UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF A MEETING OF THE TRUST BOARD, HELD ON THURSDAY 1 OCTOBER 2015 AT 9AM IN SEMINAR ROOMS A & B, 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
Mr A Furlong – Acting Medical 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

In attendance:
Ms C Ellwood – Chief Pharmacist (for Minute 220/15)
Dr R Green – Consultant Respiratory Physician (for Minute 208/15/1)
Mr D Henson – LLR Healthwatch Representative (up to and including Minute 215/15)
Mr D Kerr – Director of Estates and Facilities (for Minute 219/15)
Ms H Leatham – Assistant Chief Nurse (up to and including Minute 208/15/1)
Ms N Mills – Clinical Specialist Physiotherapist (for Minute 208/15/1)
Dr N Sanganee – LLR CCG representative (up to and including Minute 215/15)
Ms H Seth – Head of Partnerships
Ms H Stokes – Senior Trust Administrator
Ms L Tibbert – Director of Workforce and OD
Mr S Ward – Director of Corporate and Legal Affairs
Mr M Wightman – Director of Marketing and Communications (up to and including Minute 210/15/1)
Ms E Wilkes – UHL Reconfiguration Programme Director (for Minutes 208/15/2 and 208/15/3)

ACTION

202/15 APOLOGIES AND WELCOME

Apologies for absence were received from Professor A Goodall, Non-Executive Director and Ms K Shields, Director of Strategy. The Trust Chairman welcomed Dr N Sanganee to the meeting as the LLR CCG representative on UHL's Trust Board.

203/15 DECLARATIONS OF INTERESTS IN THE PUBLIC BUSINESS

The Chairman declared an interest in the new ED front door arrangements briefly referred to in paper H (Minute 208/15/4 below refers) and confirmed that he would absent himself from any detailed discussion on that item.

204/15 MINUTES

Resolved – that the Minutes of the 3 September 2015 Trust Board be confirmed as a correct record and signed by the Trust Chairman accordingly. **CHAIR MAN**

205/15 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 181/15 of 3 September 2015** – arrangements for the signing of the Armed Forces Covenant on 5 November 2015 were in hand;

(b) **Minute 184/15/3 of 3 September 2015** – the nature and timing of any Better Care Together workstream presentations remained under consideration;
(c) **Minute 185/15/4 of 3 September 2015** – it was confirmed that the LLR emergency care system would be one of the issues discussed at the Board to Board on 8 October 2015 involving UHL, the LLR CCGs and Leicestershire Partnership NHS Trust, and
(d) **Minute 185/15/1 of 3 September 2015** – the Senior Trust Administrator reported an update on this issue from Professor A Goodall Non-Executive Director and University of Leicester representative; in principle the University supported the joint use of the Robert Kilpatrick Building examination facilities, but suggested revisiting this issue once the new curriculum was known, as this would give a more informed indication of expected usage and timetabling.

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

206/15 CHAIRMAN'S MONTHLY REPORT – OCTOBER 2015

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

(a) planned discussions on the 'Well-Led Framework' requirements, at the October 2015 Trust Board thinking day, mindful of the Trust's wish to be an exemplar in this issue;
(b) the challenge of balancing the financial position with the need to provide safe and high quality clinical care. The Chairman had therefore asked that the reconfiguration implications of the current financial position be discussed at the November 2015 Trust Board thinking day; **CFO/ CE**
(c) the planned 'Board to Board' meeting on the afternoon of 8 October 2015, involving representatives from the Boards of UHL, the 3 LLR CCGs, and Leicestershire Partnership NHS Trust, and
(d) his recognition of the commitment shown by front-line staff to patient care, as evidenced at the 2015 Annual Public Meeting health fair event. He also noted his appreciation for the good attendance of staff at the APM itself, at the 29 September 2015 Leadership event and at the September 2015 Caring at its Best awards.

<u>Resolved</u> – that the implications of the current financial position for reconfiguration, to be discussed at the 12 November 2015 Trust Board thinking day. **CFO/ CE**

207/15 CHIEF EXECUTIVE'S MONTHLY REPORT – OCTOBER 2015

The Chief Executive's October 2015 monthly update 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) that 115 people had attended UHL's 2015 APM and health fair event, with a very positive atmosphere;
(b) feedback from the UHL Leadership event of 29 September 2015, noting that the externally-facilitated session on positivity had been particularly well-received. It was planned to repeat this event in 2016;
(c) his recent meeting with the Chair of NHS Providers, which had confirmed that the challenges facing UHL were mirrored across the national healthcare system, and
(d) his stocktake of progress against UHL's annual priorities, at this half-year point. He advised that all of the annual priorities were reflected on this Trust Board agenda in some form.

In discussion on the report, the Trust Board:-

(i) suggested using the Leadership event external speaker for similar, CMG-level events; **DWOD**

(ii) requested that future iterations of the quality and performance dashboard also include compliance dates for currently non-compliant metrics (where known, or an appropriate footnote if not); **CE**

(iii) welcomed the strategic objective charts within the reports and suggested that these be more widely communicated through the Trust; **CE/ DMC**

(iv) queried the Chief Executive's level of confidence that the ambulatory care strategy would come to fruition. The Chief Executive and the Acting Medical Director outlined progress on this issue (being led internally by Dr C Free, Associate Medical Director), including discussions with clinical partners across the healthcare system. The issue of GP access to senior clinical advice at UHL was also being explored, as the 'red phone' was not used in all areas, and

(v) noted comments from the Director of Corporate and Legal Affairs that UHL's response to Freedom to Speak Up/new national whistle-blowing policies would be reported to the Executive Quality Board and Quality Assurance Committee en route to the December 2015 Trust Board. **AMD**

<u>Resolved</u> – that (A) use of the September 2015 leadership event external speaker be considered for CMG-level events; **DWOD**

(B) future iterations of the quality and performance dashboard include compliance dates (where known, or an appropriate footnote if not); **CE**

(C) consideration be given to appropriate wider organisational communication of the strategic objective/annual priority tables, and **CE/ DMC**

(D) UHL's response to 'Freedom to Speak Up'/new national whistle-blowing policies be reported to the Executive Quality Board, Quality Assurance Committee and 3 December 2015 Trust Board. **AMD**

208/15 KEY ISSUES FOR DECISION/DISCUSSION

208/15/1 <u>Patient Story – Impact of a Team Approach and Effective Communication in the Management of Patients with Highly Complex Presentations</u>

The patient attended this Trust Board meeting to outline the background to her condition and treatment, and to advise the Trust Board of the very significant positive impact that an innovative, multi-disciplinary team approach had had on her care. She also outlined the significant personal and professional goals that she had achieved despite her clinical condition. Ms H Leatham, Assistant Chief Nurse, Dr R Green Consultant Respiratory Physician and Ms N Mills, Clinical Specialist Physiotherapist also attended for this item.

The Trust Chairman thanked the patient for her courage in sharing her story, commenting on the inspirational nature of her presentation and experiences. He also thanked the staff involved for their commitment and dedication. In discussion on the patient story, the Trust Board:-

(a) noted the patient's view (in response to a query) that a strong, supportive, team-based approach was vital in assisting patients and demonstrating/explaining the benefits of their treatment;

(b) suggested a need to consider how the Trust could offer appropriate psychological, emotional and spiritual support to patients;

(c) noted (in response to a query) the nature of the specific innovative physiotherapy approach used for this patient, which involved adapting machinery for use at home. This innovation had now been shared nationally and was being written up as a case

study for publication. The Clinical Specialist Physiotherapist also outlined her very frequent communication with the patient (including discussions with the patient's personal trainer to develop an appropriate exercise regime) and the use of home physiotherapy to avoid unnecessary admissions;

(d) welcomed the comments of the Healthwatch representative that this was the more positive side of the NHS seldom covered in the media;

(e) noted that the Head of Partnerships would contact the patient outside the meeting to discuss the holistic team approach of the 'exercise as medicine' workstream in the LLR longterm conditions programme, recognising the large-scale benefit of a relatively small investment; **HoP**

(f) suggested that the patient and her clinical team would be good NHS role models for school presentations;

(g) noted (in response to a query) the various levels of support the patient had experienced at higher education and other NHS facilities, and

(h) agreed to explore the scope for the patient to participate in making a video for UHL staff re: positivity and motivation. **DMC**

Resolved – that (A) the holistic team approach of the 'exercise as medicine' workstream in the LLR longterm conditions programme, be discussed with the patient outside this meeting, and **HoP**

(B) the scope for the patient to participate in a video for staff re: positivity and motivation, be explored further outside the meeting. **DMC**

208/15/2 Strategy Update – UHL Reconfiguration Programme

This monthly update from the Director of Strategy updated the Trust Board on (i) the governance of UHL's reconfiguration programme; (ii) progress on 1-2 selected workstreams, and (iii) the 3 key programme risks, while the high-level dashboard appended to the report provided an overview of the programme status and key risks as a whole. In terms of key workstream deep dives, paper F focused on the 'out of hospital shift and plan B' (as requested at the September 2015 Trust Board) and on estates.

Noting that the 17 September 2015 Audit Committee meeting had agreed that Committee's key role in commissioning Health Checks for reconfiguration projects, Ms E Wilkes, UHL Reconfiguration Programme Director advised that she would be reviewing wider programme governance issues with the Director of Corporate and Legal Affairs – any Trust Board comments on the role of UHL's Committees were welcomed. **ALL**

With regard to the out of hospital shift and plan B workstream as detailed in paper F, the UHL Reconfiguration Programme Director noted the slippage in timescale due partly to workforce and contracting issues and advised that this workstream continued to be a key risk area for the programme. Contracting elements had now been resolved. Despite a collective will to resolve workforce issues also being in place, progress on this aspect remained slow. In further discussion on this workstream, the Trust Board:-

(a) noted a request from the Healthwatch representative for clear and joined-up communication on the proposed changes, to patients, the public and staff, appropriately aligned to ongoing communication about ICU changes. The Healthwatch representative also voiced some concern about the long-term sustainability of the moves; **DS/ DMC**

(b) queried the level of granular detail available on the implementation plan for the

movement of 130 beds by 31 March 2016. The Head of Partnerships advised that the joint working group recognised the need for close monitoring as this workstream moved in to the operational phase;

(c) queried the level of confidence that the bed shifts would be delivered. Although confident of the first shift, the Head of Partnerships recognised the need to support LPT in recruitment to enable the second shift. These aspects would be covered in further detail at the November 2015 Trust Board thinking day on reconfiguration; **DS**

(d) noted a query from the CCG representative regarding medical leadership in respect of community patients. In response, the Head of Partnerships advised that medical governance would sit with LPT;

(e) noted a need to consider when it would be appropriate to remove/reduce the existing acute capacity freed up due to the bedshift in to the community. This was a key issue and would be made still more complex by ICU transfer considerations and increasing front door winter demand. This issue would also be discussed further at the November 2015 Trust Board thinking day; **DS**

(f) agreed that future iterations of the Trust Board report on UHL reconfiguration should also include information on:- **DS**

- risks (and related scenario planning) to the reconfiguration programme;
- the interdependencies of the various elements and their consequences;

(g) requested that the 5 November 2015 Trust Board update on reconfiguration specifically also provide an overview of how the various winter 2015 operational capacity planning initiatives fit together, and **DS**

(h) queried progress on a contingency plan, noting (in response) discussions re: a potential UHL outreach service using mothballed wards for sub-acute patients at (eg) Loughborough community hospital providing a predominantly therapy-led service.

<u>Resolved</u> – that (A) any comments on the governance role of UHL's Committees (re: the reconfiguration programme), be provided to the Reconfiguration Programme Director; **ALL**

(B) the reconfiguration changes be clearly communicated to patients, the public and staff, aligned (where appropriate) to communication on the ICU moves; **DS/ DMC**

(C) the 12 November 2015 Trust Board thinking day on reconfiguration also cover the bed shift to LPT and the appropriate timing of reductions to/removal of acute capacity as a result of the new Community capacity being in place; **DS**

(D) future iterations of the Trust Board monthly reconfiguration update include the issues in point (f) above, and **DS**

(E) the 5 November 2015 iteration of the Trust Board monthly reconfiguration update also specifically include an overview of how the various winter 2015 operational capacity planning initiatives fit together. **DS**

208/15/3 <u>LLR Better Care Together (BCT) Programme Update</u>

Paper G provided a high-level update on the LLR Better Care Together Programme, as prepared for all partner organisations' Boards (accompanied here by an internal UHL covering report). The programme was now at the critical stage of finalising the BCT pre-consultation business case. The Trust Chairman noted the need for the Trust Board to

consider the pre-consultation business case prior to its launch, and confirmed that he would contact members regarding the timing of this consideration (potentially involving an extraordinary Trust Board meeting). **CHAIRMAN/ DCLA**

In response to a query from the Trust Chairman, the Head of Partnerships advised that a draft dashboard of LLR-wide BCT metrics would be presented to the November 2015 Trust Board. The Audit Committee Non-Executive Director Chair noted LLR-wide support for such a dashboard (as voiced at the 30 September 2015 LLR lay members' meeting) and queried whether this was a sufficient priority for the BCT project management office. The Chief Executive agreed to pursue this accordingly with the BCT Programme Director. In further discussion on paper G, the Trust Board:- **CE**

(a) noted (in response to a query from the Audit Committee Non-Executive Director Chair) the Chief Executive's view that a further Health Check on the LLR BCT programme was not necessary at this stage, given that a Gateway zero report had been undertaken initially. The Chief Executive did consider, however, that further assurance on the BCT actions was required by all parties' Boards, which he agreed to pursue with the BCT Programme Director; **CE**

(b) noted a generally-positive meeting held with the East Midlands Clinical Senate to discuss BCT, focusing on longterm conditions, urgent care, and primary care;

(c) noted the need for the consultation exercise to make the BCT changes meaningful to the public, explaining the implications for their care and providing clarity on the timescale for change. The Director of Marketing and Communications outlined his recent discussions with the BCT Programme Director, recognising the need to produce an appropriate public-facing document. The Trust Board also noted the need for staff across all organisations to be kept appropriately informed, and

(d) requested that the November 2015 Trust Board BCT programme update provide a BCT Programme Board view on when the top 2 risks to the programme would progress to an amber RAG status. The Chief Executive noted that the BCT programme featured on the Board to Board scheduled for 8 October 2015 and clarified that this was a collective LLR initiative rather than the Programme Board pursuing any separate agenda. **DS**

<u>Resolved</u> – that (A) once known, members be advised of the scheduling of Trust Board consideration of the LLR BCT pre-consultation business case; **DCLA**

(B) the development of LLR BCT programme metrics/dashboard be pursued with the LLR BCT Programme Director and appended to the November 2015 Trust Board LLR BCT update; **CE**

(C) further assurance for the UHL Trust Board (and other partner Boards) in terms of progress against LLR BCT actions, be sought from the LLR BCT Programme Director, and **CE**

(D) the 5 November 2015 Trust Board update on LLR BCT also include information on when the top 2 programme risks would progress to an amber RAG rating. **DS**

208/15/4 <u>Emergency Care Performance and Winter Contingency Plan</u>

Further to Minute 184/15/4 of 3 September 2015, paper H from the Chief Operating Officer updated the Trust Board on recent emergency care performance, which stood at 91.8% for the year to date despite continued atypically-high attendance and admission rates. Performance had deteriorated over the last 3 weeks however as attendance and admission pressures mounted, with the Trust experiencing record levels of both. New ED front door arrangements would come into force on 3 November 2015, and the Chief Operating Officer

also noted the 5 key initiatives being discussed through the Urgent Care Board, as detailed in paper H. A further meeting of the Urgent Care Board was scheduled for 1 October 2015, and the Chief Operating Officer noted the crucial need for delivery on these key measures. Reiterating the need for traction on measures to manage winter 2015, the Chief Executive advised that an update would be provided to the October 2015 Trust Board thinking day re: the leadership of and timescales for the actions which were agreed through the Urgent Care Board. In discussion on this issue the Trust Board:- **CE/ COO**

(a) queried how to progress a number of the key actions which were not primarily within UHL control (eg communication campaigns, leftshifts of activity, etc). Echoing this, the Director of Marketing and Communications also queried whether any communication on seeking early treatment would be sent direct to at-risk patient cohorts by their GPs, as previously suggested by the Trust Board. The CCG representative advised that GPs in his particular area did contact patients, and he also commented on the need more generally for two-way communication between primary and acute care clinicians regarding the care of patients in the community;

(b) noted comments from the CCG representative on the need for appropriate subsequent signposting to community care packages for elderly patients (in particular) when attending ED. The Acting Medical Director recognised the key impact of appropriate discharge and confirmed that work was underway on this issue, including the identification of 'frailty flags'. The situation was hampered however by the lack of a unified discharge process across LLR organisations;

(c) considered that the message about choosing the most appropriate healthcare setting to attend was not successfully being conveyed to the public, and

(d) noted ambulance handover time pressures at the LRI, which had been raised with the EMAS Chief Executive. Outflow from ED was a key factor in resolving this, and the Trust anticipated that the new ED front door arrangements would help to improve ambulance handover times.

Following discussion, the Trust Board reiterated that LLR emergency care changes could not be delivered without input from both the public and UHL's partner healthcare organisations.

<u>Resolved</u> – that the 8 October 2015 Trust Board thinking day receive an update on the 1 October 2015 Urgent Care Board discussions on which winter actions would be taken forward, by whom and to what timescale. **CE/ COO**

208/15/5 <u>UHL Risk Report incorporating the Board Assurance Framework (BAF)</u>

Paper I from the Acting Medical Director comprised the latest iteration of the 2015-16 Board Assurance Framework (as at 31 August 2015) and a summary of all high and extreme risks on the risk register. Two new high risks had been opened in August 2015 (relating to [i] the risk of delay in gynaecology patient correspondence due to a typing backlog and [ii] increased demand in the diabetes outpatient foot clinic), and the Acting Medical Director was confident that appropriate actions were on track to de-escalate these. In terms of the specific risks being discussed at this meeting (and noting that the proposed new-style BAF would be considered further at the October 2015 Trust Board thinking day), the Trust Board noted:-

(a) **principal risk 18** – the Chief Executive outlined discussions with the National Trust Development Authority (NTDA) to develop a potential alternative way forward on EPR. Discussions were now underway accordingly between the Trust and IBM. The NTDA was not averse to an alternative funding method providing it offered appropriate value for money, and the Trust's IFPIC had also been advised of this proposed new approach. The Chief Executive thought it was likely, however, that

the timescale for EPR would slip, and he hoped to be able to clarify this at the November 2015 Trust Board. In discussion, members considered the potential advantages/disadvantages of any phased EPR implementation, and the Acting Medical Director also noted the need to learn appropriate lessons from other implementations, to understand the risks and to focus appropriately on training. Noting his support for an early roll-out of EPMA (if possible), the Acting Medical Director agreed to contact the Chief Information Officer to discuss the prioritisation of different clinical systems. Dr S Dauncey, Non-Executive Director, also noted her support for any phasing of EPR implementation to be done rapidly (if phasing was necessary). Noting that the October 2015 IFPIC would receive a further update on EPR, it was agreed to update risk 18 to reflect the discussions above, and **AMD**

AMD /CE

(b) **principal risk 19** – the Chief Executive noted the good progress being made through the 'IM&T frustrations' Listening into Action (LiA) process. Any contractual performance issues were being pursued with IBM as appropriate through the Joint Governance Board.

It was further agreed to review principal risk 16 (delivery of UHL's 2015-16 deficit control total) at the November 2015 Trust Board. **AMD/ CFO**

Resolved – that (A) principal risk 18 be updated to reflect the Trust Board discussions, and to clarify the timescale for the programme; **AMD/ CE**

(B) discussions be held with the Chief Information Officer about prioritisation of different clinical systems within the EPR programme roll-out, and **AMD**

(C) principal risk 16 be reviewed at the 5 November 2015 Trust Board meeting. **AMD/ CFO**

209/15 RESEARCH AND INNOVATION

209/15/1 Research and Innovation Quarterly Report

Paper J from Professor N Brunskill, UHL Director of Research and Innovation, described UHL's current R&D performance against metrics, the projects in development, new challenges (including cost pressures) and potential threats. The number of trials initiated had risen (which was welcomed), and UHL's performance had also improved in respect of recruiting patients to initiated trials, thus avoiding the financial penalty detailed in paper J. The Acting Medical Director noted that the September 2015 commencement of the LIFE Study trial might also serve to counteract the local and national trend (mirrored at UHL) of reduced overall patient recruitment numbers. New projects in development included the National Centre for Drug Adherence Testing (NCAT), the East Midlands Biobank, and the Leicester Institute for Precision Medicine (LIPM). In discussion on the quarterly research and innovation report, the Trust Board:-

(a) noted that UHL's R&D management and governance processes were seen as national exemplars;

(b) noted that UHL was an outlier nationally in terms of the number of Clinical Research Network (CRN) Funded Consultant PAs allocated (more than comparable other Trusts). UHL was working closely with the CRN to design transparent new criteria for a refreshed allocation process from quarter 1 of 2016-17. The Trust Chairman welcomed the planned review of outputs from these (albeit externally funded) research PAs, and

(c) agreed the need for progress in identifying suitable space at the Glenfield Hospital to develop a Hope Unit (funded by the Hope Against Cancer Charity).

Resolved – that the quarterly update on UHL research and innovation be noted.

209/15/2 NIHR East Midlands Clinical Research Network (EMCRN) – Quarterly Update

Professor D Rowbotham, EMCRN Director attended to provide an update on the work of the National Institute for Health Research East Midlands Clinical Research Network as detailed in paper K. Established in April 2014, EMCRN was hosted by UHL which therefore had overall regional responsibility for monitoring the Network's governance and performance. The quarterly update covered in particular:-

(i) EMCRN's achievements for 2014-15 as detailed in its annual report and recognised by the NIHR, including the Network's position as the top recruiting region in England for primary care research;
(ii) the challenges facing the Network, including a significant reduction in budget in 2015-16, the need for real partnership working, and a very challenging 2015-16 recruitment target, and
(iii) the performance dashboard at appendix 2. Although welcoming markedly improved performance on the proportion of commercial studies recruiting to time and target, the EMCRN Director also drew the Trust Board's attention to a significant fall in the Network's recruitment rate compared to 2014-15, broadly reflective of national trends. EMCRN recruitment currently stood at 69% against its year-to-date target, and the Network had therefore convened a senior group to analyse the reasons for this underperformance on recruitment. Key actions identified from this review were also listed in paper K.

In discussion on the EMCRN report the Trust Board:-

(a) noted the recruitment challenges in acute trials rather than in primary care trials, which were recruiting well. EMCRN was unusual in that 50% of its trials were primary care studies. In response to a query, the EMRCN Director believed that acute trial recruitment problems could be linked to where patients were being recruited from rather than to the specific service involved in the trial. The Trust Board also sought the EMCRN Director's view on what top 3 actions UHL should concentrate on to improve recruitment rates (all of which were being appropriately pursued by the Trust's Director of Research and Innovation);

(b) noted UHL's position as the most cost-effective and highly-performing Trust within the EMCRN in terms of recruitment. The Acting Medical Director noted UHL's disproportionate number of observational (rather than interventional) studies, however – UHL's Director of Research and Innovation was reviewing this accordingly;

(c) discussed how to raise the profile both internally and externally of UHL's status as a research-led, teaching organisation. It was agreed that this needed to be explored further outside the meeting, and **AMD/ DMC**

(d) received assurance from the EMCRN Director that there were no further issues he wished to raise in terms of UHL's hosting of the Network. In response, the EMCRN Director confirmed that he was content with the accommodation, access and level of challenge provided to the Network by UHL.

Resolved – that consideration be given to how best to highlight/publicise UHL's research profile. **AMD/ DMC**

210/15 WORKFORCE AND ORGANISATIONAL DEVELOPMENT

210/15/1 Workforce and OD Quarterly Update

Paper L provided a quarterly update on progress against UHL's ambitious Organisational Development (OD) Plan, which had been approved by the Trust Board in July 2015. The Director of Workforce and OD advised that a more streamlined format would be adopted for

future quarterly updates. The impact of the OD interventions was measured through the Organisational Health Dashboard (accessible through the Trust's intranet) and progress was reported to a variety of groups. In discussion on the quarterly workforce and OD update the Trust Board:-

(a) queried whether the OD dashboard could be integrated in to the 'well-led' domain of the monthly quality and performance report. The Director of Workforce and OD agreed to explore this with the Assistant Director of Information; **DWOD**

(b) queried how the long term aim of reducing staff numbers tallied with short term measures to increase recruitment, and

(c) queried whether the HR function might be involved in any early potential integration of LLR back office functions. The Director of Workforce and OD emphasised that an appropriate focus must be placed on retaining resilience and capacity.

Resolved – that consideration be given to incorporating the organisational health dashboard into the 'well-led' domain of the monthly quality and performance report. **DWOD**

211/15 QUALITY AND PERFORMANCE

211/15/1 Audit Committee

Mr R Moore, Audit Committee Non-Executive Director Chair sought Trust Board approval for 2 recommended items from the 17 September 2015 Audit Committee: (i) the External Audit Annual Audit Letter 2014-15 [as appended to paper M] and (ii) the Trust's updated corporate governance policies in respect of the Standing Financial Instructions, Standing Orders, and Reservation of Powers to the Trust Board [hyperlinked from paper M]. He also noted the following issues from that busy September 2015 Audit Committee meeting:-

(a) presentations on reconfiguration and on the women's services project, and an agreement that the Audit Committee would assume a lead role in commissioning major project healthchecks as a mechanism to oversee their delivery and provide independent challenge to the process;

(b) discussions on the proposed new-format of the Board Assurance Framework, which would be considered further at the October 2015 Trust Board thinking day, and

(b) the Committee's consideration of Internal Audit reports on UHL's performance framework 2014-15 and on the 2015-16 review of the CQC inspection. The Chief Executive noted that members had queried whether 'medium' risk rating ascribed to the latter report was too harsh, but it was noted that both the lead officer and the Chief Nurse considered that the rating was reasonably fair. Dr S Dauncey, Non-Executive Director and QAC Chair, confirmed that this specific report had also been considered at the September 2015 QAC meeting, with availability of evidence having been the primary issue for Internal Audit.

Resolved – that the summary of issues considered at the 17 September 2015 Audit Committee meeting be noted, and the 2 recommended items be approved as follows:-
(A) External Audit Annual Audit Letter 2014-15, and
(B) updated UHL corporate governance policies (Standing Financial Instructions, Standing Orders, Reservation of Powers to the Trust Board).

211/15/2 Quality Assurance Committee (QAC)

Dr S Dauncey, QAC Non-Executive Director Chair, outlined the key issues discussed at the 24 September 2015 QAC meeting (paper N) noting in particular:-

(a) the report from the Local Supervising Authority Annual Review visit 2014 (as presented to QAC by 2 supervising midwives from Women's and Children's CMG);

(b) verbal notification to that QAC meeting of a reported never event. A report would be presented to QAC accordingly following investigation, and

(c) a report on the reviews of out of hospital SHMI and readmissions – a summary of that report would be shared with his LLR Chair colleagues by UHL's Chairman.

Resolved – that the summary of key issues considered at the 24 September 2015 QAC meeting be received and noted.

211/15/3 Integrated Finance, Performance and Investment Committee (IFPIC)

Ms J Wilson, IFPIC Non-Executive Director Chair outlined the key issues discussed at the 24 September 2015 IFPIC meeting (paper O), including detailed consideration of the month 5 financial position and delivery of the 2015-16 revised financial plan. The Committee had also received presentations from the Endoscopy team (taking assurance accordingly about the improvements underway) and the Emergency and Specialist Medicine CMG. In a busy agenda, IFPIC had also discussed the continuing improvements in cancer performance. In discussion on paper O, the Chief Operating Officer advised that external (NHS IQ) endoscopy support would begin in mid-October 2015, spanning three 30-day cycles.

Resolved – that the summary of key issues considered at the 24 September 2015 IFPIC meeting be received and noted.

211/15/4 2015-16 Financial Position – Month 5 (August 2015)

This item was taken in conjunction with the discussion on delivery of the 2015-16 financial plan (Minute 211/15/5 below refers), noting that both papers had been discussed in detail at the September 2015 Executive Performance Board and IFPIC. From the November 2015 Trust Board onwards, these 2 items would be covered through a single, integrated report which would still provide the appropriate detail. The Trust's year to date position and full year forecast was now rated as amber, and the month 5 position reflected the Trust's revised deficit control total of £34.1m as submitted to the NTDA on 11 September 2015. Commissioners were also required to submit revised plans to NHS England, and the Chief Financial Officer confirmed that LLR plans would be appropriately triangulated. As noted in paper P, the month 5 position was £0.5m off the revised plan, due primarily to pay issues and an inability to reduce agency spend at this time. The Chief Financial Officer noted that the agency spend ceiling of 4% of qualified nursing and midwifery spend from quarter 3 of 2015-16 (reducing to 3% from quarter 1 of 2016-17), would be challenging.

Resolved – that the month 5 financial performance report be noted.

211/15/5 Delivery of the 2015-16 Financial Plan

Further to Minute 211/15/4 above, paper Q updated members on UHL's 2015-16 financial recovery plan, confirming the revised deficit control total of £34.1m. The Chief Financial Officer advised that 4 of UHL's 7 CMGs were significantly off plan at this stage, and he noted that UHL's cost improvement target was £1.5m off plan as at month 5. In discussion on this report the Trust Board noted:-

(a) the need to balance financial considerations with safety and quality requirements, particularly moving into winter. The Chief Nurse recognised this challenge and noted that her revised nursing and midwifery monthly report contained a detailed plan to reduce vacancies and reduce agency spend (including greater use of the nursing bank). She also reiterated that patient safety was paramount. The QAC Non-Executive Director Chair

confirmed that UHL's Quality Assurance Committee did review quality and safety issues very closely and would seek further assurance when necessary;

(b) comments from the Chief Financial Officer on the need to ensure the most efficient use of UHL's substantive workforce (eg nursing e-rostering efficiencies). Non-Executive Directors suggested that a reprofile of the workforce might also be useful, as a longer term measure;

(c) discussions at the September 2015 IFPIC on what activities/measures might potentially be paused in 2015-16, and

(d) the view of the Chief Executive that month 6 financial results remained key to being able to be 'assured' on the issue of financial delivery 2015-16.

Resolved – that the update on delivery of the 2015-16 revised financial plan be noted.

212/15 REPORTS FROM BOARD COMMITTEES

212/15/1 Quality Assurance Committee (QAC)

Resolved – that the 27 August 2015 QAC Minutes be received and noted, and the recommendations therein be endorsed.

212/15/2 Integrated Finance, Performance and Investment Committee (IFPIC)

Resolved – that the 27 August 2015 IFPIC Minutes be received and noted and the recommendations therein be endorsed.

213/15 TRUST BOARD BULLETIN – OCTOBER 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 July 2015 [noting the continuing cleanliness concerns expressed by the Trust] (paper 1), and

(2) updated declarations of interests for Mr J Adler Chief Executive [reflecting his appointment as a Trustee of NHS Providers for a 1-year period from 1 July 2015 – unremunerated role], Mr P Traynor Chief Financial Officer [reflecting that a family member was undertaking a 3-month project role for the LLR Alliance as of 29 September 2015], and a declaration of interest for Dr N Sanganee, LLR CCG representative [reflecting his position as a GP at Ashby Health Centre, his membership of the WLCCG Quality and Performance Committee and Primary Care Commissioning Committees, and his role as a GP and Practice Appraiser] (paper 2).

214/15 QUESTIONS AND COMMENTS FROM THE PRESS AND PUBLIC RELATING TO BUSINESS TRANSACTED AT THIS MEETING

There were no questions/concerns/comments raised by public attendees in respect of the subjects discussed at the meeting.

215/15 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 216/15 – 224/15), having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.

216/15 DECLARATIONS OF INTERESTS IN THE CONFIDENTIAL BUSINESS

The Trust Chairman reiterated his declaration as reported in Minute 203/15 above, and noted that he would absent himself from the meeting accordingly if this item was discussed.

Resolved – that the Chairman's declaration be noted.

217/15 CONFIDENTIAL MINUTES

Resolved – that the confidential Minutes of the 3 September 2015 Trust Board be confirmed as a correct record and signed by the Trust Chairman accordingly. **CHAIR MAN**

218/15 CONFIDENTIAL MATTERS ARISING REPORT

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

219/15 JOINT REPORT FROM THE DIRECTOR OF ESTATES AND FACILITIES AND THE DIRECTOR OF WORKFORCE AND DEVELOPMENT

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

220/15 REPORT FROM THE CHIEF FINANCIAL OFFICER

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

221/15 REPORT FROM THE HEAD OF PARTNERSHIPS

Resolved – it be noted that this report had been withdrawn.

222/15 REPORTS FROM BOARD COMMITTEES

222/15/1 Audit Committee

Resolved – that this item be classed as confidential and taken in private accordingly, on the grounds that public discussion at this stage would be prejudicial to the effective conduct of public affairs.

222/15/2 Integrated Finance, Performance and Investment Committee (IFPIC)

Resolved – that (A) the confidential 27 August 2015 IFPIC meeting Minutes be received and noted, and any recommendations therein endorsed, and

(B) the summary of confidential issues from the 24 September 2015 IFPIC, be noted.

222/15/3 Remuneration Committee

Resolved – that the confidential Minutes of the 3 September 2015 Remuneration Committee be received, and the recommendations and decisions therein be endorsed and noted respectively.

223/15 ANY OTHER BUSINESS

223/15/1 Non-Executive Director Ward Visit 26 November 2015 (Emergency and Specialist Medicine)

The IFPIC Non-Executive Director Chair advised that ESM CMG had invited Non-Executive Directors for a ward visit after the 26 November 2015 IFPIC meeting. The Chief Operating Officer confirmed that Ms S Leak had agreed to continue covering the Head of Operations posts for both Emergency and Specialist Medicine and Renal, Respiratory, Cardiac and Vascular CMGs until 31 March 2016.

Resolved – that the position be noted.

223/15/2 Report by the Director of Corporate and Legal Affairs

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

223/15/3 Report by the Chief Executive

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

224/15 DATE OF NEXT TRUST BOARD MEETING

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

The meeting closed at 12.44pm

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	7	7	100	R Moore	7	7	100
J Adler	7	7	100	C Ribbins	4	3	75
I Crowe	7	7	100	J Smith	3	3	100
S Dauncey	7	5	71	M Traynor	7	6	86
A Furlong	7	7	100	P Traynor	7	7	100
A Goodall	5	4	80	J Wilson	7	7	100
R Mitchell	7	7	100				

Non-Voting Members:

Name	Possible	Actual	% attendance	Name	Possible	Actual	% attendance
D Henson	7	7	100	E Stevens	4	4	100
R Palin	5	3	60	L Tibbert	3	3	100
N Sanganee	1	1	100	S Ward	7	7	100
K Shields	7	5	71	M Wightman	7	7	100