

Integrated Performance Committee

minutes

Minutes of the Integrated Performance Committee Meeting Tuesday 23rd October 2023

Present:	Louise Robson Margaret Carney	Non-Executive Director (Chair) Non-Executive Director
In Attendance:	Karen Edge Jonathan Mathews Jennifer Ohlsson	Chief Finance Officer Chief Operation Office Senior Executive Assistant (Minutes)
Apologies for Absence:	Bob Burgoyne James Bradley	Non-Executive Director Deputy Chief Finance Officer

1. Apologies for Absence

Apologies and attendance noted above.

Actions

2. Declarations of Interest

None declared.

3. Minutes of meeting held on 15th August 2023.

Minutes from the meeting of 15th August 2023 were noted and approved as a true record of the meeting.

4. Action Log

Action 1: Patient Level Costing and reference costs on the agenda for discussion. Action closed.

Action 2: Model Hospital and Operational benchmarking on the agenda for discussion. Action closed.

5. BAF Extract

COO provided an overview of the BAF extract paper, which provides an overview of the Board Assurance Framework in relation to finance and performance risks; BAF 2, Inability to deliver annual plan activity & performance, BAF 3, Capital programme and BAF 5, Failure to deliver financial plans.

The high-risk register includes risks that have a residual score of 15 or over. Whilst in Q1 the Trust did not identify any risks with a score of 15 or higher on the Trust's Risk Register, the Executive Team have now reviewed the risk regarding statutory waiting times and operational delivery. This risk was reduced from a residual risk score of 16 to 12 in Quarter 1 of 2023/24 but a decision has now been made to increase the risk back to a 16 due to workforce pressures. The continued uncertainty and impact of industrial action, along with theatre staffing constraints and operational challenges, including cancellations, are contributing to a heightened risk in this area. A thorough review of risk mitigations is being undertaken and this will be reflected in the high-risk report and Board Assurance Framework (BAF 2).

The Risk Management Committee continue to review all risks with a residual score of 12 or above. There are 43 risks relating to finance and performance situated across all Divisional risk registers.

All risks are reviewed monthly through the Divisions and have actions in place to manage and mitigate the risks. The agenda for integrated performance committee has aligned to the key risks concerns for Q3/Q4 with further detail provided in the deep dives. All risks are reviewed monthly through the Divisions and have actions in place to manage and mitigate the risks.

The Integrated Performance Committee were asked to review the content of the report and supporting BAF extract alongside the assurances received by the Committee.

Comments and questions were welcomed and it was noted that it was really helpful to set it in this context and it would be good to add the commentary to the report.

Chair agreed that this report was a really helpful and excellent report, that makes a clear link back to discussions at the board.

6. New SOF

COO provided an overview of the SOF and noted that at the end of month 6 the Trust has seven indicators that have shown statistically significant changes in performance. These changes have been against a backdrop of workforce pressures due to industrial action, anaesthetic capacity and more significantly scrub nurse staffing within theatres.

Activity in month although has demonstrated a small improvement against M5 has not delivered the required Elective activity plan and subsequently financial case mix as demonstrated in the finance update.

Cancer Performance is reported a month in arrears and all Cancer standards continued to be challenged by disturbance in activity. In August the Trust were able to achieve the 14 day and 31 day targets but faster diagnosis and the 62 day standards were not within the desired limits.

Waiting list size has been re-baselined in month to support the incorporation of EMIS, IOM and Wales patients. Overall the average weeks wait of patients that are over 18 & 26 weeks has reduced from the April position, however the RTT percentages are currently not demonstrating an improved position due to increased tip-over volumes. Consistent focus is being placed on long waiters, taking in to consideration clinical priority.

DM01 unfortunately has failed in September due to both industrial action and equipment issues. Although there are actions in place to meet end of year targets, if workforce pressures continue this will increase risk of not delivering against performance standards. The continued actions and issues will be escalated through Operational Board

Theatre scrub staffing for Q2 has been at its lowest establishment, which has significantly impacted Surgery activity. Actions have been put in place to mitigate and prioritise capacity for clinical urgency, however Q3 is not expected to see significant improvements. Short notice sickness and staff being called out overnight also continue to impact rostering. Although improvements have been seen within the Cancer Standards, capacity constraints and workforce challenges (including industrial action) continue to impact full compliance. Underperformance of the FSD standard is expected to continue within Q3, with recovery inter dependant on supporting the C&M position equalising wait times with LUFT. The 31 day standard is expected to be maintained but will be dependent on industrial action impact. Long waits within the Trust has grown in month impacted by annual leave and reduction in mini mitral capacity within the Surgical team.

IPC colleagues were asked to note the SOF report circulated prior to the meeting and comments and questions were welcomed and further detail was requested on the cap. COO confirmed that the national target is currently to not have any 65 week waiters by the end of March 2024 and added that given where the Trust are with the waiting list position, there will be a cap on incoming referrals for mini-mitral robotic procedures. Outsourcing and alternative options will be looked at.

Further clarity was sought on the outcomes for mini-mitral patients and confirmation sought that the procedures offer similar outcomes. COO confirmed that there is no demonstrated research that the outcomes are different from open and mini mitral.

7. Performance Report

7.1 Surgery Activity (scrub vacancies)

COO provided an update on the surgical activity and noted that previous challenges have been escalated regarding anaesthetic staffing and subsequently managed to be a more stable workforce. However, there

has been a shift change over Q2 of this financial year within the scrub staff workforce created by both maternity leave and turnover that has created a significant risk to theatre activity.

Proactive recruitment and agency requests have been enacted however, the timescale for start dates as well as supernumerary periods have exceeded the notice periods for leavers resulting in an availability gap within Theatres. This has resulted in a shortfall in being able to cover core theatre lists, impacting on the delivery of Surgical Activity since June 2023.

IPC colleagues were asked to note the paper, which outlines the actions that have been taken to mitigate this risk as far as possible, and the impact of this pressure on the theatre capacity. The Integrated Performance Committee are asked to note the actions delivered and the next steps in managing the risk within the Trust.

Comments and questions were welcomed, and COO noted that going forward there will be a theatre staffing review weekly. COO also added that governance needs to be demonstrated and there needs to be improvement on communication and escalation.

It was noted that this was a good report and further detail was sought on the impact, understanding the trajectory. COO shared the trajectory and explained in further detail. COO also noted the gap is more a financial gap.

CFO noted that the month 3 position started to go off plan in terms of income and the root cause of this was scrub staff availability.

7.2 Diagnostics (DM01 & FSD)

COO provided an update on diagnostics and provided an update on regional FDS performance and noted CMCA provider FDS was 69.0% in August 2023, compared with 75% operating standard. Of 14,536 patients, another 747 patients needed to meet 75% operating standard 6 of 13 trusts met 75% operating standard.

CT guided biopsy September position is an average 17 days wait. October position deteriorated from September, due to loss of capacity in September due to IA and annual leave. The activity against plan is down year to date. There is an increased demand expected due to LUHFT mutual aid. There are two new interventional Radiologists to commence performing biopsies from 6th November and templates have been reviewed and revised to increase weekly biopsy capacity by 1. There will be weekend WLI sessions to flex capacity to continue to be utilised.

EBUS September position is an average 17 days wait and 5 of the 7 patients achieved target, resulting in 71% compliance. There were no appointable candidates to a new Consultant post, feedback on role sought but limited opportunity. There is a plan to readvertise in 6 months. There is a reliance on additional sessions and flexibility to cover leave. The year-to-date plan variance is due to unplanned Consultant absence.

Radiology experienced a deteriorated position against DM01 compliance in August owing to the following compounding factors; Significant CT and MR equipment failure, Industrial Action impact and loss of supervised capacity. There is a trajectory in place to recover to compliance against all Radiology services by reviewing in hours capacity for pressured exam lines and increasing WLI sessions out of hours.

Comments and questions were welcomed and the equipment failure was raised and the impact that this has. COO confirmed that the Siemens regional manager has been contacted for support.

Further detail was also sought on the mutual aid and the impact on LHCH performance. COO confirmed that there is eagerness for LUHFT to do the same actions as LHCH and there are new governance forums to try and drive this. COO added that the mutual aid is the right thing to do for the patients.

Chair requested further information on whether the ICB have any specific requirements for mutual aid. COO confirmed CT guided biopsy comes through the Cancer Alliance, DMO1 mutual aid comes through productive partners and the ICB. COO added that the Cancer Alliance are fully signed on the mutual aid and joining Cancer Board regularly and have agreed a Project Manager to support.

7.3 Safer Waiting List

COO provided an overview of the safer waiting list highlight report asked IPC colleagues to note the paper circulated prior to the meeting.

The Trust has a monthly Safer Waiting List Management Group (SWMG), which meets to ensure that patient administration processes within the Trust are safe and effective in delivering patient pathway management. As part of SWMG a number of areas have been identified that require further development to ensure that the Trust is processing patients through its waiting list in an effective and safe manner, reducing risk and ensuring escalation processes are in place.

The Safer Waiting List Group provides assurance to the Trusts Operational Board to ensure identified risks are effectively managed and that all works are planned and carried out in a structured and joined up manner.

Overall, steady progress has been made to ensure the safety of patients on a waiting list. An overarching and detailed action plan has been developed and the Task and Finish group continues to take forward the actions. The iDigital team presented key updates on three key projects which will support the management of patients under the care of the Trust.

SWMG will develop an overarching timeline of the different projects running concurrently, particularly their implementation dates due to the interdependences from the senior operational managers and their teams. This help support the decision making process of which project to

prioritise to ensure that the projects are delivered with quality rather than quantity and risks are managed accordingly.

Comments and questions were welcomed and further detail was requested on the timescales. COO confirmed that digital has a 3 to 6 month implementation period, PTL is a 3 month implementation and remote monitoring needs clinical input

8. Finance report including CIP

CFO presented an overview of the finance report and provided context to the external position. The NW has a 450m deficit at month 5. The main drivers for this are; CHC and prescribing and undelivered CIP. The three ICBs within the NW are ranking 1,2 and 4 worst in the country.

National leaders are concerned, as there is a deficit of £1b. Significant improvement is needed. Two areas of concern are workforce growth and delivery of CIP

It was noted that C&M system is £50m worse than plan at this point in the year. Key drivers include; Industrial action costs, undelivered CIP, prescribing inflation above funded levels, CHC activity.

The growth in staffing was noted and further clarity on the rational. CFO confirmed that the national team are concerned. Organisations are being asked to account for this. Level of frustration nationally and will remain a focus for the remainder of the year.

Comments and questions were welcomed and the challenging position was noted and it was stated that CIP was always going to be challenging.

CFO provided an overview of the LHCH month 6 position and noted a £712k surplus, a £107k adverse variance to plan in-month). The year-to-date surplus is £4,939k which is a £27k favourable variance.

The national guidance regarding activity reporting has been amended in light of the industrial action. The income target for the variable elements has been reduced by 2%, with this moving to the block. This is to take account of the industrial action in April, with further adjustments anticipated. This has been enacted in the Trust's reported figures. Activity income from NHSE, ICB and Wales is £479k behind plan in month and £637k behind plan year to date.

Private patient income returned to above planned levels, with a £14k over-performance in month. The year-to-date income is £238k above plan. Income from the Isle of Man was £73k behind plan in September, with a year to date under-performance of £228k.

The number of TLHC scans and health checks is slightly behind plan in month but higher than projected YTD. Activity has been high this year, and commissioners have secured additional fixed income to offset some of the financial challenges caused by the revised prices.

Pay costs are below budget for both September and the year to date. Agency costs continue to be significantly lower than last year and nursing costs continue to underspend against plan.

There is a shortfall on transacted CIP (£1,187k 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. There continues to be an overspend in drugs budgets. Inflationary pressures continue to be analysed and some funding transferred from risk reserves to fund net price increases. The Trust has received the energy bill for M7-12 of last year, and these are within the amounts accrued last year. The trust continues to pursue costs and usage for this financial year.

Medicine elective activity is 93% of 23/24 activity plan in September and the case mix is 108% of the year-to-date plan. Surgery elective activity is 81% of 23/24 of activity plan in September and the case mix is 86% of the year-to-date plan.

To date, the Divisions have identified 72% of their CIP target for the year, an increase of £20k from last month. £3,841k of recurrent CIP has been transacted for the year, broadly in line with last month. Undelivered CIP is the Trust's single largest budgetary pressure, and Divisions will need to urgently identify and transact CIP schemes in the coming months to alleviate this.

The Trust cash balance is £45.8m. Capital expenditure in the year to date is £1,209k. This primarily relates to the Cath Lab project and agreed high risk maintenance schemes.

Comments and questions were welcomed, and it was noted that it is good to see Surgery's performance in CIP and raised a query on the confidence in maintaining and sustaining the surgery financial position. CFO stated that this is easier for Surgery than Clinical Services as it is all relating to theatre staffing and the Surgery costs are well controlled. This issue is around not delivering activity. CFO confirmed that the governance needs to be strengthened and there needs to be work on recruitment and retention. CFO added that it has been a challenging year for Surgery but with action it can be overcome and won't impact the overall position.

Chair raised the undelivered CIP from Clinical Services and asked for further clarity on what proportion of CIP schemes are cross-divisional. CFO confirmed that opportunities are cross divisional such as procurement, pathology and contract schemes. The leaders within Clinical Services are contributing and driving these schemes. COO confirmed that the Clinical Services Divisional Director is proactive.

COO stated that conversations have taken place on whether anything different needs to be done when going into annual planning, in terms of splitting out the budgets. COO also added that it is difficult for Clinical Services from an income opportunity point of view, given the services they do provide.

8.1 Forecasting

Forecasting not discussed at this meeting.

9. Capital Report

CFO provided an overview of the capital report and noted that the Trust started the year with a capital allocation of £6,111k, and had a detailed plan of how this allocation would be utilised. This focused predominantly on the conclusion of the original cath lab project and a range of backlog maintenance schemes.

At the halfway stage of the year, the Trust has spent £1,209k against this original plan. Much of the plan is scheduled to take place in the latter half of the year. In addition, some VAT refunds relating to last years capital programme have been received and have reduced the capital spend in the year to date.

The Trust received notification from the Integrated Care Board (ICB) of an additional £4m capital allocation for this year. This will enable the Trust to develop cath lab 7 which was recently approved by the Board. Capital planning for next year is to commence. A working group consisting of divisional representatives, estates, IT and capital projects will collaborate to prepare a risk-prioritised list of capital schemes for 2024/25.

The Trust now has a capital allocation of £10,111k. This has increased by £4m to fund the cath lab 7 programme of works. The Trust has been able to create a contingency in order to respond to risks as they emerge. The capital programme is managed through the work of the Capital Management Group, and the Trust is forecasting to spend all of its capital allocation this year.

Capital planning for 2024/25 is commencing and a Working Group is being established to prioritise the schemes to fit within the constrained capital funding envelope.

Comments and questions were welcomed and further detail was sought on the risks and mitigations. CFO confirmed that a high proportion of the capital programme is based around estates schemes, which requires a lot of planning. CFO added that there is an internal monthly update and risk profile at Capital Management Group. CFO added that Cath Lab 7 is a risk that needs to be managed and mitigations are being looked at. CFO noted that there are gaps in the Capital Team currently and extra work is being done to provide assurance.

10. Costing Strategy Update

CFO provided an overview of the costing strategy update and noted that the Costing team is responsible for producing and promoting the use of the Patient Level Information Costing System (PLICS), along with mandatory returns such as the annual National Cost Collection (NCC) which underpins Model Hospital and GIRFT.

Costing can play a role in supporting the delivery of high-quality sustainable services across the NHS, allowing trusts to understand

service costs, reduce unwarranted variation and develop new models of care.

In 2019, the Trust devised a Costing Strategy, with regular progress updates presented to the IPC. The Strategy focused on improving data quality, implementing new costing software and developing reporting templates.

Recent completion of the costing Assessment Tool (see appendix 1) highlights that many of the improvements aimed for in the original strategy have been implemented. However, there are still shortfalls in the area of wider engagement (including clinical engagement), and usage of the data. This refreshed strategy aims to address these issues.

The costing team's previous strategy focused on improving data quality and implementing new costing software. This has largely been delivered, and the focus now shifts to building wider engagement, and using the data to release the benefits envisaged.

IPC were asked to note the refreshed costing strategy, and its focus on building engagement and data usage.

Comments and questions were welcomed and a query raised on how the effectiveness of this will be assessed. CFO confirmed that the self assessment will be undertaken and added that the Trust's costing practitioner is part of the HFMA costing working group and is engaged in the development of costing nationally.

A further query was raised on the level of confidence of clinical champions across the Trust. CFO confirmed that Consultants will be engaged via the Finance Business Partners.

11. Outcomes of benchmarking data

CFO provided an update on the outcomes of benchmarking data and noted that Model Hospital provides a wide range of metrics that help the Trust identify improvement and productivity opportunities. The Trust operates a Benchmarking Framework to encourage the use of and optimise the benefits of benchmarking.

Benchmarking analysis and template Highlight Reports had been shared with relevant executive leads for the previous period, and progress is noted above. The latest available benchmarking from Model Hospital will be subjected to the Benchmarking Framework from Q3.

Remedial action plans are in development as detailed above to minimise unwarranted variation. Progress on identifying and delivering cash releasing savings has been slow.

Across fourteen priority areas, the calculated potential productivity opportunity is £7.92m but as evidence emerges from the benchmarking framework activities, key PPO's have been shown to be potentially overstated, and work continues to refine the underlying or true PPO.

Updated dataset for corporate information and for PLICS based metrics are now available.

A CIP workshop has been agreed (date TBC) to progress CIP plans in Estates and Facilities supported by relevant benchmarking.

The focus of the Benchmarking Framework is on addressing unwarranted variation. It is important to note that the Trust benchmarks very well across a range of metrics, which are not within the scope of the framework (although these metrics may provide contextual information for example to support variation being warranted).

Funding for the important benchmarking tool Public View has been withdrawn by the ICB with effect from 1 October 2023. The Trust will consider alternative ways, if possible, to access this information.

Comments and questions were welcomed and query raised on whether the divisions have the quality and transformation support to deliver the opportunities. COO confirmed that this has been revisited at the Executive Group meeting and added that there are some challenges with directing the right resource to the right programme.

12. IPC Work Plan

IPC colleagues were asked to note the work plan and comments and questions were welcomed. COO suggested that some changes may be needed and it was agreed that CFO and COO to meet and update the workplan.

JM/KE

13. Minutes from the Finance & Performance Group meeting

Colleagues were asked to note the Finance and Performance Group minutes circulated prior to the meeting and there were no further comments or questions.

14. 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.

9. Date and Time of Next Meeting:

Thursday 7th March, 10.00am – 12.00pm, MS Teams