UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF A MEETING OF THE TRUST BOARD, HELD ON THURSDAY 5 FEBRUARY 2015 AT 9AM IN SEMINAR ROOMS A & B, CLINICAL EDUCATION CENTRE, LEICESTER GENERAL HOSPITAL

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
Ms R Overfield – Chief Nurse
Mr P Panchal – Non-Executive Director
Mr M Traynor – Non-Executive Director
Mr P Traynor – Director of Finance
Mr M Williams – Non-Executive Director
Ms J Wilson – Non-Executive Director
Professor D Wynford-Thomas – Non-Executive Director

In attendance:
Professor S Carr – Associate Medical Director, Clinical Education (for Minute 28/15/1)
Ms J Gilmore – Imaging Service Manager, Clinical Support and Imaging CMG (for Minute 37/15)
Mr D Henson – LLR Healthwatch Representative (up to and including Minute 32/15)
Mr D Kerr – Interim Director of Estates and Facilities
Ms S Khalid – Clinical Director, Clinical Support and Imaging CMG (for Minute 37/15)
Ms H Leatham – Assistant Chief Nurse (for Minute 25/15/1)
Mrs K Rayns – Acting Senior Trust Administrator
Ms C Ribbins – Deputy Chief Nurse
Ms K Shields – Director of Strategy
Ms E Stevens – Acting Director of Human Resources
Dr M VanWattinghen – Consultant Radiologist, Clinical Support and Imaging CMG (for Minute 37/15)
Mr S Ward – Director of Corporate and Legal Affairs (from part of Minute 23/15)
Mr M Wightman – Director of Marketing and Communications

ACTION

18/15 APOLOGIES

There were no apologies for absence.

19/15 DECLARATIONS OF INTERESTS IN THE PUBLIC BUSINESS

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

20/15 CHAIRMAN'S ANNOUNCEMENTS

The Chairman welcomed Ms C Ribbins, Deputy Chief Nurse and Mr D Kerr, Interim Director of Estates and Facilities to the meeting and highlighted the following issues:-

(a) the recent appointment of Mr R Moore as a Non-Executive Director with effect from 1 April 2015. The Board also endorsed the proposal to appoint Mr Moore as a Non-Executive Director Designate with immediate effect until the commencement of his substantive appointment;
(b) that this would be the last UHL Trust Board meeting for Ms R Overfield, Chief Nurse before she left the Trust at the end of February 2015 to take up her new role with the NHS Trust Development Authority (TDA). He thanked Ms Overfield for her contribution

to the Trust's nursing services, and

(c) that this would also be the last UHL Board meeting for Professor D Wynford-Thomas before he stood down from his role as the nominated University of Leicester Non-Executive Director at the end of February 2015. He thanked Professor Wynford-Thomas for his support, noting the importance of this role as a bridge between the Trust and the University, and

(d) the Trust's support of the "Hello my name is …" campaign.

<u>Resolved</u> – that the Trust Board endorse the proposal to appoint Mr R Moore as a Non-Executive Director Designate with immediate effect until his substantive Non-Executive Director appointment commences on 1 April 2015. **DCLA**

21/15 MINUTES

<u>Resolved</u> – that the Minutes of the 8 January 2015 Trust Board (paper A) be confirmed as a correct record and signed by the Trust Chairman accordingly. **CHAIR**

22/15 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 2 (Minute 6/15/2 of 8 January 2015) – the final emergency floor full business case was provisionally scheduled for Trust Board consideration on 5 March 2015, pending feedback from the TDA on the outline business case;

(b) item 4 (Minute 6/15/3(b) of 8 January 2015) – the Chief Executive confirmed that UHL was working with the CCGs to determine whether there was any evidence of GP over-referring and the Medical Director advised that the results of an ongoing practice and patient level audit on referral pathways would be available within the next month. The Chief Operating Officer commented upon work taking place in order to reduce patient DNA (did not attend) rates and review referral patterns. The Director of Marketing and Communications provided feedback from an Executive Team demonstration of some new software which might be able to provide more time-sensitive data on referrals from primary care in future, and

(c) item 5 (Minute 6/15/3(c) of 8 January 2015) – the Director of Marketing and Communications reported on the Urgent Care Board winter resilience planning workstream which was looking at avoiding attendances at A&E, noting that an opportunity for GPs to write to their most "at risk" patients advising them of early warning signs relating to their condition was under consideration by the CCGs.

<u>Resolved</u> – that (A) the update on outstanding matters arising and the timescales for resolution be noted, and

(B) the Chairman to be kept informed of any developments in respect of items (b) and (c) above to inform his monthly meetings with the CCG Chairs. **CE**

23/15 CHAIRMAN'S MONTHLY REPORT – FEBRUARY 2015

The Chairman introduced paper C, providing a summary of current environmental themes and specific issues arising from this month's Trust Board reports. He particularly drew members' attention to the following points:-

(a) his thanks to all staff for their hard work in supporting emergency performance in the context of challenging national and local activity levels;

(b) the size of the Trust as an employer and the importance of encouraging staff input in

terms of innovation (eg the robotic surgery programme and Listening into Action Programme);

(c) the intended focus on patients at UHL's Trust Board meetings, as evidenced by the real life patient story scenarios which featured near the beginning of the agenda each month, and

(d) the report on the reconfiguration of the Trust's Intensive Care Unit (ICU) services, including the potential relocation of ICU services on the LGH site to the LRI site (Minute 25/15/2 below refers).

Resolved – that the position be noted.

24/15 CHIEF EXECUTIVE'S MONTHLY REPORT – FEBRUARY 2015

The Chief Executive introduced his monthly update report (paper D refers), noting that substantive reports on emergency care performance and the Trust's month 9 financial position featured later in the agenda. He briefed the Board on the following issues:-

(a) satisfactory progress in respect of the Emergency Floor business case and the intentional overlap between the approvals processes for the outline and full business cases. A recent independent Gateway Review had provided an amber-green delivery/competence rating with no significant urgent recommendations being highlighted. A small number of non-urgent recommendations had been made which included clarification of the benefits realisation and commissioning arrangements. CCG colleagues had indicated (informally) that they would be in a position to support the final business case;

(b) a quality improvement partnership opportunity being explored by the NHS Trust Development Authority with the Virginia Mason Hospital in Seattle, USA, which would be subject to the appropriate approvals and UHL being one of the Trusts selected to participate;

(c) the percentage of formal objections raised during the 2015-16 tariff consultation process (71%), noting that 50% was the threshold for a further consultation process to be instigated. The most controversial element of the proposed tariff had related to the potential impact upon specialised services. Consequently a degree of uncertainty now surrounded the 2015-16 financial outlook, pending the development of a holding position and revised proposals, and

(d) assurance that the recruitment processes were all underway for the posts of (1) Director of Estates and Facilities, (2) Medical Director, (3) Chief Nurse and (4) Director of Human Resources and Organisational Development, and that the final round of interviews was scheduled for April 2015.

Responding to a query raised by Col (Ret'd) I Crowe, Non-Executive Director, the Chief Executive advised that no feedback had yet been received from the TDA following submission of UHL's business case for the procurement of an Electronic Patient Record (EPR) solution. The Gateway Review for this scheme was due to take place mid-March 2015.

In discussion on the Emergency Floor Gateway Review, it was agreed that a summary of the findings would be circulated to Board members via the Integrated Finance, Performance and Investment Committee. **DS**

Resolved – that (A) the position be noted, and

(B) a summary of the findings arising from the Emergency Floor Gateway Review be circulated to Board members via the Integrated Finance, Performance and Investment Committee. **DS**

25/15 KEY ISSUES FOR DECISION/DISCUSSION

25/15/1 Patient Story – Emergency Admission through the Emergency Department

Ms H Leatham, Assistant Chief Nurse attended the meeting to introduce paper D and to show a short DVD detailing the negative experiences of a male patient who had been diagnosed as suffering from pneumonia and had been admitted to the Trust through the Emergency Department. The patient's wife (who was also his carer) provided the video feedback but the family had declined an invitation to attend the Board meeting for this discussion. During the showing of the DVD and the subsequent discussion, Board members noted that:-

(a) there was a long wait in ED to be assessed and only 1 family member was allowed to remain with the patient during that time;
(b) there appeared to be a lack of continuity and handover arrangements between staff, as multiple case histories were taken and the patient was almost sent for a second chest x-ray in error;
(c) the patient (who had recently been diagnosed as suffering from dementia) had been moved 3 times during his admission including a stay on the Medical Assessment Unit and an outlying Orthopaedic ward due to a shortage of medical beds. These moves had increased his levels of anxiety and stress and security arrangements had been required to prevent him from wandering, which (in turn) had made the patient feel like a prisoner on the ward;
(d) the family had commended the efforts of staff who they felt were extremely busy, but they had commented upon the scope to (i) improve communications with patients' family members, (ii) reduce the number of internal transfers, and (iii) increase the level of family involvement within care pathways;
(e) in response to the issues outlined in the patient story, Board members noted that a draft Carers' Charter (appendix 1) had been developed which set out to identify patient carers on the wards, assess their needs and ensure open channels of communication regarding patient progress and discharge planning. The policy for outlying patients with a confirmed diagnosis of dementia or cognitive behaviour related issues had been amended and the Datix incident report form revised to take account of such incidents and the position was being closely monitored. Arrangements to provide carers with drinks and meals on the wards were also being explored. Appendix 2 provided the new patient profile form, which clearly identified a space for comments from patients' friends, family and carers.

Board members commented upon the patient story and raised questions on the related training processes, the arrangements for ensuring that the right information ended up on each patient's file and how the Trust could seek assurance that such incidents would not occur again. In response, it was noted that a carers' engagement event had been held recently and the Trust continued to work through the action plan arising from this event. Monthly carers' surveys continued to demonstrate an improving trend. One of the key issues was to simplify the process for clinical staff to identify when patients' carers wished to be actively involved in planning care. The Chief Executive commended the actions taken in response to this negative patient story, noting the connection between high emergency activity levels and outlying patients. He particularly welcomed the initiative to provide carers with food and drinks whilst they were present on the wards and he offered his support to the Assistant Chief Nurse in the event that she encountered any barriers in this respect.

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

25/15/2 The Proposed Move of Level 3 Intensive Care off the LGH Site and its Impact upon Other Services

The Director of Strategy introduced paper F, outlining the operational and safety issues likely to impact upon the Leicester General Hospital intensive care service within the next 12

months, and seeking Trust Board approval to consolidate UHL's intensive care services into 2 units based on the Leicester Royal Infirmary and Glenfield Hospital sites. She briefed Board members on the contributory factors arising from the removal of training designation for the LGH service and the planned retirement of a further Consultant which would result in the clinical rota for the level 3 intensive care service becoming unsustainable. Previous attempts to recruit substantive staff to strengthen the intensive care rota had been unsuccessful; this was largely due to the reduced patient acuity on the LGH site and a national shortage of experienced nursing and medical staff.

The report detailed the proposed governance arrangements, project framework, timeline, risks, benefits and consultation and engagement arrangements and the accompanying appendices provided the bed numbers, activity data, communications plan and associated entries on the Trust's risk register.

In discussion on the proposals, Trust Board members:-

(a) sought and received confirmation that there was no other feasible solution for the future of this service, as it was proving impossible to recruit to the clinical posts and noted the impact upon other supporting services (such as Imaging);
(b) highlighted the complex nature of service-level reconfiguration plans and associated opportunities to improve theatre and bed utilisation and implement 6 or 7 day operating schedules in parallel;
(c) noted that reports on this subject had been presented to the Joint Staff Consultation and Negotiation Committee (JSCNC) and the Local Negotiating Committee (LNC) and a number of staff engagement listening events had been held;
(d) requested that a further report be provided to the Trust Board in April 2015 to provide feedback on the formal consultation requirements, once this dialogue had been held with the local Health Overview and Scrutiny bodies; **DS**
(e) requested additional assurance regarding the arrangements for transferring any LGH patients requiring level 3 intensive care to a suitable facility in a timely manner and queried how this would be audited going forwards;
(f) received additional information from the Director of Marketing and Communications on the recruitment process for a dedicated communications and engagement specialist to support the Trust's 5 year plan, reconfiguration programme and the Better Care Together Programme. Until that appointment had been made, the Director of Marketing and Communications was leading on this work. In response to a further query, the Chief Executive and the Director of Marketing and Communications agreed to explore the use of additional interim communications resources (if this was likely to be helpful); **CE/DMC**
(g) considered the scale of any additional investment required for theatres at the LRI and GH sites, noting that the laminar flow theatre facilities on the LGH site would continue to be used as Orthopaedics was not one of the specialties affected by this change;
(h) queried whether there was any scope to increase the flexibility of ITU facilities to improve patients' privacy and dignity by providing single sex accommodation, and
(i) noted the Medical Director's comment that under UHL's original reconfiguration proposals, no provision had been made for level 3 ITU facilities on the LGH site.

<u>Resolved</u> – that (A) the operational and safety issues surrounding future provision of level 3 intensive care services on the LGH site be noted;

(B) the proposal to consolidate UHL's intensive care services into 2 units on the LRI and GH sites be endorsed, subject to confirmation of the formal consultation requirements at the April 2014 Trust Board meeting; **DS**

(C) the Chief Executive and the Director of Marketing and Communications be requested to explore the use of additional interim communications resources (if appropriate), and **CE/DMC**

(D) regular reports on the implementation arrangements be provided to the Executive Strategy Board and the Integrated Finance, Performance and Investment Committee for assurance purposes. **DS**

26/15 QUALITY AND PERFORMANCE

26/15/1 Quality and Performance Report – Month 9 (December 2014)

Paper G 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. Members welcomed the recent introduction of the accompanying Chief Executive's highlight report, providing a summary of the key issues for the Board's attention.

The Chief Executive drew members' attention to the impact of recent emergency activity pressures and the associated deteriorating trend in certain quality metrics. In respect of Referral to Treatment (RTT) performance, 2 of the 3 main metrics were now compliant and a revised trajectory had been agreed with the CCGs and NHS England to deliver compliant admitted RTT performance by the end of April 2015. The Chief Executive's main concern related to cancer performance, where limited progress appeared to have been achieved in respect of 3 key performance indicators.

The Chief Operating Officer provided assurance that the Trust continued to focus upon the longest waiting RTT patients (both admitted and non-admitted) and the total number of UHL patients who were waiting over 18 weeks had now reached an all-time low. He also expressed confidence that cancer performance would improve within the next month, as a result of recent progress with 2 week wait and 31 day performance. The biggest concern for cancer services continued to be 62 day performance and an additional focus was being provided by Mr W Monaghan, the Trust's new Director of Performance and Information. In response to a query, the Chief Operating Officer offered to meet with the LLR Healthwatch Representative outside the meeting to brief him on the key factors affecting UHL's recent cancer performance. **COO**

Responding to a Non-Executive Director observation that 3 of the performance exception reports related to research study recruitment, the Medical Director highlighted the Board's responsibility as host of the Local Clinical Research Network (LCRN) and advised that regular LCRN performance reports were presented to the Trust Board for assurance purposes. He further advised that such exception reports would be triggered at key points within the year and he suggested that the Board might like to challenge whether these trigger points were appropriate when the next LCRN performance report was discussed. The Director of Corporate and Legal Affairs agreed to check when the next such report was due for Trust Board consideration. **DCLA**

Dr S Dauncey, Non-Executive Director and Chair of the Quality Assurance Committee (QAC) introduced a summary of the key issues considered at the 29 January 2015 QAC meeting (paper H1 refers) and confirmed that the Minutes of that meeting would be presented to the 5 March 2015 Trust Board meeting. She noted the short (half day) turnaround time for producing the briefing notes following the QAC and IFPIC meetings and the Board commended the Trust Administration team for their work.

Ms J Wilson, Non-Executive Director and Chair of the Integrated Finance, Performance and Investment Committee (IFPIC) presented paper H2, providing a summary of the issues discussed at the 29 January 2015 IFPIC meeting, noting that a confidential recommendation would be considered in the private section of today's Trust Board meeting due to commercial interests. She commended the work of the Director of Finance and his team in concluding the negotiations in respect of the 2014-15 year end position and highlighted a presentation received from the Musculo-skeletal and Specialist Surgery CMG in respect of

the challenges surrounding RTT performance in the context of increased referrals. The Minutes of the 29 January 2015 IFPIC meeting would be presented to the Trust Board in March 2015.

<u>Resolved</u> – that (A) the month 9 Quality and Performance report be received and noted as paper G;

(B) the Chief Operating Officer be requested to brief the LLR Healthwatch Representative on the factors affecting UHL's cancer performance outside the meeting (if required), and **COO**

(C) the Director of Corporate and Legal Affairs be requested to ascertain the date when the next LCRN report was scheduled to be submitted to the Trust Board. **DCLA**

26/15/2 <u>2014-15 Financial Position – Month 9 (December 2014)</u>

The Director of Finance presented paper I, updating the Board on performance against the Trust's key financial duties and providing further commentary on the month 9 financial performance by CMG and Corporate Directorates, and the associated risks and assumptions. He noted an in-month adverse movement to plan (£0.3m worse than forecast), but provided assurance that the year-end forecast deficit of £40.7m would still be delivered, subject to the CMGs and Directorates delivering their control totals. A summary of any lessons learned from the 2014-15 financial forecasting and outturn performance would be presented to the Integrated Finance, Performance and Investment Committee in March 2015.

Agreement had now been reached in respect of the 2014-15 contract with CCGs and the specialised commissioning contract negotiations were almost complete. Performance against the Trust's cost improvement programme remained strong. The Chairman highlighted the significance of the Trust's financial deficit and members noted the importance of delivering the planned position going forwards (despite the severe operational pressures) and the Trust's aim to build a track record for consistent financial planning and delivery.

The Director of Finance briefed the Board on the outcome of the consultation process for the 2015-16 national contract and national tariff, noting that widespread concerns had been expressed regarding the proposed risk share arrangements for specialised commissioning. Whilst there was not expected to be any additional funding made available, it was hoped that the revised version (once developed) would contain a fairer solution to avoid any perverse incentives in terms of patients' treatment. In the meantime (with effect from 1 April 2015) a draft outline proposal had been put forward to continue using the existing 2014-15 tariff. A suggestion had also been made to reduce non-tariff related funding (eg CQUIN payments) to compensate for the lack of a tariff deflator.

Col (Ret'd) I Crowe, Non-Executive Director sought and received additional information regarding the potential impact of the specialised services reduction and the benefits of emergency care threshold adjustments, noting that the negative movement in specialised services income would far outweigh the income adjustments for emergency activity. In addition, the Director of Strategy expressed concern that the proposed payment mechanism for specialised services (if it went ahead) might lead to some Trusts rationing access to healthcare on the basis of financial quantum.

<u>Resolved</u> – that the month 9 financial performance report (paper I) and the subsequent discussion be received and noted.

26/15/3 <u>Emergency Care Performance Report</u>

The Chief Operating Officer introduced paper J providing the Trust Board with the regular monthly update on UHL's emergency care performance and progress against the Leicester, Leicestershire and Rutland (LLR) Improvement Plan. The LLR Improvement Plan continued to be reviewed weekly by the Urgent Care Board and the main workstreams were focused upon the following 3 areas:-

- *discharge* – there was some evidence of improvement in terms of the volume of discharges and the ratio between discharges and admissions. The Chief Operating Officer recorded formal thanks to staff from the Leicestershire Partnership Trust (LPT) who had been supporting timely UHL discharge processes from the LRI and GH sites;
- *internal processes* – progress continued to be made and there was evidence of improved patient flows and reduced ED occupancy, and
- *attendances and admissions* – the Urgent Care Centre continued to see and treat high volumes of low acuity attendances, but concern was expressed that the level of UHL admissions was still higher than expected for the time of the year (eg 6,600 projected adult emergency admissions for January 2015 compared to 6,442 in January 2014).

Overall, UHL's performance against the 95% 4 hour target was improving, with the whole of January 2015 being in excess of 90% and the latter half of the month being above 95%. There had been a couple of challenging days, but performance had recovered and work continued to fully understand the drivers for these "dips". Nationally, the Trust appeared to have been performing better than some peer group Trusts in the last 2 months. In conclusion, the Chief Operation Officer highlighted the following factors which he felt were making the biggest contribution to improved emergency care performance:-

(1) support from external partners in terms of discharge;
(2) on-site senior management presence which had strengthened the arrangements for 7 day working and increased the weekend management structure;
(3) the huge efforts on the part of staff which had led to a cumulative improvement;
(4) the quality of management support for the programme of change and the strong clinical engagement in these plans, and
(5) the personal impact of Dr I Lawrence, Clinical Director for the Emergency and Specialist Medicine, during the first 5 weeks of his appointment.

In discussion on this report, Non-Executive Director members queried whether any additional resources might help to bolster the position and when the next iteration of the LLR emergency care dashboard would be available. In response, the Chief Operating Officer noted that the cultural improvements and the required reduction in admission rates were not directly attributed to additional resources. He briefed the Board on the arrangements for the Urgent Care Board to identify the key metrics for a more concise health economy wide dashboard, suggesting that this would be complete within the next month and would then be shared with Board members on a quarterly basis. **COO**

Resolved – that (A) the update on emergency care performance and implementation of the recommendations arising from the Sturgess report be received and noted, and

(B) the revised LLR Emergency Care Dashboard be circulated to Trust Board members on a quarterly basis. **COO**

27/15 GOVERNANCE

27/15/1 Fit and Proper Persons Test

Further to Minute 324/14/1 of 22 December 2014, the Acting Director of Human Resources introduced paper K providing a briefing on the proposed arrangements for meeting the new requirements to ensure that all Directors employed by the Trust were fit and proper for their role. She particularly drew members' attention to paragraph 2.5 on page 2 of the report,

which set out the categories of persons who were prevented from holding office. Based on advice received from the TDA, the term "Director" was being interpreted as those Directors who reported directly to the Chief Executive or who regularly attended Trust Board meetings. Appendix 1 detailed the evidence and assurance to be sought in respect of each standard; appendix 2 provided the proposed pre-employment checklist, and appendix 3 set out the draft annual declaration form.

During a detailed discussion on the draft annual declaration form, the Trust Board:-

(a) sought clarity regarding the wording of paragraph 9, item (l) [relating to staff who had been dismissed from any paid employment with a health service body] and queried whether this would include voluntary resignations prior to any impending disciplinary procedures, or compromise agreements. The Acting Director of Human Resources suggested that such circumstances would usually come to light as part of the pre-employment references, but she agreed to seek additional clarity on whether such individuals would be barred from employment; **ADHR**

(b) queried whether the wording of paragraph 9, item (g) [relating to convictions and sentence of imprisonment in the British Islands] would also be extended to convictions on non-British territory. Professor D Wynford-Thomas, Non-Executive Director noted that section 1.1 of appendix 1 included a clause relating to convictions elsewhere of any offence which, if committed in any part of the UK, would constitute an offence;

(c) commented that there appeared to be no reference to political restrictions in the draft declaration form, and received assurance that any political issues were covered under other provisions, although there would be some scope to include this in the declaration (if required);

(d) recognised that the annual declaration wording was not perfect but agreed that it should be taken in the spirit of the requirements;

(e) noted that the CQC had issued some further interim guidance and that a more substantive report would be presented to a future Trust Board meeting on the final implementation arrangements, and

(f) requested the Director of Corporate and Legal Affairs to feedback the Board's comments and queries to the CQC for their consideration. **DCLA**

<u>Resolved</u> – that (A) the report on the arrangements for implementation of the Fit and Proper Persons Test be received and noted as paper K,

(B) the Director of Corporate and Legal Affairs be requested to feedback the Trust Board's comments and queries to the CQC, and **DCLA**

(C) the Acting Director of Human Resources be requested to report on the final implementation arrangements to a future Trust Board meeting. **ADHR**

27/15/2 <u>Board Assurance Framework (BAF)</u>

The Chief Nurse introduced paper L detailing UHL's Board Assurance Framework as at 31 December 2014 and notifying the Trust Board of 3 new high risks opened during December 2014 (as detailed in appendix 3). Board members particularly noted the key points set out in paragraph 2.2, points (a) to (e) relating to individual risk scores and gaps in assurance. As requested under paragraph 2.3, the Trust Board undertook a detailed review of the 5 risks linked to the strategic objective *"a clinically and financially sustainable NHS Foundation Trust",* incorporating principal risks 18 to 22 inclusive:-

(a) ***principal risk 18 (lack of effective leadership capacity and capability)*** – the Acting Director of Human Resources confirmed that this risk had recently been updated with additional control measures and good progress was being maintained. The Chairman and the Chief Executive noted the importance of developing the 360° feedback tool and the Medical Director advised that this was a mandatory element of the medical appraisal

and revalidation processes. The current (9) and target (6) risk scores were confirmed as appropriate;

(b) ***principal risk 19 (failure to deliver financial strategy [including cost improvement programme])*** – the Chairman noted that the Trust was beginning to develop a "firm grip" on its financial performance and that work was taking place to refresh the 5 year strategy and its links with the Better Care Together Programme and the re-configuration programme. The current (15) and target (10) risk scores were confirmed as appropriate;

(c) ***principal risk 20 (failure to deliver internal efficiency and productivity improvements)*** – the narrative had not yet been updated due to the Chief Operating Officer being away on annual leave prior to the circulation of reports for this meeting. He reported verbally on progress of appointments to the 8 cost improvement management positions, cross cutting CIP themes, and advised that plans for the workforce cross-cutting theme (led by the Director of Finance) would be available in March 2015. The current (16) and target (6) risk scores were confirmed as appropriate, although members suggested that the current scores for risk 19 (score 15) and risk 20 (score 16) should be aligned;

(d) ***principal risk 21 (failure to maintain effective relationships with key stakeholders)*** – all of the actions to address gaps in assurance were noted to have been completed, but the Director of Marketing and Communications noted the need to update the narrative to reflect the implementation of the revised Patient and Public Engagement Strategy which was due to be presented to the Trust Board on 5 March 2015, and

(e) ***principal risk 22 (failure to deliver service and site reconfiguration programme and maintain the estate effectively)*** – the Director of Strategy noted an opportunity to update the narrative to reflect recent progress with the reconfiguration programme and cross cutting cost improvement themes. Members queried whether the current risk score (10) was high enough and it was agreed that this would be reviewed at the next Board meeting on 5 March 2015.

Section 3 of the report detailed outline proposals for re-development of the BAF for the 2015-16 financial year. However, the Chief Executive advised that following consideration by the Executive Team, some alternative proposals had been developed which focused upon a monthly review of key annual priorities (instead of strategic objectives). Mr M Williams, Non-Executive Director commented upon this development in the light of some recent guidance another Trust had received from Monitor on this subject. However, further discussion on these proposals was scheduled for the Trust Board thinking day on 12 February 2015. **CN**

<u>Resolved</u> – that (A) the December 2014 Board Assurance Framework (BAF) be received and noted as presented in paper L, and

(B) further discussion on the proposed BAF refresh be held at the Trust Board thinking day on 12 February 2015. **CN**

28/15 EDUCATION

28/15/1 <u>Quarterly Update on Medical Education Issues</u>

Further to Minute 260/14/1 of 25 September 2014, the Associate Medical Director for Clinical Education attended the meeting to present paper M, briefing Board members on key medical education issues in UHL, and highlighting the following points:-

- positive comments arising from the Level 2 multi-professional Health Education East Midlands (HEEM) quality review visit in October 2015;
- progress with the development of the new library facilities (in the old Odames ward) which was due to be opened in February 2015;
- potential redistribution of training posts, and
- work taking place with the Director of Finance to strengthen the accountability

arrangements for medical education funding.

The Trust Board sought and received additional information regarding Information Management and Technology support during induction days, and the timescale for further development of the IT Strategy for Medical Education. The Trust's strategy for simulation facilities was currently under development, and proposals were due to be presented to the Executive Workforce Board in March 2015.

The Chief Nurse highlighted the need to improve education facilities for nursing staff, noting that the HEEM visit was a multi-professional visit. The Chairman suggested that it would be helpful to hold a future Trust Board thinking day in respect of workforce development and training issues and that representatives from the University of Leicester, De Montfort University and Loughborough University would be invited to attend. **CHAIR/ DCLA**

Noting that a planned HEEM visit relating to Obstetrics and Gynaecology education had recently been postponed, the Chief Executive sought and received a verbal update on the key issues which related to split site working and members noted that an interim visit would now be arranged (possibly in October 2015). The Director of Strategy noted the links with the development of the business case for UHL's maternity services and provided assurance that this was being monitored through the Trust's reconfiguration programme.

<u>Resolved</u> – that (A) the quarterly update on clinical education be received and noted, and

(B) consideration be given to scheduling a future Trust Board thinking day on workforce development and training issues. **CHAIR/ DCLA**

29/15 REPORTS FROM BOARD COMMITTEES

29/15/1 <u>Audit Committee</u>

Mr M Williams, Interim Non-Executive Director and Audit Committee Chair introduced paper N, providing the Minutes of the 8 January 2015 Audit Committee meeting. He particularly commented upon the robust risk management arrangements within the Clinical Support and Imaging CMG and the further work required in respect of strengthening the EMPATH governance arrangements.

<u>Resolved</u> – that the Minutes of the Audit Committee meeting held on 8 January 2015 be received and noted.

30/15 CORPORATE TRUSTEE BUSINESS

30/15/1 <u>Charitable Funds Committee</u>

<u>Resolved</u> – that the Minutes of the Charitable Funds Committee meeting held on 19 January 2015 be submitted to the 5 March 2015 Trust Board meeting.

31/15 TRUST BOARD BULLETIN – FEBRUARY 2015

<u>Resolved</u> – that the following Trust Board Bulletin item be noted:-

- **NHS Trust Over-Sight Self Certification return for the period ended 31 December 2014.**

32/15 QUESTIONS AND COMMENTS FROM THE PRESS AND PUBLIC RELATING TO BUSINESS TRANSACTED AT THIS MEETING

The following questions and comments were received:-

(1) a query regarding the training provided to staff in respect of dementia care. The Chief Nurse outlined the key training requirements arising from the Dementia Strategy and associated work plan, providing assurance that a wide range of training was available and that this was being rolled out throughout the Trust (according to the nature of individual staff roles). In addition, she noted that De Montfort University had developed a dementia training model for nursing staff and that medical staff were also able to access this course;
(2) a question regarding the high patient throughput in the Emergency Department and ward 33 and whether any plans were in place to ensure that staff had sufficient time to document the care needs of patients with dementia. In response, the Deputy Chief Nurse advised that staff from the ED and ward 33 had been involved in the interactive training sessions recently held at the Curve Theatre and these areas were also piloting the Carers' Charter. It was noted that the process of clearly documenting patients' needs at an early stage tended to save staff time in the longer term;
(3) a query regarding the flexibility of the Carers' Charter in seeking carers' support for patients who might develop deliria following treatment in Intensive Care Units, noting that this might occur in approximately 80% of cases. The Deputy Chief Nurse confirmed that 1 of the 7 workstreams associated with dementia related to deliria and pain management and that staff were being trained to recognise non-verbal communications in this respect, and
(4) a question regarding the proposed expansion of Intensive Care bed capacity and whether the Trust would be able to recruit to any additional posts. In response, the Director of Strategy briefed members on the vision to develop world class ICU facilities which would help to support clinical recruitment. The Chief Nurse noted the intention to continue local and international nurse recruitment workstreams in parallel for the ICU service, alongside increased commissioning for local nurse training and the development of new roles (eg advanced practitioners).

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

33/15 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 34/15 – 41/15), having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.

34/15 DECLARATIONS OF INTERESTS IN THE CONFIDENTIAL BUSINESS

Professor D Wynford-Thomas, Non-Executive Director declared a non-prejudicial interest in the confidential item of business discussed under Minute 38/15 below.

35/15 CONFIDENTIAL MINUTES

Resolved – that the confidential Minutes of the 8 January 2015 Trust Board be confirmed as a correct record and signed accordingly by the Trust Chairman. **CHAIR**

36/15 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.

37/15 REPORT FROM THE CHIEF EXECUTIVE

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

38/15 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.

39/15 REPORTS FROM BOARD COMMITTEES

39/15/1 Integrated Finance, Performance and Investment Committee

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

39/15/2 Remuneration Committee

Resolved – that (A) the confidential Minutes of the 22 December 2015 Remuneration Committee be received and noted, and

(B) the Minutes of the 29 January 2015 Remuneration Committee be presented to the 5 March 2015 Trust Board.

40/15 ANY OTHER BUSINESS

40/15/1 Report by the Director of Finance

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

41/15 DATE OF NEXT MEETING

Resolved – that the next Trust Board meeting be held on Thursday 5 March 2015 from 9am in the C J Bond Room, Clinical Education Centre, Leicester Royal Infirmary.

The meeting closed at 12.35pm

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)	5	5	100	R Mitchell	12	11	92
R Kilner (Acting Chair from 26.9.13 to 30.9.14)	7	7	100	R Overfield	12	12	100
J Adler	12	10	83	P Panchal	12	12	100
I Crowe	12	11	92	M Traynor (from 1.10.14)	5	5	100
S Dauncey	12	11	92	P Traynor (from 27.11.14)	4	4	100
K Harris	12	11	92	M Williams	5	5	100
K Jenkins (until 30.6.14)	3	3	100	J Wilson	12	10	83
				D Wynford-Thomas	12	5	42

Non-Voting Members:

Name	Possible	Actual	% attendance	Name	Possible	Actual	% attendance
T Bentley*	9	7	78	K Shields*	12	12	100
K Bradley*	9	9	100	S Ward*	12	12	100
D Henson*	8	8	100	M Wightman*	12	12	100