UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF A MEETING OF THE TRUST BOARD, HELD ON THURSDAY 31 OCTOBER 2013 AT 9.30AM IN SEMINAR ROOMS A & B, CLINICAL EDUCATION CENTRE, LEICESTER GENERAL HOSPITAL

Present:
Mr R Kilner – Acting Trust Chairman
Dr K Harris – Medical Director
Mr R Mitchell – Chief Operating Officer
Ms R Overfield – Chief Nurse
Mr P Panchal – Non-Executive Director
Mr I Sadd – Non-Executive Director
Mr A Seddon – Director of Finance and Business Services and Acting Chief Executive
Ms J Wilson – Non-Executive Director (excluding part of Minute 266/13/2)

In attendance:
Dr T Bentley – Leicester City CCG Representative (from Minute 271/13)
Mr C Blainey – Empath Finance Director (for Minute 265/13/2)
Ms K Bradley – Director of Human Resources (excluding part of Minute 266/13/2)
Mr E Charlesworth – Healthwatch Representative (from Minute 271/13)
Ms R Doyle – Meaningful Activities Co-Ordinator, Patient Experience Team (for Minute 277/13/1)
Mr T Flanagan – Empath Commercial Director (for Minute 265/13/2)
Mr R Manton – Risk and Safety Manager (for Minute 278/13/1)
Mrs K Rayns – Trust Administrator
Mr T Sanders – Managing Director, West Leicestershire CCG (for Minute 272/13)
Dr P Shaw – Empath Managing Director (for Minute 265/13/2)
Mr B Teasdale – Clinical Lead, Emergency Department (for Minute 272/13)
Mr S Ward – Director of Corporate and Legal Affairs
Mr M Wightman – Director of Marketing and Communications

ACTION

259/13 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 259/13 – 270/13), having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.

260/13 APOLOGIES AND WELCOME

Apologies for absence were received from Mr J Adler, Chief Executive, Col (Retd) I Crowe, Non-Executive Director, Ms K Jenkins, Non-Executive Director and Professor D Wynford-Thomas, Non-Executive Director.

The Acting Chairman welcomed Mr I Sadd, Non-Executive Director to his first meeting of the UHL Trust Board and noted that Mr A Seddon, Director of Finance and Business Services was attending in the capacity of Acting Chief Executive.

261/13 DECLARATIONS OF INTERESTS IN THE CONFIDENTIAL BUSINESS

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

262/13 ACTING CHAIRMAN'S AND ACTING CHIEF EXECUTIVE'S OPENING COMMENTS

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.

263/13 CONFIDENTIAL MINUTES

Resolved – that the confidential Minutes of the Trust Board meeting held on 26 September 2013 and the 16 September 2013 Trust Board Development Session be confirmed as a correct record.

264/13 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.

265/13 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 and that public consideration at this stage could be prejudicial to the effective conduct of public affairs.

266/13 REPORTS BY THE DIRECTOR OF HUMAN RESOURCES

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

267/13 REPORT BY THE MEDICAL DIRECTOR

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

268/13 REPORT BY THE DIRECTOR OF CORPORATE AND LEGAL AFFAIRS

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

269/13 REPORT BY THE ACTING CHAIRMAN AND THE DIRECTOR OF CORPORATE AND LEGAL AFFAIRS

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

270/13 REPORTS FROM BOARD COMMITTEES

270/13/1 Finance and Performance Committee

Resolved – 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.

270/13/2 Quality Assurance Committee

Resolved – that the confidential Minutes of the Quality Assurance Committee meeting held on 25 September 2013 be received and noted.

270/13/3 Remuneration Committee

Resolved – that the confidential Minutes of the Remuneration Committee held on 26 September 2013 be received and noted.

271/13 DECLARATIONS OF INTERESTS IN THE PUBLIC BUSINESS

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

272/13 EMERGENCY CARE

The Acting Chairman noted a change to the running order of the agenda, advising that agenda items 15, 24.2 and 24.3 had been amalgamated.

272/13/1 CCG Perspective on Emergency Care and the Collaborative Hub

Mr T Sanders, Managing Director, West Leicestershire CCG attended the meeting to brief the Board on the work of the Collaborative Emergency Care Hub, noting that he had recently assumed the lead role for this work on behalf of the 3 local CCGs. He summarised the emergency care position in the middle of Summer 2013 when UHL had been ranked as one of the poorest performing Trusts in the country, together with UHL and health economy wide actions that were being taken to respond to concerns and deliver a recovery plan. These recovery actions were continuing to be progressed, but by mid-September 2013 it had become apparent that this approach would not wholly address the current challenges.

On 19 September 2013, the Collaborative Hub had been formed as a vehicle for "changing the conversation" and developing a more collaborative approach to problem solving. Direct input was now provided by Commissioners, community based services and transport providers to support UHL and the focus on the consistent application of the Trust's internal systems and processes had been strengthened. A series of 5 rapid improvement workshops had been held over a 3 day period involving a wide range of both clinical and non-clinical staff and printed copies of the rapid improvement work programme were tabled at the meeting. The work programme was structured to focus on (1) inflow, (2) ED/specialty working, (3) ward practice, (4) operational issues, and (5) multi-agency integration.

CCG management resources had been aligned with key workstreams and intensive work was underway to identify where the additional winter funding (£10m for the local health economy) would be spent to deliver the maximum benefits. Outline plans for this funding were due to be considered at a meeting of the Collaborative Hub later that afternoon. Members noted the benefits of constructive relationships that were being formed, and the progress being made with TTO medications, specialty engagement and internal discharge processes. Significant input by the Chief Nurse in respect of discharge processes had been very welcome. Mr Sanders provided his view that the Collaborative Hub was focusing on the most appropriate plans and that this focus was likely to continue for the next 6 months.

In discussion following the presentation, Board members raised the following comments and queries:-

(a) Ms J Wilson, Non-Executive Director recorded her support of the new collaborative approach and queried how the underlying causes behind a recent 8% increase in admissions would be addressed within the work programme and whether there were any opportunities to "smooth" patient inflow. In response, the CCG Managing Director reported on plans to identify appropriate actions to reduce inflow (eg improved management of long term conditions in the community) and he confirmed that these

would be built into the work programme by Easter 2014. Action 1.1 on the work programme made reference to an analysis of patient inflow strands by time of day and feedback to the referring GP was one of the expected outcomes. Dr T Bentley, CCG representative reported on arrangements to improve the timing of admissions arising from the Emergency Assessment Service;

(b) the Director of Marketing and Communications provided feedback from recent Overview and Scrutiny meetings and a King's Fund conference where discussions had taken place regarding winter capacity plans and care of the frail elderly in the context of the current out of hours arrangements for GP services. He queried the scope for GPs to contact their most at risk patients to provide them with key health messages to prevent their condition deteriorating to such a point that they required an acute admission. In response, Dr T Bentley, CCG representative reported on the risk stratification processes already in place which included MDT meetings and regular appointments with their most at risk patients. The CCG Managing Director commented upon future opportunities to develop a more systematic (red flag) approach in this area, and

(c) Ms J Wilson, Non-Executive Director queried what arrangements would be put in place to reduce admissions amongst UHL's most frequently attending patients and noted in response that the engagement work was still taking place to support this workstream. Implementation arrangements would be discussed at a meeting of the inflow working group to be held on 4 November 2013.

Resolved – that the presentation and subsequent discussion on Emergency Care and the work of the Collaborative Hub be noted.

272/13/2 UHL Emergency Department (ED)

The Chief Operating Officer introduced Dr B Teasdale, ED Clinical Lead who had attended the meeting to provide a presentation on UHL's ED performance from a clinician's perspective. Dr Teasdale tabled copies of a briefing paper outlining the context of recent changes to ED processes, the work undertaken by the Emergency Care Action Team (ECAT) and the Collaborative Hub. He particularly highlighted the following key areas of activity and focus:-

(a) changes to the physical ED environment, including the completion of the ambulance handover area, additional resuscitation bay accommodation, a dedicated psychiatry assessment area, and plans to increase paediatric accommodation within the existing paediatric footprint;
(b) successful recruitment to vacant nursing posts – by the end of 2013, all but 9 of the vacant posts were expected to be filled;
(c) the medical workforce recruitment strategy closely aligned with the departmental development plan, "ED pillars" and attendance levels, with the aim of achieving sustainable reductions in locum staffing, and
(d) the further actions required to deliver sustained improvements in ED performance, including a relentless and consistent approach to achieving meaningful patient flows, improving interactions with support services and specialty teams, and robust delivery of individual and team performance objectives.

Resolved – that the presentation on UHL's Emergency Department be noted.

272/13/3 Emergency Department Performance Report

The Chief Operating Officer introduced paper Y, providing an overview of the Trust's performance against the 95% 4 hour target and ED quality indicators, noting that September 2013 performance stood at 89.5% and the year to date performance was 87.84%. Performance during October 2013 had been variable, although 1 week of compliant performance had been delivered (week ending 13 October 2013).

The Chief Operating Officer reported on the continued actions underway in order to (1) reduce rates of attendances and admissions, (2) accelerate the arrangements for safe and timely discharge, and (3) address gaps in staffing rotas. He noted the cultural changes required within the organisation to consistently adhere to internal processes for a full 20 day period in order to demonstrate the sustainable benefits to the system.

The Acting Chairman noted constraints surrounding acute bed capacity and Dr T Bentley, CCG representative provided feedback from the General Practice perspective, noting that:-

- Bed Bureau referrals were not now channelled through ED and this was welcomed;
- an appropriate focus was being maintained on improving access to primary care services and Commissioners were monitoring GP out of hours performance. The CCG Managing Director commented that there was no reliable system to gather feedback on access to out of hours GP services, hence the reliance upon patient experience and GP Practice appraisal data;
- feedback to GPs on admissions data, inappropriate referrals and frequently attending patients was considered helpful;
- admissions avoidance measures were being built into patient pathways, but the GP helpline, choose and book service and protected education and learning time for GPs would all help to support this work;
- improved GP access to patient records via System 1 was required;
- GPs needed to be informed of patient discharges in a timely manner and good quality discharge planning was considered crucial in this respect;
- the District Nurse service had been reconfigured within Leicester City, and
- support was being provided by the Intensive Community Support Service in respect of managing patients' conditions safely in the home environment.

The CCG Managing Director commented that 3 of the 5 Collaborative Hub workstreams were considered to be within UHL's control and he expressed concern that more progress had not been made with these prior to intervention by the Hub. The Acting Chairman responded by highlighting opportunities to reduce delayed transfers of care to non-acute providers. He queried the approval process for UHL's winter capacity plan noting a material shortfall in bed capacity relative to the activity modelling and the negative impact of having the equivalent of between 1 and 2 wards full of patients not requiring acute care services waiting in UHL beds for alternative care arrangements. The CCG Managing Director also reported on the CCG arrangements for supporting continuing health care, through appropriate access and use of community hospital and LPT beds and provision of hospital transport, suggesting that available community bed capacity and transport arrangements were not always utilised effectively by UHL.

Discussion also took place regarding the following issues:-

(a) opportunities to reconcile differing views on bed capacity modelling at that afternoon's Collaborative Hub meeting. The CCG Managing Director particularly challenged the Trust's ability to staff any additional capacity beds appropriately (once these had been agreed);
(b) clear accountability arrangements for compiling an accurate daily list of patients ready for discharge which would alleviate the need for nursing staff from each ward area to attend bed management meetings 3 or 4 times per day;
(c) the benefits of the recently re-instated Elderly Frailty Unit (EFU) and the longer term aim to co-locate this unit alongside the ED under future reconfiguration plans;
(d) progress with the medications element of discharge processes – the Medical Director advised of the results of a recent pilot which aimed to provide TTOs within 30 minutes, and
(e) the expected benefits of the provision of a separate 4-chaired area for streaming patients requiring mental health support.

Resolved – that the monthly update on ED performance (paper Y) be received and noted.

272/13/4 Winter Bed and Capacity Planning

The Chief Operating Officer introduced paper Z, providing an overview of additional bed capacity and other capacity changes required to manage patient flows and expected increases in demand between 1 December 2013 and 31 March 2014. An updated briefing paper for the Urgent Care Working Group was circulated as an additional appendix to paper Z. Trust Board members noted that the Acting Chairman and the Chief Executive would be presenting the Winter Plan to the Trust Development Authority (TDA) for approval during week commencing 4 November 2013.

Mr E Charlesworth, Healthwatch Representative, made reference to the Healthwatch letter of concern, a copy of which was appended to paper Z. He commended the workstreams already being implemented but he highlighted opportunities to commence discharge planning or transfer of care arrangements as soon as patients arrived in the Trust and for these arrangements to be communicated effectively.

Resolved – that the reports on winter bed and capacity planning for 2013-14 (paper Z) be received and noted and the Winter Plan for 2013-14 be endorsed. **COO**

273/13 ACTING CHAIRMAN'S AND ACTING CHIEF EXECUTIVE'S OPENING COMMENTS

The Acting Chairman welcomed Mr I Sadd, Non-Executive Director and Dr T Bentley, co-opted non-voting CCG representative to the meeting. He drew members' attention to the following issues:-

(a) the Trust Board had earlier endorsed the appointment of Mr E Charlesworth as a non-voting co-opted member representing the Leicester, Leicestershire and Rutland Healthwatch organisations and he invited Mr Charlesworth to join Trust Board members around the table for the remainder of this meeting and for future meetings;
(b) the Director of Finance and Business Services was attending this meeting in the capacity of Acting Chief Executive;
(c) presentations had already been provided on the emergency care system and he had requested the Medical Director to provide a short presentation to support the UHL mortality report (Minute 277/13/4 below refers), and
(d) Executive Directors had been asked to improve the presentation of future Trust Board reports (and their accompanying cover sheets) to adopt a more concise and clear style.

The Acting Chief Executive highlighted the following issues for particular attention:-

(i) UHL's mortality rates had been re-based following changes in the comparative positions, and this would be explained in more detailed during the Medical Director's presentation (Minute 227/13/4 below refers);
(ii) the Care Quality Commission had assessed the Trust at a level 1 and an inspection was now expected early in 2014 (Minute 277/13/2 below refers), and
(iii) the implications of the Trust's half year end financial position for 2013-14 would be considered later in the agenda (Minute 281/13/1 below refers).

Resolved – that the verbal information provided by the Acting Chairman and the Acting Chief Executive be received and noted.

273/13/1 Appointments to Board Committees and Changes to the Empath and NHS Horizons Boards

The Director of Corporate and Legal Affairs introduced paper K, seeking Trust Board approval for the following appointments arising from the appointment of Mr R Kilner as

Acting Chair, Mr I Sadd as Non-Executive Director and Ms R Overfield as Chief Nurse:-

(a) Mr R Kilner, Acting Chair to temporarily stand down from membership of the Audit Committee and the Empath Board (while Acting Chair) and the Director of Finance and Business Services be appointed temporarily as the Trust's representative on the Empath Board;
(b) Mr I Sadd, Non-Executive Director be appointed to the membership of the Audit Committee, Charitable Funds Committee and the Finance and Performance Committee (succeeding Mr P Panchal, Non-Executive Director on the latter Committee); **DCLA**
(c) Mr P Panchal, Non-Executive Director be appointed as Chair of the Charitable Funds Committee;
(d) Ms K Jenkins, Non-Executive Director be appointed to the membership of the Quality Assurance Committee;
(e) confirmation of the voting and non-voting membership of the Charitable Funds Committee (as set out in paper K), and
(f) the appointment of the Chief Nurse to the membership of the NHS Horizons Board (succeeding the Director of Finance and Business Services).

Resolved – that (A) the proposed appointments to Board Committees, the Empath Board and the NHS Horizons Board be endorsed (as detailed in paper K), and

(B) the Director of Corporate and Legal Affairs be requested to amend the membership and terms of reference for the Audit Committee, Charitable Funds Committee, Finance and Performance Committee and Quality Assurance Committee accordingly. **DCLA**

274/13 MINUTES

Resolved – that the Minutes of the Trust Board meeting held on 26 September 2013 (paper L) be confirmed as a correct record.

275/13 MATTERS ARISING FROM THE MINUTES

Paper M detailed the status of previous matters arising, particularly noting those without a specific timescale for resolution. In discussion on the matters arising report, the Board received updated information in respect of the following items:-

(a) item 3 – Minute 249/13/1 of 26 September 2013 – the Medical Director advised that the appointment of CMG education leads was expected to be completed over the next 2 to 3 weeks and that meanwhile, the CMG management teams had been made aware of requirements for SIFT expenditure reports to be provided to the Associate Medical Director for Clinical Education;

(b) item 5 – Minute 251/13/1(c) of 26 September 2013 – the Chief Nurse advised that none of the delays in processing urgent Estates requests had been escalated to SUI status or logged as a health and safety concern. However, there had been occasions when the patient environment had not been as expected;

(c) item 6 – Minute 252/13/1 of 26 September 2013 – the Chief Nurse had not yet met with Ms K Jenkins, Non-Executive Director to consider the monitoring arrangements for risk 4 on the Board Assurance Framework; **CN**

(d) item 7 – Minute 222/13/2 of 29 August 2013 – the expected report consolidating the common themes arising from the Berwick and Keogh reviews and the Francis Inquiry had been withdrawn from today's agenda on the grounds that it did not respond to all of the Board's questions. The report would now be considered at the next Quality Assurance Committee meeting prior to presentation to the November 2013 Trust Board; **CN**

(e) item 8 – Minute 227/13/1 of 29 August 2013 – the Director of Marketing and Communications advised that the recently appointed CMG leaders had been invited to nominate their accountable leads for PPI engagement. The responses received to date indicated that this role might be undertaken by the lead nurse, but this option would be discussed in more detail at the forthcoming CMG time out on 1 November 2013; **COO/ DHR**

(f) item 9 – Minute 227/13(2) of 29 August 2013 – the Acting Chairman reflected on his consideration of opportunities to invite contributions from members of the public during the course of Trust Board meetings. He recognised the following key points:-

- the commitment demonstrated through regular attendance at Trust Board meetings by members of the public;
- the positive step taken today in appointing a non-voting co-opted representative from Healthwatch to the Trust Board;
- the distinction between a public Board meeting and a Board meeting which was held in public, and
- opportunities to invite questions at the start of each meeting or in writing in advance of each meeting,

concluding that questions would continue to be invited at the end of each meeting from the public gallery, but that any questions raised were expected to be made explicit from the outset without any lengthy pre-amble;

(g) item 10 – Minute 194/13 of 25 July 2013 – an updated Trust Board calendar of business and programme of Trust Board development would be presented to the 20 December 2013 Trust Board meeting; **DCLA**

(h) item 11 – Minute 199/13/1 of 25 July 2013 – the results of the Equality Audit would be included in the quarterly Workforce and Organisational Development update to be presented to the Trust Board on 20 December 2013, and **DHR**

(i) item 12 – Minute 167/13/3 of 27 June 2013 – the Chief Executive had advised that there was not likely to be a further LLR-wide response to the Francis Inquiry.

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

276/13 REPORTS BY THE ACTING CHIEF EXECUTIVE

276/13/1 Monthly Update Report – October 2013

The Acting Chief Executive introduced paper N, the Chief Executive's monthly summary of key issues. Noting that separate reports featured elsewhere on the Trust Board agenda in respect of financial performance and facilities management service provision, he drew members' attention to the following issues:-

(i) Emergency Care performance (as detailed in the reports and presentations received under Minute 272/13 above);
(ii) confirmation of the TDA's recently published level 4 (material issue) performance rating for the Trust, and
(iii) publication of Monitor's 2014-15 tariff consultation document.

Resolved – that the Chief Executive's monthly update report for October 2013 be received and noted.

277/13 CLINICAL QUALITY AND SAFETY

277/13/1 Contrasting Experiences – the Role of the Meaningful Activity Facilitator

The Chief Nurse introduced paper O detailing the arrangements for this new role which was being trialled currently on wards 19, 32 and 37 at the LRI as part of the Quality Commitment workstream for improving the care for older people in hospital. The activities provided were aimed to support hospital inpatients suffering from dementia by providing them with cognitive stimulation to support their physical, sensory and psychological well-being.

Ms R Doyle, Meaningful Activities Co-Ordinator attended the meeting to provide Board members with an insight into her role and demonstrated some of the practical ways in which patients had been made to feel more at ease in the hospital setting. Members noted the wide ranging benefits that psychological improvements had made in terms of reducing agitation and breaking down cycles of behaviour which were acting as a barrier to providing effective care.

Trust Board members commended this excellent initiative and thanked Ms Doyle for attending the meeting. The following comments and queries were raised:-

(a) the Director of Marketing and Communications suggested that Professor A Burns, the National Lead for Dementia Care might be interested to hear about this workstream, following his recent presentation at the King's Fund Silver Book Summit. The Chief Nurse agreed to contact Professor Burns accordingly; **CN**
(b) Mr P Panchal, Non-Executive Director welcomed this initiative in the context of changing population demographics, suggesting that appropriate investment from core NHS funds be sought urgently following the detailed evaluation of patient outcomes evidence in January 2014;
(c) the Acting Chairman queried the scope to provide weekend meaningful activity support as part of the wider implementation arrangements;
(d) the Medical Director sought further information on the training that Ms Doyle had received to undertake this role. In response, Ms Doyle reported on the extensive learning she had received through practical experience, other ward based HCAs, challenging behaviour courses, dementia training, seminars on dementia friendly environments, a visit to another Trust in Bradford, liaison with Age UK and the Alzheimer's Society and her own research. The Medical Director noted opportunities to develop a more structured approach to the future training programme for this role;
(e) the Chief Nurse confirmed that the person specification and job description were being formalised with a view to implementation of the wider roll out of this service;
(f) the Director of Finance and Business Services recognised the tangible benefits of moderating patients' behaviour, noting that preventing the downward spiral of challenging behaviour would also impact upon improved patient experience and reduced length of stay for affected patients, and
(g) the Director of Human Resources noted the enthusiasm with which the meaningful activities programme was being delivered and undertook to share this positive development with colleagues from the Leicestershire Partnership NHS Trust at the next meeting of the LLR Workforce Group. **DHR**

<u>Resolved</u> – that (A) the presentation on meaningful activities for dementia patients be received and noted, and

(B) the Chief Nurse and the Director of Human Resources be requested to highlight this positive initiative to the National Lead for Dementia Care and the LLR Workforce Group (respectively). **CN/ DHR**

277/13/2 <u>Care Quality Commission (CQC) Intelligent Monitoring</u>

The Chief Nurse and the Medical Director introduced paper P, briefing the Trust Board on the new CQC surveillance model and the outcome of the October 2013 review which had identified 5 risks and 5 elevated risks for UHL out of the 150 indicators analysed.

Consequently the Trust had been placed in risk category 1 (the highest risk rating) and would now be 1 of 19 trusts to be inspected as part of the wave 2 inspection programme being carried out between January and March 2014.

The Medical Director summarised the Trust's response to the risks and elevated risks (as set out in section 4.2 of paper K), particularly noting the importance of accurate clinical coding in respect of death rates from low risk diagnosis groups and the maternity outlier alert in respect of puerperal sepsis and other puerperal infections. In addition, the Director of Human Resources highlighted the statistical anomaly surrounding staff transfers to the outsourced IM&T and Facilities Management providers, noting that these had contributed to the Trust's composite risk rating for staff turnover.

The Healthwatch representative sought and received assurance that significant progress was being made with the areas of risk identified by the CQC and that robust plans were in place to address any remaining concerns.

Resolved – that (A) the briefing paper on the outcome of the CQC intelligent monitoring process be received and noted, and

(B) further reports be provided to the Quality Assurance Committee and the Trust Board regarding the arrangements for the forthcoming CQC inspection. **CN**

277/13/3 Update on LLR Response to Francis Inquiry and UHL Response to Keogh and Berwick Reviews

Resolved – that the expected update on responses to the Francis Inquiry and the Keogh and Berwick reviews be deferred to the November 2013 Trust Board meeting. **CN**

277/13/4 UHL Mortality Review Report – Saving Lives Update

Paper R provided a detailed summary of UHL's current and historical mortality performance and the actions being taken under the "Saving Lives" workstream of the Quality Commitment which aimed to save an extra 1,000 lives over the next 3 years. The Trust Board noted that UHL's Hospital Standardised Mortality Ratio (HSMR) for 2012-13 was 101 – slightly above the average of 100, but within the expected range. Within the Trust level data, there were differences between the hospital sites which were noted to be 114 for Leicester Royal Infirmary, 81 for Leicester General Hospital and 82 for Glenfield Hospital.

In addition, the Medical Director provided a presentation reminding members of the various ways in which mortality rates were measured and the national correlation between hospital sites with and without accident and emergency facilities. Copies of the presentation slides were circulated to Trust Board members following the meeting. In discussion following the presentation:-

(a) Ms J Wilson, Non-Executive Director referred to the "tree chart" provided in section 7.3 of paper R (showing the diagnosis groups contributing to the Trust's HSMR) and sought additional information regarding the areas for future focus. In response, the Medical Director advised that the size of each diagnosis box and the depth of the colour indicated the number of deaths and the relative risk (respectively). He briefed members on the arrangements already in place to divert appropriate respiratory admissions to Glenfield Hospital and similar proposals for patient streaming within the chest pain pathway. These proposals were currently awaiting approval by the East Midlands Ambulance Service (EMAS). He also stressed the importance of accurate clinical coding within each diagnosis and noted that HMSR did not take into account patient acuity (ie the severity of the condition);
(b) Ms J Wilson, Non-Executive Director also sought and received additional information regarding the arrangements for improving performance in respect of responding to

sepsis, and noted that this was being progressed as a new Critical Safety Action and would be escalated accordingly;

(c) Dr T Bentley, CCG representative noted the impact of some "end of life" patients being coded with the diagnosis of pneumonia and then being transferred to the appropriate end of life pathways. He reported on the arrangements for improving end of life care plans for those patients who chose to die outside of the hospital setting;

(d) the Medical Director advised that frail elderly patients approaching the end of their life were often diagnosed with urinary tract or chest infections but this was not always the primary cause of death;

(e) the Chief Nurse highlighted the contribution that good nursing leadership and appropriate nurse to bed staffing ratios could make in improving patient outcomes;

(f) Mr P Panchal, Non-Executive Director challenged whether the Trust's 4 hour ED performance had contributed to the elevated HSMR data on the LRI site, and

(g) in response to a query raised by the Acting Chairman, the Medical Director confirmed that elective mortality on the LGH site was within the expected range. **MD**

<u>Resolved</u> – that (A) the update on UHL's mortality be received and noted, and

(B) reports on UHL's Mortality and progress with the Saving Lives workstream continue to be presented to the Trust Board for assurance. **MD**

277/13/5 <u>Nursing Workforce Update</u>

The Chief Nurse introduced paper S, providing an overview of UHL's nursing workforce position following recent ward staffing reviews which had resulted in additional investment of £5.9m being built into ward nursing budgets. Table 4 on page 5 of the report detailed the number of reported nurse vacancies each month over the last 12 months and members noted that as at the end of September 2013, there had been 500 vacant posts. Staff turnover rates and the current recruitment schedule were provided at appendix 5 and appendix 6 respectively.

The Chief Nurse expressed her view that approximately half of these vacancies would be filled by March 2014 and use of bank and agency nurses was expected to continue in the interim period. In parallel, arrangements were being made to free up more nursing time on the wards and any gaps in shifts were being monitored twice daily (including weekends). A copy of a recent report to the Executive Strategy Board was also appended to paper S, outlining the criteria for wards requiring special support. In discussion on the nursing workforce update, the Board noted:-

(a) the work taking place to increase visibility of ward staffing levels to patients and visitors on the wards via notice boards at the entrance which stated the ward level establishment and the actual number of staff on duty for each shift;

(b) that name badges were being ordered for all nurses to wear on their lapel as a Listening into Action "quick win". These badges would help to clearly identify individuals and their position held. The Medical Director advised that colour coding had been recently introduced for medical staff ID badges and lanyards;

(c) that many other Trusts were also undertaking overseas nursing recruitment campaigns due to national shortages of trained nurses, and

(d) the recruitment campaigns and associated training courses offered with a view to attracting qualified nurses back into the profession following a career break.

Ms J Wilson, Non-Executive Director confirmed that the Quality Assurance Committee would be monitoring the nursing workforce position on a regular basis and she queried what the process would be for monitoring the wider workforce. The Acting Chairman undertook to consider these governance arrangements with the Chief Executive at his next 1 to 1 meeting. **ACTING CHAIR**

Resolved – that (A) the update on the UHL Nursing Workforce be received and noted, and

(B) the Acting Chairman be requested to consider the governance arrangements for monitoring the Trust's wider workforce with the Chief Executive outside the meeting. **ACTING CHAIR**

277/13/6 Deed of Gift Donation for Scalp Cooling Package

The Director of Marketing and Communications presented paper T, which sought Trust Board approval (as Corporate Trustee) to accept a deed of gift from the national Breast Cancer Charity "Walk the Walk" for up to £250,000 to enable the Chemotherapy service to purchase approximately 15 scalp cooling caps. The cooling caps were designed to reduce hair loss for patients undergoing chemotherapy.

Resolved – that (A) the Deed of Gift from the Breast Cancer Charity "Walk the Walk" for the purchase of scalp cooling caps (as set out in paper T) be endorsed, and

(B) the Acting Chairman be authorised to sign the Deed of Gift and apply the Trust's seal accordingly. **ACTING CHAIR**

278/13 RISK

278/13/1 Board Assurance Framework (BAF) Update

The Chief Nurse presented the latest iteration of UHL's BAF (paper U) and Mr R Manton, Risk and Safety Manager attended the meeting for this item. The Board noted that there had been no new risks added to the BAF this month, but an additional risk relating to ward level staffing would be included for consideration at the 28 November 2013 meeting. In respect of the 3 risks selected for detailed consideration at today's meeting, the Trust Board noted the following information:-

- risk 12 – failure to exploit the potential of IM&T – the Director of Finance and Business Services reported that a number of IT systems were nearing the end of their life and that replacement systems were currently being considered. Confirmation was provided that the ERDM and EPR projects were progressing appropriately now that the Trust's Chief Medical Information Officers were both in post;
- risk 13 – failure to enhance education and training culture – the Acting Chair queried whether there were opportunities to revise the likelihood rating for this risk but the Medical Director suggested that this might be premature as good progress was being made by the CMG teams towards identifying their education leads and improving engagement in education and training issues, and
- risk 1 – failure to achieve financial sustainability – the Director of Finance and Business Services advised that discussion on this risk would take place later in the agenda (Minute 281/13/1 below refers).

The Risk and Safety Manager reported that the action relating to section 1.17 in the action tracker provided at appendix 2 had now been completed and that this would be reflected in the next iteration of this report.

Resolved – that (A) the Board Assurance Framework (presented as paper U) be received and noted, and

(B) a new risk surrounding ward level staffing be included in the BAF report to be presented to the 28 November 2013 Trust Board meeting. **CN/RSM**

279/13 HUMAN RESOURCES

279/13/1 Implementation of the Clinical Management Structure

Further to Minute 248/13/1 of 26 September 2013, paper V provided a progress report on the implementation of the new Clinical Management Groups (CMGs), noting that recruitment to the CMG Clinical Leads, General Managers and Heads of Nursing was largely complete and that the supporting structures underneath that level were being finalised within the next phase of the work plan. A facilitated event was being held for the CMG leaders on 1 November 2013 in order to establish the objectives and expectations and identify any developmental support that might be required to achieve them. A copy of the updated risk assessment was provided at appendix 1.

The Acting Chairman queried whether there had been sufficient visibility externally of the new CMG arrangements, noting that Dr T Bentley, CCG representative did not recall seeing any communications on this theme. The Director of Marketing and Communications confirmed that an article had been included in the last GPs' newsletter and that a new organisation chart was being tested which might be capable of providing photographs alongside the names of key post holders.

Resolved – that (A) the update on implementation of UHL's Clinical Management Group structure be received and noted;

(B) a final report on the implementation of the new Clinical Management Structure be provided to the 31 October 2013 Trust Board meeting. **DHR**

280/13 RESEARCH AND DEVELOPMENT

280/13/1 Quarterly Update on Research and Development

Further to Minute 198/13/1 of 25 July 2013, Professor N Brunskill, Director of Research and Development attended the meeting to introduce paper W, the quarterly update on research and development activities and current related challenges. Members noted that UHL featured in the NIHR "first division" (out of 4) in respect of high-class clinical research activity outputs and the Trust was working hard to retain this ranking. 111 new clinical trials had been reported for quarter 1 and recruitment to portfolio trials was progressing well with 5505 patients already recruited against the year-end target of 8381. The monthly NIHR activity report was appended to paper W for members' information.

The Trust currently hosted 3 Biomedical Research Units (BRUs), the Collaboration for Leadership in Applied Health Research and Care (CLAHRC) for the Leicestershire, Northamptonshire and Rutland area and the East Midlands Clinical Research Network (EMCRN). A Clinical Director for the EMCRN was due to be appointed during November 2013. Confirmation was provided that effective patient and public involvement took place in respect of research. Section 3 of paper W set out the challenges in supporting the BRUs to achieve their stated objectives and create a credible application for the NIHR Biomedical Research Centre. The R&D Office was noted to be working with the new Clinical Management Group teams to appoint R&D leads to embed the R&D culture within the Trust.

The Acting Chairman sought specific examples of any support services which might be limiting the Trust's ability to deliver the full R&D potential. In response, the Director of R&D highlighted some of the challenges previously experienced in respect of Pharmacy and Imaging services, although the new CMG structure was expected to support improved partnership working. The Chief Operating Officer undertook to advise the Clinical Supporting and Imaging CMG management team of these concerns. **COO**

Finally, the Medical Director highlighted the Trust Board's accountability (as the host Trust) for monitoring performance of the EMCRN and he agreed to liaise with the Director of Corporate and Legal Affairs to ensure that future quarterly reports to the Trust Board

properly described how the Trust was discharging its responsibilities in this regard.

<u>Resolved</u> – that (A) the quarterly update on Research and Development be received and noted (paper W refers);

(B) the Chief Operating Officer be requested to advise the Clinical Supporting and Imaging CMG management team of concerns raised by the Director of Research and Development, and **COO**

(C) the Director of Research and Development be requested to ensure that future quarterly reports properly described how the Trust was discharging its responsibilities for monitoring performance of the EMCRN. **DR&D/ MD**

281/13 QUALITY AND PERFORMANCE

281/13/1 <u>Month 6 Quality, Performance and Finance Report</u>

Paper X, the quality, performance and finance report for month 6 (month ending 30 September 2013) advised of red/amber/green (RAG) performance ratings for the Trust, and set out performance exception reports in the accompanying appendices. Ms J Wilson, Non-Executive Director and Quality Assurance Committee (QAC) Chair briefed Trust Board members on the following points, as considered at the 29 October 2013 QAC meeting:-

- the UHL Quality Commitment was due to be formally re-launched at the November 2013 QAC meeting and a schedule of Trust Board presentations would be prepared, and
- the Clwyd report on complaints handling was due to be considered in depth by the Executive Team and the QAC.

The Acting Chief Executive noted a correction to the table of NTDA indicators provided on page 2 of paper X, advising that there had been no maternal deaths during the 2013-14 year to date. The Medical Director reported on a Never Event involving human error in selection of the correct lens for a patient undergoing an ophthalmology procedure. Once the investigation had been completed, a detailed report would be presented to the QAC on this Never Event.

Papers X1 and X2 provided the Minutes of the QAC and Finance and Performance Committee meetings held on 25 September 2013 for noting.

The Chief Nurse reported on the quality and patient safety issues outlined in section 3 of paper X, noting that trends relating to pressure ulcer incidence and patient falls were reducing, but Clostridium Difficile performance remained challenging although this was within the agreed threshold. Dr T Bentley, CCG representative queried the impact of the discharge experience workstream being 4 months behind schedule and noted that this delay referred to the patient experience survey process rather than the discharge process itself which was being progressed through the Quality Commitment.

Ms J Wilson, Non-Executive Director reported verbally on the Finance and Performance Committee's consideration of the Trust's month 6 operational performance position at the meeting held on 30 October 2013. Noting that the meeting had been chaired by the Acting Chairman, she drew the Board's attention to the following key issues:-

- recovery plans provided in respect of the Trust's Ophthalmology service and the backlog of clinic letters;
- operational performance for admitted and non-admitted 18 weeks RTT, and
- continued improvements in performance against cancer targets. She commended the significant contribution of Mr M Metcalfe, Cancer Centre Lead Clinician in this respect and highlighted opportunities for organisational learning from this improvement process.

The Chief Operating Officer reported on the key operational performance issues reflected in section 5 of paper X, highlighting the actions to address 6 key challenges within the Ophthalmology service, RTT backlogs, cancelled operations and emergency care activity. A plan was being developed in order to outsource some elements of elective care activity to the private sector. Cancer performance targets had all been met with the exception of the 2 week wait symptomatic breast cancer target (although 2 additional patients being seen within their 2 week thresholds would have resulted in this target being delivered for September 2013). Confirmation was provided that all cancer targets had been achieved for October 2013.

The Director of Marketing and Communications commented that issues relating to the Ophthalmology service had been raised regularly at the quarterly meetings held between UHL and Healthwatch and the Chief Nurse suggested that the forthcoming CQC visit was likely to focus upon patient care aspects of this high volume service.

The Director of Human Resources reported on section 6 of paper X, highlighting disappointing performance in respect of appraisal rates and the discussions underway with the CMG and Corporate Directorate teams to understand the causes and seek assurance of recovery plans. Three new e-learning packages were due to be launched to support improvements in statutory and mandatory training compliance. Discussion took place regarding the expected seasonal variation in sickness absence rates, progress with the flu vaccination programme and the definition of front line clinical staff – as the Trust was expected to vaccinate at least 75% of this staff group. A correction to page 28 was noted, in that the number of UHL staff receiving counselling from Amica was almost 100 (not 1,000 as stated).

The Director of Finance and Business Services briefed members on the status of contractual queries as highlighted in section 7 of paper X, noting the different levels of penalties being enacted for service line penalties for individual specialties and the organisation wide penalties resulting in 2% of the overall contract being levied.

Section 8 of paper X reported performance against the Facilities Management key performance indicators and provided an update on the process to review and implement improvements with a particular focus on cleaning and ward level patient catering. The Chief Nurse advised that changes to the style of reporting would be implemented for the November 2013 Trust Board meeting to evidence trends over the past 6 months. She noted that, recently, there had been some evidence of improved service delivery.

A range of meal deal options had been introduced to mitigate concerns regarding the pricing structure of retail catering, staff only areas had been created within the restaurants and progress towards re-instating the water coolers was being made. The Board sought and received assurance that the quality of patient meals was good and this had been confirmed by patient satisfaction surveys. However, menus were being further reviewed to adopt more of the options which suited steam heating methods best.

Paper X3 provided the results of the September 2013 Patient Led Assessment of the Care Environment (PLACE). Members noted that a contractual issue was being followed up to address the 2 hour window for delivering patient meals to the ward, which was compliant contractually but was considered too wide for patient experience and operational reasons. Key actions arising from the PLACE results were due to be considered at a meeting with Interserve and Horizons on Monday 4 November 2013.

Section 9 of the report provided highlights of the IM&T service delivery. The Director of Finance and Business Services invited any questions on this section, noting that a more robust set of indicators would be introduced for the November 2013 Trust Board meeting.

Ms J Wilson, Non-Executive Director reported verbally on the Finance and Performance Committee's consideration of the Trust's month 6 financial performance position at the meeting held on 30 October 2013, noting that the year to date income and expenditure position was £16m adverse to plan and that approximately £15m of additional funding assumed within the Annual Operational Plan would not now be forthcoming. The Committee had recommended that the Board considered a month 7 re-forecast at the 28 November 2013 meeting to include a careful consideration of all available options to deliver a break-even year end position and an appropriate recognition of any associated quality and patient safety implications.

The Director of Finance and Business Services reminded Board members of the context of the current challenges within the healthcare environment and the substantial changes made recently to the Commissioning side of the NHS. He particularly highlighted challenges related to Specialised Commissioning which equated to approximately 1/3 of UHL's potential activity. Members noted that the Trust's income lines remained flat and operational expenditure continued to overspend in the areas of pay and non-pay with substantial sums being incurred for ED and non-contracted staffing. Pay costs were beginning to reduce although not in line with the Trust's financial recovery plans.

The Director of Finance and Business Services tabled copies of paper X4 at the meeting, providing an assessment of the Trust's half year review of financial performance and setting out recommendations for the forecast outturn. The Executive Performance Board and the Finance and Performance Committee had review the projected position alongside the Trust's statutory duty to achieve a break-even position. It had been agreed that a further review of the CMG and Corporate recovery plans would be held in November 2013 and that a reforecast would be prepared for further discussion with the NTDA and submission to the 28 November 2013 Trust Board meeting. During the discussion on paper X4, the Board:-

(i) considered any potential requirements for public consultation in respect of proposed recovery actions;
(ii) queried the significance of the £3m penalties for readmissions and whether other Trusts had been affected by similar levels of penalties, and
(iii) challenged the scope for UHL to seek financial reimbursement for delayed transfers of care to non-acute providers.

<u>Resolved</u> – that (A) the quality, performance and finance report for month 6 (month ending 30 September 2013) be noted;

(B) the Director of Finance and Business Services be requested to present the 28 November 2013 Trust Board meeting with a range of options to address the in-year and longer term financial position and the related risks; **DFBS**

(C) the Trust shares the revised position and the underlying assumptions with the TDA and seeks advice regarding the revised forecast; **CE/DFBS**

(D) the Minutes of the 25 September 2013 Quality Assurance Committee meeting (paper X1) be received and noted, and

(E) the Minutes of the 25 September 2013 Finance and Performance Committee meeting (paper X2) be received and noted.

281/13/2 <u>NHS Trust Over-Sight Self Certifications</u>

The Director of Corporate and Legal Affairs introduced UHL's self certification returns for August 2013 (paper AA refers) and invited any comments or questions on this report. The Director of Finance and Business Services noted the comments provided in section 10 (relating to ED and RTT performance) and he queried the scope to include some additional **ACTING CHAIR/**

wording within section 6 regarding the recommendation for the Trust Board to receive a month 7 re-forecast at the 28 November 2013 meeting. **ACTING CE**

Subject to the above amendment, the October 2013 self certification against Monitor Licensing Requirements (appendix A), and Trust Board Statements (appendix B) were endorsed for signature by the Acting Chairman and the Acting Chief Executive and submission to the TDA accordingly.

Resolved – that subject to additional wording regarding the proposed month 7 re-forecast, the NHS Trust Over-Sight Self Certification returns for October 2013 be approved for signature by the Acting Chairman and Acting Chief Executive, and submitted to the TDA as required. **ACTING CHAIR/ ACTING CE**

281/13/3 Annual Operational Plan (AOP) Quarter 2 Review

Paper BB provided a high level overview of performance against the actions identified in the Trust's 2013-14 AOP and the Director of Finance and Business Services recorded his appreciation to Ms H Seth, Head of Planning and Business Development for preparing this report.

Ms J Wilson, Non-Executive Director sought additional information regarding the arrangements for sharing the contents of this report with the wider workforce and members of the public. The Director of Marketing and Communications responded by highlighting the separate engagement work in relation to emergency care and financial performance, confirming that this report featured on the Trust's external website alongside the other public Trust Board papers. Board members expressed their views that the Trust's progress was worthy of note in the Annual Report and the Chief Executive's monthly briefings.

Resolved – that (A) the quarter 2 AOP progress report (paper BB) be received and noted, and

(B) consideration be given to including extracts from the report within the Trust's Annual Report and the monthly Chief Executive's briefings. **DMC**

282/13 TRUST BOARD BULLETIN – OCTOBER 2013

Resolved – that the Trust Board Bulletin report containing declarations of interest, Trust Board meeting dates for 2014 and a briefing note on the Keogh review (paper CC) be received for information.

283/13 QUESTIONS AND COMMENTS FROM THE PUBLIC RELATING TO BUSINESS TRANSACTED AT THIS MEETING

The following question was received from Mr G Smith, Patient Adviser, regarding the business on the Trust Board meeting agenda:-

- was the Trust aware that the slow progress in determining the accountable leads for patient and public involvement (PPI) within the new clinical management structure communicated the message that this was seen as a low priority within the organisation?

In response to this question, the Director of Marketing and Communications noted that this was the third occasion that the requester had raised this particular issue and that separate correspondence had already taken place on this issue. He provided assurance that the senior CMG leadership team had been appointed as the first phase and that upon completion of this phase, the new CMG leaders had been asked to identify the appropriate leads within their own CMG. The Acting Chairman noted that a similar process had been adopted for appointing the research and development and education leads. It was also

noted that PPI leadership would also be considered at the facilitated CMG event to be held on 1 November 2013.

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

284/13 ANY OTHER BUSINESS

Resolved – that there were no items of any other business.

285/13 DATE OF NEXT MEETING

Resolved – that (A) the next Trust Board meeting be held on Thursday 28 November 2013 in the Cumulus Room, Diabetes Centre of Excellence, Leicester General Hospital, and

(B) the rescheduled date for the December 2013 Trust Board meeting be noted as Friday 20 December 2013 in Seminar Rooms 2 and 3, Clinical Education Centre, Glenfield Hospital.

The meeting closed at 4.28pm

Kate Rayns,
Trust Administrator

Cumulative Record of Members' Attendance (2013-14 to date):

Name	Possible	Actual	% attendance	Name	Possible	Actual	% attendance
R Kilner (Acting Chair from 26.9.13)	8	8	100	R Overfield	2	2	100
J Adler	8	7	88	P Panchal	8	7	88
T Bentley*	7	3	43	I Reid	4	4	100
K Bradley*	8	6	75	C Ribbins	4	4	100
I Crowe	4	3	75	I Sadd	1	1	100
S Dauncey	1	1	100	A Seddon	8	8	100
K Harris	8	8	100	J Tozer*	3	2	66
S Hinchliffe	2	2	100	S Ward*	8	8	100
M Hindle (Chair up to 26.9.13)	7	7	100	M Wightman*	8	7	
K Jenkins	8	7	88	J Wilson	8	7	88
R Mitchell	4	4	100	D Wynford-Thomas	8	3	38

* non-voting members