Paper ref:	TB (10/21) 020

Sandwell and West Birmingham Hospitals NHS
NHS Trust

FINANCE AND INVESTMENT COMMITTEE - MINUTES

Venue: Meeting held via WebEx **Date:** 30th July 2021, 9:00-11:00

Members:

Mike Hoare	(MH)	Non-Executive Director (Chair)
Harjinder Kang	(HK)	Non-Executive Director
Liam Kennedy	(LK)	Chief Operating Officer
Dave Baker	(DB)	Director of Partnerships & Innovation

Joined:

Amanda Wharton	(AW)	Head of Costing
Chris Archer	(CA)	Assistant Director of Strategic Development

In Attendance:

Simon Sheppard	(SS)	Director of Operational Finance
Paul Stanaway	(PS)	Assoc. Director of Financial Management

Apologies:

Dinah McLannahan	(DM)	Chief Finance Officer
Richard Beeken	(RB)	Interim Chief Executive

Minutes	Reference
1. Introductions	**Verbal**
The Chair welcomed Committee members and attendees to the meeting. Committee members provided an introduction for the purpose of the meeting recording.	
2. Apologies for absence	**Verbal**
Apologies were received from Richard Beeken and Dinah McLannahan.	
3. Minutes of the previous meeting held on 28th May 2021	**FIC (07/21) 001**
The minutes of the FIC meeting held on 28th May 2021 were reviewed and **ACCEPTED** as a true and accurate record of the meeting.	
3.1 Matters arising and update on previous meeting actions	**FIC (07/21) 002**

The action log was reviewed and updated as follows:

- *FIC (03/21) 002 – Investigate the theatre team arrangements/staffing at Moorfields Eye Hospital and report back.*
  - LK reported that their surgical team was linked in with Moorfields. They were pretty well aligned from a theatre staffing perspective within complex or day case procedures, apart from Moorfields being one less on day cases, which was being investigated. They were awaiting performance data on what Moorfields put through the theatres, to see how aligned they were compared to Model Hospital data. They were looking into how Moorfields was slightly more productive and how to replicate their hub and spoke model in London Ophthalmology procedures across the Midlands as the regional eye centre. The initial meeting had taken place. They were waiting for more data before having further meetings.
- *FIC (03/21) 006 – Add the percentages for the efficiencies in each of the areas against the value*

to the CIP 2021/22 update and circulate to Committee members.

- MH commented that this was part of the CIP papers – see item 5. **Closed.**

- *FIC (05/21) 003 – Confirm a nominated NED attendee from SWBH to the Procurement Board.*
  - MH reported that he had spoken to Mike Hanson and it had been confirmed that MH would be the NED representative for the Procurement Board. **Closed.**
- *FIC (05/21) 005 – Bring an item on the underlying financial position to the July FIC meeting and regularly going forward.*
  - See item 8 for the underlying deficit review. **Closed.**
- *FIC (05/21) 006 – Raise concerns about the system funding advice with the Chair of the Trust Board and the Trust's Interim CEO.*
  - MH reported that he had a meeting planned with the Chair and RB about this that afternoon. There was also a paper describing the System update on the agenda – see item 13. **Closed.**

ITEMS FOR DISCUSSION – 2021/22

4. Month 3 Finance Report	**FIC (07/21) 003**

SS referred the Committee to the Month 3 Finance Report, highlighting the following points to note:

- There was a small surplus at the end of Month 3, which was £1 million better than plan.
- Their efficiency programme progress and work to reduce the COVID spend were both positive.
- None of the Elective Recovery Funding (ERF) income had been assumed in the Q1 position, apart from a small contribution of a few hundred thousand pounds. This would help the Q2 and H2 position. This was being handled consistently as a System with other Integrated Care System (ICS) providers.
- They were working on a 'no surprises' culture, as reflected in the risks section of the report.

LK commented that over the last four weeks, they had seen a significant increase in their COVID pressures. This increased pressure was not expected to be at its peak yet. Whilst a lot of good work had been done to manage COVID costs, the realistic position would be that costs would start to rise.

The anticipated ERF would now be unlikely to be delivered. The goal posts had been changed to 95% in July rather than 85% with a week's notice, likely because more ERF was being earned than had been anticipated.

HK queried whether they expected the financial modelling based on the COVID-19 situation to increase, decrease, or stay the same. SS reported that they were saying that they would hit their H1 target. They were expecting COVID costs to go back up higher than they were, but not as high as at the peak.

All the Groups for Month 4 would be doing a detailed forecast of where they would be for the end of Quarter 2 and for the whole year, down to Directorate level, to highlight specific risks and to help with H2 planning. More granular work would also help to identify what COVID costs would remain regardless. They were not expecting guidance until September to start planning for October.

LK added that the costs being incurred now would not materialise until Month 4 or 5. Some previous COVID costs were still being managed. Unlike last time, they were seeing an increase in amber non-COVID admissions, which meant they were having to create extra ward areas over and above their establishment. They were being forced to deviate from the 1 to 8 nursing staff ratios and to try to recruit agency and bank staff but there was no agency staff available at any level. This was reducing their costs but stretching their current staff.

MH queried the level of deviation they were at from the anticipated production plan and financial modelling they had done. LK reported that they had been tracking above plan, with £2.2m of ERF to date. By the end of July, they expected to be at 96% of their 2019/20 production plan. It was disappointing to be on the verge of getting back to the same levels of activity and throughput when the elective activity was now being looked at to pull staff into areas where they were at over 100% capacity. They had anticipated a wave in August/September but they hadn't anticipated the increased amber admissions as well as increased red, which meant that wards couldn't be flipped over to avoid more than a small impact on elective activity. A larger impact was now being investigated due to the increase in non-COVID admissions at 1.2% more than they had anticipated.

SS highlighted slide 16, showing their activity plan performance by POD. Year to date, they were only £8.4m behind where that would have been. In Month 3, they were only at £1.4m behind, showing the trend of underperformance going down and the gap being expected to close. The following slide on elective recovery showed how they were performing against their trajectory. They were £756,000 better in April, £1.9m better in May, another £1.6m in June, and that then reduced in July due to the last-minute change to the goal posts. They were tracking this at Group level to know what to expect for 2022/23.

LK added that their elective element underperformance was the biggest variance in slide 16, which was partially around the reluctance of some patients to have their procedures. A lot more last-minute cancellations were happening because the swab results weren't back, meaning a risk that they would need to place the patients into an amber or red post-op area with associated risks, or the patients had COVID or had been 'pinged' for isolation or decided they didn't want to go ahead with the risk. The timely engagement from patients they were used to had turned into a range of standby lists in an effort to bring patients in at short notice where possible, further challenging their work on elective provision.

SS reported that after negotiating approval for the capital programme of £22.8m from the ICS, their capital performance showed that at the end of Quarter 1, they had spent £1.6m from a pot of £5.4m. They had made it clear with the ICS that they would be spending this underspend without any slippage. For Estate, IT, and medical equipment, for Month 4, they would be tracking the capital spend against their original plan and against these areas' revised trajectory plans for the following reasons:

1. To give assurances to FIC and the Board that they were delivering the benefits of the capital programme
2. To show the ICS
3. As they had asked for coverage of an enhanced capital resource limit to support MMUH.

HK queried whether they should be mapping the variation in accuracy against forecast instead of showing it as green, and whether their approach was creating early warnings on issues. He queried whether they were all joint up on the narrative around why it looked like they had slippage.

SS reported that they now had a Capital Monitoring Group meeting monthly. This helped them to understand actions going forward and the commonly held view on where they were at. For example, there had been delays in ordering that had led to a lack of medical equipment spending being investigated and put right. From a cash perspective, things were green but from a delivery assurance and getting the benefits of the programme, he acknowledged that it was probably red. He undertook to take this evaluation method into consideration, as HK suggested.

LK reported that they hadn't spent any money on capital equipment because the final verification by the Clinical Leadership Executive (CLE) had been delayed. Replacement items had been swapped for more important items to address productivity or backlogs due to COVID or because of changes in pathways for Midland Metropolitan University Hospital (MMUH) after review of clinical models. Now that CLE had approved the capital equipment plan, this would be going ahead.

5. 2021 – 22 Better Value Quality Care (CIP) Programme	FIC (07/21) 004

SS explained that the renaming of CIP had been changed to move the words around to Quality Care Better Value. He highlighted the following points from the report:

- Good progress was reported, with £8.8m savings that had been made against a stretched internal target of £13.2m.
- The H1 actual target was approximately £1m. A stretch target of 3% was being considered for H2, which would be £8m to £9m. They were not including any non-recurrent benefits around reduction in COVID costs compared to the budget or ERF contributions to the bottom line.
- A lot of work had been done on the Quality and Equality Impact Assessments by the Medical Director and Chief Nurse. A separate paper was going to Quality & Safety Committee today showing that the vast majority of these had been signed off apart from three as of today. The focus was now on setting up a resilient and sustainable plan for 2022/23/24.

MH queried whether the £8.8m of savings were recurrent. SS explained that £8.8m was in-year. £7.5m of these were recurrent and £1.3m were non-recurrent. They were tracking these by Group.

LK queried whether any of the schemes identified from the programme were anticipated to be impacted by the current COVID surge or whether there was still a need for operational and clinical input or development to achieve the outcomes. SS reported that the vast majority had been delivered but the challenge would be around the capacity and time for people to drive the later profile schemes and in planning for 2022/23/24. LK and SS undertook to investigate these risks of delivery and planning together, given the pressure the Groups were under with COVID again.

MH queried whether there was a time period over which the £8.8m had to be recovered. PS estimated that they had delivered between £400k and £500k in total in June. In the Month 3 report, the phasing of the plans could be seen. He suggested the risk be borne in mind regarding the extent to which improvements had been built into the MMUH modelling.

SS reported that rounding up, 40% of the profiling was in the first half of the year and 60% was in the second half. This compared well against other Trusts who had more of a 20%/80% profile. MMUH was a factor that was being built into CIP setting of targets and delivery for the next two to five years.

Action: LK and SS to investigate the risks caused by recent COVID pressures to the Groups in planning and delivering their Quality Care Better Value Improvement Programme schemes.

6. Workforce Report	FIC (07/21) 005

SS described the need that he and PS had identified to look into the detail behind the numbers to understand the actions and the impacts of particular schemes on their workforce. They needed to consider how FIC and People & OD linked together in the consistency of their reports and how they fed into each other. The following points were highlighted from the workforce report:

- 70% of their costs were workforce.
- They were currently over-established against their core establishment, yet there were significant substantive vacancies. They were filling these with spending on bank and agency but there were risks attached to this.
- The paper sought to establish where they were and what the trends were, showing the financial impact of the work being driven by Frieza Mahmood, their Chief People Officer, around recruitment, retention, and sickness. The financial consequences of improving their workforce, quality, and patient care would be shown. They also sought an understanding with and without COVID.

HK commented on the importance of understanding the COVID impact, being over-established, and what the underlying run rate was. He queried whether they were running below the establishment figure and suggested that they reassessed the optimal establishment, reviewing this as they prepared for the MMUH move. SS reported that Mel Roberts would be presenting the establishment figures to the September Board for sign-off from a clinical quality perspective. They had a substantive establishment of 6,440, with about 1,000 bank and agency people. One of their challenges was, despite what everyone was doing, recruitment figures were not greater than the number of people leaving. They needed to keep recruiting to fill the gaps in the key areas, focus on retention, and make sure that the bank and agency staff exited at the same time as new people started. Mel Roberts was looking to refine and refresh the e-rostering system. They needed to recruit to the substantive vacancies at a Trust level as quickly and safely as possible, retaining staff, and as part of ongoing monthly monitoring, let the bank and agency staff go. This would also increase quality benefits.

DB commented on the link between the volume of the gap shown in this paper and the previous paper showing the strategic initiatives to narrow the gap. He queried how they would get the value and volume of those initiatives to contribute towards this as the next step. SS agreed. They had been working with HR to describe the financial return of the recruitment, retention, and sickness elements. These needed to be evaluated so that work could be prioritised in terms of rate of return for the workforce strategy and to see its benefits.

DB queried whether monitoring average pay would help, as more staff could be recruited if this was lower. SS described the suite of KPIs behind the figures and the benefit of having metrics down to Group and Directorate level to provide assurance that what was being done was having an impact.

PS agreed with HK's earlier points and commented that PCCT was consistently underspent against their pay budget and yet they largely delivered their objectives. Whether they could run at a lower establishment using less bank and agency as cover and the value to them of filling vacancies would be a complicated question to answer but should be asked across the Groups.

HK acknowledged the difficulty in finding time to do this work. The mix of bank, agency, and Trust staff had changed over time but the overall numbers had stayed the same. This could potentially be changed with more examination. He queried whether the assumptions behind the trajectories of pay expenditure compared to the 2020/21 actuals were realistic. SS reported that this was partly why they had requested detailed forecasts from the Groups. They needed to articulate the reasons behind rising run rates and whether it was linked to COVID or getting back to 100% of the activity plan. The forward look from the work they were now doing would be more helpful than looking backwards to understand why so that they could break the cycle of it always having been that way.

DB commented on next year's plans for shadow budgeting with the ICPs and queried whether they had thought about how they would be moving money and staff out of the hospital and into the ICPs. SS commented that this was reflected in what they were trying to understand and that different areas would be affected differently.

7. Elective Recovery Fund	**FIC (07/21) 006**

SS took the paper as read and made the following points to note:

- Through LK's leadership, the Trust was generating significant amounts of Elective Recovery Fund (ERF), recognising that it had to go through the System consolidation, which looked positive.
- As an organisation and as a System, the change to the trajectories and goal posts had had an impact. The July reset reduced potential income by about £5m for the System and about £2m for the Trust. They were expecting in the next weeks to get the money promised in April or May.

LK reported that Dudley and Walsall were also in a position where they were starting to step down elective work, hence affecting the overall System recovery position. Unless Wolverhampton's support

to continue delivering elective work in spite of the COVID pressures across the other organisations continued, it was unlikely that they would deliver ERF certainly in August and maybe into September, depending on how long the surge continued. The money coming in would be non-recurrent. They needed to consider how this £2.2m was used, whether it was to support them in H2, as an invest and save scheme to recoup later, or what was best.

DB suggested that they invested in a long-term people development fund, like an organisation he had met with that gave 7% of their income towards the development of staff.

PS had read that 60% to 70% of people were managed by Band 7s and yet only about 25% of the training budget went into those grades. He queried whether they were investing enough into middle management, clinical or otherwise. DB voiced his agreement.

ITEMS FOR DISCUSSION – Strategic

8. Underlying Deficit Review	**FIC (07/21) 007**

SS referred Committee members to the underlying deficit review paper. Through the respective teams and with DM, they had gone through their assumptions. The last formal review from the end of 2018/19 into 2019/20 had showed a £17.3m deficit. The paper described the following two aspects:

1. With a number of assumptions, they did have a route back to break even. The key assumptions included releasing a significant amount of reserves and because of COVID, the Financial Recovery Funding (FRF) regime would be replaced by something similar.
2. If they excluded the £25m FRF replacement, they had an underlying deficit of £40m including a £5m contingency.

MH queried earlier discussions and SS confirmed that there had been a £30.8m deficit proposed but reserves had been released and CIP had been added. A prudent but realistic £5m development fund moved them back to the £40m. This all linked back to the LTFM.

PS queried whether this excluded any non-recurrent COVID impact. SS confirmed that this was the case. System guidance was the working assumption that COVID costs would come with income.

DB queried how a deficit would be perceived in terms of well-led and what the right level of reserves should be compared to other Trusts. SS reported that other Trusts were transparent with their I&E but less so with reserves and uncommitted contingency. In terms of well-led, it was positive to be able to articulate the underlying deficit and to show how over time this would be reduced according to a plan. Every System and funding regime was different but many organisations did not have a plan of what to do about any underlying deficit, nor did they know how much it was. DB agreed with SS's assertion that it was important that the Trust understood their deficit and that was a key thing about being well-led.

LK agreed that it was good that they had a five-year financial plan, an understanding of their financial deficit, and plans to address it. In Option 7, where they took all their pressures into consideration and added back reserves, he challenged whether there was more they could be doing. He acknowledged that some things were out of their hands but asserted that they should try to come up with other ways of coming up with income to offset financial pressures or to get agreement through the System about how they were compensated. He commented that it was good that they were transparent but that there were commercial activities that they could explore from an income perspective.

SS suggested that they needed to refine their key actions going forward and to quantify these across the respective subsets. He commented that the aim wasn't always to break even but to preserve the safety and the quality. The downside of running a regular deficit was running out of cash and having to get loans, so the aim to break even was the best place to be.

PS noted that there was a risk that the plan included very little on MMUH in the current modelling.

9. 5-year capital programme – cash forecast	FIC (07/21) 008

Chris Archer, Assistant Director of Strategic Development, introduced himself for the meeting recording purposes as having joined the meeting in preparation for the next agenda items, as the author of the report on delivery of the logistics strategy – phase 2 and the car parking policy.

SS assured the Committee that they were refreshing their 5-year capital programme, including getting additional input from Estates and IT. They had received the draft programme at the Capital Monitoring Group in July. The teams were doing further work, such as to quantify MMUH work and cash allocations. The paper set out where they were and key next steps going forward, to come back to the Capital Monitoring Group in August, with the final versions then going to the Operational Committees and then coming back to FIC in September. The programme had a good process and structure. Once it was refreshed, it would go to Board. He invited questions.

HK queried how the approved amounts had been prioritised. SS reported that the core work around strategy standards had to be done but other things that had been classified as necessary were going back through the cycle to determine if they were an absolute must in terms of things like risk and whether they needed to be done in 2021/22 or later. These were being looked at professionally by appropriate experts for phasing and priorities in terms of risks and profile.

Amanda Wharton, Head of Costing, introduced herself as having joined the meeting.

10. Delivery of logistics strategy – phase 2	FIC (07/21) 009

SS provided an update on the logistics business case for MMUH. A paper had been promised in July to update them on the process and timeliness and to provide a chance to ask questions prior to the business case submission [in October]. They had partnered with DHL, who had expertise in this field. The logistics side was being funded from Taper Relief in 2021/22.

Chris Archer (CA) introduced the paper's aim, which was to provide focus on what they needed to do to deliver a business case and subsequently to implement it. It outlined how the programme was working to create a single business case with four elements:

1. A single team

2. Automated Guided Vehicles (AGVs) that would work at Midland Met

3. Inventory optimisation and EDC Gold

4. Warehousing and transport.

It prompted thinking on working through the options, economic and financial analysis, what needed to be tendered and to have commercial arrangements for, and how the project team worked. Some strategic decisions would need to be taken around where the logistics function would sit. There would be cost pressures attached so this business case would also be focused on presenting the benefits associated with the working model and using the AGVs at Midland Met, to justify the required investment.

MH queried whether these were each to be reviewed individually as standalone against the total development for MMUH. CA reported that this would be separate from the overall MMUH but part of it would be a subset. For example, the £1.8m investment in AGVs was part of the MMUH programme. They would be hoping to find this as a separate source of funding.

DB queried whether the four areas and their objectives could be tighter, such as how they would know whether they had efficient logistics processes and looking at the AGVs, what their KPIs were for performing well and whether they had service level agreement-type financial parameters linked around those objectives. CA reported that this was a planning draft to be used to prompt this type of conversation by the time they had the business case or by having a process by which the

implementation plan would identify those KPIs.

11. Car parking update	**FIC (07/21) 010**

CA introduced his paper and explained how the government concessions that had been announced for implementation on 25th March 2021 had been expected to be implemented during April 2021 despite the industry as a whole protesting that this would take at least three months to put in place. The key points were as follows:

- They had updated the car parking policy with their parking provider, Q-Park.
- Concessions had been announced for disabled staff and visitors, frequent out-patient attenders, parents of sick children staying overnight, and staff working overnight.
- They had updated the financial forecast for parking which reflected not only the estimated impact of the concessions, but also an update of the COVID impact with free parking for staff, which took them to 30th September. This paper assumed that free parking would cease on 30th September but it was not known whether or not this would be the case.

LK queried logistically how they would go about giving out free parking for frequent out-patient attenders and whether they had to evidence that they had been there three times or more or if it was recorded on the system. CA reported that this had been a challenging aspect to implement. The onus had been put on the patient to keep track of their attendances. Having looked back at the past year's attendances, and the way patients went from one service to another and the different areas patients touched on in the hospital, the best way to manage this was decided as having patients collect their receipts to claim because it wouldn't work to have areas like, say, cardiology rehab keeping track. LK commented that this would be difficult for patients who weren't aware of the policy.

LK queried whether previous regulations around cancer and chemotherapy still applied as an exclusion, even if they hadn't hit the three markers. CA confirmed that there was an updated list of concessions in the policy that included the frequent out-patients. The key change to the policy was that as part of the financial mitigation, tickets that used to be available had been withdrawn from general sale to patients and visitors.

HK commented that they should be prepared for backlash from patients because other places gave patients an exit ticket, especially when they came frequently. He queried why they hadn't made it easy by allowing staff to make those judgement calls because the system would show that these patients were there on a regular basis. CA reported that looking at the evidence, it hadn't worked that way. There was only a degree of that and they would keep this under review with Q-Park because particularly for frequent out-patients, this was an unsatisfactory mechanism. They had canvassed Trusts about what they were doing and the response rate had been poor. Other Trusts had different arrangements that had people all going through a central area which made management easier, whereas they had different logistics that caused people to walk through various areas and buildings.

HK queried whether they had canvassed views on other parts of the System to see how other Trusts managed this. He commented on how slick UHB's process was. MH added that Q-Park also managed UHB's parking and that registering and claiming back could be done online as well, with automatic recognition systems. CA reported that they had canvassed nationally to try to get responses but people hadn't been willing to respond. UHB's process was different because they had ANPR (Automatic Number Plate Recognition). The Trust's plan was not to introduce ANPR at the moment but they had regular conversations about it.

SS commented on how the paper described changes to tariffs and the financial position, which made sense to come to FIC but he queried whether the policy should have to be signed off by People & OD or if it was only coming to FIC before going to the Board because the impact on the patient, the reputation, and the non-financial benefits were where the debate should happen. MH reported that

they had discussed this at Public Board with their previous CEO, Toby Lewis. He suggested that they discussed this with RB for presentation at the Public Board to discuss not just the financials but also the ethics and the humanisation of it within the Trust.

12. Costing strategy	**FIC (07/21) 011**

SS introduced the paper, written by Amanda Wharton (AW), around the costing strategy, what they were recommending was done next with this, and how this linked with some of the earlier discussions they had had around sustainability, efficiency, and benchmarking.

AW highlighted the following key points from the costing strategy paper:

- The paper outlined the costing landscape, how costing functions had changed, and how they needed to drive forward a costing strategy within their organisation.
- There were numerous platforms where costing information was incorporated, little of which was used as part of making strategic decisions.
- With the rapid changes made to the payment system that had been happening over the last 12 months, costing would become more important, as CCG expenditure and Trust income was largely going to be fixed.
- Several workstreams were underway, including Service Line Reporting (SLR), which was the only place where all costing, income, and activity data was reported together at a service level. They would be moving to a quarterly SLR report rather than annually. This would drive an awareness for the services of their income, costs, and activity, as it would all be seen together.
- They were also supporting Patient-Level [Information] Costing (PLICS), the Model Health System, and GIRFT, all of which incorporated key costing metrics. These tools held a large amount of transformation and efficiency data that they could link with their costing data.
- The next stage was the move to SLR, triangulating with all the other resources they had, to prioritise a service review to look at benchmarking, productivity, and collaboration with their ICSs, which Model Health System reported on with their tool.

MH queried whether this was based on the latest revised figures pre- or post-COVID. AW reported that this was still pre-COVID based on the 2019/20 service line report. They were currently undertaking the 2020/21 service line report. For 2020/21, they were only looking at producing a costing model rather than including income due to the changes in payment methodology. Moving forward for 2021/22, they would be producing a quarterly SLR report published for November to show quarters 1 and 2 combined in a service line report and then quarterly after that. She confirmed for MH that this would include the changes to some of the procedures they had to do to be COVID compliant.

DB advised that all the Black Country Trusts were below 100 on the national cost collection index. There was a question around how a Black Country Trust could work at lower costs than other areas. They were carrying a £40m underlying deficit, so he queried whether they could have a strategic conversation about how they were more efficient but they needed more money. He commented that they had discussed a workforce paper today and strategic initiatives in the CIP paper, all of which linked together in terms of how they used Model Hospital to quantify and address these. He suggested that whether it was an ambassador outside of costing or a clear link into the Efficiency Board, these things needed to be triangulated. Thirdly, he raised the 'so what' question after SLR showed that they weren't profitable and whether that meant they would divest or if there was a link between SLR and acute collaboration to look at other Black Country SLRs within the specialties to bring the financial and quality sides together. Otherwise, they would be looking at certain areas making a loss without a route forward.

HK queried what their expectations were in moving from an annual basis to a quarterly one, and

whether they would change something as a result or observe it and continue to do what they were doing. AW advised that their first stage was to drive that awareness of the combination of costs, income, and activity. SLR information had only ever been reported annually, so the fact that they were reporting quarterly would create awareness and drive more clinical questions once they showed the differentials in costs between services, patients, and treatments.

PS expressed the view that it would be good to draw comparisons if the Trust could align its service lines with the rest of the ICS as a minimum. The Trust should understand what services it would not be willing to divest. As a district general hospital, they would never get rid of their Emergency Department even if it made a loss for example, but they may be more willing to get rid of vascular or oral surgery, which could drive the 'so what' question about any margins or return on capital or other measures. There was work they could do but a lot of it wasn't just a finance question.

SS agreed with the data driven comment by LK about it only being as good as the information fed in. He cautioned that the reference cost index (RCI) was different to SLR, which was all income and costs, whereas RCI was a subset of the costs. It didn't explain if they would be paid for it, only if they were efficient at doing something which may not be wanted, needed or paid for so there was a health warning along with RCI. He supported quarterly SLR reporting, which should be more strategic, so as to supplement rather than replace budgeting work. That moved them into the acute care sustainability part. It then became more of a Board discussion around service line management such as what was done by other Trusts where SLR was only one aspect of the financial quadrant alongside workforce, quality, operations, and the metrics DB was working on. SLR attached a currency to the question of which services were thought to be more efficient, helping to define what to do more of. This could be an exciting next step answering what to do with the data, as the Black Country would be using it in any case. MH added that this would help the Trust to have consistent conversations with them.

LK queried whether AW would recommend SLR or PLICS, as both were time intensive. SLR was high level, whereas PLICS broke it down into granular detail within each patient journey. Where they were now, he suggested that SLR would be the preference. Historic budgets were based on assumptions, whereas SLRs helped to understand the difference between income and expenditure to understand services' profitability, being mindful to avoid incorrect decisions being made on poor data. AW agreed and explained that a combination of SLR and PLICS care pathways would enable a sensible discussion with their ICSs about what their care pathways were and how they were to move forward in reviewing them. It would be SLR to initiate and then a hybrid with PLICS.

DB asserted that SLR was more of an acute collaboration tool, whereas PLICS was more of an ICP tool and getting that vertical integration flow. Model Hospital or Model Health System would help them to pinpoint Efficiency Board work from the workforce gaps. AW confirmed this.

LK commented that this relied on PHE, CCGs, social care, etc., all having a robust understanding of their patient level information as well because they had to add up the whole patient journey and pathway rather than taking one in isolation. If everyone understood the cost of the patient journey, they could add it up to see what added value and what didn't so that they could drive down the costs of the efficiency. So, for example, if they found that four community contacts were better than one acute contact, they could aim to improve the community element to drive better patient level value but this relied on having a good understanding of each costing element. Ultimately this was exactly what they wanted to try and do.

DB proposed that they could use PLICS to say who their top 200 most expensive patients were to try to develop ways of dealing with them better and more economically. They could then apply the learnings elsewhere.

13. Integrated Care System Update	**FIC (07/21) 012**

SS reported that they were on track but there was a forecast deficit at the end of H1. The governance

within the Integrated Care System (ICS) was recognised as not being ideal. An appendix outlined his proposals for a System Efficiency Board, a System Investment Board, and System reporting. If the System reported a deficit at the end of H1, it would come with scrutiny, bureaucracy, and challenge. Yesterday, a governance proposal was agreed as a key next step, whereby everyone fed in their results, the cross-System team consolidated it, and then there could be push back from the System to try again. The System had to get better at functioning in a way that managed consequences and repercussions.

LK commented that WMAS were driving most of the deficit, which they were linking to 111 and 999 calls. It would be interesting to see the contacts across the System because if they were picking up the primary care deficit as it appeared on the face of it, there needed to be a conversation about the CCG funding allocation and a redirection of this. SS agreed.

14. SBAF review	**FIC (07/21) 013**

SS summarised that the paper showed where they were against SBAF timescales and their respective scores for 2021/22.

MH queried whether there were any risks that SS was assumptions worried about. SS reported that there was uncertainty around planning for H2. They hoped to break even for H2 with a caveat of not knowing what was going to happen then, because their efficiency programmes were in place and they hadn't yet banked their ERF.

MATTERS FOR INFORMATION / NOTING

15. FIC workplan	**FIC (07/21) 014**

Noted.

16. Matters to raise to the Trust Board	**Verbal**

It was suggested that the following topics were raised at the Trust Board:

- Workforce planning and the three triangulation components to work through
- The car park policy and ethics discussions
- The underlying deficit and how to monitor and reduce it.

17. Meeting effectiveness feedback	**Verbal**

Not discussed.

18. Any other business	**Verbal**

None discussed.

19. Details of Next Meeting

The next meeting will be held on **Friday, 24th September 2021**, **09:00 - 11:00** by WebEx meetings.

Signed …….

Print …….

Date …….