

Council of Governors: 18.1.2018

Agenda Item: CGo.1.18.18

Report from the Chair of the Finance and Performance Committee

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| Presented by: | Pauline Vickers, Non-Executive Director | Author: | Sarah Worstead, Corporate Compliance Manager |
| Previously considered by: | Board of Directors held 11 January 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 20 December 2017 and 29 November 2017. | To discuss and note |
| 2. The confirmed minutes from the Finance and Performance Committee meetings held on 27 September, 25 October and 29 November 2017 are attached at Appendix 1. | To discuss and note |

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| Executive Summary: |
| The purpose of the Finance and Performance Committee, as set out in its Terms of Reference, is to provide detailed scrutiny of financial and performance matters in order to provide assurance and, if necessary, raise concerns or make recommendations to the Board of Directors. |
| The Council of Governors is asked to note the report presented to the Board of Directors on 11 January 2018. |

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| Financial implications: |
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| Regulatory relevance: |
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| Monitor: | |
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| Equality 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: | To deliver our financial plan and key performance targets |
| <i>Reference to Strategic Objective(s) this paper relates to</i> | |
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Finance and Performance Committee – 20 December 2017

1. Introduction

The purpose of this paper is to advise the Board of Directors of the key matters discussed and a brief summary of agenda items of the Committee which was held on 20 December 2017.

2. Key Matters discussed at the meeting held on 20 December 2017

- Financial Metrics
- Trust Improvement Plan
- Organisational Performance
 - RTT
 - Cancer waits
 - VTE

3. Agenda items

3.1 Finance and Performance Committee Dashboard

The Finance and Performance Committee dashboard was discussed by the Committee and used as the mechanism to discuss key performance indicators.

3.2 Finance Report

The Trust reported a pre-STF deficit of £7.5m at the end of Month 8 which is £3.3m behind the pre-STF control total. None of the £2m STF can be recovered for Months 7 & 8. Including STF recovered for Q1 & Q2, the YTD post-STF position is a deficit of £4.3m against a planned £1.2m surplus, meaning the Trust is £5.5m behind the cumulative post-STF control total. The in-month position is an adverse pre-STF variance of £1m. A YTD pre-STF deficit £6.2m was forecast in the revised Improvement Plan, which means the Trust is £1.3m behind the Improvement Plan trajectory.

Expenditure in November was higher than forecast in a number of areas and many of the improvement plan measures scheduled for November were delayed. This was partially offset by further non-recurrent measures; however these were insufficient to bring the Trust back into line with the revised Improvement Plan trajectory. Work is ongoing to identify new measures to improve the current trajectory forecast.

Cash is lower than plan by £5.7m mainly due to the Quarter 2 payment for STF with NHS England.

Liquidity is 2.2 days below plan at the end of November, reflecting the use of non-recurrent measures to offset improvement plan shortfalls, lower than planned levels of clinical income and delays with STF payments.

The Trust spent £1.3m on revenue agency staffing in November, which is £0.4m (47%) higher than the phased in-month ceiling. YTD agency spend is £9.7mm which is £1.7m higher than the £8m YTD ceiling (21%). The year end forecast is full year agency spend of £14.5m - £15m, which is significantly greater than the full year ceiling of £12.3m.

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The forecast delivery from the original CIP programmes have been amalgamated with the £12.2m Improvement Plan requirement to arrive at a projected combined efficiency requirement of £25.8m in 2017/18. This extended 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 control total in Quarters 1 & 2. At present, plans are in place to deliver £21m of efficiencies against this target, resulting in a shortfall of approximately £4.6m. BTHFT is investigating a number of options to address this shortfall, however delivery at present is not assured.

3.3 Medical Pathways Review by NHSI

An NHSI Improvement team led by Dr Vincent Connolly visited BTHFT on 24 November 2017 to review urgent care medical pathways. The team reviewed BTHFT's Urgent Care Improvement Plan and observed many areas including ED, admissions units and 2 downstream wards; respiratory and cardiology. Initial feedback was given to clinical and managerial colleagues and a follow up letter was sent and discussed by the Committee.

3.4 RTT

A presentation was given on the 18 weeks RTT and Non RTT post EPR implementation. Currently BTHFT cannot report an accurate RTT position post Cerner implementation. This is due to an inability to accurately split the incomplete PTL into admitted and non admitted pathways plus data quality issues. BTHFT is also unable to report the accurate position on endoscopy and neurophysiology.

No date is available as to when this can be fixed.

Internally the incomplete PTL is run daily rather than weekly and daily validation of over 18 weeks patients is occurring.

3.5 Performance Report

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

The Emergency Care Standard performance for November 2017 was 84.97%.

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 remained relatively stable.

A Cancer position for September has been produced which reports failures against the Cancer 2 week wait, Cancer 62 day first treatment and Cancer 62 day screening targets.

The maximum C Difficile position for financial year 2017/2018 is currently 12 cases with 7 cases awaiting post infection review. 2 cases were reported in November 2017.

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

The Stroke indicator was achieved in November 2017.

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VTE assessment performance for November 2017 was 80.22%.

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 Informatics Performance Report

As the Electronic Patient Record (EPR) is becoming embedded the focus is now on adoption metrics and using the EPR as in a standard and consistent way. Key Performance Indicators (KPIs) have been developed.

The Information Technology team is now actively focussing on upgrading the core switches that run the network. The air conditioning unit in the main Data Centre was replaced in November 2017. Planned work is being expedited to provide a more resilient architecture for the link for Pathology.

3.8 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 Director of Governance and Operations

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.

5. Recommendation

The Board of Directors is asked to note the above points.

Finance and Performance Committee – 29 November 2017

1. Introduction

The purpose of this paper is to advise the Board of Directors of the key matters discussed and a brief summary of agenda items of the Committee which was held on 29 November 2017.

2. Key Matters discussed at the meeting held on 29 November 2017

- Financial Metrics
- Improvement Plan
- Organisational Performance
- Cancer Services Recovery Plan
- Winter Planning

3. Agenda items

3.1 Finance and Performance Committee Dashboard

The Finance and Performance Committee dashboard was discussed by the Committee.

3.2 Financial Report

The Trust reported a pre-STF deficit of £6.6m at the end of Month 7 which is £2.4m behind the pre-STF control total. None of the £0.98m STF can be recovered for Month 7. Including STF recovered for Q1 & Q2, the year to date (YTD) post-STF position is a deficit of £3.4m against a planned £0.1m surplus, meaning the Trust is £3.6m behind the cumulative post-STF control total. The in-month position is an adverse pre-STF variance of £2.4m. An adverse variance of £1.5m was forecast in the Improvement Plan, which means the Trust is £0.9m behind the Improvement Plan trajectory shared with NHSI.

The pre-STF forecast position for October including Improvement Plan measures was a net deficit of £1.33m. A pre-STF deficit of £2.3m was delivered, meaning after one month the Trust is behind its improvement plan trajectory by £0.97m. This £0.97m adverse variance is explained at a high level by the income run rate position being £0.8m worse than forecast and the delivery of non-recurrent improvement measures being £0.17m lower than planned. The underlying variances to the forecast for pay and non-pay expenditure and divisional income net off to only £2k, reflecting a broadly accurate forecast. The most substantial issue is the capture, count and coding of activity from EPR, which is reporting a material drop in activity for October. The teams in place to capture the activity and provide assurance around data quality continue to focus efforts on the targeted areas. It is anticipated the issues will be resolved and recovered for the reporting of the November position and the deadlines for reporting to commissioners. The recovery trajectory therefore assumes the Trust will reinstate the lost income in November and report an on plan position for the period ending 30 November. However, if this income cannot be substantiated and retrospectively charged for, the Trust's position will remain almost £1m behind the Improvement Plan after the first month. In this scenario, the Trust would need to make financial run rate improvements throughout the remainder of the year to recover the slippage.

Liquidity is broadly in line with plan at the end of October. The factors that strengthen the forecast liquidity position are the changes to the accounting treatment of NHS injury benefits (road traffic act); movement from non-current to current receivables (£1.7m). Liquidity is forecast to become negative from November. Should the Improvement Plan be delivered, liquidity is forecast to slowly improve from January 2018 onwards.

The Trust spent £1.4m on revenue agency staffing in October, which is £0.5m (56%) higher than the in-month ceiling. YTD agency spend is £8.4m which is £1.3m higher than the £7.1m YTD ceiling (18%). A forecast based largely on an extrapolation of the current run rate results in full year agency spend of £14.5m - £15m, which is greater than the full year ceiling of £12.3m.

3.3 Approval Process for New Consultant Appointments

The updated Standing Financial Instructions and Scheme of Delegation were presented to the board in November and included a number of amendments.

Following the Board Meeting and subsequent discussion between the Chair and Chief Executive, it was agreed that the approval process for the appointment of new consultants would be summarised for the November meeting of the Finance and Performance Committee.

It was agreed that the current business case process will be followed.

Following approval, a summary FBC will be presented to the Finance and Performance committee that captures the key objectives of the approved appointment. In addition the summary FBC will detail the financial implications including the cash flow impact and will also detail the proposed realisable benefits.

A six month post implementation review will be undertaken and initially presented to EMT then subsequently to the Finance and Performance Committee.

3.4 Performance Report

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

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 remained relatively stable.

The last nationally reported Cancer position was in August 2017. Work is continuing to re-establish reporting post Cerner implementation.

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 achieved with no breaches reported for CT tests.

The rerun of September stroke data did not improve performance and the indicator is reported as not achieved for both September and October.

A draft report on VTE assessment performance for October 2017 has been prepared which reports performance as 85.35%. The recreation of reporting via Cerner highlights the need to review the original cohorting rules via the VTE Steering group.

The Emergency Care Standard performance for October 2017 was reported as 84.5%.

The maximum C Difficile position for financial year 2017/2018 is currently 10 cases with 7 cases awaiting post infection review. 3 cases were reported in October 2017.

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

3.5 Emergency Care Standard Recovery Plan

In response to the reduced level of performance of the Accident & Emergency 4 hour standard and a request from NHS Improvement (NHSI), the Trust has developed and agreed a Trust wide Urgent & Emergency Care Improvement Programme.

The programme has been split into three separate, although wholly linked and integrated workstreams. These workstreams are Emergency Care Access, Emergency Care Flow and Hospital Flow and Discharge.

This programme reports directly to the Trust Improvement Committee and whilst the programme is all encompassing, is chaired by the Divisional Clinical Director for Medicine & Integrated Care.

3.6 Improvement Programme Update

The Improvement Programme update focussed on the organisational support now in place and the success of the facilitated leadership working session in early November, whereby the senior leaders in the Trust spent two full days evaluating the criteria and success factors that are required to be in place to manage and run a complex organisation. From a productivity improvement perspective, the programme initially looks to deliver operational efficiencies in theatres and the endoscopy unit which are scheduled to deliver tangible financial benefits in the 2017/18 financial year.

3.7 Trust Improvement Committee Report

The original improvement programme savings as at the end of October show a total of £9.6m savings delivered against planned savings of £11.1m. Key contributors to the offplan variance are:

- failure to maintain a pipeline of new Divisional housekeeping savings;
- high levels of agency spend;
- a slowdown in the theatre efficiency programme resulting from EPR Go-Live, and,
- the exhaustion of non-recurrent savings in previous months.

In support of the Trusts aggregate position and to reinvigorate its current Improvement Programme a new Improvement Plan has been developed to support existing priorities and to consider new opportunities. These opportunities are currently being prioritised, scoped, and in some areas delivery have already commenced.

3.8 Informatics Performance Report

EPR is in steady state and transitioning to business as usual.

The data warehouse projects continue.

The Information Technology team is now actively focussing on upgrading the core switches that run the network. There continues to be an operational issue with the air conditioning unit in the main Data Centre with replacement completing in November 2017. Planned work is being expedited to provide a more resilient architecture for the link for Pathology.

3.9 Winter Planning

The Director of Governance and Operations gave the Committee a verbal update on the WYAAT winter planning bid submitted to NHSI.

3.10 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 Director of Governance and Operations

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

4. Escalation to the Corporate Risk Register

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

5. Recommendation

The Board of Directors is asked to note the above points.

Appendix 1

FINANCE AND PERFORMANCE COMMITTEE MINUTES, ACTIONS & DECISIONS

| | | | |
|-----------------------|---|---------------|---|
| Date: | Wednesday 27 th September 2017 | Time: | 8:30 – 9:30 |
| Venue: | Trust Meeting Room, Chestnut House, BRI | Chair: | Pauline Vickers, Non-Executive Director |
| Present: | <p>Non-Executive Directors:</p> <ul style="list-style-type: none"> - Mr David Munt, Non-Executive Director (DM) - Mrs Pauline Vickers, Non-Executive Director (PV) - Mr Trevor Higgins (TH) via telephone <p>Executive Directors:</p> <ul style="list-style-type: none"> - Mr. Matthew Horner, Director of Finance (MH) - Mrs Cindy Fedell (CF) - Ms Donna Thompson, Director of Operations and Governance (DT) | | |
| In Attendance: | <ul style="list-style-type: none"> - Professor Clive Kay, Chief Executive (CLK) (from 8.45) - Mr Chris Smith, Deputy Director of Finance (CS) - Mr James Mackie, Head of Performance (JM) - Ms Fiona Ritchie, Trust Secretary (FR) - Mrs Isabel Greenwood, Minute taker (IG) | | |

| No. | Agenda Item | Action |
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| F.9.17.1 | Apologies for absence | |
| | Apologies were received from: <ul style="list-style-type: none"> - Ms Karen Dawber, Chief Nurse (KD), Executive Director - Dr Mohammed Iqbal, Non-Executive Director (MI) | |
| F.9.17.2 | Declaration of Interests | |
| | There were no declarations of interest. | |
| F.9.17.3 | Minutes of the Finance & Investment Committee meeting held on 30th August 2017 | |
| | The minutes were accepted as a correct record. | |
| F.9.17.4 | Minutes of the Performance Committee meeting held on 30th August 2017 | |
| | The minutes were accepted as a correct record. | |
| F.8.17.5 | Matters Arising | |
| | <p>Actions;</p> <p>F.6.17.8 Completed reference cost check list. This was resubmitted on the 15th Sept with a score is 104, which was a one point improvement. A formal report will be presented at the next</p> | |

| No. | Agenda Item | Action |
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| | <p>committee on the 25th October 2017.</p> <p>P16/148.0 JH to produce refreshed corporate communications strategy to the BoD. This was presented at the September BoD meeting.</p> <p>P.7.17.5 Performance Report - 62 Day Cancer Standard A verbal update was given at the meeting. JM will table the full report at the meeting on the 25th October 2017</p> <p>The Chair advised that the order of the agenda would be changed.</p> | |
| F.9.17.9 | EPR Go-Live update | |
| | <p>CF provided an update on the EPR that went live the weekend of 23/24 September 2017. She confirmed that there were no safety issues reported. The risk team have been doing walkrounds on the wards and talking to clinicians to ensure any potential safety issues are raised and resolved.</p> <p>The training position pre go-live was that 94% of people received training. The training rate is now above this as training sessions continues to ensure the remainder of staff are trained.</p> <p>At cutover the data migration statistics where above 99.9%, which meant the cutover was able to maintain the schedule and fewer resource and time needed to manually enter data</p> <p>CF reported that AED went live at 4.39am on Sunday morning, earlier than expected, followed by a rolling wave of wards. The first wards went live at 12.46pm (Wards 20/21); with the last ward (Westwood Park Community Hospital) going live at 11.27pm. Fast track clinics ran on Monday And yesterday all other clinics went live with some clinics with a reduced in size of around 25%.</p> <p>The biggest issue so far has been access. A different approach to access has been put in place. Our issues logged are lower volumes than our peers.</p> <p>The routes for reporting issues are; calls to the IT service desk, attend the access desks set up, floor walkers and bronze command reporting to silver and gold command. The escalation seems to be working well as the issues are correlating.</p> <p>DT added that operationally, the weekend before go-live in AED was challenging, which was the worst performance for many weeks. Command and control was started at that point and ran through the week, including night-time coverage in AED by KD. This worked saw performance turn around. Friday was at 87%, and Saturday at 96%, going into the go-live with strong performance and over 100 beds available. Command and control continues with strong links between the operational and technical teams.</p> <p>Key points to highlight are that we have had fantastic support from external, internal staff and corporate staff to push tea trolleys, enter data, walk the wards. This support has made it more manageable.</p> | |

| No. | Agenda Item | Action |
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| | <p>The go-live has gone exceptional well. This does not mean that there are not problems coming through, but this was expected, for example, we have outpatient clinics running today with consultants who were not in yesterday.</p> <p>In response to a query from PV, DT informed the Committee that some clinics are not reduced at all, some are taken out completely and some are reduced between 50% to 75%. How this will be increased back to the normal levels will be assessed in the coming weeks.</p> <p>The next step is prepare for transitioning to business as usual. The hospital is now getting busier and people have less time, so the teams will need all support patient flow. That is the focus over the next 10 days.</p> <p>We are also now looking at getting the reporting systems back on line with data flowing. CF added that data is available today, e.g., number of patients being seen. Data quality meetings are being this afternoon, to review patterns and trends, supported by external experts.</p> <p>The Committee acknowledged the teams and thanked all staff across the Trust.</p> <p>TH (via telephone) noted that we have assurance from the EPR Assurance Committee's perspective. He added that he has never seen an IT project that has had this level of preparation and formally gave thanks to all the staff.</p> | |
| F.9.17.7 | Improvement Plan | |
| | <p>MH handed out three documents to the Committee members;</p> <ul style="list-style-type: none"> - Trust Improvement Plan - Detailed Improvement plan measures - Bradford: External partnership <p>MH described that the document reads as a financial plan, as this is what is required for the committee and external audiences, however we need to ensure that messaging and tone is correct when distributed internally.</p> <p>The emphasis of the plan is on financial improvement, governance, performance management arrangements and grip and control. The Executive Directors have not yet had sight of the paper due to EPR, so some elements still need to be confirmed.</p> <p>The plan has identified maximum run rate improvements of £11.4m against a requirement of £10m. It is considered to be the case that £15m of plans are required to allow for slippage and to guarantee delivery of £10m in 17/18.</p> <p>The paper focuses on what is going to be different between now and the end of the financial year.</p> <p><u>Clinical Income</u></p> <p>The Trusts needs to recover back to plan at the very least, plus extra</p> | |

| No. | Agenda Item | Action |
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| | <p>activity to address the current under delivery of the contract. Section 6.3 in the paper details the additional grip that will be put in the system.</p> <p>MH highlighted page 14, which details the proposed Contract Income Oversight Panel. This group will be established in October 2017, and propose to meet on a fortnightly basis. They will identify areas to target, and exert increased grip and control of all aspects on contract income across the Trust. The panel will develop and review the management information available to support divisions in targeting areas for improvement.</p> <p><u>Financial Control</u></p> <p>It is proposed that a financial control oversight panel is to be introduced. This group's remit is to review compliance with existing controls, introduce new control, plus other measures to reduce run rate.</p> <p>This meeting would take place fortnightly.</p> <p>MH described the other areas that the Financial Improvement Plan focuses on;</p> <ul style="list-style-type: none"> - Proposal of how business cases are managed between now and the end of the financial year. - Overtime approvals will go through the recruitment approval panel post EPR implementation. - Further controls around the Health Roster system. - Additional miscellaneous controls for example bringing forward the liquidity challenge. - Reduce delegated authority levels, for example reducing the level at which investment decisions require approval by the Board of Directors from £1m to £0.5m to increase visibility. - Introduce measures that NHSI would expect to see in their grip and control paper. <p>MH further discussed what resources would be required to make this happen. There is currently an interim manager in the Trust supporting DT with the elective care programme.</p> <p>A KPI pack, when developed, will go to the ED team on a weekly basis.</p> <p>There will be a focus on the proposal for facilitated support with the draft proposal/scope circulated. The Trust is in process of developing the consultancy business case for NHSI, to gain their approval to proceed. The proposal includes the opportunity to pursue a contingent fee arrangement based on an agreed rate of return.</p> <p>MH confirmed that the EDs need to sign off the detail.</p> <p>MH directed the Committee to page 22 and 23 which focusses on the proposal to introduce a monthly Divisional budgetary performance meeting, with all ED's in attendance. This will be in addition to the existing Divisional performance review meetings.</p> | |

| No. | Agenda Item | Action |
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| | <p>The Trust Improvement Committee have also updated their terms of reference and representation in light of the financial challenge, as described in 13.2</p> <p>MH highlighted the importance of getting the message right. An article will be published in the Trusts "Lets Talk" newsletter and a letter will be sent out to all budget holders, jointly signed by DT & MH.</p> <p>DT agreed that there does need to be a focus on the e-Rostering system.</p> <p>MH circulated a list of opportunities that the Trust has been exploring. The areas of focus are grip and control, reducing costs and increasing income, with a project lead, a baseline, a target improvement value and a timescale identified for each.</p> <p>PV questioned the track record of a facilitated support arrangement; MH replied that they have included a number of case studies in their proposal that demonstrate success.</p> <p>TH (via telephone) asked if the Financial Improvement Plan will address AED and RTT.</p> <p>MH & CS confirmed that a number of the initiatives focus on improved productivity that would increase throughput and as such improve income and the RTT position.</p> <p>DT added that the plan isn't prepared on the basis of supporting improved delivery of the Emergency Care Standard. In addition, the Trust requires a detailed proposal and trajectory around AED and cancer performance.</p> | |
| F.9.17.6 | Finance Report | |
| | <p>The Finance Report was circulated in advance of the meeting.</p> <p>MH highlighted the key messages as;</p> <p>The Financial position was on plan at the end of August 2017. It is anticipated that the Trust would deliver Quarter two and as such recover the Sustainability and Transformation Funding (STF)</p> <p>DM asked with there was any penalties associated with the overspend on agency. MH confirmed that there were no penalties.</p> <p>TH (via telephone) asked if the EPR system offered more control over the prescribing of medication.</p> <p>CF confirmed that there is opportunity in the system. MH further added that the new pharmacy system, would improve the management information provided.</p> <p>The Committee noted the financial report.</p> | |
| F.9.17.8 | Performance Report | |
| | <p>MH presented the highlights from the performance report, noting the decline in the RTT position but an improvement in the Emergency Care</p> | |

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| | <p>Standard.</p> <p>The deterioration of the Cancer 2 week standard is continuing, especially within Dermatology, which is expected to continue into September.</p> <p>DT noted that a report will be presented at the next committee, to highlight the pressures within each speciality and the scale of the challenge.</p> <p>CLK noted the deteriorating position in General Surgery and requested an exception report at the next meeting.</p> <p>DT replied that this was not in relation to staffing issues, but the ability to get into the operating theatres and bed issues. CLK questioned the DMO1 performance and the timescales for recovery, with JM projecting delivery by the year end but with continuous improvement.</p> <p>DM noted that the Termination of pregnancy services position is deteriorating.</p> <p>JM replied that he has spoken to the Division and it was an administrative error around the numbers. DM asked that this is confirmed at the next meeting.</p> <p>PV highlighted that VTE is still off track.</p> <p>CF responded that VTE should improve with the implementation of EPR.</p> | <p>Director of Finance</p> <p>Director of Finance</p> |
| F.9.17.10 | Any Other Business | |
| | There was no any other business raised | |
| F.9.17.11 | Matters to escalate to the Board of Directors | |
| | <p>The matters to escalate to the board of Directors are;</p> <p>Update on EPR</p> <p>Financial Improvement</p> <p>Sighted on performance, RTT, 32 62 cancer waits, diagnostic waits and AED, and VTE</p> | |
| F.9.17.12 | Matters to escalate to Corporate Risk Register | |
| | There were no matters to escalate. | |
| F.9.17.13 | Items for Corporate Communication | |
| | There were no items to escalate for Corporate Communication. | |
| F.9.17.14 | Date and time of next meeting | |
| | <p>Finance & Performance Committee</p> <p>25th October 2017 8.30 -10.30</p> <p>Conference Room, Field House, BRI</p> | |

**BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST
ACTIONS FROM FINANCE AND PERFORMANCE COMMITTEE – 27th SEPTEMBER 2017**

| Date of Meeting | Agenda Item | Required Action | Lead | Timescale | Comments/Progress |
|-----------------|-------------|--|---------------------|------------|--|
| 30/08/2017 | F.8.17.8 | Final results from the Reference cost submission to be presented. | Director of Finance | 25/10/2017 | Full report to be presented at the F&PC meeting on the 25 th October 2017 |
| 26/07/2017 | P.7.17.5 | Performance Report - 62 Day Cancer Standard CLK requested a breakdown be undertaken of the reasons given for delaying treatment. JMac to undertake a review of all breaches. | Director of Finance | 25/10/2017 | This will be tabled at the F&PC meeting on the 25 th October 2017. |
| 27/09/2017 | F.9.17.8 | General Surgery exception report to be produced. | Director of Finance | 25/10/2017 | |
| 27/09/2017 | F.9.17.8 | Clarification to be given on termination of pregnancy figures. | Director of Finance | 25/10/2017 | |

FINANCE AND PERFORMANCE COMMITTEE MINUTES, ACTIONS & DECISIONS

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|-----------------------|--|---------------|---|
| Date: | Wednesday 25 October 2017 | Time: | 8:30 – 10:30 |
| Venue: | Trust Meeting Room, Trust HQ, BRI | Chair: | Pauline Vickers, Non-Executive Director |
| Present: | Non-Executive Directors: <ul style="list-style-type: none"> - Mr David Munt, Non-Executive Director (DM) - Mrs Pauline Vickers, Non-Executive Director (PV) - Mr Trevor Higgins, Non-Executive Director (TH) via telephone - Dr Mohammed Iqbal, Non-Executive Director (MI) Executive Directors: <ul style="list-style-type: none"> - Mr. Matthew Horner, Director of Finance (MH) - Mrs Cindy Fedell (CF) | | |
| In Attendance: | <ul style="list-style-type: none"> - Mr James Mackie, Head of Performance (JM) - Ms Fiona Ritchie, Trust Secretary (FR) - Mrs Isabel Greenwood, Minute taker (IG) - Sally Scales, Deputy Chief Nurse (SS) - Mrs Terri Saunderson, Deputy Director of Operations (TS) - Mrs Sandra Shannon, Associate Director of Operations for Planned Care (SSh) For item F.10.17.13 | | |

| No. | Agenda Item | Action |
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| F.10.17.1 | Apologies for absence | |
| | Apologies were received from: <ul style="list-style-type: none"> - Ms Karen Dawber, Chief Nurse (KD), Executive Director (represented by Sally Scales (SS) Deputy Chief Nurse - Ms Donna Thompson (DT), Director of Operations and Governance (represented by Terri Saunderson (TS), Deputy Director of Operations) | |
| F.10.17.2 | Declaration of Interests | |
| | There were no declarations of interest. | |
| F.10.17.3 | Minutes of the Finance & Performance Committee meeting held on 27th September 2017 | |
| | The minutes were accepted as a correct record. | |
| F.10.17.4 | Matters Arising | |
| | F.8.17.8 Final results from the reference cost submission. This item is included on the agenda. P.7.17.5 Performance Report, 62 Day Cancer Standard. Due to sickness this needs to be deferred to the next meeting. F.9.17.8 General Surgery exception report. This item is included on the agenda. | |

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| | F.9.17.8 Clarification on the Termination of pregnancy figures. JM explained that the service had failed this target for first time. He has spoken to the Division, and they explained that they had to cancel a session during the run up to EPR. The patients have been rescheduled. | |
| F.10.17.5 | Finance & Performance Committee Terms of Reference | |
| | Were noted by the Committee. | |
| F.10.17.6 | Finance & Performance Dashboard | |
| | <p>CF presented the new dashboard for the Committee. CF explained that the dashboard integrates with the Board of Directors dashboard. The indicators are a broad-level focus of the Trust, and it is meant to be visual. CF noted that she expects that there will be some corrections and tweaking.</p> <p>IQ added that it looks easy to read. TH stated that it will help the Committee to focus on the key areas that are important to us and it will help drive decisions to improve performance. He then asked if it would be filtered down through the organisation. The Committee also requested that the key indicators are clear.</p> <p>CF noted that there are a number of indicators that are also picked up in other committees for different discussions, for example the Emergency Care Standard, which is a Quality indicator but also discussed as a Finance and Performance indicator.</p> <p>DM noted that he likes the way it shows the trends over the years. He noted that there does not appear to be improvement in a number of areas. He also noted some deterioration, for example, in Cancer.</p> <p>MH advised that performance is monitored at Divisional Performance meetings and some of the access indicators are monitored in the weekly access meeting. In response to a question from PV, TS noted the Access meetings are attended by , the Directorate Managers, Business Support Managers and administrative staff from the Divisions, and then information is fed back to the teams.</p> <p>PV asked how the dashboard benchmarks against other Trusts, to which CF replied that the dashboard was generally more progressive than other Trusts.</p> <p>TH noted that he liked the presentation and that he would like the Executive Directors to sign up to this as a working method, focusing on areas and working on the performance.</p> <p>CF replied that there are executive meetings in place to review the indicators. CF noted, in response to PV, that the next steps are for each Committee to review their dashboard and begin using them and the full dashboard for the Board of Directors will be circulated shortly.</p> | |
| F.10.17.7 | Finance Report | |
| | <p>MH presented the Finance Report.</p> <p>The pre Sustainability and Transformation funding (STF) plan at the end of September 2017 was a £4.4m deficit, which was on plan. We were able to</p> | |

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| | <p>recover the vast majority of the STF funding at quarter 2. £3.4m was available, but recovered £3.2m due to the ECS performance. The rules were changed in quarter two, to region wide performance of ECS, so the Trust recovered the full amount in quarter 2.</p> <p>MH referred to the line graph on the summary position tab. The Trust is on plan at the end of September, but, as highlighted on a number of occasions, this was due to £6m of non-recurrent benefits dropped into the position. The graph shows that if the Trust does nothing, we will be off plan by £1.5m each month until the end of the financial year, with a year-end deficit of £17m, which is £10m off plan.</p> <p>The improvement plan identifies opportunities to a value of £14m. These are risk rated, and some are very challenging, and the trajectory is a delivery of £10m (i.e. risk adjusted to 70% delivery). The Trust is still projecting to deliver the control total of £7.8m by the year end, which will ensure the full STF is recovered, but noting that the Q3 position will be off plan. As such the Q3 STF funding will be recovered at the end of Q4.</p> <p>MH highlighted the material risk to delivering the plan that will be reported to NHSI and that it requires a significant turnaround in the underlying position.</p> <p>The Liquidity graph shows that we currently have £35m in the bank. If we do nothing, this would drop to £20m by the year end. By putting in the appropriate recovery actions to deliver the control total the year end cash balance will be £36m.</p> <p>The Use of Resources graph (UoR) shows that the plan was a rating of 2, with the Trust achieving this. There are two metrics that have rating of 3, Capital Servicing Capacity, and the I&E Margin which is off plan due to the loss of the £200k STF funding associated with the ECS target.</p> <p>The summary of agency spend shows that the Trust is above the planned trajectory. At the end of September the ceiling was £6.2m, and we have spent £7m. An annual comparison highlights that the Trust has reduced its spend on Estates and Facilities and admin staff but this has been offset by an equal increase in clinical agency staffing costs. There will be a further down turn in the Corporate area agency spend due to EPR.</p> <p>The final table is a snap shot of the CIP position.</p> <p>The plan for the year is £20.4m. At September 17, the target was £9.3m, and Trust has delivered £9.3m, of which £5.3m is non-recurrent. There are material shortfalls in a number of areas, divisional housekeeping CIP is £2.8m behind, workforce is £1m behind. Procurement is £0.7m behind, and struggling to deliver the same levels of savings as in previous years. The WYATT work has identified opportunity of around £6m, but because of the contracts the Trust has in place it already has very competitive prices which reduces the potential opportunity. The WYAAT price benchmarking analysis suggests a high level opportunity of £11m, but the data needs validating.</p> | |

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| | <p>PV asked if this is an additional opportunity above what is in the recovery plan. MH confirmed that it is.</p> <p>MH further reported that the contract income position is £1.3m behind on electives, £2m behind on outpatients. Other activity revenue is showing the highest under trade of £3.7m, which reflects high cost pass through items (including cost per case drugs). This is offset by the underspend on drugs. The Trust is reporting a £1m over recovery on non-elective income.</p> <p>MH highlighted that because the Trust is under the STF regime, it has to date, avoided £3m of contract performance penalties from RTT, cancer waits and ambulance handovers.</p> <p>The activity reported through A&E remains high but is not running at planned levels, with the plan reflecting last year's activity with additional growth assumptions built in. Other areas that take direct admissions has increased their activity significantly which could indicate patients are bypassing A&E.</p> <p>CF asked if agency spend on consultants is up, why is activity down.</p> <p>MH replied that in some areas, such as Acute Medicine, where there is high agency spend; there is no impact on activity.</p> <p>PV asked that once the agency consultants are appointed, do we go back and check that they did deliver their job plan.</p> <p>MH replied that we don't actually go back and look at this. It is expected that agency consultants would deliver more, as they don't have SPA time built into their job plans.</p> <p>TH expressed concern about the Divisions not achieving their contract income plans and were the planned volumes realistic.</p> <p>MH referred to the previous committee paper that described how the income plans were set, with the initial baseline calculated on the forecast outturn for the previous year's activity. The planning timescales for 2017/18 were brought forward, and therefore the Trust had to make an estimate on month 4, projected forward. Subsequent adjustments are made for growth assumptions, full year effects of service developments of non-recurrent gaps in capacity. In addition, the Divisions proposed their own income CIP's over and above the baselines to generate extra income.</p> | |
| F.10.17.8 | Improvement Plan | |
| | <p>MH gave a verbal update on the document that was tabled last month.</p> <p>There has not been much change, other than some wording around the external proposal and further opportunities added.</p> <p>MH and other members of the Executive and Non-Executive team are meeting with NHSI the following week, and are in the process of collating a presentation and supporting evidence to demonstrate the planned recovery and that there is sufficient internal capacity and capability to deliver. It is also imperative that the commitment of the Board of Directors</p> | |

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| | <p>is demonstrated.</p> <p>MH drew attention to the grip and control document issued by NHSI which consists of 250 initiatives, and for each one the Trust needs to demonstrate the level of compliance, and how it links into the current improvement plan.</p> | |
| F.10.17.9 | Tender Report – Extension BTH 082 – Outsourcing Dispensing of Out-Patient Medication | |
| | <p>It is proposed to extend the contract for outsourcing dispensing outpatient medication for two years.</p> <p>The benchmarking work undertaken suggests the contract offers value for money and is inclusive of a non-recurrent and recurrent savings.</p> <p>This was approved by the Committee.</p> | |
| F.10.17.10 | Reference Cost update | |
| | <p>The final submission score has been estimated at 104.4, with the average being 100, indicating the Trust is above average from a cost perspective. The Trust has used the new PLICS system to develop the submission which abides by the NHSI guidance for costing.</p> <p>The paper also included the education and costs, with an estimated score of 109.</p> <p>CF asked if there was a programme of work to explore savings opportunities based on the output.</p> <p>MH confirmed that the productivity and efficiency group which feeds into the Carter programme and TIC would be exploring opportunities.</p> | |
| F.10.17.11 | Performance Report | |
| | <p>The ECS was 88.3% in September.</p> <p>October was a very high month with an average of 381 attendances per day, compared to October 2016 which was 369 per day. There is further development in progress to review data quality across a number of data fields in order to reproduce previous performance monitoring.</p> <p>The Cancer 62 day target was not delivered, but did improve.</p> <p>The Trust reported 7 CDIFFS, of which 4 attributable.</p> <p>There have been 3 MRSA cases reported year to date, with 1 awaiting a report.</p> <p>DMO1, the performance regarding cardiac CT is improving. Referrals have reduced so an assessment will be undertaken to see if the additional capacity in place can be removed.</p> <p>Stroke and TIA fell behind standard in the month, with more detail in the papers.</p> | |

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| | <p>Cancer 2 week wait, has deteriorated to 88.4%, with the vast majority in the skin breaches, which account for 25% of volume. This is due to consultant gaps. The Service is working with CCG to undertake a service review.</p> <p>General Surgery (action F.9.17.8) exception report highlights the RTT position, which is deteriorating. Admitted performance is the challenged area. Overall, the referral patterns are reasonably static, but the specialty is reporting a significant drop in patient throughput. As such, the waiting list has increased significantly.</p> <p>The Division continue to work on the detail to understand why this position has been created. The exception report is expected from the division from next month.</p> <p>PV asked how much impact is EPR having on productivity.</p> <p>TS replied that it was planned to impact for the first 4 weeks, but evidence is suggesting the recovery back to business as usual, is variable. The most challenged areas in outpatients are the high volume specialities (e.g. ENT, ophthalmology and Dermatology).</p> | Director of Finance |
| F.10.17.12 | Integrated Quality & Performance Dashboard – (Capacity & Demand) Bo.7.17.8 | |
| | SS is finalising a report to EMT which will go to the Board of Directors in November 2017. | |
| F.10.17.13 | Cancer Services Recovery Plan | |
| | <p>SSh presented the recovery plan.</p> <p>The cancer improvement plan will focus on 8 key objectives that will have the biggest impact on improving and sustaining cancer performance and quality of patient care.</p> <p>To deliver this improvement plan a number cancer improvement groups have been set up.</p> <p>The trajectory for the compliance of the 32 day target is by April 2018</p> <p>The recovery for Dermatology is to be compliant with 2 week wait by November 2017.</p> <p>The work streams/improvement groups are to be set up over the next couple of weeks, with each one having a Speciality and Operational lead, They will identify key tasks and milestones to be able to deliver the plan,</p> <p>CF asked if any additional resources are required to deliver the plan.</p> <p>SSh replied that these are the things that we should be doing anyway. It will look at the demand and capacity across the Trust. It is focussed around clinical capacity, outpatients and theatre capacity.</p> <p>PV stated that this was very comprehensive recovery plan which included</p> | |

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| | <p>business as usual and transformation, with SSh confirming this to be the case. A range of tasks across the specialties are in progress, but not all are 100% embedded.</p> <p>TH asked if the April recovery date has been shared with NHSI.</p> <p>MH replied that the cancer recovery plan will be sent to NHSI with the financial and ECS improvement plans on Friday.</p> | |
| F.10.17.14 | Informatics Performance Report | |
| | <p>CF confirmed that there were no urgent topics to be discussed from the report.</p> <p>The report was noted by the Committee.</p> | |
| F.10.17.15 | EPR Update | |
| | <p>CF provided an update on the implementation of the Electronic Patient Record (EPR). She informed the Committee that the General Manager for Cerner UK had been on site and had remarked that this was the best go-lives he had seen.</p> <p>The Trust is now in week 5 post go-live and has continued on with some command and control to pick up outstanding issues. There is a downtime planned at the end of the month due to clock change.</p> <p>Technically the outstanding issues include; completing the interfaces with the regional cancer system, DM01 diagnostic waits and RTT regulatory reporting. Each of these are nearing completion. The interfacing of Pathology Results into the EPR is also being worked on and continues to be planned for completion in December 2017.</p> <p>Operationally, there are a small number of hot spot areas where there is support in place with floorwalkers, and the command structure continues to pick up things here and there. The focus is now on making sure that the admissions and outpatients are recorded properly so the income is correct. TS added that the hot spot areas, such as, Ward 18 and Endoscopy, have teams working with them. The biggest challenge now is making sure everything is correctly coded for the income.</p> | |
| F.10.17.16 | Integrated Quality & Performance Dashboard – (Performance and access) | |
| | Refer to F10.17.6 | |
| F.10.17.17 | Integrated Quality & Performance Dashboard – (broader themes than individual deep dives) | |
| | <p>The broader themes include cancer, emergency care and RTT.</p> <p>PV asked for a timetable for when these would be presented. This would provide assurance that can be fed back to the Board of Directors</p> | Director of Governance and Operations |

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| F.10.17.18 | Trust Improvement Committee (TIC) Terms of Reference | |
| | The Committee approved the updated terms of reference for the TIC. It was agreed that a written report will be provided each month from the TIC to this Committee. | |
| F.10.17.19 | Trust Improvement Committee (TIC) Report | |
| | The committee discussed and noted the report. | |
| F.10.17.20 | Any other business | |
| | PV asked when they will get the updated BAF. She was advised that the updated BAF should be available for the next Committee meeting. | |
| F.10.17.21 | Matters to escalate to the Board of Directors | |
| | <ul style="list-style-type: none"> • EPR go-live • Financial Metrics • Organisational Performance • Cancer Services Recovery Plan • New Finance and Performance Committee Dashboard | |
| F.10.17.22 | Matters to escalate to Corporate Risk Register | |
| | There were no matters to escalate. | |
| F.10.17.23 | Items for Corporate Communication | |
| | There were no items for Corporate Communication | |
| F.10.17.24 | Date and time of next meeting | |
| | 29 November 2017, 08:30-10:30 Conference Room, Field House, BRI | |

**BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST
ACTIONS FROM FINANCE AND PERFORMANCE COMMITTEE – 25th OCTOBER 2017**

| Date of Meeting | Agenda Item | Required Action | Lead | Timescale | Comments/Progress |
|-----------------|-------------|---|---------------------------------------|------------|---|
| 26/07/2017 | P.7.17.5 | Performance Report - 62 Day Cancer Standard CLK requested a breakdown be undertaken of the reasons given for delaying treatment. JMac to undertake a review of all breaches. | Director of Finance | 29/11/2017 | Report deferred from October 2017 Committee |
| 27/09/2017 | F.9.17.8 | General Surgery exception report to be produced. | Director of Finance | 29/11/2017 | Verbal update given at October 2017 Committee. Exception report due November 2017 |
| 25/10/2017 | F.10.17.17 | Timetable to be produced for themed deep dives | Director of Governance and Operations | 20/12/2017 | |

FINANCE AND PERFORMANCE COMMITTEE MINUTES, ACTIONS & DECISIONS

| | | | |
|-----------------------|--|---------------|---|
| Date: | Wednesday 29 November 2017 | Time: | 8:30 – 10:30 |
| Venue: | Trust Meeting Room, Trust HQ, BRI | Chair: | Pauline Vickers, Non-Executive Director |
| Present: | Non-Executive Directors: <ul style="list-style-type: none"> - Mrs Pauline Vickers, Non-Executive Director (PV) - Mr Trevor Higgins , Non-Executive Director (TH) Executive Directors: <ul style="list-style-type: none"> - Mr. Matthew Horner, Director of Finance (MH) - Mrs Cindy Fedell (CF) - Mrs Donna Thompson (DT) | | |
| In Attendance: | <ul style="list-style-type: none"> - Mr James Mackie, Head of Performance (JM) - Ms Fiona Ritchie, Trust Secretary (FR) - Mr Chris Smith, Deputy Director of Finance (CS) - Sally Scales, Deputy Chief Nurse (SS) | | |
| Observing | <ul style="list-style-type: none"> - Donna Cassidy, NHS Improvement (DC) | | |

| No. | Agenda Item | Action |
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| F.11.17.1 | Apologies for absence | |
| | Apologies were received from: <ul style="list-style-type: none"> - Ms Karen Dawber, Chief Nurse (KD), Executive Director (represented by Sally Scales (SS) Deputy Chief Nurse - Mohammed Iqbal, Non-Executive Director | |
| F.11.17.2 | Declaration of Interests | |
| | There were no declarations of interest. | |
| F.11.17.3 | Minutes of the Finance & Performance Committee meeting held on 25th October 2017 | |
| | The minutes were accepted as a correct record. | |
| F.11.17.4 | Matters Arising | |
| | P.7.17.5 Performance Report, 62 Day Cancer Standard. Report was provided at November Performance Committee. Item concluded F.9.17.8 General Surgery exception report. The committee was informed of delays in production. The report was deferred to the December committee meeting. F.10.17.7 Timetable to be produced for themed deep dives. DT explained that the main deep dives scheduled are on the Emergency Care Standard and Cancer standards in January and February 2018 respectively and for this action to be considered closed. | |

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| F.11.17.5 | Finance & Performance Committee Dashboard | |
| | <p>The committee noted the content of the dashboard.</p> <p>PV suggested the main focus of the meeting should be on the Finance Report and recovery plan (F.11.17.6 and F.11.17.6a), including the GE Finnamore Improvement Programme update (F.11.17.10).</p> | |
| F.11.17.6 | Finance Report | |
| | <p>MH presented the Finance Report.</p> <p>MH explained that the main report includes details of both the original CIP plan and the Improvement Plan and that this will be merged in future months' reports.</p> <p>The pre Sustainability and Transformation funding (STF) position at the end of October 2017 was a £6.6m deficit, which is £2.4m behind plan. MH advised the committee to note that there is now an adverse variance both pre- and post-Sustainability & Transformation Funding (STF) and that this means no STF can be recovered for October. This was the first month since May that we have not delivered the pre-STF control total.</p> <p>If the current trajectory continues, the year end pre-STF deficit will be £17.5m which is £9.7m behind the pre-STF control total and £16.3m behind the post-STF control total. No further STF cash would be recovered in this scenario.</p> <p>However if the Improvement Plan is delivered the Trust is scheduled to recover the pre-STF position by the end of the financial year.</p> <p>TH stated that delivery of the Improvement Plan is extremely important for the Trust and queried why the Trust is £1m behind this plan.</p> <p>To explain the situation, MH referred the committee to item 3A in the Summary Finance Report. The vast majority of the recovery initiatives targeted in October were delivered, however the contract income performance was significantly below both the contract and Improvement Plan forecasts. MH highlighted the expenditure and divisional income being only 2% off the forecast and that contract income was the biggest single problem, being almost £1m below the forecast.</p> <p>MH explained that following the EPR implementation the Trust has experienced difficulty in coding and reporting on activity and income in some areas. This resulted in some activity being missing from the datasets used to charge commissioners.</p> <p>Income estimates were added for some known areas pending the issue being resolved, eg Endoscopy and Critical Care. MH confirmed that there was a lot of work being done to catch up and log missing activity in the system.</p> <p>PV queried exactly what was meant by "missing activity". MH confirmed that the work has been done but it is either not logged in the system or cannot be extracted for reporting purposes.</p> | |

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| | <p>DT assured that lots of manual work is being done to log activity manually in EPR.</p> <p>PV queried the level of resource put in to achieve this.</p> <p>DT confirmed the Division of Medicine and Integrated Care (DOMIC) has sufficient resource and less issues, but that resources and support was being deployed from elsewhere in the organisation to support the Division of Anaesthesia, Diagnostics and Surgery (DADS). The DADS management team provided assurance at the Trust Improvement Committee meeting that they have confidence that the logging work will be done successfully to recover the income.</p> <p>TH queried when will we know if this work has succeeded in getting the Trust back on track?</p> <p>MH explained assurance cannot be given until the work is complete and highlighted this would normally need to be completed by the contractual freeze date of 8th December if the income is to be recovered.</p> <p>CF highlighted that progress is being monitored daily.</p> <p>PV queried if we can see on a daily basis whether the activity logging recovery is on track with what is expected.</p> <p>DT explained that was not possible to say with certainty at that point.</p> <p>TH queried that the Trust may not actually be behind plan at the end of October, that the issue may just be coding which will be resolved?</p> <p>MH explained we cannot say this with confidence as we have already included an additional £1m estimated income (as discussed earlier).</p> <p>PV queried what the Trust is doing to offset this risk of lost income. Whether, as further mitigation, any of the other Improvement Plans are being brought forward or if any of the Improvement Plan items with no financial target are being firmed up?</p> <p>CS highlighted the potential implications of revaluing assets, DT mentioned the start of weekend elective operating lists.</p> <p>MH highlighted the forecast cash trajectory. If the Improvement Plan is delivered, cash will remain broadly static for the remainder of the year. If the plan does not deliver, cash balances will deteriorate for the remainder of the year and the Trust will end the year with a cash balance of £20m. Failure to deliver the plan would result in a negative 12 days liquidity position.</p> <p>TH expressed concerns about any short-termism in the plans and the cash/liquidity outlook.</p> <p>MH highlighted that the initiatives in the improvement plan are not “slash and burn” plans but are sustainable plans which is not indicative of short-termism.</p> | |

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| | <p>Documentation to support the plans' sustainability is being developed, including Quality Impact Assessments (QIAs), Equality Impact Assessments (EIAs) and Financial Impact Assessments (FIAs).</p> <p>TH asked what the Trust is doing about the forecast cash position?</p> <p>MH referred to the controls applied via the Cash Committee which has been in place for some months.</p> <p>The Trust has security in its existing cash position and the "do nothing" scenario highlighted in the Summary Finance Report is unlikely to arise in full. Actions are being taken to mitigate this. The Trust is unlikely to require any working capital loans or other external financial support and will be able to use its cash to address any trading shortfall in 2017/18, although this will not deliver the control total.</p> <p>The use of cash to finance day to day expenditure will impact on the Trusts strategic options, however. The Trust must deliver the Improvement Plan and protect cash if it is to deliver on its ambitious clinical strategy..</p> <p>MH brought the Use of Resources Risk Ratings (UoRR) to the committee's attention. For the first time in 2017/18, the Trust has fallen below plan and now has an overall risk rating of 3. The Trust has been forecasting this, the Improvement Plan recognises a dip before the plans are implemented and if the plan is delivered the UoRR position will be recovered by year end.</p> <p>MH confirmed that it is recognised that the Improvement Plan is ambitious and that there are substantial risks to full delivery and therefore delivery of the control total in 2017/18. For the organisation's longer term future, it is imperative to go into Quarter 4 with a sustainable income and expenditure run rate. If the Trust falls short in 2017/18, it needs to be able to demonstrate to NHS Improvement (NHSI) that it is in run rate balance going into 2018/19.</p> <p>MH highlighted the agency expenditure position which is £8.4m cumulatively against a ceiling of £7.1m. The reduced expenditure reported for September was a result of revised accruals and did not reflect an improvement in underlying run rate. October's agency spend was £1.4m and the full year forecast agency expenditure is £14.5m - £15m against the £12.3m ceiling.</p> <p>The Trust has seen a reduction in agency spend on non-clinical posts but an increase in agency nurses and doctors. For example, the DADS division currently has approximately 130 nursing vacancies.</p> <p>PV queried the impact on agency spend of consultant vacancies being filled.</p> <p>MH confirmed that the impact of this is factored into the forecast and a subsequent discussion took place on the methodology used to construct the forecast. Assurances were provided on the methodology reflecting divisional expectations and recruitment profiles.</p> | |

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| | <p>The discussion moved to the delivery of the Improvement Plan.</p> <p>TH queried whether the Trust is getting the same buy-in from clinical staff as it did for the EPR programme and whether the leadership workshops had improved clinical engagement.</p> <p>MH updated on the TIC meeting earlier in the week. The meeting was very positive and none of the attendees ruled out any of the Improvement Plans. There are still a number of plans with no scoped financial benefits which must be addressed, although the immediate challenge is turning the red and amber rated schemes green through detailed planning and implementation. As an example of how this is being done, in some of the divisions, the previous “EPR Fridays” have been converted to “CIP Fridays”.</p> <p>PV stated it was positive that the Improvement Plan message is getting through to the Trust’s leaders, but queried what is being done to get the message to the front line staff?</p> <p>DT confirmed there is clear evidence that the divisions are committed to delivering [the Improvement Plan]. The divisions themselves have established their own “CIP Fridays” and anyone in the division is invited to generate new ideas. There was positive feedback to MH’s presentation on the Improvement Plan at the Trust’s open leadership forum in the lecture theatre. The staff “get it” but there remains a lot of work to be done to ensure the whole organisation understands it.</p> <p>MH highlighted the positive response from the Orthopaedic consultants to support their elective activity which has encouraged greater engagement to explore further improvement work.</p> <p>TH queried the impact of the new Executive Director Financial Performance meetings with the divisions and how progress is monitored.</p> <p>DT confirmed they are a useful meeting which gives more focus and time to look at the finances. CLK holds fortnightly meetings with DT and MH to review improvement plan progress and the forecast. The first GE Fিন্নamore project steering group was also in diaries.</p> <p>MH highlighted the red rated schemes in the Improvement Plan that are turning green. These include weekend working and clinical coding. BG tabled a paper to EMT on 28th November updating on progress against the coding plans and the investment to deliver this. Approximately £100k has been invested non-recurrently. TH queried the financial return for this, MH confirmed this is targeted at £0.8m. PV queried would this [coding practice changes] become business as usual, MH confirmed it would.</p> <p>PV queried if the Trust would need to inform the commissioners if the coding work increases our tariff income. MH confirmed that the Trust issues the commissioners with an annual coding notice. The Trust has already notified Julie Lawrenuik (CCGs Chief Financial Officer) that the Trust is improving its coding to ensure all parties can understand the complexity of the work done in the hospitals as this has wide-ranging</p> | |

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| | <p>implications, e.g. tendering for services and Accountable Care System baselines.</p> <p>CF queried if agency controls have been strengthened in November. CS referred to the Improvement Plan projects led by Pat Campbell (Director of HR). The focus is on long term vacancies, over-established departments and non-clinical agency staff.</p> <p>MH noted that agreement will be sought to realise the planned £150k benefit from Research income that was not recovered in November.</p> <p>GE Finnermore is currently increasing the resource they are supporting the organisation with and this should yield benefits in their efficiency programmes.</p> <p>MH highlighted the potential from the Modern Equivalent Value work and that a paper is going to the Audit Committee to gain agreement from the External Auditors for this change in accounting policy. Many Trusts are doing this.</p> <p>MH summarised by stating that although there is a lot of positive work going on, he remains nervous about the November position. There is a stepped change in efficiency requirement in November and it is not certain that sufficient plans have been implemented to address this. There is therefore a real risk to delivery in November. Due to ongoing work following the EPR implementation, there is a risk that the Trust will not see the benefits of productivity increases until later in the year.</p> <p>PV summarised the position and captured the salient points</p> | |
| F.11.17.7 | Approval Process for New Consultant Appointments | |
| | <p>The document was taken as read by the committee and accepted.</p> <p>PV stressed the importance of Post Implementation Reviews and that agreed action be taken if business cases do not deliver as planned.</p> | |
| F.11.17.8 | Performance Report | |
| | <p>CF highlighted issues with performance against RTT, Cancer and Diagnostics targets reporting from the EPR system. Cerner are putting a lot of resource and focus into resolving this issue.</p> <p>PV queried if the committee should be concerned that these reports are not available. DT responded to confirm that Sandra Shannon (Interim Assistant Director of Operations) and divisional management teams are tracking all waiting lists on a regular basis [via the Access Meeting]. The issue is inability to report externally rather than not knowing where patients are on the RTT pathway.</p> <p>PV queried what are the consequences of not submitting this information externally?</p> <p>DT explained the Trust is in regular dialogue with NHSI over this issue and that they are fully aware of the situation. The situation is obviously not positive but the regulators are aware of it. CF confirmed that it is not</p> | |

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| | <p>possible to provide a resolution date at present. Cerner are fully aware of the importance of this and are already under pressure to resolve it.</p> <p>TH queried whether we knew our RTT position as a Trust?</p> <p>JM informed the committee that there is a position but it involved reconciling the pre- and post-Cerner RTT positions and was therefore a manual process which provides an unvalidated RTT position.</p> <p>PV requested that the unvalidated position and the information that has been distributed to NHSI be emailed to the NEDs before the next committee meeting.</p> <p>MH confirmed that the reported ECS performance in October was 84.5%.</p> <p>ECS performance remains a challenge for the organisation and in response has developed an Emergency Care Recovery Plan, that will be discussed later in the agenda.</p> <p>DM01. The Trust has put additional resource in to address the Cardiac CT backlog, which has now been cleared. DT referred to confusion from Calderdale & Huddersfield NHS Foundation Trust (CHFT) as to their requirements for support from BTHFT causing capacity issues which now should be resolved.</p> <p>The Stroke position remains a challenge. JM has done a lot of work with Chris Patterson (Consultant Stroke Physician) to ensure the data is now accurately captured.</p> <p>VTE performance is below target. There has been a shift in wards performing well before and after EPR implementation. SS explained there has been a change in roles. Prior to EPR, the VTE assessments were done by nurses but this work is now done by doctors. EPR will help improve this but staff need to get used to an entirely new approach to this.</p> <p>PV highlighted that this issue has been going on for a long time and asked when it would be resolved?</p> <p>JM highlighted the fact that this is the first report run directly from Cerner and that although the performance is below target it is relatively positive that performance has not deteriorated further after EPR implementation. CF also confirmed that the improvement plan runs until March.</p> <p>On Elective same day cancellations, MH explained that the reported position has improved from a run rate of 68 per month to 38 in October. In recent weeks it has also been noted that there has been a reduction in cancellations due to work ongoing to protect the elective bed base. However, due to coding issues post-EPR, the number of elective episodes is potentially understated which could have an impact on this metric. The data must be validated to fully understand this position.</p> <p>TH expressed concern about the performance on Ambulance Handovers.</p> | <p>Director of Informatics</p> |

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| | MH and DT agreed this is a worrying trend and a dialogue with Yorkshire Ambulance Service (YAS) is required as this is a system wide issue, with drop off practices requiring a review. | |
| F.11.17.9 | Emergency Care Standard Recovery Plan | |
| | <p>DT fed back on the ECS Recovery Plan.</p> <p>The Trust has been working on a recovery plan that has been shared with NHSI and this is now the plan the organisation is working to under the governance of TIC.</p> <p>The Trust received a helpful visit from Vincent Connolly from NHSI to review the emergency care service. Mr Connolly visited key areas in the Trust and provided interim feedback on his findings to managers and clinicians at the end of his visit. He will also be issuing the Trust with a more detailed written report.</p> <p>Positive feedback included the Trust's Delayed Transfers of Care (DTC) and acute length of stay are amongst the best in the country. The virtual ward and short stay wards were also considered positives.</p> <p>Key Recommendations</p> <p>Demand for the Surgical Assessment Unit (SAU) is exceeded the available space. We have 6 trolleys but this is being expanded to 12 this winter. This may still be insufficient but doubling capacity helps going into winter.</p> <p>The Ambulatory Care Unit (ACU) is used relatively effectively but could be done more effectively to support the ED position. The clinical team recognises this and is going to visit South Tees NHS FT to learn from best practice.</p> <p>The urgent and emergency care service at BTHFT is impacted by an early evening surge in demand. NHSI is providing support in trying to understand this issue and a whole system solutions in Bradford is required to address this. DT explained it is partly a consequence of when the Bradford GPs schedule their clinics and home visits which results in a surge in patients being advised to attend AED. The Trust needs to ensure its staffing profile is aligned to attendance profiles.</p> <p>The key message from NHSI on the ECS Recovery Plan was that the plan is sensible and to now focus on delivering it.</p> <p>DT provided further updates on ECS improvement measures taken since the last committee meeting:</p> <ul style="list-style-type: none"> - The Clinical Decisions Unit (CDU) is now open and clinical colleagues are identifying the best way to maximise usage. The CDU can deal with approximately 30 patients per day but current usage is 20 patients per day. - The CCGs are now managing the GP streaming contract and streaming is in place from midday to midnight each day. - The Ward reconfiguration work is being completed leading into winter. HR change management processes and estates work are ongoing so | |

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| | <p>the exact implementation date is unclear at present.</p> <ul style="list-style-type: none"> - This will increase short stay ward capacity and convert some beds from surgical to medical beds while increasing the number of side rooms and ring fencing orthopaedic beds. - Matron led, criteria based discharge is being implemented which will support the SAFER initiative - A Winter Room is being introduced to support patient flow, with Executive or senior operational manager support between 10am and 10pm, 7 days per week. <p>PV welcome this as a useful update and queried what is the biggest risk to delivery of the ECS recovery plan.</p> <p>DT confirmed that the risks relate to process, behaviours and people.</p> | |
| F.11.17.10 | Improvement Programme Update | |
| | <p>The paper was taken as read.</p> <p>PV commented that the paper was very positive and contained a number of areas of good news.</p> <p>MH agreed that the paper highlighted the successful leadership event. The draft report on the outcomes of this event will be presented to EMT soon.</p> <p>MH highlighted the improved productivity workstreams with a focus on orthopaedics and endoscopy. In addition the tactical workstreams will focus on organisational development and strengthening a range of core support services such as business intelligence and the project management office.</p> | |
| F.11.17.11 | Trust Improvement Committee (TIC) Report | |
| | <p>DT updated that Outpatients is an area in which the Trust has failed to make significant efficiencies but that there remain substantial opportunities. There is now a renewed focus on this area with support from Sandra Shannon, Interim Assistant Director of Operations and Planned Care.</p> <p>PV queried whether this would provide financial benefits in the current financial year.</p> <p>DT explained the detailed plans have not yet been presented so cannot say for certainty. MH explained Sandra Shannon has introduced a more robust project management approach to Outpatients that has previously been lacking.</p> <p>PV expressed concern about the shortfall in delivery against the Housekeeping CIP target but recognises this has now been superseded by the Improvement Plan.</p> | |
| F.11.17.12 | Informatics Performance Report | |
| | <p>The committee noted the report.</p> | |

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| | CF highlighted issues with RTT reporting discussed under the Performance Report earlier in the meeting. | |
| F.11.17.13 | Risk Appetite | |
| | This item was discussed under the Board Assurance Framework (F.11.17.14). | |
| F.11.17.14 | Board Assurance Framework | |
| | <p>PV welcomed the new BAF.</p> <p>PV agreed with the amber risk rating.</p> <p>FR recommended that at the next F&P Committee meeting the committee should further discuss the risk ratings.</p> | |
| F.11.14.15 | Any Other Business | |
| | There were no items raised under any other business. | |
| F.11.17.16 | Matters to escalate to the Board of Directors | |
| | <ul style="list-style-type: none"> Financial Metrics Improvement Plan Organisational Performance Cancer Services Recovery Plan Winter Planning | |
| F.11.17.17 | Matters to escalate to Corporate Risk Register | |
| | There were no matters to escalate. | |
| F.11.17.18 | Items for Corporate Communication | |
| | There were no items for Corporate Communication | |
| F.11.17.19 | Date and time of next meeting | |
| | 20 December 2017, 08:30-10:30 Conference Room, Field House, BRI | |

**BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST
ACTIONS FROM FINANCE AND PERFORMANCE COMMITTEE – 29th November 2017**

| 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 | 20/12/2017 | Verbal update given at October 2017 Committee. Exception report deferred to December 2017 |
| 29/11/2017 | F.11.17.8 | Unvalidated RTT position to be emailed to committee members in advance of next meeting | Director of Informatics | 20/12/2017 | Emailed 14.12.17 – item concluded |