Trust Board Paper A

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF A MEETING OF THE TRUST BOARD, HELD ON THURSDAY 7 JANUARY 2016 AT 9AM IN ROOMS A & B, EDUCATION CENTRE, LEICESTER GENERAL HOSPITAL

Voting Members present:
Mr K Singh – Trust Chairman (excluding Minutes 1/16, 2/16, 5/16 and 7/16/1)
Mr J Adler – Chief Executive
Col (Ret'd) I Crowe – Non-Executive Director
Dr S Dauncey – Non-Executive Director
Mr A Furlong – Acting Medical Director
Professor A Goodall – Non-Executive Director (excluding Minute 7/16/1)
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 (Acting Chair for Minutes 1/16, 2/16, 5/16 and 7/16/1)
Mr P Traynor – Chief Financial Officer

In attendance:
Ms D Baker – Service Equality Manager (for Minute 7/16/5)
Professor N Brunskill – Director of Research and Innovation (for Minute 9/16/1)
Mr J Currington – Head of Tertiary Partnerships (for Minute 7/16/8)
Mr G DiStefano – Head of Strategy (for Minute 7/16/9)
Mr D Henson – LLR Healthwatch Representative (up to and including Minute 14/16)
Ms H Leatham – Assistant Chief Nurse (for Minute 7/16/1)
Ms J Newstead – Clinical Team Leader (for Minute 7/16/1)
Professor D Rowbotham – EMCRN Clinical Director (for Minute 9/16/2)
Ms K Shields – Director of Strategy
Mr N Sone – Financial Controller (for Minute 10/16/4)
Ms H Stokes – Senior Trust Administrator
Ms L Tibbert – Director of Workforce and OD
Ms C Trevithick – Chief Nurse and Quality Lead, West Leicestershire CCG (for Minute 18/16)
Mr S Ward – Director of Corporate and Legal Affairs
Mr M Wightman – Director of Marketing and Communications
Ms E Wilkes – UHL Reconfiguration Programme Director (for Minute 7/16/6)

ACTION

1/16 APOLOGIES

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

2/16 DECLARATIONS OF INTERESTS IN THE PUBLIC BUSINESS

No declarations of interest were made.

3/16 MINUTES

Resolved – that the Minutes of the 3 December 2015 Trust Board be confirmed as a correct record and signed by the Trust Chairman accordingly. — **CHAIRMAN**

4/16 MATTERS ARISING FROM THE MINUTES

Paper B detailed the status of previous matters arising and the expected timescales for resolution. The Chief Operating Officer advised that action 7a (Minute 254/15/16 of 3 December 2015) was now complete and could be removed accordingly from the log. He also advised that the provision of Committee Chair feedback to CMGs immediately after their presentations to the Integrated Finance Performance and Investment Committee would — **STA**

begin from January 2016.

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

5/16 CHAIRMAN'S MONTHLY REPORT – JANUARY 2016

In introducing his monthly report for January 2016 (paper C), the Trust Chairman particularly highlighted:-

(a) the further discussions on reconfiguration planned for the January 2016 Trust Board thinking day, in light of the significant national pressures on capital, and
(b) the key need to balance current financial pressures with safety and quality issues, with the latter considerations being paramount for the Trust. Lord Carter's team would be attending the January 2016 Trust Board thinking day to present the 'model hospital' concept, focusing on safety, quality and risk as well as efficiency.

The Chairman had also extended his congratulations (on behalf of the Trust Board) to the Vice-Chancellor of the University of Leicester and to Professor M Davies, Consultant in Diabetes, both of whom had received CBEs in the New Year's Honours list.

Resolved – that the Chairman's January 2016 report be noted.

6/16 CHIEF EXECUTIVE'S MONTHLY REPORT – JANUARY 2016

The Chief Executive's January 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 be 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) that the key issue of the CQC inspection of ED was covered in detail at Minute 7/16/2 below;

(b) quarter 3 progress against UHL's annual priorities for 2015-16. As detailed in appendix 5, progress had slowed on certain quality aspects due to capital constraints (eg ITU and vascular reconfiguration). Although progress had also slowed on the Emergency Floor it was hoped to recover this. The Chief Executive clarified that progress on the electronic patient record (EPR) should be amber (rather than green) due to delays in the approval process. The 5-year financial strategy was also rated as amber due to national capital shortages. However, improvements had been made in respect of the medical education quality assurance process, the very recent progress re: the Biomedical Research Units/Biomedical Research Centres [BRUs/BRC] (hence the difference in rating to the BAF dashboard), and to the Trust's financial performance;

(c) the outcome of the Trust's quarterly review with the NTDA – with regard to the issues detailed in appendix 4, the Chief Executive outlined the position in respect of orthodontics, diagnostics, emergency care, and measures to accelerate patient flow, and

(d) that the new planning guidance for 2016-17 was covered later on the agenda (Minute 7/16/9 refers).

In discussion on the report, the Trust Board noted:-

(i) (in response to a Non-Executive Director query) that potential appropriate sources of DoH capital were being explored for the EPR project, although UHL was now pursuing the bulk of the finance for that project with IBM;

(ii) confirmation from the Chief Operating Officer that the MRI scanners had now been repaired – an operational resilience plan was also in development;

(iii) the rising demand in endoscopy, despite the additional activity put on within that service – agreement had now also been reached to increase the number of lists undertaken by the Alliance. The backlog was reducing therefore but not as rapidly as had been hoped;

(iv) comments from the Healthwatch representative relating to:-
- the welcomed focus on cancer waiting time targets;
- concerns over the further slippage in timescale for ICU reconfiguration. These concerns related to the impact on both patient safety and clinical sustainability, and on the commitments made to the Health Overview and Scrutiny Committee. In response, both the Acting Medical Director and the Director of Strategy emphasised that this was a slowing down not a 'stop', and they advised that the project was being considered by the NTDA in March 2016;
- a query on the status of the BRUs if BRC status was not achieved – in response, the Chief Executive advised that the configuration approach used by the NIHR had changed, as it now intended to accredit BRCs only. He considered that UHL and its partners had a very credible BRC bid, and reminded members that only UHL had 3 BRUs. Professor A Goodall Non-Executive Director clarified that the 5-year BRU grants had always been due to end in March 2017, and she noted that UHL's 3 BRUs covered areas which were all priorities for the NIHR, and

(v) comments from the Audit Committee Non-Executive Director Chair welcoming the inclusion of the BAF and risk register dashboards within the Chief Executive's report. He also commented however on the significant number of workforce and capacity-related risks and queried what further remedial actions were needed. In response, the Chief Executive voiced his assurance in respect of UHL's approach to these risks, and noted also the Director of Workforce and OD's focus on strategic workforce issues such as those within the Better Care Together programme.

<u>Resolved</u> – that the Chief Executive's monthly report for December 2015 be noted.

7/16 KEY ISSUES FOR DECISION/DISCUSSION

7/16/1 <u>Patient Story – Patient Experience of the Trust Falls Prevention Programme (LGH)</u>

Paper E from the Chief Nurse advised the Trust Board of a patient's positive experience of the therapy care delivered within the Trust's falls prevention programme (based at the Leicester General Hospital). As detailed in the video presentation, the falls prevention programme had greatly improved the patient's mobility, self-confidence, and general well-being. Ms J Newstead, Clinical Team Leader advised that the Trust's falls prevention programme was aimed primarily at city patients, with other services available elsewhere for county patients. The service saw an average 85% improvement by the end of the falls prevention programme (based on outcome measures). The Trust Board welcomed being informed of this very positive intervention service, and noted:-

(a) (in response to a query) that there was no direct self-referral route into the programme, with access therefore being through professional referral (either in-house referral [for inpatients] or GP/District Nurse/Community Nurse/Community Occupational Therapist referral), and

(b) the extent of the Trust falls prevention programme based at the LGH (providing both

1 hour of exercise and an education/advice session on a twice-weekly basis), which was quite significantly more frequent than the provision of the county-based programme.

The Acting Chairman thanked the staff involved in the falls prevention programme for their dedication, and noted the inspiring nature of this story.

Resolved – that the falls prevention programme patient story be noted.

7/16/2 CQC Inspection

Paper F advised the Trust Board of the actions taken in response to the CQC's 30 November 2015 unannounced inspection of UHL's Emergency Department – that visit had resulted in the CQC issuing a notice imposing conditions on UHL's registration as a service provider under section 31 of the Health and Social Care Act 2008. The Trust Chairman noted that today's meeting was the earliest opportunity for the Trust Board to discuss this issue in public, and he commented on UHL's wish to make information as open as possible.

A risk summit had also taken place on 18 December 2015, involving NHS England, the National Trust Development Authority (NTDA), the CQC, and local healthcare organisations, resulting in various actions across the LLR emergency healthcare system. The Chief Executive confirmed that the Trust had taken every effort to respond quickly to the issues raised by the CQC from its inspection, and paper F outlined the actions taken in respect of the 3 key areas covered by the conditions:-

(i) time to initial assessment on arrival at the Emergency Department (within 15 minutes of arrival);
(ii) appropriate staffing levels;
(iii) sepsis management.

The Chief Nurse emphasised her view that patients in ED were safe at all times, and that UHL had been aware of the issues above and had been working to resolve them. She outlined the work of the quality and safety overview group whose fortnightly meetings also involved the NTDA, Healthwatch, and the CQC. The issues highlighted in the inspection were featured on the Trust's risk register, and an ED quality dashboard was being further developed to include all elements of the current weekly reporting. The Chief Nurse advised that the CQC would reinspect the Trust and then set out a timeline for the removal of the section 31 conditions. In discussion on the CQC inspection and the Trust's actions as detailed in paper F, the Trust Board:-

(a) queried how the Trust would be sighted to progress on non-UHL actions arising from the December 2015 risk summit. The Chief Executive noted that the key action had been for the community to reduce demand, which had led to a refresh of the Urgent Care Board action plan. The Chief Executive understood that the NTDA and NHS England were not currently assured on whether the reductions in attendances and admissions would be delivered – he noted that activity remained very high. The Urgent Care Board meeting later on 7 January 2016 would review progress further, but the UHL Chief Executive noted his concerns over whether the actions were sufficient to reduce demand;

(b) noted a full review of quality assurance mechanisms which was currently underway throughout the Trust. UHL was also reviewing its preparedness for a full CQC visit, which was being discussed further at the January 2016 Trust Board thinking day;

(c) noted comments from Mr D Henson, Healthwatch representative (who had also attended both the risk summit and the quality and safety overview group) that he was less confident on the wider actions than on the actions ascribed to UHL. He did not feel assured that there was sufficient control/traction on those wider emergency care system issues (also covered

in Minute 7/16/3 below);

(d) noted a request (from the Healthwatch representative) for future assurance on the sustainability of the actions taken in response to the CQC visit, and

(e) noted that the next risk summit was scheduled for early February 2016.

<u>Resolved</u> – that the report on the CQC inspection of ED and the resulting actions taken by UHL (and its partners where appropriate), be noted.

7/16/3 <u>Emergency Care Performance and Winter Contingency Plan</u>

Further to Minute 254/15/16 of 3 December 2015, paper G from the Chief Operating Officer updated the Trust Board on recent emergency care performance, which stood at 89.4% for the year to date despite continued atypically-high attendance and admission rates. The Chief Operating Officer advised that December 2015 had been very challenging for both UHL and the wider LLR healthcare economy, and he thanked the ED staff who had been working over Christmas and New Year – despite attendances being up 6.4% and admissions being up 4%, relatively good 4-hour performance had been achieved in that month.

The Chief Operating Officer emphasised, however, that UHL was under immense pressure at present, in terms of both the number and acuity of its patients. Significantly more elective work was being reduced than originally intended, particularly on the LRI site. Internally, UHL was focusing on (i) reducing ambulance handover times; (ii) reducing time spent in ED, and (iii) increasing bed numbers in assessment units (seen as a key action). The Chief Operating Officer reiterated the need to begin planning for winter 2016-17 now, in terms of capacity and admission rates. Although the new Emergency Floor would be better able to cope with surge activity (being significantly larger than the existing space), appropriate flow of patients remained the key issue. In discussion on emergency care performance, the Trust Board noted in particular:-

(a) the continuing challenge of improving ambulance handover times. The new cohorting measures had initially yielded improvements, but delays were beginning again. UHL was an outlyer on this issue, and the Chief Executive emphasised the need to resolve it. The Director of Strategy suggested commissioning a public health review to understand why UHL received more 'red' ambulance calls than elsewhere in the East Midlands and assess whether current interventions were appropriate;

(b) the crucial need to learn appropriately from any modelling of the incoming demand, and thus avoid repeating the current position once the new Emergency Floor opened. Members queried whether there was a direct correlation between the number of patients and the ability to achieve the 4-hour standard;

(c) a query as to how UHL could increase the pace of community actions to reduce demand and improve system flow. It was also vital for the Trust and its community partners to reach a shared understanding of the challenge, and of the actions needed;

(d) the proposal to hold a further Trust Board thinking day session on emergency care, covering demand modelling and scenario planning for winter 2016-17 and exploring the pragmatic solutions available. These discussions should take place as soon as possible, and it was agreed therefore to dedicate appropriate time at the February 2016 Trust Board thinking day. The Chief Executive emphasised the need to have a credible capacity plan in place going into winter 2016-17;

COO/ Chairman

(e) the Acting Medical Director's comments on the need to avoid simply establishing

ever-bigger wards and assessment areas – UHL should seek instead to move towards improved vertical integration to address the multiple conditions that patients presented with at the Trust, most likely involving some kind of earlier triage system;

(f) the Director of Strategy's view that it would be helpful to review UHL's use of community hospitals, as this differed from other healthcare economies, and

(g) the need for a coherent, transparent, system-wide plan focusing on outcomes.

Resolved – that emergency care performance and contingency plans be discussed further at the February 2016 Trust Board thinking day, covering:- **COO/ Chairman**

(1) demand modelling and scenario planning for winter 2016-17, and

(2) the need for a coherent, system-wide plan focusing on outcomes.

7/16/4 Emergency Preparedness and Resilience Response (EPRR) Self-Assessment Report

Following the November 2015 Paris attacks, NHSE had sought further national assurance on Trusts' EPRR position. Paper H from the Chief Operating Officer confirmed that UHL was fully compliant with 98% of the core standards, partially compliant on 2% and not compliant on 0%. As the lead Non-Executive Director for emergency planning, Col (Ret'd) I Crowe welcomed these levels but reminded members that this was a self-assessment exercise. He advised that he had passed his comments on training and improving security (eg the need to feed in the dynamic lockdown procedures advice) to the emergency planning team. It was also noted that paper H had been discussed in detail at the January 2016 Executive Quality Board.

Resolved – that the EPRR self-assessment report be approved.

7/16/5 Equality Update

Paper I from the Director of Workforce and OD detailed UHL's compliance with the Public Sector Equality Duty (PSED) and sought Trust Board approval prior to the internet publication of UHL's 2014-15 workforce equality and diversity monitoring report (appendix 1). Ms D Baker, Service Equality Manager attended for this item, and drew the Trust Board's attention to the following key issues:-

(a) the % of BME staff in leadership positions (11.2%), compared to UHL's BME workforce overall (32%);
(b) that 50% of UHL's disabled staff had reported that inadequate 'reasonable adjustments' had been made for them – although very small numbers this was an issue which needed to be addressed;
(c) progress on the WRES;
(d) progress by the UHL equality and diversity task and finish group (established by the Trust Chairman) – the group would report its work to the February 2016 Trust Board thinking day and on to the March 2016 public Trust Board. In discussion, the Chairman requested that all members of the task and finish group, and Mr D Henson, Healthwatch representative, be invited to attend the February 2016 Trust Board thinking day accordingly; **DWOD**
(e) the significant increase in the Trust's use of the interpreting service, with more Eastern European languages being accessed than previously. The unit cost of the service had decreased, however, despite increased usage. The Service Equality Manager advised that she planned to meet with the supplier to discuss a rising number of payment problems;
(f) the results of the complaints analysis for disabled patients. It was planned to undertake a similar analysis for BME patients in 2016-17, and
(g) that due largely to IT issues, the Trust would likely not be compliant with the Accessible Information Standard (AIS) in place as of April 2016. A workshop was planned for January 2016.

In discussion, the Trust Chairman voiced concern over BME staff perception of unequal career progression. He also noted the need to make leadership/training opportunities more accessible for staff, to create a talent pipeline. The Director of Workforce and OD advised that UHL had recently accessed some free EMLA training re: 'unconscious bias', which she proposed be undertaken by the Trust Board prior to Trust-wide roll-out. **DWOD**

Resolved – that (A) the 2014-15 workforce equality and diversity monitoring report be approved, noting its intended publication on the website; **DWOD**

(B) the equality and diversity task and finish group findings be reported to the February 2016 Trust Board thinking day (task and finish group members and Mr D Henson, Healthwatch to be invited) and then on to the public March 2016 Trust Board, and **DWOD**

(C) the Trust Board undertake the 'unconscious bias' training being organised through the East Midlands Learning Academy. **DWOD**

7/16/6 UHL Reconfiguration Programme

This monthly report from the Director of Strategy updated the Trust Board on (i) the governance of UHL's reconfiguration programme; (ii) progress on 1-2 selected workstreams, and (iii) the 3 key programme risks, while the high-level dashboard appended to the report provided an overview of the programme status and key risks as a whole. In terms of key workstream deep dives, paper J focused on the out of hospital beds Intensive Community Support (ICS) service. In introducing the report, the Reconfiguration Programme Director noted the following:-

(a) the risk that constraints on capital funding posed to the 2015-16 programme, including the impact on ICU relocation progress (which would be reported further to the January 2016 Executive Strategy Board);

(b) that a 'by when' column had been added to the programme dashboard, in light of comments at the December 2015 Trust Board;

(c) the impact on certain business cases of the delay to the Better Care Together public consultation launch. Although UHL was assuming a 3-month delay at present, any significant further delay could have a material impact on business case timelines. The Trust Chairman advised that the January 2016 Trust Board thinking day would cover this issue in its dedicated reconfiguration session, and

(d) the regular updates provided to staff by the Trust's reconfiguration communications lead.

In discussion on paper J, the Trust Board:-

(1) queried who would be opening the new carpark, due to be available for parking from the end of January 2016;

(2) noted that the Acting Medical Director had briefed the Clinical Senate on the implications of capital constraints on 5 January 2016. He confirmed that he would also update the Clinical Senate on reconfiguration progress following the January 2016 Trust Board thinking day, noting their particular interest in the ICU reconfiguration;

(3) noted that UHL's 2015-16 capital programme had now been capped at £49.5m compared to the originally-planned £120m. The Chief Financial Officer advised that the 2016-17 guidance was looking at a 25% reduction in capital, although more detail would be known after March 2016;

(4) noted that 16 ICS beds were now open, and

(5) noted that this was the final public Trust Board meeting for Ms E Wilkes, Reconfiguration Programme Director. The Trust Board thanked her for her work on the reconfiguration programme and wished her well for the future.

<u>Resolved</u> – that the monthly update on the UHL reconfiguration programme be noted.

7/16/7 <u>LLR Better Care Together (BCT) Programme Update</u>

Paper K provided a high-level update on the LLR Better Care Together Programme, as prepared for all partner organisations' Boards (accompanied here by an internal UHL covering report). The latest iteration of the proposed LLR BCT dashboard was attached to the report at appendix 2 – the top 2 risks were outlined as workforce and organisational culture issues. The Director of Strategy also outlined the work underway to address the BCT pre-consultation business case issues raised by NHS England, noting the target date of May 2016 for consultation.

In respect of workstreams, the LLR workforce and OD leads had met to discuss the BCT workforce and OD workstream, and the ICS beds workstream was rolling out as planned, with 110 patients treated to date. Potential expansion of the ICS service across LLR was being explored, focusing on longterm conditions. In discussion on paper K the Trust Board:-

(a) queried how the quality and safety of care provided by the ICS service was being audited (recognising that UHL did not provide those beds). The Director of Strategy advised that relevant FAQs had been issued to address certain queries, and noted her views that the service governance was sound and that concerns had begun to diminish;

(b) considered that the BCT consultation document would need to address the variance issues highlighted at paragraphs 17-19 of paper K;

(c) suggested that the supporting information for the top 2 risks could be expanded to include the length of time the risk had been at that level, the timeframe to resolve the risk, and the further actions planned; **DS/ DWOD**

(d) agreed to advise the BCT Programme Officer of the request for the dashboard to include more information on the specific step targets needing to be achieved and to provide a more comprehensive vision of the progress needed, and of the need for the key programme milestones to include the current review of capital availability and its BCT impact; **DS**

(e) noted the need to make bids for appropriate national transformation monies (where available), and

(f) agreed (in response to a request from the Healthwatch representative) to include the patient/carer experience of ICS in the next BCT update. **DS**

<u>Resolved</u> – that (A) the narrative on the top 2 programme risks be expanded to cover how long the risk had been at that graded level, the timescale to resolve the risk, and the further actions planned; **DS/ DWOD**

(B) the BCT Programme Management Office and BCT Programme Board (as appropriate) be advised of the following points raised by the Trust Board, with a view to them being reflected in the next iteration of the report:- **DS**

(1) the request for the dashboard to include more information on the specific step targets needing to be achieved and provide a more comprehensive vision of the

progress needed;

(2) the need for the key programme milestones to include the current review of capital availability and its BCT impact, and

(C) the next monthly report provide an update on the patient/carer experience of the ICS beds. **DS**

7/16/8 Tertiary Partnerships Strategy 2015-2020

Paper L outlined the Trust's draft Tertiary Partnerships Strategy for the period 2015-2020, as introduced by the Director of Strategy and the Head of Tertiary Partnerships. UHL needed to be clear as to what position it was occupying in each of its tertiary relationships, which sectors it wished to grow, and have an appropriate focus on return on investment considerations. In discussion on the Strategy, the Trust Board noted the need for it to include awareness of (and development of appropriate rules of engagement with) the National Defence Rehabilitation Centre. Col (Ret'd) I Crowe Non-Executive Director also noted the need for clear financial oversight of overseas relationships as part of their overall governance framework. The Trust Chairman noted the need to reflect appropriately the issue of risk within the various partnerships. **DS** **DS**

Resolved – that (A) subject to the comments below, the tertiary partnerships strategy 2015-2020 be approved, and **DS**

(B) the strategy be amended to reflect:-
(1) awareness of (and development of appropriate rules of engagement with) the National Defence Rehabilitation Centre, and
(2) appropriate risk issues for all partnerships/arrangements. **DS**

7/16/9 Draft Annual Priorities 2016-17

Further to discussion at the December 2015 Trust Board thinking day, Mr G DiStefano, Head of Strategy, attended to present the Trust's draft annual priorities for 2016-17 (paper M). Also appended to the report was the 2016-17 national planning guidance published on 24 December 2015. In discussion on the priorities, the Trust Board agreed to:-

(a) amend the strategic objective 2 priorities to include the issue of capacity to match 2016-17 demand; **DS**

(b) expand the strategic objective 5 priorities to reflect UHL's growing relationship with its academic partners (wording to be provided by Professor A Goodall, Non-Executive Director); **DS**

(c) give consideration to including 'reducing agency spend' in the 2016-17 strategic priorities (item from the discussion on the workforce and OD quarterly update – Minute 9/16/1 below refers); **DS**

(d) present the 2016-17 Quality Commitment to the January 2016 QAC and on to the February 2016 Trust Board for approval, and **CN**

(e) delegate authority to the Chief Executive to approve the updated annual priorities in line with the NTDA first-cut submission dates (noting that the finalised version would then be presented to a future Trust Board). **CE**

It was also agreed to undertake an appropriate communication exercise with internal and external stakeholders, following the finalisation of the annual priorities 2016-17. Following a suggestion by the Audit Committee Non-Executive Director Chair, consideration would also to be given to holding a larger-scale public event to communicate both the 2016-17 annual **DMC/ DS** **DS**

priorities and the Trust's wider vision for coming years prior to the BCT launch.

<u>Resolved</u> – that (A) the 2016-17 draft annual priorities be amended to reflect points (a) – (c) above; **DS**

(B) authority be delegated to the Chief Executive to approve the updated 2016-17 annual priorities in line with the NTDA first-cut submission dates; **CE**

(C) the 2016-17 Quality Commitment be presented to the January 2016 QAC and onto the February 2016 Trust Board for approval; **CN**

(D) an appropriate communication exercise be developed with internal and external stakeholders, following the finalisation of the annual priorities 2016-17, and **DMC/ DS**

(E) consideration be given to holding a larger-scale public event to communicate both the 2016-17 annual priorities and the Trust's wider vision for coming years prior to the BCT launch. **DS**

8/16 RESEARCH AND INNOVATION

8/16/1 <u>Research and Innovation Quarter 3 Report</u>

Professor N Brunskill, Director of Research and Innovation attended to present the quarter 3 2015-16 research and innovation update, covering research performance, projects in development, innovation activities, and new/existing challenges. As detailed in paper N, the Director of Research and Innovation noted in particular:-

(i) that UHL's 2015-16 performance in recruiting patients to trials was exceeding 2014-15 levels, and was much higher than that of other East Midlands Trusts;

(ii) the decision that UHL would bid for a single BRC covering the themes of its existing 3 BRUs (as also discussed in Minute 6/16 above). The University of Leicester would be UHL's lead academic partner, with input also from Loughborough;

(iii) progress on the 100,000 Genome Project, which was very high-profile nationally, and

(iv) progress on the Leicester Institute of Precision Medicine (LIPM), in which UHL was a partner.

In discussion on the report the Trust Board also:-

(a) requested that the Director of Research and innovation circulate the slides from his recent meeting with the Trust Chairman, to other Trust Board members for information; **AMD**

(b) queried the position re: Glenfield Hospital site accommodation for the Hope Centre. It was agreed to pursue this with the Director of Estates and Facilities (and to raise it at the UHL-UoL Strategic Partnership Committee, as appropriate); **DS**

(c) agreed to consider offering the University of Leicester a seat on UHL's Space Reconfiguration Group, and **DS**

(d) agreed that a future Trust Board thinking day should include a dedicated session on research and innovation (also covering the Trust's relationship with the University of Leicester). **AMD**

<u>Resolved</u> – that (A) the slides from the Director of Research and Innovation's recent meeting with the Trust Chairman be circulated to Trust Board members for **AMD**

information;

(B) the issue of Glenfield Hospital site accommodation for the Hope Project be pursued with the Director of Estates and Facilities and raised at the UHL-UoL Strategic Partnership Committee as appropriate; **DS**

(C) consideration be given to offering the University of Leicester a seat on the UHL Space Reconfiguration Group, and **DS**

(D) a dedicated session on research and innovation be held at a future Trust Board thinking day. **AMD**

8/16/2 East Midlands Clinical Research Network (EM CRN) Quarter 3 Update

Professor D Rowbotham, EM CRN Clinical Director attended to present the report (paper O), noting in particular:-

(i) improved research recruitment performance, currently standing at 81% against the year to date goal. Although the 2015-16 stretch target remained challenging, the EM CRN Clinical Director considered that the network was likely to recruit as many participants as in 2014-15;

(ii) continued good performance on the time to trial target;

(iii) progress in setting the 2016-17 EM CRN budget, and

(iv) progress in establishing the Study Support Service for researchers across the network (the EM CRN Clinical Director was also involved in extending this to small and medium enterprises, and in response to a query he confirmed that the study support team would link with all relevant partners). It was noted that a number of partners within the EM CRN had also invited the central team to visit their Trusts and advise them on appropriate R&D governance structures. As Chair of the relevant Executive group, the Acting Medical Director commented on the robust governance arrangements in place for EM CRN.

In discussion, the Trust Board welcomed the EM CRN's recognition of the importance of commercial research targets and activity. In response to a query re: recruitment challenges, the EM CRN Clinical Director advised that the EM CRN was performing the best nationally in terms of primary care recruitment to research – although some constituent partners were experiencing more difficulties than others with recruitment generally, the EM CRN team was working with those partners to resolve this.

Resolved – that the EM CRN quarter 3 update be noted.

9/16 WORKFORCE AND ORGANISATIONAL DEVELOPMENT

9/16/1 Workforce and OD Quarterly Update

Paper P comprised the quarterly update on workforce and OD issues, noting the launch of the 'UHL Way' in January 2016 supported by the new UHL Academy. There was also a continued focus on cross-LLR working, and the Director of Workforce and OD noted the need to envisage OD in terms of cultural change and transformation. Resource forecasting work was underway, with the establishment of a Resource Steering Group involving both Corporate Nursing and Corporate Medical representatives. The Trust was also currently reviewing first cut workforce planning and development plans for 2016-17, with appropriate confirm and challenge sessions scheduled with the CMGs. In response to a comment from the Trust Chairman, the Director of Workforce and OD considered that the varying use of agency staff across different wards/areas often reflected differing CMG leadership styles re:

workforce issues. The Trust Chairman further commented on the need to impact appropriately on the workforce waterfall chart and reduce agency use. The Chief Executive suggested that UHL's 2016-17 annual priorities should include a statement about reducing agency spend (Minute 7/16/9 above refers). In response to a Non-Executive Director query, the Chief Nurse advised on he number of nursing vacancies, currently between the 280-310 range.

DS

The Director of Workforce and OD also noted LLR's receipt of £20,000 HEEM monies for a system-wide recruitment and attraction approach.

Resolved – that (A) the quarterly update on workforce and OD be noted, and

(B) reducing agency spend be appropriately included in the Trust's 2016-17 annual priorities as per Minute 7/16/9 above.

DS

10/16 QUALITY AND PERFORMANCE

10/16/1 Quality Assurance Committee (QAC)

Dr S Dauncey, QAC Non-Executive Director Chair commented on the significant length of time devoted to the CQC inspection at the 17 December 2016 QAC, as evidenced in the Minutes of that meeting (paper Q).

Resolved – that the Minutes of the 17 December 2015 QAC meeting be received, and the recommendations and decisions therein be endorsed and noted respectively.

10/16/2 Integrated Finance, Performance and Investment Committee (IFPIC)

Mr M Traynor, IFPIC Non-Executive Director Chair noted that the 17 December 2015 IFPIC had endorsed the 2016-17 capital programme for Trust Board approval, as evidenced in the Minutes of that meeting at paper R.

Resolved – that the Minutes of the 17 December 2015 IFPIC meeting be received, and the recommendations and decisions therein be endorsed and noted respectively (including the recommendation for Trust Board approval of the 2016-17 capital programme).

CFO

10/16/3 2015-16 Financial Position – Month 8 (November 2015)

Paper S provided an integrated report on month 8 financial performance (month ending 30 November 2015) 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. As at 30 November 2015, UHL's financial performance was £1.7m adverse to plan (current deficit of £31m), and the Chief Financial Officer advised that the income position and runrate has been closely scrutinised at the December 2015 IFPIC. He also noted the risks posed by the planned junior doctor strikes due to the impact on elective activity and therefore income. For the reasons detailed in paper S, 4 CMGs required additional support to ensure the achievement of their year-end totals. The Chief Financial Officer also advised that IFPIC would be kept informed of ongoing discussions with both specialised and local Commissioners.

The Chief Financial Officer noted his view that UHL's £34.1m control total remained deliverable, although its achievement was not without risk. The Chief Executive echoed this view, commenting particularly on the impact of emergency demand on elective activity. In further discussion, Mr A Johnson Non-Executive Director commented that it would be helpful for future financial reports also to include the original plan in charts 2-6 – the Chief Financial

Officer confirmed that he would include these from the January 2016 IFPIC onwards. **CFO**

<u>Resolved</u> – that (A) the financial position for month 8 be noted, and

(B) future reports also include the original plan in charts 2-6. **CFO**

10/16/4 <u>Interim Revenue Support Loan Application</u>

Paper S1 from the Chief Financial Officer sought retrospective Trust Board agreement to the decision taken to apply for an interim revenue support loan up to the value of UHL's agreed stretch deficit target of £34.1m. The loan would be used to repay the Trust's current financing arrangement and had a 2% lower interest rate which would save UHL £56000 per month. As the submission date for the application had been 6 January 2016 it had not been possible to wait for a full Trust Board meeting to obtain the necessary Board resolution required by the Department of Health, and in line with UHL's Standing Orders re: delegated authority the decision to apply had therefore been approved by the Trust Chairman and Chief Executive following consultation with 2 Non-Executive Directors. As also required under UHL's Standing Orders, Trust Board approval was therefore now sought to ratify that decision taken under delegated authority.

The Trust Board noted that the loan was not repayable until February 2019, and that the revolving facility was still available for short-term cash.

<u>Resolved</u> – that the Board resolution re: the Interim Revenue Support Loan application be ratified as detailed in paper S1 (as required under UHL's Standing Orders) and signed accordingly. **Chair Man/ CE**

11/16 REPORTS FROM BOARD COMMITTEES

11/16/1 <u>Quality Assurance Committee (QAC)</u>

<u>Resolved</u> – that the 26 November 2015 QAC Minutes be received and noted, and any recommendations therein be endorsed.

11/16/2 <u>Integrated Finance, Performance and Investment Committee (IFPIC)</u>

<u>Resolved</u> – that the 26 November 2015 IFPIC Minutes be received and noted and any recommendations therein be endorsed.

12/16 TRUST BOARD BULLETIN – JANUARY 2016

<u>Resolved</u> – that the Trust Board Bulletin containing the following reports be noted:-
(1) NHS Trust Over-Sight Self Certification return for the period ended 30 October 2015 [noting the continuing cleanliness concerns expressed by the Trust] (paper 1), and
(2) updated declarations of interest from Mr A Johnson Non-Executive Director [Director, Glebe Terriers Ltd; Chairman, Morcott Parish Council, Rutland] and Col. (Ret'd) I Crowe Non-Executive Director [extension of part-time Consultant Adviser role with General Dynamics Information Technology Ltd to November 2016] (paper 2).

13/16 QUESTIONS AND COMMENTS FROM THE PRESS AND PUBLIC RELATING TO BUSINESS TRANSACTED AT THIS MEETING

The following questions/concerns/comments were raised by public attendees in respect of the subjects discussed at the meeting:-

(1) a query as to the number of operations cancelled in the last 4 weeks, the impact on

UHL's finances, and how the Trust would compensate for that impact. In response, the Chief Operating Officer acknowledged that the Trust had had to cancel more elective operations than it wished, but advised that elective work had been consciously planned to be reduced in January 2016 in light of known winter pressures. All cancellation decisions were taken clinically, focusing on daycases and elective inpatients. Patient groups were stratified, such that cancer patients, urgent patients and long waiters would go ahead. The Chief Operating Officer advised that until this week, UHL had remained compliant with the 0.8% national target re: on the day cancellations – he confirmed that 45 patients had been cancelled on the day in the last 4 weeks, in the context of approximately 1000 patients per week being operated on although he recognised that cancellation was worrying for patients. In response, the questioner advised that he was seeking information on all cancellations not only those on the day – the Chief Operating Officer agreed to provide this data outside the meeting. In respect of the financial impact of cancellations, the Chief Financial Officer confirmed that loss of elective income was a recognised risk to the Trust's financial position, and he noted that a number of mitigating actions were in place, including the recently-signed loan agreement in Minute 10/16/4 above which would save the Trust £56000 per month in interest repayments. The Chief Financial Officer also commented on his wish for contract negotiations to recognise the activity pressures on the Trust, and he noted the reduced capital charges associated with a reduced capital programme; **COO**

(2) a query as to what penalties would be sought from CCGs by the Trust for the 'overuse' of ED, and whether this would be a joint approach with EMAS. In response, the Chief Executive advised that there were no penalties that Trusts could levy on Commissioners, and he noted the efforts underway within LLR to improve the working of the healthcare system generally;

(3) a query as to whether there was any update available on the Interserve contract position, and whether the Trust had advised the NTDA of the contract issues. The Trust Chairman advised that the Trust Board discussed this issue each month in its private session, and he noted the legal and financial considerations to be taken into account in terms of what could be shared publicly at present. The Trust was keeping its staff informed as far as possible, and would share information publicly when it was able to do so. The NTDA was fully apprised of the situation, and the Trust Chairman noted that UHL's monthly return to the NTDA (which referred to the contract situation) was in the public domain via the Trust Board Bulletin at Minute 12/16 above, and

(4) a query as to why issues with the orthodontics service had not been resolved and why patients were having to go elsewhere for treatment. In response, the Chief Executive advised that recruitment attempts had been unsuccessful, and that all alternative providers in community settings were under pressure. He advised that the Trust was meeting with the NTDA and NHS England shortly to discuss the mismatch between orthodontics demand and capacity, and he recognised that the current waiting time position was unacceptable. In response to a further comment from the questioner, the Chief Executive requested details from him of any situations where other Trusts could run (eg UHL's) orthodontic service as a 'satellite' so that this could be appropriately reviewed.

DCLA

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

14/16 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 15/16 – 22/16), having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.

15/16 DECLARATIONS OF INTERESTS IN THE CONFIDENTIAL BUSINESS

No declarations of interest were made in respect of the confidential business.

16/16 CONFIDENTIAL MINUTES

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

17/16 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 could prejudice the effective conduct of public affairs.

18/16 REPORT FROM THE ACTING MEDICAL DIRECTOR

Resolved – that this Minute be classed as confidential and taken in private accordingly, on the grounds that public discussion at this stage could prejudice the effective conduct of public affairs.

19/16 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.

20/16 REPORTS FROM BOARD COMMITTEES

20/16/1 Quality Assurance Committee (QAC)

Resolved – that the confidential 17 December 2015 QAC Minutes be received and noted.

20/16/2 Integrated Finance, Performance and Investment Committee (IFPIC)

Resolved – that the confidential 26 November 2015 IFPIC Minutes be received and noted.

20/16/3 Remuneration Committee

Resolved – that the confidential 10 December 2015 Remuneration Committee Minutes be received and noted.

21/16 ANY OTHER BUSINESS

21/16/1 Junior Doctors' Strike – 12 January 2016

Noting the expectation that the planned January 2016 junior doctors' strike would go ahead, the Director of Workforce and OD outlined the planning guidance issued to all staff and noted that any patients cancelled would be given clear notice in advance (and allocated a new date as soon as possible). The Chief Executive clarified that the first 2 of the planned strikes would continue to provide emergency cover, with the impact of the 3rd all-out strike likely to be much greater. In response to a comment from the Trust Chairman, the Acting Medical Director confirmed that he was already providing information to the Leicester Mercury on the Trust's arrangements for 12 January 2016. **AMD**

Resolved – that the Leicester Mercury continue to be appropriately informed of the Trust's arrangements for the 12 January 2016 planned junior doctors' strike. **AMD**

21/16/2 Ms K Shields – Director of Strategy

Noting that this was her last public Trust Board meeting, the Trust Chairman thanked Ms K Shields Director of Strategy for her significant contribution to the Trust and wished her well for the future.

Resolved – that the position be noted.

22/16 DATE OF NEXT TRUST BOARD MEETING

Resolved – that the next Trust Board meeting be held on Thursday 4 February 2016 from 9am in Seminar Rooms 2 & 3, Clinical Education Centre, Glenfield Hospital.

The meeting closed at 1.49pm

Helen Stokes – **Senior Trust Administrator**

Cumulative Record of Attendance (2015-16 to date):

Voting Members:

Name	Possible	Actual	% attendance	Name	Possible	Actual	% attendance
K Singh	10	10	100	R Mitchell	10	10	100
J Adler	10	10	100	R Moore	10	10	100
I Crowe	10	10	100	C Ribbins	4	3	75
S Dauncey	10	8	80	J Smith	6	6	100
A Furlong	10	10	100	M Traynor	10	9	90
A Goodall	8	7	88	P Traynor	10	10	100
A Johnson	3	3	100	J Wilson	9	9	100

Non-Voting Members:

Name	Possible	Actual	% attendance	Name	Possible	Actual	% attendance
D Henson	10	10	100	E Stevens	4	4	100
R Palin	5	3	60	L Tibbert	6	5	83
N Sanganee	4	2	50	S Ward	10	10	100
K Shields	10	7	70	M Wightman	10	10	100