UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF A MEETING OF THE TRUST BOARD, HELD ON THURSDAY 6 AUGUST 2015 AT 9AM IN SEMINAR ROOMS 2 & 3, CLINICAL EDUCATION CENTRE, GLENFIELD HOSPITAL

Voting Members Present:
Mr K Singh – Trust Chairman (excluding Minute 175/15)
Mr J Adler – Chief Executive
Col (Ret'd) I Crowe – Non-Executive Director
Dr S Dauncey – Non-Executive Director
Mr A Furlong – Acting Medical Director
Professor A Goodall – Non-Executive Director
Mr R Mitchell – Chief Operating Officer
Mr R Moore – Non-Executive Director
Ms J Smith – Chief Nurse
Mr M Traynor – Non-Executive Director
Mr P Traynor – Chief Financial Officer
Ms J Wilson – Non-Executive Director (Chair for Minute 175/15)

In attendance:
Ms D Baker – Service Equality Manager (for Minute 165/15/1)
Ms J Browning – Continence Specialist Sister (for Minute 163/15/1)
Mr P Gowdridge – Head of Strategic Finance (for Minute 163/15/2)
Mr D Henson – LLR Healthwatch Representative (up to and including Minute 170/15)
Mr D Kerr – Director of Estates and Facilities (for Minutes 165/15/3 and 174/15)
Ms S Mulla – Equality Adviser (for Minute 165/15/1)
Dr R Palin – Eastern Leicester and Rutland CCG Chair and Representative
Ms C Ribbins – Deputy Chief Nurse
Ms K Shields – Director of Strategy
Ms H Stokes – Senior Trust Administrator
Ms L Tibbert – Director of Workforce and OD
Ms N Topham – Project Director, Site Reconfiguration (for Minute 163/15/2)
Mr S Ward – Director of Corporate and Legal Affairs
Mr M Wightman – Director of Marketing and Communications
Ms E Wilkes – Project Director, BCT-UHL (for Minute 164/15)

ACTION

157/15 APOLOGIES AND WELCOME

There were no apologies for absence.The Chairman welcomed Ms L Tibbert, Director of Workforce and Organisational Development and Ms J Smith, Chief Nurse, to their first Trust Board meetings in post. The Chair also congratulated Dr R Palin on his appointment as Chair of Eastern Leicester and Rutland Clinical Commissioning Group (ELR CCG).

158/15 DECLARATIONS OF INTERESTS IN THE PUBLIC BUSINESS

The Chairman declared an interest in the new ED front door arrangements briefly referred to in paper J1 (Minute 164/15/2 below refers) and confirmed that he would absent himself from any detailed discussion on that item.

159/15 MINUTES

Resolved – that the Minutes of the 2 July 2015 Trust Board be confirmed as a correct record and signed by the Trust Chairman accordingly. **CHAIR MAN**

160/15 MATTERS ARISING FROM THE MINUTES

Paper B detailed the status of previous matters arising and the expected timescales for resolution. Members particularly noted:-

(a) **Minute 144/15/3 of 2 July 2015** – the Chief Financial Officer confirmed that a response was still awaited from the Trust's external auditor, and

(b) **Minute 116/15 of 4 June 2015** – the Director of Marketing and Communications confirmed that UHL's volunteers received the same briefings/communications as Trust members. This action could now be closed.

<u>Resolved</u> – that the update on outstanding matters arising and any related actions be noted, and progressed by the identified Lead Officer(s).

161/15 CHAIRMAN'S MONTHLY REPORT – AUGUST 2015

In introducing his monthly report for August 2015 (paper C), the Trust Chairman particularly highlighted:-

(a) progress by the task and finish group established at his request to review the diversity and appropriate talent management of UHL's workforce. Outputs from the task and finish group would be reported to a Trust Board thinking day in February 2016; **CHAIR MAN/ DWOD**

(b) a multi-faith service being conducted at Leicester Cathedral by UHL Chaplaincy staff on 8 August 2015, to celebrate Caring at its Best. He encouraged Board members to attend if available, and noted that the event could become an annual one if well-attended generally, and

(c) his thoughts on the increasing need to operate in partnership with other parts of the health and social care system, and on the benefits of a cross-organisational risk register to ensure all partners were appropriately sighted to wider challenges. He considered that the August 2015 Trust Board thinking day would touch on this to a certain degree. In light of certain other Better Care Together events being held in the week beginning 10 August 2015, the Chief Executive advised that it would be beneficial for the Board to consider BCT issues at both its August and September 2015 thinking days. **DS/CE**

<u>Resolved</u> – that (A) the outputs from the diversity and equality task and finish group be reported to the 11 February 2015 Trust Board thinking day, and **CHAIR MAN/ DWOD**

(B) Better Care Together progress be discussed at both the August and September 2015 Trust Board thinking days. **DS/CE**

162/15 CHIEF EXECUTIVE'S MONTHLY REPORT – AUGUST 2015

The Chief Executive's August 2015 monthly update at paper D followed (by exception) the framework of the Trust's strategic objectives. As the attached quality and performance dashboard also covered core issues from the monthly quality and performance report, the full version of that report would no longer be taken at Trust Board meetings but was accessible on the Trust's external website (also hyperlinked within paper D). The Chief Executive noted in particular:-

(a) five large-scale staff events held in July 2015 by UHL to launch the Trust's 5-year plan for Delivering Caring at its Best. The majority of those attending considered that the 5-year plan would successfully deliver Caring at its Best, which was encouraging. The detailed feedback from the events was now being analysed – the quality of the staff working at UHL and teamworking had emerged as strong positive themes, whilst the need for process improvements in care delivery had been cited as a frustration;

(b) UHL's positive quarterly review with the National Trust Development Authority (NTDA) in terms of quality metrics. That quarterly review had also discussed the financial position, and the Chief Executive noted that all Trusts had recently

received revised financial targets for year-end. UHL had been asked to deliver a £2m improvement to its reported year-end position;

(c) a renewed national focus on improving and sustaining cancer performance, via the establishment of a national delivery group. Fourteen Trusts nationally (including UHL) had been identified for attention. In terms of UHL cancer performance, the Chief Operating Officer expected July 2015 compliance with the 31-day wait target, with 2-week wait compliance anticipated in September 2015. The 62-day wait indicator remained challenging, however, with compliance hoped for by October 2015. An integrated cancer performance improvement plan was in place and would be discussed by UHL's Integrated Finance Performance and Investment Committee (IFPIC) on 27 August 2015. In discussion, the Chair of ELR CCG noted that CCGs were impressed with UHL's planning work in respect of the cancer targets – he also noted the CCGs' confidence that UHL had a granular knowledge of this issue. This was echoed by the IFPIC Non-Executive Director Chair. Although welcoming these comments, the Chief Operating Officer noted that the cancer improvement plan was not without risk, and

(d) the completion of UHL's review of waiting list practices, and the Trust's confidence that all issues had now been identified. Minor issues had emerged in 3 areas. The Chief Operating Officer also noted plans to move to full electronic waiting list implementation in the next 3 months.

In further discussion, the Healthwatch representative welcomed the format of the performance dashboard appended to the Chief Executive's monthly report. He also requested, however, that UHL's plans to improve cleaning standards be shared with the public at an appropriate time. **CE**

<u>Resolved</u> – that an update on plans to improve cleaning standards be shared publicly at an appropriate time. **CE**

163/15 KEY ISSUES FOR DECISION/DISCUSSION

163/15/1 <u>Patient Story – "The Impact of Urinary Incontinence Treatment for the Older Person"</u>

The DVD presentation accompanying paper E described how an elderly patient had significantly benefited from a referral (during an inpatient episode) to the UHL continence team. Ms C Ribbins, Deputy Chief Nurse and Ms J Browning, Continence Specialist Sister attended for this item. The Trust Board was advised that having been given some relatively simple procedures for the patient's nursing home to follow, the patient had become completely continent and was experiencing a very significantly improved quality of life. The Continence Specialist Sister emphasised that incontinence should not be seen as inevitable by older patients, and she advised that the Continence team always tried to help patients irrespective of their age. There were also many clinical benefits of tackling incontinence, including reduced UTI admissions. The Continence team already provided inpatient and outpatient clinics, and was now exploring a more proactive inreach service to identify those with a continence issue. In discussion on the patient story and the issues raised, the Trust Board:-

(a) queried how the education and learning from this patient experience had been rolled out beyond the Trust. In response, the Continence Specialist Sister advised that she had attended CCG meetings and also ran an older persons' clinic in the community. As a general point, all of UHL's patient stories were now held in a central library and used as a learning resource;

(b) agreed that it would be helpful to raise the profile of the Continence team, both within UHL and in nursing homes. Current primary care continence responses appeared to focus on managing continence (eg through use of pads) rather than curing incontinence, hence the UHL Continence team's inreach initiative. Dr R Palin, ELR **ELR CCG CHAIR/ DS**

CCG Chair, and the UHL Director of Strategy agreed to discuss the scope for progressing a potential integrated continence service through Better Care Together (follow-up report on these discussions to be provided to UHL's Quality Assurance Committee [QAC]). The Director of Marketing and Communications also noted that his team would be happy to assist in raising the profile of the existing continence service, and **DS /QAC CHAIR**

(c) noted a query as to whether Healthwatch could access any of UHL's patient stories to use in its public 'listening programme'. The Trust Chairman welcomed this suggestion, and it was agreed that UHL's Director of Marketing and Communications would liaise with Mr D Henson, Healthwatch representative, accordingly. **DMC**

ELR CCG CHAIR/ DS

Resolved – that (A) the scope to develop an integrated (primary/secondary care) continence service, be pursued outside the meeting;

(B) a progress report re: development of such an integrated service be provided to a future Quality Assurance Committee meeting, and **DS /QAC CHAIR**

(C) the Director of Marketing and Communications contact Healthwatch about potentially incorporating some of the UHL patient stories into Healthwatch's listening programme with the public. **DMC**

163/15/2 Vascular Business Cases (papers F-I)

Paper F from the Director of Strategy outlined the background to the 3 vascular full business cases being presented for Trust Board approval:-

- ICU enabler 1 – vascular ward full business case (paper G);
- ICU enabler 2 – vascular angiography and VSU full business case (paper H), and
- vascular hybrid theatres full business case (paper I).

All 3 business cases had been discussed in detail by IFPIC on 30 July 2015 and recommended for Trust Board approval, subject to further assurance information as provided in the addendum (v2) to paper F.

In discussion on the business cases and the additional information detailed in that addendum report, the Trust Board noted a query from the IFPIC Non-Executive Director Chair, on the level of confirm and challenge of the assumption that any increased revenue costs would be covered from the Trust's annual £4m contingency for operating cost pressures. She voiced concern that there might be other operational calls (which were – at this stage – unknown) on that contingency. Other Board members also queried the quantum of the Trust's 2015 contingency, and whether other capital projects would be a call on those monies. In response, the Director of Strategy advised that the vascular business cases built in a certain amount of double running in terms of revenue, as it was necessary to build new/replacement facilities before removing the current ones. She would not expect this also to be the case for strategic business cases, however. She also noted that the revenue costs of the vascular business cases had reduced, due to the level of confirm and challenge undertaken on the plans – this process was also being repeated for the capital costs. She emphasised that the vascular business cases would provide a safe and effective service.

With regard to concerns over precommitting the Trust's contingency, the Chief Financial Officer clarified that the 2016-17 Long Term Financial Model (LTFM) was currently based on high-level assumptions, not all of which had yet been confirmed nationally (eg the tariff). He also clarified that the £4m referred to was intended specifically for cost pressures only. Given the crucial need for the vascular business cases to proceed, he advised that the proposed use of contingency monies was a pragmatic solution to enable a key strategic project. The Chief Executive echoed this point, although noting that BCT transitional monies might possibly be a potential future option.

In response to a query from the Audit Committee Non-Executive Director Chair regarding the 2016-17 LTFM, the Chief Financial Officer confirmed his view that the vascular business cases commitment on the contingency was not a 'tipping point' issue. He also clarified that the precommitment was not recurrent. Following the discussion above, the IFPIC Non-Executive Director Chair stated her confidence in the need for the vascular business cases. She requested, however, that when the ICU business case was presented for Trust Board approval, it be appropriately contextualised within the overall reconfiguration piece, to enable an informed decision. Professor A Goodall, Non-Executive Director, also requested clear communication to staff re: the timing of the vascular service moves – this would be welcomed from a University perspective.

DS/CFO

DS

In further discussion, the Audit Committee Non-Executive Director Chair then raised certain queries regarding the vascular hybrid theatres full business case (paper I). He considered that the investment appraisal within paper I needed strengthening to improve its transparency and credibility. The financial benefits also needed clarifying, as did the capital charges involved. Although the hybrid theatres business case could be slipped by up to 1 month without significant adverse effect on the vascular services timeline, there would be a potentially-significant cost attached to any such slippage. It was also confirmed that the purchase orders for the other 2 vascular business cases were required to be placed on 10 August 2015. The Director of Strategy advised the Trust Board that the business cases at papers G and H could not stand alone without the hybrid theatre case at paper I. The Acting Medical Director supported this point from a clinical perspective, noting that the lack of vascular hybrid theatre could lead to a downgrading of the vascular service and a resulting loss of skilled staff. In light of these points, the Trust Chairman proposed that the hybrid theatre full business case be approved, on the basis that further information also be circulated to the Trust Board during the week beginning 17 August 2015 (and subsequently presented to IFPIC for noting), providing additional assurance on:-

(a) the option/investment appraisal;
(b) the financial benefits, and
(c) the clinical need for the theatre.

DS/CFO

It was also agreed that the hybrid theatre business case issues would be included in the 'project assurance' review being undertaken by the September 2015 Audit Committee (Trust Board minute 145/15/1 of 2 July 2015 refers).

AC CHAIR/ CFO/DS

Following the discussions above, the Trust Chairman suggested that appropriate Trust Board thinking day time be dedicated to reconfiguration issues as a whole, including (i) financial and planning implications; (ii) Trust Board comments on the need for clarity re: precommitments against cost-pressure contingency funds, and (iii) the presentation of business cases, to ensure they provided the appropriate level of assurance.

DS/ CFO

<u>Resolved</u> – that (A) approval be given to the full business cases for the vascular ward and vascular angiography and VSU (papers G and H respectively), and purchase orders be placed accordingly;

DS

(B) approval be given to the vascular hybrid theatre full business case (paper I) on the basis that further information also be circulated to the Trust Board (and subsequently presented to IFPIC for noting), providing additional assurance on:-

(1) the option/investment appraisal;
(2) the financial benefits, and
(3) the clinical need for the theatre.

DS/CFO

(C) hybrid theatre issues be included in the 'project assurance' review being undertaken by the September 2015 Audit Committee;

AC CHAIR/ DS/CFO

(D) clear communication take place with staff regarding the timing of the moves

DS

associated with the vascular business cases;

(E) the ICU reconfiguration full business case be placed in appropriate contextual detail within the overall reconfiguration programme when presented to the Trust Board, and **DS**

(F) appropriate Trust Board thinking day time be dedicated to reconfiguration issues as a whole, including:- **DS/CFO**
(1) financial and planning implications;
(2) Trust Board comments on the need for clarity re: precommitments against cost-pressure contingency funds, and
(3) the presentation of business cases, to ensure they provided the appropriate level of assurance.

164/15 STRATEGY

164/15/1 Monthly Strategy Update – UHL Reconfiguration Programme

Paper J from the Director of Strategy provided an overview of the Better Care Together-UHL reconfiguration programme, which had been running since January 2015. An A3 copy of the dashboard was now tabled, recognising the continued difficulty in reading the document on a tablet. The Trust Board discussed what level of dashboard detail was required for it to review, noting the need to be able to understand project progress in the round, ideally at a glance. In response to a comment from the Healthwatch representative, the Director of Strategy advised that the Trust's communications lead was developing a route map for public communications re: BCT. In further discussion, it was suggested that the dashboard should also include dedicated workstreams re: operational impact, and workforce/OD issues.

Although agreeing that layered information was useful (eg different levels of detail for different Committees), the Board noted that it had not yet been agreed which Committees (eg below Trust Board level) would monitor progress. It was also noted that there was no overarching 'reconfiguration board' within UHL involving all Non-Executive Directors, who did not have sight of the detailed monthly scrutiny performed by the Executive Strategy Board. It was agreed to discuss the various options for detailed Non-Executive Director and Trust Board scrutiny of the BCT programme progress at the August 2015 Trust Board thinking day (eg, possible separate reconfiguration board involving all Non-Executive Directors; routing detailed scrutiny through IFPIC/Audit Committee etc, or retaining scrutiny at Trust Board), including the desired level of dashboard granularity. **CE/DS**

Resolved – that the 13 August 2015 Trust Board thinking day consider:- **CE/DS**
(1) the appropriate level of detail required for Trust Board reports on this issue (eg granularity of the dashboard), and
(2) options for appropriately sighting Non-Executive Directors to the reconfiguration programme.

164/15/2 Strategic and Partnership Update

The Trust Board received paper J1 for information, noting a need for clarity on the geographical areas covered in paragraph 12.

Resolved – that the strategic and partnerships update be noted.

164/15/3 LLR Better Care Together Programme Update

Paper K provided a high-level update on the LLR Better Care Together Programme, as prepared for all partner organisations' Boards. Members requested that Executive Directors **DS/EDs**

agree an appropriate framework for the Trust Board to receive periodic reports on BCT workstreams, and that consideration be given to also presenting the EM Clinical Senate review of BCT workstreams to the Trust Board for information (once available). The Audit Committee Non-Executive Director Chair noted that it would also be helpful to receive RAG-rated key milestones for the BCT project. **DS**

<u>Resolved</u> – that (A) Executive Directors agree an appropriate framework for the Trust Board to receive periodic reports on BCT workstreams; **DS/EDs**

(B) consideration be given to also presenting the EM Clinical Senate review of BCT workstreams to the Trust Board for information (once available), and **DS/ AMD**

(C) BCT updates include RAG-rated key milestones. **DS**

165/15 GOVERNANCE

165/15/1 <u>Equality Bi-Annual Update</u>

The Service Equality Manager and the Equality Adviser attended to present UHL's bi-annual equality report for Trust Board approval, and the Equality Annual Report 2014-15 for information (papers L and L1 respectively). The bi-annual update covered UHL progress on (i) the Equality System Delivery plan; (ii) the Quality Schedule; (iii) the new CQUIN for the Learning Disability Services, and (iv) the recently-implemented Workforce Race Equality Standard (WRES – this also needed to be placed on the NHSE website). In discussion on papers L and L1, the Trust Board:-

(a) agreed the need to learn good practice WRES lessons from other organisations, both public and private sector. The Director of Workforce and OD agreed to pursue this accordingly; **DWOD**
(b) welcomed the format of the annual equality report at paper L1;
(c) supported the request to delay the extension of the data collection elements of the Quality Schedule until the electronic patient record was implemented in 2016 (as per paper L), and
(d) endorsed the WRES self-assessment and supporting actions as per paper L.

<u>Resolved</u> – that (A) examples of good practice in respect of the WRES requirement be sought from other organisations, both public and private sector, and **DWOD**

(B) the recommendations within paper L be endorsed as presented. **DWOD**

165/15/2 <u>Emergency Preparedness Resilience and Response (EPRR) – Self-Assessment</u>

The Trust Board received the emergency planning annual report 2014-15 for approval, providing assurance that UHL was meeting its statutory EPRR duties (paper M). As the Non-Executive Director lead for emergency planning, Col (Ret'd) I Crowe noted his support for the report, which showed evidence of organisational learning from incidents and regular refreshes of plans. Dr R Palin, ELR CCG Chair welcomed UHL's handling of incidents as evidenced by paper M, and the Trust Chairman also considered that communications issues were well-handled. In discussion, the Acting Medical Director noted that he had passed comments on IT/communications issues in the event that UHL had to receive mass casualties, to the Emergency Planning Officer.

<u>Resolved</u> – that the Emergency Preparedness Resilience and Response (EPRR) – Self-Assessment be approved.

165/15/3 <u>UHL Risk Report Incorporating Board Assurance Framework (BAF)</u>

Paper N from the Acting Medical Director comprised the latest iteration of the 2015-16 Board Assurance Framework (as at 30 June 2015) and a summary of all high and extreme risks on the risk register. The Acting Medical Director particularly noted the new risk entry in respect of NNU cleaning standards. In terms of the specific risks being discussed at this meeting, the Trust Board noted:-

(a) **principal risk 11** – an assessment of UHL's capacity for infrastructure improvements was underway, exploring bolstering the project management elements of the estates team, and

(b) **principal risk 12** – it would be helpful if the 'road map' being developed could be available for the August 2015 Trust Board thinking day discussions on reconfiguration. The Trust Board also discussed whether the current risk score (12) needed increasing and also whether the current target risk score (8) was realistic given the gaps in controls. It was agreed to consider reviewing the risk score for principal risk 12 as part of the August 2015 Trust Board thinking day reconfiguration discussions. **DEF** **ALL/DS**

In broader discussion, the Trust Board agreed the need for dedicated time at a future Trust Board thinking day to review the format and nature of the BAF, focusing also on its useability. It was noted that the September 2015 Audit Committee would also be looking at progress in reviewing the BAF. **CHAIR MAN/ DS**

Resolved – that (A) UHL risk report incorporating the Board Assurance Framework (BAF) be noted;

(B) the 'road map' referred to in risk 12 be available for the 13 August 2015 Trust Board thinking day session on reconfiguration; **DEF**

(C) consideration be given to reviewing the score for risk 12 at the August 2015 Trust Board thinking day, and **ALL/DS**

(D) future Trust Board thinking day time be allocated for a review of the risk register/BAF. **CHAIR MAN/DS**

165/15/4 Armed Forces Community Covenant

Paper O from Col. (Ret'd) I Crowe Non-Executive Director, invited Trust Board approval for an Armed Forces Community Covenant between UHL and the local Armed Forces community. The Trust Board fully supported this initiative, and requested that the signing of the Covenant be given an appropriately high profile. The Acting Medical Director also welcomed the proposals within paper O for an honorary contract between UHL and 2 Medical Regiment for the placement of clinical personnel within the Trust. The Trust Chairman thanked Col (Ret'd) I Crowe for his work on this issue, noting the proposal to appoint him as UHL's first Armed Forces Champion (now approved accordingly). **DMC**

In response to a query, it was not known how many reservists were currently employed by UHL – the Trust Board agreed that work should be undertaken to celebrate the contribution of such staff and raise their profile accordingly. **DMC/ DWOD**

Resolved – that (A) the recommendations within paper O be approved, namely:- **ALL**

(1) the signing of a Community Covenant between UHL and the local Armed Forces Community;

(2) the appointment of Col. (Ret'd) I Crowe, Non-Executive Director, as UHL's first Armed Forces Champion;

(3) the signing of an honorary contract between UHL and 2 Medical Regiment for the placement of clinical personnel within the Trust;

(B) appropriately high-profile communications be organised for the signing of the covenant in (A)(1) above, and **DMC**

(C) consideration be given to how best to highlight the work of UHL staff who were also reservists. **DMC/ DWOD**

166/15 QUALITY AND PERFORMANCE

166/15/1 LLR Learning Lessons to Improve Care – Quarterly Update

The Acting Medical Director introduced the quarterly report from the LLR Learning Lessons to Improve Care clinical taskforce (paper P), noting that the same report was submitted to the Boards of all involved partners. The clinical taskforce had identified 5 key areas on which to focus:- (i) clinical leadership; (ii) public and patient involvement; (iii) integrated care pathways; (iv) acute care pathway review and redesign, and (v) end of life transformation, and paper P outlined the progress made in these areas.

Professor A Goodall, Non-Executive Director, welcomed the report and queried whether the University of Leicester could work more closely with the taskforce in terms of data analysis. Dr S Dauncey, Non-Executive Director, noted the need to view Learning Lessons to Improve Care as a positive driver for change, and the Trust Chairman considered that there were also OD lessons in terms of ensuring that UHL was an appropriately learning organisation. He asked the Director of Workforce and OD to review this aspect and factor it in (as appropriate) to the September 2015 Trust Board thinking day on organisational development. **DWOD**

Resolved – that the organisational learning aspects of the LLR Learning Lessons to Improve Care review be explored, and appropriately factored into the September 2015 Trust Board thinking day on workforce and OD issues. **DWOD**

166/15/2 Quality Assurance Committee (QAC)

Dr S Dauncey, QAC Non-Executive Director Chair outlined the key issues discussed at the 30 July 2015 QAC meeting (paper Q). She particularly highlighted UHL's response to the 'Dying without Dignity' Parliamentary and Health Service Ombudsman report, and the report on the process for monitoring the quality and safety impact of UHL cost improvement programme (CIP) schemes.

Resolved – that the summary of key issues considered at the 30 July 2015 QAC meeting be received and noted.

166/15/3 Integrated Finance, Performance and Investment Committee (IFPIC)

Ms J Wilson, IFPIC Non-Executive Director Chair outlined the key issues discussed at the 30 July 2015 IFPIC meeting (paper R), noting in particular the Committee's review of the vascular service full business cases and their recommendation for Trust Board approval accordingly (Minute 163/15/2 above refers), the planned patients review, a funding application in respect of the emergency floor business case, the Trust's continued compliance with referral to treatment (RTT) targets, and lengthy discussions on the Trust's financial performance and the 2015-16 financial plan (Minutes 166/15/4 and 166/15/5 below refer).

Resolved – that the summary of key issues considered at the 30 July 2015 IFPIC meeting be received and noted.

166/15/4 2015-16 Financial Position – Month 3 (June 2015)

This item was taken in conjunction with the discussion on delivery of the 2015-16 financial plan (Minute 166/15/5 below refers), noting that both papers had been discussed in detail at the July 2015 IFPIC. Paper S outlined the month 3 financial position, noting that pay costs remained an issue as in months 1 and 2. Income and non-pay remained generally on track.

Resolved – that the month 3 financial performance report be noted.

166/15/5 Delivery of the 2015-16 Financial Plan

Further to Minute 166/15/4 above, paper T comprised the first draft of UHL's 2015-16 financial recovery plan, with a further iteration to be discussed by the August 2015 IFPIC. The report outlined the CMG recovery plans, the further centralised actions needed, and runrates for the remainder of the year. An additional £2m was now required of UHL by the NTDA, as reported in Minute 162/15 above. Although significant improvements were not expected in month 4, the Chief Financial Officer advised that he would expect to see progress from month 5 onwards. He also noted that the Executive Team would be reviewing any further financial recovery actions which might be needed. **CFO**

In discussion, the Trust Board noted the assurances provided to the NTDA that quality and safety would not be compromised. As noted in Minute 166/15/2 above, all CIPs were required to have their quality and safety impact assessed and monitored.

Resolved – that the actions to deliver the 2015-16 financial plan be supported, and a further report provided to the 27 August 2015 IFPIC. **CFO**

166/15/6 Emergency Care Performance

Further to Minute 142/15/4 of 2 July 2015, paper U from the Chief Operating Officer updated the Trust Board on recent emergency care performance, which remained at around the 91-92% mark despite continued high levels of both attendances and admissions. However, the particular spike of admissions and attendances in July 2015 had significantly impacted on performance, and the Chief Operating Officer voiced his concern at potential winter activity levels and the emergency system's ability to cope. He also noted that the current LLR levels of attendances and admissions were atypical nationally.

Dr R Palin, ELR CCG Chair commented that it was useful to see the LLR improvement plan as appended to paper U and acknowledged that CCG impact would focus predominantly on inflow aspects. Although he considered that GPs had changed admission practices, he recognised that the impact of primary care initiatives was yet to be felt significantly. He considered that the emergency care vanguard work would be useful, as would increased use of minor injury units and walk-in centres.

Although welcoming the LLR improvement plan, the UHL Chief Executive echoed concerns over potential winter activity levels, and noted urgent discussions planned for the coming week. The Trust Board requested that the September 2015 emergency care performance report identify both the actions required to reverse the current trend of high ED attendances and admissions, and the strategy to manage the situation if those actions did not take effect. This could also potentially be discussed at the proposed October 2015 Board to Board with partners. In discussion, the Trust Board queried whether the particular cohort(s) of patients at higher risk of increased attendances had been identified, and also queried what actions had been taken in other healthcare economies to reduce attendances and admissions. The Chief Operating Officer considered that learning was available, in light of visits to other Trusts. However, he also emphasised the need to be realistic about the scope for significant improvements in a relatively short time. The Trust Board recognised this point, noting the need for appropriate mitigating actions accordingly. **COO** **CHAIR MAN**

In response to a query on public awareness of alternatives to attending the emergency

department, Dr R Palin ELR CCG Chair acknowledged that there was an education and communications issue to be tackled. However, the Chief Operating Officer commented that a key issue was also to ensure that people sought the right intervention at the appropriate time, to avoid acute admission becoming necessary (where possible). It was agreed that UHL's Chairman and Chief Executive would contact CCG colleagues regarding potential targeted admission/attendance avoidance measures. The Director of Corporate and Legal Affairs queried whether the Trust was still required to produce a winter plan for Trust Board review, and he also questioned whether winter activity risks were appropriately reflected in BCT work.

CHAIR MAN/ CE

Resolved – that (A) the September 2015 emergency care performance report identify:- **COO**

(1) the actions required to reverse the current trend of high ED attendances and admissions, and

(2) the strategy to manage the situation if those actions did not take effect;

(B) consideration be given to discussing LLR emergency care issues at the Board-to-Board scheduled for 8 October 2015, and **CHAIR MAN**

(C) discussions be held with CCG colleagues about potential targeted admission/attendance avoidance measures. **CHAIR MAN/ CE**

167/15 REPORTS FROM BOARD COMMITTEES

167/15/1 Quality Assurance Committee (QAC)

Resolved – that the 25 June 2015 QAC Minutes be received and noted, and the recommendations therein be endorsed (noting that the date on page 9 of paper V should read 2016 not 2015).

167/15/2 Integrated Finance, Performance and Investment Committee (IFPIC)

Resolved – that the 25 June 2015 IFPIC Minutes be received and noted and the recommendations therein be endorsed.

168/15 TRUST BOARD BULLETIN – AUGUST 2015

Resolved – that the Trust Board Bulletin containing the following reports be noted:-
(1) NHS Trust Over-Sight Self Certification return for the period ended 31 May 2015 [noting that cleanliness concerns would also be highlighted within the June 2015 return] (paper 1), and

(2) declarations of interests for Mr K Singh Trust Chairman [update reflecting his role as a non-remunerated Trustee of the GNP Sikh Temple, Coventry, for a 5-year period from 4 July 2015] and Professor A Goodall, Non-Executive Director [Non-Executive Director and minority shareholder of Haemostatix Ltd] (paper 2).

169/15 QUESTIONS AND COMMENTS FROM THE PRESS AND PUBLIC RELATING TO BUSINESS TRANSACTED AT THIS MEETING

There were no questions raised.

170/15 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 171/15 – 178/15), having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public

interest.

171/15 DECLARATIONS OF INTERESTS IN THE CONFIDENTIAL BUSINESS

The Trust Chairman declared an interest in respect of Minute 175/15 below (nature of that declaration as now detailed to the Board), and absented himself from the meeting accordingly during its discussion.

Resolved – that the Chairman's declaration be noted.

172/15 CONFIDENTIAL MINUTES

Resolved – that the confidential Minutes of the 2 July 2015 Trust Board be confirmed as a correct record and signed by the Trust Chairman accordingly. **CHAIR MAN**

173/15 CONFIDENTIAL MATTERS ARISING REPORT

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

174/15 REPORT FROM THE DIRECTOR OF ESTATES AND FACILTIES

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

175/15 REPORT FROM THE DIRECTOR OF STRATEGY

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

176/15 REPORTS FROM BOARD COMMITTEES

175/15/1 Integrated Finance, Performance and Investment Committee (IFPIC)

Resolved – that (A) the confidential 25 June 2015 IFPIC meeting Minutes be received and noted, and any recommendations therein endorsed, and

(B) the summary of confidential issues highlighted at the 30 July 2015 IFPIC meeting be noted (paper CC1).

176/15 ANY OTHER BUSINESS

There were no items of Any Other Business.

177/15 DATE OF NEXT MEETING

Resolved – that the next Trust Board meeting be held on Thursday 3 September 2015 from 9am in the C J Bond Room, Clinical Education Centre, Leicester Royal Infirmary.

The meeting closed at 2.05pm

Helen Stokes
Senior Trust Administrator

Cumulative Record of Attendance (2015-16 to date):

Voting Members:

Name	Possible	Actual	% attendance	Name	Possible	Actual	% attendance
K Singh	5	5	100	R Moore	5	5	100
J Adler	5	5	100	C Ribbins	4	3	75
I Crowe	5	5	100	J Smith	1	1	100
S Dauncey	5	4	80	M Traynor	5	4	80
A Furlong	5	5	100	P Traynor	5	5	100
R Mitchell	5	5	100	J Wilson	5	5	100

Non-Voting Members:

Name	Possible	Actual	% attendance	Name	Possible	Actual	% attendance
D Henson	5	5	100	E Stevens	4	4	100
R Palin	5	3	60	L Tibbert	1	1	100
K Shields	5	4	80	S Ward	5	5	100
				M Wightman	5	5	100