Paper J

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF A MEETING OF THE TRUST BOARD, HELD ON THURSDAY 25 OCTOBER 2012 AT 10AM IN THE C J BOND ROOM, CLINICAL EDUCATION CENTRE, LEICESTER ROYAL INFIRMARY

Present:
Mr M Hindle – Trust Chairman
Mr J Birrell – Interim Chief Executive
Ms K Bradley – Director of Human Resources
Dr K Harris – Medical Director
Mrs S Hinchliffe – Chief Nurse/Deputy Chief Executive (excluding Minutes 286/12/2 and 286/12/3, and Minutes 288/12 – 304/12 inclusive)
Ms K Jenkins – Non-Executive Director
Mr R Kilner – Non-Executive Director
Mr P Panchal – Non-Executive Director
Mr I Reid – Non-Executive Director
Mr A Seddon – Director of Finance and Business Services
Ms J Wilson – Non-Executive Director
Professor D Wynford-Thomas – Non-Executive Director

In attendance:
Ms J Ball – Head of Nursing, Planned Care (for Minute 298/12/1)
Dr D Briggs – GP Lead, East Leicestershire CCG (for Minute 296/12)
Mr A Chatten – Acting Director of Estates and Facilities (up to and including Minute 291/12)
Mr J Clarke – Acting Director of IM&T
Miss M Durbridge – Director of Safety and Risk (for Minute 287/12/2)
Mr A Furlong – Divisional Director Planned Care
Mrs J Gillett – Patient (for Minute 298/12/1)
Mrs S Priestnall – Information Manager (for Minute 285/12/2)
Ms C Ribbins – Director of Nursing (for Minute 298/12/1)
Dr D Skehan – Divisional Director, Acute Care
Ms H Stokes – Senior Trust Administrator
Mr S Tanner – PwC (for Minute 285/12/1)
Mr J Tozer – Interim Director of Operations
Mr P Walmsley – Head of Operations (for Minute 296/2)
Mr M Ward – Director of Corporate and Legal Affairs
Mr M Whitworth – Project Director CCGs (for Minute 296/12)
Mr M Wightman – Director of Communications and External Relations

ACTION

280/12 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 281/12 – 291/12), having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.

281/12 APOLOGIES

There were no apologies for absence.

282/12 DECLARATIONS OF INTERESTS IN THE CONFIDENTIAL BUSINESS

There were no declarations of interest in the confidential business being discussed.

283/12 CONFIDENTIAL MINUTES

Resolved – that the confidential Minutes of the Trust Board meeting held on 27 September 2012 be confirmed as a correct record.

284/12 CONFIDENTIAL MATTERS ARISING REPORT

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

285/12 REPORTS BY THE DIRECTOR OF FINANCE AND BUSINESS SERVICES

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

286/12 REPORTS BY THE INTERIM CHIEF EXECUTIVE

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

287/12 REPORTS BY THE MEDICAL DIRECTOR

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

288/12 REPORT BY THE ACTING DIRECTOR OF ESTATES AND FACILITIES

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

289/12 CONFIDENTIAL TRUST BOARD BULLETIN

Resolved – that the reports circulated for the October 2012 confidential Trust Board Bulletin be noted for information.

290/12 REPORTS FROM BOARD COMMITTEESE

290/12/1 Finance and Performance Committee

Resolved – that the confidential Minutes of the 26 September 2012 Finance and Performance Committee be received, and the recommendations and decisions therein be endorsed and noted respectively.

290/12/2 GRMC

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.

290/12/3 Remuneration Committee

Resolved – that the confidential Minutes of the 19 and 27 September 2012 Remuneration Committees be received, and the recommendations and decisions therein be endorsed and noted respectively.

291/12 CORPORATE TRUSTEE BUSINESS

291/12/1 Charitable Funds Committee

Resolved – that the confidential Minutes of the 14 September 2012 Charitable Funds Committee be received, and the recommendations and decisions therein be endorsed and noted respectively.

292/12 DECLARATIONS OF INTERESTS IN THE PUBLIC BUSINESS

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

293/12 CHAIRMAN'S ANNOUNCEMENTS

The Chairman apologised for the delay in starting this public section of the UHL Trust Board meeting, and also welcomed Mr J Tozer, Interim Director of Operations, to the meeting.

294/12 MINUTES

Resolved – that the Minutes of the meeting held on 27 September 2012 be confirmed as a correct record.

295/12 MATTERS ARISING FROM THE MINUTES

Paper B detailed the status of previous matters arising, particularly noting those without a specific timescale for resolution. In discussion on the matters arising report the Trust Board noted in particular:-

(a) Minute 260/12 – a briefing on the maternity and gynaecology interim solution business case would be circulated outside the meeting by the Acting Director of Estates and Facilities; **ADEF**
(b) Minute 260/12 – UHL's Chairman and Interim Chief Executive were meeting with the Local Area Team and CCG colleagues on 7 November 2012 to discuss communications issues;
(c) Minute 262/12/3 – the Interim Chief Executive outlined feedback from the 2 October 2012 ECN Board meeting, including discussions on stepdown wards and delayed discharge issues, and
(d) Minute 262/12/5 – a separate Trust Board presentation on falls was not required (as confirmed by the GRMC Chair in Minute 298/12/5 below).

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Resolved – that the update on outstanding matters arising and the associated actions above, be noted. **NAMED EDs**

296/12 LLR WINTER PLANNING 2012

The Trust Board received presentations on both UHL-specific and LLR-wide winter planning actions for 2012, as presented (respectively) by the Trust's Head of Operations and the GP Lead for East Leicester CCG. Although unable to attend, it was confirmed that Local Authorities were closely involved in the 2012 LLR winter planning preparations.

In terms of UHL-specific preparations for winter, the Head of Operations' presentation covered the following key points:-

(i) the additional capacity required – assessed as being approximately 100 extra beds, although recognising that 'capacity' was not limited exclusively to additional beds. Appropriate lessons had also been learned from winter 2011-12 experiences;

(ii) the actions taken by UHL to prepare for winter planning requirements (recognising the key need then to start closing any additional opened beds from April 2013), including initiatives such as introduction of the non-weight bearing care pathway; the discharge to assess scheme; rapid assessment in ED; strengthened Duty Management arrangements; increased focus around discharge especially the "BEDs b4 11" project; UHL's internal waits project to reduce length of stay; a new build on CDU at the Glenfield Hospital; an increase in acute clinicians at AMU; the AMU and SAU triage schemes; the community IV service; CCG agreement in principle for supporting ward 2 stepdown beds at the Leicester General Hospital; daily communication with partner agencies; and ongoing development of estates and bed plans for 2012 /2013. The Head of Operations also outlined UHL's close contact with community health and social care partners, and ongoing work with them to reduce (where appropriate) demand for emergency care. Internally, UHL was also working to reduce internal waits and improve early discharge, and

(iii) associated risk factors, including potential further increases in the already-experienced 2012-13 rise in emergency attendances and admissions; a lack of clarity over LLR community bed requirements; the risk of providing less than optimal sub-acute care; the risk of increased delayed transfers of care; the impact of the Christmas and New Year closure of social care services, and the overall robustness of LLR healthcare economy admission-deflection schemes. The timing of availability of the additional capacity beds outlined below was also a potential risk issue for UHL.

Dr D Briggs, GP Lead for East Leicester CCG then presented the LLR winter planning preparations for 2012-13, noting in particular:-

(1) the focus on delivering the 'left shift' approach to moving appropriate activity into the community away from an acute setting. This included a focus on reducing the number of patients attending ED and increasing patient access to primary care facilities;
(2) plans to increase bed capacity across the LLR healthcare system for winter 2012 by approximately 70 beds, across CCGs, LPT and UHL. These plans included a 24-bedded step down facility, a potential increase in LPT capacity from 316 community beds to 346 beds if commissioned, an increase (from 0 to approximately 16) in discharge to assess dementia beds, a general increase in discharge to assess beds, and an increase in Local Authority commissioned beds, and
(3) key winter planning/preparedness risks from a Commissioner perspective, which included levels of demand, the ability to sustain improvements throughout winter in its entirety, and the possibility of an influenza pandemic (although one was not predicted).

In discussion on the winter planning presentations, the Trust Board:-

(a) noted a query from Mr I Reid Non-Executive Director and Finance and Performance Committee Chair, as to when a decision would be taken on commissioning additional LPT community beds. In response, the GP Lead for East Leicester CCG advised that although such beds could be established relatively quickly, the decision to commission would be dependent on need. The Chief Nurse/Deputy Chief Executive pressed further on when a decision would be taken on the number of additional community beds required for winter 2012, and she also queried whether staff had been identified for those beds. In response, the CCG representatives reiterated the need to model the likely demand and undertake appropriate scenario planning before a decision was taken by the Emergency Care Network Board – they agreed to advise the 30 October 2012 ECN Board, however, of UHL's wish for appropriately rapid progress on this matter. The Trust's Interim Chief Executive emphasised the urgency of this work, given that UHL and the LLR system as a whole were already experiencing capacity pressures. He also queried what LLR contingency plans were in place. The CCG representatives considered that the LLR winter plan was robust, and noted UHL's involvement to date in that planning process; **CCGs**

(b) queried the cause of the significant increase in 2012-13 referrals from West Leicestershire, and how to address this rise. An increase in older patients and the closure of community beds in winter 2011 were both thought to have had an impact on this issue;

(c) voiced concern over a rise in delayed transfers of care, although noting that levels had recently fallen again. Although noting certain beneficial process changes made within the Trust, UHL's Head of Operations agreed that availability of community dementia beds remained an issue and he welcomed the CCGs' commitment to increasing the number of discharge to assess beds;

(d) noted a query from Ms J Wilson Non-Executive Director and Workforce and Organisational Development Committee Chair, as to whether the communication plans for reducing emergency demand within the community also covered services for the homeless. The CCG representatives advised that the 2011 "Choose Better" primary care campaign was being repeated in 2012 and would cover hard to reach groups. In response to comments from the Director of Communications and External Relations on the merits of various communication methods, the CCG representatives advised that primary and acute care communications teams would be working together to ensure that consistent and targeted public messages were issued re: deflecting admissions; **DCER/ CCGs**

(e) noted that concerns over the timing of ambulance arrivals at hospital (and their impact on the likely need for a resulting admission) were shared by both acute and primary care, recognising the need for further work on this issue;

(f) queried progress on standardising and sharing patients' medical information between primary and acute care partners. In response, the CCG representatives outlined national changes to policy on this issue and also noted certain local IT interface challenges, and

(g) sought clarity on what community services (including GP surgeries and Local Authority provision) would be open over the Christmas and New Year period 2012 – the GP Lead East Leicester CCG agreed to provide this information outside the meeting. **CCGs**

<u>Resolved</u> – that (A) the joint UHL/CCG presentations on LLR 2012 winter planning be noted;

CCGs/ DCER

(B) CCG and UHL Communications Teams discuss consistent public messages (and the best ways of sharing those messages) re: alternatives to attending ED in winter 2012;

CCGs

(C) the 30 October 2012 ECN Board be advised of the need for an urgent decision on the number of LLR community beds required for winter 2012, and

CCGs

(D) confirmation of opening times and availability of primary care services over Christmas/New Year 2012 be shared with UHL.

297/12 INTERIM CHIEF EXECUTIVE'S MONTHLY REPORT – OCTOBER 2012

In discussion on paper O, the Trust Board queried whether the April 2014 Monitor and NHS Commissioning Board assumption of responsibility (from the Department of Health) for pricing NHS services was to be welcomed. The likely impact was not yet clear, and the Director of Finance and Business Services advised that UHL would coordinate its response through AUKUH on this issue in due course.

<u>Resolved</u> – that the Interim Chief Executive's report for October 2012 be noted.

298/12 QUALITY AND SAFETY

298/12/1 Patient Story – Planned Care

The Trust Board watched a DVD illustrating a patient's (generally positive with the exception of the food) care experience within UHL's Planned Care Division, noting that both the patient herself and members of the Planned Care senior nursing team were in attendance for this item. In introducing the item, the Director of Nursing reminded members that this DVD was part of a rolling programme of patient experience presentations to the Trust Board – UHL was also working currently on refreshing its patient experience strategy (which would be informed by patient feedback mechanisms such as this). UHL's 5 key patient experience priorities over the next 2 years would cover (i) improving how patients felt informed about their care; (ii) improving the efficient use of resources; (iii) end of life care (as previously presented to the Trust Board on 28 May 2012); (iv) improved care for dementia patients, and (v) improved care for older people.

Following the 8-minute DVD presentation, the Interim Chief Executive advised that the Trust Board would also in future receive examples of both positive and less positive care experiences, covering both nursing and medical teams. In respect of the specific lessons being taken forward from the DVD, the Divisional Director Planned Care outlined work by UHL's orthopaedic surgeons to improve customer service and interaction with patients, which would be rolled out to other specialties if successful. In discussion, the Trust Board commented on the need for appropriately interlinked initiatives covering both medical and nursing staff. The Trust Board also thanked the patient for sharing her experience and for attending in person today.

Resolved – that the patient experience presentation be noted.

298/12/2 Safe and Sustainable (Children's Cardiac Surgery Services) – Update on Clinical Case

The Medical Director reported verbally on this issue, noting that the day to day clinical service continued to be delivered by UHL. Clinically-led discussions also continued with Birmingham Children's Hospital re: a Midlands network for congenital paediatric heart services. The Medical Director also outlined the Secretary of State for Health's recent decision to refer the JCPCT decision to an Independent Review Panel, following the Parliamentary debate triggered by Leicester having obtained a 100,000 signature petition (the Trust Chairman voiced this thanks to all those involved in the petition, particularly Mr A Tansey and his family, and noted the efforts of both the OSC and local MPs in securing this IRP review). Although written confirmation was still awaited, it now seemed likely that the IRP review would encompass ECMO services.

Resolved – that the update on children's cardiac surgery services be noted.

298/12/3 Emergency Care Delivery – Monthly Update

Paper R updated members on month 6 emergency care delivery – however, the Chief Nurse/Deputy Chief Executive advised of a subsequent deterioration in ED performance during October 2012 which was not therefore reflected in the report. In discussion, the Trust Board:-

(a) queried whether it was now possible to achieve the 95% ED performance threshold for October 2012 and if not, what penalties would be levied against the Trust. In response, the Director of Finance and Business Services advised that a penalty of £27,000 per month had been incurred for the first 3 months of 2012-13, with a further 2% contract penalty possible now for each month which missed the trajectory, and

(b) queried the reason for the declining level of UCC diverts. In response, the Chief Nurse/Deputy Chief Executive noted that the UCC provider (George Eliot NHS Trust)

considered this to be the result of the staff skillmix within the UCC facility – UHL had sought further information on the actions planned to address this issue. Although no targets were in place, Commissioners were appropriately aware of current UCC performance. In discussion, the Medical Director clarified the clinical model underpinning the divert rationale.

Resolved – that the update on emergency care delivery be noted.

298/12/4 Foundation Trust (FT) Update

Paper S advised members of progress on UHL's FT application and the timetable set out in the Trust's Tripartite Formal Agreement (TFA), noting that the Trust Board would continue to receive monthly updates on this issue. The Interim Chief Executive advised that most of the red rated items related to the wider LLR Better Care Together programme and were not therefore within the Trust's sole control. UHL would submit the first draft of its Integrated Business Plan (IBP) – underpinned by key quality and safety drivers – to NHS Midlands and East by 31 October 2012 as required, with a further iteration then due in December 2012. Estates transformation remained work in progress, and it was hoped to have this ready in December 2012. In discussion and noting that December 2012 was only 5 weeks away, Non-Executive Directors sought assurance on the likelihood of obtaining the Better Care Together inputs – in response, the Interim Chief Executive advised that although the detailed work might not be available for the December 2012 readiness meeting, progress was underway re: the overarching assumptions. The Interim Chief Executive also thanked the FT Programme Manager for her circulation of weekly FT updates to Trust Board members.

Resolved – that the Trust Board continue to receive monthly updates on its FT Application process. **ICE**

298/12/5 Quality and Performance Report (Month 6) and Provider Management Regime (PMR) Return

As agreed at the 26 April 2012 Trust Board, the discussion on the monthly quality and performance report (paper T) was now structured to receive opening comments from the Chairs of the GRMC, Finance and Performance, and Workforce and Organisational Development Committees (if they had all met) followed respectively by issues of note from the appropriate lead Executive Directors for quality and patient safety, patient experience, operational performance, HR, and finance. Views were then invited from the wider Trust Board. The quality and performance report for month 6 (month ending 30 September 2012) advised of red/amber/green (RAG) performance ratings for the Trust, and set out individual Divisional performance in the accompanying heatmap.

With regard to quality aspects of the month 6 report, Mr D Tracy Non-Executive Director and GRMC Chair highlighted the following issues from the GRMC meeting of 22 October 2012:-

- assurance received re: progress in reducing falls, noting the challenging 50% reduction target by 31 March 2013. Fielding Johnson ward remained an outlier on falls however, and was likely to require capital investment to address its environmental issues. Progress on reducing falls would be monitored through the monthly quality and performance report and a separate Trust Board report was not therefore now necessary. In discussion, Mr R Kilner Non-Executive Director, commented that a number of adverse indicators appeared to apply to Fielding Johnson ward, and he queried whether non-ambulatory patients were no longer placed on that ward as agreed a few months previously. It was agreed that the most appropriate use of Fielding Johnson ward would be discussed further by the Executive Team; **Exec Team/ IDO**
- progress on the action plan in response to the Appreciative Enquiry, with a further update scheduled for the December 2012 GRMC;
- continued good progress in reducing the number of formal complaints received by UHL (target reduction of 10% in 2012-13), with a focus on trying to resolve issues at source before escalating to a formal complaint. In discussion, Ms K Jenkins Non-Executive

Director and Audit Committee Chair, queried whether the 10% reduction applied across all Divisions or was being targeted at specific areas. She also sought assurance that patients and the public were still able to make complaints if they wished (this was the case). Ms Jenkins also requested that the Trust Board have greater visibility on the top 5 themes within UHL complaints, and it was agreed that these would be explicitly mentioned in the GRMC Chair's future verbal reports to each Trust Board meeting (and be reflected in the Minutes of the relevant GRMC meeting). Although welcoming the progress in reducing complaints, the Medical Director noted a recent rise in complaints relating to cancelled operations and also waiting times (as advised to the October 2012 GRMC); **GRMC CHAIR**

- a lengthy discussion on temporary staff and also the level of UHL nursing vacancies, noting plans in place to fill approximately 125 substantive vacancies and the expected resulting fall in nursing bank and agency use, and
- consideration of the new 'nursing healthcheck' dashboard, incorporating both the existing nursing metrics and performance against the 4 harms.

With regard to the remaining quality and operational performance aspects of the detailed month 6 report, the Medical Director, the Chief Nurse/Deputy Chief Executive and the Director of Human Resources highlighted the following issues:-

(i) the results of the external review of readmissions, which indicated that 21% of readmissions were potentially avoidable – UHL was now in negotiation with Commissioners regarding appropriate reinvestment (within the Trust) of the related penalty, given that the Trust's ability to discharge patients was affected by the availability of community facilities. Mr I Reid Non-Executive Director and Finance and Performance Committee Chair confirmed that this had also been discussed by that Committee on 24 October 2012, with the suggestion that it would be appropriate for the GRMC to monitor progress on UHL's plans to reduce avoidable readmissions; **Exec Team**

(ii) progress on the 5 critical safety actions – the Trust Board agreed that it would be helpful to have clear and visible performance measures on the 5th of these actions, to measure progress; **MD**

(iii) disappointment that a case of MRSA bacteraemia had been reported in September 2012. The root cause analysis meeting (which had identified contamination as the cause) had been very well attended, however, particularly by clinicians. Once finalised, the root cause analysis report would be circulated to Trust Board members in the usual way;

(iv) a national review of the Net Promoter Score, noting that the questionnaire would be given separately to patients from April 2013;

(v) good performance on lower GI cancer waits, with only 2 patients exceeding a 62-day wait;

(vi) good progress on cancelled operations, with UHL also on track to meet the target in October 2012, and

(vii) a disappointing red rating in respect of appraisal rates, which had dipped slightly below 90%. Ms J Wilson Non-Executive Director and Workforce and Organisational Development Committee Chair, suggested a need to review the phasing of appraisals to avoid bottlenecks.

In discussion, Mr R Kilner Non-Executive Director queried the performance breach in respect of compliance with the WHO surgical checklist, which he had thought was well-embedded within the Trust. The Medical Director and the Chief Nurse/Deputy Chief Executive outlined the audit thresholds for this indicator and confirmed that appropriate corrective action was in place. The breach was thought to result from an instance of manual data recording (rather than computerised entry), rather than being due to non-compliance. On a separate matter, the Trust Chairman queried whether performance issues with the Non-Emergency Patient Transport service had now been resolved – the Chief Nurse/Deputy Chief Executive advised

that performance appeared to have improved, with only 5 rebeds in October 2012 to date.

The Trust Chairman then asked the Finance and Performance Committee Chair for that Committee's comments on the financial elements of month 6 performance, as discussed on 24 October 2012. From that meeting, Mr I Reid, Non-Executive Director and Committee Chair particularly highlighted:-

- detailed discussions on the month 6 financial position and potential year-end forecast. Although still disappointing, the level of in-month deficit against plan was the lowest since month 2, and the Committee would continue to monitor the impact of the financial recovery actions;
- UHL's delivery of 93% of its in-month cost improvement programme (88% year to date). Only 11% of the CIP programme was rated as red, and UHL was therefore confident of delivering the majority of the outstanding amount, and
- lengthy discussions on the 2012-13 financial recovery plan, with UHL now forecasting a breakeven position for year end. Based on the case presented, the Finance and Performance Committee considered that this forecast was broadly achievable.

With regard to the remaining financial aspects of the detailed month 6 report, the Director of Finance and Procurement noted the improved position compared to months 4 and 5. Non-contracted pay remained an issue however, not having fallen as much as expected in month 6. With regard to non-pay, although UHL's drug spend was starting to reduce, expenditure on clinical supplies continued to rise. The Trust's clinical procurement catalogue was being relaunched in November 2012 however, and procurement issues had also been discussed at the 24 October 2012 Finance and Performance Committee. The Director of Finance and Business Services also advised that a cash management plan was in place with UHL's suppliers.

The Trust Board also considered the October 2012 Provider Management Regime (PMR) return for approval and submission to NHS Midlands and East, as detailed within paper T. The Trust Board endorsed the PMR return as presented, for signature by the Chairman and Interim Chief Executive and submission to the SHA accordingly. **CHAIR MAN/ ICE**

<u>Resolved</u> – that (A) the quality and performance report for month 6 (month ending 30 September 2012 be noted;

(B) GRMC Chair's verbal meeting update to each Trust Board include a summary of the top 5 complaints themes each month (that information also to be included in the relevant GRMC minutes); **GRMC CHAIR**

(C) the most appropriate future use of, and environmental changes required to, Fielding Johnson Ward be discussed further by Executive Directors; **EDs**

(D) appropriate performance measures/KPIs be developed in respect of the 5th of the 5 critical safety actions (senior clinical review, ward rounds and notation), to demonstrate continued improvement; **MD**

(E) the Executive Team consider whether the GRMC should be asked to look further at the Trust's management of plans to reduce readmissions (as suggested by the 24 October 2012 Finance and Performance Committee); **EDs**

(F) the Minutes of the 24 September 2012 GRMC be received, and the recommendations and decisions therein be endorsed and noted respectively (paper U);

(G) the Minutes of the 26 September 2012 Finance and Performance Committee be received, and the recommendations and decisions therein be endorsed and noted respectively (paper V);

(H) the Minutes of the 17 September 2012 Workforce and Organisational Development Committee be received, and the recommendations and decisions therein be endorsed and noted respectively (paper W), and

(I) the Provider Management Regime return for October 2012 be approved for signature by the UHL Chairman and Interim Chief Executive, and submitted to NHS Midlands and East as required. **CHAIR MAN/ICE**

298/12/6 Financial Recovery 2012-13 – Update

Tabled paper X summarised progress against UHL's 2012-13 financial recovery plan, expanding on the version considered by the 24 October 2012 Finance and Performance Committee. UHL's internal capacity had now been augmented by the temporary appointment of an Interim Director of Operations and a Director of Service Improvement (who would focus particularly on the Trust's transformation programme). Section 4 of paper X detailed the various risks and opportunities arising from the central activities being pursued to deliver the Trust's year-end position. The recovery plan was broadly split into 2/3 internal actions and 1/3 external actions. In discussion on paper X the Trust Board:-

(a) sought assurance that the moves to recruit more permanent staff (eg away from temporary staff) would not simply be replacing the headcount already reduced – in response, the Director of Finance and Business Services advised that the new permanent heads would be clinical staff, whereas previous reductions had related to non-clinical support staff;
(b) requested that future iterations of the graph on page 4 be expanded to provide additional detail on which elements of the deficit sat within the trajectories for (1) the Divisional forecast; (2) the post-internal actions, and (3) the post-external actions, and **DFBS**
(c) queried how other NHS Trusts were affected by (and thus handled) the marginal rate for emergencies, and whether UHL would develop a pragmatic solution with its Commissioners on MRET, as had happened in other healthcare economies.

Resolved – that the 'UHL H2 revised forecast by month' graph be expanded in future iterations of the financial recovery update, to provide more detail on which elements of the financial recovery plan were internal to UHL's control and which were more externally-affected. **DFBS**

298/12/7 Local Staff Polling Results

Paper Y updated the Trust Board on the results of UHL's local staff survey (staff polling) and outlined progress against key actions to improve staff experience. The Director of Human Resources acknowledged that the local staff polling results were disappointing, showing an overall deterioration in the responses to most questions despite also evidencing some pockets of very good practice (the latter would be shared Trust-wide as appropriate). Although not attached to paper Y, the free-text answers received from staff as part of the polling results would inform the CBU action plans being developed. The Workforce and Organisational Development Committee Chair (Ms J Wilson Non-Executive Director) emphasised the need for a systematic, rigorous, robust and consistent way to address the survey findings, with outputs shared at an appropriately granular level. She also noted the need to work with staff in developing the remedial action plans and in embedding improvements.

The Divisional Director Planned Care advised that as of 1 December 2012 all Divisions (and the Medical Director) would use Friday afternoons to meet and engage with staff. As of January 2013, the Executive Directors' informal meeting would also be moved to free up Friday lunchtimes for staff engagement and enhanced Executive visibility. In discussion on

paper Y the Trust Board:-

(a) sought assurance that an apparent lack of staff clarity on the Trust's expectations of them was not impacting adversely on patient safety. In response, the Director of Human Resources advised that this particular finding highlighted the importance of good quality feedback and appraisals for staff (an integral part of which was clear objectives for/expectations of staff). Staff accountability was also key, however;

(b) noted a suggestion from Mr P Panchal Non-Executive Director, that appropriate trends/targets be set for improvement in the local staff polling results. The Director of Human Resources recognised the need to measure improvements, and she noted that UHL was currently also revising its Organisational Development Plan (for presentation to the November 2012 Trust Board); **DHR/ ETs**

(c) commented on the difficulty in reconciling the poor results with the good staff communication work known to be underway within the Trust. It was crucial therefore for Executive and Divisional management teams to lead by example, and the Director of Human Resources noted that UHL had recently developed management standards for managers, and

(d) noted that the local polling captured only 25% of UHL staff, and queried how to improve the response rate. In response to a further query, the Director of Human Resources confirmed that the response rate was greater from corporate areas than from elsewhere.

<u>Resolved</u> – that appropriate trend targets be set for improvements to the local staff polling results. **DHR/ ETs**

299/12 STRATEGIC RISK REGISTER/BOARD ASSURANCE FRAMEWORK (SRR/BAF)

The Medical Director presented the latest iteration of UHL's SRR/BAF (paper Z), noting that the document was now undergoing a full revision following the 1 October 2012 Trust Board development session on risk. Both the existing version and a proposed new (unpoulated) format were therefore attached to paper Z. Recognising the crucial importance of the strategic risk register, the Interim Chief Executive advised that a fully reviewed and reformatted version would not be available until the December 2012 Trust Board – this was being pursued by the Executive Team (who also recognised the need for the next iteration SRR/BAF to marry appropriately with the IBP). In further discussion on this point, Ms K Jenkins Non-Executive Director and Audit Committee Chair commented that a realistic SRR/BAF was crucial to ensure that the Trust's Internal Auditors were focusing their efforts on the right risk issues. **MD**

In terms of the 3 specific risks to be discussed at this Trust Board meeting, it was noted that ***risk 1*** (continued overheating of the emergency care system) had already been covered in Minutes 296/12 and 298/12/3 above. With regard to ***risk 3*** (deteriorating relationships with CCGs), the Trust Board agreed that the current risk rating of 16 was too high in light of recent improvements – the title of this risk should also be amended to remove the term 'deteriorating'. However, the Director of Communications and External Relations acknowledged that the departure of the Trust's Head of GP Services had resulted in slippage on some of the actions in risk 3. In respect of ***risk 4*** (failure to acquire and retain critical clinical services), it was agreed that the current risk score of 20 was too high and should be revised downwards. **DCER** **DFBS**

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

(B) risk scores be reviewed (with a view to reducing them) in respect of risks 3 (deteriorating relationships with CCGs) and 4 (failure to acquire and retain critical **DCER/ DFBS**

clinical services);

(C) the wording of the title of risk 3 be reviewed to avoid use of the term 'deteriorating', and **DCER**

(D) the new format SRR/BAF be presented to the December 2012 Trust Board, following discussion by the Executive Team. **MD**

300/12 REPORTS FROM BOARD COMMITTEES

300/12/1 Audit Committee

Resolved – that the Minutes of the 13 November 2012 Audit Committee be submitted to the 20 December 2012 Trust Board. **STA**

300/12/2 Research and Development Committee

Resolved – that the list of issues discussed at the 8 October 2012 Research and Development Committee be noted (paper AA), with Minutes from that meeting to be submitted to the 29 November 2012 Trust Board. **STA**

301/12 CORPORATE TRUSTEE BUSINESS

301/12/1 Charitable Funds Committee

Resolved – that the Minutes of the 14 September 2012 Charitable Funds Committee be received, and the recommendations and decisions therein be endorsed and noted respectively.

302/12 TRUST BOARD BULLETIN

Resolved – the following Trust Board Bulletin report be received for information:-
(1) updated declaration of interests from Mr R Kilner, Non-Executive Director.

303/12 QUESTIONS FROM THE PUBLIC RELATING TO BUSINESS TRANSACTED AT THIS MEETING

The Chairman advised that at future Trust Boards, 1 question per questioner would be taken at the meeting, with any additional questions therefore to be advised to the Director of Corporate and Legal Affairs who would coordinate a response outside the meeting. The following queries/comments were received regarding the business transacted at the meeting:-

(1) a question raised on behalf of the Leicestershire LINk, as to the Trust Board's level of confidence that the 2012-13 financial recovery plan would be delivered, and the LINk's view that this was now a reputational issue for UHL. In response, the Trust Chairman advised that the Trust Board took assurance from the Finance and Performance Committee and the Director of Finance and Business Services, in addition to considering a range of upside/downside scenarios. The Trust Board was therefore fully aware of the risk range and considered that achievement of the projected small surplus was realistic;

(2) a comment from Mr D Gorrod, Leicester Patients' Panel, that the public would appreciate greater detail on UHL's charitable funds holdings and its spend compared to investment levels (Charitable Funds Committee minutes – paper BB). In response, the Trust Chairman advised that UHL aimed to encourage both donations to the Trust's charitable funds, and the subsequent appropriate expenditure of those funds. In response to a further query, it was not considered that FT status would affect this

approach. The Director of Finance and Business Services advised that the September 2012 Charitable Funds Committee had reviewed the performance of UHL's charitable funds investment managers (Cazenove), who had been found to be meeting all of their targets. He recognised the need, however, to spend the Trust's charitable funds holdings in a more timely manner, and

(3) a question from Mr Gorrod, Leicester Patients' Panel, as to whether UHL was likely to seek an FT partner (in light of recent FT Network comments on the financial difficulties affecting FTs), and on whether there was any contingency plan in place re: UHL's FT timeline. In response, the Trust Chairman reiterated UHL's dedication to achieving FT status in April 2014, with no changes envisaged to that plan.

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

304/12 DATE OF NEXT MEETING

Resolved – that the next Trust Board meeting be held on Thursday 29 November 2012 at 10am in rooms A & B, Clinical Education Centre, Leicester General Hospital.

305/12 ANY OTHER BUSINESS

305/12/1 Report by the Director of Communications and External Relations

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

The meeting closed at 4.40pm

Helen Stokes – **Senior Trust Administrator**

Cumulative Record of Members' Attendance (2012-13 to date):

Name	Possible	Actual	% attendance	Name	Possible	Actual	% attendance
M Hindle (Chair)	9	9	100	I Reid	9	9	100
J Birrell	3	3	100	A Seddon	9	9	100
K Bradley	9	7	78	D Tracy	9	7	78
K Harris	9	7	78	A Tierney*	6	5	83
S Hinchliffe	9	9	100	S Ward*	9	8	89
K Jenkins	9	8	89	M Wightman*	9	9	100
R Kilner	9	9	100	J Wilson	9	7	78
M Lowe-Lauri	5	5	100	D Wynford-Thomas	9	5	56
P Panchal	9	8	89	Mr A Chatten*	2	2	100
Mr J Clarke*	2	1	50				

* non-voting members