Trust Board paper R

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: 7 January 2016

COMMITTEE: Integrated Finance, Performance and Investment Committee

CHAIR: Ms J Wilson, Non-Executive Director

DATE OF COMMITTEE MEETING: 17 December 2015

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

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

- **Minute 131/15 – Revised 2015-16 Capital Programme (for Trust Board approval);**
- **Minute 134/15/1 – CMG presentation;**
- **Minute 136/15/1 – Endoscopy performance;**
- **Minute 136/15/3– Cancer performance;**
- **Minute 137/15/1 – Month 8 Financial performance**
- **Minute 137/15/3 – Cost Improvement Programme and efficiency metrics requirement for CQC ratings, and**
- **Minute 137/15/5 – 5 Year Financial Strategy Scenarios.**

DATE OF NEXT COMMITTEE MEETING: 28 January 2016

Ms J Wilson
Non-Executive Director and Committee Chair (until 31 December 2015)

Mr M Traynor
Non-Executive Director and Committee Chair Designate (from 1 January 2016)

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF A MEETING OF THE INTEGRATED FINANCE, PERFORMANCE AND INVESTMENT COMMITTEE (IFPIC), HELD ON THURSDAY 17 DECEMBER 2015 AT 8.30AM IN THE BOARD ROOM, VICTORIA BUILDING, LEICESTER ROYAL INFIRMARY

Voting Members Present:
Ms J Wilson – Non-Executive Director (Committee Chair)
Colonel (Retired) I Crowe – Non-Executive Director
Mr J Adler – Chief Executive
Dr S Dauncey – Non-Executive Director
Mr M Traynor – Non-Executive Director
Mr P Traynor – Chief Financial Officer

In Attendance:
Mr S Barton – Director of CIP and Future Operating Model
Mr C Benham – Director of Operational Finance
Ms J Fawcus – Head of Operations, CHUGGS CMG (for Minutes 135/15/1 and 136/15/1 only)
Dr G Garcea – Clinical Director, CHUGGS CMG (for Minutes 135/15/1 and 136/15/1 only)
Mr P Gowdridge – Head of Strategic Finance (for Minute 137/15/5 only)
Mr A Johnson – Non-Executive Director
Mr D Kerr – Director of Estates and Facilities
Ms D Mitchell – Integrated Services Programme Lead (on behalf of the Director of Strategy up to Minute 137/15/4)
Mr W Monaghan – Director of Performance and Information
Mr R Moore – Non-Executive Director
Mr M Nattrass – Deputy Head of Operations, CHUGGS CMG (for Minutes 135/15/1 and 136/15/1 only)
Mr K Singh – Trust Chairman
Mr N Sone – Financial Controller (for Minute 137/15/2 only)
Mrs K Rayns – Trust Administrator

	RECOMMENDED ITEMS	ACTION

131/15 2015-16 REVISED CAPITAL PROGRAMME

The Chief Financial Officer introduced paper J, seeking the Committee's approval of the revised 2015-16 Capital Programme. He briefed the Committee on discussions held at the Capital Monitoring and Investment Committee and the Executive Strategy Board on those elements of the Reconfiguration Programme to be progressed and those elements likely to be delayed. In general, the Vascular schemes would be continued, but the only ICU expenditure to be incurred would relate to developmental and planning workstreams.

The Committee noted the potential impact of the revised capital programme upon core estates activities (including any statutory compliance on health and safety issues) and the Chief Financial Officer was requested to include a section of risk assessment within future iterations of this report. Assurance was provided that a robust prioritisation process was in place to reflect both estates and medical equipment priorities. The Committee Chair requested that a bi-annual review of the Capital Expenditure Programme be added to the IFPIC calendar of business. **CFO/ TA**

The Trust Chairman suggested that it would be helpful to hold a further Trust Board thinking day on the subject of the Reconfiguration Programme to include the revised capital programme and the impact upon estates workstreams. Members queried whether January 2016 might be too early for substantive advice on the capital availability, but it was agreed that a scenario based approach could be used to reflect the various funding options and it would be advantageous to hold this event before the current Director of Strategy left the Trust. Further discussion took place regarding the following themes:- **DCLA/ Trust Chair**

(1) opportunities to lobby for additional financial support for UHL's reconfiguration programme;
(2) risks of reduced CIP savings in 2016-17 and 2017-18 as many of these CIP schemes were linked to the reconfiguration programme;
(3) the scope to learn lessons from a Trust in Newcastle which had successfully reduced its estate from 3 to 2 acute sites, and had been successful in delivering a financial surplus as a result, and
(4) a forecast 3 month delay in completion of the Younger Disabled Unit (YDU) refurbishment works and the impact of using the decant accommodation on ward 2 at the LGH for longer than expected. Alternative accommodation was being provided to the Diabetes Centre for storage of equipment. It was noted that clear communications with staff and patients would be required to manage expectations surrounding this project.

Recommended – that (A) the revised 2015-16 Capital Programme be supported for Trust Board approval on 7 January 2016; **CFO**

(B) future iterations of the Capital Programme be scheduled on the IFPIC calendar of business on a bi-annual basis; **CFO/TA**

(C) the next iteration of the Capital Programme to include a section on risk assessment, and **CFO**

(D) consideration be given to scheduling a further Trust Board thinking day session on the Reconfiguration Programme in January 2016. **DCLA/ Trust Chair**

RESOLVED ITEMS

132/15 APOLOGIES AND WELCOME

Apologies for absence were received from Professor A Goodall, Non-Executive Director, Ms M Gordon, Patient Partner, Mr R Mitchell, Chief Operating Officer and Ms K Shields, Director of Strategy.

133/15 MINUTES

Resolved – that the Minutes of the 26 November 2015 IFPIC meeting be confirmed as a correct record.

134/15 MATTERS ARISING

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

(a) **Minute 123/15(c) of 26 November 2015** – the planned completion date for the development of the estates "route map" was noted to be February 2016, however the Chief Executive advised that some early headlines might be available for consideration at the 14 January 2016 Trust Board thinking day or the 28 January 2016 IFPIC meeting (subject to availability), and **DEF**

(b) **Minute 126/15/2 of 26 November 2015** – the Trust Board would continue to monitor the arrangements for improving ambulance handover performance through the monthly emergency performance report. **COO**

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

135/15 STRATEGIC MATTERS

135/15/1 CMG Presentation – Cancer, Haematology, Urology, Gastroenterology and General Surgery (CHUGGS)

Paper C provided an overview of the CHUGGS CMG's current financial and operational performance, including achievements, risks, workforce indicators, strategic changes, key commitments and requests for support from the Trust Board. Prior to the arrival of the CHUGGS CMG management team and although noting the improving financial performance in the second half of the financial year, IFPIC members agreed to seek further assurance on the following issues in particular:-

- challenges around development of sufficient 2016-17 CIP schemes;
- concerns expressed by community GPs regarding the current waiting times for a first gastroenterology appointment;
- the CMG's ability to deliver additional Urology cancer activity from Lincoln, in the context of UHL's current Urology cancer performance;

The CHUGGS CMG management team then arrived and reported on the following issues:-

(a) ***RTT performance*** – General Surgery RTT performance was almost compliant with the target and sustainable plans were in place to maintain the position moving forwards. An action plan was being worked through with additional external support to address Gastroenterology 18 weeks performance and this target was expected to be met early in 2016;

(b) ***cancer performance*** – upper and lower GI performance was linked to Endoscopy performance and a separate report on this subject was provided later in the agenda (Minute 136/15/1 below refers). 31-day cancer performance was compliant and significant progress had been made in respect of 62-day cancer targets, where the backlog had now reduced to 12 patients. The Director of Performance and Information commended the efforts of Ms K Boyle, the new Deputy Cancer Lead in reducing this backlog. In respect of Urology cancer performance, good clinical engagement was supporting the development of a new prostate cancer pathway, and

(c) ***financial performance*** – the CMG was forecasting to deliver its agreed year end control total (£1.985m income and expenditure deficit). Good agency expenditure controls were in place, but the forecast income relating to the bowel cancer screening programme had been removed from the plan (due to a pause in the rollout arrangements). Other known issues which might impact upon the CMG's financial performance included junior doctor sickness rates, premium pay and WLI payments for weekend activity.

In discussion on the presentation and the CHUGGS comments detailed above, IFPIC members:-

(i) queried the reason for pausing the rollout of the bowel cancer screening programme (for patients over the age of 50) to the next tranche of GP practices, noting in response that Public Health had instigated the pause in the context of current Endoscopy performance challenges. The CMG provided assurance that work was taking place with Public Health to re-start the rollout as soon as possible once an identified Pathology issue had been resolved. The Chief Executive offered his support if the CMG encountered any barriers to progress with this;

(ii) sought and received additional information regarding nurse staffing on ward 22, noting good progress with recruitment (6 new starters to commence in January 2016 and the appointment of a new ward sister). Additional measures were in

place to support staff on this high acuity ward, with a view to improving staff retention in the longer term through high quality appraisals and staff development;

(iii) expressed concern about the rate of CHUGGS readmissions, noting in response that Oncology re-admissions were within the expected range, but a piece of work was taking place to validate General Surgery readmissions. It was thought that some patients who attended for triage purposes prior to their admission were being incorrectly classified as a readmission;

(iv) noted the recent appointment of 2 Gastroenterologists and the intention to recruit 3 more early in the new year and queried whether activity plans had been sufficiently tested to manage the continuing increase in referrals (14% currently). The CMG provided assurance that appropriate measures were in place to address this rise in demand, including a new GP triage model and use of additional external capacity;

(v) discussed the identified risks surrounding delays with replacement of the Bosworth linear accelerator (Linac). The expenditure for this replacement had recently been re-phased from quarter 4 2015-16 into quarter 1 2016-17, but the CMG confirmed that the bunker preparations and commissioning of the new Linac would take up to 12 months in any case. The risk of the old Linac machine breaking down and requiring patients to be rescheduled was being managed accordingly. The Chief Financial Officer sought and received assurance that the re-phasing of the Linac scheme would have little real impact on the overall timeline as the procurement process would continue to be worked up during the interim period, and

(vi) requested additional information regarding potential additional Lincolnshire Urology cancer activity, noting that UHL would only be undertaking the theatre procedures for these patients and that follow-up care would continue to be provided in Lincolnshire. Reciprocal arrangements for Lincolnshire to deliver some of UHL's RTT activity from Grantham and Melton were also being explored. The Clinical Director provided assurance that these developments would only be progressed if the CMG management team was happy with the overall Urology performance. The Chief Executive supported this approach, noting that the philosophy of tertiary partnerships had been well thought-through and an update on tertiary partnerships would be provided to the 7 January 2016 Trust Board meeting. **CE/DS**

In summary, the Committee Chair noted that the December 2015 IFPIC meeting was being held earlier in the month than usual and the individual CMG performance meetings had not yet taken place. She congratulated the CMG on their significant improvement in operational performance, noting the challenges that remained.

<u>Resolved</u> – that (A) the performance presentation from Cancer, Haematology, Urology, Gastroenterology and General Surgery CMG be noted, and

(B) an update on tertiary partnerships be provided to the Trust Board on 7 January 2016. **CE/DS**

136/15 PERFORMANCE

136/15/1 <u>Endoscopy Performance</u>

Further to Minute 99/15/2 of 24 September 2015, paper D detailed progress in respect of reducing the Endoscopy backlog and delivering the diagnostic waiting time targets. The Clinical Director, Head of Operations, and the Deputy Head of Operations briefed the Committee on the following issues:-

(a) the number of patients waiting over 6 weeks had reduced from 1546 in September 2015 to 740 as a result of the additional external capacity. However, the backlog

reduction was slightly behind trajectory due to a continued increase in referrals (an additional 471 patients to date);

(b) 2 new Gastroenterologists had been appointed and plans were in place to recruit 3 additional Consultants in 2016;

(c) the booking team had been centralised at Glenfield Hospital and the Unisoft patient scheduling system had been implemented;

(d) a further focus was required on reducing patient DNA (did not attend) rates. Members noted that patients currently received a text reminder prior to their appointments, but an additional text reminder was being considered, and

(e) continued work being undertaken with NHSIQ to reduce the reliance upon external service provision going forwards, including a review of UHL's weekend lists.

The Committee Chair congratulated the Endoscopy team on their continued good progress recognising the contributions made by the whole team (including administrative staff). Endoscopy rooms were now being used 7 days of the week. However, a limiting factor was emerging in respect of patient choice, ie some patients were unwilling to attend for their Endoscopy procedure prior to Christmas.

Discussion took place regarding an adverse trend in DNA rates, which might be attributed to longer term surveillance patients being less worried about their condition. In order to compensate for the DNA rate, it had been necessary to start overbooking some clinics. It was also noted that patients sometimes cancelled their Endoscopy appointments because they had not collected their bowel preparation medication. A new service had been developed with Lloyds Pharmacy whereby this medication was delivered to the patient's own home. Members commented upon the importance of Patient Partner involvement within the Endoscopy improvement workstream.

Assurance was provided that UHL's own activity would continue to be maximised once the agreed 9 lists were transferred to the Alliance in January 2016. CT colonoscopy (a new development that had been implemented in the last 4 weeks) was proving to be helpful, but UHL's imaging capacity was likely to hamper a wider rollout at the current time and a business case would be required to expand future capacity.

The Director of Estates and Facilities queried whether the CMG would be requiring any capital investment in re-processing equipment for scopes, noting that this was a key issue for maintaining compliance with CQC standards. In response, the Deputy Head of Operations advised that an options appraisal for replacement equipment was being undertaken and proposals would be submitted to the Capital Monitoring and Investment Committee in January 2016. **CHUGGS**

Members welcomed the CMG's invitation for Board members to visit the Endoscopy department in the near future. It was agreed that a further update would be provided to the 25 February 2016 IFPIC meeting, in the event that the diagnostic 6-week wait target was not achieved in January 2016 (as per the current trajectory). **TA/ CHUGGS**

<u>Resolved</u> – that (A) an options appraisal for replacement of Endoscopy re-processing equipment be prepared for consideration by the Capital Monitoring and Investment Committee in January 2016, and **CHUGGS**

(B) a Trust Board visit to the LRI Endoscopy Department be arranged to take place after the IFPIC and QAC meetings in January 2016 (eg 4pm). **TA/ CHUGGS**

136/15/2 <u>Month 8 Quality and Performance Report</u>

Paper E 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 November 2015. Noting that separate reports featured on this agenda in respect of Endoscopy and cancer performance, particular discussion took place regarding the

following key issues:-

(a) ***diagnostics performance*** – the Director of Performance and Information advised that 3 of the Trust's 12 MRI scanners were currently out of service and that this was impacting upon the planned recovery trajectory. An urgent meeting with the managed equipment service provider (Asteral) had been held and a remedial action plan had been agreed. However, the required mobile MRI units would not be available until January 2016. Assurance was provided that the TDA was currently reviewing whether it would be possible to divert any of the mobile scanning units to UHL within a shorter timescale. In the meantime, existing fixed scanner capacity was being maximised (including extended operating hours until midnight) and this was helping to mitigate the position;

(b) ***RTT incomplete pathways*** – UHL's performance remained compliant despite a continued rise in referrals and a non-compliant position nationally within the NHS. Some slight concerns were noted around Gastroenterology and non-admitted ENT performance;

(c) ***cancelled operations*** – on the day cancellations rates were improving, but the volume of cancellations prior to the day of surgery continued to cause concern. Access to elective surgery beds for children was becoming problematic in the context of a seasonal increase in children's admissions for bronchiolitis and the QAC Chair advised that she would be raising this issue at that afternoon's QAC meeting with a view to requesting an in-depth review. Staffing of extra capacity beds for children was expected to improve in January 2016 once an additional 6 nurses completed the supernumary phase of their employment; **QAC Chair**

(d) ***emergency readmissions*** – October 2015 performance stood at 9% against the 7% threshold and this indicator had been RAG-rated as red each month throughout the year. Colonel (Retired) I Crowe, Non-Executive Director queried whether there was any scope to review the causes for these and reduce them further (possibly learning lessons on good practice evidenced by other Trusts). In response, the Chief Executive provided assurance that a workstream on reducing readmissions was already being led by the Acting Medical Director under the UHL Quality Commitment. Regular updates were provided to the Quality Assurance Committee and the next such report was expected in March 2016. **AMD**

<u>Resolved</u> – that (A) the Committee's concerns regarding cancellation of children's elective surgery be highlighted at that afternoon's QAC meeting, and **QAC Chair**

(B) monitoring of the actions to reduce emergency re-admissions be undertaken as part of the UHL Quality Commitment reporting mechanism to QAC. **AMD**

136/15/3 <u>Cancer Performance</u>

Further to Minute 126/15/1 of 26 November, paper F provided a summary of the factors contributing to 62-day cancer pathway breaches during the months of August, September and October 2015. Members noted that of the 215 avoidable delays, 148 had contributory factors internal to the host CMG and 67 had external contributory factors. During December 2015, it was noted that 15 operations on cancer patients had been cancelled due to lack of access to HDU or ITU capacity.

The Committee noted that a recent Cancer Listening into Action event had been well-attended and positively evaluated. One of the ambitions arising from this event was for all cancer patients to leave hospital with a clear understanding of the next step(s) in their care pathway, even if this was awaiting the outcome of an MDT meeting or a date for a further diagnostic procedure. Patients would be encouraged to "own" and engage in their care pathways and the Communications team was helping to prepare a patient information

booklet to support this approach. The initial pilot would be undertaken within the upper and lower GI patient pathways.

The Committee commended the robust approach being taken to drive improvements in cancer performance. The Director of Performance and Information was requested to share the contents of paper F with Mr D Henson, the Healthwatch Trust Board Representative, ahead of the 7 January 2016 Trust Board meeting.

Resolved – that the Director of Performance and Information be requested to share the 62 day cancer performance report with Mr D Henson (prior to the 7 January 2016 Trust Board meeting). **DPI**

136/15/4 Fractured Neck of Femur Performance

Further to Minute 89/15/3 of 27 August 2015, the Committee had requested a report on fractured neck of femur performance in the event that this indicator was not compliant by December 2015. However, members noted that November 2015 performance was compliant (72.5% against the 72% threshold) and the December 2015 position currently looked strong. The expected report had therefore been withdrawn.

Resolved – that the position be noted.

136/15/5 RTT Recovery Plans

The Director of Performance and Information briefed the Committee on the issue of 52 week breaches within the Orthodontics service, noting the alternative arrangements that had now been agreed for a small number of patients to be treated by other providers and confirming that the service continued to be closed to new referrals (with some clinical exceptions). The Chief Executive provided feedback from his discussions with the TDA on 16 December 2015. A tripartite meeting was due to be held with NHS England and the TDA in January 2016 to review the position further (including the risk of incurring any performance-related penalties).

The notice served on the Orthodontics service was due to expire in May 2016, at which point a new strategy would be required to reduce the reliance of Maxillo Facial surgery upon the Orthodontics service. It was agreed that a verbal report on Orthodontics would be provided to the January 2016 IFPIC meeting. **COO**

Paper H provided a briefing on the elective activity lost due to the proposed Junior Doctors' strike on 1 December 2015. Whilst this industrial action had been called off, the late nature of the cancellation meant that 392 outpatient appointments and 41 daycase/ inpatient procedures were cancelled. Discussion took place regarding the potential for further industrial action being planned for early 2016 (subject to the appropriate ballot arrangements and notice periods). The QAC Chair noted that a small number of elective patients had been advised to attend for their appointments in the event that the industrial action was called off and she commented upon the scope to include this learning point in any future contingency planning.

Resolved – that (A) the information in respect of Orthodontics 52 week breaches and the impact of planned industrial action upon RTT recovery plans be received and noted, and

(B) a verbal report be provided to the January 2016 IFPIC meeting detailing the proposed approach for removing the Orthodontics backlog. **COO**

137/15 FINANCE AND PLANNING

137/15/1 Month 8 Financial Performance and Forecast 2015-16

Paper I 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). The Chief Financial Officer noted that this data had been produced earlier in the month than usual and that the regular confirm and challenge meetings with the CMG management teams had not yet been held. IFPIC members noted an in-month variance of £0.7m against plan, with a year to date adverse variance of £1.7m. Capital spend for the year to date was £24.2m (against a plan of £33.5m) whilst 2015-16 CIP delivery year to date stood at £27.3m (£1.3m adverse to plan). In discussion on paper I, IFPIC members:-

(a) requested clarity regarding the phrase "underspends on depreciation", noting that depreciation costs had been lower than planned as a result of reduced capital expenditure and that this reduction had helped to offset the higher than expected costs of delivering additional clinical activity;

(b) commented upon the unrealistic nature of the TDA non-pay trajectory post January 2016 (the graph provided in section 5.6 refers), noting that the green dotted line showed the correct forecast, but the Trust was not able to adjust the red dashed line without agreement from the TDA;

(c) welcomed a suggestion from Mr A Johnson, Non-Executive Director that it would be helpful to include tracking against the original forecast position in future iterations of this report; **CFO**

(d) noted that emergency activity levels were currently high, but they appeared to be lower than the forecast position. In response, the Chief Executive confirmed that this was already being examined, including whether the original capacity plans were insufficient and whether there was any connection between operational changes and reconfiguration of services;

(e) noted that draft activity and capacity plans for 2016-17 would be available by the end of January 2016 and that these would then be modified following appropriate confirm and challenge. Further iterations would be produced at the end of February and March 2016 and the outputs would be reflected in the financial performance reports; **CFO**

(f) commented upon the national announcement on 16 December 2015 that hospitals would be receiving an additional £1.8 billion for sustainability and transformation and queried UHL's ability to attract a proportion of this funding. The Chief Financial Officer agreed to circulate the relevant guidance on accessing this transformation fund to IFPIC members (outside the meeting); **CFO**

(g) supported the proposed approach for evaluating the Lakeside emergency care pilot mid-term and requested the Chief Operating Officer to present a report to the Trust Board in either April or May 2016. The Chief Financial Officer suggested that it would also be helpful to link this report to the tender for the Urgent Care Centre, and **COO**

(h) considered the financial performance of the most challenged CMG's (RRCV, ESM, W&C, and MSS), noting that the MSS CMG were due to present to the Committee in January 2016. **COO/ TA**

<u>Resolved</u> – that (A) tracking against the original financial forecast position be provided in future iterations of the financial performance report; **CFO**

(B) outputs of the activity and capacity confirm and challenge processes be reflected in the financial performance reports for January, February and March 2016; **CFO**

(C) the Chief Financial Officer be requested to circulate information on accessing

the national sustainability and transformation funding to IFPIC members (when available); **CFO**

(D) the Chief Operating Officer be requested to undertake a mid-term evaluation of the Lakeside emergency care pilot and present a report to the Trust Board in either April or May 2016, and **COO**

(E) the MSS CMG be invited to present an update on their financial and operational performance to the January 2016 IFPIC meeting. **COO/ TA**

137/15/2 Working Capital Strategy and Cash Flow

The Chief Financial Officer introduced paper K, providing the quarterly update on UHL's performance against the agreed 2015-16 Working Capital Strategy. Mr N Sone, Financial Controller also attended the meeting for this item. Particular discussion took place regarding access to the revolving working capital facility and limitations on the amount that the Trust would be allowed to draw down. Further work was taking place to assess the potentially significant implications of some recent changes in the TDA's guidance. Feedback on these implications and any further developments would be provided to the Committee as appropriate. During the discussion on paper K, IFPIC members:- **CFO**

(a) raised questions on the comparative charges between the various borrowing options and received assurance that all borrowing costs were taken into account before the final funding route was agreed;

(b) commented upon the monthly spikes in forecast cashflow, noting the impact of local agreements with the CCGs and the inherent tolerance levels. The Chief Financial Officer provided assurance regarding the larger (and more predicable) elements of UHL's income profile;

(c) welcomed the introduction of the "SME" supplier category and queried what proportion of the Trust's in-year Better Payment Practice Code (BPPC) performance was attributed to payment processes or cash limitations. In response, members noted access to cash was not the primary cause of BPPC non-compliance. Purchase order compliance was still a key issue to be resolved. To improve this performance, the parameters for the automatic payment system had been re-adjusted. The Audit Committee Chair received assurance that appropriate controls were still in place, and that triangulation between the purchase order, invoice and good received note (GRN) was required prior to payment. The Chief Financial Officer agreed to consider including a brief Internal Audit review of the automatic payment system within the 2015-16 IA plan, and **CFO**

(d) sought additional information regarding the working capital balances and performance against the liquidity metric (figures 3 and 4 on page 6 of paper K refer). Non-Executive Director members voiced concerns regarding the apparent gap between current liabilities and current assets and the negative liquidity ratio, suggesting that this did not provide a true reflection of the balance sheet. In response, the Chief Financial Officer agreed to provide a Trust Board awareness session on this subject at the end of the IFPIC and QAC meetings in February 2016. **CFO**

Resolved – that (A) feedback on the implications of TDA guidance on working capital and cash flow be provided to the Committee as appropriate; **CFO**

(B) consideration be given to including a brief IA review of the automatic payments system within the 2015-16 IA plan, and **CFO**

(C) a Trust Board awareness session on the subject of balance sheet and liquidity ratings be scheduled for 4pm on 26 February 2016. **CFO**

137/15/3 Cost Improvement Programmes 2015-16 and 2016-17

The Director of CIP and Future Operating Model provided an update on CIP progress for 2015-16 and 2016-17 (paper L). £27.3m of the 2015-16 CIP had been delivered in the year to date, which was a £1.3m adverse variance to plan. 98% of schemes were already delivering, and every effort was being put in place to address the variance to plan by year end, including 7 new schemes and an assessment of whether any CIP schemes could be brought forward from 2016-17. With regard to 2016-17 CIPs, a provisional figure of £41m was planned, £29m (70%) of which had been identified to date against an internally-set aspirational target of 75% by 30 November 2015.

In discussion on the CIP programme, IFPIC members sought and received additional clarity regarding the Carter Review outputs (including any opportunities for "quick wins") and the leadership arrangements for the cross-cutting CIP themes. The Director of CIP and Future Operating Model responded to a number of queries raised by Mr A Johnson, Non-Executive Director regarding the phasing of cross-cutting CIP targets, procurement opportunities and potential workforce skill-mix changes, providing assurance that each of these opportunities was already being pursued. Trust Board members had recently attended a valuable Board awareness session on value for money and procurement and the Committee Chair suggested that Mr Johnson might like to arrange a meeting with Mr B Shaw, Head of Supplies and Procurement to learn more about the Trust's Procurement Strategy and related CIP development. **AJ, NED**

Finally, the Committee noted the intention for the CQC to include efficiency metrics within future CQC ratings and the expectation that Trust Boards would review organisational efficiency metrics on a regular basis. **COO**

Resolved – that (A) Mr A Johnson, Non-Executive Director meet with Mr B Shaw, Head of Procurement and Supplies to discuss the Trust's Procurement Strategy and related CIP development, and **AJ, NED**

(B) consideration be given to the development of appropriate efficiency metrics for onward reporting to the Trust Board (as required by the CQC). **COO**

137/15/4 Overview of the Outpatients Cross-Cutting CIP Theme

The Director of CIP and Future Operating Model introduced the monthly update on the cross cutting CIP schemes, which for month 8 focused on outpatients (paper M). He commented that the main focus appeared to relate to efficiency rather than system re-design, consequently most of the savings opportunities centred around improving clinic utilisation rates and reducing DNAs. The Director of Performance and Information highlighted an opportunity to provide daily visibility of clinic room availability and members received assurance that good quality patient engagement was in place for this workstream.

Opportunities for a centralised Outpatients function were being explored on a specialty by specialty basis and the timeline for development of non face-to-face consultations was under review. The Committee supported the continued development of these workstreams, noting the scope to improve the pace of developing a single point of contact for outpatient appointments in order to reduce patient complaints on this theme. The Chief Operating Officer was requested to identify what additional support might be needed in order to progress the centralisation of the outpatients function. **COO**

Resolved – that (A) the overview of the Outpatients Cross Cutting CIP Theme be received and noted, and

(B) the Chief Operating Officer be requested to review what additional support might be needed in order to progress the centralisation of the outpatients function. **COO**

137/15/5 5 Year Financial Strategy Scenarios

Further to Minute 125/15/2 of 26 November 2015, paper N provided further scenarios regarding national capital availability constraints in addition to the "base case" considered at the last IFPIC meeting. In discussion on the report, members noted that the Director of Estates and Facilities and the Director of Strategy had both been engaged in the development of the scenarios. CIP assumptions remained unchanged, although the size of the CIP challenge would become more difficult without support from the Reconfiguration Programme.

The Chief Executive commented upon the current breakdown between the Trust's operational and structural deficits and he queried how this would be distinguished in each of the scenarios modelled. The Audit Committee Chair suggested that the paper might actually provide more questions than it answered, but members agreed that the re-prioritisation process had been helpful in identifying the minimum level of expenditure required to progress the Trusts strategic reconfiguration plans. Mr M Traynor, Non-Executive Director requested that a review of the estates-related risks (eg backlog maintenance) be considered at the January 2016 IFPIC meeting. **DEF**

Resolved – that (A) the updated 5 Year Financial Scenarios (paper N) be received and noted, and

(B) the Director of Estates and Facilities be requested to present a review of the estates-related risk assessments to the January 2016 IFPIC meeting. **DEF**

138/15 SCRUTINY AND INFORMATION

138/15/1 Updated Timetable for UHL Business Case Approvals

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

138/15/2 Executive Performance Board

Resolved – that the notes of the 24 November 2015 Executive Performance Board meeting be received (paper P).

138/15/3 Revenue Investment Committee

Resolved – that the notes of the 20 November 2015 Revenue Investment Committee meeting be received and noted (paper Q).

138/15/4 Capital Monitoring and Investment Committee

Resolved – that the notes of the 20 November 2015 Capital Monitoring and Investment Committee meeting be received and noted (paper R).

138/15/5 Updated IFPIC Calendar of Business

Resolved – that the updated IFPIC calendar of business be received and noted (paper S).

139/15 INVESTMENT BUSINESS CASES

139/15/1 Planned Ambulatory Care Hub Project Initiation Document

Resolved – that the previously circulated PID (paper T) be withdrawn and presented **DS**

to the January 2016 IFPIC meeting.

139/15/2 Women's Services Project Initiation Document

Resolved – that the previously circulated PID (paper U) be withdrawn and presented to the January 2016 IFPIC meeting. **DS**

140/15 ANY OTHER BUSINESS

140/15/1 Mrs J Wilson – Non-Executive Director and Committee Chair

Noting that this would be the last IFPIC meeting before Ms Wilson left the Trust, the Trust Chairman thanked her for her chairing this Committee. In return, Ms Wilson thanked members for their support, contributions and challenges and wished them well for the future.

Resolved – that the position be noted.

141/15 ITEMS TO BE HIGHLIGHTED TO THE TRUST BOARD

Resolved – that (A) the Minutes of this meeting be presented to the Trust Board meeting on 7 January 2016, and **TA/ Chair**

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

- **Minute 131/15 – Revised 2015-16 Capital Programme (for Trust Board approval);**
- **Minute 134/15/1 – CMG presentation;**
- **Minute 136/15/1 – Endoscopy performance;**
- **Minute 136/15/3– Cancer performance;**
- **Minute 137/15/1 – Month 8 Financial performance**
- **Minute 137/15/3 – Cost Improvement Programme and efficiency metrics requirement for CQC ratings, and**
- **Minute 137/15/5 – 5 Year Financial Strategy Scenarios.**

142/15 DATE OF NEXT MEETING

Resolved – that the next meeting of the Integrated Finance, Performance and Investment Committee be held on Thursday 28 January 2015 from 8.30am – 12noon in the Board Room, Victoria Building, Leicester Royal Infirmary.

The meeting closed at 12noon

Kate Rayns – **Trust Administrator**

Attendance Record 2015-16

Voting Members:

Name	Possible	Actual	% attendance	Name	Possible	Actual	% attendance
J Wilson (Chair)	9	9	100	R Mitchell	9	7	78
J Adler	9	6	67	M Traynor	9	9	100
I Crowe	9	9	100	P Traynor	9	8	89
S Dauncey	9	8	89				

Non-Voting Members:

Name	Possible	Actual	% attendance	Name	Possible	Actual	% attendance
A Johnson	2	2	100	K Singh	9	9	100
D Kerr	9	7	78	G Smith	5	5	100
M Gordon	5	4	80	K Shields	9	4	44
R Moore	9	9	100				