UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF A MEETING OF THE TRUST BOARD, HELD ON THURSDAY 5 MAY 2016 AT 9AM IN ROOMS 2 & 3, CLINICAL EDUCATION CENTRE, GLENFIELD HOSPITAL

Voting Members present:
Mr K Singh – Chairman
Mr J Adler – Chief Executive
Col (Ret'd) I Crowe – Non-Executive Director
Dr S Dauncey – Non-Executive Director
Mr A Furlong – Medical Director
Professor A Goodall – Non-Executive Director
Mr A Johnson – Non-Executive Director
Mr R Mitchell – Chief Operating Officer
Mr R Moore – Non-Executive Director
Ms J Smith – Chief Nurse
Mr M Traynor – Non-Executive Director
Mr P Traynor – Chief Financial Officer

In attendance:
Ms E Gyesi-Appiah – Matron (for Minute 94/16/1)
Mr D Henson – LLR Healthwatch Representative (up to and including Minute 100/16)
Mr D Kerr – Director of Estates and Facilities (for Minute 104/16)
Ms H Leatham – Assistant Chief Nurse (for Minute 94/16/1)
Mr P Molloy – Comptons (for Minute 105/16)
Ms A Reynolds – Volunteer Services Manager (for Minute 94/16/2)
Professor D Rowbotham – EMCRN Director (for Minute 95/16)
Ms Z Sotta – Ward Sister (for Minute 94/16/1)
Ms H Stokes – Senior Trust Administrator
Ms L Tibbert – Director of Workforce and OD
Ms J Tucker – Comptons (for Minute 105/16)
Mr S Ward – Director of Corporate and Legal Affairs
Mr M Wightman – Director of Marketing and Communications (from Minute 96/16)

ACTION

88/16 APOLOGIES AND WELCOME

Apologies for absence were received from Dr N Sanganee, LLR CCG representative.

89/16 DECLARATIONS OF INTERESTS IN THE PUBLIC BUSINESS

The Chairman declared an interest in the Lakeside House practice, which was referred to in the month 12 finance report at Minute 96/16/3 below, and confirmed that he would 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, it was not necessary for the Chairman to absent himself from the discussion on that report.

90/16 MINUTES

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

91/16 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 2 (Minute 71/16 of 7 April 2016) – it was confirmed that the Deputy Chief Nurse

had made contact with the Healthwatch representative on that issue, and

(b) action 3a (Minute 73/16/2 of 7 April 2016) – the Chief Operating Officer confirmed that he would cover Glenfield Hospital Clinical Decisions Unit (CDU) issues in his report on emergency performance at Minute 94/16/3 below).

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

92/16 CHAIRMAN'S MONTHLY REPORT – MAY 2016

In respect of the issues highlighted in paper C, the Chairman noted both the key capacity and demand challenges facing the Trust, and the potential impact of constrained national capital availability on UHL's ambitious reconfiguration programme. He also noted that former Interserve FM employees had transferred back to Trust employment as of 1 May 2016. The Trust remained open, however, to future commercial partnerships if that was in the best interests of its patients, and the Chairman emphasised that quality must be the driving factor in any such partnerships. A future Trust Board thinking day would review the various types of partnership working open to the Trust. **DMC**

The Chairman also confirmed that an advertisement had been placed for a new UHL Non-Executive Director and for a new (non-voting) 'Associate Non-Executive Director'. While all appointments would be made on merit, the Chairman recognised the relative lack of diversity on UHL's current Trust Board.

Resolved – that the various types of potential partnership working be discussed at a future Trust Board thinking day. **DMC**

93/16 CHIEF EXECUTIVE'S MONTHLY REPORT – MAY 2016

The Chief Executive's May 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 therefore no longer considered separately at the Trust Board meetings but were available on the Trust's external website and also hyperlinked through paper D.

In introducing his report, the Chief Executive noted:-

(a) its focus on the Trust's priorities for 2016-17. The launch of the Leicester Academy for the Study of Ageing had been added to the priority of 'an enhanced reputation in research, innovation and clinical education' and was not yet reflected in the current iteration of UHL's 2016-17 Annual Operational Plan;

(b) that all contracts had now been signed with Commissioners. The settlement was deemed to be reasonable, and the agreed contracts did not adversely affect the basis of either UHL's financial plan or its 2016-17 Annual Operational Plan. The Chief Executive thanked the Chief Financial Officer and his team for their work in finalising the contracts;

(c) that although the Trust's preparations for the April 2016 all-out junior doctors' strike had worked well, elective activity had needed to be sacrificed and he recognised the impact of this upon patients. Although UHL recognised the potential work-life balance impact of the new contract and was keen to work with junior doctors to mitigate this as far as possible, the new contract would nonetheless have to be implemented from 1 August 2016. the Medical

Director noted that progress was also being made on the issue of the Safe Working Guardian, and

(c) (in response to a query) that emergency care performance would be discussed in detail in Minute 94/16/3 below, and financial performance under the month 12 finance report at Minute 96/16/3 below, while the Sustainability and Transformation Funding improvement trajectories were covered in the 2016-17 Annual Operational Plan (Minute 94/16/6 below).

In discussing the Chief Executive's May 2016 report, the Trust Board noted queries from the Healthwatch representative relating to:-

(i) how in-year progress on the 2016-17 annual priorities would be monitored – although recognising that different performance areas were reported on through a number of individual Trust Board reports the Healthwatch representative suggested that a consolidated summary would also be helpful for the public. In response the Chief Executive confirmed that he provided a quarterly RAG-rated summary of progress to the Trust Board through his Chief Executive's report, and he advised that the Director of Corporate and Legal Affairs was currently reviewing each priority to ensure an appropriate reporting line was in place. In further discussion on monitoring progress against the annual priorities, the Trust Chairman suggested that the August 2016 Trust Board thinking day with UHL's partner organisations should seek their views on what further information (if any) was needed at the Trust Board, and **CE/ DMC**

(ii) his concern over the non-achievement of the fractured neck of femur performance target in March 2016. As noted in paper C, the QAC Non-Executive Director Chairman confirmed that this issue had been discussed at length at QAC's April 2016 meeting, with the underlying granular detail now being reviewed by the Medical Director outside the meeting. A contingency plan was in development, as referenced in the April 2016 QAC summary in Minute 96/16/1 below.

<u>Resolved</u> – that the 11 August 2016 Trust Board thinking day seek partner organisations' views on the clarity/adequacy of the information presented to the public Trust Board re: in-year progress against UHL's annual priorities. **CE /DMC**

94/16 KEY ISSUES FOR DECISION/DISCUSSION

94/16/1 <u>Patient Story – "a quick hello and a smile makes a difference" (specialist medical ward, Leicester Royal Infirmary)</u>

Paper E (and accompanying DVD) from the Chief Nurse advised the Trust Board of the negative experience of the family of a patient admitted to a specialist medical ward at the LRI in late 2015. The story covered concerns relating to dignity at mealtimes and the behaviour and attitude of staff members. The patient's daughter (who was also her main carer) attended for this item, and recounted how her mother had not been given the required assistance at mealtimes, and had been left with a drink spilled in her lap, in addition to finding one or two individual staff rude. The Ward Sister and the Matron were both in attendance for this patient story, and they apologised for the shortcomings experienced by the patient and her family and thanked them for bringing them to their attention. They then outlined the steps taken by the ward to address the concerns raised, including:-

(i) discussing the concerns with the staff involved, who now recognised that their behaviour had been unacceptable and were sorry for the resulting poor experience. The staff were now being monitored and supported by the management team to ensure that they reflected Trust values in their dealings with patients and relatives;
(ii) wide sharing of the "if looks could kill" Patient Experience Team video and participation on a customer care course;

(iii) introduction of a weekly 'afternoon tea' event providing a designated time when staff could talk to patients and their families about their experiences on the ward, and
(iv) changes in practice to address the dignity at mealtimes issues raised by this story, including promotion of Protected Mealtimes on the ward, and ensuring that patients' hands and face were washed before and after meals.

The Assistant Chief Nurse also noted that the patient's relative had agreed to come back into the Trust and do a '15-step challenge' to see the improvements made and advise on any further measures needed.

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

(a) thanked the patient's relative for sharing this story, although it had been uncomfortable to hear. The Trust was keen to share such stories transparently, and to learn from and respond to poor patient experience;
(b) noted (in response to a query) that although the ward's Friends and Family Test scores had never been bad, there had previously been more negative comments, whereas since the steps had been taken to address the concerns from this story the patient comments were now all positive. The March 2016 FFT score for the ward stood at 99%. The QAC Non-Executive Director Chair clarified that QAC did also review the patient comments in the FFT, not only the score;
(c) welcomed the emphasis on helping staff improve their poor attitude/behaviour, and
(d) noted the power of hearing such comments from a patient and/or their relative, and how this really impacted on staff.

<u>Resolved</u> – that the ward 27 end of life care patient story be noted, and

(B) the Chief Nurse write to the patient's family on behalf of the Trust Board, thanking them for sharing their story.

94/16/2 <u>Volunteers' Annual Report 2015-16</u>

The Trust's Volunteer Services Manager attended to introduce the Volunteers' Annual Report for 2015-6 (paper F), detailing the work of the Trust's 659 volunteers. The report acknowledged the invaluable resource provided by the Trust's flexible and committed volunteers, who were constantly seeking ways to improve the patient journey through UHL's hospitals. All UHL volunteers were clearly identifiable through the wearing of aqua blue polo shirts and ID badges, and the Trust worked closely with other volunteering organisations to ensure that it was meeting national volunteering standards. The Trust was also currently focusing on how to attract more volunteers from both younger and older age cohorts, and on how best its volunteers could be utilised within the new Emergency Floor.

The Trust Board welcomed this update on the work of UHL volunteers, who were greatly appreciated by the Trust. In discussion on this issue the Trust Board:-

(a) queried the scope for volunteers to deliver newspapers to patients on the wards (and also the scope for a related agreement with the local press for provision of local papers). The Chief Nurse agreed to pursue this suggestion, although it was noted that issues re: existing newsagent provision on-site might also need be taken into account; **CN**
(b) received (in response to a query) an explanation of UHL's 'e-greeting' service, which involved UHL's volunteers printing and delivering messages to patients which friends and family had left on a dedicated website. This was a very popular service and had been adopted by several other Trusts;
(c) queried whether the split of volunteer placement across UHL's sites reflected the need on those sites or the volunteers' own preferences. In response, the Volunteer Services Manager advised that the LRI was the most popular site for volunteers

because it was busier and easier to attend;

(d) queried the scope to extend the reception 'meet and greet' service to all areas, as per the US model. Although welcoming this suggestion (which had been adopted in some other Trusts), the Volunteer Services Manager noted that volunteers liked to be busy and thus tended to prefer being placed in reception areas;

(e) noted comments from the Volunteer Services Manager that more visible recognition of the work of volunteers would help with recruitment of other volunteers. Realistic management of volunteers' expectations was also important. The Chairman encouraged his Trust Board colleagues to attend the UHL Volunteers Awards evenings, if available; **CN**

(f) queried how wards ensured that enough mealtime assistance volunteers were available at breakfast time, noting (in response) that the UHL volunteer services team worked closely with wards on this issue;

(g) suggested that younger volunteers might be interested in helping patients understand and access social media, and

(h) suggested that local media might be interested in running a story on the work of UHL volunteers, including possibly interviewing some of them. **DMC/CN**

<u>Resolved</u> – that (A) the Volunteer Services Annual Report 2015-16 be noted;

(B) the scope for volunteers to deliver newspapers to patients on the wards (and the scope for a related agreement with the local press for provision of local papers), be explored; **CN**

(C) details of the UHL Volunteers' awards evening be circulated to Trust Board members, with a view to them attending if available, and **CN**

(D) consideration be given to inviting local media to run a story on the work of UHL volunteers. **DMC/CN**

94/16/3 <u>Emergency Care Performance</u>

Further to Minute 73/16/2 of 7 April 2016, paper G from the Chief Operating Officer updated the Trust Board on recent emergency care performance. March 2016 performance stood at 77.8% compared to 90.1% in March 2015, and the poor performance had continued into month 1 of 2016-17 (79.8%) despite a certain plateau-ing of admission and attendance levels. The long-continued winter pressures did now seem to be easing somewhat, and the Trust was now revisiting its ED plan and hoped to see 3-4 months of sustainable improvement. However, forecast emergency admissions for 2016-17 remained of concern, given the imbalance between capacity and demand. Work would now focus on longer-term solutions relating to admission avoidance, preventative care, improvements to the discharge process and addressing that capacity and demand imbalance.

The Chief Operating Officer confirmed that as of the June 2016 Trust Board his report would also cover issues relating to the Glenfield Hospital CDU. In discussion on the report the Trust Board noted:- **COO**

(a) comments from the Chief Executive on the need for further work on ambulance handovers, despite some sustainable improvements already having been seen. April 2016 EMAS data indicated a 56% reduction in lost time from the November 2015 peak, and UHL was no longer the worst performer in the EMAS catchment area. In response to a query from the QAC Non-Executive Director Chair, the Chief Executive considered that it was difficult to isolate one individual deciding factor for the improvement;

(b) comments from Col (Ret'd) I Crowe Non-Executive Director on the need to focus attention on those issues within UHL control, such as the physical ED space and ED team performance. In response to additional comments from Mr A Johnson Non-Executive

Director, the Chief Operating Officer outlined the physical changes being made to ED to increase capacity – he also noted the need to address flow issues and ensure that overall processes were improved ahead of the new Emergency Floor opening;

(c) that the 2016-17 demand and capacity would be presented to the June 2016 Trust Board (which would also include the impact of wider LLR measures). The Chief Operating Officer outlined plans to increase the number of medical beds available, both currently and at the end of summer – in discussion the Chief Nurse noted that she would need also to review the planned staffing of those additional wards; **COO** **CN**

(d) a query from the Healthwatch representative as to when a robust plan for winter 2016 might be available. The Trust Chairman suggested that progress be shared with partner organisations at the August 2016 Trust Board thinking day, and views sought accordingly on what further measures might be needed, and **COO**

(e) a query from the Non-Executive Director Audit Committee Chair as to whether a robust risk assessment of winter 2016 had been undertaken (ie the demand/capacity imbalance and its impact). The Chairman proposed that a holistic risk assessment (appropriately triangulating performance, quality and safety, and financial issues) be discussed at a future Trust Board thinking day. The Chief Executive also noted the need for the Executive Team to ensure that it had a comprehensive picture of all of the capacity initiatives planned. **COO**

<u>Resolved</u> – that (A) future such reports to the Trust Board cover the Glenfield Hospital CDU as well as the ED; **COO**

(B) the 2016-17 demand and capacity plan be presented to the 2 June 2016 Trust Board; **COO**

(C) the 11 August 2016 Trust Board thinking day with partner organisations share progress on emergency care pressures and invite views on further measures needed; **COO**

(D) the planning for the staffing requirements of the planned additional medical wards be reviewed, and **CN**

(E) a future Trust Board thinking day explore a holistic risk assessment of the 2016-17 demand and capacity current imbalance. **COO**

94/16/4 <u>UHL Reconfiguration Programme</u>

This monthly report 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. The Chief Financial Officer confirmed that a new format report would be presented from June 2016 onwards.

In terms of key workstream deep dives, paper H focused on the Emergency Floor project, noting the March 2017 timescale for completion of phase 1. The Chief Financial Officer was currently reviewing the need for a significant increase in project resource, and he also noted key Emergency Floor challenges around (i) workforce and OD issues and (ii) IT systems in the absence of an electronic patient record (EPR). In discussion on the reconfiguration update the Trust Board:-

(a) supported the need for appropriate resourcing of UHL's reconfiguration project as a whole, and
(b) noted Non-Executive Director views that the level of challenge/difficulty seemed to be rising rather than decreasing, and queries on whether delivery was realistic. Non-Executive Directors also sought clarity on when the reconfiguration roadmap would

be available. In response, the Chief Executive noted that this was difficult in the absence of clarity on the national availability of capital, which was felt unlikely to emerge before the end of June 2016. Although echoing that view, the Chief Financial Officer acknowledged a need to include more specific timelines in the reconfiguration action log, and he agreed also to include critical decision points where known. **CFO**

Resolved – that information on critical decision-making points be incorporated into future monthly updates on reconfiguration. **CFO**

94/16/5 LLR Better Care Together (BCT) Programme Update

Paper I 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 detailing what had been delivered in 2015-16). The top 2 risks continued to be the availability of transformational funding and staff/public/patient engagement, and the Chief Operating Officer suggested that 'timelines' was another key area of risk. In introducing the report, the Chief Executive advised that feedback had been from the NHS England Assessment Panel on the BCT pre-consultation business case; although the timescale for consultation was not yet finalised this was likely to be after the referendum on continued UK membership of the EU. The Chief Executive also noted the key 'wicked issues' facing BCT, namely the national availability of capital and the need to remodel underlying demand and capacity assumptions. In further discussion, the Chief Executive also noted a forthcoming meeting with senior NHSE colleagues regarding capital and control total issues.

The Audit Committee Non-Executive Director Chair noted that the BCT dashboard was no longer appended to the report, and requested that this be reintroduced. **DMC**

Resolved – that (A) the BCT Programme Management Office be requested to provide the LLR BCT dashboard for future monthly updates. **DMC**

94/16/6 Annual Operational Plan (AOP) 2016-17

Further to Minute 73/16/5 of 7 April 2016, paper J set out UHL's updated Annual Operational Plan for 2016-17, which had also been discussed at the April 2016 IFPIC. The changes to the previous iteration were listed on the covering sheet, although it was possible that the now-finalised contract agreement would require the plan to be further refreshed – if so the plan would be re-presented to the June 2016 Trust Board. The Chief Financial Officer also reiterated that the £23.4m Sustainability and Transformation Plan funding was dependent on the Trust achieving improvement trajectories in key performance areas and delivering the overall financial control total – the position on these issues would be made clear in each monthly finance report to the Trust Board (which would map the position against both the original control total and the STP funding). **CFO**

In discussion, the Trust Board noted:-

(a) that an easy-to-read version of the AOP would be available on the Trust's public website, as required, and

(b) a query from the Healthwatch representative regarding the fairness of the improvement trajectories. The Chief Financial Officer acknowledged that the ED improvement trajectory was very challenging, and the Chief Executive advised that the detail of UHL correspondence with NHS Improvement about the trajectories would be reported to IFPIC. **CE**

Resolved – that (A) the updated 2016-17 Annual Operational Plan (including the financial plan, capital programme, activity plan and workforce plan) be approved as **CFO**

presented, on the understanding that any further amendments required as a result of finalising the contracting round would be reported to the June 2016 Trust Board, and

(B) UHL's discussions with NHSI regarding the improvement trajectories be reported to IFPIC. **CE**

95/16 RESEARCH & INNOVATION

95/16/1 East Midlands Clinical Research Network Quarter 4 Report Including the Governance Framework and Annual Plan for 2016-17

The East Midlands Clinical Research Network (EM CRN) Director attended to present the 2015-16 quarter 4 update on the work of the EM CRN, and to seek Trust Board approval (as Network host) for the EM CRN 2016-17 annual delivery plan. The report at paper K also comprised the EM CRN 2016-17 governance plan (presented for host review) and a short presentation on progress in making the UK a key destination for the delivery of clinical research. In presenting the composite elements of the report the EM CRN Director drew the Trust Board's particular attention to:-

(1) continued good performance on portfolio study recruitment rates, with EM CRN remaining 5th in a league of 15 (although slightly disappointing as the aim had been 3rd);
(2) EM CRN's position as 3rd in the league for commercial performance measured through the recruitment time and target in closed studies (behind the West Midlands and Manchester);
(3) ongoing work to address the envisaged reduction in 2015-16 recruitment levels compared to 2014-15;
(4) the EM CRN's confirmed 2016-17 budget allocation of £21.4m – this was more than had been envisaged and the EM CRN therefore intended to establish a 'strategic fund' in 2016-17 which had not been possible previously;
(5) the challenges facing the EM CRN in 2016-17 and the planned remedial actions, and
(6) the EM CRN key performance indicator dashboard at appendix 1 of paper K.

In discussion, the Trust Board queried how other host Trusts shared information within their research networks, and questioned whether UHL should be contacting the Boards of other Trusts involved in the EM CRN. In response, the EM CRN Director confirmed that a Partnership Board was in place comprising all EM CRN member organisations who all received the same level of information on the Network's performance and delivery. The Director of Marketing and Communications suggested that additional external communications should take place to highlight the good work of the EM CRN – welcoming this suggestion (and noting that a communications plan was in development) the EM CRN Director also confirmed that he would attend a future Trust Board thinking day to report on research and innovation both within UHL and more widely (including how to enhance UHL's research performance further). **MD/ DMC** **EMCRN D/MD**

As agreed with the Trust Chairman, the EM CRN Director then presented a short series of slides on progress in making the UK a key destination for the delivery of clinical research, briefing Trust Board members on the background to such provision and the steps taken from 2006 (establishment of the NIHR) to improve the UK's position. The presentation also provided data on the increase in both the numbers of commercial studies and in their participants, and on the significant reduction in the time taken to obtain NHS permission for commercial studies (more than an 82% reduction in the last 5 years, with the 2014-15 median length of time 20 days from 115.5 in 2010-11). The EM CRN was a key performer on this latter indicator, although there was always scope for further improvement. In discussion on the presentation the Trust Board:-

(a) noted (in response to a query) the high level of Government support for research and innovation. Although NIHR funding had not been reduced in 2016-17, CRNs were now

expected to demonstrate their cost-effectiveness and the EM CRN Director confirmed that appropriate metrics were in place for this;

(b) suggested that it would be helpful for the EM CRN to make contact with UK Trade and Invest organisation, and **EMCRN D**

(c) queried what obstacles (if any) were facing EM CRN specifically and CRNs more generally. In response, the EM CRN Director commented on the need for a flexible workforce and to focus on the 'time to target' indicator.

Resolved – that (A) the EM CRN 2016-17 annual delivery plan be approved as presented and progressed accordingly; **MD**

(B) the EM CRN 2015-16 quarter 4 update and the 2016-17 governance framework be noted; **ALL**

(C) consideration be given to appropriate external communications on the work of the EM CRN; **DMC/ MD**

(D) UHL-specific and wider research and innovation issues be discussed at a future Trust Board thinking day, including how to enhance research performance further, and **MD**

(E) the EM CRN Director contact the UK Trade and Invest EM regional lead. **EMCRN D**

96/16 QUALITY AND PERFORMANCE

96/16/1 Quality Assurance Committee (QAC)

Paper L from the QAC Non-Executive Director Chair summarised the issues discussed at that Committee's 28 April 2016 meeting, particularly noting QAC's support for the recommended continuation of the midwifery supervision role.

Resolved – that the summary of issues discussed at the 28 April 2016 QAC be noted (Minutes to be submitted to the 2 June 2016 Trust Board).

96/16/2 Integrated Finance, Performance and Investment Committee (IFPIC)

Paper M from the IFPIC Non-Executive Director Chair summarised the issues discussed at that Committee's 28 April 2016 meeting, Minutes of which would be presented to the June 2016 Trust Board.

Resolved – that the summary of issues discussed at the 28 April 2016 IFPIC be noted (Minutes to be submitted to the 2 June 2016 Trust Board).

96/16/3 2015-16 Financial Position – March 2016

Paper N provided an integrated report on month 12 financial performance (month ending 31 March 2016) and delivery of the revised 2015-16 financial plan. As per its revised financial plan submitted to the NTDA on 11 September 2015, UHL was now planning for a deficit of £34.1m in 2015-16, including delivery of a £43m cost improvement programme. Paper N confirmed that UHL had delivered its 2015-16 revised financial plan accordingly and had also delivered its financial duties in respect of achieving the External Financing Limit and the Capital Resource Limit. Total capital expenditure for 2015-16 was £45.6m, representing all of the available capital budget excluding donations and finance leases. In respect of financial performance during March 2016, month 12 had seen an in-month variance of £0.9m favourable to plan, and an over-delivery of £0.1m on UHL's cost improvement

programme (CIP), resulting in a 2015-16 CIP delivery of £43.1m (£0.1m favourable to plan). Following detailed discussion of 'above the line' issues at the April 2016 IFPIC, the Chief Financial Officer confirmed that these were now reflected in the EBITDA line of table 1 within paper N.

The Chief Financial Officer drew the Trust Board's attention to the pay spike in March 2016, and advised that his team's review of this issue would be reported to the May 2016 IFPIC, with the aim of repeating a recurrence in month 12 of 2016-17. The Trust's Annual Accounts for 2015-16 were now being finalised and would be presented to the Audit Committee in May 2016 en route to the June 2016 Trust Board for approval. **CFO**

Resolved – that (A) the financial position for month 12 (year-end) be noted, and

(B) the review of the month 12 pay position be reported to the 26 May 2016 IFPIC. **CFO**

97/16 REPORTS FROM BOARD COMMITTEES

97/16/1 Quality Assurance Committee (QAC)

Resolved – that the Minutes of the 24 March 2016 QAC be received and noted, and any recommendations approved accordingly.

97/16/2 Integrated Finance Performance and Investment Committee (IFPCI)

Resolved – that the Minutes of the 24 March 2016 IFPIC be , noting that the two specific recommendations within Minute 25/16/1 had been approved at the April 2016 Trust Board.

98/16 TRUST BOARD BULLETIN – MAY 2016

Resolved – it be noted that no papers had been circulated for the May 2016 Trust Board Bulletin.

99/16 QUESTIONS AND COMMENTS FROM THE PRESS AND PUBLIC RELATING TO BUSINESS TRANSACTED AT THIS MEETING

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

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

100/16 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 101/16 – 108/16), having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.

101/16 DECLARATIONS OF INTERESTS IN THE CONFIDENTIAL BUSINESS

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

102/16 CONFIDENTIAL MINUTES

Resolved – that the confidential Minutes of the 7 April 2016 Trust Board be confirmed **CHAIR MAN**

as a correct record and signed by the Trust Chairman accordingly.

103/16 CONFIDENTIAL MATTERS ARISING REPORT

In respect of paper R, the Director of Corporate and Legal Affairs advised that the visit referred to in action 37/16 from 4 February 2016 would take place on 18 July 2016.

Resolved – that the confidential matters arising report be noted.

104/16 REPORT FROM THE DIRECTOR OF ESTATES

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

105/15 CORPORATE TRUSTEE BUSINESS

105/16/1 Report from the Director of Marketing and Communications

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

106/16 REPORTS FROM BOARD COMMITTEES

106/16/1 Quality Assurance Committee (QAC)

Resolved – that the confidential Minutes from the 24 March 2016 QAC be received and noted, and any recommendations approved accordingly.

106/16/2 Integrated Finance Performance and Investment Committee (IFPIC)

Resolved – that the summary of confidential issues discussed at the 28 April 2016 IFPIC and the confidential Minutes of the 24 March 2016 IFPIC be received and noted, and any recommendations approved accordingly.

107/16 ANY OTHER BUSINESS

There were no items of any other business.

108/16 DATE OF NEXT TRUST BOARD MEETING

Resolved – that the next Trust Board meeting be held on Thursday 2 June 2016 from 9am in the C J Bond Room, Clinical Education Centre, Leicester Royal Infirmary.

The meeting closed at 1.20pm

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	2	2	100	R Mitchell	2	2	100
J Adler	2	2	100	R Moore	2	1	50
I Crowe	2	2	100	J Smith	2	2	100
S Dauncey	2	2	100	M Traynor	2	2	100
A Furlong	2	2	100	P Traynor	2	2	100
A Goodall	2	1	50				
A Johnson	2	2	100				

Non-Voting Members:

Name	Possible	Actual	% attendance	Name	Possible	Actual	% attendance
D Henson	2	2	100	L Tibbert	2	2	100
N Sanganee	2	1	50	S Ward	2	2	100
				M Wightman	2	2	100
