**UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST**

**MINUTES OF A MEETING OF THE TRUST BOARD, HELD ON THURSDAY 27 NOVEMBER 2014 AT 9AM IN SEMINAR ROOMS 2 & 3, CLINICAL EDUCATION CENTRE, GLENFIELD HOSPITAL**

**Present:**
Mr K Singh – Trust Chairman
Mr J Adler – Chief Executive
Col (Ret'd) I Crowe – Non-Executive Director
Dr S Dauncey – Non-Executive Director (from Minute 295/14)
Dr K Harris – Medical Director
Mr R Mitchell – Chief Operating Officer
Ms R Overfield – Chief Nurse
Mr P Panchal – Non-Executive Director
Mr M Traynor – Non-Executive Director
Mr P Traynor – Director of Finance
Mr M Williams – Non-Executive Director
Ms J Wilson – Non-Executive Director

**In attendance:**
Ms K Bradley – Director of Human Resources
Mr J Clarke – Chief Information Officer (for Minute 311/14)
Ms J Fernihough – IBM Executive Partner (for Minute 311/14)
Mr P Gowdridge – Head of Strategic Finance (for Minute 311/14)
Mr D Henson – LLR Healthwatch Representative (up to and including Minute 306/14)
Dr S Jackson – Chief Medical Information Officer (for Minute 311/14)
Ms H Leatham – Assistant Chief Nurse (for Minute 299/14/1)
Ms U Mehta – Haematology Nurse Practitioner (for Minute 299/14/1)
Mrs K Rayns – Trust Administrator
Ms P Richards – IBM Executive Partner (for Minute 311/14)
Ms K Shields – Director of Strategy (from part of Minute 297/14)
Mr N Sone – Financial Controller (for Minute 303/14/1)
Ms E Stevens – Deputy Director of Human Resources (for Minute 311/14)
Ms H Titman – Haemoglobinopathies Clinical Nurse Specialist (for Minute 299/14/1)
Mr S Ward – Director of Corporate and Legal Affairs
Mr M Wightman – Director of Marketing and Communications

**ACTION**

## 293/14 APOLOGIES AND WELCOME

Apologies for absence were received from Dr A Bentley, Leicester City CCG representative, Dr D Jawahar, Leicester City CCG representative, and Professor D Wynford-Thomas, Non-Executive Director. The Trust Chairman welcomed Mr P Traynor, Director of Finance to the meeting.

## 294/14 DECLARATIONS OF INTERESTS IN THE PUBLIC BUSINESS

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

## 295/14 MINUTES

**Resolved – that, subject to the removal of a duplicated entry in the attendance list, the Minutes of the 30 October 2014 Trust Board (paper A) be confirmed as a correct record and signed by the Trust Chairman accordingly.** **CHAIR**

## 296/14 MATTERS ARISING FROM THE MINUTES

Paper B detailed the status of previous matters arising and the expected timescales for resolution.

At the invitation of the Trust Chairman, the Chief Nurse provided an update in respect of items 19 and 20 (Minute 259/14/2 of 25 September 2014 refers), advising that a report was provisionally scheduled to be provided to the 15 December 2014 Quality Assurance Committee meeting on the implementation of the complaints engagement event action plan and arrangements for strengthening the ways in which patients and the public could raise concerns about patient care and other issues of concern.

The Trust Chairman noted opportunities to refer some of the remaining Trust Board matters arising to other groups and he requested the Director of Corporate and Legal Affairs to explore this further. **DCLA**

**Resolved – that (A) the update on outstanding matters arising and the timescales for resolution be noted, and**

**(B) the Director of Corporate and Legal Affairs be requested to explore opportunities to refer any Trust Board matters arising to other Groups.** **DCLA**

**297/14 CHAIRMAN'S OPENING COMMENTS**

The Chairman introduced paper C, outlining the key areas of focus for the Trust Board over the coming months. He particularly drew members' attention to the following issues:-

(a) the Trust Board development session on 22 December 2014 would focus on engagement and would include the exploration of opportunities to harness Non-Executive Directors' existing networks to expand engagement opportunities;
(b) part of the January 2015 Trust Board development session would focus upon innovation and opportunities to increase the current emphasis on innovation at UHL;
(c) the importance of increasing internal transparency and understanding of the costs of the services provided by the Trust, and
(d) UHL's responsibility as an employer, service provider and public body to listen to public voices in the community and respond in a considered and structured manner to the issues raised.

**Resolved – that the position be noted.**

**298/14 CHIEF EXECUTIVE'S MONTHLY UPDATE REPORT – NOVEMBER 2014**

The Chief Executive introduced paper D, briefing the Trust Board on the following key issues (some of which featured later in the agenda as substantive items for discussion):-

(a) a re-invigorated approach to system wide emergency care performance (Minute 300/14/3 below refers);
(b) the Trust's RTT performance would also be covered later in the agenda (Minute 300/14/1 below refers), but the headline message was that the milestone to achieve admitted performance by November 2014 had been missed;
(c) month 7 financial performance (Minute 300/14/2 below refers) had remained relatively stable and discussions with Commissioners were ongoing regarding the arrangements to de-risk the year-end position;
(d) good progress with the development of the Better Care Together Strategic Outline Case and Project Initiation Document, which were expected to be presented to the 22 December 2014 Trust Board meeting for approval. The process for subsequent TDA approval was less clear thereafter (pending next year's general election);
(e) the NHS 5 Year Forward View (as published on 28 October 2014) had been endorsed

by Monitor, the TDA, the CQC and all the Royal Colleges. In summary this document set out proposals for reducing reliance upon the acute care sector and creating more community based care;

(f) feedback from the annual conference and exhibition of the Foundation Trust Network held in Liverpool on 18 and 19 November 2014 (as attended by the Chief Executive, Chief Operating Officer and Director of Strategy), noting national recognition of the current NHS climate and the consultation on the 2015-16 national tariff, and

(g) the recent launch of MyNHS by the DoH, expanding the arrangements for publication of Consultant level patient outcomes and a related press release relating to positive aspects of UHL's vascular services. Discussion took place regarding the arrangements for the Trust Board to be sighted to such feedback and assurance was provided that the mechanism for this was through the daily press release bulletins (which also included postings on the NHS Choices website). In addition, this feedback was triangulated with patient feedback and reported to the Quality Assurance Committee on a quarterly basis. The Director of Strategy advised that a briefing paper was being prepared on the expected implications of the MyNHS data and she undertook to circulate this document to Trust Board members (once it became available). **DS**

In discussion on the Chief Executive's monthly report, members sought and received additional information regarding the positioning of the Better Care Together Programme, and future accountability and governance structures. Confirmation was provided that the current partnership approach was expected to continue. The Chairman noted the intention to focus upon any implications for UHL at a future Trust Board development session and a subsequent formal Trust Board meeting. **Chair**

**<u>Resolved</u> – that (A) the positioning of the Better Care Together Programme and the future governance and accountability arrangements be considered at a future Trust Board development session and subsequent formal Trust Board meeting, and** **Chair**

**(B) the Director of Strategy be requested to circulate an analysis of the MyNHS data to Trust Board members outside the meeting.** **DS**

**299/14 KEY ISSUES FOR DECISION/DISCUSSION**

299/14/1 <u>Patient Story</u>

Ms H Leatham, Assistant Chief Nurse, Ms U Mehta, Haematology Nurse Practitioner, and Ms H Tiltman, Haemoglobinopathies Clinical Nurse Specialist attended the meeting to introduce this month's patient story, a short DVD detailing the experiences of a young male patient who had transferred to the care of the Osborne Day Care unit at the LRI, from the equivalent Children's Unit for his four weekly blood transfusions. The patient himself also attended the meeting for this item, although he had not been named for reasons of patient confidentiality.

Upon transfer, the patient was unable to secure a Saturday morning service in Leicester and began travelling to Coventry for his transfusions to avoid unnecessary time off work. In response to patient feedback, the Osborne unit had since been able to introduce a Saturday service and the patient had been able to transfer his care back to Leicester, thus reducing his travelling time and enabling him to work full-time. The patient story also highlighted the following additional areas where there was scope to further improve the service:-

- extending clinic opening hours mid-week (eg up to 7pm on 1 day per week);
- wider choice of patient meals (particularly for elderly patients);
- additional blood machines to reduce waiting times, and
- free wi-fi access to alleviate boredom during the procedure.

In discussion on the patient story, Trust Board members:-

(1) thanked the patient for his input and for taking the time and trouble to record the DVD and attend this meeting;
(2) sought and received feedback from the staff about the management of change process for implementing a Saturday service and how this had been achieved;
(3) commented upon the long-term nature of many patient conditions treated by this service and queried whether there were any challenges surrounding staff training, recruitment and retention. In response, it was noted that the majority of staff had been in post for a considerable length of time, but students also benefited from the positive atmosphere on the unit;
(4) commented that learning from the specialised Haemoglobinopathy service in Leicester had influenced and helped to shape this service at a national level;
(5) commended the responsive nature of this service in recognising the needs of individual patients and supporting them in their working life (in line with the Trust's values as a corporate citizen);
(6) provided assurance that the capacity to provide free wi-fi to patients was currently being tested and (subject to assurance being provided that there would be no impact on UHL's business continuity) it was hoped to roll this out within the next 12 months, and
(7) noted the relatively low cost of additional blood machines (eg £900 plus giving sets) and commented on the need to improve the approvals process for items of medical equipment below £5,000 in value – the Chief Nurse agreed to meet with the team outside the Board meeting to address this particular shortfall. **CN**

The Trust Chairman thanked the patient and the presentation team for their valued contribution to this meeting.

**<u>Resolved</u> – that (A) the Patient Story and the Board's discussion on associated learning opportunities be noted, and**

**(B) the Chief Nurse be requested to progress the requirement for additional blood machines in the Osborne Day Care Unit.** **CN**

299/14/2 <u>UHL Response to NHS England Consultation on the Congenital Heart Disease Review</u>

The Director of Strategy introduced paper F, inviting the Trust Board to consider the key issues arising from the above consultation and to endorse UHL's proposed response for submission to NHS England before the consultation ended at midnight on 8 December 2014.

Particular discussion took place regarding the arrangements to achieve the minimum activity level for a clinically sustainable service (500 cases) and achieve a 1 in 4 on call rota. In respect of the timescale for co-locating children's services onto 1 hospital site, it was expected that NHS England would develop plans in partnership with the relevant Trusts, and that clarity would be provided at each stage of the indicative commissioning intentions.

Opportunities for networking with other centres were being explored and the Medical Director commented that the increased volume of activity would also increase the scope for innovation and research within the specialty of Congenital Heart Disease. The Director of Marketing and Communities sought and received additional information regarding stakeholder engagement and clinical effectiveness.

In summary, the Trust Board endorsed the Trust's response for submission to NHS England and requested that an update on the Congenital Heart Disease Review be provided to the Trust Board in June 2015. **DS**

**<u>Resolved</u> – that (A) the Trust's response to the Congenital Heart Disease Review be endorsed for submission to NHS England by midnight on 8 December 2014, and** **DS**

**(B) a further update on the Congenital Heart Disease Review be provided to the Trust Board in June 2015.** **DS**

## 300/14 QUALITY AND PERFORMANCE

300/14/1 Month 7 Quality and Performance Report

The month 7 Quality and Performance report (paper G – month ending 31 October 2014) highlighted the Trust's performance against key internal and NTDA metrics, with escalation reports appended where required.

In terms of the 26 November 2014 QAC meeting, Dr S Dauncey, Non-Executive Director and Acting QAC Chair, highlighted the following issues:-

(i) breast screening performance against the 62 day target, and
(ii) arrangements for UHL to take over provision of renal dialysis services at Corby Hospital with effect from 1 December 2014 until the scheduled closure of this service in August 2015. Trust Board members noted the requirement for UHL to register these premises with the CQC and the formal requirement for this registration to be brought to the Board's attention.

In addition, the Chief Nurse highlighted concerns relating to the internal threshold for Clostridium Difficile and the potential impact of cleaning quality within the Facilities Management contract. An update on this issue would be provided to the December 2014 QAC meeting. The Medical Director reported verbally on a never event involving a retained thread which was used to tie bundles of surgical swabs together. A full investigation was being carried out but it appeared that the member of staff involved had not been aware that these threads (in addition to the swabs) formed part of the theatre checklist.

The Trust Chairman noted the scope to present more concise reports on quality and performance to future Trust Board meetings and he invited the Chief Nurse and the Medical Director to consider which elements of the existing reporting format were causing the most concern. In response, the Chief Nurse highlighted cleaning standards and the friends and family test analysis data. The Medical Director recommended a focus upon patient mortality and vigilance in respect of any reputational issues. The Trust Chairman requested that any specific issues which the Trust should be vexing about be highlighted within the quality and performance covering sheet in future. **CN/MD/COO/DHR**

The Chief Executive suggested that the existing reporting format be continued with a greater emphasis on the process for escalating issues of concern and monitoring the responses to ensure that appropriate actions were being taken. He noted (as an example) a long-standing issue with fractured neck of femur performance, which was considered to be symptomatic of wider pressures on the trauma service. However, this team had recently been selected as one of the fourth wave of Listening into Action Pioneering Teams and it was anticipated that this would be one of the catalysts for improving fractured neck of femur performance.

In the context of publishing Consultant outcomes, the Director of Marketing and Communications commented on opportunities to increase transparency regarding site specific differentials in mortality rates, noting the potential impact of case mix and emergency activity upon the LRI statistics. The Medical Director provided assurance that the Mortality Review Committee reviewed detailed mortality data within all specialties and a clear escalation process existed in the event of any concerns being raised. In addition, the quality and performance report detailed the Trust's performance against 9 standard mortality KPIs and escalation reports would be appended to this report in the event of any indicators being RAG-rated as red.

Ms J Wilson, Non-Executive Director and Acting Finance and Performance Committee Chair then outlined key operational issues discussed by the 26 November 2014 Finance and Performance Committee, namely:-

(a) operational performance issues (including admitted RTT, cancer waits, cancelled operations, delayed transfers of care, ambulance handovers and the related exception reports);
(b) financial performance for month 7 and the year to date and the assurance provided in respect of meeting the planned year end deficit of £40.7m, and
(c) consideration of the revised activity assumptions for inclusion in the Emergency Floor outline business case and the letter of support received from Commissioners in relation to the business case.

The Chief Operating Officer highlighted the 3 performance issues which he was most vexed about, namely (1) RTT performance, (2) cancer performance, and (3) emergency performance and he provided a verbal report on progress towards addressing each of these themes.

The Director of Human Resources noted improving performance on staff appraisals which stood at 91.8% for October 2014. She also highlighted opportunities to further analyse the staff friends and family test results to understand the factors affecting those areas with particularly high or low scores in this survey and incorporate this data into the organisational dashboard to monitor CMGs' performance.

In discussion on the issues highlighted above and on the month 7 Quality and Performance report generally, the Trust Board:-

(I) considered the attendance level at corporate induction sessions (98%) and the wide variety of training and development opportunities on offer for UHL staff;
(II) noted the inconsistent approach to monitoring of staff friends and family test scores by other NHS Trusts and that national benchmarking data was not yet available in this area. Once available, this data would be reported to the Executive Workforce Board and a subsequent quarterly update to the Trust Board or appropriate Board Committee;
(III) commented upon opportunities to improve activity forecasting processes, and noting (in response) that elective activity was already modelled on real time referrals and that the recently appointed Director of Performance and Information would be focusing upon the appropriateness of GP referrals in January 2015, and
(IV) noted that a Trust in the Bournemouth area was making arrangements to commence re-charging families for any exceptional delays in discharge and queried whether such measures would be in the best interests of patients. The Trust would continue to work with its partner agencies to address discharge delays for patients whose acute episode of care had been completed – as at 27 November 2014 there were 91 such patients awaiting discharge.

The Minutes of the 29 October 2014 Quality Assurance Committee meeting were received and noted as paper G1.

**<u>Resolved</u> – that (A) the month 7 quality and performance report for the period ending 31 October 2014 be received and noted, and**

**(B) UHL's registration with the CQC for provision of renal services at Corby Hospital be endorsed.** **CN**

300/14/2 <u>Month 7 Financial Position</u>

The Director of Finance presented paper H advising members of UHL's financial position as

at month 7 (month ending 31 October 2014), particularly highlighting performance against the Trust's statutory financial duties and the following key issues:-

(a) an adverse in-month variance to plan of £0.3m, and a year to date deficit against plan of £1.7m;
(b) data warehouse issues which had led to the Trust's entire inpatient income being estimated for the month 7 reporting cycle. Since the report had been circulated, income levels had been confirmed and the position had improved by £0.6m;
(c) the contractual position with Commissioners (including fines and penalties) and the work ongoing to identify and agree a revised process for resolution of contractual queries. A key task for the Director of Finance would be to de-risk the contractual position for the 2014-15 year end and the 2015-16 contract going forwards;
(d) strong performance against the Trust's 2014-15 Cost Improvement Programme (CIP) and good progress with the CIP plans for 2015-16.

In discussion on the month 7 financial performance update, the Trust Board:-

(i) noted the views of the Director of Finance on the level of risk surrounding contractual penalties in 2014-15 (within the maximum threshold of £10m), and the level of confidence that greater clarity on this matter would be available before Christmas 2014;
(ii) received assurance surrounding the resilience of the forecast outturn assumptions (provided on page 4 of paper H) and that the forecast year end control total would be met;
(iii) noted the need to stabilise financial performance within the current financial year and improve the trajectory for financial recovery over the next 5 years, and
(iv) received a position statement on bank and agency nursing expenditure from the Chief Nurse, noting the quality and safety benefits of maintaining appropriate ward staffing levels. In addition, temporary nurse staffing costs were currently being off-set by an under-spend in permanent staffing costs whilst the Trust continued to actively recruit to approximately 350 vacant nursing posts.

**Resolved – that the month 7 financial performance update be noted.**

300/14/3 Emergency Care Performance and Recovery Plan

The Chief Operating Officer introduced paper I providing the monthly overview of emergency care performance, noting that October 2014 performance against 4-hour waits in ED had deteriorated to 89.9% (compared with 91.8% in September 2014). However, November 2014 performance for the month (up to 20 November 2014) had improved to 90.1%.

In summary the main areas of focus were highlighted as (a) reductions in emergency admissions, (b) internal UHL processes and (c) improvements in the discharge function. In respect of (a) and (c), it was becoming apparent that the actions put in place by the LLR healthcare community were not working as planned. In respect of (b) internal processes, it was crucial to achieve certainty that the right processes were in place for the best possible service to patients and some good progress was being made in this area.

A report on the LLR emergency care system had now been issued by Dr I Sturgess. This report set out 80 key recommendations for UHL to address, such as reducing the time to assessment on the medical assessment units, implementation of change management support and a reduction in clinical variability. A briefing note from the Nuffield Trust was appended to paper I, summarising acute activity trend projections and the need for sustainable changes in NHS provision going forwards. The Chief Operating Officer highlighted the need to focus on day case utilisation rates, implement improvements in discharge functions and promote wider use of alternative models of care for intermediate

services in the community.

The Chief Executive briefed the Trust Board on recent developments for re-vamping the arrangements for LLR oversight of emergency care performance. UHL was fully engaged in this process which would include additional programme support and change management resources. It was anticipated that a refined list of key interventions would be agreed by the end of the week for consideration by the system resilience group on 1 December 2014.

The Trust Chairman advised that the January 2015 Trust Board development session would be focusing upon the whole local health economy emergency care system and representatives from UHL's partner agencies would be invited to attend. He requested the Director of Corporate and Legal Affairs to contact the relevant CCG, LPT and local authority representatives (to invite them on his behalf) and confirm the arrangements to Trust Board members. **DCLA**

In discussion on emergency care performance, the Trust Board:-

(a) noted an offer of support from the Healthwatch representative in seeking clarity from key stakeholders in respect of access to community hospital beds, or discharge processes. In response, the Chief Executive invited Healthwatch to scrutinise the LLR plans (once published) to assess whether they would be effective at reducing admissions, improving the pace of safe patient discharges and reducing inappropriate ED attendances;
(b) highlighted an article in that week's Health Service Journal in respect of emergency activity trends for frail older people, admissions avoidance schemes and planning for a scenario in the event that the "left shift" principle of moving more care into the community was not effective;
(c) commented on the impact of the following issues in relation to ED attendances:- (i) availability of appointments at GP surgeries and (ii) standardised DoH advice for schools regarding pupils attending ED in the event of a minor accident;
(d) supported an increased emphasis on alternative models of care at a local and a national level;
(e) sought assurance regarding adherence to internal process and whether any internal metrics would be implemented for monitoring this. In response, the Chief Operating Officer commented upon the current pressures on staff working in the ED, confirming that each of the 8 identified workstreams would have dedicated change management support and would report directly to the weekly Emergency Quality Steering Group which was chaired by the Chief Executive;
(f) noted that the Sturgess report was due to be published on 9 December 2014 and agreed that the arrangements for implementation of the recommendations would be considered at the 22 December 2014 Trust Board meeting, and
(g) supported the recommendations (as outlined on page 4 of paper I) for seeking assurance on the LLR plans for reducing emergency admissions and accelerating discharges.

**<u>Resolved</u> – that (A) the update on Emergency Care Performance (paper I) be received and noted and support be expressed for the actions being taken to strengthen performance, and**

**(B) the Sturgess report on LLR emergency care and the arrangements for implementation of the recommendations be presented to the Trust Board on 22 December 2014.** **COO**

## 301/14 GOVERNANCE

301/14/1 <u>NHS Trust Over-Sight Self Certifications</u>

The Director of Corporate and Legal Affairs introduced the Trust's over-sight self certification

return for October 2014 (paper J refers). Following due consideration, and taking appropriate account of any further information needing to be included from today's discussions (including the month 7 exception reports, as appropriate), the Board authorised the Director of Corporate and Legal Affairs to finalise and submit the November return to the NHS Trust Development Authority in consultation with the Chief Executive. **DCLA/ CE**

**Resolved – that (A) paper J, now submitted, be received and noted,**

**(B) the Director of Corporate and Legal Affairs be authorised to agree a form of words with the Chief Executive in respect of the NHS Trust Over-sight self certification statements to be submitted to the NHS Trust Development Authority by 30 November 2014.** **DCLA/ CE**

301/14/2 Board Assurance Framework (BAF)

The Chief Nurse introduced paper K detailing UHL's Board Assurance Framework as of 31 October 2014 and notifying members of 3 new extreme/high organisational risks opened during that month (as summarised in appendix 3 to the report). She particularly highlighted the following key points:-

(a) a gap in the controls associated with principal risk 21 *(failure to maintain effective relationships with key stakeholders)*. The Director of Finance and the Director of Strategy were invited to confirm the actions being taken in respect of the Stakeholder Engagement Strategy to inform the next iteration of the BAF report, and **DF/DS**

(b) principal risks 23 and 24 *(failure to effectively implement EPR programme and failure to implement the IM&T strategy and key projects effectively)* did not have any identified gaps in controls or assurance and the Board was invited to consider whether these risks should be re-scored accordingly. In response, the Chief Executive agreed to consider with the Chief Information Officer whether any additional actions should be documented here to demonstrate the risk mitigations in place. He voiced his view that it was too early in the EPR planning process to reduce the risk score at this time. The Chief Operating Officer suggested that it would be appropriate to make reference to UHL's ability to realise the benefits of EPR within this risk entry. **CE**

The Trust Board then reviewed the strategic objective *'enhanced reputation in research, innovation and clinical education'*, incorporating principal risks 11, 12, 13 and 14 from within the BAF:-

- **risk 11** *(failure to meet NIHR performance targets)* – the Medical Director confirmed that the Trust was managing this risk effectively and that there was nothing more to add at the current time;
- **risk 12** *(failure to retain BRU status)* – the Medical Director reported verbally on recent consideration of the requirements and timescales for maintaining BRU status. He noted the need to update the narrative accordingly (and potentially the risk score) for the next iteration of this report; **MD**
- **risk 13** *(failure to provide consistently high standards of medical education)* – the Medical Director confirmed that the risks were currently captured appropriately. The Director of Human Resources commented upon issues relating to reductions in training numbers and a renewed focus upon the quality of education. This item was expected to feature on the next agendas for the Executive Workforce Board and the LETB, and
- **risk 14** *(lack of effective partnerships with universities)* – the Medical Director advised that some significant work was required to restructure the narrative on this risk to describe the risk more accurately through the appropriate lens. As a result, he would expect the risk scoring to rise in the next iteration of the report. **MD**

In discussion on this strategic objective, the Trust Chairman noted an opportunity for a 2015

Trust Board development session to focus on clinical and nurse education, research and development and links with the higher education sector. He suggested inviting the Vice-Chancellors of the 3 local universities to attend this session. **CHAIR/ DCLA**

Finally, in view of the revised meeting dates for 2015, it was agreed that the next BAF report would be provided to the Trust Board on 8 January 2015.

**Resolved – that (A) the BAF for period ending 31 October 2014 and the subsequent discussion on key risks be noted;**

**(B) the Director of Finance and the Director of Strategy be requested to populate the controls for principal risk 21 *(failure to maintain effective relationships with stakeholders)*;** **DF/DS**

**(C) the Chief Executive be requested to liaise with the Chief Information Officer in respect of the narrative for principal risks 23 and 24 *(failure to effectively implement EPR programme and failure to implement the IM&T strategy and key projects effectively);*** **CE**

**(D) the Medical Director be requested to update the narrative for risk 12 *(failure to retain BRU status)* and 14 *(lack of effective partnerships with universities)*,** **MD**

**(E) consideration be given to holding a Trust Board development session on clinical education, R&D and links with the higher education sector, and** **CHAIR/ DCLA**

**(F) the next iteration of the BAF be submitted to the 8 January 2015 Trust Board meeting.** **CN**

## 302/14 REPORTS FROM BOARD COMMITTEES

302/14/1 Audit Committee

Mr M Williams, Non-Executive Director and Interim Audit Committee Chairman introduced paper L, providing the Minutes of the Audit Committee meeting held on 6 November 2014, drawing the Board's attention to the following key issues:-

(a) concerns raised that the Audit Committee had not been sighted in advance to variations in the timetable for the 2014-15 Internal Audit Plan. Arrangements had since been put in place to prevent this happening in future;
(b) update on the clinical coding service and the need for CMG teams to be appropriately aware of the impact of delays in coding and the importance of accurate coding, and
(c) further work being undertaken in respect of the Internal Audit review of delayed transfers of care. This audit had been carried out on a relatively small sample and had highlighted some data quality issues. An update on this audit and the associated audit rating would be presented to the next meeting of the Audit Committee.

In discussion on the above points, Trust Board members noted the importance of good governance surrounding the Internal Audit plan and received assurance that the newly appointed Director of Performance and Information would be leading a task and finish group to drive improvements in clinical coding. In the interim period, work was taking place to improve staff recruitment and retention within the Medical Records Department and reduce the backlog of clinical coding.

**Resolved – that the Minutes of the 6 November 2014 Audit Committee (paper L) and the subsequent discussion be noted.**

## 303/14 CORPORATE TRUSTEE BUSINESS

303/14/1 Final Accounts and Annual Report 2013-14 for Leicester Hospitals Charity

Mr P Panchal, Non-Executive Director and Charitable Funds Committee Chairman introduced paper M, providing the audited annual accounts, Trustee's annual report and letter of representation for the Leicester Hospitals Charity for the year ended 31 March 2014. These reports had been reviewed by the Charitable Funds Committee on 17 November 2014 and endorsed for Trust Board approval (as Corporate Trustee).

The Director of Finance commented upon the timeliness of the External Audit review process and undertook to arrange for improvements to be embedded for future years.

**Resolved – that Trust Board approval (as Corporate Trustee) be granted in respect of the audited annual accounts, Trustee's annual report and letter of representation for the Leicester Hospitals Charity for the year ended 31 March 2014.** **DF**

303/14/2 Charitable Funds Committee

Mr P Panchal, Non-Executive Director and Charitable Funds Committee Chairman introduced paper N, providing the Minutes of the 17 November 2014 meeting and highlighting the discussions on composition of the Charitable Funds investment portfolio and the wider process for approval of charitable funding expenditure.

The Trust Chairman noted future opportunities to consider and re-confirm the relationship between charitable funds and core NHS funds, in supporting improvement and innovation and direct patient benefits. The Director of Finance noted the need for improved forward planning and the development of a prioritisation process to shape the spending plans for this finite resource. He also raised opportunities to link with the Capital Monitoring and Investment Committee to ensure best use of charitable funds.

Finally, the Director of Marketing and Communications advised that the Charity's Annual General Meeting would be held on Thursday 18 December 2014, confirming that invitations had already been circulated for this event.

**Resolved – that (A) the Minutes of the 17 November 2014 Charitable Funds Committee be received and noted and any recommendations endorsed by the Trust Board (as Corporate Trustee), and** **DF**

**(B) the date of the Charity's AGM be noted as Thursday 18 December.**

**304/14 TRUST BOARD BULLETIN**

**Resolved – that the following Trust Board Bulletin item be noted:-**

- **Declarations of Interests from Mr P Traynor, Director of Finance and Mr M Williams, Non-Executive Director**

**305/14 QUESTIONS AND COMMENTS FROM THE PUBLIC RELATING TO BUSINESS TRANSACTED AT THIS MEETING**

A patient raised a query regarding non-availability of patient case notes when attending multiple outpatient clinics and whether the implementation of the Electronic Patient Record (EPR) would resolve this problem. In response, the Chief Executive apologised that the patient had been affected by this issue and confirmed that one of the key benefits of the EPR system was to facilitate multiple access to patient notes at the same time. However, he noted that the timescale for implementation would be in the region of 3 years, subject to the necessary approvals being granted.

The same patient raised a supplementary question regarding the absence of notes in clinics for the purposes of typing clinical letters and queried whether there were sufficient staff working on this back-office function. In response to this question, the Chief Operating Officer reported on a recent focused workstream with the Renal, Respiratory and Cardiac CMG, during which the backlog of clinical letters (in that CMG) had reduced from 1400 to 400 and the relevant administrative and clerical vacancies had been recruited to. He also advised that a policy was in place for clinics to check whether a patient had an appointment with another specialty in the near future and he commented upon the scope to increase compliance with this policy to prevent such issues arising in future.

**Resolved – that the questions and related responses, noted above, be recorded in the Minutes.**

**306/14 ANY OTHER BUSINESS**

**Resolved – that no items of other business were raised.**

**307/14 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 308/14 – 313/14), having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.**

**308/14 DECLARATIONS OF INTERESTS IN THE CONFIDENTIAL BUSINESS**

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

**309/14 CONFIDENTIAL MINUTES**

**Resolved – that the confidential Minutes of the 30 October 2014 Trust Board be confirmed as a correct record and signed accordingly by the Trust Chairman.** **CHAIR**

**310/14 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.**

**311/14 REPORTS BY THE CHIEF EXECUTIVE**

**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**

**312/14 REPORTS FROM BOARD COMMITTEES**

312/14/1 Audit Committee

**Resolved – that the confidential Minutes of the 6 November 2014 Audit Committee be received, and the recommendations and decisions therein endorsed and noted respectively.**

312/14/2 Quality Assurance Committee (QAC)

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

**313/14 DATE OF NEXT MEETING**

**Resolved – that the next Trust Board meeting be held on Monday 22 December 2014 at a time to be confirmed in Seminar Rooms A and B, Clinical Education Centre, Leicester General Hospital.**

The meeting closed at 1.40pm

Kate Rayns
**Acting Senior Trust Administrator**

**Cumulative Record of Members' Attendance (2014-15 to date):**

| Name | Possible | Actual | % attendance | Name | Possible | Actual | % attendance |
|---|---|---|---|---|---|---|---|
| K Singh (Chair from 1.10.14) | 2 | 2 | 100 | R Mitchell | 9 | 8 | 89 |
| R Kilner (Acting Chair from 26.9.13 to 30.9.14) | 7 | 7 | 100 | R Overfield | 9 | 9 | 100 |
| J Adler | 9 | 9 | 100 | P Panchal | 9 | 9 | 100 |
| T Bentley* | 8 | 7 | 87 | K Shields* | 9 | 9 | 100 |
| K Bradley* | 9 | 9 | 100 | M Traynor (from 1.10.14) | 2 | 2 | 100 |
| I Crowe | 9 | 8 | 89 | S Ward* | 9 | 9 | 100 |
| S Dauncey | 9 | 8 | 89 | M Wightman* | 9 | 9 | 100 |
| K Harris | 9 | 8 | 89 | M Williams | 2 | 2 | 100 |
| D Henson* | 5 | 5 | 100 | J Wilson | 9 | 7 | 78 |
| K Jenkins (until 30.6.14) | 3 | 3 | 100 | D Wynford-Thomas | 9 | 4 | 44 |

* non-voting members