East Suffolk and North Essex NHS Foundation Trust

MINUTES OF FINANCE & PERFORMANCE ASSURANCE COMMITTEE MEETING HELD ON 20 DECEMBER 2018
Castle Room, Trust Offices, Colchester Hospital

Present:

Julie Parker	Non-Executive Director – Chair (JP)
Eddie Bloomfield	Non-Executive Director (EB)
Laurence Collins	Non-Executive Director (LC)
Dawn Scrafield	Director of Finance (DS)
Barbara Buckley	Chief Medical Officer (BB)
Catherine Morgan	Chief Nurse (CM)

In Attendance:

David White	Chair (DW)
Michael Horley	Public Governor (MH)
Jennifer Rivett	Public Governor (JR)
Alison Power	Director of Operations Group 1 Medicine (AP)
Nicky Leach	Director of Logistics and Patient Services (NL)
Andrew Lehain	Deputy Director of Finance (AL) – *items 103/18 – 109/18*
Jason Kirk	Head of Business Planning and Cost Improvement (JK)
Simon Rudkins	Associate Director of Finance – Operational (SR)
Sean Whatling	Associate Director of Finance – Analytics (SW) – *items 112/18 and 113/18*
Lorna Fraser	Senior Committee Secretary (Minutes)

		Actions
103/18	**Welcome and Apologies for Absence** Apologies for Absence were received from: Neill Moloney, Karen Lough, John Tobin	
104/18	**Declarations of new interests** No new declarations of interests were received.	
105/18	**Minutes of meetings held on 22 November 2018** The minutes of the meetings held on 22 November 2018 were reviewed and agreed.	
106/18	**Action Chart** The Action Chart was reviewed. 22 November 2018 92/18 Commissioning, Contracting & Procurement Update (quarterly update). More detail of horizon scanning of tenders to be added to report for the information of the Committee. Update 20/12/18 from JR – This is being reviewed and is to be added from the information posted on the area procurement portals / best knowledge. Revised narrative to be included in the next quarters report (Q4) and to be included quarterly prospectively. On agenda for February 2019. 94/18 Performance - Stroke – RAG ratings to be used for the data with actual numbers rather than just percentages. 20/12/18 – AP advised that this action had been completed. **ACTION CLOSED** 94/18 Performance – Community Services - KL to follow-up provision of the community performance data for inclusion in the Performance Report for future meetings. 20/12/18 – Community Report provided. **ACTION CLOSED** 25 October 2018 70/18 Performance Report – RTT - The process for harm reviews to be considered by the Directors of Operations to align with the process followed for cancer treatment delays with verbal feedback provided to the next meeting. Update from Karen Lough - 70/18 – RTT - Cancer Harm SOP reviewed and Elective SOP drafted and circulated to the Elective Care Board for comments and ratification – due for sign off by end of November. 20/12/18 – AP advised that the SOP had been signed off by the Elective Care Board. CM noted that there was confidence that this had been put in place and the action could be closed. **ACTION CLOSED** 72/18 - Theatre Productivity – Action referred from the Audit & Risk Committee CKI (23 July 2018) "that the F&P committee reviews this report and the future report for the Colchester site to provide board assurance that the underlying issues are fully understood and addressed". To be followed up by the Finance Committee in February 2019. 73/18 Internal Audit Assurance Review of Quality – Cancer Waiting times - Further Internal Audit to be progressed and added to the Internal Audit Schedule for a review of Quality relating to Cancer waiting times for ESNEFT. 20/12/18 – AP advised that the audit of Quality relating to cancer waiting times for ESNEFT had been added to the audit schedule for next year. **ACTION CLOSED** 27 September 2018 55/18 Strategy – Medium Term Performance Planning - Executive's to consider the content of this report going forward for future reports. Report due back to Committee in February 2019. 23 August 2018 26/18 Finance Report – 22/11/18 – Capital report provided and page included within Finance Report. Action to remain on log as reminder to the Committee to review the capital programme. Ongoing action. 26 July 2018 10/18 Assurance Framework – Merger - DS to liaise with Denver Greenhalgh re the capture of the risk regarding tracking of the business case benefits and in particular consideration as to how to capture the risk of non-delivery. 22/11/18 – Some conversations held. Discussion of appropriate group to have oversight of this matter to be continued by the Executives. Action changed to "red". **20/12/18** – DS advised that this remained an ongoing issue and that a decision had not yet been reached regarding the appropriate group to provide oversight. The executives were requested to hold conversation regarding the appropriate oversight group and come back to the Committee with a plan to address the action. COLCHESTER HOSPITAL 18th April 2018 18/20 HR & Organisational Development - Workforce reporting to set out the predicted workforce gaps on a post by post basis. Update 27 September 2018 - Ongoing. The Committee agreed that the action should be moved to Red. 22/11/18 – Action remains ongoing. **20/12/18** – DS reported that this action remained ongoing. The challenge being that ESR had multiple posts under one heading and the team were trying to use technology to speed up the process. IPSWICH HOSPITAL 20 March 2018 50/18 Policy on Implementing the Overseas Visitors Hospital Charging Regulations. Update 5/11/18 – Associate Director of Finance – Commercial - The timeline to have all in place is March 2019. Update on track for March 2019.	
107/18	**Chairs Key Issues feedback from Board** 1. The Committee was informed that the CKI from the Finance & Performance Assurance Committee had been received by the Board at the meeting on 29 November 2018. The following response had been received from the Board: *The Chief Executive informed the Board that a letter had been received from the Clinical Commissioning Groups highlighting their concerns about the Trust's cancer position. He would ensure that the letter was shared with everyone after the meeting.* *The Managing Director stated that he was focusing on the key areas with the highest priority and that winter would always present challenges especially when there were the issues of Allied Healthcare closing, who the Trust was reliant on.* *The Managing Director expressed regret that there had not been as much progress made with cancer as he would have expected as this had significant impact on the patients and their outcomes. He was pleased to report*	

	that with the strengthened management within the urology team, and although he recognised there were significant issues within urology due to the increase in activity and referrals, he was confident that improvements would be made. Questions and comments 2. JP noted that the letter received from the CCGs highlighting their concerns about the Trust's cancer position, which the Chief Executive had stated would be shared had not been circulated to the Board members and requested that this was followed up with the Chief Executive.	
108/18	**Finance Report – M8** AL and DS presented the Finance Report for M8 and highlighted the following – 1. In November the Trust had incurred a deficit of £5.2m. This was adverse to plan by £3.6m and was mainly caused by overspends on expenditure and the loss of Provider Sustainability Funding (PSF). 2. Notwithstanding the loss of PSF, total income was actually over recovered by approximately £1m. This was because of spend associated with pass through drugs being higher than planned and the over recovery of other operating income by £0.5m. 3. Pay was adverse in the month by £1.6m. Approximately £0.5m of this variance to plan was caused by the higher than planned pay rise, the income to fund this had been received and was reflected against NHS clinical income. 4. Non-pay was £1.6m overspent and this was driven by a range of factors including CIP under delivery (£0.8m) and the increased spend on high cost drugs. 5. A financial forecast exercise had been undertaken at the end of Q2 and had indicated an outturn adverse variance of £14.2m (before PSF). When the PSF loss was included this adverse variance increased to £31.3m (PSF for the ESNEFT period was £16.9m). This was a base position, with no contingency for any unexpected costs or any additional winter pressure costs over and above that assumed in the divisional forecasts. It also required the current CIP forecast to be delivered. 6. Draft recovery plans from divisions had identified a total value of £5.5m (£3.1m of the recovery plan was considered high risk in terms of delivery), which would not be sufficient to achieve full financial recovery for 18/19, a further £8.44m needing to be identified per the draft financial recovery plan considered at the Board in November. The temporary 'Specialist Financial Recovery Team' continued to highlight and drive immediate opportunities for recovery. The importance of tight financial control was also being reiterated to divisional leadership teams. The actual M8 position represented a worse position than that anticipated in this forecast. Using the M8 outturn, the finance team were updating the projected outturn to finalise the recovery plan. 7. AL highlighted the two main ongoing risks as being the Agenda For Change pay award and the Oaks (RES) activity; which was being mitigated by discussions with the CCG regarding additional funding. 8. NHSI had set the Trust an agency expenditure ceiling of £16.7m for months 4 to 12. For Month 8 agency costs were above ceiling (£2.3m v £1.8m). Most significantly the Surgery & Anaesthetics division was over their devolved ceiling. 9. The finance team continued to be focussed on paying all appropriately due invoices, which was reflected in the continued reduction in cash balance which had fallen to below £9m at the end of November. AL highlighted that the Trust's current level of revenue deficit, including the loss of PSF, would erode cash and would mean that additional borrowing would be required. Questions and comments 10. EB questioned whether there was a cost of borrowing. AL advised that the Trust incurred a 1.5% charge on borrowing. JP noted that the Trust would also then have an outstanding debt which would need to be noted in the year end accounts. 11. The over spend in the Surgery & Anaesthetics division above their devolved agency staff ceiling was discussed. DW questioned whether there were issues with the medical job plans. BB stated that the issues in Surgery & Anaesthetics were not related to job plans. DS advised that the tender process for a partner to work with the Trust to address the additional theatre sessions was just concluding. 12. JP noted that there was an 8.5% increase in spend and challenged whether a corresponding 8.5% increase had been seen in activity. DS advised that a corresponding increase in activity had not been seen. AP advised that a piece of work was required to ensure that the additional resource was appropriate and highlighted that there were challenges within the divisions. 13. DW expressed his concern regarding the position and stated that he felt it was important to work with the divisional teams to ensure there was buy in to work within their budgets. 14. DS advised that an escalated process had been put in place whereby any additional sessions had to be agreed by the Managing Director or Directors of Operations. A transformational piece of work was also being carried out to look at ESNEFT theatres which would require practices to change to ensure	

	that the resource was being used appropriately. 15. JP questioned how the cultural changes would be introduced. DS stated that the approach to the communications had not yet been agreed but that the executives had agreed that further measures would be required from January and that these would need to be appropriately communicated. NL advised that this was one of the topics for discussion at the core briefing session later in the week which would be led by the Chief Executive. 16. JP stated that she was disappointed that following the discussion held by the Board regarding the implementation of the "7 must dos" this had not been progressed. 17. LC stated that he felt that the discussion at the last Board meeting had illustrated the problem, there having been a range of views around the table with lack of consensus, and stated that the Trust would need to be clear on what the priority objective, which would be communicated to every budget holder, was. LC noted that the importance of providing clarity for the divisions regarding the priorities had been highlighted at a previous Finance & Performance Committee meeting. 18. DW agreed that the Board had signed off the revised communications plan and discussions by the executive regarding the appropriateness of the plan needed to be undertaken without delay. DW stated that it was his view that the executive leadership needed to have expectations that budget holders would take control and responsibility for their budgets and suggested simplifying the message to them focusing on the impact of the loss of the provider incentive. 19. JP noted that whilst the organisation was talking about the problems for this year it should be noted that next year would also be very challenging and that she felt that if the clinical leaders were unable to demonstrate that they could run the current business effectively there could be a lack of confidence by the Board members as to their ability to take on provision of additional services which might be considered within the Clinical Strategy. The Clinical Strategy would need to have the financial assessment alongside it and if this was recognised this might be an incentive to the leadership to deliver. 20. JR questioned whether there were examples of good practice at other organisations. BB advised that the practices at other organisations had been reviewed but the difficulty was to change entrenched working practices. 21. EB noted that whilst he felt that some of the actions were the right things to do there was limited time to implement these. 22. LC noted that winter period reserve had been brought forward to cover the staffing costs being currently incurred (page 3) and questioned the policy for this. DS advised that this was specifically in relation to Colchester and that additional resources had now been obtained from the CCG to cover the whole year, however, the reserves had had to be brought forward earlier in the year due to timing of receipt of the additional funds. AP noted that tracking of the position regarding additional areas being open had improved alongside obtaining resource from the CCG. 23. MH noted that it was reported that Estates and Facilities were £2,638k overspent for non-pay. DS responded that there were two issues driving this; the budget at Ipswich relating to biofuel which had not given the expected return and the other area was the overspend on the OCS contract. Both areas would be budgeted for next year but would increase the requirement for CIP. 24. DS advised that the Trust would be looking to formalise the capital spend. JP challenged whether schemes which had not been contractually agreed should be stopped in view of the current financial position. DS stated that there were schemes which could be delayed without adversely impacting on care, however, it had been agreed that backlog maintenance should be delivered and it was recognised that there was not currently a comprehensive equipment replacement programme across ESNEFT and any plans would need to ensure this was in place.	
109/18	**Financial Recovery Plan** 1. The Committee received an update on the Financial Recovery Plan from the Director of Finance. 2. At the end of October (Month 8) the Trust had incurred a deficit of £5.2m; this was adverse to plan by £3.6m. The year to date deficit at the end of Month 8 stood at £25.0m; an adverse variance to plan of £14.9m; £8m of this variance related to a shortfall in Provider Sustainability Fund (PSF) which had been lost because the Trust had failed to deliver its financial control total for quarter 2, October and November. 3. An updated forecast had been undertaken based on the November financial position, which concluded that under a do nothing scenario the Trust would be £13.2m variant to plan (at £14.2m at month 6), which would result in the loss of £16.9m of PSF. In the absence of any recovery actions this would result in a deficit by the year end of £51.4m compared to the £21.3m deficit including PSF achievement. 4. The key drivers of the deficit included overspending in pay, CIP under delivery and some income under achievement. 5. Divisions had been asked to submit proposed recovery plans to address the financial deficit, these plans had been updated to reflect further information from Month 8.	

	6. Any schemes within the Divisional recovery plans which were CIP in nature would be overseen through the CIP governance. Any schemes which were to address the run rate would be overseen by the Special Financial Recovery Team (SFRT). Divisional leadership teams were expected to drive forward recovery actions which had been approved through the QIA + process. The SFRT were supporting the identification of further recovery actions and would support divisional leadership teams to hold teams to account to deliver. 7. DS advised that following conversations with the CCGs the position regarding additional support had been firmed up with a £6.2m upside in the position. 8. The Committee was informed that the value from the divisional plans had changed from the draft presented to the Board in November; this now being c£3.1m and there was higher confidence in the quantum, to achieve the best case position for delivery of the control total there was now a £3.8m gap unidentified. 9. It was noted that the Board had delegated the review of the Financial Recovery Plan to the Finance & Performance Committee to conclude the forecast but had been keen to maintain the forecast as per the control total, however, with the recent information from Month 8 the Committee was informed that the ability of realising the ambition of delivering the financial recovery by the end of March was a higher risk and less likely than when presented to the Board in November. <u>Questions and Comments</u> 10. DW stated that the Non-Executives needed to guard against trying to "manage" the organisation but that he felt strongly that the messaging to the teams in terms of the spend for quarter 4 needed to be about collective ownership of the challenge. 11. DS advised that NHSI were nationally revisiting the control totals for future years but would require evidence that robust processes and controls were in place to manage the financial position of the Trust and achieve financial recovery. The Committee were informed that NHSI were visiting later in the day and DS advised that she proposed to provide them with the financial information and inform them of ESNEFTs continued ambition to deliver the control total, whilst noting the higher risk of non-delivery, but leave NHSI to decide how they would present the Trust's position nationally. 12. JP emphasised the importance of the Trust evidencing to NHSI that the actions, which they would carry out if they came into the Trust, were already being carried out internally. 13. JP stated that ESNEFT should aim to be one of the trusts nationally who had delivered their targets to help to motivate and enthuse staff. 14. BB commented that this position was the first big challenge for the new organisation. 15. EB questioned the measures being taken to close the £3.8m unidentified gap. AL advised that conversations had been held with the divisions and opportunities had been identified, but there was some concern that these would not be progressed when the SFRT ceased providing support. AL noted that the SFRT had found an apparent lack of awareness within the wider organisation about the current financial position. 16. CM noted that there was a balance required between devolved responsibility and central control and that she would agree with AL's concern regarding achieving traction on the mitigating actions, the approach used would need to be targeted to the different areas of the organisation. 17. NL and AP noted the need for clarity of focus for the last quarter and the need to provide support to the divisions regarding prioritisation. 18. JP noted that the Board and executive would need to support staff if decisions were taken to cease any particular services and to recognise the impact this might have on achievement of targets. 19. DS circulated a pictorial representation of the current position (£7m gap with £3.8m currently unidentified) compared to the plan for the information of the Committee. 20. EB stated that he felt that the recovery of the £3.8m gap was achievable within this quarter. 21. JP stated that whilst the Board had delegated the review of the Financial Recovery Plan to the Finance & Performance Committee requesting a view was taken on the control total, as there had been a change in the position from that previously reported she would recommend that the whole Board should be aware of this. 22. DW stated that it had been agreed by the Board that if the Finance & Performance Committee recommended that the control total would have to change a letter would be written round to the Board members to make them aware of that. DW stated that he would not support a revision of the control total at the moment and would recommend emphasising to NHSI that there was continuing Board scrutiny of the financial position with determination to pull the position back. **Action:** DS to circulate the revised FRP and the F&P CKI with detail of the discussion held by the F&P Committee to the Board members for information.	DS
110/18	**Cost Improvement Programme (CIP) progress Report** 1. The Committee received the CIP progress report and were informed that the Trust's CIP forecast had	

	remained steady at £26.6m against the Q2-4 ESNEFT target of £32.7m. The focus had now moved to the impact on the 19/20 schemes. 2. The team had pulled together a range of resources which were stored in a central resource area for use by the divisions. <u>Questions and Comments</u> 3. JP questioned how the team were ensuring that most of the energy was put into areas where there were the greatest opportunities. JK advised that all opportunities were being explored and shared with the divisions. 4. LC questioned whether the non recurrent £9m CIP would be rolled over to the next financial year. JK confirmed that the CIP target was anticipated to be at least £45m next year. 5. LC questioned the gain share proposal mentioned and commented that this could be used as an incentive to the departments within the organisation. JK advised it was planned that cost savings would be shared across divisions where possible to recognise divisions, such as the community, for their work which had had a beneficial impact for other areas of the organisation.	
111/18	**Performance** 1. <u>ED</u> – Performance against the 4 hr standard for November 2018 was 93.61% for Colchester and 86.51% for Ipswich. Colchester was above and Ipswich was below the November trajectory of 92% and both were below the National Standard of 95%. ED Economy performance for November 2018 was 96.61% for Colchester which was above the trajectory and National Standard both of which were 95%. Ipswich ED Economy Performance was 87.85% which was below both. The ESNEFT performance was 93.64% which was below the National Standard. 2. The Committee was informed that a 10 % rise in activity had been seen at Colchester. 3. AP advised that the Ipswich position had been encouraging, however, there had been challenging capacity issues at the beginning of November and there were now some external pressures from NHSI and NHSE. A detailed recovery plan for Ipswich performance had commenced focusing on 7 must do's which was Director led and models of care were being reviewed. A clear message had been given to the Department that this was the correct plan and way forward. 4. As part of the detailed winter plan the site operations team were working closely with ED to ensure flow on both hospital sites with contingency areas in use as required. There was good CCG engagement with extra capacity being provided in the community. However, AP informed the Committee that some of the external elements of the winter plan were not coming to fruition. The capacity issues at Ipswich were highlighted going into the winter period with the potential impact on ED. 5. AP advised that a slide showing the "Average Patient Wait for Admission" had been provided to give more detail of how long patients were actually waiting in ED. 6. AP informed the Committee that the challenges relating to ambulance handovers, with an increased number of breaches, had remained an ongoing issue through November. 7. <u>Cancer</u> – The Committee was informed of the significant ongoing challenges with cancer performance, especially at Ipswich. Some resource had been moved across from Colchester and a significant amount of support had been put in place to deal with this priority area. AP stated that it had been recognised that the trajectory would be lower in November/December due to patient choice. 8. Additional clinics had been put on within Urology at Colchester to help address the issues and work was ongoing at Ipswich to find a solution but the early signs pointed towards the target not being achieved before April/May. AP stated the need to ensure that the "gain" from the additional resource put in place was seen in improved performance. 9. <u>Diagnostics</u> – Diagnostic performance was currently at 1.86% against target of 1%. However, there were still capacity issues, particularly for consultant specialty cases; however, the position was expected to be back on track by the end of January following the progression of a fixed term recruitment of consultants with expected start dates in January 2019. 10. <u>RTT</u> – November RTT position was 89.11%, just below trajectory of 90.87%. There was noted to be increasing external pressure to reduce the backlog. AP highlighted to the Committee that elective work might need to slip to ensure that the cancer target was achieved and the work to reduce the longest waiters was being balanced against treating the cancer patients. 11. BB noted the need for there to be clarity on the priorities. 12. LC noted the increased number of referrals. BB commented that the CCG needed to play their part to understand why the referral patterns had changed. AP advised that she would add a note of caution regarding the data reported. 13. <u>Community Services</u> – The Committee noted that a report on Community Services had been provided but a representative from the Community was not available to present this. However, no questions being raised on the report this was taken as read.	

112/18	**Costing Transformation Plan** 1. The Deputy Director of Finance – Analytics provided the Committee with an update on the Costing Transformation Plan (CTP). This being a five year plan to improve the quality of health cost information in the NHS. The Approved Costing Guidance formed a co-ordinated approach to patient level costing (PLICS), the reference costs collection and the reference costs assurance programme. 2. From 18/19 reporting would be for acute providers, however, this did not cover all of the areas of the acute services and in the case of ESNEFT, community services would continue to be required via Reference Costs. 3. Areas of the organisation which were known to be more expensive than the norm had been identified for focus. A significant piece of work would need to be done in the community regarding collection of data. <u>Questions and Comments</u> 4. EB questioned how this work joined up with the other work taking place in the organisation and BB questioned how this work was relevant. SW advised that the work for external reporting had to be carried out by the Trust, but that the benefit of doing this properly would be to identify where the organisation was more expensive than it should be and allow actions to rectify this to be put in place. 5. JP advised the Committee that at a recent NHS Providers event which she had attended the importance of using PLICS data to engage with the consultants to make changes had been highlighted by another attendee. 6. SW noted that the team were keen to move to a patient level analytics approach rather than costs when working internally. 7. DS commented that this work was complimentary with GIRFT and that as the move was made away from cost and volume the Trust would need to be able to identify how resources were being spent. 8. EB questioned when the benefits from this work would be seen. SW advised that year one for ESNEFT was about merging the systems across the new organisation, the national return would be submitted in August and following this the data would be used more internally.	
113/18	**Capacity Planning** 1. The Deputy Director of Finance – Analytics provided the Committee with an update on the Capacity Planning and highlighted that the work was being carried out for two main purposes, firstly the capacity demand data for incorporation into the Trust Strategy and secondly for 19/20 planning. 2. SW advised the Committee that the element of the work looking at the impact of population growth had not picked up the spike in activity seen at Colchester over the past year. 3. The capacity constraints were noted to be theatres and beds and models were being built to identify the impact of changes of practice. <u>Questions and Comments</u> 4. AP questioned the increase in activity. SW advised that there had been a general increase in activity. 5. JP questioned what this work would be used for. DS advised that the development of the Clinical Strategy needed clear costing and this work would set out the current position and identify if and where changes were required, which would then need to be looked at to address the challenges identified. 6. JP noted that the work did not appear to cover staffing. DS acknowledged that the Clinical Strategy currently had a gap in the workforce data and further work would be required to address this.	
114/18	**Annual Delivery Plans 2019/20** 1. The Committee was provided with an update on the Annual Delivery Plans 2019/20 by the Associate Director of Finance – Operational and the Head of Business Planning & Cost Improvement. 2. The assumed control total target for the Trust in 19/20 was as per the FBC submission; a deficit value of £16.6m, after receipt of Provider Sustainability Funding of £22.4m. 3. At the time of drafting the plan, the proposed tariffs for 19/20 were not issued and so the income modelling reflected initial activity plans including growth assumptions. 4. The draft budget as presented was a summary of the first cut business planning undertaken with Divisions for 2019/20. The next cut of the budgets would incorporate further information, ready for January Board and NHSI submission on 12 February. 5. The new CIP requirement was £37.8m; but this did not incorporate any potential increase in income from commissioning settlements and an expectation of cost pressures; brought forward under delivered recurrent CIP from 18/19 would increase the size of any final deficit. 6. SR highlighted that due to the lack of guidance and the set control total assumptions had had to be	

	made and the key assumptions were outlined in the report (page 5). Questions and Comments 7. BB questioned whether the divisions were using their clinical strategy plans as part of their planning for next year. JK stated that some of the plans from the divisions were referencing the clinical strategy; however, DS and NL stated that this approach was not consistent and some areas were less robust. 8. EB stated that he felt that the cost improvement programme looked to be very challenging for next year at this stage. 9. JP stated that she found it disappointing that mental health and people taking responsibility for their own health were not more prominently coming through within the plans as these areas were included in the Trust's Strategy and this would need further consideration. NL advised that the development process was iterative with a 5 year strategy and a one year delivery plan.	
115/18	**Use of Resources** 1. The Head of Business Planning & Cost Improvement provided the Committee with an update on the Use of Resources. 2. A Use of Resources assessment was now the 6th domain in a full CQC assessment, although it was undertaken by NHSI. It carried the same weight as the other domains and might, therefore, improve or worsen the overall Trust assessment. Trusts would be alerted to the upcoming Use of Resources assessment when the CQC issued a Provider Information Request (PIR), which would usually be undertaken before the CQC's Well Led assessment. The Use of Resources assessment was different to the Well Led assessment in that it primarily focused on trust's current and past (over the previous 12 months) performance against the five Key Lines of Enquiry (KLOE). 3. Following the initial KLOE and supporting evidence submission, NHSI would review the initial metrics and would also look to review wider information in making their assessment. This analysis would be followed by a qualitative assessment carried out during a one-day site visit to the trust. Each area would be probed in turn using the prompt questions as a starting point. 4. NHSI would collate the responses into a briefing report and use this to reach a proposed rating and to identify potential support needed at trusts. NHSI would also submit the draft Use of Resources assessment report and proposed rating to the CQC. 5. JK advised that the Use of Resources assessment was expected to take place around March 2019 and preparations had been discussed by the Resource Optimisation Board yesterday. Questions and Comments 6. DS commented that this assessment was useful to ensure the Trust was spending its money well and could potentially impact on the Trust's overall CCQ rating. 7. JP questioned how the Non-Executives could be assured that the preparation was appropriate. DS advised that to provide assurance that the preparation was being appropriately planned the team had provided the Plan to the Committee for their review. JP stated that she would suggest that this Plan was also presented to the other assurance committees for their information to allow them to determine whether they had been given the required level of assurance regarding their areas. 8. DW noted the need to ensure the correct balance between preparing, getting the work done and oversight. DW stated that he would not want the assurance committees to become involved in the detail but agreed that this work would need to be on their agendas. JK confirmed that he would ensure that the other assurance committees had sight of this work. **Action:** JK. 9. DS questioned whether a piece of work was being carried out to communicate to the wider organisation how the preparation for the Use of Resources and CQC assessment was being carried out. CM advised that the Director of Governance was leading on this work and that this would include some Board preparation.	JK
116/18	**Transformation Report (from the Time Matters Board)** 1. The Committee received the Transformation Report from the meeting held on 21 November 2018 for information. Questions and Comments 2. JP questioned whether the Time Matters Board was felt to be adding any value to the organisation and what had changed as a result of this Board being set up. AP stated that she felt that the Time Matters Board was valuable to the organisation and helped to co-ordinate the high level oversight. DS agreed with this view stating that this group allowed better integration between the commissioning and	

	provider plans and from the resource optimisation point of view held the organisation to account and allowed good visibility. 3. NL agreed with the value of the Time Matters Board noting that this was the forum where the organisational change plans were brought together and discussed and this would be the group which drove the plan for the Strategy.	
117/18	**Committee Effectiveness** 1. The Committee received and noted the Committee effectiveness form responses for quarterly review.	
118/18	**Any other business** 1. DS noted that this would be Simon Rudkins', Associate Director of Finance, final attendance at the Committee and on behalf of the Committee thanked Simon for his work on behalf of ESNEFT and previously Ipswich Hospital and wished him well for his new role with the Cambridge STP.	
119/18	**Items for escalation to the Board** The CKI report was discussed and would be finalised by the Chair and Director of Finance.	
120/18	**Committee Effectiveness questionnaire** The Committee Effectiveness questionnaire was circulated to members for completion.	
121/18	**Work Plan** The Work Plan was presented to inform Committee members of planned future agenda items.	
122/18	**Date of Next Meeting** – Thursday 24 January 2019	