EXTRA-ORDINARY BOARD OF DIRECTORS MEETING

DATE AND TIME:  11:30am – 12:30, 11th January 2018
VENUE:  Teleconference Call – (For those in Glebe House, Chairman’s Office)

<table>
<thead>
<tr>
<th>TIME</th>
<th>ITEM</th>
<th>SUBJECT</th>
<th>ACTION</th>
<th>LEAD</th>
<th>ENCLOSURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>11:30</td>
<td>1.</td>
<td>OPENING ADMINISTRATION</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11:30</td>
<td>1.1</td>
<td>Apologies</td>
<td>-</td>
<td>-</td>
<td>(verbal)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>F. Wise</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11:30</td>
<td>1.2</td>
<td>Declarations of Interest</td>
<td>-</td>
<td>Chairman</td>
<td>(verbal)</td>
</tr>
<tr>
<td>12:05</td>
<td>2.</td>
<td>STRATEGY/FINANCE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11:35</td>
<td>2.1</td>
<td>Financial Re-forecasting Position</td>
<td>Approval</td>
<td>Director of Finance</td>
<td>(to follow)</td>
</tr>
<tr>
<td>12:05</td>
<td>2.2</td>
<td>Urgent Care Hub: To receive feedback from Board Members following last meeting and to agree submission of the Outline Business Case</td>
<td>Approval</td>
<td>Chief Operating Officer</td>
<td>(no)</td>
</tr>
</tbody>
</table>

3. DATE & TIME OF NEXT MEETING
   - 10:00am
   - 2nd February 2018
   - Boardroom, Glebe House
Update since December 2018 Board of Directors.

All comments have been received and were welcomed as they have helped to strengthen the OBC further. Appendix 1 includes a table of all comments received, and any response over what has changed in the OBC document as a result.

There remains two outstanding but related issues to be discussed on Thursday 11th Jan:

a) The remaining estate.

b) The affordability of the scheme

1. The remaining estate.

The OBC has consciously not considered how the trust might use any estate that is vacated as part of the options. Principally as this would make the OBC itself unmanageable; with so many assumptions and risks that it would invalidate the basis of the case itself.

That said the trust does need to consider what it could do with the vacated space if it approved the recommended option. Possible options include:

i) Using the current A&E space as outpatients department. Many of the rooms are already configured as suitable clinic rooms and/or would not take significant work to make this a reality. Initially we could decant all of outpatients into this area, and allow the refurbishment of our current outpatients in order to address many of the privacy and dignity concerns raised by the CQC in our current outpatients. In the longer term this could allow the growth of outpatient services in terms of repatriating clinics from the private sector, and increasing market share from the eastern semi-circle of our geography. With increasing emergency attendances over time, this area could also be used to expand specialty ‘hot clinics’ and avoid A&E attendances.

ii) Using the current MAU/Clifford. There are a few different options for these:
   a. Use them as decant wards to allow refurbishment of the remaining inpatient wards at the trust.
   b. Use them as a winter pressure facility.
   c. Use them as dedicated elective wards to drive improvements in our elective income, either from repatriation of work from the private sector or from growing market share from the eastern semi-circle of our geography. This could include Cardiology as the move of Papworth to the Addenbrookes campus will leave large parts of western Cambridgeshire, Peterborough and South Lincolnshire with excess travel times. The clinical view of the NGH cardiology collaboration is that by working together we could also bring more specialist cardiology work into the county.

iii) Using either of the vacated areas as office and training accommodation. This will maximise the clinical space in the new UCH, giving the build itself a higher contribution. It could also be used to prevent the trust needing to rent out additional office space from KBC or others in the long term and allow complete demolish of Thorpe House.

2. The affordability of the scheme

There are a number of ways we could affect the affordability model in the case. These will be presented to the discussion on the 11th.

i) Reduce the staffing levels by 10% as part of a ‘vacancy factor reality’ check.
ii) Reduce the Optimum bias from 15% to 12% and the planning contingency from 10% to 8%.

iii) Base the activity on the last 12 months of activity

iv) Increase the clinical space by moving non-clinical office and training space to the vacated current A&E department.

**Initial Advice from John Plumer NHSI, Senior Finance Lead, Central and South Midlands**

- He has not yet seen the case and does not wish to review it until complete and final submission. He has been engaged a number of times throughout the OBC production however so is not a stranger to what it includes or hopes to provide. We are required to submit a complete document (including letters of support) by the 31st Jan 2018.

- He supports the fact that we have split the capital amount down into chunks related to A&E itself, and what is related to the efficiencies of having a co-located MAU. In his view if they turn down the second element we won’t need to start from scratch and can get going on with the FBC for A&E whilst we negotiate the rest.
  - This does possibly mean we are more likely to get the MAU turned down, but there could be options around an FBC to include a build of the second floor shell, and fund the kitting out of this via a different route, or keep plugging the centre for the a second round of monies to do this based on the improved efficiencies (see later section on the Autumn statement).

- There are a number of other capital cases being presented at the moment so there is some backlog, some of them quite large including two which are complete new builds of hospitals. These are somewhat stuck at the moment, which he feels could be positive in that smaller scale projects are getting through as the attention is going on the larger cases, or could be a hindrance if we get stuck behind them. All cases are getting prioritised based on the Autumn statement (see appendix 2).
  - I suggest we strengthen our OBC and make it explicit from the outset that our case meets all requirements for capital spending as set out in the Autumn statement.

- He thinks that despite it being under the ‘golden’ £50m, HM Treasury are quite likely to still be interested as there are tighter restrictions on capital funding currently so they are taking more of an interest in lots of things.

- He feels it likely that this will only get approved through the £2.6billion set aside from STP’s. This is being allocated in summer 2018. We will therefore need both commissioner and STP letters of support prior to submission.

**Next Steps**

- Complete case depending on the affordability discussions as agreed on the 11th Jan.
- Review the exec summary/whole case and strengthen based on:
  - Ensure it is more clearly in line with every aspect of the Autumn statement
  - Ensure it discusses or is flexible to be in line with a hotter and colder site
  - Strengthen the efficiency and productivity improvements by having a co-located MAU.
- Receive commitment from Corby CCG that it supports progression to FBC.
• Receive support from the STP.
• Engage Kettering and Wellingborough MP’s in the case for change to drive the political will.
<table>
<thead>
<tr>
<th>Page/Para</th>
<th>Comment</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>P4</td>
<td>Would have expected to see site development plan as Appendix</td>
<td>Agreed, this would usually be the case. Our DCP however, although presented to Trust board in Jan 2016 was not agreed as it was too expensive and hasn't been re-presented since. We do not have one that can go into the public domain as part of this case therefore. Section 6.10 pg 151 explains this. We will need to have one agreed before FBC is submitted.</td>
</tr>
<tr>
<td>P5</td>
<td>HBN typo</td>
<td>Corrected</td>
</tr>
<tr>
<td>P11 pp2 2nd line</td>
<td>Missing “it” after treatment</td>
<td>Corrected</td>
</tr>
<tr>
<td>P11 2nd bullet</td>
<td>“patients”</td>
<td>Corrected</td>
</tr>
<tr>
<td>P11 final line</td>
<td>As FT its a Board of Directors not Trust Board- common mistake</td>
<td>Corrected throughout the document.</td>
</tr>
<tr>
<td>P12 1st Bullet</td>
<td>YTD ED attendances are approx 87,500 pa so nearly 90,000 more accurate</td>
<td>Corrected</td>
</tr>
<tr>
<td>P12 missing bullet point</td>
<td>Upper and lower projected activity levels</td>
<td>Added to above bullet.</td>
</tr>
<tr>
<td>P13</td>
<td>Need brief para commenting on actions in the light of ECIP comment to mitigate some of the issues in the meantime</td>
<td>Done</td>
</tr>
<tr>
<td>P16</td>
<td>Planning Permission submission needs to be revised- should this not be post acceptance of the OBC, otherwise it could be a wasted exercise if there is no green light</td>
<td>It depends whether we want to proceed at risk on the assumption that as a minimum then the new ED will be agreed. I have amended the words for now, but this is perhaps a point of discussion once we have initial feedback from NHSI in Feb.</td>
</tr>
<tr>
<td>P16 /17</td>
<td>Financial Case second para is incorrect in that it maybe that the ED element is in surplus and then deficit but it does not say this it states the Trust is in surplus in 2017/18 A mention of efficiencies should be more prominent, if there are none then this will be seen as weakness. Financial impact of achieving the transit time target has to be stated here as current financial risk that plan mitigates (with risk of failure to find beds not addressed) S years for ED to return to surplus is a long lead in. This is a weak financial case</td>
<td>Amended</td>
</tr>
</tbody>
</table>

**To be discussed tomorrow**
<table>
<thead>
<tr>
<th>Page</th>
<th>Issue</th>
</tr>
</thead>
<tbody>
<tr>
<td>P17/18</td>
<td>There needs to be a short comment re governance of the project - a NED chaired committee should be overseeing this especially given the track record on Capital projects at the Trust. Limited comment on use of technology in new facility to drive more efficient and effective care. Management Case also should comment on the lack of Site development plan if it is not to be included. Recommendation does not state which option is preferred. A NED is included as a member of the project board as well as staff and patient governors – described in 6.2. I have added in an explanatory statement here also though. I accept the risk about previous capital projects that have been run almost exclusively by our Estates department. A well represented project board and project team, with key estates representation but not being directed by them should service to mitigate the risk of unplanned ‘creep’.</td>
</tr>
<tr>
<td>P18</td>
<td>General Upto p19 little comment on how increase in ED activity will be managed when it translates into demand for beds etc. There is no comment regarding the training and development of Junior Doctors in the new facility whether this would improve or not? What is the Deanery’s view? All other amendments agreed and made.</td>
</tr>
<tr>
<td>P22</td>
<td>There is no comment re other providers such as primary care and especially the Corby Urgent Care Centre. Corrected.</td>
</tr>
<tr>
<td>P22 3rd para At this stage it would be wrong to quote the agreed deficit without comment on the likely outturn. NB confirmed this would be in FBC not OBC as it will be in line with the outputs of the LTFM.</td>
<td></td>
</tr>
<tr>
<td>P27 para 1</td>
<td>Is this picture of age profile abnormal for EDs? Yes it is – amended to make this clearer.</td>
</tr>
<tr>
<td>P27 para 2</td>
<td>It states on page 29 this is good but gives no comparator in the table. It is against the threshold in the table. Amended to make this clearer.</td>
</tr>
<tr>
<td>P31-32</td>
<td>CQC action plan references and Appendix 1 seem to duplicate – appendix should maybe have been October’s tracker as it relates to ED to provide more background. No duplication. The appendix lists the issues originally identified, the OBC gives an updated commentary on progress against the CQC issues.</td>
</tr>
<tr>
<td>P37</td>
<td>The quote is not needed twice in the document – however the comments below it are what are missing when it is first used on p13. Needs to be in here as the previous quote was only the exec summary, I have removed the third later reference though.</td>
</tr>
<tr>
<td>P38</td>
<td>Diagram is too cramped it ought to be whole page. Done.</td>
</tr>
<tr>
<td>P40</td>
<td>This could be an Appendix. To be discussed.</td>
</tr>
<tr>
<td>P42 section d</td>
<td>Not sure where table 7 referred to is or whether this is the correct reference. Removed for clarity.</td>
</tr>
<tr>
<td>Page</td>
<td>Comment</td>
</tr>
<tr>
<td>------</td>
<td>---------</td>
</tr>
<tr>
<td>P57</td>
<td>Upside and downside activity – are these mapped in affordability?</td>
</tr>
<tr>
<td>P60</td>
<td>Key risks does not include construction risk, which given the track record must be high even if mitigated</td>
</tr>
<tr>
<td>P61</td>
<td>Even with DTOCs close to zero is there not a dependency in later years of available beds for onward transfer of care</td>
</tr>
<tr>
<td>P62</td>
<td>ECIP quote for third time twice is excessive</td>
</tr>
<tr>
<td>Economic Appraisal</td>
<td>I cannot see how the empty estate has been factored into the calculation - this is a cost to some but not all options</td>
</tr>
<tr>
<td>Economic Case</td>
<td>Is the loss of car parking income factored into the appropriate options?</td>
</tr>
<tr>
<td>P79</td>
<td>This is the economic appraisal yet we have Vat in the table, it is not carried through to the appraisal but looks confusing to be included in this way</td>
</tr>
<tr>
<td>P80 table 25</td>
<td>Other overheads included at 10% this does not allow for any benefit of scale and will impact on affordability</td>
</tr>
<tr>
<td>Commercial Case</td>
<td>Looking at the preferred option is there sufficient local storage built in for M&amp;SE etc and disposables and if this is outside the new build is the expansion included in the case</td>
</tr>
<tr>
<td>P119</td>
<td>S.2.3 - this table is opaque especially regarding the years leading up to the Build why would we build if the surplus is achieved and increased activity? Again there is no cost for the vacated space factored in I am left to assume that this table is for preferred option - is the second placed option not modelled as a comparator</td>
</tr>
<tr>
<td></td>
<td>Capital charges in 17/18?</td>
</tr>
<tr>
<td></td>
<td>Growth in workforce where we are borrowing to pay bills would lead to interest costs for borrowing to pay them</td>
</tr>
<tr>
<td>P121</td>
<td>Table 41 - this shows the scheme to be unaffordable if the local tariff is</td>
</tr>
<tr>
<td>Page</td>
<td>Issue</td>
</tr>
<tr>
<td>------</td>
<td>-------</td>
</tr>
<tr>
<td>P126</td>
<td>ERROR reference on second to last line</td>
</tr>
<tr>
<td>P127</td>
<td>5.7 Existing charitable funds would have only marginal impact on reducing Vat</td>
</tr>
<tr>
<td>P128</td>
<td>There is no context given that the Trust already has significant deficit and preferred option with its extra staff and build is unaffordable unless commissioners are willing to fund the actual cost</td>
</tr>
<tr>
<td>P131</td>
<td>Should not EMAS be either a member of project board or at least Ad hoc attendee</td>
</tr>
<tr>
<td>P131</td>
<td>There should be a principle that as well as controlling overall capital spend on project that revenue should be capped and any design changes be assessed for full life cost and a funding stream identified.</td>
</tr>
<tr>
<td>P146</td>
<td>What are the risks if the increases in medical staffing and nursing are unrealistic? Can the model work with lower levels of senior medical staff?</td>
</tr>
<tr>
<td>150-151</td>
<td>This is insufficient – traffic flows not just when open but during construction. How do our ED patients arrive how does this differ over 24 hours and by day. Does this have a site impact. Where does the car parking get sorted? It may be there but cannot find it and we know preferred option will immediately lead to questions on disabled parking etc. Fig 26 &amp; 27 too blurred to be of benefit</td>
</tr>
<tr>
<td>P162</td>
<td>Still does not state what preferred option is a its a cut and paste from pp18-19</td>
</tr>
<tr>
<td>Affordability and Economic case</td>
<td>There is in management section and elsewhere points made about IT required but there is no obvious inclusion of the cost of that IT whether capital or revenue</td>
</tr>
<tr>
<td>How does the Urgent Care Hub fit in with the STP and at what point should the economy be asking</td>
<td>For clinical reasons one cannot build a central A&amp;E department without the majority of</td>
</tr>
</tbody>
</table>
the DoH to discuss the future of both sites, i.e. with a central A&E Department on a site between NGH/KGH

the rest of the hospitals also being re-provided on the same site. Whilst this might be a longer term goal, at the moment neither the STP or either acute has any real plans to progress this as an option, principally due to the larger amount of capital required. Whilst plans may emerge over the coming years, it is likely that these would take many years in the planning due to the public sensitivities, and further years to build. Therefore this UCH would still be required and relevant regardless of that being a future decision. Should these plans progress then the UCH could still be sued for other healthcare purposes such as a local urgent care centre or other purposes.

Derek Shaw did a piece with the estate strategy where the amount to bring the estate up to par was circ £200m+ - so the query is about the spend of £49m on a Urgent Care Hub when it is reported that the Estate requires considerable capital spend.

The Estates strategy was never approved by Board. There is still however a large amount of capital that is required to upgrade electrics and utilities on the remainder of the site even without any demolition and new build. Vacating ward and A&E space into the new UCH could allow upgrading of all wards and outpatients on a rotational basis.

If this were submitted would be given the financial pressure in NHS why would any one fund a substantial capital project that would just make matters worse?

From discussion with NHSI, there are other capital projects being submitted and getting approved. Some more substantial than ours. The Autumn statement makes the qualifying criteria for capital spend in the health sector clear, so our case needs to ensure it aligns with that. It is accepted by regulators that KGH require a new ED if it is to meet performance and quality standards, the question is whether they also agree to a new MAU on the basis of clinical efficiencies.

1. FLOW is critical.
With the current parlous state of the "system" approach to Urgent & Emergency Care in Northamptonshire, unless the system fixes the root causes of patients getting "stuck" in hospital, spending £50m on the UCH will create capacity to facilitate flow only for a limited period of time, then we will inexorably return to the daily struggle with the 4hr transit time performance for primarily admitted patients. The end result being a UCH that is full and blocked. What assurance guarantees are needed from partners to underpin the long term operational viability of this investment?

Agreed that reduction in DTOC's remain a key risk of the UCH being able to function. We are however even more unlikely to get approval for any capital if we base it on us holding the system DTOC's. There is an expectation (however unrealistic) that DTOC's will improve and therefore we have had to assume that in our capacity. We have made it clear in the case that this is a risk, and also accounted for it in our scenario mapping exercise. At FBC we will need to work through more robust plans regarding delayed discharges and will require assurances. Current work on winter pressures with the COO's will feed into this.

2. CAPITAL COST
In discussions of the UCH concept over the last four years, the affordability question has bounced back and forward between ourselves and NHS-I. The original capital cost estimate of around £30m was considered too rich by NHS-I, with suggestions of around £20m being more affordable. While it is right for us to pitch a solution that is fit for purpose in the long term, is there a view from NHS-I that a total cost (capital and revenue) of around £50m is going to be one that they can

We are expecting some challenge on the £50m – please see point from recent conversation with NHSI above.

‘He supports the fact that we have split the capital amount down into chunks related to A&E itself, and what is related to the efficiencies of having a co-located MAU. In his view if they turn down the second element we won’t need to start from scratch and can get going on with the FBC for A&E whilst we negotiate the rest.’
The other element of affordability is the income and cost balance between the new UCH once up and running versus the existing Emergency Care facility, then adding in the benefits from new or expanded other hospital services occupying the vacated A&E Department? I would like to see this picture laid out clearly please.

### Table 40
Table 40 in the case sets out the staffing costs of business as usual (with predicted growth in activity) compared to the OBC. The main income difference is being able to expand ambulatory care and this is shown in table 39 in 2022/3. No income or cost has been included about the remaining estate as described in the main body of this update paper.

### 3. PARKING/SITE FLOW/DISRUPTION
There is no doubt that Car Park A sits at the heart of a number of our time-critical services......A&E, Maternity, Outpatients.

We have spent the last three years first living with and then addressing the parking/flow challenge as our number 1 patient/visitor complain topic, to the point now where the noise is minimal. None of us wants to go backwards now.

3.1 What is the plan for displacing Car Park A short-stay, taxi, drop-off, disabled parking...to another/other locations?

3.2 The UCH is a major construction project, many times larger than the build of the new Endoscopy suite which itself occupied significant areas of the surrounding estate during the build. How will the UCH "build" be contained in order to minimise disruption for patients, visitors, staff, ambulances, etc.?

### 4. TIME TO COMPLETE
Minimising the time from first ground-breaking to opening the doors of the new UCH will be critical with this build being undertaken at the heart of our estate. Our recent experience with the 5th Endoscopy Suite and the Theatres Ventilation Programmes has not been encouraging. In contract however, the Foundation Wing (Phase 55) was completed on time, on cost and - barring a last minute downpour - on quality, 5 years ago.

How can we be assured that this extensive construction/migration/change programme will be managed and controlled tightly - in all respects - to ensure the Trust is able to deliver the promises we make to our stakeholders about its availability, impact and benefits?

Also, how will the "ownership" of delivery remain with/be actively shared by the Leadership Team of our Emergency services rather than as we have seen recently, "sub-contracted" off to estates to deliver?

### 5. STAFFING
Like many Urgent & Emergency Care Departments across the country, we struggle to recruit and Agreed. We have had to put in safe and recommended staffing levels as otherwise it would not get approved. We feel recruitment will improve with a new facility but this


<table>
<thead>
<tr>
<th>retain sufficient staffing capacity (on a substantive basis) across the range of roles, to consistently deliver the excellent service to which we aspire. With the UCH being a much larger facility requiring more staff, why is the team so confident that we will be able to consistently and appropriately resource the hub? Even those hospitals with new or substantially more modern Emergency Care facilities struggle with recruitment and retention.</th>
<th>does not mean we think we will be fully staffed. Discussion tomorrow about adding in a 10% vacancy factor. We have also mentioned that we will be flexible on skill mix and emerging roles nationally if we struggle to recruit.</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. DRIVING THE CHANGE AGENDA SUCCESSFULLY The UCH is a major new build, but at its core as an investment programme, its success requires major changes in the way KGH and partners organise and provide the targeted services. What is the plan for determining, specifying, training and then successfully implementing the new underlying patient care processes/pathways and how much time is allowed in the plan for successful transition from the &quot;old&quot; to the &quot;new&quot;? Has another Trust been identified within the Region that has been through such a major transformation/investment successfully in Emergency Care, that we can learn from?</td>
<td>Good point. External partners were engaged in the workshops and the models are in line with the STP and national guidance on collaborative and integrated care. I have added in some commentary about the change process and that this will need a work-up during FBC. We have linked already with Rotherham and the visit took on learning lessons. We have made contact with Leicester and will look to undertake further site visits during FBC stage.</td>
</tr>
<tr>
<td>One final point. I could find nowhere any mention of consideration of a joint KGH/NGH Emergency Care centre for Northamptonshire. The report focuses solely on the proposal to build on the KGH site. This broader topic has been raised and discussed on a number of occasions and is likely to be raised again considering the size of the bill. It may be helpful in avoiding this becoming a stumbling block that slows the project down, to include an appendix that mentions this but gives all the sensible/logical reasons why this is not a viable option. If we don't address it, I suspect someone will ask us to.</td>
<td>As per previous question – but I will also add some commentary into the exec summary.</td>
</tr>
</tbody>
</table>
7.2 Health

The government will provide the NHS with £6.3 billion of additional funding in England.

NHS funding – At Spending Review 2015, the government funded the NHS’s ‘Five Year Forward View’ plan. Even with this significant investment the health service remains under pressure, with high demand on its services caused by the UK’s ageing population and rapidly advancing technology. The government will therefore provide the NHS with £2.8 billion of additional resource funding in England. This will help it get back on track to meet its performance targets on waiting times both in A&E and after patients are referred to treatment: (8)

- £335 million of this will be provided this year, to help the NHS to increase capacity over winter
- £1.6 billion will be provided in 2018-19 – taking the overall increase in the NHS’s resource budget next year to £3.75 billion
- £900 million will be provided in 2019-20, to help address future pressures

This funding should enable the NHS to meet the A&E four-hour target next year, make inroads into waiting lists and improve performance against waiting time targets. It will therefore ensure that more patients receive the care that they need more quickly. Alongside this investment, the government expects the NHS to continue to improve its efficiency and productivity, and deliver its plan to transform services and deliver seamless care for patients.

NHS pay – To protect frontline services in the NHS, the government is also committing to fund pay awards as part of a pay deal for NHS staff on the Agenda for Change contract, including nurses, midwives and paramedics. Any pay deal will be on the condition that the pay award enables improved productivity in the NHS, and is justified on recruitment and retention grounds. This does not prejudice the role of the independent NHS Pay Review Body in recommending the level of pay award that these staff should receive.

NHS capital investment – The government is delivering on its share of the £10 billion package of investment recommended by Sir Robert Naylor’s review of NHS property and estates, by providing a further £3.5 billion of new capital funding for the NHS in England – on top of the £425 million already provided at Spring Budget 2017. (9) This will be allocated as follows: (9)

- £2.6 billion will be for local groups of NHS organisations (Sustainability and Transformation Partnerships) to deliver transformation schemes that improve their ability to meet demand for local services. This funding will enable them to deliver more integrated care for patients, more care out of hospital and reduce waiting times. Alongside the Budget, the government has announced the first group of schemes to benefit from this funding, subject to the usual approvals processes
- £700 million will support turnaround plans in the individual trusts facing the biggest performance challenges, and tackle the most urgent and critical maintenance issues that trusts are facing – to help ensure every patient is treated in a safe environment, conducive to the highest quality of care
- £200 million will support efficiency programmes that will, for example, help reduce NHS spending on energy, and fund technology that will allow more money and staff time to be directed towards treating patients.

This £3.5 billion will allow the NHS to increase the proceeds from selling surplus NHS land and buildings to at least £3.3 billion, almost doubling the scale of investment available to the NHS, and unlocking land for housing. It will also be accompanied by private finance investment in the health estate where this provides good value for money. And it will be complemented by work to review and improve the rules that inform trusts’ use of capital funding, to help make sure that they can maintain their facilities most effectively. Taken together, these
measures will help hospitals and commissioners to bring down running costs and invest in high quality patient care.
**TRUST BOARD:**

**AGENDA ITEM:**

**SUBJECT:** Q3 REFORECAST

**RESPONSIBLE DIRECTOR:** Nicci Briggs  
Director of Finance

**AUTHOR:** Nicci Briggs  
Director of Finance

**PREVIOUSLY CONSIDERED BY:**

**EXECUTIVE SUMMARY:**

This paper provides the Finance & Resources Committee members with a report which provides an assessment of the current financial projections and forecast outturn scenarios complete with risks and mitigations.

**ACTION REQUIRED:** The Finance & Resources Committee is asked to discuss the options and put forward recommendations to the Trust Board.

**RISK TO THE TRUST** (include reference to BAF or Corporate Risk Register)  
Ability to deliver the financial plan

**WORKFORCE ISSUES:** (including training and education implications)  
Noted in the report

**DIVERSITY & INCLUSION’**  
Equality Impact is Neutral

**FINANCIAL IMPLICATIONS:** Specify No/Yes (Detailed within the report).  
Yes detailed within the report

**COMMUNICATION/CONSULTATION ISSUES** (including patient and public involvement)  
Communication will need to be considered once recommendations are made.

**STRATEGIC OBJECTIVE:** (specify trust strategic objective)  
Become a financially sustainable organisation

**CQC DOMAINS**

- safe.
- effective.
- caring.
- responsive to people’s needs.
- well-led

Please indicate which domain the report is providing assurance on

Safe, effective, well led
Q3 REFORECAST

1. M8 YTD POSITION

The 2017/18 financial year has seen an above average amount of non-recurrent spend as a result of capital delays and other decisions that have largely impacted the Trusts trading position. The YTD deficit of £19m is a £5.4m variance to plan and £4.7m of that variance is due to reduced activity related income. The remainder of the adverse variance is on non pay which is largely offset by agency reductions. This would suggest the Trust set its plan to deliver a certain level of activity, thus any recovery must be aimed at improving trading or right sizing the organisation if the 2017/18 activity levels are believed to be recurrent. Any right sizing will take time as reducing costs is more difficult and require process change or consultation.

There have been significant improvements over the last 2 months since theatres have been fully operational and the grip and control and financial recovery actions have been developed and moved to delivery. These improvements have seen the run rate reduce from a year to date average of £2.6m in the first 2 quarters to £1.6m in M8 but in order to deliver a £19.9m plan this run rate would need to reduce by a further £1m to £0.5m a month for the final 4 months of the year.

2. M9 EXPECTED POSITION

The M9 position was expected to be broadly in line with plan (£2m deficit) with the following known adjustments;

<table>
<thead>
<tr>
<th>Description</th>
<th>M9 Forecast</th>
</tr>
</thead>
<tbody>
<tr>
<td>M9 Planned Deficit</td>
<td>(2.0)</td>
</tr>
<tr>
<td>Endoscopy delays</td>
<td>(0.1)</td>
</tr>
<tr>
<td>Teleradiology / Clinical Support non-pay</td>
<td>(0.2)</td>
</tr>
<tr>
<td>CBU CIP slippage</td>
<td>(0.2)</td>
</tr>
<tr>
<td>NEL HRG 4+</td>
<td>(0.1)</td>
</tr>
<tr>
<td>FRP &amp; Corporate CIPs</td>
<td>0.3</td>
</tr>
<tr>
<td>Cost of capital</td>
<td>0.1</td>
</tr>
<tr>
<td>Theatres recovery</td>
<td>0.1</td>
</tr>
<tr>
<td>Agency reduction</td>
<td>0.1</td>
</tr>
<tr>
<td><strong>M9 Forecast Deficit</strong></td>
<td><strong>(2.0)</strong></td>
</tr>
</tbody>
</table>

This would have taken the YTD position to £21.2m with an assumption that January pressures would be covered by Winter funding and leaving a challenge to deliver trading improvements in February and March.

3. M9 ACTUAL POSITION

M9 actual position was a £2.8m deficit against a £2m plan and was significantly worse than forecast and 100% of the impact seen has been on the trading position. Again costs have been controlled and reduced due to central iniatives and close management but elective(DC/ EL/ OP)
income has seen a sharp reduction. Appendix 1 shows the M9 position and movement between M8 and M9.

The income variance to plan is £0.8m after factoring in £364k Tranche 1 winter funding released straight to the bottom line and £468k of Tranche 2 funding against winter initiatives and costs approved to support the winter position. After removing these one-off income the variance to plan is £1.6m and a £2.2m reduction from M8. If this income was removed the position would be £3.6m deficit for M9. The detailed movements are shown in the table below.

<table>
<thead>
<tr>
<th>Bridge between M8 and M9 income</th>
<th>£m</th>
</tr>
</thead>
<tbody>
<tr>
<td>M8 Clinical income</td>
<td>19.1</td>
</tr>
<tr>
<td>Outpatients</td>
<td>(0.7)</td>
</tr>
<tr>
<td>DC - Cardiology, Gastro, General Surgery</td>
<td>(0.3)</td>
</tr>
<tr>
<td>Pathology Direct Access</td>
<td>(0.2)</td>
</tr>
<tr>
<td>NEL</td>
<td>(0.2)</td>
</tr>
<tr>
<td>Maternity pathway</td>
<td>(0.3)</td>
</tr>
<tr>
<td>Elective - Orthopaedics due to increased Trauma</td>
<td>(0.2)</td>
</tr>
<tr>
<td>Non PBR drugs</td>
<td>(0.3)</td>
</tr>
<tr>
<td>M9 Clinical Income (after removal of winter funds)</td>
<td>16.9</td>
</tr>
</tbody>
</table>

4. REFORECAST POSITION

On the 21st December the Trust received a letter from NHSE and NHSI to put in place plans to cancel non urgent planned care for the 2 week period over Christmas and New Year. On the 2nd of January the Trust received a letter from National Director for Urgent and Emergency Care requiring us to extend these arrangements up until the 31st of January. The potential impact on the Trust is:

- Up to £6m if all planned work is stopped
- Up to £4.5m impact if only urgent 52 weeks and cancers continue
- Up to £2.5m if clinical support, WCH and surgical outpatients and day case continue thus going against the National Director or Urgent and Emergency Care’s instruction.

Given such volatility to the forecast position the Board needs to weigh up reforecasting and getting it wrong and waiting for the actual position in January to materialise thus giving more certainty to the year end position. The table below shows the large variations that could materialise, there are upsides if the pressures cease and winter funding is used to support flow and reduce additional costs thus bringing the forecast under £24m and non recurrently below this years plan of £19.9m with the £2m HRG 4+ tariff impact (under £18m on like for like planning basis)
<table>
<thead>
<tr>
<th>Forecast Outturn adjustments</th>
<th>YTD Position</th>
<th>Jan</th>
<th>Feb</th>
<th>March</th>
<th>Forecast Outturn</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planned Deficit</td>
<td>(1.8)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continued Pressures (NEL, Endoscopy, CS Non Pay, CBU CIP)</td>
<td>(0.8)</td>
<td>(0.7)</td>
<td>(0.7)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Theatres</td>
<td>0.1</td>
<td>0.3</td>
<td>0.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agency</td>
<td>0.2</td>
<td>0.2</td>
<td>0.2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Corporate CIP</td>
<td>0.3</td>
<td>0.3</td>
<td>0.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contingency</td>
<td>0.4</td>
<td>0.3</td>
<td>0.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FRP</td>
<td>0.2</td>
<td>0.3</td>
<td>0.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Winter Pressures cost</td>
<td>(0.6)</td>
<td>(0.4)</td>
<td>(0.3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Winter Pressures Tranche 1</td>
<td>0.4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Winter Pressures Tranche 2</td>
<td>0.6</td>
<td>0.4</td>
<td>0.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>M9 Forecast prior to Elective reduction</td>
<td>(22.0)</td>
<td>(1.0)</td>
<td>(1.1)</td>
<td>(1.1)</td>
<td>(25.2)</td>
</tr>
<tr>
<td>Upside Impact Jan Elective Income</td>
<td>(2.5)</td>
<td></td>
<td></td>
<td></td>
<td>(27.7)</td>
</tr>
<tr>
<td>Base Impact on Jan Elective Income</td>
<td>(4.5)</td>
<td></td>
<td></td>
<td></td>
<td>(29.7)</td>
</tr>
<tr>
<td>Downside Impact on Jan Elective Income</td>
<td>(6.0)</td>
<td></td>
<td></td>
<td></td>
<td>(31.2)</td>
</tr>
</tbody>
</table>

6. RISKS AND MITIGATIONS

The main risks that are not taken into account in any of the scenarios above are:

- **Sepsis** – In April 2017 NHS Digital changed its guidance on the clinical coding of sepsis. As a result CCGs have raised a concern about the financial impact of such changes. A determination will be made between NHSE and NHSI and the risk to the Trust is £0.3m

- **MRET** – In April 2017 the Trust saw its MRET penalty increase from £1.5m to a proposed £4.8m. The Trust decided to challenge the baseline assumptions and recognised 50% of the potential benefit putting only a £3.4m penalty into the 2017/18 plan
## Appendix 1 – M9 ACTUAL POSITION

<table>
<thead>
<tr>
<th>Monitor Group</th>
<th>Monitor Category</th>
<th>Plan</th>
<th>Actual</th>
<th>VAR to Plan</th>
<th>Actual</th>
<th>VAR to M8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operating Income</td>
<td>NHS Clinical Income</td>
<td>(18,369,818)</td>
<td>(17,604,546)</td>
<td>(765,272)</td>
<td>(19,085,815)</td>
<td>(4,481,269)</td>
</tr>
<tr>
<td></td>
<td>Other Clinical Income</td>
<td>(84,779)</td>
<td>(90,266)</td>
<td>5,487</td>
<td>(42,160)</td>
<td>48,106</td>
</tr>
<tr>
<td></td>
<td>Research &amp; Development Income</td>
<td>(44,882)</td>
<td>(34,891)</td>
<td>(9,991)</td>
<td>(46,287)</td>
<td>(11,396)</td>
</tr>
<tr>
<td></td>
<td>Education &amp; Training Income</td>
<td>(609,423)</td>
<td>(608,585)</td>
<td>(838)</td>
<td>(600,573)</td>
<td>8,012</td>
</tr>
<tr>
<td></td>
<td>Other Non Clinical Income</td>
<td>(473,959)</td>
<td>(634,882)</td>
<td>160,923</td>
<td>(548,031)</td>
<td>86,849</td>
</tr>
<tr>
<td></td>
<td><strong>Operating Income Total</strong></td>
<td><strong>(19,582,861)</strong></td>
<td><strong>(18,973,170)</strong></td>
<td><strong>(609,691)</strong></td>
<td><strong>(20,322,868)</strong></td>
<td><strong>(1,349,698)</strong></td>
</tr>
<tr>
<td>Contracted Pay</td>
<td>Medical Pay</td>
<td>3,621,190</td>
<td>3,897,565</td>
<td>(276,375)</td>
<td>3,882,679</td>
<td>(14,886)</td>
</tr>
<tr>
<td></td>
<td>Nursing Pay</td>
<td>3,869,485</td>
<td>3,912,579</td>
<td>(43,094)</td>
<td>3,912,703</td>
<td>124</td>
</tr>
<tr>
<td></td>
<td>Scientific &amp; Technical Pay</td>
<td>1,314,102</td>
<td>1,214,914</td>
<td>99,188</td>
<td>1,214,032</td>
<td>(881)</td>
</tr>
<tr>
<td></td>
<td>Directors &amp; Sen. Managers Pay</td>
<td>560,464</td>
<td>558,479</td>
<td>1,990</td>
<td>535,516</td>
<td>(22,958)</td>
</tr>
<tr>
<td></td>
<td>Hca &amp; Other Support Staff Pay</td>
<td>2,082,596</td>
<td>2,187,384</td>
<td>(104,788)</td>
<td>2,154,828</td>
<td>(32,555)</td>
</tr>
<tr>
<td></td>
<td>Administration &amp; Estates Pay</td>
<td>1,681,076</td>
<td>1,584,949</td>
<td>96,127</td>
<td>1,545,288</td>
<td>(39,661)</td>
</tr>
<tr>
<td></td>
<td><strong>Contracted Pay Total</strong></td>
<td><strong>13,128,913</strong></td>
<td><strong>13,355,864</strong></td>
<td><strong>(226,951)</strong></td>
<td><strong>13,245,046</strong></td>
<td><strong>(110,818)</strong></td>
</tr>
<tr>
<td>Agency Pay</td>
<td>Agency Medical Pay</td>
<td>471,962</td>
<td>326,089</td>
<td>145,873</td>
<td>483,036</td>
<td>156,947</td>
</tr>
<tr>
<td></td>
<td>Agency Nursing Pay</td>
<td>444,922</td>
<td>483,916</td>
<td>(38,994)</td>
<td>446,491</td>
<td>(37,425)</td>
</tr>
<tr>
<td></td>
<td>Agency Scientific &amp; Tech Pay</td>
<td>64,473</td>
<td>55,070</td>
<td>9,403</td>
<td>41,224</td>
<td>(13,846)</td>
</tr>
<tr>
<td></td>
<td>Agency Hca &amp; Support Staff Pay</td>
<td>23,027</td>
<td>32,791</td>
<td>(9,764)</td>
<td>30,628</td>
<td>(2,164)</td>
</tr>
<tr>
<td></td>
<td>Agency Admin &amp; Estates Pay</td>
<td>9,219</td>
<td>77,356</td>
<td>(68,137)</td>
<td>49,735</td>
<td>(27,621)</td>
</tr>
<tr>
<td></td>
<td><strong>Agency Pay Total</strong></td>
<td><strong>1,013,603</strong></td>
<td><strong>975,222</strong></td>
<td><strong>38,381</strong></td>
<td><strong>1,051,113</strong></td>
<td><strong>75,891</strong></td>
</tr>
<tr>
<td>Drugs</td>
<td>Drugs</td>
<td>1,880,753</td>
<td>1,713,668</td>
<td>167,085</td>
<td>1,961,883</td>
<td>248,215</td>
</tr>
<tr>
<td></td>
<td><strong>Drugs Total</strong></td>
<td><strong>1,880,753</strong></td>
<td><strong>1,713,668</strong></td>
<td><strong>167,085</strong></td>
<td><strong>1,961,883</strong></td>
<td><strong>248,215</strong></td>
</tr>
<tr>
<td>Supplies &amp; Services Clinical</td>
<td>Supplies &amp; Services Clinical</td>
<td>1,643,073</td>
<td>1,905,258</td>
<td>(262,185)</td>
<td>1,988,494</td>
<td>83,236</td>
</tr>
<tr>
<td></td>
<td><strong>Supplies &amp; Services Clinical Total</strong></td>
<td><strong>1,643,073</strong></td>
<td><strong>1,905,258</strong></td>
<td><strong>(262,185)</strong></td>
<td><strong>1,988,494</strong></td>
<td><strong>83,236</strong></td>
</tr>
<tr>
<td>Supplies &amp; Services General</td>
<td>Supplies &amp; Services General</td>
<td>193,239</td>
<td>198,552</td>
<td>(5,313)</td>
<td>278,633</td>
<td>80,081</td>
</tr>
<tr>
<td></td>
<td><strong>Supplies &amp; Services General Total</strong></td>
<td><strong>193,239</strong></td>
<td><strong>198,552</strong></td>
<td><strong>(5,313)</strong></td>
<td><strong>278,633</strong></td>
<td><strong>80,081</strong></td>
</tr>
<tr>
<td>Other Operating Expenditure</td>
<td>Cnst Premium</td>
<td>649,967</td>
<td>635,883</td>
<td>14,084</td>
<td>635,884</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Establishment Expenses</td>
<td>160,133</td>
<td>201,467</td>
<td>(41,334)</td>
<td>210,156</td>
<td>8,689</td>
</tr>
<tr>
<td></td>
<td>External Contract</td>
<td>44,338</td>
<td>54,459</td>
<td>(10,121)</td>
<td>94,832</td>
<td>40,373</td>
</tr>
<tr>
<td></td>
<td>Serv Recd - Purchase Of H/C</td>
<td>520,939</td>
<td>853,718</td>
<td>(332,779)</td>
<td>845,180</td>
<td>(8,538)</td>
</tr>
<tr>
<td></td>
<td>Premises &amp; Fixed Plant</td>
<td>680,245</td>
<td>749,843</td>
<td>(69,598)</td>
<td>767,516</td>
<td>17,673</td>
</tr>
<tr>
<td></td>
<td>Business Rates</td>
<td>110,737</td>
<td>103,474</td>
<td>7,263</td>
<td>105,090</td>
<td>1,616</td>
</tr>
<tr>
<td></td>
<td>Misc Expenditure</td>
<td>300,844</td>
<td>262,469</td>
<td>38,375</td>
<td>253,402</td>
<td>(9,067)</td>
</tr>
<tr>
<td></td>
<td><strong>Other Operating Expenditure Total</strong></td>
<td><strong>2,467,203</strong></td>
<td><strong>2,861,314</strong></td>
<td><strong>(394,111)</strong></td>
<td><strong>2,912,060</strong></td>
<td><strong>50,745</strong></td>
</tr>
<tr>
<td>Capital Charges &amp; Restructuring</td>
<td>Interest Payable</td>
<td>265,000</td>
<td>222,825</td>
<td>42,175</td>
<td>250,598</td>
<td>27,773</td>
</tr>
<tr>
<td></td>
<td>Finance Lease Interest</td>
<td>466</td>
<td>2,293</td>
<td>(1,827)</td>
<td>398</td>
<td>(1,895)</td>
</tr>
<tr>
<td></td>
<td>Interest Receivable</td>
<td>(1,978)</td>
<td>(3,873)</td>
<td>1,895</td>
<td>(1,540)</td>
<td>2,332</td>
</tr>
<tr>
<td></td>
<td>Depreciation</td>
<td>526,851</td>
<td>457,094</td>
<td>69,757</td>
<td>465,424</td>
<td>8,329</td>
</tr>
<tr>
<td></td>
<td>Dividends On Pdc</td>
<td>33,000</td>
<td>33,417</td>
<td>(417)</td>
<td>33,416</td>
<td>(1)</td>
</tr>
<tr>
<td></td>
<td>Fixed Asset Impairments(Frs11)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Gross Redundancy Payments</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Unwind Discount On Provisions</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td><strong>Capital Charges &amp; Restructuring Total</strong></td>
<td><strong>823,339</strong></td>
<td><strong>711,757</strong></td>
<td><strong>111,582</strong></td>
<td><strong>748,296</strong></td>
<td><strong>36,539</strong></td>
</tr>
<tr>
<td>Non Pay Contingency</td>
<td>Non Pay Contingency</td>
<td>320,833</td>
<td>0</td>
<td>320,833</td>
<td>(187,500)</td>
<td>(187,500)</td>
</tr>
<tr>
<td></td>
<td><strong>Non Pay Contingency Total</strong></td>
<td><strong>320,833</strong></td>
<td><strong>0</strong></td>
<td><strong>320,833</strong></td>
<td><strong>(187,500)</strong></td>
<td><strong>(187,500)</strong></td>
</tr>
<tr>
<td>Pay Contingency</td>
<td>Pay Contingency</td>
<td>129,167</td>
<td>53,418</td>
<td>75,749</td>
<td>(60,466)</td>
<td>(113,884)</td>
</tr>
<tr>
<td></td>
<td><strong>Pay Contingency Total</strong></td>
<td><strong>129,167</strong></td>
<td><strong>53,418</strong></td>
<td><strong>75,749</strong></td>
<td><strong>(60,466)</strong></td>
<td><strong>(113,884)</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Grand Total</strong></td>
<td><strong>2,017,262</strong></td>
<td><strong>2,801,882</strong></td>
<td><strong>(784,620)</strong></td>
<td><strong>1,614,690</strong></td>
<td><strong>(1,187,192)</strong></td>
</tr>
<tr>
<td>NHS Clinical Income</td>
<td>Plan</td>
<td>Actual</td>
<td>VAR to Plan</td>
<td>Plan</td>
<td>Actual</td>
<td>VAR to Plan</td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>----------</td>
<td>----------</td>
<td>-------------</td>
<td>----------</td>
<td>----------</td>
<td>-------------</td>
</tr>
<tr>
<td>A&amp;E Income</td>
<td>(1,030,017)</td>
<td>(985,461)</td>
<td>(44,556)</td>
<td>(997,689)</td>
<td>(954,550)</td>
<td>(43,139)</td>
</tr>
<tr>
<td>Cquin Income</td>
<td>(308,180)</td>
<td>(306,578)</td>
<td>(1,602)</td>
<td>(308,180)</td>
<td>(348,633)</td>
<td>40,453</td>
</tr>
<tr>
<td>Critical Care Income</td>
<td>(860,188)</td>
<td>(723,268)</td>
<td>(136,920)</td>
<td>(844,292)</td>
<td>(712,958)</td>
<td>(131,334)</td>
</tr>
<tr>
<td>Day Case Income</td>
<td>(2,009,930)</td>
<td>(1,795,337)</td>
<td>(214,393)</td>
<td>(2,238,093)</td>
<td>(2,082,010)</td>
<td>(156,083)</td>
</tr>
<tr>
<td>Direct Access Income</td>
<td>(1,013,701)</td>
<td>(765,664)</td>
<td>(248,037)</td>
<td>(1,045,018)</td>
<td>(981,011)</td>
<td>(64,007)</td>
</tr>
<tr>
<td>Elective Income</td>
<td>(1,047,189)</td>
<td>(1,124,132)</td>
<td>76,943</td>
<td>(1,241,986)</td>
<td>(1,345,700)</td>
<td>103,714</td>
</tr>
<tr>
<td>Excluded Drugs Income</td>
<td>(1,309,678)</td>
<td>(1,063,563)</td>
<td>(246,115)</td>
<td>(1,238,318)</td>
<td>(1,358,835)</td>
<td>120,517</td>
</tr>
<tr>
<td>Haemodialysis Income</td>
<td>(5,172)</td>
<td>(5,219)</td>
<td>47</td>
<td>(5,006)</td>
<td>(6,801)</td>
<td>1,795</td>
</tr>
<tr>
<td>Maternity Pathway</td>
<td>(1,391,246)</td>
<td>(1,235,924)</td>
<td>(155,322)</td>
<td>(1,448,528)</td>
<td>(1,532,123)</td>
<td>83,595</td>
</tr>
<tr>
<td>Non Elective Income</td>
<td>(6,382,461)</td>
<td>(6,217,431)</td>
<td>(165,030)</td>
<td>(6,583,496)</td>
<td>(6,408,789)</td>
<td>(174,707)</td>
</tr>
<tr>
<td>Other Income</td>
<td>(785,055)</td>
<td>(761,286)</td>
<td>(23,769)</td>
<td>(798,038)</td>
<td>(849,182)</td>
<td>51,144</td>
</tr>
<tr>
<td>Outpatient Fu Income</td>
<td>(816,312)</td>
<td>(689,618)</td>
<td>(126,694)</td>
<td>(975,761)</td>
<td>(906,593)</td>
<td>(69,168)</td>
</tr>
<tr>
<td>Outpatient Procedure Income</td>
<td>(710,146)</td>
<td>(635,612)</td>
<td>(74,534)</td>
<td>(947,048)</td>
<td>(825,056)</td>
<td>(122,992)</td>
</tr>
<tr>
<td>Per Excluded Devices</td>
<td>(134,785)</td>
<td>(20,243)</td>
<td>(15,545)</td>
<td>(230,848)</td>
<td>(230,697)</td>
<td>(151)</td>
</tr>
<tr>
<td>Penalties Income</td>
<td>684,803</td>
<td>(125,054)</td>
<td>809,857</td>
<td>684,803</td>
<td>706,696</td>
<td>21,893</td>
</tr>
<tr>
<td>S&amp;T Funding</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Unbundled Chemotherapy</td>
<td>(128,946)</td>
<td>(93,313)</td>
<td>(35,633)</td>
<td>(114,852)</td>
<td>(118,710)</td>
<td>3,858</td>
</tr>
<tr>
<td>Grand Total</td>
<td>(18,369,818)</td>
<td>(17,694,547)</td>
<td>(675,271)</td>
<td>(19,531,591)</td>
<td>(19,085,816)</td>
<td>(445,775)</td>
</tr>
</tbody>
</table>