UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF A MEETING OF THE TRUST BOARD, HELD ON THURSDAY 4 AUGUST 2016 AT 9AM IN ROOMS A&B, EDUCATION CENTRE, LEICESTER GENERAL HOSPITAL

Voting Members present:
Mr K Singh – Chairman
Mr J Adler – Chief Executive
Professor P Baker – Non-Executive Director
Col (Ret'd) I Crowe – Non-Executive Director
Mr A Furlong – Medical 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:
Dr A Bolger – Consultant Cardiologist (for Minute 163/16/2)
Mr H Dagash – Consultant (for Minute 163/16/1)
Mr C Dingwall – Hempson's Solicitors (for Minute 177/16)
Ms C Ellwood – Chief Pharmacist (for Minute 176/16)
Mr D Henson – LLR Healthwatch Representative (up to and including Minute 165/16/2)
Ms T Jones – Deputy Director of Communications
Mr D Kerr – Director of Estates and Facilities (for Minute 175/16)
Ms H Leatham – Assistant Chief Nurse (for Minute 163/16/1)
Mr B Leigh – Hempson's Solicitors (for Minute 177/16)
Ms J Morrissey – Midwifery Matron (for Minute 163/16/1)
Mr T Pearce – Financial Projects Lead (for Minute 176/16)
Ms H Stokes – Senior Trust Administrator
Mr S Ward – Director of Corporate and Legal Affairs

ACTION

157/16 APOLOGIES AND WELCOME

Apologies for absence were received from Mr R Mitchell Chief Operating Officer, Dr M Sanganee LLR CCG representative, and Mr M Wightman Director of Marketing and Communications. The Trust Chairman welcomed Mr B Patel, new UHL Non-Executive Director, to the meeting.

158/16 DECLARATIONS OF INTERESTS IN THE PUBLIC BUSINESS

The Chairman declared an interest in the Lakeside House practice, which was referred to in the emergency care performance update at Minute 167/16/4 below. He confirmed that he would therefore absent himself from the discussion on that item if members wished to discuss the ED front door arrangements in any further detail (in the event, that did not prove necessary).

159/16 MINUTES

Resolved – that the Minutes of the 7 July 2016 Trust Board be confirmed as a correct record and signed by the Trust Chairman accordingly. **CHAIR MAN**

160/16 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 3a (Minute 139/16/2 of 7 July 2016) – the Chairman confirmed that once finalised, a copy of his letter re: EMCHC to the Secretary of State for Health would be included in the weekly EMCHC stakeholder bulletin. **DMC**

<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**

161/16 CHAIRMAN'S MONTHLY REPORT – AUGUST 2016

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

(a) the importance of diversity and equality considerations to the Trust, and the need to be appropriately reflective of the community served by UHL. The Trust Chairman noted his wish for UHL to be an exemplar on this issue;
(b) the issue of how to ensure that all Trust Board members had an appropriately rounded awareness of the multiple issues facing UHL and how to measure success on those issues. Consideration was also needed on how to make the best use of the various expertise around the Trust Board table (both Executive and Non-Executive);
(c) the Trust Board's continuing focus on emergency care performance, and the recognition that performance was not where it was wished to be;
(d) the Trust's commitment to sharing information on the review of children's heart surgery services, and its continued efforts to reverse the stated view of NHS England on this issue;
(e) that requests for information were still being received from the Care Quality Commission (CQC) following its June 2016 inspection of UHL;
(f) his thanks for the valued work by Dr S Dauncey, who had regretfully had to resign as a UHL Non-Executive Director due to personal circumstances. In light of Dr Dauncey's departure, it was proposed that the following changes to the Non-Executive Director Chairing of Trust Board Committees be approved with effect from 14 July 2016:-
    - QAC – Chair to be Col (Ret'd) I Crowe Non-Executive Director, and
    - Charitable Funds Committee – Chair to be Mr A Johnson Non-Executive Director;
(g) a very frank and positive meeting held at the Glenfield Hospital with Mr E Smith, Chairman of NHS Improvement (NHSI) on 18 July 2016, which had also involved visits to the East Midlands Children's Hearts Centre and the Clinical Decisions Unit, and
(h) the very useful Trust Board thinking day in July 2016 hosted by North Luffenham Army Base, which had also involved witnessing field theatre arrangements. The Chairman thanked Col (Ret'd) I Crowe Non-Executive Director for arranging that visit.

<u>Resolved</u> – that the Chairman's August 2016 monthly report be noted.

162/16 CHIEF EXECUTIVE'S MONTHLY REPORT – AUGUST 2016

The Chief Executive's August 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 – in a change to previous reporting practice the full BAF and risk register entries were now detailed in a separate report at Minute 164/16 below. In introducing his report, the Chief Executive noted:-

(a) the continued high level of activity during the summer, both locally and nationally. As discussed at UHL's July 2016 Integrated Finance Performance and Investment Committee (IFPIC), a national 'reset' exercise had now taken place in respect of NHS financial and ED 4-hour waits performance. The Chief Executive confirmed that UHL remained in line with its 2016-17 financial plan and would therefore receive the quarter 1 Sustainability and Transformation Plan funding. However, emergency performance remained a key challenge for the Trust, and

(b) a 'never event' involving the mistaken administration of potassium. A root cause analysis (RCA) of the never event was now underway led by the Chief Nurse, the outcome of which would be reported through the Trust's Quality Assurance Committee. Steps had also been taken to minimise the risk of recurrence. **CN**

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

(i) received a verbal briefing on the NHS paybill growth issue, as recently featured in the media. UHL had been identified as one of the Trusts with high levels of paybill growth, and the Chief Financial Officer clarified that this growth was primarily due to two factors:- the 1 May 2016 transfer of facilities management staff back to UHL employment from IFM, and the transfer of responsibility for the Urgent Care Centre to UHL from George Eliot Hospital NHS Trust. £35m of the £43m growth was accounted for by these two factors;

(ii) noted a query from the Healthwatch as to the reasons for the dip in fractured neck of femur performance, and the plans in place to mitigate this. In response, the Medical Director outlined his recent discussions with the service and noted the agreed intention to move towards a more holistic 'frailty service' approach (as discussed at the July 2016 UHL Quality Assurance Committee [QAC]). The steering group on this issue chaired by the Medical Director would report to the September 2016 meetings of the Executive Quality Board and QAC, and then on to Commissioners in October 2016, although noting that such a redesign of service provision (and the mindset behind it) was a longterm project. The Medical Director was happy to share the July 2016 QAC report with the Healthwatch representative); **MD** **MD**

(iii) noted concerns voiced by the Healthwatch representative over the sustainability of the 62-day cancer target after September 2016, and the ringfencing of beds. The Chief Executive agreed that it was vital to identify a sustainable solution and noted the significant increase in cancer referrals. He had recently written to NHS England regarding the cancer 62-day target, and he was happy to share that letter with the Healthwatch representative, and **CE**

(iv) noted that Healthwatch planned to meet with the CQC to discuss the burden of Regulators' information requests on both primary and secondary care.

<u>Resolved</u> – that(A) the outcome of the administration of potassium never event RCA be reported to QAC; **CN**

(B) outputs from the #NOF steering group be reported to the September 2016 EQB and QAC; **MD**

(C) the July 2016 QAC report on #NOF be shared with the Healthwatch representative, and **MD**

(D) the Chief Executive's letter to NHSE re: the cancer 62-day waits position be shared with the Healthwatch representative. **CE**

163/16 KEY ISSUES FOR DECISION/DISCUSSION

163/16/1 Patient Story – Maternity and Neonatal Experience

As detailed in paper E (and accompanying video presentation) from the Chief Nurse, this patient story was a positive experience of care collaboratively provided from maternity and neonatal services for the safe delivery of a baby diagnosed with an abdominal mass. The baby's parents attended the Trust Board for this item, with the Assistant Chief Nurse, Dr H Dagash Consultant, and Ms J Morrissey Midwifery Matron. As detailed in the video clip, key positives related to the immediate involvement of senior medical and nursing staff once the mass had been detected on the ultrasound scan, the level of communication with the parents throughout the remainder of the pregnancy and during the subsequent (successful) surgical treatment, and the compassionate, honest and dedicated care provided by the medical and midwifery teams at all stages. A key aspect had also been the opportunity for the parents to Skype from theatre recovery, to enable them to view their newborn son on the Neonatal unit. The family commented that the unit had been "remarkable" and praised all the staff involved in their son's care.

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

(a) noted that the tumour removed from the baby's abdomen had weighed 0.5kg (as per photographs now shown to members). In response to a query, Dr H Dagash, Consultant, advised that this type of tumour was extremely rare and he noted the potential complications of the surgery involved. Professor P Baker Non-Executive Director and Dean of the University of Leicester Medical School encouraged Dr Dagash to write up the case accordingly. The Chief Nurse also commented on the need to recognise the impact on staff of such complicated surgical cases;
(b) particularly welcomed the innovative use of Skype, which was now used regularly in the unit for mothers/parents unable to hold their newborns immediately. The family featured in this patient story had been the first ones to use the Skype facility, which was funded through UHL charitable funds. In response to a query it was considered that the Skype facility was used approximately once per week;
(c) noted the parents' reiterated comments on the "fantastic" care provided by UHL's staff, on both a clinical and emotional level. The Trust Chairman noted that the compassion and dedicated of UHL staff had also been recognised by the CQC during its June 2016 visit to the Trust, and
(d) noted a query from Dr Dagash, Consultant, on the scope to review (in light of the rare and complicated surgery successfully performed in this case) the decision for children's cancer services to be located in Nottingham rather than at UHL. **CE/ MD/ COO**

Resolved – that consideration be given to reviewing the provision of children's cancer services in Leicester. **CE/MD /COO**

163/16/2 East Midlands Congenital Heart Centre (EMCHC)

Further to Minute 139/16/2 of 7 July 2016, paper F updated the Trust Board on the actions taken since that date in response to NHS England's stated intention to cease commissioning children's heart surgery from the Glenfield Hospital East Midlands Congenital Heart Centre. Dr A Bolger, Consultant Cardiologist attended the Trust Board for this item and made a presentation (as also delivered recently to stakeholders) which highlighted in particular:-

(a) the background to the current and previous national reviews of children's heart surgery services, and the steps taken by both Government and clinicians since the initial enquiry into Bristol children's heart surgery;
(b) the current position of the EMCHC, noting its excellent evidence-led quality indicators including:-
    - no patient deaths within 30 days of surgery for 18 months;
    - average waiting times of 3 weeks for surgery;
    - a 15% higher chance of paediatric survival at UHL's ECMO (extracorporeal

membrane oxygenation) compared to other ECMO units in England;

(c) queries over the pre-eminence attached to the activity standard within the latest national review. It was also noted that no centre met all 240 standards;
(d) significant concerns arising from any closure of EMCHC, including:-
    - the East Midlands' position as the only region nationally left without a children's heart surgery service;
    - threats to the national ECMO programme;
    - severe additional pressure on nationwide PICU capacity;
    - destabilisation of PICU services in Leicester, threatening overall East Midlands provision;
    - the loss of one of the UK's highest quality services;
(e) the options open to UHL, which included:- negotiation, referral to an IRP, seeking legal advice, and political lobbying and a public campaign, and
(f) the intention of the service to carry on with 'business as usual'. 331 cases had been undertaken in 2015-16 and the Trust was aiming to reach the 375 mark in 2016-17.

The Chief Executive thanked Dr Bolger for his clear presentation, and noted that NHS England had committed to a period of pre-consultation and full public consultation – this therefore opened up access to Scrutiny Committees and formal Secretary of State for Health review. He also noted that NHSE would be considering the issues of ECMO and PICU capacity nationally – UHL's Chief Executive considered that these were issues outstanding from the previous IRP, and noted his intention to highlight such outstanding aspects in the UHL Chairman's letter to the Secretary of State for Health (Minute 160/16 above refers). **CE**

In further discussion on EMCHC, the Trust Board:-

(1) noted the view of the Healthwatch representative that removal of the service would present an increased risk to patients, with no identifiable patient gain. He further noted his hope that there was a central commitment to genuine public consultation;
(2) was assured of the University of Leicester's support for UHL's position, as now reiterated by Professor P Baker Non-Executive Director. He queried whether any elements of the paediatric surgical profession were publicly supporting NHSE's position – in response Dr Bolger outlined various organisations' concerns over the stated intentions, including the Paediatric Intensive Care Society and the British Congenital Cardiac Association. The Chief Executive added that although recognising a certain level of support for the principle of consolidation, UHL considered that the NHSE proposals would cause severe collateral damage to national PICU and ECMO services, whilst any stated gains would be marginal at best;
(3) noted (in response to a Non-Executive Director query) that although outcome data was rigorously audited and widely shared nationally, this was not yet the case for the quality dashboards;
(4) welcomed UHL's mobilisation of information and its collaborative work with stakeholders on this issue;
(5) suggested a need to be clear on the nature of the intended consultation (eg whether it would be NHSE-led). Mr B Patel Non-Executive Director agreed to contact the Chief Executive outside the meeting to discuss any specific concerns further, and Mr M Traynor Non-Executive Director also advised confirming compliance with all of the legal requirements re: public consultation; **BPNED** **DCLA**
(6) queried the reasons for NHSE's view that UHL would not meet the activity requirements, which was not felt to be evidence-based. The Chief Executive also commented on the role played by catchment and commissioning patterns, and
(7) reiterated its full commitment to keeping the EMCHC children's heart surgery service at UHL open.

<u>Resolved</u> – that (A) the issues remaining outstanding from the previous IRP be **CHAIR**

appropriately reflected in the Trust Chairman's letter re: EMCHC to the Secretary of State for Health; **MAN /CE**

(B) any specific concerns about clarifying the nature of the NHSE public consultation, be discussed with the Chief Executive outside the meeting, and **BPNED**

(C) steps be taken to confirm that the legal requirements of formal public consultation were being observed. **DCLA**

163/16/3 Emergency Preparedness and Resilience Response (EPRR) Core Standards

In the absence of the Chief Operating Officer, the Chief Executive sought Trust Board approval for the 2015-16 EPRR self-assessment assurance report and 2016-17 priorities as detailed in paper G. UHL's annual self-assessment ranked the Trust as 91.6% green and 8.4% amber, with no 'red' areas. Major incident training was a key 2016-17 priority and UHL was also working to develop an automatic call-out system for notifying staff of a major incident. As the emergency planning Non-Executive Director lead for UHL, Col (Ret'd) I Crowe also highlighted the third priority of supporting the Trust through the transition to the new Emergency Floor. The Trust Board was assured by the EPRR report, and noted that during 2016-17 Internal Audit would be looking at business continuity.

Resolved – that the 2015-16 EPRR self-assessment assurance report and priorities for 2016-17 be approved as presented.

164/16 RISK MANAGEMENT

164/16/1 Integrated Risk Report

As referred to in Minute 162/16 above, paper H comprised a 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. The Trust Board was also invited to consider whether there were any assurance gaps or inadequate controls in the current Board Assurance Framework. In response to a query regarding one of the organisational risks highlighted within paper H, the Medical Director advised that an audit of DNACPR forms had indicated that the discussion with the patient or family was not consistently being recorded – the relevant CMG (Renal, Respiratory and Cardiovascular) was planning to reaudit this later in August 2016. He also briefly outlined the nature of the other three organisational risks currently rated with a score of 15 or over.

In discussion on the integrated risk report and updated BAF, the Trust Board:-

(a) supported the proposed splitting of BAF principal risk 10 into three separate entries, as detailed in paper H; **DWOD/ MD**

(b) requested that the relevant Executive Lead consider splitting BAF principal risk 18, to separate out cybersecurity risk elements, and **CMIO/ CE**

(c) queried why the June 2016 risk score BAF principal risk 13 had been reduced to 12 (from 16), given the continuing limitations on capital. In response, the Chief Financial Officer clarified that the changed score reflected the view that the 'impact' would be less than previously thought, although the 'likelihood' rating remained the same. The reduced score did not imply that the capital situation itself had altered. The Trust Chairman reiterated his view that a Trust Board thinking day should be used for further discussion on capital. In light of the query raised over this risk score, the Chief Executive noted his view that the method of scoring the more strategic risks needed further review. The Director of Corporate and Legal Affairs agreed to discuss this with the risk team. **CHAIR MAN/ CFO** **DCLA**

Resolved – that (A) BAF principal risk 10 be split into 3 separate components as **DWOD/ MD**

detailed in paper H;

(B) consideration be given to splitting BAF principal risk 18 to separate out cybersecurity risk elements; **CMIO/ CE**

(C) the nature of the BAF scoring matrix for the more strategic issues be discussed with the risk team, and **CHAIR MAN/ CFO**

(D) consideration be given to holding a future Trust Board thinking day on capital. **DCLA**

165/16 STRATEGY

165/16/1 UHL Reconfiguration Programme

This monthly report updated the Trust Board on (i) the governance of UHL's reconfiguration programme; (ii) the position regarding a number of required business cases which had been or would be set up as projects in 2016-17, and (iii) the top 5 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 introducing paper I, the Chief Financial Officer reiterated the continuing uncertainty over the availability of national capital in 2016-17, with further clarity now unlikely before October 2016. Following an internal review, UHL did not consider that its overall capital requirements could be significantly further reduced and still deliver the reconfiguration programme, although the proportion of national capital required had reduced slightly due to the passage of time. Recent discussions with NHS England on the Sustainability and Transformation Plan funding had also touched upon the proposed use of 'PF2' funding to create a blended capital solution for certain developments. The Chief Executive emphasised that PF2 was not the same as PFI, and advised that a further iteration of the capital programme would be developed in due course, following appropriate further consideration.

In discussion on the reconfiguration monthly update, the Trust Board:-

(a) was advised (in response to a query) that capital receipts would be appropriately shown;
(b) reiterated its support for the Trust's overall 3-to-2 strategy, although voicing frustration at the current pace. The Audit Committee Non-Executive Director Chair suggested that UHL explore the development of a short, clearly-articulated business plan for the Trust's 3-to-2 strategy focusing on reconfiguration and PF2, and the delivery of sustainable and safe services; **CFO/ CE**
(c) noted a query from the Healthwatch representative on the Trust's level of confidence that safe, quality services were being delivered despite the delay in national capital approvals, with specific reference to the ITU/vascular moves projects. In response, the Medical Director acknowledged that this was a complex issue which remained a key focus for the Executive Directors – he considered that the Leicester General Hospital ICU service was currently relatively stable due to the existence of a longer term reconfiguration plan;
(d) noted that Mrs N Topham would become the UHL Reconfiguration Programme Director on an interim basis;
(e) noted the detail within paper I in relation to the Theatres/Beds/Longterm ICU capacity projects, project initiation documents for which would be reviewed by IFPIC. The Chief Financial Officer welcomed the fact that Executive/Senior Directors were leading these projects as the SROs, and
(f) noted the additional projects being established in 2016-17, relating to (i) the impact of the reconfiguration programme on diagnostics and support services and (ii) an assessment of the reconfiguration of corporate services.

Resolved – that the development of a short, clearly-articulated business plan for the Trust's 3-to-2 strategy focusing on reconfiguration and PF2, and the delivery of sustainable and safe services, be explored. **CFO/ CE**

165/16/2 LLR Better Care Together (BCT) Programme Update

In the absence of the Director of Marketing and Communications, the Chief Executive introduced the BCT monthly update, and also advised that the LLR Sustainability and Transformation Plan was judged to be in cohort 1 nationally, eg in the group of the best developed plans. Further work was needed on a number of interconnected issues prior to the final October 2016 submission, namely:-

(i) demand management – this would be extremely challenging, with 2 key focus aspects [reducing the number of frail elderly attendances, and urgent community-based care facilities];
(ii) primary care capacity issues (particularly re: Leicester city), and
(iii) improving LLR emergency care performance.

Work on the above aspects was being coordinated by the Managing Director of West Leicestershire CCG, with further plans being discussed at the September 2016 BCT Partnership Board. The Chief Executive commented on the helpful focus being provided by the national STP programme. In discussion on the Chief Executive's verbal update and paper J, the Trust Board:-

(a) noted comments from Non-Executive Directors on the need for the BCT programme to move more quickly out of the planning stage and into implementation. The Chief Executive agreed to feed these comments back to the BCT Programme Board; **CE**
(b) queried how realistic the bedbase reduction assumptions were within BCT, in light of continuing demand challenges;
(c) noted (in response to a Non-Executive Director query) that the BCT assurance process had been temporarily superseded by the STP process – the Chief Executive was seeking confirmation from NHS England re: the timescale for public BCT consultation, and
(d) noted reiterated comments on the high level of financial consistency between UHL's own 5-year plan, BCT, and the STP.

Resolved – that the Trust Board's comments on the need for more rapid movement into implementation phase, be fed back to the BCT Programme Board. **CE**

166/16 WORKFORCE AND ORGANISATIONAL DEVELOPMENT (OD)

166/16/1 Medical Workforce Strategy

The Medical Director and the Director of Workforce and OD jointly presented paper K, outlining work on UHL's medical workforce strategy and also providing a specific update on recruitment to and development of new roles. The latest position re: medical workforce vacancies and medical appraisal/revalidation was also detailed in paper K. The Trust Board noted in particular:-

(a) the significant work undertaken re: non-training grades, with a rolling central recruitment process now in place. Although successful, the Medical Director noted the cost pressures associated with making appropriately-attractive offers to non-training grade doctors;
(b) the recent arrival of 4 Physicians Associates from America, who had started work at UHL on 4 July 2016 in paediatrics, orthopaedics [spine and trauma] and gastroenterology;

(c) continued work to support the development of Advanced Nurse Practitioners, with 37 such posts in place across UHL. Further work was needed however re: longterm sustainable funding for the training and deployment of ACP posts within the Trust;
(d) good progress on job planning, medical appraisal and revalidation;
(e) development of a new microsite acting as a single portal for marketing both Leicester as a place to live and work, and the specific benefits of working for UHL;
(f) plans to provide information on medical staff premium spend in future updates. There was increasing movement both nationally and locally towards publishing internal locum rates, and within UHL CMGs had agreed the need for internal consistency on such rates;
(g) the recent launch of the 'United' Hospitals of Leicester initiative, and
(h) comments from Professor P Baker Non-Executive Director that Health Education East Midlands had now ceased to exist, replaced by a new structure covering the Midlands and East of England. It was not yet clear how this would impact on UHL, and the Trust's Medical Director noted the need to ensure that UHL needs were not lost within a larger patch.

The Trust Chairman also sought assurance that all Consultant vacancies were reviewed to assess whether they were still required in that form. In response, the Medical Director outlined the tiered process in place to review and approve Consultant recruitment, and noted his view that there was an appropriate level of challenge in place. The Chairman noted this update and suggested it would also be helpful for IPFIC to receive a report on Consultant workforce planning, providing assurance that vacancies were appropriately reviewed to confirm the continuing need for the post. Non-Executive Directors also requested that future iterations of appendix 3 of paper K (Consultant vacancy position by service) include a prioritised RAG rating. **MD/ DWOD** **MD/ DWOD**

<u>Resolved</u> – that (A) a future IFPIC meeting receive a report on Consultant workforce planning, providing assurance that vacancies were appropriately reviewed to confirm the continuing need for the post, and **MD/ DWOD**

(B) future iterations of the list of Consultant vacancies by service (appendix 3 of paper K) include a prioritised RAG rating. **MD/ DWOD**

166/16/2 <u>Equality Delivery System (EDS) and Workforce Race Equality Standard (WRES) Updates</u>

Paper L presented the EDS 6-monthly update and sought Trust Board approval for (i) UHL's 2016 WRES submission to NHS England and (ii) adopting the British Sign Language Charter. Although there was no cost associated with the Charter, there were some training implications. The report also set out progress on the action plan arising from the equality and diversity task and finish group convened by the Trust Chairman (which had reported its findings to the Trust Board in March 2016). In discussion on the report the Trust Board:-

(a) noted a number of new initiatives underway, including UHL's in-principle agreement to work with the Institute of Health Improvement on using the Quality Improvement Methodology to close the gaps in the workplace experience of BME and White staff;

(b) noted work to implement positive action interventions as part of UHL's recruitment and retention strategy, including targeting of hard to reach groups and work to attract Non-Executive Directors from under-represented communities/sectors;

(c) noted that CMG-level workforce data was now captured and RAG rated in terms of BME/White unspecified staff at all bandings;

(d) voiced concern at the finding that BME staff were more likely to experience discrimination than White staff, and queried the exact wording of that finding – the Director of Workforce and OD agreed to clarify this outside the meeting. Non-Executive Directors **DWOD**

also noted the need to consider how best to learn lessons from other organisations and sectors and adopt a creative approach re: improving the experiences of BME staff; **DWOD**

(e) noted the Trust's ageing workforce and the need therefore to make the best use of the internal talent coming through;

(f) noted a query form the Chairman on whether WRES performance should be recorded on the monthly dashboard appended to the Chief Executive's Trust Board report. In response, the Chief Executive advised that although some of the WRES timescales did not align to a monthly dashboard, the Trust Board had already committed to including the BME leadership target performance on that dashboard, and **DWOD**

(g) requested that the next 6-monthly update also cover information on outcomes in addition to progress updates. **DWOD**

Resolved – that (A) the precise wording of the finding re: BME staff experiencing discrimination be confirmed to members outside the meeting; **DWOD**

(B) consideration be given to how best to learn lessons from other organisations and sectors and adopt a creative approach re: improving the experiences of BME staff; **DWOD**

(C) the inclusion of the BME leadership targets on the dashboard appended to the Chief Executive's monthly Trust Board report be pursued; **DWOD**

(D) UHL's proposed sign-up to the British Sign Language Charter be approved, noting that a signing ceremony would be held in October 2016; **DWOD**

(E) UHL's 2016 WRES submission be approved and lodged with NHSE accordingly, and **DWOD**

(F) the next 6-monthly equality update (February 2017) also include information on outcomes. **DWOD**

166/16/3 UHL Way Update

Paper M updated the Trust Board on delivery of the 2016-17 UHL Way implementation plan, and reminded members of the 3 main components of the UHL Way (Better Engagement, Better Teams, and Better Change) as supported by the UHL Academy (web portal also in development). Discussions were also underway regarding the development of a potential 'LLR Way', and LPT NHS Trust was interested in UHL's Listening into Action approach. In discussion, the Trust Board noted the good progress being made on this issue.

Resolved – that the UHL Way update be noted.

167/16 QUALITY AND PERFORMANCE

167/16/1 Quality Assurance Committee (QAC)

Paper NM from the QAC Non-Executive Director Chair summarised the issues discussed at that Committee's 28 July 20165 February meeting. identified the key issues from that meeting as UHL's request to the Health & Safety Executive for a May 2016 extension to the sharps Improvement Notice.

Resolved – that the summary of issues discussed at the 28 July 5 February 2016 QAC be noted (Minutes to be submitted to the 1 September 7 April 2016 Trust Board).

167/16/2 Integrated Finance, Performance and Investment Committee (IFPIC)

Paper O from the IFPIC Non-Executive Director Chair summarised the issues discussed at that Committee's 28 July 2016 meeting, particularly noting discussion on the Trust's working capital strategy and cashflow issues. The Chief Financial Officer confirmed that he had established a weekly Cash Committee, and he advised that the factors behind the current cash position would be explored in further detail by IFPIC.

Resolved – that (A) the summary of issues discussed at the 28 July 5 February 2016 IFPIC be noted (Minutes to be submitted to the 1 September 7 April 22016 Trust Board)., and

CFO/

(B) the paediatric dentistry and daycase surgery business case be approved as recommended by the February 2016 IFPIC..

167/16/3 2016-17 Financial Performance – June 2016

Paper PO presented the Trust's month 3 financial position (as discussed in detail at the July 2016 IFPIC), noting that the Trust's deficit position for the year to date was in line with plan. UHL was ahead on its cost improvement programme as of quarter 1 of 2016-17, with the current position being £1.1m favourable to plan. Agency expenditure for the year to date was £6.5m compared to planned expenditure of £6m (therefore £0.4m adverse to plan), and the Chief Financial Officer repeated his previous comments that UHL's 2016-17 £20.6m agency spend cap would be challenging. In discussion on the financial performance update, Mr A Johnson Non-Executive Director requested that the 'improved profit' and 'cost reduction' elements of the 2016-17 cost improvement programme be separated out in future CIP update reports – it was agreed to do so for future IFPIC iterations. **CFO**

Resolved – that for ease of understanding, the 'improved profit' and 'cost reduction' elements of the 2016-17 cost improvement programme be separated out in future CIP update reports to IFPIC. **CFO**

167/16/4 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 discussion if the Trust Board wished to cover those aspects in detail (this did not prove necessary). Further to Minute 144/16/4 of 7 July 2016, paper Q updated the Trust Board on recent emergency care and Clinical Decisions Unit performance. The report advised that the Trust remained under acute operational pressure due to increasing emergency demand, with July 2016 4-hour performance at 80.6% to date. Emergency care performance issues had been discussed in detail at the July 2016 Trust Board thinking day, noting the main drivers of [i] the demand and capacity imbalance, and [ii] sub-optimal internal processes. A new Trust action plan was in development to address those internal issues, and an updated UHL emergency care governance process was also appended to paper Q. The NHSE/NHSI/ADASS letter re: the 2016-17 A&E Improvement Plan (part of the 'reset' referred to in Minute 162/16 above) was also attached to paper Q, and the Chief Executive noted that he would chair the local A&E Delivery Board. In response to a query, he outlined the Local Authority level input to that group. The Chief Executive also highlighted his recent discussions with the Secretary of State for Health regarding emergency performance (current performance recognised to be unacceptable).

In further discussion, the Chief Executive specifically highlighted the recommendation within paper Q that at the LRI access to beds should be prioritised for cancer and RTT patients, noting that medical capacity would be increased by the planned use of ward 7 to avoid medical outliers. **COO**

The Trust Board also discussed the Trust's engagement with ECIP (Emergency Care

Improvement Programme); verbal feedback from the 3-day diagnostic in ED had identified 5 key priorities for the new ED leadership team and was welcomed by UHL. Further ECIP resources would be made available in the Autumn, focusing on the LLR emergency system as a whole. It was also noted that the EMAS Chairman had requested a meeting with the UHL Chairman to discuss ambulance handover issues.

The Chief Executive also noted a meeting later on 4 August 2016 with Commissioners to discuss the next steps in respect of the Urgent Care Centre – an update would be provided accordingly to the September 2016 Trust Board. **COO**

Resolved – that the recommendation in paper Q that at the LRI access to beds should be prioritised for cancer and RTT patients be agreed, and **COO**

(B) an update on next steps re: the Urgent Care Centre be provided to the September 2016 Trust Board. **COO**

168/16 REPORTS FROM BOARD COMMITTEES

168/16/1 Audit Committee

Paper R comprised the Minutes of the 7 July 2016 Audit Committee, seeking Trust Board approval for the 2015-16 External Audit Annual Audit Letter as recommended in (and appended to) those Minutes.

Resolved – that the Minutes of the 7 July 2016 Audit Committee be received and noted, and any recommendations endorsed accordingly, including the 2015-16 External Audit Annual Audit Letter.

168/16/2 Quality Assurance Committee (QAC)

Resolved – that the Minutes of the 30 June 8 January 2016 QAC be received and noted, and any recommendations endorsed accordingly.

16816/3 Integrated Finance Performance and Investment Committee (IFPCI)

Resolved – that the Minutes of the 30 June 8 January 2016 IFPIC be received and notedreceived , and any recommendations endorsed accordingly. and noted, and any recommendations approved accordingly.

169/16 TRUST BOARD BULLETIN – AUGUST 2016

Resolved – that paper 1 of the August 2016 Trust Board Bulletin be noted, comprising declarations of interest for:-

(1) Professor P Baker, Non-Executive Director – minority shareholder of Metabolomic Diagnostics; Trustee of 'The Bridge' (charity), and
(2) Mr B Patel, Non-Executive Director - member of PPG Highfields Surgery.

170/16 QUESTIONS AND COMMENTS FROM THE PRESS AND PUBLIC RELATING TO BUSINESS TRANSACTED AT THIS MEETING

A public attendee commented on Health Education East Midlands and work by Derby Hospitals re: overseas nurse language skills – in response Professor P Baker Non-Executive Director reiterated his concerns over the recent ending of Health Education East Midlands, as noted in Minute 166/16/1 above.

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

171/16 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 172/16 – 180/16), having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.

172/16 DECLARATIONS OF INTERESTS IN THE CONFIDENTIAL BUSINESS

There were no declarations of interests made in respect of the confidential business.

173/16 CONFIDENTIAL MINUTES

Resolved – that the confidential Minutes of the 7 July 2016 Trust Board be confirmed as a correct record and signed by the Trust Chairman accordingly. **CHAIR MAN**

174/16 CONFIDENTIAL MATTERS ARISING REPORT

Resolved – that the confidential matters arising report be noted.

175/16 JOINT REPORTS FROM THE DIRECTOR OF FACILITIES AND ESTATES AND THE DIRECTOR OF WORKFORCE AND OD

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

176/16 REPORTS FROM THE CHIEF FINANCIAL OFFICER

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

177/16 REPORT FROM THE DIRECTOR OF CORPORATE AND LEGAL AFFAIRS

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

178/16 REPORTS FROM BOARD COMMITTEES

178/16/1 Audit Committee

Resolved – that the confidential Minutes of the 7 July 2016 Audit Committee be received and noted, and any recommendations endorsed accordingly.

178/16/2 Quality Assurance Committee (QAC)

Resolved – that (A) the confidential Minutes of the 30 June 2016, and

(B) the summary of confidential issues from the 28 July 2016 QAC be received and noted, and any recommendations endorsed accordingly (Minutes to be submitted to the 1 September 2016 Trust Board).

178/16/3 Integrated Finance Performance and Investment Committee (IFPIC)

Resolved – that this Minute be classed as confidential and taken in private

accordingly on the grounds that public consideration at this time would be prejudicial to the effective conduct of public affairs.

179/16 ANY OTHER BUSINESS

179/16/1 Report from 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.

180/16 DATE OF NEXT TRUST BOARD MEETING

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

The meeting closed at 2.25pm2.25

Helen Stokes – **Senior Trust Administrator**

Cumulative Record of Attendance (2016-175-16 to date):

Voting Members:

Name	Possible	Actual	% attendance	Name	Possible	Actual	% attendance
K Singh	5	511	10092	A Johnson	5	5	100
J Adler	5	512	100100	R Mitchell	5	4	80
P Baker	2	2	100	R Moore	5	4	80
I Crowe	5	5	100	B Patel	1	1	100
S Dauncey	4	3	75	J Smith	5	5	100
A Furlong	5	4	80	M Traynor	5	5	100
A Goodall	3	2	67	P Traynor	5	5	100

Non-Voting Members:

Name	Possible	Actual	% attendance	Name	Possible	Actual	% attendance
D Henson	512	512	100100	L TibbertE Stevens	5	44	80100
N SanganeeR Palin	55	2	4060	S WardL Tibbert	58	57	10087
N Sanganee	6	3	50	M WightmanS Ward	512	412	80100
K Shields	11	7	64	M Wightman	12	11	92