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 April 2016**

**COMMITTEE: Integrated Finance, Performance and Investment Committee**

**CHAIR: Mr M Traynor, Non-Executive Director**

**DATE OF COMMITTEE MEETING: 25 February 2016**

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

- **Minute 13/16/1 – paediatric dentistry and day case FBC.**

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

- **Minute 17/16/1 – month 10 financial performance;**
- **Minute 17/16/2 – draft operation plan submission 2016-17;**
- **Minute 17/16/4 – CIP update;**
- **Confidential Minute 17/16/5 – report by the Chief Financial Officer;**
- **Confidential Minute 17/16/6 – report by the Chief Information Officer;**
- **Confidential Minute 18/16/3 – report by the Director of Estates and Facilities, and**
- **Minute 19/16/2 – demand and capacity planning 2016-17.**

**DATE OF NEXT COMMITTEE MEETING: 24 March 2016**

**Mr M Traynor**
**Non-Executive Director and Committee Chair**

**UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST**

**MINUTES OF A MEETING OF THE INTEGRATED FINANCE, PERFORMANCE AND INVESTMENT COMMITTEE (IFPIC), HELD ON THURSDAY 25 FEBRUARY 2016 AT 9AM IN THE BOARD ROOM, VICTORIA BUILDING, LEICESTER ROYAL INFIRMARY**

**Voting Members Present:**
Mr M Traynor – Non-Executive Director (Committee Chair)
Mr J Adler – Chief Executive
Colonel (Retired) I Crowe – Non-Executive Director
Dr S Dauncey – Non-Executive Director (from Minute 17/16/3)
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
Mr N Bond – Head of Capital Projects, Estates and Finance (for Minute 13/16/1 only)
Mr N Callow – Finance Director, Empath (for Minute 19/16/4 only)
Mr J Clarke – Chief Information Officer (for Minute 17/16/6 only)
Mr A Fleming – Senior Finance Manager (for Minute 21/16/1 only)
Ms L Gallagher – Workforce Development Manager (for Minutes 18/16/1 and 18/16/2 only)
Ms M Gordon – Patient Adviser
Ms L Hamadallah – Student shadowing the Acting Director of Strategy (from Minute 17/16/1)
Ms G Harris – Deputy Head of Operations, ITAPS (for Minute 21/16/1 only)
Ms J Hollidge – Head of Nursing, ITAPS (for Minute 21/16/1 only)
Mr J Jameson – Deputy Medical Director (for Minutes 13/16/1 and 21/16/1)
Mr A Johnson – Non-Executive Director
Mr D Kerr – Director of Estates and Facilities
Ms K Khaira – HR Lead, ITAPS (for Minute 21/16/1 only)
Dr D Kirkbride – Deputy Clinical Director, ITAPS (for Minute 21/16/1 only)
Mr W Monaghan – Director of Performance and Information
Mr R Moore – Non-Executive Director
Mr T Pearce – Major Projects Finance Lead (for Minute 17/16/5 only)
Mrs K Rayns – Trust Administrator
Ms K Renacre – Interim Assistant Director of Workforce (for Minutes 18/16/1 and 18/16/2 only)
Ms H Seth – Acting Director of Strategy (from Minute 17/16/1)
Mr K Singh – Trust Chairman
Ms J Smith – Chief Nurse (for Minutes 13/16/1 and 21/16/1)
Dr J Visser – Consultant Paediatric Oncologist (for Minute 13/16/1 only)

**RECOMMENDED ITEMS** **ACTION**

## 13/16 INVESTMENT BUSINESS CASES

13/16/1 Paediatric Dentistry and Day Case Surgery Unit

The Head of Capital Projects and the Consultant Paediatric Oncologist attended the meeting to present paper U, seeking the Committee's approval of the full business case for the interim reconfiguration of elements of the Children's Day Case Surgery and Children's Community Dental Services located at the LRI. IFPIC members particularly noted that the proposed unit would provide a fully compliant position against the CQC requirement to separate children's day case activity from adult services and facilitated the ICU business case by releasing ward 9 for adult services. The business case had already been supported by the Capital Monitoring and Investment Committee on 12 February 2016, but due to the value of the capital investment (£1.22m), IFPIC and Trust Board approval were also required.

The Committee supported the business case (as set out in paper U) subject to an amendment to the proposed timing of the project. The Committee requested that the commencement of the works be brought forward to mid-March 2016 (instead of 1 April 2016) to enable the new unit to become fully operational prior to 20 June 2016.

**Recommended – that the Paediatric Dentistry and Day Case Surgery Full Business Case be supported for Trust Board approval on 3 March 2016, subject to the accelerated timescale set out above.** **CFO/ DEF**

## RESOLVED ITEMS

### 14/16 APOLOGIES AND WELCOME

Apologies for absence were received from Mr A Furlong, Medical Director; Professor A Goodall, Non-Executive Director, and Mr R Mitchell, Chief Operating Officer. Upon their arrival under Minute 17/16/1, the Chairman welcomed Ms H Seth, Acting Director of Strategy and Ms L Hamadallah (a student who was shadowing Ms Seth) to the meeting.

### 15/16 MINUTES

**Resolved – that the Minutes of the 28 January 2016 IFPIC meeting be confirmed as a correct record.**

### 16/16 MATTERS ARISING

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

(a) **Minute 123/15(c) of 26 November 2015** – the Executive Strategy Board had reviewed an early iteration of the estates 'route map' on 9 February 2016 and this had primarily focused upon the LGH site. An update on the development of the Trust-wide 'route map' would be provided to the 24 March 2016 IFPIC meeting, and **DEF**

(b) **Minute 77/15 of 30 July 2015** – a summary of the cost improvement opportunities relating to non-urgent patient transport provision was scheduled for consideration at the 24 March 2016 IFPIC meeting. **CFO**

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

### 17/16 FINANCE AND PLANNING

17/16/1 Month 10 Financial Performance and Forecast 2015-16

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 January 2016. IFPIC members noted an in-month positive variance of £0.5m against plan, with a year to date adverse variance of £1.6m. Capital spend for the year to date was £34.5m (against a plan of £36.2m) whilst 2015-16 CIP delivery year to date stood at £35.2m (£1.1m adverse to plan). A year-end settlement had been reached with specialised commissioners and negotiations continued to be held in respect of the local commissioning settlement. Assurance was provided that the Trust's year-end control total was considered to be deliverable. In discussion on paper C, the Committee:-

(a) received additional information on the main areas of financial variance (including additional clinical activity and the associated cost pressures) and noted that a detailed review of the material factors causing variances would be undertaken during the

coming 6 week period to inform the 2016-17 budget setting process;

(b) queried the financial impact of the Interserve contract termination, noting that work was currently in progress to quantify the impact of known and committed expenditure and establish how these would be treated within the annual accounts for 2015-16 and 2016-17. A separate briefing paper would be provided to the Committee on 24 March 2016 on this subject; **CFO**

(c) considered the level of risk remaining in the year-end forecast and the potential impact of the local commissioning contract settlement in this respect;

(d) noted from Section 3.15 of paper C that the Trust was currently employing 276 whole time equivalents more than 12 months previously and that 135 of these were non-clinical staff. The Audit Committee Chairman queried what proportion of the additional non-clinical staff were directly supporting clinical activity. From his experience of the vacancy controls panel, the Chief Executive speculated that the bulk of these additional posts would be supporting clinical activity, but it was agreed to seek a breakdown of these posts from the Workforce Development Manager (outside the meeting);

(e) queried whether the new emergency department front door arrangements continued to be financially viable. In response, the Chief Financial Officer confirmed that the cost of the Lakeside contract was covered by Commissioners, but he voiced concerns regarding the higher than expected running costs of the Urgent Care Centre;

(f) queried whether the 4 most challenged CMGs would require any additional support in order to deliver their year-end control totals. In response, the Chief Financial Officer advised that the main focus would be to improve the quality and accuracy of activity and expenditure plans and strengthen the links between income and costs through improved information flows (including service line reporting), and

(g) Mr A Johnson, Non-Executive Director commented upon the Trust's financial position generally and queried whether a potential over-reliance upon income represented any significant risk. In response, the Chief Financial Officer briefed members on the potential scale of the year-end settlement with local commissioners noting that there were still 3 or 4 significant issues to be addressed and confirming that was some degree of risk around these.

**<u>Resolved</u> – that (A) the month 10 Financial Performance report (paper C) and the subsequent discussion on this item be received and noted;**

**(B) a report on the expected financial impact of the Interserve contract termination be presented to the March 2016 IFPIC meeting, and** **CFO**

**(C) the Workforce Development Manager be requested to circulate a breakdown of the 135 additional non-clinical posts appointed to in the last 12 months (outside the meeting).** **WDM**

17/16/2 <u>Draft Operational Plan Submission 2016-17</u>

The Acting Director of Strategy introduced paper D, providing the first draft of the Trust's 2016-17 Operational Plan, as submitted to the TDA on 8 February 2016. She welcomed any comments on the document and thanked all of the lead officers for their input. IFPIC members noted the further work that had taken place since the original draft submission (including updated information on the Quality Commitment and the Trust's highest scoring risks). The TDA had since provided their feedback on the draft submission and the relevant lead officers were now working on the next iteration of this document. The next TDA submission was scheduled for 11 April 2016 and assurance was provided that the relevant Committees would have an opportunity to sign off this version prior to submission.

The Committee Chair requested that an updated narrative be made available to the Trust's representatives at a scheduled confirm and challenge meeting with the TDA on 29 February 2016. The Chief Executive provided an overview of the key risks surrounding availability of national NHS capital and failure to control emergency admissions, which he would be highlighting at the 29 February 2016 meeting. Members also commented upon **ADS**

the risks relating to delays in implementation of the Electronic Patient Record project and demand and capacity plans (Minute 19/16/2 below refers).

**Resolved – that (A) the draft Operational Plan Submission for 2016-17 and the subsequent discussion on this document be received and noted;**

**(B) the Acting Director of Strategy be requested to provide an updated Operational Plan narrative to inform the discussion at a meeting with the TDA on 29 February 2016, and** **ADS**

**(C) a further iteration of the 2016-17 Operational Plan be presented to the 24 March 2016 IFPIC meeting.** **ADS**

17/16/3 Review of Board Assurance Framework Risk 11 – Estates Infrastructure Capacity

Further to Minute 28/16 of the Trust Board meeting held on 4 February 2016, paper E provided a copy of the existing entry on the BAF for risk 11. The Director of Estates and Facilities advised that the outputs from a comprehensive infrastructure survey would be available in March 2016 and that this would support a more informed review of this risk at the 24 March 2016 IFPIC meeting. In the meantime, the Audit Committee Chairman sought and received confirmation that the existing risk score rating (impact 5 x likelihood 4 = 20) was appropriate, given the current level of uncertainty. **DEF**

In addition, the Director of Estates and Facilities briefed members on the arrangements for harmonisation, repatriation and recruitment of additional flexible resources to support strategic capacity going forwards. Particular discussion took place regarding the importance of maintaining robust electrical sub-stations and non-interruptible supplies on all sites.

Responding to a query from Mr A Johnson, Non-Executive Director, the Director of Estates and Facilities confirmed the scope to include any high-risk infrastructure issues within a re-prioritised 2016-17 capital programme, although availability of capital would be the restricting factor. Until the report was available, he was not able to comment on the expected quantum of any high-risk infrastructure issues.

**Resolved – that a detailed review of BAF risk 11 be scheduled for the 24 March 2016 IFPIC meeting.** **DEF**

17/16/4 Cost Improvement Programme

Paper F1 provided the monthly update on progress of the 2015-16 CIP programme and set out the position in relation to identification of schemes for 2016-17. The forecast outturn for 2015-16 remained at £43.05m (against the £43m target) and all CMGs were committed to delivering their forecast savings.

In respect of 2016-17 schemes, the current position was £31m (against the indicative target of £41.4m) and this represented approximately 75% of the requirement. A robust process was in place for undertaking quality impact assessments and progressing the individual scheme RAG-ratings to green. Weekly meetings were being held with the 4 most challenged CMGs in order to address and mitigate their shortfalls. Members noted that the links with strategic reconfiguration schemes were key for some CMGs and these could unlock significant additional cost improvements. Discussion took place regarding the cross-cutting CIP opportunities for Corporate re-design (lead by the Director of Workforce and Organisational Development as the SRO) and the recommendations arising from the Carter Review. Development of energy efficiency and procurement savings schemes were both progressing well.

The Committee Chairman queried the Trust's ability to deliver CIP targets of this scale year

upon year and noted the views expressed by the Director of CIP and Future Operating Model that the Trust had not yet reached the point where this became too challenging. Strategic planning for 2017-18 was already underway, with a view to developing more sustainable transformational schemes which typically had longer lead-in times. Members also considered opportunities to reduce clinical variation (eg length of stay and re-admissions), implement Lean programmes/system changes based upon thorough analysis of existing processes and ways in which such developments could be incorporated into the 'UHL Way' improvement methodology.

The Chief Executive briefed IFPIC members on discussions held at the 23 February 2016 Executive Performance Board (EPB) meeting in respect of a potential reduction to the 2016-17 CIP target (in line with the expected tariff deflator movement). The EPB had not yet concluded whether such a change would be affordable, but they had recognised the need to create additional headroom in order to develop more strategic schemes.

In discussion upon strengthening UHL's transformational resources and reducing the reliance upon Ernst Young, the Committee Chairman queried whether the Trust had considered introducing a competition to encourage staff to come forwards with new ideas. The Chief Executive undertook to consider such a development under the LiA methodology, noting that the current awards-based approach currently focused upon delivery of the Trust's values. **CE**

Paper F2 provided an update on the Workforce cross-cutting CIP theme as at the end of January 2016, noting a forecast outturn of £1.061m against the target of £2.145m for 2015-16. In respect of 2016-17, savings opportunities of £1.017m had now been identified and work continued to identify additional savings. IFPIC members noted that the Director of Workforce and Organisational Development had recently taken over the role of SRO for this cross-cutting theme from the Chief Financial Officer. Areas of future focus would include premium pay, job planning and the development of strategic workforce plans for the next 3 to 5 years (total headcount and appropriate skill mix).

The Committee Chairman sought and received assurance that the use of e-rostering was becoming well-embedded in the organisation. The Chief Financial Officer confirmed that this was the case and advised that UHL had been highlighted as an exemplar by the Carter team for their use of e-rostering for nursing staff. The next challenge would be to roll out the e-rostering software to other staff groups (eg medical staff). The Director of Estates and Facilities agreed to review this option for facilities staff in the longer term (once the initial mobilisation phase was complete). **DEF**

**<u>Resolved</u> – that (A) the CIP progress report and cross-cutting Workforce scheme update be received and noted as papers F1 and F2;**

**(B) the Chief Executive be requested to consider the scope to hold a competition to encourage staff to come forwards with new CIP/service improvement ideas under the LiA workstream, and** **CE**

**(C) the Director of Estates and Facilities be requested to review longer term opportunities to implement e-rostering for facilities staff.** **DEF**

17/16/5 <u>Report by the Chief Financial Officer</u>

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

17/16/6 <u>Report by the Chief Information Officer</u>

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

**18/16 STRATEGIC MATTERS**

18/16/1 Workforce Update

The Workforce Development Manager attended the meeting to introduce paper I, providing the monthly overview of a range of workforce-related datasets. She particularly noted that ESR data had been used throughout the report to ensure consistency with reports to the TDA. The net starters and leavers position over the last 12 months was an overall increase of 277. In respect of opportunities to commence recruitment earlier within the academic pathways, arrangements were in place for AHP and therapy staff to undertake bank work as second year students. Junior doctor vacancies continued to reduce as a result of intensive recruitment activity and this included some international recruitment. The report also covered bank and agency usage, sickness reporting and exit interview trends.

Discussion took place regarding ways in which the existing exit interview/survey process could be strengthened and built into the automated culture whenever a member of staff left the Trust. The Trust Chairman suggested that all CMG Boards should be reviewing their exit feedback on a regular basis. In addition, it was noted that ITAPS and ESM were undertaking retention surveys and this was expected to provide some rich feedback to inform their future workforce plans. The Committee Chairman requested that an update on the NHS apprentice allocation for UHL and the associated costs be provided in the March 2016 iteration of the Workforce update. **WDM**

In respect of nursing vacancies, members considered whether the recruitment ambition for 2016-17 was achievable in the context of the current vacancy levels, the aging workforce profile and unfilled quotas of commissioned nurse training places. The Workforce Development Manager briefed the Committee on the consultation arrangements for a new nursing associate role and the future development of non-traditional career frameworks without the added cost of a full degree course. Finally, the Director of Estates and Facilities commented upon the scope to make better use of nursing staff time by reducing the amount of basic cleaning duties within their role, suggesting that such infection prevention tasks could be undertaken by support staff instead. He also noted opportunities to strengthen recruitment processes by improving the quality of UHL's staff accommodation provision.

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

**WDM**

**(B) the Workforce Development Manager be requested to provide information on the NHS apprentice allocation for UHL (including projected costs).**

18/16/2 Capped Rates for Agency Staff

The Interim Assistant Director of Workforce attended the meeting to present paper J, providing a briefing on the Trust's compliance with national capped rates for agency staff (as introduced by NHS Improvement on 23 November 2016), the number of breaches made in order to support patient safety, and the actions in place to improve controls on premium pay expenditure. Members noted that a Premium Pay Working Group had been established in October 2015 and this group reported to the cross-cutting Workforce CIP Board. Detailed recruitment plans had been developed to address all substantive vacancies and tracking tools were used to provide clear performance monitoring and trajectories towards compliance. Considerable work had been undertaken to encourage the use of internal bank or locum staff in the first instance and the Trust was collaborating with other centres to develop a common approach within the East Midlands.

Appendix 2 to paper J identified the value of the potential savings lost broken down by

CMG for week commencing 11 January 2016, totalling some £33,000. If this figure was extrapolated throughout the year, then potential available savings would be in the region of £1.36m per annum. The Committee noted the helpful nature of the data in appendix 2 and suggested that this was provided to CMGs on a regular basis. The Chief Financial Officer commented on proposals for NHS Improvement to implement tighter controls for the 2016-17 financial year and extend the caps to other staff groups. **IADW**

**Resolved – that (A) the update on Capped Rates for Agency Staff and the subsequent discussion be received and noted, and**

**(B) the Interim Assistant Director of Workforce be requested to consider sharing the data relating to lost agency cap savings opportunities with CMGs on a regular basis.** **IADW**

18/16/3 Report by the Director of Estates and Facilities

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

**19/16 PERFORMANCE**

19/16/1 Month 10 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 January 2016. IFPIC members particularly noted the following key issues:-

(a) continued good progress with the quality metrics;
(b) an improvement in ambulance handover performance (despite continued emergency pressures);
(c) compliance with the RTT incomplete pathway target in January 2016 and predicted compliance for February 2016. Good progress had been made in Gastroenterology, but significant pressures still existed with ENT and the volume of elective cancellations was having a cumulative adverse effect;
(d) non-compliant performance in respect of cancelled operations and cancelled surgery being re-booked within 28 days – an update on the risks and mitigating actions was requested for the 24 March 2016 IFPIC meeting; **COO**
(e) readmission rates and whether the implementation of the readmissions tool had made any significant difference – the QAC Chair advised that she would seek clarity on this point at the 25 February 2016 QAC meeting; **QAC Chair**
(f) progress being made in respect of cancer performance – 2 week wait performance had now achieved a sustainable position and the backlogs for 31 day and 62 day cancer were reducing, and
(g) a significant reduction in over 6 week diagnostic waits – performance for February 2016 was expected to be 2.5% and the 1% standard was now expected to be delivered for March 2016.

**Resolved – that (A) the Quality and Performance report be received and noted as paper K;**

**(B) an update on the risks and mitigating actions surrounding cancelled operations and the process for re-booking cancelled operations within 28 days be provided to the 24 March 2016 IFPIC meeting, and** **COO**

**(C) the QAC Chair be requested to seek clarity on readmission rates and the impact of implementing the readmissions tool at the 25 February 2016 QAC meeting.** **QAC Chair**

19/16/2 Demand and Capacity Planning 2016-17

The Director of Performance and Information introduced paper L, outlining the activity assumptions for 2016-17 and the proposed capacity modelling based upon 85% and 90% bed occupancy scenarios. Members noted that a substantive amount of time would be set aside at the 8 March 2016 Executive Strategy Board meeting to finalise the service level bed capacity plans. The Chief Executive briefed the Committee on the proposal to develop a robust baseline prior to the application of a range of mitigating actions including (i) the number of emergency admissions, (ii) alternative capacity types, eg ICS beds, (iii) the net additional capacity required, and (iv) internal process changes, such as reducing length of stay and improving productivity. None of these tasks were considered to be easily achieved and conflicting priorities within the Trust (eg ICU reconfiguration) compounded the challenges.

The Chief Executive provided assurance that these issues would be raised at the 29 February 2016 meeting with the TDA, as it was essential to develop a balanced demand and capacity plan to inform the performance trajectories the Trust would be measured against. A further update on demand and capacity planning would be provided to the 24 March 2016 IFPIC meeting and (subject to the outcome of the contract negotiations) a final iteration might be required in April 2016. **COO**

Colonel (retired) I Crowe, Non-Executive Director queried the Trust's ability to flex emergency and elective capacity and provide decant ward accommodation to support the infection prevention deep cleaning programme and provide contingency plans in the event of any catastrophic event. In response, the Chief Executive highlighted the significant challenges surrounding the basic capacity planning but the Director of Estates and Facilities provided assurance that the Strategic Reconfiguration Programme would create decant ward accommodation for future use and would aim to repatriate key areas of ward accommodation being used for non-clinical purposes (where appropriate).

**Resolved – that (A) the update on Demand and Capacity Planning be received and noted, and**

**(B) further updates on demand and capacity planning be presented to the 24 March 2016 IFPIC meeting and (if required) the 28 April 2016 IFPIC meeting.** **COO**

19/16/3 Access to HDU/ITU Bed Capacity for Cancer Patients

Further to Minute 6/16/1 of 28 January 2016, paper M provided a briefing on the Level 3 and Level 2 critical care capacity on all 3 hospital sites, the arrangements for prioritising these on the basis of clinical urgency and the impact upon the Trust's cancer performance. IFPIC members particularly welcomed the additional 6 ITU beds which were due to be opened on the LRI site before the end of March 2016.

**Resolved – that the briefing on arrangements for accessing HDU and ITU bed capacity for cancer patients be received and noted as paper M.**

19/16/4 Empath Financial and Operational Performance Update

Paper N provided the quarterly update on Empath financial and operational performance. Mr N Callow, Empath Finance Director attended the meeting to introduce this item. Members noted that the new governance arrangements for Empath were now in place and that the first meetings of the Operational Board and the Strategic Board had taken place. The Committee Chairman sought and received additional information regarding the following key performance indicators which were RAG-rated as red and amber (respectively) on the performance scorecard:-

(a) Cellular Pathology turnaround time for diagnostic biopsies – performance against the target to complete 90% of samples within 7 days had deteriorated to 39%. There had been a significant increase in activity which was partly attributed to the roll-out of the

bowel cancer screening programme. The Director of Performance and Information advised that these delays were affecting UHL's cancer performance and that some patient appointments had been cancelled when patients were expecting to receive their results. Empath had commissioned a review of its business processes in order to address this deterioration. The review was expected to report back within 6 weeks and in the meantime some additional interim resources had been implemented in order to improve the turnaround times. Work was also being prioritised on the basis of clinical need, and

(b) Internal Order Communications ratio – performance currently stood at 70% (against a target of 100%). The low take-up rate of electronic test requesting was a material factor and significant cost and efficiency savings were available, if the Trust decided to mandate electronic requesting. It was agreed to escalate this issue to the Empath Operational Board and the UHL Executive Quality Board. The Patient Adviser suggested that it might be helpful to remove the paper-based forms to support the required change in staff culture. **CFO**

**Resolved – that (A) the update on Empath Financial and Operational Performance (paper N) be received and noted, and**

**(B) the issue of low take-up rates for electronic test requesting be escalated to the Empath Operational Board and the UHL Executive Quality Board.** **CFO**

19/16/5 Orthodontics Referrals

Further to Minute 6/16/3 of 28 January 2016, paper O briefed the Committee on the actions being undertaken to manage the backlog of approximately 301 patients who were actively awaiting treatment on UHL's orthodontics waiting list. Constructive meetings had been held with the TDA and NHS England and alternative providers had been identified with capacity to treat approximately 80 patients. Assurance was provided that the TDA and NHS England were addressing the sustainable provision of orthodontic services across the Midlands and East region appropriately.

**Resolved – that the position be noted.**

**20/16 SCRUTINY AND INFORMATION**

20/16/1 IFPIC Calendar of Business 2016-17

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

20/16/2 Updated Timetable for UHL Business Case Approvals

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

20/16/3 Executive Performance Board

**Resolved – that the notes of the 26 January 2016 Executive Performance Board meeting be received and noted (paper R).**

20/16/4 Revenue Investment Committee

**Resolved – that the notes of the 15 January 2016 Revenue Investment Committee meeting be received and noted (paper S).**

20/16/5 Capital Monitoring and Investment Committee

**<u>Resolved</u> – that the notes of the 15 January 2016 Capital Monitoring and Investment Committee meeting be received and noted (paper T).**

## 21/16 CLINICAL MANAGEMENT GROUP PRESENTATION

21/16/1 <u>Critical Care, Theatres, Anaesthetics, Pain and Sleep (ITAPS)</u>

Following an informal discussion over the lunchtime period, the ITAPS management team introduced an updated version of their slide presentation (previously circulated as paper V), providing an overview of their current financial and operational performance, key risks, achievements and areas where additional Trust Board support would be welcomed. During the presentation, IFPIC members:-

(a) received progress updates against the key commitments outlined in the CMG's last presentation to the Committee in March 2015;
(b) noted that the CMG had recruited to virtually all of their middle-grade doctor vacancies and eliminated use of agency staffing. The Chief Executive sought the CMG's advice on the reasons for their success with medical staffing, noting in response that a recruitment task and finish group had been established some 6 months ago. Meetings were held every 2 weeks and representatives had included education leads and medical trainees. The group had particularly focused on 'selling' their departments and the services provided;
(c) sought additional information regarding the arrangements for Operating Department Practitioners, noting that an additional band 7 post had been developed in order to avoid breaching the agency caps;
(d) noted the impact of the theatre trading model in reducing clinical variation and short notice cancellation of sessions;
(e) received an invitation to visit the new theatre recovery area, and requested details of the formal opening ceremony be provided (when known);
(f) the Director of Estates and Facilities requested that the maintenance programme for the LRI theatre refurbishment be brought forward to 2016-17 from 2017-18;
(g) noted that the CMG was aiming to deliver its deficit control total of £1.4m, despite challenges surrounding clinical coding, additional ITU bed capacity and continued delivery of additional theatre sessions. An under-funding issue relating to the Consultant baseline had been identified for discussion in the budget setting process for 2016-17;
(h) CIP performance was forecast to deliver the target for 2015-16 although work continued to mitigate the non-recurrent elements (approximately £1.1m) going forwards;
(i) sickness absence stood at 3.95% against the 3% stretch target and a focused piece of work was taking place to ensure that episodes of sickness were closed down appropriately;
(j) appraisal rates stood at 94% and work was taking place to align appraisal dates with incremental dates;
(k) staff turnover had increased to 10% and a poor response rate was reported in respect of exit feedback. A retention survey was being undertaken and was due to close at the end of March 2016. IFPIC members expressed an interest in seeing these results;
(l) received assurance that the CMG was working closely with the Alliance to develop joint roles and rotational posts, and
(m) noted the intention to re-launch the safer surgery training programme and the Chief Executive's recommendation that this workstream be incorporated into the Trust's Quality Commitment, to avoid the risk of this becoming an 'orphan programme'. The Deputy Medical Director and the Chief Nurse were requested to make the necessary arrangements for this to be taken forwards.

**<u>Resolved</u> – that (A) the CMG presentation (paper V) and subsequent discussion be noted;**

**(B) the ITAPS CMG team be requested to:-**

- **provide details of the formal opening ceremony for the new theatre recovery area to Trust Board members (when known);** **ITAPS**
- **bring forward the maintenance programme for the LRI theatre refurbishment into 2016-17, and** **ITAPS**
- **circulate feedback from the staff retention survey to Board members (outside the meeting);** **ITAPS**

**(C) the Deputy Medical Director and the Chief Nurse be requested to explore opportunities to re-launch the safer surgery training programme, under the UHL Quality Commitment.** **DMD/ CN**

**22/16 ANY OTHER BUSINESS**

**Resolved – that no items of additional business were noted.**

**23/16 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 3 March 2016, and** **TA/ Chair**

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

- **Minute 13/16/1 – paediatric dentistry and day case FBC (recommended item);**
- **Minute 17/16/1 – month 10 financial performance;**
- **Minute 17/16/2 – draft operation plan submission 2016-17;**
- **Minute 17/16/4 – CIP update;**
- **Confidential Minute 17/16/5 – report by the Chief Financial Officer;**
- **Confidential Minute 17/16/6 – report by the Chief Information Officer;**
- **Confidential Minute 18/16/3 – report by the Director of Estates and Facilities, and**
- **Minute 19/16/2 – demand and capacity planning 2016-17.**

**24/16 DATE OF NEXT MEETING**

**Resolved – that the next meeting of the Integrated Finance, Performance and Investment Committee be held on Thursday 24 March 2016 from 9am to 1pm in the Board Room, Victoria Building, Leicester Royal Infirmary (note change of venue).**

The meeting closed at 1.15pm

Kate Rayns, **Trust Administrator**

**Attendance Record 2015-16**

Voting Members:

| Name | Possible | Actual | % attendance | Name | Possible | Actual | % attendance |
|---|---|---|---|---|---|---|---|
| M Traynor (Chair from January 2016) | 11 | 11 | 100 | R Mitchell | 11 | 8 | 73 |
| J Adler | 11 | 8 | 73 | P Traynor | 11 | 10 | 91 |
| I Crowe | 11 | 11 | 100 | J Wilson (Chair until December 2015) | 9 | 9 | 100 |
| S Dauncey | 11 | 10 | 91 | | | | |

Non-Voting Members:

| Name | Possible | Actual | % attendance | Name | Possible | Actual | % attendance |
|---|---|---|---|---|---|---|---|
| A Johnson | 4 | 4 | 100 | H Seth | 1 | 1 | 100 |
| D Kerr | 11 | 9 | 82 | K Singh | 11 | 10 | 91 |
| M Gordon | 7 | 6 | 86 | G Smith | 5 | 5 | 100 |
| R Moore | 11 | 11 | 100 | K Shields | 10 | 5 | 50 |