UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF A MEETING OF THE TRUST BOARD, HELD ON THURSDAY 7 APRIL 2016 AT 9AM IN ROOMS A & B, EDUCATION CENTRE, LEICESTER GENERAL 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
Mr A Johnson – Non-Executive Director
Mr R Mitchell – Chief Operating Officer
Ms J Smith – Chief Nurse
Mr M Traynor – Non-Executive Director
Mr P Traynor – Chief Financial Officer

In attendance:
Professor N Brunskill – Director of Research and Innovation (for Minute 75/16)
Mr G diStefano – Head of Strategic Development (for Minute 73/16/5)
Ms L Gallagher – Workforce Development Manager (for Minute 74/16)
Mr D Henson – LLR Healthwatch Representative (up to and including Minute 80/16)
Mr M Hotson – Head of Business, Commercial and Contracts (for Minute 84/16)
Ms B Kotecha – Assistant Director of Learning and OD (for Minute 74/16)
Ms H Leatham – Assistant Chief Nurse (for Minute 73/16/1)
Dr N Sanganee – LLR CCG representative (up to and including Minute 80/16)
Ms H Stokes – Senior Trust Administrator
Ms L Tibbert – Director of Workforce and OD
Mr S Ward – Director of Corporate and Legal Affairs
Mr M Wightman – Director of Marketing and Communications
Ms C Wimbury – Haemodialysis Unit Sister (for Minute 73/16/1)

ACTION

67/16 APOLOGIES AND WELCOME

Apologies for absence were received from Professor A Goodall, Non-Executive Director and Mr R Moore, Non-Executive Director.

68/16 DECLARATIONS OF INTERESTS IN THE PUBLIC BUSINESS

The Chairman declared an interest in the Lakeside House practice, which was referred to in the month 11 finance report at Minute 76/16/3 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.

69/16 MINUTES

Resolved – that the Minutes of the 3 March 2016 Trust Board be confirmed as a correct record and signed by the Trust Chairman accordingly. **CHAIR MAN**

70/16 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) **actions 3a and 3b (Minute 49/16/2 of 3 March 2016)** – these actions were being progressed by the Director of Workforce and OD, who advised that appropriate targets would be finalised by 30 April 2016. With regard to action 3c of that same Minute, the

Chairman confirmed that BME applicants would be encouraged for the vacant UHL Non-Executive Director – he would be raising this accordingly with the NTDA, and

(b) **action 12 (Minute 28/16 of 4 February 2016)** – the first of the planned quarterly reports on estates performance/issues would be presented to the April 2016 Integrated Finance Performance and Investment Committee. **DEF/ CE**

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

71/16 CHAIRMAN'S MONTHLY REPORT – APRIL 2016

In respect of the issues highlighted in paper C, the Chairman advised that in the run-up to the June 2016 CQC inspection he intended to visit all 90 of UHL's wards (accompanied by either a UHL Patient Partner or a representative from a partner health organisation), and he encouraged Trust Board colleagues to join him. He also noted that as of 1 May 2016, UHL was likely to be the largest employer in Leicester, Leicestershire and Rutland, and he recognised the workforce challenges facing the Trust (particularly in nursing, with a task and finish group being established accordingly). The Chairman also commented on UHL's corporate social responsibility to the community, which would be discussed further by the Trust Board at its June 2016 thinking day.

The third issue he wished to highlight was that of End of Life Care, following the recent national audit report on palliative care services within hospitals. That report had been discussed by UHL's Executive Quality Board on 5 April 2016 and was also scheduled for consideration at the April 2016 Quality Assurance Committee (QAC). Mr D Henson, Healthwatch representative noted feedback from UHL patients on end of life care issues, and the Chief Nurse agreed to contact him to discuss this further. **CN**

As a final issue, the Chairman advised that his term of office had been extended by the NTDA until September 2019, which was welcomed by the Trust Board.

Resolved – that contact be made with the Healthwatch representative regarding public feedback on end of life care (to inform the report scheduled for QAC on 28 april 2016). **CN**

72/16 CHIEF EXECUTIVE'S MONTHLY REPORT – APRIL 2016

The Chief Executive's April 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) that the report from the CQC's 30 November 2015 visit to ED was due to be published today (circulated internally on 6 April 2016 to Trust Board members on an embargoed basis). The report contained no 'new' issues, and the Chief Executive confirmed that UHL's actions in response to the CQC's findings continued to be rigorously monitored through QAC and other appropriate groups;

(b) that 2016-17 contracting negotiations continued to be held and had not yet resolved all

issues. As further discussions were scheduled with Commissioners on 8 April 2016, the Chief Executive advised that the Trust's Annual Operating Plan 2016-17 at paper I (Minute 73/16/5 below refers) was not yet finalised. He also emphasised that the financial position across LLR remained challenging, although relationships had improved significantly from previously;

(c) a cross-LLR event held on 6 April 2016 to explore the scope for progressing the integration of services in the context of Better Care Together. Attended by more than 200 people and with the Kings Fund Chief Executive as the keynote speaker, the event had been co-hosted by UHL's Medical Director and West Leicestershire CCG's Managing Director. It had been a very positive session, and a number of threads were now being pursued including issues re: the co-location of primary and secondary care services. The West Leicestershire CCG Managing Director was also leading work on linkages with the Sustainability and Transformation Fund, and

(d) his yearly review of performance against the Trust's 2015-16 annual priorities, with markedly more either achieved or partly achieved than not achieved. Although the review was not yet able to take account of month 12 performance, the Chief Executive did not expect the current position to change significantly once those results were available. UHL was performing strongly on the quality agenda, appeared to be bucking the national trend in respect of financial sustainability, and was strong on research and innovation performance. However, the Chief Executive recognised the continuing significant challenges in ED, and underperformance on cancer access targets (although UHL had achieved referral to treatment targets).

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

(i) queried whether the electronic patient record (EPR) situation had progressed. In response the Chief Executive noted the continuing national constraints on capital availability, and advised that UHL still required an amount of DoH capital funding to supplement the funding arrangement agreed with the Trust's private IM&T partner. He confirmed that he had escalated his concerns over this project to the NTDA, reflecting the fact that due to the delays UHL was now having to invest money in existing systems which would not be recouped. The Medical Director also commented that the role of an EPR (and the availability of a single healthcare record accessible by all healthcare organisations) in assisting service integration had been one of the key messages from the 6 April 2016 event;
(ii) noted (in response to a query) that the Torbay model had been identified as a useful case study at the 6 April 2016;
(iii) reiterated (in response to a query from the Healthwatch representative) that UHL continued to aim to achieve the 62-day cancer target by June 2016;
(iv) welcomed the Trust's progress against the core objective of providing safe, high-quality care;
(v) confirmed its view that capacity and performance challenges in ED remained the key issue facing UHL. ED performance also impacted on the other key performance metrics (Minute 73/16/2 below refers), and
(vi) noted comments from the CCG representative on the similar challenges facing primary care in terms of rising demand and workforce pressures. He recognised that access to primary care also impacted on secondary care providers.

<u>Resolved</u> – that the Chief Executive's April 2016 monthly report be noted.

73/16 KEY ISSUES FOR DECISION/DISCUSSION

73/16/1 <u>Patient Story – Nocturnal Dialysis Service</u>

Paper E from the Chief Nurse advised the Trust Board of the Nocturnal Dialysis service

offered at the Leicester General Hospital, and its positive impact on patients. A patient of the service attended to outline how the service had significantly improved his quality of life (also shown on the DVD now watched by the Trust Board), and he particularly also commented on the friendly, compassionate and dedicated care provided by the staff on the unit. Currently running for 3 nights per week, the Nocturnal Dialysis service offered 6.5 hours of dialysis per time, thus increasing the treatment provision by 50% over a week, and paper E noted that research indicated that increased haemodialysis provision resulted in better mortality. The patient attending for this item commented that Nocturnal Dialysis had given him a 'normal life' by freeing up time during the day, and commented that he had not found dialysis at home to be suitable. The service had been trialled in June 2014 as a result of patient survey feedback – currently accommodating 12 patients it was hoped to increase this to 18 in June 2016.

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

(a) particularly welcomed that the Nocturnal Dialysis service had been established as a result of listening to and acting upon patient feedback and needs. In response to a Healthwatch query, it was advised that it had taken 6 months to establish the service;

(b) queried the scale of the 'unmet need' for the service. In response, the Haemodialysis Unit Sister advised that the waiting list internally was between 3-7 patients, although as the service was also provided across other dialysis units there could be up to 20 patients waiting. The service could only physically accommodate 18 patients, however;

(c) queried how easy it was to staff the unit overnight – in response, the Haemodialysis Unit Sister advised that it would be easier to staff once the service operated 6 nights per week, as this was a more stable working pattern;

(d) noted the reiterated comments from the patient on the high quality care and compassion provided by the nursing staff, not only in the dialysis unit but across UHL's hospitals;

(e) noted that the Leicester General Hospital had been the first NHS unit nationally to run a Nocturnal Dialysis service, and had been approached for advice on doing so by several other large hospitals. The Trust Board welcomed this example of innovative and patient-centred practice. In response to a query from the CCG representative, the service also noted moves to develop a GP-led service in line with care closer to home principles;

(f) noted comments from the Chief Executive on the wide geographical spread of UHL's renal dialysis service (which covered a number of units in Cambridge, Peterborough, Lincoln, Kettering and Northamptonshire). He also welcomed the positive innovations in this service, although recognising that developments such as the Nocturnal Dialysis service impacted significantly on staff working patterns, and

(g) thanked both the patient and the staff members for attending to share this story.

<u>Resolved</u> – that the Leicester General Hospital Nocturnal Dialysis service patient story be noted.

73/16/2 <u>Emergency Care Performance</u>

Further to Minute 49/16/3 of 3 March 2016, paper F from the Chief Operating Officer updated the Trust Board on recent emergency care performance, which stood at 86.4% for the year to date despite continued atypically-high attendance and admission rates. In a candid introduction on the current emergency performance, the Chief Operating Officer advised that – at 77.8% – March 2016 performance was likely to be the worst ever to date for UHL. He considered that the situation was extremely challenging for both ED and the Clinical Decisions Unit (CDU) at the Glenfield Hospital, driven primarily by the increasing

level of admissions. The Chief Operating Officer reiterated that this was a key concern for the Trust, both in terms of the quality of care to patients and the pressure on staff. He recognised that too many patients were waiting too long for their treatment, with (on average) 145 patients waiting longer than four hours every day in March 2016, which was unacceptable. UHL was working with the emergency teams to make sure they took every possible action to reduce that number, and the Chief Operating Officer noted that a key group of patients were the 'non-admitted breaches', ie the lower-acuity patients, who were not admitted into a bed and often did not go through the majors department.

Following comments from the Chief Financial Officer at the March 2016 Trust Board regarding the short-term nature of the action plan, the Chief Operating Officer had reviewed those actions – he considered that despite changes in governance, demand was unlikely to reduce in either the short or longer term, and he advised that the action plan contained no 'game-changes'. As an organisation UHL was therefore expecting an ongoing increase in demand and was trying to plan accordingly. Despite the view that demand was not going to reduce, the Trust nonetheless believed that it was appropriate to expect the LLR health system to deliver schemes which reduced avoidable attendance and admissions, and the Chief Operating Officer commented that taking decisive action to integrate primary and secondary care might help in achieving this. He also noted the need for UHL to continue working on its successful plans to discharge patients (UHL was discharging 7% more patients than the same time in 2015, and length of stay had reduced by 16%). The Chief Operating Officer also advised of the need to go back to basics in terms of expectations re: behaviours and performance in ED. In concluding his introduction to paper F, the Chief Operating Officer also noted:-

(i) progress made on ambulance handovers – however that progress had now stalled;
(ii) completion of the actions around demand and capacity work. Pending the completion of contract negotiations the Trust was facing a bed deficit in 2016-17; although work continued on resolving this it remained a risk issue;
(iii) the Executive Team decision to protect a proportion of elective beds at the LRI – although not without risk and complications, it was viewed as the most appropriate action, and
(iv) (in response to a previous Trust Board query) confirmation that the acuity of patients brought in by private ambulance crews was generally lower than that of EMAS-transported patients.

In discussion on emergency performance and the Chief Operating Officer's comments, the Trust Board:-
(a) reiterated that emergency performance was the highest risk facing UHL, and noted its wide impact on other services and performance indicators across the Trust;

(b) queried whether there was any geographical pattern to ED demand. Although there were differences between the CCGs in terms of demand, the Chief Operating Officer considered that this was multi-factorial in nature. He also noted the need to apply successful measures to all areas;

(c) noted the national ED challenges facing all Trusts, with UHL currently mid-table on ED performance. In the absence of any 'game-changers' the Chief Executive emphasised the need to focus on system integration and also to improve the outflow from ED. He also reiterated that the mismatch between capacity and demand was the key issue underlying ED performance, and he confirmed that UHL did not currently have a balanced plan. The Trust Chairman requested that the Trust's 2016-17 demand and capacity plan be presented to the Trust Board once finalised; **COO**

(d) noted that the staff involved in emergency performance efforts would also be needed to focus on the transition to the new emergency floor facility in 2016-17;

(e) noted comments from the Healthwatch representative (1) querying whether internal ED processes and outflow processes were followed consistently and (2) seeking assurance that the existing ED challenges would not be repeated in the new emergency floor facility. The Chief Operating Officer welcomed both of these points, acknowledged that processes were being applied inconsistently and advised that UHL was trying to remedy this where it was within the Trust's control;

(f) noted that the April 2016 Trust Board thinking day would discuss both ED and CDU issues, and suggested that further thought be given to how to keep the Trust Board appropriately sighted to CDU challenges; **COO**

(g) noted Non-Executive Director comments on the need to ensure that the LLR healthcare economy could 'think nationally and act locally' on this issue, and avoid parochialism. This was echoed by the CCG representative who also commented on the need to focus on integration and continued mutual dialogue between primary and secondary care, given that demand was unlikely to reduce;

(h) received assurance that the opening of ICS beds was on track (130 such beds opened by 31 March 2016). The Chief Operating Officer also outlined the referral routes into those beds, noting that in March 2016 UHL had referred approximately 70% of its expected ICS referrals;

(i) noted Non-Executive Director comments on the need to follow through the ED recommendations proposed at the March 2016 Trust Board thinking day, and

(j) agreed that the Director of Marketing and Communications would review opportunities to increase Executive and Non-Executive Director visibility with GPs in ED and the Urgent Care Centre. **DMC**

<u>Resolved</u> – that (A) UHL's 2016-17 demand and capacity plan be presented to a future Trust Board; **COO**

(B) consideration be given to how best to sight the Trust Board appropriately to capacity issues facing the Glenfield Hospital Clinical Decisions Unit, and **COO**

(C) opportunities to improve Trust Board and Executive Director visibility with GPs in the ED/Urgent Care Centre be reviewed. **DMC**

73/16/3 <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. In terms of key workstream deep dives, paper G focused on the Children's Hospital capital reconfiguration business case.

As the new SRO for reconfiguration, the Chief Financial Officer noted his intention to refine the monthly update report slightly, to provide a more pictorial illustration of the timelines and refresh the risk log content and dates (in addition to the change already made to provide more detail on the six major reconfiguration capital business cases). He also noted the continuing impact of constrained capital availability, with further clarity on the 2016-17 national capital allocations unlikely before the end of June 2016. In discussion on the reconfiguration update, the Trust Board noted in particular:-

(a) the emerging clinical risk linked to demand and capacity issues, as now outlined by the Medical Director. He noted the need to ensure that the Glenfield Hospital site in particular

was appropriately prepared to receive the reconfigured services, in terms of both its diagnostic capacity and ward-based services. The Healthwatch representative reiterated his previously-expressed concerns about the point at which ICU services might become clinically unsustainable – in response, the Medical Director advised that ICU service provision at the Leicester General Hospital site had now stabilised due to the Trust's commitment to the longer-term reconfiguration plan which was enabling the recruitment and retention of staff. Difficulties might resurface however if that commitment was to change for any reason. The Healthwatch representative suggested the need for appropriate communication on this issue, to reassure patients and the public that there was no clinical sustainability issue with ICU at the moment; **MD**

(b) Non-Executive Director queries about model of care work aimed at reducing demand, and the Chief Operating Officer's response, and

(c) a Non-Executive Director suggestion that it might be helpful to consider wider public communication of the Medical Director's '3 models of service' approach as discussed at the 6 April 2016 LLR event, and to reflect this in the Better Care Together [BCT] consultation narrative. In response, the Director of Marketing and Communications (as the new UHL SRO for BCT) confirmed that the thinking had now moved on and become more nuanced from the original 'smaller and more specialised' focus – he agreed to circulate information on this to Trust Board members ahead of the April 2016 Trust Board thinking day. Further thought could then also be given on whether any more detailed discussion was required on this issue subsequently. **DMC**

With regard to the Children's Hospital capital reconfiguration scheme (as per the workstream deep dive in paper G), the Director of Marketing and Communications noted that this was a significant project in terms of both size and impact. As UHL was planning provision for a 0-18 age range rather than 0-16, the development would therefore also cover the transition from children's to adult services. The Director of Marketing and Communications also clarified that a new build children's hospital was not affordable, and that the Trust was therefore likely to be exploring options to use refurbished Balmoral Building estate at the LRI. Architects had now been shortlisted, with the outline and then full business case due in August 2016 and February 2017 respectively (due to capital availability). In discussion, the Chief Nurse and the Medical Director reiterated that the age appropriateness of children's services was a key issue, particularly for 16-18 year olds.

Members agreed that it would be helpful to receive a standalone report on the Children's Hospital development at a future Trust Board, also covering all funding aspects. In further discussion, the Chief Financial Officer advised that the scale and scope of any charitable fundraising appeal for the Children's Hospital had not yet been confirmed, and would be progressed through the Charitable Funds Committee. **DMC/ CFO**

<u>Resolved</u> – that (A) the format of the reconfiguration monthly update be further refined to (i) provide a more pictorial illustration of the timelines and (ii) refresh the risk log content and dates; **CFO**

(B) consideration be given to how to keep the public informed and reassured of the clinical sustainability position of the (LGH) ICU service; **MD**

(C) more nuanced information on the service model options available to UHL be circulated ahead of the April 2016 Trust Board thinking day (consideration then to be given to whether any further information session was required on that issue), and **DMC**

(D) a report on the Children's Hospital development be provided to a future Trust Board at an appropriate date. **DMC/ CFO**

73/16/4 <u>LLR Better Care Together (BCT) Programme Update</u>

Paper H from the Director of Marketing and Communications 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 continued to be the availability of transformational funding and staff/public/ patient engagement. Following a suggestion from the Chief Operating Officer it was agreed to recommend (to the BCT Programme Management Office) that a third top risk of demand be added. **DMC**

The Director of Marketing and Communications confirmed that public consultation on BCT would not now be possible before the 23 June 2016 referendum of continued UK membership of the EU, due to purdah. The BCT pre-consultation business case had been updated following its discussion by all appropriate organisations in March 2016 and passed to NHS England for review (confirm and challenge session with NHSE scheduled for 18 April 2016). In discussion on this item, the Trust Chairman noted the need for the BCT consultation to have a coherent narrative, and for the activity assumptions underpinning the BCT programme to be clear and realistic. The Chief Executive also clarified that BCT should be seen as a subset of the LLR Sustainability and Transformation Plan, and noted his view that it was clear how the two aligned.

<u>Resolved</u> – that the inclusion of 'demand' as a 3rd 'top risk' in the monthly BCT updates, be proposed to the BCT Programme Management Office. **DMC**

73/16/5 <u>Annual Operational Plan 2016-17</u>

The Head of Strategic Development attended to introduce the Trust's updated Annual Operational Plan for 2016-17, as detailed in paper I. He clarified that the submission date for the finalised AOP was now 18 April 2016, to enable contract negotiations to be appropriately reflected. Delegated authority was therefore sought for the Chairman and Chief Executive to sign off the finalised plan for submission to NHS Improvement accordingly. The Trust Board approved this delegated authority, and agreed to include Mr M Traynor Non-Executive Director and Deputy Trust Chairman in the event that the Trust Chairman was unavailable. In discussion on the 2016-17 Annual Operating Plan as presented, the Trust Board noted:- **ALL**

(a) the Chief Executive's wish to review the wording of strategic priority 7(c) (re: models of care for outpatients, medicine and surgery); **CE**
(b) the very challenging position re: the agency spend caps, noting that UHL had appealed against its total on a largely technical basis linked to the UCC;
(c) the national context of both continued contractual negotiations and the requirement for Trusts to meet stringent improvement trajectories in order to receive Sustainability and Transformation funding. The Chief Executive highlighted to the Trust Board that UHL's improvement trajectory on ED looked extremely challenging at this point given the continued imbalance between demand and capacity, and would likely be very difficult to achieve;
(d) comments from the Chief Financial Officer outlining the March 2016 IFPIC's discussion on the level of 2016-17 CIP targets and the agreed level reached of £35m as reflected in the AOP at paper I;
(e) that the efficiency targets for Trusts had been halved nationally, and
(f) a query from the Healthwatch representative on the scope for in-year changes to the AOP. In response, the Chief Executive advised that there was no flexibility to alter the plan in respect of the improvement trajectories and financial outturn.

Subject to any changes detailed above, the Trust Board approved the draft Annual Operating Plan 2016-17 as presented and delegated authority to the Chairman (or Deputy Chairman in his absence) and Chief Executive to approve the finalised version for **CHAIR MAN/ DEP CHAIR/**

submission to NHSI on 18 April 2016. **CE**

<u>Resolved</u> – that (A) the Chief Executive review the wording of point (c) of strategic priority 7, and advise the Head of Strategic Development accordingly; **CE**

(B) subject to the rewording of strategic priority 7c above, the draft 2016-17 AOP – including the 2016-17 financial plan and capital programme – be approved, recognising the potential need for further amendments before the final submission date; **ALL**

(C) authority be delegated to the Chief Executive and Trust Chairman [or Deputy Trust Chairman in the latter's absence] to review and sign off the finalised 2016-17 AOP for submission to NHS Improvement on 18 April 2016, and **CHAIRMAN/ DEP CHAIR/ CE**

(D) the final iteration of the 2016-17 AOP be submitted to the 5 May 2016 Trust Board. **CFO**

74/16 WORKFORCE AND ORGANISATIONAL DEVELOPMENT (OD)

74/16/1 <u>Workforce Plan Update</u>

Paper J from the Director of Workforce and OD provided a quarterly update on progress against the Trust's OD Plan and 5-year Workforce Development Plan 2014-19. The Workforce Development Manager and the Assistant Director Learning and OD attended for this item. The Workforce Development Manager advised that the workforce plan was currently 126 whole time equivalents (WTEs) off-plan, due largely to nursing staff recruitment. She also outlined the very significant work done re: the medical workforce (where Trust grade doctor recruitment measures were starting to reduce the use of agency locums) and commented on the Physician's Associate initiative (noting that their scope of practice could not currently be expanded as the staff involved were not yet on a statutory register in the UK). In discussion on the workforce plan update the Trust Board:-

(a) was advised by the Chief Nurse of the significant additional activity underway re: nursing and HCA recruitment, beyond that described in paper J. National consultation had now ended on the Nurse Associate role, which could fundamentally change the shape of the nursing workforce – it was noted that UHL had applied to be a pilot site for this role. The Chief Nurse also outlined work with the Open University as a 2nd partner in nurse education and training. UHL was also focusing on retention of nursing staff, and exploring the possibility of a post-registration faculty within the Trust;

(b) noted comments from the Trust Chairman re: the potential (nursing and midwifery) workforce impact of any UK exit from the EU, and the need to take appropriate account of this possibility; **DWOD**

(c) noted (in response to a query) that figure 2 (staff group change bridge) was approximately 40-50 behind the revised September 2015 plan;

(d) noted (in response to a query from the CCG representative) the nature of the proposed new pharmacy roles within the Emergency Floor;

(e) discussed the need to understand staff productivity issues (including reducing clinical variation) – it was agreed to discuss this further at the June 2016 Trust Board thinking day on workforce and OD. The Director of Workforce and OD confirmed that the Trust was reviewing staff productivity measures in the context of the Carter Review and cost improvement programme targets, as part of the cross-cutting workforce stream, and **DWOD**

(f) was advised of ED's view that Physician's Associates would not add as much value in that Department as other roles which could prescribe (eg Advanced Nurse Practitioners). In response to a query from the Chief Executive, the Medical Director advised that Physician's Associates were now affiliated to the Royal College of Physicians, although they were not yet statutorily regulated in the UK.

Resolved – that (A) the possible implications (for the nursing workforce) of a 'Brexit' decision in the referendum on continued UK membership of the EU be appropriately considered, and **DWOD**

(B) staff productivity issues be considered further at the June 2016 Trust Board thinking day on workforce and OD issues. **DWOD**

74/16/2 National Staff Survey Results 2015

Paper K updated the Trust Board on the results of the 2015 national staff survey and UHL Pulse Check survey, and also outlined progress on the actions arising from the 2014 national staff survey findings. The Workforce Development Manager and the Assistant Director Learning and OD attended for this item. A sample of 850 UHL staff had been contacted as part of the 2015 national staff survey with a response rate of 25% (which was lower than in 2014), while the Pulse Check had been conducted on 25% of UHL staff. The results had been triangulated using a methodology developed by Wrightington Wigan and Leigh NHS Foundation Trust, and had shown:-

(1) improvements on a number of quality issues (including a reduction in staff witnessing incidents or near misses), valuing appraisal, and in the number of staff recommending the Trust as a place to work, and
(2) the need for further work on staff engagement and involvement.

The 2015 national staff survey findings had been discussed in detail at the Executive Workforce Board on 28 March 2016, and the Workforce Development Manager noted that they demonstrated an overall improvement on the 2014 results. In discussion on paper K, the Trust Board:-

(a) queried what measures were in place to improve staff wellbeing overall, recognising that although work pressures could not always be removed, employers could try and alleviate stresses in other aspects of staff life. The Director of Workforce and OD noted that wellbeing issues would also be covered at the June 2016 Trust Board thinking day on workforce and OD;

(b) noted that the CQC would review the Trust's national staff survey results as part of their inspection of UHL. The Chief Nurse confirmed that there would be an opportunity to provide an appropriate accompanying narrative, and

(c) noted the Healthwatch representative's comments on the scope to correlate instances of good levels of staff empowerment and good patient experience within UHL.

Resolved – that the report on the 2015 national staff survey be noted.

74/16/3 UHL Way and LiA 4-Year Plan

Paper L provided an update on the 'UHL Way' as reported to the Trust Board on 3 December 2015 (Minute 254/15/2 refers), including continuing the 'Listening into Action' (LiA) programme as part of the better engagement strand of the UHL Way. Launched in January 2016, the UHL Way comprised 3 components (better engagement; better teams, and better change) and was supported by the UHL Academy and a 'Community of Experts'. The first cohort to adopt the 'better teams' component (around 10 teams) would begin in June 2016. The Assistant Director of Learning and OD also advised that an incremental approach was being adopted for the 'better change' component, involving testing the methodology on larger-scale projects. Further discussion was also planned with the Chief Executive on the best way of reporting progress against the 3 UHL Way components.

In discussion on the update (any detailed comments on the drafting of which would be provided outside the meeting), the Trust Board:-

(a) requested that Healthwatch input be sought to the LiA 'involvement into action' workstream. In terms of patient and public involvement generally, it was noted that one of UHL's Patient Partners was already also a member of the UHL Way Steering Group; **DWOD**

(b) welcomed the UHL Way implementation plan 2016-17 detailed at paper L, and suggested a need to consider how to ensure that staff had the necessary skills and what was required of leaders at the various points along the UHL Way. The Assistant Director of Learning and OD confirmed that work was now underway to set out the core requirements/competencies for the programme. The Chief Executive further advised that he had asked Executive Directors to identify any UHL Way-related skillgaps in their current portfolios and take steps to address those through their personal development plans. The Assistant Director of Learning and OD would be able to advise Executive Directors of the basic requirements accordingly. The Chairman requested that appropriate consideration also be given to Non-Executive Directors in this regard; **EDs/ DWOD/ ADLOD**

(c) queried how the overall success of the UHL Way would be measured – in response the Director of Workforce and OD confirmed that she was looking to identify relevant outcome measures and organisational performance indicators, rather than only measuring take-up; **DWOD**

(d) noted a query from the Healthwatch representative on how to ensure that staff felt appropriately engaged with the UHL Way initiatives, and

(e) agreed to receive a further update in 6 months' time, in addition to the planned wider OD discussions at the June 2016 Trust Board thinking day. **DWOD**

<u>Resolved</u> – that (A) Healthwatch input be sought to the LiA "involvement into action" workstream; **DWOD**

(B) Executive Directors address any current UHL Way skillgaps through their 2016-17 personal development plans (basic requirements to be advised by the Assistant Director of Workforce and OD), with further thought also to be given to how to address any gaps for Non-Executive Directors; **EDS/ DWOD/ ADLOD**

(C) appropriate organisational performance indicators be identified to measure the success of the UHL Way, and **DWOD**

(D) a further report on LiA/UHL Way be provided to the Trust Board in 6 months' time. **DWOD**

74/16/4 <u>Junior Doctors' Contract</u>

Paper M outlined the scope of the changes and the implications for UHL of implementing the National Junior Doctors' Contract with effect from August 2016. Although the BMA had objected to the contract's imposition by the Government (which remained the subject of ongoing industrial action), Trusts were required to make appropriate arrangements for the implementation of the new contract. As detailed in the report, key contract changes fell into 3 areas: pay, safety, and training, and required the Trust also to appoint a Guardian of Safe Working. Within UHL, over 900 junior doctors and 121 full rota templates (plus 70-85 individual rota templates) would be affected by the changes – given this significant scale paper M therefore also proposed that an appropriate project structure be established to oversee the implementation of the necessary contract provisions. In discussion on the report, the Trust Board noted:-

(a) plans to request some temporary project resource from the Trust's Revenue Investment Committee. It was also planned to invite a group of junior doctors to co-produce the rotas work;

(b) the national position that implementation of the new rotas would be 'cost-neutral', although it was not certain that this would in fact be the case;
(c) comments by the Medical Director regarding recent difficult discussions with junior doctors. The Trust recognised the potential impact of the new contract on junior doctors and was keen to work with that staff group to mitigate the situation as far as possible. The Chief Executive emphasised the need for appropriately-resourced implementation of the contract to avoid worsening relations any further, and he noted the recognised need to improve relations on this issue, and
(d) the comments at section 3.3 of paper M regarding the regional modifications needed to the 12-month phased implementation plan for changes to the rota template, as that timescale (proposed by NHS Employers) did not align with junior doctor changeover dates for the East Midlands region. In order to streamline the transition for junior doctors, the rota template and contract of employment changes at UHL would therefore be made as detailed in section 3.3.3 of paper M. **DWOD**

DWOD

Resolved – that the recommendations within paper M be endorsed as follows:-

(1) establishment of a task and finish group to oversee and manage the implementation of the new junior doctors' contract;
(2) appointment of a 'Guardian of Safe Working Practices' at UHL (once further details were known);
(3) agreement to the implementation of the rota changes in section 3.3 for August 2016, and
(4) approval of the costs of the additional project resources required to implement the changes.

75/16 RESEARCH & INNOVATION

75/16/1 Research & Innovation Quarter 3 Report

Professor N Brunskill, Director of Research and Innovation attended to introduce the quarter 3 update on research and innovation (R&I) activity within UHL. Paper N described current R&I performance against metrics, projects under development, new challenges and potential threats. The Director of Research and Innovation advised that UHL was in league 1 (of 7) of Trusts in respect of R&I, in terms of both the volume and timeliness of studies. In quarter 3 of 2015-16 the Trust had initiated 116 clinical trials, reflecting the increase throughout the year to date, and UHL continued to be the highest recruiting Trust in the East Midlands by some considerable distance with almost 11,000 patients recruited by the end of quarter 3. In introducing the quarter 3 update, the Director of Research and Innovation particularly highlighted:-

(a) the focus on the Biomedical Research Centre (BRC) application process, led by UHL with the Universities of Leicester and Loughborough as its academic partners. The application covered 3 themes: cardiovascular, respiratory, and diet and lifestyle, and would amount to £17m over the lifetime of the award. Precision medicine would also feature as a cross-cutting theme. In response to a query, the Director of Research and Innovation advised that there was already good Board-level engagement with the BRC application;
(b) UHL's work in response to the NIHR 'renew and refresh' call for Clinical Research Facility (CRF) funding, which would also cover the Hope Unit and embedded UHL projects;
(c) the Trust's continued good engagement with its academic partners;
(d) the innovation and enterprise activities in section 4 of the report, which he would be happy to share in more detail at a future Trust Board thinking day, and
(e) agreement to retain the Life Study Centre as a clinical research facility, and to rename it as the Leicester General Hospital Clinical Research Centre. It was envisaged that cancer studies and Women's and Children's-related research would

be given the highest priority at that facility.

The Trust Board welcomed the impressive list of R&I initiatives and activity. In discussion, the Chief Executive requested that the Director of Research & Innovation brief him on progress in identifying Glenfield Hospital space for the Hope Unit, at their forthcoming meeting. The Medical Director noted that progress on that issue was also likely to assist UHL's bid for Cancer Research:UK funding. **DRI/CE**

Resolved – that the Chief Executive be briefed on progress in identifying appropriate space at the Glenfield Hospital for the Hope Unit. **DRI/ CE**

76/16 QUALITY AND PERFORMANCE

76/16/1 Quality Assurance Committee (QAC)

Paper O from the QAC Non-Executive Director Chair summarised the issues discussed at that Committee's 24 March 2016 meeting, Minutes of which would be presented to the May 2016 Trust Board. The QAC Non-Executive Director Chair advised of a correction required to page 2 of paper O, and noted that the HSE sharps visit was taking place today.

Resolved – that the summary of issues discussed at the 24 March 2016 QAC be noted (Minutes to be submitted to the 5 May 2016 Trust Board).

76/16/2 Integrated Finance, Performance and Investment Committee (IFPIC)

Paper P from the IFPIC Non-Executive Director Chair summarised the issues discussed at that Committee's 24 March 2016 meeting, Minutes of which would be presented to the May 2016 Trust Board. As detailed in paper P, Trust Board approval was sought for (i) the establishment of a task and finish group exploring ways to increase the number of self-funded nursing trainees, and (ii) a refresh of BAF principal risk 10 (re: a caring, professional and engaged workforce). The Trust Board approved these recommendations, although noting comments from the Chief Nurse that the task and finish group would have a wider remit beyond self-funded nurse trainees (she was currently developing the group's terms of reference with the Director of Workforce and OD). The IFPIC Non-Executive Director Chair requested that the task and finish group report into IFPIC. **CN/ DWOD**

Resolved – that (A) the summary of issues discussed at the 24 March 2016 IFPIC be noted (Minutes to be submitted to the 5 May 2016 Trust Board), and

(B) the recommended items in respect of the workforce update to be approved, including the proposed refresh of BAF risk 10 and establishment of a (nursing) workforce task and finish group to report into IFPIC. **CN/ DWOD**

76/16/3 2015-16 Financial Position – Month 11 (February 2016)

Paper Q provided an integrated report on month 11 financial performance (month ending 29 February 2016) and delivery of the revised 2015-16 financial plan. Noting the brief reference to Lakeside House at section 4.5 of paper Q, the Trust Chairman reiterated his previously-declared interest in Lakeside House and confirmed that he would withdraw from the meeting if Trust Board members wished to discuss that element in any further detail. In the event, this issue was not raised further and it was not therefore necessary for the Chairman to withdraw from the discussion.

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 29 February 2016, UHL's financial performance was £0.8m adverse to plan, with a deficit of £35.6m compared to the planned deficit of £34.8m. Despite

being a short month, the deficit in February 2016 had been better than expected, and the Chief Financial Officer considered that UHL remained on target to deliver its 2015-16 £34.1m control total, although acknowledging that quarter 4 of 2015-16 had been challenging financially.

The Chief Financial Officer noted that 2016-17 was likely to be a difficult year financially, and he advised that the finance team's current focus was on the finalisation of the 2016-17 financial plan and the production of the 2015-16 annual accounts.

Resolved – that the financial position for month 11 be noted.

77/16 REPORTS FROM BOARD COMMITTEES

77/16/1 Audit Committee

In the absence of the Audit Committee Non-Executive Director Chair, Col (Ret'd) I Crowe Non-Executive Director introduced the 3 March 2016 Audit Committee Minutes (paper R), noting that risk management issues had also been discussed further at the March 2016 Trust Board thinking day. He also noted that the Trust's Annual Governance Statement 2015-16 was due by 22 April 2016.

Resolved – that the Minutes of the 3 March 2016 Audit Committee be received and noted, and any recommendations approved accordingly.

77/16/2 Quality Assurance Committee (QAC)

Resolved – that the Minutes of the 25 February 2016 QAC be received and noted, and any recommendations approved accordingly.

77/16/3 Integrated Finance Performance and Investment Committee (IFPIC)

Resolved – that the Minutes of the 25 February 2016 IFPIC be received and noted, and any recommendations approved accordingly.

78/16 TRUST BOARD BULLETIN – APRIL 2016

Resolved – that the Trust Board Bulletin containing the following reports be noted:-
(1) full list of 2016-17 Trust Board declarations of interests, and

(2) a retrospectively-reported 2015-16 declaration of interest for the Acting Director of Strategy, noting that she was exploring the possibility of establishing a small consultancy.

79/16 QUESTIONS AND COMMENTS FROM THE PRESS AND PUBLIC RELATING TO BUSINESS TRANSACTED AT THIS MEETING

There were no questions or comments from 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**

80/16 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 81/16 – 87/16), having regard to the confidential nature of

the business to be transacted, publicity on which would be prejudicial to the public interest.

81/16 DECLARATIONS OF INTERESTS IN THE CONFIDENTIAL BUSINESS

There were no declarations of interests in the confidential business.

82/16 CONFIDENTIAL MINUTES

Resolved – that the confidential Minutes of the 3 March 2016 Trust Board be confirmed as a correct record and signed by the Trust Chairman accordingly. **CHAIR MAN**

83/16 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.

84/16 JOINT REPORT FROM THE DIRECTOR OF ESTATES AND FACILITIES AND THE DIRECTOR OF WORKFORCE AND OD

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

85/16 REPORTS FROM BOARD COMMITTEES

85/16/1 Audit Committee

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.

85/16/2 Quality Assurance Committee (QAC)

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

85/16/3 Integrated Finance, Performance and Investment Committee (IFPIC)

Resolved – that the summary of confidential issues discussed at the 24 March 2016 IFPIC, and the confidential Minutes from the 25 February 2016 IFPIC be received and noted, and any recommendations approved accordingly.

85/16/4 Remuneration Committee

Resolved – that the confidential Minutes of the 17 March 2016 Remuneration Committee be received and noted.

86/16 ANY OTHER BUSINESS

86/16/1 HSE Sharps Improvement Notice

The Medical Director advised the Trust Board of the outcome of the 7 April 2016 HSE sharps reinspection, confirming that UHL had fully met all of the Improvement Notice requirements. The Trust Board welcomed this outcome.

Resolved – that the position be noted.

86/16/2 NTDA Annual Infection Prevention Inspection - LRI

The Chief Nurse advised of a positive outcome from the NTDA's annual infection prevention visit to UHL – following a visit to 6 LRI wards no environmental cleanliness concerns had been raised, and the NTDA had given UHL the highest possible rating subject to resolution of certain relatively minor issues within 7 days. The CQC would also be advised of this outcome by the NTDA.

Resolved – that the position be noted.

87/16 DATE OF NEXT TRUST BOARD MEETING

Resolved – that the next Trust Board meeting be held on Thursday 5 May 2016 from 9am in Rooms 2 & 3, Clinical Education Centre, Glenfield Hospital.

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	1	1	100	A Johnson	1	1	100
J Adler	1	1	100	R Mitchell	1	1	100
I Crowe	1	1	100	R Moore	1	0	0
S Dauncey	1	1	100	J Smith	1	1	100
A Furlong	1	1	100	M Traynor	1	1	100
A Goodall	1	0	0	P Traynor	1	1	100

Non-Voting Members:

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