

Report from the Chair of the Finance and Performance Committee

Presented by:	Pauline Vickers, Non-Executive Director	Author:	Jacqui Maurice, Head of Corporate Governance
Previously considered by:	Board of Directors held 8 March 2018		

Key points	Purpose:
1. This paper provides a brief summary of the key matters that were discussed at the meetings of the Finance and Performance Committee held on 31 January 2018	To discuss and note
2. The confirmed minutes from the Finance and Performance Committee meeting held on 31 January 2018 are attached at Appendix 1.	To discuss and note

Executive Summary:
<p>1. Key Matters discussed at the meeting held on 31 January 2018</p> <ul style="list-style-type: none">• Financial Metrics• Liquidity• Trust Improvement Plan• Organisational Performance• RTT (Referral To Treatment)• Cancer waits• ECS (Emergency Care Standards) <p>2. Agenda items</p> <p>3.1 Finance and Performance Committee Dashboard</p> <p>The Finance and Performance Committee dashboard was discussed in detail by the Committee and used as the mechanism to discuss key performance indicators.</p> <p>3.2 Finance Report/Trust Improvement Plan</p> <p>The Foundation Trust reported a pre-STF (Sustainability and Transformation Fund) deficit of £7.7m at the end of Month 9 which is £1.6m behind the pre-STF control total. A YTD (Year to Date) pre-STF deficit £7.7m was forecast in the revised Trust Improvement Plan, which means the Foundation Trust is in line with the Improvement Plan trajectory at Month 9. None of the £3m STF can be recovered for Quarter 3. The YTD post-STF position is a deficit of £4.5m against a planned £0.2m surplus, meaning the Foundation Trust is £4.7m behind the cumulative post-STF control total. The in-month position is a favourable pre-STF variance of £1.8m, reflecting non-recurrent flexibility deployed. The Forecast Year End forecast presented is full delivery of the pre-STF control total, although there remain unmitigated risks to this forecast.</p> <p>There is a risk relating to the income estimate as the Trust's ability to substantiate its income position remains restricted following the EPR (Electronic Patient Record) implementation.</p> <p>Cash is lower than plan by £7.1m and this reflects the shortfall against the post-STF control total, the reliance on non-recurrent flexibility to deliver this position and an underspend on capital plans.</p> <p>Liquidity is 1.3 days below plan at the end of December 2018, reflecting the use of non-recurrent measures to offset improvement plan shortfalls, lower than planned levels of</p>

clinical income and delays with STF payments. Liquidity is forecast to remain negative from December 2018 onwards. The current improvement plan trajectory is forecast to result in negative liquidity of -10.6 days at the end of March 2018.

The Foundation Trust spent £1.4m on revenue agency staffing in December which is £0.4m (40%) higher than the phased in-month ceiling. YTD agency spend is £11.2m which is £2.2m higher than the £9m YTD ceiling (21%). The year end forecast is full year agency spend of £15m - £15.7m, which is significantly greater than the full year ceiling of £12.3m. The forecast delivery from the original CIP programmes have been amalgamated with the £12.2m Improvement Plan requirement and run rate deterioration to arrive at a projected combined efficiency requirement of £28.3m in 2017/18. This target reflects deteriorations in the income and expenditure run rate in recent months and additional unplanned cost pressures arising in the year, as well as the reliance on non-recurrent measures to deliver the improvement plan trajectory in Quarters 1-3. At present, plans are in place to deliver £22m of efficiencies against this target, resulting in a shortfall of approximately £6.3m. Even this forecast contains a significant degree of risk and the actual outturn may be even less favourable.

3.3 Contract update 2018/19

The Director of Finance provided the Committee with an update of where BTHFT was with regard to the 2018/19 contract. Central guidance on the 2018/19 contractual process has not yet been published.

3.4 2018/19 Financial Plan

The Director of Finance gave a presentation on the 2018/19 Financial Plan. There will be the opportunity to discuss this in more detail at the Board session of the 8th February 2018.

3.5 Performance Report

Post Cerner implementation full reporting for a number of key access targets remains outstanding including: RTT and Diagnostics.

The Emergency Care Standard performance for December 2017 was reported as 82.96%.

Reporting of the total elective waiting list size is being developed as part of the RTT reporting suite. Long waiting patients are being managed by Divisions by front end Cerner applications. The number of long waiting patients >40 weeks has increased since December and was reported as 232 in mid-January 2018.

The Foundation Trust has reported 2 RTT Incomplete 52 week waiters as part of the unofficial return for December 2017. Both patients were in the Trauma and Orthopaedic specialty.

A Cancer position for November has been submitted as a national return. Failures to deliver the standards have been reported against the Cancer 2wk, Cancer 31 day, Cancer 62 day first and Cancer 62 day screening thresholds.

The maximum C Difficile position for financial year 2017/2018 is currently 15 cases with 8 cases awaiting post infection review. 3 cases were reported in December 2017.

No MRSA cases were reported in December 2017. There have been 3 attributed cases year to date.

Due to further development required by Cerner regarding diagnostic reporting for endoscopy and neurophysiology the DM01 position is reported excluding these tests. For

other tests the threshold was not achieved in December due to breaches in Non Obstetric Ultrasound and Rheumatology.

The number of Ambulance handover delays increased sharply in December 2018 with 97 30-60 minute breaches and 78 60 minute plus breaches.

Following clinical review of the long standing VTE cohorting rules the positions for October November and December have been recalculated and report an improvement in performance with December 2017 at 90.4%.

3.6 Trust Improvement Committee Report

The Trust Improvement Committee report was discussed. The majority of this item was covered under the Finance Report.

3.7 Post EPR Outpatients Productivity

The majority of specialties are back to pre EPR levels in outpatients.

Endoscopy and elective surgery are still below pre EPR levels.

A detailed recovery plan is in place which is monitored through the weekly data quality group chaired by the Acting Chief Operating Officer.

3.8 Cancer Deep Dive Presentation

The Acting Chief Operating Officer gave an in depth presentation on Cancer waiting standards. Discussion focused on the delivery of the Cancer Improvement Plan.

3.9 Board Assurance Framework

The Finance and Performance Committee is responsible for the following strategic risks in the Board Assurance Framework.

- **SR2a: To deliver our financial plan** - The Executive Lead is the Director of Finance
- **SR2b: To deliver our key performance targets** - The Executive Lead is the Chief Operating Officer

The Committee discussed and gained assurance on the management of the risks and discussed gaps in assurance.

4. Escalation to the Corporate Risk Register

There were no items to escalate to the Corporate Risk Register.

The confirmed minutes from the Finance and Performance Committee meeting held on 31 January 2018 are attached at Appendix 1.

The Council of Governors is asked to note the report presented to the Board of Directors on 8 March 2018

Financial implications:

Regulatory relevance:

Monitor:	Risk Assessment Framework
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Impact / Implications:	<p>Is there likely to be any impact on any of the protected characteristics? (Age, Disability, Gender, Gender Reassignment, Pregnancy and Maternity, Race, Religion or Belief, Sexual Orientation, Health Inequalities, Human Rights)</p> <p>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p> <p>If yes, what is the mitigation against this?</p>
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Other:	
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Strategic Objective: <i>Reference to Strategic Objective(s) this paper relates to</i>	To deliver our financial plan and key performance targets

Appendix 1

FINANCE AND PERFORMANCE COMMITTEE MINUTES, ACTIONS & DECISIONS

Date:	Wednesday 31 January 2018	Time:	08:30 – 10:30
Venue:	Conference Room, Field House, BRI	Chair:	Pauline Vickers, Non-Executive Director
Present:	<p>Non-Executive Directors:</p> <ul style="list-style-type: none"> - Mrs Pauline Vickers, Non-Executive Director (PV) - Mr Trevor Higgins, Non-Executive Director (TH) - Ms Laura Stroud, Non-Executive Director (LS) - Dr Mohammed Iqbal, Non-Executive Director (MI) <p>Executive Directors:</p> <ul style="list-style-type: none"> - Mr. Matthew Horner, Director of Finance (MH) - Mrs Cindy Fedell, Director of Informatics (CF) - Mrs Sandra Shannon, Acting Chief Operating Officer (SSh) 		
In Attendance:	<ul style="list-style-type: none"> - Mr James Mackie, Head of Performance (JM) - Ms Fiona Ritchie, Trust Secretary (FR) - Mr Chris Callaghan, Divisional Head of Finance (CCa) – Minute taker - Ms Sally Scales, Deputy Chief Nurse (SSc) – Attending for Karen Dawber - Mr Chris Smith, Deputy Finance Director (CS) 		
Observing	<ul style="list-style-type: none"> - Mr Barry Senior, Non-Executive Director (BS) 		

No.	Agenda Item	Action
F.1.18.1	Apologies for absence	
	Apologies were received from: <ul style="list-style-type: none"> - Ms Karen Dawber, Chief Nurse (KD) - Ms Donna Thompson, Director of Governance (DT) 	
F.1.18.2	Declaration of Interests	
	There were no declarations of interest.	
F.1.18.3	Minutes of the meeting held on 20 December 2017	
	<p>The minutes were accepted as a correct record, subject to the following corrections :</p> <p>Page 4 - F.12.17.6 Paragraph 4 requires a change in the narrative from change “The second graph plots the current trajectory which without additional improvement initiatives will result in a £4.6k shortfall” to “The second graph plots the current trajectory which without additional improvement initiatives will result in a £4.6m shortfall”</p>	
F.1.18.4	Matters Arising	

No.	Agenda Item	Action
	<p>F.9.17.8 General Surgery Exception report – update in October. The validated report will be distributed following the committee meeting.</p> <p>F.12.17.5 – Dashboard update. CF and MH to meet to discuss the presentation of the liquidity chart to ensure narrative, RAG rating and charts presented display a clear, consistent message reflecting the report with the financial plan and it will be completed for next month.</p>	Director of Finance
	Board Dashboard	
F.1.18.5	Finance & Performance Committee Dashboard	
	<p>PV stated that the aim from the previous committee meeting was to focus on the dashboard, and encourage challenge to each lead Executive Director.</p> <p>It is also the intent to consider the Board Assurance Framework (“BAF”) at each agenda point rather than at the end of the meeting.</p> <p>Finance and Performance Committee Dashboard PV introduced the discussion on the Dashboard, beginning with the Operational elements.</p> <p>Operational Elements of Dashboard SSh discussed the key highlights from the dashboard :</p> <ul style="list-style-type: none"> Increased Length of Stay, noting this was to be expected over a winter period (particularly in the areas of Respiratory and Gastroenterology). In order to address this, the Trust is to develop the use of the virtual ward and virtual diagnostics and expand and embed SAFER principles on the wards. <p>LS queried regarding whether BTH Performance targets had been amended following the recent instruction to Trust to cancel non urgent procedures and to focus on Non Elective patients. SSh confirmed that no target was amended.</p> <p>A discussion followed regarding winter planning and management of the resulting pressures. SSh confirmed that part of the winter planning process is to optimise current capacity. Length of Stay will always fluctuate and systems should be put in place to manage this. For next year the Trust needs to consider increasing activity prior to winter.</p> <p>PV queried how Non-Executive Directors can gain assurance that this will actually happen as it was also discussed to do this last year.</p> <p>SSh referred to the second phase 2 of the demand and capacity modelling and that by April the Trust will have a weekly activity monitoring tool to enable weekly tracking of activity which will help with the clearance of Waiting List backlogs and forward plan for winter. Separating Elective and Non Elective workflows allows better control over capacity and the</p>	

No.	Agenda Item	Action
	<p>reconfiguration of the bed base will help reduce outliers, providing beds where they're needed.</p> <p>SSc agreed and commented that ward reconfiguration has helped protect the bed base and should be completed by end of February.</p> <p>TH referred the Committee back to the dashboard and queried why indicators such as Length of Stay are reporting figures outwith the SPC range and the actions being taken.</p> <p>CF replied that if it's a continued trend it would be explored in greater detail. Work continues on the creation and validation of a number of indicators which includes the Length of stay indicator but it was agreed that this was a fair challenge and as we've historically had a low Length of Stay it has not been a focus.</p> <p>SSh drew attention to the other key highlights contained within the dashboard :</p> <ul style="list-style-type: none"> • Bed occupancy has been consistently at 95% for a number of months. Such a low level of spare capacity gives challenges for bed availability. The focus on the SAFER work will help, as it will generate discharges earlier in the day, and allow a focus on non added-value delays in the patient pathway. Occupancy can be affected by number of admissions but also by the number of hours in a bed, time of day etc. <p>A discussion followed regarding the optimum bed capacity.</p> <p>PV queried the organisations view on the targeted level of occupancy.</p> <p>SSh replied that the optimum would be 85% although it's not clear how many Trusts are actually achieving this, especially as over the years there's been such an increase in demand for services. BTH does a lot better than many other Trusts over winter where SSh has previously worked, through successful initiatives such as virtual ward etc.</p> <ul style="list-style-type: none"> • There are a number of issues concerning DNA's, which relate to both data quality and process issues. The majority of services are back to planned ePR activity levels. There are a small number of services where clinicians are still struggling with ePR, with the Trust looking at options to support them to increase productivity (e.g. extra admin staff). Pre-ePR there was a tendency for some areas to overbook clinics to offset DNAs but ePR won't allow this, so there's an ongoing piece of work to review templates. The first priority is of course to get to root cause of why patient's DNA. <p>TH stated there was an impatience around the availability of post ePR data analysis and trends on levels of DNA's as it has been on the agenda for a while but not yet delivered.</p> <p>SSh stated that there is now a dashboard available to the Outpatient Improvement Programme that allows the group to monitor trends at</p>	<p>Director of Informatics</p>

No.	Agenda Item	Action
	<p>specialty level, to target services where there are higher DNAs. Work is ongoing on the other factors that impact DNAs e.g. sending letters.</p> <p>PV requested that an update to the outpatient improvement workstream is provided to the next committee.</p> <p>LS queried if there is there a systematic review of DNA's by demographic as health literacy is an issue.</p> <p>SSh confirmed that the Trust is aware of this and that there are mandatory fields to identify interpreter, special needs etc. With some high risk patients e.g. suspected cancer in children, for repeated DNAs the Access policy allows for us to contact the GP to investigate and obtain further information.</p> <p>Regarding First to Follow Up Ratios and their influence on DNAs, there are some services with lifelong follow ups and people become complacent in their attendance. We need to look at delivering that support in a different way e.g. services closer to home, virtual follow up/telephone clinics and considering how the Trust can support the patient to manage their own follow up.</p> <p>PV queried if the Trust has the resource and capacity to move this forward at the pace it desires</p> <p>SSh commented that it would be fair to say there hasn't been as much focus as there ought to have been due to other priorities. For 18/19 the improvement programmes need to focus in these areas. The Trust needs to optimise the capacity we've got to reduce unnecessary follow ups.</p> <p>PV noted short-notice cancellations have been previously discussed.</p> <p><i>Finance Elements of Dashboard</i></p> <p>MH discussed the key highlights from the dashboard :</p> <ul style="list-style-type: none"> • First table highlights that the Trust is materially off plan for December 17, showing a pre Sustainability and Transformation Fund ("STF") deficit of £7.7m against a control total of £6.1m (£1.6m variance). As such the Trust is unable to recover STF income for Q3 c£3m. • The improvement plan forecast a deficit of c£7.7m and as such the Trust is on trajectory with continued efforts to deliver the control total by Mar-18. The Trust is carrying a risk of c£4.7m in the plan, with ongoing discussions with NHS Improvement ("NHSI") was around the plausibility of the plan and the ability to recover an element of the gap from our Host Commissioner. The gap has worsened over recent months due to a deterioration in the underlying run rate which has been offset through the use of non recurrent measures to support the position. There are now very few non recurrent items left with which to provide further support. 	

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	<p>In reality the Trust is struggling to materialise the transformational and productivity changes in the improvement plan which is posing a significant delivery risk in Q4.</p> <ul style="list-style-type: none"> Discussions continue with the Commissioner but the limited assurance available on the income and activity position as a result of a range of ePR issues are compromising the discussions, particularly in light of the significant degree of estimation used to derive the figures. It is anticipated that the commissioner discussions will be concluded shortly which will determine the internal improvement challenge required to deliver the control total. The scale of the challenge has been highlighted at the recent budget meetings with further controls expected around expenditure approvals/escalation. <p>TH queried the level of support and realised benefits from the work being undertaken by GE Healthcare Finnamore.</p> <p>MH commented that the steering group meeting with GE Healthcare Finnamore has taken place. There was a focus on Gastroenterology, Orthopaedics and some outpatient work in 3 specialties. The opportunities are there but we are struggling to realise them for various reasons. In Orthopaedics the acute work is impacting on the ability to sustainably run the proximity lists, but when they are run they are proving very productive, with one consultant significantly reducing their waiting list size.</p> <p>In Gastroenterology the Trust is running on average at about 8.5 points per list. GE Healthcare Finnamore had targeted that by April it would be 13 points per list, subject to the EPR issues being resolved. MH will update at the next committee meeting.</p> <p>MH confirmed that process for admitting patients onto EPR is having a significant bearing on the data quality with Elective patients admitted as Non Elective.</p> <p>SSh added that some of these issues are related to user error and that the Trust is working through the backlog to ensure correct data recording. Once complete this also will impact on the Waiting List (i.e. if patients have been admitted Non-Electively but are booked for an Elective procedure, the Elective procedure will remain on the Waiting List).</p> <p>PV queried what the timeframe is for this piece of work. SSh confirmed that it is ongoing, with week on week monitoring. It will be at least a 6 month programme of work to get full assurance that the data quality is error free.</p> <p>TH queried what support was available from NHSI, particularly if there was any flexibility on the control total or if they were looking for an exemplar Trust and could BTH fill this role? MH confirmed the Trust is in regular dialogue with NHSI and they are acutely aware of the risks we carry. At this point PV requested an assessment of whether anyone perceived</p>	<p>Director of Finance</p>

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	<p>any gaps in control or gaps in assurance. MH commented that from his perspective the gaps in assurance are the deliverability of the schemes in the improvement plan.</p> <p>MH commented that it has been widely communicated that the Non recurrent measures used to support the position would eventually be exhausted and that sustainability will be reliant on transformational and behavioural change.</p> <p>MH continued the key highlights from the dashboard :</p> <ul style="list-style-type: none"> Regarding the Use of Resources ratings, it was noted that 3 of the 5 metrics are reporting the highest level of risk category. The 2 metrics supporting the overall rating are liquidity and agency spend. Liquidity is at risk and the Trust will quickly have a significant liquidity risk based on underlying income and expenditure run rates and steps must be taken to protect cash The Trust has an aspirational clinical strategy which will need cash to support the potential investments which will only be available if the Trust has a sustainable financial plan. The overall CIP position reports that the Trust is on track at the end of December 17, but it is very reliant of the non recurrent measures. The plan submitted to NHSI detailed c£3m of technical accounting adjustments. In this month's report the technical accounting adjustments equate to c£7m. If the Trust delivers what is currently projected (i.e. c£22m) this is a significant saving and a huge achievement, which should be celebrated. Last year's achievement (16-17) was the largest ever recorded at the Trust (c£16m). <p>Performance Elements of Dashboard</p> <p>SSh discussed the key highlights from the dashboard :</p> <ul style="list-style-type: none"> Reporting diagnostic waits, The Trust is unable to report endoscopy and neuro-physiology modalities as a result of data quality and EPR issues. December's achievement was 98% and the key risk was non Ultrasound test for Rheumatology. The team has a plan for this and JM stated that this will be back on trajectory soon but this is not likely by next month as they have had administration booking issues and consultant capacity issues. <p>PV queried if there is a timeframe for resolution of these data quality issues. SSh commented that there is no definitive timeframe, but a significant amount of work continues with a key challenge being how and when the backlog will be addressed. There are significant challenges booking patients and filling the available lists.</p> <ul style="list-style-type: none"> The Emergency Care Standard ("ECS") remains a significant challenge with the Trust implementing a number of additional support measures. SSh highlighted the changes in clinical 	

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	<p>leadership to provide more focus.</p> <p>PV commented she recently went in to the Emergency Department (“ED”) to observe, particularly the links to assessment areas and the Clinical Decisions Unit (“CDU”). With a reasonable flow it was clear to see how the whole system functions well together. PV queried how the staff are feeling and SSh commented that they are coping well. ED staff are proud to work in ED, but it is accepted that it can be de-motivating to work as hard as they do and then not meet the targets so the Trust needs to support them and keep morale high.</p> <p>Bed pressures have an impact, if there are patients waiting it can cause crowding which then impacts on the pace of flow through the department. There is evidence that this slows down decision making. SSh has spoken to the head of flow about how the Trust adopts a zero tolerance on bed waits.</p> <p>LS commented that every year c230 students from the Leeds School of Medicine volunteer to help with winter pressures and queried if BTH use this additional resource. SSh replied that we have put expressions out for people in doing extra work (e.g. retired nurses etc.) but the proposal will be explored.</p> <p>A discussion took place regarding the recovery plan and the assurance provided to the committee (inclusive of the additional measures being taken). TH expressed concern about the current level performance against the expected standard.</p> <p>Both the overall size of the Waiting List and waiting times have increased. A small number of specialties have significant capacity gaps exacerbated by planned capacity reductions. Trauma & Orthopaedics have a particular problem around a specific hip procedure. The two 52 week wait patients in this specialty were as a result of loan equipment availability. MH noted the concerning trend regarding 40 week waiters. TH agreed and stated that focus should be addressed here rather than wait until patients get to a 52 week wait. PV commented that the action plans for these specialties were discussed in the Quality Committee.</p> <p>PV queried if there were any further assurance or data gaps not picked up in the discussion and it was agreed that there were not.</p>	<p>Acting Chief Operating Officer</p>
	Finance	
F.1.18.6	Finance Report	
	<p>MH commented that there was nothing to add further to what has already been discussed in this Committee meeting. The key messages around the Trust Improvement plan have been discussed.</p> <p>LS noted that agency costs are exceeding the ceiling value and queried if this is well controlled.</p> <p>MH confirmed that it was and that there is a robust process for agency</p>	

No.	Agenda Item	Action
	<p>requests. The vacancy recruitment panel meets weekly and assesses each individual request. This has been discussed at recent committee meetings. Currently the Trust is reporting an agency spend position that is similar to last year's spend at this point of the year, but the mix is different (more medical and nursing spend and less administration and clerical).</p> <p>A discussion followed concerning the impressive reductions in sickness levels and how this can be translated into financial benefits. MH commented that there has been a 1% improvement in overall sickness, and this should translate to an improvement in agency spend. It is difficult to quantify a direct correlation due to changes in funded establishment and the mix of agency spend.</p> <p>TH commented that it was still felt to be a worthwhile exercise to investigate this area. MH agreed to consider this and PV and TH offered support to assist.</p>	Director of Finance
F.1.18.7	Trust Improvement Plan	
	It was agreed that this had been covered through discussion elsewhere in the agenda.	
F.1.18.8	Contract update 2018/19	
	<p>MH updated on the 2018/19 contract noting that the national timescales for the overall operational plan were not available. The Trust is working with Bradford and Districts CCG to discuss the outturn position, which is taking up a significant amount of time but the Trust already has a signed 18-19 contract as it set a 2 year contract. The Divisions have been issued the 18-19 capacity templates to complete to inform any adjustments to activity.</p> <p>PV queried how the Trust can give assurance the capacity work will be more effective this year. MH responded that this assurance cannot be provided at this time due to outstanding issues concerning ePR.</p> <p>It was agreed to defer this agenda item to the next committee meeting.</p>	
F.1.18.9	2018/19 Financial Plan	
	<p>MH stated that a presentation will be delivered at the Board of Directors development session on the 2018/19 Financial Plan, but an overview would be provided to the Committee.</p> <p>MH referred to the "Draft Financial Plan 2018/19" document and commented that the Trust has a clear mission, clear clinical strategy and a range of strategies in support of this.</p> <p>Work has been undertaken with internal and external stakeholders and an internal engagement programme has been completed but to deliver its strategic ambition the Trust requires a sustainable financial plan.</p> <p>MH drew attention to:</p> <ul style="list-style-type: none"> The current underlying run rate 	Director of Finance

No.	Agenda Item	Action
	<ul style="list-style-type: none"> The new cost pressures identified in year The key drivers behind the off plan variance The workforce changes over recent years (circa 500 more than 15/16) The trend in the income profile and in particular the drop in elective income The potential investments for 18/19 The cash and liquidity challenge faced and the implications The current 18/19 financial challenge (c£30m CIP) and the indicative/unconfirmed list of opportunities, that must be validated and impact assessed 	
	Performance	
F.1.18.10	Performance Report	
	PV confirmed that there were no further points to be raised other than those already discussed and the report was noted.	
F.1.18.11	Trust Improvement Committee Report	
	PV commented that there was nothing to note regarding this report.	
F.1.18.12	Informatics Performance Report	
	<p>The report was noted.</p> <p>CF confirmed that the Informatics Performance Report is a quarterly report so there are some areas that haven't been discussed in Committee recently. This agenda item will be deferred to the agenda of the next Committee meeting.</p>	
F.1.18.13	Post EPR Outpatients Productivity	
	The report was noted.	
F.1.18.14	Cancer Deep Dive Presentation	
	<p>SSh noted the key points of the presentation :</p> <ul style="list-style-type: none"> Since August the Trust has struggled with 62 day and 2 week wait standards. The issue with the PPM interface and Cerner did have an impact in terms of visibility of where each patient was in their pathway. The Trust now has a detailed improvement plan in place, by tumour site, and the Transformation Team has been requested to identify initiatives to improve pathway design. <p>The key area of focus is on for the 2 week wait and the demand/capacity modelling and ensuring a recovery plan is in place for endoscopy (which impacts lower Gastro-Intestinal ("Lower GI")).</p> <ul style="list-style-type: none"> Skin cancer waits are an ongoing challenge and the Trust is seeing 65% of all skin referrals as 2 week waits which puts pressure on capacity. 	

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	<ul style="list-style-type: none"> A number of pathway changes are underway in a range of specialties e.g. dermatology, straight to test colonoscopy and the haematuria one stop shop starts in March. The Prostate shared care pathway starts in March, which will have a significant impact on early diagnosis. <p>The other key factor that impacts the 62 day target is that the size of the overall Patient Tracking List ("PTL") which currently outstrips capacity. The Trust is therefore focusing on reducing long waiters to avoid people becoming breaches. For December 17, January 18 and February 18 the key focus is to get those who've already breached the 62 day threshold treated.</p> <ul style="list-style-type: none"> Inter trust transfers are another area of focus, with a particular challenge faced in Urology who reported 77 breaches in 2017. Detail was provided for the profile of the referrals for the 77 patients. The Cancer Alliance breach reallocation process came into force this year and now allocates any breaches for patients transferred out after day 38 to the transferring Trust. Any breaches on patients transferred before day 38 are wholly owned by the receiving Trust. <p>TH queried if there are any 3 way transfers. SSh confirmed that there are some. Complex head and neck cancers are an example of these but they are long and complex pathways. It can be hard to confirm diagnosis for such cases. Nationally 62 day performance is c74% for head and neck.</p> <p>LS queried if the Trust is sighted on the effect such breaches have on the patient, and has any work been completed regionally on this e.g. are they more likely to be a re-admission?</p> <p>SSh replied that the Cancer Alliance has discussed this. The Trust has got some projects underway (e.g. Haematuria, straight to test colonoscopy etc.) and other Trusts are working together to look at inter trust referral processes. In February we are looking to establish a breach panel to review each and every breach, to look at risk of harm and identify areas to reduce breaches.</p>	
F.1.18.15	Board Assurance Framework	
	PV commented that the level of assurance remains as limited based on what has been discussed in Committee today.	
F.1.18.16	Any other business	
	No other business to discuss.	
F.1.18.17	Matters to escalate to the Board of Directors	
	To note MH has an action to add a detailed 18-19 Financial Plan discussion to the agenda for the Board timeout.	
F.1.18.18	Matters to escalate to Corporate Risk Register	
	PV noted	

No.	Agenda Item	Action
	<ul style="list-style-type: none"> Increasing risk on 62 day cancer breaches Liquidity and overall financial position, particularly the risk to achieving control total <p>It was agreed that there was no cause for formal escalation on these matters. The Trust is still sighted on the financial plan and performance has looked at key targets. Finance will be covered in detail at the Board timeout next week.</p>	
F.1.18.19	Items for Corporate Communication	
	No items were noted for Corporate Communication.	
F.1.18.20	Date and time of next meeting	
	28 February 2018, 08:30-10:30 Conference Room, Field House, BRI	

BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST
ACTIONS FROM FINANCE AND PERFORMANCE COMMITTEE – 31st JANUARY 2018

Date of Meeting	Agenda Item	Required Action	Lead	Timescale	Comments/Progress
27/09/2017	F.9.17.8	General Surgery exception report to be produced.	Director of Finance	31/12/2017	Verbal update given at October 2017 Committee. Exception report due November 2017. Discussed at December Committee. Paper not available. Validated paper to be sent out virtually to the Committee once available.
20/12/2017	F.12.17.5	CF and MH to meet to discuss presentation of Liquidity chart to ensure narrative, RAG rating and charts presented display a clear, consistent message	Director of Informatics	31/01/2018	
20/12/2017	F.12.17.5	Outpatient Improvement Programme to be discussed at the February Finance and Performance Committee	Acting Chief Operating Officer	28/02/2018	To include update on the Outpatient Dashboard being developed for the Outpatient Improvement Programme (added 31/01/2018).
20/12/2017	F.12.17.13	MH to consider re-prioritising the Internal Audit annual plan	Director of Finance	28/02/2018	
31/01/2018	F.9.17.8	MH to distribute General Surgery exception report to Committee Members	Director of Finance	15/02/2018	
31/01/2018	F.1.18.5	CF to consider how internally set targets for	Director of	15/02/2018	

		Length of Stay benchmark against national indicators with a view to ensuring they are appropriate metrics to use for the dashboard	Informatics		
31/01/2018	F.1.18.5	MH to update the Committee members before the next meeting regarding the measures being put in place to address ePR issues in Gastroenterology around booking patients onto Waiting Lists, with a view to increasing the number of points per list up to the GE Finnamore recommended level of 13 points per list	Director of Finance	15/02/2018	
31/01/2018	F.1.18.5	SSh to investigate the potential to ask medical students to volunteer to assist in the Emergency Department in the same way as that utilised by Leeds Teaching Hospitals NHS Trust.	Acting Chief Operating Officer	28/02/2018	
31/01/2018	F.1.18.6	MH to investigate an analysis of the link between a reduction in reported sickness rates and any associated reduction in expenditure	Director of Finance	28/02/2018	
31/01/2018	F.1.18.6	MH to add "Financial Plan 18/19" to agenda of upcoming Board Meeting, where a detailed discussion will take place	Director of Finance	01/02/2018	