Bradford Teaching Hospitals
NHS Foundation Trust

Meeting Title	Board of Directors		
Date	13.9.18	Agenda item	Bo.9.18.33

CONFIRMED MINUTES OF FINANCE & PERFORMANCE COMMITTEE MEETINGS 27 JUNE & 25 JULY 2018

Presented by	Chair of the Finance & Performance Committee	
Author	N/A	
Lead Director	Matthew Horner, Director of Finance and Sandra Shannon, Chief Operating Officer	
Purpose of the paper	To present the Board with the confirmed minutes of the Finance & Performance Committee 27 June and 25 July 2018	
Key control	This paper provides the minutes of the meeting of a Board Committee that assures the strategic objectives to: - deliver the Foundation Trust's financial plan and to - deliver the Foundation Trust's key performance targets.	
Action required	To receive	
Previously discussed at/ informed by	Finance & Performance Committee	
Previously approved at:	**Committee/Group**	**Date**
	Finance & Performance Committee	25 July 2018 & 29 August 2018
Recommendation		
The Board is asked to note the content of the minutes and any actions and escalations identified.		

FINANCE AND PERFORMANCE COMMITTEE
MINUTES, ACTIONS & DECISIONS

Date:	Wednesday 27th June 2018	**Time:**	08:30 – 10:30
Venue:	Conference Room, Field House, BRI	**Chair:**	Mrs Pauline Vickers, Non-Executive Director
Present:	Non-Executive Directors: - Mrs Pauline Vickers, Non-Executive Director (PV) - Mr Trevor Higgins, Non-Executive Director (TH) Executive Directors: - 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 - Mr Paul Pallister, Trust Secretary (PP) - Mrs Cindy Fedell, Director of Informatics (CF) - Ms Tanya Claridge, Director of Governance and Corporate Affairs for the agenda item F.6.18.10 – Assurance, the way forward presentation (TC)		
Observing	-		

No.	Agenda Item	Action
F.6.18.1	**Apologies for absence**	
	Apologies were received from: - Mr Jon Prashar, Non-Executive Director (JP) - Mr Matthew Horner, Director of Finance (MH) - Mr Michael Quinlan, Deputy Director of Finance (MQ) - Professor Laura Stroud, Non-Executive Director (LS)	
F.6.18.2	**Declaration of Interests**	
	None.	
F.6.18.3	**Minutes of the meeting held on 30th May 2018**	
	The minutes were accepted as a correct record, subject to the following corrections : P12. 5th paragraph “increasing tracking gives positive assurance” should read “increasing tracking enables the possibility of assessing for positive assurance”.	

No.	Agenda Item	Action
F.6.18.4	**Matters Arising**	
	F.5.18.5 – MH has updated the Board Assurance Framework ("BAF") sentence. Action closed. F.5.18.7 – An update on Commissioner income is on the agenda (F.6.18.9). Action closed. F.5.18.17 and F.5.18.18 are on the agenda for upcoming Open Board meetings (July and September respectively). Action closed.	
F.6.18.5	**Board Assurance Framework**	
	PV commented that discussing the BAF early in the agenda would help to focus on presenting challenge or seeking assurance or re-assurance. Regarding the finance section, PV queried the meaning of the status of "Open and Compromised" as opposed to "Open". SSh commented that it referred to an action that is in progress but for which there may be some delay. KD agreed and commented that the overall end point might not be met on schedule but progress is not so far behind as to prejudice actual delivery. CS commented that the main points are documented, namely Cost Improvement Programme ("CIP") delivery, and assurance around activity/income reports. Planned delivery of the CIP risk is back-end loaded towards the end of the year and it is stated that urgent action is required. PV commented that to help improve the numbers the Trust should also be sighted on productivity and efficiency as this links into the activity/income reporting. TH commented that discussing having the BAF at the beginning of the meeting may mean a significant part of the agenda is discussed under this one agenda item. PV suggested a BAF discussion at the beginning and then again at the end. This would help to focus on the BAF at the beginning and allow for review at the end to see if appropriate consideration of the BAF requirements has been given. Where there are perceived gaps in controls the review at the end can document if assurances have been received throughout the meeting. PV noted that improvement plans are in place for RTT and Cancer and that these should be the main focus during the meeting (tied into the BAF). TH agreed and commented that the Quality committee would be aware of these things and this should therefore be an area of focus. PP commented that the cover sheet provided by TC is an opportunity for the committee to re-confirm risk appetite. Currently it is cautious. PV commented that this was reviewed recently, but confirmed a	

No.	Agenda Item	Action
	continuation of limited assurance and a cautious risk appetite.	
	Board Dashboard	
F.6.18.6	**Finance & Performance Committee Dashboard**	
	PV tabled a question originating from Barrie Senior, Non-Executive Director regarding what assurance do the Committee have around the quality of the data that goes into the dashboard. KD commented that there is a tool that sits behind the dashboard that scores the data, so KD can get assurance around the data. CF commented that there is a data quality kitemark within the dashboard, allowing the Trust to be transparent about the quality of the data. There are levels of assessment, which are colour coded. If something is assessed as red then clearly there are issues. Data quality around the Electronic Patient Record system ("ePR") is clearly an issue. For any assessment showing green or blue there has to have been an independently assessment of that data. PV commented that a rating of red or amber on the kitemark may lead to a desire for more assurance around the data. CF agreed and that discussing in committee would be an appropriate place to do so. **Performance** SSh updated on the performance elements of the dashboard: • SSh – Length of Stay is rated as green, although bed occupancy is high so further improvement is required in this area. The Trust is focusing on Stranded Patients (defined as patients with an over-21 day Length of Stay) where there is a daily review. Nationally the Trust benchmark well in this area and there are some Data Quality issues in that group so it may be the case that actual performance is even be better than reported. Bed occupancy did reduce in Work As One week, but now it is slowly beginning to rise again. Discharges before 1pm also improved during Work As One week. • There has been a change in methodology in recording patients who did not attend ("DNA") for outpatient appointments, meaning that the Trust cannot compare the previous run rate with current. There has not however been a significant change outside normal variability. Two way SMS messaging is being rolled out and there should be financial benefits reported due to this. One way SMS messaging to patients is available in all specialties.	

No.	Agenda Item	Action
	A discussion around outpatient and SMS texting followed. PV commented that it may be possible to benchmark against other Trusts even if the methodology change means run rates cannot be compared. TH queried if the actual narrative in the SMS messages include the day of the week as well as the date of the appointment, as this may serve as a more appropriate reminder. SSh commented that the narrative within the reminders will be investigated and reported back at the next Committee meeting. PV queried what other areas in Outpatients are targeted for improvement. SSh commented that the Outpatient Improvement Programme element of the wider Bradford Improvement Programme ("BIP") identifies some real opportunity but the challenge is delivering on the workstreams. Using some benchmark data from the Getting It Right First Time ("GIRFT") programme provides opportunity and this is being rolled out to specialties. Regular conversations take place with Commissioners to look at pathways, moving low added value work into Primary Care so the Trust can focus on the more intense, higher level work. PV commented that it was a challenge to segment the target audience and appropriately communicate to each demographic. • The Elective Waiting list now has increased its validation team and full recovery programme including Data Quality has been rolled out. Activity trackers have begun to be rolled out to really start to monitor and micro manage utilisation of capacity which will impact on Waiting Lists. The Trust has recovery plans in place for endoscopy, Dermatology and ENT. A discussion around Dermatology took place. PV commented that previously the Committee had an in-depth dermatology discussion and queried what progress had been made. SSH commented that slow progress has been made. There has been good support from Commissioners in terms of pathway reviews and a discussion has taken place regarding better utilisation of alternative models e.g. GPSI's etc. Currently in progress are two pathway reviews and a full clinical Waiting List review with consultants and GPs. This is partly to assess whether the patients can be seen in the community and partly for training and education for GPs. 65-68% of referrals are referred in on a two week wait and these patients are highly unlikely to have cancer so do not need urgent referrals. Urgent referrals will go to the front of the queue and therefore exacerbate the problem.	Chief Operating Officer

No.	Agenda Item	Action
	Longer term the Trust need to look at a whole system wide service provision. Those discussions are going forward through the West Yorkshire Association of Acute Trusts ("WYAAT") and the Trust is exploring a network approach, and telemedicine work (for dermatology) alongside the Cancer Alliance. This has been raised with NHS Improvement to progress this more quickly and it will be brought up in the Alliance meeting next week (w/c 2nd July 2018). TH commented that a system wide approach is sensible as there is the potential for GPs to delay things if they operate within a framework which means that they do not have a defined timeframe and may therefore refer inappropriately. SSh commented that there are a lot of GPs with special interest in this area and the Trust need to maximise that capacity and opportunity. The Trust has histopathology capacity issues and the service attempt to turn everyone round to timescale, although they are stretched. CF commented that part of the revised Informatics strategy will enable pathway changes linked into ePR using technology as an enabler. TH stated a general concern as to how the Trust can ensure that as productivity increases in Dermatology there is no reduction in the level of patient care. PV queried how the Trust assesses clinical risk. SSh commented that the Trust do patient harm reviews for long waiters. At the moment the Trust is putting on extra two week wait capacity to ensure the Trust see everyone although the standard is not being met for everybody at the moment. This is addressed in the recovery plan. The Trust only has a resource of 1.50 Dermatology consultants and 0.50 Plastic Surgery consultant performing Dermatology work. Recruiting another 0.50 Plastic Surgery consultant's time is being explored. Another neighbouring Trust has fourteen consultants but only do approximately twice as much work, so the Trust is productive and efficient. TH queried if the Trust should decide if it is appropriate to continue the Dermatology service at all. SSh commented that this is a priority discussion within WYAAT • The Diagnostics Waiting Time and Activity Data Set ("DM01") now include neurophysiology. Endoscopy is excluded but the full Waiting List has been validated and this should be included in the next submission. There is still work to be done to put the data into the DM01 format. The data to the Joint Advisory Group on GI Endoscopy ("JAG") have been submitted but a DM01 submission including endoscopy is more likely to be next month. There are c300 breaches to be included so overall reported performance will significantly worsen when a full submission is made.	

No.	Agenda Item	Action
	The Waiting List validation is completed but several hundred patients still need pathway amendment/corrections to be made so it could be August/September before the Waiting List is accurate. PV commented it was useful to quantify what "significant" means (i.e. c300) and reassuring that there is a recovery plan in place already. • SSh – The Emergency Care Standard ("ECS") showed significant improvement in May around the Work As One week. Since that week there has been an achievement of over 90% on several days. Over the 10 days previous to the Committee meeting the Trust has experienced a very high number of attendances, with over 400 per day being reported (with associated higher bed occupancy levels and congestion in patient flow). Nationally there has been slow growth and the underlying data suggests no one specific reason as to the rise in attendances. On some days the ECS has been below 80% achievement and the average is c81% at the moment. The areas being focused on are assessment units and trying to increase usage of the Assess to Admit model (focusing on bed flow across the organisation). PV queried how confident the Trust is of achieving their 90% target by September 2018. SSH commented that this is realistic but there is still a lot of work to do to achieve this. There is a working group focusing on this, with three key priorities : ➢ Effective streaming at the front door. SSh had a conversation with Commissioners, who are keen to set up an urgent treatment centre at the front door taking minor illness and injuries run by GPs and Advanced Nurse Practitioners. These are currently separate workstreams so would need further integration. ➢ The Ambulatory pathway and the Assess to Admit model. The Trust is involved with a national project for these areas. ➢ Discharge processes and bed flows. PV queried if there are any plans from Bradford Metropolitan District Council to have a walk in centre. SSh commented the Trust is not aware of any. The Trust does not have enough physical capacity for the level of attendances, so a walk in centre would be an enormous help in adding extra capacity.	

No.	Agenda Item	Action
	It is currently being assessed how can the Trust stream these patients better and the Estates department have been tasked with working up a Commissioner funded proposal to do this. • The performance against the eighteen week Referral to Treatment ("RTT") target, an increasing Waiting List and Data Quality errors drive the performance metrics. The focus has to be on increasing Elective activity. The activity trackers will help with this, with around eighteen services using them already and a rollout plan for the rest. Their effectiveness is variable at the moment, as getting Directorate managers to fill them in is a challenge. Areas where 'quick wins' are available and those where most recovery is required have both been targeted in the rollout. The priority is to get more income in and see more patients. The discipline of completing these will be instilled as part of weekly Elective care Delivery Group, and the trackers will form part of future performance reviews. For any area where financial and BIP performance are off line an escalation meeting will take place and the completion of the trackers will be part of this meeting. A discussion around the RTT target took place. TH queried how the Non-Executive Directors can have sight of the recovery plans. SSh commented that individual specialty details are on the activity trackers. JM commented that the Trust is looking at summarising all of the trackers into one schedule for the next committee meeting. PV and TH agreed that receiving this feedback at the next Committee would be useful as the Committee only obtain confidence if the Trust can evidence the improvements. PV queried how long it would be before the 18 week trajectory would bottom out and the Trust would start to see improvements. SSh commented that the Trust should see a step change when trackers are used in earnest and full Waiting List validation is complete. This validation is likely to be around a six month process. The Elective Care Improvement Programme also supports this, which is focussed on particular specialties' booking, theatre improvement etc. PV commented that the Waiting List validation and Activity trackers are two important workstreams that are being implemented that will have a step change. SSh commented that it is a long process and the Trust has proper plans in place although it may not see the benefits for potentially eighteen months.	

No.	Agenda Item	Action
	• The biggest challenge to achieving the target for the Cancer two week from GP urgent referral to first consultant appointment standard is in Dermatology. Haematology is also a challenge and there is pressure on achieving the target from some diagnostic challenges in Gynaecology. • Within the sixty two day standard from urgent GP referral for suspected cancer to first definitive treatment by the far biggest challenge is Urology. Urology has large patient numbers and therefore a huge impact on overall performance. There are real capacity pressures in Clinical Oncology related to Urology patients. Clinical Oncology is provided by Leeds Teaching Hospitals but they cannot provide further capacity until September. The national pathway has changed which is a further challenge. SSh gets weekly updates but at present the Trust are only treating long waiters and this does not address the issue. The Trust has spoken to the Cancer Alliance and they are looking into support. Diagnostics is big challenge in the Cancer pathway around radiology and histology capacity. PV commented RTT is a big challenge but that addressing performance against the Cancer standards needs more focus. SSh commented that Cancer has systemic problems impacting on the pathway so it will be difficult to fix. • Regarding patients waiting over fifty two weeks, there have been two incomplete breaches in May and seven complete and two incomplete for June. There is the potential for one more incomplete breach in Dermatology and one further complete breach (which is dependent on when the patient completes treatment). Automatically a root cause analysis is undertaken for all patients waiting fifty two weeks and there is a Clinical Harm review panel where they will be assessed. • Regarding performance against the target for Ambulance Handovers from the ambulance team within 15 minutes of arrival at ED, the Trust has struggled last week after the improvement seen during the Work As One week. There are ongoing issues with data quality from Yorkshire Ambulance Service (“YAS”). The Trust is in discussion with YAS regarding this. • Achievement against the standard for patients who are risk assessed for Venous Thromboembolism (“VTE”) has improved – the Trust were at 94.7% for the last 3 months but achieved 95.58% for June.	

No.	Agenda Item	Action
	PV commented that the challenge will be to sustain this improvement but things have been embedded that should maintain this and that the team should be congratulated on achieving this. KD updated on the infection control elements of the dashboard: • Infection Control figures are positive. An infection control report will be tabled at the Quality Committee this afternoon (27th June 2018). Instances of C-Difficile and MRSA infections have reduced again (although MRSA was previously at a high level). The days between cases achievement is definitely improving. The Infection Control team is running a campaign around Cannula insertion and that has produced good results. The focus going forward is around a back to basics approach (hand hygiene audits, hand gel between patients etc.). Figures suggest that the staff group where this is a concern is amongst clinicians. PV queried if clinicians are challenged on this issue. TH queried if Dr Bryan Gill, Medical Director was aware. KD commented that not as much challenge has been forthcoming as there could have been. KD gave the example of challenging staff where scrubs were being worn outside theatre. Dr Gill is aware and taking action to address and a Trust wide communication is being considered as it needs a concerted effort. It is important to consider the public perception and confidence, with staff being seen by patients to engage in Infection control activities (i.e. wash hands, wear appropriate work clothing etc.). SSh agreed and commented that there is evidence that appropriate clothing does impact on Infection Control rates. There is evidence that gelling is not as effective as washing but it is the public perception of being seen to do so which is equally as important.	
	Finance	
F.6.18.7	**Finance Report**	
	CS updated on the key points from the Finance report: • The Year to Date position regarding delivery of the financial plan shows that the Trust is on line with plan. The Sustainability and Transformation Fund (“STF”) has now been re-named the Provider Sustainability Fund (“PSF”). The plan was for a £4m deficit, and this was delivered. It is assumed the Trust will recover all PSF to Month 2 (£1m) and assumes full delivery of ECS at quarter one. This is not expected to materialise, so PSF achievement will be adjusted for this in the Month 3 position.	

No.	Agenda Item	Action
	BIP achieved delivery of £1.7m – this includes £0.8m non-recurrent technical balance sheet adjustments which were not in the original plan. A discussion around BIP plans took place. PV commented that the Trust needs to focus on sustainable improvements. CS commented that the Trust's full year BIP plan is for £25.6m, which equates to a Year to Date equivalent of £4.2m if phased in even 12ths, but reported achievement was only £1.7m (and this was supported by the non-recurrent £0.8m adjustments). It is sensible to report against straight twelfths as the plan is loaded towards the end of year to provide proper context. The Executive Management Team ("EMT") discussed yesterday (26th June 2018) about the best approach to addressing BIP. Each Division has their own BIP target, and at next steering group the Trust is hoping for improvements in reported schemes and achievements. If that is insufficient then an escalation process to SSh and MH occurs. SSh commented that the escalation process is a focussed, detailed, line by line review of Divisional plans. The Divisional representatives are questioned regarding what they plan to do week by week to address the position. The further behind plan the position is then the more oversight and supervision there will be for the Division. The Trust is keen to promote earned autonomy so there is further incentive for Divisions to keep on track as greater freedom and decision making authority can be achieved. PV commented that the Non-Executive Directors are concerned and so will require that they are kept up to date. CS commented that it is a cause of concern for Finance. The Year to date position appears fine as it is in line with plan, but forecasting forward the Trust has non-recurrent flexibility for quarter one but there appears to be no further flexibility available after that. The Trust will keep looking but it is not likely. • The Trust is likely to fall behind plan in Month 4 if current run rates continue. This is being raised at Committee now as a future pressure, rather than waiting until the Trust report an off plan retrospectively. PV queried if a contingency/recovery plan is in place, detailing what actions are going to be taken, which cost reductions will be made or which initiatives will not be progressed. CS commented that this was the discussion at EMT on the 26th June. Against the rebased budgets the Divisions are managing reasonably well, but the issue is the BIP non achievement. A discussion took place around the division of Diagnostics, Anaesthesia and Surgery ("DADS") financial position, and Trust wide support from GE	

No.	Agenda Item	Action
	Healthcare. PV commented that DADS has the biggest gap. CS commented that DADS are £3m off plan, which is linked to under achievement of contract income targets. A large amount of this relates to BIP (e.g. endoscopy target £2.5m increased income, GE Healthcare are supporting improvements in Theatres and Orthopaedics). TH queried how the Non-Executive Directors can help Surgery to improve their position. SSh commented that there are actions in place for Endoscopy and a fortnightly recovery meeting takes place. Support from GE Healthcare is also available. The biggest challenge was data quality but that is mostly resolved. The Trust need to complete pathway corrections and are ensuring Standard Operating Procedures are being followed in Endoscopy booking (e.g. organising some training to ensure staff are getting the direct booking onto ePR and not double booking). The Trust is also looking at the best way to add extra points onto Endoscopy lists. The work with GE Healthcare is targeting 14-15 points per list but achieving improvements is proving to be problematic. There is a 20% DNA rate in the service so there has been challenge from clinicians regarding the necessary overbooking to accommodate this, but maximising list capacity is the best model for the service. Cultural issues across the local demographic also drive the DNA rate. Clinicians would prefer to initially improve the DNA rates and then change the booking rules, but they need to be done at the same time if financial benefits are to be realised in 2018/19. TH commented that no details regarding delivery of improvements that GE Healthcare has delivered to date have been shared, and queried if GE Healthcare is having a positive impact. CS commented that the improvement metrics do not suggest that they are. There is no hard evidence to demonstrate that they have helped improve productivity or throughput. They are however paid on achievement, so until this can be evidenced no payment is due and therefore the Trust has not paid GE Healthcare anything as yet. SSh commented that the work that GE Healthcare has undertaken so far has helped teams get organised, focussed and analyse current systems for suitability. Potentially therefore the situation could be worse without GE Healthcare's involvement. TH queried if it was felt that the relationship with GE Healthcare was positive. KD and SSh commented that they felt that it was. SSh commented that it is felt that initially the Divisions believed that GE Healthcare would design and implement the programmes for them, whereas they are only enablers and that staff own each of the projects.	

No.	Agenda Item	Action
	• Cashflow is likely to become a major concern if the Income and Expenditure position does not improve. Cashflow problems mean the Trust may need to seek external financing (e.g. interest bearing loans) or restrict the capital programme to manage this. A discussion took place around cashflow and the capital programme. PV queried how the Trust would fund large capital projects (e.g. the Command Centre) if cashflow become a major concern. In this circumstance such a large outgoing may be more appropriately diverted to more essential expenditure. CS commented that for the specific Command Centre project, the outgoings total £5m spread over a number of years and this would be funded from last years' STF that was added into the extended capital programme. The full capital programme has yet to be agreed. Any item on the capital programme has the same status as anything other in that it could be re-prioritised down the list. PV commented the Trust may need more draconian measures around productivity and this may be more palatable than a Command Centre. CS commented that the Trust may end up in a position where day to day finances actually stop us achieving some strategic initiatives. • CS commented that the recently agreed national pay awards will be paid to staff in July, with back pay being received in August. Funding from the centre is not confirmed to arrive by August, so it is good news that the cash position allows the Trust to pay this without needing to wait for the external funding. This is due to the achievements in identifying savings made by the Trust in recent years being reflected in the financial position.	
F.6.18.8	**Working Capital Reporting**	
	A report entitled "Working Capital Reporting" is included in the papers to the meeting and discussions concerning working capital were covered elsewhere on the agenda.	
F.6.18.9	**2018/19 Commissioner Income Plans**	
	CS tabled a document entitled "Contract Income Planning & Reporting 2018/19" which explains the process for establishing Commissioner contracts and how that filters into individual activity targets within the Trust. The document also highlighted a significant risk to the reported and forecast income position and also to recovery of income related to BIP efficiency programmes. CS outlined the historic (pre-2018/19) approach for establishing	

No.	Agenda Item	Action
	Commissioner contracts. Internally the Trust did not previously have a system for identifying capacity and demand but SSh has led on work to develop one, meaning that for the 2019-20 contracting round the Trust should have a mature system to do so. CS outlined the 2018-19 approach for establishing Commissioner contracts. • For 2018-19 the process is essentially the same as the historic process but for some specialties it will also be informed by this recently developed capacity/demand model. • The quality of data available to support the contracting process has deteriorated since ePR was implemented and has made contract setting extremely challenging. Historically the Trust had a solid basis from the previous Patient Administration system (iPM). For 2018-19 the Trust had five months data from iPM and 4 months' data from ePR, with effectively a change in currency. The quality of the data produced from the EPR system has compounded this problem. • A bottom line income value with Commissioners was agreed and the Trust has accepted the Commissioner activity breakdown to specialty and point of delivery (POD). These do not necessarily match with the Divisions' original capacity proposals. • The Trust has therefore produced a separate internal plan based far more closely on divisional capacity proposals, particularly for areas such as outpatients and elective care, where the divisions were able to use the interim outputs of the draft capacity and demand model. This internal plan comes to the same bottom line value as the external plan, but aligns with divisional capacity plans. Divisional performance management will be based on this internal plan, whereas external reporting to commissioners is based on agreed contract plans. • Income from contracts totals £342.0m and a further £13.5m income efficiencies from BIP give a Trustwide total of £355.5m, which is the figure that was shared with NHS Improvement. • The actual activity and income data produced by the Trust's systems which is provided to the Finance department to generate charges to the commissioners is now so inconsistent with the data provided before the EPR implementation that the Trust cannot reliably substantiate its income. There is a risk that the Trust will not be able to realise the full income due for activity carried out and that commissioners may not pay for overtrades relating to BIP plans if the income and activity cannot be reliably substantiated via reliable data. PV summarised that the overall process improved and the Trust calculated	

No.	Agenda Item	Action
	income total was different to the Commissioners version and that it is important that the Trust ensures it gets fairly paid for the actual work undertaken. CS commented that there is a data quality action plan for address staff to use the ePR system correctly. The worst case would be that the Trust cannot substantiate outputs from ePR, and Commissioners have no assurance as to their accuracy. Commissioners have a range of options, from agreeing to pay only the agreed contract amount, to a detailed challenge to the data (which may result in the Trust receiving less than the contract amount). PV queried what the options are if the Trust genuinely believes it should be paid more than Commissioners may be willing to pay. CS commented that this situation would require a difficult negotiation if the Trust cannot substantiate the figures. The unadjusted actuals forecast for May is for £59.5m. When adjusted for known errors this forecast becomes £55.9m, and it is this £55.9m upon which the Trust's year end forecast is based. CS summarised the key messages : • The risk to income through not being able to adequately evidence data is real and very significant. • The Trust is not confident in the currently reported income numbers. The Trust has been through a contracting process (which will now be shared with Divisions). There is a data quality action plan in place, which (if successful) may mean the Trust can substantiate and receive appropriate payment. • The Trust may not be able to achieve income BIP. In this scenario, the £13.5m efficiencies currently planned to be realised via income growth would need to be achieved via cost reductions. PV and TH commented that there is very limited assurance. There is a process and some data available but there are significant data quality issues.	
F.6.18.10	**2018/19 Operational plan feedback**	
	PV commented that a report entitled "2018/19 Operational plan feedback" is included in the papers to the meeting and that this came to Board with a comprehensive summary. SSh commented that this is mostly covered in the dashboard discussion.	
	Performance	
F.6.18.11	**Assurance, the way forward presentation**	

No.	Agenda Item	Action
	TC commented that at the recent Board meeting Professor Bill McCarthy, Chairperson (BM) states a desire for Committees to strengthen the way they think about assurance and their own role. The challenge is to ensure that the Trust makes assurance more overt and fully understands what it actually is. TC presented the highlights of the Assurance, the way forward presentation : • The recent presentation at the Audit Assurance Committee detailed a workplan for TC and the Corporate Governance team to optimise assurance around the Trust to underpin its Governance statement. This represents the end point of a number of years' worth of work around Governance. The intent is that the Trust is assured that systems and processes around risk and escalation are appropriate. • The Trust needs to optimise the assurance that underpins the annual governance statement. Assurance is achieved through : An established governance framework Clearly defined strategic objectives Effective internal controls Maturing risk management culture • Assurance is the balance between strategy, risk and controls. There needs to be an assessment of how risk is being controlled and there then needs to be reasonable assurance. BM challenged TC to articulate a virtual cycle of assurance, where every step builds on the previous one. Each Trust has its own objectives, key purposes and aspirations. The risks are what prevent the Trust from achieving those objectives. The Trust must put in place effective controls to mitigate these risks and then obtain Assurance, which is the evidence that the controls are effective. PV queried what can be used as evidence, citing in-depth discussions as potential for evidence. TC commented that this is dependent on the organisation. Risk control and risk appetite need balancing due to their influence on each other. If a Trust is risk-seeking there might not be the need for high levels of assurance, but there will be a need for high levels of control. If a Trust has a zero risk appetite, it would want to see more evidence and higher levels of assurance (the proof). These steps complement each other. PV commented that the Committee is cautions so there is likely to be a need for high levels of assurance. TC commented that if this was the case the Committee may seek to inject a high level of evidence e.g. external review, audits etc. • The Trust is developing a control audit assurance map, to understand its relationship between risk control and risk appetite. • The key is obtaining evidence based assurance. A Committee	

No.	Agenda Item	Action
	should look at the nature of assurance, what value the Trust place on it and what assurance tools the Trust has (plan, audit etc.). • In terms of the types of assurance, this can be verbal, paper based, an action plan etc. Empirical evidence is the strongest, (e.g. audit, research, first hand observation etc.). PV queried if the Committee asking to see a recovery plan can be classified as assurance evidence. TC commented that it would be and even after receiving such assurance evidence there is always the opportunity to request further evidence if required. • The level of assurance must be understood. The relationship between operational assurance and oversight can give such examples as a tracker providing the assurance and the Committee providing the oversight (e.g. escalation for BIP). Things can also be escalated to Committee asking for Operational Assurance. Independent evidence should be sought where possible. SSh commented that for the system to work it needs to be reasonable and at the appropriate level, otherwise the Trust may end up escalating and evidencing everything. TC commented that the Trust may end up with a hierarchy of assurance. PV provided an example that in a meeting the Committee may minute that e.g. “the Trust has operational assurance, but there is a gap in independent assurance”. • There are many sources of assurance, including external audit, internal audit, clinical audit, peer review, accreditation, Walkaround, EMT assurance (e.g. Clinical Negligence Scheme for Trusts (“CNST”) for Maternity, where EMT had challenged the Division and received assurance) etc. • The Committee needs to evaluate the value of the assurance. Something that is quite old might erode its value for assurance e.g. Clinical Audit, as it is reported at a point in time and this value may therefore be time limited as the national audit programme is a biennial cycle. PV commented that the activity trackers are live, so this will help with timely assurance. • An assessment must be made of whether the assurance endures as a permanent assurance on an historical matter must be evaluated e.g. Auditors Report on Financial Statements, or loses relevance over passage of time e.g. clinical audit. • The Relevance (the degree to which assurances aligns to a specific area or objective over which it is required) must be assessed. Lots of assurance evidence may be low level and not relevant so a Committee should look to quality of assurance evidence and not quantity.	

No.	Agenda Item	Action
	• The reliability and trustworthiness of the source of the assurance should be evaluated. This does not necessarily refer to the person providing the assurance evidence, rather the source of the evidence itself. • The independence (i.e. degree of separation between the function over which assurance is sought and the provider of assurance) should also be evaluated. The higher the degree of separation from the function, the higher assurance required. • Supporting the identification and evaluation of assurance requires implementing a suite of complementary tools. A review of where the Trust was in terms of understanding the effectiveness of different types of assurance was undertaken. The Trust has an established relationship with Internal Audit and the Trust has a regular audit programme. For external audit the Trust has peer reviews on a rolling programme. PV commented that in the past the Committee found it useful to have had sight of Internal Audit reports, as this helped to identify where any assurance gaps existed. • The Trust also have a programme of internal assurance reviews, which have been established for eighteen months and the Quality Committee have discussed how this will change to focus on compliance. This needs further work to embed. • Stakeholder feedback and how the Trust engage with stakeholders is a key assurance tool. A new policy around External Visits is being drafted, which will help with this. • The BAF is an important part of control infrastructure and this is an ongoing piece of work. • External reviews are an established tool, whereby the Trust invites in a review, or where a review is imposed upon us. The Trust is developing an understanding of how the Trust manage those but need better processes and integrating Care Quality Commission (“CQC”) other regulators and how the Trust integrate the results of these. E.g. Human Tissue Authority, Health & Safety Executive • Two new areas which are being worked on are the Assurance Map and the Assurance Directory. The directory is pulling together source, type, level, different controls and associated assurance. The incident reporting system (Datix) now maps to CQC lines of enquiry. The CQC view the Trust by site (i.e. care delivery point) so the Trust can now identify how it can assure itself around the level of CQC compliance. The Trust can then suggest types of evidence required in specific CQC areas. The Trust is doing two mock inspections requested by two services	

No.	Agenda Item	Action
	(theatres and renal) so this assessment of CQC compliance can be tested on them. If the Trust can get the Assurance Map established it will be very powerful (e.g. it can give ward level info on training rather than a Division wide which might suggest on the whole training metrics are positive). TH queried where the Corporate Risk Register would be included in this framework. TC commented that the Corporate Risk Register and Management Assurance Risk Register are included within the BAF.	
F.6.18.12	**Performance Report**	
	The Performance Report is included in the papers to the meeting and key items from the Performance Report were discussed under other agenda items.	
F.6.18.13	**Trust Improvement Committee Report**	
	SSh commented that the Trust Improvement Committee is more focussed on BIP, and as such the Trust Improvement Committee has been replaced by the BIP Programme Board and associated meetings. It is early days and there is a good governance structure in place. All BIP programmes have been agreed and documentation has been standardised. Highlight reports are being generated and the Trust is assessing the discipline on reporting and progress of schemes. There is clear ownership of all schemes. PV commented that there is confidence that meeting dates have been established and the structure gives some positive assurance. TH commented it was good to see some areas over achieving on BIP targets.	
F.6.18.14	**Informatics Performance Report**	
	CF commented that the Informatics Performance Report was the short version, and that there was nothing significant to highlight. PV queried that only partial submission for EPR related reports had been recorded. CF commented that recording is almost fully done, but endoscopy in the DM01, as discussed elsewhere on the agenda, means it is only a partial submission.	
F.6.18.15	**Cancer Services Recovery Plan Update**	

No.	Agenda Item	Action
	The Cancer Services Recovery Plan Update is included in the papers to the meeting and has been covered in discussions under other agenda items PV commented that there is positive assurance that detailed plans are in place for each tumour site. SSh commented that there is a Cancer Improvement Group and it is also covered in BIP. PV queried if an update from the Outpatient Improvement Programme is scheduled to be presented to a future Committee meeting. SSh commented that this is covered under the governance arrangements for BIP and it is therefore not a recovery plan as such but aims to identify financial and productivity opportunities.	
F.6.18.16	**Work As One Week evaluation**	
	SSh presented the highlights of the Work As One Week evaluation : • The Work As One was w/c 14th May with the intent to do something different in the week focusing on bringing the values of Trust to life and to work together particularly around patient flow across the organisation. The focus was to be on behaviours and not process. The week had been planned for eight weeks via a steering group. • There was good organisational engagement, with many areas displays information on their noticeboards. There were competitions across Divisions around who had the best board. Staff were enthused and felt it was a great week. Hundreds of people involved. In the region of nine hundred shifts were covered through ward liaison officers, with around forty staff in command and control process. • A key area of focus was patient experience (i.e. no delays), with capacity freed up earlier in day, long waits in ED reduced, a reduced number of patients waiting for discharge and bed occupancy reduced. The Trust did not hit 95% for ECS but it did rise to 90%. • Professor Clive Kay, Chief Executive (CK) and SSh undertook a walkaround, where one Acute Medical Unit ("AMU") staff member discussed the challenges of this week. The staff member stated that the Work As One week was "the best week in my career as flow was so good". On one day there were 30 free beds. • Bed occupancy at the start of the week was 97.9% and by Sunday had reached 88.4% and this was sustained for a period after the week had ended. This may be due to other factors, but Work As One did seem to have a positive effect in this area. • The ECS at the beginning of the week was 81% and ended the	

No.	Agenda Item	Action
	week at 93% on Sunday. There have been similar weeks (in terms of weather, environment etc.) that did not show this trajectory so there is evidence here that Work As One had a positive effect. PV queried if staff had seen this feedback. SSh commented that they had. There was a hot debrief during the following week and a presentation in the leadership forum. • One of the most significant things was that it generated creativity and thinking about different ways to do things across the organisation. Most wards did a board, with a daily update to staff and celebrated good work. The Trust supported staff to work differently, e.g. mentored a 3rd year student to take control of ENT outpatients. • Feedback was sought and some of the comments included phrases such as "energised", "different", "allowed to try different things", "open and honest conversations" and "empowered". There was a perceived significant reduction in stress. • Ward 27 had never had proper ward rounds in place, so now a Multi Disciplinary Team ("MDT") one for all staff takes place, including plaster room staff. This has been continued as it has made a big difference. It improved communication as everyone knew what was going on with the patients on the ward. • There was a focus on recording SAFER on ePR and not paper. Some shift pattern changes were made to better align with nurse availability and ENT implemented a one stop shop for assessment (where it was possible to deliver these). • There was a drive to use criteria led discharge, with particular successes in Ward 27 and AMU. The key challenge is sustainability. Pharmacy noted an increase in prescriptions prepared for patients to take out ("TTO") with them on discharge. There was also a 66% reduction in phone calls to pharmacy to chase TTO's that had been requested. This reduced late finishes in the pharmacy department. • Porters worked more efficiently and fewer delays were apparent. It was easier to triage and prioritise referrals to porters as they were all booked through a common route. • There was a significant increase in patients to the discharge lounge (which was actually full at one point), further evidencing the success of the week in improving flow to discharge. • The Assessment unit assessed the performance levels of different initiatives such as consultant streaming and see-and-treat to identify which had the best performance (in terms of admission avoidance). • The first Friday of each month will be branded "Work As One Friday" and in every four to six months there will be a full Trust	

No.	Agenda Item	Action
	week again. The next one is planned for 20th September 2018, which will be values and behaviours driven. • However, the Trust has seen a slow decline in the benefits as the full Trust wide resource to sustain this improvement evidenced during the Work As One week is not available. It was massively resource intensive with lots of cancelled work and meetings. The Command Centre concept would replicate this but using technology as the enabler not staff resource. TH commented that a real positive is the wards taking ownership of their own area. The risks are the resource is not available for this to be sustainable, and the possibility that silo working through competition does not become apparent. SSh agreed and commented that having key themes that the Trust all undertake at the same time keeps the momentum but the Trust need to focus on two or three big ticket improvements. Assess to Admit is a huge opportunity for which the Trust needs to keep the momentum going. CF commented that the Work As One week in May was focussed on patient flow, so the Trust can look at other areas in future e.g. quality, coding etc. PV commented that this says a lot about leadership as the senior team were leading in a different way. All of the teams involved should be credited from a work and from a leadership development point of view. SSh commented that it is a good approach to Trust wide problem solving.	
F.6.18.17	**Review Committee Terms of Reference**	
	PP commented that the current Terms of Reference expire next month (June) and a draft updated Terms of Reference is included in the papers to the meeting. Amendments in the revised draft are : • Additional section “10. Review of Terms of Reference”, detailing the frequency of review should be annual. • Additional section “11. Sub-committees reporting to this Committee” detailing that the Board of Directors has conferred upon the Finance and Performance Committee the power to establish sub-committees. • Further amendments required not in the draft included in the papers to the meeting are : • References to the Trust Improvement Committee will be updated to read Bradford Improvement Programme • Inclusion of SSh as Chief Operating Officer, as this had	

No.	Agenda Item	Action
	inadvertently been omitted Subject to these changes, the Committee approved the revised Terms of Reference.	
F.6.18.18	**Any other business**	
	None.	
F.6.18.19	**Matters to share with other Committees**	
	PV commented that VTE achievement and Infection Control rates will be discussed at Quality Committee.	
F.6.18.20	**Matters to escalate to the Board of Directors**	
	The risk to delivery of the control total for July and for the full year. The data quality risk to recovery of income for 2018/19. PV commented that the Board need to be sighted on key recovery plans including Cancer and RTT. The Committee fully support the deep dive into Cancer. Work As One week has also been reviewed and the Committee support the recommendations for actions to take this forward.	
F.6.18.21	**Matters to escalate to Corporate Risk Register**	
	None.	
F.6.18.22	**Items for Corporate Communication**	
	None.	
F.6.18.23	**Date and time of next meeting**	
	Wednesday 25th July 2018, 08:30 am - 10:30 am Conference Room, Field House, BRI	

BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST
ACTIONS FROM FINANCE AND PERFORMANCE COMMITTEE – 27th JUNE 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	Board Assurance Framework has been updated. Action Closed
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. Action Closed
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. Action Closed
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. Action Closed
27/06/2018	F.6.18.6	SSh to confirm the narrative used in SMS text reminders to confirm if day of the week as well as date is included	Chief Operating Officer	25/07/2018	To update at next Committee meeting

FINANCE AND PERFORMANCE COMMITTEE
MINUTES, ACTIONS & DECISIONS

Date:	Wednesday 25th July 2018	**Time:**	08:30 – 10:30
Venue:	Conference Room, Field House, BRI	**Chair:**	Mrs Pauline Vickers, Non-Executive Director
Present:	Non-Executive Directors: - Mrs Pauline Vickers, Non-Executive Director (PV) - Mr Trevor Higgins, Non-Executive Director (TH) - Mr Jon Prashar, Non-Executive Director (JP) - Professor Laura Stroud, Non-Executive Director (LS) Executive Directors: - Mrs Sandra Shannon, Chief Operating Officer (SSh) - Ms Karen Dawber, Chief Nurse (KD) - Mrs Cindy Fedell, Director of Informatics (CF) - Mr Matthew Horner, Director of Finance (MH)		
In Attendance:	- Professor Clive Kay, Chief Executive (CK) - Mr Chris Smith, Deputy Director of Finance (CS) - Mr Carl Stephenson, Acting Head of Performance (CSt) - Mr Paul Pallister, Trust Secretary (PP) - Mr Christopher Callaghan, Divisional Head of Finance (CCa) – Minute taker		
Observing	-		

No.	Agenda Item	Action
F.7.18.1	**Apologies for absence**	
	No apologies for absence were received.	
F.7.18.2	**Declaration of Interests**	
	None.	
F.7.18.3	**Minutes of the meeting held on 27th June 2018**	
	The minutes were agreed subject to the following amendments : F.6.18.5 – 2nd paragraph should state : "SSh commented that it referred to an action that is in progress but for which there may be some delay. KD agreed and commented that progress was still being made and the Trust still planned to deliver" F.6.18.6 – 2nd paragraph should state : "KD commented that there is a tool that sits behind the dashboard that scores the data, so the Committee can get assurance around the data." F.6.18.6 – 3rd paragraph should state : "CF commented that there is a data quality kitemark within the dashboard, allowing the Trust to be transparent about the quality of the data. There are levels of assessment, which are colour coded. If something is	

DRAFT

No.	Agenda Item	Action
	assessed as red then clearly there are issues. Data quality around the Electronic Patient Record system ("EPR") is clearly an issue. For any assessment showing green or blue there has to have been an independent assessment of that data." Regarding the 3rd paragraph from the end in F.6.18.6 regarding the comment from KD on considering a Trust wide communication on Infection Control, CK queried how all Trust Committees co-ordinate their individual actions and if additional work is needed in this area. F.6.18.6 – 3rd paragraph should state : "TH commented that a real positive is the wards taking ownership of their own area. The risks are the resource is not available for this to be sustainable, and that the benefits of the Work As One week are shared across the Trust."	
F.7.18.4	**Matters Arising**	
	F.5.18.5 – MH has updated the narrative relating to Financial Controls Panel in Board Assurance Framework. Action Closed. F.5.18.7 – MH updated Committee on Commissioner income. Action Closed. F.5.18.17 - A presentation to the Board of Directors on the Activity Tracker has been added to the open board agenda for September. Action Closed. F.5.18.18 – A summary report for the Board of Directors has been added to the open board agenda for September. Action Closed. F.6.18.6 – SSh confirmed that the narrative used in SMS text reminders does not include day of the week, but does include date, time and location of the appointment. Jo Young (Head of Access) is going to contact the company providing SMS services for the Trust to see if it is possible (and how much it would cost) to show the day of the week within the message. Action Closed.	
F.7.18.5	**Board Assurance Framework**	
	PV commented on a discussion at Board regarding levels of risk and risk appetite. During this discussion Professor Bill McCarthy, Trust Chairman commented on the dichotomy of balancing risk with achieving patient safety. PV further commented that the Trust may need to take measured risks and be creative and queried if this was readily apparent in the Board Assurance Framework ("BAF"). CF commented that, using the example of the upcoming refresh of the Informatics Strategy and other innovations (e.g. the Command Centre) within the Trust, the BAF does not seem to reflect this way of working. The BAF states that "The Trust will adopt a cautious approach to financial risk" and that "The Trust also has a cautious approach to commitments other than those related to the quality of care that it provides."	

DRAFT

No.	Agenda Item	Action
	TH commented that the wording could be amended to include the following statement "It is prepared to invest for potential return and is prepared to invest in resources that deliver improvements in quality and patient safety" reflecting that the Trust is prepared to innovate and invest in such schemes. KD suggested that an approach akin to using a balanced scorecard is utilised, so the impact of decisions regarding safety, quality and finance are assessed. PV agreed and commented that the Non-Executive Directors ("NEDs") seek assurance across those dimensions. TH commented that a separate session may need to be organised across the Committees to ensure committee alignment and crossover with subsequent feedback to the Board. KD commented that CK's earlier query concerning coordination between committees is key here and this is an example of ensuring that this takes place. LS agreed and commented that each Committee can include comments but it has to be a corporate decision as to the final wording. The principles that underpin this and the wording have to be a joint effort. Version control is important but the Committee can note that it agrees with the underlying principles of the document. Regarding the content of the BAF itself, PV commented that for the items in red text on the Quarter 2 table, these are narratives that have been updated. MH commented that for items 2a and 2b the Finance commentary in the Assurance Overview summary needs updating. The two key issues are assurance around delivery of the Bradford Improvement Programme ("BIP") and the Data Quality issues the Trust is facing to provide assurance around contracted activity and income. The two issues are further reflected in the committee papers and on the Corporate Risk Register PV commented that under section 2a on financial plan there is detail of both positive and negative assurance and gaps in assurance and reflects what has been discussed	
	Board Dashboard	
F.7.18.6	**Finance & Performance Committee Dashboard**	
	Performance SSh updated on the performance elements of the dashboard: • The Trust is challenged across a range of access standards, which include Cancer waiting times, the Referral to Treatment ("RTT") target and the Emergency Care Standard ("ECS").	

DRAFT

No.	Agenda Item	Action
	• There are detailed recovery plans in place in each of these areas. Achievement of the ECS has been impacted by the recent hot weather, with higher attendances and higher acuity of patients attending. • Key actions are the plans for the development of an extended minors area. The Trust are also utilising the ambulatory assess to admit model to reduce the number of emergency attendances and looking at new workforce roles to bridge gaps. There has been a challenge in the last few days with longer waits for ambulance handovers (with some handovers taking over sixty minutes) and SSh is aiming to set up a secondary triage area so paramedics can handover and then the patient can wait for a cubicle. • There is a lot of work in progress and for the Work As One fortnight the aim is to reset the balance again. **Emergency Care Standard ("ECS")** PV commented that the challenge is to get it back to 90% by September. SSh highlighted that ambulatory care is an area where opportunities for improvement are available. SSh agreed to update on the three key areas (Ambulatory Pathways, Assess to Admit model, and Improving triage for ambulance referrals) identified to manage patients moving through the department at the next Committee Meeting TH queried why the rating for ECS on page nine is green for ECS but June performance was 84.96%, which is behind trajectory. SSh commented that the Trust struggled against the ECS in the second half of June, so would check why the rating was showing green and update at the next Committee meeting. PV commented that as there are so many things to do it is helpful for NEDs to hear what the priorities are, as so many actions may mean some things are lost. SSh commented that this has been a problem in the past where too many workstreams shifted focus away from the key areas. The Command Centre will help to manage flow, and the work underway with Ambulatory pathways, assess to admit and improving triage ambulance referrals will help. A separate and extended minors area in ED will help with capacity. LS queried if the Trust is utilising volunteers in ED when it gets busy. SSh agreed to check and update at the next Committee meeting. CK commented that Richard Barker, Regional Director NHS England stated everyone else is doing better in terms of achievement. The North of England has had a significant increase in, but less so in the South of England. Including a ranking on the dashboard would provide context	Chief Operating Officer Chief Operating Officer

DRAFT

No.	Agenda Item	Action
	around the North England and the national picture SSh advised a note of caution on the rankings, as during June the Trust ranking moved from 26th (out of 137 Trusts) in one week to 132nd the next. LS queried if there is a way some contingency can be built into plans, given extreme weather events are unpredictable. SSh commented that the Trust does have them. For example extra beds are opened when necessary. In the main there are enough beds in the system but the issue is patient flow, with the evidence suggesting that the Trust is actioning discharges around four hours later than is required to maximise flow. The Work As One initiative and the planned work around flow will improve this position. **Referral to Treatment ("RTT")** PV queried if resource was available for validation work on waiting lists with a view to improving the quality of RTT reporting. SSh confirmed that this resource is available and work is ongoing to validate the full waiting list. PV queried if SSh is assured that the recovery plans are delivery and if there are any barriers. SSh commented that the key area of focus is increasing elective activity. CSt has developed specialty capacity, demand and activity trackers and thirty three are in place. Of these, twenty two have recovery plans and through which the rate of activity recovery can be monitored. PV commented that it is good to see the activity being tracked and queried how productivity was being addressed. SSh commented that it can be seen from the dashboard. CSt chairs a weekly delivery group and SSh chairs the monthly turnaround board. This board sets actions and these feed into the programme for the weekly delivery group with each week focussing on a different area (e.g. week one focuses on activity, week two focuses on emerging trends, week three focuses on the heatmap etc.). TH noted the comment on page 6 which states that regarding the Elective Waiting List "A programme of validation to remove data quality issues has commenced" and queried the timescale for delivery. SSh commented that the Trust will see the biggest gains in the first three months then continuous improvement over the next nine months. CSt commented that the Trust is starting to see signs of recovery in theatre in terms of patient numbers although volumes remain below historic levels. PV queried if there is there ownership in the specialties and CSt commented that the streamlining of waiting list management has improved the situation. SSh commented that, previously the focus was on why patients waited rather than taking action to address the wait itself. **Other Performance Metrics**	

DRAFT

No.	Agenda Item	Action
	PV commented that there has been a deep dive on Cancer. Diagnostic waits for tests have improved but there is also a need to monitor waiting times. It would be useful to include on the dashboard the time for referral to test time to report. In endoscopy the report is done at the same time as the test. SSh commented that within cancer diagnostics reporting time is a hidden wait (i.e. the wait for results for the patients). Careful consideration must be given to an appropriate standard to measure against. Actuals are readily available to report and will be included on the dashboard. TH commented that the report states that potential Data Quality issues are being investigated regarding patients who Did Not Attend ("DNA") in outpatient follow ups, as some clinics were showing the had had zero DNA's since EPR go-live. TH queried if any checks had been made with those clinics to get assurance if zero is the correct number. SSh commented that this has happened and clinics are outcomed, where numbers of DNA's, attendances etc. are recorded. The number of DNA's is therefore checked in clinic itself. It is part of the Data Quality recovery plan, for which CSt chairs a weekly meeting. Resolving the issue around clinics currently reporting zero DNA's will likely mean an increase in reported DNA's. CK commented that this is a serious issue as the actual DNA rate (when Data Quality issues are resolved) could potentially be higher than reported but this won't be known until the reported data is accurate. CSt commented that until the investigation is complete, other risks such as quality and finance cannot be assessed. The patients may not get the next steps in their treatment pathway if not recorded appropriately. CK sought confirmation on the planned improvement trajectory and what good would look like. SSh commented that it varies between specialties. The DNA rate in Paediatrics is always high (c10% - 20%). Some specialties have a DNA rate as low as 4%. The Trust needs to aim for a 50% reduction in the baseline in each specialty. SSh advised deferring the setting of targets until the Trust has resolved the data quality issues. SSh commented that the September agenda includes an item for activity trackers. The focus, to date, has been on Elective activity for the trackers, but it does include Outpatients. As such a full Outpatient dashboard will be developed. CK proposed that the dashboards include planned trajectories, and milestones. Being able to see actual trajectory versus planned will improve understanding and will then focus attention towards where subsequent deep dives are required. CF agreed to investigate the feasibility of including trajectories on future dashboards.	Chief Operating Officer

DRAFT

No.	Agenda Item	Action
	PV commented that the trajectories are visible in the deep dive information but not on the dashboard itself. LS commented that there is a lot of information contained within the dashboard and other reports and queried if the Committee need a separate session around what each of these measures are. This will provide clarity and ensure assumptions are not being made around the information produced.	Director of Informatics
	Finance	
F.7.18.7	**Finance Report**	
	MH updated on the key points from the Finance report: • Overall the pre-Provider Sustainability Fund ("PSF") plan for month three (quarter one) was for a deficit of £5.6m. The Trust delivered the deficit of £5.6m against that target. It should be noted that the quarter one plan was far less challenging than that set for quarters two to four. Quarter 1 Plan £5.6m Deficit, Quarter 2 Plan £2.1m Deficit, Quarter 3 Plan £0.0m surplus Quarter 4 Plan £1.0m surplus. This reflects the expectation that BIP plans will deliver later in the year. The current underlying deficit run rate is c£2m per month. In order to meet the quarter two plan it will need to be c£1m deficit per month. • The Trust has therefore recovered £1.1m in PSF against a plan of £1.6m (£0.4m under recovery which is associated with ECS performance). • Contract Income is behind plan by £3m. This is driven by a shortfall on BIP income plans (£1m) a Cost per Case undertrade (£1m) and a trading variance (£1m). • Expenditure is underspent by £3m. This is driven by a general expenditure underspend (£1m), a Cost per Case underspend (£1m) and the use of non-recurrent items (£1m). • The two key issues are therefore delivering the Contract Income plan and delivering the BIP. The report contains a separate appendix that builds on last months' income presentation highlighting issues on Data Quality and the impact on Contract Income. To spell out the degree of estimation being used, the report shows the key areas where raw outputs are being adjusted. The system generated position was an income total of £87.1m (excluding £2.2m for CQUINS and block funding). Adjustments totaling net £3.1m bring this down to £84.0m (excluding £2.2m for CQUINS and block funding).	

DRAFT

No.	Agenda Item	Action
	• The biggest issue is where Elective patients have been registered as Non Elective. The income position has been adjusted for this by examining historic data to look at what a reasonable spilt ought to be. There have been many meetings in recent weeks to highlight the recovery plan (internal and external) and timeframes for correcting key issues. PV queried how commissioners are responding to the income position. MH commented that the Commissioners are aware of the challenges faced and meetings are taking place to discuss the improvement plan. TH commented that the Division of Anaesthesia, Diagnostics and Surgery ("DADS") is still the outlier. MH commented that DADS expenditure run rate is below plan and the Division is underspent by £0.5m but is c£1m under delivered on BIP. When including contract income the divisional variance is an unfavourable £3.6m. BIP and delivery of contract income plans are the main challenges for DADS and all Divisions. The three reasons explaining performance in DADS are: 1. Data Quality, especially the issue around recording Elective patients as Non Elective. 2. Lower levels of productivity post-EPR. At the most recent DADS performance review meeting it was fed back Orthopaedics were back at 2016-2017 levels of productivity. 3. Under achievement of BIP. Assurance cannot currently be given that there are plans in place to fully address the BIP challenge. A discussion took place on the financial challenge with MH reiterating the process for quantifying the scale of the BIP challenge required to deliver the control total The budget rebasing exercise set the £25m BIP challenge figure, which then needed allocating across programmes. The process to establish the improvement programme and identify the schemes to secure the £25m, allocated the vast majority of the challenge directly to Divisions. For example, the majority of the elective income improvement relates to DADS. PV queried what the plans are to turn around the financial position, given the challenge will increase in terms of the phasing of the annual plan. MH commented that regarding the effectiveness of BIP, it has taken a number of months to establish the meeting structures and documentation. The Trust continues to refine the KPI's and data flows to ensure robust performance management can take place going forward. Significant effort has been focussed on enablers e.g. activity trackers and now these are embedded, focus can turn to delivery and holding divisions to account through the BIP governance structure. Given the scale of the challenge, assurance around achievement of the full £25m BIP challenge	

DRAFT

No.	Agenda Item	Action
	cannot be given at this time, particularly given the data quality issues and their potential impact on the income BIP schemes. CK made the Committee aware that NHS Improvement ("NHSI") is concerned about the financial position and its ability to achieve the control total. As such, the Trust is experiencing an increased level of scrutiny and attendance at Trust meetings from the NHSI team (e.g. BIP Programme Board and Steering Group). PV passed on a comment from the Council of Governors in the previous week (w/c 16th July) whereby the feeling in the meeting was that the message around challenging finances was one that was always communicated at this time of year. MH commented that in terms of a year-on-year comparison, Pay expenditure is broadly similar (inflation adjusted) whilst less was spent on agency (which is a BIP success). For this year, Drugs spend is below plan and Clinical Supplies expenditure is on line. The use of non-recurrent measures in 2018-2019 has not been to the same extent as in 2017-2018 (as these measures are not available) so the position for non-clinical spend is worse. LS queried how the NEDs can support in this area, to maintain staff are on board and that a focus on patient safety and quality is maintained. This is in particular reference to Mid Staffordshire NHS Foundation Trust, where a focus on finance was found to be at the detriment to safety and quality. CK commented that the current financial challenges in the NHS are unchartered territory. NEDs and Executive Directors together need to help to deliver the control total and deliver quality and safety. There must be a continuation of a culture of challenging each other (through committees and Boards) to say when something "is not good enough" or if there are plans in place but delivery of the plans is not quick enough. The Trust needs some large plans/achievements to secure the BIP target. The run rate is not improving adequately so something significant must be done in order to hit the control total. MH commented that it is a huge challenge for all organisations to identify where the opportunities will come from. The Trust has been fortunate in the past where adequate funding was available and there were good Commissioner relationships around the cost of healthcare across the system. The good relationships continue but the financial challenge may put a strain on maintaining them. TH commented that the Committee discussion had been useful and MH proposed that a future executive summary be provided to capture the key issues and contextualise the financial position, with the existing reports remaining as appendices.	Director of Finance
	Performance	
F.7.18.8	**Performance Report**	
	The key points of the Performance Report were discussed elsewhere on	

DRAFT

No.	Agenda Item	Action
	the agenda. SSh commented that : • Regarding RTT, the overall Waiting List fell by approximately fifty patients in June compared to May. It currently stands at approximately 34,000 and this needs to be reduced by c30%, which is a reasonable level to be able to achieve 18 weeks. Validation will help reduce this but the focus has to be more activity. • There was one never event in June, which is currently under investigation. • The VTE target was achieved in June. • The number of Ambulance handover delays remained relatively stable compared to May with 88 30-60 minute breaches and 37 60 minute plus breaches. Work is underway to improve this. KD commented that Infection Control rates are positive and noted that the MRSA position is the best performance in a number of years. Congratulations were offered to the teams for achieving this.	
F.7.18.9	**Elective Care Recovery Plan Update**	
	SSh gave an update on the Elective Care Recovery Plan. The plan focusses on three key areas: • Validation (to ensure Waiting List is accurate) • Capacity / demand management (to increase Elective work) • Training for staff to recognise clock starts and stops / completion of Clinic Outcome Forms. The standard is for 92% of patients on an incomplete Waiting List. The latest Trust position is 73.91% due to the backlog. A high volume of patients have passed their date to come in (“TCI’s”) and have been admitted but were admitted as a Non Elective (and consequently will not have been removed from the Elective Waiting List). This will be addressed through Data Quality work. As the Trust clears longer waiters and the overall list reduces it will be expected that performance will deteriorate. Regarding the governance structure which feeds into BIP and in addition to the weekly delivery groups, the review of activity trackers and monthly turnaround boards, there is a new Clinical Harm Review panel that undertakes a detailed review of over 52-week waiters. Demand/capacity modelling will be completed each year. Activity trackers will be refined and embedded as required. The dashboards monitor referral rates, under-18 week bookings versus	

DRAFT

No.	Agenda Item	Action
	over-18 weeks bookings as a safety check that patients are booked in chronological order. CSt commented that for additional assurance, the trackers identify where specialties are not seeing patients chronologically as well as identifying increased activity. They also ensure patients are booked chronologically at sub specialty level. One of the key reasons for specialty backlogs tends to relate to sub-specialty capacity issues. There were two incomplete 52-week wait patients in June (which were Plastic Surgery patients requiring a specialist procedure). It was a particularly complex procedure requiring two consultants, for which the Trust did have a consultant who could perform the procedure on his own but is now no longer available. These have since been treated and plans are in place for these types of patients in future. PV commented that the overview that was helpful as it identified the three key areas. In addition the trackers are an effective tool but they need embedding.	
F.7.18.10	**Cancer Inter-Provider Transfers: Performance Report**	
	SSh gave an overview of the Cancer Inter Provider Transfers ("IPT's") Performance Report. As the Trust is a specialist centre for Urology and Head & Neck tumour sites, it receives IPTs. The Trust also sends out patients to other places for Gynaecology and some other smaller specialties. The data shows that for IPTs into the Trust, performance against the 62 day standard from urgent GP referral for suspected cancer to first definitive treatment is much lower than when the Trust does not receive IPTs. There has been deterioration in performance in the last three months in Urology, which has impacted Cancer performance as a whole. There is a capacity gap in Urology as a result of a consultant vacancy but a new consultant has now started. There is limited availability of Clinical Oncology capacity (radiology services for urology patients). Most Trusts would have a combined Clinical Oncology and Urology joint clinic. Demand for the Trusts services is increasing as men are more aware of Urological issues and there are more treatment options available. There is a demand/capacity mismatch. The Trust has negotiated with Leeds Teaching Hospitals NHS Trust for an increase in the service level agreement for Clinical Oncology, which has been agreed but will not commence until September 2018. The Prostate pathway has changed with patients now having a pre-biopsy MRI scan. As such the Trust is carrying out more MRIs, which is impacting on MRI capacity. PV queried if there was any further support the NEDs could provide. SSh commented that the Trust knows what needs to happen and has	

DRAFT

No.	Agenda Item	Action
	plans but needs to find a way to increase capacity. Daily reviews, as opposed to weekly reviews, will be put in place. The Trust has increased the tracking team to remove delays in managing pathways. If the Trust improves IPT performance so that patients are transferred out or received before 38 days it would improve performance by 7.5%. Eliminating IPTs would result in c80% achievement against the standard. The Trust cannot stop the transfers as it is a specialist centre. CSt commented that the Trust does not receive as many IPTs as it sends so there is a benefit. In October the rules change around how breaches are allocated so if nothing changes our reported performance will worsen. The Trust is assessing the feasibility of getting from IPT to Multidisciplinary Team ("MDT") assessments quicker. PV queried when the Committee can expect to see improvements being reported, and how NEDs can obtain positive assurance that the position is improving. SSh commented that the challenge is to clear the backlog and stop more patients falling into backlog, which will be achieved through analysing pathways and increasing capacity. Reporting the number of patients treated, and the number in backlog compared to number of referrals would provide assurance. CF queried what the target and trajectory are. KD commented that a walkround had been undertaken in Radiology yesterday (24th July 2018). In the CT scan room screenings for the lung cancer MDT were taking place. The staff involved were sighted on 2 week waits, increasing numbers of patients scanned and reporting quickly to feed into MDTs. They were also sighted on also doing the urgent patients to feed into MDTs. PV commented that this was good to hear. TH queried what was driving the performance against the Cancer 2 week from GP urgent referral to first consultant appointment standard. SSh commented that it is Dermatology and Endoscopy impacting on Lower Gastro Intestinal ("GI"). The Trust is starting to see some improvement in endoscopy and although the service is still booking breach patients, the position is improving. Dermatology has a plan in place, with Commissioners agreeing to pathway changes but it has taken time to obtain clinician involvement. As part of the West Yorkshire Association of Acute Trusts ("WYAAT") there is agreement to look at a network approach. Other organisations had been referring work in to the Trust, but this has reduced and the Trust is now moving non urgent patients into Community and focussing on urgent patients only. The Trust has worked with Commissioners to identify more primary care capacity to carry out lower level work. 68% of referrals come	

DRAFT

No.	Agenda Item	Action
	through as 2 week wait urgent referrals with only a 5% conversion rate to actual cancer.	
F.7.18.11	**Bradford Improvement Programme Board Report**	
	The key points of the Bradford Improvement Programme Board Report were discussed elsewhere on the agenda. MH commented that the report is intended to highlight the scope and breadth of the work of the BIP and the stage that the programme is at. • The report contains details of the governance structure and demonstrates the work of the Programme Board and how it can act as an enabler to unlock opportunities. • The Steering Group undertakes 'holding to account meetings' for Divisions who are off plan with their BIP achievement. • A number of enabling schemes with support from GE Healthcare are underway. Dr Bryan Gill, Medical Director is aiming to establish a clinically led Getting It Right First Time ("GIRFT") and Model Hospital group to identify opportunities. • The process and RAG rating for documentation across the programmes is included. The report also includes details on delivery, accountability and addressing the gaps. • Financial tables are also included demonstrating planned and actual achievement. For example DADS have an £11.8m challenge, and associated plans suggest £7.9m delivery. Once these plans have been risk stratified this figure comes down to £6.0m. • MH and SSh will have individual meetings with Divisions to challenge on the level of achievement. • The report contains details of Governance structures and Programme Charters for all of the programmes. These contain a number of workstreams owned by a named, nominated individual. Their goal is to deliver the aims and KPI's within the project charter. The programme will identify the problem statement, programme goals, what is in scope and out of scope, Quality Impact Assessment ("QIA") assessment process outcomes and how delivery will be measured. When assessing measurement any targets still not yet finalised will be included. PV commented it is important to understand if it is a national target or an internal target. MH commented that subsequent highlight reports will focus on delivery and improvements. The content of reports in terms of what comes to the Committee will need to be decided. CF commented that this could to be looked at as a risk based approach i.e. reporting risks to delivery, as this may help consideration of how the risk	

DRAFT

No.	Agenda Item	Action
	can be mitigated. MH commented that there is still an assurance gap around delivery. PV commented that this goes back to the earlier discussion around risk appetite whereby the Trust may have to take a risk to achieve a return.	
F.7.18.12	**Informatics Performance Report**	
	CF updated on the quarterly Informatics Performance report: • Work outside of EPR is increasing, particularly in Business Intelligence ("BI"). • Informatics has added further metrics around adoption of EPR (in detail slides), which looks positive from adoption perspective, notwithstanding the Data Quality issues and income issues. • An uncoded spells position is also now included and the lost income due to Data Quality issues has been highlighted. MH queried that there are still a number of vacancies within BI and what the planned trajectory for recruitment is. CF commented that Informatics needed a change management process in order to restructure. This has now completed and vacancies are now out to advert. Demand for BI work has increased so there are plans to get support from GE Healthcare in the interim.	
F.7.18.13	**Any other business**	
	None	
F.7.18.14	**Matters to share with other Committees**	
	MH queried that regarding the items discussed in Committee, if the Quality Committee are content with the Quality Impact Assessment undertaken by the BIP in relation to the schemes that form the overall improvement programme.	
F.7.18.15	**Matters to escalate to the Board of Directors**	
	KD commented that comment around risk appetite should be communicated to the Board so they are sighted on the discussion that has taken place.	
F.7.18.16	**Matters to escalate to Corporate Risk Register**	
	None.	
F.7.18.17	**Items for Corporate Communication**	
	PV queried how best to communicate the challenging financial position to staff.	

DRAFT

No.	Agenda Item	Action
	MH commented that this has been discussed with CK.	
F.7.18.18	**Date and time of next meeting**	
	Wednesday 29th August 2018, 08:30 am - 10:30 am Conference Room, Field House, BRI	

DRAFT

BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST
ACTIONS FROM FINANCE AND PERFORMANCE COMMITTEE – 25th JULY 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	CLOSED
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 – CLOSED
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 – CLOSED
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 – CLOSED
27/06/2018	F.6.18.6	SSh to confirm the narrative used in SMS text reminders to confirm if day of the week as well as date is included	Chief Operating Officer	25/07/2018	Updated at July Committee meeting – CLOSED
25/07/2018	F.7.18.6	In the Finance & Performance Committee Dashboard the Emergency Care Standard is rated as Green (p.9) but June performance was 84.96%. SSh to confirm why rating is showing as Green	Chief Operating Officer	29/08/2018	To update at next Committee meeting
25/07/2018	F.7.18.6	Update requested from SSH at next Committee Meeting regarding the use of volunteers in the Emergency Department, and also for the three key areas identified to manage patients moving through the department. • Ambulatory Pathways • Assess to Admit model • Improving triage for ambulance	Chief Operating Officer	29/08/2018	To update at next Committee meeting

DRAFT

		referrals			
25/07/2018	F.7.18.6	The time from referral to report as well as referral to scan to be added to the Diagnostic Wait section in the Dashboard	Chief Operating Officer	29/08/2018	
25/07/2018	F.7.18.6	The feasibility of adding trajectories to Finance & Performance Committee Dashboard to be considered and updated at next Committee Meeting	Director of Informatics	29/08/2018	To update at next Committee meeting
25/07/2018	F.7.18.7	Executive Summary to be added to Finance Report	Director of Finance	29/08/2018	

DRAFT