Worcestershire NHS
Acute Hospitals NHS Trust

3 February 2016 **Enclosure H1**

Report to Trust Board (in public)

Title	**Finance & Performance Committee – Chairman Report**
Sponsoring Director	**John Burbeck – F & P Committee Chairman / Non-Executive Director**
Author	**Haq Khan – Deputy Director of Finance Information** **Thekla Goodman – F&P Committee Secretary**
Action Required	The Board is requested to: - Receive the concern expressed about the further deterioration of the position. Note that the forecast before mitigations and excluding additional winter capacity costs stands at £65.1m and the proposed actions to improve on this position. - Receive the Committees concerns regarding the precarious cash position and the escalation in reporting to the Department of Health. - Note the likelihood of mediation/arbitration on the local CCG contract positions. - Note the improvement of some key performance metrics and compliance with the RTT standard for the second month running. - Note the TDA self-assessment submission
Previously considered by	*N/A*

Strategic Priorities (√)

Deliver safe, high quality, compassionate patient care	
Design healthcare around the needs of our patients, with our partners	
Invest and realise the full potential of our staff to provide compassionate and personalised care	
Ensure the Trust is financially viable and makes the best use of resources for our patients	✓
Develop and sustain our business	

Related Board Assurance Framework Entries	2666 Inability to secure sufficient income placing the financial position at further risk and affecting long term sustainability 2888 Deficit is worse than planned and threatens the Trust's long term financial sustainability 2667 If expenses are not sufficiently contained and reduced there will be a serious impact on financial position & cash availability 2889 Sufficient access to capital to achieve change and conduct backlog maintenance 2668 If plans to improve the cash position do not work the Trust will be unable to pay creditors impacting on supplies to support services.

Legal Implications or Regulatory requirements	It is expected that the F&P Committee will give assurance to the Trust Board that plans are in place to achieve the Trust's financial forecasts. The Trust has a statutory duty to breakeven over a 3 year period.
Glossary	***Commissioning for Quality and Innovation (CQUINs)*** *– payments ensure that a proportion of providers' income (currently up to 2.5%) is conditional on quality and innovation and is linked to service improvement. The schemes that qualify for CQUIN payments reflect both national and local priorities.* ***Earnings before interest, taxation, depreciation and amortisation (EBITDA)*** *– is a measure of a trust's surplus from normal operations, providing an indication of the organisation's ability to reinvest and meet any interest associated with loans it may have. It is calculated as revenue less operating expenses less depreciation less amortisation.* ***Liquidity*** *– is a measure of how long an organisation could continue if it collected no more cash from debtors. In Monitor's Risk Assessment Framework, it is measured by the number of days' worth of operating costs held in cash or cash-equivalent forms and is a key component of the continuity of services risk rating.* ***Quality, innovation, productivity and prevention (QIPP)*** *– is a programme designed to identify savings that can be reinvested in the health service and improve quality of care. Responsibility for its achievement lies with CCGs; QIPP plans must therefore be built into planning (and performance management) processes.* ***Marginal rate emergency tariff (MRET)*** *– is an adjustment made to the amount a provider of emergency services is reimbursed. It aims to encourage health economies to redesign emergency services and manage patient demand for those services. A provider is paid 70% of the national price for each patient admitted as an emergency over and above a set threshold.* *Introduced in 2003,* ***payment by results (PBR)*** *was the system for reimbursing healthcare providers in England for the costs of providing treatment. Based on the linking of a preset price to a defined measure of output of activity, it has been superseded by the national tariff.*

Key Messages

The Committee met on Friday, 29 January and as agreed at an earlier Trust Board meeting, noted the new membership arrangements and the change in Chairman of the Committee.

Also present as observers were the Trust Development Authority and the Department of Health.

£10m full year savings target

The Committee received a presentation from each Division giving details of their achievement to date against their share of the £10m recurrent savings target to be delivered by 31.3.16 and thereby an immediate £10m reduction on the run rate going into 2016/17.

Although progress has slowed the review of the Divisonal progress by the Committee received assurance that the minimum £10m target will be achieved. The divisions will present updated plans to the next Committee.

Financial Performance

The month 9 position reported a further revision to the forecast outturn by £3.5m to £65.1m owing to the removal of the risk share with the commissioners (£2m) and a reduction in the assumed income particularly activity related, reduction in Road Traffic Accidents (RTA) compensation and a reduction in the level of education funding received (that has also affected other Trusts in the region).
It was noted that the risk share agreement with the Commissioners had not materialised even though 3 high level meetings with the TDA and NHS England had taken place to resolve this and a number of other issues between the Trust and the CCGs. The outturn position has not been agreed commissioners as the final offer from commissioners falls short of the Trust's view, which could result in mediation/arbitration. The CCGs have since indicated their support in aiding the Trust to close down beds and thereby ensuring new costs, associated mainly with winter, do not enter the system.

The Trust must continue to rigorously pursue the identified recovery actions to bring about an urgent improvement in the run rate despite the above additional setbacks.

The main areas for focus are locum and nursing agency micro management and adherence to cap compliance; exploit CDU and Ambulatory Care to manage better at the front door and manage down MFFD to support better flow; compliance with the Trust's SFIs to control non-pay expenditure; improve theatre productivity.

QIPP/Improvement Schemes – The Committee noted the forecast achievement of £10.3m against a target of £15.6m and £1.9m for the turnaround plan and whilst schemes are still being explored the main focus for the Trust is achieving the £10m recurrent savings.

Capital – Close scrutiny and tight management of the capital programme remains. The Committee noted the deferred schemes and associated risks that will be discussed further along with the bids for 2016/17 at the Capital Prioritisation Group meeting in February.

Cash – The Trust's cash position continues to be precarious and is managed on a daily basis.

Operational Performance

The Committee received the report and noted the main headlines therein.

EAS – the Trust's performance slightly declined in December (89.1% compared to 90.6% the previous month) with ambulance attendances 4% higher than in December 2014. It was also noted that there was a 14% increase in all emergency admissions to the Trust and in the third week of January the Trust received the highest attendances/emergency admissions in the history of the Trust but all the hard work and pre-planning that had taken place in advance had put the Trust in good stead, albeit under tremendous pressure especially at the Worcester site with over 100% occupancy.

The Chief Operating Officer briefed the Committee members on the actions in support of delivering the EAS standard drawing out the Safer Bundle initiative arising from the Emergency Care Improvement Programme (ECIP) with a view to significantly reducing Medically Fit for Discharge (MFFD) patients. The Chief Executive has personally visited some of these patients and brought their individual background to the attention of the relevant parties highlighting the reasons for the inappropriateness of remaining on Trust premises not least the susceptibility and vulnerability in attracting harm (i.e. falls, pressure ulcers etc.) for these stranded patients but also how the health system is failing them in receiving the specialist care they need that cannot be provided in an acute setting.

The other work streams commencing by the first week in February include 'Frailty Model' that will support assessment of the frail and elderly at the front door, 'transfers of care' for which social and external healthcare support is essential and daily multi-agency review of 'stranded patients' and DTOCs

RTT – the Trust was able to report compliance with the 18 week referral to treatment incomplete pathways target in November and his has continued into December. Nevertheless, fines are still accruing as they are applied at specialty level by commissioners.

Cancer – the 62 day target for cancer first treatment was achieved in December but the two week wait was not.

Financial Plan 2016/17 (draft)

The operational plan along with financial, workforce and activity returns need to be submitted on 8 February in draft form with a final output on 11 April. A paper was presented setting out the key considerations in developing the initial draft plan.

Other Committee Business

1. **Procurement Strategy –** The Committee noted good progress against the target which is just under the target of £1.5m (shortfall of £145k). The department's strategy is aligned with the Lord Carter report into hospital efficiency.

   The Bravo solutions benchmarking and analytics tool went live in November which will provide meaningful date to support identification of opportunities and an enabler to the Divisions in the development of 2016/17 procurement work-plan.

   Going forwards the procurement team will (a) maximise further opportunities to close the in-year gap and develop the workplan for 2016/17 (b)explore benefits of procurement shared service collaboration outside of Birmingham (c) re-energise the Standardisation and Rationalisation Committee and (c) focus on clinical engagement and communications strategy regarding procurement.

   Finally, the Committee was pleased to note that the team had been shortlisted for the Public Procurement Go awards.

2. The Committee received a quarterly report on progress against the delivery of the **CQUIN** target. Delivery risks to note are Sepsis and Acute Kidney Injury which are being monitored and escalated for action through the Strategic, Planning and Improvement team not only from a financial point of view but mainly from a patient safety aspect.

3. The Committee reviewed the **BAF risks** in terms of risk rating, controls, assurance and mitigating actions for reasonableness. It was agreed that an additional risk be added around sustainability and transformation, further discussion needed as to which Committee will oversee this risk.

4. The Committee received the **TDA monthly return** for December 2015 and agreed non-compliance for declaration 10 i.e. A&E 4 hour wait and cancer 2 week wait (all and breast) with dates of compliance as follows:

   A & E 4 hours – 31.3.16
   Cancer, 2 week wait (all) 31.3.16
   Cancer 2 week wait (breast)t – 30.4.16