UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF A MEETING OF THE TRUST BOARD, HELD ON THURSDAY 4 MAY 2017 AT 9AM IN ROOMS 2 & 3, CLINICAL EDUCATION CENTRE, GLENFIELD HOSPITAL

Voting Members present:
Mr K Singh – Chairman (excluding Minute 128/17)
Mr M Traynor – Deputy Chairman (Acting Chair for Minute 128/17)
Mr J Adler – Chief Executive
Professor P Baker – Non-Executive Director
Dr S Crawshaw – Non-Executive Director
Col (Ret'd) I Crowe – Non-Executive Director
Mr A Johnson – Non-Executive Director
Mr B Patel – Non-Executive Director
Ms J Smith – Chief Nurse
Mr P Traynor – Chief Financial Officer

In attendance:
Mr J Clarke – Chief Information Officer (for Minute 127/17)
Dr M Duddridge – Consultant Clinical Immunologist (for Minute 114/17/1)
Ms H Finch – Research Delivery Manager, EMCRN (for Minute 117/17)
Dr C Free – Deputy Medical Director (attending in the absence of the Medical Director)
Ms H Leatham – Assistant Chief Nurse (for Minute 114/17/1)
Mr E Rees – LLR Healthwatch representative (up to Minute 123/17)
Ms R Sango – Specialist Nurse (for Minute 114/17/1)
Ms G Staton – Head of Nursing, Emergency and Specialist Medicine CMG (for Minute 114/17/3)
Ms H Stokes – Senior Trust Administrator
Mrs L Tibbert – Director of Workforce and Organisational Development
Mr S Ward – Director of Corporate and Legal Affairs
Mr M Wightman – Director of Communication, Integration and Engagement

ACTION

108/17 APOLOGIES AND WELCOME

Apologies for absence were received from Mr A Furlong Medical Director, Mr R Mitchell Chief Operating Officer, and Mr R Moore Non-Executive Director. The Trust Chairman welcomed Mr E Rees, LLR Healthwatch representative to his first UHL Trust Board meeting.

109/17 DECLARATIONS OF INTERESTS IN THE PUBLIC BUSINESS

The Trust Chairman declared an interest in Lakeside House, which was mentioned in the emergency care performance report at Minute 114/17/3 below. If members wished to discuss ED front door arrangements in any further detail, the Chairman would withdraw from the discussion. In the event, this did not prove necessary. The Trust Chairman also declared a familial interest in respect of the research item at Minute 117/17 below – it was agreed that it was not necessary for him to absent himself from that discussion.

110/17 MINUTES

Resolved – that the Minutes of the 6 April 2017 Trust Board meeting be confirmed as a correct record and signed by the Trust Chairman accordingly. **CHAIR MAN**

111/17 MATTERS ARISING FROM THE MINUTES

Paper B detailed the status of previous matters arising and the expected timescales for resolution. Members noted in particular:-

(a) action 4a (Minute 88/17/2 of 6 April 2017) – an update on the meaning of question 14b and its response findings from the 2016 national staff survey would be included in the next iteration of the Trust Board matters arising log; **DWOD**
(b) action 4c (Minute 88/17/2 of 6 April 2017) – the Director of Workforce and OD advised that any

sample size of over 30% was classed as reasonable. She advised that all East Midlands Trusts were experiencing challenges in terms of response rates;

(c) action 18 (Minute 290/16 of 1 December 2016) – given that the System Leadership Team organisational and governance arrangements were still in development, a cross-organisational dashboard was not imminent, and

(d) action 21 (Minute 189/16/1 of 1 September 2016) – feedback was awaited on the national capital allocation process before progressing further with the reconfiguration strategic outline case.

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

112/17 CHAIRMAN'S MONTHLY REPORT – MAY 2017

In introducing his monthly report for May 2017 (paper C), the Chairman drew the Trust Board's particular attention to the following issues:-

(a) the Trust Board's intention to discuss capital constraints in more detail at its May 2017 Thinking Day;

(b) the recognised need for a clear narrative on the nature and implementation of future Trust plans;

(c) the need to develop a mindset of 'frugal innovation' in light of the increasing demands and financial challenges facing the NHS. At the request of Trust Board members, the Chairman agreed to circulate the slides from Dr B Bhargava's recent presentation on this issue, for information; **CHAIR MAN**

(d) his thanks to all of the staff involved in the planning for and 26 April 2017 opening of the Trust's new Emergency Floor, and his appreciation of the significant work involved, and

(e) the need for members to observe the current period of purdah in the run-up to the General Election, and avoid making any political statements.

Resolved – that the slides from the recent 'frugal innovation' presentation by Dr B Bhargava be circulated to Trust Board members for information. **CHAIR MAN**

113/17 CHIEF EXECUTIVE'S MONTHLY REPORT – MAY 2017

The Chief Executive's May 2017 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 now detailed in a separate report at Minute 115/17 below. In introducing his report, the Chief Executive noted:-

(a) the Trust's 2016-17 performance on a range of indicators. He particularly welcomed UHL's good progress on quality outcomes (including the reduction in harms) and in-year diagnostics performance. The Trust was close to delivering the referral to treatment standard with compliance anticipated later in 2017, although this was closely linked to demand and capacity issues. However, the Chief Executive also recognised that not all indicators had been achieved in 2016-17, including the initial financial forecast;

(b) the Trust's strategic objectives and 2017-18 annual priorities, as detailed in section 4 of paper D, reiterating the central importance of the Trust's Quality Commitment;

(c) that a new format Board Assurance Framework would be presented to the June 2017 Trust Board; **MD**

(d) the need to deliver the Trust's 2017-18 financial plan in the acknowledged context of demand pressures. This had been emphasised to staff through the Chief Executive's May 2017 briefings, and

(e) the opening of the new Emergency Floor (Minute 114/17/4 below also refers).

In discussion on the Chief Executive's May 2017 update, the Chairman reiterated NHS Improvement's view that financial responsibility sat with individual NHS Trust Boards. The Chairman queried the plans in place to communicate UHL's strategic objectives and 2017-18 annual priorities to stakeholders – in response, the Chief Executive advised that the initial focus had been on internal briefings but that attention would now turn to wider external communication. UHL's quality priorities had already been shared with stakeholders as part of the Trust's Quality Account. The Chief Nurse

voiced her thanks to all UHL staff for their 2016-17 performance on quality metrics (particularly in respect of infection prevention) despite activity pressures. Quality and safety remained the Trust's key focus, which was welcomed by the Trust Board. In further discussion the Chief Executive commented that it was recognised that – with a few exceptions (eg where additional capacity investment was required for delivery) – high quality care was also more cost-effective care. The Chairman recognised the need for appropriate prioritisation of investment, given that resources were finite.

Resolved – that the new format Board Assurance Framework be presented to the June 2017 Trust Board as part of the integrated risk register report. **MD**

114/17 KEY ISSUES FOR DECISION/DISCUSSION

114/17/1 Patient Story – Home Therapy Immunoglobulin

Paper E from the Chief Nurse focused on the positive experience of a patient receiving clinical immunology service home therapy. In the video link accompanying paper E, the patient shared their experience of administering subcutaneous immunoglobulin replacement therapy at home, using the new daily rapid push method without the use of any syringe drivers (as required for traditional weekly therapy). This new method and home administration had given the patient control over their illness and treatment plan, reduced the number of hospital visits required and also reduced the risk of infection and resulting hospital admissions. This method of therapy also ensured a more stable level of treatment, reducing the 'peaks and troughs' associated with traditional intravenous immunoglobulin therapy.

Following the video, Dr M Duddridge, Consultant Clinical Immunologist outlined the differences between the various methods of administration and noted the benefits of the new rapid push method (both clinical and in terms of the patient experience). Ms R Sango, Specialist Nurse detailed the training provided to patients to enable them to administer at home, and she confirmed that patient choice remained key to all discussions with patients. Patients were assessed re: their suitability for home therapy, and a detailed information booklet was provided in addition to personal support from the nursing team. Doses were also tailored to the specific patient needs. In discussion on the patient story, the Trust Board noted:-

(a) a query from Dr S Crawshaw Non-Executive Director on whether there was any difference in the safety and effectiveness of the different methods. In response, the Consultant Clinical Immunologist noted the 'steady state' benefits of the subcutaneous injection method, avoiding the peaks and troughs noted above. The subcutaneous rapid push method described in paper E was used widely in North America. There was no difference in the methods from an adverse reactions perspective;

(b) queries from Mr B Patel Non-Executive Director re: the extent to which family members were involved in the discussions/training, and whether all patients were initially confident to home administer. In response, the Specialist Nurse advised that the level of family involvement depended on the patient's own wishes. She acknowledged that some patients might be nervous to start with, and she noted that the discussions with patients began using very simple, straightforward language to explain the therapy and what was involved. A training DVD was also used. The Consultant Clinical Immunologist noted his view that more patients should be offered the home therapy (unless contraindicated), and he noted the need not to pre-suppose which patients might be interested in/capable of undertaking it themselves;

(c) a query from the LLR Healthwatch representative on the scope for community provision, as an alternative to administering at home/in hospital. The Consultant Clinical Immunologist considered that this home administration offered patients more flexibility, control and freedom, by removing the need to attend either a hospital or community setting. In a follow-up query, the LLR Healthwatch representative queried whether community provision was an option for learning disability patients – in response, the Consultant Clinical Immunologist noted that relatives and carers could be trained to home administer for those patients (where appropriate);

(d) (in response to a query from the Chief Financial Officer) that specialised Commissioners were supportive of the home therapy approach. It was noted that the rapid push method was less expensive per patient on an overall healthcare economy basis because pumps did not need to be bought, and

(e) comments from the Chairman on the need for appropriate consideration of end of life care scenarios, with an integrated approach to ensure that all organisations involved were aware when a patient had died. The Chairman also reiterated the key importance of providing appropriate education and training to patients (including the clinical risks) with regard to home therapy administration.

The Trust Board welcomed the patient story and thanked all those involved in this very positive development.

Resolved – that the Home Therapy Immunoglobulin patient story be noted.

114/17/2 East Midlands Congenital Heart Centre (EMCHC) Update

Paper F updated the Trust Board on the new congenital heart disease review process, the key actions for immediate attention and the associated risks. Due to the General Election purdah period, the public consultation had been extended for 6 weeks to 17 July 2017 and all formal public events planned between 22 April – 9 June 2017 would be rearranged. The Trust would also be required to withdraw from public stakeholder events. The Director of Corporate and Legal Affairs noted that the Trust's response to the consultation would therefore be presented to the July 2017 Trust Board for approval. The Trust Chairman noted the crucial need to maintain momentum on the EMCHC campaign during the extended public consultation period, and to continue to make the strongest possible case for the EMCHC. Surgical numbers remained the only outstanding issue, and the Trust was meeting with NHS England on 18 May 2017 to discuss the EMCHC growth plan. In response to a query from Col (Ret'd) I Crowe Non-Executive Director, the Trust hoped to receive some feedback from that meeting on the day itself. **DCIE**

Resolved – that UHL's response to congenital heart disease review public consultation be presented to the 6 July 2017 Trust Board for approval, ahead of submission to NHS England. **DCIE**

114/17/3 Emergency Care Performance and update on Red 2 Green

Further to Minute 88/17/4 of 6 April 2017, paper G updated the Trust Board on recent emergency care performance. 79.3% performance had been achieved overall in 2016-17, with March 2017 performance of 83.9% at similar levels to that achieved in February 2017. April 2017 had seen a comparatively strong start, achieving over 80% on 16 of the first 19 days of that month – this was due primarily to the impact of continued benefits from the taking down of elective work in March 2017 and to the strong planning for Easter 2017. However, performance in later April 2017 had been more challenging, as discussed in Minute 114/17/4 below.

Ms G Staton, Head of Nursing for the Emergency and Specialised Medicine Clinical Management Group (ESM CMG) attended to update the Trust Board on progress in implementing the 'Red 2 Green' approach across that CMG. Paper G1 detailed how the specialty medicine wards at the Leicester Royal Infirmary had embraced the Red 2 Green methodology, and advised that they were beginning to see improvements across the key metrics. Further roll-out of Red 2 Green was planned for the Leicester General Hospital renal wards and Leicester Royal Infirmary children's wards in May 2017, followed by respiratory and cardiology wards at the Glenfield Hospital in June 2017. The report also reminded Trust Board of the rationale behind the Red 2 Green initiative, which aimed to identify wasted time in a patient's journey and reduce both internal and external delays. Early findings indicated a number of areas of positive progress using this initiative, including a greater understanding on the part of patients as to why they were in hospital and a reduction in the number of 'stranded patients'. A weekly 'dragons den' approach had been implemented to review the 3 longest length of stay patients for each ward, and paper G1 noted a clear reduction in both the number of the most stranded patients and in the length of time they were waiting. The Head of Nursing ESM CMG also emphasised the crucial importance of a team approach internally, and of an integrated approach externally with other health and social care partners.

In discussion on the Red 2 Green update (the progress on which was welcomed), the Trust Board noted:-

(a) a query from the Deputy Medical Director regarding progress on continuing healthcare aspects (in terms of resolving external delays). In response, the Head of Nursing ESM CMG noted the impact of a new provider in April 2017;
(b) (in response to a query from Professor P Baker Non-Executive Director) the impact of

individual ward leadership on the successful (or otherwise) implementation of Red 2 Green. The Trust Board agreed that it was not acceptable for some wards not to be doing the basic elements of Red 2 Green; this would be reinforced to medical and nursing staff accordingly. In response to a further query, it was noted that there all wards were able to view their own and others' performance on the Red 2 Green metrics; **MD/ CN**

(c) comments from Mr A Johnson Non-Executive Director welcoming this initiative, which he saw as an example of 'frugal innovation' which could be applied to other issues facing UHL;

(d) the key need to focus on stranded patients (particularly those with a hospital length of stay of more than 10 days), and to monitor progress in reducing the number of such patients. The Head of Nursing ESM CMG noted the key links to medical decision-making and clinical pathways, and confirmed that as the medical lead for Red 2 Green, Dr I Lawrence Clinical Director ESM CMG was reviewing medical decision-making aspects; **COO**

(e) (in response to a comment from the Chief Financial Officer) that the new Non-Emergency Patient Transport provider was aware that the Red 2 Green initiative envisaged more patients travelling home in the morning;

(f) comments from Mr B Patel Non-Executive Director [1] welcoming the idea of an integrated discharge team also covering the community; [2] querying whether appropriate lessons were being learned about the physical location of discharge lounges on each hospital site in terms of patient access to their cars, and [3] querying the level of flexibility in the current community hospital discharge criteria, and

(g) that corporate oversight of the Red 2 Green initiative was via the 'organisation of care' strand of the 2017-18 annual priorities. The Chief Executive congratulated the Head of Nursing ESM CMG on her continued delivery of the Red 2 Green initiative.

Resolved – that (A) the update on emergency care performance and on the Red 2 Green initiative be noted;

(B) progress on reducing the number of patients with a length of stay exceeding 10 days be appropriately monitored, and **COO**

(C) the need to deliver the Red 2 Green basics be emphasised to all medical and nursing staff. **MD/CN**

114/17/4 Emergency Floor Update

This monthly update advised the Trust Board of progress on the Emergency Floor, which had formally opened on 26 April 2017. In introducing paper H, the Chief Executive advised that the opening of the facility had gone smoothly (with double-running required for only 3 hours), and he reiterated the Chairman's earlier thanks to all of the staff involved. In a further verbal update, the Chief Executive noted however that the Trust had recently experienced significant emergency pressures and had been in critical incident mode for much of the week beginning 1 May 2017. This was driven by a number of factors including (i) the impact of the Spring Bank Holiday weekend and demands on medical bed capacity, with discharge causing particular problems; (ii) managing the inflow of patients to the new Emergency Floor. Attendances had increased, resulting in the need to use 2 streaming nurses instead of 1, and (iii) the impact on majors capacity of having 8 majors cubicles currently housing the GP Assessment Unit – although this would be addressed by phase 2 of the Emergency Floor development, work was now urgently underway to relocate GPAU for the intervening year. The Trust continued to take all appropriate measures to resolve the issues outlined above. Phase 2 construction would begin during the week beginning 8 May 2017 and would open in 2018.

In discussion, the Trust Chairman requested that the May 2017 Integrated Finance Performance and Investment Committee (IFPIC) undertake a deep dive review of emergency performance. In response to a query from Dr S Crawshaw Non-Executive Director, the Chief Nurse confirmed that plans were now being progressed to move GPAU to the space currently envisaged for eye casualty in the blue zone. In response to comments from the Chairman and recognising the Trust's limited ability to affect attendance levels, the Chief Executive reiterated the crucial importance of appropriate streaming of those attendances. The Chief Executive also commented on the workforce and capacity pressures facing primary care. In further discussion, the Trust Board commented on the patient experience improvements of the new Emergency Floor (eg in terms of privacy and dignity), and noted that no feedback had been received which would indicate any fundamental flaws in the facility. **COO**

Resolved – that the 25 May 2017 IFPIC undertake a deep dive review of emergency care performance. **COO**

114/17/5 Annual Operational Plan 2017-19

Further to Minute 92/17/2 of 6 April 2017, paper I presented the finalised Annual Operational Plan 2017-19 for Trust Board approval. The plan had been through a number of iterations since December 2016, which had been reviewed at various Executive and Trust Board Committees as appropriate. The most significant change in the finalised plan (to the version approved at the 19 January 2017 Trust Board) was a £3m improvement to the forecast financial deficit position for both 2017-18 and 2018-19; the planned deficits for those years were now £26.7m and £21.7m respectively.

The Chief Financial Officer drew Trust Board's attention to the operational performance standards trajectories in section 3.4 – capacity would be a key factor in delivering these trajectories, and the emergency care performance requirements were likely to be challenging. The activity plan forecasts were based on 'downside' scenarios assuming QIPP part-delivery. The IFPIC Non-Executive Director Chair confirmed that the Annual Operational Plan 2017-19 had been discussed in detail at the 27 April 2107 IFPIC, and he noted the need for appropriate control of the Trust's runrate. The April 2017 IFPIC had also reviewed a detailed 2017-18 financial plan for the Trust.

Resolved – that the UHL finalised Annual Operational Plan 2017-19 (including the Trust capital plan 2017-18 and 2018-19) be approved as presented. **CFO**

115/17 RISK MANAGEMENT – INTEGRATED RISK REPORT

Paper J comprised the integrated risk report, presenting the final report on the 2016-17 Board Assurance Framework (BAF) for endorsement and also summarising any new organisational risks scoring 15 or above in March 2017 (3 which related to:- the potential delay with outpatient correspondence to referrer/patient following clinic attendance; Registered Nurse vacancies in Thoracic Surgery, and nursing vacancies on the trauma wards). In addition to those 3 new high risks, 1 risk had been increased from moderate to high, relating to the LRI mortuary floor.

Within the report, the Trust Board was also invited to consider whether there were any assurance gaps or inadequate controls in the current Board Assurance Framework. The Chief Executive reminded members that the integrated risk register and Board Assurance Framework were in the process of being extensively refreshed in light of the Trust's updated strategic objectives and 2017-18 annual priorities, with a new format being presented accordingly to the June 2017 Trust Board. The Chairman commented on the need for a dynamic document able to capture future/emerging risks such as the projected future national nursing shortage.

Resolved – that the integrated risk report (as at 31 March 2017) be noted.

116/17 STRATEGY AND RECONFIGURATION

116/17/1 Sustainability and Transformation Partnership and UHL Reconfiguration Programme – Update

Paper K updated the Trust Board on the LLR Sustainability and Transformation Partnership (STP)/Better Care Together (BCT) Programme, which set the context for UHL's reconfiguration programme. Although planning remained somewhat fluid, LLR-wide clinical teams were currently reviewing key 'wicked issues' (including beds) with a view to reporting to the System Leadership Team at the end of May 2017. In respect of UHL's reconfiguration programme, the national capital position remained unclear, and the May 2017 Trust Board thinking day would discuss various scenarios further. The Chief Financial Officer confirmed that bids had been invited for the £325m capital outlined in the Spring 2017 Budget – the nature of the bids being put forward by UHL was as set out in paper K and included progressing the interim ICU project and a new 2-ward block both at the Glenfield Hospital. Submitted after Easter 2017, the outcome of the bids would not be known until after the General Election.

Resolved – that the STP and UHL reconfiguration programme update be noted.

117/17 RESEARCH & EDUCATION

117/17/1 East Midlands Clinical Research Network (EMCRN): Annual Delivery Plan 2017-18

Ms H Finch, EMCRN Research Delivery Manager attended to seek UHL Trust Board approval – as required of the network's host organisation – for the EMCRN annual delivery plan 2017-18 (paper L). The report had been endorsed at the April 2017 UHL Executive Performance Board and was supported by the Trust's Medical Director as Executive Sponsor. The EMCRN Research Delivery Manager noted a 3.4% reduction to the EMCRN budget for 2017-18, and advised that the network was focusing on 3 key areas: NHS and broader engagement; STPs, and managing performance of the network's research studies. EMCRN would also seek to work more smartly and develop a supra-network approach to sharing good practice.

Resolved – that UHL Trust Board approval (as the Host organisation) be given to the EMCRN annual delivery plan 2017-18, as presented. **MD**

118/17 QUALITY AND PERFORMANCE

118/17/1 Quality Assurance Committee (QAC)

Paper M summarised the issues discussed at the 27 April 2017 QAC. Although there were no formal recommendations or decisions arising from that meeting, the QAC Non-Executive Director Chair noted assurance received that the works required to the LRI post-mortem suite floor would be carried out. The Chief Executive now confirmed that capital had been allocated accordingly, and that this issue had been discussed further at the May 2017 Executive Quality Board. He also commented on the need to have a licence to undertake post-mortems in any decant facility while those works were underway.

Resolved – that the summary of issues discussed at the 27 April 2017 QAC be noted as per paper M, and any recommended items be endorsed accordingly (Minutes to be submitted to the 1 June 2017 Trust Board) and taken forward by the relevant lead officer.

118/17/2 Integrated Finance, Performance and Investment Committee (IFPIC)

Paper N summarised the issues discussed at the 27 April 2017 IFPIC, noting the recommendations to [1] approve the finalised Annual Operational Plan 2017-19 as presented at Minute 114/17/5 above, and [2] approve the 2017-18 financial plan. In response to a query on the latter, the Chief Financial Officer clarified that the group reviewing cost pressures would be chaired by the Chief Executive, with clinical engagement as required. That process would not be undertaken through the Revenue Investment Committee. **CFO**

Resolved – that the summary of issues discussed at the 27 April 2017 IFPIC be noted as per paper N (Minutes to be submitted to the 1 June 2017 Trust Board), and any recommended items endorsed accordingly and taken forward by the relevant lead officer. **CFO**

118/17/3 2016-17 Financial Performance – March 2017

Paper O presented the Trust's month 12 financial position, which had been discussed in detail at the 27 April 2017 Integrated Finance Performance and Investment Committee meeting (paper N also refers). The Trust had delivered the revised year-end forecast deficit of £38.6m (£6.9m adverse to plan) excluding Sustainability and Transformation Funding. The audit process for the 2016-17 annual exchequer accounts had begun on 2 May 2017 and the accounts would be presented to the May 2017 Audit Committee and on to the 1 June 2017 Trust Board for approval. In response to comments from the Trust Chairman, the Chief Financial Officer noted the 2017-18 need for Trusts to improve upon their 2016-17 financial delivery positions, hence the change to the UHL Annual Operational Plan 2017-19 as reported in Minute 114/17/5 above.

Resolved – that the month 12 financial position and 2016-17 year-end financial delivery be noted.

119/17 REPORTS FROM BOARD COMMITTEES

119/17/1 Quality Assurance Committee (QAC)

Resolved – that the Minutes of the 30 March 2017 QAC be received and noted, and any recommendations endorsed accordingly (paper P).

119/17/2 Integrated Finance Performance and Investment Committee (IFPIC)

Resolved – that the Minutes of the 30 March 2017 IFPIC be received and noted, and any recommendations endorsed accordingly (paper Q).

120/17 TRUST BOARD BULLETIN – MAY 2017

Resolved – it be noted that no papers had been circulated for the May 2017 Trust Board Bulletin.

121/17 CORPORATE TRUSTEE BUSINESS

121/17/1 Charitable Funds Committee

Resolved – that the Minutes of the 6 April 2017 Charitable Funds Committee be received and noted, and any recommendation endorsed accordingly (paper R).

122/17 QUESTIONS AND COMMENTS FROM THE PRESS AND PUBLIC RELATING TO BUSINESS TRANSACTED AT THIS MEETING

Attendees at the public session of the Trust Board raised the following queries/comments in relation to the business discussed:-

(1) a query as to whether the same level of scrutiny was applied to the corporate cost improvement programme (CIP) schemes as to the clinical ones. This was thought vital, in order to ensure that quality and safety remained paramount. In response, the Trust Chairman supported the need for a consistent approach, and reiterated the Trust's commitment to maintaining quality and safety. The Chief Nurse advised the requester that all CIP schemes – whether corporate or clinical in nature – underwent the same review process which included a quality and safety impact assessment and review by herself and the Medical Director. The Chief Financial Officer added that all CIP schemes were also presented to CCG colleagues. The Chairman assured the requester that there was no difference between the requester's view of how it should be done, and how it actually was done by UHL;

(2) a query as to when the Electronic Patient Record (EPR) would be discussed by the Trust Board, noting that it was referenced in paper Q (30 March 2017 IFPIC Minutes) but did not appear to be on today's Trust Board agenda. The Chairman advised that EPR was being discussed in the private session of today's Trust Board meeting due to its commercially sensitive nature, and would be reported in public as soon as was feasible. The Chairman further advised that although the Trust conducted as much of its Trust Board business as possible in the public session, it was appropriate that issues of a commercial or (eg) personal information nature should be discussed in private. The requester noted the need – nonetheless – for the public to be kept updated on EPR and reassured that progress was being made. The Chief Executive commented that an update could potentially be brought to the public session of the June 2017 Trust Board, and **CE/CIO**

(3) a comment on the perceived lack of transparency around the STP, which was not viewed as a co-production with the public. The questioner specifically asked when the System Leadership Team minutes would be reported to LLR Boards as stated, and whether these would be in the public session. In response, the Trust Chairman noted the position of the UHL Trust Board as a sovereign Board, and advised that it was not appropriate for UHL to comment on how other LLR Boards might choose to discuss the SLT outputs. He reiterated UHL's commitment to being open and transparent, and noted the Trust's support for a cross-organisational STP dashboard.

Resolved – that the query above and any associated actions, be noted and progressed by the identified lead officer(s). **Named Lead(s)**

123/17 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 124/17 to 133/17) having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.

124/17 DECLARATIONS OF INTERESTS IN THE CONFIDENTIAL BUSINESS

The Trust Chairman declared an interest in confidential Minute 127/17 below and absented himself from the meeting for its discussion. The meeting was chaired by Mr M Traynor Non-Executive Director and Deputy Chairman during that item.

125/17 CONFIDENTIAL MINUTES

Resolved – that the confidential Minutes of the 6 April 2017 Trust Board meeting be confirmed as a correct record and signed by the Trust Chairman accordingly. **CHAIR MAN**

126/17 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 would be prejudicial to the effective conduct of public affairs.

127/17 REPORT FROM THE CHIEF INFORMATION OFFICER

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

128/17 REPORT FROM THE CHIEF OPERATING OFFICER

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

129/17 REPORT FROM THE CHIEF FINANCIAL OFFICER

Resolved – that this Minute 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.

130/17 REPORTS FROM BOARD COMMITTEES

130/17/1 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 would be prejudicial to the effective conduct of public affairs.

130/17/2 Integrated Finance Performance and Investment Committee (IFPIC)

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

130/17/3 Remuneration Committee

Resolved – that the confidential Minutes of the 6 April 2017 Remuneration Committee be received and noted, and any recommendations endorsed accordingly.

131/17 CORPORATE TRUSTEE BUSINESS

131/17/1 Charitable Funds Committee

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

132/17 ANY OTHER BUSINESS

There were no items of any other business.

133/17 DATE OF NEXT TRUST BOARD MEETING

Resolved – that the next Trust Board meeting be held on Thursday 1 June 2017 from 9am in the C J Bond Room, Clinical Education Centre, Leicester Royal Infirmary.

The meeting closed at 1.35pm

Helen Stokes – **Senior Trust Administrator**

Cumulative Record of Attendance (2017-18 to date):

Voting Members:

Name	Possible	Actual	% attendance	Name	Possible	Actual	% attendance
K Singh	2	2	100	R Mitchell	2	1	50
J Adler	2	2	100	R Moore	2	1	50
P Baker	2	2	100	B Patel	2	2	100
S Crawshaw	2	1	50	J Smith	2	2	100
I Crowe	2	2	100	M Traynor	2	2	100
A Furlong	2	2	100	P Traynor	2	2	100
A Johnson	2	1	50				

Non-Voting Members:

Name	Possible	Actual	% attendance	Name	Possible	Actual	% attendance
L Tibbert	2	2	100	E Rees	1	1	100
S Ward	2	2	100				
M Wightman	2	2	100				