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INTRODUCTION TO REPORT OF 1 DECEMBER 2004

Alvarez and Marsal, Europe was engaged by Monitor and the Bradford Hospitals NHS Foundation Trust ("Bradford Trust") to provide the following financial and operational consulting and management advisory services to Monitor in connection with Monitor's oversight role of the Bradford Trust (as described in the engagement letter of 5th October, 2004:

a. Review and analyze Bradford Trust's most recent liquidity position and assist it to prepare a detailed, line-item rolling 13-week Cash Flow.
b. Review and analyze Bradford Trust's working capital changes during the period 1 April 2004 to 31 August 2004.
c. Review and analyze Bradford Trust's operating results and closing position (income statement and balance sheet) for the 5 months ended 31 August, 2004.
d. Review and assess Bradford Trust management's turnaround plans including its monthly pro forma cash flows through to 31 March 2006.
    i) identify risks and opportunities to management plan
    ii) assess deliverability and timing of projected improvements/initiatives
e. Review and assess management information, reporting and control systems.
f. Assess Bradford Trust's management team and Board oversight capabilities.
g. Assist Monitor and Bradford Trust in its communications with key constituents.
h. Other activities as mutually agreed upon by A&M and Monitor."

The attached report addresses this brief with the exception of reviewing management's turnaround plan. The management plan delivered to Monitor in September was withdrawn by Bradford Trust's management and no alternative plan was delivered to A&M before the first report date of 11th November, 2004. A&M was not requested to develop a turnaround plan for the Bradford Trust and did not do so.

The report is based upon four weeks of intensive analysis that included:

a. A detailed review of the Bradford Trust financial position.
b. Discussions with the operating and financial management of the Bradford Trust.
c. Discussions with the Board of Bradford Trust.
d. Discussions with the local PCTs on their perspective on the issues being disputed between Bradford Trust and themselves.

The first draft report was presented to the Bradford Trust on the 9th November 2004. A revised draft, reflecting comments from the management and the then Chairman of the Trust, was presented to Monitor on 11th November. Subsequently, written comments from Bradford Trust, received on 23rd November, were reflected in the attached draft, delivered to Bradford Trust and Monitor on 1st December 2004.

FINAL DRAFT

Bradford Teaching Hospitals NHS Foundation Trust

Review for Monitor and the Board of Bradford Teaching Hospitals NHS Foundation Trust

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I. Executive Summary

A. Financial Summary

- Projected Liquidity
  - BTH currently has cash availability as a consequence of delaying payments in excess of the 30 day NHS policy and of receiving advanced payment from Bradford City PCT.
  - Assuming that BTH conforms with the NHS payment policy in November 2004, then the cash requirement is projected to exceed the funds available and the existing facility in early December.
  - Continuing to delay payments might postpone the problem until January.
  - By the end of March 2005, BTH is projected to require £14.6 million in excess of the current facility.
  - A&M is of the belief that there are material risks to the projections (which are outlined herein).
- Income and Expenditure
  - BTH currently forecast a loss for the fiscal year of £11.3 million.
  - The estimated loss of £11.3 million compares with a budgeted surplus of £2.3 million.
  - The loss was caused by meaningful cost increases over the original Budget because of staffing for growth and carry-over expenses stemming from fiscal year 2003.
  - A&M believes there is significant risk to fiscal year 2005 revenues.

I. Executive Summary

A. Financial Summary (cont)

- Risks
  - Budget controls have been weak and so the risk of unexpected expenditures is significant.
  - Based on our detailed analysis of the 3,014 queries raised by the Bradford North Primary Care Trust (PCT) in the first 5 months of fiscal year 2005, the estimated denial rate for inpatient income could be as high as 9% (see Appendix D) - this would increase the income at risk to £11.3 million compared to the £5.1 million provision by BTH (an increase of £6.2 million).
  - The cash impact from the denial rate is significantly higher and could be an additional £3.7 million.
  - Of the clinical income of £195 million, £13.6 million can be classified as “other clinical income” and £4.8 million as “adjustments”. We believe that some £4.3 million of these two categories is at risk because it is not clear that the PCTs will pay for all these charges.
  - A&M risk adjusted projections:
    - March 2005 liquidity need of £25.6 million
    - Fiscal Year 2005 loss of £21.8 million

I. Executive Summary

A. Financial Summary (cont)

- Reasons for the "Sudden" Deterioration in BTH's Liquidity Position and Earnings
  - There was no one problem that has created the liquidity problem. Rather there were weaknesses in the previous operations that then crumbled under a barrage of changes that all occurred at the same time: foundation status, HRGs, Payment by Results, the new consultant contract, the working time directive etc.
  - Last year brokerage was used to offset a loss of £2.3 million. The loss had not impacted cash because of delayed payments to creditors.
  - The potential problem in fiscal year 2005 was identified in a paper from the CFO in April 2004 (Appendix B) – where he estimated a loss of £11 million. A memo from the CEO on 9 April, 2004 (Appendix C) warned of the same problems and highlighted many of the issues that still exist today.
  - The variance in the BTH forecast can be attributed to a number of cost issues: (i) An increase in personnel costs due to an increase of around 300 WTEs since March 2003, and an increase in the costs of employment from internal and external factors (e.g. pensions, national consultant contracts) (ii) increases in drug and medical supply costs (iii) an increase in the use of temporary staff.
  - The problems have been compounded by budgeting weaknesses, poor reporting, and computer delays in pricing activities on the new basis, delays in invoicing and poor data from West Yorkshire Shared Service Centre (WYSSC).
  - Underlying coding issues have had a significant impact on data accuracy and have contributed to the challenge and denial problems with the PCTs.

I. Executive Summary

B. Role of Management

- The executive management, including the Executive and Operations Directors, display an impressive grasp of the day to day mechanics necessary to provide quality patient care.

- The management response to the early warnings from the CFO was inadequate. No urgent drive for cost savings was initiated.
  - Questions have been raised as to the urgency of the CFO's message
  - It was thought that there were numerous mitigating factors, such as a growth in the number of cases and the collection of old receivables
  - There was a directive from the CEO, recognising such issues and re-iterating the challenges of becoming a Foundation Trust (see Appendix C)
  - Despite all the above, over spending in the first half and poor results indicate a lack of commitment to resolve the identified potential financial problem.

- There is no organised process for resolving PCT challenges and denials.
  - A history of friction continues to exist
  - Significant differences of opinion about the interpretation of payment by results and what is/ is not included
  - Strong willed personalities on both sides
  - Lingering bad faith from prior year arbitration
  - Differing opinions exist on other issues, such as a new wing and actions taken to resolve outstanding issues to date
  - Need to rebuild relationship based on facts and analysis.

- No formal turnaround plan has been presented to A&M. There have been statements of intent but no clear actions, dates, responsibilities or financial impact. There is a reliance on external solutions where other parties will provide additional funds. The recent track record causes scepticism about management's ability to execute a plan.

I. Executive Summary

C. Role of the Board of Directors

- The non Executive Directors are clearly looking to understand their new roles as a Board, rather than as community representatives. There is recognition that the hospital faces a problem, but only now is the scale and implications of the problem apparent.

- The Board was warned of a potential problem by the CFO in April.
  - Distractions from implementation of a governance structure needed for the new Foundation status diverted attention from prioritising this issue.
  - Non executive directors maintain that continued efforts were made to obtain follow up information on issues raised by the CFO.
  - [redacted]
  - As a group, they appear to have confidence in the new CFO.

There is a need for a fundamental change in culture at BTH. The organisation must learn to stand alone at every level and learn to live within the financial constraints that exist.

II. Financial Review

Key Elements

Liquidity

- At 8 November 2004, BTH had £4.4 million in the bank.
- Assuming that "overdue" trade creditors of £6.0 million at 8 November are unwound in the next 30 days, BTH will exceed its credit facility in December. At the end of 13 weeks, the requirement above the existing facility of £3 million will be £6.7 million.
- The cash requirement will continue to rise through to 31 March 2005 when it will be £14.6 million (before risks) in excess of the existing facility.
- If the risks identified on pages 21 & 22 eventuate, the cash requirement could be as high as £22.6 million in excess of the existing facility in March 2005.

Working Capital

- Due to weaknesses in financial reporting processes, there is currently no reliable or properly reconciled balance sheet for BTH.
- While the debtors ledger indicates a balance of £4.1 million at 8 November 2004, we do not believe that significant cash is tied-up in debtors. In fact, given underlying activity levels and denial rates, BTH may well owe the major PCTs.
- Trade creditors at 8 November 2004 are estimated at £12.6 million. Given annual non-pay purchase volumes, this represents creditor stretch of £6.0 million.
- In addition, transitional relief of £4.0 million and £1.6 million clinical negligence insurance are currently owed.

Income & Expenditure

- BTH is currently forecasting a deficit of £11.3 million in the current financial year against an original budget of surplus £2.4 million and against breakeven in FY 2004.
- The significant decline in performance from both budget and prior year can be analysed:

	Actual vs Budget	Actual vs Prior Year
Income	£ 3.1	£ 18.7
Payroll	-6.5	-16.1
Non Payroll	-11.3	-12.6
Other	0.9	-1.4
Net Movement	£ -13.8	£ -11.3

Risks & Opportunities

- Income Risk – there are 2 main risks to income:
  1. Denials – from PCTs based on claims made year to date. We estimate that the impact of denials could be £6.2 million higher than included in the current income forecast by BTH. The incremental cash impact could be £3.7 million adverse.
  2. Other income – from a review of the components of other income, we estimate that up to £4.3 million may not be realised
- On the cost side, there may be some opportunity to mitigate the impacts of 1 and 2 above.

II. Financial Review

Short Term Liquidity (13 Week Cash Flow)

(£ in Millions)

	Week 1 08-Nov Forecast	Week 2 15-Nov Forecast	Week 3 22-Nov Forecast	Week 4 29-Nov Forecast	Week 5 06-Dec Forecast	Week 6 13-Dec Forecast	Week 7 20-Dec Forecast	Week 8 27-Dec Forecast	Week 9 03-Jan Forecast	Week 10 10-Jan Forecast	Week 11 17-Jan Forecast	Week 12 24-Jan Forecast	Week 13 31-Jan Forecast	TOTALS Forecast
RECEIPTS														
PCTS - Base														
Bradford North		3.0				3.0				3.0				9.0
Bradford City		5.2				5.5				5.5				16.2
Bradford South & West		5.3				5.1				5.6				16.0
Airedale		0.6				0.6				0.6				1.8
Other PCTs		1.0				1.0				1.0				3.0
		15.1				15.2				15.7				46.0
Other Income	0.1	1.9	0.1			2.0				2.0				6.1
	£ 0.1	**£ 17.0**	**£ 0.1**	**£ -**	**£ -**	**£ 17.2**	**£ -**	**£ -**	**£ -**	**£ 17.7**	**£ -**	**£ -**	**£ -**	**£ 52.0**
PAYMENTS														
Creditors - Unwind	-2.0	-2.0	-1.7											-5.7
Creditors - Trading	-1.3	-2.9	-1.3	-1.3	-1.3	-5.3	-1.3	-1.3	-1.3	-1.3	-1.3	-1.3	-1.3	-22.5
Creditors - Capex	-0.2	-0.2	-0.2	-0.2	-0.6	-0.6	-0.6	-0.6	-0.3	-0.3	-0.3	-0.3	-0.3	-4.6
Salaries & Wages	-0.1	-0.1	-6.4	-0.1	-0.1	-0.1	-6.4	-0.1	-0.1	-0.1	-0.1	-6.4	-0.1	-20.0
Pensions		-1.6				-1.6					-1.6			-4.7
Tax & NI		-2.9				-2.9					-2.9			-8.6
	-3.6	**-9.6**	**-9.6**	**-1.6**	**-2.0**	**-10.5**	**-8.3**	**-2.0**	**-1.6**	**-1.6**	**-6.1**	**-8.0**	**-1.6**	**-66.1**
NET CASHFLOW	**-3.5**	**7.3**	**-9.5**	**-1.6**	**-2.0**	**6.7**	**-8.3**	**-2.0**	**-1.6**	**16.0**	**-6.1**	**-8.0**	**-1.6**	**-14.1**
OPENING CASH	4.4	0.9	8.3	-1.2	-2.8	-4.8	1.9	-6.4	-8.4	-10.0	6.0	-0.1	-8.1	4.4
CLOSING CASH	0.9	8.3	-1.2	-2.8	-4.8	1.9	-6.4	-8.4	-10.0	6.0	-0.1	-8.1	-9.7	-9.7
FACILITY	-3.0	-3.0	-3.0	-3.0	-3.0	-3.0	-3.0	-3.0	-3.0	-3.0	-3.0	-3.0	-3.0	-3.0
FACILITY AVAILABLE	**£ 3.9**	**£ 11.3**	**£ 1.8**	**£ 0.2**	**-£ 1.8**	**£ 4.9**	**-£ 3.4**	**-£ 5.4**	**-£ 7.0**	**£ 9.0**	**£ 2.9**	**-£ 5.1**	**-£ 6.7**	**-£ 6.7**

II. Financial Review

Short Term Liquidity (Notes)

a) Cash Receipts

Cash receipts have been forecast based on (i) the roll-out of opening trade debtors at 8 November 2004 and (ii) underlying trading cash flows going forward.

(i) Opening Trade Debtors

Given that debtors are in theory invoiced and paid within each month, BTH debtors outstanding should not exceed £9.0 million each month (based on a turnover of £216 million). However, the trial balance at 30 September 2004 shows outstanding "Debtors" of £27.3 million.

Reconciliation of Debtors Account (£'000s)

		30-Sep-04
Gross Debtors (Per Ledger)	£	63,808
Less: Unallocated Cash Received	-	33,507
Less: Other Adjustments	-	3,020
Debtors (Per Trial Balance)	£	27,281

Due to the fact that no invoices were raised in the first half of the year and a number of reconciling items on the ledger, we do not believe that the £27.3 million figure should be relied upon for cash forecasting purposes. Given several large "counterclaims" from large PCTS (e.g. Bradford City £2.0 million, North Bradford £0.7) and the uncertainty as to income at risk (See Financial Review Section), we do not believe in the short term that there is any significant cash tied up in debtors.

(ii) Underlying Trading Cash Flows

These have been modelled based on payment on account schedules agreed with the PCTs.

II. Financial Review

Short Term Liquidity (Notes)

b) Cash Payments

(i) Creditor Payments

At 30 September 2004, the trial balance showed a “Creditors” figure of £34.8 million. As with the debtors figure, we question the reliability of the figure per the trial balance due to reconciling items. From a detailed review of the unpaid creditors listing, we estimate that the “true” level of trade creditors outstanding at 8 November was £12.6 million.

Assuming compliance with the NHS payment policy (30 days), this represents an “overdue” trade creditor backlog of £6.0 million which will require payment in the coming 13 week period. In addition, transitional relief of £4.0 million and clinical negligence insurance £1.6 million is outstanding and will also require payment.

The run rate for non-pay spend is estimated at £1.3 million per week (based on an annual forecast of £66.6 million).

Capex going forward has been estimated on a monthly basis by BTH.

(ii) Salaries, Pensions, Tax and NI

Over the past 3 months, pay costs have been running at £11 million per month. Given the “hiring freeze” currently in place, these should remain constant going forward.

II. Financial Review

Short Term Liquidity (Notes)

c) Proposed BTH Action Plan

- BTH have identified a number of actions in order to address the cash shortfall. These include:

Action	Impact (£m)
Delay March payment of tax and NI	2.8
Delay March pension payment	1.5
Capital expenditure deferral	1.0
Non payment/ return of PDC	5.1
Return of capital brokerage (FY 2003/ 2004)	3.2
Advance of PDC re SHA nominated capital schemes	4.0
Possible increase in overdraft facility	6.0
Total	**18.0**

- While these measures may temporarily address the cash shortfall in the current financial year (FY 2005), the underlying imbalance between income and costs (see pages 14 – 18) is not addressed by these actions. The result will be that a residual cash short fall will be moved to FY 2006.

II. Financial Review

Medium Term Liquidity (to 31 March 2005) – pre Risks and Opportunities

(£ in millions)

	Week 14 07-Feb *Forecast*	Week 15 14-Feb *Forecast*	Week 16 21-Feb *Forecast*	Week 17 28-Feb *Forecast*	Week 18 07-Mar *Forecast*	Week 19 14-Mar *Forecast*	Week 20 21-Mar *Forecast*	Week 21 28-Mar *Forecast*
RECEIPTS								
PCTS - Base								
Bradford North		3.0				3.0		
Bradford City		5.5				5.5		
Bradford South & West		5.2				5.2		
Airedale		0.6				0.6		
Other PCTs		1.0				1.0		
		15.3				15.3		
Other Income		2.0				2.0		
	£ - £	**17.3**	**£ - £**	**- £**	**- £**	**17.3**	**£ - £**	**-**
PAYMENTS								
Creditors - Unwind								
Creditors - Trading	- 1.3	- 1.3	- 1.3	- 1.3	- 5.3	- 1.3	- 1.3	- 3.8
Creditors - Capex	- 0.4	- 0.4	- 0.4	- 0.4	- 0.4	- 0.4	- 0.4	- 0.4
Salaries & Wages	- 0.1	- 0.1	- 6.4	- 0.1	- 0.1	- 0.1	- 0.1	- 6.4
Pensions	-	1.6			-	1.6		
Tax & NI	-	2.9			-	2.9		
TOTAL PAYMENTS	**- 1.8**	**- 6.3**	**- 8.1**	**- 1.8**	**- 5.8**	**- 6.3**	**- 1.8**	**- 10.6**
NET CASHFLOW	**- 1.8**	**11.0**	**- 8.1**	**- 1.8**	**5.8**	**11.0**	**- 1.8**	**- 10.6**
OPENING CASH	- 9.7	- 11.5	- 0.5	- 8.6	- 10.4	- 16.2	- 5.2	- 7.0
CLOSING CASH	- 11.5	- 0.5	- 8.6	- 10.4	- 16.2	- 5.2	- 7.0	- 17.6
FACILITY	- 3.0	- 3.0	- 3.0	- 3.0	- 3.0	- 3.0	- 3.0	- 3.0
FACILITY AVAILABLE	**-£ 8.5**	**£ 2.5**	**-£ 5.6**	**-£ 7.4**	**-£ 13.2**	**-£ 2.2**	**-£ 4.0**	**-£ 14.6**

Note: week 18 payments includes £4.0 million transitional relief (part 2) and week 21 includes £2.5 million PDC payment (part 2)

II. Financial Review

Income & Expenditure (FY 2005 vs FY 2004) (per BTH)

(£ in thousands)

FINANCIAL PERFORMANCE	FINANCIAL YEAR 2004/ 2005 Half 1 Estimate (i)	Half 2 Forecast (ii)	Total Forecast (iI)	FINANCIAL YEAR 2003/ 2004 Half 1 Actual	Half 2 Actual	Total Actual	Favourable/ (Unfavourable) Variance
INCOME							
Clinical Income	£ 96,935	£ 98,386	£ 195,321	£ 93,050	£ 83,840	£ 176,890	£ 18,431
Other Income	10,414	11,427	21,841	6,924	6,611	13,535	8,306
	107,349	**109,813**	**217,162**	**99,974**	**90,451**	**190,425**	**26,737**
Transitional Relief	- 4,002	- 4,002	- 8,004	-	-	-	- 8,004
NET INCOME	**103,347**	**105,811**	**209,158**	**99,974**	**90,451**	**190,425**	**18,733**
Pay	- 70,915	- 70,915	- 141,829	- 56,617	- 69,153	- 125,770	- 16,059
Non-Pay (excl depn)	- 32,862	- 33,711	- 66,573	- 38,039	- 15,905	- 53,944	- 12,629
EXPENSES	- 103,777	- 104,626	- 208,402	- 94,656	- 85,058	- 179,714	- 28,688
EBITDA	**- 430**	**1,185**	**756**	**5,318**	**5,393**	**10,711**	**- 9,955**
Depreciation	- 3,644	- 3,644	- 7,288	- 3,219	- 3,296	- 6,515	- 773
PDC	- 2,562	- 2,562	- 5,124	- 2,191	- 2,189	- 4,380	- 744
Interest Receivable	197	150	347	92	92	184	163
	- 6,009	- 6,056	- 12,065	- 5,318	- 5,393	- 10,711	- 1,354
NET SURPLUS/ (DEFICIT)	**-£ 6,439**	**-£ 4,871**	**-£ 11,309**	**£ -**	**£ -**	**£ -**	**-£ 11,309**

Income & Expenditure (FY 2005 vs FY 2004)

- Overall, the forecast outturn for FY 2005 is £11.3 million worse than the prior year.
- An analysis of the areas of adverse performance is:

Item	Movement	Drivers of Movement (estimated impact)
Income	+ 18.8 million	❑ According to BTH, in patient procedures have increased 6% in the first 5 months this year. This fact is contested by the PCTs and cannot be corroborated by A&M. ❑ The apparent price per spell has dropped 2.5% reflecting an increase in zero stay or < 1 day spells.
Pay costs	- 16.1 million	❑ Employed 300 more WTEs than last year (- £10 m) ❑ Pension cost increase (- £8 m)
Non-Pay costs	-12.6 million	❑ The Half 1 FY 2004 figure of £38.0 million includes a £15.2 million "smoothing adjustment" to balance expenses to income. Consequently, the 2003/ 2004 reported half year numbers may be at risk, thus comparison to 2004/2005 is not meaningful. ❑ The overall increase in non-pay costs reflects the increase in drugs, blood, medical equipment and supplies.
Other	- 1.4 million	
Net Variance	- 11.3 million	

II. Financial Review

Income & Expenditure (LTF vs Budget) (per BTH)

(£ in thousands)

	HALF 1		
	Actual	Budget	Favourable/ (Unfavourable) Variance
FINANCIAL PERFORMANCE			
INCOME			
Clinical Income	£ 96,935	£ 98,614	-£ 1,679
Other Income	10,414	8,383	2,031
	107,349	**106,997**	**352**
Transitional Relief	- 4,002	- 4,002	-
NET INCOME	**103,347**	**102,995**	**352**
Pay	- 70,915	- 66,726	- 4,189
Non-Pay (excl depn)	- 32,862	- 27,655	- 5,207
EXPENSES	- 103,777	- 94,381	- 9,396
EBITDA	**- 430**	**8,614**	**- 9,044**
Depreciation	- 3,644	- 3,767	123
PDC	- 2,562	- 2,688	126
Interest Receivable	197	23	174
	- 6,009	- 6,432	423
NET SURPLUS/ (DEFICIT)	**-£ 6,439**	**£ 2,182**	**-£ 8,621**

Income & Expenditure (LTF vs Budget)

- Overall, the actual performance for the first half of FY 2005 is £8.6 million worse than the budget for that period.
- An analysis of the areas of adverse performance is:

Item	Movement	Drivers of Movement (estimated impact)
Income	+ 0.4 million	❑ Increase in "other income" of £2.0 million offset by reduction of £1.7 million in clinical income.
Pay costs	- 4.2 million	❑ Use of temps (- £ 1.2 m), specifically in Womens and Children, Theatres and Ambulatory, Clinical and Scientific Support ❑ Admin and clerical staff (- £ 1.0 m) ❑ Overspend on doctors (- £0.9 m) – consultant contracts
Non-Pay costs	- 5.2 million	❑ Drug overspend (- £1.0 m) ❑ Medical supplies (- £2.6 m) – including bloods ❑ Equipment (- £0.8 m), specifically in administration ❑ Admin and clerical (- £0.2 m) ❑ Write off of FY 2003/ 2004 debt (- £2.3m), offset by other central reserves
Other	+ 0.4 million	
Net Variance	- 8.6 million	

Working Capital

- As of September 30, 2004, recorded debtor and creditors represented on the BTH trial balance were:

	30, Sept 2004	
Debtors	£	27.281
Creditors	-	34.844
Net Trade	-£	7.563

- From a detailed review of the trial balance and discussions with the BTH finance team, A&M do not believe that reliance can be placed on these figures due to:
  - The absence of a reconciled balance sheet from the WYSCC with a number of unexplained and unreconciled amounts.
  - Significant unresolved disputes with PCT's.
  - The failure of BTH to raise invoices to the PCTs from April to August and weaknesses in the invoicing process.
  - The absence of a robust link between the income & expenditure statement and the balance sheet.

- Moreover, the significant level of outstanding debtors is not consistent with A&M's understanding of the underlying operations of BTH:
  - The PCTs, who comprise the majority of the debtors, have been making interim "payments on account" representing approximately the monthly amount due on the 15th of each month (hence no debtor build up).
  - At least one PCT (Bradford City) has made significant "advance payments" (e.g. £5 million in June) in the first 6 months of the year and is "owed" money at 30 September.
  - Based on these 2 facts, debtors should, in the ordinary course stand at £9.0m at the end of each month.
  - Given these factors, recorded debtors of £27 million may be overstated.

Working Capital (1)

- Similarly, a trade creditors balance of £34.8 million at 30 September 2004 requires significant adjustment to reflect the "true" amount of working capital required by the hospital:

Breakdown of Creditors Account (£'000s)

	30-Sep-04 per ledger	Adjustment	30-Sep-04 "true" balance	Explanation of Adjustments
NHS Creditors	£ 11,641	-£ 4,400	£ 7,241	Removal of £2.7m from PCTs (in debtors) and £1.7m error
Non-NHS Creditors	11,903	-	11,903	
Accruals (no invoice; goods recd)	2,124	-	2,124	
Pension	3,201	- 1,600	1,601	Removal of £1.6m double count.
Tax & NI	2,761	-	2,761	
Deferred Income/ Other	3,214	- 3,214	-	Removal of accounting entries
Total	**£ 34,844**	**-£ 9,214**	**£ 25,630**	

- Excluding pay related accruals (£2.8 million), transitional relief (£4.0 million), clinical negligence insurance(£1.6 million), and cash movements (£4.6 million), trade creditors outstanding at 8 November were estimated at £12.6 million.

- Based on the above, and significant cash movements in October A&M estimates net working capital as follows:

	30, Sept 2004	31, October 2004
Debtors	£ 10.100	£ 3.100
Creditors	- 25.630	- 21.000
Net Trade	-£ 15.530	-£ 17.900

(1) In the absence of reliable BTH data, but without performing an audit, A&M had to estimate creditors for cash forecasting purposes.

Risks

- From the A&M review, there are 2 additional risks that should be considered in estimating the outturn for FY 2005. These are (a) Basic Clinical Income at Risk arising from successful challenges by the PCTs; (b) Other Clinical Income at Risk

a) Basic Clinical Income (£177 million)

- BTH have estimated that Basic Clinical Income at risk is £5.1 million for FY 2005. As detailed in Appendix D, based on the queries raised by North Bradford in the YTD, one of the large PCTs, and a predicted denial rate of 9%, we believe that the actual income at risk could be £11.3 million (£6.2 million more than in the current estimate).

- Assuming that PCTs hold payments of disputed amounts in February and March and given a query rate of 21%, the potential lag in cash receipts could add £3.7 million to the cash requirement in the current financial year.

	I & E Impact	Cashflow Impact
Income at Risk (Denial rate 9%)	-£ 11,250	-£ 9,375
Cash at Risk (Timing 21%)	-	- 4,420
Risk already in Cashflow	-	5,000
	- 11,250	- 8,795
Current Provision (per BTH)	- 5,078	- 5,078
Additional Financial Risk	-£ 6,172	-£ 3,717

Risks

b) Other Clinical Income (£18 million)

- From a detailed review of other clinical income (consisting £13.6 million specified items and adjustments of £4.8 million) and conversations with PCTs, we estimate that an additional £4.3 million of income could be at risk.

- Overall impact

  - The overall impact of these risks on the income & expenditure statement and cash flow can be therefore summarised as:

	I & E	Cashflow
Position (pre-risk) - per BTH	-£ 11,309	-£ 17,600
Risk to Basic Clinical Income	- 6,172	- 3,717
Risk to Other Clinical Income	- 4,300	- 4,300
Position (post-risk)	-£ 21,781	-£ 25,617

III. Information & Control Systems

Areas Reviewed

- Payment Cycle
  - Basic Clinical Income
  - Other Clinical Income (e.g., ward attenders)
- Procurement
- Financial Reporting (incl Shared Services)

Basic Clinical Income

- Issue
  - There are a number of problems with the present system of collecting data from basic clinical notes: for example in one, perhaps extreme case, the coding error rate approached 50% in one specialty area.
- Risks
  - Billing accuracy is lost, making collection efforts more difficult.
  - Some income is lost due to under coding.
  - Severity of illness remains undocumented leading to seemingly unjustified increases in clinical cost.
- Solutions
  - Active participation in the coding process at all levels of the organization, particularly clinicians.
  - Proper staffing levels for coder based on workload.
  - Proper education and training for coding staff.
  - Standard protocols for coding charts.
  - Verification of completed coding by consultants.
  - Establishment of metrics (e.g., query rate by Specialty) to measure coding improvements.
  - Consultant performance needs to be linked to success of coding and documentation.

Other Income

- Issue
  - Other Clinical income of £18.4 million represents 10% of total clinical income.
  - Other Income has increased by £8.3 million (61%) from the prior year.
  - PCT's are looking very closely at revenue sources that were not reimbursed in prior years.

- Risks
  - Invoicing is not done by one central unit, rather a significant number of items (£3 million income) are negotiated and invoiced by Planning & Performance. As a consequence there is no internal challenge on the preparation of these charges.
  - Finance does not have a unified view of the amount due from a particular PCT and why. This is compounded by the current state of the debtor ledgers.
  - The other clinical charges are a source of considerable question on the part of the PCTs. Many of the charges have not been formally agreed and hence may be difficult to collect; moreover, the PCT's, having not been charged for these services in the past, are challenging the medical necessity and validity of the services charged by the Planning Department.
  - Given lack of internal controls over operations and coding it is likely that certain revenue may be missed.

- Solutions
  - Develop internal control and reporting process to ensure that the revenue cycle captures all services provided.
  - Negotiate interim solutions with PCT's.

Procurement

- Issue
  - Review of supply chain and inventory management to ensure lowest possible pricing and minimal waste.

- Risks
  - Although the processes are in place, there is a reliance upon Operation Directors to enforce them. E.g. in FY 2004 and also in the first 6 months of FY 2005, Sevoflurane, a general anaesthetic, was the second most used drug by value in the hospital. Ideally Sevoflurane should have been restricted to children, at-risk patients and those patients with learning difficulties. The anaesthetists have been using the drug for the majority of patients. A specific guideline has been introduced to restrict the use of the drug but it will be up to the department managers to ensure that the guideline is followed. The undetected use of the drug for over six months reflects the absence of an effective, formal monitoring of drug use by department.
  - Too many purchases are outside the formal PO system, in particular pharmaceuticals, and therefore costs cannot be effectively monitored until invoices are received.
  - The move to WYSS should have resulted in purchasing staff being able to concentrate their time on contract negotiation. As a result of processing problems time is spent matching invoices for payment (with the Finance Staff) and dealing with suppliers who have not received payment.
  - The Invoice Query Manager (IQM) process is not operating efficiently. Invoices have to be reprinted and distributed to the relevant operations managers for sign-off. This process relies upon the knowledge of the finance staff who must determine where invoices should be sent.

Procurement (cont)

- Solutions
  - Processes are in place that should enable purchases to be tightly controlled within the parameters set e.g. the WANDER system and the Southern Syringe re-order process.
  - A supply chain project with KPMG has helped focus the organisation towards being as efficient as possible during the purchasing process.
  - The purchasing department staff appear to be motivated and understand what they are trying to achieve.
  - Quality control can limit waste and ensure proper patient care is being distributed.
  - One person should be responsible for driving the final completion of centralised purchasing.

Financial Reporting and Controls (including shared services centre)

- Issue
  - Poor accounting controls, policies and processes result in presentation of incorrect financial position; poor reporting and utilisation of finance department results in insufficient information being utilised to oversee the day to day operations.

- Risks
  - In October 2003, the processing of the general ledger, accounts receivable and accounts payable was transferred to the West Yorkshire Shared Service Centre ("WYSCC"). The result has been a deterioration in the understanding of ledger balances and the flow of paperwork. There is a consequent risk to the reliability of the financial information then generated.
  - No individual has taken responsibility to validate the information that is delivered by the WYSSC; moreover accounting personnel have concluded much of the information is incorrect, yet no corrective action plans have been developed.
  - Net Working Capital has grown (per the general ledger) to inexplicable levels.

	Balance 30 November 2003	Balance 31 October 2003	Difference
Debtors	23.2	9.0	14.2
Creditors	(40.7)	(12.3)	(28.4)

  - "Smoothing" of operating expenses has been noted in financial work papers.
  - Double counting of creditors has been identified (£100k).

Financial Reporting and Controls (including shared service centre) (cont)

- Risks (cont)
  - Financial controls are lacking and add to risk of financial misstatement (e.g. lack of separation of duties between planning & performance and finance for preparing invoices for other income; manual and automatic payment procedure weaknesses result in the double payment of certain creditors).
  - Weaknesses in financial reporting structure have been noted (e.g. the management accounting team do not review the balance sheet as a cross check on the accuracy of the income and expenditure statement).
  - General lack of checks and balances in reporting structure; inconsistencies exist between roles of operations, planning and accounting departments
    - Difficult to evaluate operational effectiveness of individual departments or wards
    - Poor internal controls over revenue recognition function
    - Budgeting and forecasting are dysfunctional processes

- Solution
  - Financial function needs to be completely reengineered to ensure accurate and useful information is provided to key decision makers.
  - Interface with operations will create an environment where operators are owners of their individual income statements.
  - Someone must take responsibility for information received from WYSSC and take ownership of related reconciliation process.

III. Information and Control Systems

Financial Reporting and Controls (including shared service centre)

- Financial Controls

Area	Areas of Concern	Issues
Invoicing	Invoices are raised in at least 3 separate parts of the hospital by numerous individuals (i) Planning & performance (ii) Management accounts (iii) Contract income. There is limited co-ordination of the activity.	❑ There are no checks and balances to ensure that charges are properly justified - the potential exists for "double-invoicing" for the same activity. ❑ It is not currently possible to get an accurate view of outstanding debtors (due to multiple different types of invoice on the accounts with no "one" owner of the account).
Accounts Receivable	Credit notes are communicated to the shared service centre which raises them and reduces the outstanding amount owed.	❑ It does not appear that there are significant controls over the raising of credit notes (shared services respond to instructions). As a result, amounts owed can be "written-off" without real validation. ❑ No reconciliation due to large unapplied cash balance – account seems to be materially overstated.
Accounts Payable	Payments can be made either through the shared service centre (through the PGO account) or manually within the Finance Department (through the HSBC account).	❑ Bills can get paid twice (we have been informed that £100k of invoices were paid twice in the period to 31 March 2004 as manual cheques were raised for creditors who were also paid through the shared service centre. ❑ There have been no checks since March 31st to see if the problem persisted.

III. Information and Control Systems

Financial Reporting and Controls (including shared service centre)

- Financial Reporting

Area	Areas of Concern	Issues
Balance Sheet	BTH does not have a meaningful, reconciled balance sheet. The reported balance sheet is not driven by transactions entered into Oracle. Rather, it is the result of the income estimate provided by Contract Income.	❑ There are likely to be large adjustments to both sides of the balance sheet when it is reconciled. The impact of these is unknown. ❑ Controls over the hospital are weakened by the absence of any reconciled numbers.
Accounts Receivable	There is no accurate picture of debtors (given the failure to invoice for the first 5 months of the year). Invoices subsequently raised have not been raised on the basis of activity (but rather to clear unapplied cash).	❑ BTH does not have a clear picture of what is owed by each PCT (due to significant unapplied cash and the failure to link activity with invoicing)
Division of reporting	Reporting is split between planning & performance, financial reporting and management accounts. There is no integrated view of the financial results.	❑ It is difficult to get a clear, integrated view of the income & expenditure, balance sheet and cash flow of the hospital since reporting is split across many people and there do not appear to be reconciliations to hand, linking the underlying figures to those reported.

IV. Governance

Board of Directors

- Strengths
  - The non Executive Directors are clearly looking to understand their new roles as a Board, rather than as community representatives.
  - There is recognition that the hospital faces a problem, but not yet the scale and implications of the problem.
  - An oversight committee of the Board, consisting of the Chairman, CEO, CFO and two non Executive Directors was formed in September to monitor the creation of a turn around plan. In A&M's opinion it is important that the CEO and CFO report to the Committee, in substance if not in legal form.
- Weaknesses
  - There is a lack of a regular financial package for the Board and financial reporting was not on the Board agenda for April, May and June. The Board has been concerned about the lack of financial reporting and maintain they have demanded answers.
  - There is a lack of financial expertise on the Board to evaluate the reports that may have been given orally.
  - The response of the Board to the warnings placed in writing by the CFO on April 22nd (see Appendix B), stating that there was a danger that the hospital could lose £12 million, was problematic. With the benefit of hindsight it is unfortunate that no oversight committee was formed at that time to ensure that corrective actions were taken as a matter of urgency. The failure to insist on follow up financial reports from the CFO until, apparently, July, compounded this failure.

IV. Governance

Executive Management

- Strengths
  - The executive management, including the Executive and Operations Directors, display an impressive grasp of the day to day mechanics necessary to provide quality patient care.
  - Operations Directors appear be open to understanding the real causes of the problems in order to generate practical solutions that will protect the services of the hospital while delivering a more efficient cost structure.
  - There is considerable pride in running a facility that provides superior healthcare to the local community.
- Weaknesses
  - Lack of understanding of the way Foundation status and payments by results profoundly changes the way in which the system operates and, therefore, the way in which the hospital has to be managed – best characterised as a cost plus approach. This is reflected in a response that concentrates more on finding traditional NHS funding solutions instead of looking internally for what needs to be changed in terms of costs and processes.
  - Very poor executional response to early warning signs provided by the CEO and CFO.
  - There is currently no thought through turn around plan – just a statement of intentions.
  - Lack of financial experience in management, combined with a failure by the financial staff to provide accurate, timely and effective information. There are accounting managers whose role is to support the Operations Directors, but who are not empowered to provide comprehensive analytical support and appropriate financial information.

IV. Governance

Executive Management (cont)

- Weaknesses (cont)
  - The management response to the early warnings from the CFO was inadequate. No urgent drive for cost savings was initiated.
    - Questions have been raised as to the urgency of the CFO's message
    - It was thought that there were numerous mitigating factors, such as a growth in the number of cases and collection of old receivables
    - There was a directive from the CEO, recognising such issues and re-iterating the challenges of becoming a Foundation Trust (see Appendix C)
    - With respect to all the above, the ensuing lack of action, over spending in the first half and poor results indicate a lack of commitment to resolve the identified potential financial problem.

V. Conclusions

- Need to repair Financial Department support for this business
  - Systems are antiquated and are not interfaced.
  - Accounting department needs to be re-engineered.
    - Improve budget process
    - Provide more timely and accurate financial information which can be used by operations
    - Analyse relationship between revenue and expenses by department
    - Independently assess recoverability of reserves
    - Develop more meaningful reporting and forecasting packages
    - Centralise cash flow forecasting
    - Centralise invoicing

V. Conclusions

- Need to develop standardised process to resolve differences with PCT's
  - Put aside historical disagreements and differing interpretations of PbR.
  - Develop internal process to systematically review denied claims item by item, and respond on a real time basis.
  - Rebuild strong relationship with PCT's based in facts and analysis [redacted]
  - Negotiate past issues and move on; utilise arbitration where necessary.
  - Set in place procedures to check all invoices to supporting documentation before submitting.
- Improve Accountability
  - Board needs to become more proactive and challenging towards management team, and demand higher and more sophisticated levels of financial review.
  - Operations needs to agree on a basic set of operating metrics, to be provided by the Finance department, which ensure profitability.
  - Operations need to look at best practices and, where appropriate, put in place changes to balance resources and demand.

V. Conclusions

- Operating at a Cash Flow deficit is not a surprise (see Earp and Jackson memos of April 2004)
  - Develop plan which deals with the realities of PbR.
  - Cease looking primarily towards PCT's to resolve operating shortfalls.
  - Develop and document a meaningful turnaround plan.
    - Stretching payables does not constitute a plan
    - Identify services that cannot sustain themselves financially
    - Need to re-evaluate administrative personnel and costs.
    - Develop and evaluate productivity models to ensure financial viability of services and to dispute (with facts) positions taken by PCT's.
    - Do not increase operating costs until revenue can be confirmed.

V. Conclusions

- Need for fundamental change in culture at BTH. The organisation must learn to stand alone at every level and to live within the financial constraints and realities of PBR :
  - Fiscal year revenues have been as follows:

    2003 £165 m

    2004 £186 m

    2005 £215 m
  - While there has been some change in mix, patient activity for these 3 years has remained relatively flat.
  - Costs have increased dramatically matching increases in revenue; in FY 2005 costs are expected to materially exceed revenue.
  - BTH must match resources to a realistic assessment of demand and realisable revenue.

VI. Appendix

A. Preamble

B. Memorandum from Paul Earp (22 April 2004)

C. David Jackson Memo

D. Support for Denied Claim Risk

E. Chronology of Events

Appendix A - Preamble (1)

We wish to draw attention to the following key provisions of the engagement letter between Alvarez and Marsal (A&M), the Independent Regulator of NHS Foundation Trusts (Monitor) and Bradford Trust:

- A&M was retained to provide financial and operational consulting and management advisory services to Monitor – Independent Regulator of NHS Foundation Trusts (Monitor) and Bradford Trust in connection with Monitor's oversight role of the Bradford Trust.
- Monitor and Bradford acknowledged that the services to be rendered by A&M would include the assessment or preparation of projections and other forward-looking statements, and that numerous factors outside the control of A&M could affect the actual results of Bradford Trust's operations, which could materially and adversely differ from those projections. In addition, A&M were relying on information provided by Bradford Trust in the preparation of those projections and other forward-looking statements. A&M made no representations or guarantees that projected results would be achieved or that an appropriate restructuring proposal could be formulated for Bradford Trust. Further, A&M did not assume any responsibility for the implementation or selection of any proposal which it assisted Monitor or Bradford Trust in formulating.
- In addition, Monitor and Bradford Trust agreed to promptly correct any information so provided to A&M if it subsequently appeared that any such information was or had become inaccurate or misleading in any respect. Moreover, prior to A&M finalising its Phase I report, Bradford Trust agreed to provide A&M with a statement that its management confirmed the accuracy of the financial information it provided to A&M. Monitor and Bradford Trust understand that A&M may have relied upon, and will not be responsible for independently verifying the accuracy of any information provided to them with respect to Bradford Trust, and A&M shall not be liable for any inaccuracies therein.

Appendix A - Preamble (2)

- Monitor and Bradford Trust have confirmed that they have the right to supply such information to A&M and that the supply of such information by Monitor and Bradford Trust and its receipt by A&M for the purposes of the services as set out in the Agreement did not infringe any rights held by any third party, involve the unauthorised use of confidential information belonging to a third party or result in a breach by A&M of any law, regulatory obligation, fiduciary duty owed to any third party, intellectual property rights or agreement. A&M has agreed not to transfer personal data outside the EEA.
- Monitor and Bradford trust have also acknowledged that except as may be required by law or court process, any opinions or advice (whether written or oral) rendered by A&M (or any of A&M's affiliates or advisers) pursuant to this agreement were intended solely for the benefit and use by Monitor and Bradford Trust, and could not be publicly disclosed in any manner or made available to third parties (other than Monitor and Bradford Trust's advisers, accountants, auditors and lawyers) without the prior written consent of A&M (such consent not to be unreasonably withheld).

Appendix B – Paul Earp Memo (22 April)

From: Paul Earp
To : Chairman, Non-Executive Directors, Duncan Newton
cc :

22 April 2004

Heading : **Financial Position 2004/05**

We discussed the financial position going into the new financial year at the Board of Directors meeting yesterday. I was aware that the situation of entering a financial year without a clear statement of the financial position is less than satisfactory and I raised this with both the Chairman and Chief Executive after the meeting. This concern is heightened by the fact that we will not be able to discuss the financial position collectively until the June meeting as the Chief Executive will not be present at the May Board of Directors meeting.

Colleagues will be aware from the discussion that took place yesterday that I had prepared a draft paper outlining the financial position going into 2004/05 as best as it is known at the present time and that this paper had been discussed with the Chief Executive, Director of Hospital Services and the Director of Planning & Performance. The paper is very much an initial draft and significant work has to be done in certain areas such as Budget setting, Modular business case and the finalisation of the 2003/04 financial position before the paper could be described as a robust analysis.

In view of the uncertainty of the financial position and given the magnitude of the potential financial difficulty to be managed I have agreed with John and David that it would be reasonable to circulate the paper to other Board of Director colleagues.

In distributing the paper I would ask you to;

1. Treat the paper as confidential, it could be potentially very damaging within the organisation if the financial position was leaked prior to senior management having a coping strategy developed.
2. Treat the paper as 'work in progress' and accept its rather unrefined status.
3. Discuss points of clarification on the paper and receive any further updates as the financial picture emerges at the May meeting of the Board of Directors.
4. Debate and discuss the financial position fully at the June Board of Directors meeting.

In the meantime if you have any specific queries regarding the paper then please do not hesitate to give me a call on 01274 364792 or 07973 109527

Paul Earp
Finance Director

Appendix B – Paul Earp Memo (22 April) – page 2 FINAL DRAFT

Financial Position into 2004/05

1. Introduction

This paper sets out the financial position going into 2004/05. The paper is informed by key elements of work some of which are as yet not finalised however it is considered necessary to be able to portray the position as best as it is known currently as the Trust faces a most difficult financial year, certainly the most challenging in the seven years that I have been in post as Finance Director.

The context of the current financial position needs to be set out in order to fully understand the financial picture that is presented.

2. Context to financial position

The Trust has enjoyed significant success in terms of its ability to manage the competing demands of finance, activity and quality enhancements, this has been achieved not without some difficulty but the Trust has remained broadly in recurrent balance over recent years. However over the past two years and specifically throughout 2003/04 the Trust has found it increasingly difficult to balance on a recurrent basis and therefore starts the financial year 2004/05 with a recurrent imbalance between income and expenditure.

The Trust faced an extremely difficult and tortuous settlement of the 2003/04 contracting position with our main PCT's resulting in Strategic Health Authority involvement in the form of 'mediation' against the cliff edge of requiring signed agreement on cash and activity for both financial years 2003/04 and 2004/05 as an essential element of securing a licence from the Regulator in respect of the Foundation Trust application.

The Trust faces great uncertainty regarding the impact of the introduction of the new financing system of 'Payment by Results', and whilst this should be generally good news to a Trust performing at some four percentage points below the national average cost base the interpretation and lack of clarity around crucial elements poses significant uncertainty and therefore risk to the organisation.

There is the usual stress in the funding of cost pressures and inflation with an assessment being made that the provision within the tariff will be around £1.5million less than required. This year the 'underfunding' appears to have a greater reality to it in that it relates predominantly to pay awards, superannuation increases and CNST premiums. The information that is available on these issues would indicate that the assessment underfunding is real and will materialise.

There is a specific issue surrounding the affordability of the additional capacity that was commissioned in the modular wards and theatre development. The initial business case identified a projected deficit of £1 million which was accepted with the understanding that this deficit would have to be addressed at the point the new facility was commissioned and brought into use. The current situation is that this deficit has not been removed and further it is projected that the deficit will be significantly in excess of this figure, latest estimates indicate a financial gap of between £1.5 to £2.0 million.

Finally the Trust faces the challenge of introducing a number of key national imperatives all of which are likely to require significant additional costs over and above funding provided, these include; the new consultant contract, Agenda for Change and National Programme for Information Technology.

Each of these areas are discussed in more detail below.

3. Financial Position in 2003/04

The Trust will achieve its financial duties in 2003/04 but this will be at a cost of utilising all of the general assistance that it has been possible to hold in reserve 'on the balance sheet' from previous years.

The settlement with the PCT's cost the Trust £800k in discounts in 2003/04 less the £300k retained for the City PCT undertrade, we will need to deliver £300k of activity free of charge in 2004/05 and we have given a credit note for £250k in respect of 2005/06.

In the last quarter of the financial year significant levels of increased overspend arose within the operations groups budgets. It is considered that this is partly as a result of the requirement to fulfil activity levels towards the end of the financial year consequent upon the slippage in the availability of the new modular wards and theatre block. The resultant impact being that additional weekend working was required above planned levels to achieve activity targets. In addition it is considered that insufficient attention has been given to budgetary control over the course of 2003/04.

The Trust has not been as successful as it should have been in securing ongoing cost reductions through the Supply Chain Management process and this contributes to the recurrent deficit position.

The assessed deficit brought forward into 2004/05 is considerable; it is assessed that there is around £1million shortfall on cost reduction programmes and whilst work has yet to be finalised on draft budgets for 2004/05 it is forecast that there is a minimum financial gap of at least £1.5 to £2.0 million between first cut budgets and funding available.

4. Introduction of Payment by Results

The publication of the reference costs for 2002/03 indicated that a move to tariff for those services to be included within the 2004/05 PbR arrangement would bring into the Trust additional revenues to the Trust of £10.6 million at the end of the four year transition period and £2.6 million in the first year. It should be borne in mind that the services currently not included within the PbR arrangement in 2004/05 are those services where generally 'local' prices are in excess of national tariffs and therefore the Trust stands to lose income when these services are included within the national tariff arrangements from 2005/06 onwards.

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There are a number of issues where there is a lack of clarity surrounding the impact of the introduction of the tariff, the most important ones relate to; the treatment of developments both in terms of the lag of expenditure into the tariff and the phased introduction of tariff, the impact on cost per case items within existing contracts and baselines, the impact of coding changes and the impact of a move to spells as the contracting currency.

The position in respect of developments is not yet resolved and the Trust has potentially £400k at risk, in addition to the additional revenue costs of the MRI/CT scanners that we agreed to finance as evidence of a quality improvement.

5. Inflation and cost pressures

As referred to earlier the Trust generally faces pressure on the level of inflation funding received each year, the financial impact in 2004/05 is assessed as more severe than normal. The calculation of the additional cost of both the national pay award of 3.225% and the increase in employers superannuation contributions from 7% to 14% has been based on an assumed pay : non-pay ratio of 59% pay to 41% non-pay, the Trusts has 65% pay to 35% non-pay ratio within its expenditure budgets therefore the funding within tariff is significantly short of the increased requirement.

The second major issue relates to CNST premiums where the cost has risen from £2.2 million for 2003/04 to £3.7 million for 2004/05. Again a straightforward analysis of the provision within the tariff uplift of 7.9% indicates uplift for CNST of 0.5% this is around half of what would be required to fully finance the increase. The additional cost of CNST is partially offset by the achievement of Level 1 standards of the 10% discount that is available as a result.

The impact of underfunding against these three headings results in a shortfall of around £1.75 million, which is equivalent to a further cost reduction requirement of one percent.

6. Additional Capacity

The agreed business case for the modular ward and theatre development identified a potential deficit of £1 million. It was agreed that the commissioning of the full three storey development should proceed at risk and that the business case be revisited and actions taken in order to produce a financially viable business case, i.e. one that was at worst revenue neutral.

Further work has been undertaken on the business case and it has not been possible to achieve a revenue neutral business case, indeed the projected shortfall is estimated at around £2.5 million. Whilst the issues are somewhat complex in fully understanding the finances this does not present a realistic option for the Trust.

A number of factors have changed since the development of the business case, firstly the anticipated levels of increased trauma work have not materialised, secondly activity assumptions from PCT's have been significantly reduced. However whatever the changes that have been made it simply has to be addressed, a deficit of this magnitude would indicate expenditure levels 30% higher than income streams.

The issue will be further exacerbated in 2005/06 as significant more activity is withdrawn as a result of PCT's achieving 2008 access times by 2005. As currently configured the business case represents a major financial problem to the Trust and must be addressed to achieve financial stability.

7. National Imperatives

The three most significant national initiatives that the Trust faces in 2004/05 are outlined below.

Consultant Contract, whilst the exact cost cannot as yet be finally assessed with any accuracy, a further 60 job plans remain to be reviewed, it is likely that the cost will be in excess of the funding available. The current assessment is that average programmed activities within job plans will be between 11.0 and 11.5, whilst it is not easy to predict what level of shortfall this will result in a good working estimate is that costs will exceed funding by a minimum of £1.5 million. It is difficult to see how this can be afforded within the finances available.

Agenda for Change, the financial position here is much less clear. The Trust has estimated an additional cost of £200k in respect of ancillary staff on local pay and conditions. The Trust has no flexibility within its finances to pay any more than funding available in respect of A4C. We need to understand the basis of the funding calculation and base implementation on the same principles.

NPfIT, the Director of Health Informatics has produced a paper that identifies gross implementation costs of £2.1 million in year one with significant additional revenues required in years two and three of the project. Detailed discussion has been held with the StHa in respect of these costs and they have promised to assist in identifying resources. However as currently configured the business case could not be advanced without exposing the Trust to significant financial risk. I would estimate that even on an optimistic assessment the Trust could potentially be faced with additional costs of £700k in 2004/05.

8. Other Issues

There are further issues that need to be taken into consideration.

Whilst the Trust has now formally withdrawn from the batch in respect of the PFI project there will be financial difficulty in supporting the advancement of the planning work necessary to advance the alternative redevelopment strategy. The post of Director of Redevelopment together with his PA has historically been financed from a capital to revenue transfer. This is no longer possible as capital to revenue transfers are no longer allowed, the fact that we are a foundation trust has no bearing on this issue. The Trust therefore faces a budget shortfall of around £100k plus any additional support in the form of design team input in 2004/05.

The increased investment in respect of risk management has to be provided for within baseline budgets.

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The cost of recruitment / retention premia is not budgeted for and therefore presents an increased demand on existing budgets.

9. The Overall Analysis

The Appendix attached to this paper sets out the financial position of the Trust, it does not make good reading indicating a substantial financial deficit that has to be addressed. The worst case scenario paints a bleak picture of a deficit of around £10 million. Through determined management actions a best case scenario could potentially be delivered that could deliver a surplus of around £2 million, it would be a tremendous result if the Trust were to achieve all actions required to deliver any surplus and a more likely situation would be that sufficient management control will be put in place to deliver a balanced outturn position.

However given the fact that we have broadly agreed contracts in terms of activity and finance at an early stage of the financial year this should free up management capacity to address the financial position.

This overall assessment is somewhat crude and has not attempted to identify each area where the Trust would seek to improve service delivery; its primary focus is on key issues in order to portray a working assessment of the difficult task facing the organisation in 2004/05. Additionally work continues in two important areas; budget setting and the modular business case, neither of these pieces of work are fully completed however to wait for the completion of this work would result in further delay which given the size of the problems faced would not be helpful.

10. Remedial steps required

The options available to the Trust in bringing finances back into control within the Trust are set out below, the Chief Executive and Executive Directors need to consider the list and to decide which they wish to see taken forward.

i. The need for a more hard edged financial aspect to performance monitoring within the Trust. The Executive team have already discussed this and arrangements are in place to introduce this.
ii. Operation Directors to be charged with setting budgets within the finance available (the control total) whilst maintaining activity levels required within agreed contracts with PCT's
iii. The business case for Modular Wards & Theatres to be brought into financial balance with compensating reductions in capacity as required to achieve this. [What approach do we take in respect of the 1st Quarter of 2004/05]
iv. Cost reduction programmes driven hard centrally to deliver £1.8 million (1%) 2004/05 efficiency together with £1 million shortfall from prior years.
v. The cost of the consultant contract, when finally assessed, to be challenged and reduced to nearer the funding levels available, i.e 10.8 PA's etc.
vi. A continuation of the January 2004 action plan to reduce expenditure with increased levels of monitoring
vii. Tighter monthly monitoring of activity to ensure precise delivery of PCT contracts by specialty in order to avoid the financial risk of unfunded overtrades.
viii. Agree and implement a revised business planning process for the Foundation Trust. Malcolm has already drafted a version for comment / agreement.
ix. Agree a capital programme for 2004/05
x. Establish a capital planning process where all capital 'bids' are scrutinised for revenue costs and only approve those that generate revenue savings or are revenue neutral but which have significant quality / value for money improvements.
xi. Take steps to market surplus capacity or take immediate steps to close down such spar capacity.
xii. Consider the delay of the implementation of the NPfIT until financing of the revenue is clearer and available.
xiii. Take steps to understand the basis of the assessment of the cost of Agenda for Change and implement this within these guiding principles
xiv. Deliver additional activity that has to be provided free of charge at a maximum of a 50% marginal rate, and similarly for any activity required to be provided as part of the Trust's contribution to the risk pool.

Paul Earp
Finance Director
15th April 2004

Appendix B – Paul Earp Memo (22 April) – page 5 FINAL DRAFT

Financial Position into 2004/05

	Worst Case Scenario £000	Best Case Scenario £000	Actions Required to achieve best case
Financial Position in 2003/04			
Outstanding Cost Reduction Programme	1,000	0	Drive efficiency targets hard centrally & achieve £2.6m
Underlying budget deficit in Hospital Services	2,000	0	Direct Ops Directors to balance budgets
	3,000	**0**	
Impact of 2003/04 Settlement in 2004/05			
City activity f.o.c.,	300	150	Requires activity to be delivered at 50% marginal cost
Contribution to 'risk pool';	500	250	Requires activity to be delivered at 50% marginal cost
	800	**400**	
Impact of Payment by Results			
MRI / CT Development	218	218	
Other Developments	372	93	Assume we win the argument with PCTS
Ward Attenders	?	?	Assume that estimate within reference costs is accurate
Oncology	?	?	
	590	**311**	
Inflation & Cost Pressures			
General shortfall on pay, superann & CNST	1,770	1,000	Closely review distribution of pay & prices and fix at lower level
Level 1 CNST discount @ 10%	-370	-370	discount achieved
	1,400	**630**	
Additional Capacity			
Modular business case - est shortfall	**1,750**	**0**	Ops Directors directed to balance business case, attract additional work or close capacity
National Imperatives			
Consultant Contract	1,600	800	Reduce job plans by 50% of excess costs
Agenda for Change	200	200	Implement A4C within funding provided
NPfIT	2,100	0	Delay implementation of NPfIT
	3,900	**1,000**	
Other Issues			
Investment in risk management	200	200	
Redevelopment Office costs	100	100	
Recruitment / Retention premia	250	60	Do not extend beyond new appointees
	550	**360**	
Sub-Total	**11,990**	**2,701**	
Measures to bridge financial gap			
PbR transitional Relief	-2,700	-2,700	guaranteed
Introduce enhanced coding		-1,000	assume 6 months impact
Reassessment of Asset lives		-1,000	broad brush assessment of results in other Trusts
	-2,700	**-4,700**	
Overall Deficit (Surplus)	**9,290**	**-1,999**	

Appendix C – David Jackson Memo

FINAL DRAFT

David Jackson – Chief Executive

Tel: 01274 364788
Fax: 01274 364786
Ref: DJ/DS

8 April 2004

Dear

CREATING STRONG FOUNDATIONS

At our meeting held on 2 April I said that I had 5 key messages for the Directors of Bradford Teaching Hospitals on becoming one of the very first NHS Foundation Trusts and at the beginning of the financial year 2004/05. This letter restates those key messages and the action and information that underpins them and should be regarded as one of the foundations of our newly independent NHS hospital.

My 5 key messages are:

1 Bradford Teaching Hospitals is a hugely successful NHS hospital. Amongst other things this is due to the skill and commitment of its Level 4 Directors for which I both thank and congratulate you.

2 However, beneath the surface there are some very serious concerns that have to be addressed if we are to remain successful.

3 On becoming an NHS Foundation Trust on 1 April our operating environment changed radically and irrevocably.

4 The financial year 2004/05 will be a very difficult year operationally, financially and politically.

5 As the Directors of Bradford Teaching Hospitals we need much tighter performance management and new ways of communicating with each other and collectively reviewing progress and performance.

1 Our Success

All the indications are that we will end 2003/04 on a very successful note.

- Our key targets are likely to have been met and our 3 star performance rating retained
- The huge capital programme of over £20 million in 2003/04 was delivered successfully
- The modular wards and theatres have been commissioned
- CNST level 1 has been regained and Level II achieved in Maternity
- The Medical School expansion has been successfully achieved and enhanced our reputation
- The Health and Safety Inspection had a very positive outcome
- Good progress is being made on the Consultant Contract and Agenda for Change
- Bradford Teaching Hospitals has an excellent reputation at a national level for our work on Pursuing Perfection and in connection with Foundation Trusts
- Bradford Teaching Hospitals is one of the first 10 English hospitals to receive a Foundation Trust Authorisation.

However despite our undoubted success, beneath the surface there are some worrying developments that must be addressed.

2 Serious Concerns

These serious concerns fall into 3 categories:

1 We almost failed to achieve the Key Performance Targets in 2003/04 because we were not on top of them from April 2003. The last minute effort on the Accident and Emergency maximum 4 hour wait and on booked admissions made the task far more difficult, required disproportionate effort and nearly failed.

2 We failed to deliver our December 2003 revised plan for the PCTs and in consequence at the year end, we have yet again a huge under-trade of elective cases with Bradford City PCT. Moreover, we keep under-trading with City PCT, year after year. This complicated the Foundation Trust sign off and will cause operational difficulties in 2004/05.

3 **We are spending more than we are earning, we are not controlling budgets and we are not bringing in the required level of recurrent savings.** There are many reasons for this including:

- The mechanisms in place to control TNR/BNA expenditure are failing to avoid high spending which is exceeding the budgeted establishment in a number of wards. In some instances staffing establishments have not been worked too.
- Despite the large investment in junior doctors, the trend on locum spend is up from £1.4M in 2001/02, to a projected spend of £1.9M in 2003/04. More robust measures are needed to control expenditure both in terms of mechanisms for approving locums and also in extending locum bookings. We need a decision making process that allows for a financial evaluation of the cost implications of appointing locums **before** they are made.
- Changes in clinical practice have taken place without sufficient prior financial evaluation eg changing the predominant manufacturer of the orthopaedic implant used cost us £250,000!
- Although the situation has improved in the last month Shared Services has complicated the task of reporting an accurate financial position in the latter half of 2003/04. More needs to be done to ensure that from now on there are no significant issues around the accruals that are made.
- Inconsistencies in existing budgets have not been addressed. There are examples of unfunded posts remaining unfunded for a number of years without corrective action to fund or extinguish the post.

In addition, I am aware of several regradings or attempted regradings over the last few months. Whilst Level 4 Managers are the prime budget holders and have considerable

Appendix C – David Jackson Memo

FINAL DRAFT

freedom to manage their budgets, I have not delegated the authority to regrade staff and do not intend to do so. All potential regradings must be discussed with the appropriate Executive Board Director, normally Rose, who will seek my approval if she considers it appropriate. Personnel will not action any regradings without an Executive Board Director's signature or any other decision regarding staff in the absence of the appropriate Level 4 approval in writing.

The primary purpose of operational management within Bradford Teaching Hospitals is to deliver contracted activity, ie diagnosis treatment and care within budget. This is to be the primary focus of every Level 4 manager in every discipline, eg Planning, Estates, Information, Finance or Operations. This effort is led by the Operations Directors who have the specific responsibility to deliver contracted activity within budget but every other Level 4 Manager is required to support them.

I expect all Level 4 Managers to develop a very sharp business focus. We survive and prosper only if we make a surplus. This requires ensuring that income is properly obtained and expenditure is tightly controlled. Our attitude and commitment towards commissioners must be that we deliver to contract but if a service or cost is not included in the contract it must not to be provided unless there is an explicit written commitment to meet our charges.

Within Bradford Teaching Hospitals I want a "can do" attitude towards colleagues on all matters related to achieving our explicit objectives. In particular, on our core business of delivering activity within budget, I expect the answer to be invariably "yes" or "I've got a better, cheaper, more efficient/effective alternative". I recognise that this demand to support colleagues positively in achieving our objectives, particularly our core business of delivering activity to contract and budget, will require Level 4 colleagues to constantly reappraise priorities within their Directorate/Group and this may involve scaling down or even eliminating some activities in order to release resources to support our core business. If asked or if necessary, in cases of doubt or of conflicting priorities, I will confirm the Foundation's overall priorities and authorise changing priorities within Directorate/Groups to support the core business. Colleagues and their Directorate/Groups who only support colleagues at a price or for some other consideration are not meeting the specific personal obligation that I have placed on you all to support your colleagues in achieving their and the Foundation's objectives.

The focus in Bradford Teaching Hospitals must be on delivering the service contracts and achieving a surplus and I expect every Level 4 Manager to constantly reassess their priorities and activities to ensure that their Directorate is properly supporting the production function.

I do not accept "David says" or "David wants" as an excuse for committing unfunded expenditure. As Level 4 Mangers you are the prime budget holders and when I ask you to do something you also have to find the money!

3 The Operational Context

As from 1 April we were a different organisation, operating in a very different environment and this is going to require us to manage Bradford Teaching Hospitals more tightly than we have ever done. The national spotlight will be on us with a vengeance because:

- We are in the run up to an election in 2005
- Politicians and others will use us as an exemplar of a successful organisation for others to emulate whilst simultaneously seeking to find the fault and trying to knock us off the pedestal on which they have placed us.
- The price of independence is that we are on our own. If we get into difficulties, we can't go to anybody else, such as the PCTs, the Strategic health Authority or the Department of Health for help.

We are running a business, and we need to be in control. This means specifically that:

1 We cannot afford to give away intelligence to our customers and competitors inadvertently. Therefore I must remind you that **no data about Bradford Teaching Hospitals must leave the Foundation from your Directorate unless you have approved it**.

2 Every part of the business must generate a surplus or add value. **Therefore a mandatory personal objective for all Level 4s in 2004/05 is to review the support activities in their Directorate, demonstrate they add value or make money and develop plans to phase out those that don't meet these criteria.**

3 **There are to be no developments undertaken at risk without my specific written authorisation.**

We have to develop a new and different relationship with the PCTs in designing and implementing service change and we have to develop a new and different attitude to capital expenditure.

With regard to service change, I am firmly committed to the "right treatment, right place, right time" philosophy and its inevitable consequences that more complex work will flow into Bradford Teaching Hospitals, whilst work that can be undertaken safely in treatment centres and in primary care premises will move out. The revised management arrangements introduced 2 years ago were based on the concept of patient centred teams to facilitate service modernisation at the care level. We should use the benefits of becoming an NHS Foundation Trust to accelerate the modernisation of service delivery by adopting evidence based best practice and innovative solutions to improve quality and reduce costs. Our expertise is in service design and delivery and, under the management control of the Operations Directors supported by Level 4 colleagues generally, I want our patient centred teams to be liberated to redesign service delivery to meet the relevant standards of provision and work with our partners in primary and tertiary care to resolve the interface issues. Of course the service and its overheads must be provided within the tariff price and in redesigning services great care will be required to avoid unjustified cost dumping on to other organisations or accepting costs which are not included in the tariff price.

As a matter of principle, all service change implemented within Bradford Teaching Hospitals should demonstrate both an improvement in quality and a reduction in cost.

Whilst Payments by Results means that we will receive payment at the tariff price for all activity undertaken with commissioner agreement, in the absence of that agreement we cannot develop new services or impose new costs and expect to be paid. That is why point 3 above is fundamental to our financial security as an NHS Foundation Trust.

With regard to capital investment, I expect Managers to both understand and act on the fact that all capital money has to be generated by achieving a surplus and all capital expenditure has an on going revenue cost which must be financed from our income achieved through activity x tariff. It follows that every investment must generate a surplus or add value and to the extent that some investments are not revenue producing or enhancing others have to work harder to achieve an overall surplus for

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the Trust. Therefore to be considered, all investment proposals must demonstrably generate a surplus or add value and capital expenditure will be reflected in the operational plan with individual responsibility for achieving the surplus or the added value clearly identified.

It is important that Level 4 colleagues understand and explain that on becoming an NHS Foundation Trust the context of our Capital Programme changed significantly in two respects. Firstly, there is no longer any need to spend the capital allocation each year or loose it – as a Foundation Trust we can carry under-spendings and surpluses openly into the next financial year. Secondly, as an NHS Foundation Trust our capital strategy is to limit spending in the short term to generate the cash for substantial investment in new facilities and refurbishment in the medium term.

Finally, the clarity of a regulated system is very different from the classic fudge of conventional NHS management and this is very much to our advantage as an NHS Foundation Trust. However clarity cuts both ways and we will not be able to fudge compliance with the Terms of Authorisation, our service contracts, national data definitions and the rules of PBR etc, but will have to demonstrate compliance.

4 The Financial Year 2004/05

I must emphasise that 2004/05 will be very difficult operationally, financially and politically because:

- We have allowed expenditure to exceed income
- We have to do over 400 cases for City free of charge because we didn't deliver our revised December plan
- We face major inflationary pressures, eg consultants contract, Agenda for Change, CNST, superannuation etc.
- We don't really know how Choice and PBR will work in practice. There will be winners and losers.
- PCTs will watch their expenditure, will challenge our invoices, will expect full cost refunds and will resist paying for additional work!
- There will be an election circa May 2005
- We are on our own but being a Foundation Trust means taking control of our future.

And remember that as a Foundation Trust:

- We do not get development money from the PCTs
- We do not receive a separate allocation of Capital money
- We have to create money for investment from our total overall income which comes from activity x price
- We must achieve financial balance across the Foundation – Prime Budget Holders must balance their budgets
- We have to create the surplus necessary to develop services and to fund the major redevelopment of Bradford Teaching Hospitals

We won't be able to do this, unless we deliver our contracted activity by PCT and by specialty. We must bring in additional work to **utilise our spare capacity or close it down now – not in 6 months time. We must not overtrade on combined elective and acute activity for any PCT without explicit written agreement to pay**.

But remember also that this year we have some specific advantages over previous years.

- The Performance Indicators for our star rating for 2004/05 have already been published and we know what we have to deliver from 1 April 2004 and on what we will be monitored. The clock is already running and we must meet the performance targets from now on.

- For the first time ever our Contracts are agreed and we know what activity we have to deliver from 1 April 2004. Again the clock is running and we must deliver the activity by PCT and by specialty in each and every month of the year.

5 Performance Management and Corporate Review

We need a new system for Performance Management that gives the Board of Directors a clear and detailed overview, that enables Rose and Malcolm to be proactive with the PCTs and demonstrates to Operations Directors that they are delivering or that remedial action is required before they are told by others! We also need to align our performance processes and measures with PCT contract monitoring arrangements. **Malcolm is working on this with a view to early implementation.**

We also need a process through which as the Directors of Bradford Teaching Hospitals we can collectively review our performance and progress, call on colleagues for assistance and be accountable to each other for our personal performance when this impacts on corporate achievement. Therefore I will chair one meeting of the HSE each quarter which all Level 4 Managers will attend and which will be devoted to this corporate review.

6 Performance, Survival and Remuneration

Throughout this letter I have emphasised that Bradford Teaching Hospitals is a trading organisation. We survive and prosper only by making a surplus on our activities which are primarily diagnosis, treatment and care. All of us as Directors share responsibility for delivering the service contracts, earning the income and making the surplus. Each of us has a personal responsibility to achieve the Trust's objectives by achieving our personal objectives and this includes managing our budgets to ensure that the Trust's planned surpluses are not frittered away. There is an inescapable link between performance and survival and this extends to our pay.

The remuneration scheme for Level 4 managers in Bradford Teaching Hospitals has always been:

i) That all pay increases for Level 4 Managers including annual cost of living awards are dependant on the Trust achieving its objectives, ie delivering the contracted activity within budget, implementing planned quality enhancements and service change on time and creating the required surplus. If the Trust does not achieve these objectives its Directors should not expect a pay rise.

ii) Within this overall approach to pay and performance individual Level 4 managers who fail to deliver or fail to support the delivery of contracted activity within budget or fail to achieve other important objectives **will not receive an annual pay rise and can expect a very serious conversation with me about their future within Bradford Teaching Hospitals.**

iii) **But when the Trust and individual managers perform well and meet all targets, there is plenty of scope within our pay system for significant financial rewards over and above cost of living increases.**

There can be no escape from the necessity to deliver the finance activity and other targets each year including annual cost reductions. Within the remuneration scheme, Level 4 colleagues who succeed in achieving their targets including cost reductions will be free to use any further savings at their discretion to progress the plans and priorities of their Group/Directorate.

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My final message is that we have a huge opportunity. We are now an independent NHS organisation and provided we manage well, we will have control of our own destiny and the money to continue to develop Bradford Teaching Hospitals and to deliver our Vision. All we need is focus, commitment and determination and whilst it could be a rough ride, particularly this year, I have no doubt that as the Directors of Bradford Teaching Hospitals we are all up to it and up for it.

Yours sincerely

DAVID JACKSON
Chief Executive

Please see attached circulation list

Copy:
John Ryan – Chairman
Paul Earp – Finance Director
John Evans – Legal Advisor
Dr Duncan Newton – Clinical Director
Malcolm Poad – Director of Planning & Performance
Mrs Rose Stephens – Director of Hospital Services
Miss Debbie Carroll – Non-Executive Director
Mrs Nadira Mirza – Non-Executive Director
Balbir Singh – Non-Executive Director
Roger Stones – Non-Executive Director
Richard Wilson – Non-Executive Director

Bradford Hospitals NHS
NHS Trust

TRUST HEADQUARTERS

MEMORANDUM

To: **Level 4 Directors – See Circulation List**
Copy: *Paul Earp – Director of Finance*
Malcolm Poad – Director of Planning & Performance
Rose Stephens Director of Hospital Services

From: David Jackson – Chief Executive

Date: 21 April 2004

CREATING STRONG FOUNDATIONS – ACTION POINTS

This memo allocates personal responsibility for achieving the challenge set out in my letter of 8 April.

		Action
1	Identify key performance targets and the responsible Level 4 Director for each one	Malcolm Poad
2	Deliver key performance targets	Identified Level 4 Directors
3	Deliver activity to contract by specialty and PCT	Relevant Operations Directors
4	Implement monitoring system for key performance targets and contract delivery	Malcolm Poad
5	Set Prime Budgets and revisit Prime Budget Management arrangements	Paul Earp
6	Control expenditure to budget	All Prime Budget Holders
7	Implement mechanism to ensure that regradings or any decision about staff with a cost implication are supported by an Executive Director signature before being actioned	Barry Mortimer
8	Review all support activities within sphere of responsibility and submit proposals to eliminate any that do not meet the income surplus/added value requirement	All Prime Budget Holders
9	Implement systems to ensure no data leaves BTH without explicit Level 4 approval	All Level 4 Directors
10	Ensure no developments at risk without Chief Executive's	All Prime Budget Holders

Appendix C – David Jackson Memo

11	Identify in the Operational Plan personal responsibility for achieving investment objectives	Malcolm Poad
12	Deliver investment objectives	Identified Level 4 Directors
13	Identify spare patient capacity. Utilise to generate surplus/added value or close down	Rose Stephens
14	Redesign Business Planning and Performance Management arrangements	Malcolm Poad
15	Support colleagues in achieving personal/BTH objectives and the requirements of these action points	All Level 5 and Level 4 Directors

DAVID JACKSON
Chief Executive

Appendix D – Support for Denied Claim Risk

- BTH is facing significant challenges from the PCTs as to the accuracy of its coding as well as with its admission criteria for inpatient stays. A lead role in challenging the information provided has been taken by North Bradford PCT.

- From April to August (5 months), North Bradford PCT generated 3,014 queries out of 9,178 inpatients billed by BTH. An analysis of the queries is as follows:

North Bradford Queries (April - August)	# of Queries	Per BTH	Per North Bradford PCT	Difference
Resolvable Queries				
Administrative Resolution	1,359	727,003	17,644	-709,359
Obstetrics	211	112,212	10,211	-102,001
Subtotal	1,570	839,215	27,855	-811,360
Policy Issues				
Re-admission	365	698,675	16,138	-682,537
Zero-length of stay	1,079	892,634	138,947	-753,687
Subtotal	1,444	1,591,309	155,085	-1,436,224
Total	3,014	2,430,524	182,940	-2,247,584

- The amount queried (£2.4 million) represented 21% of the total amount billed (£11.3 million) to North Bradford during this period.

Appendix D – Support for Denied Claim Risk

- Our assessment of the nature and likely resolution of the queries is as follows:
  - Of the 3,014 queries, 1,359 appear to be administrative and presumably can be resolved by providing additional documentation on an item by item basis. Based on discussions with BTH, the Obstetrics issue has been resolved with BTH agreeing that these patients did not qualify as an inpatient spell.
  - The remaining 1,444 queries are based on differences in the interpretation of the inpatient admission policy. Of these, 365 cases (a value of £698,675) were challenges to situations where patients were re-admitted within 28 days. The PCT wishes to treat these as simple extensions of the original spell. There is no clear justification for the PCTs approach; although, some day threshold may be ultimately agreed upon. Conversely, 1,079 cases (a value of £892,634) represents a challenge to an apparent spike in same day admissions coincident with the desire to meet the NHS policy of a 4 hour maximum for resolution of A and E cases. There is statistical support for the PCT challenge and resolution will require external intervention.
  - For purposes of this analysis we have assumed that BTH will prevail on administrative resolutions, obstetrics will be resolved as agreed, re-admissions are mainly resolved in favor of the hospital but the zero-length of stay issue is resolved in favor of the PCTs. The result is a denial rate of 9.0% of the amount claimed from North Bradford PCT.

Appendix D – Support for Denied Claim Risk

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- The denial rate on inpatient billing can then be summarized as follows:

North Bradford Queries (April - August)	Number of Queries	Claimed by BTH	Proposed by North PCT	Challenge Rate	I & E Impact
Administrative Resolution	1,359	727,003	17,644	0%	0
Obstetrics	211	112,212	10,211	90%	-100,991
Subtotal	1,570	839,215	27,855		-100,991
Policy Issues:					
Re-admission	365	698,675	16,138	25%	-174,669
Zero-length of stay	1,079	892,634	138,947	84%	-749,813
Subtotal	1,444	1,591,309	155,085		-924,481
Total	3,014	2,430,524	182,940		-1,025,472
North Bradford PCT Actual (e.g., PbR) Payments					11,353,709
Inpatient Query Rate %		21.4%			
Inpatient Denial Rate %					9.0%

- From meeting the PCTs it is clear that North Bradford is taking the lead on issues in which all the PCTs concur. It is unlikely that the analysis for the other PCTs would be fundamentally different, therefore, A&M has applied the same risk factor of 9% to all inpatient revenue.

- The risk is that the issues will not be resolved and that the PCTs will begin to reduce their payments in February and March based on the query rate, (i.e., stop paying for items in dispute).

- One positive factor would be that resolution of the North Bradford situation – could help to resolve the issues with all the PCTs.

Appendix E – Chronology of Events

Chronology of Events