West Hertfordshire Hospitals NHS
NHS Trust

Agenda Item 155/11

Minutes of Finance Committee Meeting

14 July 2011

West Herts Meeting Room, Watford General Hospital

Committee Members

Sarah Connor	Non Executive Director (acting Chair)
Robin Douglas	Non Executive Director
Jan Filochowski	Chief Executive Officer
Anna Anderson	Finance Director
Chris Pocklington	Director of Delivery
Matt Tattersall	Deputy Director of Finance
Phil Bradley	Corporate Finance Officer
Dave Self	Financial Controller and Capital Accountant
David McNeil	Board Secretary

Joined by; Kyle McClelland for item 8 (Additional Capacity); and Esther Moors for item 6 (SLR)

Agenda Item	Comment	Action
	OPENING ITEMS	
01	**Chair's Opening Remarks** SC opened the meeting and welcomed the members of the committee and confirmed that everyone had received the papers and had read them in advance.	
02	**Apologies** SL	

03	**Minutes of the previous meeting** The minutes of the meeting of the 12 May 2011 were approved.	
04	**Matters Arising and Action Log** None	
05	**Cash Update** At its May meeting, the Committee discussed the cash plan. It assumed the Trust's loans were successfully re-phased and a proposal should this falter. The proposal was that the Trust's cash balance be allowed to reduce from the planned £6.5m (10 days cash) to £0.5m (less than 1 days' cash). It is becoming increasingly probable the Trust will be required as a minimum to pay the loan instalments (interest and principal) of the existing loans due in September. Discussion concerning the re-phasing of the Trust's loans continues. Actual month end cash balance April to June compared with plan. As at the end of June the Trust is holding £5.1m more cash than planned, but this is mostly due to timing differences which will reverse. However, it is unlikely slippage in capital payments will catch up until late in the year, it is assumed the Trust will receive £1m from the transformation fund in September, and by the end of September CIPs will have released £4.9m of cash through reduced payments/increased receipts (£2.1m assumed to the end of June) The meeting discussed the implications of what might	

	Plan	**Actual**
	£m	£m
April	3.2	7.7
May	4.1	8.1
June	5.0	10.1

	happen if Capital expenditure did not slip. RD asked if any decision on the loan would come with Treasury strings attached. It was agreed this was likely, but at this stage what they might be would be speculation. SC asked if there were any projections yet for the cash position in 2012/13. DS responded not at this stage but discussions would be had with the PCT later in the year.	
08 (taken early)	**Additional Capacity – waiver of SFIs** (Joined by Kyle McClelland) KMc presented a paper which detailed a record of the issues and benefits impacting on the Trust's selection of its procurement strategy for capital works to deliver the Capacity Programme. The document identified each of the projects forming the capacity programme, identifying particular project challenges and issues that will require resolution during the project. KMc also presented a paper supporting the tender waivers for developments for the Clinical Decision Unit (CDU) and Women's & Children's (WACS) Capacity Expansion (part of the Trust's wider Capacity Programme) in favour of ARJ Construction Ltd. The scales of the waivers for the CDU were around £300k plus VAT and for WACS they were around £750k plus VAT. SC said that her concern was whether the process represented good governance. RD asked if it would be useful to get an external view to give assurance that this was the right option at this time. CP said that what the committee were hearing today was the financial risk, but needed to also bear in mind the operational risk presented by another surge in activity and the threat to patient safety this would bring. He said that a lack of a CDU was a clear risk. RD suggested that the Trust seek the opinion of an external quantity surveyor to reassure the committee and the Board this was the best option KMc agreed to seek external QS to undertake this work. AA asked the Committee to formally agree that it was	**KMc**

	appropriate for JF and AA to approve the waivers. The principle was agreed. KMc left the meeting	
06	**Service Line Reporting** (Joined by Esther Moors) PB presented a paper that updated the Committee on progress since December 2010. It also outlined key strategic questions and decisions and looked for support for the proposed next steps Previous objectives agreed by Finance Committee: 1. **SLR system robust and able to directly produce monthly information**. The SLR system is now much more robust with sufficient processing capacity and disc space. Monthly reports have been run since the autumn of 2010-11. 2. **SLR reports routinely reviewed by key Trust committees**. Reports for Divisions have been reviewed for February to May. Reports for Month 1, 2011-12 showing the SLR position for individual specialties should be available by early August 2011 and from then on monthly specialty contribution should be routinely available. The underlying data quality and the complexity of the accounting methodology in allocating costs to individual patients means that there are concerns about the quality of the SLR information at an individual patient level. 3. **Six tangible service / efficiency changes.** SLR information has been used to inform re-costing exercises e.g. Private Obstetrics / Cardiology which will lead to an increase in income. Several areas have been identified over the past year for which the Trust is not gaining the income it could be. This has not yet translated into tangible cash gains and undoubtedly the PCT would challenge them. However, they may assist our negotiating position for the next financial year. The overall objectives of SLR are: 1) Provide robust performance information every month, that can be used as the basis for financial decision making; 2) Engage clinicians and service managers with managing their service as an individual business unit and deliver efficiency gains	

	PB/EM proposed three interlinked strategic questions that the Steering Group discussed and need to be asked about the current project approach: 1) Is PLICS (patient-level costing) the most appropriate strategic approach? 2) Is the IT system we have able to provide the information we need? 3) Should we invest in a new reporting system or use Which Doctor? In addition, is our investment of resources in SLR appropriate? 1) The recommendation for producing SLR reports going forward is to provide top down apportionment by assigning known costs to individual specialities on which a centrally dedicated portion of the general overheads is added. PLICS uses bottom up approach using a unit cost for every intervention or resource used, that can be linked back to an individual patient. The new approach is theoretically less accurate, but in practice more believable and will therefore gain credibility. RD suggested that rather than impose a top down approach, it might be better to do both in tandem – recognising that the top down approach would be easier. PB said that some areas would be easier to do than others and, whilst still working to produce a bottom up approach, the divisions needed a high level view now. This view was supported by EM who reiterated that it would be useful to get something to divisions ASAP, perhaps by using SLR headlines with some of the info currently available on Which Doctor. This could be reported back at the Committee in November. The Committee agreed that something should be put out that was useful to divisions but also to keep working on patient level costs. 2) It was recommended and agreed to remain with the current IT system 3) It was recommended and agreed to use Which Doctor for reporting. Investment of resources – The numbers were noted and the committee agreed that it was important to move quickly on this, particularly as Monitor recommended using SLR (but not PLICS necessarily). PB thanked EM for her work and informed the	**PB**

	committee that she would be moving across to help service redesign work. AA and NE would discuss future project leadership. SC said that the committee supported the pragmatic approach of getting some details out to the divisions, but were disappointed that the objectives were not met and, whilst recognising the challenges faced in developing this project, SL would no doubt want to make the Board aware.	**AA/NE**
08	**Financial Targets** AA presented a short paper to inform the Committee of the work in progress to assess the overall financial position for 2011/12 and identify how the Trust could achieve its financial targets. JF said that the Board meeting in July would be an opportunity to present plans demonstrating a more proactive approach that would move the trajectory upwards. It was recognised that the trajectory was slow off the mark and this trend needed to be reversed by September. SC said that it was reassuring to note that action was being taken early.	
09	**Pathology** AA presented a paper explaining the process the SHA has set up to improve cost effectiveness of pathology services across the Region through tendering direct access service. A similar exercise is being undertaken in London and elsewhere in line with the national QIPP programme. The Trust is working with Luton and Dunstable, Bedford and Princess Alexandra Hospitals on a joint proposal. There area number of financial risks: • A very short timescale in which to respond to the tender and to evaluate all the issues – a business case will need to be approved by the board in November • Loss of pathology direct access income and potentially an unviable pathology service as a result. In order to mitigate this we will evaluate options for centralising all cold pathology and only retaining hot lab services on hospital sites	

	• The length of the proposed contract, possibly only 2/3 years, which will make it extremely difficult to make the contract viable • Funding and size of implementation costs which will include capital, redundancies and IT • Possible GP unwillingness to accept a contract for direct access being imposed on them • Agreement between partners on sharing of implementation and exit costs • Commercial confidentiality as Bedford Hospital's partner is Guys & St Thomas' /Serco RD asked if the reality was that this was going to happen. JF said that the SHA and others were determined to push this through as part of the QIPP agenda as there were potential large savings regionally. A paper will be presented to the November Board.	
10	**Date of next meeting(s)** **15 September 2011** Executive Meeting Room, Watford **10 November 2011** Executive Meeting Room, Watford	

David McNeil
Trust Board Secretary
July 2011

Signed……..Dated…….

Sarah Connor (deputy Chair) on behalf of Stuart Lacey, Chair & Non Executive Director