Bradford Teaching Hospitals
NHS Foundation Trust

Board of Directors: **12.7.18**
Agenda Item: **Bo.7.18.29**

Confirmed Finance & Performance Committee Minutes
25 April 2018 & 30 May 2018

Presented by:	Pauline Vickers, Chair	**Author:**	Sheridan Osbourne, Corporate Governance Officer
Previously considered by:	Finance & Performance Committee		

Key points	**Purpose:**
Finance & Performance Committee minutes 25 April 2018 & 30 May 2018	To receive

Executive Summary
Finance & Performance Committee minutes 25 April 2018 & 30 May 2018

Financial implications:
No

Regulatory relevance:

Monitor:	

Equality Impact / Implications:	Choose an item. Choose an item. Choose an item. **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) Yes ☐ No ☒ If yes, what is the mitigation against this?

Other:	

Strategic Objective: *Reference to Strategic Objective(s) this paper relates to*	To deliver our financial plan and key performance targets Choose an item. Choose an item.

FINANCE AND PERFORMANCE COMMITTEE
MINUTES, ACTIONS & DECISIONS

Date:	Wednesday 25th April 2018	**Time:**	08:30 – 10:30
Venue:	Conference Room, Field House, BRI	**Chair:**	Mrs Pauline Vickers, Non-Executive Director
Present:	Non-Executive Directors: - Professor Laura Stroud, Non-Executive Director (LS) - Mr Jon Prashar, Non-Executive Director (JP) - Mr Trevor Higgins, Non-Executive Director (TH) - Mrs Pauline Vickers, Non-Executive Director (PV) Executive Directors: - Mr Matthew Horner, Director of Finance (MH) - Mrs Sandra Shannon, Chief Operating Officer (SES) - Ms Karen Dawber, Chief Nurse (KD)		
In Attendance:	- Mr James Mackie, Head of Performance (JMa) - Mr Chris Smith, Deputy Director of Finance (CS) - Mrs Siobhan Hughes, Divisional Head of Finance (SH) – Minute taker - Mr David Hollings, Deputy Director of Informatics (DH) – Attending for Cindy Fedell - Ms Jacqui Maurice, Head of Corporate Governance (JMu)		
Observing	- Mr Barrie Senior, Audit Committee		

No.	Agenda Item	Action
F.4.18.1	**Apologies for absence**	
	Apologies were received from: - Mrs Cindy Fedell, Director of Informatics (CF)	
F.4.18.2	**Declaration of Interests**	
	There were no declarations of interest.	
F.4.18.3	**Minutes of the meeting held on 28th March 2018**	
	The minutes were accepted as a correct record.	
F.4.18.4	**Matters Arising**	
	Action F.3.18.8 will be covered under agenda item F.4.18.7 Action F.3.18.16. The Executive Directors have had / are scheduled to have individual sessions with TC to review the BAF. There is also a session planned for the Non-executive Directors. The risks have been amalgamated into principle risks. Action F.3.18.20 regarding whether the risks associated with the 2018/19 capital programme being limited to only £8m should be on the corporate risk register. MH updated that there is now potential to increase the capital programme to £12m through additional STF thereby reducing the risk. Action F.3.18.10 will be covered in the Informatics update.	

	Board Dashboard	
F.4.18.5	**Finance & Performance Committee Dashboard**	
	Performance RTT performance is 73.4% against the 92% target for incompletes. There has been a decrease in the waiting list this month for under 18 admitted. Long waits have increased due to the number of patients being treated as urgent. Specialties are reviewing and changing the level of urgency where required. The volume of patients waiting over 40 weeks is a concern and is being tracked by specialty each week. There have been 52 week breaches in ENT, Orthopaedics and General Surgery. The 52 week breach panel is reviewing the root cause analysis (RCA) for each breach and completing a clinical harm review. There is no evidence of clinical harm at present. The key focus must be on increasing activity. There has also been agreement to increase the central validation team to undertake a full waiting list validation. The first round of the new activity trackers are being rolled out, which include detailed information on waiting list size, forecast on time to 18 week RTT performance recovery and financial performance. The trackers will mainly be prepopulated with information and will be at speciality level with summaries at divisional and trust level. LS asked whether there was a risk that teaching activity would slip while services were focused on recovery. SES responded that both the Medical Director and Chief Nurse were focused on training and the feedback received from students. TH raised a concern about the potential cost of treating the waiting list backlog. The plan is based on recovery over a 12 to 18 month period. The emphasis needs to be on maximising the current capacity, although there will be a requirement for some additional work and discussion with the CCG. There are capacity gaps within some specialties. The plan will concentrate on fixing the top 8-10 specialties first which will improve the overall position. TH asked if the Trust was looking to repatriate work from the private sector how this would be managed in light of current performance. MH responded that this work was not part of the current baseline and referral patterns, so would be additional income if extra capacity could be sourced however it may not be possible to undertake at present with the current backlog. Clearing the current backlog would also be likely to result in an overtrade. The CCG have estimated the value of the backlog to be £1.7m.. PV asked whether the committee could do anything to assist. SES responded that the attention just needed to be on undertaking the planned activity. Emergency Care Standard (ECS) performance is showing an improvement in recent months with some days in April achieving over 90%. The new post for a Director of Urgent Care has been successfully appointed to. Improvements are being made in the streaming process, co-ordination of internal flow within A&E and clarity on roles and responsibilities. The option to develop a Medical Day Unit to move some of the current activity out of the Ambulatory Care Unit (ACU) so that ACU can focus on taking patients from A&E is being explored. Focus is on small performance	

No.	Agenda Item	Action
	improvements and quick wins in helping to change culture and behaviour. There has been a step change in staff responsiveness to urgent care pressures. There have been a couple of very difficult days with high attendances and high ambulance arrivals. Discussions are ongoing with YAS regarding which trusts patients are taken to. TH asked what progress was being made as the same issues were raised a few meetings ago. Regular meetings are taking place, however it is not straight forward and will require changes in policy and patient choice has to be taken into consideration. Issues will be picked up via the weekly operational meetings and the regional Emergency Care Programme Board. TH asked if there was a cultural issue and whether clinicians saw the ECS as a target just for management. SES responded that there had been a national decline in performance and significant increases in attendances. There has also been a case mix change as work is undertaken to keep patients out of hospital. Cultural change is required, which is the reason the Director of Urgent Care was appointed. There are daily huddles to review performance, weekly programme meetings and a bi weekly review of breaches. The graph presented in the dashboard does not illustrate an increase in attendances. Activity has grown significantly since 2014/15 and there has been a change in acuity. Graph to be amended to show percentage achievement and an increased time frame. Comparison year on year is complicated and a lot of investment has gone into projects such as the Virtual Ward and into Primary Care to help avoid A&E attendances. Cancer performance is a significant area of concern with a focus on clearing the 62 day backlog. There has been a meeting with Dermatology regarding 2 week waits and the plan is to run additional GPWSI clinics to help clear the backlog. Progress is being made in Endoscopy which is helping with upper and lower GI. Urology late referrals are having an impact. Improvements need to be made in treating patients referred under 35 days. Directorates own their plans and performance is review weekly. VTE performance was 93.9%. DMO1 performance was 99.9% with only 4 breaches however this does not include endoscopy. There were 53 same day cancellations in March, with 8 predicted 28 day breeches in April due to the adverse weather conditions in early March. There were 17 cases of CDiff which is an improvement over the previous year. There were 4 cases of MRSA during the year, which is also an improvement on the previous year. The Stroke service is still working through the recovery plan with SSNAP data improving. £100k has been allocated for an external review to be undertaken across both Bradford and Airedale.	Head of Performance / Director of Informatics
	Finance	
F.4.18.6	**Finance Report**	
	The year-end position was a £7.1m deficit after impairments, which was	

No.	Agenda Item	Action
	£0.7m better than the pre-STF control total and resulted in the Trust receiving an extra £0.7m STF. In addition the Trust has been notified that it will receive £5.1m bonus STF. The delivery of the year end control total means that quarter 3 and quarter 4 financial elements of core STF will be recovered. The additional STF will enable the capital programme for 2018/19 to be increased. The Trust ended the year with a UoR rating of 2 which is an improvement on previous months. By agreeing to the 2017/18 control total the Trust avoided paying £6.5m in contract penalties relating to missed targets. CIP was reported as being fully delivered however there was significant reliance on non-recurrent measures. The cash position at the end of March was £25.6m compared to the planned £36m, which is reflective of the non-recurrent measures used to support the underlying trading position. The liquidity position was broadly on plan however both cash and liquidity will be a risk going into 2018/19. The 2017/18 agency target was £12.3m, with actual expenditure of £14.8m. Agency expenditure on clinical posts increased by £3m but this was offset by reductions in other areas. The proposed target for 2018/19 is just over £10m, NHSI have been informed that this target is unlikely to be achieved. There is currently no penalty for not meeting the agency ceiling however overspends have to be explained and it is one of the metrics in the risk rating calculation. The Trust has asked NHSI for advice on how agency expenditure could be reduced further and feedback has been positive in that a lot of best practice is already being followed. Surgery ended the year with an expenditure over spend of £8.6m and an under delivery on contract income of £15m.	
F.4.18.7	**Financial Improvement Plan**	
	MH tabled the report that was recently presented to NHSI**.** The presentation highlighted the governance arrangements that will form The Bradford Improvement Programme (BIP). The BIP includes savings opportunities of around £33m. £25m of which are currently rated as deliverable but with £6m still carrying a high delivery risk.	
F.4.18.8	**18/19 Financial Plan & Budget Setting**	
	CS tabled a report describing the process that had been undertaken in setting the 2018/19 budgets and how this had changed from budgets being rolled forward in previous years. Continuing to roll forward budgetary control totals would have hidden the true scale of the financial gap, therefore there has been a fundamental review of the budget allocations which reflects the current run rate. This method has however increased the Trust's CIP requirement and the overall principles of the proposal still need to be discussed with the Executive Directors and Divisions. The forecast deficit is £32.8m while the pre-STF control total is a	

No.	Agenda Item	Action
	deficit of £7.5m, resulting in a £25.3m CIP requirement. Trust reserves have been set for pay awards, inflation and a small number of cost pressures (both new and brought forward) Contract income includes £4.5m growth over 2017/18 outturn however although the overall value has been agreed with the CCG the detail is still to be finalised which may impact on expenditure. The contract with NHS England has still to be agreed. The key principles were - If nothing changes expenditure will continue at the same monthly run rate - 2017/18 forecast outturn (based on month 11 straight line) has been adjusted for non-recurrent items, full year effects and new cost pressures. - All Divisions and Departments will get a share of £25m CIP - Before CIP allocations and reserve distributions, no Division or Department can spend more in 2018/19 than they did in 2017/18. This will need careful management to avoid areas becoming demotivated and losing the incentive to underspend but it must be noted that most Divisions/Department will receive an overall increase in budget. For underspending Divisions/Departments there may be the potential to allocate a lower CIP allocation. - Funded establishments remain unchanged in terms of wte with vacancy factors applied to align the overall budget with 2017/18 expenditure. £13m has been included relating to the premium costs of using bank, agency and premium rate sessions to deliver services, which offers the opportunity to realise savings through improvements in service efficiency. Pay budgets across all staff groups have had significant increases (before CIP). A £6m vacancy factor is required to align with 2017/18 pay expenditure. Reserves have been set for a 1% pay award increase. The CIP target will be allocated out across all divisions, and will include allocations from the BIP schemes. 2017/18 performance will also be taken into consideration in the allocations. All budgets have been set based on 2017/18 expenditure with known adjustments, so the focus must be on controlling run rate, delivering activity and CIP.	
F.4.18.9	**Treasury Management Annual Review**	
	The report highlighted how the cash position has changed over the last 4 years with a focus on 2017/18. The plan for 2018/19 is to start the year with £25m cash and assuming £12m is spent on the capital programme and the CIP is met, the year-end position is forecast to be £30m. It should be noted that this cash position equates to 4 days liquidity. The liquidity position during 2017/18 has not been impacted as directly as the cash position due to the deployment of non-recurrent measures. The 2018/19 liquidity profile will be more reflective of the I&E position and will	

No.	Agenda Item	Action
	follow a similar trajectory. The cash committee saved around £200k during 2017/18, with further actions planned for 2018/19 looking at how Public Dividend Capital (PDC) can be minimised.	
	Performance	
F.4.18.10	**Performance Report**	
	The report was noted and approved by the committee. All key points had already been covered under the performance dashboard agenda item.	
F.4.18.11	**Informatics Performance Report**	
	The report was received and noted by the committee. The key highlights were - Full availability of all critical systems and services during March - EPR adoption continues to go well and is activity being encouraged at ward level - The Business Intelligence structure changes and recruitment are progressing to plan - EPR administrative metrics will be included within next month's report, including the recoding of non-elective/elective activity and failed patient registrations. - The EPR nursing and clinical leads have been nominated for a national award. - Electronic discharges are currently not achieving the 95% target, so focused work is being undertaken.	
F.4.18.12	**Trust Improvement Committee Report**	
	The report was received and noted by the committee.	
F.4.18.13	**RTT Recovery Plan Update review of performance against trajectory**	
	The update regarding the RTT recovery plan was covered under agenda item F.4.18.5 Performance Dashboard. The clinical divisions are continuing to work on their recovery plans which are being reviewed every two weeks.	
F.4.18.14	**Pathology Key Performance Indicators**	
	DH reported that the Pathology Joint Venture had produced draft metrics and that pathology KPI's would be included within the Informatics performance report from next month. This was an action point from the Quality Committee.	Director of Informatics
F.4.18.15	**Bilateral Relationship with Airedale Foundation Trust**	
	Airedale Foundation Trust has appointed a new substantive Chief Executive. The first three services being reviewed for collaboration opportunities are	

No.	Agenda Item	Action
	Gastroenterology, ENT and Stroke, with focus on a whole population models, a shared understanding of the end goals and the financial and performance sustainability of both trusts. All formal and informal arrangements that are in place between the two organisations are being reviewed, including ensuring that clinical governance arrangements form part of the SLAs.	
F.4.18.16	**Board Assurance Framework**	
	The BAF was reviewed. There is limited assurance regarding the financial position for 2018/19. The financial risks were managed effectively in 2017/18 but included a number of non-recurrent measures. The BIP aims to provide further assurance going forward. Performance is also rated as limited confidence, with the long waiting list a concern. An action plan section to be added to illustrate the measures being undertaken to bridge any gaps in assurance or controls	Director of Finance / Chief Operating Officer
F.4.18.17	**Any other business**	
	There was no any other business raised	
F.4.18.18	**Matters to share with other Committees**	
	Confirmation that pathology KIPs will be part of the informatics performance report going forward to be shared with the Quality Committee.	
F.4.18.19	**Matters to escalate to the Board of Directors**	
	Matters to escalate to the Board of Directors include - RTT, ECS and Cancer performance - The positive financial position for 2017/18 with a caveat regarding the level of non-recurrent measures. - Assurance regarding the 2018/19 plan	
F.4.18.20	**Matters to escalate to Corporate Risk Register**	
	There were no further items to escalate to the corporate risk register	
F.4.18.21	**Items for Corporate Communication**	
F.4.18.22	**Date and time of next meeting**	
	Wednesday 30th May 2018, 08:30 - 10:30 am Conference Room, Field House, BRI	

BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST
ACTIONS FROM FINANCE AND PERFORMANCE COMMITTEE – 25th APRIL 2018

Date of Meeting	Agenda Item	Required Action	Lead	Timescale	Comments/Progress
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	Deferred for 3 months until agenda for May 2018 Committee meeting.
28/03/2018	F.3.18.6	SSh confirmed that a presentation will be added to the agenda for the next Committee meeting to demonstrate the weekly Activity Tracker and trajectories by specialty.	Chief Operating Officer	25/04/2018	On May agenda.
25/04/2018	F.4.18.5	Emergency Care Standard graph to be updated to show performance over a increased time period	Head of Performance / Director of Informatics	30/05/2018	
25/04/2018	F.4.18.14	Pathology KPIs to be added to the Informatics report	Director of Informatics	30/05/2018	
25/04/2018	F.4.18.16	Action plans to bridge gaps in assurance and controls to be added to the BAF	Director of Finance / Chief Operating Officer	30/05/2018	

FINANCE AND PERFORMANCE COMMITTEE
MINUTES, ACTIONS & DECISIONS

Date:	Wednesday 30th May 2018	**Time:**	08:30 – 10:30
Venue:	Conference Room, Field House, BRI	**Chair:**	Mrs Pauline Vickers, Non-Executive Director
Present:	Non-Executive Directors: - Professor Laura Stroud, Non-Executive Director (LS) - Mrs Pauline Vickers, Non-Executive Director (PV) - Mr Jon Prashar, Non-Executive Director (JP) - Mr Trevor Higgins, Non-Executive Director (TH) (attending via telephone conference call) Executive Directors: - Mr Matthew Horner, Director of Finance (MH) - Mrs Sandra Shannon, Chief Operating Officer (SSh) - Ms Karen Dawber, Chief Nurse (KD)		
In Attendance:	- Mr James Mackie, Head of Performance (JM) - Mr Chris Smith, Deputy Director of Finance (CS) - Mr Christopher Callaghan, Divisional Head of Finance (CCa) – Minute taker - Ms Jacqui Maurice, Head of Corporate Governance (JMa) - Mr David Hollings, Deputy Director of Informatics (DH) – attending for Mrs Cindy Fedell - Mr Carl Stephenson for the agenda item F.5.18.13 – Weekly activity tracker & trajectories by specialty update (CSt)		
Observing	-		

No.	Agenda Item	Action
F.5.18.1	**Apologies for absence**	
	Apologies were received from: - Mrs Cindy Fedell, Director of Informatics (CF)	
F.5.18.2	**Declaration of Interests**	
	For agenda item F.5.18.15 - Draft Internal Audit Plan 2018-19 TH declared the interest regarding his position on the Audit Committee, and was not therefore involved with the discussion on this agenda item.	
F.5.18.3	**Minutes of the meeting held on 25th April 2018**	
	The minutes were accepted as a correct record.	
F.5.18.4	**Matters Arising**	
	F.3.18.6 - Presentation to demonstrate the weekly Activity Tracker and trajectories by specialty is on the agenda (item number F.5.18.13). Action closed.	

No.	Agenda Item	Action
	F.1.18.6 - Analysis of the link between a reduction in reported sickness rates and any associated reduction in expenditure is on the agenda (item number F.5.18.15). Action closed. F.4.18.5 – Emergency Care Standard graph has been updated to show performance over an increased time period. Action closed. F.4.18.14 – Pathology Key Performance Indicators ("KPIs") have been added to the Informatics report. DH confirmed that these appear on the dashboard not the report itself. Action closed. F.4.18.16 - Action plans to bridge gaps in assurance and controls to be added to the Board Assurance Framework ("BAF"). The BAF has been updated for this, although as new action plans are generated the BAF will need further amendment so the document is a Work In Progress. Action closed.	
F.5.18.5	**Board Assurance Framework**	
	It was agreed that the approach adopted for the BAF in this Committee would be to discuss early in the agenda and further discussion during the meeting as required. Significant work has been undertaken outside of Committee in relation to updating the BAF, particularly on peformance and it will be used to identify where positive assurance can be given and also any gaps in assurance (and mitigating actions). As an example, the Workforce Committee have included Internal Audit reports. MH stated that a good example of positive assurance is the 2018-19 budget realignment exercise. The April financial position demonstrates that each Divisions variance from budget is more realistic than the previous significant overspends seen in previous years for the same period. SSh commented that regarding performance, positive assurance would be related to delivery of the actions that are included in the detailed recovery plans for all access targets. Individual programmes are part of the Bradford Improvement Programme ("BIP") initiative and as such are subject to the monitoring and management arrangements within the agreed governance structure. PV stated that the narrative in the BAF refers to the new Financial Controls Panel being not yet bedded in and MH confirmed that the narrative requires updating.	Director of Finance
	Board Dashboard	
F.5.18.6	**Finance & Performance Committee Dashboard**	
	Performance SSh updated on the performance elements of the dashboard: • Length of Stay has improved. Reduced bed occupancy suggests a	

No.	Agenda Item	Action
	reduction in acuity (and therefore reduced Length of Stay). In winter, admissions increase but Length of Stay also increases (due to such factors as acuity, frail elderly, and pneumonia). A natural reduction in acuity at this time of year is to be expected. The Work as One initiative also means that the Trust has seen more proactive practices matching admissions to discharges, to improve flow. • Overall bed occupancy has reduced and that is having a positive impact. Discharges before 1pm have not shown an improvement but the Work as One initiative has seen better alignment between admission patterns and discharges. • The new pathology indicator has been included and has been achieved. This is a new metric and as such developing trends can be reported in future. • The indicators for patients who did not attend ("DNA") have improved slightly but within normal variation. There has been a change in counting so it may be due to this rather than a genuine drop. There has been an improvement following text reminders and the Trust is in the process of rolling out two-way texting for outpatient appointments over the next few months with the help of GE Healthcare. A discussion followed concerning DNA follow up and demographics. LS queried if the Trust understands at a granular level the demographics of which groups do not attend. There may be a residual level that will not be reached by text message and therefore different methods need to be developed for these groups. SSh commented that in terms of the access policy there is clear guidance concerning to whom text messages should be sent and also around when to discharge. Certain groups have different rules applied and are specifically identified in the policy (for example children, suspected cancer, first language not English). These groups would be sent another appointment and not automatically discharged if a text message was not replied to. If it is a referral for a serious condition (not cancer) every effort is made to contact the patient up to and including contacting their GP. LS stated a concern that if an appointment is offered in the same format there would be the same result (i.e. no reply) as it would be across the same socio-economic group. LS is assured that this is being dealt with but queried if data is available around this. Public health departments in local authorities can link in to identify the communication needs. SSh confirmed data by specialty rather than demographic is available. For certain specialties some patients are less likely to attend for example in endoscopy some patients are reluctant to attend due to cultural issues. Work is ongoing in the community to help improve these types of factors. In this instance the Trust has implemented such things as When looking at implementing Faeco Immunochemical Testing ("FIT") that might reduce the	

No.	Agenda Item	Action
	need for endoscopy. • The Trust has started a validation programme tesing and correcting waiting list data quality issues. The Elective Care recovery programme is in place and the presentation at agenda item F.5.18.13 will demonstrate the activity trajectories, so this will be a key working tool to track activity against waiting list sizes. • The Emergency Care Standard ("ECS") has improved. On Saturday 26th May the Trust achieved 95%. The figure for the Bank Holiday Monday (28th May) was 94% but overall the Trust is reporting an improvement. The biggest area of concern is Cancer where work on tracking and pathway improvements is ongoing to improve achievement against the target for patients seen by a specialist within 14 days of an urgent GP referral for suspected cancer. The Trust is working with Commissioners, looking particularly at Dermatology and endoscopy (where there is a recovery plan in place). A discussion concerning Dermatology took place, during which TH dialled in to the meeting. PV queried if the Trust were able to close referrals and re-direct patients if adequate resource to treat all patients were not available. SSh confirmed this is being discussed with Commissioners. Dermatology capacity is very challenged and the Trust should only see urgent or suspected cancer patients. All other referrals (level 1 referrals) should be seen in primary care, so the Trust are trying to optimise GP's with a Special Interest ("GPSI's") and use this service more. The Trust is also looking at waiting list validation to remove unnecessary follow ups and also reviewing the feasibility of introducing telemedicine. The Trust only has 1 full time consultant at the moment and a lot of other providers are already closed to referrals, so these patients are already being re-directed to the Trust. There is a private company who provide Dermatology services where there is potential to re-direct but it is more appropriate to agree revised pathways with Commissioners. LS queried if providers outwith the regional footprint could be used to re-direct referrals and patients treated via telemedicine. SSh commented that there is a pilot in the Cancer Alliance underway around this model so it is possible to undertake enhanced triage. Nationally Dermatology is a problem and several options are being explored (for example could Commissioners help train GPSI's, different pathway models using Plastic Surgery consultants). PV commented that there is positive assurance around the exploration of options. Telemedicine seems positive but there is a national shortage of capacity.	

No.	Agenda Item	Action
	LS commented that the region has trained physician associates and although there are only the first couple of cohorts graduating there may be an opportunity to target them into areas the Trust would want them to develop into. • The Trust achieved the stroke indicator for April with 80% of patients spending 90% of time on a designated stroke ward. PV commented: achievement against the target of number and proportion of admitted adult patients in England who have been risk assessed for Venous Thromboembolism ("VTE") has improved as well so there is positive assurance there.	
	Finance	
F.5.18.7	**Finance Report**	
	MH stated that as the Trust has thus far only reported the month 1 position, an abridge report is being tabled at Committee. MH updated on the Finance Report : • A deficit of £2.0m was reported which was in line with plan. The plan for quarter one is for a deficit of £5.6m, to recognise the fact that Cost Improvement Programme ("CIP") plans will begin to generate savings later in the year. The summary report shows a deterioration in the deficit position for quarter two and then a static trend from September onwards PV queried if the focus ought to be on being ahead of plan at this early stage, particularly as it reflects a lower level of achievement of CIP in the earlier months. MH commented that the quarter one CIP plan is not ambitious but this does accelerate in future months. CIP achievement for month 1 is very low although underspends in other areas have offset this. The BIP will focus on these areas. Programme documentation is due for completion and submission on 31st May and performance will be managed through fortnightly meetings. • The income planned for April was £32.8m and actual achievement was £31.1m (£1.7m behind on contract income). The Trust continues to work on devising plans at a detailed level (by Point of delivery ("POD"), by specialty, by income type etc.). The income total has been agreed but the Trust is going through the process of detailing a plan to identify what this means for the divisions and how it aligns to the weekly trackers. An update will be brought to the next Committee meeting. • Pay expenditure is online with plan and non-pay expenditure is under plan by £1.8m, which offsets the income under recovery. There is a degree of overlap between these categories (for example; reduced spend on high cost drugs ties in with lower	Director of Finance

No.	Agenda Item	Action
	activity and therefore lower income recovered). • The planned pre-Sustainability and Transformation fund ("STF") control total is for an increasing deficit until September (£8.4m deficit). The plan for September onwards shows a more flattened trend line and a planned £7.5m deficit by year end. • The planned post-STF total has a slightly different trajectory due to the planned value of STF achieved in quarters three and four (planned STF achievement is for £3.6m in quarters one and two, and £6.7m in quarters three and four). • From a balance of £25.6m in cash at the beginning of the year, the in-month planned cash trajectory broadly tracks to the I&E profile for the year. This creates an April cash balance of £23m (as planned). Projections forward show the Trust expects £28m cash by the year end which is dependent on the Income and Expenditure plan being delivered inclusive of a full CIP and capital programme being delivered. The bonus STF achieved in 2017/18 by the Trust hasn't, as yet, been allocated to specific schemes within the capital programme and is undergoing an internal prioritisation/review process before being submitted for approval. A discussion took place around potential initiative overload and the assurances that they did not prevent sufficient focus on delivering core objectives. KD commented that Work as One is not about adding to the risk of initiative overload but is about a coherent plan and a structured way of tackling the work that needs to be done. Those initiatives allow for bite sized chunks to be done so that it doesn't overwhelm people. The structured nature of the initiatives give the Trust more progress than has been evidenced in past years. SSh agreed, adding that what the Trust is doing is putting in place enablers to help delivery. Performance and finances are huge challenges, so the BIP is a much more comprehensive way of improving performance and achieving our finance and efficiency targets. The presentation under agenda item F.5.18.13 will demonstrate activity trackers, which are important working tools to help us deliver this. Most initiatives are enablers to give a structured way of tackling the challenges. For example One of the key outcomes from the Work as One is an improvement in the ECS. MH commented that: • Liquidity days are planned for 1.3 by the end of the year and it broadly matches the I&E profile for the year. • The Use of Resources risk rating is on plan for Month 1. Within this	

No.	Agenda Item	Action
	plan the Capital service and I&E cover metrics were planned to be 4. Liquidity and control total variance metrics are planned for 1 (the highest rating) and agency spend is planned for a rating of 2 (so within 25% of ceiling of £10.7m). The Trust did indicate to NHS Improvement that an agency ceiling of £10.7m was undeliverable so the internal target is last year's ceiling of £12.3m. Performance against £10.7m is what is reported to NHS Improvement. MH highlighted the key messages providing both positive and negative assurance. • A fundamental budget reset has taken place (which was presented at the last Committee meeting) • All internal monitoring and management governance around BIP have been completed • Performance meetings are focused on run rates. This month's meetings focused on run rate and identified some control issues around stock with the Trust needing to develop internal mechanisms to allow Finance to be informed and for the Divisions to introduce improved grip and control. • BIP meetings are focused on CIP schemes and achievements. • A new process for receiving income and expenditure requests through Executive Management Team ("EMT") meeting has been introduced. It is recognised that the Board undertook a number of challenging discussion regarding acceptance of the Control Total and the challenge posed by a £25m CIP. Whilst a plausible plan has been submitted it remains a very challenging proposition. As such, EMT is not in a position to add incremental cost pressures and extend the CIP. The Trust has been clear that for any papers to EMT there has to be a degree of escalation if there is a bid for new money. If a bid were to impact on CIP levels then it needs a higher level of sign off. • Enablers to manage the financial position in more real time have been developed and in particular the activity trackers, which will allow the Trust to take more immediate action or more immediately signpost where the Trust is going off trajectory. • Further enablers are maximising the financial benefits of the embedded ePR (it has already improved safety of care, and delivered benefits through reporting e.g. VTE where the Trust has achieved the target), stretching GE to maximise benefits and outputs from the new pharmacy system (EMIS) etc. • Regarding the BIP, CK and MH have discussed how the Trust start to get the message out to the front line to ensure they understand the control total regime, the scale of CIP challenge etc. Examples	

No.	Agenda Item	Action
	could include a programme of roadshows or a monthly briefing pack. It is imperative that the Trust ensures full ownership of BIP. A lot of clinical and non clinical staff have a genuine interest and as such the Trust needs to harness this. • MH reiterated the importance of protecting the cash position and noted that slippage on the I&E plan could compromise the capital programme. • Negative assurance would be that some of the key lines are not delivering at the moment PV commented that the Trust is on plan and has built in more systems around performance, established more controls and has enablers in place. Income & productivity is critical as well as cash and also getting buy in and ownership on plans.	
F.5.18.8	**Budget Re-basing exercise 2018-19**	
	Following on from the detailed presentation that CS gave at the last Committee meeting, MH commented that feedback from the Trust has been reasonably positive. Whilst there are areas of clarity that were naturally questioned, it is felt that overall the Divisions recognise and understand the approach. The principles have been applied consistently and genuine errors have been corrected. PV commented that it has been done transparently and this has helped with ownership. MH confirmed that there have been sufficient opportunities for the Trust to voice concerns. The EMT meeting has discussed this three times and individuals have approached CS directly, who dealt with their queries. KD commented that the whole approach is different from previous years. This year feels much more open and transparent and a good two way conversation. MH's team should be congratulated on the step change. MH commented that assessing whether budget holders are feeling more accountable is a work in progress and that it will take time to get genuine ownership as the Divisions need time to recognise that the budgets reflect what they have been spending. PV commented that the Trust will learn from it but it is a stepped change and congratulated CS for leading on this.	
	Performance	
F.5.18.9	**Performance Report**	
	PV commented that this has been covered under agenda item F.5.18.9. MH highlighted key positive messages. • ECS for April was 83% and is 87% in May	

No.	Agenda Item	Action
	• The Diagnostic waiting times (DM01) position has improved but noted the increased trend on cardiac CT referrals. EMT has discussed what is driving this • The VTE target was achieved for first time since 2016 • There is one never event being discussed at Quality Committee PV passed congratulations to the team and commented that it was good to see these benefits being delivered, noting performance in Stroke. KD commented that there was no MRSA in April (as is indicated in the narrative). The event related to a patient who came in through Accident & Emergency and as such is o attributed to community and not the Trust.	
F.5.18.10	**Informatics Performance Report**	
	DH summarised the key highlights from the short report for April. • Full support has been provided for clinical teams for ePR. New adoption metrics will appear in the quarterly reports. • Post April a full set of commissioning datasets have been submitted for first time post ePR. PV commented that within Clinical Informatics, adoption of the Discharge Summary around the Trust has remained static and queried what has been done to increase engagement. DH commented that the operational teams are supporting adoption and standardisation, and more detail on those points will appear in the quarterly report. Informatics are developing a target in advance of the next performance report. PV queried the nature of the performance notice relating to commissioners. MH commented that these relate to information breach notices that have been served by NHS England for post ePR activity submissions outside mandated timescales. To allow it to be rescinded the Trust need 3 clear months of reporting. Unless the Trust breach again there are no penalties. 1% of contract value can be withheld for each month until the notice is resolved. NHS England is not withholding funds at the moment. • The apprenticeship programme is for both Information Technology and Business Intelligence but for specific vacancies. The Trust is aligning the national profiles for apprenticeships to align with these to use the apprenticeships to fill vacant posts. These will be at Level 7. This will allow the Trust to recruit into hard to fill posts and grow talent internally.	

No.	Agenda Item	Action
F.5.18.11	**Trust Improvement Committee Report**	
	Updates on the key items from the Trust Improvement Committee Report were discussed under other agenda items.	
F.5.18.12	**Recovery Plan Update**	
	Updates on the key areas relating to Recovery Plan updates were discussed under other agenda items. The latest recovery plans were tabled for information.	
F.5.18.13	**Weekly activity tracker & trajectories by specialty update**	
	SSh gave thanks to Carl Stephenson, Divisional Planning and Performance Manager and Fabienne Peraudeau, Business and Performance Support Manager for their work on this project. SSh summarised the key highlights and developments from the Capacity and Demand Project: • The Trust started developing a tool for capacity and demand analysis by specialty in November 2017, focusing on the true core capacity. In the past there had been a reliance on non-core capacity to deliver activity, often at premium rate. It wasn't visible that the Trust always utilised all core activity before going to premium rate. • A validation process followed to adjust and refine figures, working with the specialties. The tool has been tested and rolled out to main the Referral to Treatment ("RTT") specialties and the next step is to focus on cancer pathways and capacity. • The Trust wants to ensure all specialties have sustainable waiting lists. Within the waiting list model most patients are looking for 6 week waits for a first appointment. The Urgency rate (number of patients who need to be seen within 2 weeks e.g. cancer) is identified. The total waiting list is also identified. • The annual capacity and demand exercise is based on job plans and using all capacity resource, looking at waiting lists, theatre capacity, clinic templates etc. and this ultimately gives the Trustwide core capacity to inform what the Trust can deliver sustainably. • Going forward, specialties will be provided with a dashboard showing activity versus plan, with reference to associated income and performance metrics. There will be an area for directorate managers to add in changes to core capacity in any one week. It is simple to use and most data pulled direct from the Trust's information systems. It also shows forecast performance.	

No.	Agenda Item	Action
	• Next phase of development for the tool will be to look at capacity for urgent pathways for patients to be seen by a specialist within 14 days of an urgent GP referral for suspected cancer. CSt demonstrated the weekly activity trackers that were developed as part of this process. The tool is configured to fit whichever screen it is being viewed on, regardless of device and screen size. Data quality improvements are ongoing and amended as and when they are identified. Whilst the demonstration model shown in this Committee meeting is not fully populated, the live models which will actually be used should be fully populated next week (w/c 4th June). This was launched in last week's (w/c 21st May) Trustwide Access meeting and bespoke one to one support has been offered to end users if required. The tracker ties activity, income and RTT performance. A significant amount of data processing is undertaken in the background before the tracker can be published. Currently there are 16 specialties using the trackers, which will rise to 30 in total when fully rolled out. The tracker demonstrates that if a specialty delivers activity as planned, with sufficient capacity to do so then the 18 week RTT target should be met. Using ENT as an example the tracker shows increased activity above plan but less income. In this case for ENT the specialty has completed fewer Elective and more Daycase spells than planned so income is less than expected (as Elective cases generally attract a higher tariff than Daycase). Healthcare Resource Group ("HRG") tariffs are assumed so the income quoted is an estimate, which will be updated for actual data when available from SLAM (the software package used by the contract income team within Finance to derive actual income due from Commissioners). The note sheet has a guide to what is being seen and the underlying data assumptions which is pre-populated for the specialties. The team are still working on metrics regarding conversion from Outpatient to Inpatient, and once complete these will be used in a future iteration of the tracker. The tracker demonstrates the extent to which a specialty undertakes chronological booking, identifying clock stops and their relative position on the waiting list (i.e. the proportion of stops on patients who have a wait of less than eighteen weeks). This can also be seen graphically. The model also has information regarding the expected amount of Direct Clinical Care ("DCC") activity to help drive the capacity numbers, which will be measured against actual delivery. This functionality is due for the next iteration of the model. There is an opportunity for every specialty to fill in an action plan and any capacity changes. Changes to plans will show improved performance on	

No.	Agenda Item	Action
	the dashboard. The only changes directorate managers will make is around increased or reduced capacity. It is powered by actual activity so if a directorate manager for example reduces DNA rates the tracker will reflect this. Future iterations will have some 'what if' scenarios/analysis on the charts. If the tracker states that there is a shortfall of 129 First Attendance slots (as per the demonstration) it is a shortfall against contract. The Trust set a contract to deliver income and RTT. The contract may not deliver RTT so the Trust needs to address that through capacity. If a specialty falls behind on activity targets against contract then future in year targets must increase to address the shortfall. For RTT it needs manual plans and manual intervention on the tracker. Going forward, when contracts are more closely aligned with RTT, it should be able to be addressed through the automated element of the tracker. From next week (w/c 4th June) in addition to doing long wait management (i.e. over 40 week waiters, urgent cancer waits, non RTT over 3 months etc.), directorate managers will also be able to look at the wider core capacity for each week. PV commented that this is a great enabler. TH commented that increasing tracking enables the possibility of assessing for positive assurance. TH queried if the Trust is tracking any ensuing impacts on quality and safety. (i.e. is the Trust assured that patient care is not being compromised and is it tracked anywhere)? SSh commented that one of the biggest risks to patients is waiting too long and the tracker addresses this by showing the waiting list and if patients are being treated in chronological order. Within the Follow Up Attendance review process for non-RTT patients there is a process to bring them back in if required so they're not removed from the waiting list. There is therefore the opportunity for patients to come back in urgently if required. This should help improve quality and safety avoiding patients waiting too long. LS commented that the tracker is a positive step forward but was there a risk that given the volume of date, some staff may not embrace it due to issues of understanding. LS queried what organisational development the Trust is planning to undertake to get buy-in, and suggested it ought to utilise the longitudinal story which picks a patient and contextualises across the whole pathway. . SSh commented that CSt launched this last week (w/c 21st May) and there has been positive feedback. It was well received as people have been requesting this type of data for quite some time. It is been made simple and updated weekly and full support as necessary has been offered. CSt commented that the Elective Care Recovery programme is a wider piece of work so the tracker is not the only initiative. The programme itself will have a dashboard showing key metrics but also with balancing measures to measure safety and quality (ensuring that as a minimum there	

No.	Agenda Item	Action
	will be no negative impact on quality). Within the programme there are other workstreams supporting this. There is a data quality workstream to identify any errors and correct if appropriate. The process current brings together around 7 datastreams, and they do not all correlate immediately. This has been a challenge to integrate each of these, liaising across the Trust with appropriate staff, but until this is the best way for the Trust to understand the intricacies within the data. LS commented that CSt is a great ambassador for this programme. PV commented that balancing this with quality and engagement makes the tracker a powerful tool.	
F.5.18.15	**Draft Internal Audit Plan 2018-19**	
	PV commented that Barrie Senior, Non-Executive Director wanted visibility on the Internal Audit plan regarding the utilisation of audit days and where time is being focussed. PV noted the Audit plan provides this transparency. PV is impressed with the scope and queried if all Committee members are happy with the scope. TH declared his position on the Audit Committee and took no part in the discussion of this agenda item. SSh commented that the Chief Operating Office has already met with Internal Audit and agreed a workplan. MH commented that this was the same for Finance and that it is possible to request changes to the plan during the year.	
F.5.18.15	**Financial Savings estimate as a result of reducing sickness rates between 2015/16 and 2017/18**	
	MH commented the best way to try and understand this is to analyse the year on year sickness rate reduction (from 5.16% to 4.6%) and how this had an impact on run rate. The overarching conclusion is that it is difficult to reconcile the 2 figures. Referring to the paper submitted for this agenda item, the table on page 3 attempts to realign the pay position from 2015-16 and inflate it to an equivalent 2017-18 position and then compare to actual 2017-18 spend. The two numbers are very similar. There are some significant movements across the various temporary staffing costs. Over the timeframe analysed, bank costs have increased by £3.7m whereas agency costs have reduced by £6.2m. Substantive costs have increased by £2.3m. The efforts made by the Trust to move away from agency usage and into bank appear to have worked. 2016-17 agency spend was £20m whereas in 2017-18 it was £14m. The impact in Estates and Facilities is highly likely to be linked to the significant reduction in sickness rate over the timeframe analysed. It cannot be said if the overall sickness rate reduction has categorically impacted elsewhere.	

No.	Agenda Item	Action
	PV commented that there have been a significant amount of savings especially in using bank and avoiding the agency premium. LS commented it is important to also look at culture and values. Including the work done on the wards would really make a difference (face to face understanding of sickness reasons, health and wellbeing, caring for staff etc.). Just tabling data can possibly cause a disconnect between sickness and patient care.	
F.5.18.16	**Any other business**	
	None.	
F.5.18.17	**Matters to share with other Committees**	
	Presentation of the Activity Trackers to the Board of Directors	Chief Operating Officer
F.5.18.18	**Matters to escalate to the Board of Directors**	
	PV stated that several items should be noted but not formally escalated, namely • Cancer recovery plans • The Activity trackers • RTT and ECS performance • The financial position being generally on plan, whilst recognising the risks • Discussion around the BAF It was agreed JMa would work with CCa to generate a summary report on these points for the Board of Directors.	Head of Corporate Governance
F.5.18.19	**Matters to escalate to Corporate Risk Register**	
	None.	
F.5.18.20	**Items for Corporate Communication**	
	None.	
F.5.18.21	**Date and time of next meeting**	
	Wednesday 27th June 2018, 08:30 am - 10:30 am Conference Room, Field House, BRI	

Bradford Teaching Hospitals NHS
NHS Foundation Trust

BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST
ACTIONS FROM FINANCE AND PERFORMANCE COMMITTEE – 30th MAY 2018

Date of Meeting	Agenda Item	Required Action	Lead	Timescale	Comments/Progress
30/05/2018	F.5.18.5	MH to update narrative relating to Financial Controls Panel in Board Assurance Framework	Director of Finance	30/06/2018	
30/05/2018	F.5.18.7	MH to update next Committee on detailed Commissioner income	Director of Finance	30/06/2018	Added to F&P committee June agenda
30/05/2018	F.5.18.17	SSh to provide a presentation to the Board of Directors on the Activity Tracker	Chief Operating Officer	13/09/2018	Added to BOD open September agenda
30/05/2018	F.5.18.18	JMa to prepare summary report for Board of Directors	Head of Corporate Governance	30/06/2018	Added to BOD Open July agenda