UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF A MEETING OF THE TRUST BOARD, HELD ON THURSDAY 3 NOVEMBER 2016 AT 9AM IN ROOMS 2 & 3, CLINICAL EDUCATION CENTRE, GLENFIELD HOSPITAL

Voting Members present:
Mr K Singh – Chairman
Mr J Adler – Chief Executive
Professor P Baker – Non-Executive Director (from Minute 251/16)
Col (Ret'd) I Crowe – Non-Executive Director
Mr A Johnson – Non-Executive Director
Mr R Moore – Non-Executive Director
Mr B Patel – Non-Executive Director
Ms J Smith – Chief Nurse
Mr M Traynor – Non-Executive Director
Mr P Traynor – Chief Financial Officer

In attendance:
Mr D Henson – LLR Healthwatch Representative (up to and including Minute 260/16)
Ms T Jones – Deputy Director of Communications
Mr M Layton – Charge Nurse (for Minute 252/16/1)
Ms H Leatham – Assistant Chief Nurse (for Minute 252/16/1)
Mr W Monaghan – Director of Performance and Information
Ms H Stokes – Senior Trust Administrator
Ms K Ward – Matron (for Minute 252/16/1)
Mr S Ward – Director of Corporate and Legal Affairs

ACTION

246/16 APOLOGIES AND WELCOME

Apologies for absence were received from Mr R Mitchell, Chief Operating Officer and Mr M Wightman, Director of Marketing and Communications. In their respective absence the meeting was attended by Mr W Monaghan, Director of Performance and Information and Ms T Jones, Deputy Director of Communications.

247/16 DECLARATIONS OF INTERESTS IN THE PUBLIC BUSINESS

The Chairman declared an interest in the Lakeside House practice, as ED front door arrangements were mentioned in the emergency care performance update at Minute 252/16/3 below. He confirmed that he would absent himself from the meeting if members wished to discuss ED front door arrangements in any further detail – in the event it was not necessary for him to withdraw from the discussion.

248/16 MINUTES

Resolved – that the Minutes of the 6 October 2016 Trust Board be confirmed as a correct record and signed by the Trust Chairman accordingly. **CHAIR MAN**

249/16 MATTERS ARISING FROM THE MINUTES

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

(a) action 2b (Minute 218/16 of 6 October 2016) – the Director of Workforce and OD confirmed that this action was complete and that performance against UHL's BME leadership targets was now included in the performance dashboard appended to the

Chief Executive's monthly report;

(b) action 6 (Minute 221/16/1 of 6 October 2016) – in the absence of the Director of Marketing and Communications it was agreed that an appropriate update would be included in the next iteration of the Trust Board matters arising log (re: learning any transferable lessons from the Government's 'Troubled Families' initiative), and **DMC**

(c) action 7a (Minute 222/16/1 of 6 October 2016) – the Director of Workforce and OD confirmed that she would identify the timescale for this action in the next iteration of the Trust Board matters arising log (re: review of establishment/recruitment benchmarks in other staff groups). **DWOD**

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

250/16 CHAIRMAN'S MONTHLY REPORT – NOVEMBER 2016

In respect of the issues highlighted in paper C, the Chairman noted:-

(a) the continued pressures on the Trust's Emergency Department, and the need to ensure that these did not create an imbalance for the Trust's future plans. The Chairman and Non-Executive Director colleagues had recently visited 2 other Trusts to see their Emergency Departments and explore any transferable lessons;

(b) the Trust Board's continuing focus on equality and diversity issues, building on the work of the task and finish group. The January 2017 Trust Board thinking day would discuss equality and diversity issues in further detail (with external speakers present), and review the Trust's progress on these matters. The Chairman's report also outlined his own engagement with the Muslim and Sikh communities in the last month, and **DWOD**

(c) continuing work across the Leicester, Leicestershire and Rutland health economy on the system-wide LLR Sustainability and Transformation Plan (STP). The Trust Chairman noted that UHL's Trust Board remained accountable for the use of UHL resources, and noted also the need for an appropriate level of transparency and engagement with local communities.

<u>Resolved</u> – that equality and diversity issues be discussed further at the January 2017 Trust Board thinking day, with external speakers present. **DWOD**

251/16 CHIEF EXECUTIVE'S MONTHLY REPORT – NOVEMBER 2016

The Chief Executive's November 2016 monthly update followed (by exception) the framework of the Trust's strategic objectives. As the attached quality and performance dashboard covered core issues from the monthly quality and performance report, the full version of that report was no longer taken at Trust Board meetings but was accessible on the Trust's external website (also hyperlinked within paper D). The new template Board Assurance Framework dashboard and the extreme and high risks dashboard were also attached to the Chief Executive's report at appendices 2 and 3 respectively – the full BAF and risk register entries were now detailed in a separate report at Minute 253/16 below. In introducing his report, the Chief Executive noted:-

(a) the Trust's receipt of the CQC comprehensive inspection draft reports, for factual accuracy checking and comment back to the CQC by 16 November 2016. The Chief Nurse was coordinating the process of checking the lengthy draft reports, which were not yet in the public domain;

(b) disappointing performance against a number of national access standards, including the RTT incomplete target and both the 31 and 62 day cancer wait targets. Compliance with the standards in the 'responsive' section of the performance dashboard remained very challenging, given the continuing emergency pressures and the very high referral rates for

both elective and cancer care pathways. This combination continued to cause cancellations and pressures were felt likely to increase over the winter. Efforts to open additional ward capacity had proved difficult due to an inability to recruit sufficient staff, but additional wards would be opened as soon as it was safe to do so. These issues remained a key focus for Executive Directors and were discussed at both Executive Performance Board and Integrated Finance Performance and Investment Committee (IFPIC) meetings;

(c) the submission of the draft LLR STP to NHS England and NHS Improvement on 21 October 2016, feedback on which was now awaited. Even after the STP interventions, there was the potential for a significant capacity shortfall (both emergency and elective) and the situation remained challenging as noted in point (b) above. The LLR health system was keen to place the LLR STP in the public domain as soon as appropriate once feedback had been received;

(d) the generally-positive initial feedback from the GMC visit of 25 October 2016, although the formal report was not expected until the New Year. GMC feedback to date recognised UHL's commitment to training and education, and particularly welcomed the appointment of a Non-Executive Director lead on those issues (Col [Ret'd] I Crowe). No serious patient safety concerns had been raised by the GMC, which was welcomed, and

(e) a clarification that the financial position in section 11 related to an underlying adverse variance of £2m due to underlying runrate issues. Financial control issues had been discussed at the November 2016 Executive Quality Board and were scheduled to be considered further at the November 2016 IFPIC meeting.

In discussing the Chief Executive's November 2016 report, the Trust Board:-

(i) noted the need for appropriate pace and change to be delivered through the LLR STP. The Healthwatch representative commented on the need for appropriate system alignment behind the STP, to ensure a collective commitment and drive. The Healthwatch representative also recognised that delivering the STP would be challenging, and noted Healthwatch's role in that delivery;
(ii) noted confirmation from the Medical Director that the medical training and education quality improvement plan was scheduled for the December 2016 Trust Board – this would reflect both the GMC visit feedback and discussions planned for the November 2016 Trust Board thinking day. Appropriate aspects of the quality improvement plan were already being progressed in the intervening period;
(iii) noted the Healthwatch representative's wish to bring a briefing report to the appropriate UHL Committee following his forthcoming visit to cancer services at the Trust; **COO**
(iv) noted (in response to a query from the Healthwatch representative) the Director of Corporate and Legal Affairs' explanation of the 'segmentation' reference in section 10.6 of paper D;
(v) was advised of encouraging progress on reducing 52-week waits, and
(vi) noted the focus on outpatients at the November 2016 Trust Board thinking day.

<u>Resolved</u> – that the appropriate UHL Committee (EQB/QAC) be identified to receive a briefing from the Healthwatch representative, following his forthcoming visit to UHL cancer services. **COO**

252/16 KEY ISSUES FOR DECISION/DISCUSSION

252/16/1 <u>Patient Story – Post-operative Surgical Care</u>

As detailed in paper E (and accompanying video presentation) from the Chief Nurse, this patient story focused on a negative experience of a patient in post-operative recovery on a

surgical base ward at the Leicester Royal Infirmary. The patient attended for this item, as did the ward Matron and the Charge Nurse. Although the patient had initially had a positive experience in the Urgent Care Centre, his post-operative experience had identified unsatisfactory issues relating to the cleanliness of side rooms, being moved late at night without explanation, a lack of ward staff visibility and discouraged interaction, and the lack of information provided to patients by staff regarding ward admission and ward-orientation.

The staff attending for this item thanked the patient for subsequently raising his concerns with the ward, apologised for his experience and detailed the 8 key changes which had been made as a result of his feedback. These changes included development of a welcome letter and information pack for ward patients; development of a 'bed space checklist' to ensure that side rooms had been cleaned (this was now used across UHL) and appropriate communication with the patient to advise them of the potential need to be moved if required; and measures to raise the visibility and accessibility of ward nursing staff. The patient's view of the National Patient Safety Agency-initiated 'do not disturb' tabards worn by nurses undertaking medication rounds had also been noted, and patients were now informed that such staff wore the tabards as a safety initiative (and that other staff could be contacted via the call bell for any assistance required by patients). The Chief Nurse suggested a potential need to review the use of the 'do not disturb' tabards, as practice varied between teams and there appeared to be little evidence that it reduced medication errors.

In discussion on the patient story, the Trust Board:-

(a) queried how widely the welcome letter (or any alternative) was used across the Trust, and agreed the need to explore developing a personalised local-area-specific version for inclusion in bedside booklets (also including appropriate reference to carers); **CN**
(b) reiterated the importance of good communication with patients, noting that this was a recurring theme within complaints;
(c) noted comments from Healthwatch on not just assuming what information was needed/wanted by patients. The Trust Board agreed that it would be helpful to explore 'mapping out' the patient journey in a consistent and holistic manner, to understand what communication was required with the patient at each stage; **CN**
(d) noted the need to review ward information folders to ensure that they were up-to-date and adequate for patients' needs, and **CN**
(e) thanked the patient for raising his concerns and for attending the meeting today.

<u>Resolved</u> – that (A) it be confirmed how widely the ward welcome letter (or any alternative) was used across the Trust, and to explore developing a personalised local-area-specific version for inclusion in bedside booklets (also including appropriate reference to carers); **CN**

(B) consideration be given to 'mapping out' the patient journey in a consistent and holistic manner to understand what communication was required with the patient at each stage, and **CN**

(C) ward information folders be reviewed to ensure that they were up-to-date and adequate for patients' needs. **CN**

252/16/2 <u>East Midlands Congenital Heart Centre (EMCHC) Update</u>

Further to Minute 219/16/2 of 6 October 2016, paper F updated members on the congenital heart disease (CHD) review, the key actions for immediate attention, and associated risks. UHL's revised self-assessment of its ability to meet the key time-sensitive standards in respect of co-location and numbers was due to be provided to NHS England by 7 November 2016 – this would require a plan which included the recruitment of a 4th Cardiac Surgeon to meet the anticipated growth of cases by 2021. UHL was disappointed by NHS England's

decision that the assessment of the knock-on effect on other services would not now be done jointly between UHL and the regional branch of NHS England, as had initially been agreed on 16 September 2016.

Public consultation was still anticipated to begin during December 2016, and the composition of the panel undertaking the national review of ECMO and PICU provision was now known. Paper F also noted significant local activity in relation to EMCHC, including an Inside Out programme on 31 October 2016, a public demonstration held in Leicester, and ongoing (broadly constructive) discussions with other hospitals regarding referral activity. In response to a Non-Executive Director query, the Director of Marketing and Communications confirmed that Ward 30 would be officially opened on 2 December 2016 by local MPs Liz Kendal and Nicky Morgan – Non-Executive Directors would also be invited accordingly.

Resolved – that the progress update on EMCHC be noted.

252/16/3 Emergency Care Performance

The Trust Chairman reiterated his declaration of interest in relation to Lakeside House and confirmed that he would absent himself from the meeting if this issue was discussed in detail (this did not prove necessary).

Further to Minute 219/16/3 of 6 October 2016, paper G updated the Trust Board on recent emergency care and Clinical Decisions Unit performance. To provide additional assurance to the Trust Board, the expanded report included the latest iteration of the LLR recovery action plan at appendix 1 and advised the Trust Board of progress on 7 key actions within that plan, namely:-

(i) improving utilisation of ambulatory pathways and use of the yellow zone;
(ii) reducing out-of-hours breaches;
(iii) reducing non-admitted breaches;
(iv) improving the streaming/treating and redirecting of patients from the ED front door;
(v) reopening the discharge lounge;
(vi) rolling out the rapid flow “SAFER placement”, and
(vii) reducing the number of patients breaching by 10 minutes or less.

Paper G also advised that the Trust remained under acute operational pressure due to increasing emergency demand, with September 2016 4-hour performance at 79.8% and October 2016 performance at 78.8% as of 16 October 2016. Attendances, admissions and occupancy levels remained high, placing significant pressure on the ED. The September 2016 Sustainability and Transformation Funding (STF) trajectory of 85% had not been achieved, and based on current performance nor would the October 2016 trajectory.

The imbalance between capacity and demand remained a key challenge, and there was no plan in place yet for staffing ward 7 to reduce the beds gap. In addition to this imbalance, the Trust was also facing the challenge of transforming a service whilst simultaneously focusing on the ‘here and now’. Although UHL remained committed to improving internal performance, emergency care performance was a system-wide issue requiring system-wide action.

In discussion on the emergency care performance update, the Trust Board:-

(a) noted a development event held on 2 November 2016 for AE Delivery Board Chairs – the key emerging message had been to focus on system flow, and the Chief Executive had therefore asked the Chief Operating Officer to develop a systematic approach to the ‘red to green’ initiative

(b) noted discussions at the November 2016 EMAS Board re: ambulance handovers. There had been a significant deterioration in performance across the EMAS patch, highlighting the need to address fundamental process issues. UHL's Chairman and Chief Executive intended to meet regularly with their EMAS counterparts;
(c) queried the staffing shortfall for ward 7, noting (in response) the shortage of registered nursing staff. A phased opening was now being explored. For information, the Chief Nurse outlined both the good progress made on HCA recruitment to medicine (with no ED HCA vacancies going into Christmas 2016) and the January 2017 commencement of 30 Nursing Associates, which was welcomed;
(d) queried the position in respect of ward 23a, which was anticipated to open at the start of December 2016;
(e) noted the need for a formal opening of the new non-medical education facility, with appropriate communications in place; **DMC**
(f) commented on the scope to learn ED lessons from elsewhere, eg introduction of short-stay units etc. The Chief Executive considered, however, that UHL had most of the key elements in place but was hampered by capacity constraints and inconsistency of process/practice;
(g) noted a query from the Healthwatch representative on how to get appropriate messages out to the public regarding the steps being taken by UHL to improve ED performance. In response, the Deputy Director of Communications outlined the work in place across LLR to highlight key national messages about using the 111 service, seeking primary care help earlier etc;
(h) suggested exploring the IM&T initiatives being used at the Royal Wolverhampton Trust ED, including (eg) RFID-enabled smartcards on admission; **COO**
(i) received clarification on the meaning of the stranded patient metric;
(j) voiced concern over the rise in delayed transfers of care (DToCs) – this was also a concern for the AE Delivery Board which had requested a further update in 2 weeks' time. However, the Chief Executive noted that LLR DToC levels were lower than in many other areas, and
(k) queried whether there was sufficient 'process expertise' within the system, and the possible need to review this further. Although acknowledging this point, the Chief Executive emphasised that this was not only a process engineering issue, in light of the crucial need to understand clinical process aspects to deliver the SAFER placement and the red to green initiative.

<u>Resolved</u> – that (A) consideration be given to a formal opening event and appropriate communications programme for the new non-medical education and training facility, and **DMC**

(B) the IM&T initiatives being used at the Royal Wolverhampton Trust ED, including (eg) RFID-enabled smartcards on admission, be explored as appropriate. **COO**

253/16 RISK MANAGEMENT

253/16/1 <u>Integrated Risk Report</u>

Paper H comprised the new integrated risk report, presenting the revised 2016-17 Board Assurance Framework (BAF) for endorsement and also summarising any new organisational risks scoring 15 or above (5 were listed – the Medical Director advised that the risk in relation to wards 42 and 43 had been addressed, and he also outlined the decision taken not to progress the Sofia system at this point until it avoided dual systems being used). The Trust Board was also invited to consider whether there were any assurance gaps or inadequate controls in the current Board Assurance Framework. The Medical Director confirmed that the Executive team suite of meetings continued to review specific relevant risks.

The Audit Committee Non-Executive Director Chair confirmed that the Board Assurance

Framework would be discussed in detail by the Audit Committee immediately following today's Trust Board. He noted, however, that nothing had been added to the action plan for principal risk 2 (*failure to provide an appropriate environment for staff/patients*), despite its risk rating having been increased to 16 and a 'red' assurance rating given. He also queried whether the increased risk related to capital constraints. In response, the Medical Director noted advice from the Director of Estates and Facilities that very significant detail underpinned this BAF entry, and he suggested that the Director of Estates and Facilities could be invited to attend the Audit Committee if concerns persisted.

The Healthwatch representative noted that he had been contacted by local media regarding food standards at the Glenfield Hospital, in light of recent Food Standards Agency findings. In light of the results of the March 2016 PLACE audit, he queried whether the Trust Board could receive a report setting out the improvements made on those issues since May 2016. In response, the Chief Executive advised that scheduled November 2016 Executive Quality Board discussions on an estates and facilities performance dashboard had been deferred to the November 2016 Executive Strategy Board to enable sufficient time for debate – it was hoped that such a dashboard would be available from December 2016. The QAC Non-Executive Director Chair also reiterated that the PLACE audit had been undertaken in March 2016 – UHL was performing an internal review however in November 2016, with a report scheduled for either the December 2016 or January 2017 QAC accordingly. He was happy for that report to be shared with the Healthwatch representative. **DEF**

<u>Resolved</u> – that the December 2016/January 2017 QAC report on the internal re-audit of PLACE indicators be shared with the Healthwatch representative **DEF**

254/16 STRATEGY

254/16/1 <u>Sustainability and Transformation Plan (STP), Better Care Together (BCT) and UHL Reconfiguration Programme – Update</u>

This new integrated report at paper I updated members on LLR STP and BCT progress, noting that this set the context for UHL's own reconfiguration programme. The report also outlined the revised timetable for the reconfiguration programme rephased strategic outline case (SOC), which would now be presented to the February 2017 Trust Board thus allowing for appropriate internal discussion at the UHL Reconfiguration Programme Board, Executive Strategy Board and IFPIC en route. As reported in Minute 251/16 above, the draft LLR STP had been submitted to NHS England and NHS Improvement on 21 October 2016 and was broadly consistent with UHL's reconfiguration objectives. Although the STP provided an opportunity to lobby for national capital, UHL continued also to explore potential alternatives such as PF2 options. **CFO**

In terms of operational developments, Ms N Topham had been appointed as the Trust's Reconfiguration Programme Director, and the Reconfiguration Programme Board was now focusing on the need for increased communication and engagement with both internal and external stakeholders (particularly clinical stakeholders). In discussion on paper I, the Trust Board:-

(a) noted comments from Mr B Patel Non-Executive Director on the crucial importance of appropriate public engagement and involvement with the STP, building on the good work already in place via the Better Care Together programme. The Healthwatch representative echoed these comments and noted also that he and Patient Partner colleagues were meeting with UHL's Reconfiguration Programme Director to discuss patient and public involvement input to the reconfiguration projects, and
(b) noted a request for future iterations of this update report to contain fewer acronyms. **CFO**

<u>Resolved</u> – that (A) the timetable for internal Committee consideration of the **CFO**

rephrased reconfiguration SOC be approved as detailed in paper I, culminating in presentation to the February 2017 Trust Board, and

(B) the next iteration of this monthly update report contain fewer acronyms. **CFO**

254/16/2 2-Year Planning Process Guidance

Paper J summarised the recently-published national planning guidance and its implications for UHL's internal planning processes. Key messages from the planning guidance included the need for organisations to produce a 2-year plan covering 2017-18 and 2018-19, aligned to the STP. A 2-year tariff was being set for the first time, and the report also noted that the timescale for producing the 2-year plan was much shorter than usual, as both planning and contracting were required to be concluded by 23 December 2016. This would be extremely challenging.

The Trust Chairman confirmed that this issue would be discussed further at the November 2016 Trust Board thinking day, and that 2 additional Trust Board meetings were also planned in November 2016 and December 2016 for formal sign off of the 2-year operational plan. The Chairman also noted the need for appropriate communication plans to be implemented once the plan was approved. **CFO** **DMC**

Resolved – that (A) the update on the 2-year planning process guidance be noted;

(B) the Trust's operational plans for 2017-18 and 2018-19 be discussed further at the November 2016 Trust Board thinking day and at extraordinary Trust Board meetings to be convened for 24 November and 22 December 2016, and **CFO**

(C) once approved, an appropriate communications exercise take place in respect of the 2-year operational plans. **DMC**

255/16 QUALITY AND PERFORMANCE

255/16/1 Quality Assurance Committee (QAC)

Paper K summarised the issues discussed at QAC's 27 October 2016 meeting, and sought Trust Board approval for the recommended item re: the application to add the 'Dr Chandra Mistry Haemodialysis Unit' at Peterborough Hospital to UHL's CQC registration (for the 'treatment of disease disorder or injury' and 'diagnostic and screening procedures'). The QAC Non-Executive Director Chair also highlighted that Committee's discussion on a never event root cause analysis report; HM Coroner had concluded that the patient's death was not related to the never event but the Chief Nurse noted that there were nonetheless lessons to be learned by the Trust. Following a review of practice, a business case was now in development for the use of pre-filled potassium vials as used by a number of other Trusts. Discussions were also underway regarding the implementation of Trust policies. **MD**

In discussion on paper K, the Healthwatch representative requested a copy of the fractured neck of femur action plan which had been discussed at the October 2016 QAC. **MD**

Resolved – that (A) the summary of issues discussed at the 27 October 2016 QAC be noted (Minutes to be submitted to the 1 December 2016 Trust Board) and any actions progressed as appropriate;

(B) the recommended item re: adding the 'Dr Chandra Mistry Haemodialysis Unit' at Peterborough Hospital to UHL's CQC registration (for the 'treatment of disease disorder or injury' and 'diagnostic and screening procedures') be approved as presented, and **MD**

(C) the fractured neck of femur action plan discussed at the 27 October 2016 QAC be shared with the Healthwatch representative. **MD**

255/16/2 Integrated Finance, Performance and Investment Committee (IFPIC)

Paper L summarised the issues discussed at IFPIC's 27 October 2016 meeting, noting the volume of business discussed.

Resolved – that the summary of issues discussed at the 27 October 2016 IFPIC be noted (Minutes to be submitted to the 1 December 2016 Trust Board).

255/16/3 2016-17 Financial Performance – September 2016

Paper M presented the Trust's month 6 financial position (as discussed in detail at the October 2016 IFPIC). The Trust's deficit position for the year to date (£7.9m) was in line with plan and included £11.7m of STF based on financial and operational performance delivery (on a best endeavours basis) for quarter 2 of 2016-17. The Trust continued to forecast to deliver its planned year-end deficit of £8.3m, although this was not without risk. Agency spend continued to be challenging, and the Chief Financial Officer reiterated his view that UHL was unlikely to achieve the £20.6m cap for 2016-17 (currently £1.3m adverse to plan). Further discussions were scheduled with NHS Improvement on this issue. The Chief Nurse reiterated the efforts being made by UHL to minimise nursing agency spend, but emphasised the challenges posed by nurse staffing shortages and the need to protect quality and safety standards. The Chief Financial Officer noted UHL's relatively low use of agency staff for a Trust of its size, with agency use primarily concentrated in emergency medicine.

As noted in Minute 251/16 above, financial control actions were being discussed at appropriate Executive level meetings, recognising the need to avoid impacting on quality and safety. In response to a query from the Healthwatch representative, the Chief Financial Officer advised that it was appropriate to review requests for non-clinical/non-key posts and assess whether recruitment should proceed. There was no intention to impact on recruitment to key clinical or operational posts however. The Chief Financial Officer also clarified that the financial controls were not linked to cashflow issues. Although the Trust's cash position remained as key focus area, the Chief Financial Officer noted a degree of relaxation in the national rules for accessing cash, which would be of benefit to UHL.

Resolved – that the September 2016 financial position be noted.

256/16 REPORTS FROM BOARD COMMITTEES

256/16/1 Quality Assurance Committee (QAC)

Resolved – that the Minutes of the 29 September 2016 QAC be received and noted, and any recommendations endorsed accordingly.

256/16/2 Integrated Finance Performance and Investment Committee (IFPCI)

Resolved – that the Minutes of the 29 September 2016 IFPIC be received and noted, and any recommendations endorsed accordingly.

257/16 CORPORATE TRUSTEE BUSINESS

257/16/1 Charitable Funds Committee

In introducing the 6 October 2016 Charitable Funds Committee Minutes at paper P, the Non-Executive Director Chair of that Committee advised that the Leicester Hospitals Charity

Accounts 2015-16 had not yet been signed off by External Audit. The accounts would be presented to the Trust Board for approval once that sign-off was received and prior to the 31 January 2017 deadline for Charity Commission submission. In response to a query from the Trust Chairman, the Director of Corporate and Legal Affairs confirmed that the unavailability of signed-off accounts would not impact on the November 2016 Leicester Hospitals Charity Annual General Meeting (AGM), as there was no statutory requirement to present the accounts or annual report at that meeting. It was agreed to confirm the date of the Charity's AGM to Trust Board members, who were encouraged to attend. **CFO** **DMC**

<u>Resolved</u> – that (A) the Minutes of the 6 October 2016 Charitable Funds Committee be received and noted, and any recommendations endorsed accordingly as Corporate Trustee (subject to the clarification above re: availability of the accounts for 2015-16);

(B) the Leicester Hospitals Charity annual accounts 2015-16 be submitted to the Trust Board by January 2017 once signed off by External Audit, and **CFO**

(C) the time and date of the Leicester Hospitals Charity AGM be confirmed to Trust Board members. **DMC**

258/16 TRUST BOARD BULLETIN – NOVEMBER 2016

<u>Resolved</u> – it be noted that no papers had been circulated for the November 2016 Trust Board Bulletin.

259/16 QUESTIONS AND COMMENTS FROM THE PRESS AND PUBLIC RELATING TO BUSINESS TRANSACTED AT THIS MEETING

The following queries/comments were raised in response to the business transacted above:-

(a) a Patient Partner comment on the need for clear communication with patients at all stages of their care journey, even before arriving at hospital. He welcomed the actions agreed as part of the patient story in Minute 252/16/1 above, and noted that the Patient Partners would be very happy to be involved in those actions, and

(b) a Patient Partner comment on the need for effective LLR communication regarding the STP, and his hope that it would be shared publicly as soon as permissible. In response, the Chief Executive considered that the Senior Responsible Officer for the LLR STP had tried to be as open as possible within national constraints, and he reiterated that it was not currently possible to publish the draft STP. The PPI arrangements developed through the Better Care Together programme would also be used for the STP once it could be shared publicly. The Trust Chairman also reiterated that UHL's Trust Board was committed to being as open and transparent as possible.

<u>Resolved</u> – that the queries above and any associated actions, be noted and progressed by the identified lead officer(s). **NAMED LEADS**

260/16 EXCLUSION OF THE PRESS AND PUBLIC

<u>Resolved</u> – 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 261/16 – 270/16), having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.

261/16 DECLARATIONS OF INTERESTS IN THE CONFIDENTIAL BUSINESS

The following members made declarations of interests in items of confidential business – none of the declarations were deemed to be pecuniary in nature or to require those members to absent themselves from the relevant discussions:-

(a) Mr A Johnson Non-Executive Director – Minute 266/16/1, and
(b) Professor P Baker Non-Executive Director and Mr K Singh Trust Chairman – Minute 266/16/2.

262/16 CONFIDENTIAL MINUTES

Resolved – that the confidential Minutes of the 6 and 17 October 2016 Trust Boards be confirmed as a correct record and signed by the Trust Chairman accordingly. **CHAIR MAN**

263/16 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 would be prejudicial to the effective conduct of public affairs.

264/16 REPORT FROM THE CHIEF EXECUTIVE

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

265/16 REPORT FROM THE CHIEF NURSE

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

266/16 REPORTS FROM THE DIRECTOR OF CORPORATE AND LEGAL AFFAIRS

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

267/16 REPORTS FROM BOARD COMMITTEES

267/16/1 Quality Assurance Committee (QAC)

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.

267/16/2 Integrated Finance Performance and Investment Committee (IFPIC)

Resolved – that the confidential Minutes of the 29 September 2016 IFPIC and the confidential summary of the 27 October 2016 IFPIC be received and noted, and any recommendations endorsed accordingly.

268/16 CORPORATE TRUSTEE BUSINESS

268/16/1 Charitable Funds Committee

Resolved – that the Minutes of the 6 October 2016 Charitable Funds Committee be received and noted, and any recommendations endorsed accordingly as Corporate Trustee.

269/16 ANY OTHER BUSINESS

There were no items of Any Other Business.

270/16 DATE OF NEXT TRUST BOARD MEETING

Resolved – that the next Trust Board meeting be held on Thursday 1 December 2016 from 9am in the C J Bond Room, Clinical Education Centre, Leicester Royal Infirmary.

The meeting closed at 1pm

Helen Stokes – **Senior Trust Administrator**

Cumulative Record of Attendance (2016-17 to date):

Voting Members:

Name	Possible	Actual	% attendance	Name	Possible	Actual	% attendance
K Singh	10	10	100	A Johnson	10	10	100
J Adler	10	10	100	R Mitchell	10	7	70
P Baker	7	6	86	R Moore	10	9	90
I Crowe	10	9	90	B Patel	6	6	100
S Dauncey	4	3	75	J Smith	10	10	100
A Furlong	10	8	80	M Traynor	10	9	90
A Goodall	3	2	67	P Traynor	10	10	100

Non-Voting Members:

Name	Possible	Actual	% attendance	Name	Possible	Actual	% attendance
D Henson	8	8	100	L Tibbert	10	9	90
N Sanganee	5	2	40	S Ward	10	9	90
				M Wightman	10	7	70