NHS
East Suffolk and North Essex
NHS Foundation Trust

PUBLIC MINUTES OF FINANCE & PERFORMANCE ASSURANCE COMMITTEE MEETING HELD ON 23 AUGUST 2018
Executive Meeting Room, Trust Offices, Colchester Hospital

Present:

Julie Parker	Non-Executive Director - Chair
Richard Kearton	Non-Executive Director (RK)

In Attendance:

Michael Horley	Public Governor (MH)
Andrew Lehain	Deputy Director of Finance (AL)
Alison Power	Director of Operations – Group 1 Medicine/Women and Children (AP)
Karen Lough	Acting Director of Operations – Group 2 Surgery (KL)
Nicky Leach	Director of Logistics and Patient Services (NL)
Alison Smith	Director of Operations – Group 3 (AS)
Simon Rudkins	Associate Director of Finance (SR) – Operations
Sean Whatling	Associate Director of Finance (SW) – Analytics
Jason Kirk	Head of Business Planning and Cost Improvement (JK)
Ivan Catling	Head of Integrated Programmes (IC) – item 28/18
Alan Page	Head of Commissioning (APage) – item 29/18
Paul Fenton	Director of Estates & Facilities (PF) – items 31/18 and 32/18
Lorna Fraser	Senior Committee Secretary (Minutes)

19/18	**Welcome and Apologies for Absence** **Apologies for Absence**: Dawn Scrafield - Director of Finance, Elaine Noske - Non-Executive Director, Neill Moloney - Managing Director, Barbara Buckley - Chief Medical Officer, Joanne Thain - Public Governor, Simon Hallion - Director of Operations – Group 2. The Chair highlighted that due to the absence of the Director of Finance, Managing Director, Chief Medical Officer and the Chief Nurse the meeting was not quorate for approval of items but would proceed "noting" items raised.	
20/18	**Declarations of new interests** No new declarations of interest were received.	
21/18	**Minutes of meetings held on 26 July 2018.** The minutes of the meetings held on 26 July 2018 were reviewed and noted.	
22/18	**Action Chart** The review of the Action Chart was deferred to the September meeting, due to time and the Committee not being quorate:	
23/18	**Chairs Key Issues feedback from Board** The Chair advised that the discussion held by the Committee regarding the Winter Plan had been escalated to the Board at the meeting held on 2 August 2018. The Chair and Chief Executive would be escalating this issue as appropriate with the CCG. <u>Update on the Winter Plan</u> Alison Power, Director of Operations Group 1, provided a verbal update on the Winter Plan and highlighted the following – 1. The Finance Analytics and Operational teams had been working together on the bed plan. A significant gap in bed numbers had been identified and there was a lack of confidence around the delivery of the demand management schemes. 2. AP suggested that the Committee carried out a deep dive on winter planning followed by escalation to a Board Seminar. The Chair questioned whether a Board Seminar would be the best approach across the organisation or whether this matter should be dealt with by the wider senior management team. 3. AS stated that she would agree that winter planning needed to be undertaken by EMC, but recognised that the Board would require assurance that this was being appropriately managed. 4. AP stated that she felt that this was an issue which would need to be considered by the Board due to the external oversight which would take place and the level of overview which could be provided by EMC. 5. Following the discussion held the Committee agreed that a deep dive on winter planning would be carried out at the September meeting focusing on the effect on the finance and performance	

	positions, following which the matter would be escalated to the Board for their decision on the appropriate level of oversight of the winter planning. **ACTION:** AP and Chair	AP and chair
24/18	**Terms of Reference** The Committee received and discussed the Terms of Reference with the following issues "noted": • The 4 named executive members were noted; the Chair stating that the decision on membership which had been made by the Board would need to be accepted by the Committee. • Clarity on roles of deputies and voting rights to be requested. • Ideally review of the Terms of Reference should be carried out earlier than July 2019, within 6 months.	Company Secretary

25/18	**Performance** 1. ED – AP advised that the organisation was externally reporting as ESNEFT (95.59%), separate data was available internally for Ipswich (90.5%) and Colchester (98.18%). Extra oversight at senior level had been put in place for Ipswich with a detailed plan to address the issues. 2. NHSE and NHSI had feedback on the plans for Ipswich ED. Feedback had been generally positive; however, the organisation now needed to deliver the plan for the 7 "Must Dos". 3. Michael Horley questioned whether Ipswich ED had seen an increase in activity over the last 2 weeks, as had been seen at Colchester. AP advised that Ipswich ED had not seen the same rise in activity over this period. 4. Cancer – AP advised that the Cancer 62 day trajectory shown in the Performance Report was not accurate, however, confirmed that the information shown in the narrative was correct. 5. AP advised that conversations were taking place with NHSI regarding the action plan and it was anticipated that performance could worsen in July and August as a result of prioritising treatment of the long waiters. Urgent meetings with the divisional teams had been set up for those areas which were felt to require additional oversight. 6. The Chair questioned whether the move to "straight to test" was a change in process and noted that with the level of transformation taking place it was important to be satisfied that the transition time was appropriately resourced so as not to disadvantage those already in the pathway. AP agreed that this was a change in process but highlighted that it was anticipated to be positive for patients. 7. Diagnostics – KL informed the Committee that performance had improved in month, however, there were continuing issues in ultrasound and a demand and capacity review would be undertaken. 8. The Chair noted that the total of diagnostic patients had increased from 8,000 to 10,000 over the past year. AP advised that this was a combined picture across the two organisations and work would be carried out to model the figures to show what was driving the increase and to understand the baseline number of requests and movement. KL agreed that there had been a considerable year on year increase in certain specialities which were heavy users of diagnostics. 9. The Chair noted that whilst the clinical strategy might look to repatriate services the organisation would need to be able to support this with diagnostics and questioned whether there were metrics available showing appropriate testing levels. AP advised that whilst it was considered that there might be some level of over testing the operations teams were carrying out detailed work to ensure patients were seen by the appropriate members of staff at their first visit in order to reduce this; and that she felt there had previously been a lack of understanding of the impact of transformation on other services. 10. Stroke performance – The concerns raised by the CCG were being investigated and it was noted that a deep dive into stroke performance was scheduled to be carried out by the Committee in October. 11. RTT – KL advised that the Trajectory slide in the Performance report contained incorrect information. The Committee was informed that there were currently 4 patients waiting over 52 weeks, but the number was continuing to decline. The main focus had been on the treatment of cancer patients but there was confidence that ESNEFT would achieve the trajectory for August. Meetings had been set up with the urology team and would be scheduled with the respiratory team to support delivery of the trajectory. 12. KL advised that the team had been engaging with the NEE CCG and a combined ESNEFT patient access policy had been approved by EMC and both Clinical Commissioning Groups. 13. Outpatients – NL advised that the team were continuing to look at the policies across Ipswich and Colchester in order to standardise these across both sites. 14. Work was underway to bring the Netcall system from Ipswich to Colchester as this had led to a reduction in the DNA rate at Ipswich. 15. An internal audit carried out at Ipswich of hospital cancelled clinics had identified process issues which were being addressed with the clinical teams. 16. The Elective Care Programmes were investigating the opportunities to identify best practice and introduce automation of the pathways where appropriate. It was noted that clarity regarding the potential for reduction in staff numbers/change of roles would be required following the introduction of automation of processes. AS noted the importance of future proofing the processes and realigning staff to deal with increased activity and demand. 17. NL confirmed in response to a question raised by Michael Horley that the number of slots cancelled by the hospital with less than 6 weeks' notice (4395 in July) related to the number of individual patients rather than clinic sessions. 18. RK questioned the position regarding the aim to reduce the number of follow-up appointments which had been discussed previously at Ipswich. KL agreed that this work had not been as successful as anticipated due to a number of barriers but as part of the Red to Green process	

	planned for September the team would work with clinical colleagues to focus on this. It was agreed that the ongoing work to reduce the number of follow-up appointments would be added to the Performance report within the Outpatient section to enable the Finance Committee to keep this under review. **ACTION**: NL 19. Community services – The Chair noted the need for the Committee to be informed of the key community metrics in future. **ACTION:** AS	NL AS
26/18	**Finance Report – M4** Andy Lehain presented the Finance Report for M4 and highlighted the following – 1. M4 was effectively M1 for the new organisation and as anticipated the set-up of finance systems for ESNEFT was still ongoing and not all necessary data had been available for the production of the report. An estimation of some agency and non-pay costs had been required and there was a risk that actual costs might, therefore, be over or under estimated. It was expected that for Month 5 normal processes would be in place. 2. In July the Trust incurred a deficit of £2.1m; this was on plan, with a very small variance of £5k; AL explained the reasons behind this £5k variance. 3. AL advised the Committee that due to delays in the Trust receiving historic data and delays in scanning implementation, a backlog of unpaid invoices had arisen. The actions that had been put in place to address the matter were shared with the Committee, the position being constantly monitored, but it was anticipated that it would take a further month to return to normal processing times. 4. AL advised that the Risks and Opportunities log was provided to identify any material risks, quantify the level of risk and the likely impact but that this was a subjective process. The risks would continue to be assessed and monitored throughout the year. 5. AL highlighted an error on the CIP table with the wrong variance figure shown which should read "£988k underachievement". Questions and Comments 6. AP questioned whether there was a formal agreement with the commissioners regarding the variance value to the guaranteed income contract which would initiate a conversation regarding the requirement for additional support to be provided. **ACTION:** AL to check the value which would trigger escalation conversations and report back to the Committee. 7. AP noted that in the original plan regarding the escalation ward the CCG had agreed that they would spot purchase beds. AP stated that as the demand management mitigations had not been achieved she had held conversations with Dawn Scrafield regarding the need for the Trust to formally write to the CCG regarding this matter. JP suggested that this issue was discussed further out of this meeting. **ACTION:** AL and AP to consider formal approach to CCG regarding payment for spot purchase of beds with Dawn Scrafield. 8. In response to a question raised it was noted by SR that STF funding; now known as Provider Sustainability Funding (PSF); would be based on ESNEFT for Q2 onwards and would be reliant on A&E delivery and the financial position. 9. The Chair noted the need to achieve stable processing of invoices in a timely manner to ensure there was confidence in the figures reported. 10. The Chair requested that the capital programme was given more focus in future reports. **ACTION:** AL.	AL AL / AP AL
27/18	**CIP progress Report – Jason Kirk** Jason Kirk, Head of Business Planning and Cost Improvement presented the CIP progress report and highlighted the following: 1. The Trust was currently forecasting to deliver £26m CIPs against the Q2-4 ESNEFT target of £32.5m and had agreed a trajectory for CIP development with NHSI. This included forecast CIPs plus those that had been Quality Impact Assessed (signed off by Medical and Nursing Directors) showing as gateway 2. 2. The Trust had met the second milestone of £27.4m to be identified by 10th August; the requirement would increase by £2.3m by 14th September. The previous milestones had been met by non-divisional CIP and corporate savings following the merger and, therefore, this	

	milestone presented the greatest leap in performance as it was wholly dependent upon clinical divisions to deliver, who were currently showing a £8m shortfall against target. 3. Areas of focus were: • Confirming residual savings from medicines, corporate TOM and rotational posts. • Consolidation of procurement contracts into single ESNEFT contracts based on best current pricing. • Implement new PID and electronic sign-off process to give greater visibility of progress and streamline authorisation of new schemes. • Review of bed management opportunities alongside work to deliver 92% occupancy and associated funding opportunities. • Focus on Integrated Pathways and Surgery and Anaesthetics. 4. The Full Business Case for the merger had identified a number of benefits; the analysis tracked delivery of those benefits against the FBC assessment and gave a first cut following the assessment of the restructure. A second pass was underway which might identify further savings. 5. Agency savings were coming from improved fill rates from rotational posts. Some August savings were still being assessed. 6. As part of the approval for the merger NHSI had stated they would undertake a financial deep dive on September's results. <u>Questions and Comments</u> 7. AP highlighted to the Committee that the 92% bed occupancy would require funding. AS advised that the Transformation Panel who would review the bids was not due to meet until the 30 August. 8. The Chair questioned the processes in place to ensure that divisions would deliver their target figure and the consequence of non-delivery. JK advised that the CIP position was reported weekly. KL noted that specific meetings were held with the areas of concern and the Accountability processes were in place to monitor and manage CIP delivery with CIP also being looked at as part of the wider conversations held with the divisions. 9. JK confirmed that all CIP savings come from the divisions and those from the merger were included in the divisional plans. 10. RK questioned whether external consultants were being used to consider CIP opportunities. JK advised that there had been external input at Colchester but that the focus was now internal. NL stated that external support was not required at present for the detailed review of CIPs but the Trust was putting together a specification for support for the future large transformation projects. 11. The Chair stated that external metrics such as the model hospital should be utilised and it was important to consider the "spans of control and layers". NL confirmed that consistent models were used for ESNEFT which considered spans of control and layers. AS noted that some areas such as Integrated Care supported other areas which affected CIP across the organisation and discussions were being held regarding alignment of the CIP. 12. The Chair noted that an aim of the merger had been that staff would not be put in place to "cover for failure" and questioned how this was being monitored and captured within CIP. JK replied that the team were looking at opportunities within the CIP but that this was not shown on the programme as it was not an in year piece of work. 13. RK questioned which organisation demonstrated best practice system wide and how this could be incorporated into ESNEFT. AS responded that the networks which had been built up were robust and would pick up on good practice from other organisations, although not formally, and national reviews, such as the Carter Review, provided a standard view and detail of themes across the NHS.	
28/18	**Transformation Report (from Portfolio Board)** Ivan Catling, Head of Integrated Programmes, presented the Transformation Report and highlighted the following: 1. The Portfolio Board was to be renamed the Time Matters Board going forward. 2. The report summarised the outcomes from the Portfolio Board meeting held on 18 July 2018. The following programmes had had their charters approved: PB3: Informatics, PB6: Quality Improvement and PB7: Emergency Care. The Elective Care programme received feedback on	

	their charter and this was being updated for presentation at Portfolio Board on 15 August for review and approval. 3. Project Initiation Documents (PIDs) were being drafted and reviewed by the applicable programme boards and as these were approved, the PIDs would be submitted to Portfolio Board for review and ratification. 4. The July meeting had been the first meeting when programmes had submitted formal highlight reports. 5. There were currently no risks to flag. 6. A performance report with milestones and KPIs would be provided in future but this was being developed iteratively to avoid duplicating information which was already provided in other forums. <u>Questions and Comments</u> 7. The Chair noted that she felt it was key to receive information on the milestones and KPIs.	
29/18	**Commissioning and Contracting update** Alan Page, Head of Commissioning, presented the Commissioning and Contracting update and highlighted the following: 1. The paper outlined the material requirements and the steps the Trust would undertake in accordance with the anticipated commissioning cycle which was based on best known current information and was subject to potential change to reflect updated national guidance, templates and planning but was currently on track. 2. National guidance on the term of proposed new contracts was currently awaited, but it was anticipated that a two year term would be indicated. 3. The process had linked closely with the clinical strategy work being undertaken in order to capture the information required and had involved continuing engagement with clinicians. 4. A Memorandum of Understanding and a Charter have been agreed with the CDGs, with the Charter looking forward to negotiating a single contract for ESNEFT with a single commissioner, it being likely that NEE CCG would be the host for the new contract. 5. The clinical commissioning cycle required the Trust to deliver its Commissioning Intentions to the Commissioners by 30th September 2018. It was, therefore, planned to share the draft contract with the EMC at the end of August. <u>Questions and Comments</u> 6. The Chair highlighted the need to flag the Pathology services because of the way the CCG commissioned the service to the GPs in North Essex. Alan Page advised that work was in progress with the new senior pathology team but that he would note the comments made by the Chair.	
30/18	**Clinical Coding Quarterly Update** Sean Whatling, Assistant Director of Finance Analytics, presented the Clinical Coding Quarterly Update and highlighted the following: 1. As a consequence of the risk Q10 on the Board Assurance Framework, highlighting ongoing concerns with the sustainability of the Clinical Coding function, this report provided the quarterly update to the Committee on the Clinical Coding function across ESNEFT. 2. It was recognised that consistency needed to be achieved across the function and the Head of Clinical Coding would be working to implement systems and processes across the department to drive up the depth of clinical coding and identify options to reduce the backlog. <u>Questions and Comments</u> 3. RK questioned the term “depth” used in the report. Sean Whatling advised that this term related to the number of codes applied for a patient’s admission and that the reasons behind the differences between the two sites were being investigated, the merger having created the opportunity to share skills and good practice across the two sites. The national annual audit would look at data recording and accuracy levels and inform whether these altered the payment received by the organisation. 4. The Chair noted that the Committee had been previously informed of a lack of skilled coding staff and questioned whether this should be highlighted to the Board due to the impact on timeliness of coding. 5. AS questioned the risks from incorrect coding now that the organisation was on a fixed income. Sean Whatling advised that some elements of care commissioned by the specialist	

	commissioners were not fixed income but that incorrect coding most significantly impacted on mortality reviews. 6. The Chair informed the Committee that the impact of incorrect coding on quality metrics had been raised and discussed at the Quality & Patient Safety Committee.	
31/18	**Essex County Hospital (ECH) Project and STP Capital Schemes Update** <u>Essex County Hospital (ECH) Project Update</u> 1. Paul Fenton, Director of Estates & Facilities provided an update report relating to the transfer of ECH services and the disposal of the site following decommissioning, noting that the final service transfers would be occurring later than planned due to building delays. 2. The Committee was informed that discussions had been held with the wheelchair services regarding relocation. Two public communication events would be held regarding this. Other solutions for service delivery would also be looked at. <u>Questions and Comments</u> 3. The Chair questioned the communication of the relocation of the wheelchair services and whether it would be useful for the governors, particularly the stakeholder governors, to be updated on this matter with an appropriate version of the paper being shared at the next governors meeting. Paul Fenton advised that the Communications team had been fully involved with communication regarding the project but agreed that the governors would be kept informed of the plans. **ACTION**: PF. <u>STP Capital Schemes Update</u> 4. The Committee was provided with a report to update on ESNEFT's proposed approach to developing the suite of business cases associated with the Trust's successful bid for sustainability and transformation partnership (STP) capital funding and on progress to date of the specific schemes, following a number of discussions with both NHSI and NHSE over the constitution and route of the STP business cases. 5. The STP bid covered investment in the following schemes: • Emergency and Urgent Care Pathway; • Diagnostics (MRI and CT); • Estate rationalisation; • Day case electives; • Inpatient elective. 6. A total of £69.3m had been approved in April 2018. The Trust had started to develop each scheme and its associated post-merger, clinical strategy and the pre-consultation business case (PCBC) which would be required by NHSE ahead of a proposed public consultation into the future of inpatient elective services. In due course the Trust would produce: • Business cases for the £69.3m investment. • A PCBC for changes to elective and potentially day-case services which would reflect the newly merged Trust's clinical strategy. 7. Although the £69.3m formed a single sum for approvals purposes, the Trust had separated the five projects listed above into two business case streams. The two streams were necessary to reflect the inter-dependency with the new clinical strategy and public consultation that would be required for significant clinical service reconfiguration, and the more "stand-alone" nature of the changes to the two EDs, diagnostics and estates rationalisation that would not require formal public consultation. 8. The Trust would also request within a paper to DHSC, NHSI, NHSE that they considered a variant option that would extract the diagnostic imaging business case from stream one. This business case had a value of less than £5m, had been worked-up in detail and was affordable. The scheme would both improve patient experience and quality and reduce revenue costs to ESNEFT. Separating this business case out from the rest of stream one had the advantage of allowing a relatively straightforward scheme to proceed more quickly than the other schemes. 9. Paul Fenton advised that the work was on track for development of the Strategic Outline Case at the end of September. <u>Questions and Comments</u>	PF

	10. The Chair stated that the organisation should be mindful that delays could be taken as an opportunity to ensure that schemes were correctly assessed and developed prior to the funding being spent. 11. The Chair highlighted to the Committee that the inference in the report was that the papers which had been provided to the Trust Board in June 2018 had been "business case papers"; however, this had not been the case. Paul Fenton confirmed that no business cases had been produced yet and that only papers for information had been presented to the Board.	
32/18	**Retail Development** 1. The Committee considered a paper that covered this development. The Board was to consider matter the following week.	
33/18	**New Finance Ledger Review** - Item deferred for discussion at next meeting.	
34/18	**Any other business** No other items of business were raised.	
35/18	**Items for escalation to the Board** The Chair advised that as the Committee was not quorate the items to be highlighted to the Board by the Chair in the Chairs Key Issues report which would be drafted with Andy Lehain, Deputy Director of Finance after the meeting	
36/18	**Committee Effectiveness questionnaire** The Committee Effectiveness questionnaire was circulated to members for completion.	
37/18	**Work Plan** The Committee Work Plan was provided to inform the Committee members of future agenda items.	
38/18	**Date of Next Meeting** – Thursday 27 September 2018	