UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF A MEETING OF THE TRUST BOARD, HELD ON THURSDAY 3 DECEMBER 2015 AT 9AM IN ROOMS 2 & 3, CLINICAL EDUCATION CENTRE, GLENFIELD HOSPITAL

Voting Members present:
Mr K Singh – Trust Chairman
Mr J Adler – Chief Executive (for Minutes 253/15, 254/15/6, 254/15/7, and from Minute 258/15/1 onwards).
Col (Ret'd) I Crowe – Non-Executive Director
Dr S Dauncey – Non-Executive Director
Mr A Furlong – Acting Medical Director
Professor A Goodall – Non-Executive Director (for Minutes 253/15, 254/15/6, 254/15/7, and Minutes 255/15/3 – 262/15 inclusive)
Mr A Johnson – Non-Executive Director
Mr R Mitchell – Chief Operating Officer (from Minute 254/15/6)
Mr R Moore – Non-Executive Director
Ms J Smith – Chief Nurse (for Minutes 253/15, 254/15/6, 254/15/7, and from Minute 258/15/1 onwards)
Mr M Traynor – Non-Executive Director
Mr P Traynor – Chief Financial Officer
Ms J Wilson – Non-Executive Director

In attendance:
Professor S Carr – Associate Medical Director (Clinical Education) (for Minute 257/15)
Mr C Green – ICU Reconfiguration Project Manager (for Minute 254/15/3)
Mr D Henson – LLR Healthwatch Representative (up to and including Minute 262/15)
Ms B Kotecha – Assistant Director, OD and Learning (for Minute 254/15/2)
Ms H Leatham – Assistant Chief Nurse (for Minute 254/15/1)
Ms M Payne – Matron (for Minute 254/15/1)
Ms K Renacre – Interim Assistant Director of Workforce and OD
Mr N Sone – Financial Controller (for Minute 259/15/1)
Ms H Stokes – Senior Trust Administrator
Mr S Ward – Director of Corporate and Legal Affairs
Mr M Wightman – Director of Marketing and Communications
Ms E Wilkes – UHL Reconfiguration Programme Director (for Minutes 254/15/3 – 254/15/5 inclusive)

ACTION

248/15 APOLOGIES

Apologies for absence were received from Dr N Sanganee, LLR CCG representative, Ms K Shields Director of Strategy and Ms L Tibbert Director of Workforce and OD.

249/15 DECLARATIONS OF INTERESTS IN THE PUBLIC BUSINESS

No declarations of interest were made.

250/15 MINUTES

Resolved – that the Minutes of the 5 November 2015 Trust Board be confirmed as a correct record and signed by the Trust Chairman accordingly. **CHAIR MAN**

251/15 MATTERS ARISING FROM THE MINUTES

Paper B detailed the status of previous matters arising and the expected timescales for resolution. An update on the provision of wi-fi within Children's Services would be included in the January 2016 Trust Board matters arising log (Minute 231/15/1 of 5 November 2015 refers). **CE**

Resolved – that the update on outstanding matters arising and any related actions be

noted, and progressed by the identified Lead Officer(s).

252/15 CHAIRMAN'S MONTHLY REPORT – DECEMBER 2015

In introducing his monthly report for December 2015 (paper C), the Trust Chairman particularly highlighted:-

(a) his attendance at a recent HSJ-McKinsey Hospital Institute Conference. One of the issues covered had related to clinical variation, which the Chairman suggested should also be the subject of a Trust Board thinking day during 2016. The Acting Medical Director noted his own forthcoming presentation on clinical variation to the Clinical Senate, and suggested that this should be one of the Trust's Quality Commitment workstreams for 2016-17. Also covered at that Conference had been the fact that – as of 2016 – the CQC would also rate the economy, efficiency and value of provider/acute Trust services. The Chairman had volunteered UHL to be involved in the CQC's engagement process on this; **CHAIR MAN**

(b) his continuing desire to encourage innovation within UHL, and

(c) the continuing operational pressures facing UHL's Emergency Department (ED), which were covered in detail on the agenda for today's meeting.

<u>Resolved</u> – that issues around clinical variation be considered at a 2016 Trust Board thinking day. **CHAIR MAN/ AMD**

253/15 CHIEF EXECUTIVE'S MONTHLY REPORT – DECEMBER 2015

The Chief Executive's December 2015 monthly update followed (by exception) the framework of the Trust's strategic objectives. As the attached quality and performance dashboard covered core issues from the monthly quality and performance report, the full version of that report was no longer be taken at Trust Board meetings but was accessible on the Trust's external website (also hyperlinked within paper D). The Chief Executive emphasised that pressure within ED remained the key challenge for the Trust (covered later on the agenda – Minute 254/15/6 refers). He also noted:-

(a) UHL's continued generally-good performance on quality metrics;

(b) that despite its cancellation, the planned 1 December 2015 junior doctors' strike had impacted on UHL's clinical activity, as only a minority of the Trust's cancelled clinics and elective operations had been able to be reinstated;

(c) that UHL was working through the implications of the agency price caps, the required implementation speed of which was proving challenging particularly re: medical agency staff. Although supportive of the direction of travel, UHL was unable to implement the caps immediately and had advised the NHS Trust Development Authority (NTDA) accordingly, and

(d) the recent visit to UHL by Health Education East Midlands (HEEM), feedback from which had been very positive other than some training issues in cardiology (Minute 257/15 below also refers).

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

(i) that the issue of ambulance handovers would also be covered in the emergency care performance discussions later on the agenda;

(ii) a query from the Healthwatch representative regarding the dip in fractured neck of femur performance – in response, the Chief Operating Officer understood that the November 2015 figures would demonstrate compliance with this standard, although the position remained somewhat fragile, and

(iii) a query from the Healthwatch representative as to whether the timescale for compliance with the cancer targets was now June 2016. In response, the Chief Operating Officer advised that UHL remained committed to delivering the cancer targets by March 2016 – 8 of the 10 cancer targets were expected to achieve compliance in November 2015 but the 62-day wait target remained challenging.

The Healthwatch representative noted that – following information from CMGs – he was much more assured about the actions planned to achieve the cancer targets.

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

254/15 KEY ISSUES FOR DECISION/DISCUSSION

254/15/1 Patient Story – Poor Experience of Care on Ward 28 Glenfield Hospital

Paper E from the Chief Nurse advised the Trust Board of a poor experience of care on Glenfield Hospital ward 28. The patient wished to remain anonymous and the Trust Board therefore listened to an audio-only account which highlighted that the patient had been:-

(1) *taken to x-ray by mistake, due to errors in confirming the patient's identity before leaving the ward.* The correct process for checking a patient's identity had now been reiterated to all ward staff, and a meeting had also been held with portering staff;
(2) *given anticoagulant medication which the patient believed had resulted in a post-operative bleed*'. The Assistant Chief Nurse advised that the medical team had taken a conscious clinical decision to continue the patient's anti-platelet medication as the safest option for that patient. The patient had found the doctor to be a little 'sharp', however, and the medical staff were reviewing their communications with patients accordingly, and
(3) *delayed by 1 day in being discharged, due to medication delays*. The ward recognised that the steps involved in, and associated timescale for, discharge had not been clearly communicated to the patient

Paper E outlined the steps taken to rectify these shortfalls, noting that Ward 28 had been very sorry to hear of this poor experience and had responded proactively. A breakdown in communication clearly underpinned the issues highlighted above, and ward 28 planned to hold a 'Listening into Action' event in January 2016 focusing on this patient's poor experience and how to improve practice. Ms M Payne, Matron (in attendance for this item) emphasised the need for visible leadership and monitoring of junior staff by Matrons to ensure a positive patient experience, and advised that lessons would be shared across the Renal, Respiratory and Cardiovascular Clinical Management Group. In discussion on the patient story, the Trust Board noted:-

(a) a query from the Healthwatch representative on how to remind staff of the importance of communicating with – and listening to – patients. The Assistant Chief Nurse advised that the patient story in paper E would be shared more widely through the Matrons' Forum, as a powerful way of highlighting this issue. In further discussion, Non-Executive Directors commented on the need to sustain communication improvements in the future;

(b) the suggested need to develop a consistent process for advising patients of the discharge process and likely timescale – in response, the Acting Medical Director considered that this element should be added to the existing list of standard issues about which patients should expect to be informed by their care team, and **AMD/ ACN**

(c) a query on how the process-shortfalls would be addressed, including how the correct processes would continue to be reiterated with (eg) portering staff. Non-Executive Directors also sought assurance on whether similar errors were occurring elsewhere in the Trust, and queried whether (eg) an audit might be undertaken. The Assistant Chief Nurse advised that the wider issues within this patient story would be highlighted at the Matrons' Forum and Patient Experience Group. The Director of Corporate and Legal Affairs suggested that the wider issues (eg discharge, portering) should also be considered by UHL's Quality Assurance Committee – the Trust Chairman requested that QAC receive a report assessing the wider lessons from the patient stories presented to the Trust Board over the last 12 **CN**

months.

Resolved – that (A) clear, consistent communication about discharge (timescale) be added to the list of standard issues about which patients should expect to be informed by their care team, and **AMD/ ACN**

(B) QAC receive a report on patient story lessons and themes from the last 12 months. **CN**

254/15/2 UHL Way – Update

Paper F and accompanying presentation slides from the Director of Workforce and OD advised the Trust Board of work to develop the 'UHL Way'. The presentation had been shared at the September 2015 UHL Leadership Conference, and also discussed at the October 2015 Trust Board thinking day. The UHL Way proposed a standardised approach to staff engagement re: change, and would also be reflected in the Trust's refreshed OD Plan being presented to the February 2016 Trust Board. Work was also underway with LLR partners regarding an 'LLR way', with UHL hosting a recent workshop for LLR HR and workforce leads. The 3 main components of the UHL Way focused on (1) "better teams"; (2) "better engage" (supported by a 'UHL Academy' Faculty of Specialists from April 2016), and (3) "better change". The final slide of paper F detailed the next steps in the development and implementation of the UHL Way, beginning with finalisation of the Better Change model in December 2015. In discussion on the presentation, the Trust Board:- **DWOD**

(a) welcomed the clear timescales and milestones set out in the plan, noting the crucial role of the UHL Way in the overall OD and reconfiguration programmes;

(b) considered that clear, appropriate communications and messaging would be crucial to embed the UHL Way with staff. Improving and sustaining staff engagement would be vital, and members queried what success measures would be used, noting the need for clear outcome measures;

(c) suggested that it would be helpful to describe how the Faculty would work with external partners (including the EM Leadership Academy and LIIPs); **DWOD**

(d) agreed a key need to progress 'team training'; **DWOD**

(e) suggested that a simplified message about the UHL Way would be useful (although acknowledging that this might be difficult to distil);

(f) agreed that it would be helpful to map 'coverage' of the UHL Way (eg the number of staff reached and their organisational spread), to ensure as wide an awareness as possible; **DWOD**

(g) noted the importance of incorporating feedback into the UHL Way, and

(h) noted comments from the Healthwatch representative on the need to motivate staff to participate in the UHL Way (and sustain that motivation).

Resolved – that (A) clarification be provided on how the Faculty would work with external partners (including the EM Leadership Academy and LIIPs); **DWOD**

(B) a UHL 'team training' approach be progressed; **DWOD**

(C) coverage of the UHL Way be mapped (number of staff reached), and **DWOD**

(D) the updated OD Plan be presented to the 4 February 2016 Trust Board. **DWOD**

254/15/3 ICU Business Case

Paper G from the Director of Strategy presented 4 component business cases for Trust Board approval comprising the adult level 3 ICU Project (Glenfield ICU medium term) and individual enabling cases relating to the Glenfield beds enabler, the LRI beds enabler and the Glenfield imaging enabler. The ICU business cases required capital approval of £16.5m, in addition to the £0.7m previously approved. Paper G detailed the checklists for all 4 business cases, while the component business cases themselves were available in full on the Trust's public website (also hyperlinked via paper G). The business cases had been considered by the Executive Strategy Board, and were also recommended for Trust Board approval by the 26 November 2015 IFPIC (Minute 255/15/2 below refers).

In presenting the business cases for Trust Board approval, the Reconfiguration Programme Director outlined the clinical and cultural change consequences of not progressing the ICU reconfiguration. This was augmented by the Acting Medical Director, who noted that July 2016 would be a critical point in light of planned Consultant retirements, and noted the very significant clinical buy-in to the ICU reconfiguration and changes to ways of working. He also emphasised that the ICU service would be safe during the reconfiguration, although not ideal.

The Reconfiguration Programme Director outlined the 2 key areas of risk to the ICU reconfiguration, namely:-

(1) capital availability and access – the Strategy and Finance teams were reviewing phasing options and potential alternative access routes. The Chief Financial Officer emphasised, however, that approval of the business cases must be subject to capital being made available, and
(2) operational capacity and headroom to enable the service moves – the potential use of ICS beds and outreach facilities to create headroom was being explored, with a further update scheduled for the December 2015 Executive Strategy Board.

Mr C Green, ICU Reconfiguration Project Manager then briefed the Trust Board on the detailed cost of the business cases (as shown in paper G), and outlined the involvement of clinicians and Heads of Service in the operational delivery phase now being entered. The IFPIC Non-Executive Director Chair confirmed that Committee's support for the ICU business cases detailed in paper G, and confirmed that IFPIC had discussed both capital availability issues and the potential revenue impact. Glenfield Hospital operational capacity remained an issue, however, and the January 2016 IFPIC was scheduled to receive a further report on operational considerations.

In discussion on paper G (which he supported) the Healthwatch representative emphasised the need for clear communications to both staff and patients, with an appropriate distinction drawn between the ICU reconfiguration and the LLR BCT programme. The IFPIC Non-Executive Director Chair noted the need for a patient voice in the communications plan, and the Trust Chairman noted that the UHL PPI team would be able to advise on the organisations to involve. **DS/ DMC**

Resolved – that (A) the adult level 3 ICU project (Glenfield ICU medium term) business case and enabling cases relating to the Glenfield beds enabler, the LRI beds enabler and the Glenfield imaging enabler be approved subject to capital being made available (noting the capital cost of £16.5m in addition to the £0.7m previously approved), and **DS**

(B) clear communication be provided to patients and staff about the ICU changes, differentiating appropriately between the ICU reconfiguration and the Better Care Together changes. **DS/ DMC**

254/15/4 Strategy Update – UHL Reconfiguration Programme

This monthly report from the Director of Strategy updated the Trust Board on (i) the governance of UHL's reconfiguration programme; (ii) progress on 1-2 selected workstreams, and (iii) the 3 key programme risks, while the high-level dashboard appended to the report provided an overview of the programme status and key risks as a whole. In introducing the report, the Reconfiguration Programme Director confirmed that the issues raised at the November 2015 Trust Board thinking day on reconfiguration were being appropriately pursued, and she noted the establishment of a network of 'know-it-alls' to aid communication. In terms of key workstream deep dives, paper H focused on Workforce, and noted the significant progress made since the Director of Workforce and OD had joined UHL.

The Trust Chairman drew the Board's particular attention to the 'key challenges' and 'programme risks' sections of paper H, the latter of which identified (i) capital availability, (ii) growth in activity resulting from failure of demand management initiatives, and (iii) non-delivery of out-of-hospital beds jeopardising the ability to provide additional bed base at Glenfield for ICU level 3, as the key programme risks.

In discussion on paper H, the Trust Board:-

(a) proposed adding 'technology' to the elements covered by the workforce activity roadmap; **DS**
(b) queried the predominantly green/amber nature of the workstream progress report, compared to the red/amber nature of the risk log;
(c) requested that internal beds be included as a specific separate programme risk, rather than conflated within the existing risk re: 'unmitigated growth in activity from failure of demand management initiatives to reduce acute admissions impacting original bed model assumptions', and **DS**
(d) requested that the next iteration of the reconfiguration risk log include greater information on timelines, milestones and progress. **DS**

Resolved – that (A) technology be added to the elements covered by the workforce activity roadmap; **DS**

(B) internal beds be included as a separate, specific programme risk, and **DS**

(C) the next iteration of the risk log include additional information on timelines, milestones and progress. **DS**

254/15/5 LLR Better Care Together (BCT) Programme Update

Paper I provided a high-level update on the LLR Better Care Together Programme, as prepared for all partner organisations' Boards (accompanied here by an internal UHL covering report). The latest iteration of the proposed LLR BCT dashboard was attached to the report at appendix 2. Demand and operational pressure issues remained the key aspects of the BCT programme impacting on UHL's own 5-year plan, and paper I also commented on the inherent programme risks presented by the continuing demand management gap. The Trust Chairman noted that the BCT pre-consultation business case was not now due for public launch until Spring 2016.

Resolved – that the update on the LLR Better Care Together programme be noted.

254/15/6 Emergency Care Performance and Winter Contingency Plan

Further to Minute 231/15/6 of 5 November 2015, paper J from the Chief Operating Officer updated the Trust Board on recent emergency care performance, which stood at 90.1% for

the year to date despite continued atypically-high attendance and admission rates. The Chief Executive advised that a product of these high attendance and admission levels was the unacceptable delays in ambulance handover times, and he noted that the CQC had made an unannounced visit to the LRI Emergency Department on 30 November 2015 following its recent inspection of EMAS. The ED had been under particularly severe pressure on 30 November 2015 (769 patients through the Department), and UHL had received some immediate feedback from the CQC on issues it had identified as needing further assurance. The formal CQC report was awaited. The CQC also reported on a meeting between the NTDA/NHSE and all LLR parties (excluding social care) earlier on the morning of 3 December 2015, at which concern had been voiced that the LLR plan for winter was not sufficiently robust. The practicalities of any suggestions were now being worked through, and the Chief Executive noted the need for UHL to ramp up its internal capacity to improve the current situation. The Chief Operating Officer noted the need to start considering winter 2016-17 now in the context of rising demand, and he also commented on the significant pressure currently being faced by the Clinical Decisions Unit at the Glenfield Hospital.

The Chief Operating Officer then invited feedback from the Non-Executive Directors' 26 November 2015 visit to ED, and Col. (Ret'd) I Crowe Non-Executive Director read out a list of questions as outlined below:-

"1. Have we sufficient beds for the winter?
2. What crisis expansion capability do we have or is planned?
3. The Unipart work makes clear that standardisation is variable depending on who is on duty. What are we doing to improve standardisation of triage, process and treatment?
4. Senior staff are extremely busy and this appears to prevent them from undertaking their supervisory role. Could we generate some form of oversight for procedural activities in Resus and Majors?
5. What team training is undertaken or could be undertaken in ED?
6. The current action plan contains too many items that have not been started or are late. Can the necessary resources be found to address these items and what action is being taken regarding late items that require external engagement?
7. Could we revisit workforce issues to ensure we have done all we can, for example:
a. Would more diagnostic capability help, more phlebotomists, radiographers, sonographers or biomedical scientists?
b. Would greater general assistance help, more HCAs, porters, cleaners or volunteers?
8. Could we see the Comms plan for all matters related to Urgent and Emergency care?"

Non-Executive Directors noted the very significant efforts being made by ED staff, and suggested that it would be helpful for the Chief Executive and Trust Chairman to have a more visible presence in the Department, to show the Trust Board's support. The Chairman requested that a clear message be sent to the ED staff noting the Trust Board's appreciation of their efforts. They also noted the very real need for the new Emergency Floor, given the physical constraints of the current space. Dr S Dauncey, Non-Executive Director commented on anecdotal cases of inappropriate referral to ED, and requested that this be fed back to CCGs and GPs. Notwithstanding the dedication and professionalism of the ED staff, Mr A Johnson, Non-Executive Director considered that the ED was operating at overcapacity, with staff working in a very pressurised environment. He also suggested a need to divide actions into short-term immediate actions and longer-term solutions. Non-Executive Directors also noted that the frequency of arrivals at ED later in the day, and the general activity in the wider hospital contributed to difficulties in outflow. Professor A Goodall, Non-Executive Director queried why UHL had the busiest ED (eg whether this was linked to numbers or acuity or both) – in response the Chief Executive noted Leicester's city centre location and very large catchment area, difficulties in accessing primary care, and lack of physical space in ED as contributory factors. Non-Executive Directors agreed to send any further comments to the Chief Executive.

CE/ CHAIR MAN /DMC

COO

NEDs

The Trust Chairman noted that UHL was unable to influence demand directly, and voiced concern over the current demand management actions. The Chief Executive noted that although demand management actions had been put in place within the community, they had not yet served to reduce ED attendances. It was noted that the new ED front door arrangements were proving beneficial, with a 9% decrease in referrals from the UCC to ED. There was a discussion to be had, however, about the scope to extend the opening hours beyond the current slot.

Resolved – that (A) clear messages be fed back to the Emergency Department staff regarding the Trust Board's recognition of the pressures facing the ED, and consideration be given to how to raise the visible profile/presence of the Chairman and Chief Executive within the ED; **DMC/ CE/ CHAIR MAN**

(B) anecdotal reports of inappropriate referral to ED be fed back to CCGs and GPs, and **COO**

(C) any additional comments arising from the Non-Executive Directors' 26.11.15 visit to ED be passed to the Chief Executive. **NEDs**

254/15/7 UHL Risk Report incorporating the Board Assurance Framework (BAF)

Paper K from the Acting Medical Director comprised the latest iteration of the 2015-16 Board Assurance Framework (31 October 2015) and a summary of all high and extreme risks on the risk register. The revised template for the BAF now included a high-level dashboard at the start (incorporating risk movement) and an 'action tracker' for each individual principal risk. From 2016, it was planned that each Trust Board would review the highest risk(s) and/or risk(s) showing the greatest movement. Principal risk 2 re: emergency activity had moved to an 'extreme' risk rating of 25 (now graded as black) and had been covered in detail in Minute 254/15/6 above. Five new high risks had been opened in October 2015 as detailed in paper K, and had been discussed through the most appropriate branch of the Executive Team meetings.

The Trust Board welcomed the new BAF template, particularly the transparency of the risk ratings, and suggested that further information on the different types of controls would also be helpful. Given its risk rating of 20 ('major' - red) and the overdue nature of some of the actions, the Audit Committee Non-Executive Director Chair requested that principal risk 11 (estates infrastructure and team capacity) be reviewed at a future Trust Board. **AMD/ DEF**

Resolved – that principal risk 11 (re: estates infrastructure and team capacity) be considered at a future Trust Board. **AMD/ DEF**

255/15 QUALITY AND PERFORMANCE

255/15/1 Quality Assurance Committee (QAC)

Dr S Dauncey, QAC Non-Executive Director Chair, outlined the discussions held at the 26 November 2015 QAC, including the HSE Improvement Notice received in respect of sharps management. An extension was being pursued for the March 2016 HSE deadline for compliance with the Improvement Notice, and the Trust Board would be kept informed of QAC discussions on this issue. A sharps management report was also scheduled for the December 2015 Executive Strategy Board. As detailed in paper L, the November 2015 QAC meeting had also discussed the quality impact of performance against the cancer targets (quality dashboard to be developed and presented to QAC in February 2016). **QAC CHAIR**

Resolved – that (A) the summary of key issues considered at the 26 November 2015 QAC meeting be received and noted (no specific recommendations for Trust Board

approval) – paper L, and

(B) the Trust Board be kept informed of progress against the HSE Improvement Notice in respect of sharps management, through receipt of the QAC Minutes. **QAC CHAIR**

255/15/2 Integrated Finance, Performance and Investment Committee (IFPIC)

Ms J Wilson, IFPIC Non-Executive Director Chair, outlined the discussions held at the 26 November 2015 IFPIC, particularly noting a good presentation from the Renal, Respiratory and Cardiovascular CMG. The Chief Operating Officer suggested that it might be helpful for the IFPIC Chair to provide feedback to the presenting CMG(s) immediately after each IFPIC meeting. The November 2015 IFPIC had also been advised of slippage on the NTDA/Department of Health approval process for UHL's Electronic Patient Record (EPR) – as previously reported to the Trust Board alternative funding sources were currently being explored. In general discussion, the Chief Operating Officer noted a very positive cancer Listening into Action event held on 27 November 2015. **COO/ IFPIC CHAIR**

In addition to the discussion items identified in the meeting summary, paper M also noted IFPIC's support for the adult level 3 ICU (Glenfield ICU medium term) business case and individual enabling cases relating to (i) the Glenfield Hospital beds enabler; (ii) the LRI beds enabler and (iii) Glenfield Hospital imaging enabler, totalling a capital spend of £16.5m (in addition to the £0.7m previously approved). These business cases were recommended for Trust Board approval, and had been discussed at Minute 254/15/3 above.

Resolved – that (A) the summary of key issues considered at the 26 November 2015 IFPIC meeting be received and endorsed (including the recommendation relating to the adult level 3 ICU business cases) – paper M, and

(B) feedback on CMGs' presentations be provided back to those CMGs after each IFPIC meeting. **COO/ IFPIC CHAIR**

255/15/3 2015-16 Financial Position – Month 7 (October 2015)

Paper N provided an integrated report on month 7 financial performance (month ending 31 October 2015) and delivery of the revised 2015-16 financial plan. As per its revised financial plan submitted to the NTDA on 11 September 2015, UHL was now planning for a deficit of £34.1m in 2015-16, including delivery of a £43m cost improvement programme. As at 31 October 2015, UHL's financial performance was £1m adverse to plan (current deficit of £28m), resulting primarily from income over-performance of £0.6m offset by a pay overspend of £0.7m and a non-pay overspend of £0.9m. Capital spend was £21.5m compared to a plan of £25.8m and UHL's month 7 cash balance stood at £7.8m (£4.8m above the planned level). Although acknowledging that the Trust was slightly off-plan, the Chief Financial Officer considered that the position was manageable (albeit challenging). However, operational winter pressures would potentially have a key financial impact, and the Chief Financial Officer and the Chief Operating Officer had met with all CMGs to discuss their forecasts in detail. Cost improvement programme performance remained strong, and the Chief Financial Officer was confident of 2015-16 CIP delivery. The Chief Financial Officer emphasised that all CIP schemes were checked for their impact on quality and safety considerations.

In respect of capital, the Chief Financial Officer had received confirmation from the NTDA that UHL's emergency floor capital programme would go ahead, which was welcomed - £10m of external capital funding was therefore being made available to UHL. The Trust's capital availability in 2015-16 therefore amounted to £49m (£39m internal capital, £10m external capital funding), and the Finance Team was now meeting with Estates and IM&T colleagues to understand the implications for the planned 2015-16 capital programme, with a revised programme scheduled accordingly for the December 2015 Executive Strategy

Board.

In response to a query from the Audit Committee Non-Executive Director Chair, the Chief Financial Officer confirmed that the capital constraints would not result in UHL experiencing any cash 'squeeze' at the end of 2015-16. The Audit Committee Non-Executive Director Chair also queried the likely ability of NHS Trusts nationally to meet their financial stretch targets.

Resolved – that the financial position for month 7 be noted, and the CMG and Directorate control totals be approved as detailed in paper N. **CFO**

256/15 PATIENT AND PUBLIC INVOLVEMENT (PPI)

256/15/1 Patient and Public Involvement and Engagement Strategy – Quarterly Update

Paper O from the Director of Marketing and Communications advised the Trust Board of progress to date against UHL's Patient and Public Involvement Strategy, as approved in April 2015. The profile of both the PPI Strategy and UHL's Patient Partners was increasing, which was welcomed, with interviews currently scheduled for a further 8 Patient Partners. However, PPI was still perceived as overwhelmingly 'nurse-led' and work was in hand with the Acting Medical Director to encourage medical input. Patient and public involvement was also being incorporated into the process of setting UHL's annual strategic objectives and priorities, with an emphasis on 'co-creation'. This latter point was welcomed by the Healthwatch representative. In discussion on paper O, the Trust Board:-

(a) noted a Non-Executive Director query on where the PPI portfolio should sit – it was agreed that Executive Directors would consider this further; **EDs**

(b) queried how to tap into the research-related PPI work involving clinicians (in the Biomedical Research Units);

(c) noted the need for Patient Partners to be recent or current users of Trust services (or to have experience of them), to ensure a genuine patient perspective;

(d) queried whether equality and diversity considerations were appropriately taken into account as part of the PPI agenda, including the recruitment of Patient Partners. The Director of Marketing and Communications confirmed that his team had worked closely with UHL's Service Equality Manager, and

(e) noted the Chairman's comments on the need for sustained momentum on PPI. He suggested repeating the August 2015 Trust Board thinking day with PPI partner organisations, focusing on outcomes. **DMC/ CHAIR MAN**

Resolved – that (A) Executive Directors consider the most appropriate placement of the PPI portfolio, and **EDs**

(B) a Trust Board thinking day event with PPI partner organisations be repeated in 2016 (focusing on outcomes). **DMC/ CHAIR MAN**

257/15 EDUCATION AND TRAINING

257/15/1 Multi-professional Clinical Education and Training – Quarterly Update

Further to Minute 185/15/1 of 3 September 2015, paper P provided a quarterly update on multi-professional clinical education and training (joint report from the Acting Medical Director and the Chief Nurse). Recent positive developments included the November 2015 Executive Strategy Board's support for the multi-professional education facilities strategy (as

part of the Trust's overall reconfiguration programme), and a Listening into Action event with University of Leicester medical students. Paper P also outlined the findings from the November 2015 HEEM visit – as reported earlier in the meeting the feedback had been generally positive although identifying training concerns within cardiology. The Renal Respiratory and Cardiovascular CMG was taking these issues very seriously. In discussion on paper P, the Trust Board noted:-

(a) comments from Professor A Goodall Non-Executive Director and University of Leicester representative, that the purpose of the LiA event had been to understand and address medical trainees' dissatisfaction. She also noted the new University of Leicester medical curriculum (as appended to paper P), and moves to reflect teaching roles in Honorary appointments. Professor Goodall was also meeting with Laboratory and AHP staff groups to discuss training and research opportunities;

(b) the thanks expressed by Col (Ret'd) I Crowe Non-Executive Director, for the organisation of the Army clinical placements, noting the positive feedback from both sides. It was also hoped to explore non-clinical placements involving (eg) Army medical administrators and logisticians;

(c) (in response to a query) that the medical education strategy and dashboard aimed to provide a longterm plan and clear milestones re: medical education provision. The Autumn 2016 GMC accreditation visit would also be a key consideration, and

(d) the key need to increase the local nursing intake for UHL.

Resolved – that the quarterly update on multi-professional clinical education and training be noted.

258/15 REPORTS FROM BOARD COMMITTEES

258/15/1 Audit Committee

Paper Q comprised the Minutes of the 5 November 2015 Audit Committee meeting, noting 3 items recommended for Trust Board approval (nomination of the Audit Committee to act as the Auditor Panel to appoint the Trust's Auditors; proposals for Leicester Hospitals Charity Corporate Trustee to appoint its own Auditor appointments, and Leicester Hospitals Charity Accounts and Annual Report 2014-15 [Minute 259/15/1 below refers]). The Chief Financial Officer advised that as of April 2017, the Trust would appoint External Audit for the main accounting business and charitable funds accounts, and Internal Audit for the Internal Audit function. He also advised that it would be good practice for the charitable accounts to be available earlier in the year than was currently the case. The Audit Committee Non-Executive Director Chair advised that the governance programme for reconfiguration would be circulated to Trust Board members. **DCLA**

Resolved – that (A) the 5 November 2015 Audit Committee Minutes be received and noted, and the recommendations therein be endorsed, and

(B) the reconfiguration governance programme be circulated to the Trust Board members. **DCLA**

258/15/2 Quality Assurance Committee (QAC)

Resolved – that the 29 October 2015 QAC Minutes be received and noted, and any recommendations therein be endorsed.

258/15/3 Integrated Finance, Performance and Investment Committee (IFPIC)

Resolved – that the 29 October 2015 IFPIC Minutes be received and noted and any recommendations therein be endorsed.

259/15 CORPORATE TRUSTEE BUSINESS

259/15/1 Leicester Hospitals Charity Annual Accounts and Annual Report 2014-15

Paper T presented the audited accounts 2014-15, Trustees' Annual Report 2014-15, and Letter of Representation for Leicester Hospitals Charity for the year ending 31 March 2015. These were approved as presented (relevant certificates to be signed accordingly as detailed in paper T) for submission to the Charity Commission by 31 January 2016 as required. **CFO**

Resolved – that the Leicester Hospitals Charity Accounts and Annual Report 2014-15 be approved by the Trust Board as Corporate Trustee, and the relevant certificates signed as detailed in paper T, for submission to the Charity Commission as required. **CFO**

260/15 TRUST BOARD BULLETIN – DECEMBER 2015

Resolved – that the Trust Board Bulletin containing the following reports be noted:-
(1) NHS Trust Over-Sight Self Certification return for the period ended 30 September 2015 [noting the continuing cleanliness concerns expressed by the Trust] (paper 1), and
(2) updated declaration of interest from Mr M Traynor Non-Executive Director [Non-Executive Chairman and Trustee, Leicestershire Rural Community Council Ltd – formerly a Trustee of the same] (paper 2).

261/15 QUESTIONS AND COMMENTS FROM THE PRESS AND PUBLIC RELATING TO BUSINESS TRANSACTED AT THIS MEETING

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

(1) concerns about the inappropriate use of ED by members of the public, and the need for greater understanding of where to seek treatment;

(2) the need for all UHL staff to put themselves in the place of the patient, and thereby understand the patient's perspective;

(3) a number of points relating to PPI, including:-

- the need to embed PPI into the UHL Way;
- disappointment that – despite the good progress made – it had not yet proved possible to appoint to the supporting band 5 post;
- an interesting East Midlands PPI Senate document, which would be provided for circulation to the Trust Board; **STA**
- the Patient Partners' gratitude to Ms J Wilson, Non-Executive Director, for her support to them, and

(4) a query on the pilot project to extend Leicester City GP opening hours. In response, the Chief Operating Officer advised that Leicester City CCG had commissioned an additional 1700 GP slots across 4 hubs. Although usage of those slots was increasing, they had not yet resulted in reduced ED attendances.

262/15 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 263/15 – 271/15), having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.

263/15 DECLARATIONS OF INTERESTS IN THE CONFIDENTIAL BUSINESS

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

264/15 CONFIDENTIAL MINUTES

Resolved – that the confidential Minutes of the 5 November 2015 Trust Board be confirmed as a correct record and signed by the Trust Chairman accordingly. **CHAIR MAN**

265/15 CONFIDENTIAL MATTERS ARISING REPORT

Resolved – that the confidential matters arising log be received and noted.

266/15 REPORT FROM THE DIRECTOR OF ESTATES

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

267/15 REPORT FROM THE ACTING MEDICAL DIRECTOR

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

268/15 REPORT FROM THE CHIEF FINANCIAL OFFICER

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

269/15 REPORTS FROM BOARD COMMITTEES

269/15/1 Audit Committee

Resolved – that the confidential Minutes of the 17 September 2015 Audit Committee be received and noted, and the recommendations therein be endorsed.

269/15/2 Quality Assurance Committee (QAC)

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

269/15/3 Integrated Finance, Performance and Investment Committee (IFPIC)

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

270/15 ANY OTHER BUSINESS

270/15/1 Ms J Wilson, Non-Executive Director

Noting that this was her last Trust Board meeting, the Trust Chairman thanked Ms J Wilson Non-Executive Director for her very significant contribution to the Trust during her terms of office, and wished her well for the future.

Resolved – that the position be noted.

270/15/2 Leicestershire Combined Fire Authority Consultation

Mr M Traynor, Non-Executive Director agreed to brief the Chief Executive on the consultation re: Leicestershire Combined Fire Authority, for a potential UHL response in light of the possible impact on the Trust. **MT NED**

Resolved – that Mr M Traynor Non-Executive Director, advise the Chief Executive of the consultation re: Leicestershire Combined Fire Authority, for a potential UHL response. **MT NED**

271/15 DATE OF NEXT TRUST BOARD MEETING

Resolved – that the next Trust Board meeting be held on Thursday 7 January 2016 from 9am in Seminar Rooms A & B, Education Centre, Leicester General Hospital.

The meeting closed at 2.37pm

Helen Stokes – **Senior Trust Administrator**

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

Name	Possible	Actual	% attendance	Name	Possible	Actual	% attendance
K Singh	9	9	100	R Mitchell	9	9	100
J Adler	9	9	100	R Moore	9	9	100
I Crowe	9	9	100	C Ribbins	4	3	75
S Dauncey	9	7	78	J Smith	5	5	100
A Furlong	9	9	100	M Traynor	9	8	89
A Goodall	7	6	86	P Traynor	9	9	100
A Johnson	2	2	100	J Wilson	9	9	100

Non-Voting Members:

Name	Possible	Actual	% attendance	Name	Possible	Actual	% attendance
D Henson	9	9	100	E Stevens	4	4	100
R Palin	5	3	60	L Tibbert	5	4	80
N Sanganee	3	2	67	S Ward	9	9	100
K Shields	9	6	67	M Wightman	9	9	100