University Hospitals of Leicester NHS
NHS Trust

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT BY TRUST BOARD COMMITTEE TO TRUST BOARD

DATE OF TRUST BOARD MEETING: 30 May 2013

COMMITTEE: Finance and Performance Committee

CHAIRMAN: Mr I Reid, Non-Executive Director

DATE OF COMMITTEE MEETING: 24 April 2013

RECOMMENDATIONS MADE BY THE COMMITTEE FOR CONSIDERATION BY THE TRUST BOARD:

None

OTHER KEY ISSUES IDENTIFIED BY THE COMMITTEE FOR CONSIDERATION/ RESOLUTION BY THE TRUST BOARD:

None

DATE OF NEXT COMMITTEE MEETING: 29 May 2013

Mr I Reid
23 May 2013

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF A MEETING OF THE FINANCE AND PERFORMANCE COMMITTEE, HELD ON WEDNESDAY 24 APRIL 2013 AT 9.15AM IN SEMINAR ROOMS A & B, CLINICAL EDUCATION CENTRE, LEICESTER GENERAL HOSPITAL

Present:
Mr I Reid – Non-Executive Director (Committee Chair)
Mr J Adler – Chief Executive
Mr R Kilner – Non-Executive Director
Mr A Seddon – Director of Finance and Business Services (from Minute 38/13/1b)
Mr G Smith – Patient Adviser (non-voting member)

In Attendance:
Ms K Bradley – Director of Human Resources (for Minutes 40/13/2 (part), 40/13/3, 40/13/6 and 41/13)
Ms K Jenkins – Non-Executive Director
Mrs K Rayns – Trust Administrator
Mr S Sheppard – Deputy Director of Finance
Mr J Tozer – Interim Director of Operations

ACTION

RESOLVED ITEMS

36/13 APOLOGIES AND WELCOME

The Committee Chairman welcomed Ms K Jenkins, Non-Executive Director to the meeting. Apologies for absence were received from Ms J Wilson, Non-Executive Director.

37/13 MINUTES

Resolved – that the Minutes of the Finance and Performance Committee held on 27 March 2013 (papers A and A1) be confirmed as a correct record.

38/13 MATTERS ARISING

38/13/1 Matters Arising Report

The following items were noted in respect of the matters arising report provided at paper B:-

(a) Minute 28/13/2 (bullet point 1) – the Committee Chairman confirmed that the Trust Chairman had noted the Committee's request to expand the Non-Executive Director membership of the Committee but advised that further consideration would be given to this matter once the current recruitment process for the vacant Non-Executive Director post was concluded; **FPC Chair**
(b) Minute 28/13/2 (bullet point 2) – further discussions were planned with the Chairs of the Finance and Performance and Audit Committee Chairs to clarify the respective roles of these Committees in reviewing Monitor's guidance on the Risk Assessment Framework. The consultation period for this Framework had closed on 4 April 2013, but it was not known when the final version was due to be published. The Chief Executive requested the Trust Administrator to re-circulate the April 2013 Trust Board bulletin paper which provided a useful briefing on Monitor and TDA Guidance; **TA**
(c) Minute 28/13/5 – the Interim Director of Operations confirmed that a Lead Nurse had now been appointed within the Emergency Care CBU;
(d) Minute 29/13/2 (bullet point 1) – outputs from the Divisional Confirm and Challenge sessions held in early and mid April 2013 would be covered later in the meeting agenda;
(e) Minute 29/13/2 (bullet point 2) – the Deputy Director of Finance briefed the Committee on the additional training sessions for CBU and Divisional teams with a view to improving forecasting accuracy throughout the Trust. A new process was also being implemented for monitoring the accuracy of forecasts going forward and identifying any areas that might require additional focus. The outputs from this workstream would be

presented to the June 2013 Finance and Performance Committee. Ms K Jenkins, Non-Executive Director requested that an overview of the forecasting process also be provided to the June 2013 meeting. The Deputy Director of Finance noted that the rolling three month forecasts had not been circulated with the month 12 financial data and he agreed to circulate these to members outside the meeting; **DDF**

(f) Minute 30/13/4 – the Chief Executive confirmed that he would be discussing any opportunities to introduce arrangements for UHL Shadow Governor with the Director of Communications and External Relations at a meeting scheduled for that afternoon. An update on this issue would be presented to the Trust Board in due course as appropriate. **CE**

Resolved – that the matters arising report and any associated actions above, be noted.

39/13 2012-13

39/13/1 Month 12 Quality and Performance Report

Paper C provided an overview of UHL's quality, patient experience, operational targets, HR and financial performance against national, regional and local indicators for the month ending 28 March 2013. A separate review of UHL's financial performance for 2012-13 was being presented later in the agenda (paper D refers) and it was agreed that any financial issues would be considered under Minute 39/13/2 below. The Interim Director of Operations particularly highlighted the following aspects of UHL's operational performance for the financial year ended 31 March 2013:-

(1) corrections to some of the 2012-13 Operating Framework Indicators currently RAG-rated as amber which should be rated as red – these included 62 day cancer waits and admitted RTT performance for ENT and Stroke services;
(2) ED 4 hour performance continued to cause concerns despite the implementation of phase 1 of the Right Place Consulting work streams to remodel the Emergency Care Pathway (ECP). Phase 2 of the ECP work would focus on ward and bed management processes and it was hoped that this would help to improve ED flows, surgical bed capacity and separation of day case activity. The impact of phase 2 work was expected to be evidenced by the end of May 2013;
(3) a deterioration in RTT performance was expected in April 2013 following a decision to address some of the backlog cases, but assurance was provided that trajectories had been agreed for all specialities to deliver their admitted RTT performance, and
(4) 62 day cancer performance for the year stood at 83.7% (against a target of 85%). Changes recently implemented in the 2 week cancer pathway had been effective and the 2 week cancer wait targets had been met for all tumour sites. Similar methods were being used to address 62 day cancer performance with a focus on the diagnostics stages of the pathway. It was expected that performance targets would be achieved for June 2013.

Mr R Kilner, Non-Executive Director raised the following comments and queries relating to operational performance:-

(i) a query regarding the timescale for the Trust to establish the optimum number of beds to meet existing demand. In response, the Chief Executive reported on the challenges surrounding the suitability of some sub-acute bed locations for particular cohorts of patients and provided assurance that all bed capacity that could be kept open with safe staffing levels was being maintained and arrangements to return ward 19 to the Planned Care Division had been postponed. The Interim Director of Operations suggested that to manage the current activity levels, the Trust required an additional 24 acute beds within an appropriate ward location;
(ii) a query regarding the impact of minors breaches upon the Trust's overall ED performance and the response provided that the net contribution was less than 1%;
(iii) a request for clarity surrounding potential reasons for ED process breaches. The

Interim Director of Operations advised that any breaches where the ED processes had not gone according to plan were classified as ED process breaches and one of the common causes for this was lack of cubicle availability due to high activity levels. He also noted that compliance with the targets for 2 of the ED quality indicators had been maintained throughout February and March 2013 – median time to treatment and percentage of patients leaving the department without being seen, and

(iv) comments arising from a discussion held at the Acute Care Divisional Board meeting regarding significant concerns raised by the ED leadership team regarding the quality and safety of UHL's emergency care service provision. The Chief Executive confirmed that the issues raised by the ED leadership team had been considered in depth at meetings of the Quality Assurance Committee and the informal Executive Team. Further discussion on this important issue was due to be held at the next day's meeting of the Trust Board. In order to provide a more balanced approach, the Chief Nurse/Deputy Chief Executive was in the process of preparing a summary of the actions already underway to address some of the concerns raised, and both sets of documentation would be shared with Trust Board members for information.

The Interim Director of Operations tabled copies of the action plan agreed at the 18 April 2013 meeting of the Emergency Care Access Team (ECAT). Whilst the timescales were not indicated on the action plan, he confirmed that all actions had been agreed for immediate implementation. Members noted the discussions held with partner health agencies at a recent whole system health care summit relating to delayed transfers of care and re-assignment of community beds. In addition, the ECAT action plan supported the establishment of a separate Frail Elderly Unit (in place of the previous arrangements for additional Geriatrician presence on the admission units). This decision had been taken following a significant increase in the number of patients being admitted who were aged 85 and over (as evidenced by consistent midnight bed state data). The Chief Executive also advised that he had been informally requested to consider revising UHL's trajectory for achieving ED 4 hour performance (as submitted to the Trust Development Authority) but he had so far declined this opportunity.

Ms K Jenkins, Non-Executive Director referred to the quality and performance heat map report circulated with paper C, drawing members attention to the following items:-

- page 21 – a reported in-month increase in staff sickness levels in the ED (from 4.8% in February 2013 to 6.2% in March 2013) and a query regarding the contributory factors for this. In discussion, it was considered that the increase in staff sickness was a direct result of the pressures that staff were working under rather than an unwelcome shift in staff culture. Members discussed the possibility that staff might become accustomed to not meeting performance targets and that this might affect their behaviour once activity levels returned to normal, however the rapid assessment model had now been widely accepted as best practice. The Chief Executive reported on the arrangements for implementation of Listening into Action (LiA), advising that Ms L Milnes, Modern ED Matron had been seconded as one of the clinical LiA Co-ordinators and it was hoped that the ED would be one of the first cohort of early implementers, and
- page 29 – the percentage of patients waiting over 3 weeks for CT scans and MRI scans (27.2% and 39.2% respectively against a target of 5%) and a query regarding the extent that ED activity was considered to be driving demand. In discussion on this item members noted the combination of pressures on imaging services which included improvements in the diagnostic phases of the 2 week and 62 day cancer pathways. A capacity and demand review of imaging services was currently underway and a business case to meet forthcoming cost pressures was being developed. Members also noted the recent transfer of imaging services from the Clinical Support Division into the Acute Care Division and considered the scope for transforming imaging services and improving equipment utilisation following the Deloitte and Finnamore review carried out in 2012. The Director of Finance and Business Services was requested to report back to the Finance and Performance Committee in May 2013 on the plans to support the CBU Manager with additional resources to drive transformation of services and investment **DFBS**

proposals in this highly complex area. Mr R Kilner, Non-Executive Director also requested that consideration be given to an options appraisal for an outsourced model for the provision of UHL's imaging services.

The Committee Chairman sought and received clarity regarding the following additional issues:-

(a) penalties for RTT non-compliance in April 2013 were expected to be in the region of £100,000 and the theoretical maximum impact of choose and book non-compliance was estimated at £700,000 for the full year. The Director of Finance and Business Services was requested to ensure that appropriate visibility of such penalties was provided within the regular reporting process for financial forecasts; **DFBS**

(b) the arrangements for UHL's partner agencies to determine the optimum number of community beds, noting in response that these outputs would be incorporated into UHL's winter capacity planning work and that outline proposals for winter capacity would be available for consideration by the Committee at the end of June 2013, and

(c) the number of incidents reported under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) for March was unusually high (14 compared to 4 in February 2013). The Committee noted that a proportion of these reports related to potential TB exposure at the Harborough Lodge Renal Unit, where the HSE had issued an Improvement Notice. The Chief Executive advised members that the Trust's action plan to respond to the Improvement Notice had been submitted and the HSE would not be taking any further enforcement action in this respect.

Resolved – that (A) the month 12 Quality and Performance report be received and noted;

(B) proposals for supporting the Imaging CBU with developing proposals for transformation of services and investment proposals be presented to the May 2013 meeting, and **DFBS**

(C) additional visibility of performance penalties be provided within the regular financial forecasting reports. **DFBS**

39/13/2 Report by the Director of Finance and Business Services

Resolved – that this item be classed as confidential and taken in private accordingly.

39/13/3 2012-13 Cost Improvement Programme Delivery

Paper E detailed performance against the 2012-13 CIP target of £32m, confirming that £26.8m (83.8%) of the target had been delivered at the year end, leaving an outstanding shortfall of £5.2m. Ms K Jenkins, Non-Executive Director queried whether there was any scope to produce a more detailed analysis of underperformance to increase the opportunities for organisational learning. Members agreed that the main contributory factors for non-delivery of CIP schemes in 2012-13 (such as the central allocations for cross-cutting transformation work streams) were appropriately addressed within the governance arrangements and reporting controls under the new Improvement and Innovation Framework.

Resolved – that the 2012-13 CIP update (paper E) be received and noted.

40/13 2013-14

40/13/1 Annual Operational Plan 2013-14

Paper F provided an update on the key issues and risks identified in the Executive Summary of the Annual Operational Plan for 2013-14 as presented to the Trust Development Authority on 5 April 2013. The Director of Finance and Business Services noted that he had reported

on the salient issues earlier in the meeting (Minute 39/13/2 above refers) and the Trust Board had debated the AOP submission in some depth at the Extraordinary Trust Board meeting held in private on 5 April 2013.

Resolved – that the updated briefing note on the Annual Operational Plan for 2013-14 be received and noted.

40/13/2 Implementation of the Improvement and Innovation Framework (IIF) and Service Line Management (SLM) Development Programme

The Chief Executive introduced paper G, which apprised members of progress in respect of the implementation of the IIF (following consideration by the Executive Team on 16 April 2013) and introduced the concept of a SLM development programme to complement the framework. The report had been circulated electronically on 23 April 2013 and printed copies were made available at the meeting. In discussion on the proposals, the Finance and Performance Committee particularly noted:-

(a) that clarification regarding the future roles for Ms D Mitchell, Head of Transformation and Ms S Khalid, Head of Service Improvement within the framework would be provided in the next update to the Committee; **CE**
(b) that opportunities were being explored with IBM relating to shared use of their Programme Management Office (PMO) function tools;
(c) that the Improvement Support Office (ISO) would require very few dedicated staff as responsibility for delivery of individual projects and programmes within the IIF would be allocated to the most appropriate senior clinical leader or manager chosen for that role and the Project Management Tracking Tool (PMTT) mechanism would be used consistently for monitoring progress against each scheme;
(d) the discussion surrounding UHL's previous arrangements for transformation governance and examples of best practice suggested by Ms K Jenkins, Non-Executive Director relating to Barclays Bank, where the project leaders had been the key to success (and not the mechanisms used);
(e) whilst the development and population of the IIF continued, members agreed to pursue an offer received from the Boston Consulting Group to undertake a free-of-charge transformation diagnostic review;
(f) the arrangements for implementation of SLM at UHL to strengthen the dimensions of (1) organisational structure, (2) strategy and service line planning, (3) performance and management, and (4) information management;
(g) a request by Mr R Kilner, Non-Executive Director, for additional clarity on the outputs/deliverables arising from the IIF and the arrangements for engaging clinical and non-clinical staff in the implementation of SLM. In response, the Director of Finance and Business Services noted the involvement of Dr S Agrawal, Assistant Medical Director in supporting clinical engagement advising that a report on this issue would be presented to the Executive Team within the next few weeks; **CE**
(h) a suggestion from Ms K Jenkins, Non-Executive Director that it would be helpful to map the IIF goals (provided in appendix 1) across to the Annual Operational Plan in the near future;
(i) a comment raised by the Patient Adviser that the Trust might like to consider including a patient voice within the governance arrangements for IIF. In response, the Chief Executive suggested that this might be better taken forward through the Listening into Action workstream as LiA was as much about listening to patients as it was about listening to staff. It was agreed that gathering patients' views was a crucial activity to inform any service re-design work;
(j) the next steps (as set out in section 7 of paper G) and the Chief Executive's assurance that none of the existing transformational activity would be brought to a halt during this implementation phase.

Finally, it was agreed that monthly progress reports on the implementation of IIF would be provided to the Finance and Performance Committee and the next iteration would include an organogram of the governance structure. A final report on the implementation **CE**

arrangements would then be presented to the Trust Board in June 2013 for formal sign-off. **CE**

<u>Resolved</u> – that (A) monthly progress reports on the implementation of the Improvement and Innovation Framework be provided to the Finance and Performance Committee, and **CE**

(B) an organisational structure chart be incorporated into the May 2013 report together with clarity surrounding the roles of Head of Transformation and Head of Service Improvement. **CE**

40/13/3 <u>Delivery of 2013-14 Cost Improvement Programme Schemes (Risks)</u>

The Director of Finance and Business Services introduced paper H providing an update on delivery of the 2013-14 cost improvement programme, delivery risks, and the arrangements to guard against any negative impacts on patient quality and safety. He briefed the Committee in respect of the work in progress to migrate schemes currently RAG rated as red and amber to green, according to their deliverability risks. Where appropriate, the value of individual schemes would be differentiated between red and green where any schemes were progressing well with slight concerns over delivery of the total savings. Discussion took place regarding the 4 schemes currently rated as red with the highest value:-

(1) medical productivity (section 3.1 of paper H) – some of the potential savings identified were beginning to look over-ambitious, but assurance was provided that supplementary schemes were being developed to mitigate against any non-delivery. The Director of Human Resources noted the intrinsic links between this scheme and the arrangements to reduce waiting list initiatives within the Trust. Assurance was being evidenced through the fortnightly confirm and challenge meetings with Divisional teams and an additional workstream was in place to review the Trust's top 10 highest earning Consultants. In response to queries raised by Mr R Kilner, Non-Executive Director, it was noted that the Medical Director was the accountable Executive Director lead for this scheme (with additional support being provided by the Director of Human Resources) and visibility of the scheme would be monitored through the Improvement and Innovation Framework;
(2) bed savings schemes (section 3.2) – emergency activity was currently restricting progress with some elements of these schemes and the Committee recognised the need for strong project management where appropriate. The Chief Executive advocated a cautious approach to these schemes, avoiding putting excessive pressure on CBUs to close beds when beds were still required to support additional activity. In view of the scope for transformational funding to support increased activity levels, he suggested that progress of these schemes might become an exception to the rule surrounding robust delivery of identified CIP savings;
(3) clinical nurse specialist review (section 3.3) – this scheme linked to the acuity review of nurse staffing ratios arising from the Francis Inquiry and developments surrounding the staffing models for acute care beds, and
(4) critical care beds – discussion took place regarding the flexible staffing models between levels 1 and 2 and levels 2 and 3 where it was noted that the staffing levels did not always align with the acuity of patients in the unit. The Director of Finance and Business Services reported on a forthcoming specialised commissioning review of UHL's critical care capacity and future modelling. Mr R Kilner, Non-Executive Director queried whether the ECMO capacity was ring fenced and noted in response that whilst ECMO units were separated as "special units", there was some flexibility at Glenfield Hospital for staff to move across the corridor between ECMO and ITU.

Ms K Jenkins, Non-Executive Director referred to the Divisional breakdown of CIP schemes appended to paper H noting that the Acute and Planned Divisions were forecasting to achieve CIP savings over and above their allocated targets to provide a contingency. She queried the arrangements in place to increase the forecast savings for the Women's and Children's Division. In response, the Director of Finance and Business Services were

developing further CIP schemes since the position had been re-based following their achievement of CNST Level 2 and the reduced premiums associated with this success. Responding to a further query regarding milestones in the profile for migrating schemes from red to green, the Director of Finance and Business Services advised that whilst no clearly defined milestones had been set, he would not be happy with more than 5% of schemes being red and 15% being amber. He also noted the scope to accelerate IM&T relating savings to improve the position for Corporate Directorates.

It was agreed that the Finance and Performance Committee would receive monthly progress reports on the phasing of CIP savings and that visibility surrounding headcount reductions would be provided within the standard reporting format. **DFBS**

Resolved – that (A) the contents of paper H and the subsequent discussion on CIP progress be noted, and

(B) monthly progress reports on the delivery of the 2013-14 CIP be presented to the Finance and Performance Committee for assurance. **DFBS**

40/13/4 Report by the Director of Finance and Business Services

Resolved – that this item be classed as confidential and taken in private accordingly.

40/13/5 Finance and Performance Committee Draft Work Plan for 2013-14

Further to Minute 30/13/6 of 27 March 2013, paper J provided the updated draft work plan for the Finance and Performance Committee. The Chief Executive advised that discussion surrounding the requirements for Corporate Directorate presentations to the Finance and Performance Committee was due to be held at the 30 April 2013 Executive Team meeting and feedback would be provided to the May 2013 Finance and Performance Committee meeting. **CE**

Resolved – that (A) the updated Finance and Performance Committee work plan be received and noted, and

(B) the Chief Executive be requested to provide feedback from the Executive Team's consideration of Corporate Directorate presentations to the May 2013 Finance and Performance Committee meeting. **CE**

40/13/6 Report by the Director of Human Resources

Resolved – that this item be classed as confidential and taken in private accordingly.

41/13 REPORT BY THE ACTING DIRECTOR OF FACILITIES

Resolved – that this item be classed as confidential and taken in private accordingly.

42/13 MCKINSEY LLR BETTER CARE TOGETHER OUTPUTS

The expected report on the outputs from the Better Care Together economic modelling (paper M) was withdrawn. Instead the Director of Finance and Business Services advised that a verbal report on this work would be presented to the 25 April 2013 Trust Board meeting. **DFBS/ CE**

Resolved – that a verbal report on the Better Care Together economic modelling be presented to the 25 April 2013 Trust Board meeting. **DFBS/ CE**

43/13 REPORT BY THE DIRECTOR OF FINANCE AND BUSINESS SERVICES

Resolved – that this item be classed as confidential and taken in private accordingly.

44/13 MINUTES FOR INFORMATION

44/13/1 Divisional Confirm and Challenge

Resolved – that the notes of the 20 March 2013 Divisional Confirm and Challenge meeting (paper N) be received and noted.

44/13/2 Quality Assurance Committee

Resolved – that the Minutes of the 19 March 2013 QAC meeting (papers O and O1) be received and noted.

44/13/3 Quality and Performance Management Group

Resolved – that the notes of the 6 March 2013 QPMG meeting (paper P) be received and noted.

44/13/4 CIP Programme Board

Resolved – that the notes of the 25 March 2013 CIP Programme Board meeting (paper Q) be received and noted.

45/13 ITEMS FOR DISCUSSION AT THE NEXT FINANCE AND PERFORMANCE COMMITTEE

Resolved – that the items for consideration at the Finance and Performance Committee meeting on 29 May 2013 be noted.

46/13 ITEMS TO BE HIGHLIGHTED TO THE TRUST BOARD

Resolved – that the issues to be highlighted verbally to the Trust Board meeting on 25 April 2013 already featured on the Trust Board meeting agenda. **FPC CHAIR**

47/13 ANY OTHER BUSINESS

Resolved – that there were no items of any other business for discussion.

48/13 DATE OF NEXT MEETING

Resolved – that the next Finance and Performance Committee be held on Wednesday 29 May 2013 from 9.15am – 12.15pm in the C J Bond Room, Clinical Education Centre, Leicester Royal Infirmary site.

The meeting closed at 12.15pm

Kate Rayns, **Trust Administrator**

Attendance Record

Name	Possible	Actual	% attendance	Name	Possible	Actual	% attendance
I Reid (Chair)	1	1	100%	G Smith *	1	1	100%
J Adler	1	1	100%	J Tozer *	1	1	100%
R Kilner	1	1	100%	J Wilson	1	0	0%
A Seddon	1	1	100%				

* non-voting members