Yorkshire Ambulance Service NHS
NHS Trust

Finance & Investment Committee (F&IC) Meeting Minutes

Venue: Boardroom, Springhill 2
Date: Thursday 6 September 2012
Time: 1000 hours

Attendees:

Name	(Initials)	Title
Roger Holmes	(RH)	Non-Executive Director (Chair)
Pat Drake	(PD)	Non-Executive Director
Elaine Bond	(EB)	Non-Executive Director
Rod Barnes	(RB)	Executive Director of Finance & Performance
David Whiting	(DW)	Chief Executive
Observing:		
Barrie Senior	(BS)	Non-Executive Director
Iain McInnes	(IM)	FT Programme Director, Strategic Health Authority
Guy Musson	(GM)	FT Programme Director - Financial, Strategic Health Authority
In attendance:		
Anna Rispin	(AR)	Associate Director of Finance
Joanne Halliwell	(JH)	Associate Director for Business Development

Apologies:

Minutes produced by:
Andrea Wort (AW) Executive PA to Executive Director of Standards & Compliance

		Action
1	**INTRODUCTION & APOLOGIES** There were no apologies, and members introduced themselves.	
2a	**MINUTES OF THE LAST MEETING** The minutes of the meeting held on 6 September 2012 were agreed as a correct and accurate record with the following amendments: Under item 12b, page 11 – initials EB to be changed to DB (David Bacon) to read "DB circulated appendices to support the presentation…."	

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2b	**ACTION LOG & MATTERS ARISING** The action log was discussed and updated. The remaining open items were covered on the agenda. <u>Action 2011</u> All business cases had been received. This item therefore now closed. <u>Action 2012/12</u> The business case for effective sickness management had been recirculated and item now closed. <u>Action 2012/15 & 2012/10</u> The action relates to private & events therefore comment in last column is incorrect. <u>Action 2012/16</u> The query relating to QBE fund is explained in paper this time. <u>Action 2012/17</u> Detailed CIP procedure for managers was produced and circulated for the meeting but would be discussed at the extra meeting scheduled for 24 Sept 12. <u>Action 2012/18</u> RH asked whether the committee could be given assurance that that has been done. AR advised of a separate document that could be circulated on the action plan relating to accident reduction. RB reported this was now incorporated into IPR. RB agreed to locate the document and ensure circulated. <u>Action 2012/19</u> Item closed. <u>Action 2012/20</u> The Estates Strategy had been approved at Board, therefore item closed. <u>Action 2012/21</u> The ICT strategy had gone through another reiteration. Comments had been fedback and will now be incorporated into the next version, but this wasn't ready for today. <u>Action 2012/22</u> YTD financial position – IPR had been amended to provide more details on CIP but any on-going concerns to be discussed in agenda. <u>Action 2012/23</u> 111 action covered in the short term, but update to be provided later in the meeting.	

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3	**Review of Members Interests** There were no interests to be declared in relation to the agenda items.	
4	**Update on Current Tenders Active** JH updated the Committee that currently the 111 contract was the only current tender active. DW provided an update on the position with 111 at this point. Part A – which was the main contract was expected to be formally signed off at 2pm Friday 7 Sept. There had been delays following the announcement of the preferred bidder status, and two to three weeks were lost due to the speed with which commissioners had turned around the draft contract. In early August issues arose around the IT solution, as commissioners wished us to look at an alternative system, as at the time the bid was placed the only interface between the 999 system and urgent care transfer was Adastra. There was now a solution called TPP from System 1, widely used at the front end for GPs across Yorkshire and Humber, and there was an opportunity to review this system. A number of weeks were spent looking at that solution and discussing the options with commissioning colleagues. This resulted in a review, at which it became clear Adastra was the only credible solution. The System 1 solution wasn't developed sufficiently to be assured it could be implemented well within the 26 week window. YAS and commissioners agreed Adastra would provide all the connectivity required. DW reported that having the CCG lead involved had proved helpful in providing assurance that the CCG community would accept this solution. Once this issue was resolved final contract discussions began, and debates occurred over the delays due to late receipt of the contract and IT discussions and the potential risk that puts in the system for mobilisation. Agreement was reached with commissioning colleagues around changes to liquidated damages and clauses and go-live *vs* soft go-live. A phased approach had been agreed starting with soft go-live on 5 March 13 working up to go-live on 19 March 13. The whole process had been difficult but the right outcome gained from working with Commissioners, although the process was intense and quite a distraction from other business. DW stated he could not forsee anything that would affect the go-live now. There were risks within the project but believe the time could be caught up appropriately. The main risk was around working with NHSD to release TUPED staff in order to undergo training ready for go-live. PD questioned the delay in HR impact of staff in out-of-hours; and also in terms of the contract with LCD, and whether this delay had an impact on contract negotiations?	

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	DW didn't think there would be any major problems. Good relationships had been established with NHSD and felt confident about sensible dialogue and work with NHSD. He noted if that if there were any potential blocks then it had been agreed with commissioners these would be escalated quickly. DW noted Keeley Townend and team were quite clear in terms of next steps and important appointments were already being undertaken particularly around the customer relationship side. RH appreciated the good news, and confirmed the job of this committee would be to monitor any financial risks arising from it in the future. PD also confirmed from a clinical governance and governance perspective this was planned for discussion at the Quality Committee later that day to ensure a clear run through. RB confirmed contract negotiations with LCD had been going on for some time, and there had been some queries re: indemnity between the organisations this week, but that Steve Page was confident sign-off would be achieved today. The committee noted the update and looked forward to further progress.	
5	**Investment/Treasury KPIs** RB presented the paper relating to Treasury Management Key Performance Indicators (KPIs) for the five months of the financial year 2012/13. RB wished to highlight some points from the detailed twelve month rolling cash flow statement attached to the paper, and noted an abridged version was included in the IPR. He referred to the public dividend capital received and commented that this was complex and that headings in the cash flow statement were not helpful regarding purchase of the Springhill site. Temporary borrowing had been arranged from the DH, for £2m in June followed by an additional £1m in July which was due to be repaid this month, as the permanent loan had now been approved and cash would be received in Sept. The public dividend later in the year represented funding for the HART facility, which is in discussion with the DH. A Memorandum of Understanding (MOA) is in place for that. RH noted the Trust was left with an uncomfortably low cash position in July due to the Springhill funding, and questioned why only £3m was taken rather than nearer the full amount. RB agreed the preference to receive nearer the £6m, but as a temporary loan the DH only grant sufficient funding to meet short term requirements.	

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	RH asked if there was any assurance that the cash position has in fact been covered. AR confirmed there will be £3.7m in the bank in August. RH asked if debtors had risen. AR reported one PCT had not paid their invoice on the due date but this was now resolved. RB explained the QBE interest was a result of motor insurance arrangements. This was a national ambulance contract fund that all Trusts pay in to, to cover damages not covered by the insurance policy between £500-£25k, over which the insurance policy pays out. YAS has £463k lodged in the fund to cover those damages and interest showing on the report represented interest in earned on that sum. RH felt the cash flow forecast going out through the remainder of the year seemed fairly robust. PD asked if the commissioners had agreed funding for ECS. RB confirmed they had received support from PCT cluster Chief Executives in principle but the business case was being developed prior to circulation for approval. The committee were assured about the KPIs subject to the thin cash position at the end of July.	
6	**Year to Date Financial Performance** RB provided an update referring to the finance section of the IPR. The Trust was on track in terms of operating surplus £805k *vs* a plan of £806K. In the expenditure position we are continuing to see upward trends in A&E, with a 5.5% rise for the year. The plan was last year's outturn, although it was recognised with commissioners at the start of the year there would probably be a 3% growth on previous trends. Currently the Trust is still projecting a forecast outturn of 3% but concern is growing and discussions are being held with commissioners about whether a capacity review should be instigated and this was still an option available going forward. RH asked how a capacity review would help us and what we would gain from this. RB responded that it would formalise the discussions around rising demand and what can be done from a commissioner's perspective to try and better manage demand. DW said there were other schemes that were being discussed for example, the referral to GPs in-hours, which is a small number of referrals being taken by GPs during their practice hours. This has been tried in small pockets and made a difference to the system but was difficult to get through to completion because of issues with GPs requesting to be commissioned first. There are lots of other options on the table but these would require further discussions.	

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	Discussions were already on-going in North Yorkshire locally around eligibility criteria for urgent admissions. PD asked if the 5% was across the board or whether there were particular pressures. RB said there were pressures in certain areas and some areas had seen peaks as high as 13% growth. PD suggested commissioners may support schemes being implemented in the key areas. DW advised those discussions are taking place at contract meetings on a local level. RB also informed that demand management schemes had been rolled out into North Yorkshire following discussions with commissioners about three months ago. PD questioned whether this was a national trend or whether YAS was experiencing a particular pressure. RB confirmed there were a number of Trusts experiencing demand well above last year's levels and higher than Yorkshire. RB informed the committee that PTS had seen the largest area of overspend in the first four months of the year. During the first month it was due to use of external resources Sheffield, South Yorks, that had now shifted and last month cost pressures were in East Yorkshire. Meetings have been held with the PTS management team. TEG had a meeting a week ago where the PTS team and Unipart were asked to present the early findings from the diagnostic work and it was identified a number of issues were down to operational management control, particularly planning and utilisation of our own internal capacity. Higher levels of external resource were being used than should to meet demand and discussion held with senior management team about taking action immediately to try and turn that situation around. Largely the capacity is there in terms of our internal resources but there are some issues with control staff based here lacking knowledge of local resources and geography. RB felt contractual KPIs were dysfunctional and were therefore resulting in a lower level of service being provided to most patients, and discussion therefore required with commissioners on renegotiation of contracts, with a beneficial outcome for both parties as the current position was not tenable for either going forward. DW advised a senior meeting was to be setup before the end of Sept and actions will be implemented by PTS team in Hull. EB asked what the current variance was year to date and what was the forecast. RB responded if the situation carried on as is, there would be a £1m overspend. _____ **Action** RH suggested this required monitoring closely and a report back on the short term action plan for next meeting. _____	**RB**

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	RB highlighted the £149k overspend in Fleet. Implementation of new processes are happening. In terms of run rate the actual expenditure in Fleet was less than last year so controls are having a positive effect. Last year Fleet had a £1.3m overspend and a number of actions had been taken, i.e. 25 vehicles removed in last month as these were poorly utilised and have now been disposed of. RB informed the committee that the A&E overspend was within the EOC area rather than A&E frontline. RH asked how much progress had been made towards controlling the overspend, and EB questioned the root causes for that. JH responded that this was a combination of issues, overtime rates in EOC were high, some of which linked to rota configuration which goes back to the rota review already discussed. The new Locality Director had now commenced in post this week, and there were a number of posts and acting up arrangements to try and address performance in EOC, that were never substantially funded. The EOC reconfiguration needs to establish which of those posts we need to keep and therefore retain a budgeted establishment for and which need to move back into their substantive roles. There has been much change in leadership within EOC and duplicated roles now required removing. With the arrival of the new EOC Locality Director, the group were confident changes would be implemented imminently. Given these changes, EB asked if we could draw back some of the overspend. JH reported that the overtime profile had already reduced on last year, and was set to reduce further in-year, there was sensitivity as some of the posts are tied up in HR processes which we have to abide by. Dependent on the ultimate decision around structure, that may or may not, be quick depending on HR processes affecting certain individuals, therefore the establishment cost is a little difficult to quantify for this year. Phasing would be on-going between now and March 2013. The committee noted the future was clear, pending the interim pace and cost. --- RH raised a query on progress of capital schemes delayed relating to defibrillator and vehicle replacement, around whether they would be caught up in this financial year? RB confirmed Board approval was obtained in July for the purchase of additional defibrillators. The type was identified (Lifepak 15) and are being processed. Fleet was a phasing issue, with A&E fleet expected in before Christmas. --- EB and RH raised a query in the cost improvement risks summary (5.10) and how we get from £3.7m probable value of risk to forecast of	

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	£2m. They wished to understand the gap? RB explained the forecast varies and is refreshed on a regular basis. Each of the probabilities would be assessed each month. One area that changed significantly since the IPR was produced was the PTS situation as a lot more is known now. The most worrying aspect was the forecast of £300k and year to date of £400k. There was a lot more work to do with this. DW felt confidence with the programme of change through Unipart. EB suggested a little more commentary may be helpful on this document. RH suggested the committee had reasonable assurance on performance year to date overall and the immediate outlook was subject to areas of overspend in PTS and EOC and Fleet being tackled and minimised.	
7a	**CIP Delivery Update** AR presented the CIP finance tracker that goes to the CIP management group meeting highlighting the CIP target of £10.3m. Schemes had actually been identified totalling just short of £10.9m which is slightly different to the figure presented in IPR as continuing to refine, hence the increased figure. The £578k in the column 'shortfall excess to budget' shows the difference between the target and actual schemes identified. Schemes are tracked monthly, against a plan which was submitted in March and a profile gauged on CIPs at that point and savings are being tracked against those phased targets. As things have obviously moved on these are being refined. The target for end of July was £2.6m and have achieved £2.5m. The paper therefore points out the areas of slippage i.e. sickness management and reduction in A&E meal breaks. AR advised the backing sheets provided were a breakdown by CIP scheme showing the target, and what had been achieved, to the end of July. _____ **Action** RH suggested the group focussed on particular areas of shortfall and began by commenting on sickness management. EB felt there was no deeper information in shortfalls and going forward suggested it would be useful to have that extra detail in the document and in the action plan by exception. The group also felt it would be helpful to have the appropriate owner of this paper to be present to give feedback on the relevant information. _____ RH queried what confidence we had, if any, on sickness management, that we can deliver the business case based on where we are. AR advised the scheme was scheduled to commence 1 July but	**AR**

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	slipped a month. DW commented that actions hadn't been put in place yet and if anything there had been a positive impact on long term sickness but short term sickness had increased. Confidence was required that those actions will kick in. The scale of the impact financially was not clear but actions were being taken. This discussion is held on a fortnightly basis at the CIP management group and at TEG. The £600k was a major concern. RB confirmed discussions were held in TEG around sickness reporting and processes, and confirmed more assurance around long term sick at this stage as case reviews were being undertaken and action with regard to Occupational Health, although there were limits to actions being undertaken, taking into account tendering processes. PD confirmed the confidence required as NEDs, is that these policies are being applied appropriately and supported by HR to do that. RB commented that these issues also brought up issues identified at CIP management meetings and the steady cultural shift from being good at bringing ideas to the table, but not at implementation. The situation was improving due to better behaviours, and mitigations were in place through other parts of the CIP which were over-delivering. It was recognised that A&E have a number of schemes potentially amber rated, i.e. meal breaks and negotiations with unions were progressing as well as could be expected. RB explained a lesson learned this year was around clear leadership with CIPs. It was a significant challenge to get from where we were to having a 3-5 year CIP programme in the timescales but we had successfully overcome this and achieved an awful lot in a limited period of time. There was more work to do but confidence was much improved from where were 12 months ago. RH felt there was commendable honesty in terms of staff engagement. JH explained in terms of corporate support there was the key appointment of the AD HR. All appointments will help us move forward. RH queried the Clinical leadership CIP of £325k saving against a plan of £0 and asked if this was due to vacancies in the system or savings against the business case. AR explained the reason this was nil at the start was because the business case hadn't been worked up at the time the FIMS plan was submitted. EB asked what the cut offs were between amber and green. AR explained green shows that a CIP is on track and achieving planned savings as determined at the end of July. These are allocated by the senior business finance managers who are responsible for producing the tracker but in conjunction with the lead manager for each scheme. EB suggested this is documented on this tracker to ensure being applied correctly throughout and gives the group confidence.	

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	_____ **Action** RH tasked AR to revisit this and ensure clear descriptions and ratings are provided. _____ DW commented that there was an executive overview where larger key schemes were being monitored, and also require confidence in the ratings. _____ **Action** PD presumed the ratings would need to be included in the procedure. _____ RH queried the clinical hub being behind on savings as planned, and having thought this was a scheme that would've come through quickest, and was not dependent on union negotiations or anything, therefore questioned why implementation had slipped. RB confirmed the business case had been reviewed with a number of different iterations of it, including another today. Originally when the business case was produced the projected savings for it were £1.4m, these have now been revised down now to £505k for year and is on track for new forecast. RH queried the establishment review rated amber, and questioned RB's confidence that the number for the year as a whole would be achieved. RB said this target should be achieved or close to it. Actions in some areas had slipped a little but were still in action. It was noted Operations, Finance & Performance and Standards & Compliance were the areas most affected. Having discussed this with these director colleagues, all felt confident at this stage 80-100% would be achieved by year end. RH noted reasonably close to the first 4 months plan, but do have a concern about the big challenges that are ahead i.e. on A&E, and therefore cannot express a high level of assurance at this stage on the outlook of the year as a whole and the group was relying on the executive focus to bring through schemes. DW confirmed early warning messages would be in place, and a lot of executive led activities were in place on these schemes, so through this committee, and outside, awareness would be raised should anything be likely to go off track.	**AR** **AR**
7b	**Five Year CIP Plan** AR presented the Five Year CIP plan and reported that more schemes were identified than targeted for. The areas were highlighted where business case is in the process of being worked up and PIDs were	

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	being developed for the final two years. Workshops were being held this week across directorates to pull these together and it was anticipated these would be presented to the next CIP management. RB advised the CIP plan had been rolled forward another year and also began to put together a high level plan for 2018-19, identifying a number of priority areas. EB commented taking into account PD's comment on the amount we've had this current year that's dependent on workforce change, would it be useful to look at the 5 year plan and almost categorise that from a risk perspective as well? _____ **Action** RH agreed an understanding was required on how the risks would be addressed in this and there were different ways of doing that. _____ RB agreed the 5 year summary could be made more explicit. RH had been concerned over the CIP set against 111 to save £550k per year from 2014/15 onwards and was unsure of the thinking behind that. He queried whether there was a specific business plan behind that and whether it was about integration between emergency and urgent care or experience of call handling. RB stated that related to the nature of the contract at the time the bid was put together, it was explicit that the national inflation assumptions would apply that are currently running at -1.8% tariff deflator. The expectation therefore was that required efficiency savings would be made within 111 to deliver a surplus against that contract. Areas were identified within the 111 cost base where efficiency savings are expected to be made going forward. RH asked how this was planned to be taken forward. RB advised of the new areas where we are working on business cases currently, an extra F&I committee was now planned for 24 Sept. There were two large areas: workforce model and clinical hub. Clinical hub was a business case seen before but was now modelled for additional years. The clinical hub business case has been rolled forward so that by year 6 (2017/18), we would expect to be closing around 9.5% of calls through telephone triage. The business case also identified the capacity that would be required to do that (App3 of business case) and expect by year 6 another 9 posts would be required over and above the current establishment in clinical hub to deliver. RB explained because there will be a number of business cases at the next meeting, it was proposed the outline of the business cases were covered in this meeting but members peruse in further detail outside the meeting. RB referred to the consultation document that was attached to the A&E workforce business case which goes through the model in some detail and asked for any questions to be fedback that	**??**

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	could be touched upon at the meeting on 24 Sept. RB discussed briefly and requested comments to be returned within 10 days. RH commented that the overall plan looked as if it had enough in it, but the issue would be about how robust schemes are looking like at this stage. PD raised a general comment, in terms of education requirements, and the different training access required to ensure we have the right amount of paramedics. We need a feel of the release and backfill and asked whether it will it be more or less than is now. RH asked what other business cases were planned to be presented, if any. He wondered whether the committee needed to see any below the top eight listed, to test out. _____ **Action** The committee agreed to task RH along with RB to suggest a sample selection of Business Cases on the next level down to be discussed at the next meeting. _____ The committee noted progress with the five year plan, with plenty of progress and plenty of testing to be done, at the next meeting.	**RH/RB**
7c	**Business Case Review** <u>A&E Workforce Model</u> RB gave a brief outline. The proposal was to have a band 5 and band 3 model for all frontline. Band 5 paramedic role and band 3 ECA role, have a job description created, and has been banded and seen by staff side. The intention would be to introduce the new band 3 role this calendar year and start recruiting against it and then convert the AP's and support tier staff to this role. YAS has a 5 year pay protection policy in place. Technicians to train to paramedic level to fulfil the paramedic rota lines, which would in turn clear a space for the new band 3 to come in on the rota. Detailed discussions were held with staff side relating to the number of technicians that would train each year, the model is forecasting by year 5 there would be circa 50 technicians who would not have gone through paramedic training and financials take account of that. Discussion held with staff side also covered staff close to retirement age who may wish to go early releasing places. Approximately 30 technicians would fall into this category and the number increases over a 5 year period. _____ **Action** Detailed financials had been enclosed with papers instead of summary documents, these would be obtained from PBW and recirculated.	**RB**

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	_____ The high level summary compares the current staffing model which for the current year has a budget of £82,462k, with different scenarios worked through. Noted item 2.a.1. was the scenario negotiated with staff side. The summary table that should've been circulated focusses on this scenario. The marginal demand growth income was factored in, leaving WTE numbers as are now and managing the demand for next 5 years through the same resource base, so again tied into other LTFM IBP assumptions, expect will get marginal funding attached to that, and expected that 85% will go into operations. As staff go through training and posts are replaced by band 3 roles, savings will be year on year. At the end of year 5, pay protection will be exhausted and new arrangements will see a two year pay protection scheme enabling more flexibility regarding changes to workforce from then. PD asked what the anticipated reduction in reference costs would be. RB confirmed this area in isolation once fully implemented would take about 3-4% off our reference costs. RH reiterated incorrect schedules had been included in the papers, therefore RB to recirculate straight away and any comments to be returned to RB by Friday 14 September in order to finalise views on business cases on at the meeting held 24 September.	
8	**Finance HDD2 Results** HDD2 results had been distributed and an action plan developed. This was a positive report, and would prepare for SHA and DH stages and the FT process coming up. RH picked up a couple of errors that were in the document and questioned whether they were good or bad in terms of LTFM. RB said overall level of surplus comes down so we are not in the position that we were but maintain a robust level of service throughout the five years of LTFM based on where are today. Number of actions coming through and working through downsides. There were no alarm bells ringing. The action plan will be discussed at the 24 Sept meeting along with a longer agenda item for LTFM. Discussion deferred to next meeting.	
9	**Review of changes to LTFM/Downside Risk (including Key Financial Risks)** RB presented the paper which provided an update on potential downside scenarios and updates to the LTFM following discussions with SHA and other Ambulance Trusts including South Central (SCAS),	

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	North West (NWAS) and North East (NEAS). RB noted NWAS were at DH phase therefore slightly further ahead than YAS in the FT pipeline, and NEAS and SCAS were already authorised as FTs'. Discussions focussed on LTFM assumptions and downside scenarios. Included in the document circulated (App2) are the original downside scenarios that were included in the last IBP submitted to the SHA. App3 was the proposal for amendments to be made to the downside scenarios based upon discussions with the SHA and other ambulance services. All Trusts had made similar assumptions for in year payment at a marginal rate for A&E over performance and then going up to a full tariff in future years. It was noted the other Trusts' in year marginal income for activity above contract was funded at 50% of the full tariff as opposed to 75% for YAS, and therefore these had been identified as a new downside risk (item 13, page 8). There were wide fluctuations in PTS assumptions. Some organisations assumed a steady state with no downside scenarios at all, some had downsides where they lost their whole PTS business over a period of time. YAS downside scenarios include the loss of two out of four contracts, which seems to be a middle ground therefore the decision was taken to remain with the PTS downside with no change. There were risks around contract penalties, and as well as contract loss the downside scenario required strengthening to reflect this position. CIP non-delivery was included at 20%, whereas other organisations had 25%. Feedback from SHA seemed that 25% was deemed to be the norm therefore the new downside scenario is non-achievement of 25% in 5 yrs. Also included was a downside scenario for an additional CIP requirement of 1%, no-one else had this and planning assumptions were now clearer therefore it was removed but left in the downside of non-pay pressure through non-pay inflation being 1% greater than the plan. Progress had been made with 111where previous discussions related to the downside related to not obtaining the contract. This is now replaced with one more focussed on liquidated damages and potential loss of contract after 3 years. The most significant downside scenario was Payment by Results (PbR). The issue for YAS was that if the national tariff is implemented, based around the 100% reference costs introduced, how would we	

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	manage that. In the acute sector the introduction was phased in at four years, therefore perhaps 25% could be factored in per year for 4 years from 14/15. The above were the main changes, and discussion had been held at executive team about developing these into business cases. These were felt to be pragmatic scenarios and RB opened up this question to the committee to decide if challenging enough etc. EB queried feelings about having an arbitrary % against CIPs as didn't feel these should be comparable as schemes are individual in nature. Monitor's assumption coming in and doing the actual work does seem to be applying the standard 25. RB commented the risks of non-delivery of the CIP in the first couple of years at 25% was quite low but need to recognise over a 5-6 year period this would get more challenging. Schemes will get harder as time goes on. Downside business plan templates were included within the paper. The aim was to steer people into testing the validity of their mitigations before coming back to board for review, emphasising that mitigations should not be created without the confidence that they can be implemented. SCAS seemed to have been lightly challenged in terms of mitigations, and feedback received suggested downsides included variation from A4C Terms & Conditions, but these hadn't been fully developed within the organisation. NWAS proposals seemed to be more resilient. RB stated our focus has got to be coming up with mitigations that can be defended. RB was happy to share the summary document of the feedback received. RH asked when we would see proposals for mitigations. RB reported the revised mitigation plan had been given out last week, started working up this week with a deadline for Friday 14 Sept, therefore short timescales. _____ **Action** Templates would begin to be fed into into LTFM and the meeting on 24 Sept. _____ RH raised a query regarding PTS. On top of contract loss and non-delivery of CQUIN, the HDD2 report did seem to query strongly the assumption we would pass an income growth during the planned period. Our assumption on that is we will lose volume but the mix is going to enrich so our income still goes up. Are we going to remain where we were or robust enough to carry out. RB responded there was a very detailed exercise being undertaken in relation to PTS currently, focused not just on activity but in terms of resource, helping to inform workforce and fleet plans. Work completed	**RB**

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	so far identified that saloon car and abort volumes would fall. Within IBP levels of growth were identified for the over-75 population group and those are the largest makeup by far of wheelchair and stretcher vehicle cohort, and so there was no reason not to expect, that those numbers would not continue to rise. Overall a reduction in numbers was being seen, but with an increased complexity and our challenge going forward was how to implement a differential tariff related to patient complexity. Work on PTS is quite well advanced, activity models are now completed, the workforce plan and the fleet plan aligned to these numbers has been shared and has gone back with some challenges and another draft is expected this week which will allow us to have a clearer picture going forward for LTFM and again a brief on that on 24 Sept. RH asked, as a committee, whether there was any amendments it wished to make to the revised downside scenarios. Subject to that these would be shared soon after next Friday for comment. --- RH had asked for the Board Assurance Framework (BAF) to be presented at the meeting in order to check financial risks were being sufficiently addressed. <u>Item 1a - IT system.</u> RB questioned whether the group was happy the actions to address gaps were progressing satisfactorily. RB stated a lot of work had been put in place since the 2011 incident in CAD, to improve the upgrade and change process, and there was now a procedure. The piece of work that is being undertaken currently was around the telecoms rather than IT software. There were issues in relation to the telephone switches, although isolated issues have now been addressed, ICT have been asked to have an independent investigation carried out into switchboard maintenance. The trust has very up to date technology but questions remain why repeated problems were occurring with the switches not working. In terms of day to day operation there was enough capacity in the switchboard. <u>Item 4a – PTS loss of business</u> – Discussed already but only thing in action to address gaps was the introduction of a commercial director. RB confirmed interviews were planned later this month. <u>5a – Inability to deliver service transformation and organisational change</u> - Discussed sufficiently and qualified assurance. <u>7a – Business Continuity generally</u> – It was not clear whether this related to F&IC or more Quality Committee but no doubt has a financial impact. Some of the actions to address gaps were very much within our the remit of this group, however, the training aspect probably	

		Action
	related more to Quality committee. 8a – 111 – Risk now related to running the contract rather than not obtaining it.	
10	**Finance & Investment Strategy** The annual review of this document was expected at this meeting. RB expressed the need to bring this back as implicit to chapter 6 and LTFM discussions. As services are developed in future years, plans for those surplus's would be questioned. Some organisations use a build-up of surplus's to achieve their liquidity position, some use it to fund capital developments, and YAS has the estate reconfiguration scheme but also the reference cost position, which was a significant issue. Discussion was to float ideas around in advance of re-visiting with chapter 6 and LTFM discussion in more detail. The trust should decide on objectives for the financial strategy and from a risk mitigation point of view, emphasis would be placed on cost profile, and whether reducing unit costs on A&E service, for commissioners, to make us more competitive to peers. This reflects feedback from the SHA review of the LTFM and IBP. Once the LTFM was completed, the document required updating in light of this and should be brought back to the meeting. _____ **Action** RB advised that as a Board, sight of this was required by the end of Sept and throughout October, therefore item should come back to 24 Sept meeting with an update on progress. _____ _____ **Action** It was noted the Business Development strategy review was scheduled in the work plan for this meeting, however RH had agreed with RB this should be deferred to the November meeting as currently being worked on. _____	**RB** **RB**
11	**Better Payment Practice Code** RB presented the paper to note the progress of the Trust against its Better Payment Practice Code (BPPC). RB reported this was still improving, the big shift in improvement will come when the scanning project goes live. A lot of work was happening on this in the last month or two, but unsure of exact go live date. AR advised testing would be taking place next week. This should enable us to reach the 95% target in time. RH queried para 3.1 which stated the Trust has a target of 90% for	

		Action
	2012/13, but then para 3.2 stated the Trust had a 90% target to be achieved by end of year. RH queried which was correct. RB confirmed internally the target was to reach this by the year end. The committee agreed it felt assured on progress and the process for getting the number up to the target.	
12	**ICT Strategy** It had been hoped to present this to the meeting. It had been to the Board Development Meeting in August but was not yet ready for another version yet. RB thanked the committee for feedback received, and had incorporated this into the document. _____ **Action** It was anticipated this would be emailed out in the next few days. The Board has to see and agree the document on 25 Sept therefore comments were required very quickly on receipt of the email. _____	**RB**
13	**Service Line Management Update** RB was working on this, but there was some slippage due to other priorities. _____ **Action** A full briefing would be presented to the November meeting with a position statement giving the service line position on each of the areas. Information was likely to be shared in the Board Development Meeting before next Finance & Investment, but currently this was not in a presentation condition that could easily be shared. _____	**RB**
14	**Private & Events Review** The P&E review had been scheduled for this meeting. RB advised Agilitise had been commissioned to undertake an in-depth market assessment of private events and private training and they had met with management teams, and commissioners. The deadline for completion was 23 Sept therefore a report would be expected soon after. When information is received, it would be used to inform the IBP and also shared widely with the board at a board development session. RH was concerned about the non-focus on making decisions about this business and hoped it was not having an effect on the running of it. RB said a lot of discussions had been held with Mark Ruud and various bits of development work with P&E were on-going, and some of the opportunities outlined in document were being taken forward.	
15	**111 Update** This item already discussed under item 4.	

		Action
16	**Any Other Business** There was no other business. The meeting closed at 1255 hrs.	
Date and Time of Next Meeting – An extra meeting was scheduled for: Monday 24 September 2012.		