

Integrated Performance Committee

minutes

Minutes of the Integrated Performance Committee Meeting Tuesday 15th August 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 Jennifer Ohlsson	Chief Finance Officer Chief Operation Office Deputy Chief Finance Officer Senior Executive Assistant (Minutes)
Apologies for Absence:		

1. Apologies for Absence

Apologies and attendance noted above.

Actions

2. Declarations of Interest

None declared.

3. Minutes of meeting held on 19th June 2023.

Minutes from the meeting of 19th June 2023 were noted and approved as a true record of the meeting.

4. Action Log

Action 1: Patient level costings to be picked up at October 2023 meeting.

Action 2: Additional meeting scheduled. Action closed.

Action 3: Model hospital update to be brought back to the October 2023 meeting. Action closed.

5. New SOF

Integrated Performance Committee colleagues were asked to note the new SOF circulated prior to the meeting and COO provided an overview.

Comments and questions were welcomed and the 6 data point to show statistical variation was raised and a query raised on whether it will be compared to the previous year or on a rolling 6-month data point. COO confirmed this report has started with the previous year and it will include continuous data points. COO added that for Board of Directors there can be a change in which of the 6 data points to drive and the data points specific to Integrated Performance Committee can also be driven. COO also confirmed that there will be a rolling data set.

Concern was raised with the fact that the methodology is retrospective and what does this tell us about forecasting and how do we bring those two things together.

A similar point was also raised, for example, take the overall size of the waiting list and there being a big jump and some description of the impact. There would be interest in seeing a description and comment on where this is going next and whether it would be coming down. COO noted that Board reporting will always be retrospective and added that in terms of the methodology and visual point, unsure whether it can be done in an automated fashion.

Chair noted that it is difficult to anchor where the Trust is this year and added that there is a need for a trajectory, even if the plans to deliver it change. It is felt like the Trust is still looking back at what has happened. COO noted that at the moment, with the instability it is very hard to challenge the divisions and that trajectories go out of date quickly. NED colleagues agreed that it would be good to know what is likely and unlikely in the narrative.

The number of metrics were noted, and a comment made on how IPC would need to think about how this is reviewed as a committee and how the relevant risks to patients are monitored.

CFO noted the finance metrics and the SOF and stated that it is difficult to derive indicators in the way that makes data count for finance. There is a danger of creating duplication. CFO requested feedback and asked colleagues if significantly more finance metrics are needed. NEDs agreed that they are comfortable with the finance report as the primary document and would not want to compromise this.

Summary of SOF review

- Continue to rely on the methodology around making data count. That will inform the drive and the watch metrics based on real data.
- Interested in what's coming up and what the projected issues will be given the level of uncertainty.
- Include actions and important to see who's doing what, who's accountable and what the time frames are.

- Trajectory and not completely taking our eye off the ball around where the trust needs to be.
- Be realistic and transparent.

Questions around the SOF

- Chair asked IPC colleagues if they were comfortable with the metrics. NEDs confirmed.
- Drill down where needed. How would this be done in practice?

CFO noted that the SOF gives the points for escalation and then actions can be seen from the management response and the impact of those actions.

It was suggested that there needs to be commentary narrative on the difficult and worrying areas as the committee needs to be aware of where things are going in the next few months.

It was agreed that the committee are relatively comfortable with this as a process. CFO and COO will identify the risks from their perspective and the NEDs will challenge and support. It was noted that it would be good to understand the thought process of what represents a risk. It was agreed that the SOF and the data, and some narrative has a good read across to the BAF.

6. Performance Report

6.1 Cancer Update

COO highlighted a recent issue and informed colleagues that recently sadly an ODP suffered cardiac event on site. This resulted in staff being sent home on the day and theatre activity cancelled on that date. From a wellbeing point of view staff have been asked to reach out to wellbeing teams. COO noted that there will also be the funeral to consider, which will have an impact on activity.

COO provided a cancer update to colleagues and noted that apart from 2ww the cancer standards have been non-compliant in Q1. There is a cancer action plan in place that reports through Trust Cancer Board. RCAs are completed for all 31 day and 62 day breaches and trends reviewed. The number of patients managed through the service has increased since 19/20, impacted by the Targeted Lung Health Check.

Proposed new cancer standards include; Maximum 28-day wait to communication of definitive cancer/not cancer diagnosis for patients. Maximum two month (62-day) wait to first treatment from urgent GP referral and NHS cancer screening. Maximum one month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.

COO provided an update on outpatients and noted that changes include thoracic clinics on each weekday to support availability throughout the week and to support the neoadjuvant pathway patients. Also some clinics will be moved away from Monday's to minimise the impact of Bank Holidays

The plan is to monitor capacity and demand and look to flex clinics at times of increased demand. There is potential for increased weekly capacity. This has the potential to benefit 31 day and 62 day cancer standards by reducing outpatient waiting time for thoracic clinics

RALC patients receive first contact by virtual appointment in most cases by CNS. 2ww standard is consistently achieved. There are no clinic capacity issues

Waiting time for CT biopsy is currently at 14 days. There is a revised trajectory to achieve 7 day wait in August 2023. There was lost capacity in June and July due to annual leave. The team are exploring further weekend lists and recruitment to a Consultant Radiologist post to replace leaver.

Waiting time for EBUS is currently at 14 days for patients on the faster diagnosis pathway. Additional Consultant will provide further EBUS capacity to reduce waiting times to 7 days. The post is out to advert.

PET reporting times fluctuate, and the team will escalate to Nuclear Medicine to raise any concerns. No breaches in Q1 were attributable to PET delays and the team will continue to review and escalate where necessary.

LCL has faced significant challenges since laboratory move in December 2022. The current average turnaround time is 6.2 days for June with 90% of biopsies reported in 11 calendar days. An escalation process has been implemented for chasing outstanding patient results and no breaches in Q1 were solely attributable to histology delays.

There was lost theatre capacity from December 2022 to June 2023 and approximately 51 majors and 25 minors lost. A thoracic recovery plan has been implemented and July and August are above usual operating capacity. Current waiting time from waiting list to TCI is at 15 days down from 26 days in May. Hybrid lists with ¾ cases in Cardiac Surgery have been implemented.

Comments and questions were welcomed, and concern was raised that there was only one candidate to interview for the EBUS Consultant post. COO confirmed that joint appointments and SLAs have been considered, however were unsuccessful. The Cancer Alliance have been approached for other options. There is a longer-term view of training up a Nurse Consultant for EBUS.

The review of the MDT processes was noted that this would be useful from a demand and capacity point of view. COO confirmed that the Trust Cancer Lead and the Cancer Lead within Surgery, who would be leading on this.

7. Finance/Performance Reporting

7.1 Month Finance Update

CFO provided an overview on the Month 4 position and noted that this is £964k surplus, a £145k favourable variance to plan in-month). The year-to-date surplus is £3,111k which is a £164k adverse variance. The

single largest cause of the adverse variance in the year to date is the undelivered CIP.

Income is consistent with the national guidance, the Month 4 NHS commissioned income has been matched to the plan. The trust is reviewing the recently received national guidance regarding revised activity baselines in light of the industrial action. The Divisional positions reflect the over/under-performance against internal activity plans. Across all commissioners, the elective/daycase activity is broadly consistent with the plan, with over-performances in Medicine largely offsetting the surgical under-performance.

Private patients' income is slightly below planned levels in July, with a £24k under-performance. The year-to-date income is £160k above plan. Income from the Isle of Man was £10k lower than plan in July, with a year-to-date under-performance of £212k. The number of TLHC scans and health checks is higher than projected. A working group has been set up with the commissioners and Cancer Alliance to review and address the financial challenges caused by the revised prices.

Pay costs are underspent in July by £63k. Agency costs continue to reduce and nursing costs are stable. Medical staffing costs exceed budget resulting from the cover arrangements for the junior doctor industrial action. In total, pay costs are broadly in line with the budget.

The most significant non-pay pressure is caused by a shortfall on transacted CIP, £c. £1,238k in the year to date – reflected in overhead expenses. Clinical supplies costs are lower than budget, in part due to lower activity in surgery, and also a reversal of a prior year accrual enacted in month 3. Inflationary pressures in drugs has been analysed and some funding transferred from risk reserves to fund net price increases in a number of areas.

Comments and questions were welcomed and a query was raised on whether there is any update on the THLC repricing. CFO confirmed that progress has been made, however the position is not finalised. There have been positive moves in terms of the level of activity and as it is on a cost per case basis, this provides some mitigation. There has also been confirmation of fixed funding for this year, which will help with the legacy programmes that are coming to an end. The workforce model for phase 4 is also being looked at.

DCFO presented a CIP update to colleagues and note the CIP target has been set at 3% of influenceable spend. This is added to the unidentified balance brought forward from last year, giving a divisional target of £4.9m. The interest receivable has been added to CIP giving a total target of £5.9m. To date, the divisions have identified £3.7m of recurrent savings, an improvement of £0.8m since June. Only £1.4m of recurrent divisional savings has been transacted to date. Although this has increased each month, it still remains far behind the identified target.

Further confirm and challenge sessions with CFO and COO will take place, alongside month CIP progress meetings. Key lines of enquiry will be identified within each division and cross-divisional leads will be assigned. There will be focus on productivity through the theatres, cath

lab and outpatients transformation workstreams. There is also engagement with the Cheshire and Mersey CIP workstream.

Comments and questions were welcomed, and a query was raised on how much is dependent on the cross divisional schemes. CFO noted that a lower level has been transacted on the cross divisional schemes, but opportunities are seen. The structure and approach is being built around the cross divisional schemes and progress is being made. It is thought that the cross divisional schemes are the opportunities that will close the gap.

CFO provided an update on a recent C&M DoF meeting and informed colleagues that there is a significant CIP challenge across the ICB, with low levels of recurrent CIP identified and LHCH are in a favourable position in comparison to peers. CFO also added that data has been collected from each of the providers around the make up of their CIP programme and there was nothing ground breaking in the data.

7.2 Costing Submission – pre-submission report

Colleagues were asked to note the NCC submission, pre-submission report circulated prior to the meeting and colleagues are asked to review the costing plan and supporting information provided to ensure that it meets the expected requirements noted in the approved Costing Guidance.

The data collected is the source data for work by the Model Health System. Therefore, the board assurance process has been updated to reflect the importance of cost submissions and raise the profile of costing across the organisation, especially at a senior level.

The Integrated Performance Committee approved the plan in place to complete the mandated costing submissions for 2022-23.

8. Evaluation of Meeting.

Chair noted that it was important to get the SOF piece right and it will need to be iterated for each IPC meeting to check it is serving its purpose.

9. Date and Time of Next Meeting:

Monday 23rd October 9.30am – 11.30am