

Integrated Performance Committee

minutes

Minutes of the Integrated Performance Committee Meeting Monday 21st October 2024

Present:	Claudette Elliot Bob Burgoyne John Doyle	Non-Executive Director (Chair) Non-Executive Director Non-Executive Director
In Attendance:	James Thomson Jonathan Mathews Kiran Chhokar Lucy Currie Carla Richardson Ben Davies	Chief Finance Officer Chief Operational Officer Divisional Director of Operations, Clinical Services Divisional Director of Operations, Surgery Head of Financial Management Associate Director of Transformation
Apologies for Absence:	Margaret Carney James Bradley	Non-Executive Director Deputy Chief Finance Officer

1. Introduction and Apologies for Absence

Introductions made and apologies and attendance noted above.

2. Declarations of Interest

All meeting participants were asked to declare any interests in respect of items listed on the agenda. All participants confirmed that they had no interests to declare beyond those that may already be known and on Trust registers.

3. Minutes of meeting held on 17th June 2024.

Minutes from the meeting of 17th June were noted and approved as a true record of the meeting.

4. Action Log

No outstanding actions.

5. Trust SOF

- Productivity Proposal

IPC colleagues were asked to note the Trust SOF included in the meeting papers. COO noted that the Trust is in a good position and noted that areas of concern will be discussed below. COO also noted the elective and non-elective activity split in terms of activity and forecasting. COO stated that in terms of productivity proposal the Trust is looking at aligning the SOF to a similar approach that is used for performance, finance, workforce and quality.

COO noted the question raised on potential CIP for DOSA and noted that bed occupancy on a Wednesday and Thursday is a bit tricky and they Trust has had to open and expand beds, which impacts the DOSA implementation. There is hope that the bed base can be managed. COO noted that overall CIP is unlikely given that implementation relies on closing beds and the Trust is not looking to close beds any time soon. DOSA is about working appropriately to ensure that the Trust maximised throughput, and hopefully reduce cancellations.

COO also noted that there is good month 5 Private Patient performance and noted that this generates income, however WLI initiatives are needed for Private Practice as these are picked up at the weekend. There needs to be a balance of the two, to look at the financial income overall and how opportunities are maximised.

Ben Davies, Associate Director of Transformation attended IPC and shared an overview of the Productivity Improvement Plan. Data is submitted nationally to NHS England which is analysed to model hospital, and they present a high-level national picture of performance against the key metrics. This allows the Trust to benchmark their productivity and highlights areas for improvements across a range of different services. It was noted that there was a workshop in August with key stakeholders to review the data and it was agreed that the Trust will focus on some key areas for improvements that have been highlighted.

The four areas to focus on are theatre and Cath labs, outpatients, diagnostic delivery and coding and data capture. Specific areas of focus for improvement have been identified and an SRO has been agreed for each pillar of work. It was noted that the driving factor behind the work is how services can be improved for patients. Each of the four programmes of work will meet on monthly basis to ensure that there is progress against agreed KPIs. There is also a Transformation Programme Board, which meets monthly to keep track of progress and highlight and risks or concerns. Transformation Board will provide assurance to Operational Board.

Comments and questions were welcomed, and it was noted that it was good to see the governance arrangement and the Executive Sponsors.

A query was raised on how the four areas were chosen. It was noted that with model hospital, it models everybody against the same set of criteria, so it can be difficult to track LHCH as a Specialist Hospital. However, the data can be drilled down into. When this data was looked

at it was agreed that these areas of focus would be the areas that the Trust feel it could improve. COO added that there has been clinical engagement and workshops and conversations on how this aligns in the Trust.

Chair noted in the context of comparisons with other hospitals that LHCH is different in the sense that the Trust provides speciality care. A query was raised on whether there were any local ones to add to this or any localised performance targets that may need to be picked up on. COO confirmed that the localised one that was picked up on was the coding and capture area of focus. There has been interrogation into the SUS and SLAM data and clinical codes and it was found that this is an opportunity. It has been highlighted in the Liverpool Joint financial plan. CFO added that there will develop over time and they will need review periodically to ensure they are providing the Trust with the right information to measure performance and take action.

Chair noted that there would not be an IPC meeting until February and suggested sharing an update in advance of that. COO confirmed that it should be drafted in January for January Operational Board and agreed to circulate this to IPC colleagues.

COO

6. Performance Areas of Concern

- **Cardiac MRI**

Kiran Chokkar, Divisional Director of Operations for Clinical Services provided an MRI update. An overview was also provided on the radiology DM01 diagnostics and it was stated that 95% of patients referred for diagnostic tests should be seen within six weeks of the referral. US and CT have continued DM01 compliance. MR is experiencing the biggest strain of resources, with 456 breaches in month 6. Overall, the compliance for radiology diagnostics is 77.7%.

There has been an increase in demand for stress, MCARD, congenital scans from 2019/20 to 2023/23. MR growth has been seen across all commissioners except for Scotland. The largest increase has been seen in Isle of Mann.

On average the referrals exceed the core capacity by 155 per month (30% greater than core capacity). There are large variances in referrals, that can be very unpredictable and small reductions in the patient waiting list size. There is a large over performance in activity through WLIs in a bid to overcome demand and capacity deficit.

DM01 has been non-compliant since August 2023. There has been an addition of provider to provider breachers which equates to a steep decline in performance. There has been a recovery plan in place from January 2024. 24/25 MRI activity is overperforming by 8% year to date creating only small incremental gains in performance. Significant additional activity would be required to achieve DM01 compliance.

In terms of capacity actions include, additional WLIs, converting sessions to cover most pressurised areas and mutual aid with LUHFT. In terms of referral there are CAMRIN discussions, meetings with providers for

PPMs to stem referrals and clinical review. There will also be daily PTL oversight and calls to patients for most pressurised areas.

The next steps include a 7-day business case, wider clinical engagement, horizon scanning, workforce review, capital review and external collaboration.

Comments and questions were welcomed and it was noted that a key issue is around the capacity of the scanners and a further query raised on whether there were any additional issues around staff availability to interpret the data causing delays in the provision of the final results from the scans. It was confirmed that MRI scans are reported with 28 days and the vast majority of additional work is sent to an external outsourced provider to enable delivery of the 28 days. This comes at a significant cost to the Trust and to the division and is offset by the income generated because they are specialist scans.

The issues around sickness and workforce were noted and a query raised on whether nationally this picture is similar and whether enough Radiologists are being trained. A follow-on query was raised on whether there is confidence in recruiting if the Trust move to a 7 day model. It was noted that the Radiographer workforce is very strained. This strained workforce is exacerbated at LHCH as only 3% of that workforce is cardiac trained. It was noted that the Trust do need to start to look at growing their own workforce and collaborative working. COO added that the 7-day business case is one of the three priority business cases that are hoped will be resolved early in annual planning. Hopefully there will be an income opportunity as diagnostics comes under a bundled and unbundled conversation. It will come through Board of Directors due to the revenue significance.

- **Long Waiters (Surgery Waiting List)**

Lucy Currie, Divisional Director of Operations for Surgery provided an overview of the long waiters position and noted that the current NHS England target as of September 2024 is that there are no patients waiting over 65 weeks and there is a target to have no patients waiting over 52 weeks by March 2025.

There are currently 11 patients waiting over 65 weeks at the end of September 2024. 60 patients waiting over 52 weeks at the end of September 2024, reduced from 117 in May 2024. There is an improving position overall.

There was a waiting list cap for sub-specialised procedures implemented from 1st February 2024 following Specialist Commissioner agreement.

There are outsourcing contracts in place for mini-mitral patients which has reduced the mini-mitral waiting times to <52 weeks. A 3rd Surgeon commenced mini-mitral training in September 2024.

There has been a 10% increase in Cardiac Elective activity since 2023/24 delivered through improved core utilisation or theatre sessions and a reduction in overall Cardiac waiting list size from 786 to 649 over 6 months.

The number of patients waiting over 36 weeks has reduced by 36%.

There has been an improved distribution of patients across Cardiac Surgeons to improve equity of access for patients and clinical prioritisation of patients to balance to urgent and P2 patients with waiting times.

Weekend WLIs are being held to provide capacity for long waiting patients.

There are a number of challenges including; Surgeon sickness, requirement of additional diagnostic delaying pathways, increase in urgent demand and sub-speciality pressures such as mitral surgery.

The risks include; the continuing increase in urgent demand reducing the ability to deliver planned elective activity levels, financial cost pressure of outsourcing in excess of £150,000, Surgeon unavailability and an increase in thoracic demand.

Future actions include; expansion of outsourcing, establishing an additional core list on Fridays in the fallow session and a business case for a 9th theatre to enable a 12% increase in theatre capacity. It is hoped that the impact of these actions would result in the trajectory for 65 weeks wait to reduce to 7 in October 2024, 4 in November 2024 and 0 in December 2024. It is also hoped that the 52-week trajectory will reduce to 0 by March 2025.

Comments and questions were welcomed, and it was noted that the presentation highlights the positive steps taken to address the long waiters.

A query was raised on whether patients that are unfit for surgery are still counted towards the 65 weeks and over. It was confirmed that there are a number of reasons that clock would be stopped for a patient and one of these reasons would be if the patient is unfit or unwell. They would then go on a different waiting list to ensure that they are still followed until fit for surgery again. A further question was raised on whether these patients could be deemed unfit because they haven't had the surgery done. It was confirmed that patients are usually deemed unfit because they require additional intervention from another speciality.

CFO noted that the increase in non-elective work is significant and for planning purposes it is important for the Trust to know whether this is going to be sustained or not and would be a key assumption going into next year. It may also impact the capacity and demand planning.

Confirmation was sought on whether LHCH still offer mutual aid to LUHFT. COO confirmed that LUHFT provide mutual aid to LHCH for Cardiac MR and LHCH provided mutual aid to LUHFT for CT guided biopsy.

Clarity was sought on Private versus NHS waiting list and whether the long waiters would come down quicker if the Trust focused solely on NHS waiting list patients. It was confirmed that this would not make

much difference as Private Patients are done exclusively as additional activity, so they would never take the place on an NHS patient on a list.

It was noted that it was pleasing to see the positive progress that has been made and it was added that it would be such a good outcome if the current trajectory is maintained. Lucy Currie Surgery colleagues were congratulated on their hard work.

An update was also provided on Day of Surgery Admission (DOSA) and colleagues were informed that this is being led by the Divisional Director of Nursing for Surgery and supported by the Head of Improvement and Transformation. 6 new pathways have been developed which look across the different professional groups such as Surgeons, Anaesthetists, Admin, Pathway Coordinators and Pharmacy. It was noted that work has been progressing really well and the Trust are now in a position to start a trial of DOSA and this will start on 2nd November 2024.

Comments and questions were welcomed on the DOSA update and a query was raised on what the connection was between LHCH and Papworth in terms of benchmarking and working together to improve services. It was confirmed that there is an upcoming meeting with Papworth and it is hoped this will be discussed further. It was added that National Cardiac Benchmarking Conference (NCBC) is due to take place in December 2024 and this is an opportunity for organisations to come together and share learning.

- **FDS (Cancer Breach Analysis)**

COO provided an overview of faster diagnosis and noted that the Trust is sustainably hitting the 31 day target and the 62 day target is moving in the right direction.

The actions include; maintaining improved surgical waiting times and 31 day compliance and achieving 62 day compliance. There will be close monitoring of delaying in pathway via PTLs and escalation of trends. There will also be a deep dive into delays within each breach pathway at Trust Cancer Board, along with monitoring the Cancer action plan.

An update was also provided on the EBUS trajectory, and it was noted that there has been a reduction in capacity due to two Doctors no longer performing EBUS. Referrals have increased for 2024/25 and there is a risk to capacity due to being the single provider of EBUS. Joint appointments have now been made with LUFT. An updated trajectory will be shared with Finance & Performance Group.

The average wait time for CT guided biopsies is 13 days. Pressures include increased requests without MDS and lost capacity in August.

The plan is to have better visibility of the patients position on the cancer pathway and a monthly cancer team meeting to review breaches and provide feedback.

Comments and questions were welcomed and concern was noted with EBUS and CT guided biopsy as this has been going on for some time

without a proper resolution. Concern was also noted that a locum is not a very stable solution and an update was requested on the joint appointment. COO confirmed that there was a discussion recently and it is thought that this appointment will be in post in the new calendar year.

7. Finance Report (Including CIP & Capital)

COO provided an overview of the Trust finance report for the period ending 30th September 2025. The Trust's planned surplus for the year is £14.1m in response to the stretch target given by the ICB. The Trust continues to forecast achievement of the plan.

In the first half of the year, the Trust has achieved a surplus of £5,698k, which represents an adverse variance of £943k. The primary reasons for this variance are slippage against the CIP plan, delays to the expansion of the Targeted Lung Health Check programme and overspends in a number of areas, predominantly theatres, Cath labs and drugs. Emergency pressures are driving higher spend levels, but the block contract for non-elective care means that there is no growth in income to support it. Although pay costs have remained largely stable and within budget, there are pockets of overspends that need to be addressed.

The financial pressure caused by the delay in TLHC expansion is a temporary one, with the programme now operational. CIP delivery has improved in-month but remains a risk. Managing the budgetary overspends in pay and non-pay remain key areas of focus.

Comments and questions were welcomed, and a query was raised on whether there are any other pressures from the system likely to arise over the next six months. CFO confirmed that the issues tend to arise in response to the worsening or deterioration of the position. CFO also noted that there are things happening across the system, such as pay awards, that are driving pressures. There is also a level of non-elective increase in activity, which is going to put pressure on the elective programme over winter. CFO also noted that the Trust is working towards hitting its own £14.1m surplus plan and working with partners in Liverpool to improve that position.

Clarity was sought on whether there would be a further ask from LHCH, if the position of colleagues in the system deteriorates even further. CFO clarified that this could be the case. A follow-on question was asked on whether this would be a Board of Directors discussion. CFO confirmed that it would be a Board discussion on feasibility and what the implications would be.

8. M6 – M1

2 Forecasting

COO also provided an update on the financial forecast for 2024/2025 and noted that the C&M system is financially challenged, and the current run rate is behind plan. NHS England are monitoring the system and individual provider run rates and extrapolating to understand risk to achieving the approved financial target. At month 6 the system had a reported deficit of £184m. The annual plan is £150m deficit.

The ICB have also required the Trust to support the Liverpool provider system c£2.7m and plan for 0.5% headroom. This is an addition to the £14.1m plan. This would mean an overall surplus of c£18.1m .

The Trusts financial position has improved at month 6, with a £5.7m surplus against a plan on £6.6m. However it continues to manage a range of financial risks and uncertainties. It is important to understand the outturn position and raise the risks internally and externally to the ICB as required. It will also frame the ability to deliver any additional surplus, above plan.

Following the reporting of the month 6 financial position, each division has developed detailed forecast scenarios based on run-rate and known risks/benefits. The scenarios are, likely, best and worst.

These have been shared with the COO, CFO and senior finance colleague , with assumptions being reviewed and challenged with divisional management teams. The review focused on risk areas and mitigations in place or proposed.

The forecasts have been aggregated and overlaid with central mitigations to calculate a Trust wide forecast, again with likely, best and worst case scenarios.

CFO presented an update on the forecast outturn and noted that the aggregation of divisional likely forecasts is £12.4m, a £1.7m adverse variance to plan. The best-case scenario forecasts a £175m surplus. The potential downsides of the worse-case scenario results in a £11m surplus.

Comments and questions were welcomed and clarity was sought on whether it is the pay award was the biggest number that has tipped the Trust. CFO confirmed that in the worst case, this is something that is likely to happen. It was added that the biggest uncertain variable is really around contracts and whether there is the reserve to cover this.

It was noted that it is unfortunately that the pressure is not above LHCH managing finances appropriately, rather pressure from the ICB to increase surplus.

CFO noted that it is Operational Board and the forecast will be presented to the clinical leaders so that there is an understanding of the range of the risk.

9. BAF Extract

- System & Trust Risk

IPC colleagues were asked to note the BAF extract circulated with the papers.

Comments and questions were welcomed and CIP was noted and the acceptable assurance and whether this should be partial given that CIP has not been delivered. It was agreed that this should be considered and taken to the Board Strategy day.

10. 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.

11. 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.

12. Date and Time of Next Meeting:

Monday 17th February 2025, 9.30am – 11.30am