UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF A MEETING OF THE TRUST BOARD, HELD ON THURSDAY 5 MARCH 2015 AT 9AM IN THE C J BOND ROOM, CLINICAL EDUCATION CENTRE, LEICESTER ROYAL INFIRMARY

Voting Members Present:
Mr K Singh – Trust Chairman
Mr J Adler – Chief Executive
Col (Ret'd) I Crowe – Non-Executive Director
Dr S Dauncey – Non-Executive Director
Dr K Harris – Medical Director
Mr R Mitchell – Chief Operating Officer (from part of Minute 44/15)
Mr P Panchal – Non-Executive Director
Ms C Ribbins – Acting Chief Nurse
Mr M Traynor – Non-Executive Director
Mr P Traynor – Director of Finance
Mr M Williams – Non-Executive Director
Ms J Wilson – Non-Executive Director

In attendance:
Sr J Carlin – Matron, Ward 22, LRI (for Minute 49/15/1)
Mr J Clarke – Chief Information Officer (for Minute 52/15/1)
Mr D Henson – LLR Healthwatch Representative (up to and including Minute 55/15)
Ms H Leatham – Assistant Chief Nurse (for Minute 49/15/1)
Mr K Mayes – Patient and Public Involvement/Membership Manager (for Minute 49/15/4)
Mr R Moore – Non-Executive Director Designate
Dr S Oldroyd – Dean, Faculty of Health and Life Sciences, De Montfort University (for Minute 49/15/3)
Dr R Palin – Leicester, Leicestershire and Rutland CCG Representative (up to and including Minute 55/15)
Mrs K Rayns – Acting Senior Trust Administrator
Sr K Richardson – Ward Sister, Ward 22, LRI (for Minute 49/15/1)
Ms K Shields – Director of Strategy
Ms E Stevens – Acting Director of Human Resources
Ms M Thompson – Patient Experience Sister (for Minute 49/15/1)
Mr S Ward – Director of Corporate and Legal Affairs
Mr M Wightman – Director of Marketing and Communications (from part of Minute 46/15)

ACTION

42/15 APOLOGIES

There were no apologies for absence.

43/15 DECLARATIONS OF INTERESTS IN THE PUBLIC BUSINESS

The Trust Chairman indicated a non-prejudicial interest in the item of business discussed under Minute 49/15/3 (in his capacity as Trustee of the Joseph Rowntree Foundation).

44/15 CHAIRMAN'S ANNOUNCEMENTS

The Chairman welcomed Mr R Moore, Non-Executive Director Designate, Ms C Ribbins, Acting Chief Nurse and Dr R Palin, LLR CCG representative to the meeting. He recorded the Board's thanks to Dr K Harris, Medical Director, Mr P Panchal, Non-Executive Director, and Mr M Williams, Interim Non-Executive Director, noting that this would be their last Board meetings before they stepped down from their respective roles at the end of March 2015.

Members noted that discussions were underway with the University of Leicester with a view

to recruiting to the vacancy arising from Professor D Wynford-Thomas's recent resignation from his role as a UHL Non-Executive Director and that the Trust Development Authority would be advertising for an additional Non-Executive Director in April 2015 (to fill the vacancy created when Mr Panchal stood down).

Resolved – that the information be noted.

45/15 MINUTES

Resolved – that the Minutes of the 5 February 2015 Trust Board (paper A) be confirmed as a correct record and signed by the Trust Chairman accordingly. **CHAIR**

46/15 MATTERS ARISING FROM THE MINUTES

Paper B detailed the status of previous matters arising and the expected timescales for resolution. The Board received updated information on the following items:-

(a) item 3 (Minute 25/15/2(c) of 5 February 2015) – the Chief Executive confirmed that an additional communications resource had been agreed to support the Trust's reconfiguration programme, (including the Intensive Care service provision);
(b) item 4 (Minute 25/15/2(d) of 5 February 2015) – the Director of Strategy briefed Board members on the engagement activity being undertaken in relation to the ICU reconfiguration, advising that more detail would become available on the required service moves by the end of May 2015, and
(c) item 15 (Minute 324/14/1(a) of 22 December 2014) – Dr S Dauncey, Non-Executive Director and QAC Chair confirmed that a report on the arrangements for meeting the requirements of the Duty of Candour would be scheduled on the QAC agenda for 26 March 2015.

Resolved – that the update on outstanding matters arising and the timescales for resolution be noted.

47/15 CHAIRMAN'S MONTHLY REPORT – MARCH 2015

The Chairman introduced paper C, providing a summary of key considerations in respect of (a) UHL's aging demographic patient profile and its impact upon future provision of healthcare services, and (b) the need to ensure that a constant patient focus was embedded throughout the NHS, highlighting opportunities to learn from other organisations in this area.

In respect of the reports which featured on that day's Board agenda, he particularly drew members' attention to paper G, the report on the Institute of Frail Elderly Medicine and the proposed partnership with De Montfort University and paper H, the Patient and Public Involvement and Engagement Strategy (Minutes 49/15/3 and 49/15/4 below refer).

Resolved – that the position be noted.

48/15 CHIEF EXECUTIVE'S MONTHLY REPORT – MARCH 2015

The Chief Executive introduced his monthly update report (paper D), noting that substantive reports on emergency care performance and the Trust's month 10 financial position featured later in the agenda. He briefed the Board on the following key issues:-

(a) the appointment of Mr A Furlong as UHL's Interim Medical Director from 1 April 2015 to 31 December 2015 and the arrangements for Dr K Harris to retain his role as a clinical academic, whilst undertaking a senior role with NICE (3 days per week) and continuing to support the relationships between UHL and its academic partners;
(b) progress with the recruitment to the substantive posts of Director of Estates and

Facilities, Director of Human Resources and Organisational Development, and Chief Nurse, with interviews arranged to be held on 1, 13 and 17 April 2015 (respectively);

(c) the Emergency Floor outline business case (OBC) had been approved by the TDA national capital group and was due to be considered by the full TDA Board meeting on 19 March 2015. Feedback on the OBC would now be incorporated into the full business case for submission to the TDA national capital group in April 2015 and the full TDA Board in May or June 2015;

(d) recent developments relating to the national tariff for 2015-16, noting the scope to develop a local tariff arrangement with the Trust's commissioners;

(e) the recommendations contained in the "Freedom to Speak Up report" published in February 2015;

(f) progress during the final month of formal support for the Mutuals in Health Pathfinder Project, noting that a draft feasibility study had been circulated for comments and that discussions were underway in respect of a potential pilot for an 'Autonomous Team' working within a 'mutualisation' framework, and

(g) the health and social care reform proposals for Greater Manchester, and the potential implications for the LLR Better Care Together Programme.

In discussion on the Chief Executive's monthly update report, the Board considered:-

(i) the scope to adopt the principles behind increased local accountability in future (as indicated by the developments in Greater Manchester), noting the differences in the political landscape and the local government structure. In response, the Trust Chairman suggested that the Chief Executive might like to raise this matter with the Better Care Together Programme Partnership Board once the outcome of the May 2015 General Election was known;

(ii) whether there would be any risks to service delivery for UHL services which were not being progressed as an 'Autonomous Team' pilot. The Chief Executive agreed that this was an important point and he confirmed that consideration would be given to developing an assurance process to prevent the pilot from disrupting other UHL services, and

(iii) whether any other healthcare providers were in the process of developing local contractual agreements with their commissioning bodies.

Resolved – that the position be noted.

49/15 KEY ISSUES FOR DECISION/DISCUSSION

49/15/1 Patient Story – Patient Experience on Ward 22 at the Leicester Royal Infirmary

Ms H Leatham, Assistant Chief Nurse, Ms M Thompson, Patient Experience Sister, Sr K Richardson, Ward Sister and Sr J Carlin, Matron attended the meeting to present paper E and to introduce 2 short video clips detailing the following examples of patient experience:-

- video clip 1 was filmed 8 months ago on ward 22 and detailed the negative experience of a female inpatient suffering from acute pain. The issues highlighted related to the timing of pain medication, uncaring attitude of staff, poor communications and use of inappropriate and unprofessional terminology (eg "babysitting"), and
- video clip 2 was filmed 6 months later on the same ward and highlighted the positive experience of a male patient who had been apprehensive about his treatment and care. He had found that the staff had been courteous, supportive, reassuring and kind. He had also observed that all patients had been treated with the same level of attentive care and professionalism during his stay.

Board members noted the key interventions that had taken place as a result of the earlier poor patient feedback, including the appointment of a replacement Ward Manager, implementation of daily visits from the Pain Management Team, improved staff training,

performance management measures to address examples of poor staff attitude and behaviours, hourly patient rounds, improved team working, daily management walkabouts, effective sickness management, closer working between the housekeepers and the catering and nutrition teams, and weekend staffing levels to provide a full 7 day service.

Mr C Sutton, Head of Service and Consultant Surgeon had shown the videos to all of UHL's Gastro Surgeons and a number of changes had been made as a result. For example, the term "babysitting" was no longer used when referring to a patient's care and the referrals process to the Pain Management Team had been clarified. The Acting Chief Nurse summarised the significant change in culture on ward 22 since Sr Richardson's appointment as Ward Manager some 7 months earlier and commended the strength of her leadership skills and the benefits of a multidisciplinary approach.

During the discussion on this item, Board members considered any opportunities to improve the wider culture on UHL's base wards, noting that staff culture was now a feature of the interview process for new staff and that staff culture formed a key area of focus for leadership and mentoring programmes. Targeted support was also provided by the Corporate Nursing Directorate (as required) to drive improvements in staff culture.

Mr P Panchal, Non-Executive Director reflected upon the need for some patients' relatives to become actively involved in aspects of patient care, particularly when the patients were elderly or suffering from dementia. The Board noted that Dr S Conroy, Head of Service for Geriatric Medicine was developing improvements in the communications process with families of elderly patients.

The Chief Executive sought and received assurance that the 25% nurse vacancy rate on ward 22 (8 months ago) had reduced significantly, noting that there was currently only 1 vacant nursing post on this ward. In addition, the Acting Chief Nurse briefed the Board on the surveillance mechanisms for tracking ward performance, advising that regular ward dashboard reports were presented to the Executive Quality Board, Quality Assurance Committee, Nursing Executive and the Clinical Quality Review Group and that a range of "special measures" were available for implementation in the event of any deteriorating trends in patient feedback or ward performance. The Trust Chairman thanked the presenters for this insightful presentation.

Resolved – that the patient story and the related discussion be noted.

49/15/2 Learning Lessons to Improve Care – Quarterly Update

Further to Minute 275/14/2 of 30 October 2014, the Medical Director introduced paper F, providing the second quarterly progress report on the work undertaken since the Learning Lessons to Improve Care Review report was published in July 2014. Section 3 of the report highlighted the planned activity during the next quarter, including a second Clinical Summit to be held in March 2015.

The Clinical Leadership Taskforce was now embedded within the healthcare community through the Better Care Together Clinical Leadership Group and the programme timeline was provided at Appendix 1. Access to primary care records had been a key enabler and some significant improvement in tangible patient outcomes had been evidenced, eg the published SHMI mortality data had reduced from 107 to 104 in the last 12 months. Members noted that the Clinical Leadership Taskforce would continue to be chaired by the UHL Medical Director and that regular progress reports would be presented to the Trust Board meetings of all the LLR healthcare organisations.

During the discussion on this item, Board members commended the progress being made. Noting the challenges associated with measuring outcomes for the 8 system challenges listed in appendix 3, they queried the scope for "softer" measurements, such as the LiA

pulse check. Members requested that the next iteration of the joint action plan be strengthened in terms of the timescales, noting the Medical Director's response that the individual organisations' action plans already contained more firm dates.

In respect of action 3.6 in appendix 2, the LLR CCG Representative noted that the 3 CCGs were addressing the issue of individual care plans for patients over the age of 75 (based upon identification of risk stratification) in slightly different ways. He also advised that this information should be collated and measured as a percentage, due to natural fluctuations in patient numbers within this age category. Finally, the Chief Executive noted the benefits of the electronic patient record (EPR) as an enabler to enhance information flows within the healthcare community. The results of the EPR Gateway Review had been announced on 4 March 2015 and an amber/green rating had been awarded with a score of 2 out of 5 (with 1 being the best achievable score).

Resolved – that the update on Learning Lessons to Improve Care (paper F) be received and noted.

49/15/3 Institute of Frail Elderly Medicine – Proposed Partnership with De Montfort University

The Medical Director introduced paper G seeking the Board's support for the establishment of an Institute of Health for Older People in Leicester, in conjunction with the Leicestershire Partnership NHS Trust (LPT), De Montfort University (DMU) and Age UK. Dr S Oldroyd, Dean Faculty of Health and Life Sciences, De Montfort University attended the meeting for this item. The proposals had been supported by the DMU Board of Governors and a commitment had been made to fund one of the professorial posts and contribute expertise, research and ongoing leadership and support. Indicative support had been provided by LPT's Medical Director and the proposal would be presented to the LPT Board in due course.

The Trust Board supported the proposals subject to the development of appropriate governance mechanisms, business planning processes, budget planning and financial controls. They also commented upon the need to ensure that the arrangements were truly representative of the diverse population within local communities. The Acting Chief Nurse advised that other key voluntary sector bodies (eg Vista) had contributed to the Listening into Action (LiA) listening event "fixing the basics". Members also commented upon the scope to strengthen the branding of this partnership arrangement and noted the positive aspects of involvement with care homes.

Resolved – that (A) the Trust Board endorse the development of the proposed Institute of Health for Older People in Leicester in principle, and **MD**

(B) a further report on the proposals be presented to the Trust Board in 3 months' time (in June 2015) – to include the proposed governance structure. **MD**

49/15/4 Patient and Public Involvement (PPI) and Engagement Strategy

The Director of Marketing and Communications presented paper H, seeking the Board's endorsement of the Trust's new PPI and Community Engagement Strategy and Plan. Mr K Mayes, Patient and Public Involvement/Membership Manager attended the meeting for this item. The report was taken as read, but the Director of Marketing and Communications highlighted the salient points, noting that the proposed strategy was intended to take PPI, engagement and community relations up to a different level (where it was seen as core business for the Trust) and to identify a trajectory towards achieving this goal.

The Trust Chairman made an exception to the usual process and he invited the 3 Patient Advisers present to comment upon the proposed strategy. In response, the following comments were noted:-

(a) Mr M Caple, Patient Adviser was supportive of the new strategy, but he stressed the need for UHL to demonstrate its commitment and provide appropriate CMG level resources to underpin the process. He felt that the CMG teams would need to develop a greater understanding of "involvement" and he recommended a robust monitoring process with periodical reviews;
(b) Mr D Gorrod, Patient Adviser queried the proposed process for measuring success (or failure), noting the potential for such initiatives to lapse after the initial "fanfare". Whilst he had not been able to attend the PPI away day, he queried whether the strategy was likely to tackle all the "low hanging fruit" and might miss the harder to reach sectors of the community (eg student population, Roma community and different faith and ethnic groups). He also commended the Trust's proposed plan to recruit a secular chaplain, and
(c) Mr G Smith, Patient Adviser commended the inclusive approach towards the development of this strategy. He highlighted opportunities to work with other Trusts in the East Midlands, learn from other organisations, and strengthen the links with the Patient Experience Team. He encouraged the Trust to call the CMG teams to account and noted the Board's accountability to monitor progress, suggesting that a formal review be undertaken within the next 12 months.

Board members commented upon the strategy, noting the importance of making engagement events accessible to all communities by arranging them outside of school hours or working day commitments and/or providing crèche facilities. The LLR Healthwatch representative advised that Healthwatch was undertaking a series of planned engagement events in the County and that they were planning to replicate these arrangements within the City. Members also queried whether the proposed measures for supporting and managing PPI engagement in the CMGs would resolve all the issues and whether a greater emphasis on use of social media and E-Advisers would be helpful.

The Chief Executive observed the need to review the position of PPI within UHL's Caring at its Best Framework, suggesting that it might be beneficial to move PPI from the "Strategy" section into the "Quality" section, thus enabling follow-up monitoring to be undertaken at the CMG quality and performance meetings. He also noted the cost pressure surrounding the creation of an additional band 5 PPI officer post to support the PPI and Membership Manager.

The Trust Chairman summarised the key themes arising from the discussion on this item, including the arrangements for leadership, accountability, listening and how they might affect the way that the Trust carried out its business and operated its CMGs in the future. He noted the questions raised regarding networking with contacts and how success would be measured and he requested that a formal review of progress be undertaken in March 2016.

<u>Resolved</u> – that (A) the new PPI and Community Engagement Strategy be endorsed (as presented in paper H), subject to resolution of the identified cost pressure surrounding PPI resources, and **DMC**

(B) a review of the PPI and Community Engagement Strategy be presented to the Trust Board in 12 months' time (in March 2016). **DMC**

50/15 QUALITY AND PERFORMANCE

50/15/1 <u>Quality and Performance Report – Month 10 (January 2015)</u>

Dr S Dauncey, Non-Executive Director and Chair of the Quality Assurance Committee (QAC) introduced a summary of the key issues considered at the 26 February 2015 QAC meeting (paper N1 refers) and confirmed that the Minutes of that meeting would be

presented to the 2 April 2015 Trust Board meeting.

Ms J Wilson, Non-Executive Director and Chair of the Integrated Finance, Performance and Investment Committee (IFPIC) presented paper O1, providing a summary of the issues discussed at the 26 February 2015 IFPIC meeting, drawing members' attention to the recommended item in respect of the tariff selection process for 2015-16. She highlighted concerns relating to progress of the capital expenditure programme, advising that the Committee would be reviewing delays in the backlog maintenance programme at its next meeting. A positive presentation had been received from the Clinical Support and Imaging CMG where service improvement opportunities were being explored as an enabler for improving UHL's wider performance. In-month financial performance remained stable, although the run-rate for premium pay expenditure had started to cause concern. The Minutes of the 26 February 2015 IFPIC meeting would be presented to the 2 April 2015 Trust Board meeting.

Paper I provided an overview of the Trust's quality and operational performance and detailed performance against key UHL and TDA metrics. Escalation reports were appended to the report detailing any areas of underperformance. The Chief Executive introduced his highlight report, providing a summary of the following key issues for the Board's attention:-

- Quality metrics – Clostridium Difficile performance, avoidable pressure ulcers and continued concerns in respect of fractured neck of femur (NOF) performance. A Listening into Action (LIA) workstream had been established to support improvements in NOF performance, and
- Key Performance Indicators – Referral to Treatment (RTT) performance for admitted patients, cancer 31 day and 62 day performance and diagnostic waits.

The Chief Operating Officer briefed the Board on progress with recovery plans for the key operational targets, advising that a particular focus was being maintained on reducing the longest waiting RTT patients and that compliant admitted performance was expected to be achieved for April 2015. In respect of cancer performance, the 2 week wait target had been achieved in December 2014, 31 day performance was improving, and a recovery trajectory for 62 day performance had just been agreed with Commissioners to achieve compliance by July 2015. Significant progress was reported in respect of reducing cancelled operations for non-clinical reasons (0.8% in January 2015 compared to 1.6% in January 2014).

The Acting Director of Human Resources highlighted the exception report detailing under-performance against the 90% target for compliance with statutory and mandatory training. This target would be raised to 95% for March 2015 and individual emails were being circulated to highlight areas of non-compliance.

In further discussion on the Quality and Performance report, the Board:-

(a) sought and received assurance that all CMGs and Directorates were performance managing statutory and mandatory training compliance and that an appropriate focus was being maintained in respect of information governance training;
(b) noted the need for a fresh approach towards fractured NOF performance, and received additional information on the LiA workstream and an identified cost pressure for 2015-16 to undertake a re-design of the medical trauma service. A bid for discretionary expenditure had been made for a Chief of Residence post and this was likely to be prioritised accordingly;
(c) queried the arrangements for preparing for the next CQC inspection (likely to take place during quarter 2 of 2015-16);
(d) noted concerns raised by the LLR CCG Representative relating to cancer performance and his recommendation that the business case for additional administrative staff in the Cancer Centre be supported. The LLR Healthwatch Representative echoed this recommendation. The Chief Operating Officer highlighted significant improvements in 2

week wait performance, noting that some breaches were occurring as a result of patient choice, and that this might sometimes be as a result of the patients not being informed of their diagnosis prior to the cancer centre contacting them to make their first appointment;

(e) commented on the deteriorating trends in respect of research performance and noted opportunities being explored for an in-year re-design of this area of the quality and performance report to reflect a review of the reporting arrangements for UHL as LCRN host.

Resolved – that the month 10 Quality and Performance report (paper I) and the subsequent discussion be received and noted.

50/15/2 2014-15 Financial Position – Month 10 (January 2015)

The Director of Finance presented paper J, updating the Board on performance against the Trust's key financial duties and providing further commentary on the month 10 financial performance by CMG and Corporate Directorates, and the associated risks and assumptions. He provided assurance that the planned control total for 2014-15 would be achieved and CIP performance remained strong. The contract for specialised commissioning had now been agreed with NHS England and a briefing note on the 2015-16 tariff selection had been circulated to all Trust Board members for information.

The Capital Monitoring and Investment Committee had expressed concerns regarding the Trust's capital expenditure profile (including backlog maintenance, IM&T expenditure and medical equipment expenditure) and mitigating actions were being progressed to deliver the Trust's Capital Resource Limit (CRL) for 2014-15. A report on opportunities to learn from this process was being developed for consideration at the next IFPIC meeting.

A range of immediate measures and operational workstreams were being progressed to address deteriorating pay expenditure trends as part of the workforce cross-cutting CIP theme. In addition, the Acting Director of Human Resources noted an opportunity to consolidate the volume of reports provided to the CMGs in respect of workforce expenditure and she briefed the Board on some proactive measures being taken to fill the gaps in UHL's medical rotas.

Resolved – that the month 10 financial performance report (paper J) and the subsequent discussion be received and noted.

50/15/3 Approval of 2014-15 Capital Loan Application

Paper J1 detailed the terms of the Trust's £12m capital loan for 2014-15 and sought the Board's delegated authority for the Director of Finance to sign the Loan Agreement on behalf of the Trust Board. Members noted that the primary purpose of this loan from the Independent Trust Financing Facility (ITFF) was to support the Emergency Department enabling schemes which were (in turn) linked to an approved scheme and the agreed financial plan for 2014-15. The loan would be drawn down on 16 March 2015 and would be repayable over a 22 year term at an interest rate of 2.27%. The original request for external funding had been £16.3m, but the Trust had been advised that £12m was the upper limit and the Board noted that UHL would be managing the position accordingly within the financial plan.

Resolved – that (A) the Trust Board endorse the application for a £12m capital loan for 2014-15 (as per the terms and conditions set out in paper J1), and **DF**

(B) delegated authority be provided to the Director of Finance to execute the loan documents on behalf of the Trust Board. **DF**

50/15/4 Emergency Care Performance Report

Further to Minute 26/15/3 of 5 February 2015, paper K provided the monthly update on recent emergency care performance and progress against the LLR action plan. The Chief Operating Officer provided a presentation on emergency performance (revised paper K1 refers) and he showcased a short video which had been produced in house as part of the "Everybody Counts" campaign. In discussion on the monthly update, the presentation slides and the video, the Trust Board:-

(a) noted that proposals for LLR activity and capacity modelling were due to be presented to the Better Care Together Partnership Board on 19 March 2015 for approval;
(b) queried the reasons why recent improvements in discharge planning processes were not sustainable in the longer term, noting in response the emphasis on patient safety and the impact of changes in admission rates. The Medical Director also highlighted the need to focus upon the appropriate nature of discharge locations in future;
(c) commended recent reductions in patient length of stay, but noted the finite nature of this improvement;
(d) queried the scale and pace of commissioner-led interventions to achieve reductions in UHL attendances and admissions;
(e) noted the successful interactions with LPT and social care partners in respect of improving discharge processes and the associated need to reduce patient inflow, eg making better use of ambulatory care pathways;
(f) considered the difficulties surrounding engagement and communications relating to activity pressures, capacity restraints and bed closures;
(g) noted the potential impact of the proposed 2015-16 commissioning contract upon admissions and re-admissions and the need to develop a shared understanding with Commissioners through the Better Care Together programme, and
(h) commended the high quality of the video and the important messages it conveyed.

Resolved – that the report and presentation on emergency care performance (papers K and K1) and the subsequent discussion be received and noted.

51/15 WORKFORCE

51/15/1 Organisational Development Strategy – Quarterly Update

Paper L highlighted progress with implementation of UHL's Organisational Development Plan. Due to time constraints at this meeting, the Board agreed to defer discussion on this item to the next meeting on 2 April 2015.

Resolved – that discussion on UHL's Organisational Development Strategy be deferred to the 2 April 2015 Trust Board meeting. **ADHR/ DCLA**

52/15 GOVERNANCE

52/15/1 Board Assurance Framework (BAF)

The Medical Director introduced paper M detailing UHL's Board Assurance Framework as at 31 January 2015 and notifying the Trust Board of 2 new high risks surrounding quality within the nuclear medicine service and medical on-call rota vacancies. As requested under paragraph 2.2, the Trust Board undertook a detailed review of the 2 risks linked to the strategic objective *"enabled by excellent IM&T"*, incorporating principal risks 23 and 24 and the Chief Information Officer attended the meeting for this item:-

(a) ***principal risk 23 (failure to effectively implement EPR programme)*** – discussion took place regarding the key controls and assurance sources. Ms J Wilson, Non-Executive Director noted that the governance arrangements for onward reporting to the Trust Board had not yet been finalised and she queried whether this would be agreed at

the April 2015 Trust Board thinking day. In response, it was noted that the first meeting of the EPR Board was due to be held in the next week and that one of the actions arising from the EPR Gateway Review recommendations was to implement an Executive IT Board with meetings to be held on a quarterly basis, and

(b) ***principal risk 24 (failure to implement the IM&T strategy and key projects effectively)*** – Mr M Williams, Non-Executive Director suggested that this risk might be considered in 2 parts: delivering the IT strategy and then persuading staff to use the systems provided efficiently and effectively. The Chief Operating Officer noted that this issue was captured within risk 23 (above) surrounding the implementation of the EPR programme. Responding to a query raised by the Chief Operating Officer regarding the "big bang" approach and the level of confidence that the new technology would be fit for purpose, it was agreed that some additional wording would be provided to clarify that there would be a degree of phasing within the EPR roll-out.

The Director of Strategy commented upon risk 22 (failure to deliver service and site reconfiguration programme and maintain the estates effectively) and highlighted some gaps in assurance and the need to re-define this risk in terms of the organisation's cultural readiness to drive the change management process.

The Chief Executive noted that whilst a number of risks had reached their target score (with no further actions identified to address any gaps in assurance), the 2014-15 BAF would be superseded by the 2015-16 BAF in May 2015. With this in mind, it was proposed and agreed that the Board would note any anomalies in the existing BAF and seek assurance that these had been addressed in the next iteration.

Resolved – that (A) the January 2015 Board Assurance Framework (BAF) be received and noted as presented in paper M, and

(B) that the 2015-16 iteration of the BAF be presented to the Trust Board on 7 May 2015 for approval. **AMD**

52/15 REPORTS FROM BOARD COMMITTEES

52/15/1 Quality Assurance Committee (QAC)

Dr S Dauncey, Non-Executive Director and Chair of the Quality Assurance Committee introduced paper N, the Minutes of the 29 January 2015 QAC meeting, particularly highlighting an amendment to the CQC registration certificate for Rutland Memorial Hospital (Minute 7/15/3 refers).

Resolved – that (A) the Minutes of the Quality Assurance Committee meeting held on 29 January 2015 be received and noted, and

(B) the amendment to the CQC registration certificate for Rutland Memorial Hospital be noted.

52/15/2 Integrated Finance, Performance and Investment Committee (IFPIC)

Resolved – that the Minutes of the Integrated Finance, Performance and Investment Committee meeting held on 29 January 2015 be received and noted and the recommendations contained therein be endorsed.

53/15 CORPORATE TRUSTEE BUSINESS

53/15/1 Charitable Funds Committee

Mr P Panchal, Non-Executive Director and Chairman of the Charitable Funds Committee introduced paper P, providing the Minutes of the Charitable Funds Committee meeting held on 19 January 2015. Noting that this meeting had been inquorate (with only 2 voting members present), he sought the Board's approval (as Corporate Trustee) of all the recommendations contained therein.

The Trust Chairman advised that the Charitable Funds Committee meetings had now been rescheduled to coincide with the Trust Board meeting dates in April, June, August and October 2015 and that attendance was expected to improve as a result of this change. On behalf of the Trust Board, the Chairman thanked Mr P Panchal, Non-Executive Director for Chairing this Committee.

Resolved – that (A) the Minutes of the 19 January 2015 Charitable Funds Committee (paper P) be confirmed as a correct record and all recommended items be endorsed; **DF**

(B) the following recommended grant applications be approved:- **DF**

- **application 5345 for room hire and facilities for a carers event (£1,500),**
- **application 5346 room hire and facilities for a patient experience celebration event (£4,500),**
- **application 5356 for provision of wheelchairs for patients with complex needs (£6,973), and**
- **application 5364 for biometric access lockers in the LRI Chemotherapy Suite (£21,670.80);**

(C) applications 5345 and 5346 (see above) be funded from the nursing charitable fund; **DF**

(D) the Director of Marketing and Communications be requested to liaise with Ms H Leatham, Assistant Chief Nurse regarding the structure of the patient experience celebration event (application 5346 above refers) and the arrangements for improving wheelchair availability; **DMC**

(E) the Charity Finance Lead to feed back to the applicants in respect of applications 5240, 5331, 5332 and 5363, advising of the decision not to support these applications, and **DF**

(F) application 5241 be deferred to a future Charitable Funds Committee meeting. **DF**

54/15 TRUST BOARD BULLETIN – MARCH 2015

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

- **NHS Trust Over-Sight Self Certification return for the period ended 31 January 2015.**

55/15 QUESTIONS AND COMMENTS FROM THE PRESS AND PUBLIC RELATING TO BUSINESS TRANSACTED AT THIS MEETING

Resolved – that no questions were raised.

56/15 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 57/15 – 64/15), having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.

57/15 DECLARATIONS OF INTERESTS IN THE CONFIDENTIAL BUSINESS

Resolved – that there were no declarations of interest in the confidential items of business.

58/15 CONFIDENTIAL MINUTES

Resolved – that the confidential Minutes of the 5 February 2015 Trust Board be confirmed as a correct record and signed accordingly by the Trust Chairman. **CHAIR**

59/15 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.

60/15 REPORT FROM THE INTERIM DIRECTOR OF ESTATES AND FACILITIES

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

61/15 REPORT FROM 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 data and that public consideration at this stage could be prejudicial to the effective conduct of public affairs.

62/15 REPORTS FROM BOARD COMMITTEES

62/15/1 Integrated Finance, Performance and Investment Committee

Resolved – that the confidential Minutes of the 29 January 2015 meeting and the summary of issues discussed at the 26 February 2015 meeting be received and noted.

62/15/2 Remuneration Committee

Resolved – that the confidential Minutes of the 29 January 2015 Remuneration Committee be received and noted.

63/15 ANY OTHER BUSINESS

63/15/1 Report by the Medical Director

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

63/15/2 Report by the Acting Director of Human Resources

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

63/15/3 Mr P Panchal – Non-Executive Director and Dr K Harris – Medical Director

The Trust Chairman recorded the Board's appreciation to Mr Panchal and Dr Harris for their

significant contributions to the Trust and wished them well for the future.

Resolved – that the position be noted.

64/15 DATE OF NEXT MEETING

Resolved – that the next Trust Board meeting be held on Thursday 2 April 2015 from 10am in Seminar Rooms 2 and 3, Clinical Education Centre, Glenfield Hospital.

The meeting closed at 12.55pm

Kate Rayns
Acting Senior Trust Administrator

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

Voting Members:

Name	Possible	Actual	% attendance	Name	Possible	Actual	% attendance
K Singh (Chair from 1.10.14)	6	6	100	R Overfield (until 28.2.15)	12	12	100
R Kilner (Acting Chair from 26.9.13 to 30.9.14)	7	7	100	P Panchal (until 31.3.15)	13	13	100
J Adler	13	11	85	C Ribbins (from 1.3.15)	1	1	100
I Crowe	13	12	92	M Traynor (from 1.10.14)	6	6	100
S Dauncey	13	12	92	P Traynor (from 27.11.14)	5	5	100
K Harris (until 31.3.15)	13	12	92	M Williams (until 31.3.15)	6	6	100
K Jenkins (until 30.6.14)	3	3	100	J Wilson	13	11	85
R Mitchell	13	12	95	D Wynford-Thomas	12	5	42
R Moore (from 5.3.15)	1	1	100				

Non-Voting Members:

Name	Possible	Actual	% attendance	Name	Possible	Actual	% attendance
T Bentley	9	7	78	K Shields	13	13	100
K Bradley	10	10	100	E Stevens (from 1.1.15)	3	3	100
D Henson	9	9	100	S Ward	13	13	100
R Palin (from 1.3.15)	1	1	100	M Wightman	13	13	100