UNIVERSITY HOSPITALS OF LEICESTER (UHL) NHS TRUST

MINUTES OF A MEETING OF THE TRUST BOARD HELD ON THURSDAY 8 AUGUST 2024 FROM 1.30PM IN SEMINAR ROOMS 2/3, CLINICAL EDUCATION CENTRE, GLENFIELD HOSPITAL

Voting Members present:
Mr A Moore – Trust Board Chair
Mr M Brearley – Interim Chief Financial Officer
Mr A Furlong – Medical Director
Ms J Hogg – Chief Nurse
Mr J Melbourne – Chief Operating Officer
Mr R Mitchell – Chief Executive
Mr D Moon – Non-Executive Director and Audit Committee Non-Executive Director Chair
Mr J Worrall – Non-Executive Director and Operations and Performance (OPC) Non-Executive Director Chair

In attendance:
Ms R Abeyratne – Director of Health Equality & Inclusion
Mr S Barton – Deputy Chief Executive
Professor I Browne – Associate Non-Executive Director
Professor N Brunskill – Director of Research and Innovation (for minute 260/24/1)
Professor J Burton – Consultant Nephrologist (for minute 260/24/1)
Mr A Carruthers – Chief Information Officer
Ms B Cassidy – Director of Corporate and Legal Affairs
Mr M Farmer – Associate Non-Executive Director
Professor A Garcea – Associate Non-Executive Director
Mr S Harris – Associate Non-Executive Director
Ms S McLeod – Head of Patient Experience (for minute 255/24)
Mr M Reeves – Corporate and Committee Services Officer
Mr M Sandhu – Attendee for Patient Story (accompanied by British Sign Language interpreter) (for minute 255/24)
Dr R Singh - Consultant and Junior Doctors' Guardian of Safe Working (for minute 258/24/4)
Ms M Smith – Director of Communications and Engagement
Ms C Teeney – Chief People Officer

		ACTION
250/24	**APOLOGIES AND WELCOME**	
	Apologies for absence were received from Ms V Bailey, Non-Executive Director, Professor T Robinson, Non-Executive Director, Dr A Haynes MBE, Non-Executive Director and Ms H Kotecha, Healthwatch. Mr A Moore, Trust Board Chair informed the Trust Board that this would be the last meeting for Mr J Worrall, Non-Executive Director wished him well in his new role as Chairman of East Midlands Ambulance Service.	
251/24	**CONFIRMATION OF QUORACY**	
	Resolved – the meeting was confirmed as quorate (i.e. at least one-third of the whole number of Directors were present, including at least one Executive Director and one Non-Executive Director).	
252/24	**DECLARATIONS OF INTERESTS**	
	There were no declarations of interest.	
253/24	**MINUTES**	
	Resolved – that the Minutes of the public Trust Board meeting held on 11 July 2024 be confirmed as a correct record.	
254/24	**MATTERS ARISING: BOARD ACTION LOG**	

	Paper B provided progress updates for the matters arising from the 11 July 2024 Trust Board meeting and any outstanding items from previous meetings, the contents of which were received and noted.	
	<u>Resolved</u> – that the matters arising report be received and noted as paper B.	
255/24	**PATIENT STORY – MAX'S STORY**	
	The Director of Health Equality and Inclusion introduced the patient story to hear from Mr M Sandhu (known as Max) following his and his wife's experience as profoundly deaf people using the Emergency Department at UHL, as well as other support services. Mr M Sandhu was joined by his British Sign Language interpreter. Mr M Sandhu provided details of his experience. He explained about the occasion where his wife was feeling ill. There were initial difficulties using the NHS 111 service, where an interpreter was needed to call the number and explain details of the illness as the app was inaccessible. Mr Sandhu's wife's condition deteriorated to the point of fainting and this required the use of an interpreter from the 111 service to explain the situation to a doctor and they arranged an ambulance which arrived promptly. The NHS 111 interpreter remained involved when the ambulance arrived, but this did not work well as the paramedics were unsure as to how to engage with a remote interpreter. Mr Sandhu travelled separately to the hospital and faced difficulties at reception trying to find out where his wife had been taken, but eventually using a pen and paper to communicate he received instructions about where his wife was. An interpreter was requested with those responsible for his wife's care noting that this could take time to arrange, therefore a prompt request was recommended, with ongoing communication undertaken using paper and pen. A long wait followed and the provision of an interpreter did not materialise. Mr M Sandhu attempted to stay awake in order to communicate by lip reading with those caring for his wife, but this proved difficult due to the use of face masks and he could not explain to his wife what was happening. There was therefore no communication undertaken when tests and vital signs were taken. After a lengthy wait it was confirmed that a request for an interpreter had not been made, therefore Mr Sandhu was required to seek the services of one of his known regular interpreters which his managed to connect with who could interpret using a phone video call, which was less than optimal. Through the interpreter the necessity of having an interpreter present in person was explained and it was very stressful trying to communicate in other ways. In summary, Mr Sandhu commented that he and his wife had been through an awful experience. The Director of Health Equality and Inclusion commented that Mr M Sandhu's experience showed that there was a need to improve the services delivered, and he had been invited to contribute to the development of the accessible information standard which sought to enable a consistent approach to meeting the information and support needs of patients and carers with a disability, impairment or sensory loss. The Head of Patient Experience outlined some of the actions which were now being taken to avoid the issues which Mr M Sandhu faced. This included a dedicated lead on support for deaf people, problems with hearing loops had been repaired, more staff in the Emergency Department were being trained in the use of British Sign Language and greater staff involvement in relevant disability forums. It was noted that the main problem that Mr M Sandhu faced was that he could not do what he needed to do and the use of pen and paper was not appropriate, therefore a video first approach would be taken in future. In terms of access to interpreters, considerable communications work had now been undertaken to inform staff how to access them and a tender for a new interpreter service was underway. It was acknowledged that despite these improvements there was still further work to do to improve the situation. Mr A Moore, Trust Board Chair thanked Mr M Sandhu for telling his story and for providing a better understanding for the experiences of a person who was profoundly deaf. The distressing nature of Mr M Sandhu's experience was acknowledged, and although there had been positive improvements arising from the experience, it was recognised that there was more to do. The Chief Nurse noted that the Emergency Department could be a distressing place and she was sorry for the bad experience. It was noted that the 15 steps programme, which sought to identify issues arising from a patient's experience, was being developed to address concerns raised by Mr M Sandhu's experience.	**CN**

	The Medical Director also apologised to Mr M Sandhu for his and his wife's experience and noted that it was important for the Trust Board to hear about such experiences, and it also showed the importance of developing the Accessible Information Standard. Mr J Worrall, Non-Executive Director stated that as well as being a UHL Non-Executive Director he was also Chair of East Midlands Ambulance Service (EMAS). He was sorry to hear of Mr M Sandhu's experience and invited him to present his experience to EMAS, to which Mr M Sandhu accepted the invitation. Mr M Farmer, Associate Non-Executive Director referred to his own experience as a person with mild hearing loss and could appreciate the disempowering nature of Mr M Sandhu's experience. He noted the positive development of the 15 steps programme, but enquired whether there was an audit programme which looked at any issues. The Head of Patient Experience commented that this was being explored. In terms of the 15 steps programme this was being developed to involve a deaf person and a blind person and covered different departments and AccessAble, the disability access guide providers would provide advice on the process. Mr A Moore, Trust Board Chair enquired whether there was an action plan which addressed the issues raised by Mr M Sandhu's experience. The Director of Health Equality and Inclusion confirmed that there was, but acknowledged that more could always be done. Progress, including more detail on the Accessible Information Standard would be reported to the Trust Leadership Team and to the Quality Committee. Mr A Moore Trust Board Chair requested that consideration be given to improving the visibility of the action plan. Mr A Moore, Trust Board Chair thanked Mr M Sandhu for sharing his story and noted that hearing such stories could help make further improvements.	**DoHE&I**
	<u>Resolved</u> – that (A) the 15 steps initiative be developed to consider service provision for people with disabilities, and **(B) ways of improving the visibility of the action plan for delivery of the accessible information standard be explored.**	**CN** **DoHE&I**
256/24	**STANDING ITEMS**	
256/24/1	<u>Chair's Report</u>	
	Reporting verbally, Mr A Moore, Trust Board Chair highlighted the following items: a) Riots / disturbances – he condemned the recent and ongoing riots and disturbances which had affected Leicester as well as many places across the country. He was particularly disturbed that UHL colleagues going about their job role were impacted by these events. He commended those colleagues who continued to bravely undertake their roles not knowing what they may have to face as a result of the riots and disturbances. He asked that a communication be made to staff to express support for those who had been affected by the disturbances. Mr A Moore further commented that the recent events highlighted the need for UHL to put more effort into addressing cultural issues within the Trust ensuring that it was an inclusive organisation which recognised and rejected intimidation and racism. b) Change – ongoing change was noted as a constant day to day feature on people's lives. In a UHL context, there were a number of changes noted which the Trust was adapting to, such as a change of government, changes to the Trust Board, and more day to day changes in systems, strategy, structures and new colleagues. Change could often be unsettling and it was not always possible to provide reassurance, but effective communication, acknowledging situations and how they would be addressed and in what timescale was vitally important. The forthcoming Trust leadership event was felt to be a major opportunity to communicate with Trust leaders. Experience from other sectors had shown the importance of such events. Executive Directors were urged to plan for this event in order to make the most out of it and consider how colleagues will be best impacted by the event. c) Collaboration – details were provided of the engagement which the Trust Board Chair had been undertaking recently such as attending the LLR Integrated Care Board (ICB) board	**DoC&E** **Executive Dirs**

	meeting and holding discussions with ICB colleagues, focussing particularly on the winter plan. He noted that there did not appear to be total alignment on the way forward and further discussions would be needed. Mr A Moore intended to continue engaging with partner, regional and wider colleagues in order to assist the UHL Chief Executive and other executive colleagues. d) Health Care Support Workers – there would be a more detailed update later on the agenda, but it was noted that this dispute had been a difficult, lengthy process, but he considered that it had been handled by Trust leaders in a professional way with integrity. e) GP collective action – it was noted that this had been discussed at the recent LLR ICB board meeting, where there was a sense that the impact was not as detrimental as first anticipated. f) Trust Board meeting arrangements – Mr A Moore noted that Non-Executive Directors had been discussing the timing of Board meetings noting the clash with the LLR ICB board meeting. Other options were being considered and this would be reported in due course. In terms of reports submitted to the Trust Board, views were sought with regard to the papers which were submitted, whether they could be more succinct and make better use of executive summaries and appendices. He also urged Executive colleagues to ensure that reports were submitted in line with deadlines, to give Trust Board members time for due consideration and to avoid the risk of papers potentially not being circulated if they came through late.	**Trust Board Chair** **Executive Dirs**
	<u>Resolved</u> – that (A) a communication be sent to Trust staff stating the Trust's position in response to the riots and support for those staff who worked during disturbance period; **(B) Executive members undertake appropriate preparation for the forthcoming Trust leadership event in September in order to deliver the most effective outcomes; ~~and~~** **(C) concerns about wider Integrated Care System alignment on the Winter Plan be raised with the LLR ICB Interim Chair and Chair, and** **(D) reports to future Trust Board meetings be appropriately succinct, making use of executive summaries and appendices and submitted in line with deadlines.**	**DoC&E** **Executive Dirs** **Trust Board Chair** **Executive Dirs**
256/24/2	<u>Chief Executive's Report</u>	
	The Chief Executive presented paper E and particularly highlighted the following: a) Health Care Support Workers (HCSW) – reference was made to the re-banding exercise, which began in Autumn 2023 for HCSWs who were considered to be undertaking tasks at a level which was higher than the band they were appointed to. All those affected by the re-banding were written to in the week prior to this Trust Board meeting about them formally moving to their new band, and details of back pay, set to August 2021. If those affected felt that they had been working at a higher level prior to August 2021, then it was noted that they could follow existing local procedures to review the position. If was noted that four staff unions had now accepted the proposal and it was felt that it was time to move this difficult process forward, but noted that the operational impact from recent strike activity had been minimal. He thanked the Chief Nurse and Chief Operational Officer for their operational response during the dispute and the Chief People Officer for her role in overseeing the dispute process. b) Riots – the Chief Executive condemned the actions undertaken by those who participated in the recent riots and disturbances which affected Leicester and other parts of the country. He expressed pride that there were 70 nationalities who worked within the Trust creating a rich diversity. He thanked the Director of Communications and Engagement for her involvement in the response and the Director of Health Equality and Inclusion for speaking of her experience in response to the events. c) Winter – It was noted that winter officially started 54 days after the day of this Trust Board meeting. Concern was expressed about preparedness for the winter period. The Chief Operating Officer was asked to provide a view regarding whether a timely plan of care was in place. In response, the Chief Operating Officer acknowledged and understood the concern	

	expressed by the Chief Executive and noted that demand was still at a level which was above planned levels. He also noted that across the System, there was acceptance of the need to do more to meet anticipated demand. The Medical Director also commented that escalation capacity was currently being used, along with a rapid flow of patients, more ambulance waiting than was desired and a bed capacity gap, therefore there was still more work to do to deliver an acceptable winter plan. The Chief Nurse further commented that corridor care was now business as usual in UHL and that this should not be tolerated with the aim to provide a service that we would all want for our own relatives. The Chief Operating Officer in response to a question further noted that there were elements of the winter plan which were in the Trust's control, and elements which were not. He also noted that he, with support from colleagues would work with partners to develop a more robust winter plan. Mr M Farmer, Associate Non-Executive Director referred to the riots and the wider impacts that staff faced from intimidation and aggression and queried whether there could be communications response which covered the wider public sector. The Director of Communications and Engagement supported this as a good idea and noted the increases in abuse which public sector staff were facing. It was confirmed that the Trust were speaking to local Councils and the Police communications teams to see if any joint communications could be done. Mr A Moore, Trust Board Chair requested that the winter plan be presented to the Trust Board as soon as possible.	**COO**
	<u>Resolved</u> – that the Winter Plan be completed and presented to the Trust Board for consideration at either the September or October 2024 Trust Board meetings;	**COO**
256/24/3	<u>UHL Performance Update and Integrated Performance Report (Month 3)</u>	
	The Chief Operating Officer introduced paper D, comprising the Integrated Performance Report (IPR) for June 2024. It was noted that Urgent and Emergency Care (UEC) remained in a challenging position as it faced significant increases in demand. There had been a deterioration in ambulance handover performance compared to the previous month and increases in UEC demand compared to previous years. This arose from a significant increase in people presenting at the Emergency Department, but this was also the case in Urgent Treatment Centres (UTC) and primary care, which signified a likely challenging winter period. The plan for winter was still being developed and there were also exciting plans to improve productivity, patient flow and allied health support. It was also reported that Ms J Frake-Harris had started in her post as Interim Leicester, Leicestershire Rutland (LLR) ICB System Director for UEC. In relation to planned care, the Chief Operating Officer reported ongoing improvements in reducing waiting lists, particularly in relation 65 and 52 week waits, but there was a minor increase in 78 week waits, but there was still confidence that there would be no 65 week waits by the end of September. Further, positive productivity developments were noted in areas such as triage, clinic templates, texting technology and reduced non-attendance rates. The total waiting list however continued to grow and the reasons for this were being explored. Performance regarding cancer waiting times continued to be strong but challenging and it was acknowledged that further progress was needed regarding the 62 day waiting time, but challenges remained due to radiology and oncology capacity. There were ongoing developments in terms of working with the University Hospitals of Northamptonshire NHS Group (UHN) where patients and capacity were being shared and a report would be presented to the Trust Board at a future meeting which provided further detail. Mr D Moon, Non-Executive Director welcomed the areas of progress which had been made, but queried the reduction in the number of day cases undertaken. The Chief Operating Officer confirmed that the primary reason was due to the industrial action which had taken place. Mr D Moon Non-Executive Director suggested that going forward, lost activity be included when totalling the costs of industrial action. The Interim Chief Financial Officer confirmed that this was usually the case. Professor A Garcea, Associate Non-Executive Director referred to the GP collective action, noting that this was starting to gain momentum, such as limiting contact per day and may have an impact on footfall presenting at the Emergency Department. Further, it was noted that GPs were moving away from a standardised referral form for treatment which may or may not have an operational impact in due course. The Chief Operational Officer commented that daily meetings with System	

	partners were ongoing which considered the impact of the collective action, but the position was still currently being established. He was also aware of the proposed changes regarding referral processes. Each of the Executive Director IPR leads were invited to provide an overview of the key aspects of paper F relating to their portfolios and the Non-Executive Director Chairs of Board Committees were invited to comment as follows:- **(1) Quality –** The Medical Director reported most of the Quality metrics remained stable, such as hospital mortality which was within the expected range. It was however noted that rates of Methicillin-susceptible Staphylococcus Aureus and Clostridium difficile infections were above target but assurance was provided that actions were being put in place to address this. Complaints were also above the target level, but this was an improving picture. It was acknowledged that patient waits in the Emergency Department were too long and whilst this did not impact the recording of metrics, it was impacting on the patient experience. **(2) People –** There were no further updates at this point in the meeting. **(3) Finance –** The Interim Chief Financial Officer reported that at month 3, the Trust deficit was £5.2m adverse to plan. The Cost Improvement Programme (CIP) was £3.8m behind target, however assurance was provided that the work with the Trust's delivery partners had advanced and a better position was expected at month 4. A re-prioritisation exercise had been undertaken on the capital plan due to a reduction in funding. The current deficit position had meant an impact on the cash balance and a determined effort to ensure that the Trust met its target of paying 95% of creditors in 30 days, which required controls on expenditure, but assurance was provided that local and priority suppliers were prioritised for payment to ensure ongoing medicine provision. Mr M Farmer, Associate Non-Executive Director enquired whether future reports could contain further information about the Trust's backlog maintenance position, as there were an increasing number of comments relating to this being raised at the Quality Committee. The Interim Chief Financial Officer commented that more details of capital expenditure had been provided and noted that there had been a reduction in the backlog over a number of years. Mr A Moore, Trust Board Chair raised queries with regard to the summary financial position within the report which appeared to indicate a number of variances to plan on some key financial metrics such as pay and non-pay costs, which may be worse than the issues reported regarding UEC cost impacts. The Interim Chief Financial Officer explained that the overall deficit position was informed by a range of factors which may be above or below plan in order to define the actual figure. Mr A Moore requested that consideration be given to providing a clearer explanation in future financial summaries. Mr A Moore, Trust Board Chair also referred to the Trust overview within the report which showed a notable number of metrics in 'red' (falling target) in the current month which appeared to be showing a deteriorating position from the year to date position. The Chief Operating Officer commented that the definitions of some of the metrics had been amended following comments at the previous meeting. He did not believe the overall position was deteriorating, but some areas clearly were, but the overview aimed to provide a snapshot, but he agreed to review the document. Mr A Moore, Trust Board Chair commented further that if the position was worse than shown, then that should be explained.	**CFO** **COO**
	<u>Resolved</u> – that (A) the finance information within the IPR be reviewed to ensure that large variances were suitably explained; and **(B) an Executive summary of the Trust's overall operational performance be provided in future IPR reports.**	**CFO** **COO**
257/24	**HIGH QUALITY CARE FOR ALL**	
257/24/1	<u>Maternity Assurance Committee Update / Perinatal Surveillance Scorecard – June 2024</u>	
	The Chief Nurse presented the update from the Maternity Assurance Committee which took place on 3 July 2024. A key role of the Committee was to have oversight of the 10 safety actions from the	

	NHS Resolution Maternity Incentive Scheme. Action 8 regarding multi professional training was noted as a risk, but assurance was provided that a plan was in place which included agreement with UHN to provide additional training dates. An exploratory learning meeting took place in April 2024 with NHS England Midlands Workforce, Training and Education regarding the previous incident regarding the recording of births that trainee midwives had participated in. Positive verbal feedback was received and the Trust was placed into category 2 intensive support framework for training. A subsequent action plan had been developed to work towards the safer learning environment standard. It was further noted that following NHSE guidance, a vaccination plan had been developed for the Respiratory Syncytial Virus (RSV) as this was expected to grow as an issue, with work ongoing with System colleagues to deliver the plan, despite issues with funding. The Chief Nurse presented the Perinatal Surveillance Scorecard for June 2024. There had been ongoing improvements regarding the vacancy rate for midwives. An issue was noted in relation to Neonatal nurses reaching the Qualified in Specialty (QiS) standard in order to meet the regional NHSE requirement of 70% of nurses reaching the standard, which currently stood at 55% however a plan to meet the target was in place. Efforts had been made to improve the response rate for the Friends and Family Test, but further improvements were being considered. Professor I Browne, Associate Non-Executive Director noted the category 2 level for intensive training support in which the Trust had been placed, and queried what was required to meet the desired standard level. The Chief Nurse commented that it was aimed to become removed from the Nursing and Midwifery critical concern list. In order to develop training practice there needed to be clarity regarding the hours spent during training activities, consistency of monitoring of trainees and support during spontaneous births out of hours. Therefore, the aim was to spread trainees out across hours of operation. Mr A Moore, Trust Board Chair raised a general query in relation to maternity assurance, asking how the current level of performance compared to the desired level of performance. The Chief Nurse stated that good progress had been made over the past 18 months with better oversight, better staffing levels, key safety checks undertaken and improved training. There was further work to do on how the service engaged with women, addressed inequalities and met equity standards. There was also a need to be curious on perinatal mortality rates, as a cause had not yet been defined for the level of neonatal mortality, but it was felt that addressing inequalities remained of key importance. Mr A Moore Trust Board Chair commented that the response provided an excellent summary and was an example of how an overview of a service could be provided to the Trust Board to enhance their understanding. Mr A Moore, Trust Board Chair further queried about how staff feedback was sought in order to develop workplace culture. The Chief Nurse noted that an initiative called empowering voices had been undertaken 2022 with maternity staff and in 2023 with neonatal staff to seek views and feedback. It was acknowledged that there was further work to be done to develop how people worked together, but also around how patients were treated, but this could be dependent on the culture of the different workplaces. It was also noted that there was a national development programme regarding maternity. In summary, Mr A Moore, Trust Board Chair requested that options for continuing to improve perinatal services be considered such as benchmarking with high performing peers and undertaking a safety survey with staff to seek feedback.	**CN**
	<u>Resolved</u> – that options for continuing to improve perinatal services be considered such as benchmarking with high performing peers and undertaking a safety survey with staff to seek feedback.	**CN**
257/24/2	<u>Update on Health Equality and Inclusion</u>	
	The Director of Health Equality and Inclusion presented a report which provided an update and assurance on work relating to improving health inequalities in access, experience and outcomes for patients using UHL services and to underline any barriers to development and highlight suitable mitigations where possible. Key areas highlighted included the tracker within the report which outlined areas of engagement on dealing with inequalities but noted that progress had slowed due to operational pressures, however an approach was being developed to included addressing inequalities as business as usual within quality improvement processes. A particular issue was noted with Tuberculosis (TB) within Leicester City which was becoming an emerging public health	

	concern with efforts being made to identify resources to address the range of issues regarding engagement with affected communities. Feedback was provided from the UHL Health Equality Summit where 95% of attendees felt the day was a helpful and positive experience and it was noted that a further summit would be held next year. Details were also provided about the NHS Providers Health Inequalities Self-Assessment which showed that UHL was operating at a good level. It was acknowledged that it was a self-assessment and that there was more work to do in terms of implementing health equality and inclusion in Trust services. This would be discussed in more detail at a Trust Board development session in future. Also included with the report was the report on addressing racial disparities in maternal outcomes for the people of Leicester, Leicestershire and Rutland. Improvements had been seen in the services to improve outcomes for black communities, but there were actions to develop workplace culture and address systemic racism, and this approach could be expanded beyond maternity. Professor I Browne, Associate Non-Executive Director noted that the TB project was a good example of an issue which could be worked on systemically with partners, notably Public Health in this case, which would enhance scoring on the health inequalities self-assessment. It was also suggested that following discussions at the Health Equality summit, it was recommended that UHL become an early adopter of the new Office for National Statistics method of ethnicity recording. Professor A Garcea, Associate Non-Executive Director raised issues regarding the adoption of the Accessible Information Standard, particularly around patients' information being able to follow them on their healthcare pathway. The Chief Information Officer noted that the development of the Electronic Patient Record in Nervecentre would begin to enable this in a more effective way, but there were challenges in addressing the fragmented nature of many different systems which were currently in use and crossing organisational boundaries, as well as a role for NHSE to ensure wider implementation. It was requested that further consideration be given to the development of improved sharing of patient information, both in the interim and longer term.	**CIO**
	Resolved – that consideration be given to the development of improved sharing of patient information.	**CIO**
257/24/3	Maintaining Focus and Oversight on Quality of Care and Experience in Pressurised Services	
	The Chief Nurse and the Chief Operating Officer presented a report which responded to a requirement from NHS England (NHSE) for Integrated Care Boards and NHS Trusts to assure themselves about how their organisation was meeting 6 measures of various care standards and processes. This requirement arose following a Channel 4 documentary. The overarching aim of the letter received from NHSE was about providing alternatives to Emergency Department attendance and maintaining good patient flow through a hospital. The responses to the measures were prepared on a System level basis. There was full compliance on 2 of the 6 measures, with partial compliance on 4. The areas of partial compliance were acknowledged and the need for further action in some areas but assurance was provided that they would be addressed. It was also noted that many of the areas of partial compliance related to discussions regarding capacity which had been ongoing with System partners, and coming to an agreement amongst 3 organisations had been a challenge. Mr M Farmer, Associate Non-Executive Director referred to the measure within the report regarding Non-Executive Directors undertaking visits within hospitals and suggested a proforma approach similar to that in place at Leicestershire Partnership NHS Trust. Mr M Farmer, Associate Non-Executive Director also referred to the lack of a national NHS winter plan, and queried whether pressures were being considered all year round. The Chief Operating Officer stated that there was a UEC plan which covered the whole year, but there was also the requirement for a System winter plan, but there was an attempt by the NHS to address issues on a longer term basis. Mr M Farmer, Associate Non-Executive Director further enquired about issues with long waiters in the Emergency Department. The Chief Operating Officer noted that a later report on the agenda covered progress which had been made in addressing UEC capacity, which had been positive in some cases with some positive assistance from System partners. Mr J Worrall, Non-Executive Director welcomed the report as a thorough piece of work. However, in those areas where there was only partial compliance he felt that this understated the position in	

	some cases, not recognising the stress that some services faced, such as in relation to ambulance waits above an hour and did not represent any ambition to provide a high quality effective service. The Chief Nurse noted that it had been difficult to develop a shared view amongst System partners and similar points of concern were raised in discussion when coming to a view. It was further commented that a UHL only response may look different. Mr A Moore, Trust Board Chair welcomed the report but commented on the need to ensure that there was clarity about the actions which the Trust needed to take in response. He also requested that there should be a programme of Non-Executive Director visits planned, but they be undertaken on a low key basis.	**COO / CN / DCLA**
	Resolved – that a programme of Non-Executive Director visits to wards be developed, structured to be a low key view of day to day operations.	**COO / CN / DCLA**
257/24/4	CQC Improvement Action Plan: Maternity Care and Urgent and Emergency Care	
	The Medical Director presented a report which provided an update on the responses to the Care Quality Commission (CQC) inspection visits which took place in January 2024 and followed on from previous visits, and the resulting inspection reports which were received in June 2024. With regard to the Maternity inspection, it was noted that following the inspection the Trust was no longer subject to a Section 29a Warning Notice under the Health and Social Care Act (2009) and the inadequate rating had been moved up to 'requires improvement'. There were 3 'must do' actions as follows; consistent implementation of the Maternity Early Obstetric Warning System; enough suitably qualified and skilled staff on duty; and all incidents to be reported in line with policy. These actions had been included in the action plan and progress was reported to the Maternity Assurance Committee. With regard to the outstanding actions arising from the 2023 CQC report, these had been discussed at a regional review quality meeting, which determined that LLR ICB would have oversight to ensure full assurance on these actions and there was confidence that this would be delivered. The Medical Director reported in relation to the Emergency Department (ED) inspection that it also had a Section 29a Warning Notice lifted; the overall rating remained at 'requires improvement', but progress had been recognised. There was one 'must do' action and seven 'should do' actions arising from the inspection and assurance was provided that these had been included in the Emergency Department Improvement Plan and would be monitored through the Emergency and Specialist Medicine CMG Quality and Safety Board with updates provided to the Patient Safety Committee and Quality Committee. Mr A Moore, Trust Board Chair welcomed the report noting the lifting of the warning notices and the action plans in place. He enquired whether, following the implementation of the action plans that the rating of requires improvement would be improved on in a future inspection. The Chief Nurse commented in relation to Maternity that this may be possible but there were a number of areas of improvement still to be delivered. The Medical Director felt that it was unlikely that the rating for the Emergency Department would improve due to the capacity pressures within the department, but he still expected progress to be made.	
	Resolved – that the report be noted.	
257/24/5	Update on Urgent and Emergency Care Partnership	
	The Chief Operations Officer presented a report which outlined the progress made following the external review undertaken on the LLR Integrated Care System (ICS) UEC programme governance and partnership working. There were key developments noted including the appointment of an Interim Director of Urgent and Emergency Care and recruitment of a UEC Clinical Director, as well as progress in relation to aligning resources and the development of a governance structure. Further details were provided in terms of the governance arrangement such as the vision, which would inform the structure and a proposed joint committee involving LLR ICB, LPT and UHL to oversee UEC within LLR and this would be the subject of a decision at a future Trust Board meeting. Professor I Browne, Associate Non-Executive Director enquired whether the UEC Clinical Director would be in post in time for the winter pressure period. The Chief Operating Officer commented that this would depend on recruitment / interview / notice period timescales.	

	Mr A Moore, Trust Board Chair raised queries regarding the use of statistical analysis on demographics to improve UEC services, and the capacity to develop this. The Chief Operating Officer confirmed that there was access to data and work in this area was improving, but there were limited numbers of analysts. He also confirmed that the new System Director of UEC had been requested to lead on business intelligence. The Chief Executive commented in relation to the use of data, querying whether it was used to inform how services were resourced and prioritised. Professor I Browne, Associate Non-Executive Director supported the use of data to inform actions in order to address root causes of problems and support prevention with possible actions within communities. The Director of Health Equality and Inclusion commented that the data existed to use as suggested and would be the subject of a report to a future private Trust Board meeting. Professor A Garcea, Associate Non-Executive Director further commented on the necessity to ensure the data collected was useful and relevant and delivered quality improvement. The Director of Communications and Engagement noted that there were examples of where independent market research had been sought regarding why people attended walk in care services which then informed information campaigns about accessing services. In summary, Mr A Moore, Trust Board Chair requested that consideration be given to resource allocation for data analysis and its appropriate use in developing actions or policy decisions.	**COO**
	<u>Resolved</u> – that consideration be given to resource allocation ~~given~~ for data analysis, and its appropriate use in developing actions or policy decisions.	**COO**
257/24/6	<u>Escalation Reports</u>	
	<u>Operations and Performance Committee</u> Mr J Worrall, Operations and Performance Committee Non-Executive Director Chair presented the escalation report from the Operations and Performance Committee held on 31 July 2024. Improvements in cancer performance were noted with reductions in long waits, however limitations in radiotherapy capacity were holding back further improvements. Discussion at the meeting also considered ongoing work to standardise outpatient clinics which would deliver increased capacity. There was also consideration of the current situation within UEC which was pressured and challenging, but it was urged that plans be made to improve services for the future and be ambitious in achieving this and to celebrate achievements. Mr A Moore, Trust Board Chair agreed with the need to ensure there was a balanced narrative and to celebrate success. The Chief Executive agreed that success needed to be celebrated but this should be balanced with the pressures being faced by staff who work in challenging area and there was a need to be realistic. <u>Quality Committee</u> Professor I Browne, Quality Committee Non-Executive Director member presented the escalation report from the Quality Committee held on 25 July 2024. The Committee considered a report on improving uptake levels of staff vaccination and further discussion planned on this at the People and Culture Committee. As part of the discussion on the Quality and Safety dashboard report the ongoing issue of aggression towards staff was noted and would remain a consideration for the Committee. Data was also discussed regarding the levels of readmission into the Emergency Department which developed a further action to consider the data at community level to determine impacts on different population sectors. Mr A Moore, Trust Board Chair enquired about the issue of violence against staff. The Chief Nurse reported that aggression was more of an issue than violence, but confirmed that staff were becoming more proactive in raising issues with the police and reporting internally was encouraged. There were also actions being undertaken such as engaging Eric Baskind, a leading expert on violence against staff, and there was a violence reduction group which reported into the Health and Safety Committee. The ongoing support of the Trust Board was also required when taking decisions such as recently happened in response to a persistent case. The Chief Executive sought assurance that staff felt that the response was appropriate when they reported issues. The Chief Nurse commented that where an incident was known about, she was confident that a consistent response was provided. Managers were given autonomy in their areas to provide support to staff and only the more serious cases were raised with senior managers and Security Management. Mr A Moore,	

	Trust Board Chair noted that one of the key responsibilities of the Trust Board was ensuring that staff were protected and that if the issue was a growing one, the Trust Board should be fully aware. He therefore requested that the Trust Board receive an update report on this matter. <u>Finance and Investment Committee</u> Mr J Worrall, Finance and Investment Committee (FIC) Non-Executive Director Chair (for the meeting) presented the escalation report from the Finance and Investment Committee held on 26 July 2024. Two areas of discussion were highlighted including the monthly workforce position, where the low level of use of agency staff was recognised. The other area highlighted was the discussion on the on the Cost Improvement Programme where despite some optimism about the programme being delivered, there was a lack of clarity about ~~many~~ elements of the programme, particularly around the number of schemes involved. <u>Our Future Hospitals and Transformation Committee</u> Mr D Moon, Our Future Hospitals and Transformation Non-Executive Director member presented the escalation report from the Our Future Hospitals and Transformation Committee held on 24 July 2024. It was noted that a positive update on the implementation of Electronic Patient Record and Patient Administration System and prioritisations within those schemes had been received. Also discussed was the need for data analysis and business intelligence capacity going forward, which reinforced the points made earlier in this Trust Board meeting. It was also reported that the gateway review meeting had taken place in June 2024 and confirmed that the go live date for the Patient Administration System would now be Spring 2025 – the Trust Board noted this new implementation date. Mr A Moore, Trust Board Chair noted his agreement with the points made regarding data analyst capacity.	**CN**
	<u>Resolved</u> – that (A) the Board Committee escalation reports be noted and any recommendations be endorsed; **(B) an update be provided to Trust Board on staff safety to consider whether further actions to protect staff were required.**	**ALL** **CN**
258/24	**GREAT PLACE TO WORK**	
258/24/1	<u>Escalation Report from People and Culture Committee – 25 July 2024</u>	
	Professor I Browne, People and Culture Committee Non-Executive Director Chair presented the escalation report from the People and Culture Committee held on 25 July 2025. A key issue highlighted was the delay in providing rotas for junior doctors. Also noted was a detailed discussion on the Freedom to Speak Up service where staff could report any concerns they might have about their work and details of the processes and outcomes were provided. The plan for the annual staff survey was also considered where the intention to build on the achievements of the 2023 survey were noted. The discussion on the monthly workforce report covered areas such as staff safety and monitoring workforce costs. It was noted that the Committee had now moved to be a monthly meeting with the intention of undertaking 'deep dives' into particular work areas. In discussion, matters regarding the Freedom to Speak Up processes and assurance on the investigations and level of feedback were highlighted. Professor I Browne, Associate Non-Executive Director confirmed that the Committee would be exploring the Freedom to Speak Up processes in more detail at future meetings. The Chief Executive further commented that it would be useful to have examples of where improvements had been made as a result of Freedom to Speak Up as well as hearing about where things may have not gone so well, he also felt that it would be useful to learn from other NHS organisations who may be high performing in this area.	**DCLA**
	<u>Resolved</u> – that the People and Culture Committee consider a report to seek assurance of the impact of the Freedom to Speak Up processes.	**DCLA**
258/24/2	<u>Agency Compliance, Usage and Reduction</u>	
	The Chief People Officer presented an update on use of agency staff within UHL and compliance with the NHSE Agency Rules. It was noted that the Trust was comparatively a low user of agency	

	staff and sought to avoid reliance on temporary external staffing. The Trust was compliant with most areas as required by the Agency Rules, but areas where it was not were being monitored and actioned, such as seeking a regional approach with regard to procuring staff below the price caps as set out in the rules. Mr A Moore, Trust Board Chair welcomed the assurance that the Trust had good control over its use of agency staff, but noted a particular issue with regard to the employment of 16 agency security officers, and queried if this matter was being dealt with. The Chief People Officer confirmed that this matter was being addressed.	
	Resolved – that the position be noted.	
258/24/3	Staff Survey – Progress Against Priorities	
	The Chief People Officer presented a report which outlined the progress made against priority areas from the 2023 staff survey and the readiness and plan for the launch of the 2024 staff survey in September 2024. The staff survey provided an opportunity for all UHL colleagues to provide views and feedback which determined where resources were allocated and key areas of management focus. Actions arising from the 2023 survey going forward would include a focus on leadership support and inclusion actions. It was noted that plans were in place to launch the 2024 staff survey with actions to raise awareness starting in September 2024, including at Clinical Management Group level. The intention was for improved response rates and scores for the 2024 staff survey. Mr A Moore, Trust Board Chair noted that a response rate of 58% was considered low in different sectors and suggested that ways of improving this be considered, such as developing a competitive approach between departments. The Chief People Officer confirmed that this was being looked into and competitive approach was used to improve response rates. Mr M Farmer, Associate Non-Executive Director raised queries regarding priorities arising from the 2023 survey, specifically around providing challenging work, and also about whether the survey covered disability and access to work, feeling that access to work did not meet the aims of supporting people to work effectively. The Chief People Officer in response stated that there could be a range of reasons why staff felt that they were not provided with challenging work such as a lack of career development. It was confirmed that Nursing teams in particular had undertaken work to consider the development career pathways. With regard to disability and access to work, it was confirmed that the survey did cover the disability standard and the equality standard, but there was the option to include additional questions and there was the opportunity for staff to provide narrative responses. It was further noted that staff were encouraged to report issues regarding disability and barriers to work, but this did not always happen. Further, there were a number of different schemes which sought to provide people with access to employment, such as the Princes Trust, and other employability programmes with placements as part of the scheme. The Chief Executive reflected upon the fact that there were 46 days until the survey started and that from a workforce perspective the most important metric to be reviewed once responses were received was about the recommendation of UHL as a place to work. He also noted that areas which did not improve in the 2023 survey related to question subjects around discrimination and bullying, which he acknowledged was an issue and the Trust was not where it wanted to be in terms of workplace culture on these issues.	
	Resolved – that the report be noted.	
258/24/4	Junior Doctors' Guardian of Safe Working – Update	
	Dr R Singh, Junior Doctors' Guardian of Safe Working presented the report which, in line with the 2016 Junior Doctors' Contract, met the requirement for the Guardian of Safe Working to provide a quarterly report on exception reporting to the Trust Board. Dr Singh informed the Trust Board that there had been a significant increase in exception reports over the past reporting period, 200, which was an increase of 61 compared to the previous quarter. 2 notable areas of reporting were first year doctors in surgery and respiratory. The reasons were noted as primarily hours and working pattern which mostly arose from increases in workload. Despite these increases, there were no specific concerns at the current time as there were various,	

	complex different reasons for the increases, but ongoing reporting was being encouraged. A Guardian of Safe Working drop in session was to be planed for Autumn 2024 to pick up on any particular concerns. In terms of the safety concerns raised, there were no particular concerns with those reported and it was thought that there may be some mis-reporting arising from a view from those reporting that they needed safety issues in order for them to be addressed, which was not the case, but this would be looked into further. A further key issue noted was the delay in providing rotas to new starter doctors, which arose from a national software issue, along with 45 extra staff provided to UHL, and the Safe Working Guardians had been involved in resolving matters arising from these issues, and it was anticipated that further issues would arise. A specific issue was highlighted in relation the Renal middle grade rota where changes had been made and there were not sufficient doctors available to provide cover, with discussions ongoing to resolve the matter. There had been positive feedback regarding the Safe Working Guardians from the Trust Junior Doctors Forum, as well as good engagement with British Medical Association representatives, and it was hoped that the new intake of doctors would become engaged with the Safe Working Guardians. Mr A Moore, Trust Board Chair referenced the increase in exception reporting and a recent General Medical Council report which referred to increased incidences of burnout and queried whether this was an issue of concern. Dr R Singh commented that there had been more of a focus on burnout in recent years and there was support and signposting in place with good resources to address any issues. This issue was also being considered at a national level along with local solutions. Mr D Moon, Non-Executive Director enquired about whether there were any particular matters of concern from the two highest areas of exception reporting, general surgery and respiratory. Dr Singh commented that in respiratory, the issue was generally workload and in general surgery the concerns related to culture issues which it was felt would be assisted by the August staffing change over. The Medical Director also acknowledged that there were some workplace culture issues in general surgery, but there had been a positive response to these by the Clinical Management Group. With regard to respiratory, staffing levels were noted as an issue, but this was being reviewed as part of a wider piece of work. The Chief People Officer commented in relation to the 45 additional staff which UHL received and noted that this had a subsequent impact on arranging work rotas, and subsequently it meant a range of personal impacts on those doctors affected. She felt that this issue was largely as a result of receiving late information from NHSE and should be seen as such. In summary, Mr A Moore, Trust Board Chair noted the increase in exception reporting, but that this was not viewed as a particular concern at the current time. There were some concerns noted about burnout which would be address in future reports.	
	<u>Resolved</u> – that the report be noted.	
259/24	**PARTNERSHIPS FOR IMPACT – no items**	
260/24	**RESEARCH AND EDUCATION EXCELLENCE**	
260/24/1	<u>Research and Innovation Quarterly Trust Board Report</u>	
	The Director of Research and Innovation presented the UHL Research and Innovation quarterly report which covered activities, performance and delivery of the past few months. The key performance metric for research was regarding the number of patients recruited into research studies and trials which was performing well with 4500 newly recruited patients. Commercial trials were another key area of importance as these generated revenue for investment and it was anticipated that 16 trials would be undertaken in the current year. Details in the report showed that research projects covered a range of different areas along with those high recruiting studies. Also highlighted were events which had taken place including the annual Clinical Research Network Conference which attracted over 550 delegated and received positive feedback at a national level. There had also been a joint UHL / University of Leicester visit which visit to Nantong, China where Clinical Research Network staff attended and participated in the opening of a hospital. <u>Presentation – Kidney Research</u> Professor J Burton Consultant Nephrologist gave the Trust Board a presentation which outlined kidney disease as an issue and his work in kidney research. Details were provided of the	

	awareness, prevalence and impact of kidney disease, noting that 50% of the population were unaware of the kidneys' role in urine production and the expectation that kidney disease was expected to be the 5th leading worldwide cause of mortality by 2040. Growth of the disease in the United Kingdom was also expected from 30,000 who currently receive daily treatment to 140,000 in 10 years' time, along with one in 10 people living with the disease, but it did not receive as much attention as other conditions, receiving a low level of funding, despite having a major impact, there had been no notable improvement in outcomes over the past 15 years. Details were also provided of the studies which were undertaken. This included a particular study on dialysis and how it fitted into people's daily lives and communicating with them about how it made people feel. A further innovation was noted in the provision of overnight dialysis which had enabled patients to free up more time in their life away from treatment. Some frustration was noted with the length of time that it took to get new treatments into clinical practice, which was 17 years and research was being done to speed this process up. Other areas of development included better integration with other care providers, such as primary care to improve outcomes and costs. Mr A Moore, Trust Board Chair, thanks Professor Burton for his presentation and the work that he was undertaking. The Deputy Chief Executive, noting the length of time to get new treatments into practice enquired what progress it was hoped to make in reducing this time period. Professor Burton referred to some of the challenges, one of which was around developing guidelines for new treatments, but this was only on part of the process. He also referred to the results of a trial which showed that the introduction of iron injections into dialysis processes created better outcomes but despite this, only 10% of dialysis units implemented the change. He did feel that Leicester had shown good progress in delivering new treatments. The Chief Operating Officer asked Professor Burton about how the Trust could best help in developing kidney research. Professor Burton noted that more money would always be welcome, but recognised that this was not always realistic. Otherwise, it was about creating an organisation where research could thrive and was discussed and taken on board. The Chief Executive noted that UHL had involvement in a considerable breadth of international research. The Director of Research and Innovation noted that an audit of all the research links was being undertaken. Mr A Moore, Trust Board Chair agreed to meet with the Director of Research and Innovation to discuss research that the Trust was involved in.	**Trust Board Chair / DoR&I**
	<u>Resolved</u> – that the Trust Board Chair and the Director of Research and Innovation meet to consider research within the Trust.	**Trust Board Chair / DoR&I**
261/24	**CORPORATE GOVERNANCE/REGULATORY COMPLIANCE – no items**	
262/24	**CORPORATE TRUSTEE BUSINESS – no items**	
263/24	**BOARD SERVICE VIDEO**	
	The Chief Nurse introduced a service video about the Deteriorating Adult Response Team (DART). The team had a role to provide additional support in difficult situations covering all 3 major hospitals and they could receive information about a patient's condition and provide assurance to patients and their relatives, supporting them at their most difficult moments. Mr M Farmer, Associate Non-Executive Director enquired about the introduction of Martha's rule noting it would relate to the work of the Team, and that it was a positive thing for relatives to be able to raise concerns using a structured approach. The Chief Nurse noted that Martha's rule was still being planned for paediatric care, but more generally there was an expectation that ward leaders would have an oversight on ensuring that families were kept updated on their relative's condition, and this was part of the development of the fundamentals of care initiative where communication was a key element. There was close working with UHN on the development of Martha's rule as they were an accelerated site for its implementation. The Medical Director also commented that it was the intention set up a team similar to the DART in the Children's Hospital later in the year.	
	<u>Resolved</u> – that the contents of the video be noted.	

264/24	**ANY OTHER BUSINESS**	
	The Chief Executive reported that Mr W Monaghan would be joining the Trust Board as UHL / UHN Group Chief Digital Information Officer. He also noted that it was likely to be last Trust Board meeting for the Interim Chief Financial Officer, Mr M Brearley and he was thanked for this contribution to the Trust.	
265/24	**QUESTIONS FROM THE PRESS AND PUBLIC**	
	There were no questions from the press or public.	
266/24	**REPORTS AND MINUTES PUBLISHED AND UHL'S EXTERNAL WEBSITE (NOT INCLUDED IN THE BOARD PACKS):**	
266/24/1	**Resolved – that it be noted that the following Minutes of meetings had been published on UHL's website alongside the Trust Board papers:-** • Quality Committee – Minutes of 27 June 2024 • Operations and Performance Committee – Minutes of 26 June 2024 • Finance and Investment Committee – Minutes of 28 June 2024 • Our Future Hospitals and Transformation Committee – Minutes of 10 June 2024	
267/24	**REPORTS DEFERRED TO A FUTURE MEETING**	
	Resolved – None.	
268/24	**DATE AND TIME OF NEXT MEETING**	
	Resolved – that (A) the next Public Trust Board meeting be held on Thursday 12 September 2024 from 1.30pm in the Clinical Education Centre, Glenfield Hospital; and **(B) it be noted that the Trust's Annual Public Meeting would be held on Tuesday 24 September 2024 from 5.30pm at Devonshire Place, Leicester.**	

The meeting closed at 17.07pm **Matthew Reeves – Committee and Corporate Services Officer**

Cumulative Record of Attendance (2024/25 to date):

Name	Possible	Actual	% attendance	Name	Possible	Actual	% attendance
A Moore	6	5	83	J MacDonald (until 30.6.24)	4	2	50
V Bailey	6	5	83	J Melbourne	6	5	83
M Brearley (from 24.6.24)	3	3	100	D Moon	6	6	100
A Furlong	6	5	83	R Mitchell	6	5	83
A Haynes	6	3	50	B Patel (until 30.7.24)	5	5	100
J Hogg	6	5	83	T Robinson	6	1	17
L Hooper (until 30.6.24)	4	2	50	J Worrall (until 31.8.24)	6	6	100

Non-Voting Members:

Name	Possible	Actual	% attendance	Name	Possible	Actual	% attendance
R Abeyratne	6	5	83	M Farmer	6	5	83
S Barton	6	6	100	S Harris	6	2	33
I Browne	6	6	100	H Kotecha	6	0	0
A Carruthers	6	6	100	M Smith	6	6	100
B Cassidy	6	6	100	C Teeney	6	5	83
A Garcea	6	5	83				