

## Integrated Performance Committee

## minutes

### Minutes of the Integrated Performance Committee Meeting Monday 24<sup>th</sup> October 2022

<b>Present:</b>	Louise Robson Bob Burgoyne	Non-Executive Director (Chair) Non-Executive Director
<b>In Attendance:</b>	Karen Edge Jonathan Mathews James Bradley Carla Richardson Dave MacMillan Mike Filek Harry Vaslam Jennifer Ohlsson	Chief Finance Officer Chief Operating Officer Deputy Chief Finance Officer Head of Income and Costing Head of Capital Projects and Decontamination Head of Improvement and Transformation Finance Trainee (Observing) Senior Executive Assistant (Minutes)
<b>Apologies for Absence:</b>	Margaret Carney	Non-Executive Director

#### 1. Apologies for Absence

MC sent apologies but submitted questions which were picked up in the meeting. The meeting remained quorate.

#### 2. Declarations of Interest

None declared.

#### 3. Minutes of meeting held on 25<sup>th</sup> July 2022.

Minutes from the meeting of 25<sup>th</sup> July were noted and approved providing the following amendments are made and clearly stated in the minutes.

Cancer performance and the request that the Executive team to look at appointing a single accountable Cancer Clinical Lead. It was noted that this has been actioned. Also that the Chair raised the diagnostic recovery trajectory, which featured achievement in Q3, whereas delivery by Q2 was more appropriate.

#### 4. Action Log

#### Actions

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**Action 1:** Further work has been undertaken to look at the cost pressure related to international nursing. Agenda item for this meeting. Action closed.

**Action 2:** IPC January date has been changed to Monday 27<sup>th</sup> February 2022. Action closed.

## **5.1 Finance Report including CIP**

### **5.1. Month 6 finance update**

#### Regional and ICB update

CFO provided a regional and local update to colleagues and noted that for C&M at month 5 there is a £156m deficit, FOT still remains at £24m deficit in line with the agreed plan. Although the run rate has improved from month 4 there is significant challenge ahead to achieve plan.

CIP year to date is £292m versus a £363m plan and only 26% of this is recurrent

ERF is c90-95% achievement of plans, leading to potential clawback. National position ERF will be honoured to commissioners

Agency spend is £190m versus a £136m target for the North West. All ICBs are above target.

Capital expenditure year to date is £147m versus a £207m plan, 28% of FOT.

The triangulation of WTE growth, vacancies, productivity, activity and beds does not correlate and does not support the narrative around increase in cost from 2019.

Comments and questions were welcomed on the regional and local update and a query raised on when will there be full clarity on the ERF situation and whether this remains a risk. CFO confirmed a deadline has not yet been received from the ICB, however LHCH is meeting the ERF activity plan and casemix and there are no concerns that this would create a significant negative impact even if actioned.

A query was also raised on whether there is an opportunity to earn more in terms of increasing activity. CFO stated LHCH have maximised their elective capacity in their current plans and additionally it is unlikely that C&M will be able to make up the ground that has been lost creating an ICB pressure.

A question was raised on whether there is confidence that C&M providers will deliver a deficit of £30M level, as agreed, or will it likely be greater and whether there are any consequences for the ICS of the overspend. CFO confirmed that there are emerging risks in providers linked to winter pressures and sickness. There will be significant scrutiny on providers that are not on plan and potential consequences.

#### LHCH update

For LHCH, CFO presented a month 6 financial update to colleagues and noted that there is a £696k surplus, a £502k favourable variance to plan in-month. A year-to-date surplus of £1,700k has been achieved. This is a £537k favourable variance to plan.

Private patient income was £17k below plan, year to date £57k below plan. Income from the Isle of Man was £149k higher than plan in September and is £596k higher for the year to date. The ERF income has been matched to plan for the first six months of the year. The Trust is still awaiting further guidance from the commissioners. Income for Targeted Lung Health Checks was marginally higher than plan in the month (£25k), and the year-to-date position is £253k higher than originally anticipated.

There is a small underspend on pay costs in September. Pay costs overall are tracking closely to the plan, with overspends in nursing and medical staff offset by vacancies in a range of other areas.

Non-pay costs relate to unidentified CIP. There are higher costs in clinical supplies in month 6 linked to higher activity levels. The utilities budget has been increased to reflect the significant rise in prices. The Trust has received 21/22 data, but is awaiting information for this year. A further £500k has been accrued in addition to the budgetary increase. This is to mitigate the risk of higher than predicted spend in the first half of the year.

Surgery elective activity is 107% of 22/23 plan in September and the Medicine elective activity is 119% of 22/23 plan in September.

To date, the Divisions have identified £3.9m of recurrent CIP savings, 91% of the target, an improvement of £20k since August. "Deep dive" meetings with each Division are helping to increase the value of schemes identified.

The Trust cash balance is £42.5m. Alder Hey IT SLA invoices are delayed and due to be paid in month 7, which will reduce our cash balance by £2.5m.

At the end of month 6, capital expenditure was £3,281k, with the Cath labs accounting for the majority of the spend. Backlog maintenance schemes have also commenced.

Comments and questions were welcomed and an update sought on whether there was an updated year end forecast for the private patients income and how this plan is progressing. Specifically also a question regarding whether the forward plan relies on continued overperformance by Medicine and how this year's performance at Divisional level compares with previous years. COO confirmed that there is monthly PP oversight meeting that monitors the data. Surgery are looking at repurposing a Friday list for mitigation but work will be required with the clinical teams. This is not 100% mitigation but will create significant improvement. COO also noted that international opportunities are being considered and a potential further increase in Medicine and Intervention PP work specifically.

Clarity was sought on whether a favourable variance at year end would be kept by the Trust or the wider system. CFO noted that the current ICB approach is that if a Trust achieves a surplus position, then it will stay with the Trust.

The utilities spend was noted and query raised on whether there is a projected position and understanding of the run rate for the rest of the year. CFO stated that this is difficult to answer as LHCH rely on LUHFT for invoicing as they control the energy on the Broadgreen site. No invoices have been received yet this year, however it was noted that the budget has been increased significantly to accommodate expected pressures and is consistent with what other providers are experiencing. CFO added that if invoices are not received then this will be escalated for CEO to CEO discussion.

The coding backlog was raised and assurance sought on how the coding workforce issue is being resolved. CFO confirmed that an update was provided to the Board and temporary resources will be used to address the backlog and the team are expected to return to a normal run rate by January. COO added that recent data shows improvements and it was agreed that this data will be shared at the next meeting.

KE/JM

Junior doctor rota gaps were noted and a question raised on whether these are expected to continue to the end of the financial year. CFO confirmed that there is a slightly improved position at the recent rotation. This will be factored into the financial forecast from month 7.

Further detail was sought on what the consequences would be if the Trust exceed the cap on agency spend. CFO noted that this is not absolutely clear and added that the Trust has a unique position in respect of the agency cap. The current cap is based on 2021/22 expenditure which is significantly lower than pre COVID-19 and in addition agency in being used to deliver new psychology projects commissioned non-recurrently. Whilst these new initiatives are non-recurrent, a workforce plan is being developed to optimise the cost and service provision vs the income risk.

Further detail was requested on divisional expenditure and whether the pattern has changed since pre COVID-19. CFO confirmed that the differences and pressures are understood at divisional level and added that there are financial recovery meetings with Surgery and Clinical Services.

#### International recruitment

CFO also provided an update on the international recruitment and informed colleagues that the Trust has recruited 110 nurses through international recruitment. In addition, the Trust has held two successful local recruitment events. New nurses undergo a period where they are supernumerary. This period is longer for international recruits, and also longer in specialist areas like theatres, critical care and cath labs. This longer supernumerary period results in overspends because there is a period of double-running, where bank shifts are still required to cover roster gaps.

Workforce numbers and costs have been modelled under two scenarios, building in assumptions around the start-date of new starters, supernumerary periods, leavers, sickness rates and maternity leave. Scenario 1 assumes that the number of leavers (5 a month) and the sickness rates continue at the current levels. Scenario 2 assumes that the number of leavers reduces to 4 a month and the sickness rates improve by 1%. In conclusion, whilst there were some non-recurrent costs of supporting international recruitment it was having a significant positive impact on nursing vacancies and the cost pressure was able to be mitigated.

## **5.2 2023/24 Capital**

Dave MacMillan, Head of Capital Projects and Decontamination attended IPC to present an update the 23/24 capital planning process and noted that individual meetings are now in with each divisional and department lead. A review will be undertaken of the deferred schemes from previous years and there will be a review of the 5 year plans signed off by Board of Directors in 2021/22. All requirements will be RAG rated.

CFO provided a regional and ICB update and noted that capital planning discussions for 2023/24 have recently commenced across the ICB. There is currently no detail in terms of funding allocations but it is expected to continue to be constrained and over-subscribed position. Latest 22/23 forecasts are being compiled by the ICB, with suggestion of potential slippage in 2022/23. This could create further pressure in 2023/24 and Trusts should review opportunities to bring spend forward.

DM informed IPC colleagues of the next steps, which include; i) continued engagement through monthly meetings with divisions to refine requirements and review data quality, ii) Maintain regional engagement with ICB to align requirements with availability of capital allocation, iii) explore alternative funding opportunities, iv) hold workshops to review the capital plan early, v) explore and refine the 5-year capital plan and review opportunities to bring spend forward.

Comments and questions were welcomed and forecast deficit position within the ICB was noted and whether this would cause further pressure on the capital expenditure next year. CFO noted that the capital allocation is separate to the revenue position and a potential risk could be that capital is withheld if the revenue position is not achieved. CFO added that there has been a 3 year allocation, however this could change with the new political outlook. CFO confirmed the Trust is working to understand its key risks, the priorities and opportunities to mobilise schemes quickly.

It was noted that £3m originally outlined for surgical corridor in 2023/24 was reduced to £500k in the current workings. It was confirmed that the position is currently under review in light of emerging issues with cost and design. It was added that the work completed to date gives a safe temporary solution and that in line with the original business case an update will be provided to the Board on the next phase.

The Chair thanked DM for his presentation and taking questions.

## **5.3 HFMA Financial Management Checklist**

CFO provided an update on the HFMA financial management checklist and noted that the 2022/23 national planning round had resulted in additional funding with conditions. One of these was for providers to engage internal audit to carry out a review of the HFMA checklist – Improving NHS Financial Sustainability: Are you getting the basics right?

Each organisation is required to complete a self-assessment against all elements of the HFMA checklist. There are 72 questions / statements under eight broad headings: Business and financial planning, Budget setting, Budget reporting and monitoring, Forecasting, Cost improvement / efficiency plans, Board reporting, Financial governance framework and Culture, training and development. All questions are scored between 1 (the statement never holds true) and 5 (the statement holds true for the whole organisation or whole process all the time).

Internal Audit have been commissioned to review the self-assessment and associated evidence, with a focus on twelve particular questions which were shared with the committee.

Comments and questions were welcomed and a query raised on whether it was possible to produce a meaningful 3-5 year outline budget given the uncertainties around ICS finances. CFO noted that it has been difficult with 2 years of uncertainty related to COVID and the developing ICB approach, however it was agreed that it would be helpful to set out a financial framework, with caveats around risks, assumptions and uncertainty with future financial flows. CFO added that there are steps that can be taken by Trust to maintain financial sustainability.

Central contingency approach was noted and the score that states no further action is needed. Confirmation was sought on whether the Trust is happy to be at level 3 for this issue. CFO stated that the Trust manage financial risk well and the preference is for contingency to be managed centrally.

The approach that was taken was raised and confidence was sought that there was real challenge and self-reflection during the process. CFO confirmed that evidence was required for every statement made which provides confidence to the scores put forward.

Confirmation was sought that other Executive Directors have had input and sign off. CFO confirmed that there has been scrutiny and support for the findings from the Executive group.

Training for all staff was noted and further detail requested on how this would be picked up. CFO stated that the team would be looking to revisit a finance training plan and the department will come up with a more structured plan for the new calendar year which will be confirmed at next IPC.

A query was raised on how other Trusts are scoring in this exercise. CFO confirmed that the deputies were coordinating and sharing best practice and the Trust ranked relatively highly in comparison to other Trusts.

**KE**

#### **5.4 National Cost Collection Update**

IPC colleagues were asked to note the paper on the National cost collection circulated prior to the meeting. The Committee is asked to note the successful submission of the National Cost Collection (NCC) on 8th August 2022. The submission was on time, contained no mandatory errors and the overall cost quantum successfully reconciled with the NHSI tool and deemed as accurate.

There were no further comments or questions.

#### **5.5. Dashboard Scorecard**

COO asked IPC colleagues to note the performance dashboard circulated prior to the meeting and the areas of focus will be highlighted below. COO noted that bed occupancy was lower in September due to reduced activity due to the annual leave period.

Comments and questions were welcomed on the dashboard and it was noted that it is difficult to assimilate the volume of information and a summary narrative would be helpful. It was agreed that COO would look at a bespoke report for IPC.

**JM**

*To note the Chair of IPC and COO have met since the meeting to discuss future plans for reporting to IPC*

#### **5.6 Area of focus**

##### **5.6.1. Admin Update**

COO presented an update on admin and noted that the 4 key phases for recovery are; Leadership, Reduction in Risk, Digital Enablement and the Future Model

COO noted that there are ongoing issues with typing backlogs and there is potential for clinical risk as a result. A question was raised asking for confirmation on whether actual harm had come to any patients to date. The COO noted the incident process hasn't highlighted any concerns and the clinical team. COO noted that there was an Admin Summit held on 4th October and clinicians agreed to take immediate action with regard to urgent patients. The Business Intelligence team will analyse data from the G2 dictation system on performance and outsourcing is postponed until the end of October, pending expected improvement.

Comments and questions were welcomed and it was noted that assurance has been received that actions are being taken to remedy the typing backlog as a matter of urgency.

##### **5.6.2. Cancer Action Plan**

COO presented an update on the cancer action plan and informed colleagues that there is a diagnostic recovery trajectory in place. Waiting times for diagnostics are improving but behind trajectory which was due to be achieved by September 2022. PET scanning & reporting has significantly improved which should have a positive benefit on cancer performance for future months.

Overall 28 faster diagnosis & 62 day recovery trajectory in place with anticipated recovery in December; this is dependent on the continued improvement in diagnostic waiting times. Micromanagement of PTL's underway by the COO through weekly performance with enhanced escalation by patient level detail.

Comments and questions were welcomed and a query raised on whether there were any EBUS operators with the right expertise that could be called upon within the region. COO confirmed that the Trust is looking into a joint appointment and LUHFT are leading the recruitment.

Further detail was sought on the timescale for recovery. COO noted that faster diagnostic is down to an average of 12 days, which is where the Trust was before the performance dip. So the expected improvement in 62 day performance should be seen within December.

COO informed IPC colleagues that the Cancer Clinical Lead post requested at the last IPC meeting is going to interview. This was to be interviewed on the 15<sup>th</sup> November.

### **5.6.3 Surgery Long Waiters position**

COO presented an update on the surgery long waiters and noted that the new C&M performance delivery target is 76 weeks in March. These targets have been communicated to all CEOs and COOs and the monitoring, oversight and 'check and challenge' around these targets will sit within the weekly system wide PTL meeting.

The Surgical Division currently have 67 patients over 52 weeks against a trajectory of 65, this includes 4 patients who are P6. The main focus remains on reducing patients waiting over 78 weeks and whilst there still remains a risk due to complexity, the surgical division is currently predicting a month end position of 13 patients over 78 weeks.

The key issues is service pressure in cardiac & aortic surgery and include; late referrals, reduction in clock stops, productivity – volume (workforce & training), reduction in weekend working on waiting list initiatives in 2021 and urgent demand impacting elective capacity

A revised trajectory and monitoring commenced from September 2022. The risk to the new trajectory is urgent referral demand increasing in winter months. Micromanagement of all patients waiting over 52 weeks will also be undertaken by Divisional teams and 1:1 meeting planned with service line clinical leads to allocate TCI dates.

Comments and questions were welcomed. Given the limited capacity of appropriately skilled and experienced Surgeons for mini-mitral work, could he/they be protected from demands of PP work. COO confirmed that Private work is on direct referral and from a financial recovery point of view this work is encouraged.

## **5.7 Annual Planning**

IPC colleagues were asked to note the annual planning presentation circulated prior to the meeting.



## **6. Governance**

### **6.1 Benchmarking update**

Mike Filek, Head of Improvement and Transformation attended IPC to provide an update on benchmarking and informed colleagues that there is a benchmarking strategy and framework in place to identify variation and develop improvement plans where variation is unwarranted

Model Hospital identifies two key opportunities of £4.4m from 2020/21 data and Improvement activities are expected to improve LHCH's performance in priority areas when updates published for 2021/22. The benchmarking identifies cost variation and further contract / SLA potential opportunities have been identified for future years' CIP

There are 8 high level Opportunities highlighted, analysed in the slides across several departments. Opportunity "high" refers generally to comparison to the Lowest Cost Quartile for either Specialist Trusts, or All providers nationally. There is focus on areas for potential cost improvement but there are many metrics where LHCH performance is better than benchmarks.

Comments and questions were welcomed and it was noted that this was valuable information and a query was raised on how the Trust balance opportunity for cost reduction versus need to maintain quality. It was noted that this exercise is about maintaining outstanding status and quality is at the forefront of this approach. CFO added that it is used as an indicator and all the head of department have access to this data to investigate opportunities.

Questions were raised as to how LHCH ensures status changes from surveillance to action on opportunities in line with the framework. MF and CFO noted the new governance approach being developed which would be shared at a future meeting.

The Chair thanked MF for the presentation and taking questions.

### **6.2 BAF review**

IPC colleagues were asked to note the BAF and no changes were proposed following review.

### **6.3 IPC Work Plan Review**

IPC colleagues were asked to note the IPC workplan and this was approved by the committee.

### **6.4 Finance and Performance Group Approved minutes & Issues for escalation for the IPC**

IPC colleagues were asked to note the Finance & Performance Group minutes and there were no further comments or questions.

## **7. Evaluation of Meeting**

All committee members confirmed that the meeting had been conducted effectively and useful documentation had been received and useful discussions had taken place.

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The Chair confirmed that the agenda for the next meeting should start with Performance to ensure sufficient focus and scrutiny. Additionally, indicative times would be included in the agenda to help those attending to present papers and plan their inputs.

**8. Date and Time of Next Meeting:**

Monday 27<sup>th</sup> February 2022, 09.30am – 11.30am, Microsoft Teams