Open Board Meeting – Part 1

<table>
<thead>
<tr>
<th>Item</th>
<th>Lead</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>The meeting will commence with a patient story.</td>
<td>Alistair Flowerdew</td>
<td>11.00 – 11.05</td>
</tr>
<tr>
<td>1. Apologies for Absence (Verbal – to note)</td>
<td>Stephen Billingham</td>
<td>-</td>
</tr>
<tr>
<td>2. Minutes - 30 April and 23 May 2013 (Attached – to approve)</td>
<td>Stephen Billingham</td>
<td>11.05 – 11.10</td>
</tr>
<tr>
<td>3. Matters Arising and Outstanding Actions Schedule (Attached to note)</td>
<td>Keith Eales</td>
<td>11.10 – 11.15</td>
</tr>
<tr>
<td>4. Declarations of Interest (Verbal – to note)</td>
<td>Stephen Billingham</td>
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**Strategy and Performance Monitoring**

<table>
<thead>
<tr>
<th>Item</th>
<th>Lead</th>
<th>Time</th>
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<tbody>
<tr>
<td>5. Executive Report (To follow – to note)</td>
<td>Ed Donald/ Executive Team</td>
<td>11.15 – 12.15</td>
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**Major Items**

<table>
<thead>
<tr>
<th>Item</th>
<th>Lead</th>
<th>Time</th>
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<tbody>
<tr>
<td>6. Update on Francis Report Implementation (Verbal – to note)</td>
<td>Alistair Flowerdew / Caroline Ainslie</td>
<td>12.15 – 12.35</td>
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***Working Lunch***

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<thead>
<tr>
<th>Item</th>
<th>Lead</th>
<th>Time</th>
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<tbody>
<tr>
<td>7. Budget 2013/14 (Attached – to approve)</td>
<td>Craig Anderson</td>
<td>13.00 – 13.15</td>
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**Business Cases**

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<tr>
<th>Item</th>
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<th>Time</th>
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**Governance Items**

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<tr>
<th>Item</th>
<th>Lead</th>
<th>Time</th>
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</thead>
</table>
### Agenda – Board of Directors

11. **Requisitions and Approvals**  
   (Attached – to approve)  
   a) Security Services and Car Parking Management  
   b) Other Requisitions and Approvals  
   - Craig Anderson 13.55 – 14.05

12. **Minutes of Meetings:**  
   (Attached – to note and agree recommendations)  
   a) Board Strategy Group – 23 April 2013  
      - Janet Rutherford  
   b) Resources Committee – 29 April 2013  
      - Tim Caiger  
   c) Nominations and Remuneration Committee – 30 April 2013  
      - Stephen Billingham  
   d) Clinical Governance Committee – 9 May 2013  
      - Janet Rutherford  
   e) Audit & Risk Committee – 20 May 2013  
      - Brian Hendon

### Information Items

13. **Board Work Plan**  
   (Attached – to note)  
   - Keith Eales 14.20 – 14.25

14. **Dates of Next Meeting**  
   Thursday 27 June 2013  
   - Stephen Billingham

15. **Exclusion of the Press and Public**  
   (Verbal – to approve)  
   - StephenBillingham

### Closed Board Meeting - Part 2

The following section of the meeting will be closed to the press and public as the material to be discussed discloses exempt information as defined by the Freedom of Information Act.

16. **Monitor Annual Plan 2013/14**  
   (Section 43, FOI Act)  
   (Attached)  

17. **Incidents and Safeguarding Report**  
   (Section 40, FOI Act)  
   (Attached – to note)  
   - Alistair Flowerdew/Caroline Ainslie 14.55 – 15.00

Close 15.00
Board
Thursday, 30 April 2013
10.15am – 1.30pm
Boardroom, Royal Berkshire Hospital, Reading

Members Present

Mr. Stephen Billingham (Chairman and Non-Executive Director)
Mr. Edward Donald (Chief Executive)
Ms. Caroline Ainslie (Director of Nursing)
Mr. Craig Anderson (Director of Finance)
Mr. John Barrett (Non-Executive Director)
Mr. Tim Caiger (Non-Executive Director)
Dr. Sue Edees (Care Group Director, Urgent Care)
Mr. Alistair Flowerdew (Medical Director)
Mr. Brian Hendon (Non-Executive Director)
Ms. Jane May (Non-Executive Director)
Mrs. Janet Rutherford (Non-Executive Director)

In attendance

Dr. Lindsey Barker (Care Group Director, Networked Care)
Mr. Keith Eales (Director of Corporate Affairs & Secretary)
Ms. Lynn Lane (interim Director of Workforce Development & Human Resources)
Mr. Hitesh Patel (Interim Commercial Director)

Apologies

Mr. Peter Malone (Care Group Director, Planned Care)

There were two members of the press, one Governor, one member of the public and a number of members of staff present.

The meeting commenced with a patient story provided by Mr. Tom Pollard, an orthopaedic surgeon. Mr Pollard outlined the experience of a patient who had attended the Trust for knee and hip replacements. An unsuccessful knee replacement had been addressed and an infection dealt with prior to a successful hip replacement.

60/13 Minutes: 28 March 2013

The minutes of the meetings held on 28 March 2013 were approved as a correct record and signed by the Chairman subject to the addition of the following resolution in minute 47/13

(f) Care Group Directors ensure greater consistency of information presented in monthly Care Group reports
61/13 Schedule of Matters Arising and Outstanding Decisions

The Director of Corporate Affairs & Secretary submitted the schedule of matters arising from the last meeting and outstanding issues from previous meetings. Progress against each decision was noted.

It was noted that the action in respect of the maternity service set out in minute 49/13 was not included in the schedule. The Director of Corporate Affairs & Secretary confirmed that this would be added, along with the action in respect of the consistency of Care Group information included in the Executive Report.

It was noted that there were a number of informal Board briefings to be held to discuss key issues. The Chair of the Strategy Group asked that consideration be given to holding the strategy seminar at the earliest opportunity.

Resolved: that the report be noted.

62/13 Declarations of Interests

There were no declarations of interest.

63/13 Executive Report

The Chief Executive submitted the Executive report.

The Chief Executive drew attention to the significant activity pressures within the health economy. The challenges that trusts across the region were facing in meeting the A&E target were indicative of these pressures. The Trust had managed a 7% increase in emergency patient demand in 2012/13 and it was anticipated that this growth would continue. This would impact on the ability of the Trust to consistently deliver high quality care, the four hour A&E standard and financial stability in the short-term.

The Chief Executive explained that, to address this, the Trust was working with partners to reduce emergency demand, lobbying to reverse the non-elective threshold tariff and readmission penalties, which were estimated to result in a £7m loss of income to the Trust in 2013/14 which was the equivalent of treating 4,000 patients for free, implementing the Emergency Care Intensive Support Team recommendations at the Trust and developing a business case to increase emergency and elective capacity in the Trust.

Clarification was sought with regard to the impact of the number of delayed discharges and patients medically fit for transfer in the Trust. The Chief Executive advised that the local health economy was responding to the findings of a report by Capita, which would assist in reducing the number of patients who were delayed discharges and medically fit for transfer.

The Chief Executive commented on the in house patient survey recommendation rate which, at 97%, was the highest ever achieved by the Trust.

The Chief Executive confirmed that the redecoration of the pre-operative assessment clinic had been undetaken.
The Chief Executive advised that work was progressing on the integrated business plan and the annual plan. Both documents would be submitted to the Board in May.

The Board noted the position in respect of the Royal Berkshire Bracknell Clinic and the support for the rental model. Clarification was sought with regard to the development of the minor injuries unit. The Chief Executive advised that commissioners would be tendering for the service to be housed at the Clinic.

The interim Commercial Director and the Director of Finance gave an overview of the financial and governance position of the Trust.

The Trust would achieve an amber-green rating for governance in quarter four, reflecting the failure to achieve the 62 day cancer targets. Confirmation was sought that the additional radiotherapy capacity planned for April was in place. The Chief Executive confirmed that this was the case.

The Board congratulated the A&E team for their achievement of the four hour standard target in quarter four.

The Director of Finance gave an overview of the draft financial position of the Trust at year end, which was subject to review by audit. A pre-impairment surplus of £500,000 had been achieved at year end. The Trust had achieved a Financial Risk Rating of 3.

Clarification was sought with regard to the reasons for the under spend in capital, with full year expenditure of £13.9m against a forecast of £15.9m. The Director of Finance advised that the under spend was not attributable to any specific project.

The Medical Director and the Director of Nursing gave an overview of quality and safety issues in March. It was noted that these, in the main, reflected the capacity issues and high demand during the month.

Clarification was sought regarding the high number of serious incidents in the month and whether the figures for April had returned to normal levels. The Medical Director and Director of Nursing advised that a number of the incidents in March, which included three falls and four pressure ulcers, could be attributed to the high levels of demand and capacity issues in the month. There had been a significant reduction in the number of incidents in April.

The Medical Director gave an overview of QIPPs delivery in 2012/13 and plans for 2013/14. It was noted that there had been a significant increase in QIPP payments between February and March. The Director of Finance advised that this reflected the payment of Best Practice Tariffs and CQUINs in the month. The Chief Executive commented that the Trust had achieved, since 2010/11, £50m in quality of service payments and cost improvements.

The Board noted the potential QIPP opportunity of £20m in 2013/14. Clarification was sought on the timescale for improving on the risk-rated sum of £6.7m. The Director of Finance advised that progress would be made over the next month as work continued on the annual plan.

Clarification was sought on progress with finalising the commercial arrangements with Newton Europe. The Director of Finance advised that this was nearing completion and that
a proposal for Newton to work with the Trust beyond the project initiation phase would be submitted to the Board.

The Director of Finance referred to the Trust working capital facility, which was due to expire on 31 March 2013. The Director of Finance advised that approval was being sought to extend this for three months, at no additional cost to the Trust, to allow for the finalisation of the terms of the facility.

The Care Group Director, Networked Care, submitted the monthly report and gave an overview of the Care Group dashboard.

The vacancy rates within the Care Group were discussed. It was noted that there continued to be a challenge in recruiting and retaining nursing staff. The interim Director of Workforce Development & Human Resources advised that discussions were continuing as to appropriate approaches to recruiting and retaining staff with a view to a plan being developed for Board consideration. It was considered that the plan should be discussed by the Resources Committee.

The Care Group Director, Urgent Care, submitted the monthly report and gave an overview of the Care Group dashboard.

It was noted that a business case would be submitted to the May Board meeting to expand the urgent care floor within the Trust. This would take account of the continuing pressures within the Emergency Department.

Clarification was sought with regard to the ventilation issues within the delivery suite. The Care Group Director, Urgent Care advised that the ventilation system needed replacing and consideration was being given to funding this in the capital programme.

In the absence of the Care Group Director, Planned Care, the Chief Executive gave an overview of the Care Group dashboard.

The Board considered that it would be useful to include in the Executive Report an overall Trust position on key workforce metrics such as appraisal, sickness and vacancy rates.

As supplementary documents to the Executive pack the Board received

- The integrated Board report for March
- The quality and patient safety report
- The Director of Finance report for March 2013

Resolved: that

(a) The Executive report be noted

(b) An overall Trust position for key workforce metrics be included as part of the Executive Report

(c) The Director of Finance submit to the Board the proposed arrangements for Newton Europe to work with the Trust beyond the project initiation phase

(d) The plan for recruiting and retaining nursing staff be submitted to the Resources Committee
(e) The working capital facility with Lloyds Bank PLC be extended to 31 July 2013 and that a report be made to the June Board meeting.

64/13 Monitor Annual Plan Review Action Plan Update

The Director of Finance and the Director of Corporate Affairs & Secretary submitted a report setting out progress in delivering the action plan agreed following the stage 2 review by Monitor of the Annual Plan for 2012/13.

The Board noted that each of the actions had been RAG rated, with the degree of completion identified in the case of the amber tasks. The Board discussed progress on these actions in particular.

It was noted that, in the last month, particular progress had been made in respect of the Royal Berkshire Bracknell Clinic and the assessment against the Quality Governance Framework.

Resolved: that the report be noted.

65/13 Monitor Quarterly Return

The Director of Finance, Director of Corporate Affairs & Secretary and the interim Commercial Director submitted a report in respect of the quarter 4 return to Monitor.

The Director of Finance explained that the Compliance Framework required the submission of a quarterly financial and governance combined return, comprising a number of declarations.

In respect of the Declaration of Performance against Healthcare Targets, the Board noted that the Trust failed the cancer 62 day targets, which would result in an amber-green rating.

The Board noted that the Finance Declaration would result in a Financial Risk Rating of 3 to the Trust. It was noted that Monitor had powers to adjust one off income in the year where this could materially distort the underlying financial position. Year to date income included £9m of one off income from commissioners to reflect levels of activity. This compared to the run rate of £5.3m for these costs as declared to Monitor in the quarter 3 return. If Monitor made this technical adjustment the FRR could reduce to 2.

The Director of Finance advised that the quarterly return required the Board to certify confirmed or not confirmed in respect of three statements

- That the Board anticipated the Trust would maintain a financial risk rating of at least 3 over the next 12 months
- That the Board is satisfied that plans in place are sufficient to ensure: ongoing compliance with all existing targets (after the application of thresholds); and a commitment to comply with all known targets going forwards
- The Board confirms that there are no matters arising in the quarter requiring an exception report to Monitor which have not already been reported
The Director of Finance recommended that the Board should confirm the finance declaration on the basis of the cash flow statement reviewed earlier in the meeting which satisfied the liquidity element of the FRR, the indicative budget for 2013/14 and the annual plan position for the first two quarters of 2013/14. In addition, the Monitor 2nd stage review had indicated that the Trust would maintain an FRR of 3. However, key dependencies in 2013/14 would need to be recognised. These would be listed in the covering letter with the return to Monitor.

The Board considered that it would also be appropriate to include in the covering letter to Monitor reference to the support received from commissioners in 2012/13 and the lack of clarity at present as to whether this would continue in 2013/14.

In respect of the governance statement, the Board noted that the most significant risk was the continuing achievement of the A&E four hour wait target. The Director of Finance explained the actions taken to meet the target. It was considered that the covering letter should reflect the discussion earlier in the meeting in respect of the continuing challenge in meeting the target.

With regard to exception reporting, the Board was recommended to confirm this on the basis of there being no material issues requiring exception reporting.

Resolved: that

(a) the Chief Executive and Director of Finance be authorised to sign the quarter 4 Monitor return

(b) confirmation of the statement be given that the Board anticipated that the Trust would maintain a financial risk rating of at least 3 over the next 12 months be approved

(c) confirmation of the statement be given that the Board was satisfied that plans in place are sufficient to ensure: ongoing compliance with all existing targets (after the application of thresholds); and a commitment to comply with all known targets going forwards.

(d) confirmation of the statement be given that the Board confirms that there are no matters arising in the quarter requiring an exception report to Monitor which have not already been reported

(e) the submission of the full return to Monitor be approved

(f) the covering letter sent to Monitor with the return be distributed to Board members.

66/13 Quality Governance Framework

The Chair of the Quality Governance Group and the Director of Corporate Affairs & Secretary addressed a report reviewing the position of the Trust against Monitor’s Quality Governance Framework.

The Chair of the Quality Governance Group advised that the Group, supported by other Board members, had reviewed evidence provided by Directors against each of the components of the Framework, information obtained from other trusts and further feedback
received from PwC team that had undertaken the second stage review of the annual plan. The Medical Director had provided an assessment of the position of the Trust against the Framework and had proposed a score. A cautious approach had been taken to applying a score. The score had been reviewed at the meeting on 23 April. The conclusion of the meeting was to award the Trust a score of 5 against the Framework. An action plan had been developed to further improve the position of the Trust against the Framework.

It was confirmed that the action plan would be reviewed by the Executive. It would then provide a basis for monitoring the position of the Trust on a quarterly basis over 2013/14.

**Resolved: that the assessment of the Quality Governance Group against the Monitor Quality Governance Framework be endorsed.**

**67/13 Board Assurance Framework**

The Director of Corporate Affairs & Secretary submitted the Board Assurance Framework.

The Director of Corporate Affairs & Secretary explained that the key changes were a reduction in the current score for financial stability, reflecting the year end financial position of the Trust, and the addition of templates in respect of engineering compliance and backlog maintenance.

The Director of Corporate Affairs & Secretary explained that the Audit and Risk Committee and the Clinical Governance Committees would be considering the Framework in detail at their next meetings.

The Director of Corporate Affairs & Secretary explained that work would begin shortly on developing the Framework for 2013/14, based on the integrated business plan, the annual plan and recognised risks in the Trust.

**Resolved: that the report be noted.**

**68/13 Requisitions and Approvals**

The Director of Finance submitted a report setting out purchase requisitions requiring Board approval.

The Director of Finance provided details in respect of each of the requisitions. The Director of Finance confirmed that the relevant Trust procedures had been followed in respect of each requisition.

Clarification was sought with regard to action being taken to identify the opportunity for the Trust to participate in joint procurement approached, such as the London Procurement Initiative. The Director of Finance advised that an assessment was being undertaken.

**Resolved: that**

**(a) the following requisitions be approved**
Minutes of the Board – 30 April 2013

### Requisitions

<table>
<thead>
<tr>
<th>Requisition number</th>
<th>Details</th>
<th>Amount (exc VAT)</th>
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<tbody>
<tr>
<td>4318183</td>
<td>Norland Managed Services</td>
<td>2,001,348.00</td>
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<tr>
<td>4320617</td>
<td>Corona Gas</td>
<td>1,892,538.00</td>
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<td>4317442</td>
<td>Berkshire West PCT</td>
<td>773,528</td>
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<td>4320297</td>
<td>NHS Blood &amp; Tissue</td>
<td>1,638,826.92</td>
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<td>4319608</td>
<td>Reading Borough Council</td>
<td>1,004,643.00</td>
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<td>4320620</td>
<td>EDF</td>
<td>681,000.00</td>
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<td>4317610</td>
<td>Crispin &amp; Borst</td>
<td>554,560.58</td>
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<td>4320394</td>
<td>Medtronic</td>
<td>507,300.00</td>
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<tr>
<td>4316661</td>
<td>Elekta Ltd</td>
<td>436,451.01</td>
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(b) VAT be included in the requisitions submitted to future Board meetings for approval.

### 69/13 Minutes of Meetings

The Board received the draft minutes of the following meetings:

- **Resources Committee**: 25 March 2013
- **Strategy Group**: 26 March and 23 April 2013
- **Joint Board/Council Briefing**: 15 April 2013
- **Quality Governance Group**: 18 and 23 April 2013
- **Patient Experience Group**: 15 March 2013

The Chairmen drew attention to significant issues discussed at the meetings.

Clarification was sought with regard to the approach to be taken to reviewing the Trust vision and values, which had been discussed at the Strategy Group meeting on 25 March 2013. The Chief Executive advised that the Trust vision would be reflected in the integrated business plan that was being developed for the next Board meeting. It was considered timely to review the Trust values, engaging with all staff in the Trust in their review and development. It was confirmed that this process would not be undertaken as part of the development of the integrated business plan.

The Chair of the Strategy Group advised that the revised minutes of the meeting held on 23 April would be submitted to the May Board meeting.

Resolved: that

(a) the minutes be received and the recommendations approved

(b) the revised minutes of the Strategy Group held on 23 April 2013 be submitted to the May Board meeting.

### 70/13 Board Work Plan

The Director of Corporate Affairs & Secretary submitted the draft work plan for the Board, setting out business to be transacted within each quarter of 2013/14. It was confirmed that this would continue to be developed over the course of the year.
Resolved: that the work plan be noted.

71/13 Use of the Trust Seal

The Director of Corporate Affairs & Secretary submitted a report setting out details of Trust seals affixed since April 2013.

The Director of Corporate Affairs & Secretary explained that Trust Standing Orders required an annual report to the Committee on the use of the seal.

Resolved: that

(a) the report be noted

(b) Standing Orders be amended to delete the requirement for a report to be made to the Board on the use of the Trust seal.

72/13 Date of Next Meeting

Resolved: that the next meeting be held at 11am on Thursday, 30 May 2013.

73/13 Exclusion of Governors, the Press and Public

Resolved: that the press and public be excluded from the remainder of the meeting given the exempt nature of the business to be conducted, as defined by the Freedom of Information Act.

74/13 Quality and Safety Report Exempt Appendix

[Section 40, Freedom of Information Act]

The Board received a confidential appendix setting out details of serious incidents reported in March.

There had been 12 serious incidents reported in the month. The Board noted the details of each.

The Board noted the schedule of open serious incidents as at 31 March 2013.

Resolved: that the report be noted.

75/13 Minutes of the Audit Committee: 10 April 2013

[Section 22, Freedom of Information Act]

Resolved: that the minutes be received and the recommendations approved.
Chairman

Date  30 May 2013
Agenda Item 2b)

Minutes of the Board – 23 May 2013

Boardroom, Royal Berkshire Hospital, Reading

Members Present

Mr. Stephen Billingham (Chairman and Non-Executive Director)
Mr. Edward Donald (Chief Executive)
Ms. Caroline Ainslie (Director of Nursing)
Mr. Craig Anderson (Director of Finance)
Mr. John Barrett (Non-Executive Director)
Mr. Tim Caiger (Non-Executive Director)
Dr. Sue Edees (Care Group Director, Urgent Care)
Mr. Alistair Flowerdew (Medical Director)
Mr. Brian Hendon (Non-Executive Director)
Ms. Jane May (Non-Executive Director)
Mrs. Janet Rutherford (Non-Executive Director)

In attendance

Dr. Lindsey Barker (Care Group Director, Networked Care)
Mr. Keith Eales (Director of Corporate Affairs & Secretary)
Ms. Lynn Lane (interim Director of Workforce Development & Human Resources)
Mr. Peter Malone (Care Group Director, Planned Care)
Mr. Hitesh Patel (Interim Commercial Director)

Apologies

76/13 Annual Report and Consolidated Financial Statements

The Director of Finance, the Medical Director and the Director of Corporate Affairs & Secretary submitted the Trust Annual Report and Consolidated Financial Statements for 2012/13, including the draft Quality Report.

The Board noted that the document had been reviewed by the Audit Committee. The Chairman of the Audit Committee gave an overview of the issues discussed by the Committee advised that the Committee had recommended that the accounts be adopted.

The Director of Finance advised that the Trust external auditors had audited the documents and had given an unqualified opinion on each.

The Director of Finance drew attention to three key areas in the accounts that had required financial judgement, on which assurance would be provided to the external auditors within the letter of Representation.
• The revaluation and consequent impairment of assets; the impairments related to the Electronic Patient Record (£18m), buildings (£6.3m) and obsolete IT assets (£3m). The Director of Finance advised that the Trust external auditors were content with the process that had been followed to underpin the financial judgements made in respect of the impairments.

• Contract income provisions in respect of £10.835m, which represented the likely repayment of cash received by the Trust from commissioners as a result of penalties enforced for the year 2012/13.

• The accounting treatment of the CSC contract.

The Director of Finance drew attention to two further matters against which the external auditors were seeking assurance within the Letter of Representation, both of which were standard.

• That with regards to the reporting of intra NHS balances the Trust had reported all such balances. The Director of Finance confirmed this and noted that a central exercise had confirmed no material imbalances although it was noted that the contract income provision was outside of this exercise.

• That with regard to buildings impairment that the Board was satisfied that GVA was an appropriate expert to use and that all appropriate information had been provided. Again the Director of Finance confirmed this was the case and that the external auditors had expressed no concerns with regards to the use of GVA for this exercise.

The Director of Finance stated that a similar Representation Letter was required for the quality accounts but that this was a standard form. The Medical Director agreed to distribute a copy of this letter to all Board members.

The Board noted that the Trust would be reporting an operating surplus. After the provisions in respect of impairment, which was a non-cash item, the resulting position would be a £27m deficit. The Board also noted that the Financial Risk Rating excluded the impairments.

The Board asked that, in future years, the annual report, financial statements and Quality Report be submitted to the meeting for approval in final form and sufficiently in advance of the date to enable detailed consideration to be given to the document. The Director of Finance, the Medical Director and the Director of Corporate Affairs & Secretary undertook to set out the timetable required to enable this to be achieved.

Resolved: that

(a) that the Annual Report and Consolidated Financial Statements for the period ended 31 March 2013 be adopted and approved

(b) the Chief Executive be authorised to sign and date

• The Statement of the Chief Executive’s responsibilities as the Accounting Officer of Royal Berkshire NHS Foundation Trust
The Annual Governance Statement
The Remuneration Report
The Quality Report
The Foreword to the Accounts
The Statement of Financial Position of the Consolidated Financial Statements

(c) the Director of Finance be authorised to sign the Letter of Representation, as submitted with the Annual Report and Consolidated Financial Statements, on behalf of the Trust Board and issue it to the Auditors

(d) the Medical Director be authorised to sign, on behalf of the Trust Board, the Letter of Representation in respect of the Quality Report, and issue it to the Auditors

(e) the Letter of Representation in respect of the Quality Report be distributed to Board members

(f) the Chief Executive and Director of Finance be authorised to sign the Monitor Chief Executive and Director of Finance FTC Summarisation Schedules

(g) in future years, the annual report, financial statements and Quality Report be submitted to the meeting for approval in final form sufficiently in advance of the date to enable detailed consideration to be given to the document.

77/13 Going Concern Review

The Director of Finance submitted a report setting out the basis for a discussion and review of the status of the Trust as a going concern. This would enable the Board to determine if it was appropriate for the accounts to be prepared on a going concern basis.

The Director of Finance advised that the accounts had been prepared on the basis that the organisation was a going concern. Whilst there were concerns going forward in respect of factors outside the control of the Trust, such as the economic and political environment, the organisation was positioning itself to be best placed to cope with these challenges. There were no particular issues that were casting doubt on the Trust being a going concern.

In reviewing this position, the Board considered the going concern review that had been undertaken, and the recommendation of the Audit & Risk Committee that the Trust accounts be prepared on a going concern basis.

Resolved: that the Trust accounts be prepared on a going concern basis.

78/13 Date of Next Meeting

Resolved: that the next meeting be held at 11am on Thursday, 30 May 2013.

Chairman

Date 30 May 2013
## Agenda Item 3

### Board Schedules of Matters Arising and Outstanding Actions

<table>
<thead>
<tr>
<th>Board Date</th>
<th>Board Minute</th>
<th>Subject</th>
<th>Decision</th>
<th>Owner</th>
<th>Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>November 2011</td>
<td>167/11</td>
<td>Real Estate Strategy (RES)</td>
<td>Final strategy to be submitted. Also January Board Minute 05/13</td>
<td>Philip Holmes</td>
<td>June 2013</td>
</tr>
<tr>
<td>February 2013</td>
<td>28/13</td>
<td>Complaints</td>
<td>The Director of Nursing report to a future meeting on appropriate measures to enable the Board to receive assurance in respect of improvements in the complaints system</td>
<td>Caroline Ainslie</td>
<td>July 2013</td>
</tr>
<tr>
<td>February 2013</td>
<td>28/13</td>
<td>Francis Report</td>
<td>A Board seminar be held to discuss the outcome of the Francis Inquiry and the proposed action by the Trust.</td>
<td>Alistair Flowerdew/ Caroline Ainslie/ Keith Eales</td>
<td>To be scheduled</td>
</tr>
<tr>
<td>March 2013</td>
<td>47/13</td>
<td>Executive report</td>
<td>Care Group Directors to ensure greater consistency of information is presented in monthly care group reports</td>
<td>Care Group Directors</td>
<td>Noted - see executive report on this agenda</td>
</tr>
<tr>
<td>March 2013</td>
<td>48/13</td>
<td>Strategy Seminar</td>
<td>A Board Strategy Seminar be held to develop a view of the Trust in five years time</td>
<td>Hitesh Patel / Keith Eales</td>
<td>Held on 23 May 2013</td>
</tr>
<tr>
<td>March 2013</td>
<td>49/13</td>
<td>Maternity Capacity</td>
<td>Report be made to the next meeting on current infrastructure issues and actions to address</td>
<td>Sue Edees / Philip Holmes</td>
<td>Paper drafted and to be circulated shortly.</td>
</tr>
</tbody>
</table>
| March 2013    | 52/13        | Board Evaluation          | A Board session be organised focusing specifically on Board effectiveness and the roles and inter-relationships between the Non Executive and Executive Directors  
  - The Chairman work with the Chief Executive and Secretary to reduce the size of board papers and agenda length and tighten the focus of agenda content.  
  - A full Board strategy session, led by the Chief Executive, be held to ensure Trust business plans are based on good knowledge, detailed and common | Keith Eales               | Seminar to be arranged                  |

For May 2013 Board
<table>
<thead>
<tr>
<th>Date</th>
<th>Action Number</th>
<th>Topic</th>
<th>Description</th>
<th>Responsible Party</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 2013</td>
<td>58/13 (05/13)</td>
<td>EPR</td>
<td>Meeting of the Board be held in June to determine a way forward.</td>
<td>Hitesh Patel / Keith Eales</td>
<td>Date to be agreed</td>
</tr>
<tr>
<td>April 2013</td>
<td>63/13</td>
<td>Urgent care floor</td>
<td>Noted that a business case to expand the urgent care floor would be submitted to the May Board.</td>
<td>Sue Edees</td>
<td>Scheduled for June 2013</td>
</tr>
<tr>
<td>April 2013</td>
<td>63/13</td>
<td>Workforce metrics</td>
<td>Include key workforce metrics in the Executive report</td>
<td>Lynn Lane</td>
<td>Quarterly workforce report scheduled for July</td>
</tr>
<tr>
<td>April 2013</td>
<td>63/13</td>
<td>Newton Europe</td>
<td>Director of Finance to submit a report to the Board on the proposed arrangements for Newton Europe to work with the Trust beyond the project initiation phase.</td>
<td>Craig Anderson</td>
<td>Scheduled for June 2013</td>
</tr>
<tr>
<td>April 2013</td>
<td>63/13</td>
<td>Nursing staff recruitment and retention</td>
<td>The plan for nursing staff recruitment and retention be submitted to the Resources Committee</td>
<td>Lynn lane</td>
<td>Scheduled for the May Resources Committee</td>
</tr>
<tr>
<td>April 2013</td>
<td>71/13</td>
<td>Use of the seal</td>
<td>Standing orders be revised to remove the need for the use of the seal being reported to the Board.</td>
<td>Keith Eales</td>
<td>Completed</td>
</tr>
</tbody>
</table>
Agenda Item 5
Executive Report
May 2013
## Contents

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<th>Lead</th>
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<td>2. Key Strategic Issues</td>
<td>4-5</td>
<td>Ed Donald</td>
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<td>3. Financial and Governance summary</td>
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<td>Craig Anderson/Hitesh Patel</td>
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<td>4. Monitor Governance Rating-Summary</td>
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</tr>
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<td>Craig Anderson</td>
</tr>
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<td>6. Quality and Safety</td>
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<td>Caroline Ainslie/Alistair Flowerdew</td>
</tr>
<tr>
<td>7. QIPP Update</td>
<td>13-15</td>
<td>Alistair Flowerdew</td>
</tr>
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<td>8. Networked Care Group Report</td>
<td>16-18</td>
<td>Lindsey Barker</td>
</tr>
<tr>
<td>9. Urgent Care Group Report</td>
<td>19-21</td>
<td>Sue Edees</td>
</tr>
<tr>
<td>10. Planned Care Group Report</td>
<td>22-24</td>
<td>Peter Malone</td>
</tr>
</tbody>
</table>

(Further supporting information is in the performance pack distributed separately, which includes the integrated Board report, the Quality and Safety report and the Director of Finance report.)
1. Operating Environment

Emergency care - continues to be in the national and local spotlight. This is the key operational issue the NHS faces. During April 2013, one Trust in the predecessor south central region delivered the 95% standard. This follows a deteriorating trend in the region, where the Royal Berkshire was one of only two to deliver this standard overall in 2012/13.

Key issues – this is a complex area which has 3 fundamental drivers:

- Increasing demand due to demographic pressures
- Insufficient capacity in primary, community, social care and acute hospitals to cope with demand
- National tariffs and regulation which place the quality and financial risks with acute hospitals under the current contract rules

Way Forward – partners need to work together to deliver a safe transition from the current emergency care service to a re-designed whole health system solution. At a local level the Royal Berkshire will agree with the West Berkshire Confederation of Clinical Commissioning Groups (CCGs) how best to invest the non-elective and readmission contract penalties, estimated at £8.4m, back into Trust services. This is to assure quality of care and financial stability today. At a national level the FTN and other professional bodies continue to lobby for the current contract penalties to be scrapped, acute providers to be paid rather than penalised for the work that they do, whilst continuing to work together on system re-design.

Chart 1: A&E performance in April 2013

<table>
<thead>
<tr>
<th>Organization</th>
<th>2012-13 Q1</th>
<th>2012-13 Q2</th>
<th>2012-13 Q3</th>
<th>2012-13 Q4</th>
<th>2013-14 Q1</th>
</tr>
</thead>
<tbody>
<tr>
<td>NUFFIELD HOSPITALS NHS FOUNDATION TRUST</td>
<td>95.4%</td>
<td>95.2%</td>
<td>95.4%</td>
<td>95.5%</td>
<td>95.3%</td>
</tr>
<tr>
<td>HAMPSHIRE HOSPITALS NHS FOUNDATION TRUST</td>
<td>96.1%</td>
<td>96.3%</td>
<td>96.3%</td>
<td>96.3%</td>
<td>96.3%</td>
</tr>
<tr>
<td>WOODFORD HOSPITALS NHS FOUNDATION TRUST</td>
<td>95.1%</td>
<td>95.3%</td>
<td>95.1%</td>
<td>95.2%</td>
<td>95.1%</td>
</tr>
<tr>
<td>EPSOM AND EWELL HOSPITALS NHS FOUNDATION TRUST</td>
<td>95.4%</td>
<td>96.1%</td>
<td>95.9%</td>
<td>95.8%</td>
<td>95.9%</td>
</tr>
<tr>
<td>SOUTHERN HEALTH NHS FOUNDATION TRUST</td>
<td>96.5%</td>
<td>96.1%</td>
<td>96.3%</td>
<td>96.4%</td>
<td>96.3%</td>
</tr>
<tr>
<td>UNIVERSITY HOSPITAL SOUTHWOLD HOSPITALS NHS FOUNDATION TRUST</td>
<td>95.5%</td>
<td>95.5%</td>
<td>95.5%</td>
<td>95.5%</td>
<td>95.5%</td>
</tr>
</tbody>
</table>

Table 1: NEL activity since 2011/12 to 2013/14 forecast, with impact of 30% rule and readmission penalties on EBITDA.

<table>
<thead>
<tr>
<th>Note:</th>
<th>2012/13 Activity Income</th>
<th>2013/14 Activity Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>NEL activity at full tariff</td>
<td>30.9%</td>
<td>70.179</td>
</tr>
<tr>
<td>70% marginal rate &quot;penalty&quot;</td>
<td>(1.226)</td>
<td>(4.193)</td>
</tr>
<tr>
<td>Number of patients &quot;treated free&quot;</td>
<td>341</td>
<td>3.209</td>
</tr>
<tr>
<td>NEL Readmissions Penalty</td>
<td>(1.250)</td>
<td>(1.250)</td>
</tr>
<tr>
<td>Number of patients &quot;treated free&quot;</td>
<td>322</td>
<td>321</td>
</tr>
</tbody>
</table>

Notes: (i) calculated as the 70% penalty as a proportion of 100% tariff multiplied by the activity
(ii) calculated as the NEL readmissions penalty as a proportion of 70% marginal rate penalty multiplied by the number of patient treated free under the NEL threshold penalty
2. Key strategic issues

Integrated Business Plan (IBP) 2013/14 to 2017/18 – this will be a main agenda item for the June Board following the detailed review of the latest draft at the recent Board seminar.

The IBP will set out the Trusts strategy to serve the needs of its local population of half a million, which increases to a million for tertiary services.

A key strand within the document is that at the end of the 5 year period the Trust will have strengthened its position as a ‘district general hospital plus.’ This means delivering hyper acute, specialist and local services for patients primarily from Newbury, Reading, Wokingham, Ascot and Bracknell and south east Oxfordshire CCGs, at our main hospital sites. It also means continuing to develop our reputation for excellence in teaching, education, research and development.

A further strand will be an increasing focus on collaborative work in clinical networks to improve the quality and financial sustainability of acute hospital services within the recently approved Oxford Academic Health Sciences Network and in east Berkshire.

This will be matched by partnership work in west Berkshire to deliver the quality and financial benefits of integrated care.

The Trust will collaborate where possible and compete where necessary. The strategy for effectively competing with private hospitals is to create planned care centres at each hospital site and provide the capacity to reduce waiting times. This is the key determinant in patient choice.

An increase in demand is forecast which will result in activity and income growth of 2% to 3% per annum as a minimum. Income is forecast to increase from £333m in 2012/13 to £360m by 2017/18. This is driven by demographics, NHS market share increases and the development of other elements of the Trusts service portfolio. This will require investment in A&E, bed, critical care, maternity and theatre capacity to deliver the strategy, allied to continuing productivity gains.

The key risks to delivery are the ability of the Trust to achieve 3% cost savings each year, the CCGs ability to fund forecast demand and the Trusts ability to invest in additional capacity to meet the forecast increases in demand, whilst ‘living within its means.’ The strategic options will be clearly set out should these risks materialise over the five year period.

Annual Plan Review 2013/14 to 2015/16 – this is a main agenda item and sets out the Trusts priorities for the year ahead. The key challenges in delivering the plan are: the ability of CCGs to fund the level of forecast demand; making sure the Trust is paid for the work it does at full tariff and having sufficient capacity to deliver the activity plan. Good progress is being made on the Quality Innovation Productivity and Prevention (QIPP) plan with £9m risk adjusted delivery forecast in year so far, the target being £10m.

There are five key business cases that are being developed for Board consideration, to support delivery of the plan in year and the IBP going forwards. These include: two replacement MRI scanners; elective orthopaedic centre; pre-operative assessment unit and additional elective ward; expanded critical care and A&E facilities; maternity high dependency unit and estate safety investments.
Key strategic issues

**Business cases** – the first cases for Board consideration include two replacement MRI scanners and the development of an Elective Orthopaedic Centre. These are main agenda items, have the full support of the executive and each is critical to delivery of the annual plan and IBP. One provides the imaging capability and capacity needed to diagnose patients. The other provides the capacity needed to deliver a centre of excellence for elective orthopaedics, deliver low waiting times and regain market share from local private and NHS hospitals.

**Royal Berkshire Bracknell Clinic (RBBC)** – in advance of the June 2013 report to the Board by Dr Lindsey Barker on the future use of the RBBC, it should be noted that more patients are choosing to be treated there. As a consequence income has increased from £600k in 2011/12 to £2.5m in 2012/13.

The Trust has also registered its interest in developing a partnership bid for the minor injuries service that is being tendered by the Ascot and Bracknell CCG. It is expected that 21,000 patients will use this service initially, rising to 29,000.

The lead is Dr Sue Edees.

**EPR Impairment** – the Board confirmed that the Trust will take an impairment charge of £27.3m in its 2012/13 accounts. The impairment charge is part of a technical accounting process and reflects a decrease in the value of an asset on the Trust’s balance sheet and recognises any decrease as a loss in the income statement. There will be no impact on the high quality patient care delivered by the Trust as a result of this impairment. It is also important to note that the financial health of the Trust is sound, with a £500k surplus, 7.1% EBITDA and £40m cash delivered in 2012/13.

**Trust in the news**

The Trust received significant media coverage for ‘Fred and Wilma’ the new pharmacy robots including regional TV coverage.

The birth of quads at the hospital has been covered by national, regional and local media – and the team has supported a documentary team filming the family.

The pressures facing the emergency department received coverage locally.

The team is handling a high volume of calls regarding rumours that the Duchess of Cambridge plans to have her baby here. Pre event filming for those news channels who want to feature our maternity services as part of overall coverage when the baby is born is also being facilitated, including CNN who will provide global coverage.
3. Financial & Governance Summary

**Authorised:** 01 Jun 2006  
**Type:** Acute  
**Region:** South

**Financial Risk Rating:**
- **13/14 Plan:** YTD FY YTD Actual April
  - YTD: 2 3 2 2

**Governance Risk Rating as at YTD Q1:**
- **13/14 Plan:** GREEN
- **YTD Actual:** GREEN
- **Declared Risks:** GREEN

**13/14 Authorised limits**
- **Long term borrowing:** £66.4m
- **Working Capital Facility:** £20.0m

**Financial & Clinical Services Strategy**
- **Draft Strategic Plan** has highlighted that demand and need will grow, there are significant capacity / estate and financial challenges indicate that for the long term we will need to review all strategic options to continue to financial viable.
- **Key priorities business cases** are being developed to address the projected demand and need over 3-5 years.
- **Board** have reviewed the IBP and considering actions to evaluate long term options.
- **Increased administrative resourcing, improved processes.** Implementation of the EPR stabilisation plan and continued dialogue with Cerner are key actions that have been undertaken. Review of operating costs is on-going.
- **EPR operating costs** still remain considerably high and operational issues are still being encountered by staff with the system.
- **EPR system**
  - Extensive resources (financial and labour) continue to be consumed on the EPR, despite there being progress on addressing the operational inefficiencies of the system.
- **Governance Targets**
  - **A&E 95% target** was not met for April. High level of A&E demand continues and with capacity constraints (particularly in A&E, theatres and critical care) and meeting the target in the future will be challenging.
  - **Cancer Targets** have been breached for April 13, but further validation needs to be undertaken and the performance will be better after validation. Continued risk in this area remains.

**Action Taken/Committed**

<table>
<thead>
<tr>
<th>Key Issue</th>
<th>Gaps and Residual Concerns</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strategic Plan &amp; Clinical Services Strategy</strong></td>
<td>Business cases are significant in nature and will therefore require significant financial funds and Executive time.</td>
</tr>
<tr>
<td>Draft Strategic Plan has highlighted that demand and need will grow, there</td>
<td>Long term option identification and evaluation will take time.</td>
</tr>
<tr>
<td>are significant capacity / estate and financial challenges indicate that</td>
<td><strong>EPR system</strong></td>
</tr>
<tr>
<td>for the long term we will need to review all strategic options to continue</td>
<td><strong>EPR operating costs</strong></td>
</tr>
<tr>
<td>to financial viable.</td>
<td>remain considerably high and operational issues are still being encountered by staff with the system.</td>
</tr>
<tr>
<td><strong>Key priorities business cases</strong> are being developed to address the</td>
<td><strong>Governance Targets</strong></td>
</tr>
<tr>
<td>projected demand and need over 3-5 years.</td>
<td>Business cases to rectify the capacity constraints are being developed. These will be presented to the Board for approval over the next few months.</td>
</tr>
<tr>
<td><strong>Board</strong> have reviewed the IBP and considering actions to evaluate long</td>
<td><strong>Additional nursing and consultant staff</strong> have been recruited to help improve the performance on Cancer targets, and these will take impact from June onwards.</td>
</tr>
<tr>
<td>term options.</td>
<td>Significant risk of breach in A&amp;E and Cancer targets remains whilst business cases are being developed and change programmes commence.</td>
</tr>
</tbody>
</table>
4. Monitor Governance Rating Summary

<table>
<thead>
<tr>
<th>MONITOR Target or Indicator (per Compliance Framework 13/14)</th>
<th>Scoring</th>
<th>Target Q1</th>
<th>April (Forecast)</th>
</tr>
</thead>
<tbody>
<tr>
<td>18 Weeks: admitted patients</td>
<td>1.0</td>
<td>90%</td>
<td>93.3%</td>
</tr>
<tr>
<td>18 Weeks: non-admitted patients</td>
<td>1.0</td>
<td>95%</td>
<td>100.0%</td>
</tr>
<tr>
<td>18 Weeks: patients on incomplete pathways monthly target</td>
<td>1.0</td>
<td>92%</td>
<td>93.9%</td>
</tr>
<tr>
<td>A&amp;E: 4hr Limit (See Note *)</td>
<td>1.0</td>
<td>95%</td>
<td>88.5%</td>
</tr>
<tr>
<td>Meeting the C Diff objective</td>
<td>1.0</td>
<td>19</td>
<td>3</td>
</tr>
<tr>
<td>Cancer 31 day wait: anti cancer drug treatments</td>
<td>1.0</td>
<td>94%</td>
<td>90.9%</td>
</tr>
<tr>
<td>Cancer 31 day wait: radiotherapy</td>
<td>1.0</td>
<td>98%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Cancer 62 day wait: GP Referral</td>
<td>1.0</td>
<td>94%</td>
<td>98.4%</td>
</tr>
<tr>
<td>Cancer 62 day wait: NHS cancer screening service referral</td>
<td>1.0</td>
<td>85%</td>
<td>80.1%</td>
</tr>
<tr>
<td>Cancer 31 day wait to first treatment</td>
<td>0.5</td>
<td>96%</td>
<td>96.0%</td>
</tr>
<tr>
<td>Cancer 2 week wait: cancer suspected</td>
<td>0.5</td>
<td>93%</td>
<td>87.5%</td>
</tr>
<tr>
<td>Cancer 2 week wait: breast patients</td>
<td>1.0</td>
<td>93%</td>
<td>74.0%</td>
</tr>
<tr>
<td>Meeting the MRSA objective (See Note**)</td>
<td>1.0</td>
<td>6</td>
<td>0</td>
</tr>
</tbody>
</table>

Indicative Governance risk rating

Key

Note *: Should the Trust fail to meet the 4 hour A&E target in Q3, Q4 of 2012/13 or Q1 of 2013/14, then Monitor may override the governance risk rating to Red in line with the procedures set out in the Compliance Framework. Note **: Monitor’s Compliance Framework (2012/13) sets the de-minimus limit to six.

Key Messages

It should be noted that the targets relating to Cancer are still in the process of being validated and it is expected when May data is reported the actual performance for April will be significantly improved.

Furthermore, the overall Monitor Governance is risk rating is a quarterly assessment and the monthly rating is an indicative assessment for the month. It is anticipated based on the some of the early indicative performance for May 13, the overall performance will improve.

Cancer Targets – There has been a significant increase in 2ww referrals, particularly for breast, gynaecology and GI cancer referrals and additional clinics have been provided. CT capacity remains one of the main factors in the diagnostic pathway which is having a significant impact on the 62 day pathway. The Endoscopy capacity is also stretched due to high demand in lower GI referrals. The team is recruiting additional nurses which will allow the Trust to undertake additional endoscopy cases. In addition, a locum consultant is due to start June 2013 and the impact of the additional consultant and nurse will come through next month.

A&E – The Trust did not April target for the A&E 4 hour wait, due to considerable pressures as a consequence of demand. Performance has improved during May and the current quarterly position at the time of writing this report was 92.7%.

Action plans are being implemented, but there is risk of on-going compliance on key targets around A&E, Cancer and 18 weeks.
## Executive Summary

### Financial Targets
- A key financial aim for 2013/14 is to maintain our FRR of 3 through:
  - Delivering a small surplus
  - Managing capital spend
- The budget shows FRR of 3 maintained with £0.5m full year surplus

<table>
<thead>
<tr>
<th>Area of Review</th>
<th>Key Highlights</th>
<th>Month Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>FRR</td>
<td>FY FRR 1.7 which rounds to a 2 for Monitor reporting.</td>
<td></td>
</tr>
<tr>
<td>EBITDA</td>
<td><strong>EBITDA</strong>: £(0.4)m (-1.5%) M1 behind indicative budget of £0.0m. But conservative view if income has been taken.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Activity / Income</strong>: Underlying income lower than previous 2 quarters. However a conservative view of income has been taken with an income provision of £0.7m having been booked.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Pay Costs</strong>: £16.7m driven by increased emergency care costs and agency use</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Drugs</strong>: Continued improvement in underlying run rate.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Non Pay</strong>: £(0.4)m adverse vs Budget due to QIPPS and budget phasing</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>QIPPS</strong>: Full year cost QIPPs in budget of £9.7m. Monthly phasing to be confirmed.</td>
<td></td>
</tr>
<tr>
<td>Liquidity FRR /</td>
<td>Liquidity metric of 14.5 days equating to liquidity FRR of 2</td>
<td></td>
</tr>
<tr>
<td>Cash</td>
<td>Cash of £37.4m</td>
<td></td>
</tr>
<tr>
<td>Capital</td>
<td>M1 expenditure of £0.93m</td>
<td></td>
</tr>
</tbody>
</table>
### Results for Month 12

#### £'000

<table>
<thead>
<tr>
<th>Month</th>
<th>Act</th>
<th>Budget</th>
<th>PY</th>
<th>vs Budget</th>
<th>vs PY</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Income from Activities</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care Trusts Income</td>
<td>24,665</td>
<td>24,804</td>
<td>21,930</td>
<td>(139)</td>
<td>2,735</td>
</tr>
<tr>
<td>Specific Drug Funding</td>
<td>22,713</td>
<td>22,629</td>
<td>20,353</td>
<td>84</td>
<td>2,361</td>
</tr>
<tr>
<td><strong>Drugs Income</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drugs income</td>
<td>1,807</td>
<td>2,021</td>
<td>1,577</td>
<td>(214)</td>
<td>230</td>
</tr>
<tr>
<td>Devices Income</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Department Of Health Income</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Operating Income</td>
<td>1,517</td>
<td>1,492</td>
<td>1,874</td>
<td>24</td>
<td>(357)</td>
</tr>
<tr>
<td><strong>Total Income</strong></td>
<td>26,559</td>
<td>26,593</td>
<td>24,067</td>
<td>(33)</td>
<td>2,493</td>
</tr>
<tr>
<td><strong>Medical Staff</strong></td>
<td>(4,600)</td>
<td>(4,595)</td>
<td>(4,311)</td>
<td>(5)</td>
<td>(289)</td>
</tr>
<tr>
<td><strong>Nursing</strong></td>
<td>(6,958)</td>
<td>(6,610)</td>
<td>(6,238)</td>
<td>(348)</td>
<td>(720)</td>
</tr>
<tr>
<td><strong>PAMs</strong></td>
<td>(881)</td>
<td>(931)</td>
<td>(860)</td>
<td>51</td>
<td>(20)</td>
</tr>
<tr>
<td><strong>Scientist and PTBs</strong></td>
<td>(1,066)</td>
<td>(1,060)</td>
<td>(1,001)</td>
<td>(6)</td>
<td>(65)</td>
</tr>
<tr>
<td><strong>Pharmacists</strong></td>
<td>(194)</td>
<td>(182)</td>
<td>(171)</td>
<td>(12)</td>
<td>(23)</td>
</tr>
<tr>
<td><strong>Admin &amp; Management</strong></td>
<td>(2,209)</td>
<td>(2,414)</td>
<td>(2,082)</td>
<td>205</td>
<td>(127)</td>
</tr>
<tr>
<td><strong>Ancillary &amp; Maintenance</strong></td>
<td>(783)</td>
<td>(771)</td>
<td>(730)</td>
<td>(12)</td>
<td>(53)</td>
</tr>
<tr>
<td><strong>Other Pay</strong></td>
<td>(45)</td>
<td>229</td>
<td>(7)</td>
<td>(274)</td>
<td>(38)</td>
</tr>
<tr>
<td><strong>Total Pay</strong></td>
<td>(16,735)</td>
<td>(16,332)</td>
<td>(15,400)</td>
<td>(402)</td>
<td>(1,335)</td>
</tr>
<tr>
<td><strong>Drugs</strong></td>
<td>(2,443)</td>
<td>(2,866)</td>
<td>(2,683)</td>
<td>423</td>
<td>241</td>
</tr>
<tr>
<td><strong>Clinical Service &amp; Supplies</strong></td>
<td>(3,453)</td>
<td>(3,207)</td>
<td>(3,070)</td>
<td>(247)</td>
<td>(384)</td>
</tr>
<tr>
<td><strong>General Supplies &amp; Services</strong></td>
<td>(656)</td>
<td>(566)</td>
<td>(529)</td>
<td>(90)</td>
<td>(127)</td>
</tr>
<tr>
<td><strong>Establishment Expenses</strong></td>
<td>(271)</td>
<td>(294)</td>
<td>(255)</td>
<td>23</td>
<td>(16)</td>
</tr>
<tr>
<td><strong>Other Establishment Expenses</strong></td>
<td>(700)</td>
<td>(764)</td>
<td>(748)</td>
<td>65</td>
<td>48</td>
</tr>
<tr>
<td><strong>Prem, Trans &amp; Fixed Plant</strong></td>
<td>(1,774)</td>
<td>(1,507)</td>
<td>(1,123)</td>
<td>(286)</td>
<td>(651)</td>
</tr>
<tr>
<td><strong>Depreciation</strong></td>
<td>(1,331)</td>
<td>(1,338)</td>
<td>(1,157)</td>
<td>7</td>
<td>(173)</td>
</tr>
<tr>
<td><strong>Leases</strong></td>
<td>(81)</td>
<td>(183)</td>
<td>(183)</td>
<td>102</td>
<td>102</td>
</tr>
<tr>
<td><strong>Miscellaneous Services</strong></td>
<td>(846)</td>
<td>(659)</td>
<td>(783)</td>
<td>22</td>
<td>(64)</td>
</tr>
<tr>
<td><strong>Total Non Pay</strong></td>
<td>(11,555)</td>
<td>(11,594)</td>
<td>(10,531)</td>
<td>39</td>
<td>(1,024)</td>
</tr>
<tr>
<td><strong>PDC Dividend</strong></td>
<td>(417)</td>
<td>(450)</td>
<td>(482)</td>
<td>33</td>
<td>65</td>
</tr>
<tr>
<td><strong>Interest Receivable</strong></td>
<td>(99)</td>
<td>(135)</td>
<td>(147)</td>
<td>37</td>
<td>48</td>
</tr>
<tr>
<td><strong>Total Other</strong></td>
<td>(515)</td>
<td>(585)</td>
<td>(629)</td>
<td>70</td>
<td>113</td>
</tr>
<tr>
<td><strong>Exceptional</strong></td>
<td>(5)</td>
<td>(15)</td>
<td>(15)</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td><strong>Net Surplus/(Deficit)</strong></td>
<td>(2,250)</td>
<td>(1,934)</td>
<td>(2,508)</td>
<td>(316)</td>
<td>257</td>
</tr>
</tbody>
</table>
1. Financial Position

**Overall Draft Financial Performance** - M1 £(2.25)m deficit resulting in a £(0.32)m shortfall against budget. High levels of Urgent Care nursing pay and shortfalls due to flat-phased QIPPs targets countered by reducing drug costs vs budget.

### Results for Month

<table>
<thead>
<tr>
<th>£m</th>
<th>Actual</th>
<th>Vs Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>26.6</td>
<td>(0.0)</td>
</tr>
<tr>
<td>Pay</td>
<td>(16.7)</td>
<td>(0.4)</td>
</tr>
<tr>
<td>Drugs</td>
<td>(2.4)</td>
<td>0.4</td>
</tr>
<tr>
<td>Non Pay ex Drugs</td>
<td>(9.1)</td>
<td>(0.4)</td>
</tr>
<tr>
<td>Other</td>
<td>(0.5)</td>
<td>0.1</td>
</tr>
<tr>
<td>Exceptional Items</td>
<td>(0.0)</td>
<td>0.0</td>
</tr>
<tr>
<td>Surplus/(Deficit)</td>
<td>(2.25)</td>
<td>(0.32)</td>
</tr>
<tr>
<td>FRR</td>
<td>1.7</td>
<td></td>
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</table>

### Cashflow from Operations

<table>
<thead>
<tr>
<th>Actual</th>
<th>Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.48</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Month</th>
<th>MONTH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash</td>
<td></td>
</tr>
<tr>
<td>37.4</td>
<td></td>
</tr>
<tr>
<td>EBITDA</td>
<td></td>
</tr>
<tr>
<td>(0.4)</td>
<td>0.0</td>
</tr>
<tr>
<td>EBDITDA margin</td>
<td>-1.5%</td>
</tr>
</tbody>
</table>

### Net Surplus/(Deficit)

<table>
<thead>
<tr>
<th>Month</th>
<th>£m</th>
<th>Vs Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent Care</td>
<td>2.0</td>
<td>0.6</td>
</tr>
<tr>
<td>Planned Care</td>
<td>1.8</td>
<td>(0.5)</td>
</tr>
<tr>
<td>Networked Care</td>
<td>0.8</td>
<td>(0.1)</td>
</tr>
<tr>
<td>E&amp;F</td>
<td>(3.9)</td>
<td>(0.0)</td>
</tr>
<tr>
<td>Corporate Services</td>
<td>(5.0)</td>
<td>(0.3)</td>
</tr>
<tr>
<td>Total Trust</td>
<td>(2.25)</td>
<td>(0.32)</td>
</tr>
</tbody>
</table>

**Overall Trust Results vs Budget**

- FRR of 1.7, which rounds up to 2.
- Income inline with budget but an income provision of £0.7m has been booked.
- Pay costs continue to increase. Impacted by increased Agency costs especially in A&E and ICU Nursing.
- Drugs costs less than budget due to flat phased budgeted inflationary increases and a continuing decline in UCG drug costs.
- Non pay £(0.4)m adverse to budget due mainly to budget assumptions around QIPP’s timing and M1/M2 budget phasing.

**Care Group/Corporate Results vs Budget**

- Urgent Care £1m above income target due to higher activity but countered by higher Nursing pay, giving a £0.56m surplus
- Planned Care £(0.49)m deficit with a £(0.19)m missed income target plus additional £(0.27)m non-pay due to QIPPs budget phasing,
- Networked Care inline with budget but upside from delayed Drugs inflationary increases countered by clinical service QIPP’s not achieved
- E&F in line with budget
- Corporate Services deficit largely driven by £(0.7)m income provision created to offset Care Groups income surplus
Following the signing on the 28 March 2013 of a Heads of Terms Agreement with the local CCGs (i.e. those taking over from BWPCT and BEPCT) regular Executive-level negotiation meetings have been held and are on-going. The key areas of focus are the Activity, Financial and Business rules schedules to the Contract, with the majority of the quality issues now agreed.

The particular areas of focus that require agreement before Contracts can be formally signed relate to the following areas. The funding of Critical Care Services (to ensure these services are financially sustainable); the funding and management arrangements for the expected growth in emergency activity in 2013/14; the investment by the Commissioners of the deductions under the national tariff rules from non-elective activity where payment is restricted to just 30% of the full tariff, and from the non-payment of defined emergency readmissions within 30 days); the agreed levels of restrictions within the Business Rules (i.e. such as the number of outpatient follow-up appointments that will be paid under each specialty).

A specific area of difficulty has been defining the activity transfers, based on the new Identification Rules for prescribed Specialised Services, which in 2013/14 will be under a separate contract directly with the NHS Commissioning Board (via the Local Area Team). The Local Area Team will be helping the Trust’s Information Team on the practical application of these national rules that are open to interpretation.

It is currently expected that the Contract with the Berkshire area CCGs will be signed by the end of June with associate commissioners to the contract being agreed a few weeks later.

Assuming this timetable is followed a formal paper will be presented to the Board in June.

In respect of the formal closure of 2012/13 Contracts, as reported last month, these will finalised with commissioners after the final ‘freeze’ contract activity reports for 2012/13 are issued (i.e. June 2013).
Key issues

**Elective Orthopaedic Pathway - Vancomycin resistant Enterococcus (VRE)**
A cluster (2 or more cases linked in place & time) of clinical samples were positive for VRE. This included 3 patients with deep joint infections and 1 patient with superficial infection.
Robust attention is being given to clinical practice including hand hygiene, antimicrobial prescribing, aseptic technique and environmental cleaning
Infection control measures implemented to reduce transmission and cross-contamination
Elective surgery was suspended for 1 week
A dedicated elective orthopaedic ward (Lister) has been created which only accepts patients that are negative for VRE.

**Venous Thromboembolism (VTE)**
In spite of achieving the highest level of performance on VTE risk assessments the target was not achieved. This is due to the target increasing from 90% to 95% in April 2013; in April 91.6% of patients assessed for VTE risk. In April 96.47% patients received appropriate VTE prophylaxis.

**Pressure ulcers**
Whole health economy workshop held on 23rd April identified a number of key themes that we will take forward with partnership working

**Mortality**
HSMR 98.4 (Feb 12 – Jan 13)
SHMI 1.05 (Oct 11 – Sep 12)
RAMI 145 (Apr 13) Data are not yet complete for the last two months and contain lots of uncoded episodes. This interpretation is corroborated by the appearance of unpredictably very low Data quality scores. Also note that RAMI has now been re-benchmarked to 2013.
Crude mortality rate 1.8% (Apr 13)
## QIPP Delivery – 2013/14

### Summary of current position & achievement as at April 2013 ytd:

<table>
<thead>
<tr>
<th>Area</th>
<th>2013/14 value of cost saving opportunities</th>
<th>2013/14 value of income opportunities</th>
<th>Current PMO Risk Rating (cost)</th>
<th>Current PMO Risk Rating (income)</th>
<th>2013/14 Target for COST QIPPs (3%)</th>
<th>Year to date achievement (COST)</th>
<th>Year to date achievement (income)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corporates &amp; Trust wide</td>
<td>5,741</td>
<td>3,079</td>
<td>1,784</td>
<td>1,227</td>
<td>1,292</td>
<td>80</td>
<td>-</td>
</tr>
<tr>
<td>Planned Care</td>
<td>2,407</td>
<td>3,631</td>
<td>827</td>
<td>2,216</td>
<td>3,414</td>
<td>23.9</td>
<td>2.9</td>
</tr>
<tr>
<td>Networked Care</td>
<td>3,577</td>
<td>2</td>
<td>1,236</td>
<td>-</td>
<td>2,131</td>
<td>48.5</td>
<td>-</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>1,737</td>
<td>800</td>
<td>990</td>
<td>300</td>
<td>2,876</td>
<td>68.8</td>
<td>15</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>13,463</strong></td>
<td><strong>7,512</strong></td>
<td><strong>4,838</strong></td>
<td><strong>3,743</strong></td>
<td><strong>9,713</strong></td>
<td><strong>221.2</strong></td>
<td><strong>17.9</strong></td>
</tr>
</tbody>
</table>

In addition to cost QIPPs of £9.7m, income QIPPs of c£7.5m have also been built into the budget & will be allocated by area in next month’s report.

Above figures include carry forward value from 12/13 (£665k) & all projects (P1-P3) including Newtons supported projects, net of fees.

### Progression of risk rating & delivery as at 22<sup>nd</sup> May 2013:

#### Total Number of Projects on the PMO tracker

<table>
<thead>
<tr>
<th>Area</th>
<th>Total</th>
<th>RED</th>
<th>AMBER</th>
<th>GREEN</th>
<th>0</th>
<th>15</th>
<th>63</th>
<th>25</th>
<th>245</th>
</tr>
</thead>
<tbody>
<tr>
<td>Networked Care</td>
<td>49</td>
<td>34</td>
<td>0</td>
<td>15</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Planned Care</td>
<td>63</td>
<td>22</td>
<td>22</td>
<td>19</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgent Care</td>
<td>25</td>
<td>6</td>
<td>12</td>
<td>7</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Corporate &amp; Trustwide</td>
<td>245</td>
<td>53</td>
<td>18</td>
<td>37</td>
<td>78</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Current (Risk Rated) value of projects on the PMO tracker

<table>
<thead>
<tr>
<th>Area</th>
<th>Total</th>
<th>RED</th>
<th>AMBER</th>
<th>GREEN</th>
<th>0</th>
<th>15</th>
<th>63</th>
<th>25</th>
<th>245</th>
</tr>
</thead>
<tbody>
<tr>
<td>Networked Care</td>
<td>1,236.9</td>
<td>778.0</td>
<td>-</td>
<td>458.9</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Planned Care</td>
<td>3,043.6</td>
<td>600.8</td>
<td>1,371.9</td>
<td>1,070.9</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgent Care</td>
<td>1,291.1</td>
<td>2.1</td>
<td>1,193.7</td>
<td>95.3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Corporate &amp; Trustwide</td>
<td>3,011.1</td>
<td>677.7</td>
<td>1,913.8</td>
<td>419.5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Whilst opportunities of £20.9m have been identified, the PMO risk rating is still low at this stage, particularly in terms of the cost target and a significant push to develop all the ideas into robust plans for delivery is required over the next few weeks.
PwC were asked to carry out an internal audit of the QIPP Programme, in particular to review the governance arrangements and key controls that are in place. Their approach was based on the CIP Process in a high performing organisation, as set out in the Monitor guidance published in January 2012.

Their key findings were:-

**PMO Processes – no areas of risk identified**
- A positive response to the APR stage 2 review – confirmation that actions are complete.
- A significant improvement in the use of Quality Impact Assessments – a clear template & examples of the process operating effectively.
- Confirmation that the PMO Risk Rating is clear & the process for determining these are sound.
- Appropriate mix of skills & experience within the PMO team, and relationships between the team and the business are noted to be ‘strong and collaborative’.
- Advised that in light of the significant number of projects in the programme, the threshold for Projects being managed by the PMO should be reviewed (this was already underway prior to the audit and will be implemented shortly).

**Strategic Approach to QIPP – 3 areas of High Risk were identified**
1. High risk that the 2013/14 QIPP does not sit within a broader 5 year QIPP plan (although when asked, PwC advised that most trusts do not have this in place) and Interdependencies between projects are not always identified & communicated by project leads/teams.
2. High risk in that the trust has yet to identify total risk assessed projects to the total value of its 2013/14 target.
3. High risk in that the completeness of project documentation is currently low and project risks/barriers are not always challenged sufficiently at the planning stage within the project teams.

PwC will be reviewing the QIPP Programme on a quarterly basis for operational effectiveness. The focus of their next review in July 2013 will be:

- **Governance** – change from Finance Director to Medical Director & accountability for overall delivery of QIPP
- **Operating effectiveness** – progress against target, completeness of documentation, performance against budgets, PMO challenge
Support to deliver the QIPP Programme

Internal Support – update:

Quality Improvement leads now recruited (3 leads – 2 x internal, 1 x external)

QI leads – aim is for them to be in place by July.

Communications team to be re-located to enable the QI team to work from level 3.

QIPP Programme Launch:

At the time of writing, 6 presentations have been given over the first 4 days with around 290 staff having attended.

Feedback on both the presentation and the Quality Improvement room has been extremely positive.

6 Staff have signed up to be quality improvement ‘ambassadors’ to date.

Around 60 ideas for quality improvement have been put forward to date.

Requests for more presentations have been received as well as requests to sign up for the training programme (still to be developed!).

Next Steps:

More presentations to be offered, including sessions for night staff and staff at community facilities.

Working with Clinical Directors to engage them in presenting the new approach and supporting the Programme.

Training Programme to be designed and rolled out, initially for the wider Quality improvement team and then Trust wide.

Initial training sessions to include the Trust Exec and Board.
Networked Care Group maintained all access / waiting times targets and is within budget for April. Staffing on the wards has improved, with new starters arriving during May, however, still remains an area of concern and a focus for the Care Group QIPP programme.
Admissions avoidance / Delayed Transfers of Care / Discharge Lounge

**Discharge lounge**
456 people came in through the discharge lounge, of those 207 used hospital transport and 234 had private transport, the others either used Red Cross or Taxis.

**Delay Transfers:**
During April official delays dropped from 33 to 26 (5.34 to 4.44% total beds with a target of less than 4.5%). The number of patients who were fit to go, but not yet official delays remained high and systems resilience calls with community partners were recommenced to address system capacity issues.

**Admission Avoidance:**
285 patients were seen by the team and 24% were turned around. 43 people came in from care homes and 8 were returned on the same day. 9 people went out from CDU to community hospitals.
Care Group Summary

Best patient outcomes:
• In depth mortality review undertaken by Elderly care. To be presented at June Clinical governance

Best patient experience:
• Elderly Care Ward managers assistant commenced this month to release time to care.
• Epilepsy Nurse agreed and interviews planned for 31st May 2013
• Diabetes Specialist Nurse Joint working with primary care reviewed with extremely positive feedback
• Successful patient and Multidisciplinary team Picker Workshop

Best place to work, train & learn
• Nursing vacancies fell by 10 in April, HCA increased by 3
• Maintaining low levels of sickness absence to ensure better continuity and quality of care and lower NHS P and Agency spending

Best Value
• For the month Networked Care had a surplus of £0.79m, which is (£0.08m) below budget.
• The operational margin for the year was 12% compared to a budget of 13%
• Income and activity have been strong, whilst pay has been controlled.

Key risks:
• Inappropriate clinical accommodation, North Block, West Drive Melrose House
• NEL capacity and related staffing issues – but pressure has eased off this month
• Isolation rooms on Adelaide for Haematology patients

Key opportunities
• Funding to develop a Service Navigation Team to manage patient pathways
• Urgent Care Centre tender out for Bracknell, based at RBBC
**9. Urgent Care Group Dashboard**

### Patient Experience

<table>
<thead>
<tr>
<th></th>
<th>2013/14 Target pcm</th>
<th>2012/13 Full Year Av pcm</th>
<th>2013/14 April</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Surveys *</td>
<td>92%</td>
<td>83.57%</td>
<td>83.2%</td>
</tr>
<tr>
<td>Access &amp; Activity</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Clinical Outcomes

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<th></th>
<th>&lt;35</th>
<th>45</th>
<th>56</th>
</tr>
</thead>
<tbody>
<tr>
<td>Falls</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pressure ulcers</td>
<td>&lt;10</td>
<td>20</td>
<td>8</td>
</tr>
<tr>
<td>CDiff</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>SI</td>
<td>&lt;2</td>
<td>1.9</td>
<td>2</td>
</tr>
<tr>
<td>Dr Foster mortality alerts</td>
<td>0</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>SHMI</td>
<td>&lt;106</td>
<td>81</td>
<td>75/82</td>
</tr>
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### Finance

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<th>2013/14</th>
<th>2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pay against target</td>
<td>£5.05m</td>
<td>£5.58m</td>
<td>£5.58m</td>
</tr>
<tr>
<td>Non Pay against target</td>
<td>£1.24m</td>
<td>£1.23m</td>
<td>£1.23m</td>
</tr>
<tr>
<td>Income against target</td>
<td>£7.74m</td>
<td>£8.82m</td>
<td>£8.82m</td>
</tr>
</tbody>
</table>

### People

<table>
<thead>
<tr>
<th></th>
<th>2013/14</th>
<th>2013/14</th>
<th>2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appraisal rate</td>
<td>95%</td>
<td>90.2%</td>
<td>90.2%</td>
</tr>
<tr>
<td>Sickness rate</td>
<td>2.8%</td>
<td>3.49%</td>
<td>3.49%</td>
</tr>
<tr>
<td>Vacancies</td>
<td>5%</td>
<td>3%</td>
<td>3%</td>
</tr>
<tr>
<td>Nursing &amp; Midwifery Vacancies</td>
<td>5%</td>
<td>6.7%</td>
<td>6.7%</td>
</tr>
</tbody>
</table>

The Amber rating for Activity and Access is based on our performance against the A&E, Cancer, Cardiology and Stroke targets. All targets were met apart from the A&E 4 hour wait, see exception slide. Dr Foster red alerts remain in place for 12 months.
Strategy / partnership working
MRI business case to Board in May and Critical Care to feasibility study.
RBFT Paediatric Pharmacist has been asked to assist with the development of the suitability of Medusa (national IV drug administration guide) for children
ECIST steering group established
Notification of visit by the Care Quality Commission to monitor Section 120 of the Mental Health Act 1983 in acute hospitals

Best Patient Outcomes
• A&E target at 88.5% for April, challenging month with high activity and acuity levels, time to treatment times deteriorated to 68 minutes, achieving quarter 1 A&E 4 hour target, will remain a challenge
• We achieved 95.7% for respiratory cancers
• We achieved our stroke national targets
• National Cardiology target for call to balloon is less than 150 minutes. National recommendation for door to Balloon is less than 90 minutes. We are within acceptable clinical parameter and in the top quartile nationally.
• In Paediatrics, temporary formulary developed to address the shortfall in Medusa which is currently being updated to become more paediatric focused.
• Waiting times have increased to 6 weeks for both CT and MRI. There were 84 MRI breaches against the 6 week diagnostic target in April. Plans in place to outsource some cancer CT scans, and increase length of working day for CT scanner

Best Patient Experience:
• Review of home birth service to commence June 2013 will report Dec 2013
• VRE outbreak on Hunter ward led to decreased capacity for trauma patients and subsequent outlying of trauma patients in medical and surgical beds
• Friends and Family Test response rate for Urgent Care is 6.57%. The majority of respondents are likely or extremely likely to recommend our service to others.

Best Place to Work, Train & Learn
• Vacancy rate is reducing, retention is increasing, appraisal rate remains high
• Entonox levels fluctuating between acceptable and high readings. Weekly monitoring in place. Plan to install new ventilation system as part of this years capital project

Best Value
• The Urgent Care Group contribution to Trust overheads was £0.56m ahead of budget in Month 1, this was driven by continuing high emergency attendances and admissions, together with income relating to long stayers in ICU/Recovery area’.
• ‘Pay costs were £(0.5)m higher than budget in Month 1, this was driven by increased temporary staffing costs in ICU relating to the period of escalated beds, high costs on Redlands Ward (this is partly catch-up in NHSP agency invoices) and continuing high temporary staffing costs in the Emergency Department - supporting the increased emergency admissions and A&E attendances, whilst new staff members have their induction period’.

Key risks:
Emergency admission marginal rate and re-admission penalties driving the Care Group to a significant loss.
Continuing high non elective pressures of elderly frail patients impacting upon patient experience and adequate staffing levels.
Current consultant vacancies in A&E may impact upon operational efficiency of the department.
• The infrastructure and fabric of the ICU environment remains a concern and there is a plan being programmed to refurbish the air conditioning to the side rooms using a staged approach to minimise impact on capacity
• Reliability issues associated with ageing equipment remains a concern, particularly in MRI.
Emergency Department:
• With continued high levels of attendance along with high acuity levels the ED has been under considerable pressure in April. At times the capacity of the department has been exceeded resulting in patient queuing in corridors post stating and time critical treatments being delivered to patients in the corridor.
• A& 4 hour target was not achieved in April and time to treatment was prolonged. Achievement of the target for Quarter 1 remains fragile.

Ambulance Targets
• Data quality issues were raised with SCAS on the validity of their monthly data for April. SCAS have re-run the data and our performance according to SCAS with handovers within 15 minutes is 67% compliance.
• Data queries raised by RBFT if accepted our performance on the 15 minute target is 75.8% with 20 breaches over 30 minutes and no breaches over 60 minutes.

Patient Experience

<table>
<thead>
<tr>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;E attendances - Type 1 only</td>
<td>N/A</td>
<td>7,372</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seen within 4 hours - RBBH site Type 1 only</td>
<td>99%</td>
<td>87.09%</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Seen within 4 hours - RBH site Type 1 &amp; 2 only</td>
<td>99%</td>
<td>88.5%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Unplanned re-attendance rate</td>
<td>&lt;5%</td>
<td>2.0%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total time spent in A&amp;E (95th percentile)</td>
<td>&lt;4 hours</td>
<td>239</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Left department without being seen</td>
<td>&lt;5%</td>
<td>3.5%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time to treatment in department (median)</td>
<td>&lt;60 mins</td>
<td>68</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
10. Planned Care Group Dashboard

### Patient Experience

<table>
<thead>
<tr>
<th></th>
<th>2013/14 Target pcm</th>
<th>Performance April</th>
<th>Performance YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Surveys *</td>
<td></td>
<td>92%</td>
<td>90%</td>
</tr>
<tr>
<td>Access &amp; Activity</td>
<td></td>
<td></td>
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</tbody>
</table>

### Clinical Outcomes

<table>
<thead>
<tr>
<th></th>
<th>No serious harm</th>
<th>No serious harm</th>
<th>No serious harm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Falls</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pressure ulcers</td>
<td>No grades 3 or 4</td>
<td>No grades 3 or 4</td>
<td>No grades 3 or 4</td>
</tr>
<tr>
<td>CDiff</td>
<td>No reportable</td>
<td>1 reportable</td>
<td>1 reportable</td>
</tr>
<tr>
<td>SI</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr Foster mortality alerts</td>
<td>TBA</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>SHMI</td>
<td>72</td>
<td>58</td>
<td>58</td>
</tr>
</tbody>
</table>

### Finance

<table>
<thead>
<tr>
<th></th>
<th>2013/14 Target pcm</th>
<th>Performance April</th>
<th>Performance YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pay against budget</td>
<td>5,411</td>
<td>5,434</td>
<td>5,434</td>
</tr>
<tr>
<td>Non Pay against budget</td>
<td>3,255</td>
<td>3,527</td>
<td>3,527</td>
</tr>
<tr>
<td>Income against budget</td>
<td>10,959</td>
<td>10,768</td>
<td>10,768</td>
</tr>
</tbody>
</table>

### People

<table>
<thead>
<tr>
<th></th>
<th>2013/14 Target pcm</th>
<th>Performance April</th>
<th>Performance YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appraisal rate</td>
<td>95%</td>
<td>77.2</td>
<td>77.2</td>
</tr>
<tr>
<td>Sickness rate</td>
<td>2.8%</td>
<td>2.6%</td>
<td>2.6%</td>
</tr>
<tr>
<td>Vacancies</td>
<td>5%</td>
<td>10.3%</td>
<td>10.3%</td>
</tr>
</tbody>
</table>

Impact of the demand for critical care in March has resulted in underperformance of cancer targets in April due to the date of discharge. VRE infection in orthopaedics resulted in a loss of orthopaedic elective overnight surgery for one week, hence low activity and income levels. Overall the Care Group continues to maintain positive performance on SHMI and HSMR.
Patient Experience
Patients have been impacted by two major issues, the lack of ICU beds and the higher rates of infection (VRE) in Orthopaedics caused in part by patients undertaking multiple moves due to a lack of surgical beds. The elective orthopaedic patients were particularly affected by this as the management team tried to cohort them separately from the other surgical patients. The VRE issue resulted in Hunter and Lister wards being closed and 1 week of elective orthopaedic surgery was lost, thus delaying treatment.

The cancer access targets were breached as a result of the lack of ICU beds, causing a delay in surgery (patients were operated on in London). Diagnostics, particularly access to CT remains a major concern for the care group.

Access targets:
18 week targets have been achieved for the month. Cancer targets remain a challenge for the group. Validations continue and the overall position will improve. The lack of ICU beds resulted in surgery being delayed. The targets were impacted despite the subsequent transfer to the Wellington. Diagnostics in particular access to CT remains a significant issue within the pathway.

Clinical Outcomes
Oncology, Gynaecology, General Surgery and ENT are reporting a RAMI higher than the peer group. Cases will be reviewed to ensure correct coding has been applied to them.. Both ENT and Gynaecology have very low levels of expected deaths that even 1 will greatly effect the mortality figures.

Finance
- £486k adverse to budget EBITDA
- Income from activities £191k adverse to budget
- Pay £23k adverse to budget
- Non-pay £272k adverse to budget

Income has been affected by the reduced inpatient activity level for the reasons stated above with inpatient activity being 102 cases below the previous month run rate. Overall the care group undertook 547 POD spells more than March.

People
Spend on agency is below the Trust rate and work is being carried out to fill existing vacancies. Budgets have been amended to reflect approved business case's and this is reflected in the sharp rise in vacancy factor from M12.

Progress against appraisal targets continues to be monitored on a regular basis and circulated to Directorate Managers, Matrons and Clinical Director highlighting the progress through directorate workforce reports on a monthly
## Context

The targets are still to be validated further. The validations have been delayed due to short notice KPI audit requirements. The current reported position does not reflect the true position which will improve significantly. There has been a significant increase in 2ww referrals, particularly for breast, gynae and GI cancer referrals and additional clinics have been provided, validations are outstanding.

Lack of ICU bed availability had a significant impact on both the 31 day surgery and 62 day targets. 6 patients were treated at the wellington Hospital and 2 were here (requiring plastic support). These patients required surgery post long course radiotherapy. They were discharged during April.

CT capacity remains one of the main factors in the diagnostic pathway with a significant impact on the 62 day pathway.

The Endoscopy capacity is also stretched due to high demand in lower GI referrals

### Actions

**Endoscopy:** The team is recruit additional nurses to enable the endoscopy unit at WBCH to open this will provide 6 lists per week. Agreement has bee reached with Dunedin to undertake additional endoscopy cases. The locum consultant is due to start June 2013. The impact of the additional consultant and nurse will come through next month.

**CT:** Agreement has been reached with Dunedin to provide a CT list  per week. This will give an additional capacity of 8 to 10 cases week, to help with the capacity issues in Radiology.
1 Background

1.1 In February 2013, Robert Francis QC published the report of the public inquiry on the failings in the Mid Staffordshire NHS Foundation Trust between 2005 and 2009. The inquiry concluded the failings at the hospital went from the top to the bottom of the NHS. The three volume report covered:

(a) Warning signs
(b) Governance and Culture
(c) Roles of scrutiny, patient and public involvement groups, commissioners, the Strategic Health Authority and regulators
(d) Themes for the present and future
(e) 290 recommendations

1.2 The Trust is required to consider the report and decide how to apply the recommendations to our own work and in particular to announce at the earliest practicable time:

- The extent to which we accept the recommendations
- What we intend to do to implement them
- How we will provide an annual progress report on our actions

2 Our Approach

2.1 We are taking a consultative Trustwide approach to the Francis Report (2013) recommendations and using this to identify other areas for quality improvement.

2.2 We have initially set up a high level “Francis” Steering Group, led by the Medical Director and Executive Director of Nursing, which has reviewed the recommendations, identified those that are relevant to the Trust, and is now in the process of undertaking a self-assessment to produce a themed gap analysis.

2.3 Recommendations considered relevant due to provider focus, and the requirement to share, or submit information to other organisations are listed: 1-4, 7, 8, 11,12, 36, 37,
2.4 This gap analysis will include named Senior leads for each relevant recommendation who will review the information and ensure that evidence of compliance is also validated by frontline staff. Senior leads will provide an assurance rating for the compliance validation and then identify key staff needed for the project group to start robust action planning and implementation.

2.5 In conjunction with this, we have assembled a project group, with a much broader multi-disciplinary membership of staff at all levels, to provide assurance for the evidence for compliance and to take forward actions from the gap analysis.

2.6 We will provide on-going monitoring and review of these actions via the Clinical Governance Committee on at least an annual basis.

3 Recommendation

3.1 The Board is asked to note progress on the Francis recommendations

4 Contact

Contact: Hester Wain, Head of Patient Safety
Phone: 0118 322 8154
Title: Budget 2013 / 2014
Date: 30 May 2013
Lead: Craig Anderson
Purpose: To present the Budget for 2013/14 to the Board for approval

Decision required: The Board is asked to APPROVE the Budget for 2013/14.

FOI Status: This report will be made available on request
Background

The Budget is the consolidated budget for the Trust, HFMS and the Trust’s Charity. The Charity is included for the first time this year because we are required to consolidate the Charity into the main Trust results for our published results for 2013/14 onwards.

The Budget is the comparator against which we will present our actual results to Monitor through the year.

Budget Summary

The Summary Statement of Comprehensive Income ("SOCI") is set out below, with comparison to full year 2012/13. The actual results for Q4 2012/13 are also shown so that the change between Q4 2012/13 and Q1 2013/14 can be easily seen. The more detailed budget, for SOCI of Statement of Financial Position ("SOFP") and Cash Flow, showing quarterly phasing is attached in appendicies 1, 2 and 3.

<table>
<thead>
<tr>
<th>Total Trust</th>
<th>2013 Act £m</th>
<th>2013-14 BUDGET £m</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Income:</strong></td>
<td>Q4 FY</td>
<td>Q1 Q2 Q3 Q4 FY</td>
</tr>
<tr>
<td>PCT</td>
<td>77.3 287.7</td>
<td>72.8 71.8 73.2 71.4 289.1</td>
</tr>
<tr>
<td>Drugs</td>
<td>5.2 23.0</td>
<td>6.4 6.5 6.4 6.5 25.9</td>
</tr>
<tr>
<td>Other</td>
<td>6.8 23.8</td>
<td>5.4 5.4 5.4 5.4 21.4</td>
</tr>
<tr>
<td>Total Income</td>
<td>89.3 334.5</td>
<td>84.5 83.6 84.9 83.3 336.4</td>
</tr>
<tr>
<td>Pay</td>
<td>(48.8) (190.0)</td>
<td>(48.2) (48.5) (48.9) (48.9) (194.5)</td>
</tr>
<tr>
<td>% Income</td>
<td>-54.7% -56.8%</td>
<td>-57.0% -58.0% -57.5% -58.7% -57.8%</td>
</tr>
<tr>
<td>Drugs</td>
<td>(6.9) (31.1)</td>
<td>(8.7) (8.6) (8.5) (8.6) (34.4)</td>
</tr>
<tr>
<td>% Recovery</td>
<td>75.7% 74.0%</td>
<td>73.9% 75.6% 75.6% 76.2% 75.3%</td>
</tr>
<tr>
<td>Non Pay exc Depn</td>
<td>(23.3) (88.2)</td>
<td>(23.4) (20.9) (21.0) (19.8) (85.2)</td>
</tr>
<tr>
<td>% Income</td>
<td>-26.0% -26.4%</td>
<td>-27.6% -25.0% -24.8% -23.8% -25.3%</td>
</tr>
<tr>
<td>EBITDA</td>
<td>10.3 25.2</td>
<td>4.3 5.6 6.5 5.9 22.4</td>
</tr>
<tr>
<td>% Income</td>
<td>11.6% 7.5%</td>
<td>5.0% 6.7% 7.7% 7.1% 6.7%</td>
</tr>
<tr>
<td>Depn</td>
<td>(5.4) (17.8)</td>
<td>(3.9) (3.9) (3.9) (3.9) (15.7)</td>
</tr>
<tr>
<td>PDC/Other</td>
<td>(1.5) (6.9)</td>
<td>(1.6) (1.5) (1.6) (1.6) (6.2)</td>
</tr>
<tr>
<td>Surplus/(Deficit)</td>
<td>3.5 0.5</td>
<td>(1.3) 0.2 1.1 0.5 0.5</td>
</tr>
<tr>
<td>% Income</td>
<td>3.9% 0.2%</td>
<td>-1.5% 0.3% 1.2% 0.6% 0.1%</td>
</tr>
</tbody>
</table>

Basis of Preparation

The budget has been prepared on the basis of principles and assumptions that the Executive agreed at the outset of the process. These are set out in Appendix 4.
The budget has largely been built from the bottom up, the exception being for income. The intent was to base the income budget on the final activity plan, which was to be built up specialty by specialty by the care groups, but at the time of writing the activity plan has not been finalised.

**Statement of Comprehensive Income – key features**

The budget has been set at a minimal surplus of £0.5m. The Charity Committee has not yet agreed the budget for the Charity, so for the purpose of setting the overall Trust budget it has been assumed that the Charity will break even, so no surplus or deficit.

The budget reflects anticipated business cases, although for capital expenditure some selective use of lease arrangements is assumed.

**Income.**

Total budget income, excluding Drugs, is broadly flat compared to full year 2012/13. Drugs income shows an increase driven by inflation, as set out in the budget assumptions and by activity growth.

Activity. The Activity Plan has not yet been finalised. At the time the budget model was locked down the latest version of the Activity Plan was v2.8 and the resultant income based on that was £2m more than budget income. We expect that in finalising the Activity Plan £2m of activity will be removed from the Activity Plan, to leave it in line with budget income, and a corresponding £2m of cost will be removed from Care Group cost budgets, in respect of the cost of undertaking that activity, however this can’t be done until the Activity Plan is near completion.

At the time of writing the latest version of the Activity Plan is v3.1d and a comparison by Point of Delivery (“POD”) of the full year 2012/13 to v2.8 and to v3.1d is attached at Appendix 6. Key highlights are:

<table>
<thead>
<tr>
<th>Point of Delivery</th>
<th>Full year 12/13</th>
<th>V2.8</th>
<th>V3.1d</th>
<th>V2.8 v 12/13</th>
<th>V3.1d v 12/13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elective (EL+DC+OPPROC)</td>
<td>66,885</td>
<td>70,603</td>
<td>71,207</td>
<td>5.6%</td>
<td>6.5%</td>
</tr>
<tr>
<td>Non Elective (NEL+ NELSD+ NELST)</td>
<td>45,707</td>
<td>45,166</td>
<td>47,265</td>
<td>(1.2%)</td>
<td>3.4%</td>
</tr>
<tr>
<td>Outpatients (first and follow ups)</td>
<td>449,396</td>
<td>454,249</td>
<td>478,727</td>
<td>1.1%</td>
<td>6.5%</td>
</tr>
</tbody>
</table>

Contract with commissioners. The Trust view of activity is higher than that which the Commissioners have budgeted for and for which they will look to be reflected as an indicative activity plan in the contract. However, it is important to note that we have agreed the adoption of a standard payment by results contract for which activity risk is held by the Commissioners. has agreed that the Contract Activity Plan will be in line with the Heads of Terms agreed in March. In response the Commissioners may look to be contractual and seek to impose as many contract penalties as possible in order to fund growth elsewhere. This is dealt with below.

Penalties. The Budget includes £nil for contract income penalties. It is estimated this represents £10m of risk of which £8m is for Non Elective Threshold Penalty and 30 Day Readmissions Penalty. The Trust believes that financial balance in the healthcare economy is not sustainable on the basis of acute Trusts being funded at only 30% of tariff for non elective work above the 2008/09 levels and, particularly given the current media attention, that these penalties will not be applied in 2013/14.
CQUIN income is 2.5% of contract income and the budget reflects 90% achievement of CQUINS. This is in line with achievement in 2012/13.

Drugs. 10% inflation has been factored into both Drug Cost and Drug Income.

Income phasing. Income has been phased based on working days for planned work, eg elective, outpatients, and calendar days for non elective work, with adjustment to the number of working days for the peak holiday periods and for April, for which it is already known that actual activity was low.

Cost

The cost budget has been built bottom up and phased by the care groups and the corporates, based on run rate expenditure in 2012/13, with validation to ensure they reflect the budget assumptions set out in Appendix 4.

Pay. Pay is budgeted to be 58% of Income, which is consistent with 2012/13. Pay includes inflationary increase of 1% in April, which is in line with the national agreement reached on Agenda for Change. Whole Time Equivalents ("wte") are budgeted to fall by 2% from 4,690 at 31 March 2013 to 4,595 at 31 March 2014. The assumption is that this will be achieved by natural wastage. There is not a budget for termination costs.

QIPPs. The budget includes £9.7m of cost QIPP’s. At the time of writing the PMO risk rated estimate of QIPPs is £5.0m. The gap of £4.7m represents a risk to the budget. All QIPPs are held at Care Group / Corporate level, all bar £0.2m are held in Care Groups and Corporates.

A summary of the QIPP’s by Care Group by Quarter is attached at Appendix 5. The budget includes a central hedge against QIPPs to reduce the risk of non delivery of cost QIPPs at the start of the year. The effect of this hedge is to reduce cost QIPPs in Q1 by £1.0m, with an equal and opposite adjustment to cost QIPPs in Q4. The net effect across the year is £nil.

EPR. EPR costs are budgeted to fall from £7.4m in 2012/13 to £5.1m in 2013/14.

Contingency. The budget includes contingency of £1.8m.

Financial Risk Rating.

FRR is budgeted at 3 for all four quarters and the FRR metrics for each quarter are shown in Appendix 7.

Headroom over FRR 2 is small, at zero in Q1 (EBITDA is the trigger), £1.5m in Q2 (EBITDA is the trigger), £1.0m in Q3 (surplus is the trigger) and £0.5m in Q4 (liquidity is the trigger).

Monitor plans to change the financial kpi’s against which it monitors Trust financial performance, from the Financial Risk Rating currently in place to a Continuity of Service Rating ("CSR"). Monitor has been out to consultation on the CSR, but the outcome of that consultation has not been announced. In the consultation Monitor indicated that it intended to introduce CSR in Q3 2013/14. We have raised concerns with Monitor over the detailed calculation they have proposed for CSR, because we believe it is not logical and in particular does not cater for Trusts that have loan repayments scheduled less frequently than quarterly. The CSR is based on two kpi’s, the first is debt cover: the second is akin to the current liquidity metric under the existing FRR rules.
Capital Expenditure and Capital Receipts

Original call on the capital were approx £30m, which through prioritisation, have been reduced to £21m with some £7m being funded through lease arrangements to leave a budget of £14m. The Trust are working to increase this to atleast £15m through incremental funding from the CCG.

The current view of the split of capital spend is as follows:

<table>
<thead>
<tr>
<th>£m</th>
<th>Contractual Obligation</th>
<th>Statutory Compliance</th>
<th>Protects Income</th>
<th>Grows Income</th>
<th>Delivers Savings</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Call</td>
<td>3.15</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3.15</td>
</tr>
<tr>
<td>Estates</td>
<td>1.16</td>
<td>5.10</td>
<td>0.68</td>
<td>0.50</td>
<td></td>
<td>7.44</td>
</tr>
<tr>
<td>Medical (incl. building works)</td>
<td>0.50</td>
<td></td>
<td>9.50</td>
<td>5.41</td>
<td>3.00</td>
<td>18.41</td>
</tr>
<tr>
<td>Total</td>
<td>4.81</td>
<td>5.10</td>
<td>10.18</td>
<td>5.91</td>
<td>3.00</td>
<td>29.00</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>£m</th>
<th>Contractual Obligation</th>
<th>Statutory Compliance</th>
<th>Protects Income</th>
<th>Grows Income</th>
<th>Delivers Savings</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Budget Allocated :</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IT</td>
<td>1.90</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1.90</td>
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<tr>
<td>Estates</td>
<td>1.16</td>
<td>4.10</td>
<td></td>
<td></td>
<td></td>
<td>5.26</td>
</tr>
<tr>
<td>Medical (incl. building works)</td>
<td>0.50</td>
<td></td>
<td>8.50</td>
<td>3.00</td>
<td>2.00</td>
<td>14.00</td>
</tr>
<tr>
<td>Total</td>
<td>3.56</td>
<td>4.10</td>
<td>8.50</td>
<td>3.00</td>
<td>2.00</td>
<td>21.16</td>
</tr>
<tr>
<td>Lease funding</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>-7.10</td>
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<tr>
<td>Net Capital</td>
<td>3.56</td>
<td>4.10</td>
<td>6.20</td>
<td>0.20</td>
<td>0.00</td>
<td>14.06</td>
</tr>
</tbody>
</table>

Capital receipts of £4.7m are included in respect of the sale of the Craven Road properties and of Battle.

Other Non Routine Payments

The Trust has budgeted to repay in Q3 £7.5m of its loan for Bracknell Brants Bridge from Foundation Trust Financing Facility.

The Trust has budgeted to pay CSC payments of £0.5m in Q1, £1.1m in Q2 and £2.3m in Q4 in respect of the outsource IT contract in accordance with the draft memorandum of understanding, in respect of the company’s completion of contracted transformation works.

Cash. Cash is budgeted to fall to £17.8m in Q3, when the one off £7.5m repayment of FTFF loan is made, rising back to £20.2m by 31 March 2014.

Risks

<table>
<thead>
<tr>
<th>Risk</th>
<th>Mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>The final activity plan does not support the level of budgeted activity. If this occurs, then either cost budgeted for additional activity will be removed from the budget,</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>income</td>
<td>or cost QIPPs will be increased to compensate.</td>
</tr>
<tr>
<td>2</td>
<td>The commissioners are unable to pay for the activity undertaken</td>
</tr>
<tr>
<td></td>
<td>Protection of the PBR contract where activity risk falls to the Commissioners.</td>
</tr>
<tr>
<td>3</td>
<td>Delay in cash receipts. The contract with commissioners is not agreed by 30 June and the commissioners resort to non contractual arrangements.</td>
</tr>
<tr>
<td></td>
<td>Influence the commissioners not to resort to this measure. No impact on FRR, but delay in contractual inflows of at least 6 weeks, c£35m. Existing cash balance and drawdown on the £20m working capital facility to bridge could bridge the gap.</td>
</tr>
<tr>
<td>4</td>
<td>Penalties</td>
</tr>
<tr>
<td></td>
<td>The key risk and one which we regard as financially unsustainable, particularly in relation to NEL. The Trust will continue its local and national campaigning to seek a change in the penalty regime.</td>
</tr>
<tr>
<td>5</td>
<td>Local prices</td>
</tr>
<tr>
<td></td>
<td>We are seeking an increase in local pricing with Commissioners of some £3m. Our budget assumes we will be successful in achieving some 50% of this.</td>
</tr>
<tr>
<td>6</td>
<td>Non delivery of QIPPs results in non delivery of budget and FRR of 2.</td>
</tr>
<tr>
<td></td>
<td>Current projects identified total some £12m cost QIPPs (in year) with PMO assessment is circa £5m out of the budgeted £10m. A monthly QIPP programme board will monitor and progress this area.</td>
</tr>
<tr>
<td>7</td>
<td>EPR</td>
</tr>
<tr>
<td></td>
<td>The budget assumes we are successful in reducing annual operating costs form circa £6m to £3m.</td>
</tr>
<tr>
<td>8</td>
<td>Pressure on the capital expenditure results in capital spend driving an FRR of 2</td>
</tr>
<tr>
<td></td>
<td>Clinically informed, Executive lead prioritisation of capital spend. All capital projects approved and monitored by the Capital Investment Group (a sub commited of the Executive).</td>
</tr>
</tbody>
</table>

**Appendicies**

<p>| Appendix 1 | Budget Statement of Comprehensive Income, phased by quarter |
| Appendix 2 | Budget Statement of Financial Position, phased by quarter |
| Appendix 3 | Budget Cash Flow, phased by quarter |
| Appendix 4 | Budget principles and assumptions |
| Appendix 5 | Budget QIPPs by Care Group / Corporate by month |</p>
<table>
<thead>
<tr>
<th>Appendix 6</th>
<th>Activity by POD (Activity Plan v3.1d) compared to outturn 2012/13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appendix 7</td>
<td>Financial Risk Rating</td>
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### Appendix 1 – Budget Statement of Comprehensive Income

<table>
<thead>
<tr>
<th></th>
<th>2013/14 Budget £’000</th>
<th>Index vs YAG</th>
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<tr>
<td><strong>Income from Activities</strong></td>
<td>Q1</td>
<td>Q2</td>
</tr>
<tr>
<td>Income from Activities</td>
<td>79,192</td>
<td>78,281</td>
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<tr>
<td><strong>Primary Care Trusts Income (exc Dev</strong></td>
<td>72,771</td>
<td>71,756</td>
</tr>
<tr>
<td><strong>Drugs Income</strong></td>
<td>5,967</td>
<td>6,063</td>
</tr>
<tr>
<td><strong>Devices Income</strong></td>
<td>454</td>
<td>461</td>
</tr>
<tr>
<td><strong>Other Patient Care Income</strong></td>
<td>879</td>
<td>888</td>
</tr>
<tr>
<td><strong>Other Operating Income</strong></td>
<td>4,477</td>
<td>4,477</td>
</tr>
<tr>
<td><strong>Total Income</strong></td>
<td>84,548</td>
<td>83,646</td>
</tr>
<tr>
<td><strong>Medical Staff</strong></td>
<td>(13,792)</td>
<td>(13,915)</td>
</tr>
<tr>
<td><strong>Nursing</strong></td>
<td>(19,975)</td>
<td>(20,228)</td>
</tr>
<tr>
<td><strong>PAMs</strong></td>
<td>(2,799)</td>
<td>(2,814)</td>
</tr>
<tr>
<td><strong>Scientist and PTBs</strong></td>
<td>(3,191)</td>
<td>(3,207)</td>
</tr>
<tr>
<td><strong>Pharmacists</strong></td>
<td>(545)</td>
<td>(549)</td>
</tr>
<tr>
<td><strong>Admin &amp; Management</strong></td>
<td>(6,609)</td>
<td>(6,675)</td>
</tr>
<tr>
<td><strong>Ancillary &amp; Maintenance</strong></td>
<td>(2,250)</td>
<td>(2,305)</td>
</tr>
<tr>
<td><strong>Other Pay</strong></td>
<td>944</td>
<td>1,212</td>
</tr>
<tr>
<td><strong>Total Pay</strong></td>
<td>(48,217)</td>
<td>(48,477)</td>
</tr>
<tr>
<td><strong>Drugs</strong></td>
<td>(8,685)</td>
<td>(8,628)</td>
</tr>
<tr>
<td><strong>Clinical Service &amp; Supplies</strong></td>
<td>(9,658)</td>
<td>(9,582)</td>
</tr>
<tr>
<td><strong>General Supplies &amp; Services</strong></td>
<td>(1,693)</td>
<td>(1,854)</td>
</tr>
<tr>
<td><strong>Establishment Expenses</strong></td>
<td>(943)</td>
<td>(810)</td>
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<tr>
<td><strong>Other Establishment Expenses</strong></td>
<td>(2,361)</td>
<td>(2,271)</td>
</tr>
<tr>
<td><strong>Prem, Trans &amp; Fixed Plant</strong></td>
<td>(5,195)</td>
<td>(4,300)</td>
</tr>
<tr>
<td><strong>Depreciation</strong></td>
<td>(3,950)</td>
<td>(3,945)</td>
</tr>
<tr>
<td><strong>Leases</strong></td>
<td>(428)</td>
<td>(409)</td>
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<tr>
<td><strong>Miscellaneous Services</strong></td>
<td>(3,099)</td>
<td>(3,668)</td>
</tr>
<tr>
<td><strong>Total Non Pay</strong></td>
<td>(36,012)</td>
<td>(35,469)</td>
</tr>
<tr>
<td><strong>PDC Dividend</strong></td>
<td>(1,259)</td>
<td>(1,214)</td>
</tr>
<tr>
<td><strong>Interest Receivable</strong></td>
<td>(312)</td>
<td>(277)</td>
</tr>
<tr>
<td><strong>Total Other</strong></td>
<td>(1,571)</td>
<td>(1,490)</td>
</tr>
<tr>
<td><strong>Disposal of Assets</strong></td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Exceptional Items</strong></td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total Exceptional</strong></td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total Surplus/(Deficit)</strong></td>
<td>(1,252)</td>
<td>210</td>
</tr>
<tr>
<td><strong>EBITDA</strong></td>
<td>4,269</td>
<td>5,645</td>
</tr>
<tr>
<td><strong>EBITDA %</strong></td>
<td>5.0%</td>
<td>6.7%</td>
</tr>
</tbody>
</table>

Note: An Index vs YAG of 101 = 1% increase vs a year ago and index of 99 = 1% decrease vs a year ago
## Appendix 2 – Statement of Financial Position

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td><strong>Assets</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Intangible Assets, Net</strong></td>
<td>10.879</td>
<td>10.879</td>
<td>10.879</td>
<td>10.879</td>
<td>10.879</td>
<td>10.879</td>
</tr>
<tr>
<td><strong>Property, Plant and Equipment, Net</strong></td>
<td>190.856</td>
<td>187.906</td>
<td>186.961</td>
<td>188.047</td>
<td>189.134</td>
<td>186.911</td>
</tr>
<tr>
<td><strong>Deferred Tax Assets</strong></td>
<td>0.111</td>
<td>0.111</td>
<td>0.111</td>
<td>0.111</td>
<td>0.111</td>
<td>0.111</td>
</tr>
<tr>
<td><strong>Trade and Other Receivables, Net, Non-Current, Total</strong></td>
<td>0.759</td>
<td>0.759</td>
<td>0.759</td>
<td>0.759</td>
<td>0.759</td>
<td>0.759</td>
</tr>
<tr>
<td><strong>Other Assets, Non-Current, Total</strong></td>
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<td>0.000</td>
<td>0.000</td>
<td>0.000</td>
<td>0.000</td>
<td>0.000</td>
</tr>
<tr>
<td><strong>Assets, Non-Current, Total</strong></td>
<td>202.605</td>
<td>199.655</td>
<td>198.710</td>
<td>199.796</td>
<td>200.882</td>
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<tr>
<td><strong>Inventories</strong></td>
<td>5.135</td>
<td>5.135</td>
<td>5.135</td>
<td>5.135</td>
<td>5.135</td>
<td>5.135</td>
</tr>
<tr>
<td><strong>Prepayments, Current, Total</strong></td>
<td>1.775</td>
<td>3.500</td>
<td>3.000</td>
<td>2.500</td>
<td>2.000</td>
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<tr>
<td><strong>Other Assets, Current, Total</strong></td>
<td>4.670</td>
<td>4.670</td>
<td>0.000</td>
<td>0.000</td>
<td>0.000</td>
<td>0.000</td>
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<tr>
<td><strong>Assets, Current, Total</strong></td>
<td>60.916</td>
<td>53.459</td>
<td>47.711</td>
<td>38.636</td>
<td>38.223</td>
<td>38.223</td>
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<td><strong>ASSETS, TOTAL</strong></td>
<td>263.522</td>
<td>253.114</td>
<td>246.421</td>
<td>238.432</td>
<td>239.105</td>
<td>239.105</td>
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<tr>
<td><strong>Liabilities</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Interest-Bearing Borrowings, Current, Total</strong></td>
<td>(3.669)</td>
<td>(3.669)</td>
<td>(3.669)</td>
<td>(3.669)</td>
<td>(3.669)</td>
<td>(3.669)</td>
</tr>
<tr>
<td><strong>Deferred Income, Current</strong></td>
<td>(0.728)</td>
<td>(0.728)</td>
<td>(0.728)</td>
<td>(0.728)</td>
<td>(0.728)</td>
<td>(0.728)</td>
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<tr>
<td><strong>Provisions, Current</strong></td>
<td>(10.863)</td>
<td>(5.400)</td>
<td>(5.000)</td>
<td>(1.000)</td>
<td>(2.500)</td>
<td>(2.500)</td>
</tr>
<tr>
<td><strong>Current Tax Payables</strong></td>
<td>(3.818)</td>
<td>(3.900)</td>
<td>(3.900)</td>
<td>(3.850)</td>
<td>(3.850)</td>
<td>(3.900)</td>
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<tr>
<td><strong>Trade and Other Payables, Current, Total</strong></td>
<td>(10.639)</td>
<td>(8.564)</td>
<td>(8.239)</td>
<td>(8.014)</td>
<td>(8.489)</td>
<td>(8.393)</td>
</tr>
<tr>
<td><strong>Other Liabilities, Current, Total</strong></td>
<td>(4.703)</td>
<td>(2.365)</td>
<td>(1.756)</td>
<td>(1.148)</td>
<td>(0.896)</td>
<td>(0.896)</td>
</tr>
<tr>
<td><strong>Liabilities, Current, Total</strong></td>
<td>(56.481)</td>
<td>(49.195)</td>
<td>(42.492)</td>
<td>(42.982)</td>
<td>(43.682)</td>
<td>(43.682)</td>
</tr>
<tr>
<td><strong>NET CURRENT ASSETS (LIABILITIES)</strong></td>
<td>4.435</td>
<td>4.264</td>
<td>5.219</td>
<td>4.346</td>
<td>5.459</td>
<td>5.459</td>
</tr>
<tr>
<td><strong>Liabilities, Non-Current</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Interest-Bearing Borrowings, Non-Current, Total</strong></td>
<td>(34.244)</td>
<td>(32.444)</td>
<td>(32.444)</td>
<td>(23.144)</td>
<td>(23.144)</td>
<td>(19.475)</td>
</tr>
<tr>
<td><strong>Provisions, Non-Current</strong></td>
<td>(0.306)</td>
<td>(0.306)</td>
<td>(0.306)</td>
<td>(0.306)</td>
<td>(0.306)</td>
<td>(0.306)</td>
</tr>
<tr>
<td><strong>Trade and Other Payables, Non-Current, Total</strong></td>
<td>(1.435)</td>
<td>(1.300)</td>
<td>(1.166)</td>
<td>(1.031)</td>
<td>(0.539)</td>
<td>0.000</td>
</tr>
<tr>
<td><strong>Other Financial Liabilities, Non-Current, Total</strong></td>
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<td>0.000</td>
<td>0.000</td>
<td>0.000</td>
<td>0.000</td>
<td>0.000</td>
</tr>
<tr>
<td><strong>Other Liabilities, Non-Current, Total</strong></td>
<td>0.000</td>
<td>0.000</td>
<td>0.000</td>
<td>0.000</td>
<td>0.000</td>
<td>0.000</td>
</tr>
<tr>
<td><strong>Liabilities, Non-Current, Total</strong></td>
<td>(35.984)</td>
<td>(34.050)</td>
<td>(33.915)</td>
<td>(24.380)</td>
<td>(23.888)</td>
<td>(19.780)</td>
</tr>
<tr>
<td><strong>TOTAL ASSETS EMPLOYED</strong></td>
<td>171.056</td>
<td>169.870</td>
<td>170.015</td>
<td>171.070</td>
<td>171.535</td>
<td>171.535</td>
</tr>
<tr>
<td><strong>Taxpayers’ and Others’ Equity</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>TAXPAYERS EQUITY, TOTAL</strong></td>
<td>171.056</td>
<td>169.805</td>
<td>170.015</td>
<td>171.070</td>
<td>171.535</td>
<td>174.068</td>
</tr>
<tr>
<td><strong>TOTAL ASSETS EMPLOYED</strong></td>
<td>171.056</td>
<td>169.805</td>
<td>170.015</td>
<td>171.070</td>
<td>171.535</td>
<td>174.068</td>
</tr>
</tbody>
</table>
## Appendix 3 – Budget Cashflow

<table>
<thead>
<tr>
<th></th>
<th>Actual for Year ending 31-Mar-13</th>
<th>Plan for Quarter to 30-Jun-13</th>
<th>Plan for Quarter to 30-Sep-13</th>
<th>Plan for Quarter to 30-Dec-13</th>
<th>Plan for Quarter to 31-Mar-14</th>
<th>Plan for Year ending 31-Mar-14</th>
<th>Plan for Year ending 31-Mar-15</th>
<th>Plan for Year ending 31-Mar-16</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Surplus/(deficit) after tax</strong></td>
<td>(26.765)</td>
<td>(1.252)</td>
<td>0.210</td>
<td>1.055</td>
<td>0.465</td>
<td>0.479</td>
<td>2.534</td>
<td>4.844</td>
</tr>
<tr>
<td><strong>Operating Cash flows before movements in working capital</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-cash flows in operating surplus/(deficit), Total</td>
<td>50.353</td>
<td>5.520</td>
<td>5.435</td>
<td>5.470</td>
<td>5.473</td>
<td>21.899</td>
<td>22.599</td>
<td>22.599</td>
</tr>
<tr>
<td><strong>Net cash inflow/(outflow) from operating activities</strong></td>
<td>23.588</td>
<td>4.269</td>
<td>5.645</td>
<td>6.526</td>
<td>5.938</td>
<td>22.378</td>
<td>25.133</td>
<td>27.444</td>
</tr>
<tr>
<td>Increase/(Decrease) in working capital, Total</td>
<td>8.853</td>
<td>(10.750)</td>
<td>(1.999)</td>
<td>(0.523)</td>
<td>4.214</td>
<td>(9.058)</td>
<td>(1.501)</td>
<td>(1.902)</td>
</tr>
<tr>
<td><strong>Net cash inflow/(outflow) before financing</strong></td>
<td>32.441</td>
<td>(6.481)</td>
<td>3.647</td>
<td>6.002</td>
<td>10.152</td>
<td>13.320</td>
<td>23.632</td>
<td>25.542</td>
</tr>
<tr>
<td>Net cash inflow/(outflow) from investing activities, Total</td>
<td>(21.390)</td>
<td>(2.970)</td>
<td>(3.000)</td>
<td>(5.000)</td>
<td>(4.500)</td>
<td>(15.470)</td>
<td>(14.200)</td>
<td>(14.200)</td>
</tr>
<tr>
<td><strong>Net cash inflow/(outflow) before financing</strong></td>
<td>11.051</td>
<td>(9.451)</td>
<td>0.647</td>
<td>1.002</td>
<td>5.652</td>
<td>(2.150)</td>
<td>9.432</td>
<td>11.342</td>
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<tr>
<td>Net cash inflow/(outflow) from financing activities, Total</td>
<td>(7.535)</td>
<td>(2.181)</td>
<td>(2.949)</td>
<td>(9.566)</td>
<td>(3.265)</td>
<td>(17.961)</td>
<td>(10.425)</td>
<td>(10.098)</td>
</tr>
<tr>
<td><strong>Net increase/(decrease) in cash</strong></td>
<td>3.516</td>
<td>(11.632)</td>
<td>(2.302)</td>
<td>(8.563)</td>
<td>2.387</td>
<td>(20.111)</td>
<td>(0.993)</td>
<td>1.244</td>
</tr>
</tbody>
</table>
Appendix 4 – Budget Principles and assumptions

- Income flat except for drugs, hence 2012/13 non recurrent income substituted by recurrent income in 2013/14
- Standard inflation rates applied to all areas of the Trust
  - Pay: 1%
  - Non Pay ex Drugs: 2.5%
  - Drugs: 10%
- 3% of income QIPP target for the Trust, applied across all areas (and held within individual budgets)
- No centrally-held QIPPs
- No double-counts between Service Developments and QIPPs
- Agreed Demand changes to be factored into CG targets
Appendix 5 – Budget QIPPs by Care Group/Corporate

The budget includes a central cost QIPP hedge, held at the centre, to reduce risk of non delivery of cost QIPPs in the early part of the year. The hedge reduces QIPP’s in Q1 by £1.0m, with an equal and opposite increase to QIPP’s in Q4. The net effect of the hedge is £nil across the year.
## Appendix 6 -
### Comparison by POD - 2012/13 Outturn vs 2013/14 Activity Plan

<table>
<thead>
<tr>
<th>POD</th>
<th>POD Desc</th>
<th>Activity Actual</th>
<th>Activity Plan v2.8</th>
<th>Activity Plan v3.1d</th>
<th>v2.8 v 12/13</th>
<th>v3.1d v 12/13</th>
<th>Change (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>AandE</td>
<td>Accident and Emergency</td>
<td>101,642</td>
<td>100,774</td>
<td>101,673</td>
<td>-0.9%</td>
<td>0.0%</td>
<td></td>
</tr>
<tr>
<td>BLOCK</td>
<td>Block Funded Items</td>
<td>684</td>
<td>804</td>
<td>804</td>
<td>17.5%</td>
<td>17.5%</td>
<td></td>
</tr>
<tr>
<td>DC</td>
<td>Day Cases</td>
<td>32,272</td>
<td>33,905</td>
<td>33,905</td>
<td>5.1%</td>
<td>5.1%</td>
<td></td>
</tr>
<tr>
<td>DI</td>
<td>Diagnostic Imaging whilst Out-Patient</td>
<td>0</td>
<td>50,432</td>
<td>65,085</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DRUGS</td>
<td>Specific Drug HRGs</td>
<td>0</td>
<td>3,642</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EL</td>
<td>Elective</td>
<td>8,101</td>
<td>8,712</td>
<td>8,580</td>
<td>7.5%</td>
<td>5.9%</td>
<td></td>
</tr>
<tr>
<td>ELXBD</td>
<td>Excess bed days Non-Elective</td>
<td>2,383</td>
<td>2,735</td>
<td>2,735</td>
<td>14.8%</td>
<td>14.8%</td>
<td></td>
</tr>
<tr>
<td>ICU</td>
<td>Critical Care Bed Days</td>
<td>9,434</td>
<td>9,265</td>
<td>11,028</td>
<td>-1.8%</td>
<td>16.9%</td>
<td></td>
</tr>
<tr>
<td>NEL</td>
<td>Non-Elective</td>
<td>29,487</td>
<td>29,402</td>
<td>30,541</td>
<td>-0.3%</td>
<td>3.6%</td>
<td></td>
</tr>
<tr>
<td>NELNE</td>
<td>Non-Elective Non Emergency</td>
<td>12,577</td>
<td>11,986</td>
<td>12,589</td>
<td>-4.7%</td>
<td>0.1%</td>
<td></td>
</tr>
<tr>
<td>NELNEXBD</td>
<td>Excess bed days Non-Elective Non-Elective</td>
<td>928</td>
<td>2,252</td>
<td>2,273</td>
<td>142.7%</td>
<td>144.9%</td>
<td></td>
</tr>
<tr>
<td>NELS</td>
<td>Non-Elective Same Day Emergency Care</td>
<td>713</td>
<td>979</td>
<td>1,134</td>
<td>37.2%</td>
<td>59.0%</td>
<td></td>
</tr>
<tr>
<td>NELST</td>
<td>Emergency Short Stay</td>
<td>2,930</td>
<td>2,799</td>
<td>3,001</td>
<td>-4.5%</td>
<td>2.4%</td>
<td></td>
</tr>
<tr>
<td>NELXBD</td>
<td>Excess bed days Emergency</td>
<td>18,213</td>
<td>19,584</td>
<td>19,199</td>
<td>7.5%</td>
<td>5.4%</td>
<td></td>
</tr>
<tr>
<td>NFT</td>
<td>Non Face-to-Face</td>
<td>1,671</td>
<td>1,702</td>
<td>1,798</td>
<td>1.8%</td>
<td>7.6%</td>
<td></td>
</tr>
<tr>
<td>OPFAMPCL</td>
<td>Outpatient FA Multi Prof Cons Led</td>
<td>3,983</td>
<td>4,132</td>
<td>4,346</td>
<td>3.7%</td>
<td>9.1%</td>
<td></td>
</tr>
<tr>
<td>OPFASPC</td>
<td>Outpatient FA Single Prof Cons Led</td>
<td>143,323</td>
<td>146,867</td>
<td>153,502</td>
<td>2.5%</td>
<td>7.1%</td>
<td></td>
</tr>
<tr>
<td>OPFASPNCL</td>
<td>Outpatient FA Single Prof Non-Cons Led</td>
<td>9,404</td>
<td>9,526</td>
<td>10,003</td>
<td>1.3%</td>
<td>6.4%</td>
<td></td>
</tr>
<tr>
<td>OPFUFMPCL</td>
<td>Outpatient FUP Multi Prof Cons Led</td>
<td>6,838</td>
<td>6,763</td>
<td>7,093</td>
<td>-1.1%</td>
<td>3.7%</td>
<td></td>
</tr>
<tr>
<td>OPFUFSPCL</td>
<td>Outpatient FUP Single Prof Cons Led</td>
<td>226,007</td>
<td>225,891</td>
<td>239,654</td>
<td>-0.1%</td>
<td>6.0%</td>
<td></td>
</tr>
<tr>
<td>OPFUFSPNCL</td>
<td>Outpatient FUP Single Prof Non-Cons Led</td>
<td>59,841</td>
<td>61,070</td>
<td>64,128</td>
<td>2.1%</td>
<td>7.2%</td>
<td></td>
</tr>
<tr>
<td>OPPRO</td>
<td>Outpatient Procedures</td>
<td>26,512</td>
<td>27,986</td>
<td>28,722</td>
<td>5.6%</td>
<td>8.3%</td>
<td></td>
</tr>
<tr>
<td>OTHER</td>
<td>Other Activity Driven Items</td>
<td>96,793</td>
<td>157,924</td>
<td>156,842</td>
<td>63.2%</td>
<td>62.0%</td>
<td></td>
</tr>
<tr>
<td>PATH</td>
<td>Pathology Direct Access</td>
<td>2,982,912</td>
<td>3,015,000</td>
<td>3,015,000</td>
<td>1.1%</td>
<td>1.1%</td>
<td></td>
</tr>
<tr>
<td>PREOP</td>
<td>Pre-Operative Assessments</td>
<td>18,367</td>
<td>18,924</td>
<td>19,868</td>
<td>3.0%</td>
<td>8.2%</td>
<td></td>
</tr>
<tr>
<td>RADAY</td>
<td>Regular Day Admission</td>
<td>3,510</td>
<td>3,614</td>
<td>2,217</td>
<td>3.0%</td>
<td>-36.8%</td>
<td></td>
</tr>
<tr>
<td>REHAB</td>
<td>Rehabilitation post discharge</td>
<td>0</td>
<td>323</td>
<td>323</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RENAL</td>
<td>Renal Patients (incl EPO Drugs)</td>
<td>244,145,190</td>
<td>238,001,100</td>
<td>238,278,812</td>
<td>-2.5%</td>
<td>-2.4%</td>
<td></td>
</tr>
<tr>
<td>UNBUN</td>
<td>Unbundled HRGs</td>
<td>16,398</td>
<td>6,590</td>
<td>-100.0%</td>
<td>-59.8%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>XRAY</td>
<td>Radiology Direct Access</td>
<td>37,592</td>
<td>35,759</td>
<td>34,515</td>
<td>-4.9%</td>
<td>-8.2%</td>
<td></td>
</tr>
</tbody>
</table>
## APPENDIX 7

### Financial Risk Rating

<table>
<thead>
<tr>
<th></th>
<th>Historic Year to 31-Mar-13</th>
<th>Forecast YTD to 30-Jun-13</th>
<th>Forecast YTD to 30-Sep-13</th>
<th>Forecast YTD to 31-Dec-13</th>
<th>Forecast Year to 31-Mar-14</th>
<th>Forecast Year to 31-Mar-15</th>
<th>Forecast Year to 31-Mar-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Underlying performance</td>
<td>EBITDA YTD from SoCI</td>
<td>23.593</td>
<td>4.269</td>
<td>9.914</td>
<td>16.440</td>
<td>22.378</td>
<td>25.133</td>
</tr>
<tr>
<td></td>
<td>Operating Income YTD from SoCI</td>
<td>335.417</td>
<td>84.548</td>
<td>168.195</td>
<td>255.123</td>
<td>336.400</td>
<td>343.260</td>
</tr>
<tr>
<td>EBITDA Margin metric</td>
<td>7.1%</td>
<td>5.0%</td>
<td>5.9%</td>
<td>6.9%</td>
<td>6.7%</td>
<td>7.3%</td>
<td>7.8%</td>
</tr>
<tr>
<td>EBITDA Margin rating</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
</tbody>
</table>

### Achievement of plan

<table>
<thead>
<tr>
<th>Actual EBITDA 2012-13 from SoCI</th>
<th>Planned EBITDA 2012-13 (original plan or assessment figure)</th>
<th>EBITDA % of plan achieved metric</th>
<th>EBITDA % of plan achieved rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>23.593</td>
<td>25.950</td>
<td>90.9%</td>
<td>4</td>
</tr>
</tbody>
</table>

### Financial Efficiency

<table>
<thead>
<tr>
<th>Net return after financing costs, YTD from SoCI</th>
<th>(1.252)</th>
<th>(1.042)</th>
<th>0.13</th>
<th>0.479</th>
<th>2.534</th>
<th>4.844</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opening Financing</td>
<td>0.538</td>
<td>(1.252)</td>
<td>(1.042)</td>
<td>0.13</td>
<td>0.479</td>
<td>2.534</td>
</tr>
<tr>
<td>Closing Financing</td>
<td>208.969</td>
<td>209.917</td>
<td>206.127</td>
<td>197.882</td>
<td>198.347</td>
<td>197.212</td>
</tr>
</tbody>
</table>

### Liquidity

| Operating expenditure YTD from SoCI     | 309.824 | 80.260 | 158.281 | 236.684 | 314.022 | 316.127 | 322.850 |

| Weighted Average Rating | 2.90 | 2.70 | 2.70 | 2.65 | 2.65 | 2.65 | 3.30 |

The FRR rounds up to a 3 in all quarters of 2013/14.
Title: Elective Orthopaedic Centre Business Case

Date: 30 May 2013

Lead: Peter Malone

Purpose: The purpose of this paper is to request the approval for the addition of two additional laminar flow operating theatres and an extension to Redlands Ward creating a self-contained Elective Orthopaedic environment.

Key Points:

- A key constraint to driving more orthopaedic activity is the availability of laminar flow theatres and protected elective orthopaedic beds for joint replacement surgery.

- The business case will address the additional theatre capacity required to improve access and waiting times for orthopaedic surgery, market share growth, service development and additional laminar flow capacity for breast surgery.

- The Trust currently lease two theatres and Redlands Ward through PKL and this business case proposes to extend the current PKL building to incorporate a further two theatres and an extension to the ward.

- The increase in lease costs amounts to £22k+VAT per month.

- The business case delivers a surplus of £4.5m per annum recurring (assuming operational from 1 April 2014).

- The cash generated from the project is forecast to be in excess of £70m over the project’s life (15 years assumed).

- In addition to providing additional theatre capacity to drive activity, the theatres will provide the Trust with resilience when there is unplanned downtime within the theatre complex, will support growth and market share claw back and provide greater robustness during the two-year planned programme of theatre refurbishment.

- Will provide patients with improved experience and outcomes throughout their 18 week pathway and will bring the Trust in line with the Enhanced Recovery principles.

Decision required: The Board is invited to approve the extension to the current PKL building to incorporate two additional laminar flow theatres, a purpose built recovery room and an extension and refurbishment of the current Redlands Ward.
FOI Status

This report will be made available on request

The following documents are available on request to the Director of Corporate Affairs:

1. Business Case – New Orthopaedic Elective Centre
2. Appendix One – Market Share & Growth
3. Appendix Two – Financial Table
4. Appendix Three – Cash Flow Statement
5. Appendix Four - Supplier Quotation
6. Appendix Five – Estates Costs
7. Appendix Six - Drawings

Contact

Mr Peter Malone
Care Group Director – Planned Care
Telephone Number: 0118 322 8271
Board of Directors

Title: Replacement of MRI Scanners in Radiology Business Case

Date: 30 May 2013

Lead: Sue Edees

Purpose: The purpose of this paper is to request approval to replace the two now obsolete 1.5Tesla (T) MRI scanners in Radiology with a 1.5T and a 3T scanner configuration. The project will include reconfiguration of the existing scanner rooms necessary to address current risks to service continuity and to accommodate the proposed scanners. Whilst a 1.5T will be required for certain clinical conditions, the addition of a 3T will provide enhanced clinical diagnostics, allow for repatriation of some scans currently outsourced and increase capacity to meet e.g. the Orthopaedic Theatres Business Case. Whilst the current tariff arrangements are such that there is no direct tariff relating to inpatient MRI scans the Trust is happy that the clinical services it supports return sufficient income and margin to cover the cost of this proposal for MRI services, given that some 60% of MRI scans support orthopaedic work which currently returns a contribution of 17.6%.

Key Points: Introduction

- MRI is a fundamental imaging technique providing a level of anatomical detail invaluable in the diagnosis and management of many clinical conditions. The Radiology Department performs in excess of 12,000 MRI scans per annum (2011/12), with an average annual increase of 3.25% over the last five years.

- MRI scanning underpins significant volumes of clinical activity across the organisation. Failure to provide this service in an efficient manner will result in a loss of income and contribution to the Trust.

- The current scanners are over eleven years old against a recommended operating life of seven years and are operating at capacity. Increasing age related performance issues and reliance on reconditioned parts has led to significant periods of downtime, with associated impact on patient care and the ability to meet performance targets. The age of the current scanners would also preclude us from AQP status, precluding us from growing our market share.

- 3T (high-field) MRI is the current generation diagnostic technology. 3T scanners offer quicker scan times and enhanced image quality so provide increased capacity and clinical benefit. It is the technology which is now required for certain investigations such as breast imaging.
• The faster scan times allow this additional capacity to be achieved without the need to increase staffing establishment or to procure additional scanners.

• Investment in a 3T scanner at the present time is necessary to support the Trust Clinical Strategy, both with regard to capacity and clinical application.

• There are scanners of higher field strength (4.5T, 7T etc) but these are currently for research purposes only.

• The on-going reliability and image quality issues have necessitated bringing the mobile scanner back to the RBH site, thus preventing the Trust from meeting its commitment to locate the mobile at West Berkshire Community Hospital.

• The current room configuration has major operational disadvantages as one of the scanners is not located on an outer wall. If the inner scanner were to fail, its removal would necessitate decommissioning and removal of the outer scanner resulting in total loss of service with associated clinical and business risk. Significant building costs would be incurred to reinstate the fabric of the rooms and restore the service.

• The existing rooms are served by a single chiller unit of the same age as the scanners. This is subject to episodes of failure which take both scanner rooms out of commission, with associated loss of clinical service.

• The proposed reconfiguration of the floor space will address the issues with the current room layout and will enable the introduction of the 3T scanner, currently precluded due to the required magnetic field size exceeding the dimensions of the current room. It will also provide flexibility to accommodate a third CT scanner in the future if ongoing growth in activity demands it.

• This business case addresses the current risks to clinical service provision and to Trust income. It will provide the additional capacity and enhanced clinical applications required to improve access and waiting times for MRI diagnostics, increase market share growth, and support future clinical service developments.

**Clinical benefits of a 3.0T MRI Scanner over 1.5T**

• The procurement of a 3T scanner will provide a range of clinical benefits not available with 1.5T technology. These are of major relevance to Orthopaedics, Neurology, Cardiology, Vascular and Oncology.

• Clinical studies have shown consistent benefits of 3T over 1.5T with respect to speed of scan, image quality and the confidence with which pathology can be detected. Some examples are:

• In musculoskeletal imaging 3T provides improved visualisation of all joints, cartilage and nerves. This offers the potential to reduce the number of patients requiring arthrograms.
• In neurological imaging the greater resolution allows subtle brain pathologies to be detected, which would not be detectable at 1.5T. This includes earlier detection of tumours and micro-bleeds, with options for earlier intervention and positive treatment outcomes.

• In tumours of the prostate 3T reduces the need for biopsies by approximately one third, it facilitates accurate targeting of biopsy procedures and allows earlier recognition and treatment of cancer.

• 3T allows more comprehensive assessment of breast tumours and informs decisions around the surgical options of lumpectomy or mastectomy, with improved health outcomes.

• In addition scanning times by 3T can be reduced by ~50%, depending on the anatomical detail required. The Radiology Department will commit to delivering the projected additional activity of 800 - 1000 scans per annum.

**Financial overview**

• Whilst the current tariff arrangements are such that there is no direct tariff relating to inpatient MRI scans the Trust is happy that the clinical services it supports return sufficient income and margin to cover the cost of this proposal for MRI services.

• Approximately 60% of MRI activity relates to Trauma & Orthopaedics and Neurology.

• The Planned Care Theatres Business Case will increase the number of inpatient hip and knee replacements by approximately 300 each p.a., generating additional annual income for the Trust of £4.2m. Orthopaedics currently generates a contribution to Trust overheads of 17.6%; on this basis the additional activity would generate an additional contribution to overheads of £740k p.a. As previously mentioned, the MRI Services are currently at capacity; the preferred option of a 3T scanner, with its increased productivity and resolution, would enable the Trust to meet this activity plan. Replacing with 2 x 1.5T scanners will not achieve this.

• In addition the Planned Care Theatres Business Case significantly increases the Arthroscopy activity which will require significant MRI support.

• The MRI Scanners also support the TIA Service; current TIA income is £0.73m, which includes £0.16m of Best Practice Tariff income.

• The Trust currently outsources open MRI scans to the value of approximately £35K p.a.; this requirement will reduce with this proposal.

• The potential loss of Direct Access Income under AQP (due to age of current scanners) equates to £0.25m per annum.

• A 3T scanner will future-proof the service and give the Trust a significant competitive advantage as the only local provider
currently offering 3T technology.

**Option appraisal**

- Seven options were considered:
  - **Option 1**: Do nothing; not viable due to age of current equipment and associated reliability issues.
  - **Option 2**: To replace the existing scanners with like for like technology (i.e. 2 x 1.5T scanners) within the existing rooms.
  - **Option 3**: To replace with upgraded technology (i.e. a 1.5T and a 3T scanner) within the existing rooms; not viable due to health & safety considerations.
  - **Option 4**: To replace with like for like technology (i.e. 2 x 1.5T scanners) within the reconfigured floor plan.
  - **Option 5**: To replace with upgraded technology (a 1.5T and a 3T scanner configuration) within the reconfigured floor plan; **this is the preferred option**.
  - **Option 6**: To replace with upgraded technology (2 x 3.0T scanners); this has been discounted as coil technology is not fully developed for all specialties and 3T technology has not been validated for Paediatric use. This option would also require a complete new estates build to contain the magnetic field.
  - **Option 7**: To replace the current 2 x 1.5T scanners with 3 x 1.5T scanners.

- Financial comparison of options:

<table>
<thead>
<tr>
<th></th>
<th>Option 2</th>
<th>Option 4</th>
<th>Option 5 – (Preferred option)</th>
<th>Option 7</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Equipment capital purchase costs</strong></td>
<td>£1,835,776</td>
<td>£1,835,776</td>
<td>£2,279,971</td>
<td>£2,753,664</td>
</tr>
<tr>
<td><strong>Lease costs p.a.</strong></td>
<td>£243,000</td>
<td>£243,000</td>
<td>£318,000</td>
<td>£364,500</td>
</tr>
<tr>
<td><strong>Additional Staff costs p.a.</strong></td>
<td>£0</td>
<td>£0</td>
<td>£0</td>
<td>£170,000</td>
</tr>
<tr>
<td><strong>Building &amp; enabling costs</strong></td>
<td>£785,440</td>
<td>£1,235,255</td>
<td>£1,238,254</td>
<td>&gt;£1,627,000</td>
</tr>
</tbody>
</table>

-£50,000 trade-in allowance has been offered against existing machines*

- Option 2 was excluded on the basis that it offers no additional capacity nor any of the enhanced clinical applications associated
with 3T technology; it therefore does not offer any opportunity to increase market share growth, or to support clinical service developments. It does not address the service continuity risks associated with the current rooms, or release space suitable for future development of the CT service.

- Option 4 was excluded on the same technological basis as Option 2; furthermore this option would utilise the only space suitable for a 3T scanner, limiting options to move to 3T technology in the future thus adversely impacting our ability to develop services and grow market share.

- Option 5 is the preferred option; it offers significant clinical benefits and delivers additional capacity within the current staffing establishment. It will provide the additional capacity and enhanced clinical applications required to improve access and waiting times for MRI diagnostics, increase market share growth, and support clinical service developments. Furthermore it will fully address the risks to service continuity associated with the current room layout and will release space suitable for future development of the CT service.

- Option 7 was excluded on the basis that it is a high cost option that would increase capacity in excess of current and future requirements, this would also require additional staffing with an associated cost of £170k per annum. In addition the estate costs to house a third scanner would make this option unaffordable.

- The recommendation is to proceed with Option 5 as proposed. The increased speed and range of applications offered by a high-field 3T scanner is essential to future-proof the MRI service and to meet the strategic aims of the organisation as outlined in the Trust Clinical Strategy.

- The option of acquiring the scanners utilising a lease arrangement will be explored.

**Decision required:**
The Board is invited to approve that the Trust proceed with Option 5. To replace the two now obsolete 1.5Tesla (T) MRI scanners in Radiology with a 1.5T and a 3T scanner configuration; including the building & enabling works necessary to reconfigure the existing floor plan. The decision regarding capital purchase or lease agreement to be made at the discretion of the Trust Executive.

**FOI Status**
This report will be made available on request

**Contact**
Sue Edees, Urgent Care Group Director
0118 8125

**Supporting documents**
The business case is available on request to the Director of Corporate Affairs:
Board of Directors

Title: Monitor Stage 2 Review – Financial Stability & Quality Governance

Date: 30 May 2013

Lead: Craig Anderson, Director of Finance
      Keith Eales, Director Corporate Affairs

Purpose: To update the Board on progress of the Trust’s high level action plan developed in response to the findings arising from the Stage 2 Annual Plan Review.

Key Points:

- As part of the Monitor Stage 2 Annual Plan review, the Trust developed a high level action plan in response to the recommendations arising from the Stage 2 review.

- Attached is the updated plan detailing the progress made against each of the recommendations.

- Key areas not yet completed have been highlighted, with appropriate commentary on actions being taken.

- Since the April Board meeting progress has been made on the actions in respect of the Royal Bracknell Clinic, the implementation of the Quality Governance Framework where the Executive has discussed the action plan and the integrated business plan that has been discussed at the recent Board seminar.

- An earlier draft of the action plan has been shared with Monitor and conference calls have been held with the Chairman in February, March and April to discuss progress further. A further call is scheduled for 30 May.

- A further report on progress will be submitted to the June Board meeting

Decision required: To note the contents of the report.

FOI Status This report will be released on request

1 CONTACT

Craig Anderson, Finance Director
Keith Eales, Director Corporate Affairs
## Financial Stability

### Item 1: CIPs – Devolution to Care Groups

- **Description:** The Trust should devolve the entire organisational CIP requirement into Care Group budgets.
- **Lead:** Director of Finance
- **Target Date:** 21st December (May 2013)
- **Measure:** CIP target devolved to Care Groups & Corporates as appropriate.
- **On Track to deliver?** 95%
- **Comment:** On track to deliver – Care Groups and Corporate teams have agreed that CIPs will be devolved for 2013/14 and there will be no centrally held CIPs. Budget setting currently being finalised, including level of CIP requirements. Board to review in May as part of the Annual Plan.

### Item 2: CIPs - Programme Board

- **Description:** The Trust has now put in place a Programme Board. This was following a verbal recommendation by PwC, although the Head of PMO had recently made the same recommendation to the Executive team. The Programme Board is chaired by the Chief Executive and will provide oversight to the CIP programme. However as this is newly established, there is a risk that the Board is not entirely effective until it has been properly bedded down and can drive the Programme forward.
- **Lead:** Director of Finance
- **Target Date:** Ongoing
- **Measure:** Self –evaluation of effectiveness of the Programme Board including use of a rolling action log to be reviewed as the first item on each QIPP Board agenda to provide a measure of self-evaluation
- **On Track to deliver?** 100%

### Item 3: CIPs - Plan development methodology

- **Description:** The PMO should separately categorise CIPs that it considers to be in development, and those that have moved into ‘implementation’.
- **Lead:** Director of Finance
- **Target Date:** Ongoing
- **Measure:**
- **On Track to deliver?** 100%
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<tr>
<th>Item No</th>
<th>Item Description</th>
<th>PWC Recommendations</th>
<th>Exec Lead</th>
<th>Target Date</th>
<th>Measure</th>
<th>On Track to deliver?</th>
<th>Comment (if &lt;100%)</th>
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<tr>
<td>4</td>
<td>CIPs - Project workbooks</td>
<td>The PMO should act as ‘gate-keeper’ between the two categories with clear and objective criteria as to what is required for the project to be allowed to move into implementation. Only when a project has moved into implementation should the financial impact be taken out of operational budgets and counted toward the Trust's identified total. This will improve the PMO's control over the robustness of CIPs that are identified, increase the level of assurance that is given to the Programme Board, and serve to reduce the volatility of forecast outturn savings.</td>
<td>Director of Finance</td>
<td>30 Oct '12 (30th Nov '12)</td>
<td>PMO reporting on status of overall Programme</td>
<td>100%</td>
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<td>5</td>
<td>CIPs - Robust plans</td>
<td>Starting with the highest value schemes, the Trust should seek to capture all existing CIPs and Revenue Generation schemes into the new project workbooks, which are then held centrally by the PMO. This discipline will help to ensure that all projects are fully and robustly developed, assessed for their impact on clinical quality, and can be effectively tracked by the PMO. The ability of the PMO to hold project leads to account for the delivery of their schemes will be greatly improved. Project teams may prefer to cross-refer to other documentation where this exists, but the PMO must ensure that visibility of the project is maintained. The Programme Board may choose to set a</td>
<td>Director of Finance</td>
<td>30th Nov '12</td>
<td>Completion of workbooks for all material existing schemes</td>
<td>100%</td>
<td></td>
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<tr>
<td>Item No</td>
<td>Item Description</td>
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<td>6</td>
<td>PMO - FY12/13 CIP reporting of delivery</td>
<td>minimum value for which the entire workbook needs to be completed, with an abbreviated version used for lower value schemes. This is particularly appropriate given the high number of existing schemes and the need to balance this against the urgency to identify new schemes to close the current shortfall. All FY13/14 projects should be captured using this process.</td>
<td>Director of Finance</td>
<td>30 Oct ‘12 (30th Nov 12)</td>
<td>Revised tracker &amp; reporting approved by programme board</td>
<td>100%</td>
<td>The tracker has been revised and will provide the budgetary comparison for all 2013/14 projects.</td>
</tr>
<tr>
<td>7</td>
<td>CIPs - Project approval</td>
<td>The Programme Board should establish a clear process for the approval of projects for implementation. Key approvals for all projects should be given (and evidenced by signature) by the Executive SRO (Senior Responsible Officer), Project Lead, Clinical Lead, and Finance lead</td>
<td>Director of Finance</td>
<td>30 Oct ‘12 (30th Nov 12)</td>
<td>Approval process and evidence of approvals for all projects</td>
<td>100%</td>
<td></td>
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<tr>
<td>8</td>
<td>CIPs – Quality safeguarding</td>
<td>In addition to the above, the Programme Board should establish a panel of senior clinical staff and/or executives responsible for reviewing and approving the QIAs.</td>
<td>Director of Finance</td>
<td>30 Oct ‘12 (30th Nov 12)</td>
<td>Approval process and evidence of approvals for all projects</td>
<td>100%</td>
<td></td>
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<tr>
<td></td>
<td>CIPs – Change Control</td>
<td>The Programme Board should ensure that a proper system of change control is established.</td>
<td></td>
<td></td>
<td>Approved process of change control established</td>
<td>100%</td>
<td></td>
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<td>Item No</td>
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<td>9</td>
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<td>This will ensure that project plans and delivery timetables cannot be altered by project teams without robust review, challenge and authorisation at the appropriate level. It will also ensure that the PMO (and the Programme Board where appropriate/material) has an improved understanding and visibility of the reasons for non-delivery, either through project under-performance, poor planning, or slippage. This will mean that learnings are not lost. Project teams will also be better incentivised to deliver their projects and/or identify mitigation for any shortfalls, particularly if the organisational CIP requirement has been fully devolved.</td>
<td>Director of Finance</td>
<td>30 Oct ’12 (30th Nov 12)</td>
<td>Plan developed to identify new CIPs.</td>
<td>100%</td>
<td>Cost CIPs for 12/13 were £2.1m adverse to budget but more than offset by income CIPs of £7m exceeding budget. Formal timetable in place and being managed for development of 2013/14 cost and income CIPs. Board will formally sign off the plan in May.</td>
</tr>
<tr>
<td>10</td>
<td>CIPs – Plan development</td>
<td>The Trust must take immediate action to address the current anticipated shortfall against the organisational CIP requirement of £12.5m. The Programme Board should formalise the process for working up new opportunities for FY12/13 and FY13/14. The Trust should set a clear process for this including a formal timetable.</td>
<td>Director of Finance</td>
<td>Plan developed by Oct ’12, fortnightly checkpoints to Programme Board thereafter</td>
<td>Plan developed to identify new CIPs.</td>
<td>100%</td>
<td></td>
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<tr>
<td>11</td>
<td>Strategic Planning for 2013/14 &amp; beyond</td>
<td>The Trust is facing a number of significant challenges that must be resolved urgently &amp; as part of a cohesive strategic plan, covering clinical strategy, estates and transformational cost saving, which aligns with the priorities of commissioners. The Trust’s newly established Board is planning on refreshing its IBP throughout 2012. The Trust Board must ensure that this process is undertaken quickly and thoroughly, using external support as appropriate, so that issues in respect of Bracknell, for example, can be resolved and the new clinical strategies determined in time to inform budget setting and the programme of transformational CIPs for 2013/14 and beyond.</td>
<td>Com Director</td>
<td>30th Nov 12 (March 13)</td>
<td>New IBP developed.</td>
<td>90%</td>
<td>The Board has reviewed the draft IBP in detail at a recent strategy seminar. Following an extremely productive discussion a revised draft will be available in mid June for initial discussion with key stakeholders and consideration at the June Board meeting. Following approval the Executive team will undertake a number of engagement sessions with key stakeholders before the final IBP is ratified in November 2013.</td>
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<td>12</td>
<td>Bracknell Strategic review</td>
<td>In 2012/13 the Trust is likely to post a loss in respect of the Bracknell facility of c£3 - £4m. The facility represents a significant financial drain on the organisation, and has increased the level of operational and financial gearing cost that the Trust is exposed to, reducing the flexibility of the trust’s cost base. While the trust has kept its options in respect of Bracknell under review, the material nature of the cash drain on the organisation means that the newly formed Board must ensure that a solution is identified and implemented urgently. The Trust should seek expert legal, corporate finance, and / or operational support, as appropriate, to ensure that Bracknell is either disposed of or, if this is not possible, incorporated into a coherent clinical estates strategy.</td>
<td>Com Director</td>
<td>30th Nov 12</td>
<td>Advice received and any negotiation commenced</td>
<td>80%</td>
<td></td>
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<td>13</td>
<td>Board Effectiveness</td>
<td>The trust Board is currently at a formative stage following a period of significant change since December 2011. The Board must quickly reach full operational effectiveness in order to drive the Trust forwards &amp; meet the challenges ahead. We understand that the Chairman is planning to carry out a review of the effectiveness of the Board. We welcome this and recommend that this is concluded, and any recommendations implemented as soon as possible. We also recommend that the Board undertake a Programme of development to help ensure that it quickly becomes fully effective, using external support as appropriate. This should include ensuring that the NEDs take part in Monitor’s non Executive Director Development Programme.</td>
<td>Director of HR</td>
<td>January 2013</td>
<td>Assessment complete.</td>
<td>100%</td>
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<td></td>
<td>March 2013</td>
<td>Development needs &amp; plans identified.</td>
<td>100%</td>
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<tr>
<td>14</td>
<td>Electronic Patient Record</td>
<td>It is our understanding that the Trust is now fully committed to the EPR system with no option to return to the previous system. The issues currently being experienced mean that the system represents a threat to both the Trust’s income and the delivery of its access targets. a) The Trust should make a full assessment</td>
<td></td>
<td>30th Nov 2012</td>
<td>Actions completed &amp; findings reported to Trust Board for consideration</td>
<td>85%</td>
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CCG’s have agreed to release non recurrent funding of £10m to enable the Trust to pay down a proportion of the outstanding loans. This enables the rental model solution to proceed.

At an individual level, Non Executive Directors will be attending the Cass Business School Programme. One Non Exec has already attended the course – two more members are booked to attend in May. Executive Directors have access to coaching from IMD.

The Board has reviewed an internal evaluation of effectiveness, reporting and relationships and an action plan has been agreed.

1 – RBFT has undertaken visits to other Trusts who have implemented

The Trust has taken a view that any decision on the EPR system should be undertaken with a detailed due diligence exercise. A series of actions have been planned by the Trust to ensure that the due diligence exercise is undertaken robustly. The actions with the latest progress are highlighted below:
<table>
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<th>Comment (if &lt;100%)</th>
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<td>of the cost of rectifying the current issues &amp; ensure that it is able to meet this requirement. b) The Trust should take legal advice to ascertain to what extent it may be able to recover unplanned costs from the supplier Cerner. The Trust should contact other Trusts who have experienced similar issues. c) While the current Board did not initiate the EPR Programme, the decision to go live was taken in June 2012 despite known implementation issues at other NHS organisations. The trust should carry out a review of the decision to press ahead with the decision, without any dual running which has resulted in these issues.</td>
<td>Commercial Director</td>
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- The Cerner system to learn from their experience in addressing issues. These visits have highlighted a few learning lessons which we have incorporated into our current practices. Overall, the experiences we face are being encountered by other Trusts, but our approach to managing the situation has been robust in comparison to other Trusts.

- We continue to have weekly discussions with Cerner to agree how to address requirements for operational improvements to the system and also the potential for financial support in recognition of the problems encountered by the Trust. These have been supplemented by monthly sessions with Senior Executives from both organisations.

- We are developing plans around the longer term use of Cerner Millennium system and supporting clinical systems with a view to achieving a full Electronic Patient Record by 2018.

- We have received initial legal advice on whether the system delivers the original procured specification, and further work is being undertaken by legal advisors.

- We continue to review our operating cost with a view to reducing this through a number of initiatives. However, some of these will take time as we undertake these through statutory policies and procedures.

We are contractually legally bound and we therefore have to wait for the outcome of the legal advice before we undertake any significant decisions.
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<th>Comment (if &lt;100%)</th>
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<tr>
<td>15</td>
<td>Financial Controls</td>
<td>The Trust should expedite the proposed alignment of its authorization process for the requisitioning &amp; ordering of goods from NHS Supply Chain with the more rigorous process for I-Procurement. It should also ensure that there is a 3 way match of GRN to purchase order to invoice for goods inward, in order to avoid possible misplacements and shortage of goods &amp; equipment for which the Trust has paid.</td>
<td>Director of Finance</td>
<td>30th Nov 2012</td>
<td>Systems in place and agreed as sound by internal auditors</td>
<td>95%</td>
<td>System now in place – to be reviewed by auditors</td>
</tr>
<tr>
<td>16</td>
<td>Cash Flow forecasting</td>
<td>The Trust should implement a rolling 12 month cash flow forecast (on an indirect basis). While the Trust currently has a high level of cash headroom (c£29m or c 30 days of operating expenditure) there is some marked risk to the delivery of the current year plan, which is likely to become more acute in years 2 and 3. As such the Trust should establish a proper cash flow forecasting process as soon as possible in line with industry best practice. This will increase the visibility of any potential emerging cash issues.</td>
<td>Director of Finance</td>
<td>Q3 12/13</td>
<td>Rolling cash flow forecast in place</td>
<td>100%</td>
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<tr>
<td>17</td>
<td>Winter planning &amp; Escalation</td>
<td>The Trust should confirm that it has an appropriate robust Trust Wide capacity plan to be able to cope with winter pressures whilst maintaining the current escalation wards in respect of delayed discharges of care. The plan should set out how the Trust plans to deliver the potential increase in non elective activity whilst maintaining its compliance with 18 week targets.</td>
<td>Care Group Directors</td>
<td>31st October 2012</td>
<td>Trust wide capacity plan approved by Exec</td>
<td>99%</td>
<td>First draft of the winter plan has been reviewed by the Executive and further modifications required including response to address continuity of planned services and incorporate red and black alert experience</td>
</tr>
<tr>
<td>18</td>
<td>Budget Setting FY13/14</td>
<td>The Trust should develop a set of documented budget setting principles and requirements that should be consistently followed by the Care Groups in setting budgets for FY13/14. This should include normalization, proper budget phasing for the seasonality of the business and devolvement of CIPs. The Trust Board should also seek a greater degree of visibility and understanding of these</td>
<td>Director of Finance</td>
<td>Q3 FY13/14</td>
<td>Budget setting principles document agreed by Trust Board</td>
<td>100%</td>
<td></td>
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<tr>
<td>Item No</td>
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<td>Exec Lead</td>
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<td>budget setting process and underlying assumptions to satisfy itself that these are robust and reasonable respectively. The Board should thereby ensure that it has discharged its collective responsibility for the financial governance of the organisation and avoid placing inappropriate levels of reliance on the Director of Finance.</td>
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<td></td>
<td>Quality Governance</td>
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<tr>
<td>1</td>
<td>Board membership &amp; effectiveness</td>
<td>The Chair should complete his review of the Board membership &amp; effectiveness as soon as practical.</td>
<td>Director Corporate Affairs</td>
<td>Within 3 mths</td>
<td>Governor approval of recommended actions from Chair’s review</td>
<td>100%</td>
<td></td>
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<tr>
<td>2</td>
<td>External review of Board Effectiveness</td>
<td>The trust should have the external review of Board effectiveness recommended by the external auditors completed once the Board has stabilized &amp; developed during 2012/13</td>
<td>Director Corporate Affairs</td>
<td>Within 6 mths</td>
<td>Agreement at Board level of outcome of external review</td>
<td>External review agreed for the end of 2013/14.</td>
<td></td>
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<tr>
<td>3</td>
<td>Clinical Governance</td>
<td>The Trust should continue to embed the Care group structure, in particular ensuring that Clinical Governance Committee and the Board obtain adequate assurance from each of the Care groups in respect of quality governance</td>
<td>Medical Director &amp; Director of Nursing</td>
<td>Within 3 mths</td>
<td>Approval of revised arrangements by Clinical Governance Committee</td>
<td>100%</td>
<td></td>
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<tr>
<td>4</td>
<td>Standardisation of Performance, Quality &amp; Safety reporting</td>
<td>Performance, quality &amp; safety reporting should be standardized across the Care Groups in order to aid comparison by the Board and its sub committees.</td>
<td>Care Group Directors</td>
<td>Within 3 mths</td>
<td>Approval of revised report format by Clinical Governance Committee</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Electronic Patient record</td>
<td>Progress against the EPR stabilization plan along with outstanding issues should be presented to the Board at every meeting until the issues with the EPR system are resolved.</td>
<td>Commercial Director</td>
<td>Within 1 mth</td>
<td>Board approval that the recovery plan has been delivered</td>
<td>75% Delivery of the plan is progressing and is reported each month to Trust Board, highlighting key improvements and remaining actions to be taken.</td>
<td></td>
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<tr>
<td>6</td>
<td>Data Quality</td>
<td>Data quality issues must be identified at a specialty and Care Group level and addressed. Where relevant, the Board should be made</td>
<td>Commercial Director</td>
<td>Ongoing</td>
<td>Exec team to provide assurance to the Board on Data Quality when</td>
<td>85% Data quality remains an ongoing area of review for the Executive. To formalise the process, a data quality action plan is being implemented and progress against delivery is being monitored through the Audit &amp;</td>
<td></td>
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<td>Comment (if &lt;100%)</td>
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<td>7</td>
<td>Reporting</td>
<td>The Trust should continue to refine the performance, quality &amp; patient safety reporting within the Care Groups and through to the Trust Board in order to ensure the requirements of the Board are met.</td>
<td>Medical Director / Director of Nursing/ Commercial Director</td>
<td>Within 3 mths</td>
<td>Board approval of revised reporting format</td>
<td>100%</td>
<td>Completed – but continually under review at Trust Board for quality improvement.</td>
</tr>
<tr>
<td>8</td>
<td>IPR</td>
<td>Once the format of the IPR is finalized, the Trust should instruct internal audit to test the key measures included in the report</td>
<td>Commercial Director</td>
<td>Within 6 mths</td>
<td>Audit Committee approval of internal audit review</td>
<td>100%</td>
<td>A Peer Group review has been completed, discussions have taken place with the PwC team that undertook the second stage review and the overall Trust position is to be assessed on 23 April.</td>
</tr>
<tr>
<td>9</td>
<td>Quality Governance framework Compliance</td>
<td>The Trust should implement a process to challenge and seek assurance over the level of compliance with the QGF. The Trust should consider a regular (at least annually, but preferably quarterly) mechanism to review their level of compliance with each of the ten areas of the QGF. This process should involve Care group senior management and utilize the skills and experience of newly appointed Executive Directors.</td>
<td>Director Corporate Affairs</td>
<td>Within 3 moths</td>
<td>Board approval of the outcome of the assessment</td>
<td>100%</td>
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<tr>
<td>10</td>
<td>Nomination of Accountable Executives</td>
<td>A short period of time at each Board meeting should be allocated for the accountable Executive Director lead for each significant external requirement to provide an update on any key changes which require the Board’s attention.</td>
<td>CEO</td>
<td>Immediate</td>
<td>Board approval of the schedule of Executive leads</td>
<td>100%</td>
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<tr>
<td>11</td>
<td>Board Effectiveness</td>
<td>See recommendation 1. Following this review the development needs of the Board should be assessed and appropriate training arranged.</td>
<td>Director of HR</td>
<td>Within 6 mths</td>
<td>HR Director to report to the Board on Board Development</td>
<td>100%</td>
<td>See point 13 in financial stability section.</td>
</tr>
<tr>
<td>12</td>
<td>NED Training</td>
<td>The Trust should ensure that recently appointed NEDs take part in Monitor’s NED Development Programme</td>
<td>Director of Corporate Affairs</td>
<td>Within 6 mths</td>
<td>Attendance at programme</td>
<td>100%</td>
<td>See point 13 in financial stability section.</td>
</tr>
<tr>
<td>13</td>
<td>Trust Board Agendas</td>
<td>The Chair, CEO &amp; Trust Board Secretary should review the agenda of future meetings to ensure that appropriate focus is given to the items on the agenda and to allow proper debate and challenge</td>
<td>CEO</td>
<td>Immediate</td>
<td>Chair, CEO &amp; Trust Board Secretary to review Board agenda in 6 mths &amp; make further changes if required</td>
<td>100%</td>
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<tr>
<td>14</td>
<td>Approval Process of projects</td>
<td>The QIPP Programme Board should establish a clear process for the approval of projects for implementation. Key approvals for all projects</td>
<td>Director of Finance</td>
<td>Immediate</td>
<td>Board approval of change in process</td>
<td>100%</td>
<td>Clear process for implementation of QIAs now developed and</td>
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<tr>
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<td>Exec Lead</td>
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<td>should be given by the Exec SRO, Project Lead, and Clinical &amp; Finance leads. In addition the Programme Board should establish a panel of senior clinical staff and/or Executives responsible for reviewing and approving the QIAs.</td>
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<td>15</td>
<td>Impact of CIPs</td>
<td>The Trust should monitor the ongoing impact on CIPs on quality as well as finances and ensure that the Board receives assurance on both of these.</td>
<td>Director of Finance</td>
<td>Within 3 mths</td>
<td>Revised Board reporting on CIPs</td>
<td>100%</td>
<td>Process now set up through use of QIAs for every project.</td>
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</tbody>
</table>

Note – Target dates in black are those defined in the PwC reports. Red target dates are those re – set by the Trust as being realistic.
Royal Berkshire NHS Foundation Trust

Board of Directors

Title: Security Services and Car Parking Management

Date: 30 May 2013

Lead: Philip Holmes

Purpose: The security services for the Trust are currently provided by Securitas Security Services Ltd who inherited the contract from the original supplier Chubb Security in 2011. The contract terms expired on the 31st January 2013. This is currently being rolled over on a monthly basis with the current supplier.

Key Points: Current Provision
- Securitas Security Services Ltd provide the contract which expired on the 31st January 2013
- Total contract value: £756,432 per annum
- Extension to the existing contract will reduce contract value to £722,312
- This involves removal of one Security Officer from North Wing Station (Mon to Fri 08:00 to 19:00)

Contract Term & Future Savings
- Contract term: 3 years (option to extend for further 2 years)
- Contract value £671,919 per annum (No RPI or any other cost increases)
- The reduction in hours relates to the reduced hours for A&E support (15 day time hours) and the provision of an officer to man the Main Reception desk after 5pm Mon to Fri and weekends.
- Reduction involves two full-time security officers
- OJEU tender process has been undertaken

<table>
<thead>
<tr>
<th>Cost</th>
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<tbody>
<tr>
<td>Current contract value</td>
</tr>
<tr>
<td>Reduction on current contract (based on reduced hours)</td>
</tr>
<tr>
<td>Value of new contract (based on new specification)</td>
</tr>
<tr>
<td>Saving (based on initial contract)</td>
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</tbody>
</table>
Decision required: 

Recommendation

The Board is invited to award the contract to Securitas Security Services - saving of £253,539 over 3-year contract duration. The contract term is 3 years with an option to extend for a further 2 years.

FOI Status

This report will be made available on request

1 Background

1.1 The security services for the Trust are currently provided by Securitas Security Services Ltd who inherited the contract from the original supplier Chubb Security in 2011. The contract terms expire on the 31st January 2013. The total current contract value per annum is £756,432 which was fixed cost for the duration of the contract. From 1st February 2013 this will reduce to £722,312 with the removal of one Security Officer from North Wing Station (Monday to Friday 08:00 to 19:00).

2 Contract Term & Future Savings

2.1 The contract term is for 3 years with an option to extend for a further 2 years with Securitas Security Services Ltd. The value of the new contract is £671,919 per annum. As part of the contract, there is an agreement for no RPI or any other cost increases. Further savings are expected based on reduced staffing levels and more efficient ways of working. The reduction in hours relates to reduced hours for A&E support (15 day time hours) and the provision of an officer to man the Main Reception desk after 5pm Monday to Friday and weekends. This involves reduction of two full-time officers from a total of 24 officers (dependant on shift patterns).

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<tr>
<th>Cost</th>
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<tr>
<td>Current contract value</td>
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<tr>
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<tr>
<td>Value of new contract</td>
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<tr>
<td>Saving (based on initial contract)</td>
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2.2 The essence of the Contract will be to provide a Service that combines both the security and car parking elements to provide proactive crime prevention measures and car park management skills in a cohesive manner including helping the Trust in developing the Park Mark accreditation standard and also provide a rapid response to incidents that occur.

3 Legal / Financial /Risk Management Implications

3.1 Process

An OJEU tender process has been run to select a single supplier to enter into a contract with the Trust from the 1st February 2013.
The Tender process was completed with a shortlist of 3 suppliers from a selection of 7 who participated in the process. This was followed up with a presentation and representatives from A&E, Emergency Planning were invited to be on the evaluation board for their input and feedback relative to their requirements. The following scores were awarded for the presentations:

<table>
<thead>
<tr>
<th>Section</th>
<th>Weighting</th>
<th>APCOA</th>
<th>Keyline</th>
<th>Securitas</th>
</tr>
</thead>
<tbody>
<tr>
<td>Value for money (overall cost effectiveness)</td>
<td>50%</td>
<td>32.50</td>
<td>37.50</td>
<td>40.00</td>
</tr>
<tr>
<td>Delivery performance &amp; innovation</td>
<td>25%</td>
<td>18.44</td>
<td>18.75</td>
<td>18.44</td>
</tr>
<tr>
<td>Quality of service</td>
<td>20%</td>
<td>13.00</td>
<td>14.25</td>
<td>14.00</td>
</tr>
<tr>
<td>Risk</td>
<td>5%</td>
<td>3.50</td>
<td>3.94</td>
<td>4.50</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100%</strong></td>
<td><strong>67.5</strong></td>
<td><strong>74.5</strong></td>
<td><strong>77</strong></td>
</tr>
</tbody>
</table>

4 Conclusion and Next Steps

4.1 The tender evaluation and presentation was used to identify the preferred supplier, Securitas Security Services Ltd based on the service and cost evaluations. Securitas demonstrated a robust understanding of the requirements from the Tender and identified innovative ways of working.

4.2 The benefits of choosing Securitas Services to provide the security and car parking service include:

- as a current provider of the security services, Securitas have a greater understanding of the Trust requirements and knowledge of the site
- awareness of the operational issues and the resource of the organisation means they have the ability to respond to the Trust needs at short notice
- innovation is available for future improvements such as introduction of handheld PDAs for officers efficiency gains
- Securitas have taken over from Chubb Security and have demonstrated that they have a co-operative and customer focused approach

5 Recommendations

5.1 The recommendation is for the contract to be awarded to Securitas Security Services which provides the Trust with a saving of £253,539 over the duration of the 3-year contract with an option to extend for a further 2 years.

6 Contact

Contact: Keith Ashby / Parminder Rai (Procurement Manager), Terry Morris (Estates Manager)

Phone: 0118 322 6895 / 6529
Board of Directors

Subject: Purchase Requisitions Requiring Approval

Date: 30 May 2013

Decision Required

The Board is asked to APPROVE the purchase requisitions detailed below

FOI Status This report will be released on request

<table>
<thead>
<tr>
<th>Requisition number</th>
<th>Details</th>
<th>Assigned User</th>
<th>Amount (excl vat)</th>
</tr>
</thead>
<tbody>
<tr>
<td>4322009</td>
<td>These are Rheumatology Drugs for home delivery from Healthcare at Home for the 2013/14 Financial Year. The cost has been confirmed by Healthcare at Home and number to order by Linda Herdman, Rheumatology Specialist Nurse.</td>
<td>ANDERSONCR</td>
<td>£ 3,115,189.64</td>
</tr>
<tr>
<td>4323443</td>
<td>These are the Home Delivery Drugs for patients from BUPA Home Healthcare for the 2013/14 Financial Year. I have confirmed the cost with BUPA and the number of drugs to order with Dr Andrew Weir.</td>
<td>BARKERL</td>
<td>£ 675,566.92</td>
</tr>
<tr>
<td>4322817</td>
<td>Line 1 Lloyds Pharmacy invoice 23832 - April 2013. Total cost of dispensing Line 2 Lloyds Pharmacy invoice 23832 - April 2013. Supply of contract outpatient scripts</td>
<td>ANDERSONCR</td>
<td>£ 507,485.88</td>
</tr>
</tbody>
</table>
Board Strategy Group
Tuesday 23 April 2013
1:00pm – 2:40pm
Boardroom, Level 4, Royal Berkshire Hospital

Membership
Mrs. Janet Rutherford (Non-Executive Director, Chair)
Mr. Stephen Billingham (Chairman)
Mr. Craig Anderson (Finance Director)
Dr Lindsay Barker (Care Group Director, Networked Care)
Mr. Ed Donald (Chief Executive)
Dr. Sue Edees (Care Group Director, Urgent Care)
Mr. Alistair Flowerdew (Medical Director)
Mr. Brian Hendon (Non-Executive Director)
Mr. Philip Holmes (Director of Estates and Facilities)
Ms. Lynn Lane (interim Director of HR and Workforce Development)

In attendance
Dr. Keith Eales (Director of Corporate Affairs and Secretary)
Ms. Hannah Oatley (Business Development Manager)
Mr. Mike Robinson (Head of Governance)

Apologies
Ms. Caroline Ainslie (Director of Nursing)
Mr. Tim Caiger (Non-Executive Director)
Mr. Hitesh Patel (Interim Commercial Director)

10/13 Minutes – 26 March 2013
The minutes of the meeting held on 26 March 2013 were agreed as a correct record and signed by the Chair.

11/13 Matters Arising
Resolved: that the matters arising schedule be noted.

12/13 Clinical Services Strategy (CSS)
The Group noted the revised CSS which had been updated with comments made at the previous meeting and Board. The Chair felt that it was generally much improved and clearer. Specific comments were made including the need to include further detail on what the Trust was doing to reduce demand and to align the document where possible with the Capita market assessment undertaken for commissioners.

The CSS would now be submitted for further Care Group and Executive consideration. The Executive would be discussing in the context of its integration within the IBP.
The Chair would pass detailed comments through and reiterated the need for a thorough editing to check for consistency.

Resolved: that the updated Clinical Services Strategy be noted.

13/13 Integrated Business Plan

Overarching Strategic Positioning

The Chair emphasised the need for consideration of the overarching strategic positioning of the Trust and where it envisaged it would be in five years. The Chief Executive explained that the Trust had good local support and provided clinical excellence. Although an acute trust, it would need to increasingly look at integration with partners as well as be competitive within the NHS quasi-market. The Trust might be described as a ‘district general hospital plus’ and that was its positioning. It would not be a tertiary centre but would continue to deliver some hyper-acute services.

There was increasing choice for commissioners, employees and patients within the system and making sure the Trust delivered what was required would be an important goal. For example, the planned care section of the CSS needed to set out its unique selling point and attractions. A patient-centric view was required with targeted investment to increase patients and income. It was noted that a marketing strategy was being drafted alongside the CSS and IBP. It was felt the need for community engagement should be incorporated. Additionally, expanding on the opportunities available to provide work experience was suggested.

Action: Lynn Lane

Networking with other Trusts was important and should be reflected in the CSS. The Chair emphasised the importance of working with Berkshire Healthcare NHS FT which should be drawn out in the CSS.

It was agreed that the Chief Executive’s overarching analysis of the Trust’s position should be drawn into a short and simple statement.

Action: Hitesh Patel

Risk

The Group raised several comments on the detailed risks which should be re-ordered and re-examined. Risks in respect of the increases in non elective activity, reduced liquidity and estates issues should be incorporated. An important issue would be the potential shortfall on capital resources. A re-phrasing of the ‘recruitment hotspots’ issue was also suggested. Additionally, the quality issues should appear more prominently.

Action: Hitesh Patel

Governance

It was noted that the section followed a Monitor style template. However, there was flexibility to include detail in a different way. It was suggested that the system of corporate governance and its purpose/role in providing assurance should be clearer and up front. The Director of Corporate Affairs and Secretary would provide detail. It was also suggested that the Council section needed to be agreed with Governors.

Action: Hitesh Patel/ Keith Eales

Workforce

The Group commented on the style of the presentation and also that the mechanisms and workings of Human Resources needed to be set out. i.e. what were the changes required and the predicted outputs. The text should be aligned to the four simple aims and also set out why the Trust was a good place to work.

Action: Hitesh Patel/ Lynn Lane
**Market Assessment**

The section was detailed and would link to the marketing strategy. It was felt that it needed to signpost key details? rather than detailed analysis and importantly to highlight how the market was evolving, what the Trust had been doing and what it would need to do to deliver market challenges?. Details from the care groups and on dementia care could be incorporated as could the results of the PEST and SWOT analyses.? The section should also highlight the impact that increased non elective activity would have on risks, costs and financial stability.

*Action: Hitesh Patel*

**Resolved; that the draft sections of the IBP be noted and that the comments made be incorporated into the next draft.**

14/13 **IBP Engagement and Stakeholder Plan**

The Group considered that the next steps would be to conclude the document and plan the next steps and consultation and engagement processes. At that point the views and input of the Council would be welcome.

The Chair emphasised the need for discussions with stakeholders and partners such as the Berkshire Healthcare Trust rather than just written responses.

**Resolved; that the IBP engagement plan be noted.**

15/13 **Draft Estates Strategy**

The Director of Estates and Facilities tabled a synopsis of the draft Estates Strategy which would be submitted to the Resources Committee the following week. He outlined the structure and contents of the document and the overall direction and options. Graphical representations were included on how the site might look in the future.

The Group felt it was important to include a way forward on the future use of North block in the strategy rather than registering that a decision needed to be made. Although the façade was iconic, it was hoped that a sustainable planning and future use option for the block could be identified. It was noted that long term clinical use of the space was not felt to be suitable and that the options would take some time to work through. In the medium term it may be required for office accommodation. Discussions with possible partners were ongoing.

It was felt that the strategy should also reference the spoke locations and their issues. Additionally, the future uses envisaged for the Craven Road properties.

In respect of funding, it was noted that ongoing maintenance and the more substantial projects would need to be developed into a funding stream. The Director of Estates and Facilities explained that the preferred option of investing £100m over 10 years would mean a residual and acceptable level of low priority backlog maintenance. The Trust Chairman felt the position on minimum condition requirements needed to be made clear and a plan devised over a suitable period to meet it.

It was recognised that as external capital funding was required for elements of the preferred option, then it might also be possible to seek support for the more transformational option. Delivering a step change might be more likely to win support.
The comments made would be incorporated into future drafts of the plan following consideration by the Resources Committee. **Action: Philip Holmes**

**Resolved that the draft estates strategy be noted.**

16/13 **IBP Project Plan**

The Head of Business Development confirmed that the comments made would be incorporated into the next versions of the CSS and IBP. The next key step was to develop with the finance team the long term financial model (LTM). That would be prepared that week and feed into the required Monitor Annual Plan and the IBP. The LTFM was being developed from the activity plans rather than from a top down approach.

The Finance director confirmed that the process would identify gaps in funding which could then be considered and proposals prioritised. The affordability of capital expenditure would be constrained by the financial position and likely surpluses of the Trust along with anticipated external support.

It was recognised that the Estates Strategy and Clinical Services Strategy were not proposing extravagant solutions but required investments. Nevertheless, affordability remained an issue.

**Resolved: that the IBP project plan be noted.**

17/13 **Dates of Future Meetings**

The next meeting would be held on Thursday 23 May 2013 at 10.30am. It was emphasised that a significant amount of work was needed to ensure that a robust IBP could be ready for the next meeting and Board and the Chief Executive confirmed that staff would need to ensure a robust draft was ready for the Executive by the second week of May. **Action: Hitesh Patel**

**SIGNED**

**DATE**
Resources Committee
Monday 29 April 2013
11.00am – 12.30pm
Boardroom, Level 4, Royal Berkshire Hospital

Members

Mr. Tim Caiger (Non-Executive) (Chairman)
Ms. Caroline Ainslie (Director of Nursing)
Mr. Craig Anderson (Director of Finance)
Mr. Stephen Billingham (Chairman)
Mr. Edward Donald (Chief Executive)
Ms. Jane May (Non-Executive Director)

In Attendance

Mr. Keith Eales (Director of Corporate Affairs & Secretary)
Mr. Philip Holmes (Director of Estates & Facilities)
Ms. Lynn Lane (Interim Director of Workforce Development & HR)
Mr. Hitesh Patel (Interim Commercial Director)
Mr. Peter Malone (Care Group Director, Planned Care) (for minute 19/13)

Apologies

Mr. Alistair Flowerdew (Medical Director)

14/13 Minutes: 25 March 2013

The minutes of the meetings held on 25 March 2013 were approved as a correct record and signed by the Chairman.

15/13 Matters Arising Schedule

The Committee received the matters arising schedule and noted progress in respect of each item.

16/13 Integrated Business Plan, Activity Update and Long-Term Financial Model

The interim Commercial Director reported on progress with the integrated business plan for the Trust. A number of component parts of the plan had now been submitted to the Strategy Group and were now being revised in the light of feedback.

The interim Commercial Director advised that the document was on target for submission to the May Board.
The interim Commercial Director reported on progress in agreeing an activity plan for the Trust. It was noted the latest version of the activity plan was being discussed with Care Groups. There was, however, a gap between the views of the Trust and the expectations of commissioners.

The Director of Finance reported on the development of the long-term financial model.

The Director of Finance confirmed that Monitor had not designated a model to be used for financial planning purposes. However, the model had been developed using most of the financial templates that Monitor would require if the Trust was seeking authorisation as a foundation trust. The Director of Finance advised that what were key with regard to the model were the assumptions built into it rather than its technical structure.

The Director of Finance undertook to discuss the Trust approach to developing the long term financial model with Monitor.

17/13 Estates Strategy

The Director of Estates & Facilities submitted a summary of the draft estates strategy for the Trust.

The Director of Estates & Facilities explained the approach that had been taken to develop the strategy, the underpinning information sources and strategies and the steps that had been taken to align it with the emerging clinical services strategy. In particular, it was proposed that the Trust estate would be notionally zoned to assist in the relevant adjacency of specific clinical services.

The Director of Estates & Facilities drew attention to the three strategic alternatives that had been assessed for the Trust site

- ‘Do nothing’, which would require expenditure to maintain the site in its current condition
- ‘Make best use’, involving a £100m investment over 10 years
- ‘Transformation’, which was based on aggressive disposal and rebuilding a central tower, involving a total cost of £120m over a five year period

In discussing the options, the Committee considered that the ‘do nothing’ option was not practical and that ‘transformation’ was not affordable.

The Committee discussed the draft strategy and identified a number of areas in which it should be developed

- Including the option of a rebuild on a green field site
- Developing the ‘make best use’ option into alternative sub-options
- Providing greater clarity on the outcomes delivered by each option
• Aligning the timescale with that of the clinical services strategy, demonstrating the linkages between the plans and setting out what each would deliver on an annual basis

• Making reference to the Trust community hospitals and sites in the summary document

It was noted that possible national policy changes and developments had not been anticipated in the strategy.

Clarification was sought with regard to funding the required level of investment. The Director of Finance advised that on the basis of the current EBITDA, and taking into account current commitments, the Trust had between £5-6m available for new capital expenditure in a year. It was recognised that as the current level of statutory compliance expenditure reduced, this would release additional funding. The Committee considered that the strategy should be supported by

• A phased capital expenditure plan setting out, on an annual basis, the anticipated spending to deliver the strategy and the available resources

• A five year capital expenditure plan

It was recognised that implementation of the strategy would require external funding. The Chief Executive commented that once the annual plan and the integrated business plan were agreed appropriate local and national potential funding sources would be identified.

The Committee sought clarification with regard to the next steps with the strategy. The Director of Estates and Facilities advised that the document would be revised in the light of the comments made by the Committee and submitted to the next meeting. It was agreed that the focus of the discussion at the next meeting should be on the scheduling, cost and funding of the proposed approach.

Resolved: that the strategy be noted, developed as discussed at the meeting and submitted to the Committee in May for detailed discussion on the scheduling, cost and funding of the proposed approach.

18/13 MRI Scanner Replacement

It was noted that this item had been withdrawn from the agenda.

19/13 Elective Orthopaedic Centre

The Care Group Director, Planned Care submitted a business case for the development of an elective orthopaedic centre.

The Care Group Director, Planned Care advised that the business case was to extend the existing two-storey Redlands building to create two additional laminar theatres, an extended Redlands ward with an additional eight beds and a distinct orthopaedic centre with theatres, recovery and beds within a self contained unit. The enabling works and equipment costs were £800,000 with leasing costs of £187,000 a year.
The Director of Finance advised that if additional revenue of £2.4m was generated, the business case would break even. The Committee noted that the reduction in waiting lists, bringing in-house currently outsourced work, organic growth and incremental market share growth gave a potential income opportunity of £10m.

Clarification was sought with regard to the possibility of achieving the additional income through extended use of existing theatres. The Care Group Director, Planned Care advised that the option of evening and weekend working had been assessed. However, it was considered to be more costly than the leasing option.

The business case was endorsed for submission to the Board on the basis that the following would be incorporated into the final case:

(a) the impact of the case on the other care Groups
(b) a cash flow forecast over the term of the lease
(c) the option for the Trust to purchase the facility before the end of the lease
(d) an assessment of whether the additional cost of laminar flow, rather than standard, theatres was appropriate
(e) an assessment of risks

The Committee noted that planning permission would be required for the unit. The Chief Executive confirmed that the order for the unit, if approved by the Board, would not be placed before planning permission was received.

The general approach to the development of business cases, and the timing for the involvement of the Board and committees was discussed. It was noted that the current approach only involved the relevant Board committee after a detailed assessment of options had been undertaken. By the time the business case was submitted to the Board or committee a number of options had been discounted. It was recognised that there was merit in business cases identifying a number of available options for early consideration by the appropriate Board committee. The list of appropriate options would then be refined through discussion by the committee. This was agreed as the appropriate way forward for the consideration of business cases.

Resolved: that

(a) the business case be endorsed for submission to the Board subject to its development on the basis discussed at the meeting
(b) the business case process be amended to involve the Board or relevant committee in the early identification and assessment of options for further consideration.

20/13 Date of Next Meeting

It was agreed that the next meeting would be arranged to take place ahead of the May Board meeting. Action: C Lynch
Resolved: that the next meeting be arranged for the end of May.

SIGNED

DATE
Nominations and Remuneration Committee
Tuesday 30 April 2013
3.00-4.00pm
Boardroom, Royal Berkshire Hospital.

**Present**

Mr. Stephen Billingham (Chairman of the Trust and Chair)
Mr. John Barrett (Non-Executive Director)
Mr. Brian Hendon (Non-Executive Director)
Ms. Jane May (Non-Executive Director)
Mrs. Janet Rutherford (Non-Executive Director)

**In attendance**

Mr. Ed Donald (Chief Executive)
Ms. Lynn Lane (Interim Director of Workforce Development & Human Resources)
Mr. Keith Eales (Director of Corporate Affairs & Secretary)

**Apologies**

Mr. Tim Caiger (Non-Executive Director)

**08/13 Minutes: 29 January 2013**

The minutes of the meeting held on 29 January 2013 were approved as a correct record and signed by the Chairman.

**09/13 Performance Related Awards Framework for Board and other Executive Directors 2013/14**

The interim Director of Workforce Development and Human Resources advised that the April meeting of the Committee determined the performance related framework for directors each year.

The Committee noted the report considered in 2012 which set out the components of the framework. For 2012/13, benchmark salaries had been reviewed. However, the other elements of the performance related framework had been suspended for a year. The interim Director of Workforce Development and Human Resources explained that the Committee had discretion to determine which, if any, elements of the framework it wished to implement in 2013/14.

The interim Director of Workforce Development and Human Resources drew particular attention to the cost of living increase of 1% which had been awarded, following national agreement, to all staff on Agenda for Change contracts.
The Committee was minded to suspend the performance related awards scheme for 2013/14. However, before a final decision was reached, it was considered that further information should be available in respect of:

(a) the approach adopted in previous years for application of the performance related framework

(b) the approach being adopted by other trusts in respect of salary reviews and the application of performance related awards

(c) any contractual obligations in respect of the application of the Trust performance related framework

(d) the financial impact of awarding the 1% cost of living increase to directors, both individually and collectively

Resolved: that a further meeting of the Committee be held to discuss the application of the performance related awards framework in 2013/14 in the light of the information available in respect of (a) to (d) above.

10/13 Salary for the Associate Director of Strategy

The Chief Executive advised that an Associate Director of Strategy had been recruited to build capacity within the Commercial Directorate. An appointment had been made on a salary of £75,000, with the successful candidate commencing on 10 June 2013.

It was noted that the position was within the salary range requiring Committee approval prior to the position being filled.

Resolved: that the appointment of an Associate Director of Strategy on a salary of £75,000 be endorsed.

11/13 Initial Thoughts on Senior Management Team Development Opportunities

The Chief Executive discussed with the Committee his initial thoughts on senior management team development opportunities.

12/13 Recruitment of Director of Workforce Development and Human Resources

The Committee discussed the recruitment of a permanent Director of Workforce Development and Human Resources.

13/13 Date of Next Meeting

Resolved: that the next scheduled meeting of the Committee be held on 30 July immediately following the Board meeting.

SIGNED

DATE
Clinical Governance Committee
Thursday, 9 May 2013
10.30am - 1.00pm
Boardroom, Level 4, Royal Berkshire Hospital

Members
Ms Janet Rutherford  (Non-Executive Director) (Chair)
Ms. Caroline Ainslie  (Nursing Director)
Mr. John Barrett  (Non-Executive Director)
Mr. Ed Donald   (Chief Executive)
Mr. Peter Malone (Care Group Director, Planned Care)
Ms. Jane May (Non-Executive Director)

In Attendance
Mr. Stephen Billingham (Trust Chairman) (via conference call)
Ms. Helen Challand (Sister, Intensive Care) (for part)
Dr. Rima Clayton (Consultant Dermatologist) (For Lindsey Barker)
Dr. Chris Danbury (Consultant Intensivist) (for part)
Mr. Mark Hughes (Risk Manager)
Mr. Bill O’Donnell (Chief Pharmacist)
Ms. Patricia Pease (Care Group Director of Nursing, Urgent Care)
Mr. Mike Robinson (Head of Governance)
Mr. Arran Rogers (Matron, Ambulatory Care) (for Sharon Herring)
Dr. Prem Sharma  (Patient Panel Representative)
Mr. John Shaw  (Reading Healthwatch) (For David Shepherd)
Ms. Gill Valentine (Director of Midwifery)
Ms. Katharine Young (Clinical Governance Manager)
Dr. Carl Waldmann (Patient Safety Representative)

Apologies
Dr. Lindsey Barker (Care Group Director, Networked Care)
Dr. Sue Edees  (Care Group Director, Urgent Care)
Mr. Alistair Flowerdew (Medical Director)
Mrs. Sharon Herring (Care Group Director of Nursing, Networked Care)
Ms. Stephanie Seigne (Deputy Director of Corporate Affairs)
Mr. David Shepherd (Reading Healthwatch Representative)
Dr. Hester Wain  (Head of Patient Safety)
Ms. Kirsty Ward (Care Group Director of Nursing, Planned Care)

37/13  Declarations of Interest

There were no declarations of interest.
38/13 Minutes – 7 March 2013

The minutes of the meeting held on 7 March 2013 were approved as a correct record and signed by the Chair.

39/13 Matters Arising and Outstanding Actions Schedule

The Committee considered the schedules and noted those issues which had been completed, were elsewhere on the agenda or scheduled for future meetings. In addition, the following issues were raised:

(a) Minute 24/13 Estates Issues
It was confirmed that the Director of Estates and Facilities had attended the Urgent Care Group Board and been on walkabouts of the area. Staff had also attended relevant Estates meetings. The Chief Executive undertook to ensure that the Director of Estates and Facilities would attend meetings within the planned and networked care groups.

   Action: Philip Holmes

(b) Minute 27/13 North Block Ambulance Entry Point
It was confirmed that the issue in relation to falls at the North Block ambulance entry point had been taken forward and an additional entrance had been used.

(c) Minute 28/13 Francis Report
The Director of Nursing confirmed that a Trust Steering Group had been established to look at the recommendations and determine a gap analysis for the Trust. This would then be validated with the July Board meeting scheduled to receive the Trust’s draft response.

(d) Minute 18/13 Medical Record Paperwork
The Director of Nursing explained that she had yet to discuss the issue of extensive documentation in the notes with the Planned Care Group Director but would do so. However, it was clear that the majority of paperwork comprised required risk assessment tools. There was already a review of pathway and care bundle documentation underway.

   Action: Peter Malone/ Caroline Ainslie

Resolved: that the matters arising and outstanding actions schedules be noted.

40/13 Electronic Patient Record

The Chief Executive explained that weekly meetings with the Head of Informatics and Cerner continued to review progress and outstanding issues. A way forward had been found in respect of correspondence issues and although vital signs monitoring had improved, a software update from the United States was awaited. It was confirmed that the accident and emergency system was now satisfactory and that a new issue in relation to the double entry of data between the maternity and EPR systems was being examined. The ongoing need for data correction was a continuing problem and a new focus on initial data entry and training was to take place.

Other Committee members confirmed that the key ongoing problems in respect of EPR were as highlighted with the addition of the RadNet Interface problems and the continuing lack of infection control and other alert data on the bed view system.
Resolved: that the EPR update be noted.

41/13 Questions from Patients’ Representatives

(a) ADSU Signage
The Care Group Director, Planned Care explained that he had responded to a request to look at the signage to the Adult Day Surgery Unit and the issue of patients queuing in that area.

(b) Issues from the Committee Papers
Dr Prem Sharma, Patient Panel Representative, outlined some common themes from meetings of the Committee including drug errors, falls, staff shortages and capacity issues, medical equipment issues, ventilation and arrangements for delayed discharge. He also suggested a local approach to NHS funding which might be discussed with local authorities. The Chair welcomed the feedback which would be taken into consideration along with the papers for the meeting. In respect of funding issues and capacity problems this was a national issue which was being addressed at that level.

(c) Falls
The Director of Nursing explained the robust process in place for analysing the reasons for falls with all serious harm cases being reported to local Clinical Governance Committees and being actively reviewed by herself. There was a Falls Steering Group and action plan with a focus on sharing lessons across the Trust. There were also instances where the correct actions have been taken and falls were classified as unavoidable. It was noted that the Care Groups also actively monitored and tracked the trends and locations of falls.

(d) Maternity Pressures
The Chief Executive explained that local NHS Chief Executives were currently focusing on emergency care pressures and funding for non-elective work.

There were also regional strategic considerations to be given to maternity provision. This would consider whether it was appropriate for one Trust to significantly increase its capacity over the 6,000 births per annum threshold.

The Director of Midwifery explained that the recent situation where several maternity units across the region had been undertaking improvement works at the same time had been due to a specific deadline on national funding to improve delivery suites. This had been a one-off issue and feedback on the resultant problems had been given.

42/13 Urgent Care Report

The Urgent Care Director of Nursing introduced the report and said the key issue was the high levels of non-elective admissions with the Emergency Department seeing its busiest ever month in April. The situation was exacerbated by high levels of delayed discharge and increases in the age and acuity of the patients seen.

There was now a robust plan for nursing recruitment within the Care Group with an anticipated reduction in the vacancy rate to 10% by June.

It was explained that although the figures for VTE assessments were low, this was considered to be a data quality issue as clinicians believed that the assessments were
being undertaken. Matrons would be undertaking spot check audits to assess the situation and assurance was given that there was good engagement with staff on the issue. The results of the audit would be reported in the next Urgent Care Report to the Committee.  

**Action: Tricia Pease**

It was requested that where local specialty Clinical Governance leads reported that standards were not being met, that this be explained further. The seriousness of the statements, mitigations being taken and the balance of risks considered should be set out. Additionally, it was requested that actions and target dates always be included within the specialty sections.  

**Action: Care Group Directors and Directors of Nursing**

The Director of Midwifery explained that there had been five unit diversions during the period with three of these due to delivery rooms being closed due to poor ventilation issues. Extensive work had been undertaken and although the root cause had not yet been identified there was ongoing monitoring of gases to ensure staff safety.

It was reported that a new room was being commissioned to improve capacity in foetal anomaly scanning such that the required standards could be met.

**Resolved: that the Urgent Care Group report be noted.**

### 43/13 Intensive and Critical Care Issues

Dr Chris Danbury and Helen Challand, Consultant and Lead Sister for the Intensive Care Unit, gave an update to the Committee on critical and intensive care issues. Critical care had been proven to be important for the overall functioning of acute care. Modelling showed that the Trust required between 24 and 30 critical care beds but currently had 11, although this would increase to 20 with the opening of the new surgical high dependency unit. (SHDU) Studies had shown that access to critical care did affect mortality ratios and it was explained the shortfall meant admission thresholds to ICU were higher than for comparable Trusts.

It was noted that the current ICU had been state-of-the-art when commissioned but was now behind in terms of best practice. For example, the standards for metres square per bed and electrical sockets were not met. It was explained that the current ventilation problem with isolation side rooms could be resolved without closing the unit altogether. However, there would still be impacts from bed closures and building works. These would be mitigated wherever possible by using the new SHDU.

It was noted that during the recent busy period within the Trust, critical care had been provided within recovery rooms and this had been far from ideal. It was noted that non-essential transfers to other intensive care units had been undertaken but this was costly, resource intensive and did not always provide the best option for patients.

The Committee concurred that the case for increasing capacity within critical care had been made and that a business case would be presented to the Board. It was noted that the Clinical Commissioning Groups were supportive in principle and recognised the historic shortfall in this area. The Chief Executive explained that agreement had also been reached with commissioners that intensive care tariffs would be paid for patients treated by the unit outside the usual area. It was also noted that the Trust operated a system of critical care outreach within other areas which mitigated risks. The Committee thanked the Intensive Care Team for their work and the helpful update.
Resolved: that the update on intensive and critical care issues be noted.

44/13 Networked Care Group Report

The Matron for Ambulatory Care introduced the report and outlined the key issues including the steps taken in respect of medical equipment issues, infection control spot checks, estates issues within North block and the improving recruitment position. Resolving the air conditioning issue in biochemistry remained a big priority for the Care Group.

The Committee congratulated the Care Group on the Picker patient survey results and it was noted that lessons and actions were being taken forward. The Chief Pharmacist confirmed that all patients received medicine information leaflets on discharge even though the survey results indicated that perhaps some may not be aware of this.

It was recognised that providing nutrition assessments and help with feeding was a key component of the patient experience and it was felt that there were no substantive issues with feeding; rather the documentation was not always robust. The assistance of volunteers was being utilised but capacity pressures had been a factor in performance. The Director of Nursing explained that the statistics showed nutrition assessments were much more likely to have been completed within 48, rather than 24 hour target. There were also projects to record nutrition and fluid intake on observations charts.

The unsuitable storage issue within pathology was highlighted and would be the subject of an update in the next Care Group report. **Action: Sharon Herring**

Resolved: that the Networked Care Group report be noted.

45/13 Planned Care Group Report

The Care Group Director, Planned Care introduced the report and outlined the key issues including the improvements in acceptance from clinical leads with the new Clinical Governance structure. The Committee welcomed this development.

It was noted that capacity pressures continued to have a significant effect on the Care Group both in terms of patient safety, patient experience and income. For example, medical outliers in surgical wards increased the risks of infections and there had been a need for ICU patients to be treated elsewhere during the Trust's busiest period.

Data quality problems with EPR continued, however, the Care Group had significantly improved the situation through the use of dedicated information coordinators. It was noted that surgical specialties continued to have difficulties with the observations system.

Resolved: that the Planned Care Group report be noted.

46/13 Health Records Update

The Care Group Director, Planned Care introduced the update which showed that the availability of clinics notes had improved from a post EPR low of 88% to over 97% in April. The Trust was targeting 99% by the end of the year. Information on performance by
specialty was available and being tracked. It was noted that some areas with lower figures were walk-in clinics which would expect to have lower case note availability in any case.

It was confirmed that approval had been granted for additional staff to improve the physical quality of notes and also that the facilities in the Medical Records Department itself were scheduled for improvement.

It was considered that the need for improving behaviours in respect of case note tracking was understood and being achieved alongside the improvements in availability.

Several clinicians present felt that the availability of notes had improved in clinic and that the next step was to reduce the number of temporary notes being seen.

In response to a query, it was confirmed that surgeons would not operate unless they felt it was safe to do so and the information required was available. This could be achieved in the absence of notes and the Care Group Director, Planned Care, confirmed he was not aware of any incidents which had arisen following medical records being unavailable.

The Committee welcomed the clear report and requested that performance continue to be incorporated within the Planned Care Group report. In addition to including percentages the actual number of consultations which took place in the absence of notes should be included.

**Action:** Peter Malone/Jesse James

**Resolved:** that the update on the medical records be noted.

### 47/13 Quality Report

The Director of Nursing introduced the report and highlighted that several of the key themes had already been covered in the meeting. It was noted that the Trust had achieved the majority of its CQUINS demonstrating improvements in quality across a range of issues.

It was noted that the Datix Incident reporting system had been upgraded but there was now a backlog of incidents requiring approval which had built up during implementation. It was agreed that an update on the current position be considered in the quality report to be submitted to the next meeting of the Committee.

**Action:** Kat Young

The Committee noted and approved the changes to the Clinical Audit Plan.

The Chair highlighted that the Quality Governance Group had reviewed the Quality Governance framework in detail and it was anticipated that an action plan to improve the position would be needed. One issue related to improving the Trust’s Clinical Governance processes and an update would be provided at the next meeting.

**Action:** Kat Young

The results of the internal audit on the Clinical Governance processes were briefly outlined with the draft report showing that practices were acceptable. Some low level risks had been identified in relation to the Care Quality Commission framework and the need to use risk registers as live management tools. Additionally, there had been a request to ensure that recommendations from clinical audits and incidents were followed up and fed back.

There was a comment made in relation to the number of incidents report and that there was concern that members of the public / those less familiar with interpreting NHS data would understand that the number of incidents reported and the actual number of incidents
reported might be different and that all data is only as good as the quality of it. The confidence that can be taken from data can be increased by considering other data sources and whether the various sources are reporting similar outcome/trend. The Chair considered this to be a general point and requested that there be consideration to ‘health warnings’ on data reported to the Committee and the Board to give an indication as to the robustness of the data quality.  

**Action: Alistair Flowerdew/Hitesh Patel**

**Resolved:** that the quality report be noted and that amendments to the Clinical Audit Program 2013/2014 be approved.

### 48/13 Legal Report

Resolved: that the report be noted.

### 49/13 Board Assurance Framework and Corporate Risk Register

The Risk Manager introduced the report and confirmed that the issues raised in the meeting matched those identified within the assurance framework and corporate risk register. He concurred with the comments made about the need to ensure action plans were in place and for there to be appropriate challenge on the statements made and the need for mitigations to be listed. The Chair commented that the Committee and Board would continue to specifically review the high-unmitigated issues raised.

**Resolved:** that the Board Assurance Framework and Corporate Risk Register be noted.

### 50/13 Committee Seminar Arrangements

The Chair reminded the Committee that it had been agreed a seminar session would be held in the summer for groups which had previously provided annual reports to the Committee to make a presentation on their key issues. **Action: Kat Young/Mike Robinson**

**Resolved:** that a seminar session be arranged

### 51/13 Safeguarding Vulnerable People Audit

The Urgent Care Director of Nursing explained that the audit had not been undertaken following a specific concern but was an in-depth benchmarking to provide the Trust with information on actions required. The provision of training was being monitored and policies were being updated. The Chair requested that safeguarding be included in the Clinical Governance seminar in the summer. **Action: Tricia Pease**

**Resolved:** that the update be noted.

### 52/13 Key Messages for the Board

The Chair outlined the key issues:
• The VRE infection control issue in orthopaedics. The issue had required reduced capacity to manage the outbreak and related to wider capacity pressures across the Trust from to multiple moves and inappropriate mixing of patients.

• Nursing staffing levels, although improving, continued to be a concern. There needed to be an improved local supply of nursing staff although it is recognised this would take some years to feed through the training system.

• It was noted that although minor in comparison there were some issues with medical recruitment. It continued to be difficult to find good quality junior and middle grade doctors.

The following were raised as emerging issues:

• It was noted the Care Quality Commission would be undertaking a routine inspection of treatment for patients with mental health issues in June. Internal planning was underway and with partners in the wider Health Care community.

• It was noted that themed inspections from the Care Quality Commission might be expected on healthcare assistants, services for patients with dementia and processes for the transfer and discharge of patients. These issues reflected topics in the Francis Report.

• The Chief Executive highlighted that data quality remained an issue and would be important in respect of publishing data on consultants’ performance. He requested that an overview of data quality issues be received at the next meeting.

  Action: Elizabeth White

• It was noted Dame Fiona Caldicott had issued a new report in relation to improving information sharing in the health and social care sectors.

53/13 Infection Prevention and Control Committee Minutes – February 2013

The Director of Nursing introduced the minutes and it was noted that issues already identified in the meeting had been discussed. She confirmed that attendance at the meeting had improved.

Resolved: that the minutes of the Infection Prevention and Control Committee held in February 2013 be received.

54/13 Date of Next Meeting

The next meeting would be held on 4 July 2013 at 10.30am.

It was noted that patient names had been included in the aggregated analysis of incidents, complaints and claims within the quality report. It was confirmed this was unacceptable and information must be anonymised in future.

  Action: Hester Wain
55/13 MRSA Root Cause Analysis Update

Patient representatives left the meeting for discussion on this item as it included patient identifiable data.

The Chair emphasised it was important to ensure lessons had been learnt from the MRSA case to ensure the situation was not repeated.

The Director of Nursing explained that the patient involved had very complex co-morbidities and that the presented root cause analysis had been part of a much broader review into all elements of the patient’s care. The Committee noted the issues which had occurred, including the failure to follow protocols on screening and decolonisation washes. There had been a problem with samples not reaching the pathology laboratory which had not been followed up. Lessons had been learned, for example, it had been made clear that the responsibility for following up on results rested with the individual requesting them and that screening must be repeated if results were not received. It was felt that there had been significant benefit from sharing the lessons learned with Care Groups, Clinical Directors and Matrons responding positively.

It was felt an important message was the need for a continuing focus on proactive and robust infection control techniques. Care Group key performance indicators included the tracking and monitoring of infection control audits. The Chair requested that in future the Care Group reports specifically highlight actions being taken in respect of specialties which had poor compliance with infection, prevention and control audits.

**Action: Care Group Directors of Nursing**

The Chief Executive reported that he had met a relative of the patient and explained with full candour the actions taken and issues for the Trust.

**Resolved:** that the update be noted.

**SIGNED**

**DATE**
Audit & Risk Committee
Monday 20 May 2013
11.00am – 2.15pm
Boardroom, Level 4, Royal Berkshire Hospital

Members

Mr. Brian Hendon  (Non-Executive Director) (Chair)
Mr. John Barrett  (Non-Executive Director)

In attendance

Advisors

Ms. Harriet Aldridge  (Senior Manager, PwC)
Ms. Kate Anderson  (Senior Manager, KPMG)
Ms. Debbie Coffey  (Local Counter Fraud Specialist) (up to minute 64/13)
Mr. Clive Everest  (Partner, PWC) (up to minute 70/13)
Mr. Joel Harrison  (Assistant Manager, KPMG)
Mr. Neil Thomas  (Partner, KPMG) (up to minute 71/13)

Trust Staff

Mr. Craig Anderson  (Director of Finance)
Mr. Graham Butler  (Deputy Director of Finance)
Mr. Ed Donald  (Chief Executive) (from minute 59/13)
Dr. Keith Eales  (Director of Corporate Affairs and Secretary)
Mr. Alistair Flowerdew  (Medical Director) (for minute 59/13)
Mrs. Angela Gardiner  (Group Financial Controller) (for minute 63/13)
Ms. Vanessa Harding  (Head of Programme Management Office) (for minute 70/13)
Mr. Philip Holmes  (Director of Estates & Facilities) (for minute 71/13)
Mr. Mark Hughes  (Risk Manager) (for minute 71/13 and 72/13)
Mrs. Caroline Lynch  (Governance Officer)
Mr. Hitesh Patel  (Interim Commercial Director) (for minute 69/13)
Dr. Hester Wain  (Head of Patient Safety) (for minute 59/13)
Ms. Nicola Wesson  (Assistant Director of Public Relations) (for minute 63/13)
Ms. Elizabeth White  (Head of Informatics) (for minute 69/13)

Apologies

Mr. Tim Caiger  (Non-Executive Director)

56/13  Audit and Risk Committee reports

The Chair emphasised the importance of ensuring that reports for the meeting were prepared in a timely manner to ensure that the agenda would be circulated a full five
working days in advance of the meeting in order to ensure that members had sufficient time to review the reports

57/13 Minutes 15 January 2013

The minutes of the meetings held on 6 March 2013 and 10 April 2013 were approved as a correct record and signed by the Chair. It was agreed that a note would be included in the minutes of the meeting held on the 10 April to state the meeting was held by teleconference.  \textbf{Action: C Lynch}

58/13 Matters Arising Schedule

The Committee received the matters arising schedule.

Minute 24/13 (107/12): Internal Audit Progress Report: The Director of Finance confirmed that an updated draft report of the estates strategy audit was included in the internal audit progress report.

Minute 29/13: IT Update and Minute 36/13: Audit Recommendations Update: The Director of Finance advised that a verbal update on IT would be provided later in the meeting by the Commercial Director and a formal report on IT would be provided at the September meeting of the Committee.  \textbf{Action: C Anderson/H Patel}

Minute 32/12: IT Asset Impairment: The Director of Corporate Affairs & Secretary confirmed that a communications plan was being currently developed with crisis management consultants and would be distributed to Board directors for review once completed.  \textbf{Action: K Eales}

Resolved: that the matters arising schedule be noted.

59/13 Quality Accounts

The Medical Director introduced the Quality Accounts 2012/13. The Committee noted the robust process for the production of the Quality Accounts.

It was noted that the staffing level figure in the quality accounts related to the number of staff employed rather than whole time equivalents. It was agreed that this would be amended to the figure quoted in the financial statements and references to the Committee would be updated to read Audit & Risk Committee.  \textbf{Action: A Flowerdew}

The Medical Director drew attention to the development of priorities for improvement. Priorities had been discussed at length with governors and other stakeholders and at the Quality Governance Committee. The Board had agreed that three priorities should be selected in order to enable focus on achieving improvement in these areas.

The Chair queried the priority to improve the appointments system. The Head of Patient Safety advised a project was ongoing to reduce rescheduling of appointments in key specialities.
The Partner, KPMG, advised that the role of external audit in respect of the Quality Accounts was to provide an opinion on the content of the Quality Accounts and the two mandated quality indicators and limited testing on the additional mandated indicator.

The Partner, KPMG, confirmed that the Trust had achieved a limited opinion on the content and the two mandated quality indicators. In respect of the additional mandated indicator no formal opinion was required however based on the current definition of the indicator the auditors considered that an opinion could not be provided in future years. The Partner, KPMG advised that this opinion however had been provided to all trusts in 2012/13 on this indicator as no trust had a robust system in place to demonstrate that every incident had been reported and captured.

The Partner, KPMG, advised that two high level and one medium level recommendation had been issued which related control environment for the patient safety incidents indicator, monitoring and update of the Quality Governance Framework and robustness of the initial Quality Report. The Chief Executive advised that in respect of the control environment for patient safety incidents further discussions would be held in the light of Francis report and best practice. Reporting of patient safety incidents was currently voluntary however there were concerns in adopting a mandatory process as evidence suggested that this may not be productive.

The Committee would receive a report at the next meeting on progress against audit recommendations for the quality accounts. **Action: C Anderson**

**Resolved: that the Quality Accounts for 2012/13 be recommended to the Board for approval.**

**60/13 Financial Statements 2012/13**

The Director of Finance introduced the consolidated financial statements for 2012/13 and drew attention to the management letter of representation. The Committee noted that KPMG had advised that they would be seeking assurance in the letter of representation in respect of revaluation and consequent impairment of assets, contract income provisions and accounting treatment of the CSC contract.

The Partner, KPMG confirmed that they were assured of the processes followed by management in respect of revaluation and consequent impairment of assets. The Director of Finance advised that the process for contract income provisions taken by management related to the considered contract penalties which would be imposed by the Clinical Commissioning Groups. The Committee noted that the accounting treatment of the CSC contract reflected the current contract renegotiations.

The Director of Finance advised the Committee that a letter of parent support would also be required as part of the year end financial statement preparation for HFMS.
Resolved: that
(a) the consolidated financial statements 2012/13 be recommended to the Board for approval
(b) a recommendation be submitted to the Board to authorise the Director of Finance to sign the Letter of Representation.
(c) a recommendation be submitted to the Board to provide a letter of support for Healthcare Facilities Management Ltd

61/13 ISA 260

The Partner, KPMG, introduced the report and drew attention to the role of the auditors in respect of the audit of the annual financial statements.

The Partner, KPMG expressed thanks to the finance team for the preparation of the financial statements. He advised that there had been no unadjusted audit differences and only minor presentational issues with the financial statements.

The Partner, KPMG, drew attention to the high risk areas considered during the audit EPR implementation, valuation of non current assets and delivery of savings plan however it considered that management’s assessment of the Trust’s ability to continue as a going concern was appropriate.

The Committee noted there was one medium level and one low level recommendation which related to contract management and management and use of the Oracle system. Management would review each of these recommendations. The Director of Finance confirmed that the Head of Procurement was currently reviewing contract management arrangements with the procurement team.

The Partner, KPMG, advised that on receipt of the signed management letter of representation an audit opinion would be given that the financial statements presented a true and fair view.

Resolved: that the report be noted.

62/13 Going Concern Review

The Committee noted the going concern review. A number of factors had been reviewed such as liquidity and profitability, general economic risks facing the Trust, financing and investment risks, safeguarding cash and bank convents. The Committee noted that the year end accounts had been prepared on the assumption that the Trust was a going concern.

Resolved: that the going concern review be recommended to the Board for approval.

63/13 Annual Report 2012/13

The Director of Corporate Affairs & Secretary introduced the annual report for 2012/13.

The Committee agreed that subject to the minor typographical changes the Annual Report would be recommended to the Board for approval.
Resolved: that subject to minor typographical changes the Annual Report be recommended to the Board for approval.

64/13 Counter Fraud Annual Report

The Local Counter Fraud Specialist (LCFS) introduced the report. The Committee noted that there had been an increase in the level of referrals and queries made to the LCFS during 2012/13 which reflected that more staff were aware of the methods available to report a suspicion of fraud. Fraud Awareness training was ongoing in addition to attendance by the LCFS at monthly corporate induction sessions.

The LCFS advised that close liaison with the UK Borders Agency was maintained and a number of enquiries relating to patients' immigration status had found that individuals were not entitled to free secondary NHS care. There patients were therefore invoices for any treatment administered. Instances where patients had not paid for treatment were passed to the UK Borders Agency who added a declaration to the individuals' visa records. The Director of Finance advised that a report had been submitted to the Executive recently on the process in place for overseas patients. A copy of this report would be circulated to the Committee.

Action: C Anderson

Resolved: that the report be noted.

65/13 Internal Audit Progress Report

The Senior Manager, PwC introduced the report and advised that seven final reports had been issued since the last meeting of the Committee. The Senior Manager, PwC drew attention to three outstanding areas of which included cost improvement plans, IT general controls and follow up draft report which had been issued to the Trust for management comment.

The Committed discussed the clinical audit findings. It was noted that only 18 of the 260 audits on the Clinical Audit programme had been completed as at February 2013. It was noted that the Chair of Clinical Governance Committee would be provided with a copy of the report in order to review these findings.

Action: C Anderson

The Committee discussed the private patient activity (audiology) audit report. It was noted that management had requested this audit and were aware that there was a need to ensure a robust process was in place relating to private patient flow across the organisation. This area would be re-visited as part of the 2013/14 audit programme.

Action: C Anderson/C Everest

Resolved: that the report be noted.

66/13 Internal Audit Annual Report 2012/13

The Partner, PwC, introduced the draft report and drew attention to the limited assurance opinion given in 2011/12 which was based on high risk findings relating to the Trust’s IT general control, EPR, Bracknell Clinic and Regulatory Risk Ratings. These areas had been followed up in 2012/13. In respect of Bracknell Clinic the Trust’s governance arrangements for business case approvals had been revised and strengthened. Follow up of the high risk finding to EPR had not been completed as the Trust was currently carrying out a review of IT and EPR. The Committee noted that the Head of Internal Audit Opinion equated to limited assurance for the second year in a row.
The Director of Finance drew attention to the internal audit results compared with the previous year and that assurance could be drawn from the fact that there had been a decrease in the number of high and medium level risk recommendations.

It was agreed that the annual report for 2012/13 would be finalised as soon as possible. **Action: C Everest**

Resolved: that that internal audit annual report be noted.

**67/13 External Audit Progress Report**

The Committee noted the report which outlined a summary of additional work performed since the last meeting of the Committee. The Committee noted that the final audit of the 2012/13 Trust financial statements had been completed as well as a review of the draft annual report and preparation of the ISA 260 audit highlights memorandum. In addition an audit of the quality report and mandated and locally selected indicators had been completed. Upcoming work included completion of the 2012/13 final accounts audit for the Charity and HFMS Ltd.

Resolved: that the report be noted.

**68/13 Audit Recommendations Update**

The Director of Finance introduced the report and advised that a number of recommendations had been completed including Bracknell realisation benefits and information governance. Actions which remained outstanding included financial systems and charity funds. A schedule of the outstanding audit recommendations would be circulated to the Committee. **Action: C Anderson**

Resolved: that the report be noted.

**69/13 IT Update**

The Interim Commercial Director advised that a status report was being prepared which would be submitted to the Executive at the end of June. **Action: H Patel**

The Head of Informatics gave a verbal update on progress. The Committee noted that the Storage Area Network (SAN) had been replaced and over 150 systems had been transferred to the new SAN over a 3 month period. The new SAN also now provided the capacity for expansion. As part of the CSC transformation programme a small virtual server farm had been installed as an interim solution to enable the upgrade and installation of additional application and a new safe had also been installed for security of back-up tapes.

The Committee noted that a significant amount of progress had been achieved following the appointment of the interim IT manager. The review of IT would be completed by the end of June and would be linked with the ongoing review of EPR. It was agreed that a detailed plan together with timescale for actions to address IT issues would be prepared for the next meeting of Committee. Details of agreements with CSC would also be provided as part of this report. **Action: C Anderson/H Patel**
70/13 Quality Improvement Programme Projects

The Head of Programme Management Office gave an update on the Quality Improvement Programme Projects (QIPPS). The current forecast was to achieve £10m cost savings through the 250 different projects against a £20.2m total value in year cost and income. The total risk rating was £8.9m which presented a £1.1m gap. The aim was to identify all possible cost savings and as the project developed some projects would become more viable than others however the main focus would be on quality.

The Committee noted that as the project was currently in the development phase a commercial arrangement with Newtons had been agreed in principle. A further update on QIPPS would be provided at the next meeting.  

Action: V Harding

71/13 Board Assurance Framework and Corporate Risk Register

The Director of Corporate Affairs & Secretary introduced the Board Assurance Framework (BAF) and advised that two new risks had been added to the BAF in respect of estates issues. The most significant BAF risks related to EPR and IT contract.

The Committee discussed BAF 1 (Failure to improve the in-patient recommendation rate to 95%). It was considered that the target risk rating should be amended.

Action: C Ainslie

The Committee noted there was no action plan included in BAF 2 (Failure to deliver the national access standards set out in the NHS Constitution) The Director of Finance confirmed that a report had been presented to the Executive. The risk would be amended accordingly.

Action: Care Group Directors

The Committee discussed BAF 3 (Risk of exposure to operational losses relating to utilisation at each of the Trusts Community hospitals or clinics). The Director of Finance confirmed that the Bracknell Steering Group monitored market share data and percentage of patients seen at community sites.

The Committee recommended that a long term target for BAF 4 (Reduce morbidity and mortality rates in the Trust so that SHMI is ‘as expected’ by the end of Q2) should be added.

Action: A Flowerdew

The Committee discussed BAF 7 (Continued implementation of EPR system and develop IT contract to ensure affordability and fitness for purpose). It was noted that the EPR stabilisation plan had been agreed however the plan was yet to be implemented. The Director of Finance confirmed that the budget for EPR had not been agreed.

The Committee noted that BAF 9 (Clinical services strategy) was currently awaiting Executive approval.

The Director of Estates & Facilities gave an update on BAF 10 (Fail to deliver first year of real estates strategy and reduce the size of the occupied floor by 5%). The Committee noted that disposal of the Battle site had been delayed due to an issue which had emerged relating South Central Ambulance Service land title. The sale of 7 Craven Road had been halted as the prospective buyer had decided not to go ahead with the purchase.

The Committee noted good progress had been achieved in respect of BAF 11 (Failure to achieve an appraisal rate of 95%).
The Director of Estates & Facilities gave an update on BAF 13 (Engineering infrastructure resilience and compliance). The Director of Estates & Facilities advised that following surveys by independent advisors a strategic action plan had been developed. Progress had been achieved in respect of water hygiene and electrical inspections had been completed across the whole site. A significant amount of work was still to be carried out over the next few years and a report on estates compliance was being submitted to the Executive for discussion later that day. It was agreed that a report setting out where improvements had been achieved in respect of engineering compliance would be submitted to the Committee.

**Action: P Holmes**

The Committee discussed BAF 14 (Quantum of back log maintenance liabilities). The Director of Estates & Facilities advised that the projection for 2013/14 was currently being reviewed in order to inform the maintenance strategy. The focus at present remained to be statutory maintenance. The risk rating related to the impact on capacity as maintenance issues were being addressed. It was agreed that the wording on the gaps in assurance section would be amended.

**Action: P Holmes**

The Risk Manager introduced the corporate risk register. The Committee noted that ten new risks had been identified, eight escalated by Care Groups, one by corporate directorate and one as a result of a Board decision. The Committee recommended that risk owners should be asked to include expected dates of completion to each risk.

**Action: M Hughes**

The Chair queried the risk relating to IT disaster recovery. The Director of Corporate Affairs & Secretary advised that further detail relating to this risk would be included on the directorate level risk register.

**Resolved: that the Board Assurance Framework and the Corporate Risk Register be noted.**

### 72/13 Risk Manager’s Report

The Risk Manager introduced the report and advised that following an initial review of Health & Safety an action plan had been developed. An external audit of Health and Safety systems in the Trust was currently underway by the Royal Society for Prevention of Accidents (ROSPA) and the results of this audit would strengthen the existing action plan. A further update would be provided at the next meeting of the Committee.

**Action: M Hughes**

The Risk Manager advised that following a review of risk management training at the Trust in addition to recent staff survey results a gap in training had been highlighted. Work was underway to ensure Health and Safety training was included as part of the mandatory training programme. The Committee queried whether this gap in training should be added to the corporate risk register.

**Action: K Eales**

**Resolved: that the report be noted.**

### 73/13 Review of the Work of Other Risk Committees

**Clinical Governance**

The Committee received the minutes of the meeting held on 7 March 2013.
74/13 **Bank Account Authorisations**

The Committee noted there had been no bank authorisations since the last meeting of the Committee.

The Director of Finance advised that there had been two breaches the Treasury policy which related to more than £35m being held in one institution on 16 April and 1 May.

75/13 **Non-NHS Debt**

The Deputy Director of Finance introduced the report.

The Committee noted the total value of non-NHS debt was £2.5m as at 31 March 2013.

Resolved: that the report be noted.

76/13 **Losses and Special Payments**

The Director of Finance introduced the report and advised that since the last meeting, two special payments had been made to the value of £3,165.

The Committee noted that there had been nine payments for loss of property, to the value of £3,103. The Committee queried the payments relating to loss of patient cash held in ward safes. The Director of Finance agreed to ascertain.

The Committee noted the write off of £54,378.39 which related mainly to historical debts which were over 7 years old and had proven difficult to trace.

Resolved: that the report be noted.

77/13 **Use of Single Tenders**

The Committee noted that there had been no single tenders since the last meeting of the Committee.

78/13 **Schedule of Significant Contracts**

The Committee noted that there had been two significant contracts since the last meeting of the Committee. One related to a two year contract to provide printed documents and a two year contract to provide glucometers.

Resolved: that the report be noted.

79/13 **Non-Audit Services**

The Director of Finance advised that there was one non-audit service currently being provided by KPMG in respect of preparation of the 2012/13 HFMS corporation tax return.

The Committee noted that KPMG had been appointed to undertake recurring VAT compliance work at a fee of £45,000 plus VAT.

Resolved: that the report be noted.
80/13 Technical Update

The Senior Manager, KPMG, introduced the report.

The Committee noted the issues of implementing the recommendations of the HM Treasury review of tax arrangements.

Resolved: that the technical update be noted.

81/13 Audit Committee Timetables 2013/14

The Committee noted the timetable 2013/14.

Resolved: that the timetable be noted.

82/13 Date of Next Meeting

It was agreed that the next meeting would be held on Wednesday 11 September at 9.00am.

Resolved: that the next meeting be held on Wednesday 11 September at 9.00am.

83/13 Private Meeting with External Audit

A telephone meeting would be held with KPMG.

84/13 Private Meeting with the Internal Auditors

A telephone meeting would be held with PwC.

85/13 Private Meeting of the Committee

A meeting of the Committee was not held.

SIGNED

DATE
Royal Berkshire NHS FT – Board Work Plan

Agenda Item 13

Items to be scheduled:
- Property disposals update (PH)
- Consolidated Pathology Services (LB)

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