

## Integrated Performance Committee

## minutes

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

<b>Present:</b>	Karen O'Hagan Margaret Carney Bob Burgoyne	Non-Executive Director (Chair) Non-Executive Director Non-Executive Director
<b>In Attendance:</b>	Karen Edge Jonathan Mathews James Bradley Jennifer Ohlsson	Chief Finance Officer Deputy Chief Operating Officer Deputy Chief Finance Officer Senior Executive Assistant (Minutes)
<b>Apologies for Absence:</b>		

#### 1. Apologies for Absence

No apologies noted

#### 2. Declarations of Interest

None declared.

#### 3. Minutes of meeting held on 25<sup>th</sup> October 2021

Minutes from the meeting of 25<sup>th</sup> October were noted and approved.

#### 4. Action Log

**Action 1:** CFO provided an update on the NCC submission and confirmed that the reports had gone out to the divisions. No queries were raised. It was noted that it was an exceptional year and the focus is on looking forward in terms of how to get the most it terms of productivity and efficiency. Action closed

**Action 2:** Further narrative on the key point areas on the performance report to be covered in the performance update. Action closed

**Action 3:** Trust benchmarking position to be covered in the performance update. Action closed

## **5. Financial / Performance Reporting**

### **5.1 Finance Reporting including CIP**

CFO provided an overview of the finance report and noted the financial performance for the period ending 31<sup>st</sup> December 2021 is a £321k surplus.

The financial plan for the second half of the year has now been finalised. The Trust plans to deliver a breakeven position. This is reliant on non-recurrent funding, including the Elective Recovery Fund (ERF), Targeted Investment Fund and Integrated Care System (ICS) funding allocations. The plan is profiled flat, with a breakeven position planned for each month until the end of the year.

The income position now reflects additional system top up funding and Targeted Investment Funding which has been agreed with the ICS.

ERF income of £40k has been assumed in the December position which has been confirmed by the ICS relating to October and November. Although the Trust's performance against the RTT baseline has been good in quarter 3, income is dependent on the wider performance across Cheshire & Merseyside which remains challenging. Work is still ongoing by the ICS to understand the overall impact of the reduced amount of ERF funding received.

The Isle of Man and Private Patients income remains on a cost per case arrangement. The total variance is £423k above plan in the year-to-date position, with the in-month performance being £237k above plan.

Research & Development and Education & Training income is £332k and £95k respectively below the year-to-date plan.

Expenditure is below plan, with the year-to-date position being a £259k underspend against budget. Pay costs are marginally lower than budget. An overspend in utilities costs are more than offset by lower drugs and clinical supplies costs.

Unachieved CIP resulted in a £1,370k budgetary pressure year to date. This is currently offset by the risk reserve. Work continues to identify further recurrent schemes to ensure financial sustainability going forward.

Elective, including day case activity is compared to the 2019/20 activity levels, with a strong focus on restoring activity to pre-Covid levels. The Trust delivered elective activity that was 92% of 2019/20 activity in December and 94% of 19/20 levels in the year to date.

Capital expenditure was £7,617k against a plan of £9,121k, with much of the variance caused by revisions to the phasing of certain capital projects.

The Trust is forecasting to achieve a breakeven position in H2 and for the year. The expenditure trends remain stable, and there are no significant income risks predicted for the last quarter. Consistent with the principles of operating within the ICS, any surplus generated by the Trust will be returned to the System through adjustment of the non-recurrent ICS allocations to support those organisations with unmitigated financial pressures.

DCFO also provided an update on CIP and noted that CIP is moving in the right direction and there are a number of forums to identify further schemes. DCFO also noted that there is now a C&M CIP group and the focus is sharing of ideas across Trusts.

Comments and questions were welcomed and a query was raised on a realistic view on CIP by the end of year. DCFO confirmed that growth is anticipated as each of the divisions looks further into CIP, however The Trust is unlikely to close the whole gap.

Clarity was sought on the R&D income being down by £334K and CFO confirmed the R&I income has been challenged over the course of the pandemic due to the reduction in commercial trials, however added that in month the plan was achieved for R&D income. It is thought the reduction is non-recurrent.

Rowan Suite and Private Patient income was raised and CFO stated that the income was set on the system allocations. The target for this year is £2.2m. JM added that Private Patients have been housed on side rooms on Wards on a 'reduced offer' basis, due to Rowan being out of use. Patient's are aware that they may not get use of Rowan.

Clarity was sought on the removal of transactions related to donated access. CFO confirmed that the revenue consequences of equipment purchased via Charitable Funds hit the income and expenditure account, however these transactions are removed in terms of hitting financial performance.

The upgrade to the generator was raised and it was confirmed that that generator came back on, on the 9<sup>th</sup> December. It had been off since early May. CFO added that now the upgrade has taken place, there should be continued efficiency and resilience. CFO added that this is offset by the inflationary pressures in energy pricing experienced nationally. This has been factored into the H2 plans.

Clarity was sought on the impact of the CIP shortfall on the reserves and what the Trusts ability was to generate more reserves. CFO confirmed that there would be limited opportunity in the future to generate reserves in the future as there is a requirement to deliver a breakeven plan.

An update was requested on the system wide CIP. It was confirmed that the figure has not yet been confirmed and there needs to be more work done at a system level

It was queried what the overall view of the RTT performance across C&M is in view of the reduction in ERF in November and December. COO noted that this will be covered in the performance report.

## **5.2 2022/23 Capital Programme**

CFO provided an update on the 2022/22 Capital programme and noted that the planning for the Capital programme for 2022/23 has commenced and is over-subscribed against the internal envelope by c£1.5m. A range of options to bring the programme back to target have been considered and further work is ongoing in firming up costs, particularly in respect of the MRI scanner and surgical corridor works. Reducing the programme brings a number of risks which have a range of mitigating actions and a final proposal will be developed for IPC and Board of Directors to consider in March 2022.

The C&M ICS capital envelope is over-subscribed by a significant value and a prioritisation process is being developed. The impact of the process on LHCH plans is as yet unknown and an update will be brought to the next meeting.

Comments and questions were welcomed and a query was raised around the MRI scanner moving into the next year and whether this was wise considering the issues experienced with the scanners. CFO confirmed that mitigations have been put in place with enhanced maintenance contracts to pre-empt any issues and mobile scanners to maintain activity if there were any significant issues. A query was also raised on whether any of the scanner replacements were compatible with the Charitable Funds remit and it was noted that the Charitable Funds is in a position to help. CFO confirmed that there are some items of medical equipment that have potential to come to the Charitable Funds Committee.

It was noted that the paper highlighted partial assurance and a question was asked on what the thought process was around that and would the actions noted in the paper, take it up to full assurance. CFO noted that the paper highlights partial assurance as a conclusion has not yet been made on balancing the internal programme and there is not yet certainty in terms of the ICS. CFO added that when the 2022/23 programme is signed off in March, then full assurance should be provided, however the 5 year programme will continue to be a risk that will continue to be monitored and mitigated against.

There were no further comments or questions.

## **5.3 2022/23 Annual Plan Update**

COO presented an overview of the 2022/23 operational annual plan and noted that the guidance recognises the uncertainty around Covid-19 variants, transmission patterns and consequent demand on the NHS.

It sets out a number of priorities for the NHS over 2022/23 to improve services and access, exploit digital technologies, invest in the workforce, address pressures in elective care, as well as respond to Covid-19. The objectives within the planning guidance are based on Covid-19 returning to a low level and will be kept under review as the pandemic

evolves. The establishment of statutory integrated care systems (ICSs) and integrated care boards (ICBs) will now be postponed to 1 July 2022

The guidance asks systems to accelerate work to transform and grow the workforce, building on existing people plans. It is expected that this will be achieved through improving retention; improving belonging and equality; working differently through the introduction of new roles and developing workforce to deliver care closer to home; and growing for the future through expanded international recruitment and supporting training programmes.

Some £90 million is being made available to support work to respond to Covid-19. This funding is expected to enable an increase in the number of patients referred to post-Covid services and seen within six weeks. It is also expected to decrease the number of patients waiting longer than 15 weeks to access appropriate post-Covid services. It is expected that the vaccination programme will remain a priority in 2022/23.

The guidance states that each system is required to develop an elective care recovery plan for 2022/23, to meet the ambition for systems to deliver over 10% more elective activity than before the pandemic. There is also an expectation that long waits will be reduced, including an elimination of waits over 104 weeks; a reduction of waits of over 78 weeks; and extension of three-monthly reviews to all patients waiting over 52 weeks by 1 July 2022. It is also expected that outpatient follow-ups will continue to reduce by a minimum of 25% against 2019/20 activity levels by March 2023. The guidance sets out a number of ways that this might be achieved. Patient initiated follow-up (PIFU) – expanding the uptake of PIFU to all major outpatient specialties, moving or discharging 5% of outpatient attendances to PIFU pathways by March 2023

The post-pandemic cancer recovery objectives set out in the 2021/22 H2 planning guidance must be completed as a priority. Cancer alliances are asked to work with local systems to improve performance against all cancer standards, with a number of specific areas of focus. Maximising the uptake of targeted lung health checks (TLHC) and the effective delivery of follow-up low dose CT scans, to meet trajectories agreed with the national team.

The guidance states that systems should increase diagnostic activity to 120% of pre-pandemic levels to support elective recovery and early cancer diagnosis. It is expected that capacity will expand further in 2023/24 and 2024/25. This ambition is supported by three-year capital allocations, planned investment through Health Education England to facilitate training and workforce, and dedicated revenue funding to support the set up and running of community diagnostic centres (CDCs).

The guidance states that up to £200 million will be available in 2022/23 and up to £250 million in 2023/24 to support the development of virtual wards. Systems are asked to develop detailed plans to maximise the rollout of this approach to deliver care for patients who would otherwise have had to be treated in hospital. Plans should cover two years and should be developed across systems and provider collaboratives, rather than individual institutions. During 2022/23 all urgent community

response services should be achieving at least 70% two-hour response times

In line with the NHS long term plan, acute, community, mental health, and ambulance providers are expected to reach a core level of digitisation by March 2025. Systems should develop plans by March 2022 to set out the first year's priorities to meet this ambition. Capital will be available to systems for three years from 2022/23 to support these plans. In 2022/23, £250 million will be allocated and directed towards those services and settings which are the least digitally mature. Funding will be provided to establish dedicated teams to support the development and delivery of costed three-year digital investment plans, which should be finalised by June 2022.

CFO also presented an overview of the finance annual plan and noted that there is a break even requirement with a single system plan submission, consistent with aggregate Trust submissions.

Revenue system allocations will comprise of system funding envelopes adjusted for backpay, SDF and net growth. There will be convergence adjustments for those systems not at target allocation (C&M)

Clinical networks will be funded through top-slice of allocations. COVID 19 system allocation will continue but reduced from H2. Non-NHS income support will be withdrawn

NHSE commissioning continues on a regional host basis into 2022/23 + joint working with ICBs. Payment arrangements to be 'reset' as per API. NHSEI centrally held investment for national priorities. HCD will continue with some in block (threshold) and some on pass through. Devices will be managed nationally with any savings paid back to systems via gain share

Contracts are to be reintroduced and signed by CCG's in April and then transferred to ICBs. There will be business rule changes to CCG mandated contingency, historical deficits and a reform of the cash regime. There will be a transition back to local agreement of contracts under Tariff Payment System simplified rules. An Aligned Payment & Incentive (API) approach will be in place. A variable element covers Best Practice Tariffs, Advice & Guidance and CQUIN schemes. By default 2022/23 contract values should fund 2019/20 activity levels (aim is to unwind COVID impact on activity). It was noted that there will be no formal dispute process and an expectations on systems to resolve.

CFO also noted that the NI increase will be funded, Pension increase will continue to be funded centrally, Revenue/capital support for CDC's will be made available and revenue support for national capital programmes.

It terms of capital the central allocations include; operational capital of c£4.0bn, national allocation funds of £1.1bn and other national capital investment of £2.7bn. The operational capital regime for 2022.23 will broadly remain the same as it did in 2021/22 and as in previous years, the overspends against 2022/23 envelopes will be deducted from the 2023/24 capital envelopes.

COO asked IPC colleagues to note the operational plan timeline and noted all elements in the planning guidance are reviewed.

It was agreed that the annual planning slides will be circulated to IPC colleagues

Comments and questions were welcomed, and it was noted that the update was comprehensive and the team are managing the risk and guidance.

## **5.4 Q3 Performance Report**

### **5.4.1. Strategy report**

COO provided an update the Trust performance for the period ending 31<sup>st</sup> December 2021 and noted that the Trust is operating in an environment that is focused on safely restoring high levels of elective activity to treat the backlog of patients as an output of the COVID-19 pandemic.

Referral to treatment waiting times remain below target as expected due to the significant backlog accumulated during the surge. Performance in month stands at 81.5% for English commissioned activity and 77.0% for Welsh commissioners, a slightly declined position compared to the previous month. This performance is in line with the Trust recovery trajectories.

There were 62 patients waiting longer than 52 weeks at the end of December, an increased position compared to previous months. Q3 challenges have been seen in relation to Anaesthetic support, theatre workforce and increased urgent demand. In Q4 we have seen an increase in staff sickness and Urgent pressures that may impact on performance against the recovery trajectory

28-day faster diagnosis standard performance in month stood at 75%, which was a significant achievement given staffing challenges. Continued work is being undertaken to review EBUS and CT Guided Biopsy capacity for compliance in Q4.

Bed Occupancy was below 80% in December at 75% but is expected above the target threshold through Q4. Mutual aid is being reviewed to support the system with G&A bed capacity.

OPA DNA Rates in Q3 have increased with a review being undertaken for Medicine for Q4 improvements.

Cath lab utilisation has reduced over Q3 with the change in logic of the report; to now exclude out of hours utilisation. A focus is being put on scheduling for Q4.

Sickness increased to 6.6% in month, 0.8% higher compared to the same period last year. The teams are focused on clear and early

intervention to avoid long term sickness where appropriate.

Safely restoring maximum levels of elective activity amongst COVID system support remains the focus for the operational teams, delivering against the ambitious recovery trajectories which the Board will be updated on monthly. The IPC should be aware that services continue to face high levels of non-elective demand as well as increased sickness that is causing disruption to the elective programme particularly in surgery.

Strong performance should be noted across the cancer indicators and the diagnostic 6 week target achievement.

#### **5.4.2. Target performance report**

IPC colleagues were asked to note target performance report circulated prior to the meeting as item 5.4.2 and noted that performance is not achieving the national standard, however comparative to the C&M position there is a very good achievement. COO also noted that LHCH are considered the exemplar for cancer performance

#### **5.5 Covid Recovery & Performance against phase 3 recovery trajectories**

COO presented an update on covid recovery and performance and asked IPC colleagues to note the H2 priorities and targets. COO noted that activity hit 93% in December with the key pressure points being bed capacity, urgent non elective demand staffing additional capacity. It terms of 52 and 104 week planning December was off trajectory and this was due to impacted urgent demand and omicron impacting staffing. There are also LAAO, EP and Aortic Surgery main sub speciality pressures. The 18 week trajectory performance has been maintained and it was noted that the non-admitted validation has been impacted by sickness and redeployment of resources to COVID support.

Comments and questions were welcomed and it was queried whether the mutual aid would impact the p2 performance and COO confirmed mutual aid capacity should not significantly impact urgent demand

The outpatient cancellations by provider was raised and it was agreed that COO would be looking into this further.

JM

The total number's on the waiting lists was raised and it was requested to see complete data, including removals and additions to provide an overview of the whole position. COO agreed to align the weekly performance reports with the Board reports.

#### **5.6 Outpatients transformation update**

COO asks colleagues to note the outpatients transformation update including the H2 guidance and the 22/23 guidance and risks.

JM



It was agreed that the outpatients update could be incorporated into the regular performance reports for regular update.

## **6. Governance**

### **6.1 IPC Work Plan Review**

IPC colleagues were asked to note the IPC work plan and there were no further comments or questions.

### **6.2 Annual Report Prior to submission to Audit Committee**

IPC colleagues were asked to note the annual report prior to submission and MC requested attendance be amended to reflect only being in post for one previous meeting.

### **6.3 Review of Terms of Reference**

IPC colleagues were asked to note the Terms of Reference and there were no further comments or questions.

### **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 feedback was noted that the Finance & Performance Group is a well-managed meeting with very good minutes.

### **6.5 BAF Risk Report**

IPC colleagues were asked to note the BAF risk report and it was noted that recovery remains the biggest concern. CFO added that this was an addition to the agenda, that will hopefully be a positive move forward.

## **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.

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

Monday 25<sup>th</sup> April 2022, 09.30am – 11.30am, Microsoft Teams