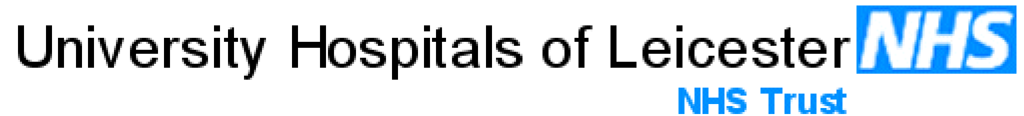

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT BY TRUST BOARD COMMITTEE TO TRUST BOARD

DATE OF TRUST BOARD MEETING: 2 June 2016

COMMITTEE: Integrated Finance, Performance and Investment Committee

CHAIR: Mr M Traynor, Non-Executive Director

DATE OF COMMITTEE MEETING: 28 April 2016

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:

- **Minute 40/16/1 – year end financial performance for 2015-16;**
- **Minute 40/16/2 – cost improvement programmes 2015-16 and 2016-17;**
- **Minute 40/16/3 – annual planning 2016-17;**
- **Minute 40/16/6 – review of Board Assurance Framework risks 10 and 18;**
- **Minute 41/16/3 – IBM contractual performance, and**
- **Minute 45/16/1 – presentation by the Clinical Support and Imaging CMG.**

DATE OF NEXT COMMITTEE MEETING: 26 May 2016

Mr M Traynor
Non-Executive Director and Committee Chair

Paper A1

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF A MEETING OF THE INTEGRATED FINANCE, PERFORMANCE AND INVESTMENT COMMITTEE (IFPIC), HELD ON THURSDAY 28 APRIL 2016 AT 9AM IN THE BOARD ROOM, VICTORIA BUILDING, LEICESTER ROYAL INFIRMARY

Voting Members Present:
Mr M Traynor – Non-Executive Director (Committee Chair)
Colonel (Retired) I Crowe – Non-Executive Director
Dr S Dauncey – Non-Executive Director
Mr R Mitchell – Chief Operating Officer
Mr P Traynor – Chief Financial Officer

In Attendance:
Mr M Archer – Head of Operations, Clinical Support and Imaging CMG (for Minute 45/16/1 only)
Mr S Barton – Director of CIP and Future Operating Model
Mr C Benham – Director of Operational Finance
Mr G DiStefano – Head of Strategic Development (for Minute 40/16/3 only)
Ms L Gallagher – Workforce Development Manager (for Minutes 40/16/2, 40/16/6.1 and 41/16/1)
Ms M Gordon – Patient Adviser
Mr A Johnson – Non-Executive Director (from Minute 39/16)
Mr D Kerr – Director of Estates and Facilities
Ms S Khalid – Clinical Director, Clinical Support and Imaging CMG (for Minute 45/16/1 only)
Mr W Monaghan – Director of Performance and Information
Mr R Moore – Non-Executive Director
Mr T Pearce - Major Projects Finance Lead (for Minute 41/16/2 only)
Mrs K Rayns – Trust Administrator
Mr K Singh – Trust Chairman
Ms L Tibbert – Director of Workforce and Organisational Development (for Minutes 40/16/2, 40/16/6.1 and 41/16/1)

RESOLVED ITEMS **ACTION**

37/16 APOLOGIES

Apologies for absence were received from Mr J Adler, Chief Executive.

38/16 MINUTES

Resolved **– that the Minutes of the 24 March 2016 IFPIC meeting be confirmed as a correct record.**

39/16 MATTERS ARISING

Paper B detailed the status of all outstanding matters arising from previous Integrated Finance, Performance and Investment Committee (IFPIC) meetings. The Committee particularly noted the updated information in respect of the following items:-

(a) **Minute 29/16/1(c) of 24 March 2016** – the IFPIC Chair had discussed the alignment between the Children's Hospital business case and the charitable fundraising campaign with Colonel (Retired) I Crowe, Non-Executive Director and Chair of the Charitable Funds Committee and agreed that a representative from the Women's and Children's CMG would be invited to attend relevant meetings of the Charitable Funds Committee for discussions on this item; **CFC Chair**

(b) **Minute 30/16/5 of 24 March 2016** – the Director of Estates and Facilities reported orally advising that UHL's non-clinical occupied space data (52.1% against the 35% target specified within the Carter Review) related to freehold estate only and did not

include any off-site leased accommodation. In addition, he advised that UHL's occupied space data benchmarked well amongst peer group Trusts and that the 35% target was currently being challenged due to the potential impact on PFI contracts and the fact that clinical teaching space was not included in the clinical space data for teaching hospitals. The Committee Chair commented upon opportunities to relocate non-clinical accommodation to other sites in order to free-up space on the LRI site for additional clinical services;

(c) **Minute 17/16/3 of 25 February 2016** – Mr R Moore, Non-Executive Director and Audit Committee Chair expressed concern that the expected review of BAF risk 11 (estates infrastructure capacity) had been deferred from this meeting and the 24 March 2016 meeting. This was now provisionally scheduled for consideration at the 30 June 2016 IFPIC meeting, ie after the Trust's forthcoming CQC inspection. In response, the Director of Estates and Facilities highlighted the Trust's reliance upon the Capita survey report (expected at the end of May 2016) to inform this review. The Committee Chair requested that a short summary of the Capita survey report and the potential implications be circulated to IFPIC members outside the meeting (once available) and suggested that 30 minutes be set aside at the June 2016 Trust Board thinking day for a discussion on estates infrastructure. Assurance in respect of estates resilience and statutory compliance, was due to be presented to the May 2016 meetings of the Executive Quality Board and Quality Assurance Committee; **DEF** **DCLA**

(d) **Minute 136/15/1 of 17 December 2015** – the business case for Endoscopy equipment re-processing was provisionally scheduled for consideration by the Capital Monitoring and Investment Committee on 13 May 2016;

(e) **Minute 123/15(c) of 26 November 2015** – the Director of Estates and Facilities advised that the development of the Estates Route Map was actually reliant upon the Trust's schedules of accommodation arising from demand and capacity plans and the reconfiguration programme (rather than the Capita survey as stated on the actions log), and

(f) **Minute 100/15/1(a) of 24 September 2015** – the Chief Nurse had not yet responded to the Committee's suggestion about sharing the patient story featuring the family of Mr R Mayne (deceased) at a future Trust Board meeting. The Trust Administrator was requested to seek a view from the Chief Nurse in order to close down this long-standing action. **TA**

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

40/16 FINANCE AND PLANNING

40/16/1 <u>Month 12 Financial Performance and Year End Position 2015-16</u>

Paper C updated IFPIC on performance against the Trust's key financial duties, including delivery against the planned deficit and achieving the External Financing Limit (EFL) and Capital Resource Limit (CRL) as at the end of March 2016. IFPIC members noted an in-month positive variance of £0.9m against plan, and welcomed the Trust's achievement of the planned annual income and expenditure deficit of £34.1m. The EFL and the CRL targets had also been achieved and were RAG-rated as green. Total CIP delivery for 2015-16 stood at £43.1m against the £43m target. A year-end fixed asset revaluation impairment of £19.4m had been excluded for the purposes of Trust financial performance monitoring. In discussion on paper C, the Committee:-

(a) noted the Chief Financial Officer's concerns regarding month 12 pay expenditure trends (particularly temporary staffing costs) and that a separate report was due to be considered by the Executive Performance Board to develop a better understanding of

the reasons for this peak in premium pay expenditure, some of which was attributed to the year-end submission of outstanding agency invoices;

(b) considered the impact of the £4.016m adverse EBITDA (earnings before interest, taxes, depreciation and amortisation) variance and opportunities to examine pay expenditure trends more closely if expenditure was sub-divided into direct labour costs and overhead charges;

(c) queried the potential implications of the 2016-17 patient care contracts, noting in response that the majority of patient care activity would be funded on a cost and volume basis with the exception of some marginal rate activity. The marginal rates for 2016-17 were noted to be more favourable than in previous years;

(d) noted that the Trust's Annual Accounts were currently being audited, prior to submission to the 25 May 2016 Audit Committee and the 2 June 2016 Trust Board meetings. The Audit Committee would be expected to review the arrangements for the revaluation of assets and a briefing on this subject would be provided accordingly;

(e) considered the impact of the year-end income and expenditure position upon the Trust's cash flow, noting the potential pressure points in March and September as highlighted by the Director of Operational Finance and the welcome support provided by the DoH working capital facility, and

(f) requested that a breakdown of the payment profile by size of supplier organisation be provided on a regular basis to provide the Committee with assurance that the Trust was supporting small and medium sized suppliers appropriately. **CFO**

Resolved – that (A) the month 12 Financial Performance report (paper C) and the subsequent discussion on this item be received and noted, and

(B) a breakdown of the payment profile (by size of organisation) be provided in future iterations of the financial performance report. **CFO**

40/16/2 Cost Improvement Programme

Paper D1 provided the monthly update on progress of the CIP programme to achieve the £43m target for 2015-16 and the £35m target for 2016-17. The year-end position for 2015-16 stood at £43.122m and the current build position for 2016-17 stood at £30.7m with an unidentified gap of £4.3m. 53% of the 2016-17 CIP programme had been RAG-rated as green. In order to address the gap for 2016-17, additional support was being applied within the CHUGGS, ITAPS and W&C CMGs and the cross-cutting themes (including outpatients and procurement) were being further developed.

In discussion on the report, the Committee:-

(a) commended the successful delivery of the 2015-16 CIP target and the significant achievements of the CMGs in delivering 546 separate savings schemes;

(b) considered the change in culture that would be required to deliver the Trust's future CIP strategy and suggested that a Trust Board thinking day session be scheduled to focus on the development of Lean techniques. The Patient Adviser commented upon the importance of leadership engagement in Lean techniques in order to deliver and embed service improvements and the Director of CIP and Future Operating Model advised that he had recently interviewed an ex-Toyota employee (with 10 years' experience of Lean processes) for a position at UHL; **DCLA/ TRUST CHAIR**

(c) noted that some elements of the premium pay expenditure reduction schemes had been removed as these did not reflect any removal of budgeted costs;

(d) queried whether any benefits of IM&T schemes had been factored into the CIP plans for 2016-17, noting in response that a summary of the key risks attributed to delays with the Electronic Patient Record project would be considered later in the agenda (Minute 40/16/6.2 below refers). The Director of CIP and Future Operating Model was working closely with the Chief Information Officer to identify any elements of the EPR project which could be factored into the 2016-17 CIP tracker, and

(e) discussed opportunities to deliver additional clinical activity using the same resources

and capacity. A clinical variation tool had been introduced which analysed length of stay, readmissions and complication rates by Consultant. The Chief Operating Officer advised that the subject of clinical variation had been discussed at the 27 April 2016 Clinical Senate meeting and it was intended to schedule a half day Clinical Senate workshop on reducing clinical variation in the near future.

The Director of Workforce and Organisational Development introduced paper D2 providing an update on the Workforce cross-cutting CIP theme as at the end of March 2016, noting the key headlines and areas of future focus. The Committee particularly noted that a review of the arrangements and rules to be applied for the management of pay was underway. In addition, the Trust was due to start publishing its gender pay gap analysis data in 2017.

The IFPIC Chair sought and received additional information regarding technical coding adjustments for 2015-16, noting that approximately £6m had been incorrectly coded between agency and internal locum expenditure. Whilst these adjustments would not affect the total income and expenditure position for 2015-16, it was important to reflect these changes for the purposes of compliance with the NHS Improvement agency caps, as UHL's position had been over-stated in this respect.

Colonel (Retired) I Crowe, Non-Executive Director welcomed progress with the medical workforce job planning workstream and he queried whether a target had been set for 2016-17. In response, the Director of Workforce and Organisational Development advised that whilst no formal target had been set, the Trust should be aspiring to have 100% of all medical job plans agreed and available electronically, and an automated process would be key to delivering this. In addition, the Director of CIP and Future Operating Model noted the importance of alignment between the job plans and the actual work being undertaken by each Consultant.

Mr R Moore, Non-Executive Director and Audit Committee Chair noted the intention for Internal Audit to undertake a review of premium pay arrangements and the Trust Chairman queried the reasons for apparent variations in premium pay expenditure between CMGs. In response, the Director of Workforce and Organisational Development commented upon the links between premium pay expenditure, leadership and recruitment to posts where there was a national shortage.

Resolved – that (A) the CIP progress report and cross-cutting Workforce CIP update be received and noted as papers D1 and D2, and

(B) the Director of Corporate and Legal Affairs and the Trust Chairman be requested to consider scheduling a future Trust Board development session on Lean techniques.

DCLA/ TRUST CHAIR

40/16/3 Annual Planning 2016-17

Further to Minute 30/16/3 of 24 March 2016, the Head of Strategic Development introduced paper E1, providing the final draft Annual Operational Plan, as submitted to NHS Improvement on 18 April 2016. IFPIC members recognised that many Trusts (including UHL) would be required to make a further final submission due to ongoing discussions on issues such as the improvement trajectories for receipt of Sustainability and Transformation Funding (STF) and development of balanced demand and capacity plans. In discussion on paper E1, IFPIC members:-

(a) queried when the Annual Operational Plan for 2016-17 would be publicly accessible, noting in response that the detailed document already featured on the external website as part of the Trust Board meeting papers for 5 May 2016 and a further iteration would be published for the 2 June 2016 Trust Board meeting. However, a more "user-friendly" version was also being developed for wider dissemination;

(b) supported the Annual Operational Plan for submission to the Trust Board meeting on 2 June 2016, noting that further work was required in respect of finalising the financial plan, capital programme and the demand and capacity plan. Additional clarity was required in relation to the relocation of Vascular and ITU services, strategic reconfiguration programme, Better Care Together assumptions for bed capacity, and the improvement trajectories to be met in order to qualify for STF, and
(c) agreed that updated versions of the annual planning documentation would be presented to the 24 May 2016 Executive Performance Board, 26 May IFPIC and 2 June 2016 Trust Board meetings.

The Chief Financial Officer introduced paper E2, providing the 2016-17 Financial Plan update, advising that a more detailed plan was being prepared which would include the phasing for the year. Particular discussion took place regarding the trajectories to be agreed in relation to ED performance, RTT performance, cancer and diagnostics improvements and compliance with the agency expenditure caps.

The Director of Performance and Information provided the latest estimated dates for compliance with key performance indicators, noting that diagnostics was expected to be compliant for the whole year, RTT with effect from quarter 2 and cancer with effect from September 2016. He expressed concerns that the trajectories being requested by NHS Improvement were not considered to be feasible in the context of current demand and capacity. The Chief Financial Officer confirmed that the Trust had been clear about which elements were felt to be deliverable, practicable and possible, in order to improve the Trust's performance and confirmed the intent to meet the agreed target compliance dates (wherever possible). In the meantime, it had been agreed that the Trust would report its financial position both gross and net of STF.

The draft 2016-17 capital programme had not changed since it was reported to the 24 March 2016 IFPIC meeting. The main issues related to external approval of the EPR project and the Vascular and ICU reconfiguration schemes and decisions on these key schemes were not expected to be made until the end of quarter 1. Therefore a secondary capital programme (plan B) had been prepared and considered by the Capital Monitoring and Investment Committee. A full risk assessment was being undertaken to develop a greater understanding of the impact of delays within the Estates, IM&T and Medical Equipment capital programmes. A brief discussion also took place regarding opportunities for the development of alternative external funding sources (eg funding partnerships with local authorities).

Paper E3 provided a briefing note on the development of balanced demand and capacity plans for 2016-17. The Chief Operating Officer detailed the key assumptions and the dependency upon the Vascular and ICU reconfiguration plans, noting the aims to transfer non-acute activity into community hospitals, independent sector beds and improve utilisation of the Intensive Community Support (ICS) bed capacity. He highlighted the work ongoing to ring-fence elective capacity, the continuing high levels of ED attendances and the impact of the Junior Doctors' strikes. Dr S Dauncey, Non-Executive Director and QAC Chair noted that staff had raised concerns regarding the rationale for providing additional bed capacity at Glenfield Hospital and she highlighted an opportunity to improve staff communications in this respect. Mr R Moore, Non-Executive Director and Audit Committee Chair sought and received assurance regarding the accuracy of forecasting and analysis sensitivity, noting in response that variability would always be a risk, but the modelling itself was deemed to be 99.8% accurate for emergency, elective and cancer pathways.

In order to support the development of balanced demand and capacity plans, the Chief Operating Officer was requested to articulate a set of clear recommendations for future Executive Team and Trust Board consideration. IFPIC members noted that the key points might include:-

- clear communications surrounding the development and progress of the Vascular and

ICU reconfiguration schemes;
- creation of empty capacity to support reconfiguration of the services to be relocated;
- greater clarity in relation to LPT assumptions and bed configuration plans, and
- confirmation of the performance trajectories to be signed up to in order to achieve STF.

Finally, the Chief Financial Officer sought and received clarity regarding the intended submissions to the 5 May 2016 Trust Board meeting, noting that the draft Operational Plan only (paper E1) would be submitted to that meeting.

Resolved – that (A) the draft 2016-17 Operational Plan be supported for presentation to the Trust Board on 5 May 2016; **HSD/ CFO**

(B) a further iteration of the 2016-17 Operational Plan be presented to the IFPIC and Trust Board meetings on 26 May 2016 and 2 June 2016 (respectively), and **HSD/ CFO**

(C) the Chief Operating Officer be requested to articulate a set of recommendations in order to finalise UHL's demand and capacity plans for consideration by the appropriate Executive forum and the Trust Board. **COO**

40/16/4 Development of PLICS/SLR/SLM 2016-17

The Director of Operational Finance introduced paper F, providing an update on the development of Patient Level Information Costing System (PLICS) and Service Line Reporting (SLR) and the arrangements for increasing engagement and use of this data at UHL. Appendix 1 detailed the SLR position by service line and specialty for month 11 (February 2016) and appendix 2 provided an example of a service level dashboard for the CHUGGS CMG. IFPIC members received and noted the report and supported the proposal to launch a Trust-wide engagement programme under the umbrella of the UHL Way.

Resolved – that the continued development of PLICS and SLR costing initiatives (as outlined in paper F) be supported.

40/16/5 Reference Costs Submission for 2015-16

Paper G provided the Committee with an update on progress with the production of the nationally mandated reference cost data and the proposed timescales for submission to the 30 June 2016 IFPIC meeting for approval. The data collection window was noted to open on 20 June 2016 and close on 27 July 2016. A copy of the self-assessment quality checklist was provided at appendix 1.

Resolved – that the final Reference Costs submission be presented to the 30 June 2016 IFPIC meeting for approval (on behalf of the Trust Board) prior to submission to the Department of Health.

40/16/6 Review of Board Assurance Framework Risks 10 and 18

40/16/6.1 Principle Risk 10 (a caring, professional and engaged workforce)

The Director of Workforce and Organisational Development introduced paper H1 providing the updated BAF entry for principle risk 10 as at March 2016. IFPIC members particularly noted recent performance in relation to reducing staff turnover and sickness absence and improving compliance with staff appraisals and statutory and mandatory training. The Internal Audit reviews of medical staffing and recruitment and retention had both been completed and the medical staffing review findings were due to be presented to the Audit Committee on 25 May 2016. In respect of the development of the BCT Workforce Strategy, a high-level plan was expected to be available during mid-May 2016 and assurance was provided that this plan would support a system wide approach.

Resolved – that the update on principle risk 10 be received and noted.

40/16/6.2 Principle Risk 18 (delay to the approvals for the Electronic Patient Record programme)

The Chief Information Officer introduced paper H2 providing a summary of progress with the procurement of an EPR system and the updated BAF entry for principle risk 18 as at March 2016. IFPIC members particularly noted the additional expenses being incurred in respect of short term extensions to existing contracts. Assurance was provided that such expenditure and any associated risks were being managed appropriately and this had been escalated to NHS Improvement, pending final approval of the EPR business case. An amber/green rating had been provided following the EPR Health Check Review and the Chief Information Officer had been invited to brief the NHS Improvement Lead on the finer points of the business case prior to consideration at the next meeting of the National Investment Committee.

Resolved – that the update on principle risk 18 be received and noted.

41/16 STRATEGIC MATTERS

41/16/1 Workforce Update

The Director of Workforce and Organisational Development and the Workforce Development Manager attended the meeting to introduce paper I, providing the monthly overview of a range of workforce-related datasets. The report was taken as read and the Director of Workforce and Organisational Development noted the close links between this report, the Workforce cross-cutting CIP theme and compliance with the agency staffing caps (Minute 40/16/2 above refers).

In discussion on the workforce update report, IFPIC members considered the available assurance in relation to improving retention rates and supporting recruitment and talent management processes with the aim of reducing key vacancy gaps. Appendix 2 provided a summary overview of the Operational Workforce Plan submitted to NHS Improvement and clarity was provided that 1222 of the additional 1485 whole time equivalent posts were directly attributable to the transfer of estates and facilities staff to UHL from Interserve following the termination of the contract.

Following the 24 March 2016 IFPIC meeting, a task and finish group had been established to build upon the existing workstreams to address gaps in the Trust's nursing and nursing support workforce. In response to a query raised by Colonel (Retired) I Crowe, Non-Executive Director, the Director of Workforce and Organisational Development agreed to double-check that the Committee's specific recommendation (in relation to expanding local nurse training capacity through the development of self-funded training places) was being addressed within the scope of the task and finish group. **DWOD**

Finally, the Committee supported the proposal to receive exit interview and staff sickness data on a quarterly basis to IFPIC to reflect the limited changes in this data on a monthly basis. In addition, the Director of Workforce and Organisational Development requested a meeting with the Committee Chair to review the terms of reference for the monthly workforce update reports to IFPIC. **DWOD/ IFPIC Chair**

Resolved – that (A) the Workforce Update report (paper J) and the subsequent discussion be noted, and

(B) the Director of Workforce and Organisational Development be requested to check and confirm that the scope of the task and finish group would address the Committee's recommendation about expanding local nurse training capacity **DWOD**

through self-funded training places, and

(C) the Director of Workforce and Organisational Development be requested to meet with the IFPIC Chair (outside the meeting) to review the terms of reference for the monthly workforce update reports to IFPIC. **DWOD/ IFPIC Chair**

41/16/2 Confidential Report by the Chief Financial Officer

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

41/16/3 IBM Contract Performance – Quarterly Update Report

The Chief Information Officer introduced paper K, providing the quarterly update on IBM contract performance and highlighting a reduction in the number of service level failures (from 51 to 16) during the last 3 month period. IBM had responded well to a review of service level agreements and additional resources had been brought on site to improve local capability. Significant progress had been made with the availability of key data for operational reporting although this performance had still not reached the optimum standard. The Chief Executive and the Chief Information Officer would shortly be meeting with IBM's senior management team to undertake the annual contract review.

Discussion took place regarding the opportunities to harness more of the technological developments available through the IBM contract and it was agreed that the Trust Chairman would liaise with the Director of Corporate and Legal Affairs to arrange a follow-up event for the Trust Board thinking day held in July 2015. **Trust Chair/ DCLA**

The Chief Information Officer briefed the Committee on the weekly meetings structure with IBM, noting that the final meeting of each month was less structured which provided an opportunity to explore new developments. In general, a pragmatic approach was being maintained towards supporting UHL's business requirements through the approved prioritisation process and delivering more with the existing resources. Assurance was provided that appropriate priority was being provided to supporting the transfer of the estates and facilities service following termination of the contract with Interserve. Responding to a query, the Chief Information Officer agreed to send Colonel (Retired) I Crowe, Non-Executive Director a briefing note on the scope of the near patient testing project. **CIO**

Resolved – that (A) the quarterly update on IBM contract performance be received and noted as paper K;

(B) the Trust Chairman be requested to liaise with the Director of Corporate and Legal Affairs with a view to arranging a follow-up Trust Board thinking day with IBM, and **Trust Chair/ DCLA**

(C) the Chief Information Officer be requested to send Colonel (Retired) I Crowe, Non-Executive Director a briefing note on the scope of the near patient testing project. **CIO**

42/16 PERFORMANCE

42/16/1 Month 12 Quality and Performance Report

Paper L provided an overview of UHL's quality, patient experience, operational targets, and HR performance against national, regional and local indicators for the month ending 30 March 2016. The Director of Performance and Information updated the Committee on 52 week waits, diagnostic performance, cancer performance, RTT performance and the short term arrangements for insourced activity to support the ENT service.

Following discussion on cancer patient experience, the Chief Operating Officer agreed to ensure that appropriate feedback was provided to the Cancer LiA workstream leads regarding the positive impact upon patient experience arising from the implementation of the "next steps" booklet for cancer patients. He also agreed to provide Colonel (Retired) I Crowe, Non-Executive Director with an update on the implementation plans for the recently piloted tool for preventing re-admissions. The QAC Chair highlighted concerns regarding recent fractured neck of femur performance and received assurance that future reports would disaggregate the statistics for those patients who were not considered to be medically fit for surgery. **COO** **COO**

Resolved – that (A) the month 12 Quality and Performance report be received and noted as paper L, and

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

(1) provide feedback to the Cancer LiA workstream leads regarding the positive impact of the recently introduced "next steps" booklet for cancer patients, and **COO**
(2) provide Colonel (Retired) I Crowe with an update on the implementation plans for the recently piloted tool for preventing re-admissions. **COO**

43/16 SCRUTINY AND INFORMATION

43/16/1 IFPIC Calendar of Business 2016-17

A brief discussion took place regarding the future scheduling of Empath reports. As detailed on the planner, the next quarterly update on Empath's financial and operational performance would be considered at the 26 May 2016 IFPIC meeting. Following the implementation of revised governance arrangements, the Committee's consideration of the Empath business case had been re-scheduled for 27 October 2016. A suggestion was raised regarding the scope to re-brand Empath under the new governance model, but this was not considered to be the best way forward at the current time.

Resolved – that the updated IFPIC calendar of business be received and noted as paper M.

43/16/2 Updated Timetable for UHL Business Case Approvals

Resolved – that the updated timetable for Strategic Business Case Approvals be received and noted as paper N.

43/16/3 Executive Performance Board

Resolved – that the notes of the 22 March 2016 Executive Performance Board meeting be received and noted (paper O).

43/16/4 Capital Monitoring and Investment Committee

Resolved – that the notes of the 11 March 2016 Capital Monitoring and Investment Committee meeting be received and noted (paper P).

43/16/5 Revenue Investment Committee

Resolved – that the cancellation of the 11 March 2016 Revenue Investment Committee meeting be noted.

44/16 INVESTMENT BUSINESS CASES

Resolved – that no business cases were submitted for consideration at the 28 April

2016 IFPIC meeting.

45/16 CLINICAL MANAGEMENT GROUP PRESENTATION

45/16/1 Clinical Support and Imaging (CSI)

Following an informal discussion over the lunchtime period, the Clinical Director and the Head of Operations attended from the Clinical Support and Imaging CMG to introduce a slide presentation (previously circulated as paper Q), providing an overview of their current financial and operational performance, key risks, achievements and areas where additional Trust Board support would be welcomed. The presentation slides were taken as read and the presentation team focussed upon key successes within 2 of the CMG's 7 services:-

(a) Imaging – this service formed an integral part of many patient pathways and was a major contributor to RTT performance. The volume of interventional radiology activity had risen from 5 or 10 patients per month to over 300 patients per month. A direct CT colon pathway had been implemented some 9 months earlier and the procedure (which was less invasive than traditional endoscopy procedures) had proved very successful. In addition, the Imaging service had successfully recruited to 10 out 11 Consultant vacancies since January 2016 (including a Breast Consultant which was a challenging post to recruit to), and

(b) Pharmacy – the Clinical Director outlined progress with 2 key commercial developments (a pharmacy insourced subsidiary and Optimed) which were providing the CMG with exciting opportunities to deliver significant improvements in quality and financial performance. However, the Committee noted the risks surrounding a potential change in policy relating to gain share agreements for drug-related savings.

In addition, the CMG team detailed areas where performance could be improved, including compliance with Imaging diagnostics targets (where issues were considered to be within the CMG's own control). Areas for future focus included:-

(i) timely decision-making regarding Electronic Document Records Management (EDRM) and Point of Care Testing (POCT);
(ii) reducing errors in Pharmacy and Radiology reporting;
(iii) development of the Outpatients Strategy, and
(iv) implementation of EMRAD.

In discussion on the presentation, IFPIC members raised the following comments and queries:-

(1) the Committee Chair queried whether there were any particular barriers preventing progress with future developments. In response, it was confirmed that the traditional barriers had been removed and there was now greater scope for the CMG to develop "best in class" services. The Chief Operating Officer advised that a meeting to progress the Outpatients Strategy was being held later that afternoon, with a view to developing a high-quality centralised Outpatients service;
(2) Colonel (Retired) I Crowe, Non-Executive Director sought and received a briefing on proposals for a fixed site CT scanner. This would be an outsourced service commissioned by NHS England and one of the key factors would be whether a corridor access would be provided to any stand-alone building. This would be an important requirement to reduce internal ambulance transfers. A briefing on the proposed site location and contractual terms would be presented to a future IFPIC meeting;
(3) Colonel (Retired) I Crowe, Non-Executive Director queried the scope to improve the timescale for implementing the Optimed project, noting in response that the full business case would be presented to IFPIC in the summer of 2016, and
(4) the Director of Performance and Information thanked the CMG for their contribution to the Trust's wider RTT performance position and he sought additional information

relating to the fragility of some MES components of the Trust's equipment infrastructure. In response, the Head of Operations advised that most of the MES equipment was within the recognised parameters. However, year upon year growth had meant that there was no back-up MRI machine. In order to mitigate this, the service had moved to 3 session days to ensure most efficient utilisation rates. During an intermittent failure from November 2015 to January 2016, a number of midnight MRI slots had been utilised. The Clinical Director briefed the Committee on the implementation of standardised sequencing which had helped with the scheduling of scans. In addition, some collaborative work was taking place with GPs to prevent inappropriate referrals. This had included an interesting round of CCG locality visits.

Finally, the Committee noted that Ms S Khalid, Clinical Director would be assuming the role of Clinical Director for RRCV in May 2016 and they thanked her for her significant contribution to the CSI CMG. An announcement regarding her successor for CSI was expected to be made in the next few days following a competitive interview process.

Resolved – that (A) the CMG presentation (paper Q) and the subsequent discussion be noted.

46/16 ANY OTHER BUSINESS

47/16 ITEMS TO BE HIGHLIGHTED TO THE TRUST BOARD

Resolved – that (A) a summary of the business considered at this meeting be presented to the Trust Board meeting on 5 May 2016, and **TA/ Chair**

(B) the following items be particularly highlighted for the Trust Board's attention:-

- **Minute 40/16/1 – year end financial performance for 2015-16;**
- **Minute 40/16/2 – cost improvement programmes 2015-16 and 2016-17;**
- **Minute 40/16/3 – annual planning 2016-17;**
- **Minute 40/16/6 – review of Board Assurance Framework risks 10 and 18;**
- **Minute 41/16/3 – IBM contractual performance, and**
- **Minute 45/16/1 – presentation by the Clinical Support and Imaging CMG.**

48/16 DATE OF NEXT MEETING

Resolved – that the next meeting of the Integrated Finance, Performance and Investment Committee be held on Thursday 26 May 2016 from 9am to 1pm in the Board Room, Victoria Building, Leicester Royal Infirmary.

The meeting closed at 12.55pm

Kate Rayns, **Trust Administrator**

Attendance Record 2016-17

Voting Members:

Name	Possible	Actual	% attendance	Name	Possible	Actual	% attendance
M Traynor (Chair)	1	1	100	S Dauncey	1	1	100
J Adler	1	0	0	R Mitchell	1	1	100
I Crowe	1	1	100	P Traynor	1	1	100

Non-Voting Members:

Name	Possible	Actual	% attendance	Name	Possible	Actual	% attendance
M Gordon	1	1	100	R Moore	1	1	100
A Johnson	1	1	100	K Singh	1	1	100
D Kerr	1	1	100				