# UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

## MINUTES OF A MEETING OF THE TRUST BOARD, HELD ON THURSDAY 29 MAY 2014 AT 10AM IN SEMINAR ROOMS 2 & 3, CLINICAL EDUCATION CENTRE, GLENFIELD HOSPITAL

**Present:**
Mr R Kilner – Acting Trust Chairman
Mr J Adler – Chief Executive
Dr S Dauncey – Non-Executive Director
Dr K Harris – Medical Director (excluding Minute 137/14/2)
Ms K Jenkins – Non-Executive Director
Mr R Mitchell – Chief Operating Officer
Mr P Panchal – Non-Executive Director
Ms J Wilson – Non-Executive Director (up to and including Minute 148/14/1)
Professor D Wynford-Thomas – Non-Executive Director

**In attendance:**
Dr T Bentley – Leicester City CCG (for Minutes 140/14 – 148/14/1 inclusive)
Ms K Bradley – Director of Human Resources (excluding Minute 135/14)
Ms J Dixon – UHL Senior Site Manager (for Minute 148/14/1)
Mr P Hollinshead – Interim Director of Financial Strategy
Mr B Hyde – Matron, Renal Respiratory and Cardiac Clinical Management Group (for Minute 146/14/1)
Mr K Fananapazir – Associate Specialist, Cardiac Services (for Minute 146/14/1)
Ms C Ribbins – Director of Nursing (in the absence of the Chief Nurse)
Ms K Shields – Director of Strategy (up to and including Minute 139/14)
Ms H Stokes – Senior Trust Administrator
Dr I Sturgess – Interim Consultant (for Minute 148/14/1)
Ms M Thompson – Patient Experience Sister (for Minute 146/14/1)
Mr S Ward – Director of Corporate and Legal Affairs
Mr M Wightman – Director of Marketing and Communications

**ACTION**

**127/14 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 128/14 – 139/14), having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.**

**128/14 APOLOGIES**

Apologies for absence were received from Colonel (Retired) I Crowe, Non-Executive Director, and Ms R Overfield, Chief Nurse.

**129/14 DECLARATIONS OF INTERESTS IN THE CONFIDENTIAL BUSINESS**

The Medical Director declared an interest in Minute 137/14/2 and absented himself from the discussion accordingly.

**130/14 ACTING CHAIRMAN'S AND 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.**

**131/14 CONFIDENTIAL MINUTES**

**Resolved – that the confidential Minutes of 24 April 2014 be confirmed as a correct record and signed accordingly by the Acting Trust Chairman.** **CHAIR**

**132/14 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.**

**133/14 REPORT BY THE DIRECTOR OF STRATEGY**

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

**134/14 JOINT REPORT BY THE CHIEF EXECUTIVE AND THE INTERIM DIRECTOR OF FINANCIAL STRATEGY**

**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.**

**135/14 REPORT BY THE DIRECTOR OF HUMAN RESOURCES**

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

**136/14 REPORT BY THE CHIEF NURSE**

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

**137/14 REPORTS 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 on the grounds that public consideration at this stage could be prejudicial to the effective conduct of public affairs.**

**138/14 REPORTS FROM BOARD COMMITTEES**

138/14/1 Audit Committee

**Resolved – that this item 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.**

138/14/2 Finance and Performance Committee

**Resolved – that the confidential Minutes of the 23 April 2014 Finance and Performance Committee be received, and the recommendations and decisions endorsed and noted respectively.**

138/14/3 Quality Assurance Committee

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

138/14/4 Remuneration Committee

**Resolved – that the confidential Minutes of the 24 April 2014 Remuneration Committee be received, and the recommendations and decisions therein be endorsed and noted respectively.**

**139/14 PRIVATE TRUST BOARD BULLETIN – MAY 2014**

There were no private Bulletin items for noting.

**140/14 DECLARATIONS OF INTERESTS IN THE PUBLIC BUSINESS**

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

**141/14 ACTING CHAIRMAN'S OPENING COMMENTS**

The Acting Chairman drew members' attention to the following issues:-

(a) the sudden death of Mr A Powell, Head of Performance and Quality, NHS Horizons. Mr Powell had been a very longstanding and valued UHL employee, and the Acting Trust Chairman paid detailed tribute to his contribution to the work of the Trust and its predecessor organisations;
(b) the ending of the terms of office for 3 UHL Non-Executive Directors in June 2014. The National Trust Development Authority (NTDA) had asked all 3 to extend their term of office until 1 October 2014 to enable the substantive UHL Chair to be involved in the selection process. Ms K Jenkins had already confirmed that she would not be extending her term of office and would therefore stand down as of 30 June 2014. The Acting Trust Chairman confirmed that UHL would use all available avenues to make the Non-Executive Director recruitment process as inclusive and accessible as possible, engaging with all community sectors;
(c) the process for recruiting a substantive UHL Chair, through NTDA use of an executive search agency. Following a national advertisement, interviews would be held on 21 July 2014 with a view to a postholder being in place from 1 September 2014. In discussion on this issue, Mr P Panchal Non-Executive Director sought assurances that the NTDA would follow appropriate stakeholder engagement procedures as part of that recruitment process, and he also queried what steps had been taken to ensure that the advertisement was accessible to diverse groups. Noting the Birmingham location of the Chair interviews, he also queried whether the Trust could ask for these to be held locally – ie in Leicester. It was agreed to make this request to the NTDA, although noting that more than one post was often recruited for on a single day, and **CHAIR**
(d) the availability of a glossary of useful NHS/UHL acronyms, for the information of public attendees at UHL Trust Board meetings.

**Resolved – that the NTDA be asked to consider holding the UHL Chairman interviews in Leicester rather than Birmingham.** **CHAIR**

**142/14 MINUTES**

**Resolved – that the Minutes of the 24 April 2014 Trust Board be confirmed as a correct record.**

**143/14 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 1** (Minute 114/14(d) of 24 April 2014) – the Chief Operating Officer confirmed that quarterly review of the Board Assurance Framework risk 2 (failure to transform the emergency care system) would begin from July 2014; **COO**
(b) **item 2** (Minute 114/14(f) of 24 April 2014) – submission of the electronic document records management system (EDRM) was scheduled for June 2014;
(c) **item 7** (Minute 116/14/3 of 24 April 2014) – progress against the CQC action plan would now be monitored through the Quality Assurance Committee, with issues escalated to the Trust Board only by exception;
(d) **item 9** (Minute 117/14/1(b) of 24 April 2014) – the issue of providing further information to the Audit Committee Chair re: the Quality Schedule and CQUIN indicators could now be moved to the Audit Committee matters arising log and deleted from this Trust Board report; **STA/ CN**
(e) **item 19** (Minute 118/14/4 of 24 April 2014) – the Director of Marketing and Communications confirmed that UHL's members favoured holding the Members' Engagement Forum meetings at the Leicester General Hospital site;
(f) **item 23** (Minute 119/14/3(b) of 24 April 2014) – in response to comments from the Acting Trust Chairman, the Director of Human Resources noted that the Delivering Caring at its Best workstream on medical education would also support the CMG workforce leads, together with the newly-established Executive Workforce Board, and
(g) **item 28** (Minute 123/14(c) of 24 April 2014) – it was noted that the 12 June 2014 Trust Board development session would receive a brief verbal update from the Charitable Funds Committee Chair, on that Committee's 9 June 2014 discussions on the preferred investment management approach for the UHL Charity's funds.

Noting any comments above, it was agreed that items 1-27 of 24 April 2014, and items 3 and 4 of 27 February 2014 could now be removed from the Trust Board action log, as either having been completed or being progressed through other avenues. **DCLA/ STA**

Following a comment from Mr P Panchal Non-Executive Director , the Acting Trust Chairman reiterated that it was not acceptable to leave the equality impact assessment and patient/public involvement parts of the Trust Board cover sheet blank – in the absence of specific comments, the equality impact assessment should be completed as follows:- "considered and no implications". **ALL**

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

## 144/14 REPORT BY THE CHIEF EXECUTIVE – MONTHLY UPDATE REPORT (MAY 2014)

The Chief Executive advised that most of the key issues within his monthly report at paper N were covered on the Trust Board agenda, particularly the Trust's financial position, emergency care performance, and progress in developing the LLR 5-year health and social care plan. The Chief Executive also noted continued 2014-15 acute contract discussions with local Clinical Commissioning Groups, which would need to proceed to formal arbitration if agreement could not be reached. The final issue highlighted within paper N was UHL's 21 May 2014 internal leadership conference, which had been very well attended.

**<u>Resolved</u> – that the Chief Executive's May 2014 monthly update be noted.**

## 145/14 STRATEGY, FORWARD PLANNING AND RISK

145/14/1 <u>Caring for the Oldest Old</u>

Paper O from the Director of Marketing and Communications set out the proposed strategic

direction for frail and older people's services at UHL, focusing on changing cultures, practices and the physical environment, and fundamentally upskilling UHL staff to enable them to meet the needs of the oldest old. It was also proposed to position care of older people as UHL 'core business' by appointing an Executive and Non-Executive Director Board lead. Delivery of the strategy would be progressed through the Delivering Caring at its Best framework, and it was agreed that more frequent updates should be received (through that framework) than the proposed 6-monthly interval. The Trust Board welcomed the strategy and the change it represented, supporting the aim of UHL becoming an exemplar for care of older people in hospital. In progressing the strategy, the Trust Board requested that the Director of Marketing and Communications:-

**DMC**

**DMC**

(a) reflect appropriate links with carer workstreams;
(b) forge relationships with other relevant community and cultural organisations beyond Age UK;
(c) learn appropriate lessons from UHL's work on teenage cancer services, and
(d) learn appropriate lessons from other Trusts.

**<u>Resolved</u> – that (A) UHL's strategy for caring for the oldest old be supported as detailed in paper O;**

**(B) points (a) – (d) above be taken into account when taking the strategy forward;** **DMC**

**(C) an Executive and Non-Executive Director lead be nominated to the Director of Marketing and Communications outside the meeting, and** **EDs/ NEDs**

**(D) updates on the strategy for caring for the oldest old be provided to the Trust Board through Delivering Caring at its Best.** **DMC/ CE**

145/14/2 <u>Bed Capacity Plan</u>

Paper P updated the Trust Board on progress in modelling the 'right-sizing' of UHL capacity for 2014-15, noting plans both to provide an additional 45 beds as a short-term measure and to increase community-based activity as the longer-term solution. The modelling was predicated on 3 elements (movement of all suitable elective work to daycase; introduction of surgical triage, and reducing DTOCs to 3.5%) which it was recognised were not all in UHL's sole control. The plan had also been discussed by the Trust's Executive Team and Finance and Performance Committee on 27 and 28 May 2014 respectively, and it was noted that the capital cost of the short-term plan had now fallen to £1.75m (capital programme adjusted as appropriate). Further detail was still required on the scheduling aspects of related revenue costs. In discussion on the plan, the Trust Board:-

(a) sought a view from Dr A Bentley, CCG representative, on the likelihood of achieving a DTOC level of 3.5%. In response, Dr Bentley acknowledged that this issue needed addressing and he commented on the need to understand nursing home issues;
(b) provided assurance (in response to a concern from Dr Bentley) that additional beds would only be opened if safely staffed. Indicative costs were also being explored for accelerating current overseas nurse recruitment;
(c) queried whether wider lessons could be learned from the Renal, Respiratory and Cardiac Clinical Management Group (RRC CMG) review of its bed needs, which had negated the originally-planned need for a further 10 beds. In response, it was not thought that this could be more widely extrapolated to other CMGs;
(d) sought assurance that quality considerations would be safeguarded despite the extra capacity open, and that this was only a short-tem measure. It was also queried whether the impact of moving elective work to daycase would be audited. In receiving assurances on quality, the Trust Board also noted the positive impact of certain planned estates design solutions (eg increase in siderooms), and

(e) noted comments from the Chief Executive on the plan's ring-fencing approach, and on the Executive Performance Board's request that the February 2015 timescale be accelerated as far as possible. Construction of the enabling ward block had already begun. Ms J Wilson, Non-Executive Director and QAC Chair, noted the need to be aware of any downside of ringfencing, and to identify mitigating actions accordingly – it was confirmed in response that an appropriate risk assessment would be undertaken and shared with the Trust Board. A further update on ringfencing would be provided accordingly at the 26 June 2014 Trust Board, including timescales. **COO**

**Resolved – that a further update on progress in ringfencing elective beds be provided to the 26 June 2014 Trust Board, including the timescale involved and any risk assessment (plus mitigating actions) of such ringfencing.** **COO**

145/14/3 UHL and LLR 5-Year Plans

The Chief Executive advised that he had nothing significant to add to his report at paper N above, and he noted the challenges of developing UHL's internal plan in parallel to the wider LLR 5-year plan. The Trust anticipated having a credible draft to submit by the required deadline of 20 June 2014.

**Resolved – that the verbal update be noted.**

145/14/4 Delivering Caring at its Best (DCaiB) – Update

Paper Q updated the Trust Board on progress in Delivering Caring at its Best, noting that Executive Director leads were now populating the project initiation documents (PIDs) and would include timescales accordingly. Each DCaiB area was now known as a 'domain', and the programme management discipline was proving useful in reviewing the detail of each workstream and identifying resourcing requirements. In response to a query from the Acting Trust Chairman on when the Board could expect to see more detailed delivery timescales, the Chief Executive agreed to provide headline deliverables for each domain by 30 September 2014 – that update would include an overview of the work programme with the financial implications. The Chief Executive also agreed that the current presentation of the programme could be improved, and he agreed to discuss this further with the Director of Strategy (with a view to clarifying the reporting arrangements for the various threads). **EDs** **CE** **CE**

The Interim Director of Financial Strategy also advised that an overview of the DCaiB programme would be included in UHL's 5-year plan submission on 20 June 2014. The Trust Board was scheduled to receive an update on both the UHL and the LLR 5-year plans at its extraordinary meeting on 16 June 2014.

**Resolved – that (A) future updates on the project initiation documents also include reporting timescales;** **EDs**

**(B) headlines re: an overview of financial and non-financial deliverables for each domain be available by 30 September 2014 and reported to the Trust Board thereafter, and** **CE**

**(C) the presentation of the various workstreams be clarified in future updates, following discussion with the Director of Strategy.** **CE/DS**

145/14/5 Board Assurance Framework (BAF) – Update

In the absence of the Chief Nurse, the Director of Corporate and Legal Affairs presented the latest iteration of UHL's BAF (paper R) and the report was taken as read, noting that all Executive Leads and risk owners would be providing progress reports on any follow-up actions to the Risk and Assurance Manager outside the meeting. Work continued to review

UHL's BAF, which would discussed in its proposed new format at the 12 June 2014 Trust Board development session and formally presented to the 26 June 2014 Trust Board thereafter. Ms K Jenkins Non-Executive Director and Audit Committee Chair emphasised the need for a refreshed BAF and noted that CMGs had been invited to present their risk management plans to the Audit Committee as part of a rolling programme. **CN**

Mr P Panchal Non-Executive Director noted that the 27 May 2014 Audit Committee had queried whether UHL's Non-Executive Director turnover needed to be reflected on its BAF. The Chief Executive advised that a review of strategic objective 1 would probably focus on being a sustainable organisation, which would include issues around the composition and stability of the Trust Board. It was acknowledged that UHL had been in a period of transition for some time, initially with Executive Directors and now with Non-Executive Directors.

In respect of the 3 risks selected for detailed consideration, the Trust Board noted the following information:-

- **risk 9** (*failure to achieve and sustain high standards of operational performance)* – as noted in Minute 145/14/2 above, the additional capacity beds had now been reduced to 45, which needed reflecting on the BAF. Ms J Wilson, Non-Executive Director and QAC Chair, requested that measures to improve productivity also be more fully captured in this risk. It was also agreed to increase the risk score to 25 (5x5); **COO**
- **risk 10** *(inadequate reconfiguration of buildings and services)* – consideration of this risk was deferred in the absence of the Director of Strategy, and
- **risk 11** *(loss of business continuity)* – although this risk had been recently updated, the Chief Operating Officer would also reflect any issues arising from Dr I Sturgess' review of ED (Minute 148/14/1 below refers). Although it was agreed to keep the overall risk score of 12, the Trust Board agreed this should comprise a 4x3 rating rather than the current 3x4 configuration. **COO**

In further discussion on the narrative report accompanying the BAF itself, the Trust Board queried the 25 risk score attributed to the 'risk to patient/staff safety due to security staff not assisting with restraint'. The Director of Nursing clarified that following review, this risk had now been reassessed as 15 or 16, as security staff were in fact assisting with violent patients. The mitigating actions would be notified to the Executive Team through its usual BAF update. **CN**

**<u>Resolved</u> – that (A) the revised BAF model be reviewed at the 12 June 2014 Trust Board development session, ahead of formal discussion on 26 June 2014;** **CN**

**(B) risk 9 be amended to:-** **COO**

- **refer to 45 additional beds rather than the initial 55;**
- **cover productivity considerations – eg making the most of existing capacity and capability, and**
- **increase the risk rating to 25 (5x5).**

**(C) risk 11 be amended to change the composition of the overall risk rating, from 3x4 to 4x3 (retaining the same overall score), and** **COO**

**(D) the risk rating for the security staff risk be reduced following appropriate review (to 15 or 16).** **CN**

## 146/14 CLINICAL QUALITY AND SAFETY

146/14/1 <u>Patient Experience – Patient Story Relating to Care Received after Cardiac Surgery</u>

Members watched a patient experience story relating to care received after cardiac surgery, in which the patient had been wrongly labelled as an "anxious patient", and noted both the

personal and potential clinical impact this had had upon that patient. The Renal, Respiratory and Cardiac Clinical Management Group (RRC CMG) staff attending for this item explained how disappointing this patient story had been for all concerned, differing markedly from the usually very positive patient experiences within their services. The RRC CMG took all patient feedback extremely seriously, and had therefore used this particular experience as a key teaching tool for staff, reiterating the need to treat all patients as individuals and listen to them rather than labelling them. The patient experience strategy was also now discussed at the CMG's monthly audit and morbidity and mortality meetings.

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

(a) welcomed the fact that the RRC CMG was clearly taking all steps to learn from (and prevent a recurrence of) this patient experience, even though patient feedback was usually overwhelmingly positive for the service. The whole team approach being used to learn from the patient story was also commended by the Trust Board, who asked that these comments be passed to all RRC staff; **CN**
(b) sought assurance that the clinicians still had sufficient time to talk to patients on an individual basis, despite service pressures. In response, Mr K Fananapazir reiterated the recognised importance of that contact with patients, and
(c) commented that pathology should not be attributed to anxiety necessarily, as it was perfectly normal for patients to feel anxious in hospital. The Medical Director considered that this was a wider learning point beyond just the RRC CMG.

**<u>Resolved</u> – that the Trust Board's congratulations be passed to the Renal, Respiratory and Cardiac CMG for its response to the cardiac surgery care patient experience story.** **CN**

**147/14 FORMAL ADOPTION OF THE 2013-14 ANNUAL ACCOUNTS**

Paper T from the Interim Director of Financial Strategy presented the Trust's annual accounts for 2013-14, and sought the Trust Board's approval to adopt those accounts, to note UHL's management response to External Audit's recommendations (appended to the accounts), to approve the Trust's Annual Governance Statement at paper T1 (updated version now tabled), to approve the Letter of Representation (paper T2 – now tabled) and to authorise the signature of the relevant statements accordingly.

Following External Audit's review of the accounts (which had been submitted and audited on a very tight timescale), an unqualified opinion would be issued on those accounts. External Audit's value for money opinion on the use of resources element would be a qualified opinion however, in light of UHL's significant year end deficit. The Interim Director of Financial Strategy advised the Trust Board that UHL had met 2 of its statutory financial duties (namely the external financing limit and the capital resource limit), although it had not achieved breakeven nor the administrative 'better payments practice code' target.

In tabling an updated version of the Trust's Annual Governance Statement (AGS – paper T1), the Director of Corporate and Legal Affairs confirmed that the new format for expressing Internal Audit's opinion on UHL's internal controls equated to the formerly-used finding of "significant assurance". He also clarified that (as agreed with the Chief Executive) UHL's commitment to equality and diversity was now covered within the Trust's annual report rather than the AGS.

Ms K Jenkins Non-Executive Director and Audit Committee Chair, then advised the Trust Board of the Audit Committee's detailed consideration of the annual accounts on 27 May 2014, and its recommendation of them for approval by the Trust Board. Following a good discussion on UHL's going concern statement, the Interim Director of Financial Strategy had agreed to add wording into the accounts to reflect this position accordingly. The Audit Committee had also received assurance from the process to monitor progress on high risk

actions identified through Internal Audit reports, although the Audit Committee Chair considered that there was still room for improvement on completing actions in a timely manner. The Audit Committee had also endorsed the Letter of Representation for Trust Board approval, appended to which would be UHL's going concern report and a statement on the Trust's 2-year plan in respect of its financial liquidity position. Both of those reports had previously been discussed by the Trust Board.

**Resolved – that the 2013-14 annual accounts, Letter of Representation and Annual Governance Statement be approved by the Trust Board as presented, and all relevant statements/certificates/letters be signed accordingly by the appropriate officers, for onward submission as required.** **IDFS/ CE**

**148/14 QUALITY AND PERFORMANCE**

148/14/1 Emergency Care Performance and Recovery Plan

In addition to the standing report on emergency care performance (paper X), Dr I Sturgess, Interim Consultant and Ms J Dixon, UHL Senior Site Manager attended to brief the Trust Board on their review to date of emergency care within LLR. Although their review was initially focusing on in-hospital emergency care, it would necessarily take a system-wide view across LLR as a whole. Key initial thoughts related to:-

(i) LLR's apparent operation of a blame culture, more markedly so than in other healthcare economies;
(ii) the crucial importance of clinical leadership in effecting and delivering change. Clinical leadership was considered to need strengthening across all parts of the LLR emergency care system;
(iii) the further need for alignment of clinical, managerial, and executive teams across all parts of the LLR emergency care system (with appropriate supporting behaviours) in order to deliver change, and
(iv) the welcomed level of openness and receptiveness within UHL, which they hoped would be mirrored across the healthcare economy.

In discussion on the presentation by Dr Sturgess and Ms Dixon, the Trust Board:-

(a) reiterated that the whole healthcare economy was committed to improving LLR emergency care, recognising the crucial importance of a whole system approach;
(b) queried how Dr Sturgess would engage stakeholders;
(c) received confirmation that Dr Sturgess would also review external care pathways (noting engagement planned with the Urgent Care Board). Ms Dixon also commented on the benefits of involving GPs on any clinical engagement group;
(d) noted Dr A Bentley, CCG representative's disappointment at references to a perceived 'blame culture'. He also commented that it would be helpful to have more information on GP practices referring inappropriately (tabled action plan accompanying paper X);
(e) queried how to ensure that clinical leaders actually assumed an appropriate leadership role, and whether UHL was currently in good shape in this regard (compared to the previous ECIST visit some 18 months previously). In response, Dr Sturgess considered that UHL had some very good clinical leaders, but he commented on a perceived system-wide culture of 'learned helplessness' and 'learned hopelessness', which must be addressed. In terms of clinical leadership UHL was considered to be at a 5-6 (out of 10), compared to a 6 18 months previously, as certain solutions had been imposed in the intervening period perhaps without sufficient engagement. The Trust Board commented on the need to measure progress on clinical leadership and engagement;
(f) discussed how to increase the visibility of the ED to other specialties/areas within UHL, to make it feel more connected to the rest of the organisation and less isolated;

(g) asked Dr Sturgess to prioritise the actions needed within UHL as a whole, based on his experience elsewhere. In response, actions included eliminating unnecessary waits across the hospital; one-stop ward rounds on acute assessment units; implementation of a holistic, end-to-end management system, mapping capacity to meet demand; having an appropriate model of clinical decision-making; more rapid requesting of diagnostic tests and same-day receipt of the results to enable safe discharge; timely availability of medication to take home within outpatient areas thus moving away from batch processing of TTOs; a robust wi-fi environment; having an Acute Physician and Geriatrician within ED at peak times to stream patients to appropriate areas; a rapid assessment process within ED and effective shopfloor management reflecting the demand profile, and

(h) voiced concern over patient safety issues prior to addressing the current challenges, given the intense pressure on UHL's ED service. In response to a query from Mr P Panchal, Non-Executive Director re: ED closure, the Medical Director confirmed that appropriate escalation procedures were in place but noted that UHL was a single provider of ED services for a very large catchment area. Ms Dixon echoed this view, noting that closure of UHL's ED was not a viable option in light of the pressure it would place on remaining East Midlands EDs and on East Midlands Ambulance Service. Dr Sturgess added his own view that diversion would increase patient safety risks across the patient pathway as a whole.

The Acting Trust Chairman requested that a further update to the June 2014 Trust Board outline any traction achieved on delivering the changes needed, and on how to ensure appropriate ownership of those changes. **COO**

**<u>Resolved</u> – that (A) the update on ED performance and the review of LLR emergency care, be noted, and**

**(B) a further update in June 2014 include details of traction achieved on the required changes, and on measures to ensure appropriate ownership of those changes.** **COO**

148/14/2 <u>Month 1 Quality and Performance Report</u>

The month 1 quality and performance report (paper U - month ending 30 April 2014) advised of red/amber/green (RAG) performance ratings for the Trust, and set out performance exception reports in the accompanying appendices. Discussion at the 28 May 2014 Quality Assurance Committee had highlighted issues relating to fractured neck of femur performance, the backlog of outpatient follow-up appointments, the need for future RTT updates to QAC to include an assessment of the clinical risk of not meeting that target, and the importance of having appropriately triangulated patient feedback (the report on which would be circulated to the Trust Board for information). **STA**

The Director of Nursing advised that there were no additional quality issues to highlight beyond those already flagged within paper U. In terms of clinical issues, the Medical Director responded to QAC concerns re: fractured neck of femur performance, remedial actions on which were being submitted to the June 2014 Executive Performance Board. With regard to outpatient follow-ups, the Medical Director outlined progress in assessing the current scale of the issue and confirmed that additional mechanisms had been introduced to ensure the appropriate use of the Choose and Book system. Ophthalmology remained a particular hotspot on this issue, and an external resource was being used to address backlog capacity.

The Acting Trust Chairman and Finance and Performance Committee Chair then outlined key operational issues discussed by the 28 May 2014 Finance and Performance Committee, including progress on the LLR and UHL 5-year plans (and his view that patient and public involvement on UHL's plan needed strengthening); Consultant recruitment challenges within ENT which should be fed in to the Board Assurance Framework; the significant increase in **MD/CN/ DHR**

2013-14 admissions and the resulting impact on bed capacity, elective activity and RTT performance, and discussions on the need for more efficient use of theatres to aid RTT performance. The Chief Operating Officer advised that improvements to theatre utilisation (which issue extended beyond surgery and anaesthesia) would be monitored by the June 2014 Finance and Performance Committee through the cross-cutting CIP report. **COO**

In response, the Chief Operating Officer noted the very detailed 28 May 2014 meeting with CCGs regarding actions to achieve the November 2014 RTT target (admitted performance), to which all parties remained committed. With regard to other operational issues in the month 1 report, he commented particularly on:-

(i) 3 patients who had exceeded the 52 week wait target. These had initially been Alliance patients and it would have been very challenging for UHL to meet the waiting time target by the time they had transferred;

(ii) the detailed plan appended to paper U for reducing on the day cancellations, and

(iii) unsatisfactory performance in respect of Choose and Book slot availability, which had also been discussed at the 28 May 2014 Finance and Performance Committee.

Lead Directors advised that there were no specific HR nor IM&T issues to report beyond the information within paper U, other than confirming that statutory and mandatory training trajectories were now included in the report as previously requested. Professor D Wynford-Thomas, Non-Executive Director, queried whether the most appropriate performance indicators were being used to monitor Facilities Management performance, noting (in response) that this was currently under review.

**Resolved – that (A) the 28 May 2014 QAC report on the triangulation of patient feedback be circulated to Trust Board members for information;** **STA**

**(B) the 28 May 2014 Finance and Performance Committee discussions on Consultant recruitment difficulties (ENT) be fed in to the Trust Board's June 2014 review of the Board Assurance Framework, and** **MD/CN/ DHR**

**(C) improvements to theatres utilisation and productivity be monitored through the cross-cutting CIP report being provided to the June 2014 Finance and Performance Committee.** **COO**

148/14/3 "Hard Truths Commitments" – Healthcare Staffing Arrangements

**Resolved – that this report (paper V) be noted in the absence of the Chief Nurse, and revisited at the June 2014 Trust Board.** **CN**

148/14/4 Month 1 Financial Position and Rvised Capital Plan 2014-15

Paper W advised members of UHL's financial position as at month 1 (month ending 30 April 2014), noting that although all key financial duties were currently shown as green the overall year-end position remained a projected deficit of £40.7m. UHL still had no agreed acute contract for 2014-15, and the financial position within paper W did not reflect the impact of any CCG penalties (£1.6m in month 1, if applied). Work also continued to bridge the 2014-15 cost improvement programme shortfall. Section 4.1 of paper W also outlined a number of other potential risks to the financial position and year-end plan. The Interim Director of Financial Strategy advised that a short-term loan had now been agreed with the National Trust Development Authority to March 2015 if needed, to address liquidity issues.

With specific regard to month 1, the Trust Board was encouraged by the reduction in pay expenditure, and noted that an underperformance on income related primarily to the

temporary suspension of the renal transplant service.

Paper W also set out a revised capital plan for 2014-15, noting overcommitments (additional bed capacity and the emergency floor plan now included) and the need to progress certain external funding assumptions.

The Chief Executive advised that the acute contract mediation decision had now been received from the NTDA and NHS England during this Trust Board meeting. Headlines included a cap of 2.5% on penalties and ruling out any carry-forward of recovery action plan penalties. The decision was broadly satisfactory from the Trust's perspective and the Chief Executive noted that all parties were now being exhorted to sign the contract. He noted, however, that the base level of that contract still needed resolving.

**Resolved – that the financial position for month 1 be noted and the revised 2014-15 capital programme be approved.** **IDFS**

148/14/5 NHS Trust Over-Sight Self Certifications

The Director of Corporate and Legal Affairs introduced UHL's self certification returns for April 2014 (paper Y). In discussion, Mr P Panchal Non-Executive Director queried whether the stated compliance with statement 13 of appendix B was appropriate, given the NTDA's plans not to renew the terms of 3 of UHL's Non-Executive Directors. In response, the Acting Trust Chairman noted his view that the UHL Trust Board was satisfied that all Executive and Non-Executive Directors had the appropriate qualifications, skills and experience to discharge their functions effectively – this was supported by the Board effectiveness review, which had identified no significant skill gaps. Mr Panchal requested that this view be reiterated to the NTDA – in response the Acting Trust Chairman clarified that Non-Executive Director renewal decisions were entirely the remit of the NTDA and should not be seen as a statement on capacity or capability. There was no right to automatic reappointment and it was open to the NTDA to test the market for complex organisations.

Following due consideration, the self certification against Monitor Licensing Requirements (appendix A), and Trust Board Statements (appendix B) were endorsed for signature accordingly by the Chief Executive and submission to the NTDA. **DCLA/ CE**

**Resolved – that the NHS Trust Over-Sight Self Certification returns for April 2014 be approved for signature by the Chief Executive, and submitted to the NTDA as required.** **DCLA/ CE**

**149/14 REPORTS FROM BOARD COMMITTEES**

149/14/1 Audit Committee

**Resolved – that the 15 April 2014 Audit Committee Minutes be received, and the recommendations and decisions therein be endorsed and noted respectively.**

149/14/2 Finance and Performance Committee

**Resolved – that the 23 April 2014 Finance and Performance Committee Minutes be received, and the recommendations and decisions therein be endorsed and noted.**

149/14/3 Quality Assurance Committee (QAC)

**Resolved – that the 23 April 2014 QAC Minutes be received, and the recommendations and decisions therein be endorsed and noted respectively.**

**150/14 TRUST BOARD BULLETIN**

**Resolved – that the quarter 4 update on progress against UHL's 2013-14 annual operational plan be noted.**

**151/14 QUESTIONS AND COMMENTS FROM THE PUBLIC RELATING TO BUSINESS TRANSACTED AT THIS MEETING**

The following comments and questions were received regarding items of business on the Trust Board meeting agenda:-

(1) appreciation for the glossary of terms and abbreviations, and
(2) welcome for the openness of the emergency care review discussion (Minute 148/14/1 above). The staff member raising this point also considered that this indicated the Trust Board's commitment to reconnect with shopfloor clinicians and staff.

**Resolved – that the questions above and any related actions be noted and progressed by the responsible Executive Director.**

**152/14 ANY OTHER BUSINESS**

152/14/1 R&D Horizon Scanning

Mr P Panchal, Non-Executive Director queried what arrangements were in place to horizon scan the potential impact (on UHL R&D activity) of pharmaceutical company takeovers/ mergers. In response, the Director of Marketing and Communications noted the recent appointment of a Communications and Marketing Manager for R&D, whose remit would also cover horizon scanning. Professor D Wynford-Thomas, Non-Executive Director and Dean of the University of Leicester Medical School suggested it would be helpful for that UHL postholder to liaise with their counterpart at the University of Leicester. **DMC**

**Resolved – that the UHL Communications and Marketing Manager for R&D liaise appropriately with their counterpart at the University of Leicester re: horizon scanning.** **DMC**

152/14/2 June 2014 Sponsored Walk

The Director of Human Resources encouraged Trust Board members to join her in participarting in a sponsored walk around Leicestershire.

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

**153/14 DATE OF NEXT MEETING**

**Resolved – that the next Trust Board meeting be held on Thursday 26 June 2014 in the C J Bond Room, Clinical Education Centre, Leicester Royal Infirmary.**

The meeting closed at 3.26pm

Helen Stokes
**Senior Trust Administrator**

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

| Name | Possible | Actual | % attendance | Name | Possible | Actual | % attendance |
|---|---|---|---|---|---|---|---|
| R Kilner (Acting Chair from 26.9.13) | 2 | 2 | 100 | R Overfield | 2 | 1 | 50 |
| J Adler | 2 | 2 | 100 | P Panchal | 2 | 2 | 100 |
| T Bentley* | 2 | 2 | 100 | K Shields* | 2 | 2 | 100 |
| K Bradley* | 2 | 2 | 100 | S Ward* | 2 | 2 | 100 |
| I Crowe | 2 | 1 | 50 | M Wightman* | 2 | 2 | 100 |
| S Dauncey | 2 | 2 | 100 | J Wilson | 2 | 2 | 100 |
| K Harris | 2 | 2 | 100 | D Wynford-Thomas | 2 | 1 | 50 |
| K Jenkins | 2 | 2 | 100 | | | | |
| R Mitchell | 2 | 2 | 100 | | | | |

* non-voting members