Trust Board Paper Z

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

Trust Board Bulletin – 28 August 2014

The following reports are attached to this Bulletin as items for noting, and are circulated to UHL Trust Board members and recipients of public Trust Board papers accordingly:-

- **Revised Trust Board meeting January 2015 to March 2016** – Lead contact point Mr S Ward, Director of Corporate and Legal Affairs (0116 258 8615) – **paper 1**;
- **Members' Engagement Forum Minutes** – Lead contact point Mr M Wightman Director of Marketing and Communications (0116 258 8615) – **paper 2**;
- **UHL Patient Advisers' Meeting Minutes** – Lead contact point Mr M Wightman Director of Marketing and Communications (0116 258 8615) – **paper 3**, and
- **Board Effectiveness Action Plan** – Lead contact point Mr S Ward, Director of Corporate and Legal Affairs (0116 258 8615) – **paper 4**.

It is intended that these papers will not be discussed at the formal Trust Board meeting on 28 August 2014, unless members wish to raise specific points on the reports.

This approach was agreed by the Trust Board on 10 June 2004 (point 7 of paper Q). Any queries should be directed to the specified lead contact point in the first instance. In the event of any further outstanding issues, these may be raised at the Trust Board meeting with the prior agreement of the Chairman.

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

TRUST BOARD MEETING DATES JANUARY 2015 – MARCH 2016

Starting in January 2015, the formal Trust Board meeting will move to the FIRST Thursday of every month.

Revised dates – venues to be confirmed

THURSDAY 8 JANUARY 2015

THURSDAY 5 FEBRUARY 2015

THURSDAY 5 MARCH 2015

THURSDAY 2 APRIL 2015

THURSDAY 7 MAY 2015

THURSDAY 4 JUNE 2015

THURSDAY 2 JULY 2015

THURSDAY 6 AUGUST 2015

THURSDAY 3 SEPTEMBER 2015

THURSDAY 1 OCTOBER 2015

THURSDAY 5 NOVEMBER 2015

THURSDAY 3 DECEMBER 2015

THURSDAY 7 JANUARY 2016

THURSDAY 4 FEBRUARY 2016

THURSDAY 3 MARCH 2016

University Hospitals of Leicester NHS Trust

Members' Engagement Forum Meeting 16/06/2014

Minutes

In attendance
Richard Kilner, Acting Chairman, UHL
Jane Wilson, Non Executive Director
Kevin Harris, Medical Director
Mark Wightman, Director of Communications and Marketing
Karl Mayes, Patient and Public Involvement / Membership Manager

Apologies
Stephen Ward, Director of Corporate and Legal Affairs

1. Welcome and Introductions

1.1 Participants were welcomed to the meeting by Mr Richard Kilner, Acting Chair of the Trust who started the meeting with an update on Trust business. He noted that for both last year and this year the Trust had a forecast deficit of just under £40 million. As of month one and two, finances this year were in line with the Trust's plan, which is an achievement in itself. Richard acknowledged that there is still much to do but said that the Trust was on plan.

1.2 Emergency Care performance remains a huge challenge for the organisation. In particular Richard noted the four hour waiting targets but added that this was just one part of the overall challenge. He said that the Trust is seeing a significant increase in the number of admissions with admissions approximately 12% higher than the year before. He also noted the trend for seeing patients that were more unwell and needing admission.

1.3 Richard said that in conjunction with the CCGs the Trust had recently employed Dr Ian Sturgess, an expert in Emergency Care, to explore how we may improve the Emergency Care pathway. Dr Sturgess would be with the Trust for six months. His early assessment is that while we are doing a lot right, there is clearly room for improvement, particularly around clinical leadership.

1.4 Work has now started on a series of enabling schemes which will pave the way for the construction of the Trust's new Emergency Floor development. Modular wards are well underway opposite the Windsor building which will allow us to move patients in to these areas and help uys cope with Winter 14/15 pressures.

1.5 Richard said that it was essential that the Trust get smarter in how it works. An example of this is the journey to electronic patient records. The Trust has now rolled out two pilot schemes in MSK and Clinical Genetics which have seen 18,000 patient files digitized. In these areas clinics are now run completely paperless which makes us more productive and effective as an organisation. The Trust intends to run a vendor selection process and roll out electronic patient records in the new ED floor when it opens.

1.6 Richard then spoke about the selection process for the position of Trust Chair person. He said that the National Trust Development Authority (NTDA) is responsible for recruiting the Chair. They hafve been working with a recruitment consultancy and

have seen a broad range of candidates applying for the position. The closing date is on June 27th, with interviews on 21st July. An appointment is expected in early September. Richard reminded the group that an open session is planned for 19th June in which interested candidates could meet Board members.

1.7 Following input from the group at previous meetings, Richard provided an update on the Trust's approach to complaints. He noted that in the private part of the Board the Board have been reviewing complaints. He said that it is important that the Board understand the frustration patients and families have felt. He added that much of the content of complaints relate to areas that can be fixed. Richard said that the Trust's complaints team, in conjunction with Healthwatch had recently held a user experience event to explore how we could improve complaints and also to make suggestions about external scrutiny of the complaints process.

1.8 The group had also raised issues around car parking at UHL, in particular the LRI site. Richard said that the Trust had made a firm commitment to building a multi storey car park at the site and foresaw this being completed within 24 months.

2.0 The floor was opened for questions from the group at this point.

2.1 How much is it costing to hire an external consultant to assist with the Chair recruitment?

Richard Kilner said that he is not privy to that information as it is the NTDA that are working with the recruitment consultants. He did stress how important it is to get the right expertise in to the Trust and therefore to find the right candidate for the job. Richard noted the high attrition rate for Trust Chairs at the moment which he said was around 20%. It is vital that we get the right candidate for the job. The Chair has a very important leadership role in a challenging environment for the NHS.

2.2 Wouldn't it be advisable to set up a pay on exit system at the LGH car park? Patients are already anxious when they come for appointments, if their clinic runs late, worrying about car parking only adds to this anxiety.

Richard Kilner acknowledged that he had heard the same thing from executive walkabouts. Mark Wightman said that the Trust has asked our facilities provider Interserve for costs for installing and managing a pay on exit system at both the LGH and GH. Once these costs are in we will review the matter.

2.3 Members are worried about the Chapel at the LRI being demolished. Can you assure us that an alternative will be provided and that this project will not be shelved?

Richard Kilner said that the Trust has been working with architects to explore alternatives to demolition and to preserve the chapel. Sadly this has not proved feasible. There is an acknowledgment by the Board that it is an incredible space and there are a number of artefacts within it that we want to preserve and incorporate in to any new space. We have also begun talking about a new Welcome Centre which may also provide opportunities to display some artefacts from the chapel. Mark Wightman thanked the Nurses' League for their engagement on this issue. He acknowledged that it is a difficult subject and the decision to build in this area was not taken lightly. Unfortunately the chapel stands in the space on which the new children's Emergency Department will go. Our Head of Chaplaincy, Mark Burleigh has ensured that before going ahead an alternative space will be provided and this will happen.

2.4 Will the Trust make sure that it consults with conservation experts to correctly store the artefacts from the chapel?

Mark Wightman said that the windows int eh Chapel were designed by Mark Kemp, a prominent artist in the Arts and Crafts movement. Preserving them is a high priority for the Trust and we will indeed be seeking expert opinion on the best mode of storage.

2.5 There are concerns about protecting privacy with the introduction of electronic patient records. It would be interesting to have a presentation on this to assure us that adequate measures are being put in to place to protect privacy.

Richard Kilner said that he was happy for this to be brought back to the group. He added that there will also be engagement form clinicians and patients as we develop the situation. There are a number of examples where the system is working well.

2.6 I have heard that car parking prices will not rise this year. Is this correct?

Richard Kilner confirmed that this was correct.

2.7 With the recruitment of the Chair it is important that the Trust does not lose the opportunity to appoint someone with strong local connections. We should look to have a patient representative on the selection and interview panels.

Mark Wightman reminded the group that the Chair recruitment is run at arms length by the NTDA. For the previous recruitment process the Trust set up a stakeholder panel who met candidates and fed in to the recruitment process. The Trust is keen to do this again for the current process.

2.8 Has the Trust received approval for the funds to build the ED floor?

Richard Kilner said that we have received approval for the enabling works. He added that the Trust's five year plan is nearing completion and a key input of this is the development of the ED floor.

2.9 Will any excess be picked up? It is common for developments ot finish above the initial projected cost.

Richard Kilner said that the Trust allows for contingency in any business plan. UHL has a good track record of delivering projects within budget.

2.10 Will the introduction of electronic patient records improve patient letters for outpatients?

Richard Kilner said that the process would indeed significantly improve the efficiency of outpatient letters.

2.11 The Trust was right to run a stakeholder meeting about the complaints process. It is important that we get this right. People still struggle however to know who to complain to and would benefit from a single point of access.

Richard Kilner noted the considerable time and resource put in to responding to complaints. He said that a more virtuous approach would be to stop them happening in the first place.

3.0 The group were shown a video produced by the Kings Fund which explored the experience of older, frail patients and their journey in to hospital. The video highlighted the ways in which patients can sometimes become "lost" in the system and end up with inappropriate referrals and where treatment could be more effective.

3.1 Medical Director Kevin Harris reflected on the issues raised by the video noting that acute hospitals were seeing increasing numbers of frail older people. If we get their care wrong we end up making people worse rather than better. While it is a generalisation, if people spend more than five days in hospital they risk deteriorating. Referring to the pathway illustrated by the video Kevin noted that there was a lack of clarity in what the benefits of referrals would be. The patient in the video had fallen. She was on a number of medications which may have contributed to her fall and there was no clear plan of what to do once she was admitted. At no time did anyone ask "why is she here and what are we going to do"? Overall the patient was debilitated by a lengthy stay in hospital.

3.2 Kevin said that it was important to have a clear holistic view of the patient and to ask whether they might be better treated at home. Hospital treatment has been the way in which we historically behave. Our mind set needs to change and we need to ensure that we have the facilities in place to enable this.

3.3 In terms of the Better Care Together programme who is taking control? We have £400 million to save over 5 years. Who is driving this agenda?

Kevin Harris said this question is best split in to two; who takes control of the system and who takes control of the patient. For the latter the central point is the General Practitioner. Kevin acknowledged the challenge in Primary Care around resources. However Primary Care has a key role. In reference to the video he said that the patient's experience was probably predictable once she was admitted to an acute hospital. Primary Care should have identified her needs and a plan and resources put in place to meet them.

3.4 There seems to be a culture among GPs that they are too ready to advise patients to call an ambulance. This should be addressed to ensure GPs are taking more responsibility for their patients. What communication does the Trust have with GPs when patients are admitted?

Kevin Harris said that GPs are informed within 24 hours of a patient being admitted.

3.5 Why aren't GPs then involved shortly after this to ensure they are appropriately discharged in to their care?

Richard Kilner said that this was exactly what needed to be addressed, for example, through the Better Care Together initiative. However, Primary Care is also very challenged. The key is to work harder on prevention and dealing with issues earlier on. He added that there were also complications with the interface between health and social care. We work with a complex structure that is not always joined up at either a local or national level. Locally we have UHL, LPT, the CCGs, in short, many silos which all add complexity and the potential for failure. We still have a lot to do to improve how healthcare is delivered.

3.6 Mark Wightman suggested that the next time the group meet we should focus on the Trust's Older People's Strategy.

4.0 Mark Wightman then provided an overview of the Trust's Five Year Plan. He said that the Trust recognised that it will be running at a deficit for the next five years. Despite projected savings of £45 million per year we will still not break even.

4.1 One of the key shifts in how we work responds to the recent Keough and Francis reports which advocate a move to 7 day a week 24 hour services.

4.2 The LLR forecast demonstrates the size of the challenge, suggesting that if nothing changes, by 2018/19 we are looking at a £395 million gap. This does not include Social Care.

4.3 Mark said that at the same time as UHL developing their five year plan the whole health economy was also drawing up a five year plan under the banner of Better Care Together. What we do clearly needs to be grounded in the whole helath economy's direction of travel.

4.4 In terms of service challenge we currently have a "hot" emergency system. We are seeing increasing numbers of people coming to UHL in crisis. This is compouinded by delayed transfers of care in which patients are ready to leave the acute site but have nowhere to go on to. This affects our referral to treatment (RTT) times because with pressures on the emergency flow we are obliged to cancel some elective procedures.

4.5 The five year plan has two chief components. The first will ensure that we do things better in hospitals. As such we will increase the number of day cases and reduce length of stay. To achieve this we need to work with colleagues in other parts of the health community to build up capacity to take people out of hospitals when the acute phase of their care is finished. We will also be creating a stand alone facility for electives so they aren't affected by fluctuations in the emergency pathway.

4.6 Phase two relates to reconfiguration. If we are on plan we will need fewer beds. As such, the LRI and GHG will become our acute centres of excellence. The LGH will concentrate on sub acute care, but will retain centres of excellence such as our Diabetes unit. For example, our Renal department will move to the GH where it will sit alongside Cardiovascular and Vascular services providing an optimal clinical configuration.

4.7 Mark noted that there was much to do and that the plan was, at this stage, still a work in progress. He invited questions from the floor.

4.8 With more people treated in the community and smaller hospitals there is a projected saving of £300 million. When does this start to happen?

Mark Wightman said that this was already beginning but noted the importance of building up an appropriate infrastructure in Primary Care to accommodate the shift. The Department of Health has top sliced £2.6 billion to support this shift nationally under the Better Care Fund. If this money isn't spent on measures to reduce hospital care there are penalties.

4.9 What is happening to Social Care with local authority cut backs? The voluntary sector play an important role in preventing people coming in to

hospital, for example supporting people with dementia. What will the effects of these cuts be on the five year plan for the health economy?

Mark Wightman said that the Better Care Together programme has brought together all of the key stakeholders in the health economy, including Social Services. As such they are all involved in discussions to ensure the system is joined up.

4.10 Can't the Trust open up the Brandon Unit [LGH Site] as a discharge unit, freeing up beds?

Mark Wightman said that the utilisation of the Brandon Unit has been looked at but the costs to upgrade the building were prohibitive. It could certainly be argued that the city lacks a community hospital. LPT are responsible for commissioning intermediate care and this issue will rest with them. The point is that many patients shouldn't be in hospital in the first place. The answer isn't to build larger hospitals but to address what is not working elsewhere.

4.11 The Trust has taken a lot of stick for the time it takes patients to get through the emergency system. In the last fortnight we have been told of two community hospitals closing and we know that care homes are also shutting down. GPs are not working 7 days a week. What pressure can UHL bring to ensure there are adequate plans to create capacity in Primary Care?

Mark Wightman said that UHL certainly needs to maintain some system leadership. He also urged the Patient Voice to hold us to account through this and other forums.

4.12 At a recent conference 2017 was spoken about as the tipping point for Dementia in the UK. If we push people out to the community what happens if there simply aren't enough carers to look after them?

Mark Wightman said that if we take beds out of acute care we need to make sure they are replaced in the community. Nationally, alternative solutions are being explored in terms of how we meet the growing demand for health and social care. For example, should we all pay more tax to support care needs? Richard Kilner noted that the percentage of GDP spent on helath and social care had fallen in recent years. While we all recognise the growing problem, with a growing economy should spending on the NHS decline as a percentage of overall GDP? With the challenges of an ageing population this is counter intuitive.

5.0 Richard Kilner drew the meeting to a close, thanking both speakers and participants for their time and contribution to the meeting.

Meeting of the Patient Advisors Support Group
17th July 2014
Meeting held in the Large Committee Room, Leicester General Hospital

Attendees:	**Apologies**
Martin Caple	Khudeja Amer Sharif
Mary Gordon	Pratiba Mkadmi
Anthony Locke	
Jenny Wells	
Paul Burlingham	
David Gorrod	
Geoff Smith	
Rosemary Stokes	
David Allen	
Tony Patel	
Nadine Wood	
Mark Wightman	
Karl Mayes	

Guest: Richard Kilner, Acting Chair of UHL

1. UHL Values – Mark Wightman

1.1 Mark noted several discussions he and others had had over recent months which indicated that there was a degree of discontent within the Patient Advisor group. One of the key issues seems to relate to the different perceptions held of the PA role among the group. As such, the group arguably lacks a clear shared common purpose. Mark noted the importance of Patient Advisors to the Trust and said that it was desirable to invest some time and resource in to the group.

1.2 In dialogue with other UHL colleagues, Mark suggested a time out day for the group which would be led by the Trust's Organisational Development (OD) team. The OD team generally work with clinical teams to develop a sense of common purpose and to look at how the team can work most effectively together to meet its common aims. The session would be led by Bina Kotecha and Helen Mancini.

1.3 The aim of the session would be a clearer focus on how the team operates. Mark shared an early suggestion for the agenda;

- What are the expectations of Pas?
- What are the benefits of the PA role for the Trust and patients?
- Where can we add most value?
- What are the barriers?

The group were asked for their reflections on the time out day.

1.4 Paul Burlingham supported the idea, saying that it would bring focus to the group and look at how it may be supported to achieve its aims.

1.5 Geoff Smith noted that if the Trust were recruiting new Patient Advisors it may wish to postpone such a session until new recruits were in place. Mark Wightman said that his preference was for the session to go ahead, not least to ensure that any new Pas come in to a group with a clear sense of direction.

1.6 Rosemary Stokes said that this may be a good time to review the core purpose of the role by asking the question "why does the Board want Patient Advisors"?

1.7 Martin Caple noted that when the Patient Advisor role was created it fulfilled a need to engage with members of the public. However, since then there are a number of other patient / public groups with whom the Trust has a relationship. Martin cited the examples of Healthwatch, the Mercury Patients' Panel and the Members' Engagement Forum. Martin agreed with Rosemary that this was something for the Board to reflect on.

1.8 David Allen wondered whether a change of name from Patient Advisor might now be necessary; a point Richard Klner thought was a good idea.

1.9 Paul Burlingham asked for two or three dates to be mooted to ensure we get the best attendance at the session. He also said that he hoped the time out session would allow the group to craft a 12 – 18 month plan.

1.10 Mark Wightman noted that he would like the session "co-created" with Martin Caple's input. Martin Caple agreed and asked the group to submit any thoughts they had for the structure and content of the session to be submitted to him.

Action – Patient Advisors to submit thoughts on the time out day to Martin Caple please.

1.11 Tony Patel said that he felt the group lacked transparency and accountability. He also said that there was too little focus on outcomes and whether Patient Advisors made a difference.

1.12 Mary Gordon said that her experience of being a Patient Advisor has been very positive and she knows that she is making a difference and can see evidence of that in the CMG she is attached to.

1.13 Richard Kilner said that he has taken on board the need to do something to clarify both the role of Pas and the understanding that the Board has of the role. He said that the Board will be discussing engagement in the near future and this would form part of that discussion.

1.14 Martin Caple noted that the real work of Pas should take place in the CMGs, coordinated by the CMG leads. There was some disparity noted by the group in relation to how proactive these leads are.

1.15 Paul Burlingham asked if a representative from the Trust Board could be invited back to give the group some feedback on actions the Trust has taken since the publication of the Francis report. This would follow up the Patient Advisors engagement with John Adler on the topic some months ago.

Action – Karl Mayes to offer an invitation to the Trust Board to provide this update to the group.

2. Minutes of the last meeting and matters arising.

2.1 The minutes of the last meeting were agreed as a true record.

Matters arising;

2.2 Complaints Engagement Session
Martin Caple gave an overview of the recent complaints engagement session that he, David Gorrod, Geoff Smith and Tony Patel had attended. The event was run jointly by Moira Durbridge and her team and Leicester City Healthwatch. The event was well attended with a wide range of stakeholders. During the event the complaints process, external scrutiny and how we might simplify the process for complainants were topics of discussion. Martin collated themes with Micheal Smith from Healthwatch. These have been passed to Moira and we are awaiting feedback.

2.3 PPI Strategy
Karl Mayes gave some feedback on the development of the new PPI strategy. There had been a delay in pulling this document together. The group expressed the desire to have some input in to the document and for it to reflect the outcome of the Patient Advisors' away day. As such, Mark Wightman suggested that the paper be developed following the away day in September. Richard Kilner supported this approach.

2.4 Sharing of Information
Martin Caple drew the group's attention to the feedback form he had circulated prior to the meeting. The form aims to provide a template for Patient Advisors to summarise their activity. Martin asked for comments. Tony Patel said that the form provided some structure and was heading in the right direction. Geoff Smith said that he would like to see how the form performed in use. Paul Burlingham noted that Pas would need to be disciplined in order to keep their accounts brief.

Action: It was agreed that all Patient Advisors should , if possible, use the template to report their activities to each meeting in future.

2.5 Timing of meetings
Martin Caple noted that following the last meeting he had canvassed the views of Patient Advisors regarding their preferred times for PASG meetings. The majority view was to

alternate times between morning and afternoon meetings, with the occasional evening meeting. Martin suggested that evening meetings could take place in the summertime to make use of the longer evenings. Geoff Smith suggested that evening meetings could be scheduled before the Members' Engagement Forum meetings to encourage PAs to attend. Tony Patel supported this saying that he has attended the last five meetings and found them to be a good opportunity to understand the wider strategic issues affecting the Trust. Martin Caple reminded the group that the next meeting in September would start at 3pm. Venue TBC.

3. Richard Kilner, Acting Chairman

3.1 Martin gave the floor to Richard Kilner who updated the group on the Chair recruitment process that was taking place at the time. He noted that the stakeholder engagement session had taken place the night before and that interviews were being held in Birmingham on the following Monday.

3.2 Richard then updated the group on the current situation with Non Executive Directors (NEDs) of the Trust. He said that recently three NED terms of service had expired and that in line with recent TDA guidance these NEDs are required to reapply for the positions. He also added that a fourth NED role was becoming available to replace his own position. Of these NEDs, Kiran Jenkins will not be reapplying. Prakash Panchal has extended his tenure until September but will not be applying for a further term. Sarah Dauncey has also extended her tenure until September, after which she is intending to reapply. Richard added that Stephen Ward has developed a NED induction which may be useful as a basis for future PA inductions.

3.3 Richard acknowledged that the PA group had discussed both the role of a NED PPI "champion" and attachment of a NED to the PASG. Richard said that he is happy for a NED to attend the group but was more in favour of this being done on a rotational basis rather than allocating a single NED to the role.

3.4 Richard then shared his thinking on the Board cycle noting that historically Boards had met a week after committee meetings. More recently this was one day after. The recent Board review showed that this was not optimal. He also questioned the efficacy of holding 12 Board meetings a year , noting that many Trusts hold between 8 – 10 meetings per year. A further issue related to the times of Board meetings. Public attendance is limited when meetings are held on week days. Richard was keen to explore the possibility of weekend meetings. This would not only encourage public attendance but might also attract a more diverse range of people to the NED position (i.e. working people and those with caring responsibilities).

3.5 The Chairman then shared with the group a brief overview of the financial position of the Trust. He said that UHL has historically broken even. Over the last few years this has been achieved through the late adjustment of contracts. When the Trust entered the 2013/14 financial year, it did so with the assumption of a certain level of funding from CCGs. This transitional funding transpired to be much less than expected. Because the Trust entered the year with flawed financial assumptions its income was effectively £20 million short. This also included an overspend, some of which was investment in nurses (*post Francis). As such the forecast predicts a further deficit at year end. This year, in the first three months we have

managed pay and non pay costs in line with our targets. As such Richard is confident that the organisation has a grip on its finances. He noted that we are a large, expensive Trust to run, particularly on 3 hospital sites. We have a significant over spend on emergency activity and the penalties are high. The Trusts five year plan builds in a programme of transition and service reconfiguration that will end up with us moving to a position of small surplus.

3.6 Martin Caple thanked Richard for his update and opened the floor to questions from Patient Advisors.

3.7 David Gorrod suggested that the Trust might focus more on income generation at the same time as its focus on cost control. He said that we should be more proactive in selling our services and attracting revenue. Richard Kilner said that we are moving in to a climate of greater competition which is driving the need to expand. For example the Trust recently got the business case through for vascular services to move, co-locating them with cardiac services. This will improve the service and make us more competitive.

3.8 Paul Burlingham noted that Outpatient activity is a significant aspect of what the Trust does. Paul understood that this is run on a payment by procedure basis and asked if this produced a perverse incentive. In other words, would it be more cost effective if UHL were paid for looking after a patient over the entire pathway? Some appointments could be conducted over the telephone. Paul asked what process existed to negotiate with commissioners on this. Richard Kilner said that much activity should be conducted in the community, not at an acute hospital site. This is better for patients. He noted that Outpatients currently lose around £8 million a year. He said that the Trust is working with the Better Care Together programme to improve the situation. As Paul suggests, the starting point is to review what consultations may be conducted virtually.

3.9 Tony Patel said that historically a NED was appointed to act as a PPI lead at Board. He suggested that if clear leadership was to be given in this area there should be one person taking responsibility. Martin Caple added that David Tracy used to occupy this role. Richard Kilner said that this was an important topic. On reflection he felt that there is a great value to exposing all the NEDs to Patient Advisors. One of the benefits of this model would be that the group would get the opportunity to meet with NEDs with different interests and responsibilities. For example, one month they would meet with the chair of the Audit Committee, another month the Chair of the Finance and Performance committee etc. Jenny wells said that she supported the idea of rotation, arguing that this would give the Board a better understanding of what PAs do. Mark Wightman noted that there are advantages to having a named NED who keeps their “foot on the ball” at Board, as is the case, for example, for the Older People’s strategy. Richard Kilner suggested that one named person could take responsibility but he felt that rotational attendance at the PASG was still preferable.

3.10 Anthony Locke remarked on what he felt were increasingly longer private sessions of the Trust Board. This was, he said, effectively shortening the public Board session. Richard Kilner said that in reality the private business of the Board was not growing. However, there were necessarily issues of commercial sensitivity and that information must be taken in private. Some Trusts cover such issues in Board Development sessions. Richard added that the Board Effectiveness review highlighted the need to shorten Board lengths which

may see shorter public sessions in the future. One way of making the public sessions more effective may be, as other Trusts do, to take questions in advance of the meeting and give responses at Board.

3.11 Tony Patel said that Foresight had judged the Trust to be effective but he is aware that the TDA have concerns. He asked how the two views could be reconciled. Richard Kilner said that the Board Effectiveness review did highlight some concerns. For example, the question was asked; why does the Board not have a NED who has been a NED on a successful Foundation Trust?

3.12 Anthony Locke said that at the recent UHL leadership conference John Adler stressed the need for staff to recognise that there was always a danger of slipping in to Special Measures and that was why strong leadership was needed. Richard Kilner said that John Adler was right to raise these concerns. There is a clear need to make changes both at UHL and in the wider Health economy. He added that this is true of the NHS as a whole.

3.13 Summarising, Martin Caple said that there were three issues the group would like Richard Kilner to take away from the meeting;

- The enthusiasm and support for the organisation within the group.
- The group would like improved liaison and clearer direction from the Board.
- PPI is on the Trust's risk register and is patchy in the CMGs. Martin said that whatever influence Richard might bring to bear on this would be appreciated.

3.14 Martin Caple thanked Richard Kilner for coming to the meeting. Richard Kilner then left the meeting.

4. Feedback from Chair Recruitment stakeholder group.

4.1 Martin Caple gave some feedback on the Chair Recruitment stakeholder session that he attended the previous evening. Martin said that the event was very successful and had good engagement from all present. Mark Wightman pointed to the quality of the questioning of each candidate.

5. Feedback from Committees

5.1 Geoff Smith gave some feedback on the PIPEEAC meetings (detail in Geoff's paper circulated with the last minutes). He noted that PIPEEAC represented a sea change in embedding PPI in to the organisation. He also noted that the partnership between the PPI leads and Patient Advisors is crucial. David Allen noted that he and PA colleagues had now had five meetings with their PPI lead cancelled. He agreed that this relationship was important.

5.2 Geoff Smith and Martin Caple gave feedback from the Finance and Performance Committee and Quality Assurance Committee respectively (see papers circulated with the last minutes). Martin Caple noted that the Quality Account this year did seem to take in to account the feedback from patient Advisors.

5.3 Paul Burlingham spoke about his involvement with the Charitable Funds Committee. He began by offering his resignation from this group. Paul said that he would like to open up the opportunity to other Patient Advisors. Five meetings are held per year, which consider bids greater than £10,000. The committee receives funding applica6tions and Pas would be required to read and consider the case. Meetings are held on Friday afternoons and attendance is logged and a percentage rating formulated at the end of the year. The purpose of the group is to approve funding for initiatives that will bring staff or patient benefit. Paul said that he has enjoyed the variety of people and organisations he has come in to contact with through the committee; from parents who have lost children and are fund raising to relationships with other charities. Both Jenny Wells and David Gorrod said that they may be interested in sitting on the Committee. Patient Advisors are asked to submit their expression of interest to Karl Mayes by email.

Action: Patient Advisors interested in sitting on the Charitable Funds Committee to contact Karl Mayes by 31 July with a written expression of interest.

5.4 Jenny Wells gave some feedback from the Research Committee that she sits on. Jenny felt that the Trust should do more to publicise the positive outcomes of research and understands that a post was recently created to do this. Jenny said that she was recently involved in a project with schools to promote careers in health.

6. Round up of Patient Advisor activity

6.1 Rosemary Stokes has been involved in reviewing patient information with the infection prevention team. She is also now sitting on the women's AND Children's CMG Board.

6.2 Mary Gordon sits on the ITAPS Board, she has also participated in ward rounds looking at improvements to ICU. She has participated in the development of an action plan and also participated in Cancer peer reviews.

6.3 Nadine Wood sits on the CMG, Quality and Safety and Infection Prevention Boards. She has also been active with patient surveys and is getting involved in work on hearing services for older people. Martin Caple said that he had been involved in a similar project and suggested that he and Nadine touch base to avoid duplication.

6.4 Jenny Wells has participated in a survey of external signage for outpatients.

6.5 David Allen has been sitting on the Strat3egic Dementia Committee with Rutland Helathwatch and has drawn on his contacts at UHL for this work.

6.6 Geoff Smith and Tony Patel have provided written reports of their activity.

6.7 Martin Caple said that he has been very encouraged by the work that Pas are doing in ITAPS. He has also been involved in Cancer peer reviews.

6.8 Paul Burlingham has been involved with infection prevention audits and also facilitated at a Urology patient feedback day.

7. Evaluation of meeting

7.1 Martin Caple asked the group to reflect on the meeting, asking if it met its objectives and we had met the values of the Trust, which Geoff Smith highlighted. . Paul Burlingham said that he appreciated Richard Kilner's input. Geoff Smith noted that the atmosphere for the meeting was much better, more collegiate. Paul Burlingham praised Martin's chairing and felt that there was a good balance to the meeting. Martin Caple also said that the meeting felt more positive this time.

Date of the Next Meeting

September 18th 2014
3pm – 5pm
Venue to be confirmed.

Trust Board Bulletin 28 August 2014 – paper 4

To:	**Trust Board**
From:	**ACTING CHAIR AND DIRECTOR OF CORPORATE AND LEGAL AFFAIRS**
Date:	**28 AUGUST 2014**
CQC regulation:	N/A
Title:	**BOARD EFFECTIVENESS ACTION PLAN**

Author/Responsible Director: DIRECTOR OF COPORATE AND LEGAL AFFAIRS

Purpose of the Report: To update the Trust Board on the implementation of the Board effectiveness action plan.

The Report is provided to the Committee for:

Decision		Discussion	
Assurance	√	Endorsement	

Summary / Key Points:
The attached action plan was approved by the Trust Board at its meeting on 31 July 2014. It was agreed by the Board to receive an update at each Board meeting on the implementation of the action plan.

Recommendations:
To receive and note the report.

Previously considered at another corporate UHL Committee? Action plan approved by the Trust Board on 31 July 2014.

Strategic Risk Register:	**Performance KPIs year to date:**
N/A	N/A

Resource Implications (e.g. Financial, HR): The proposed appointment of a Board Coach will have resource implications.

Assurance Implications: N/A

Patient and Public Involvement (PPI) Implications: N/A

Stakeholder Engagement Implications: N/A

Equality Impact: None associated with the implementation of the action plan appended..

Information exempt from Disclosure: N/A

Requirement for further review? Trust Board to receive an update at each public Trust Board meeting.

ACTION TRACKER FOR THE BOARD EFFECTIVENESS ACTION PLAN 2014/15

Monitoring body (Internal and/or External):	Trust Board
Reason for action plan:	To strengthen the effectiveness of the Trust Board
Date of this review	**August 2014**
Frequency of review:	Monthly
Date of last review:	July 2014

REF	What will be different?	What will we do to make it different?	Lead Officer	Lead Director	Date to be completed	Progress/Update	Status
Workstream 1: Formulating Strategy							
1.1	There will be a clear/shared outcome of the Board's role in formulating and determining strategy reflected in a systematic, iterative process for engaging CMGs/Executive Team/external partners/stakeholders and the Trust Board.	Trust Board to agree a revised strategic planning process which will : • Be clear and transparent; • Describe how CMGs will be engaged; • Describe how the external environment will be assessed and managed; • Agree the minimum products that CMGs will produce in the planning round; • Identify the Board meeting dates at which strategic business will be transacted.	HBPD	DS	31.7.14	A report entitled 'Developing a strategic planning function for 2014/15 and beyond' was approved by the Trust Board on 31 July 2014.	5

Status key:	5	Complete	4	On track	3	Some delay – expect to completed as planned	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Objective Revised

REF	What will be different?	What will we do to make it different?	Lead Officer	Lead Director	Date to be completed	Progress/Update	Status
Workstream 2: Ensuring Accountability							
2.1	'Intelligence' for the Board will be reshaped to improve insight which assures/warns we are or are not delivering the Trust's strategy.	Revise the Trust's quality and performance report.	ADI	CN	31.8.14	New quality and performance report discussed at Trust Board development session on 14th August 2014 and revised version to be submitted to the Trust Board on 28th August 2014.	4
		Revise the Trust's Board Assurance Framework	DSR	CN	31.8.14	New version of Board Assurance Framework in the process of being developed : revised version submitted to and approved by the Trust Board on 31 July 2014; and fully populated version to be submitted to the Trust Board on 28th August 2014.	4
		Commence bi-annual reporting to Trust Board on the delivery of Caring at its Best	STA	DCLA	31.10.14	First report on 'Caring at its Best' delivery for H1 2014/15 scheduled for submission to the Trust Board on 30th October 2014.	4

Status key:	5	Complete	4	On track	3	Some delay – expect to completed as planned	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Objective Revised

2.2	Re-sequencing of Board and Board Committee meetings to ensure more effective and formal assurance.	Trust Board to agree a revised calendar of Board and Board Committee meetings/	STA	DCLA	31.8.14	The sequencing of Trust Board meetings will change from January 2015. Trust Board meetings will take place in the first week of the month from January 2015, commencing 8 January 2015. Board members have been canvassed on their availability for new Board meeting dates to March 2016 and these are included in the Trust Board bulletin for 28th August 2014.	4
2.3	Re-ordering of business to be transacted at Trust Board meetings to take the most important items early.	Implement a revised approach to the ordering of Trust Board business.	STA	DCLA	31.8.14	In consultation with the Acting Chair and Chief Executive, a revised approach to the ordering of Trust Board business will be implemented with effect from the Trust Board meeting on 28th August 2014.	4
2.4	Reduce the amount of time taken up at Trust Board and Board Committees in 'covering the same ground' and ensure that the Board and its Committees are a focus for escalation – with detailed intelligence primarily provided in the form of exception reports – while ensuring that we also take time to celebrate success.	Map what information goes where against the Board assurance '3 lines of defence'.	DCLA	DCLA	30.9.14	Outcome of mapping and recommended changes to the way in which Board business is processed to be reported to Trust Board on 25th September 2014.	4
		Standardise exception reporting in line with the production of a new quality and performance report.	ADI	CN	31.8.14	New quality and performance report in the process of being developed in consultation with the Executive Team and revised version to be submitted to the Trust Board on 28th August 2014.	4

Status key:	5	Complete	4	On track	3	Some delay – expect to completed as planned	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Objective Revised

REF	What will be different?	What will we do to make it different?	Lead Officer	Lead Director	Date to be completed	Progress/Update	Status
2.5	Improved Trust Board profile by putting in place regular feedback from the Board to staff so that staff understand the Trust's key priorities and how they contribute as individual staff members to delivering these priorities.	Summary of up to 5 key decisions/discussions will be agreed by the Trust Board at the close of each Board meeting and communicated to all staff via a 'Chair's Bulletin'.	Acting Chair/ HOC	DCM	31.10.14	At its meeting on 31 July 2014, the Trust Board instituted a new approach of agreeing the key headlines for this month's 'Chair's Bulletin'. The Bulletin will be communicated to all staff. An item to agree the 'Chair's Bulletin' will feature as a standard item on all Trust Board agendas following the commencement in post of the new Trust Chair on 1 October 2014.	4

Status key:	5	Complete	4	On track	3	Some delay – expect to completed as planned	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Objective Revised

REF	What will be different?	What will we do to make it different?	Lead Officer	Lead Director	Date to be completed	Progress/Update	Status
Workstream 3: Shaping A Healthy Culture, Corporate Working and Good Social Processes							
3.1	There will be focused and systematic Trust Board engagement with CMGs and clinical leaders.	Quarterly informal Trust Board/CMG clinical leaders sessions to be established.	CE	CE	To commence from Q3 2014/15	Consideration being given by Chief Executive to the purpose and most appropriate format of the Trust Board/CMG clinical leaders sessions.	4
3.2	A Board 'Coach' will be appointed to support and challenge the Board in its quest to become more effective.	The Trust Board will agree a clear specification for the role of Board 'Coach' and make an appointment.	DHR	DHR	In time for Trust Board development session to be held on 16 October 2014.	Director of Human Resources in discussion with The Foresight Partnership on the appointment of Board 'Coach'. Sue Rubinstein has agreed to act as the Board Coach but this is subject to agreement with the newly appointed Trust Chair.	4
3.3	The Trust Board will discuss and agree : (a) the overall leadership model that the Board (in its role) and Executive Team (in its role) are seeking to build; and (b) the Board culture that it is seeking to shape and exemplify, and the need for positive alignment between Board and organisational culture shaping activity.	Dedicate a Trust Board development session, facilitated by the person appointed as Board 'Coach' (see item 3.2 above), to discuss and agree our position.	DHR	DHR	16.10.14 (Trust Board development session earmarked for this purpose)	As above. The date has been scheduled for a facilitated session with Sue Rubinstein on 16 October 2014 subject to the outcome of the discussion referred to in 3.2 with the newly appointed Trust Chair.	4

Status key:	5	Complete	4	On track	3	Some delay – expect to completed as planned	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Objective Revised

REF	What will be different?	What will we do to make it different?	Lead Officer	Lead Director	Date to be completed	Progress/Update	Status
3.4	The Trust Board will discuss and agree its role in shaping leadership, as part of a systematic approach to engagement.	Dedicate a Trust Board development session to discuss and agree our position on this subject.	DCM/ DS	CE/DCM/DS	End Q2 2014/15	Trust Board development session 18th September 2014 earmarked for this purpose.	4

KEY	
LEAD OFFICER	
ADI	Assistant Director of Information
DSR	Director of Safety and Risk
HBPD	Head of Business Planning and Development
HOC	Head of Communications
STA	Senior Trust Administrator
LEAD DIRECTOR	
CE	Chief Executive
CN	Chief Nurse
DCLA	Director of Corporate and Legal Affairs
DMC	Director of Marketing and Communications
DHR	Director of Human Resources
DS	Director of Strategy

Stephen Ward
Director of Corporate and Legal Affairs

15th August 2014

Status key:	5	Complete	4	On track	3	Some delay – expect to completed as planned	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Objective Revised