UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF A MEETING OF THE TRUST BOARD, HELD ON THURSDAY 1 SEPTEMBER 2016 AT 9AM IN THE C J BOND ROOM, CLINICAL EDUCATION CENTRE, LEICESTER ROYAL INFIRMARY

Voting Members present:

Mr K Singh – Chairman (excluding the last part of Minute 191/16/4 as detailed in the notes)
Mr J Adler – Chief Executive
Mr A Furlong – Medical Director
Mr A Johnson – Non-Executive Director
Mr R Mitchell – Chief Operating Officer
Mr R Moore – Non-Executive Director (Acting Chairman for part of Minute 191/16/4)
Mr B Patel – Non-Executive Director
Ms J Smith – Chief Nurse
Mr P Traynor – Chief Financial Officer

In attendance:

Mr A Appleby – Hospital Liaison Committee for Jehovah's Witnesses (for Minute 187/16/1)
Mr M Burleigh – Head of Chaplaincy and Bereavement Services (for Minute 187/16/1)
Mr M Caple – Patient Partner (for Minute 192/16)
Mr D Henson – LLR Healthwatch Representative (up to and including Minute 197/16)
Ms H Leatham – Assistant Chief Nurse (for Minute 187/16/1)
Ms E Meldrum – Assistant Chief Nurse (for Minute 190/16/2)
Ms E Moss – EMCRN Chief Operating Officer (for Minute 190/16/1)
Ms H Stokes – Senior Trust Administrator
Mr S Ward – Director of Corporate and Legal Affairs
Mr M Wightman – Director of Marketing and Communications
Mr L Wilson – Hospital Liaison Committee for Jehovah's Witnesses (for Minute 187/16/1)

ACTION

181/16 APOLOGIES AND THANKS

Apologies for absence were received from Professor P Baker Non-Executive Director, Col (Ret'd) I Crowe Non-Executive Director and Mr M Traynor Non-Executive Director. The Chairman noted that Dr N Sanganee had regretfully had to tender his resignation as the LLR CCG representative on UHL's Trust Board, due to pressure of work commitments. Thanking Dr Sanganee for his contribution to UHL Trust Board meetings, the Trust Chairman advised that he would discuss the nomination of a replacement representative with his CCG colleagues.

182/16 DECLARATIONS OF INTERESTS IN THE PUBLIC BUSINESS

The Chairman declared an interest in the Lakeside House practice, which was discussed in the emergency care performance update at Minute 191/16/4 below. He confirmed that he had received a redacted copy of the report on this issue (without the section on Lakeside House) and noted that he would absent himself from the discussion on that item, at which point the meeting would be Chaired by Mr R Moore Non-Executive Director.

183/16 MINUTES

Resolved – that the Minutes of the 4 August 2016 Trust Board be confirmed as a correct record and signed by the Trust Chairman accordingly. **CHAIR MAN**

184/16 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 11, 11a and 11c (Minute 166/16/2 of 4 August 2016) – the Director of Workforce and OD advised that the precise wording of the finding re: BME staff had now been confirmed and would be circulated for information. A specific date would also be included in the next iteration of the matters arising log for the action on how best to learn lessons from other organisations and adopt a creative approach in improving the experiences of BME staff. With regard to action 11c, a launch date was being canvassed for UHL's sign-up to the British Sign Language Charter, and **DWOD** **DWOD**

(b) action 19 (Minute 141/16/1 of 7 July 2016) – as detailed on paper B, the proposed re-phasing of the Trust's reconfiguration programme would be presented to the Trust Board in December 2016.

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

185/16 CHAIRMAN'S MONTHLY REPORT – SEPTEMBER 2016

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

(a) the need for UHL to be receptive and responsive to the needs of its diverse community of patients, carers and the public;
(b) the need for the Trust Board to continue to focus on competing tensions, including those of balancing finance requirements whilst ensuring safety and quality. The Trust recognised the need for a Sustainability and Transformation Plan which enhanced care across the wider Leicester, Leicestershire and Rutland (LLR) healthcare system, and
(c) the additional issue of the planned junior doctors' strike from 12-16 September 2016 – this issue would be covered more fully in Minute 186/16 below).

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

186/16 CHIEF EXECUTIVE'S MONTHLY REPORT – SEPTEMBER 2016

The Chief Executive's September 2016 monthly update followed (by exception) the framework of the Trust's strategic objectives. As the attached quality and performance dashboard covered core issues from the monthly quality and performance report, the full version of that report was no longer taken at Trust Board meetings but was accessible on the Trust's external website (also hyperlinked within paper D). The new template Board Assurance Framework dashboard and the extreme and high risks dashboard were also attached to the Chief Executive's report at appendices 2 and 3 respectively – in a change to previous reporting practice the full BAF and risk register entries were now detailed in a separate report at Minute 188/16 below. In introducing his report, the Chief Executive noted:-

(a) good progress on a number of clinical quality and patient experience targets, including pressure ulcers (with no grade 4 pressure ulcers reported in 2016-17 to date), diagnostics (compliant since April 2016), continued compliance with referral to treatment targets for Incompletes, and a continued patient satisfaction target of 97% for inpatients and daycases (as indicated through the Friends and Family Test [FFT]). UHL had also met the cancer 2-week wait target in July 2016, which was welcomed, although September 2016 compliance with the cancer 62-day wait target remained challenging;

(b) continued pressures on the Trust's emergency care service, which would be covered more fully in Minute 191/16 below. The Chief Executive emphasised, however, that improving emergency care performance (along with improving financial performance) was a **CN**

key national priority, and it was therefore imperative that UHL significantly improved its local performance;

(c) the broad timeline for the Sustainability and Transformation Plan (STP), as set out in section 4.14 of paper D, noting the need for organisational sign-off of the STP in October 2016. The Chief Executive advised that unlike some other areas nationally, the direction of the LLR STP was not new to the public as it was based on the LLR Better Care Together programme and the 3-to-2 acute strategy;

(d) that there was not yet any decision to report on the Trust's Biomedical Research Centre bid;

(e) the Trust's continuing efforts to try and expedite the business case approval process for the Electronic Patient Record, which had now been awaiting central approval for approximately 20 months, and

(e) the junior doctors' planned all-out strike between 12-16 September 2016. It was not yet known what the level of participation would be, which made advance planning more difficult. The Medical Director confirmed that all of UHL's Clinical Management Groups (CMGs) had been instructed to restart their strike planning processes, based on the previous 2-day strike action plans. The Medical Director also confirmed that UHL had appointed a Guardian of Safe Working and continued to work with junior doctors on their job plans, noting that most of UHL's FY1 job plans were compliant. The Chief Operating Officer emphasised the need for an appropriate organisational response to the planned strike, and noted that although both elective and diagnostic work were likely to need to be reduced it was vital to nonetheless minimise the impact on operational and financial targets. Executive Directors noted that sustained strike action over the coming months would become more difficult to manage, and the Chief Executive considered that some impact on elective care would be inevitable.

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

(i) noted assurances from the Chief Operating Officer re: the Trust's continued work to achieve the 62-day cancer waits target and reduce the backlog. 2016-17 quarter 1 referral and treatment numbers were both significantly increased from quarter 1 of 2015-16 however. It was noted that a series of formal contract queries had been issued to Commissioners by the Trust in respect of activity volumes;

(ii) queried whether the SHMI figure applied across all specialties, noting data within the Public Health England/Cancer Research UK report on national Trust-level 30-day mortality after systemic anticancer treatment for breast and lung cancer in England. In light of a supplementary query from the Chairman, the Medical Director outlined the mortality data sources available to UHL, confirmed that any themes or issues would be progressed through the Trust's Mortality Review Committee, and advised of his view that the quarterly mortality report already provided to QAC was sufficiently detailed to ensure oversight;

(iii) received a verbal update from the Chief Nurse on the various UHL activities underway re: nurse recruitment, as reported to the August 2016 QAC. The Chief Nurse also reiterated the value placed by UHL on its 400+ European nurses, and commented on recruitment efforts beyond the EU, including in India. In response to a Non-Executive Director query, the Chief Nurse advised that EU nurses tended to stay for a shorter period (ie 2-3 years), and noted that 28 EU nurses had returned home since the Brexit vote;

(iv) noted reiterated concerns voiced by the Healthwatch representative over the sustainability of the 62-day cancer target after September 2016. He also noted that it would be helpful if Healthwatch could receive further information on the reasons for the rise in cancer referrals; **COO**

(v) agreed that the Chief Nurse and the Medical Director would meet with the Healthwatch representative outside the meeting, to discuss the main areas for improvement in respect of the deteriorating patient, and **CN/MD**

(vi) noted concerns voiced by the Healthwatch representative over the impact on patients and the public of the junior doctors' strike(s), and his anxiety that quality and safety was being put at risk by such action.

Resolved – that (A) information on the reasons for the increased rate of cancer referrals be provided to the Healthwatch representative outside the meeting, and **COO**

(B) a meeting be held with the Healthwatch representative outside the meeting to discuss the main areas for improvement in respect of the deteriorating patient. **CN/ MD**

187/16 KEY ISSUES FOR DECISION/DISCUSSION

187/16/1 Patient Story – Supporting Religious Beliefs in Hospital

As detailed in paper E (and accompanying video presentation) from the Chief Nurse, this patient story was a positive experience of how religious needs had been supported by the ward 31 medical and nursing team at the Glenfield Hospital, resulting in successful surgery. The story related to the patient's wish (as a Jehovah's Witness) not to receive blood whilst undergoing an aortic valve replacement, and the patient's positive experience of how the staff had respected his wishes and his faith and provided person-centred care. On the video presentation, the patient described the care received as "faultless". The Assistant Chief Nurse, the Head of Chaplaincy and Bereavement Services, and 2 members of the Hospital Liaison Committee for Jehovah's Witnesses attended for this item.

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

(a) welcomed this positive story, and the respectful care provided to the patient;
(b) noted the existence of a Trust policy on 'Declining Blood and Blood Products' which clearly set out for staff how such patient requests should be handled. The policy had been developed with members of the Hospital Liaison Committee for Jehovah's Witnesses, whose input was valued. In discussion, those members of the Hospital Liaison Committee for Jehovah's Witnesses who were in attendance welcomed the good working relationship with the Trust, and outlined the role of the Committee in providing support for both patients and the treating teams;
(c) was advised of the other ways in which UHL sought to meet the religious requirements of its patients, as detailed in paper E. It was noted that UHL's policy on the urgent certification and release of deceased patients for burial had recently been rewritten in discussion with local Muslim groups;
(d) noted the diverse composition of the Trust's Chaplaincy Team, and
(e) was advised (in response to a Non-Executive Director query) that the Chaplaincy service was represented on the UHL Organ Donation Committee – the Hindu member of the Chaplaincy team also promoted this issue within the wider Hindu community. The Trust Chairman commented that organ donation was a crucial issue, particularly for the South Asian community.

Resolved – that the patient story on supporting religious beliefs in hospital, be noted.

187/16/2 East Midlands Congenital Heart Centre (EMCHC) Update

Further to Minute 163/16/2 of 4 August 2016, the Chief Executive provided a verbal update on the actions taken since NHS England's (NHSE) July 2016 announcement on its minded intention to cease commissioning children's heart surgery from the Glenfield Hospital East Midlands Congenital Heart Centre. The Trust Chairman requested that this update be a standing item on all future Trust Board agendas, accompanied in future by a short written **CE**

report. The Chief Executive emphasised that the children's cardiac surgery service at UHL continued to run on a 'business as usual' basis, and he advised that in quarter 1 of 2016-17 UHL had met the trajectory for reaching the 375 cases mark. The Chief Executive also noted:-

(a) that NHSE had now committed to a consultation period beginning in mid-September 2016. Senior NHSE representatives also planned to visit the Trust and meet with local stakeholders, Trust Board members, and key clinical staff. No further details were yet available regarding the formal consultation itself, but the Trust noted its expectation that NHS England would have an open mind and be willing to take evidence into appropriate account;

(b) that the Trust continued to review the legal position;

(c) the continued extensive media coverage of NHSE's announcement, focusing on patient stories. The Chief Executive welcomed the support the Trust was receiving from patients' families, and

(d) the continued work with neighbouring Trusts to discuss the potential impact on other services. He had also met with Dr C O'Connell, NHSE Regional Head of Specialist Commissioning to discuss this further.

The Trust Board also noted the various meetings and briefings taking place on this issue, and the Healthwatch representative particularly congratulated the Trust's Director of Marketing and Communications for his presentation to a recent Health and Wellbeing Board. A Joint Health Overview and Scrutiny Committee meeting was also thought likely, given the impending consultation.

In discussion, Non-Executive Directors noted the need for a clear brief to be placed in the public domain by NHS England, setting out the terms of reference for the consultation. The Chief Executive also noted 2 likely parallel national reviews underway by NHS England, relating to (i) ECMO provision and (ii) PICU capacity, although no details on these were yet available. **CE**

<u>Resolved</u> – that (A) it be agreed to pursue the development (by NHS England) of clear terms of reference for the public consultation exercise, and **CE**

(B) short written update on EMCHC be a Trust Board standing agenda item. **CE**

188/16 RISK MANAGEMENT

188/16/1 <u>Integrated Risk Report</u>

As referred to in Minute 186/16 above, paper F comprised a new integrated risk report presenting the revised 2016-17 Board Assurance Framework (BAF) for endorsement and also summarising any new organisational risks scoring 15 or above. The Trust Board was also invited to consider whether there were any assurance gaps or inadequate controls in the current Board Assurance Framework. In was noted that principal risk 8 (*failure to deliver an effective learning culture and to provide consistently high standards of medical education*) was being discussed in further detail at the September 2016 Trust Board thinking day, and that a report on cyber security issues would be provided to a future private Trust Board meeting. **MD/ PB NED** **CIO**

The Audit Committee Non-Executive Director Chair advised that the Board Assurance Framework, integrated risk register and overarching new process would be discussed further by that Committee later on 1 September 2016. In response to his specific query re: embedding the process to date, the Medical Director confirmed that consideration of the

risks was now split between the most appropriate Executive team meeting, although the method of discussion had evolved somewhat due to time constraints (ie the risks in question were now linked to the relevant agenda item rather than discussed in isolation). The Medical Director considered that the BAF was now a living document, although he recognised that there was still room for improvement. The Chief Executive advised that Executive Directors would welcome any Audit Committee feedback on the appropriateness of the risk scores and action plans. **AC CHAIR**

<u>Resolved</u> – that (A) BAF principal risk 8 (failure to deliver an effective learning culture and to provide consistently high standards of medical education) be discussed at the September 2016 Trust Board thinking day; **MD/ PB NED**

(B) a report on cyber security be provided to a future private Trust Board meeting, and **CIO**

(C) Audit Committee views on the appropriateness and adequacy of the BAF principal risk scores and action plans be provided to Executive Directors. **AC CHAIR**

189/16 STRATEGY

189/16/1 <u>UHL Reconfiguration Programme</u>

This monthly report updated the Trust Board on (i) the governance of UHL's reconfiguration programme; (ii) the top 10 key programme risks, and (iii) progress re: 2 specific projects, namely the Emergency Floor and the Women's Hospital. A high level overall workstream progress report was also appended to paper G.

In introducing the report, the Chief Financial Officer reiterated that the key programme risks remained the continuing uncertainty over the availability of national capital in 2016-17, and the imbalance between capacity and demand. Section 12 of paper G outlined the capital requirements of the reconfiguration programme by year, split between various funding sources including internal capital, external capital, and potential PF2 funding. PF2 had been relatively infrequently used within the NHS to date, and would be discussed further at the October 2016 Trust Board thinking day. **CFO** The Chief Financial Officer also noted his view that the strategic outline case (SOC) for the reconfiguration programme needed to be clarified and relaunched, for presentation to the December 2016 Trust Board. **CFO** As noted by the Medical Director, the SOC should also reiterate the compelling clinical and organisational case for reconfiguration. The Audit Committee Non-Executive Director Chair strongly supported this proposal, noting the need to provide increased clarity on the costs and phasing of the reconfiguration programme. It was agreed that the Director of Marketing and Communications should also be appropriately involved, to ensure a coherent narrative for the SOC. **DMC** In further discussion the Chief Financial Officer also noted the appointment of 3 project managers to augment the resourcing of the reconfiguration programme.

The Trust Board also:-

(a) sought further detail on the report's description of delivering the programme within the overall cost envelope as "extremely challenging". In response, the Chief Financial Officer advised that obtaining the capital would be challenging given the continued national uncertainties – he also noted the need for the programme to represent good value for money;
(b) queried how the cost of additional resourcing and upskilling of the project team would be affected by the continued delay in capital availability – eg if the projects continued to be delayed. The Chief Financial Officer advised that a flexible and pragmatic approach had been taken to the 3 appointments made, whose work was not solely dependent on availability of capital. There would, however, be likely resource implications of adopting a PF2 approach;

(c) noted the need for clarity on the differences between PFI and PF2, and
(d) noted comments from Mr A Johnson Non-Executive Director (and Charitable Funds Committee Chair) on the need to consider any lessons learned from the delays to date, acknowledging that issues may have been outside the Trust's control. The interconnected nature of the DoH/NHSE/NHS Improvement approval requirements and processes should also be recognised. **CFO**

<u>Resolved</u> – that (A) PF2 issues be discussed at the 13 October 2016 Trust Board thinking day; **CFO**

(B) the reconfiguration strategic outline case (SOC) be restated/relaunched and presented to the 1 December 2016 Trust Board, providing:- **CFO**

- **increased clarity on the total costs;**
- **clarity on phasing;**
- **a reiteration of the compelling clinical and organisational case for reconfiguration;**

(C) the Director of Marketing and Communications be appropriately involved in the development of the relaunched SOC above, to ensure a coherent narrative, and **DMC**

(D) consideration be given to any lessons learned from the delays to date, acknowledging that issues may have been outside the Trust's control. **CFO**

189/16/2 <u>LLR Better Care Together (BCT) Programme Update</u>

As previously reported, 3 very significant issues required further work prior to submission of the LLR Sustainability and Transformation Plan (STP), namely:-

(i) demand management, requiring the development of a more integrated care model. The benefits of such a system would include better care for patients, greater affordability within the system, and avoiding the need for further capital to build additional acute facilities. An update on demand management initiatives would be provided to the October 2016 Trust Board. Although acknowledging the challenges both of defining 'integrated care' and planning when that care would be needed, the Director of Marketing and Communications emphasised the need to change care models for frail, vulnerable patients in particular – work was underway with primary care colleagues to create a more rapid care pathway for these patients (ie potentially avoiding ED) and avoid unnecessary readmission; **DMC**

(ii) the significant system capacity/demand/resilience issues within primary care, and

(iii) emergency care performance, which was fundamentally linked to point (i) above. It was also vital for the LLR system to shown that it could be self-managing.

In discussion on these aspects and the general BCT update at paper H, the Trust Board:-

(a) noted the need for a more rapid pace of change across the LLR healthcare system. It was vital to start moving into the implementation phase of BCT and out of the planning stage;
(b) sought assurance on the primary care elements of a more integrated care model, given that patients would default to acute care if they felt unable to access primary care services. Social care provision was also a key issue;
(c) urged that appropriate patient and public involvement input be sought;
(d) noted the need to move to a smarter, more proactive healthcare system. In response, the Director of Marketing and Communications considered that this would need to be an incremental change;
(e) noted potential organisational changes to the BCT structure, linked to a focus on workstreams – following September 2016 discussion by the BCT Partnership Board **DMC**

proposals would be presented accordingly to the October 2016 Trust Board as part of the BCT update report;

(f) noted comments from the Healthwatch representative about the need to address the public mindset and be clear on how to access the most appropriate sector of the healthcare system (linked to point (b) above), and

(g) queried whether the BCT dashboard and KPIs were still being being produced. The Audit Committee Non-Executive Director considered that these were crucial to BCT accountability and requested that they be reinstated – the Director of Marketing and Communications agreed to raise this with the BCT programme board accordingly. **DMC**

Resolved – that (A) an update on work re: demand management initiatives be provided to the October 2016 Trust Board; **DMC**

(B) the next BCT update to the Trust Board also cover proposals for refocusing the BCT programme and its organisational arrangements, and **DMC**

(C) the Trust Board's wish for the BCT dashboard and KPIs to be reinstated, be fed back to the BCT Programme Board. **DMC**

190/16 EDUCATION TRAINING AND RESEARCH

190/16/1 East Midlands Clinical Research Network (EMCRN) 2016-17 Quarter 1 Update

The Chief Operating Officer for the East Midlands Clinical Research Network (EMCRN) attended to present paper I – as host organisation, UHL was required to take overall responsibility for the monitoring of EMCRN's governance and performance. In addition to a quarter 1 update for 2016-17 (also identifying challenges and mitigating actions), paper I detailed final year-end EMCRN performance for 2015-16 and had been discussed by both the CRN EM Executive Group and UHL's Executive Performance Board. EMCRN had performed well in 2015-16, and had received positive feedback from the National Institute for Health Research on both its 2015-16 performance and its 2016-17 annual plan (NIHR letters appended to paper I). As previously requested by the Trust Chairman, the report also provided an update on a specific development within the wider research environment, namely the introduction of the Study Support Service.

The EMCRN Chief Operating Officer advised that recent regulatory changes had led to a national trend of reduced recruitment to research studies. She considered that the 'time' elements of the performance measures were likely therefore to become more important than the number recruited. Although UHL itself was performing extremely well on recruitment to studies, the Medical Director advised that overall EMCRN performance had been adversely affected by the performance of some other member Trusts – contact had been made with those members to offer further support if needed. In response to a query, it was noted that nationally the budget was allocated on a proportional basis.

Resolved – that the EMCRN host Board report be noted.

190/16/2 Multi-professional Education and Training 2016-17 Quarter 1 Update

Paper J comprised the 2016-17 quarter 1 update on multi-professional education and training, also outlining UHL's preparation for the GMC visit on 25 October 2016. The Assistant Chief Nurse attended for this item and it was noted that a detailed discussion on training and education issues was scheduled for the September 2016 Trust Board thinking day. The Trust Chairman invited the Assistant Chief Nurse to attend that session accordingly. In respect of medical education and training issues, the Medical Director noted the feedback from the 2016 GMC National Trainee Survey (NTS), with local induction and feedback continuing to be particular issues. UHL's Department of Clinical Education had produced a summary report on the NTS findings for each CMG medical education lead to **CN**

share with their CMG Board and develop an action plan accordingly.

In respect of non-medical education and training, the Assistant Chief Nurse:-

(a) outlined progress on the Nursing Associate role, test sites for which would be confirmed in October 2016. In anticipation of being a test site, an initial LLR cohort of 40 trainees would be recruited in October/ November 2016 in readiness for a January 2017 start, with opportunities for additional recruitment throughout 2017-18 outside that testbed phase. An update on the project would be included in the next quarterly multi-professional education and training update; **CN**
(b) confirmed that all Learning Beyond Registration (LBR) modules linked to clinical and workforce priorities had been funded within the existing cost envelope, and that there had been no clinical risk associated with the reduction in funding. More advanced planning was needed however, to submit the training needs analysis appropriately early – this was particularly the case for Advanced Nurse Practitioners who relied heavily on LBR;
(c) advised that preliminary discussions were underway with Leicestershire Partnership NHS Trust re: a centralised approach to clinical placements, and
(d) confirmed a successful revalidation for quarter 1 of 2016-17, with no lapses in registration other than for retirement. The Chief Nurse thanked the Assistant Chief Nurse and her team for their very significant work on revalidation.

The Trust Chairman reiterated UHL's view that learning and teaching were key issues for the Trust, noting also their vital links to recruitment and retention.

Resolved – that (A) the next quarterly update (December 2016) include progress on UHL's potential role as a test site for the Nursing Associate role, and **CN**

(B) the Assistant Chief Nurse be invited to attend the September 2016 Trust Board thinking day session. **CN**

191/16 QUALITY AND PERFORMANCE

191/16/1 Quality Assurance Committee (QAC)

Paper K summarised the issues discussed at QAC's 25 August 2016 meeting. Mr A Johnson Non-Executive Director had chaired that meeting and drew the Trust Board's attention to a report on Freedom to Speak Up arrangements which was appended to paper K for Trust Board approval.

Resolved – that (A) the summary of issues discussed at the 25 August 2016 QAC be noted (Minutes to be submitted to the 6 October 2016 Trust Board), and

(B) the 'Freedom to Speak Up' arrangements be approved as appended to the August 2016 QAC summary, and progressed accordingly. **DWOD**

191/16/2 Integrated Finance, Performance and Investment Committee (IFPIC)

Paper L summarised the issues discussed at IFPIC's 25 August 2016 meeting, and was noted accordingly.

Resolved – that the summary of issues discussed at the 25 August 2016 IFPIC be noted (Minutes to be submitted to the 6 October 2016 Trust Board).

191/16/3 2016-17 Financial Performance – July 2016

Paper M presented the Trust's month 4 financial position (as discussed in detail at the

August 2016 IFPIC). The Trust's deficit position for the year to date (£8.6m) was in line with plan, and UHL's 2016-17 cost improvement programme was currently £1.1m favourable to plan. The Chief Operating Officer and Chief Financial Officer continued to work with those 4 CMGs in a financially challenged position. Agency spend continued to be challenging, and the Chief Financial Officer reiterated his view that UHL was unlikely to achieve the £20.6m cap for 2016-17 (currently £0.7m adverse to plan).

Cash remained a key focus area and it was felt likely that a central cash injection would be required. Work was underway with Internal Audit to review the Trust's existing cash processes.

Resolved – that the financial position for July 2016 be noted.

191/16/4 Emergency Care Performance

The Trust Chairman reiterated his declaration of interest in relation to Lakeside House and confirmed that he would absent himself from the meeting at the point this was discussed. He also reconfirmed that he had not received that part of the report which related to the ED front door arrangements.

Further to Minute 167/16/4 of 4 August 2016, paper N updated the Trust Board on recent emergency care and Clinical Decisions Unit performance. The report advised that the Trust remained under acute operational pressure due to increasing emergency demand, with August 2016 4-hour performance at 80.1%. Although the Trust had delivered the STP improvement trajectory re: ED for the last 4 months, the September 2016 trajectory was much more challenging (85%). The Emergency Care Improvement Programme [ECIP] team had visited UHL's ED in late July/early August 2016 and their findings were appended to paper N accordingly, as was the updated UHL emergency care action plan. An LLR emergency care workshop had also taken place in August 2016, and it was now intended to monitor progress on the action plan through key metrics. As also previously reported, UHL's Chief Executive was now chairing the new LLR A&E Recovery Board. The slides presented at the August 2016 'integration dividend' lock-in were also appended to paper N. In discussion, Mr A Johnson Non-Executive Director voiced his support for many of the ECIP findings, particularly those relating to the Emergency Floor and the number of ED 'priorities'.

Paper N also updated the Trust Board on actions in respect of winter opening for wards 23a and 7. However, the Chief Operating Officer emphasised that despite bedbase reconfigurations, due to continued high demand the LRI would still be going into winter 2016 with a larger capacity gap than for last winter, peaking at an approximate 40-bedded deficit (if demand did not further increase above plan). Although recognising comments on the continued demand and capacity imbalance, the Chief Executive noted that current demand was significantly reduced however, from the peaks of winter 2015 and spring 2016.

In respect of delayed discharges, the Chief Operating Officer noted approximately 90 such patients who were medically fit for discharge – the Trust Board requested that a further report on this cohort of patients be provided in October 2016, identifying the reasons for the delayed discharge and the outcome, and assessing which factors were within/outwith the Trust's control. **COO**

At this point the Trust Chairman withdrew from the meeting to enable Trust Board consideration of the ED front door element of the report. During this discussion the meeting was chaired by Mr R Moore Non-Executive Director and Audit Committee Chair. The Chief Operating Officer reminded members that Lakeside House had provided an ED front door service at UHL since November 2015 which was due to end on 31 October 2016. Discussions with Commissioners about extending the system had not yet reached any formal agreement. The Chief Operating Officer noted his view that it was vital to have a front door triage system in place for winter, but he acknowledged the additional cost

implications. In response to a query from the Acting Chair, the Chief Executive advised that the likely outcome of the discussions was not yet clear. A reversion to the original 'urgent care centre' model of triage was likely to impact adversely on 4-hour performance due to GP recruitment challenges. The Chief Operating Officer clarified that the occupancy of ED was a vital factor in determining performance and quality of care and he considered that ED occupancy would increase without a front door service.

Resolved – that an update on the 90 patients currently awaiting transfer out of UHL be provided to the October 2016 Trust Board, including:- **COO**

(A) the reasons for the delayed discharge and the outcome, and

(B) an assessment of the factors within/outwith the Trust's control.

192/16 PATIENT AND PUBLIC INVOLVEMENT AND ENGAGEMENT

192/16/1 Patient and Public Involvement (PPI) 2016-17 Quarter 1 Update

Paper O updated the Trust Board on quarter 1 of the second year implementation plan for the UHL Patient and Public Involvement Strategy. An overview of specific Patient Partner activity – as written by Mr M Caple, Patient Partners Chair – was appended to the report. The Strategy's original intention to develop an 'involvement into action' process had now been superseded by the Trust-wide UHL Way initiative, which had adopted the involvement into action PPI toolkit.

The Patient Partners Chair noted that 9 different patient groups had attended UHL's August 2016 Trust Board thinking day with stakeholders, and he commented on the need to work more closely together. The Trust Chairman confirmed that the patient groups were welcome to use Trust facilities to meet together. In discussion on paper O, Mr B Patel Non-Executive Director emphasised the need for the PPI Strategy to be as inclusive as possible and to involve other groups such as carers' organisations. He suggested that a targeted approach for different issues would be helpful, and he also noted the need for PPI to provide UHL with an appropriate external focus/perspective – this was crucial to projects such as reconfiguration.

Resolved – that the 2016-17 quarter 1 update on the UHL Patient and Public Involvement Strategy be noted.

193/16 REPORTS FROM BOARD COMMITTEES

193/16/1 Quality Assurance Committee (QAC)

Resolved – that the Minutes of the 28 July 2016 QAC be received and noted, and any recommendations endorsed accordingly.

193/16/2 Integrated Finance Performance and Investment Committee (IFPCI)

Resolved – that the Minutes of the 28 July 2016 IFPIC be received and noted, and any recommendations endorsed accordingly.

194/16 CORPORATE TRUSTEE BUSINESS

194/16/1 Charitable Funds Committee

Resolved – that the Minutes of the 4 August 2016 Charitable Funds Committee be received and noted, and any recommendations endorsed accordingly by the Trust Board as Corporate Trustee.

195/16 TRUST BOARD BULLETIN – SEPTEMBER 2016

Resolved – that the September 2016 Trust Board Bulletin be noted, comprising:-

(1) 2016-17 quarter 1 Trust sealings, and

(2) 2016-17 Trust Board, Trust Board thinking day and Trust Board Committee meeting dates – these were approved as presented and would be circulated to members' for their diaries accordingly. **STA**

196/16 QUESTIONS AND COMMENTS FROM THE PRESS AND PUBLIC RELATING TO BUSINESS TRANSACTED AT THIS MEETING

A Patient Partner attendee commented that many of the issues discussed today had been relevant to patient and public involvement and engagement considerations. He queried whether the GMC visit would involve asking patients for their views, and it was agreed to raise this with the GMC accordingly. **MD** He also noted the need for further clarity over both the Sustainability and Transformation Plan and the exact issues which were being consulted on through Better Care Together. He also suggested that it would be helpful if the integrated teams lock-in outputs (appended to paper N – Minute 191/16/4 above) could include clear timescales. The speaker then also queried whether it would be possible for future Trust Board thinking days with patient groups to be extended to cover Leicestershire Partnership NHS Trust and Clinical Commissioning Groups – the Trust Chairman agreed to consider this accordingly. **DMC/ CHAIR MAN**

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

197/16 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 198/16 – 205/16), having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.

198/16 DECLARATIONS OF INTERESTS IN THE CONFIDENTIAL BUSINESS

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

199/16 CONFIDENTIAL MINUTES

Resolved – that the confidential Minutes of the 4 August 2016 Trust Board be confirmed as a correct record and signed by the Trust Chairman accordingly. **CHAIR MAN**

200/16 CONFIDENTIAL MATTERS ARISING REPORT

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

201/16 REPORT FROM THE DIRECTOR OF CORPORATE AND LEGAL AFFAIRS

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

202/16 REPORTS FROM BOARD COMMITTEES

202/16/1 Quality Assurance Committee (QAC)

Resolved – that the confidential Minutes of the 28 July 2016 QAC be received and noted, and any recommendations endorsed accordingly.

202/16/2 Integrated Finance Performance and Investment Committee (IFPIC)

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

203/16 CORPORATE TRUSTEE BUSINESS

203/16/1 Charitable Funds Committee

Resolved – that the confidential Minutes of the 4 August 2016 Charitable Funds Committee be received and noted, and any recommendations endorsed accordingly.

204/16 ANY OTHER BUSINESS

204/16/1 Report from the Chief Executive

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

204/16/2 Report from the Chairman

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

205/16 DATE OF NEXT TRUST BOARD MEETING

Resolved – that (A) the Trust's Annual Public Meeting 2016 be held on Thursday 8 September 2016 from 6.30pm at The Big Shed, Freeman's Common, Leicester LE2 7SR;

(B) an extraordinary private Trust Board meeting take place on Thursday 8 September 2016 from 9am at the University of Leicester, and

(C) the next Trust Board meeting be held on Thursday 6 October 2016 from 9am in rooms A & B, Education Centre, Leicester General Hospital.

The meeting closed at 1pm

Helen Stokes – **Senior Trust Administrator**

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

Voting Members:

Name	Possible	Actual	% attendance	Name	Possible	Actual	% attendance
K Singh	6	6	100	A Johnson	6	6	100
J Adler	6	6	100	R Mitchell	6	4	67
P Baker	3	2	67	R Moore	6	5	83
I Crowe	6	5	83	B Patel	2	2	100
S Dauncey	4	3	75	J Smith	6	6	100
A Furlong	6	5	83	M Traynor	6	5	83
A Goodall	3	2	67	P Traynor	6	6	100

Non-Voting Members:

Name	Possible	Actual	% attendance	Name	Possible	Actual	% attendance
D Henson	6	6	100	L Tibbert	6	5	83
N Sanganee	5	2	40	S Ward	6	6	100
				M Wightman	6	4	67