Trust Board Paper AA

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: 29 May 2014

COMMITTEE: Finance and Performance Committee

CHAIRMAN: Mr R Kilner, Non-Executive Director

DATE OF COMMITTEE MEETING: 23 April 2014

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

- Minute 38/14 – updated 2 Year Operational Plan;
- Minute 39/14 – 2014-15 Financial Plan and Budget Book
- Minute 40/14 – confidential report by the Interim Director of Financial Services, and
- Minute 41/14 – UHL Capacity Plan 2014-15.

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

- Minute 46/14/1 – cancelled operations performance and the impact of continued high levels of emergency demand;
- Minute 46/14/2 – consideration of the RTT improvement plan;
- Minute 46/14/3 – clinical letters backlog reduction plans, and
- Minute 47/14/2 – Cost Improvement Programme 2014-15.

DATE OF NEXT COMMITTEE MEETING: 28 May 2014

Mr R Kilner
23 May 2014

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF A MEETING OF THE FINANCE AND PERFORMANCE COMMITTEE, HELD ON WEDNESDAY 23 APRIL 2014 AT 8.30AM IN THE LARGE COMMITTEE ROOM, MAIN BUILDING, LEICESTER GENERAL HOSPITAL

Present:
Mr R Kilner – Acting Chairman (Committee Chair)
Mr J Adler – Chief Executive
Colonel (Retired) I Crowe – Non-Executive Director
Mr P Hollinshead – Interim Director of Financial Strategy
Mr R Mitchell – Chief Operating Officer
Mr G Smith – Patient Adviser (non-voting member)
Ms J Wilson – Non-Executive Director

In Attendance:
Ms L Bentley – Head of Financial Management and Planning (on behalf of the Deputy Director of Finance)
Ms S Leak – General Manager, Renal, Respiratory and Cardiac CMG (for Minute 45/14/1)
Mr N Moore – Clinical Director, Renal Respiratory and Cardiac CMG (for Minute 45/14/1)
Mrs K Rayns – Trust Administrator

ACTION

RECOMMENDED ITEMS

38/14 **UPDATED 2 YEAR OPERATIONAL PLAN 2014-16**

Further to Minute 26/14 of 26 March 2014 and in the absence of the Director of Strategy, the Interim Director of Financial Strategy introduced paper D, providing the updated overview of key aspects of the 2 year operational plan and highlighting a specific focus on finance, capacity planning and workforce. He noted the inclusion of additional narrative relating to the CQC action plan and the Quality Commitment and opportunities identified to improve the scale and pace of changes in service delivery (such as creation of a centralised outpatients function, improving ambulatory care services and increasing rates of day case surgery).

Appendix A provided the Trust's 2014-15 financial plan and budget book as developed with all CMGs and Corporate Directorates over the last 2 months and signed off formally by the Executive Team as the basis for the 2014-15 integrated performance management meetings. A deficit plan of £40.75m had been submitted to the TDA and plans to deliver financial balance within the next 3 years were due to be submitted on 20 June 2014. Members noted that the contractual discussions regarding re-investment of penalties and fines had fallen outside the arbitration process and that these separate negotiations were not yet concluded. The Interim Director of Financial Strategy drew members' attention to the key risks surrounding CIP delivery, any penalties over and above the £3.5m already provided for within the plan, and operational risks including ED and RTT performance. From an operational risk perspective, bed capacity, winter funding and financial support for the continuation of super weekend activities would all be key. The Committee Chairman clarified that the cost of the additional capacity (due to be considered later under Minute 41/14 below) was still being scoped and was not therefore included within the financial plan.

Appendix C provided an update on the development of the 2 year detailed workforce plan and the 5 year workforce plan required as part of the Integrated Business Plan (IBP) and Long Term Financial Model (LTFM) for 2014-19 which was due to be submitted to the TDA on 20 June 2014. Section 2.4 provided an update on the nursing vacancy position and the recruitment of an additional 50 international nurses due to commence with the Trust in May 2014. Section 2.5 summarised the expected reductions in non-contracted workforce expenditure as a result of successful workforce recruitment strategies.

Particular discussion took place regarding the apparent increase of 998 worked whole time equivalent posts and the breakdown of these staff groups was provided in section 4.2 – this figure was noted to include 461 contracted nursing posts (offset by reductions in agency staffing) and 218 staff transferring across to UHL with the Alliance Elective Care contract. The Interim Director of Financial Strategy provided assurance that by the time of the 20 June 2014 submission to the TDA the workforce bridge and the financial bridge would be more aligned.

Members of the Finance and Performance Committee noted the need for further validation of the CMG level workforce plans and that workforce confirm and challenge sessions had been arranged in May 2014 for this purpose. Further opportunities to reduce workforce costs were being explored through the CIP Programme Board, alongside schemes to improve productivity. In further discussion, the Chief Executive noted the need for transparency within the process for translating reductions in non-contracted and premium rate staffing costs into whole time equivalent posts. It was also noted that the workforce impact of CIP schemes rated as red or amber had not yet been factored into the plans. The Committee Chairman highlighted some potential anomalies within the budget book relating to pay trends and whole time equivalent forecasts, suggesting that the average pay costs per head were not realistic.

Members recommended that the updated 2 year operational plan be supported for Trust Board approval, subject to appropriate clarity being provided to the Committee on 28 May 2014 in respect of the workforce impact associated with CIP schemes.

<u>Recommended</u> – that (A) the updated 2 Year Operational Plan for 2014-16 be supported for Trust Board approval on 24 April 2014 (as presented in paper D), and

(B) clarity be provided to the Finance and Performance Committee on 28 May 2014 regarding the workforce impact associated with CIP schemes.

39/14 2014-15 FINANCIAL PLAN

Paper E provided the 2014-15 Financial Plan and detailed budget book which had been discussed earlier under the 2 Year Operational Plan (Minute 38/14 above refers). The Finance and Performance Committee received and noted the contents of this report and recommended the 2014-15 Financial Plan and Budget Book for Trust Board approval on 24 April 2014.

<u>Recommended</u> – that the 2014-15 Financial Plan and Budget Book (paper E refers) be supported for Trust Board approval on 24 April 2014.

40/14 REPORT BY THE INTERIM DIRECTOR OF FINANCIAL STRATEGY

<u>Recommended</u> – that this Minute be classed as confidential and taken in private accordingly, on the grounds of commercial interests and that public consideration at this stage could be prejudicial to the effective conduct of public affairs.

41/14 UHL CAPACITY PLAN 2014-15

The Chief Operating Officer introduced paper L, providing an update on the proposals for modelling the "right-sizing" of UHL capacity for 2014-15. Members noted that the proposed additional bed capacity had reduced from 88 (in February 2014) to 55 following development of work streams relating to day case rates, decreasing delayed transfers of care and surgical triage had been taken into account. The breakdown of beds included provision of a modular ward on the LRI site for use as ward decant accommodation.

Capital and revenue costs for the additional beds were set out in paper L, although the revenue consequences of the capital costs had not yet been completed. The Chief

Executive confirmed the strong support of the Executive Team and advised that the proposals were due to be presented to an extended meeting of the Clinical Senate on 25 April 2014. In order to accommodate the capital expenditure, the Trust would be reviewing the capital programme to identify any schemes which could be removed or deferred to the subsequent year. Revenue funding was being explored through the winter plan.

The Committee Chairman particularly noted that no additional income for patient activity had been assumed and members considered ways in which the financial benefits of reducing elective cancellations, improving progress with the RTT improvement plan and reducing reliance upon independent sector providers could be included. In respect of nurse staffing, the additional beds had been costed on the basis of agency nursing rates for the first 6 months and a quality impact assessment was being undertaken to assess any risks relating to nurse staffing and recruitment.

Recommended – that the proposals for additional bed capacity (as set out in paper L) be supported for Trust Board approval, subject to additional financial modelling being undertaken to account for increases in elective activity.

RESOLVED ITEMS

42/14 APOLOGIES

Apologies for absence were received from Mr S Sheppard, Deputy Director of Finance and Ms K Shields, Director of Strategy.

43/14 MINUTES

Resolved – that the Minutes of the 26 March 2014 Finance and Performance Committee meeting (papers A and A1) be confirmed as correct records.

44/14 MATTERS ARISING PROGRESS REPORT

The Committee Chairman confirmed that the matters arising report provided at paper B detailed the status of all outstanding matters arising. Members noted updated information in respect of the following items:-

(a) Minute 30/14/2 of 26 March 2014 – the Committee Chairman and the Chief Executive noted that they now received monthly reports on e-rostering. A progress report on the resolution of e-rostering functionality issues was due to be scheduled on the June 2014 Finance and Performance Committee agenda; **CN**

(b) Minute 17/14/1(a) of 26 February 2014 – the Executive Team was due to consider the issue of management capacity to support the interface between UHL and Interserve in respect of the MES II contract with Asteral early in May 2014 and the Interim Director of Financial Strategy advised that a report was being considered at a meeting of the Capital Group later that afternoon. It was agreed to remove this item from the matters arising report; **TA**

(c) Minute 17/14/3 of 26 February 2014 – the Committee Chairman requested that the timetable for seeking PPI engagement in UHL's key strategic priorities be included in future reports to the Trust Board. **CE** The Chief Executive requested the Trust Administrator to provide him with the relevant extracts from meeting notes when PPI engagement had been discussed; **TA**

(d) Minute 5/14/1 of 29 January 2014 – members noted that a joint East Midlands procurement framework was now in place for agency nurses and it was agreed to remove this item from the matters arising report and the list of forward agenda items; **TA**

(e) Minute 5/14/3 of 29 January 2014 – in the absence of the Deputy Director of Finance at this meeting, the expected progress report on the Trust's programme of financial and business awareness training was deferred to May 2014, and **DDF**

(f) Minute 28/13/3 of 27 March 2013 – updates on the actions and timescales for apportionment of funding for clinical academic posts between UHL and the University of Leicester and the landlord elements of University occupied UHL premises were provisionally scheduled on the 28 May 2014 Finance and Performance Committee agenda. **IDFS**

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

45/14 STRATEGIC MATTERS

45/14/1 Renal, Respiratory and Cardiac CMG Presentation

Prior to the presentation team being invited into the meeting room, members considered the key issues they would like to see covered during the presentation and subsequent questions. These were identified as (1) emergency flow of patients through the Glenfield Hospital Clinical Decisions Unit (CDU), (2) any issues identified by the Care Quality Commission (CQC) for further action, (3) risks surrounding the kidney transplant service and why these hadn't been escalated earlier, and (4) the quality of the renal dialysis patient environments at Harborough Lodge and the Leicester General Hospital sites and any actions planned to mitigate their impact upon patient experience.

The Clinical Director and General Manager attended the meeting from the Renal, Respiratory and Cardiac (RRC) Clinical Management Group (CMG) to present paper C providing a summary of the CMG's financial and operational performance. Introductions took place. During the presentation, Finance and Performance Committee members particularly noted:-

(a) elements of good practice highlighted by the CQC visit and the arrangements being made to roll out such practices within the whole of the CMG;
(b) good progress with the identification of £5.9m in CIP savings for 2014-15 and the focus on delivering these schemes as planned;
(c) a proposed renal services framework agreement which would enable the Trust to call-off future renal services contracts in a more agile manner, subject to Trust Board approval and appropriate mini-competition processes to ensure value for money. Assurance was provided that any concerns regarding the quality of the renal dialysis patient environment would be addressed by the implementation of this procurement framework;
(d) the process in place to resolve issues affecting UHL's renal transplant service and the actions going forward with a view to lifting the "pause" and re-starting this service at the earliest opportunity. A detailed report on this issue was due to be considered by the Quality Assurance Committee meeting later that afternoon;
(e) that CDU emergency care performance data was provided for "time to assessment", "time to be seen by a doctor" and "time from request to senior clinical review", but the data for "time to bed" was not yet available;
(f) opportunities to grow aspects of Cardiac services through additional activity from Burton and Norwich (which might require additional UHL theatre and bed capacity), and
(g) the scope for increasing the CMG's level of earned autonomy and reducing areas of duplication within the Trust's mechanism for monitoring CMG performance.

Following the presentation, Committee members raised the following comments and questions:-

(1) the Committee Chairman queried whether the Chief Operating Officer was sighted to the areas of potential activity growth from Burton and Norwich and the associated impact upon theatre and bed capacity. In response, it was noted that this was a very recent development and plans had not yet reached that stage. However, the Chief Operating Officer advised that the methodology was now in place to capture the impact of such activity changes and model the adjustments to capacity required moving forwards;

(2) the Chief Operating Officer commented upon the impact of CDU emergency care performance upon UHL's overall performance, noting the workstreams underway to review clinical staffing levels and patient pathways with a view to delivering the 4 hour target for "time to bed". A summary of the additional resources and diagnostic standards required for the CDU was due to be presented to the Emergency Care Action Team (ECAT) meeting within the next 2 weeks. In addition, a separate reporting line was being created within the site report to increase visibility of the CDU's contribution to 4 hour ED performance;

(3) the Chief Operating Officer sought and received additional information regarding the CMG's clinical letters backlog, noting that 20% of letters were currently waiting for longer than 10 days for typing, but the average wait had reduced to 3 weeks (from a previous average of 6 weeks). In respect of reducing any clinical risks associated with the letters backlog, the CMG advised that any clinically important letters were flagged as such and prioritised accordingly;

(4) the Chief Operating Officer compared the performance for the "time from request to senior review" in Respiratory services (82 minutes) and Cardiology services (166 minutes) and sought assurance regarding clinical engagement within the Cardiology team. The General Manager, RRC advised that clinical engagement was progressing well and that all clinical teams were keen to balance their performance and address any weaknesses in their PLICS data. In addition, the Chief Executive advised that a Listening into Action (LiA) pioneering team from Cardiology services had recently been supported by the LiA Sponsor Group to develop an LiA scheme around heart failure and the role of the specialist nurse;

(5) Ms J Wilson, Non-Executive Director drew members' attention to the workforce slide within the presentation pack (paper C) and queried the current vacancy levels and the potential impact of CIP schemes upon the workforce headcount. In response, the General Manager reported on the active recruitment processes which were hoped to fill the current 50 qualified nurse vacancies by the end of May 2014. In terms of medical staffing, plans were in place to fill the gaps in junior doctor rotations and Nephrology. It was noted that the majority of the CMG's CIP schemes were income related (eg undertaking additional patient care activity with the same number of staff) and that there were expected to be very few headcount reductions delivered through the CIP process;

(6) in the final slide, the CMG had requested support from the Trust Board in reducing the amount of duplication and repeated assurance processes conducted through the various performance management meetings, eg monthly performance management meetings, quarterly quality and safety performance management meetings and other meetings which focused on workforce and strategy related themes. The Interim Director of Financial Strategy suggested that the cycle of financial and operational performance meetings might be reduced as confidence in the CMG's performance was developed – a form of earned autonomy. The Committee Chairman requested that an overview of the agendas for each of the regular CMG review meetings be undertaken to remove any unnecessary duplication; **CE/ COO/ IDFS**

(7) the Committee Chairman sought and received additional information regarding the

circumstances leading up to the suspension of renal transplantation for a period of 2 weeks as a precautionary measure. In response, the Clinical Director briefed the Committee on the impact of changes in the service since the appointment of 2 additional transplant surgeons, noting that the 2 incumbent surgeons had previously delivered a safe service but there had been some scope to improve effectiveness and efficiency. The review had highlighted weaknesses in communications and joint working practices within the team and these were now being addressed. It was estimated that between 7 and 9 transplant operations would be carried out at other centres during the pause in UHL's services. In the longer term, the number of transplant operations carried out at UHL was expected to rise from 75 to 140 (and above) transplants per annum. Discussion took place regarding any potential risks to patients and members noted the views expressed by the Clinical Director that the issues mainly related to the way that the multi-professional team functioned and the destabilisation of the existing arrangements within a small team;

(8) the Committee Chairman drew a comparison between the small renal transplantation team and the historical issue relating to single handed practice in Paediatric Neurology. He invited the Committee to consider whether there were any other service areas operated by small clinical teams which might benefit from a detailed review. Colonel (Retired) I Crowe, Non-Executive Director commented upon the scope to benchmark the performance of small teams with other similarly sized units in other Trusts and it was agreed to request the Medical Director and the Director of Human Resources to reflect upon this point and seek assurance through the CMG review meetings; **MD/ DHR**

(9) the Chief Executive sought and received additional information regarding the viability of the recent approach from Norwich to increase UHL's cardiac surgery activity, noting that discussions were at a very early phase but an expansion of the service by 100 cases per year would seem realistic at the current time. Discussions relating to additional activity from the Burton area were noted to be more developed and the Director of Strategy had started attending these meetings to support the contractual elements of these discussions.

<u>Resolved</u> – that (A) the presentation on the Renal, Respiratory and Cardiac CMG's operational and financial performance be received and noted, and

(B) the Chief Executive, Chief Operating Officer and Interim Director of Financial Strategy be requested to review the agendas for all CMG review meetings to identify any scope to avoid duplication, and **CE/ COO/ IDFS**

(C) the Medical Director and the Director of Human Resources be requested to consider the scope for benchmarking practice amongst small clinical teams and seeking assurance through the CMG review meetings to ensure that the performance of small teams was monitored appropriately. **MD/ DHR**

45/14/2 <u>Progress report on UHL's Financial and Business Awareness Training Programme</u>

In the absence of the Deputy Director of Finance, members noted that the expected progress report on the above subject (paper F) had not been circulated and this item was deferred to the May 2014 meeting.

<u>Resolved</u> – that the progress report on UHL's Financial and Business Awareness Training Programme be deferred to the 28 May 2014 Finance and Performance Committee meeting **DDF**

45/14/3 <u>Draft Finance and Performance Committee Work Programme</u>

The Interim Director of Financial Strategy introduced paper G, providing the proposed

draft 2014-15 work programme for the Committee, noting the scope to include additional elements at a later date, pending the outcome of the Board Effectiveness Review. Members commented on the schedule and proposed amendments as follows:-

(a) flexibility would be required regarding the optimum timing for the review of particular projects/business cases according to progress of each scheme and the timescales for any key milestones;
(b) workforce plans would be reviewed as part of the 2 year operational plans and the 5 year strategic plans;
(c) Emergency Department (ED) performance would continue to be scrutinised through the Trust Board meetings until sustainable compliance with the 4 hour ED target had been achieved. This would help to reduce duplication at other sub-Board Committees and maintain the current Board-level focus;
(d) there was currently no date set for the Committee's consideration of the Emergency Floor business case. Whilst it was suggested that this might be aligned with the 20 June 2014 submission of the Trust's 5 year strategic plans and any expectations relating to the TDA approval process, members noted that the Committee could also set review dates independently of such external influences where necessary. It was agreed that the work programme would be populated with dates to fit with UHL's internal processes; **DDF**
(e) monthly reports on the Cost Improvement Programme (CIP) would also include progress with the cross-cutting schemes and there would be no need for the Committee to receive the meeting notes from the CIP Programme Board, and
(f) reports on RTT performance would be presented on a monthly basis (instead of alternate months as indicated on the programme currently).

<u>Resolved</u> – that the Deputy Director of Finance be requested to update the proposed Finance and Performance Committee Work Programme for further consideration at the next meeting. **DDF**

46/14 PERFORMANCE

46/14/1 <u>Month 12 Quality, Finance and Performance Report</u>

Paper I 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 February 2014 and a high level overview of the Divisional Heatmap report. The Committee Chairman noted his intention to request each Executive Director to select 2 or 3 key areas for specific focus during the meeting.

Noting that a separate report on ED performance would be presented to the 24 April 2014 Trust Board meeting, the Chief Operating Officer reported on the following aspects of UHL's operational performance:-

Cancer Performance – all 8 of UHL's cancer performance indicators were compliant against target and this had been the case for the last 3 months. In this respect UHL's cancer services appeared to be a positive outlier when compared with national performance trends. The Committee Chairman commended this excellent performance and suggested that future reports on cancer performance would only be required on the basis of exceptions to compliant performance;

RTT 18 Week Performance – a separate report was due to be considered later on the agenda for this meeting (Minute 46/14/2 below refers);

Cancelled Operations – compliant performance against the threshold of 1.0% had not been achieved in the last 36 months. Members noted the integral link with bed capacity – although approximately 40% of cancellations were noted not to be related to bed availability and discussions continued with the ITAPS CMG to resolve other contributory

factors. Members noted the scope for Commissioners to apply significant penalties in this area.

The Committee Chairman requested that future iterations of the exception report for cancelled operations also included a breakdown of the causes for cancellations. He noted the impact of high levels of ED admissions upon elective cancellations and made reference to a recently commissioned whole system redesign review which was due to commence on 19 May 2014. Non-Executive Directors had been briefed on this issue and he intended to raise this matter during the next day's Trust Board meeting. The Chief Executive briefed members on the need for a shared formal understanding between UHL and the CCGs in respect of improving the alignment between primary care demand management and acute care capacity. The Chief Operating Officer was requested to arrange for a breakdown of the causation factors for hospital cancellations to be provided to the next meeting, alongside a proposed trajectory for reducing cancelled operations. **COO**

Financial Performance – the Interim Director of Financial Strategy reported on the Trust's financial performance under Minute 47/14/2 below.

Resolved – that (A) the month 12 Quality, Finance and Performance report (paper I) and the subsequent discussion be received and noted, and

(B) the Chief Operating Officer be requested to provide a breakdown of the causes for cancelled operations and provide a recovery trajectory for cancelled operations at the 28 May 2014 meeting. **COO**

46/14/2 Progress Report on Referral to Treatment (RTT) Improvement Plan

Further to Minute 26/14/3 of 26 March 2014, the Chief Operating Officer introduced paper J providing an update on the RTT improvement plan. Significant improvements had been demonstrated by Ophthalmology which had the highest volume of patients. The remaining 3 challenged specialties were noted to be ENT, Orthopaedics and General Surgery and it was agreed to request the Musculoskeletal and Specialist Surgery CMG to focus on their RTT improvement plans during their scheduled financial and operational performance presentation on 28 May 2014. The following comments and queries were raised in discussion on paper J:- COO/TA

(a) the Committee Chairman sought a view from the Chief Operating Officer whether the Trust should be undertaking any additional actions not already included in the improvement plans. In response, the Chief Operating Officer noted the scope to ring fence a proportion of the 12 beds allocated to the ENT service, noting that at any given time there could be up to 7 medicine patients outlying in these beds. He undertook to raise this issue for discussion at the next RTT Board meeting; **COO**

(b) the Committee Chairman queried whether the significant fines which CCGs had served notice of their intention to impose (for elements of non-compliance with the RTT trajectory) were new fines and the Chief Executive clarified that there were 2 types of fines associated with the recovery plan and a caveat surrounding overall activity levels would be incorporated into the final agreement, and

(c) Ms J Wilson, Non-Executive Director queried what actions the RTT Board were pursuing to mitigate the risks of non-compliance with the RTT trajectory. In response the Chief Operating Officer reported that it was not currently possible to reliably model the impact of additional activity upon the RTT improvement plan, although it was evident that as emergency demand increased, elective cancellations also increased. Specialty-level risk logs were being retained and the Chief Operating Officer was requested to include the key drivers for mitigating these risks in his May 2014 RTT report. **COO**

Resolved – that (A) the MSS CMG be requested to focus on the RTT improvement plans for ENT and Orthopaedics within their scheduled presentation on financial **COO/ TA**

and operational performance on 28 May 2014, and

(B) the Chief Operating Officer be requested to:-

- **raise the possibility of ring-fencing a number of ENT beds at the next RTT Board meeting, and** **COO**
- **include the key drivers for mitigating service level RTT penalties in the next update report on RTT improvements.** **COO**

46/14/3 Progress Report on Clinical Letters Backlog

Further to Minute 30/14/4 of 26 March 2014, the Chief Operating Officer introduced paper K, updating the Committee on progress with reducing the backlog of clinical letters. Following consideration at the Executive Performance Board on 22 April 2014, a centralised focus group was being established by the Clinical Director, Clinical Support and Imaging. The Chief Operating Officer and the Medical Director had been nominated as Executive Director sponsors. In addition, the Chief Medical Information Officers (CMIOs) would be supporting this work stream relating to the electronic transfer of patient letters to GPs (for completion by the end of September 2014).

The Committee considered the scope to centralise the clinical letters functions within the Trust (alongside similar proposals for a centralised outpatient booking service) and opportunities to increase the level of outsourced transcription service provision. Members noted that the Ophthalmology clinical letters backlog had reduced significantly with the application of additional resources and some outsourced activity. However, one patient incident had been escalated as a Serious Untoward Incident (SUI) where one of the contributory factors had been a delay in typing the clinic letter. A report on this incident would be provided to the Trust Board on 24 April 2014.

Resolved – that (A) the progress report on reducing the backlog of clinical letters be received and noted, and

(B) a further report on the clinical letters backlog be presented to the Finance and Performance Committee on 28 May 2014. **COO**

47/14 FINANCE

47/14/1 2014-15 Cost Improvement Programme

Further to Minute 26/14/2 of 26 March 2014, the Chief Operating Officer introduced paper M, noting that the risk-adjusted total of CMG plans for 2014-15 had risen from £20.15m (in March 2014) to £24.69m and that £14.63m of these schemes had been RAG-rated as green (approved schemes). The combined risk-adjusted value of all schemes across the Trust now stood at £30.03m, with £19.45m being RAG-rated as green.

Members particularly noted that the weekly CIP Programme Board was chaired by the Interim Director of Financial Strategy and that the Executive Team would be conducting a monthly review of the Trust-wide CIP schemes. Ernst Young had highlighted some weaknesses in the PMO function and mitigating actions were underway to address these within the next month. Appendix 6 described a series of measures aimed at reducing the Trust's expenditure run-rate for quarter 1 whilst the full CIP implementation phase was taking place. The Chief Executive noted his concerns regarding the phasing of savings and requested that a summary of the CIP financial benefits be provided to the Finance and Performance Committee and the Executive Performance Board in May 2014, setting out the values of savings broken down by pay, non-pay and additional income for each area. The Interim Director of Financial Strategy highlighted the need to avoid-any double counting in respect of CMG and cross-cutting CIP schemes.

The Committee Chairman queried at what point the Trust would make a decision to

centralise its outpatients booking function and he noted in response the Chief Operating Officer's view that such a proposal had been supported by the Executive Team on 15 April 2014.

In her capacity as Chair of the Quality Assurance Committee, Ms J Wilson, Non-Executive Director queried when that Committee would have oversight of the CIP quality and safety impact assessments. The Chief Operating Officer briefed the Committee on the process for the Chief Nurse and the Medical Director to sign-off the assessments relating to all the approved schemes and confirmed his understanding that a report on this matter would be presented to the 28 May 2014 Quality Assurance Committee meeting. Other CIP schemes (those currently RAG-rated as red and amber) would have quality and safety impact assessments completed as and when they were approved and these would be submitted for sign-off in the same way.

Resolved – that the 2014-15 CIP update be received and noted and a further progress report be presented to the Finance and Performance Committee on 28 May 2014. **COO**

47/14/2 2013-14 Financial Performance

Papers N and N1 provided an update on UHL's performance against the key financial duties surrounding delivery of a planned surplus, achievement of the External Financing Limit (EFL) and achievement of the Capital Resource Limit (CRL), as submitted to the 24 April 2014 Trust Board and the 22 April Executive Performance Board (respectively).

The Interim Director of Financial Strategy confirmed that the deficit control total of £39.8m had been delivered as forecast and both the EFL and CRL limits had been met. In addition, he highlighted performance against the subsidiary duty to pay all suppliers invoices within 30 days under the Better Payment Practice Code (BPPC). Between April 2013 and March 2014, the Trust had paid 46.4% of invoices and 72.4% of the value within the target 30 days. Members noted that the Trust was expected to receive an adverse value for money audit opinion on the 2013-14 annual accounts, in view of the year end income and expenditure deficit.

Section 4.5 of paper N made reference to a write-off of approximately £660,000 outstanding overseas visitors' debts which had already been provided for within the bad debt provision. Discussion took place regarding the review of private patient and overseas visitor processes, as considered by the Audit Committee on 15 April 2014. The Chief Executive also briefed members on the development of a new Listening into Action (LiA) pioneering team which would be looking at the appropriate identification of such debts and improving the process for collection. The Interim Director of Financial Strategy was requested to include an update on potential investment in resources to improve private and overseas visitor debt collection processes in his next financial performance report to the 28 May 2014 meeting. Section 5.2 of the report detailed the temporary borrowing in place and members noted that a longer term financial loan would be subject to submission of 3 year financial recovery plans at the end of June 2014. **IDFS**

In discussion on the Trust's financial performance, members of the Finance and Performance Committee raised the following comments and queries:-

(a) the Chief Executive drew members' attention to the 3 main areas of variance from their year end control totals (ie ITAPS, MSS and IM&T) and advised that the Interim Director of Financial Strategy was reviewing these areas closely with a view to identifying the lessons learned and applying any actions required moving forwards;
(b) Ms J Wilson, Non-Executive Director sought and received assurance that smaller local companies were being prioritised in accordance with the Better Payment Practice Code (BPPC). Members considered the process issues that were likely to prevent compliance with the target to pay 95% of invoices within 30 days and the

Interim Director of Financial Strategy confirmed that this was a realistic target which had been achieved by other Trusts. He confirmed that BPPC performance would continue to be reported on a monthly basis as it remained a good indicator for identifying other performance issues, and

(c) the Committee Chairman sought additional information regarding the risks associated with longer term borrowing in the event that robust 3 year recovery plans were not available by the end of June 2014. In response, the Interim Director of Financial Strategy reported on the scope for further short term borrowing but members noted the challenges associated with finalising the 2014-15 financial year end position on the basis of short term borrowing.

Resolved – that the report on the Trust's Month 2013-14 financial performance be received and noted as papers N and N1.

48/14 SCRUTINY AND INFORMATION

48/14/1 Clinical Management Group (CMG) Performance Management Meetings

Resolved – that the action notes arising from the March 2014 CMG Performance management meetings (papers O and O1) be received and noted.

48/14/2 Executive Performance Board

Resolved – that the notes of the 25 March 2014 Executive Performance Board meeting (paper P) be received and noted.

48/14/3 Quality Assurance Committee (QAC)

Resolved – that the 26 March 2014 QAC meeting was cancelled due to the CQC Quality Summit being held on the same date.

48/14/4 CIP Programme Board

Resolved – that (A) the notes of the CIP Programme Board meetings held on 3, 8 and 15 April 2014 be received and noted, and

(B) the Committee agreed that these meeting notes would not be required for submission to future meetings.

49/14 ITEMS FOR DISCUSSION AT THE NEXT FINANCE AND PERFORMANCE COMMITTEE

Paper R provided a draft agenda for the 28 May 2014 meeting and the following additional agenda items were agreed:-

TA

- the item deferred from today's meeting relating to UHL's programme of financial and business awareness training;
- a separate report on the 2014-15 Capital Programme, and
- clarity to be provided that the May 2014 report on CIP performance would include a progress report on each of the cross-cutting CIP schemes.

The Trust Administrator was requested to update the agenda with the additional items agreed at this meeting and circulate a revised version outside the meeting.

Resolved – that (A) the items for consideration at the Finance and Performance Committee meeting on 28 May 2014 (paper R) be noted, and

(B) the Trust Administrator be requested to update the draft agenda and recirculate **TA**

it outside the meeting.

50/14 ANY OTHER BUSINESS

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

51/14 ITEMS TO BE HIGHLIGHTED TO THE TRUST BOARD

Recommended – that the following issues be highlighted for approval at the Trust Board meeting on 24 April 2014:-

- Minute 38/14 – updated 2 Year Operational Plan;
- Minute 39/14 – 2014-15 Financial Plan and Budget Book
- Minute 40/14 – confidential report by the Interim Director of Financial Services, and
- Minute 41/14 – UHL Capacity Plan 2014-15.

Resolved – that the following issues be highlighted verbally to the Trust Board meeting on 24 April 2014:-

- Minute 46/14/1 – cancelled operations performance and the impact of continued high levels of emergency demand;
- Minute 46/14/2 – consideration of the RTT improvement plan;
- Minute 46/14/3 – clinical letters backlog reduction plans, and
- Minute 47/14/2 – Cost Improvement Programme 2014-15.

52/14 DATE OF NEXT MEETING

Resolved – that the next Finance and Performance Committee be held on Wednesday 28 May 2014 from 8.30am – 11.30am in the Large Committee Room, Main Building, Leicester General Hospital.

The meeting closed at 11.03am

Kate Rayns, Trust Administrator

Attendance Record 2014-15

Name	Possible	Actual	% attendance	Name	Possible	Actual	% attendance
R Kilner (Chair)	1	1	100%	P Hollinshead	1	1	100%
J Adler	1	1	100%	G Smith *	1	1	100%
I Crowe	1	1	100%	J Wilson	1	1	100%
R Mitchell	1	1	100%				

* non-voting members