side were disappointed that the resulting proposals put forward an opt-out basis, and he queried how this reflected UHL's values in terms of listening to its staff, and
(5) Staff Side's request, therefore, that the Trust Board take appropriate account of its staff views and consider an opt-in basis for the salary sacrifice scheme.

In discussion on the proposals to increase staff and public carparking charges, the Trust Board:-

(a) noted its support for the rise in public carparking charges from mid-November 2011, as detailed in appendix H of paper C. Ms J Wilson, Non-Executive Director and Workforce and Organisational Development Committee Chair, particularly welcomed the introduction of a 0-1 hour tariff; **ALL**

(b) queried how quickly (1) the current drop-off provision would be reviewed, and (2) the public user saver packages would be more widely publicised. The Travelwise Manager (in attendance) advised that signage would be altered before the revised charges were introduced, with related information in patient letters also under review with one of the Patient Advisers. The review of the drop-off provision would be started immediately. Work on the drop-off provision and the main clarification of information/signage etc would be concluded by the implementation of the new charges and would also then be continued on an ongoing basis as required. UHL would also be accepting the kind public offer from Messrs D Gorrod and Z Haq to assist the Trust on this issue; **DS/ DCER**

(c) queried when the proposed annual review of staff charging bands would begin – following discussion on whether to time this from the date of implementation or to fit with the Trust's internal business planning cycle, it was agreed that the first review of the staff charging proposals would be in April 2013 (April 2012 for the public charges); **DS**

(d) held lengthy discussions on the salary sacrifice scheme elements of paper C, noting in particular:-

(i) recognition by Executive Directors that the recommended opt-out basis was not favoured by the majority of staff respondents. The decision to proceed on such a basis had not been taken lightly, and reflected the Trust's view that an opt-out scheme would be of the greatest general benefit. It was also reiterated that take-up levels for opt-in schemes were significantly lower than for opt-out schemes, and that therefore staff who could benefit significantly might not do so if the scheme was run on an opt-in basis;

(ii) clarification that both standard and higher-rate taxpayers would benefit from the salary sacrifice scheme, in addition to the Trust itself. It was suggested that it would be useful to know the % of UHL staff who would benefit; **DS/ DHR**

(iii) the impact of the scheme on the calculation of pension, occupational maternity and redundancy payments. In response to a query from Mr D Tracy, Non-Executive Director and GRMC Chair, the Director of Human Resources advised that potentially 15-20% of the Trust's workforce could be affected by those payments, given UHL's workforce profile;

(iv) Non-Executive Directors' emphasis of the crucial need for appropriate and targeted staff communication on this issue. In response to a query as to how staff would be informed, the Director of Communications and External Relations advised that a letter would be sent to all staff, detailing the nature of the scheme and clarifying that anyone imminently affected by pension/maternity/redundancy payments should seek further advice. If an opt-out basis was supported, Mr D Tracy, Non-Executive Director and GRMC Chair requested that staff in those three groups also be sent an individual letter tailored to their circumstances, in addition to the more circular letter being issued to all staff. The Staff Side Chair also noted his support for all staff being contacted; **DCER** **DCER**

(v) the view of Ms K Jenkins, Non-Executive Director and Audit Committee Chair, that the engagement results indicated that staff did not have enough information to make an informed decision on this issue. She suggested that further work was needed before reaching a Trust Board decision on the opt-out/in basis of the salary sacrifice scheme. She clarified that she was not necessarily in opposition to the opt-out salary sacrifice plan, but that she did not consider that staff had enough information to make an informed decision at this stage. Following discussion on this issue (points (vi) – (viii) below refer), Ms Jenkins supported the proposals on the basis in (e) below;

(vi) the need for ongoing communication with staff also to be appropriate and sustainable, recognising that individual circumstances could change. In supporting **DCER**

this point raised by Ms J Wilson, Non-Executive Director and Workforce and Organisational Development Committee Chair, Mr I Reid, Non-Executive Director and Finance and Performance Committee Chair sought reassurance on how this would be done in reality, given workforce turnover;

(vii) the need for the communication with staff to be appropriately cognisant of the fact that the majority of respondents had not favoured an opt-out basis, eg clearly explaining the position taken by the Trust and reiterating that an opt-out scheme was seen as being of the greatest benefit to the most staff. The Chief Executive requested that the Director of Strategy and the Director of Communications and External Relations take this into appropriate account when developing the communications; **DS/ DCER**

(viii) that the fairly-lengthy implementation period for the salary sacrifice scheme and increased staff carparking charges (January 2012) would enable these issues to be appropriately addressed – the detailed communication exercise requested above could therefore be developed in the run-up to January 2012. It was noted that a communications plan would be presented to the November 2011 Trust Board meeting, followed by a further review in January 2012, and **DS/ DCER**

(e) noted its support for the increase in staff carparking charges and the opt-out salary sacrifice scheme, subject to receiving further reassurance on the communication planned with staff in point (d) above. **DS/ DCER**

The Trust Chairman confirmed that UHL would continue to engage with Staff Side during the period leading up to implementation of the increased staff carparking charges and the salary sacrifice scheme. In response, the Staff Side Chair advised that Staff Side would take a view on whether to engage in that wider communication exercise following appropriate discussion of the Trust Board's decision above.

<u>Resolved</u> – that (A) the recommendations to increase UHL public and staff carparking charges from mid-November 2011 and January 2012 respectively be supported, as detailed in paper C;

(B) in respect of public carparking charges (and with assistance from Messrs D Gorrod and Z Haq as appropriate on point (2) below), the Director of Strategy and the Director of Communications and External Relations be requested to conclude the following by 31 December 2011:- DS/ DCER
(1) a review of the current drop-off provision on UHL's sites;
(2) implementation of improved communication of the various saver packages available to public users;

(C) the Director of Strategy be requested to clarify to Trust Board members outside the meeting, the % of UHL staff likely to benefit from a salary sacrifice scheme (opt-out basis); DS

(D) in respect of staff carparking charges, and noting the Trust Board's wish for greater reassurance on communications issues, the Director of Strategy and the Director of Communications and External Relations be requested to develop an appropriate communication plan for staff, to be reported to the 3 November 2011 Trust Board and including information on:- DS/ DCER
(1) letters to all staff;
(2) targeted letters to those staff likely not to benefit from a salary sacrifice scheme;
(3) plans for ongoing and sustainable communication on these issues;
(40) clarification of the reasons for implementing an opt-out salary sacrifice scheme notwithstanding the results of the engagement exercise;

(E) the impact of the communication plan be reviewed further in January 2012, and **DS/ DCER**

(F) public and staff carparking charges be reviewed annually, starting in April 2012 and April 2013 respectively. **DS**

277/11 CHIEF EXECUTIVE'S MONTHLY REPORT – OCTOBER 2011

The Chief Executive advised that all key issues were as detailed in his monthly report at paper D. He also recorded his thanks to the LLR Joint Health Overview and Scrutiny Committee for its efforts in respect of the paediatric cardiac surgery Safe and Sustainable exercise, and noted concerns over the national process.

Resolved – the Chief Executive's October 2011 monthly report be noted.

278/11 QUALITY, FINANCE, AND PERFORMANCE

278/11/1 LLR Urgent and Emergency Care Improvements and Winter Planning

278/11/1.1 Delivery of Measures to Improve the LLR Urgent Care System by the end of October 2011

Ms C Griffiths, PCT Cluster Chief Executive attended for this item – to supplement her previously-circulated paper E2 she tabled a paper on the delivery of measures to improve the LLR urgent care system by 31 October 2011, noting that a number of supporting appendices were also available. The PCT Cluster Chief Executive had met with the UHL Chief Executive on 3 October 2011 to discuss the winter challenges facing LLR, and she recognised that system changes appeared to be taking some time to effect. She noted the need for appropriate interface between primary and secondary care and requested UHL to free up clinicians' time on either Tuesdays and Thursdays to meet with GPs.

The tabled paper identified the key measures (both strategic and interim, where required) planned in four crucial areas, noting the commitment to deliver improvements to the LLR urgent care system by 31 October 2011. As detailed by the PCT Cluster Chief Executive, the four areas listed were:-

(1) role of the Emergency Care Network (ECN) – it was proposed to increase the frequency of meetings to fortnightly, to prevent drift and enable faster tracking/responsiveness. More robust and explicit mechanisms for holding each partner to account would also be introduced, and a senior-level, cross-organisational 'troubleshooter' post was being considered for November 2011 onwards;

(2) inflow – although noting the long-term solution of improving the ED footprint, a number of key front-end solutions were proposed to be in place by 31 October 2011. An improved UCC-ED interface was crucial, involving a broader case-mix for the UCC and resolution of governance and mutual staff support issues. Late conveyancing of patients to ED required urgent resolution with EMAS, who were currently developing a costed solution for Commissioner consideration at the 12 October 2011 ECN Board meeting. The ED workforce also required to be appropriately strengthened at peak demand times;

(3) throughput and outflow from UHL Emergency Department (ED) – the strategic solution related to the completion of the ED revised capital scheme and a redesign of systems, processes and workflows. In the interim (eg by 31 October 2011), it was vital to drive delivery of the actions identified at the 21 September 2011 emergency flow workshop, and

(4) outflow from UHL – late discharge resulting in difficulties in transferring patients to community hospitals was a key issue for LLR, exacerbated by late evening peaks in ED and late conveyancing of category C and Bed Bureau patients. The tabled report identified 10 urgent actions (clarified as being for delivery by 31 October 2011) across all parties to improve discharge and community bed availability, including a step change in the % of patients discharged before 1pm (with aligned EMAS capacity); Commissioner action on reablement monies; clarification from LPT of the bed availability and escalation capability for winter 2011, and UHL-LPT agreement on an improved operational plan for flow of patients to community hospitals.

The PCT Cluster Chief Executive advised that the 12 October 2011 ECN Board would discuss and agree the above solutions (adding to them if required), identify accountable persons and provide a delivery report for the November 2011 ECN Board meeting.

PCT CLUSTER CE

The PCT Cluster Chief Executive recognised that there would be financial implications of the above actions – in addition to the costed proposal being developed by EMAS in point (2) above (which it was possible might be met from EMAS' share of the LLR transformation funding – the Cluster would also consider meeting any net additional cost given the wider financial risk of extra secondary care usage), work was also underway to scope the step-down beds facility approved at the September 2011 ECN Board. Other financial implications related to the redeployment of readmissions and reablement funds, and to the system manager post referred to in point (1) above.

In welcoming the systems-wide approach of the solutions outlined in the tabled paper and their specific 31 October 2011 timescale, the UHL Trust Board also:-

(a) discussed the nature and estimated lead-in time of the proposed step-down beds at the Leicester General Hospital, noting that this would be a community-staffed facility although using UHL estate. The PCT Cluster Chief Executive noted the agreement to the investment and reiterated the commitment for these beds to be operational by the end of October;

(b) noted a query from Ms K Jenkins, Non-Executive Director and Audit Committee Chair, as to the potential impact of the solutions on other key indicators. She also queried their actual financial impact for UHL. In response, the PCT Cluster Chief Executive noted the supporting information contained within the various appendices, and advised that work since 1 September 2011 to track the impact of ECN actions could be shared with Trust Board members;

PCT CLUSTER CE

(c) reiterated the need for leads and timescales to be identified for the workstreams outlined in the tabled paper;

(d) noted the need for appropriate EMAS awareness of any extended working hours, and the need for systems improvement rather than only additional appointments;

(e) requested further information on the Bed Bureau/out-of-hours workstream being led by the PCT Cluster Chief Executive, particularly how this integrated with other activities. The PCT Cluster Chief Executive recognised the need to progress this work in light of its links to SPA arrangements;

PCT CLUSTER CE

(f) requested that the issue of rebedding – which was not mentioned in the tabled paper – be discussed at the 12 October 2011 ECN Board meeting. The Trust Board acknowledged that earlier arrival at ED would help with this issue;

PCT CLUSTER CE

(g) commented on the particularly high level of ED attendances currently, above and beyond the approximate monthly 1000 UCC diversions. The Chief Executive commented that neighbouring Trusts were also seeing a similar rise in demand for ED services;

(h) noted assurance from the PCT Cluster Chief Executive that the 12 October 2011 ECN Board would drill down into social care aspects of winter activity, and

(i) noted assurances from the PCT Cluster Chief Executive that the Clinical Commissioning Groups (CCGs) were committed to improving LLR urgent and emergency care processes, through the solutions outlined in the tabled paper. She suggested that it might be helpful to invite the City CCG to attend a future Trust Board meeting accordingly. **UHL CHAIR**

The PCT Cluster Chief Executive then agreed to receive a number of queries/comments from Mr Z Haq, Leicester Mercury Patients' Panel, before she left the meeting. Certain elements were in fact for UHL to address, and Mr Haq queried:-

(i) how the PCT Cluster Chief Executive proposed to resolve LLR emergency care with the CCGs, noting the relatively late start to this work for 2011;
(ii) how the backlog associated with any priority operations cancellations would be addressed (if required in 2011 as in 2010). This was a Trust issue, and innovative actions had been developed to avoid medical outlying when possible – this was challenging, however, in times of high demand. The Chief Operating Officer/Chief Nurse also noted the impact or the pandemic on 2010-11 operation cancellations and confirmed that all priority patients cancelled had been rescheduled within 10 days;
(iii) how to resolve the fact that the primary care 8-to-8 centres were anecdotally turning patients away after 7pm and redirecting them to ED. Mr Haq emphasised the need for such centres to accept patients up to their 8pm close and treat them until 9pm;
(iv) what assurances the PCT Cluster Chief Executive had obtained in terms of the likelihood of delivering the improvements to the LLR urgent and emergency care system. Mr Haq further queried whether CCGs were committed and willing to take appropriate accountability for the required actions in a similar way to the UHL Trust Board. In response, the PCT Cluster Chief Executive reiterated the commitment of the CCGs and confirmed their awareness of this as a key healthcare community issue, and
(v) whether the PCT Cluster Chief Executive could guarantee that ED would not be closed during the winter months. This was a Trust issue, and the Chief Executive advised that ED had only previously been closed during the Ward 8 LRI fire (other than to resuscitation patients). He advised that UHL was committed to avoiding ED closure unless it was clinically unsafe to remain open.

<u>Resolved</u> – that (A) the tabled solutions for delivering improvements to the LLR urgent and emergency care system by 31 October 2011 be noted and supported, noting the need to finalise timescales and lead accountabilities at the 12 October 2011 ECN Board;

(B) the PCT Cluster Chief Executive be requested to:-
(1) share the work since 1 September 2011 on tracking the impact of ECN actions, with Trust Board members; **PCT CLUSTER CE**
(2) provide further detail on the Bed Bureau/out-of-hours workstream led by her;
(3) raise the need to address rebedding issues at the 12 October 2011 ECN Board meeting, and

(C) consideration be given to inviting the City CCG to attend a Trust Board meeting. **UHL CHAIR**

278/11/1.2 Emergency Care Transformation and ED Performance Update

Paper E from the Chief Operating Officer/Chief Nurse summarised August 2011 performance within UHL's Emergency Department (ED), covering arrival times, time in ED, breach time analysis, admissions, new ED clinical indicators, patient experience survey results, workforce/footprint issues, and the LLR flash report. The Chief Operating Officer/Chief Nurse highlighted the high level of ED attendances in August 2011 even taking account of UCC deflections, with type 1 attendances up by 4% and attendances between 4pm-10pm up by 6% which impacted on breaches. September attendance levels had been similarly high, and in that month a further 50 bed days per week had been lost due to closure of community provision. The Chief Operating Officer/Chief Nurse noted that a proposed community step-down facility at the LGH would be of significant benefit. She also drew attention to a new AMU triage system as of 3 October 2011 and imminent new workflow/team working initiatives in ED commencing 10th October 2011.

In brief discussion on paper E, the Trust Board:-

(a) noted queries from Mr D Tracy, Non-Executive Director and GRMC Chair, on:-

- the current fluctuations in inpatient beds, compared to the fairly static levels between December 2007-December 2008. Although the exact detail was not known, the Chief Operating Officer/Chief Nurse commented on the incremental increase in use of ED services over that time. The Chief Executive also recalled the particularly mild nature of the 2007-08 winter;
- the reason for the stated community provision closures and the need for the wider LLR process approach to be used in managing such issues in an appropriately integrated manner;

(b) agreed to seek clarity at the 12 October 2011 ECN Board meeting as to the number of community beds available for UHL patient discharges, compared to 2010-11. However, the Chief Executive emphasised that throughput was the key issue rather than absolute numbers, and **COO/ CN**

(c) noted comments from Ms K Jenkins, Non-Executive Director and Audit Committee Chair, as to the lack of targets and specific quantitative data in paper E2 (Minute 278/11/1.1 above refers). She also commented on the relatively late start in addressing this key issue and queried whether the actions in Minute 278/11/1.1 above went far enough in addressing the challenge of increased ED demand.

Leading on from the latter point of (c) above and noting a degree of cross-over with the tabled report above, the Chief Operating Officer/Chief Nurse then outlined a number of winter planning/escalation issues currently being considered within UHL, aimed at avoiding the need for unpalatable options such as priority cancellations. These included exploration of:- scope for increased UCC deflections; improved ED-UCC shared governance; ensuring patients saw their GP before attending ED; development of an appropriate contingency plan in respect of community bed provision; provision of an appropriate step-down facility for non-acute patients (noting that although happy to support such a facility, this would not be care provided by UHL); possible fining mechanisms in respect of Local Authority delayed transfers of care, and the need to hold other LLR partners to appropriate account.

The Trust Chairman emphasised the need for early discussion of these interventions with community partners, in order to mitigate the risk of having either to cancel priority operations or – as a last resort – contemplate temporary closure of the ED itself. These discussions should ideally take place through the 12 October 2011 ECN Board meeting and should also **COO/**

reflect the intended actions detailed by the PCT Cluster Chief Executive in Minute 278/11/1.1 above. In further discussion on winter planning issues, the Trust Board:- **CN**

(1) noted a query from the Medical Director as to how quickly the already-clinically-agreed single point of access (SPA) front door model could be implemented, given the crucial need to reduce attendances. The Chief Operating Officer/Chief Nurse agreed to pursue this with the ECN Board on 12 October 2011; **COO/ CN**

(2) reiterated earlier queries on the comparable number of community beds available in 2011-12, and noted a need for greater clarity on the detail of a step-down facility at the LGH to ensure that these would be additional beds;

(3) noted a query from the Director of Communications and External Relations as to how the Trust Board would assure itself of appropriate progress on the actions in Minute 278/11/1.1 above. In response, the Trust Chair considered that assurance would be obtained through Chief Operating Officer/Chief Nurse/Medical Director feedback from the ECN Board (to both the October 2011 Finance and Performance Committee and to other Trust Board members), and also suggested that GP Commissioners be formally invited to attend a future UHL Trust Board meeting to discuss the primary-secondary interface on this issue; **UHL CHAIR**

(4) noted comments from Mr P Panchal, Non-Executive Director, on the need to keep patients and the public appropriately informed. Mr Panchal also queried how patients were communicated with if their operations were cancelled – the Chief Operating Officer/Chief Nurse advised that processes were in place, although acknowledging the related need to improve communication with GPs in respect of those patients;

(5) noted a query from Mr R Kilner, Non-Executive Director, on the deterioration in the number of Saturday type 1 breaches per hour for August 2011 compared to July 2011, and what changes might have accounted for that. In response, the Chief Operating Officer/Chief Nurse noted the August 2011 impact of the junior doctor changeover and also specific instances of medical sickness that month, and

(6) suggested that the data on discharge delays (section 6.1) indicated a need to at minimum maintain the 2010 community bed capacity together with a step-down facility at the LGH to mitigate the significant number of patients waiting for discharge from UHL due to lack of capacity

The PCT Cluster Chair advised that the 13 October 2011 Cluster Board would also be discussing the issues raised in Minutes 278/11/1.1 and 278/11/1.2 – at that meeting she would also be seeking assurances similar to those sought by UHL. The PCT Cluster Chair considered that an integrated approach was being used and noted the aim of reflecting the overall 'left shift' patient care model. She agreed to advise the Trust Board of feedback from the 13 October 2011 PCT Cluster Board accordingly. **PCT CLUSTER CHAIR**

<u>Resolved</u> – that (A) the update report on the emergency care transformation programme (paper E) and the verbal information on winter planning be noted;

(B) at the ECN Board meeting on 12 October 2011, the Chief Operating Officer/Chief Nurse be requested to :- **COO/ CN**
(1) seek clarity on the current number of community beds available for discharge compared to 2010-11;
(2) discuss UHL's thinking on winter planning with wider LLR community partners
(3) pursue a timescale for implementing the SPA model in ED;
(4) (with the Medical Director) update the October 2011 Finance and Performance

Committee (and other Trust Board members) on the outcome of the ECN Board meeting;

(C) GP Commissioners be formally invited to attend a future UHL Trust Board meeting (as per Minute 278/11/1.1 above), and **UHL CHAIR**

(D) it be noted that the PCT Cluster Chair would provide feedback to UHL on the 13 October 2011 PCT Cluster Board's discussions on these issues. **PCT CLUSTER CHAIR**

278/11/1.3 Emergency Department (ED) Capital Reconfiguration Briefing

Paper E1 detailed the current position in respect of the ED capital reconfiguration and sought approval to proceed to the next stage of the project (detailed design and further development of the outline business case [OBC]). £10m of transformational funding had been awarded to ED to redesign and refurbish the department and the Project Manager noted that some actions had already been undertaken therefore. In light of the opportunity to bid for that transformational funding a draft outline business case had been developed, in a change to the usual business case route. The more detailed phase would now be informed by the key issue of patient flows, and an OBC with costings would therefore be presented to the Trust Board in January 2012. The Project Manager also outlined the timescale for the P21 procurement process after December 2011 and leading up to the development of the Final Business Case (FBC). Onsite work was scheduled to begin at the end of 2012 with phased completion in 2013-14. In discussion on the briefing, the Trust Board noted:- **COO/ CN**

(a) a query from Mr P Panchal, Non-Executive Director, on the extent to which patients and relatives had been/would be involved in the design stage. Although clinically-led to date, patient involvement was recognised as crucial to the further development – this would be progressed through the Leicester LINKS and the Acute Care Division Patient Adviser. Mr Panchal suggested that it would also be useful to involve the faith communities;
(b) a query from Mr D Tracy, Non-Executive Director and GRMC Chair, as to the potential scope for shortening the timescale further. Although acknowledging these concerns, the Project Manager noted that the P21 process was the quick route and advised that the actual timescale would not be certain until that P21 partner was procured. The Director of Strategy suggested that the elements in section 4.4 of paper E1 could potentially be compressed into a shorter timescale. The Chief Executive emphasised, however, the crucial need to ensure that the emergency care system was correct and reflect this accordingly in the capital reconfiguration;
(c) a request from the Trust Chairman that the critical path be reviewed at the January 2012 Trust Board, and **COO/ CN**
(d) a query from Ms K Jenkins, Non-Executive Director and Audit Committee Chair, as to alternative funding sources if the scheme exceeded the £10m budget (some of which would need to be allocated for fees, etc). In response, the Project Manager commented on the need for the scheme to fit the available cost envelope (with further corporate Committee discussion required if costs looked likely to exceed the amount available). She also noted that greater cost certainty would be available by the P21 stage, as costs prior to that were based on estimates.

Resolved – that (A) the proposal to progress the ED capital reconfiguration scheme to the next phase be endorsed, and **COO/ CN**

B) the Chief Operating Officer/Chief Nurse be requested to submit a review of the critical path, and the ED capital reconfiguration Outline Business Case (including costings), to the 5 January 2012 Trust Board. **COO/ CN**

278/11/2 Month 5 Quality and Performance Report

Paper F comprised the quality, finance and performance report for month 5 (month ending 31 August 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 5 report identified key issues from each Lead Executive Director, and it was noted that the report had been discussed in detail by both the Finance and Performance Committee and the GRMC at their September 2011 meetings. The financial elements of the month 5 report covered in Minute 278/11/3 below and the following points were therefore noted by exception:-

(a) that "The Quarter" publication on 5 October 2011 describing the rates/performance of NHS organisations indicated that UHL was 'performing' in all areas for quarter 1. The Chief Operating Officer/Chief Nurse outlined the headlines of the data nationally and agreed to circulate a weblink for the report (which was in the public domain); **COO/ CN**

(b) a disappointing repeat coding error which had impacted adversely on UHL's RAMI – the Medical Director advised that following investigation, 9 of the apparent elective deaths should have been correctly coded as emergencies – this coding issue was now being pursued with the relevant specialties and appeared to be due to human error, and

(c) the detailed discussions held at the 19 September 2011 Workforce and Organisational Development Committee in respect of sickness absence and appraisal performance.

In discussion on the month 5 report the Trust Board noted:-

(1) a request from Mr D Tracy, Non-Executive Director and GRMC Chair for further assurance on the issue of underperforming medical wards (nursing metrics), which had also been discussed in detail at the 29 September 2011 GRMC meeting. In response, the Chief Operating Officer/Chief Nurse advised of a current focus on medical wards in light of the August 2011 deterioration in patient polling results. She outlined the various actions to be taken in respect of those underperforming wards (as detailed to the September 2011 GRMC) and agreed to circulate the scores for those wards to Trust Board members. The Trust Chairman suggested that issue could also be taken into account during the Executive/Non-Executive Director safety walkabouts, and **COO/ CN**

(2) the following queries from Ms K Jenkins, Non-Executive Director and Audit Committee Chair (who was not a member of either the GRMC or the Finance and Performance Committee):-

- why patient polling data was not available more recently than for July 2011. In response, the Chief Operating Officer/Chief Nurse clarified that the time delay was due to a systems change; the updated polling results would be included in the month 6 report at the November 2011 Trust Board;
- other in-year elements to reduce the readmissions penalty (above the £0.5m savings already identified through coding). In response, the Medical Director outlined a number of other potential influencing elements including the split of emergency/elective readmissions and use of reablement monies, and
- the timescale for implementing actions to reduce further the sickness absence rate. The Director of Human Resources confirmed that the further actions had been implemented immediately, and she acknowledged that (at the September 2011 Workforce and Organisational Development Committee meeting) Mr D Tracy, Non-Executive Director and GRMC Chair had particularly sought assurance on when the target reductions in sickness absence would be delivered (target of 3% to be achieved over the next 3-6 months).

Resolved – that (A) the quality, finance and performance report for month 5 (month ending 31 August 2011) be noted, and

(B) the Chief Operating Officer/Chief Nurse be requested to:- **COO/**
(1) circulate the web address for "The Quarter" publication of 5 October 2011 to Trust Board members for information, and **CN**
(2) circulate the nursing metrics scores of the underperforming medical wards to Trust Board members for information.

278/11/3 Progress Against the 2011-12 Stabilisation to Transformation Plan

Paper G advised the Trust Board of progress against UHL's 2011-12 stabilisation to transformation financial recovery plan, noting that detailed discussion on this issue had also taken place at the 28 and 30 September 2011 Finance and Performance Committee and Audit Committee meetings (respectively). Paper G noted the effective in-month use of the Trust's centralised expenditure controls (as per the financial recovery plan), and advised that external support was now engaged on four main workstreams (financial baseline; CIP delivery; detailed CIP reviews, and programme management). As noted in paper G, the Director of Finance and Procurement advised the Trust Board that further work continued to address fully the projected year-end deficit. As borne out by the headlines of the Deloitte work to date, the Director of Finance and Procurement noted the key need to focus on bigger CIP schemes, commenting that only a small number of the 670+ individual schemes amounted to more than £65,000 in value. Based on a preliminary assessment, UHL's September 2011 financial position appeared generally positive in terms of the need to achieve break-even. It was also noted that pay costs had continued to reduce in August and September 2011. In discussion on progress against the financial recovery plan, the Trust Board noted:-

(a) comments from Mr I Reid, Non-Executive Director and Finance and Performance Committee Chair, regarding that Committee's lengthy September 2011 discussions on the preliminary headlines from Deloitte. The Finance and Performance Committee considered that broad initial assurance was available on the CIP work;

(b) comments from Ms K Jenkins, Non-Executive Director and Audit Committee Chair, regarding that Committee's 30 September 2011 discussions – the Audit Committee was concerned by the deterioration in 2011-12 CIP delivery and had emphasised the need to deliver as much as possible in-year. The report from Deloitte (first phase due 14 October 2011) was seen as crucial, and

(c) a query from Mr P Panchal, Non-Executive Director regarding the Director of Finance and Procurement's confidence in the year-end position. In response, and noting that these issues would be discussed further in the confidential session, the Director of Finance and Procurement commented on certain risks to delivery and noted his concern at the deterioration in the overall year-end projected deficit.

Resolved – that the update on progress against UHL's stabilisation to transformation financial recovery plan be noted.

278/11/4 Finance and Performance Committee

Mr I Reid, Non-Executive Director and Finance and Performance Committee Chair advised that all issues itemised on papers H and H1 had already been covered in discussion above. The Director of Human Resources clarified that the 28 September 2011 Finance and Performance Committee had discussed **proposed** changes to the Trust's management of sickness absence policy, on which negotiations continued.

<u>Resolved</u> – that (A) the Minutes of the Finance and Performance Committee meeting held on 24 August 2011 (paper H) be received and the recommendations and decisions therein endorsed and noted respectively, and

(B) the Minutes of the Finance and Performance Committee meeting held on 28 September 2011 be submitted to the Trust Board on 3 November 2011 (meeting contents as listed in paper H1). **STA**

278/11/5 <u>Maternity and Gynaecology Service Development</u>

Paper I sought Trust Board approval for £3.7m capital expenditure phased over 3 years to enable the Women's Clinical Business Unit to redesign maternity and gynaecology services. The project as outlined in the business case was an interim solution to addressing the two key challenges for this service provision (constrained capacity due to rising birth rates and the need for efficiency/effectiveness improvements). The Director of Finance and Procurement confirmed that the business case at paper I was supported by UHL's Executive Team and the Commercial Executive. A report to the January 2011 Trust Board had secured approval for the revenue elements of this interim solution. SHA approval would also be required for the business case due to its value. In discussion on the business case, the Trust Board noted:-

(a) a query from Mr I Reid, Non-Executive Director and Finance and Performance Committee Chair as to whether the project outline template indicated that the facility would be sustainable through to 2016-17. The Divisional Manager Women's and Children's advised that based on forward projections of birthrate assumptions, the estate capacity provided through the scheme would be sufficient through to 2016-17, but that if birthrates continued to rise then the revenue consequences of the scheme would need to be revisited (eg staffing needs);

(b) a query from Mr I Reid, Non-Executive Director and Finance and Performance Committee Chair as to whether the apparent net year 2 deficit indicated on the business case proforma related to the phased nature of the scheme, and whether that deficit could be avoided. The Divisional Manager Women's and Children's advised that this reflected the uncertainty of tariff rates year-on-year, and he confirmed that it would be appropriately incorporated into the Division's 2012-13 business plan. The Director of Finance and Procurement also noted the impact of CNST costs, which he considered were included in paper I but were separate from this scheme. For clarity, the Divisional Manager Women's and Children's agreed to recirculate the financial elements of the business case to Trust Board members, with those CNST elements removed; **DFP/ DMWC**

(c) a query from Mr P Panchal, Non-Executive Director on the length of time taken to bring the capital elements of this scheme to the Trust Board. In response, the Divisional Manager Women's and Children's outlined the clinically-led and inclusive process used to develop the most appropriate service model and ensure buy-in from other Divisions. Discussions had also taken place through the Trust's internal service reconfiguration group (chaired by the Divisional Director, Planned Care);

(d) a number of queries from Ms K Jenkins, Non-Executive Director and Audit Committee Chair, relating to whether the 2011-12 in-year spend had been included, and to the implications of the financial figures shown for 2014. The Director of Finance and Procurement reiterated his view that the current inclusion of CNST issues served to distort the movements, and he reconfirmed that the scheme was viable and profitable. The Trust Chairman commented that it would be helpful for Trust Board members to see the NPV for this scheme; **DFP/ DMWC**

(e) comments from the Director of Human Resources regarding the Trust's ongoing recruitment of midwives, and the positive feedback received from candidates, and

(f) concerns from the Director of Finance and Procurement about potential slippage on the £0.5m spend scheduled for 2011-12, given the November 2011 timescale for the SHA Capital Committee to meet. The Trust Board agreed therefore to delegate authority to the Director of Finance and Procurement (working with the Divisional Manager Women's and Children's) to assess which elements of the scheme could be progressed separately. **DFP**

<u>Resolved</u> – that (A) the project to redesign and reconfigure maternity and gynaecology services (£3.7m capital phased over 3 years) be approved, and progressed to the Midlands and East England SHA for approval;

(B) the Director of Finance and Procurement and the Divisional Manager, Women's and Children's be requested to:- **DFP/ DMWC**

(1) circulate the NPV for this scheme to Trust Board members for information;
(2) recirculate the financial details of the scheme to Trust Board members, with CNST costs removed, and

(C) authority be delegated by the Trust Board to the Director of Finance and Procurement to assess whether any aspects of the scheme could be progressed separately to avoid potential slippage. **DFP**

278/11/6 <u>NHS Litigation Authority Acute Risk Management Standards (NHSLA ARMS) Accreditation</u>

Paper J detailed UHL's position in respect of the forthcoming December 2011 NHSLA ARMS assessment, advising of the Trust's strategic decision to seek level 1 accreditation as a result of information in May 2011 on changes to the assessment criteria. This proposal had been endorsed by the Executive Team and was cognisant of the reduced discount therefore available to UHL (from 20% to 10%). It might be possible to seek reassessment at level 2 as early as December 2012, and the Medical Director noted that a number of lessons had been learned during the current reaccreditation process. The Medical Director also noted that the report at paper J applied to the general NHSLA ARMS assessment, not that which was undertaken separately within maternity services (due in October 2011). In discussion on paper J the Trust Board noted:-

(a) a query from Mr I Reid, Non-Executive Director and Finance and Performance Committee Chair, regarding the Trust's confidence of achieving NHSLA ARMS level 2 in December 2012 and how to ensure that a full 12 months of evidence was available as required. The Medical Director confirmed that a detailed work programme was in place but he recognised that it would be challenging nonetheless. The Trust Chairman requested that a report on progress towards level 2 accreditation be provided to the December 2011 Trust Board; **MD**

(b) the disappointment voiced by a number of Non-Executive Directors at this development. Ms J Wilson, Non-Executive Director and Workforce and Organisational Development Committee Chair sought assurance on whether the Trust was now carrying greater risk than before, and whether a deeper review was therefore required. The Medical Director noted his view that UHL was not carrying more risk but that it needed to be more robust in demonstrating its risk management systems and procedures. He was also confident that nothing had been omitted from the Trust's strategic risk register. In discussion, the Chief Executive commented on Monitor's likely interpretation of seeking level 1 rather than level 2 accreditation;

(c) confirmation (in response to a query from Mr P Panchal, Non-Executive Director) that this CNST reduction was factored into UHL's financial forecasting;

(d) a query from Ms K Jenkins, Non-Executive Director and Audit Committee Chair as to the learning gained from this exercise and the assurances available to the Trust Board that appropriate action plans were now in place. The Medical Director considered that the level of Executive oversight of the process had perhaps not been as robust as it should have, and he emphasised the need to ensure that systems were aligned to appropriate recording mechanisms. He also noted the need to receive assurance rather than reassurance. In discussion, the Director of Strategy clarified that UHL was above level 1 on certain NHSLA ARMS elements, but that it was a matter of being able to demonstrate sufficient compliance in total. The Trust Chairman requested that the lessons learned from the 2011 accreditation process be shared with Trust Board members; **MD**

(e) the Trust Chairman's request that the GRMC and the Audit Committee review the current position in respect of UHL's NHSLA ARMS accreditation. The Chief Executive added that it would be helpful for the GRMC to have sight of other comparable Trusts' CNST levels – in response the Medical Director advised that relatively few Trusts were in possession of level 3 and noted that UHL was not alone in going from level 2 to level 1, and **MD**

(f) a suggestion from the Chief Executive to review the current split between middle management delivery and clinical leadership of this project, when looking at the lessons learned. **MD**

<u>Resolved</u> – that (A) the decision to undertake level 1 NHSLA ARMS accreditation in December 2011 be noted;

(B) the Medical Director be requested to:- **MD**

1. **report to the 1 December 2011 Trust Board, advising of progress on the work programme for achieving level 2 accreditation in December 2012;**
2. **share the lessons learned from this year's necessity to pursue NHSLA level 1, with Trust Board members;**
3. **(as part of (2) above) review the current split between middle management delivery and clinical leadership in respect of the NHSLA ARMS work programme, and**

(C) the 27 October 2011 GRMC and the 15 November 2011 Audit Committee be requested to review UHL's position on this issue, with the GRMC also receiving information from the Medical Director on the CNST accreditation levels of other comparable Trusts. **GRMC/ AC**

279/11 RISK – STRATEGIC RISK REGISTER/BOARD ASSURANCE FRAMEWORK (SRR/BAF)

Paper K comprised the latest iteration of the new format Strategic Risk Register/Board Assurance Framework, noting that section 4 of the covering report reflected the Audit Committee's detailed discussions of 30 September 2011. The following three specific risks were then discussed by the Trust Board (risks 2, 3 and 5).

In specific discussion on **risk 2** (new entrants to the market), the Trust Board noted that the risk related primarily to the changing nature of markets. It was planned to present a quarterly market share report to the Finance and Performance Committee (as most recently discussed by that Committee on 28 September 2011 – this report would also be circulated to all Trust Board members for information), and the Director of Communications and External Relations noted the need to align such reports to PLICS data. The Trust Board also noted:- **DCER**

- a need to strengthen the actions mitigating the lack of tendering expertise at CBU/ corporate level, with further detail to be provided accordingly to the 3 November 2011 Trust Board; **DS**
- the perceived key risk area focusing on the Planned Care Division;
- concerns voiced by Ms K Jenkins, Non-Executive Director and Audit Committee Chair, at the length of timescales for completed actions. To provide greater assurance on progress, Ms Jenkins requested that 'significant milestone' dates be included in future iterations of the SRR for all risks; **MD**

In specific discussion on **risk 3** (emerging clinical commissioning groups), the Trust Board noted that an engagement strategy and dedicated lead had now been identified. The GP 'temperature check' exercise was due to be repeated in October 2011 and the Director of Communications and External Relations considered that relationships with primary care were improving. Pathway redesign remained an issue, however – this was a healthcare community wide issue with five key areas on which to focus having been identified by the 'senate'. Mr R Kilner, Non-Executive Director queried the usefulness of repeating the GP survey in light of the previous low response rate, and he also sought assurance that the senate would ensure consistency of pathways between different acute providers. In response, the Director of Communications and External Relations considered that there was merit in repeating the survey, and the Medical Director recognised the need for pathway consistency where clinically justified (he also advised that the senate had no executive powers). It was further noted that Deloitte and Finnamore planned to meet with all the Clinical Commissioning Groups.

In specific discussion on **risk 5** (loss making services), the Director of Finance and Procurement advised of his intention to include additional positive assurances in respect of counting and coding changes and PLICS usage, and additional controls in respect of (i) transactional changes to incentivise collaborative behaviour and consideration of wider-level benefits (views has been sought from other Trusts), and (ii) setting 2012-13 CIP targets based on PLICS positions. In response to a query from Professor D Wynford-Thomas, Non-Executive Director, the Director of Finance and Procurement noted his view that all services should cover their costs – the exception to this was recognised as ED in light of the particular tariff circumstances. However, greater clarity was needed on the detail of actual service costs to enable fully-informed decisions to be taken. **DFP**

<u>Resolved</u> – that (A) the SRR/BAF be noted;

(B) the Medical Director be requested to amend the SRR to include 'significant milestone' dates rather than solely a completion date for actions; **MD**

(C) in respect of risk 2 the Director of Strategy be requested to strengthen the actions mitigating the lack of tendering expertise at CBU/corporate level, with further detail to be provided accordingly to the 3 November 2011 Trust Board; **DS**

(D) in respect of risk 5 the Director of Finance and Procurement be requested to:- **DFP**

(1) include additional 'positive assurances' on counting and coding changes and the use of PLICS;

(2) include additional 'controls' on transactional changes to incentivise collaborative behaviour amongst Divisions and ensure wider-level benefits, and the setting of 2012-13 CIP targets on the basis of PLICS positions, and

(E) the Director of Communications and External Relations be requested to circulate the September 2011 Finance and Performance Committee report on market share to all Trust Board members for information. **DCER**

280/11 IM&T – UHL IT STRATEGY 2011-16

Resolved – that consideration of this item be deferred to the 3 November 2011 Trust Board meeting, with any comments on the UHL IT Strategy 2011-16 (paper L) be sent to the Director of Strategy outside the meeting. **DS**

281/11 REPORTS FROM BOARD COMMITTEES

281/11/1 Audit Committee

Resolved – that the Minutes of the Audit Committee meeting held on 30 September 2011 be submitted to the 3 November 2011 Trust Board. **STA**

281/11/2 Governance and Risk Management Committee (GRMC)

In his capacity as GRMC Chair, Mr D Tracy, Non-Executive Director noted that Committee's particular discussions on the following at its September 2011 meeting:-

(a) work to benchmark and reduce UHL's level of hospital acquired pressure ulcers. UHL was now leading on a research project and was also involved in collaborative work with other Trusts on this issue, with a further update scheduled for the January 2012 GRMC meeting. The Chief Executive commented that pressure sores were one of the four priority areas identified by the new SHA, and
(b) concerns over a rise in misdiagnosis within serious untoward incidents – this was being explored further by the Director of Safety and Risk.

Resolved – that (A) the Minutes of the Governance and Risk Management Committee meeting held on 25 August 2011 be received, and the recommendations and decisions therein be endorsed and noted respectively, and

(B) the Minutes of the Governance and Risk Management Committee meeting held on 29 September 2011 (discussion subjects as listed on the covering sheet at paper M1) be submitted to the Trust Board on 3 November 2011. **STA**

281/11/3 UHL Research and Development Committee

Resolved – that the Minutes of the Research and Development Committee meeting held on 12 September 2011 be received, and the recommendations and decisions therein be endorsed and noted respectively, including the additional membership of Mr P Panchal, Non-Executive Director and Mrs S Khalid, Chief Pharmacist.

281/11/4 Workforce and Organisational Development Committee (WODC)

In her capacity as Workforce and Organisational Development Committee Chair, Ms J Wilson Non-Executive Director particularly noted the lengthy September 2011 discussions on managing sickness absence.

Resolved – that the Minutes of the Workforce and Organisational Development Committee meeting held on 19 September 2011 be received, and the recommendations and decisions therein be endorsed and noted respectively,

282/11 CORPORATE TRUSTEE BUSINESS

282/11/1 Charitable Funds Committee

Resolved – that the Minutes of the Charitable Funds Committee meeting held on 2 September 2011 be received, and the recommendations and decisions therein be endorsed and noted respectively.

283/11 TRUST BOARD BULLETIN

Resolved – that the following items be noted as circulated with the October 2011 Trust Board Bulletin:-
(1) quarterly report on Trust Sealings (April – June 2011);
(2) response to further public questions raised after the September 2011 UHL Trust Board meeting;
(3) progress regarding the fire damage to ward 8 at the Leicester Royal Infirmary, and
(4) update on the 10 point plan.

284/11 QUESTIONS FROM THE PUBLIC RELATING TO BUSINESS TRANSACTED AT THIS MEETING

In the interests of time and noting the 20 minutes allocated, the Chairman advised that any attendee wishing to do so would be able to ask one question relating to the business transacted at today's public Trust Board meeting, with a further question each if time permitted. Any remaining questions should then be advised to the Director of Corporate and Legal Affairs, who would coordinate a response outside the meeting and ensure it was appropriately reflected through a Trust Board Bulletin item for the following meeting. The following comments and queries were received regarding the business transacted at the meeting:- **DCLA**

(1) support for sending all staff members a letter regarding the new carparking charges, with a separate letter also to be sent to those not likely to benefit from the salary sacrifice scheme. The speaker also supported an annual review of the charges but suggested that this run from January rather than April;
(2) a query as to whether the severity of the particular condition was taken into account when cancelling operations. The speaker also commented on the stress caused to patients and their relatives by such cancellations. The Chief Operating Officer/Chief Nurse agreed to explore the concerns raised by the speaker and respond accordingly outside the meeting; **COO/ CN**
(3) the need for UHL managers to be appropriately performance managed, with any underperformance addressed accordingly. The Chief Executive noted the increasingly stringent demands on NHS managers and commented on the lack of band width in certain areas. Financial management was an issue, as in many NHS Trusts;
(4) the wish of a particular public speaker to provide comments on UHL's IT Strategy 2011-16, noting the crucial and complex nature of this document, and
(5) a number of comments from Mr Z Haq, relating to:-
    - whether UHL could seek to confirm the number of GP home visits, noting that he had been unable to obtain this information from Commissioners and given his view that greater use of home visits would reduce ED attendances. The Chief Operating Officer/Chief Nurse advised that she would raise this with the PCT Cluster Chief Executive through the Emergency Care Network Board; **COO/ CN**
    - concerns over reductions in community beds, and whether a mechanism could be explored for GPs to visit patients on a daily basis following discharge from an acute setting – in response, the Chief Operating Officer/Chief Nurse advised that community bed reductions took place for a variety of reasons; it was key, however, that patients were treated/cared for in the setting most appropriate to their needs;
    - his view that UHL's reputation was being adversely impacted by primary care referral practices. The Trust Chairman reiterated UHL's wish to work with its

partners to achieve the best patient care. Mr Haq noted his view that the GP appointments system was not working, resulting in greater treatment demands on UHL. He also commented on the need to hold GPs to account. The Trust Chairman noted that GP Commissioners were being invited to attend UHL's November 2011 Trust Board meeting (Minute 278/11/1.1 and 1.2 above refer);

- whether UHL was planning to levy fines on other parties such as EMAS and Local Authorities in respect of delayed transfers of care, as he considered that UHL was unnecessarily taking the responsibility for these delays – the Chief Operating Officer/Chief Nurse confirmed that she would pursue this issue internally. The Chief Executive clarified that UHL would have no authority to fine partners other than Local Authorities on this issue, and **COO/ CN**
- his welcome for the developments in respect of maternity and gynaecology services (Minute 278/11/5 above refers).

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

285/11 DATE OF NEXT MEETING

Resolved – that the next Trust Board meeting be held on Thursday 3 November 2011 at 10am in rooms A & B, Education Centre, Leicester General Hospital.****
***** post-meeting note – the November 2011 venue was subsequently changed to rooms 1A & 1B, Gwendolen House, LGH site.***

286/11 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 287/11 – 298/11), having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.

287/11 DECLARATION OF INTERESTS

Resolved – that the declaration of interest by the Medical Director in respect of Minute 292/11 below, and the resulting agreement that it was not necessary for him to absent himself from the discussion on that item (to which he did not contribute), be noted.

288/11 CONFIDENTIAL MINUTES

Resolved – that the confidential Minutes of the meeting held on 1 September 2011 be confirmed as a correct record.

289/11 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.

290/11 REPORT FROM 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.

291/11 REPORT FROM 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.

292/11 REPORTS FROM THE DIRECTOR OF HUMAN RESOURCES

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

293/11 REPORT FROM THE CHIEF EXECUTIVE

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

294/11 CONFIDENTIAL TRUST BOARD BULLETIN

Resolved – that the items circulated with the confidential Trust Board Bulletin for October 2011 be noted.

295/11 REPORTS FROM REPORTING COMMITTEES

295/11/1 Finance and Performance Committee

Resolved – that the confidential item from the Finance and Performance Committee meeting held on 28 September 2011 identified to be highlighted to the Trust Board, be noted as having been covered in Minute 290/11 above.

295/11/2 Governance and Risk Management Committee

Resolved – that (A) the confidential Minutes of the Governance and Risk Management Committee meeting held on 28 July 2011 be received, and the recommendations and decisions therein be endorsed and noted respectively, and

(B) the confidential Minutes of the GRMC meeting held on 29 September 2011 be submitted to the 3 November 2011 Trust Board. **STA**

296/11 CORPORATE TRUSTEE BUSINESS

296/11/1 Charitable Funds Committee

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.

297/11 ANY OTHER BUSINESS

297/11/1 Trust Board Engagement in Quality – Survey

The Chief Operating Officer/Chief Nurse noted UHL's involvement in research to assess Trust Boards' engagement in quality – she would circulate the survey accordingly for members to complete. **COO/ CN**

Resolved – that the Chief Operating Officer/Chief Nurse be requested to circulate the above survey to Trust Board members for completion and return. **COO/ CN**

297/11/2 Report by the Director of Strategy

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

297/11/3 Query from the Audit Committee Chair

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.

298/11 EVALUATION OF THE MEETING

Resolved – it be noted that no meeting evaluation took place.

The meeting closed at 5.10pm

Helen Stokes
Senior Trust Administrator