Trust Board paper U

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: 26 November 2015

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

Minute 120/15 – adult ICU level 3 project (for Trust Board approval)

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

- **Minute 126/15/2 – ambulance handovers.**

DATE OF NEXT COMMITTEE MEETING: 17 December 2015

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 26 NOVEMBER 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 R Mitchell – Chief Operating Officer (up to and including Minute 125/15 and for Minute 126/15/2)
Mr M Traynor – Non-Executive Director (up to and including Minute 125/15 and for Minute 126/15/2)
Mr P Traynor – Chief Financial Officer

In Attendance:
Mr C Benham – Director of Operational Finance
Ms C Blakemore – HR Lead, RRCV CMG (for Minute 124/15/1)
Ms R Chhokar – Finance Lead, RRCV CMG (for Minute 124/15/1)
Mr J Clarke – Chief Information Officer (for Minutes 124/15/3 and 124/15/4)
Ms H Crossley – Transformation Lead, RRCV CMG (for Minute 124/15/1)
Ms J Davis – Ernst Young (for Minutes 125/15/4 and 125/15/5)
Ms J Gilmore – Deputy Head of Ops, RRCV CMG (for Minute 124/15/1)
Ms M Gordon – Patient Partner
Mr C Green – ICU Reconfiguration Project Lead (for Minute 120/15)
Ms G Harris – Deputy Head of Ops, ITAPS CMG (for Minute 120/15)
Mr J Jameson – Acting Deputy Medical Director (for Minute 120/15)
Mr A Johnson – Non-Executive Director
Mr D Kerr – Director of Estates and Facilities
Ms S Leak – Head of Ops, RRCV CMG (for Minute 124/15/1)
Mrs S Mason – Head of Nursing RRCV (for Minute 124/15/1)
Mr W Monaghan – Director of Performance and Information
Mr R Moore – Non-Executive Director
Ms L Naylor – Project Manager, Site Reconfiguration (for Minute 120/15)
Mr T Pearce – Major Projects Financial Lead (for Minutes 119/15 and 120/15)
Ms C Ribbins – Deputy Chief Nurse (for Minute 120/15)
Mr K Singh – Trust Chairman
Ms H Stokes – Senior Trust Administrator
Ms E Wilkes – Reconfiguration Programme Director (for Minute 120/15)

RECOMMENDED ITEMS **ACTION**

119/15 REPORT FROM THE CHIEF FINANCIAL OFFICER

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

120/15 BUSINESS CASES – ADULT LEVEL 3 INTENSIVE CARE UNIT

Papers R-R4 presented the adult level 3 ICU business cases for endorsement and recommendation on for formal Trust Board approval. In addition to the overarching covering report at paper R, members of the ICU reconfiguration team attended therefore to present the adult level 3 ICU (Glenfield ICU medium term) business case [paper R1] and individual enabling business cases relating to (i) the Glenfield Hospital beds enabler [paper R1]; (ii) the LRI beds enabler [paper R2], and (iii) the Glenfield Hospital imaging enabler [paper R3], totalling a capital spend of £16.5m in addition to the £0.7m already approved.

IFPIC members were advised that the 4 business cases presented aligned appropriately to UHL's overall reconfiguration programme and 5-year strategy, and noted that discussions on the business cases at the November 2015 Executive Strategy Board had raised issues relating to the availability/access/phasing of capital and to the need to manage the continued operational pressures.

Mr J Jameson, Acting Deputy Medical Director, summarised the background to the ICU reconfiguration project and outlined the risks of not proceeding with the business cases at papers R-R4, including the likely loss of tertiary work and resulting impact on recruitment and retention. He also noted the significant cross-specialty clinical engagement in the ICU reconfiguration project. Mr T Pearce, Major Projects Financial Lead advised that the cost of the 'do nothing' option could amount to approximately £8m due to loss of income. In discussion on the business cases, IFPIC members:-

(a) noted (in response to a query) that opportunities to deliver the ICU reconfiguration below the overall cost envelope would not be known until the design stage;

(b) noted comments from the Chief Financial Officer regarding the limited availability of capital, although recognising the key strategic importance of this project. Ms L Naylor Project Manager, Site Reconfiguration outlined the potential impact of not being able to progress related enabling/decant works (which could not be authorised due to capital availability restrictions). In response to a Non-Executive Director query, the Chief Financial Officer advised that he would not be able to prioritise those works in isolation at this stage (eg without further clarity on overall capital availability);

(c) noted ongoing measures to formalise CMG buy-in to the assumptions underpinning the business cases. In response to concerns (from the IFPIC Non-Executive Director Chair) Mr C Green, Reconfiguration Project Lead provided assurance that CMGs were fully sighted to the costs of the project and had been involved in many confirm and challenge sessions accordingly;

(d) were advised that the revenue costs would end in 2018-19 provided that UHL's overall reconfiguration programme proceeded to timescale;

(e) emphasised the need for assurance on the Trust's ability to accommodate the changes, in light of current operational capacity demands. Members agreed that a report on operational capacity pressures should be considered at the 28 January 2016 IFPIC; **DS/COO**

(f) queried the project's amber Gateway Review rating, and sought assurance on operational management plans. In response, the Reconfiguration Project Lead clarified that the amber rating had related to outstanding issues at the time (now resolved). He further emphasised that operational delivery was now the project priority, with an operational presence planned on each relevant site;

(g) noted comments that Patient Partners would be happy to be involved in the project from a user perspective. Ms M Gordon, Patient Partner also commented on the need to increase the quantity and quality of relatives' accommodation at the Glenfield Hospital ICU, and

(h) queried how to manage a number of known Consultant retirements in summer 2016 if this project slipped.

Following due consideration, IFPIC supported the ICU reconfiguration business cases as presented (subject to capital availability and Glenfield Hospital site operational pressures being resolved), and recommended them for approval by the 3 December 2015 Trust Board. **IFPIC CHAIR**

<u>Recommended</u> – that (A) the adult level 3 ICU project business case (Glenfield ICU medium term) and the 3 enabling business cases relating to (i) GH beds enabler; (ii) **IFPIC CHAIR**

LRI beds enabler, and (iii) GH imaging enabler, be supported at a cost of £16.5m and recommended for December 2015 Trust Board approval, subject to the availability of capital and resolution of operational capacity issues at the Glenfield Hospital site, and

(B) operational capacity pressures be discussed further at the January 2016 IFPIC. **DS/COO**

RESOLVED ITEMS

121/15 APOLOGIES AND WELCOME

Apologies for absence were received from Mr S Barton, Director of CIP and Future Operating Model, Professor A Goodall, Non-Executive Director and Ms K Shields, Director of Strategy.

122/15 MINUTES

Resolved – that the Minutes of the 29 October 2015 IFPIC meeting be confirmed as a correct record.

123/15 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 112/15/1 of 29 October 2015** – this action had now been completed;
(b) **Minute 111/15/2(d) of 29 October 2015** - a date of **28 February 2016** (following the QAC meeting on that date) had now been set for Trust Board members to visit the LRI Pathology Service, and
(c) **Minute 101/15/5(b) of 24 September 2015** – although the route map had been discussed at the November 2015 Trust Board thinking day, it was not complete. It was agreed to re-grade this action as a '4' and retain it on the action log accordingly (appropriate wording for the entry to be provided by the Chief Financial Officer and the Director of Estates and Facilities). **TA/ CFO/ DEF**

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

124/15 STRATEGIC MATTERS

124/15/1 CMG Presentation – Renal, Respiratory and Cardio-Vascular [RRCV] CMG

Prior to the arrival of the RRCV CMG management team and although noting the overall very strong performance of this CMG, IFPIC members agreed to seek further assurance on the following issues in particular:-

- RTT performance in respect of specific tumour sites including lung;
- Glenfield Hospital CDU performance including winter capacity issues. Stops had increased markedly over the last 2 weeks impacting on ED and trolley waits. IFPIC would also seek the CMG's view on the working of the ICS community beds and its comments on whether (given current activity demands on UHL) further beds could in fact be moved out to community settings as planned, and
- financial performance.

The RRCV CMG management team then arrived and commented on the 3 issues above as follows:-

(a) ***RTT performance*** – Consultant recruitment was now underway in the specific service experiencing the most difficulties. Although above target in respect of 31-day and 2-week waits, the 62-day cancer wait remained challenging; remedial actions by the CMG included pathway redesign and the appointment of a Cancer Centre Manager as part of aspiring towards 85%+ performance. Lung cancer pathways were extremely complex, however;

(b) ***CDU performance and winter pressures*** – a front door triage process would be implemented on a phased basis in December 2015, to improve patient turnaround and occupancy levels. A new cardiology pathway would also help in appropriately streaming patients from CDU to a shortstay ward. Although the overall capacity and capability of the CDU was significantly improved from 2 years ago, the RRCV Head of Ops acknowledged that winter pressures would be challenging and she outlined the various actions underway to ease flow, including additional weekend catheter labs and chaired areas on wards for patients awaiting discharge. The Glenfield Outreach (GO) project was also having a positive impact, and

(c) ***financial performance*** – the CMG was showing a year-to-date deficit of £1.051m, with a pay underspend offset by a non-pay overspend (primarily on high cost drugs and devices). Income remained a key challenge particularly within renal transplant and cardiac surgery, although the CMG was confident that the income position would recover in the second half of 2015-16.

In discussion on the presentation at paper C and the RRCV comments detailed above, IFPIC members:-

(i) noted the cardiology training issue on the 'new risks' slide. The Deputy Head of Ops RRCV advised that the issues recently highlighted by HEEM (which had been known to the CMG) were now being addressed, with an RRCV CMG education lead appointed to focus on the core issues of rotas and supervision. In light of the forthcoming known loss of F1s, new roles were also being explored (eg expansion of Nurse Specialists) although this would have a financial impact;

(ii) sought assurance that the ambulatory front door to CDU approach was sustainable once those training posts were lost;

(iii) noted (in response to a query) that RRCV clinicians were closely engaged in discussions on the income position and the CMG's overall financial performance;

(iv) noted RRCV concerns over the ability to close more beds as planned, in light of existing capacity pressures. The CMG management team considered that the March 2016 timescale for the additional bed closures was not currently deliverable, and was now working through the financial and operational implications of any alternatives. The CMG was also unsure how much Glenfield Hospital capacity would be freed up by the ICS beds, given the high acuity and specialist nature of RRCV patients. In discussion, the Chief Executive agreed to review staff communications on this issue, to clarify that further Glenfield Hospital RRCV beds would not be moved to the community unless current operational pressures on that site were appropriately resolved; **CE**

(v) queried what specific challenges remained in respect of workforce – in response the CMG noted further work to be done on nursing vacancies (although significantly reduced from 2014-15). RRCV use of agency nurses was negligible, however, and the Head of Ops noted her intention to try and replicate RRCV good practice re: nursing vacancies in the Emergency and Specialist Medicine CMG (of which she was also Head of Ops). With regard to medical workforce, it was noted that nearly all vacancies were filled as of December 2015. Vacancies in the technical specialties (where RRCV was

using agency staff) reflected national shortages. In response to a Non-Executive Director query about RRCV's sickness absence level, the CMG HR Lead detailed initiatives to address this including 'move it on' meetings to explore any trends/hotspot areas. She also commented that RRCV's sick leave primarily reflected longterm/planned absences rather than sporadic short-term absence, and

(vi) congratulated the CMG on its strong performance overall and welcomed the innovative work underway within RRCV.

Resolved – that (A) the performance presentation from Renal Respiratory and Cardio-Vascular CMG be noted, and

(B) staff communications be reviewed to clarify that further Glenfield Hospital RRCV beds would not be moved to the community unless current operational pressures on that site were appropriately resolved. **CE**

124/15/2 University of Leicester Embedded Space at UHL

Paper E from the Director of Estates and Facilities detailed his completed benchmarking of the University of Leicester's occupancy of space across the UHL estate (as agreed with UoL). A recharging basis had been developed and an invoice covering April – September 2015 was in preparation accordingly, for presentation to the University (approximately £314k including administrative fees). In response to a query from the Chief Executive as to whether UoL had formally agreed to pay the recharges, the Director of Estates and Facilities reported his understanding that the University had "made provisions", although he acknowledged that this was not the same as a formal agreement to pay. It was noted that the Trust's Director of Estates and Facilities and Chief Financial Officer were meeting with the University of Leicester's Director of Finance later on 26 November 2015.

Ms M Gordon, Patient Partner, queried whether mothballed facilities adjacent to the Leicester General Hospital sleep unit were included in paper E, as those areas still contained equipment. The Director of Estates and Facilities advised that this issue would need to be pursued with the relevant UHL CMG.

Resolved – that the update on UoL embedded space at UHL be noted.

124/15/3 EPR Project Update

The Chief Information Officer attended to provide a verbal update on the EPR project, advising of slippage on the process for National Trust Development Authority (NTDA) approval. He has also now been advised that the EPR project would require Department of Health approval – the NTDA was due to pass the project up to the DoH accordingly on 16 December 2015. Due to this slippage and additional process steps now required, the Chief Information Officer considered that approval for the EPR project was unlikely to be received before March 2016. UHL was therefore developing a contingency plan for ED, as this did not match the timescale for the new Emergency Floor. The slippage also meant that a number of UHL's existing IM&T systems would now need remedial work to upgrade them for the interim period. This would constitute a cost pressure and his team was working closely with the Finance Team accordingly.

IFPIC members noted their disappointment and frustration at this development, noting the quality and assurance improvements riding on the EPR programme. The IFPIC Non-Executive Director Chair requested that an update be provided to a future IFPIC re: the clinical implications of any alternative route to EPR. **CIO**

Resolved – that an update be provided to a future IFPIC meeting on the clinical implications of any alternative route to EPR. **CIO**

124/15/4 IBM Contract Performance Quarterly Update

Paper F from the Chief Information Officer presented the quarterly review of the IBM contract, noting reduced IBM performance against certain significant SLAs (attendant financial penalties issued). IBM had now put in significant additional resource at their cost, and November 2015 contract performance looked to have improved. In discussion on IBM's contract performance IFPIC members:-

(a) queried what back-up arrangements were in place for UHL's IT systems, in light of the issue flagged with the transplant laboratory IT system. The Chief Information Officer confirmed that all UHL IT systems were backed-up and noted that the transplant laboratory system had been developed by the service rather than by IM&T (who were now assisting the service in fast-tracking an appropriate replacement);

(b) welcomed the Business Intelligence update within paper F, noting that roll-out of the QlikSense system had been delayed until the data warehouse issues were resolved. The Chief Financial Officer also noted that the data warehouse was crucial to the work of the Finance Team and he queried why problems had again arisen. The Chief Information Officer advised that a specific code error with the data warehouse had now been resolved, although he acknowledged the need to understand why that error had not been addressed earlier, and

(c) noted work underway by the Chief Information Officer to raise awareness and knowledge of the IM&T team and UHL's IT systems, with staff. He noted the need for the IM&T service to understand user needs, and for those users to become more aware of how the IM&T service could help them.

Resolved – that the quarterly update on IBM contract performance be noted.

125/15 FINANCE AND PLANNING

125/15/1 Month 7 Financial Performance and Forecast 2015-16

Paper G 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 previously reported, UHL's control total for 2015-16 was now a deficit of £34.1m, and paper G also noted the new DoH guidance on limits to nurse agency spend from quarter 3 of 2015-16. The Chief Financial Officer noted an in-month variance of £0.5m against plan, with a year to date adverse variance of £1m. Capital spend for the year to date was £21.5m (against a plan of £25.8m) whilst 2015-16 CIP delivery year to date stood at £23.2m (£1.5m adverse to plan).

Although there was still room for further progress, the Committee was encouraged by the improvement in the month 7 financial position. UHL's runrate had improved and there were clear actions in place to meet the revised control total. The Trust's financial position had also been discussed in detail at the 24 November 2015 Executive Performance Board. Operational pressures remained a challenge, however, including the planned strike[s] by junior doctors. The Chief Operating Officer noted continued efforts to maintain the elective flow (and associated income) despite winter pressures. In discussion on paper G IFPIC members noted:-

(a) that UHL's likely delivery of the 2015-16 stretch target would be viewed nationally as good performance, in light of the financial difficulties facing many NHS Trusts;
(b) (in response to a query) the Chief Financial Officer's view that meaningful discussions with Commissioners on the 2016-17 year would be best held around December. Relatively few elements of the contract were in dispute this year, which was welcomed;
(c) a Non-Executive Director query on the likely cost of the junior doctors' strike[s]. In

response, the Director of Performance and Information noted that very significant elective activity (451 operations and 4590 outpatient appointments) was currently scheduled for 1 December 2015 – an assessment of the financial (and operational) impact of the junior doctors' strike scheduled for that date would be circulated for information; **DPI**

(d) (in response to a query from the Trust Chairman) the Chief Financial Officer's view that the CMGs' revised financial plans for 2015-16 were both realistic and deliverable. A greater amount of acute business was traditionally undertaken in the second half of the financial year, with a corresponding impact on income, and

(e) that the biggest risk to the achievement of the financial position was disruption to elective capacity and income over winter. Month 8 was critical in terms of income, more detail on which would therefore be included in the monthly finance report to the December 2015 IFPIC.

Resolved – **that an assessment of the financial (and operational) impact of the junior doctors' strike scheduled for 1.12.15 be circulated for information.** **DPI**

125/15/2 Capital Position and Availability

The Chief Financial Officer provided a verbal update on this issue, reminding members that UHL's capital programme for 2015-16 (initially amounting to approximately £120m) had been reduced to £81m in August 2015 as part of the resubmission to the NTDA. It was becoming more and more challenging to secure approval to spend for capital projects and thus draw down capital, and (as members were aware) the Emergency Floor approval remained outstanding. The Trust had also very recently been advised not to submit the carparking and vascular capital business cases for approval until March 2016 (no draw down in the 2015-16 year therefore), which was of concern.

Further discussions were planned with the NTDA in the coming week, and the IFPIC Non-Executive Director Chair requested that a detailed discussion on capital therefore be agenda'd for the December 2015 IFPIC – given the potential implications for key UHL reconfiguration projects, it would be helpful if the Director of Estates and Facilities could also attend for this item. **CFO**

The Chief Executive advised that time was now being lost on the Emergency Floor project due to an inability to commit to contractors – this had not yet incurred any increased costs, however. From a process perspective, it was agreed that IFPIC should continue to consider (and approve where appropriate) investment business cases in the usual way, with the caveat that the Chief Executive and Chief Financial Officer would review the capital handling issues.

Resolved – that a detailed discussion on capital availability (and the implications for UHL's capital and reconfiguration programmes) be provided to the 17 December 2015 IFPIC, with the Director of Estates and Facilities present. **CFO**

125/15/3 5-Year Financial Strategy Update (including LTFM)

Paper H outlined the interim refresh of UHL's financial strategy and longterm financial model, which took place at least twice yearly. The next full review would take place in 6 months' time reflecting 2016-17 planning assumptions once the relevant national guidance was published.

Resolved – that the regular refresh report on the Trust's 5-year financial strategy and LTFM be noted.

125/15/4 Cost Improvement Programmes 2015-16 and 2016-17

In the absence of the Director of CIP and Future Operating Model, Ms J Davies attended from Ernst Young to provide an update on CIP progress for 2015-16 and 2016-17 (paper

I). £23.2m of the 2015-16 CIP had been delivered in the year to date, which was a £1.5m adverse variance to plan. 97% of schemes already delivering, and every effort was being put in place to address the variance to plan by year end, including an assessment of whether any CIP schemes could be brought forward from 2016-17. Members noted that the existing programme management support was due to end shortly, with NTDA approval requested to extend this; an update on this issue would be provided to the December 2015 IFPIC. **COO**

With regard to 2016-17 CIPs, a provisional figure of £41m was planned, 49% of which had been identified to date against an internally-set aspirational target of 75% by 30 November 2015. There was significant rigour in the process, with fortnightly meetings held with CMGs and appropriately close links with the Strategy Team. IFPIC noted the Trust's intention to increase senior management mobilisation around the 2016-17 CIP, noting the particular importance of the cross-cutting schemes. In response to a query from the Audit Committee Non-Executive Director Chair, the Chief Financial Officer considered that any slippage on the reconfiguration and Better Care Together programmes were more likely to impact on later years of the CIP process rather than 2016-17.

Resolved – that the position re: the requested NTDA approval to extend the current external programme management support for the CIP programme, be clarified to the December 2015 IFPIC. **COO**

125/15/5 Overview of the Beds Cross-Cutting CIP Theme

In the absence of the Director of CIP and Future Operating Model, Ms J Davies attended from Ernst Young to provide the monthly update on the cross-cutting CIP schemes, which for month 7 focused on beds (paper J). 71 beds had been closed sustainably to date in 2015-16, and paper J outlined the key risks, non-financial benefits, and next steps of the beds cross-cutting workstream. In discussion, the Chief Executive noted the key need to balance operational capacity pressures with the planned beds closures, and requested that a robust capacity plan be presented therefore to the January 2016 IFPIC, also outlining appropriate contingencies. The Chief Operating Officer echoed these comments, noting the pressures being felt by front-line staff and emphasising the need to be more analytical before taking beds decisions for 2016-17. The IFPIC Non-Executive Director Chair requested that all future monthly CIP deepdives include an assessment of key quality and safety risks. **COO/ DCIP& FOM** **COO**

Resolved – that (A) robust capacity plan with appropriate contingencies built in, be presented to the January 2016 IFPIC (reflecting the need to balance existing operational capacity issues with the planned beds reductions), and **COO**

(B) all future monthly CIP deepdives include an assessment of key quality and safety risks. **COO**

126/15 PERFORMANCE

126/15/1 Month 7 Quality and Performance Report

Paper K provided an overview of UHL's quality, patient experience, operational targets, and HR performance against national, regional and local indicators for the month ending 31 October 2015. Particular discussion took place regarding the following key issues:-

(a) ***cancer performance*** – the Director of Performance and Information considered that UHL would be compliant with the 2-week wait target for November 2015, noting performance of 92.1% as of 26 November 2015. This was largely due to improvements in endoscopy performance as a result of the numbers of patients seen, the positive impact of new leadership in that service, and a new November 2015 care pathway for failed endoscopy to CT colon. Progress had also been made on 31-day waits, and the Director of Performance and Information was confident of delivering 8 of

the 9 key cancer targets in November/December 2015. 62-day waits remained challenging, however, despite progress. A very positive cancer performance LiA event had been held, and the focus was now on using December 2015 as a 'momentum month' to build on progress. The IFPIC Non-Executive Director Chair requested that a deepdive/thematic review re: cancer performance be provided to the December 2015 IFPIC; **COO/ DPI**

(b) ***fractured neck of femur*** – the reported performance was considered to be a blip reflecting the significant number of patients in October 2015 who had been too unwell to go to theatre. As of 26 November 2015, Trust performance was above the 70% standard;

(c) ***RTT incomplete 18 weeks*** – the Director of Performance and Information voiced concern over whether UHL would be able to remain above 92% performance for December 2015, due to the reduced activity in that month and the likely impact of the junior doctors' strike[s]. The impact of even a single strike day would be very significant, as they were scheduled for the Trust's busiest elective day of the week (Tuesday). The Chief Executive noted the need to stand theatres and patients down in good time, while trying to leave any cancellation decisions as late as possible. An appropriate communications plan had been developed, and the potential quality impact of the strike[s] would be discussed further at the QAC meeting later on 26 November 2015, and

(d) ***6-week diagnostics*** – although the improving trend was encouraging, the impact of the scheduled junior doctors' strike[s] was an unknown quantity. If the strike[s] went ahead, the medical workforce from CHUGGS would be supporting patients on the wards which would affect the number of endoscopies and gastroscopies undertaken.

The Director of Performance and Information advised that he would bring recovery plans in the event of the strike[s] for both RTT and diagnostic waits to the December 2015 IFPIC – that report would also detail what the performance position would have been if the strike[s] had not occurred. **DPI**

<u>Resolved</u> – that (A) a deepdive on cancer performance be provided to the December 2015 IFPIC, and **COO/ DPI**

(B) recovery plans for both RTT 52-week waits and diagnostic 6-week waits be presented to the December 2015 IFPIC, also covering what UHL's performance position would have been on these two targets if the planned junior doctor's strike[s] had not taken place. **DPI**

126/15/2 <u>Ambulance Handover Performance</u>

Paper L from the Chief Operating Officer updated members on the actions taken to date to try and improve ambulance handover times at the LRI. He noted that this issue reflected the fact that the LLR healthcare system was under extreme pressure, and accepted that the actions to date had not resulted in significant improvements to handover times, with patients waiting an unacceptably long time in ambulances. This then impacted on the availability of ambulances for patient call outs in the community. UHL's Chief Operating Officer and Chief Executive were now in very frequent contact each week with EMAS, the NTDA and Commissioners, and the Chief Operating Officer noted the potential for the current situation to deteriorate further unless there was a step-change in either activity, capacity, or process. In addition to the measures within paper L, the Chief Executive advised that cohorting of patients was now also being done pre-handover.

The CQC had recently visited the LRI ED as part of its inspection of EMAS; in light of the ambulance delays witnessed the Chief Executive considered that a CQC inspection of ED was now likely. This would be an appropriate priority for the Trust's Executive Directors and senior managers. In discussion on paper L, IFPIC members:-

(a) were advised that the joint EMAS-UHL Listening into Action (LiA) event had now taken place. Although very positive in terms of sharing information, a limited

number of actions had emerged from that session;

(b) noted a query from the Patient Partner as to the Unipart element of the report. The Chief Operating Officer clarified that Unipart was an external consultancy with experience of healthcare and ambulance handover issues – he had now met with Unipart to review the actions from its diagnostic exercise. Col (Ret'd) I Crowe Non-Executive Director sought assurance that the standardisation of processes referred to had been implemented – in response, although confirming work to reduce variability the Chief Operating Officer advised that the situation would not be resolved simply by standardising the process. Activity was the key challenge, which also drove the variation;

(c) queried what further actions were needed re: staffing levels. In response, the Chief Operating Officer confirmed that recruitment efforts continued and noted the positive impact of the additional agency staff being used. The Chief Executive commented that UHL would find it very challenging to implement the new caps on rates for all agency staff spend by the required date of 30 November 2015, and

(d) noted that this issue would be discussed further at the December 2015 Trust Board, as part of the Chief Executive's monthly report and the emergency care performance report. **CE/ COO**

<u>Resolved</u> – that ambulance handovers be highlighted to the 3 December 2015 Trust Board through the IFPIC meeting summary, noting that this issue would also be covered at that Trust Board meeting. **CE/ COO**

127/15 SCRUTINY AND INFORMATION

127/15/1 <u>Updated Timetable for UHL Business Case Approvals</u>

As he had done at the 25 November 2015 Reconfiguration Board, the Chief Financial Officer voiced significant concern over the proposed 4-month extension requested to the Children's Hospital project. The explanation provided in paper P was not felt to be sufficiently robust, and the Chief Financial Officer noted that he would discuss the position with the Director of Strategy outside the meeting. It was agreed to receive an update on this issue at the December 2015 IFPIC. **CFO**

<u>Resolved</u> – that (A) the updated timetable for Strategic Business Case Approvals be received and noted as paper P, and

(B) a verbal update re: concerns at slippage on the children's hospital scheme (4-month extension requested) be provided to the 17 December 2015 IFPIC. **CFO**

127/15/2 <u>Executive Performance Board</u>

<u>Resolved</u> – that the notes of the 27 October 2015 Executive Performance Board meeting be received and (paper N).

127/15/3 <u>Revenue Investment Committee</u>

<u>Resolved</u> – that the notes of the 16 October 2015 Revenue Investment Committee meeting be received and noted (paper O).

127/15/4 <u>Capital Monitoring and Investment Committee</u>

<u>Resolved</u> – that the notes of the 16 October 2015 Capital Monitoring and Investment Committee meeting be received and noted (paper P).

127/15/5 <u>Updated IFPIC Calendar of Business</u>

<u>Resolved</u> – that the updated IFPIC calendar of business be received and noted (paper Q).

128/15 ANY OTHER BUSINESS

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

129/15 ITEMS TO BE HIGHLIGHTED TO THE TRUST BOARD

Resolved – that (A) a summary of the business considered at this meeting be provided to the Trust Board meeting on 3 December 2015, and **TA/ Chair**

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

- **Confidential Minute 119/15 above (for Trust Board approval);**
- **Minute 120/15 – adult ICU level 3 project (for Trust Board approval), and**
- **Minute 126/15/2 – ambulance handovers.**

130/15 DATE OF NEXT MEETING

Resolved – that the next meeting of the Integrated Finance, Performance and Investment Committee be held on Thursday 17 December 2015 from 8.30am – 12noon in the Board Room, Victoria Building, Leicester Royal Infirmary.

The meeting closed at 12.31pm

Helen Stokes – **Senior Trust Administrator**

Attendance Record 2015-16

Voting Members:

Name	Possible	Actual	% attendance	Name	Possible	Actual	% attendance
J Wilson (Chair)	8	8	100	R Mitchell	8	7	88
J Adler	8	5	63	M Traynor	8	8	100
I Crowe	8	8	100	P Traynor	8	7	88
S Dauncey	8	7	88				

Non-Voting Members:

Name	Possible	Actual	% attendance	Name	Possible	Actual	% attendance
A Johnson	1	1	100				
D Kerr	8	6	75	K Singh	8	8	100
M Gordon	4	4	100	G Smith	5	5	100
R Moore	8	8	100	K Shields	8	4	50