

Integrated Performance Committee

minutes

Minutes of the Integrated Performance Committee Meeting Monday 27th February 2023

Present:	Louise Robson Bob Burgoyne Margaret Carney	Non-Executive Director (Chair) Non-Executive Director Non-Executive Director
In Attendance:	Karen Edge Jonathan Mathews James Bradley Lucy Currie Ellis Hayes Jennifer Ohlsson	Chief Finance Officer Chief Operating Officer Deputy Chief Finance Officer Divisional Director of Operations, Surgery Divisional Director of Operations, Medicine Senior Executive Assistant (Minutes)
Apologies for Absence:		

1. Apologies for Absence

Apologies and attendance noted above. Chair thanked colleagues for attending early for this meeting, to provide the opportunity to deep dive into the performance issues.

It was noted that Margaret Carney will need to leave the meeting 30 minutes early to lead a council of governors sessions

2. Declarations of Interest

None declared.

3. Minutes of meeting held on 24th October 2023.

Minutes from the meeting of 24th October 2023 were noted and approved.

4. Action Log

Actions

Action 1: COO provided an update on the coding backlog. This is still an issue for the December position but an improvement had been made in January and expected to be back on track for February.

Action 2: CFO updated that the finance training plan is being updated. Finance training has been added to the aspiring leaders programme. In addition there will be a relaunch of the 'Show me the money' training. New and improved training to be launched Trust wide.

Action 3: Chair of IPC and COO have met since the previous meeting to discuss future plans for reporting to IPC. This is on the agenda for discussion at the BoD strategy day.

Action 4: Agenda to start with Performance. Action complete

Performance Update

5.1 Performance Report

COO presented a performance update to IPC colleagues and informed colleagues that the clinical coding team and recovered the un-coded backlog as of February 2023. The team improved their coding numbers in January and are now in a position to hit the working day 3 deadline in March.

COO noted in terms of risk; Waiting list and RTT is amber, OPA is green, Activity and utilisation is green, DM01 diagnostics is green and Cancer performance is amber and cancelled operations and admin is amber.

COO noted that the Trust has been able to sustainably achieve the 104 week position. 78 weeks is the area of concern. 52 weeks has plateaued slightly over the year. 18 weeks and 26 weeks have veered off trajectory and this will be looked at going into next year and what the performance improvements are.

The Trust has sustained a good P2 performance across the year, until December and January, where there have been spikes. This is linked to urgent demand and industrial action.

Outpatient and inpatient activity. In terms of total outpatient numbers the Trust are on track and in terms of virtual the Trust is above the 25% regional and national trajectory. There is still some work to be done with PIFU, however improvements have been noted. The Trust are on track to achieve elective trajectories.

A complaint position was maintained in December for cancer performance.

Cancelled operations are not in line with targets. A cancelled ops working good has been developed and there are continued actions to improve performance.

Comments and questions were welcomed and a query raised on how the Trust fares comparatively to Performance across Cheshire and Merseyside and the North West. COO confirmed that in terms of long waiters there is a directive that all patients should be dated by the end of

March. COO agreed to circulate the regional performance cancer dashboard to colleagues.

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5.2 Activity and Industrial Action

COO provided an update on industrial action and highlight the strike impact. The largest being the Unison strike on 21st December, resulting in 30 INP and 88 OPA cancellations.

COO highlighted the strike impact on elective recovery and noted the inability to run Elective services, however the non-elective activity will be maintained. It was also noted that as there is block income for NHS England, income will still be received, however there will be an impact on Private Patients, Welsh and IoM income. OPA moved to virtual, but some activity unable to run.

COO updated that no derogations have been agreed for cancer, so inability to continue cancer pathways. This will result in bottle necks further extended in EBUS, CT guided biopsy and Thoracic Surgery. There has been a loss of one Diagnostic list and thoracic lists will be based on clinical need. There will also be mutual aid support in place for LUFT.

RTT validation & pathway management will be impacted based on admin team availability. 78 week target will be at significant risk with current capacity constraints, surgeon numbers in sub specialisation, urgent demand, late referrals, POCCU beds and patient complexity. All patients are currently dated, however 7 lists lost with the past industrial action dates. ACHD & ICC backlogs further impacted with staff availability

Risks, issues and mitigations include; Additional lists requested for Cancer Diagnostics & Surgical activity. Urgent capacity for Surgical demand flexed based on clinical need, Inability to catch up with demand, Staff willingness to do additional sessions bring low, POCCU staffing and perception from staff in days leading to Strike days has been a significant factor, Any industrial action day, impacts activity pre and post and access team issues also creating delays in front end of pathways

Comments and questions were welcomed and it was recognise that this is an unprecedented situation.

Further detail was sought on the balance between maintaining a safe site and maintaining the safety of the patients. COO confirmed that there is a gold, silver and bronze command structure and balance between the strategic, operation and tactical command. There is open discussions between the divisions and clinically led and appropriate governance structures in place.

The upcoming Junior Doctor strikes were raised and a query raised on what impact this will have. COO confirmed that the Junior Doctor strikes were announced on Friday and the Trust are planning a similar approach. It was noted that the biggest issue will be around on-call provision. It was noted that clinicians are attending strike discussions and there is positive engagement from the clinical teams.

Confirmed was sought on whether the discussions at Gold, Silver and Bronze command are recorded and auditable. COO confirmed that actions and decisions are recorded at these meetings.

5.3 Long Waiters

COO provided an update on long waiters and noted that all patients over 78 weeks by end March 2023 have had TCI dates planned within the date requirements. This has been impacted significantly by; Industrial Action, Anaesthetist sickness for specialist procedure and Anaesthetist unavailability.

The impact of the RCN Industrial Action on 1-2nd March is still being worked through and therefore there are subsequent risks of further breaches due to this.

Comments and questions were welcomed and concern was raised on what would happen down the line if the strikes are not resolved.

COO confirmed that the best case scenarios are planned for and recovery plans are always based around confirmed elements, such as strike dates. It was added that actions would not chance specifically in the worst case. COO added that the focus going into next year will be making sure average wait times slowly come down.

A query was raised on the mini mitral longest waiting list and whether this was the same for 52 week waits and further clarity sought on the patients over 52 weeks having mini-mitral or open surgery. COO confirmed that this is a clinically led process

5.4 Cancer

COO provided an update on a cancer performance and noted that there is a compliant position for 62 day and 62 day upgrade in December in line with trajectory. January performance significantly impacted by delays in Surgery due to Industrial Action in December and January and this is expected to continue through Q4. Diagnostic waiting times are being monitored and actions taken to reduce waiting times to support the recovery of the cancer position. Expected recovery of 62 day standards to take place in Q1 23/24 (Industrial Action dependent) with compliant position forecast for Q2 23/24

Average waiting time for EBUS approx. 16 days across the month.

Current there is an average wait time of 13 days for CT guided biopsy. Mutual aid with LUHFT and industrial action are impacting on waiting times. There is additional weekend working in place to reduce waiting times.

There is a trajectory in place to recover the Faster Diagnosis Standard during 23/24 to 75% by March 2024.

Comments and questions were welcomed and confirmation was sought on whether the Trust will be compliant in Q1. COO confirmed that

this will be a recovery trajectory and the action plan is being reviewed and updated.

5.5 Administration

COO provided an administration update and noted surgery letter management has seen an improvement in letters typed within 7 days. Pressure remains in those over 7 days (Cardiac & ACHD Surgery). Sickness has significantly impacted performance – 2 members of staff Long Term Sickness absence. Fixed term post commenced in January to support reducing backlog – typing over 7 days has reduced since start of Jan

Medicine letter management has seen a sustained improvement in letter sign off backlog but further clinical engagement required. Recruitment into 3WTE fixed terms completed. Increased administration burden to manage IA. Requirement for PAs to book clinics. Increased levels of sickness and leave in November and December.

Comments and questions were welcomed and a query was raised on whether there was 'naming and shaming' mandated by the Medical Director on the signing of the letters. COO confirmed that there is engagement with the medical team and the MD meets with the team regularly.

Further detail was sought on whether there has been a transformation approach to the processes, so that letter can be done during clinic and reduce the clinic to type time. COO confirmed that data from G2 has not been forthcoming and the data is not useful, but there is hope that this data will be improved with the implementation of EPRO. COO added that a lot of process mapping has gone into refining the processes.

COO also provided an update on the 72-hour review undertaken 25/01/23 following four incidents reported via Datix relating to referral management processes within the access team.

Actions were agreed on the 3rd February 2023 following the 72 hour review. Progress is being made in terms of the immediate actions with the mortality review resulting in the need for an RCA, and the waiting list review/validation progressing. The end to end mapping identifies a number of risks/gaps in systems which need to be mitigated. A summit needs to be held to bring a group together to agree the actions, responsibilities and timeframes, and these need to be prioritised.

Comments and questions and clarity was given that this will come under the remit of the Quality and Safety sub Committee in terms of patient safety and the remit of IPC for the issues around the processes.

Clarity was sought on whether the Trust would always investigate if a patient died whilst on the waiting list. COO confirmed that the death on the waiting list process is embedded and the pathways are reviewed.

Further detail was sought on the timeframe on the process work. COO confirmed that there was a meeting with the Admin team and the Patient

Pathway Assurance Group and added that the Exec team will review the end to end process on 15th March 2023.

Annual Planning

6.1 Operational Planning

COO asks IPC colleagues to note the annual planning updated circulated prior to the meeting and provided an overview of the 2023/2024 priorities and operational planning guidance.

The key objectives for 2023/24 are; to recover core services and productivity, Improve ambulance response and A&E waiting times, Reduce elective long waits and cancer backlogs, and improve performance against the core diagnostic standard, Make it easier for people to access primary care services, particularly general practice, Make progress in delivering the key ambitions in the Long Term Plan (LTP) and continue transforming the NHS for the future.

Key Objectives for LHCH to consider are ; Elective care, Cancer, Diagnostics, Use of Resource, Workforce and Elective Care.

The next steps include; refining activity submission against the regional targets, review cost pressures and investments based on quality, performance and finance, refining performance trajectories for weekly monitoring and delivery and CIP divisional review.

Comments and questions were welcomed and the alternative scenarios were noted and would there need to be greater understanding of these. COO confirmed that the approach is based on the forecast outturn and CFO added that C&M and other ICBs are challenged in terms of the financial position and Trust have been advised to plan for business as usual and risk is not built into the plans.

A query raised on whether the clinicians are engaged and committed. It was confirmed that that activity plan for Medicine includes a review of what has been achieved this year and the plan that has been put forward is the outcome of the conversations with the Clinical Leads and Medical Director.

6.2 Financial Planning

CFO presented an overview of the financial planning and noted the Trust starts the annual planning process with a balanced underlying budget. This is overlaid with estimates based on the latest planning guidance relating to inflation, and financial information received from commissioners relating to income contract adjustments. In addition, there are non-recurrent commitments that the Trust has made partway through the year that will impact on next years finances. Each Division has put forward a list of cost pressures which will be subject to Executive review prior to approval. In addition to the cost pressures identified by the Divisions, there are overarching risks that have been quantified based on current trends and intelligence. The minimum CIP for any provider in the Cheshire and Merseyside ICS is 3.7%. The Divisions have been tasked with delivering 3% CIP, with the remaining 0.7% coming from interest earned on cash balances. The Elective Recovery Funding regime has been applied to the draft activity plans to estimate

the additional income over and above the base contracts. Applying these assumptions delivers a modest deficit which can be managed through non-recurrent resources or additional elective activity from non-English commissioners. This leaves little room for any unfunded investments.

The national planning guidance outlined the inflation assumptions to be applied in the planning process. The pay inflation is subject to change dependent on the outcome of the national pay review, and any increase will be funded. The Trust has received notification of the CNST costs for next year, a 9% increase equating to £102k. This has been factored in to the financial plans instead of the amount indicated in the national planning guidance.

The national planning guidance funds energy inflation at 5.5%. However, the costs in 2022/23 have been far higher than funded levels and government support for energy costs will be less next year. An estimate has been made for energy costs over and above the funded levels (5.5% of the existing budget would be only £110k).

As above non-pay inflation has been assessed at 5.5%, the Trust continues to receive renewals requests and price inflation in excess of this value. An additional £250k has been added to the risks schedule for this risk.

Pressure in the drugs budget has been seen in 2022/23 with the move to a licensed drug at the moment paused, however, likely to be reintroduced and drugs cost increases in other areas of the Hospital.

Addressing the challenges in patient admin has required additional funding in 2022/23 and is likely to continue in the short term with the longer term solution potentially requiring further investment.

There have been cost pressures in a number of services provided through the LUFT SLA which are under review/negotiations with LUFT taking a harder line on SLA management.

The Trust is undertaking a 5-year valuation of the estate which will likely increase the value of the assets, driving up capital charges.

CFO also noted potential further risks not as yet recognised in the 2023/24 financial plan. Contract risks are likely to materialise or resolve over next 2-3 weeks. There is a small non-recurrent risk reserve to manage non-recurrent issues.

Next steps include; continued contract negotiations with ICB and NHSE, commence and agree Wales contract, review cost pressures and agree unavoidable, develop more certainty on I&E position prior to consideration of investments and a final submission on 27th March and an update to Board of Directors 29th March

Comments and questions were welcomed and it was noted that it is a comprehensive position. Potential worst case scenarios were noted and the extent of the risks and an understanding of what the Trusts position would be if the risk materialise significantly was requested. CFO

confirmed that the risks are RAG rated medium and low and added that while industrial action impacts elective activity, it does not destabilise the finances to a large degree. It was agreed that COO and CFO will look at some scenarios and what the mitigations would be.

6.3 Capital Planning

IPC colleagues were asked to note the capital planning paper circulated prior the meeting and note the capital plan for 2023/2024, the risks and the next steps.

The Trust has a capital plan that is within the confirmed allocation from the ICB. There are risks of overspend, particularly relating to the Cath lab project that is being actively managed.

The Trust is working with ICB colleagues to maximise the capital allocation available for the Trust, and mitigate risks.

The Trust continues to have strong cash balances and internal resources are available to fund the capital programme.

Comments and questions were welcomed and CFO added that there is a robust risk assessment of all the capital schemes put forward and anything with a risk of 12 and above is included in the programme. In terms of contingency a multidisciplinary meeting will be convened to understand the risk of delaying any of the schemes.

Financial/Performance Reporting

7.1 Financial Strategy

CFO provided an overview of the Financial Strategy and asked IPC colleagues to note the paper circulated prior to the meeting.

The Trust overarching Financial Strategy is to Increase Value and this will be achieved through the pursuit of; delivering Financial Sustainability, Optimising our use of resources and Maximising alternative Income streams

In addition, the Trust has a Capital Investment programme and a Cash resourcing plan that enables the Financial Strategy and underpins the Patients, Partnerships & Populations Strategy.

The financial strategy is presented as a framework for the next three years. The Integrated Performance Committee will oversee its delivery through regular monitoring and evaluation arrangements and will provide assurance to the Board on progress.

The detailed objectives that support the delivery of the financial strategy will be set out in the Finance business plan which will be refreshed annually.

The financial strategy is relevant to every member of staff at LHCH, led by the Trust Board and facilitated by the Finance function.

Comments and questions were welcomed and it was noted that the strategy is easy to read and there is agreement with the assumption and

impact. Further detail was sought on the external impact and CFO confirmed that Isle of Mann is a potential opportunity which may lead to increased income flow. In terms of C&M this would be linked with the development of the C&M financial strategy, however it is thought there will be engagement with organisations regarding this.

Strategic objective 3, alternative income streams was raised and a query raised on whether there is any sense of what level of income could be achieved from each of the suggested alternative income streams. CFO noted that the opportunities vary by division and added that there is an expectation that 50% of next years CIP will come from increase in income and there are a number of opportunities.

A further query was raised on whether education income has been considered and CFO confirmed that this is a smaller scale than other opportunities and education has failed to meet income targets over the past few years.

7.2 M10 Finance report including CIP

IPC colleagues were asked to note the month 10 finance report circulated prior to the meeting and Chair noted that this paper would have recently been reviewed at Board of Directors. CFO noted that the position is where the Trust expected to be.

7.3 Recovery Plan Update

Lucy Currie, Divisional Director of Operations for Surgery attended IPC to provide a recovery plan update. Colleagues were asked to note the paper circulated prior to the meeting and an overview was provided.

The Surgical Division have delivered against the recovery plan proposed in Q3 22/23. Due to a new pressure within Theatres non-pay, the division are seeking to continue to overperform to offset this new risk, whilst also taking actions to reduce future expenditure in this area. Due to the Q1-2 overspend position and contributing factors that will not fully resolve in year, it is not felt achievable to reverse the overspend year to date to deliver a balanced position at year end, however, the division will continue to seek opportunities to safely reduce expenditure and increase income throughout the remainder of Q4. The revised forecast for 22/23 is £480k, an improvement of £1,294k from the month 7 forecast run rate.

The continued delivery against this recovery plan will be reported monthly to the Finance and Performance Group and will be monitored at the Surgery Divisional Board to ensure progress continues to be made to improve the financial position of the division.

Comments and questions were welcomed and a query raised on why the TLHC position is different from the commissioner position. Initially specialised commissioning confirmed that they would fund all activity within lung cancer HRG that had over performed, however subsequent to that, they have taken one of the HRG out of the cohort of patients.

Governance

8.1 IPC Work Plan Review

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

8.2 Review Terms of Reference

IPC colleagues were asked to note the IPC Terms of Reference and this was approved by the committee.

Chair suggested that the system impact should be added to the terms of reference and it was agreed that CFO will make changes and circulate.

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8.3 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.

9. 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.

Chair provided a summary of the risks discussed today:

Performance

- long waiters – exacerbated by IA
- Mini-mitral and ACHD
- Cancellations and delays in rebooking exacerbated by IA
- Anaesthetic capacity
- Assurance today that clinicians are strongly engaged in recovery of long waiters
- Q1 perspective – expecting to deliver cancer
- EBUS and CT biopsy
- Deep dive into admin issues
- Received a lot of info on waiting list processes

Finance

- Financial planning going forward
- Key issues around level of investment in the future
- Risk around CIP
- Risk around energy
- Contractual issues – LUHFT
- Capital – understand prioritisation
- Financial strategy – assurance on the outcome
- Good update on the financial recovery in Surgery - see control and recovery into next year.

CFO requested that IPC colleagues approve the submission of a breakeven position and this was agreed by IPC colleagues.

8. Date and Time of Next Meeting:

Thursday 20th April 2023, 09.30am – 11.30am, MS Teams

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