West Norfolk Clinical Commissioning Group

MINUTES OF THE FINANCE & PERFORMANCE MEETING HELD ON TUESDAY 13 MAY 2015 AT 10.00AM AT MEETING ROOM, KING'S COURT, CHAPEL STREET, KING'S LYNN

Present:	**Chair**	Rob Bennett	(RB)	Lay Member (Finance) (Chair)
		Dr Ian Mack	(IM)	WNCCG Chair
		John Ingham	(JI)	Chief Financial Officer
		Kathryn Ellis	(KE)	Director of Operations & Strategic Planning
		Melvyn Peveritt	(MP)	Practice Representative
		Dr Sue Crossman	(SC)	Chief Officer
		Hilary De Lyon	(HDL)	Lay Member
In Attendance:		Cathy Hudson	(CH)	Admin Assistant (Minutes)
		Emma Kriehn-Morris	(EKM)	Finance Manager
		Simon Aldridge	(SA)	PMO (For item 9.3)
		Debbie Craven	(DC)	(For item 10)

ACTION

1 APOLOGIES

No apologies were received.

2 NEW DECLARATIONS OF INTEREST

There were no new Declarations of Interest

3 CONFIRMATION OF ANY PART OF THE MINUTES THAT IS EXEMPT UNDER THE FREEDOM OF INFORMATION ACT

Item 11 will be exempt under the Freedom of Information Act.

4 MINUTES OF THE PREVIOUS MEETING HELD ON 17 MARCH

The minutes of the previous meeting held on March 17 2015 were taken as an accurate record with the amendments to Page 4; Paragraph 4 will be amended to say; *HDL thought the paper raised an important issue about the relationship between the team based culture of the organisation and the control and command approach being used to achieve effective implementation of QIPP. In her view the current culture was appropriate and she suggested that the approach to QIPP might need to be adapted to achieve the best results.*

The addition of the word *NCH&C* will be added to paragraph 3 of the exempt minutes.

5 ACTION LOG/MATTERS ARISING

- **4/15 –** A paper on prescribing benchmarking is on the agenda for the day.
- **10/15 –** Amendments were made to the Terms of Reference and the updated version is on the agenda for today.
- **11/15 –** This item will be discussed under the A&E performance issues on the agenda.

6 TERMS OF REFERENCE FOR APPROVAL

The terms of reference were amended in accordance the recommendations made at the previous Finance and Performance Committee in March. There was one exception that relates to the membership of the committee. HDL had suggested the Audit Committee chair was made a member of the committee. Following further discussion it was decided to keep a separation between different roles but this will be kept under review.

ACTION

HDL asked that there is amendment to the frequency of the meetings to 'normally meets monthly' to allow for any variation. These will be finalised and be seen by the Governing Body for confirmation.

7 KEY PERFORMANCE ISSUES

7.1 **A&E:** KE gave an update to the meeting on the A&E performance. For the month of April we have seen a significant improvement in performance. Over the last three weeks performance has been over 95%. For April, the aggregate performance was just below 95%. We are seeing an early trend of improved performance but this will be monitored closely. During April there was a 'Breaking the Cycle' exercise. This is a period of time within which the system is scrutinised and tested including flow and discharge. We had a trust summary of learning from the exercise presented to stakeholders. Performance themes were pulled out, with the biggest factor giving them difficulty being delayed discharges, along with other factors including internal management of prescriptions and medicines. We have asked for the detail behind these issues to enable us to help with any issues.

During April we moved to the next level of contractual escalation around A&E performance. As contract negotiations were ongoing we decided to postpone enacting the withholdment for a further month as we wanted to continue the collaborative work. We are now revisiting this approach into May and will likely continue with the approach taking into account the improvement in performance. We will need to see evidence of internal improvement. It is important to get the detail from issues that arose during the 'Breaking the Cycle' exercise. The information has been requested on several occasions and the QEH will be chased. We will expect to see 95% for May to ensure continuous improvement. If this does not happen we will look into withholding payment. The meeting discussed any potential implications for the QEH if any payment is withheld.

7.2 **RTT:** A detailed paper reflecting the discussions at the weekly Elective Care Operational Group meeting was presented to the Finance and Performance Committee. Although the key target of 90% for admitted patients was not achieved in March. The target was met for the last quarter of the financial year, and the QEH are predicting this will continue. Four specialties have been highlighted as predicting not to meet the required 90% in April 2015 and have given revised trajectory. These are; Orthopaedics – August 2015, General Surgery – August 2015, ENT - June 2015 and Gynaecology – July 2015. We are working with the trust to review the outcome of the intensive support team review that happened in the last financial year. A modelling tool to pre-empt and predict potential capacity issues was recommended by the intensive support team. We are seeking assurance from the trust that they are utilising the tool.

It was felt that significant improvements have been made internally at the QEH to their processes which have led to achievement. EKM asked if this achievement was down to additional funding and whether this would be sustainable. KE responded to say that she would ask the trust to model in head room to achieve key performance. This would include covering sick leave and coping with additional demand as we have commissioned effectively.

IM told the meeting that discussions are still taking place for the QEH to be able to use Sandringham hospital beds to help with capacity issues. This needs to be pressed as has now been going on for a while. It has been brought up on several occasions at the System Resilience Group.

7.3 **Cancer:** There is a lack of confidence in the return to achievement of the 62-day target for cancer. WNCCG are currently waiting for a revised action plan and trajectory from the trust. There is an on-going issue which has an impact on the achievement of the target around the timeliness of diagnostic tests. This service is provided by Addenbrookes. Clinical capacity within this service is an issue.

ACTION

We are having discussions with Cambridge CCG to see how this issue is being managed. The issue has been escalated to chief executive level with both the QEH and Addenbrookes. The QEH has said they do not believe the Addenbrookes issue will be resolved until the end of March 2016. We require information from the QEH stating when they do expect to achieve target again along with data showing the impact of that particular issue on the 62-day target. This will help to gain assurance that the QEH are doing everything they can to return to target. Another area that is being looked at within the trust is the timing of the MRI. This issue is a high priority.

7.4 **Other:** Diagnostic six-week wait performance during 2014/15 had been difficult with a remedial plan to return to performance by February 2015 which was achieved along with hitting the target in March and April as agreed in the plan. An internal risk was flagged up around endoscopy capacity as being one of the issues. Monitoring of this will continue.

Stroke performance has also improved. A remedial action plan was also in place after initial issues with obtaining an action plan from the trust.

8 NHS ENGLAND Q3 ASSURANCE CALL FEEDBACK

SC updated the meeting on the NHS England Q3 assurance call. We have yet to receive a letter from NHS to let us know if they remain assured following the call. SC felt, following the call that we expect to remain assured. They were pleased with the planning and the financial position as well as governance. No issues around quality were raised. Two main issues that were pulled out were on IAPT and Dementia and recovery plans will be developed with the support of Dr Helen Geall, Interim Head of Assurance at NHS England. It would appear that WNCCG are well regarded.

During the call we informed them of our potential closer working with Fenland with the possibility of four practices moving to WNCCG. We also raised the issue of a primary to secondary care shift of activity. This became an issue after one of our practices stopped performing procedures following BMA guidance that had been sent out to all practices. Most practices have taken the position that these procedures are core GMS and as they have always historically performed these procedures therefore will continue. We have made it clear to NHS England that we do not feel this is a clinical commissioning group responsibility. This is activity that should be paid for by NHS England through GMS. This was agreed during the call. SC has received a letter from NHS England in reference to this issue. They are taking the position that they see this as additional to core and are also not responsible for paying for it. National guidance is not clear and does not provide any help.

The meeting discussed the potential financial implications of the CCGs if practices take this same stance. The activity level will be monitored by Business Intelligence and any changes in activity will be reported.

8.1 **IAPT Recovery Plan:** There is a national commitment to achieving 15% access rate to IAPT. As this had not been met an action plan is being developed to show what WNCCG will be doing to ensure these targets are. KE has had a conversation with Dr Helen Geall to gain a steer as to how this can be achieved. Examples of delivery initiatives have been shared with WNCCG for both the IAPT and Dementia rates. KE told the meeting that capacity within the commissioning team does continue to be an issue but recruitment is underway. Dementia, stoke and IAPT will be a focus for the team.

8.2 **Dementia Recovery Plan:** The national target of a 67% Dementia diagnosis rate is currently not being met. This is being dealt with as in item 8.1.

9 KEY FINANCIAL ISSUES

9.1 **Final 2014/15 Position:** EKM told the meeting that we have been able to achieve our 2014/15 1% surplus (£2.2m) which is a significant achievement for WNCCG.

ACTION

This has been achieved in part with some slippage in running costs. A number of exercises form part of the year-end include closing our cash at a certain position, having agreement balances with numerous bodies. We received positive feedback on our delivery. The audit is currently underway and at present no financial changes have been identified. They have already been through areas such as CHC. The feedback so far is reassuring with comments on the quality of the papers. The remuneration report is yet to be reviewed along with prescribing. JI and the Finance and performance committee thanked EKM and the team for all their hard work with the year-end finances.

IM asked if the report could show percentage variants in terms of out-turn. KE agreed that this would be helpful.

JI told the meeting that the debt raised by one of the Suffolk CCGs on behalf of the Clinical Academic Reserve was disputed formally by WNCCG and this was not included in the books and it has not been planned for in 2015/16 there is therefore a risk in 2015/16 that if this does then go against us then we will have to pick up two years of liability. SC informed the group that a letter has been received directly from the university. They are now threatening legal action if we do not pay. They have said that the expectation is that the NHS will fund these professorial posts for life. Our position is that this is not the CCGs responsibility. Responsibility lies elsewhere in the NHS as it is in the rest of the country.

9.2 **2015/16 Budgets:** A report went to governing body at the end of March outlining the overall position for 2015/16. This was approved by the Governing Body. The update includes any central funding for the enhanced tariff option. HDL asked if the change in marginal rate for non-elective activity (£0.8m) is based on the level of activity staying the same. JI responded to say that it was. HDL queried that as they will be getting more funding per element of activity, would there be a danger of the figure being an under estimate. JI told the meeting that this should be still at a level where they would not require extra activity.

RB asked JI if he was happy with the key assumptions made within the report. JI has based them on demographic growth, the main area this is applied to the acute contract where the payment is directly linked to the number of patients coming through the door. The rate used was agreed collaboratively within the CPT work. The £6.3m dedicated to the Better Care Fund is for the social care element and not the health part. A board is being established across health and social care locally to be responsible for the Better Care Fund. The Better Care fund does give CCGs nationally a financial pressure in 2015/16. This is one of the main areas that are contributing towards higher QIPP targets.

One of the big risks within the paper is the national discussions around tariffs for 2015/16. The draft that was sent out that is normally accepted by the service and then gets implemented was rejected by the majority of acute providers. This meant that there were two options. All of our local providers, being district general hospitals as opposed to those having a specialist component, went for the enhanced tariff option which meant that they received a 0.3% inflationary uplift and also if they are acute providers the marginal rate went from 50% to 70%. This is an estimated £1.5m for us as a CCG. There is a national pot of money, £150m, linked to this but we are unsure how this will work. £665k was received from this pot of money. This covers almost half the cost of the tariff change.
The impact this has had on the QIPP schemes are; reviewing excess bed days, the target has been increased by a couple of hundred thousand pounds. ICES had a QIPP target of £200k but there is now a chance of being able to save VAT on this. The Prior Approval work had an estimated target of £500k but following the detailed PID this is now around £700k. The final budget will be seen by the Governing Body to note the changes.

ACTION

The meeting discussed the definitions of elective and non-elective care. The QEH contract has now been signed within the envelope reported in the paper. The NSFT contract has some outstanding issues around risk and has yet to be signed.

9.3 **QIPP Update:** SA attended the Finance and Performance Committee meeting to give the group an update on QIPP. The attendees had read the report prior to the meeting. MP asked if the report could contain a one page report giving the highlights due to the high amount of useful information included. SA responded to say this will be included in the next report. The report includes details of each project and timescales of when they are due to realise savings. EKM asked if the values could be added into the timescales to give an idea of cost implications if timescales slip. SA told the meeting that the PMO log contains the information required and this could be included into the report. Having an idea of the savings throughout the year will be helpful in seeing if we are on target to meet the projected saving. EKM and SA can work together on the finances to produce this information.

SC asked about the 10 projects that have no delivery issues. The report shows the red projects but not the green projects. This information is also included in the PMO log and can be seen there. **The group would like to see the position of the schemes in September to see how they are progressing**. The QIPP away day was very useful and had a positive impact. The projects will be looked at to group together topics to ensure it is clear who is responsible. **SA**

The group discussed the QIPP processes and the challenges of the work involved with the large amount of QIPP schemes with a small team.

10 PRESCRIBING BENCHMARKING

DC came to the Finance and Performance Committee meeting to present a paper on Prescribing Benchmarking. The Paper shows information on the overall prescribing spend monitoring and compares West Norfolk CCG to the other Norfolk CCGs. The benchmarking compares our spending as a CCG against national figures. DC told the meeting that she could have a more detailed look into the data to see what this is showing us. We subscribe to Prescript, a prescribing monitoring support organisation. They have benchmarked West Norfolk against all the other CCG in the Local Area Team and beyond. This information is shown as a traffic light system along with our progress. It shows us as being green with respiratory and diabetes, both areas of work we have concentrated on. RB asked DC if it was possible to use the benchmarking data to high light areas that can be looked at for improvement. DC responded to say the data can be used in this way. DC told the group of the work that on within practices to assist with prescribing and medicine reviews.

HDL highlighted an area of higher spend with urology. DC responded to say this is partly due to issues with practice engagement. This may now be improved with changes within the urology service within the QEH. JI asked to have a clearer understanding of our high spend per AstroPU. This may highlight any areas of work that may be required. DC can breakdown the AstroPU information and compare nationally. **JI and DC will work up some detail to work up the next level of analysis.** HDL asked if it would be beneficial to look into whether a student would be able to take up this work. **JI/DC**

11 CSU UPDATE

******FOI EXEMPT ITEM******

12 AOB

There will be a review of future meeting dates to assist attendance. **RB/JI**

13 DATE OF NEXT MEETING

The next meeting of the Finance and Performance Committee will be on June 17 2015 at 2.30pm. There being no further business the meeting closed at 12.55 pm