REPORT TO:	**BOARD OF DIRECTORS**
DATE:	**7 OCTOBER 2016**
SUBJECT:	**FINANCE AND PERFORMANCE COMMITTEE CHAIR REPORT**
BOARD SPONSOR:	**FINANCE AND PERFORMANCE COMMITTEE**
PAPER AUTHOR:	**CHAIR OF THE FINANCE AND PERFORMANCE COMMITTEE**
PURPOSE:	**Discussion**

BACKGROUND AND EXECUTIVE SUMMARY:

The purpose of the Committee is to maintain a detailed overview of the Trust's assets and resources in relation to the achievement of financial targets and business objectives and the financial stability of the Trust. This will include:-

- Overseeing the development and maintenance of the Trust's Financial Recovery Plan, delivery of any financial undertakings to Monitor in place, and medium and long term financial strategy.
- Reviewing and monitoring financial plans and their link to operational performance overseeing financial risk evaluation, measurement and management.
- Scrutiny and approval of business cases and oversight of the capital programme
- Maintaining oversight of the finance function, key financial policies and other financial issues that may arise.

The committee reviewed the following matters at its October meeting.

- **ULTC Presentation By the Division**
  - Gastro and Endocrinology are both behind their activity plan but most of the Gastro under performance can be recovered.
  - Ashford CCG has reduced referrals. Thanet is above plan with a big growth in Cardiology.
  - OP FU's are down driven by endoscopy electives.
  - Emergency admissions have grown above the level of growth in A&E attendances..
  - DMO1 is compliant
  - A&E is underperforming the 4 hour target trajectory
  - Investment has occurred in acute clinicians, nurses etc. but performance has not improved significantly
  - A number of further actions could be done and need focus e.g. GP in A&E and earlier discharge from wards. There has been an impact of increased number and case mix of patients impacting delivery of the target.
  - The committee has requested an analysis predicting the impact of change and sensitivity of this to case mix and volume changes. This is available in the metric views seen by ET and the ET assured the meeting about this. The national context was also discussed for A&E.
  - Emergency income is up £4M showing the additional activity and case

mix.
    - All agency spend is being reviewed and peer reviewed to reduce Agency
    - CIP's – Division is expecting to make their target due to increased activity boosting income.
    - Recruitment is proving difficult but a number of approaches are being used.
    - The FPC understands that whilst good work is being undertaken to improve performance it is not, seemingly, resulting in improved outcomes. The Division was asked to provide better evidence of the analysis of root causes and the impact of the various plans on performance, which is inevitably affected by changes in volume and casemix of activity being undertaken. Whilst the effect on income of different activity numbers is recognised it is not possible from the information provided to gauge this in respect of costs incurred and resources used. The Division agreed to address this issue for future.
- **Cancer Waiting Times Presentation**
    - There was a discussion about cancer waits. Part of the issue was the need to deliver diagnostics e.g. endoscopy, histopathology etc. early enough in the pathway. There has been improvement and endoscopy capacity and Histopathology performance is being addressed.
    - The FPC was assured that the back log of patients is being reduced
    - Patients waiting over 100 days are reviewed by clinicians to ensure no harm is experienced and if any concerns are noted then a "root cause" analysis is carried out.
    - The new trajectory planned is 85% for 62 day wait by the end of November (previously September).
- **Financial Aims 16/17**
    - The CEO outlined the revised short term financial goals for 16/17 as notified by the NHS. These will be discussed at the next Board.
    - It was agreed that the main goal is to achieve the board approved plan. This will require significant pain and carries some risk. This will mean achieving the forecast of £24.5M deficit or better by the year end .
- **Performance**
    - Performance was discussed including the provision of I/S activity. Which is being worked on with CCGs. 18 weeks was discussed. JE described the need to deliver diagnostics and recruit sufficient consultants to deliver against the standard. One of the main problems is demand is higher than planned and cannot be serviced so reduction in demand is required to deliver long term.
- **Finance at Month 5**
    - Finance report has been circulated to the full Board.
    - Position I&E deficit £3.5M consistent in M5. Cumulative deficit £9.4M YTD. This included first quarter STF but no STF in M4 or 5.
    - Pay costs are consistent with month 1-4 but have not dropped as required. If current trajectories continue this would lead to the Agency staff cap being breached.
    - Drugs cost increased due to Homecare service.
    - CIPs reported are £5.1M ytd. There is concern in relation to achievement of the planned CIPs. The FPC was assured by management that every effort is being made to plan and deliver this.
    - The full year CIP forecast is still c£5M below plan but schemes have been identified to fill the gap.

- CCGs are issuing a high number of challenges which presents a risk to I&E and cash if CCG stops paying the contracted value.
- Cash is currently over plan but would be impacted if CCG s delayed payments. Cash will be impacted as STF will not be paid in future months. This has been raised with NHSi.
- Capital was discussed and the need for MDG catch up was described.

- **Plan update**
  - The NHSi planning guidance was discussed.
  - Plans are required for both 17/18 and 18/19 rather than the usual 1 year plans
  - Draft plans are to be submitted mid-November and final plans by 23rd December.
  - 2 year contracts also need to be negotiated and signed in the same timeframe.
  - Trust plans must align with K&M STP and must meet control totals set by NHSI
  - Final tariffs will be supplied early in November
  - The Trust will require Divisions to engage with Finance in the planning process and lead the inclusion of developments. The short timescale will limit the potential for proper engagement.
  - The governance problems of lack of review time were also raised. The FPC requires scrutiny by the Trust board and suggested that key assumptions and the financial framework as well as early drafts of the plans be circulated.to NEDs and disicussed at the Board. The planning process needs to define KPIs to measure plan outputs,
- **Turnaround Programme** - There was a discussion lead by NG. Areas discussed were:-
  - Staffing plans to reduce Agency (peer reviews and challenge). Methods of controlling this spend were discussed.
  - Vacancy management (particularly around non clinical staff)
  - Also cost avoidance is being considered to produce a one off impact in 2016/17 There was a discussion that the Quality committee should be used to ensure CIPs around agency reductions were not impacting quality.
- **Electronic Patient Record**
  - The investment proposal for the EPR system which would enable paperless working and electronic prescribing was discussed.
  - It was flagged by the DoF that there are not free funds to cover the investment leading to a lack of affordability
  - There has been a national technology fund announced but no clear method of applying for this fund. If this was available it could help the projects affordability
  - The ability to achieve the cultural change required was queried along with the need for training. There has been work done with Clinicians to review and get agreement form Doctors on the value of the programme.
  - The Medical Director felt this investment was essential to enable clinical safety, financial efficiency and would be supported in general by consultants
  - RE felt from his knowledge of IT system roll out this project was deliverable
  - It was felt the investment would require suitable time at the board for discussion and approval
  - The recommendation was the case was supported but needed to

define a way of making the investment affordable (e.g. via external investment)

- **SLR Investment**
  - There was a recognition that the development was required as part of the governance improvement mandate
  - The additional post was not agreed to start in this financial year for financial reasons
  - SLR is however considered valuable and the development is agreed in the longer term if funding can be found.
  - The development of SLR requires Clinical engagement and may therefore be able to be linked to the EPR system development.

RECOMMENDATIONS AND ACTION REQUIRED:

Discuss and note the report.