UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF A MEETING OF THE TRUST BOARD, HELD ON THURSDAY 3 MARCH 2016 AT 9AM IN THE C J BOND ROOM, CLINICAL EDUCATION CENTRE, LEICESTER ROYAL INFIRMARY

Voting Members present:
Mr K Singh – Chairman (excluding Minute 61/16/2)
Mr J Adler – Chief Executive
Col (Ret'd) I Crowe – Non-Executive Director
Dr S Dauncey – Non-Executive Director
Professor A Goodall – Non-Executive Director (up to and including Minute 51/16)
Mr A Johnson – Non-Executive Director
Mr R Mitchell – Chief Operating Officer
Mr R Moore – Non-Executive Director
Ms J Smith – Chief Nurse
Mr M Traynor – Non-Executive Director (Acting Chair for Minute 61/16/2)
Mr P Traynor – Chief Financial Officer

In attendance:
Ms D Baker – Service Equality Manager (for note 49/16/2)
Ms M Barber – BCT Programme Director (for Minute 61/16/1)
Mr M Caple – Patient Partner (for Minute 50/16)
Mr G diStefano – Head of Strategic Development (for Minute 61/16/2)
Mr D Henson – LLR Healthwatch Representative (up to and including Minute 57/16)
Mr D Kerr – Director of Estates and Facilities (for Minute 62/16)
Ms B Kotecha – Assistant Director of Learning and OD (for Minute 49/16/2)
Ms H Leatham – Assistant Chief Nurse (for Minute 49/16/1)
Ms E Meldrum – Assistant Chief Nurse (for Minutes 49/16/1 and 51/16)
Ms A Parton – Sister Ward 27 (for Minute 49/16/1)
Mr R Powell – Acting Director of Medical Education (for Minute 51/16)
Mrs H Seth – Acting Director of Strategy
Mr S Sharma – Equality and Diversity Task and Finish Group (for Minute 49/16/2)
Mr N Sone – Financial Controller (for Minute 52/16/4)
Ms H Stokes – Senior Trust Administrator
Ms L Tibbert – Director of Workforce and OD
Mr S Ward – Director of Corporate and Legal Affairs

ACTION

43/16 APOLOGIES AND WELCOME

Apologies for absence were received from Mr A Furlong, Medical Director.

44/16 DECLARATIONS OF INTERESTS IN THE PUBLIC BUSINESS

No declarations of interest were made.

45/16 MINUTES

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

46/16 MATTERS ARISING FROM THE MINUTES

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

(a) action 3a (Minute 29/16/3 of 4 February 2016) – vascular staffing and ICU access issues

had been progressed outside the meeting;

(b) action 4a (Minute 29/16/4 of 4 February 2016) – the Acting Director of Strategy advised that although there were no specific action plans for the Better Care Together 'wicked issues', an expanded narrative was now included in the BCT pre-consultation business case, and

(c) action 4c (Minute 29/16/4 of 4 February 2016 – the Chief Nurse confirmed that she had discussed night-time interventions with LPT, and noted that the ICS Operational Group was now progressing this issue as appropriate.

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

47/16 CHAIRMAN'S MONTHLY REPORT – MARCH 2016

In respect of the issues highlighted in paper C, the Chairman noted that the report of the equality and diversity task and finish group was covered in detail at Minute 49/16/2 below, and that the issue of recognising risk would be discussed at both the 3 March 2016 Audit Committee and the 17 March 2016 Trust Board thinking day.

Resolved – that the Chairman's March 2016 monthly report be noted.

48/16 CHIEF EXECUTIVE'S MONTHLY REPORT – MARCH 2016

The Chief Executive's March 2016 monthly update followed (by exception) the framework of the Trust's strategic objectives. As the attached quality and performance dashboard covered core issues from the monthly quality and performance report, the full version of that report was no longer taken at Trust Board meetings but was accessible on the Trust's external website (also hyperlinked within paper D). The new template Board Assurance Framework dashboard and the extreme and high risks dashboard were also attached to the Chief Executive's report at appendices 2 and 3 respectively – the full BAF and risk register entries were therefore no longer considered separately at the Trust Board meetings but were available on the Trust's external website and also hyperlinked through paper D.

In introducing his report, the Chief Executive noted:-

(a) a somewhat mixed picture in terms of performance against key indicators. Performance against the quality indicators remained generally good and the Chief Executive welcomed the improvement in ambulance handover times despite continued high demand pressures. However, he recognised the need for improvement on cancer performance particularly against the 62-day target (likely compliance with which had now slipped to September 2016 due to the number of elective cancellations);

(b) generally-positive feedback from the Trust's February 2016 review meeting with the NTDA to discuss UHL's 2016-17 plan. The key "wicked issues" for the Trust remained (i) the need to balance demand and capacity and (ii) uncertainty over capital availability. It was noted, however that UHL's capital requirements for 2016-17 were relatively modest;

(c) an Advancing Quality Alliance (**AQuA**) session attended by the Trust Board on 1 and 2 February 2016, the 17-point action plan from which would be presented to UHL's Quality Assurance Committee in March 2016, and **CN**

(d) continuing preparatory work ahead of the CQC's 20 June 2016 scheduled inspection of UHL. A large data submission was due from the Trust to the CQC in mid-April 2016, and the Trust Board would be undertaking a key self-assessment over the coming month.

In further discussion on the report, the Trust Board noted comments from the Healthwatch representative relating to:-

(i) the fact that Healthwatch Leicester City had been approached by the CQC to establish a regular meeting to share intelligence;

(ii) his request that the recognised further work needed on the issues of fractured neck of femur performance and ED/Outpatients FFT coverage (paragraph 2.5 of paper D) be shared with Healthwatch once available. The Chief Executive noted his frustration with the decline in fractured neck of femur performance which was related to a surge in both the numbers and frailty of patients – UHL's QAC had requested a further briefing on this issue at its March 2016 meeting. The Chief Executive also clarified that although the patient satisfaction scores for ED remained high despite increased demand (UHL being the top performer in its peer group for the ED FFT), coverage was the issue which needed addressing, and **CN/ MD**

(iii) his suggestion that it would be helpful for the performance dashboard to include workforce performance indicators, including recruitment and retention figures across all staff groups. The Trust Chairman agreed that it would be useful for the dashboard to include such information, and he noted also that a large number of staff would also be joining UHL from IFM as of 1 May 2016 (as per paper D). **DWOD**

Resolved – that (A) the AQuA action plan be presented to the 24 March 2016 QAC; **CN**

(B) the outcome of the further review of (i) fractured neck of femur performance, and (ii) Friends and Family Test [FFT] coverage in ED and Outpatients, be shared with the Healthwatch representative, and **CN/MD**

(C) appropriate workforce performance indicators be included in the performance dashboard appended to the Chief Executive's monthly report. **DWOD**

49/16 KEY ISSUES FOR DECISION/DISCUSSION

49/16/1 Patient Story – End of Life Care (Ward 27 Leicester General Hospital)

Paper E from the Chief Nurse advised the Trust Board of the high quality end of life care provided to a patient on ward 27 at the Leicester General Hospital. Following a short illness, the patient had (unusually) chosen to remain in hospital for his end of life care needs, and the DVD presentation by the patient's widow detailed the dedication and support shown by the ward staff, the close rapport developed with the patient, and the compassionate, individualised care provided to him and his family at the end of his life. Following the presentation, the Chief Nurse advised that the emotional impact on the staff providing end of life care was recognised and she confirmed that the Trust provided support to those staff.

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

(a) commented that the support provided by ward staff to the family in end of life situations was almost as important as that provided to the patient – it was clear that ward 27 staff had also cared for the patient's relatives in this case;

(b) queried whether other patients had chosen to stay in hospital for their end of life care. In response, the Ward Sister advised that this was rare, and had been a learning curve for the staff;

(c) recognised the need for appropriate time and staffing levels to be able to deliver such high quality, individualised end of life care; the Chief Executive noted the need to redouble recruitment efforts to fill vacancies on pressured medical wards;

(d) queried how other areas of the Trust could share this good practice lesson – in response, the Assistant Chief Nurse confirmed that all of the Trust Board patient stories were accessible by UHL's Clinical Management Groups (CMGs) on a shared drive. The Chief Executive noted that the AQuA action plan referred to in Minute 48/16 above also included measures to 'personalise' quality work, and the Chairman noted the need for the Trust Board to remain sensitised to patient stories and experiences, and

(e) thanked all of the staff involved on ward 27 for their dedication and compassion. The Trust Board also expressed its thanks to the patient's family for sharing their story, and the Chief Nurse agreed to write to the patient's widow on behalf of the Trust Board accordingly. **CN**

Resolved – that the ward 27 end of life care patient story be noted, and

(B) the Chief Nurse write to the patient's family on behalf of the Trust Board, thanking them for sharing their story.

49/16/2 Equality and Diversity Task Force Report

Paper F from the Director of Workforce and OD presented the report of the equality and diversity task and finish group convened by UHL's Chairman, which had focused on race issues in the first instance. The Trust Board was requested to approve both the recommendations in section 5 of the report and the Diversity Delivery Plan attached at appendix 6 of paper F. Mr S Sharma, task and finish group member attended for this item, together with UHL's Service Equality Manager, Assistant Chief Nurse and Assistant Director of Learning and OD, and it was noted that an earlier draft of the report had been considered in detail at the February 2016 Trust Board thinking day, with Healthwatch representatives also in attendance. Specific training on unconscious bias was also planned for Trust Board members in April 2016.

In discussion on the report, the Trust Board:-

(a) agreed to support the principle of target-setting re: legitimate positive action initiatives, and to delegate authority to the Director of Workforce and OD to finalise the detail of those targets. Members also noted the importance of driving and monitoring this at the topmost level, and requested therefore that appropriate target-related indicators be incorporated into the HR/workforce performance dashboards; **DWOD** **DWOD**

(b) voiced particular support for the targeted talent development for BME staff (recommendation 6 of paper F);

(c) noted the need for appropriate attention to the other protected characteristics under the Equality Act, although the task and finish group's initial focus had been on race;

(d) agreed that UHL had a social corporate responsibility to drive the equality agenda and promote fairness, particularly as it would be the area's largest employer once the IFM staff transferred to the Trust;

(e) agreed to receive an update on equality and diversity issues 3 times a year; **DWOD**

(f) suggested that the Chairman contacted the NTDA re: equality and diversity issues in respect of Non-Executive Director recruitment, and **CHAIR MAN**

(g) reiterated the wider need to align equality and diversity issues to culturally-sensitive care needs, service provision and reconfiguration, through the LLR-wide Better Care Together programme.

Resolved – that (A) the 6 recommendations and the diversity delivery plan within the **DWOD**

report be approved, and progressed accordingly;

(B) the principle of legitimate positive action target-setting be endorsed (authority to be delegated to the Director of Workforce and OD to finalise the details of those targets); **DWOD**

(C) appropriate target-related indicators be incorporated into the HR/workforce performance dashboards; **DWOD**

(D) consideration be given to contacting the NTDA regarding the issue of BME Non-Executive Director recruitment, and **CHAIR MAN**

(E) progress on the equality and diversity issues within the report be presented to the Trust Board 3 times a year (July/November/March). **DWOD**

49/16/3 Emergency Care Performance

Further to Minute 29/16/2 of 4 February 2016, paper G from the Chief Operating Officer updated the Trust Board on recent emergency care performance, which stood at 89.4% for the year to date despite continued atypically-high attendance and admission rates. February 2016 performance was 80.1% and the Trust had recently had its highest ever week of emergency admissions. UHL had now experienced 23 consecutive weeks of high pressure in ED, which impacted not only on performance against the 4-hour standard but also on cancer and elective care targets. The Chief Operating Officer noted the key need to reduce demand, and to improve the flow/management of those attending ED and the Glenfield Hospital Clinical Decisions Unit (CDU). He also advised that Ms S Leak had been recruited into the new role of Director of ESM and ED, reflecting the Trust's prioritisation of pressures in this area.

Paper G also outlined the welcomed improvement in ambulance handover performance, which had reduced from the peaks seen in November and December 2015. It was acknowledged that performance remained poor however at certain key times. In discussion on emergency care performance, the Trust Board:-

(a) echoed the Chief Operating Officer's comments on the need to build-in additional capacity for winter 2016-17 and avoid a repeat of the pressures experienced this year;

(b) queried why all ambulance handover data was not captured on the CAD+ system. In response, the Chief Operating Officer explained that while the majority of performance data for the 80% of patients brought in by EMAS was captured, 20% of ambulance patients were brought in by private ambulance (although the Chief Executive noted that all ambulances used the priority scoring system). The Chief Operating Officer confirmed that the LRI's CAD+ use was the highest in the whole area covered by EMAS. In response to a further Non-Executive Director query, the Chief Operating Officer agreed to provide detail to Trust Board members regarding the acuity of private ambulance patients as against that of EMAS ambulance patients; **COO**

(c) sought further information on the 'direct streaming' initiative. In response, the Chief Operating Officer clarified that this related to patients coming in by ambulance who did not need to go to ED. The aim was for only acutely unwell patients to attend ED, and a process had been initiated to identify those patients who could safely be triaged elsewhere (primarily in the GP-led Urgent Care Centre);

(d) noted the work underway with Commissioners to forecast demand for 2016-17 – this looked set to increase which would be challenging for all parties in terms of both capacity and costs. An internal UHL session was planned for 18 March 2016 to discuss capacity v. demand issues in more detail and the delivery of key reconfiguration moves (eg ICU). It was

not clear at this stage whether demand and capacity could be balanced. UHL's annual operational plan for 2016-17 would be presented to the Trust Board in April 2016, although the absolute final capacity plan might not be agreed until later than month in light of the contracting timetable;

(e) requested that a further update on emergency care plans be provided to the March 2016 Trust Board thinking day; **COO**

(f) noted a query from the Healthwatch representative as to when a 'confidence check' would be available on 2016-17 winter plans – this would then enable Healthwatch to exert informed pressure on other healthcare system organisations. The Chairman suggested that Healthwatch be invited to the proposed April 2016 Board-to-Board, and agreed to seek a view from his fellow LLR Chairs accordingly, and **CHAIR MAN**

(g) requested sight of the more medium-term actions to address emergency pressures, noting that those detailed in paper G were more immediate in nature. This would be covered at the March 2016 Trust Board thinking day. **COO**

Resolved – that (A) information be provided to Trust Board members on any difference in the acuity of patients brought in by (i) private ambulance and (ii) EMAS; **COO**

(B) an update on emergency care plans to be provided at the 17 March 2016 Trust Board thinking day, including the more medium-term actions, and **COO**

(C) the Trust Chairman contact his fellow LLR Chairs to suggest inviting Healthwatch to the emergency care session of the proposed April 2016 Board-to-Board. **CHAIR MAN**

49/16/4 UHL Reconfiguration Programme

This monthly report updated the Trust Board on (i) the governance of UHL's reconfiguration programme; (ii) progress on 1-2 selected workstreams, and (iii) the 3 key programme risks, while the high-level dashboard appended to the report provided an overview of the programme status and key risks as a whole. In terms of key workstream deep dives, paper H focused on the major capital reconfiguration business cases in delivery phase (Emergency Floor, ICU and vascular projects). Various capital availability scenarios (and their implications for the reconfiguration programme) had been discussed, as had the impact of the delayed public consultation on Better Care Together and any potential purdah period associated with the June 2016 EU referendum.

The Acting Director of Strategy particularly noted the key interdependencies between the vascular and ICU business cases, with the ICU reconfiguration having slowed slightly due to capital constraints. The August 2016 timing for the vascular wards did not now match with the ICU wards which would not be available before December 2016. Paper H also outlined progress on the LGH rationalisation workstream.

In discussion on the report the Trust Board noted:-

(a) the crucial need for greater clarity from the NTDA and NHS England in March 2016 re: 2016-17 capital availability. The Chief Executive emphasised that capital uncertainty made planning very challenging – although UHL's central capital requirements were relatively modest, the Chief Executive noted the need for appropriate scenario-planning in the event that capital was not received;

(b) (in response to a query) that the delay between the availability of vascular and ICU wards would cost approximately £150k per month. The clinical impact of the delays (and the impact on staff morale) was a key issue, however, and

(c) the Chief Operating Officer's view that the ICU reconfiguration remained a key priority for UHL (in response to a Healthwatch query). The Healthwatch representative also sought assurance that the service remained clinically sustainable in the event of delays – in response the Chief Executive reiterated previous comments that the key issue for clinical sustainability was the ability to recruit staff to the service, which would be adversely affected if the reconfiguration was to halt completely.

Resolved – that the update on reconfiguration be noted.

49/16/5 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 – the top 2 risks were outlined as the availability of transformational funding and staff/public/patient engagement. Paper I also advised that the revised version of the BCT pre-consultation business case was being submitted to CCG Boards for approval and was being presented for endorsement in the private session of today's Trust Board meeting, with a view to being submitted to NHS England in April 2016. In discussion on paper H, the Trust Board:-

(a) noted that an additional 80 ICS beds were now open, with a further 10 beds per week planned during March 2016. A significant amount of positive qualitative FFT feedback had been obtained re: the ICS beds, which would be included in the April 2016 Trust Board report on BCT. However, at 83% the cumulative occupancy level was still below the 90% target, and work continued with partners to address this. In discussion, Trust Board members requested clarity on the different flows of patients into ICS beds so that efforts to improve occupancy could be appropriately targeted; **ADS** **ADS**

(b) noted proposals to reinvigorate the LLR service reconfiguration workstream, involving joint chairing by LPT and CCG clinical leads;

(c) considered that the level of demand across the LLR healthcare economy should be added into the top programme risks, and **ADS**

(d) advised the Healthwatch representative that his wish for information on patients' experience of the ICS beds would be covered in the FFT data referred to in (a) above. The Acting Director of Strategy agreed to consider further how best to capture data on ICS service responsiveness to patients' discharge requirements. **ADS**

Resolved – that (A) the BCT update to the 7 April 2016 Trust Board also:- **ADS**

(1) include FFT data re: ICS beds;

(2) expand the top 2 risks and issues section to include the 'level of demand across the LLR healthcare system';

(3) clarify the various inflow routes to ICS beds, to target efforts to improve occupancy, and

(B) further consideration be given to how best to collect data on ICS' responsiveness to patients' discharge requirements. **ADS**

49/16/6 Appointment of Responsible Officer (RO) for UHL

In the absence of the Medical Director, the Director of Corporate and Legal Affairs introduced paper J, seeking Trust Board approval to appoint Dr C Free, Deputy Medical Director as UHL's Responsible Officer with effect from 1 April 2016. This appointment would

replace Professor P Furness who was UHL's Interim Responsible Officer until 31 March 2016 (Minute 231/15/8 of 5 November 2015 refers).

Paper J also provided assurance that Dr Free was a trained Case Manager and was a suitable person for the role of Responsible Officer. The Trust Board noted the statutory requirement for UHL to have a Responsible Officer and endorsed the proposed appointment of Dr Free accordingly.

Resolved – that Dr C Free, UHL Deputy Medical Director be appointed as Responsible Officer for UHL from 1 April 2016. **CE**

50/16 PATIENT AND PUBLIC INVOLVEMENT AND ENGAGEMENT

50/16/1 Patient and Public Involvement Strategy – Quarter 3 Implementation Update

Paper K from the Director of Marketing and Communications provided a quarterly update on the implementation of the Trust's PPI Strategy as approved in April 2015. The report was accompanied by a review of Patient Partner activity written by the Patient Partner Group Chair (Mr M Caple), who also attended for this item. Mr Caple had also presented his report to the February 2016 QAC, and he noted his view that the profile of Patient Partners – and their active involvement in service discussions – had improved. However, Patient Partner numbers remained small (12) and it was hoped to increase this to 20 by the end of 2016, while also broadening the diversity of those applying to be Patient Partners. Mr Caple also outlined the various ways in which Patient Partners were involved at CMG-level within UHL, noting the need for improvement in terms of (1) the consistency and (2) the earliness in the process of such involvement.

Messrs G Smith and D Gorrod, Patient Partners, were also in attendance for the meeting, and they noted the importance of continuing to receive PPI updates at Trust Board meetings. They also welcomed moves by the Medical Director to establish a Clinical Librarian post to improve the quality of patient information leaflets. Comment was also made that having Patient Partners prevented the Trust from becoming too inward looking.

In discussion on the report, the QAC Non-Executive Director Chair confirmed that discussions were in hand about scheduling regular Patient Partner stories at QAC meetings. The Trust Chairman noted that he found the Patient Partners to be helpful and insightful when involved in projects, and he reiterated his wish to repeat the July 2015 Trust Board thinking day event held with PPI partner organisations. The Director of Marketing and Communications noted his hope that the imminent consultation on BCT would demonstrate good PPI engagement across LLR. **CHAIRMAN/ DMC**

Resolved – that the July 2015 Trust Board thinking day session with PPI partners be repeated in 2016. **CHAIRMAN/ DMC**

51/16 EDUCATION AND TRAINING

51/16/1 Multi-Professional Education and Training Quarter 3 Update

Dr R Powell, Acting Director of Medical Education and Ms E Meldrum Assistant Chief Nurse, attended to introduce the quarter 3 multi-professional education and training update at paper L. Key issues included the scope to improve UHL as a learning organisation, the retention of medical students and junior doctors, and the benefits of having a well-supported training environment with good training facilities.

In discussion on both the medical and nursing elements of the report, the Trust Board noted:-

(a) that the education and training facilities strategy had not yet been approved – the Chief Executive agreed to confirm the current status of that strategy outside the meeting, and reiterated the need for education and training space to be designed into new developments; **CE**

(b) that the March 2016 opening of the new examination facilities within the Robert Kilpatrick Clinical Sciences Building would free up clinical space elsewhere;

(c) progress (by CMG) against the July 2016 deadline for all Consultants supervising a trainee to be registered with the GMC. In response to a Non-Executive Director query, the Acting Director of Medical Education considered that the availability of the online training package would help to address current challenges in certain CMGs;

(d) the measures implemented within Cardiology to address the HEE-EM findings (as reported to the Trust Board in January 2016;

(e) some identified 'quick wins' in respect of improving the experience of medical students at UHL, including new name badges and improved student access to clinical systems and patient safety reporting systems;

(f) a significant positive change in the impact on UHL of the HEE-EM proposed redistribution of medical training posts across East Midlands;

(g) the significant work underway within the Trust to prepare for the Autumn 2016 GMC visit. In response to a Trust Board query, the Acting Director of Medical Education considered that training facilities remained an issue;

(h) the need to improve UHL's retention of medical students. Dr S Dauncey Non-Executive Director agreed to share information on Northamptonshire practices re: junior doctor recruitment and retention with the Acting Director of Medical Education outside the meeting; **SDNED**

(i) the Trust's wish for a closer strategic relationship with the University of Leicester and other academic partners, and its wish also to demonstrate its continued commitment to being a teaching hospital;

(j) that no significant concerns had emerged from the February 2016 Triennial Review of De Montford University's contract to deliver pre-registration qualifications in nursing and allied health professions;

(k) the recognised need for UHL and its academic partners to work on making Leicester a more attractive training destination for nursing and midwifery students. The Trust Board emphasised the need to work with partners to attract and then retain both nursing/midwifery and medical students, and develop an appropriately integrated marketing strategy – it was agreed to consider this further at a future Trust Board thinking day involving appropriate partners (and also potentially inviting the Chief Executive of the Local Enterprise Partnership). The Director of Workforce and OD noted previously-mentioned LLR monies which could be used for retention purposes; **CN/ MD/ DWOD**

(l) national consultation underway on a proposed new non-registered nursing role (Nursing Associate) arising from the 2015 national 'Shape of Caring' review. UHL was keen to pilot this new role which it viewed as a positive development;

(m) that LLR bids to support non-medical education totalling £245k had been submitted to HEE-EM as detailed in paper L. A decision on the bids was expected in March 2016, and

(n) the Assistant Chief Nurse's confidence in the significant work done within UHL to prepare for nurse revalidation from 1 April 2016 – the measures introduced by UHL had served to alleviate initial staff concern. The Chief Nurse thanked Ms E Meldrum for her work

on revalidation.

Resolved – that (A) information on Northamptonshire practices re: junior doctor recruitment and retention be shared with the Acting Director of Medical Education; **SDNED**

(B) the current status of the education and training facilities strategy be confirmed outside the meeting, and **CE**

(C) a future Trust Board thinking day be used to consider the development of an integrated recruitment and retention strategy (in conjunction with academic partners). **CN/MD/ DWOD**

52/16 QUALITY AND PERFORMANCE

52/16/1 Quality Assurance Committee (QAC)

Paper M from the QAC Non-Executive Director Chair summarised the issues discussed at that Committee's 25 February 2016 meeting, Minutes of which would be presented to the April 2016 Trust Board. The QAC Non-Executive Director Chair identified the key issues from that meeting as UHL's request to the Health & Safety Executive for a May 2016 extension to the sharps Improvement Notice.

Resolved – that the summary of issues discussed at the 25 February 2016 QAC be noted (Minutes to be submitted to the 7 April 2016 Trust Board).

52/16/2 Integrated Finance, Performance and Investment Committee (IFPIC)

Paper N from the IFPIC Non-Executive Director Chair summarised the issues discussed at that Committee's 25 February 2016 meeting, Minutes of which would be presented to the April 2016 Trust Board. The IFPIC Non-Executive Director Chair noted particularly that Committee's recommendation of the paediatric dentistry and daycase surgery business case for Trust Board approval (hyperlinked within paper N), which was now approved accordingly. **CFO/ DEF**

Resolved – that (A) the summary of issues discussed at the 25 February 2016 IFPIC be noted (Minutes to be submitted to the 7 April 2016 Trust Board), and

(B) the paediatric dentistry and daycase surgery business case be approved as recommended by the February 2016 IFPIC. **CFO/ DEF**

52/16/3 2015-16 Financial Position – Month 10 (January 2016)

Paper O provided an integrated report on month 10 financial performance (month ending 31 January 2016) 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 January 2016 UHL's financial performance was £1.6m adverse to plan with an in-month favourable variance of £0.5m (current year to date deficit of £33.5m). The capital programme 2015-16 remained on target, and the Chief Financial Officer voiced his relative confidence in delivery of the 2015-16 cost improvement programme (year to date delivery of £35.2m [£1.1m adverse to plan]). As previously reported, discussions were already underway regarding the 2016-17 CIP plans. In month 10 UHL's qualified nurse agency spend was 5.1% of qualified nursing spend against the target of 4% and there had been no use of off-framework agencies.

As detailed in paper O, the most significant risks to delivery of the Trust's 2015-16 financial plan included the continuation of the run-rate, the management of emergency activity over winter, and settlement of income with Commissioners. In discussion on the report, the Chief

Financial Officer responded to queries from the Chief Operating Officer regarding the income graph and the 'below the line' EBITDA issues.

Resolved – that the financial position for month 10 be noted.

52/16/4 Single Currency Interim Capital Support Facility

Paper P from the Chief Financial Officer sought approval as required for the proposed Trust Board resolution (appendix A) agreeing to the terms and conditions of the £38,733,000 DoH loan to fund UHL's Emergency Floor. The resolution also nominated a named officer to manage and execute the agreement (Chief Financial Officer). The terms and conditions were the same as those included in the Interim Revenue Support Loan approved by the Trust Board in January 2016 (Minute 10/16/4 of 7 January 2016 refers). Noting that the terms and conditions had not changed, the Trust Board approved the resolution as detailed in paper P. **CFO**

Resolved – that the single currency interim capital support facility application signed loan agreement documentation be submitted to the Department of Health, as approved by the Trust Board and signed accordingly. **CFO/ CE**

53/16 REPORTS FROM BOARD COMMITTEES

53/16/1 Quality Assurance Committee (QAC)

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

53/16/2 Integrated Finance Performance and Investment Committee (IFPCI)

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

54/16 CORPORATE TRUSTEE BUSINESS

54/16/1 Charitable Funds Committee

Paper S comprised the 4 February 2016 Charitable Funds Committee Minutes – these were approved as presented including the recommendations at Minutes 1/16 and 2/16. All recommendations to be approved by the Trust Board as Corporate Trustee, and progressed accordingly.

Resolved – that the Minutes of the 4 February 2016 Charitable Funds Committee be received and noted, and any recommendations approved accordingly by the Trust Board as Corporate Trustee, including the appointment of the CFC Chair as a member of the Approvals Group for the procurement of charitable funds investment management services. **CFO/ CFC CHAIR**

55/16 TRUST BOARD BULLETIN – MARCH 2016

Resolved – that the Trust Board Bulletin containing the following reports be noted:- (1) NHS Trust Over-Sight Self Certification return for the period ended 31 December 2015 [noting the continuing cleanliness concerns expressed by the Trust and also the unannounced CQC visit of 30 November 2015] (paper 2) – it was noted that this was the final such return required by the NTDA.

56/16 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) a query as to whether the planned junior doctor strikes would have a significant impact on elective cancellations. The Chief Operating Officer advised that although fewer patients would receive surgery, they would be advised of this in advance and would not be cancelled on the day. He advised that UHL used a clinical priority matrix to assess which operations were cancelled and he noted that at present emergency pressures were the main driver for elective cancellations. In response to a further query he confirmed that emergency cover was being provided. The questioner then asked what UHL junior doctor uptake of the strike had been – although the majority of junior doctors had been in work the Chief Executive advised caution on the precise % as a number of them would have been in work anyway providing emergency cover.

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

57/16 EXCLUSION OF THE PRESS AND PUBLIC

Resolved – that, pursuant to the Public Bodies (Admission to Meetings) Act 1960, the press and members of the public be excluded during consideration of the following items of business (Minutes 58/16 – 66/16), having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.

58/16 DECLARATIONS OF INTERESTS IN THE CONFIDENTIAL BUSINESS

The Chairman declared an interest in Minute 61/16/2 below and withdrew from the meeting during its consideration.

59/16 CONFIDENTIAL MINUTES

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

60/16 CONFIDENTIAL MATTERS ARISING REPORT

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

61/16 REPORTS FROM THE DIRECTOR OF STRATEGY

Resolved – that this Minute be classed as confidential and taken in private accordingly, on the grounds that public discussion at this stage could prejudice the effective conduct of public affairs.

62/16 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.

63/16 REPORTS FROM BOARD COMMITTEES

63/16/1 Integrated Finance, Performance and Investment Committee (IFPIC)

Resolved – that the summary of confidential issues discussed at the 25 February 2016 IFPIC, and the confidential Minutes from the 28 January 2016 IFPIC be received and noted, and any recommendations approved accordingly.

63/16/2 Remuneration Committee

Resolved – that the confidential Minutes of the 4 February 2016 Remuneration Committee be received and noted.

64/16 CORPORATE TRUSTEE BUSINESS

64/16/1 Charitable Funds Committee

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

64/16/2 Report from the Director of Marketing and Communications

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

65/16 ANY OTHER BUSINESS

65/16/1 Acting Director of Strategy

Noting that it was the last formal Trust Board meeting for the Acting Director of Strategy, the Chairman thanked her for her contribution to UHL and wished her well for the future.

Resolved – that the position be noted.

65/16/2 Chief Executive

The Chairman congratulated UHL's Chief Executive on being named in the top 50 NHS Chief Executives.

Resolved – that the position be noted.

66/16 DATE OF NEXT TRUST BOARD MEETING

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

The meeting closed at 2.25pm

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	12	11	92	R Mitchell	12	12	100
J Adler	12	12	100	R Moore	12	12	100
I Crowe	12	12	100	C Ribbins	4	3	75
S Dauncey	12	10	83	J Smith	8	8	100
A Furlong	12	11	92	M Traynor	12	11	92
A Goodall	10	9	90	P Traynor	12	12	100
A Johnson	5	5	100	J Wilson	9	9	100

Non-Voting Members:

Name	Possible	Actual	% attendance	Name	Possible	Actual	% attendance
D Henson	12	12	100	E Stevens	4	4	100
R Palin	5	3	60	L Tibbert	8	7	87
N Sanganee	6	3	50	S Ward	12	12	100
K Shields	11	7	64	M Wightman	12	11	92