Paper A1

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF AN EXTRAORDINARY MEETING OF THE TRUST BOARD, HELD ON THURSDAY 21 JULY 2011 AT 9AM IN ROOMS 1A & 1B, GWENDOLEN HOUSE, LEICESTER GENERAL HOSPITAL SITE

Present:
Mr M Hindle – Trust Chairman
Dr K Harris – Medical Director
Mrs S Hinchliffe – Chief Operating Officer/Chief Nurse
Ms K Jenkins – Non-Executive Director (for Minutes 211/11 – 214/11)
Mr R Kilner – Non-Executive Director
Mr M Lowe-Lauri – Chief Executive
Mr I Reid – Non-Executive Director
Mr A Seddon – Director of Finance and Procurement
Mr D Tracy – Non-Executive Director
Professor D Wynford-Thomas – Non-Executive Director

In attendance:
Dr S Campbell – Divisional Director, Clinical Support (up to and including Minute 213/11)
Ms C Griffiths – Joint Chief Executive, NHSLCR/LC (up to and including Minute 213/11)
Dr D Skehan – Divisional Director, Acute Care (up to and including Minute 213/11)
Mrs E Stevens – Deputy Director of Human Resources (in the absence of Ms K Bradley, Director of Human Resources)
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

ACTION

207/11 APOLOGIES

Apologies for absence were received from Ms K Bradley, Director of Human Resources, Mr P Panchal, Non-Executive Director and Ms J Wilson, Non-Executive Director.

208/11 DECLARATIONS OF INTERESTS

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

209/11 CHAIRMAN'S ANNOUNCEMENTS

The Chairman confirmed that this extraordinary, single-issue Trust Board meeting would consider the actions proposed to address UHL's current financial position, following the detailed discussion at the 7 July 2011 Trust Board. The plan for agreement in Minute 211/11/1 below focused on two aspects: 'stabilisation' and subsequent 'transformation', to move to a position of financial sustainability and avoid a recurrence of the current situation. The Chairman reiterated that UHL had always achieved its financial targets and delivered financial balance (or a small surplus). He also emphasised that the Trust's Executive Directors had been asked to develop a financial recovery plan which did not impact adversely on patient care, experience, safety and quality issues. The Chairman also particularly welcomed Ms C Griffiths, Joint Chief Executive NHSLCR/LC to the meeting, noting the strong support UHL had received from the PCTs for the plans in paper A.

<u>Resolved</u> – that the position be noted.

210/11 MINUTES AND MATTERS ARISING

<u>Resolved</u> – that the Minutes of, and matters arising from, the meeting held on 7 July 2011 be submitted to the Trust Board meeting on 4 August 2011. **STA**

211/11 QUALITY, FINANCE AND PERFORMANCE

211/11/1 <u>Stability to Transformation – Financial Recovery Plan</u>

The Director of Finance and Procurement and the Chief Operating Officer/Chief Nurse presented the 'stability to transformation' plans, as detailed in paper A. The presentation particularly provided:-

(1) a diagnosis of the Trust's financial position as at month 3 (month ending 30 June 2011), noting a cumulative deficit of £8.4m against plan for quarter 1 of 2011-12. Although income was flat (noting reduced numbers of emergency admissions, due partly to some successful admission avoidance schemes in conjunction with PCTs), expenditure had not decreased, either on pay or non-pay. The seasonal winter spike in pay expenditure (reflecting increased capacity requirements) had not fallen after winter 2011, and pay costs were currently 5% higher than in June 2010 despite there being no correlating increase in patient numbers;

(2) an outline of the external national context, in terms of the financial challenges facing the NHS, including the 1.5% tariff reduction from 1 April 2011, the 6% cost improvement programme (CIP) required simply to 'stand still', pay constraints and non-inflationary pressures such as the Clinical Negligence Scheme for Trusts. The readmissions penalty within the 2011-12 NHS operating framework also impacted particularly significantly on UHL, with a potential £9m penalty. Although known of and planned for accordingly, these national issues had a significant impact on UHL;

(3) an outline of a number of internal issues affecting the Trust's financial position, particularly the continued high use of agency and locum staff at premium rates. Due to slippage, only 50% of UHL's 2011-12 CIP was currently being delivered against plan. Delivery of UHL's 2011-12 £38m CIP was now at risk, although the Director of Finance and Procurement emphasised that this was a financial rather than a clinical safety risk;

(4) information on the extent to which various UHL services were losing/making money (based on national tariff), and on their relative market share. The Director of Finance and Procurement highlighted the need to understand why some of UHL's market-leading services were not necessarily covering their costs, noting that a change in practice seemed to be indicated;

(5) detail on the 2 elements (stabilisation and transformation) of the Trust's proposed recovery plan. Key drivers/enablers for that plan included appropriate clinical and staff engagement, PCT support, a recognition that quality would not be compromised, and an increased focus on accountability and delivery. The stabilisation phase of the recovery plan focused on:-

- centralising controls over processes for vacancy management, non-discretionary spend, and decisions on premium pay staff usage. It was confirmed, however, that professional registration and revalidation requirements would be protected, as

would statutory and mandatory training;
- cash controls;
- improved management of a number of operational issues including e-rostering and a review of staff working patterns to reflect best patient care practice, more flexible bed management, dormant accounts, and carparking. Although the latter was recognised as an extremely emotive issue, it was noted that UHL carparking charges had not increased since 2007. Appropriate consultation would be taking place on proposed charging increases, and the Chief Operating Officer/Chief Nurse reiterated the need not to use patient care monies to subsidise carparking;

(6) specific detail on the transformation stage of the recovery plan, which included:-
- a 20% reduction in corporate functions, with an accompanying release of costs and likely headcount (envisaged through natural wastage processes in the first instance). Plans on a potential voluntary severance scheme for staff were already scheduled for discussion at the 4 August 2011 Trust Board meeting;
- a key focus on loss-making services;
- accelerating existing efficiency schemes, particularly relating to theatres, reducing length of stay, and outpatients;
- a recognition by the Trust that targeted external assistance would be required to deliver the recovery plan;

(7) a revised income and expenditure projection based on the financial recovery measures detailed in paper A – this envisaged achieving an in-month break-even position in month 6 (September 2011), moving away from the current position whereby expenditure exceeded income;

(8) an outline of UHL's plans in respect of cash flow management, including a slow-down of capital expenditure and renegotiation of payment terms with suppliers. It was recognised that the bottom line in respect of cash reserves was challenging, however, given that UHL spent approximately £2m per day, and

(9) an outline of the risks and opportunities presented by the current position and the proposed plan, as recognised by the Trust. The Chief Executive reiterated that UHL did not have the internal general management capacity and capability to deliver the required plan without external support. Recognising the £5m deficit currently contained within the recovery plan, the Chief Executive proposed a detailed review of progress at the 1 September 2011 Trust Board, appropriately informed by the external support findings. Subject to progress on delivering the measures within the recovery plan (which might generate savings beyond the levels quantified in paper A), plans on moving forward re: the £5m deficit would then be discussed at the 6 October 2011 Trust Board. In summarising the plan, the Chief Executive further emphasised the key need to address the loss-making position of key UHL services, in terms of both costs and overheads – medical engagement was recognised as crucial for this process. **DFP/ COO/ CN**

Following the presentation, the Trust's Medical Director emphasised UHL's paramount commitment to maintaining quality and safety – he considered that the stabilisation plan was specifically designed to protect front-line services and that the transformation plan focused on accelerating patient care benefits through process and practice improvements. He also recognised the key need to work closely with Community colleagues to review care pathways. In light of its commitment to deliver financial balance without adversely affecting patient care, UHL also intended to strengthen its monitoring of quality indicators as detailed in paper A, and the Medical Director noted that UHL's mortality rate placed it within the 20% best-performing Trusts for that indicator.

In discussion on the presentation and the stabilisation to transformation plan detailed at paper A, the Trust Board noted:-

(a) a query from Professor D Wynford-Thomas, Non-Executive Director, as to the benefits of centralising control as per point (5) above. The Chief Operating Officer/Chief Nurse outlined the rationale for this centralisation (which was not a long-term approach), which would also free up Clinical Business Units to focus on operational service delivery and patient care. Centralised control also enabled decisions to be taken with appropriate awareness of the overall strategic context, and a specific example was given of moves to establish a central UHL locum bank;

(b) additional assurance sought by Professor D Wynford-Thomas, Non-Executive Director, regarding the robustness of the savings detailed in paper A, and on the process for reviewing the clinical risk impact of the schemes. In response, the Chief Operating Officer/Chief Nurse considered that the savings were somewhat conservative, with potential yields greater than those quantified. In line with UHL's existing approach to risk assessing CIP projects, she advised that a suite of detailed metrics underpinned the schemes, particularly those with a potential impact on clinical care. In response to a governance query from Mr D Tracy, Non-Executive Director and Governance and Risk Management Committee (GRMC) Chair, the Chief Operating Officer/Chief Nurse advised that the GRMC would be appropriately involved in reviewing progress, along with other existing UHL groups such as the Finance and Performance Committee and the Executive Team. In further discussion on this point, Ms K Jenkins, Non-Executive Director and Audit Committee Chair noted her wish for the Trust's Audit Committee also to be involved in monitoring progress. The Joint Chief Executive, NHSLCR/LC also outlined the PCTs' role in monitoring the impact of patient care quality, and advised of joint UHL-PCT agreement on key early indicators accordingly; **COO/ CN /DFP**

(c) a number of further queries regarding governance and assurance, as raised by Ms K Jenkins, Non-Executive Director and Audit Committee Chair. Ms Jenkins particularly sought greater clarity on how the Trust Board itself would be kept appropriately informed, noting the need for timely receipt of information on such key issues. She also requested further assurance on realtime monitoring and tracking of progress, and stronger accountability arrangements. In response, the Director of Finance and Procurement voiced his disappointment at the apparent poor forecasting ability within CBUs, and outlined the weekly metrics and monitoring arrangements now developed. He reiterated the need for those taking decisions to be fully aware of the consequences, and to understand fully the position of their services. The Chief Executive agreed the need for a clearer relationship between the weekly meetings held with CBUs and the resulting actions to be taken, noting the Trust Board's wish for there to be appropriate follow-through and outputs from those discussions. In his capacity as Divisional Director for Acute Care, Dr D Skehan advised that service awareness was improving and confirmed that Divisions would continue to monitor clinical safety. The Chief Executive also welcomed the point regarding appropriate accountability and suggested that it would be appropriate to discuss this further at the Finance and Performance Committee meeting on 28 July 2011; **CE**

(d) the wish of the Finance and Performance Committee to receive appropriate assurances on progress, as now outlined by Mr I Reid, Non-Executive Director, in his capacity as Chair of that Committee. He commented that key likely areas of Finance and Performance Committee interest would be:-

- the extent to which there was a clear understanding of the key drivers behind the Trust's current position;

- the availability of granular plans for delivering the £15m additional savings outlined in paper A and plans for monitoring of progress;
- UHL's liquidity position;
- appropriate monitoring and measuring of the outcomes from the external support;
- reassurance of PCT and wider Community support ahead of winter pressures – the presence of the Joint Chief Executive NHSLCR/LC was particularly welcomed, therefore. The Finance and Performance Committee would also welcome reassurance on the ability of the LLR healthcare community to deliver the actions underpinning financial recovery;

(e) (in response to a query from Mr D Tracy, Non-Executive Director and Governance and Risk Management Committee (GRMC) Chair) that the stated savings from the schemes represented the 2011-12 savings, although a number of the transformation projects would also yield in 2012-13;

(f) comments from the Director of Finance and Procurement on the need for the aforementioned external support, to accelerate the action required and also learn from best practice elsewhere. Although supporting the need for such support, Mr R Kilner, Non-Executive Director, queried the number of mandays and the time period involved, and emphasised also the need for the focus to be on executing change rather than diagnosing the position. Noting the response deadline for the tender, the Director of Finance and Procurement advised that he would be seeking Trust Board representatives for the 3 August 2011 evaluation panel – he also noted that the brief for the project involved a key focus on the cardio and medicine CBUs. In discussion on the external support, Ms K Jenkins, Non-Executive Director and Audit Committee Chair advised of the need for appropriate engagement with existing UHL managers in the CBUs and Divisions, to ensure the sustainability of resulting actions; **DFP**

(g) concerns over the Trust's liquidity position, as voiced by Mr R Kilner, Non-Executive Director who advised developing a stronger cash 'buffer' plan as soon as possible, and

(h) comments from the Joint Chief Executive, NHSLCR/LC, regarding:-

- role of primary care an additional external support resource for UHL;
- the whole healthcare community approach traditionally taken by LLR, which continued to apply in supporting UHL currently;
- clarification of the transformation monies referred to in paper A, noting that the amount received by UHL (£15m) represented the Trust's proportionate share of the overall national 2% topslicing;
- the involvement of PCTs in discussions re: liquidity and payment mechanisms, and
- recognition of approaching winter pressures. The Joint Chief Executive NHSLCR/LC also commented on how primary care had appropriately recognised (and reflected in its actions) the challenges faced by UHL in winter 2011.

Following the questions above, the Chief Executive further summarised the position, noting the strength of UHL's financial recovery plan (albeit with certain further work needed on the remaining shortfall) and the recognised need for a key drive on accountability. He advised that there would inevitably be some pain associated with the measures, particularly for Corporate Directorates. If fully delivered, however, the plan would successfully move UHL forward to transformation, and the Chief Executive noted the crucial need for all UHL staff to work together on delivery. As a final point, he reiterated the Trust's absolute commitment to maintaining the quality and safety of patient care.

<u>Resolved</u> – that (A) the stabilisation to transformation plan for 2011-12 financial

recovery be approved, as detailed in paper A;

(B) the Director of Finance and Procurement and the Chief Operating Officer/Chief Nurse be requested to:- **DFP/ COO/ CN**

(1) **provide a detailed review of progress against the financial recovery plan, to the 1 September 2011 Trust Board;**

(2) **provide a report on the current £5m shortfall, to the 6 October 2011 Trust Board;**

(3) **include the Audit Committee in the arrangements for governance and monitoring of the plan, noting the existing role of the Executive Team, Finance and Performance Committee and GRMC;**

(4) **(with the Chief Executive) report further on accountabilities within the plan, at the 28 July 2011 Finance and Performance Committee, and**

(C) the Director of Finance and Procurement to seek appropriate Trust Board representatives for the evaluation panel (3 August 2011) in respect of the external support tender. **DFP**

212/11 QUESTIONS FROM THE PUBLIC RELATING TO BUSINESS TRANSACTED AT THIS MEETING

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

(1) a query as to the scope for introducing a salary sacrifice by the more highly-paid UHL staff, eg perhaps those earning in excess of £100,000. The Trust Chairman advised that the pay package for Executive Directors was regularly reviewed by the UHL Remuneration Committee, and noted that information on those salary bands was published in the Trust's Annual Accounts and Annual Report. A significant proportion of the Consultant body would be captured within a £100,000 level, and the Chief Executive noted his wish to avoid jeopardising the very positive and proactive engagement currently being received from Consultants in progressing UHL's financial recovery (as now briefly outlined by the Divisional Director, Clinical Support, and including (eg) undertaking extra work at no extra cost);

(2) a query as to how patient experience would be monitored to gauge any adverse impact from the actions, particularly in respect of elderly patient readmissions and improving outpatient experiences. As Chair of the Leicester Mercury Patients' Panel, the questioner also queried how patient concerns would be fed back to the Trust and the extent to which the risk assessments included a patient perspective. In response, the Medical Director and the Chief Operating Officer/Chief Nurse outlined the various mechanisms already in place to capture patient experience/concerns/views, particularly noting the key role of inpatient polling (approximately 1300 returns per month, with different aspects of the patient polling findings being progressed by various areas across UHL). The Chief Operating Officer/Chief Nurse acknowledged the need to be more proactive in giving patients as much opportunity as possible to comment on or raise concerns over their care/experience. Both the Director of Finance and Procurement and the Director of Strategy also commented that increased process and practice efficiency were integrally linked to an improved patient experience;

(3) a comment on the patient care benefits of better integration with community partners (eg in respect of delayed transfers of care), and a query on how this would be progressed. In response, the Joint Chief Executive, NHSLCR/LC outlined the various

factors affecting discharges and confirmed the close working between primary and secondary care on this issue;

(4) support voiced by the representative of the Leicestershire and Leicester LINks for the proposed actions. However, the representative also noted:-

- concerns regarding the level of partnership working, and suggested a need for more transparent communication. In response, the UHL Chief Executive considered that relations with community partners had improved considerably and noted ongoing discussions with the City and County Councils. This was echoed by the Joint Chief Executive, NHSLCR/LC who also noted the useful health summit events involving all appropriate LLR partners. A clear dashboard of improvement and performance indicators also been developed in respect of the LLR emergency care network transformational programme. The Joint Chief Executive, NHSLCR/LC also commented, however, on the need for appropriate review of secondary care provision in the context of flattening activity;
- concerns regarding the significant cost of lost bed days due to delayed transfers of care and rebedding, and of any failure to reduce readmissions;
- a query as to the role of Local Authorities in more efficient working with UHL;
- a query as to whether UHL was considering the most creative and flexible use of its land base/land resources. In response, the Chief Executive acknowledged the need for a continued flexible approach, learning from best practice elsewhere. He also noted that a number of UHL services were at the leading edge already;

(5) a query as to whether UHL had considered seeking early payment discounts from suppliers rather than extending payment terms, in light of the potential resulting impact upon quality of service. The Director of Finance and Procurement acknowledged this point and agreed the need to maintain service quality;

(6) support for the list of indicators to be used to monitor the quality impact of the schemes, although the questioner queried whether (and how) all available sources of patient feedback were being captured. The Chief Operating Officer/Chief Nurse confirmed that all sources were appropriately reflected, although acknowledging the continued scope for improvement through the Patient Experience Group chaired by UHL's Director of Nursing;

(7) comments from the representative of the Leicester City Council Health Committee, welcoming the transparency of the discussion today and supporting the actions outlined. The representative of the Leicester City Council Health Committee also:-

- considered that the plans were not entirely free of potential risk to patients, and therefore sought reassurances from the Trust that high quality patient care would continue to be delivered, voicing particular concern over the intended reduction to locum and agency staff use;
- noted the key need for clinical leadership – the Medical Director echoed this point and noted the well-attended meetings held with Consultants regarding financial recovery issues. Locum usage had also been discussed, and UHL Consultants were keen to move forward away from a reliance on locums – as an example, the Divisional Director noted work on a new workforce profile within the Emergency Department;
- commented that Leicester's Hospitals were a "beacon" for the community in terms of their commitment to equality and diversity – this was welcomed by UHL's Trust Board;
- queried the issue of carer support – in response, and as lead organisation for

this matter, the Joint Chief Executive NHSLCR/LC outlined the funding available to the PCTs and noted plans to develop a carer strategy with Leicester City and County Councils, which she would be happy to discuss with the questioner outside the meeting;

(8) comments from UHL's Staff Side Chair, regarding:-

- the need for staff reassurance on appropriate accountability and responsibility, on the robustness of the recovery plans and on the need for those plans to be equitably implemented. It was crucial that managers were held to appropriate account for non-delivery of plans. In response, the Chief Executive reiterated the absolute need for people to answer for their actions – he also recognised the point below and confirmed that as internal capacity and capability was not sufficient without such support, although regrettable the need for external support was unavoidable;
- accountability for the losses arising;
- a query as to how UHL could justify the cost of external support, in light of staff headcount reductions (see response above);
- the perception of ground-level staff that measures such as increased carparking charges would penalise them for the current financial position. The Staff Side Chair queried how messages could be more appropriately and correctly communicated. He also queried if it was still the intention to reinvest carparking monies (as per the original proposals when charges were extended across UHL). The Director of Strategy confirmed that appropriate consultation would take place on any increase to carparking charges. Although finalised proposals were not yet available, a linked salary sacrifice scheme was also being considered (which would mitigate the cost of an increase) and it was possible that the rate of increase would differ between staff pay bands. The Director of Strategy reiterated that UHL's carparks currently operated at a loss, with the intention being therefore to avoid subsidising this function from elsewhere within UHL's budget. The Director of Communications and External Relations acknowledged that communications on carparking charges would be challenging;

(9) a query as to whether appropriate learning was being taken forward from other organisations (in terms of both good practice, and pitfalls to avoid). The Chief Executive confirmed that this was the case, noting the particular role of the Association of UK University Hospitals (AUKUH) in terms of peer teaching Trusts, and

(10) a query as to whether appropriate staff would be held accountable for the financial position in which UHL now found itself. The questioner also voiced concerns over the current state of patient care within certain UHL areas and noted her view that patients were not encouraged/did not feel comfortable in raising concerns. She considered, therefore, that patient care quality needed to be recovered (rather than 'maintained') in certain areas. The Chief Executive noted his previous personal discussion with the questioner and acknowledged the points she raised. He considered that the transformation schemes outlined in paper A would focus on any areas of UHL where the patient experience was less than satisfactory, noting that a key aim of the transformation plan was to drive improvements to patient care/experience and services.

<u>Resolved</u> – that the comments above and any related actions, be noted.

213/11 DATE OF NEXT MEETING

Resolved – that the next Trust Board meeting be held on Thursday 4 August 2011 at 10am in the C J Bond Room, Clinical Education Centre, Leicester Royal Infirmary.

214/11 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 215/11 – 218/11), having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.

215/11 DECLARATION OF INTERESTS

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

216/11 CONFIDENTIAL MINUTES AND MATTERS ARISING

Resolved – that the confidential Minutes of, and matters arising from, the Trust Board meeting held on 7 July 2011 be submitted to the Trust Board meeting on 4 August 2011. **STA**

217/11 ANY OTHER BUSINESS

217/11/1 Report by the Director of Strategy

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

217/11/2 Report by Mr D Tracy, Non-Executive Director

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

217/11/3 Report by the Trust Chairman

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.

218/11 EVALUATION OF THE MEETING

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

The meeting closed at 12.23pm

Helen Stokes
Senior Trust Administrator