UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

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

Voting Members present:
Mr M Traynor – Deputy Chairman (Acting Chair)
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 Furlong – Medical Director
Mr A Johnson – Non-Executive Director
Mr R Mitchell – Chief Operating Officer
Mr R Moore – Non-Executive Director
Mr B Patel – Non-Executive Director
Ms J Smith – Chief Nurse
Mr P Traynor – Chief Financial Officer

In attendance:
Ms D Baker – Service Equality Manager (for Minute 39/17/1)
Mr M Caple – Chair, Patient Partners (for Minute 42/17)
Mr D Henson – LLR Healthwatch Representative (up to and including Minute 47/17)
Ms E James – Matron (for Minute 39/17/1)
Ms H Leatham – Assistant Chief Nurse (for Minute 39/17/1)
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

34/17 APOLOGIES AND WELCOME

Apologies for absence were received from Mr K Singh, Trust Chairman. In his absence, the meeting was chaired by Mr M Traynor, Deputy Trust Chairman.

35/17 DECLARATIONS OF INTERESTS IN THE PUBLIC BUSINESS

There were no declarations of interests in the public business being discussed.

36/17 MINUTES

Resolved – that the Minutes of the 5 January 2017 and 19 January 2017 Trust Board meetings be confirmed as a correct record (subject to the addition of Dr S Crawshaw Non-Executive Director to the present list for 5 January 2017), and signed by the Trust Chairman accordingly. **CHAIRMAN**

37/17 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 1 (Minute 30/17 of 19 January 2017) – following discussion at the 31 January 2017 Executive Team, this action would be incorporated in to the Trust's internal turnaround plans;

(b) action 1a (Minute 30/17 of 19 January 2017) – the Chief Executive's letter relating to the UHL Annual Operational Plan [AOP] 2017-19 would be sent to NHS Improvement once finalised at the end of February 2017. Although initially having advised that there was no opportunity for resubmitting the AOP, NHS Improvement now considered that there might be such an opportunity ahead of the 2017-18 financial year starting; **CE**

(c) action 9b (Minute 291/16/1 of 1 December 2016) – the Trust was awaiting formal feedback on the LLR Sustainability and Transformation Plan, before considering how best to provide public assurance on UHL's reconfiguration contingency plans. The Chief Executive advised that the national capital prioritisation process was now underway, and

(d) action 17 (Minute 251/16 of 3 November 2016) – the LLR Healthwatch representative confirmed that the report from his visit to UHL cancer services would shortly be shared with the Chief Operating Officer. **DH HW rep**

<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**

38/17 CHIEF EXECUTIVE'S MONTHLY REPORT – FEBRUARY 2017

The Chief Executive's February 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 C). 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 40/17 below. In introducing his report, the Chief Executive noted:-

(a) receipt of the CQC report following its June 2016 inspection of UHL's hospitals, which would be discussed further in Minute 39/17/2 below. UHL had received an overall rating of 'requires improvement', but the Chief Executive noted the CQC's message that UHL was moving in the right direction (albeit with further work to do). The Chief Executive particularly welcomed both the overall 'good' rating achieved by UHL in the caring domain (emphasising the dedicated care and compassion shown by UHL staff), and the 'outstanding' rating achieved in respect of the effectiveness of the East Midlands Congenital Heart Centre (EMCHC) at the Glenfield Hospital. EMCHC had achieved a 'good' rating overall. Of the report's 100 ratings in total, 55 were 'good', with 41 'requires improvement', 1 'inadequate' and 2 unrated for technical reasons;

(b) the continuing significant emergency performance and demand pressures facing the Trust, as covered in detail at Minute 39/17/4 below. Work was currently underway to revisit the LLR emergency care recovery action plan (RAP) and focus on key high-impact and system-wide interventions, the results of which would be included in the Chief Executive's March 2017 Trust Board update, and **CE**

(c) the Trust's forecast that it would be adversely off-plan at the 2016-17 financial year end, following a worsening of the financial position during December 2016. This issue would be covered in detail in discussions on the month 10 financial performance (Minute 43/17/3 below refers). Efforts would continue to minimise the amount by which UHL was off-plan by year end.

In discussion on the Chief Executive's February 2017 update, the Deputy Chairman sought further information on the 'significant issues' in respect of Leicestershire social care packages, and any potential impact on delayed transfers of care. The Chief Executive advised that this was an issue nationally, noting April 2017 changes to the assessment of qualification for NHS-funded care. The A&E Delivery Board was exploring these issues further.

Resolved – that the outputs from the review of the emergency care system Recovery Action Plan (to focus on key high-impact and system-wide interventions) be included in the Chief Executive's March 2017 Trust Board report. **CE**

39/17 KEY ISSUES FOR DECISION/DISCUSSION

39/17/1 Patient Story – Patient-Centred Care in Paediatrics

The patient story at paper D (and accompanying video presentation) focused upon a family's experience of paediatric care for a child with autism. The patient's parents attended for this item. The story revealed how – from an initially-negative experience – the introduction of a coordinated, pre-planned, and clearly-communicated approach through a single point of access had significantly enhanced the care experience by focusing on the needs of the patient and his family. Staff from multiple UHL specialties (and primary care) had coordinated to arrange an opportunity for all of the patient's healthcare needs to be addressed on a single visit, thus reducing the stress involved for the patient and his family. The family welcomed this approach and hoped that it would now be the norm not just for their son but for other autistic children being treated.

In attending for this patient story, Ms E James Paediatric Matron noted that a Listening into Action project had been launched before Christmas 2016, working with the families of autistic children and young people. In further discussion on this story, the Trust Board noted:-

(a) a query from the Medical Director on how to coordinate between specialties and ensure that all relevant specialties were aware when an autistic child/young person was attending for an outpatient appointment. In response, the Paediatric Matron reiterated the importance of clear cross-specialty communication (supported by processes such as appropriate system flags), although she recognised that it was a challenging issue to resolve. The Medical Director commented that identifying and tracking cross-specialty patient needs was easier if a single system was used;
(b) a query from the Chief Financial Officer on whether national support guidelines were available for families from (eg) the National Autistic Society. In response, the patient's parents commented that although national guidance was available it tended to be too generic in nature, and they reiterated the importance of healthcare professionals contacting families to discuss their child's specific needs and requirements. The Paediatric Matron advised that although national best practice ideas would be used, these would be appropriately tailored to UHL patient needs;
(c) the key importance of a single point of contact, as reiterated by the patient's family. Mr B Patel Non-Executive Director queried how far the approach was dependent on individual staff members, and also received assurance that all specialties were willing to be involved in a coordinated approach. The Medical Director reiterated that the challenge lay in coordinating the process, not in a lack of clinical willingness;
(d) comments from the Service Equality Manager that some similar issues also existed for autistic adults accessing care services;
(e) a query from Dr S Crawshaw Non-Executive Director on the potential role of GPs as contact points between families and hospital services, and
(f) comments from the LLR Healthwatch representative on recent Adult Social Care Scrutiny Committee discussions re: autism. He advised that – if the patient's parents were in agreement – he would be happy to share key headlines from today's patient story more widely across the community. **CN**

The patient's family reiterated the caring nature of the UHL staff involved in their son's care, and thanked them for having adopted such a flexible approach.

Resolved – that the Chief Nurse make contact with the Healthwatch representative to provide key headlines from this patient story, for wider use across the community. **CN**

39/17/2 CQC Inspection Reports

Further to Minute 38/17 above, the Trust Board discussed the CQC inspection reports arising from that organisation's June 2016 inspection of UHL. As referred to in the Chief Executive's monthly report for February 2017, the Trust's overall rating was 'requires improvement', with an overall 'good' rating in the caring domain. The text of the CQC reports recognised the progress made by the Trust since the previous 2014 inspection, and the Chief Nurse confirmed that UHL's plans would build on the reports' findings and explore how to learn lessons from those areas of the Trust already rated as 'good' or 'outstanding'. She also particularly welcomed the CQC reports' positive comments on the caring nature of UHL's staff. The Chief Nurse and the Medical Director advised that a plan for progressing the CQC reports' findings was scheduled for discussion at the February 2017 Executive Quality Board.

In discussion on the CQC inspection reports, Non-Executive Directors noted the need to focus on how to move from 'requires improvement' to 'good', which would be discussed further at the February 2017 Trust Board thinking day. Non-Executive Directors also voiced some disappointment at the media coverage surrounding the reports, given that individual 'good' ratings had been in the majority (1 'outstanding' [EMCHC effectiveness domain], 55 'good', 41 'requires improvement', 1 'inadequate' [LRI emergency care responsive domain] and 2 unrated for technical reasons). **CN/MD**

The Chief Executive clarified that it was not proposed to develop a separate 'CQC action plan' workstream – instead, a business as usual approach would be taken to addressing the CQC's recommendations as part of an overarching quality improvement programme. The Audit Committee Non-Executive Director Chair welcomed this approach and commented on the need also to undertake an appropriate challenge of UHL's existing quality assurance /improvement/oversight processes. The Medical Director advised that UHL was exploring potential IT systems for providing centralised assurance on such issues, and he also noted that it would be useful to review the CQC's own definition of 'good' and understand what metrics contributed to that definition, and how best to capture such information. In further discussion the Trust Board noted:- **CN/MD** **CN/MD**

(a) concerns voiced by the LLR Healthwatch representative at the length of time taken to receive the CQC report, given that the inspection had taken place in June 2016;
(b) LLR Healthwatch's willingness to assist the Trust in addressing End of Life Care issues;
(c) that emergency care remained a key vulnerability for the Trust, given the continuing pressures. The Chief Executive welcomed, however, the CQC's lifting of the ED enforcement notice;
(d) comments on the difference between 'assurance' and 'improvement' and the need to understand which one was required;
(e) the need to understand how the business as usual approach would be applied at service-level;
(f) the Deputy Chair's request that regular process updates be provided to the Quality Assurance Committee (QAC) on this issue, and **CN/MD**
(g) comments from the QAC Non-Executive Director Chair on the potential opportunities offered by the current national consultation on the CQC inspection process.

<u>Resolved</u> – that (A) proposals on how to progress from a CQC rating of 'requires improvement' to 'good', be discussed at the February 2017 Trust Board thinking day; **CN/MD**

(B) the proposed 'business as usual' approach to addressing the CQC recommendations (ie rather than developing a separate action plan) be approved, including:- **CN/MD**

- **undertaking an appropriate challenge of UHL's existing quality assurance/ improvement /oversight processes, and**

- **understanding how the business as usual approach would be taken forward at service-level;**

(C) a review be undertaken of the CQC definition of "good", to understand the key metrics used to meet that definition, and **CN/MD**

(D) appropriate progress updates be provided to the Quality Assurance Committee. **CN/MD**

39/17/3 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. The Deputy Chairman noted the Trust Board's thanks to Leicester City and Leicestershire County Councils for their matchfunding commitments in respect of this issue, and the Chief Executive clarified the nature of the £50,000 announcement earlier that morning by Leicestershire County Council. The Director of Communication, Integration and Engagement noted the continuing dedication and commitment of the EMCHC staff to providing an ongoing service to patients despite the national uncertainty, and he confirmed that signatures on the paper and online petition against closure of the EMCHC had now exceeded the 100,000 threshold for triggering a Parliamentary debate – the petition would be formally handed to Liz Kendall MP in London on 6 February 2017. **DCIE**

UHL representatives including clinicians had also attended various meetings since the January 2017 update, including a January 2017 meeting of the All-Party Parliamentary Group on Cardiac Health (with representatives from the Royal Brompton Hospital) and Lincolnshire and Derbyshire overview and scrutiny committees. No formal public consultation date had yet been provided by NHS England, although it now felt likely to be 'imminent'. In an unusual move, the Department of Health had consented to consultation during the local government election purdah period.

Resolved – that the Trust Board's thanks to Leicester City and Leicestershire County Councils be noted. **DCIE**

39/17/4 Emergency Care Performance

Further to Minute 7/17/3 of 5 January 2017, paper G updated the Trust Board on recent emergency care performance, noting that the Trust remained under acute operational pressure caused by a combination of increased demand and sub-optimal processes internally and across the system. On average, 655 patients per day were being treated through ED at the Leicester Royal Infirmary. December 2016 performance against the 4-hour target stood at 75.5%, with 2016-17 year to date performance at 78.9%. The Chief Operating Officer recognised that the emergency care pathway was a key driver in the CQC report, and he acknowledged that the situation remained very challenging.

The Chief Operating Officer advised the Trust Board of a number of issues, including the intended wider roll-out of the 'red to green' initiative at the end of February 2017, the December 2016 non-achievement of sustainability and transformation funding in respect of ED performance, continued good performance by the GP Assessment Unit (GPAU), and very good performance by the Urgent Care Centre which had cared for 99% of its patients within 4 hours during both December 2016 and January 2017.

However, January 2017 continued to be very challenging in terms of emergency demand, and a system-wide critical incident had been declared across 10 and 11 January 2017. System wide action had been required, and the Chief Operating Officer noted his particular thanks to Leicestershire Partnership NHS Trust for its support in discharging and transferring patients during that 36-hour period. Regrettably, emergency pressures had led to elective cancellations.

The Trust was meeting fortnightly with its partners and with NHS England to review the LLR emergency care action plan, and the 4 key areas of focus had been agreed as:- (i) reducing the volume of ambulances at the LRI; (ii) improving the functionality of ED, including rapid front-door triage/assessment, standardising flow and reducing clinical variation; (iii) embedding red to green across the Trust, although the focus would remain the 14 medical wards at the LRI, and (iv) working with partners to reduce discharge delays, particularly re: complex discharges.

In response to specific queries from the Deputy Chairman, the Chief Operating Officer:-

(1) provided further information on the key objectives of the red to green initiative, which was a recognised national methodology for identifying delays;
(2) outlined the successful transition to a new IT system in ED in December 2016 (Nervecentre), noting the robust implementation plans put in place in advance, and
(3) confirmed that Dr B Owens, Clinical Director of Emergency Care at Sherwood Forest Hospitals NHS Foundation Trust was assisting UHL in ED on a part-time basis.

In further discussion on the emergency care performance update, the Trust Board noted:-

(a) a query from Mr B Patel Non-Executive Director on how far any reconfiguration by partner health/social care organisations would impact adversely on UHL. In response, the Chief Operating Officer considered that the Trust was well-supported by wider system partners and he did not consider that any reconfigurations by other bodies were having a significant impact. He also reiterated the need for UHL to take action on those issues within its own gift as far as possible;

(b) a query from Dr S Crawshaw Non-Executive Director on the drivers behind clinical variation, and any out of hours impact. It was noted that Dr B Owens was undertaking an audit of evening activity and patterns to understand these issues further;

(c) Non-Executive Director queries on the mitigation actions for the 3 risks identified in paper G. The Chief Operating Officer advised that variable clinical engagement remained the key risk, while concerns over the opening of the new Emergency Floor had lessened since the time of writing the report. It was hoped that the planned roll out of red to green at the Glenfield Hospital would mitigate the loss of ward 23a capacity on that site from winter 2017-18;

(d) that poor performance on ambulance handovers remained a key challenge for the Trust, and

(e) a query from the LLR Healthwatch representative on whether the 2017-18 ED target was achievable. In response, the Chief Operating Officer recognised that 2017-18 would be challenging and noted that not all of the 4 priorities identified earlier were within the Trust's control. The Medical Director clarified the phased opening of the new Emergency Floor, with phase 1 due to open in April 2017 and phase 2 in January 2018. The Chief Executive reiterated the difficulty of predicting the impact of the various initiatives on 2017-18 performance, and he noted the need to make priority choices if the current demand and capacity imbalance remained.

Resolved – that the position be noted.

39/17/5 Emergency Floor Update

Paper H advised that phase 1 of the Emergency Floor project would be completed within the next month, with the Trust taking possession of the building from 6 March 2017 ahead of opening the new facility in April 2017. The use of this 7-week lead-in time was based on

lessons from other organisations. The report also outlined the project risks and related mitigating actions, and as the Non-Executive Director allocated to the project Col (Ret'd) I Crowe Non-Executive Director noted the very significant progress made since Christmas 2016. He was confident of the plan and the timetable, although he recognised the challenge of planning for the move to the new Emergency Floor while simultaneously maintaining service delivery.

CE

In discussion on wayfinding issues, the Deputy Chairman suggested that it would be helpful to use parking marshalls on the day of the opening to direct people appropriately. In response to further comments from the Deputy Chairman, the Chief Financial Officer confirmed that appropriate capital investment in IT for the new Emergency Floor was recognised as a key issue, with the originally-proposed level of such investment now recognised to be insufficient. The Trust had reviewed its 2016-17 and 2017-18 capital programmes accordingly, and was taking a pragmatic view to ensure that sufficient IT investment was available for the development.

CE

<u>Resolved</u> – that the appropriate use of parking marshalls on the day of the 26 April 2017 Emergency Floor opening be considered, to assist people with wayfinding.

39/17/6 <u>Equality Workforce Monitoring Report 2015-16</u>

Paper I comprised the 2015-16 equality workforce monitoring report, which was presented to the Trust Board for formal approval. Once approved, it would be placed on the Trust's external website, thus complying with legal duties. A previous iteration of paper I had been discussed at the 24 January 2017 Executive Workforce Board, noting the report's new format. The impact of the Trust's new equality and diversity workstreams from April 2016 would be reflected in the next year's report, as they were not captured by the 2015-16 reporting period. As noted in paper I, UHL's 2015-16 workforce profile remained largely unchanged from 2014-15, and although the % of BME members of the workforce had increased, BME staff, female staff and disabled staff were under-represented at senior management level.

DWOD

UHL's equality action plan was presented to the Trust Board at 6-monthly intervals, with the most recent submission having been December 2016. That action plan incorporated all elements of the Equality Delivery System (EDS), Workforce Race Equality Standard (WRES) and the 2016-17 recommendations from the UHL diversity task and finish group. Detailed discussion had also taken place at the January 2017 Trust Board thinking day, including a presentation from the NHS England Joint Director of Workforce Race Equality Standard. In discussion on the 2015-16 equality workforce monitoring report, the Trust Board noted:-

(a) that 5 UHL nominees had been put forward for the national 'stepping up' BME leadership programme (120 places would be allocated nationally);
(b) ongoing work to understand the implications of the new Workforce Disability Equality Standard in place from April 2017;
(c) ongoing gender pay gap analysis work, a public report on which was required by April 2018 at the latest;
(d) the involvement of 3 UHL Executive Directors and 1 UHL Clinical Director in the Trust's reverse mentoring scheme, with wider roll-out planned once the initiative was established. This was thought to be a unique UHL initiative not in place anywhere else;
(e) the recognised importance of workforce diversity, and the key need for UHL to be accessible and attractive to all sectors of the community;
(f) a query from the Deputy Chairman on whether the 30% 'unspecified' level of reporting re: disability might relate to mental health issues – in response, the Director of Workforce and OD noted ongoing work to understand the reasons why people with a disability might choose not to disclose it;

(g) (in response to a query from the Deputy Chairman) that caste discrimination was not recorded by the Trust;

(h) a query from Mr B Patel Non-Executive Director on whether disability was recorded only for new appointments. The Director of Workforce and OD clarified that staff could declare a disability at any time, and she noted the potential need to review the recording mechanisms. Mr Patel commented further that staff might not necessarily recognise in all cases that they had a disability, and

(i) the view of Mr A Johnson Non-Executive Director that disability declarations were underreported at the Trust, and his comments on the possibility that staff might be reluctant to make such a declaration in case it affected their work position. He also voiced his view that UHL's onsite environment was poorly equipped to respond to disability and queried if the Trust met national access standards. He further commented on the crucial need to involve disabled staff/visitors in the plans to change the LRI main access to the Windsor Building as a result of the Emergency Floor development. The Chief Executive confirmed that he had discussed the Trust's disabled facilities with Mr Johnson, and he noted his intention to ask the Director of Estates and Facilities to reconvene the UHL disability group to review access issues further. **DEF**

<u>Resolved</u> – that (A) the 2015-16 equality workforce monitoring report be approved as presented, and placed on the Trust's external website thus complying with legal duties, and **DWOD**

(B) the UHL Disability Group be reconvened and refreshed, to review access issues including the new Windsor Building access following the closure of the Balmoral Entrance. **DEF**

40/17 RISK MANAGEMENT – INTEGRATED RISK REPORT

Paper J comprised the 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 (2 new risks were listed, both for the Clinical Support and Imaging Clinical Management Group, relating to a risk of failure to deliver the TAT standards of the NHS cervical and bowel screening programmes, and to the need to address Windsor pharmacy storage issues). The Trust Board was also invited to consider whether there were any assurance gaps or inadequate controls in the current Board Assurance Framework.

The Medical Director noted that the key BAF risks rated at 25 were reflected in today's Trust Board papers, namely emergency care, the financial position, and EPR (latter referred to in the Chief Executive's monthly report at paper C). He also reiterated the processes for reviewing risks at the relevant Executive Board and CMG quality and safety boards.

In discussion, the Audit Committee Non-Executive Director Chair advised that the Audit Committee undertook a deep dive on the BAF risks, focusing particularly on medium-rated risks (as the high risks already received specific Trust Board attention). At its January 2017 meeting the Audit Committee had discussed statutory compliance issues and oversight of estate maintenance in respect of principal risk 2 (*failure to provide an appropriate environment for staff/patients*), resulting in a request that further assurance be provided to the March 2017 Audit Committee. Noting this point, the Chief Executive requested that any specific Audit Committee concerns over individual risks also be escalated to him direct. **AC CHAIR**

The Chief Operating Officer noted his intention to recommend an increase in the current risk score for principal risk 4 (*failure to deliver the national access standards impacted by operational process and an imbalance in demand and capacity*). **COO**

<u>Resolved</u> – that (A) any specific Audit Committee concerns over individual risks be **AC CHAIR**

escalated to the Chief Executive, and

(B) a recommendation be presented to the February 2017 Executive Performance Board to increase the risk score for principal risk 4 from its current level of 20. **COO**

41/17 STRATEGY AND RECONFIGURATION

41/17/1 Sustainability and Transformation Plan and UHL Reconfiguration Programme - Update

Paper K updated the Trust Board on the LLR Sustainability and Transformation Plan (STP) /Better Care Together (BCT) Programme, which set the context for UHL's Reconfiguration Programme. A 'lock-in' between NHS Improvement and the operational leaders for the 44 STPs had recently taken place (formal feedback on which was awaited), and the national capital prioritisation process was also underway. The Chief Executive advised that – informally – the LLR STP had received a high regional priority for capital, but he reiterated the scarcity of national capital available. Public consultation on the STPs now seemed unlikely before summer 2017, and LLR was using the intervening time period for further engagement on the community hospital proposals. The Chief Financial Officer reiterated that if UHL did not receive national capital there would be a significant detrimental impact on the Trust's reconfiguration programme. In discussion, the LLR Healthwatch representative voiced concerns that if the plans had to be changed (ie in the event that capital was not made available), this could adversely affect public confidence in the plans. The Trust Board also noted the need for appropriate contingency measures.

Resolved – that the update on the STP and reconfiguration be noted.

42/17 PATIENT AND PUBLIC INVOLVEMENT – COMMUNITY ENGAGEMENT PROPOSAL

Paper L set out a proposal to increase the Trust's public engagement activity, including plans for a quarterly Community Engagement Forum (to replace the existing Public Engagement Forum meetings) and also a rolling series of smaller-scale engagement events. In addition to outlining the aims and objectives of the public sector engagement proposal, paper L noted the anticipated costs of the proposal (estimated at approximately £9,750). In discussion on the proposal (which was introduced jointly by Mr B Patel Non-Executive Director and the Director of Communication, Integration and Engagement), Non-Executive Directors:-

(a) suggested amending the proposal's aims and objectives to include raising the profile of Leicester Hospitals Charity;
(b) noted the need also to link in with appropriate civic society organisations such as (eg) the Local Enterprise Partnerships, and
(c) queried whether the budget allocated was sufficient for the task. The Chief Executive noted the need to discuss the funding streams further outside the meeting, and to clarify what might already be covered elsewhere (eg AGM costs). He also noted the Director of Communication, Integration and Engagement's view that the currently-proposed budget was adequate.

Resolved – that the community engagement proposal be approved in principle, subject to:- **DCIE**

(1) inclusion of 'raising the profile of Leicester Hospitals Charity' in the aims and objectives;
(2) appropriate linkages with civic society organisations, and
(3) discussion with the Chief Financial Officer outside the meeting re: appropriate funding streams.

43/17 QUALITY AND PERFORMANCE

43/17/1 Quality Assurance Committee (QAC)

Paper M summarised the issues discussed at the 26 January 2017 QAC, noting the recommendation that a quarterly mortality report be appended to the QAC summaries provided to the Trust Board. The Medical Director clarified that the first such report would be provided at the end of quarter 1 of 2017-18. **MD**

Resolved – that (A) the summary of issues discussed at the 26 January 2017 QAC be noted as per paper M, and any recommended items be endorsed accordingly (Minutes to be submitted to the 2 March 2017 Trust Board), and **QAC CHAIR**

(B) a quarterly mortality report be appended to the QAC summary to the Trust Board, from the end of quarter 1 of 2017-18 onwards. **MD**

43/17/2 Integrated Finance, Performance and Investment Committee (IFPIC)

Resolved – that the summary of issues discussed at the 26 January 2017 IFPIC be noted as per paper N (Minutes to be submitted to the 2 March 2017 Trust Board), and any recommended items endorsed accordingly. **IFPIC CHAIR**

43/17/3 2016-17 Financial Performance – December 2016

Paper O presented the Trust's month 9 financial position – following further deterioration in December 2016 the Trust was now forecasting a year-end deficit position of £38.6m; this was £6.9m adverse to UHL's year-end plan and excluded the effect of Sustainability and Transformation Funding. The Trust's financial position had been discussed by the Trust Board on 19 January 2017 and at the 26 January 2017 IFPIC as detailed in that meeting summary at paper N.

The Chief Financial Officer advised that a level of increased financial scrutiny by NHS Improvement was now likely, as a result of declaring an (adversely) off-plan year-end position. Although financial recovery actions had been in place at the Trust for some time, the Chief Financial Officer advised that the increased variance in month 9 meant that UHL would move into internal financial turnaround – this would be discussed further at the February 2017 Trust Board thinking day. Appropriate advice available from other organisations would be used, and the Trust's aim was to improve its forecast 2016-17 year-end position and start 2017-18 on the best possible financial footing. The Chief Executive emphasised that the remaining 2 months of 2016-17 were crucially important, and noted that all non-essential expenditure was likely to be blocked. Emergency pressures had significantly affected the Trust's finances, but the Chief Executive assured the Trust Board that quality and safety would not be adversely affected by the financial recovery plans. In discussion, the Trust Board noted:- **CFO**

(a) queries from the Audit Committee Non-Executive Director Chair re: how long the internal turnaround would last and how to avoid merely deferring expenditure into 2017-18. In response, the Chief Financial Officer considered that a financial improvement programme was likely to be in place for the duration of 2017-18, and he provided assurance to the Audit Committee Non-Executive Director Chair of the seriousness with which the Trust was addressing the position;

(b) comments from the Chief Operating Officer on the need to balance emergency and elective activity, given the income impact of reducing elective work. Although noting this point, the Chief Executive reiterated the priority placed on emergency work by NHS Improvement. In response to further Non-Executive Director comments, the Chief Operating Officer clarified that outpatient elective activity was not currently restricted;

(c) assurances from the Chief Financial Officer that all efforts were being made to improve

the 2016-17 year-end forecast. The decision to declare a worsened deficit forecast had not been taken lightly, and it would have been inappropriate not to flag the position nationally and to the Trust Board at the end of quarter 3, and

(d) comments from the IFPIC Non-Executive Director Chair on the need for clear and appropriate messaging about the internal turnaround actions being taken. **CFO**

Resolved – that (A) the month 9 financial position and 2016-17 year-end forecast be noted;

(B) internal turnaround actions be discussed further at the February 2017 Trust Board thinking day, and **CFO**

(C) consideration be given to appropriate messaging and communication of the internal turnaround position and actions. **CFO**

44/17 REPORTS FROM BOARD COMMITTEES

44/17/1 Audit Committee

Paper P comprised the (draft) Minutes of the 5 January 2017 Audit Committee. In discussion, the Audit Committee Non-Executive Director Chair particularly highlighted the Internal Audit review of governance and risk management, noting the need for the Trust Board to be sighted to the lessons from that review. On that issue, the Trust Board was now advised of plans to present joint CMG-level work to the Executive Quality Board by the Chief Operating Officer, the Medical Director and the Chief Nurse.

Resolved – that (A) the draft 5 January 2017 Audit Committee Minutes be received and noted, and any recommendations endorsed accordingly, and

(B) consideration be given to how best to sight the Trust Board to the lessons to be learned from the Internal Audit review of governance and risk management (noting a planned joint presentation to the Executive Quality Board). **MD/CN/ COO**

44/17/2 Quality Assurance Committee (QAC)

Paper Q comprised the Minutes of the 22 December 2016 QAC; the QAC Non-Executive Director Chair particularly noted the assurance report presented in respect of EWS and sepsis.

Resolved – that the Minutes of the 22 December 2016 QAC be received and noted, and any recommendations endorsed accordingly.

44/17/3 Integrated Finance Performance and Investment Committee (IFPIC)

Paper R comprised the Minutes of the 22 December 2016 IFPIC, noting that the recommended item re: progressing the co-location of the EMCHC as a separate project had already been approved at the January 2017 Trust Board.

Resolved – that the Minutes of the 22 December 2016 IFPIC be received and noted, and any recommendations endorsed accordingly.

45/17 TRUST BOARD BULLETIN – FEBRUARY 2017

Resolved – it be noted that the following paper had been circulated for the February 2017 Trust Board Bulletin:-
(1) declaration of interests for Dr S Crawshaw Non-Executive Director – none to

declare.

46/17 QUESTIONS AND COMMENTS FROM THE PRESS AND PUBLIC RELATING TO BUSINESS TRANSACTED AT THIS MEETING

The following questions/comments were posed by the press or public present at the Trust Board meeting regarding the business transacted:-

(a) a request that the CQC inspection report's references to patient and public engagement be appropriately publicised; **DCIE**

(b) a query on why STP public consultation was being delayed. In response, the Chief Executive clarified that formal notification was required from NHS England/NHS Improvement before CCGs could begin that consultation. The Chief Executive reiterated the importance of national capital to those STP plans however, and noted that public engagement continued;

(c) a query as to whether patient participation groups would be invited to attend the community engagement events proposed in paper L, and also whether appropriate CCG representatives would be involved to respond to primary care questions – the Director of Marketing and Communications agreed to pursue this latter point, and **DCIE**

(d) a suggestion that the Trust had been overly optimistic in its financial forecast in quarters 1 and 2 of 2016-17, and that appropriate lessons should be learned for 2017-18. In response, the Chief Financial Officer considered that the Trust had been open throughout the year in terms of its financial reporting, and he did not feel that there were significant lessons to be learned. He noted that £6.9m was a small proportion of outturn and he considered that in-year issues had arisen the quantum of which could not have been foreseen, including the transfer of the estates and facilities function and the continuing scale of the emergency pressures. The questioner also queried the issue of EPR efficiency savings – in response the Deputy Chairman advised that as UHL's EPR business case had not been approved, contingency plans were now in development by the Trust's Chief Information Officer for discussion at the March 2017 Trust Board thinking day.

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

47/17 EXCLUSION OF THE PRESS AND PUBLIC

<u>Resolved</u> – that, pursuant to the Public Bodies (Admission to Meetings) Act 1960, the press and members of the public be excluded during consideration of the following items of business (Minutes 48/17 to 55/17) having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.

48/17 DECLARATIONS OF INTERESTS IN THE CONFIDENTIAL BUSINESS

There were no declarations of interests in the items of confidential business.

49/17 CONFIDENTIAL MINUTES

<u>Resolved</u> – that the confidential Minutes of the 22 December 2016 and 5 January 2017 Trust Board meetings be confirmed as a correct record and signed by the Trust Chairman accordingly. **CHAIRMAN**

50/17 CONFIDENTIAL MATTERS ARISING REPORT

<u>Resolved</u> – 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.

51/17 JOINT 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 that public consideration at this stage would be prejudicial to the effective conduct of public affairs.

52/17 REPORTS 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.

53/17 REPORTS FROM BOARD COMMITTEES

53/17/1 Audit Committee

Resolved – that the (draft) confidential Minutes of the 5 January 2017 Audit Committee be received and noted, and any recommendations endorsed accordingly.

53/17/2 Quality Assurance Committee (QAC)

Resolved – that the summary of confidential issues discussed at the 26 January 2017 QAC and the confidential Minutes of the 22 December 2016 QAC be received and noted, and any recommendations endorsed accordingly.

53/17/3 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.

54/17 ANY OTHER BUSINESS

54/17/1 Report from Col (Ret'd) I Crowe Non-Executive Director

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.

54/17/2 Corporate Trustee Business - report from the Deputy Chairman

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

55/17 DATE OF NEXT TRUST BOARD MEETING

Resolved – that the next Trust Board meeting be held on Thursday 2 March 2017 from 9am in Rooms A and B, Education Centre, Leicester General Hospital.

The meeting closed at 12.44pm

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	17	15	88	A Johnson	17	17	100
J Adler	17	17	100	R Mitchell	17	13	76
P Baker	14	12	86	R Moore	17	16	94
S Crawshaw	3	3	100	B Patel	13	11	85
I Crowe	17	16	94	J Smith	17	16	94
S Dauncey	4	3	75	M Traynor	17	17	100
A Furlong	17	14	82	P Traynor	17	17	100
A Goodall	3	2	67				

Non-Voting Members:

Name	Possible	Actual	% attendance	Name	Possible	Actual	% attendance
D Henson	12	12	100	L Tibbert	17	16	94
N Sanganee	5	2	40	S Ward	17	16	94
				M Wightman	17	14	82