West Norfolk Clinical Commissioning Group

MINUTES OF THE FINANCE & PERFORMANCE MEETING HELD ON WEDNESDAY 16th MARCH 2016 AT 10.00 AM AT MEETING ROOM, KING'S COURT, CHAPEL STREET, KING'S LYNN

Present:	**Chair**	Rob Bennett	(RB)	Lay Member (Finance) (Chair)
		Dr Sue Crossman	(SC)	Chief Officer
		Dr Ian Mack	(IM)	WNCCG Chair
		John Ingham	(JI)	Chief Financial Officer
		Carrol Crowe	(CC)	Director of Operations
		Melvin Peveritt	(MP)	Vida Healthcare
		Chris Humphries	(CH)	Director of Operations (designate)
		Chris Randall	(CR)	Chief Financial Officer (designate_
		Rev Hilary De Lyon	(HDL)	Lay member Audit & Deputy Chair
		Emma Kriehn-Morris	(EKM)	Finance Manager
	Attendees	Amanda Johashen	(AJ)	Interim Head of QIPP (For item 7)
		Philip Riedlinger	(PR)	Interim Project Support Officer (For Item 7)
		Maggie Carter	(MC)	Head of Clinical Quality
		Lucy Blood	(LB)	NEL CSU Clinical Pharmacist

ACTION

1 APOLOGIES

No apologies.
JI apologised for the late submission of some of the papers for this meeting. Down to pressures from this time of year.

2 NEW DECLARATIONS OF INTEREST

Vida Healthcare (Melvin Peveritt).

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

Contractual negotiations to be discussed later by CC and Clinical Academic Reserve.

4 MINUTES OF THE PREVIOUS MEETING HELD ON 17th February 2016

The minutes of the meeting held on 17th February were recorded and transcribed. JI Pg 4 item 8, amendment to last paragraph. *Increasing* to be changed to *reducing.*

The minutes were confirmed as an accurate record subject to the amendments.

5 ACTION LOG/MATTERS ARISING (Green Sections on report)

Capacity and Recruitment – this will be addressed later in this meeting and included in the Audit Committee meeting tomorrow.

- JI advised that demands have significantly increased and there is no abatement as yet, suggestions have been put forward as to how the finance resource should be increased, although noting a constrained running cost allowance across the CCG.
- Internal Audit have raised this in their report on key financial systems. IM stated that the clinical side of things would look at the wider issues of roles and responsibilities. CC asked what comes from CSU and what doesn't as we cannot benchmark CCG's against each other.

Imbedding QIPP – how do we get everyone within the organisation signed up to the culture of continuous improvement and efficiency? RB asked SC for an update, SC stated

that training and support for staff was to be further discussed. CC managing contracts is ongoing. There is work to do around recovery and an improvement plan.

JI said this would be everyone's objective within their appraisals. **QIPP training feedback overview to come from Phillip Riedlinger to next meeting.** **PR**

Better Care Fund – CC stated that £5.8m of avoidable admissions going into the top 10 diagnosis at QEH. QIPP schemes are being looked at for opportunities for example Respiratory, integrated teams. Legacy services and funding would make up the BCF number. IM said BCF is incredibly complex, with regards to delayed transfer of care. There will be a debate with QEH to whether they formal DTOC or medically optimise. The County Council has a different perception to what BCF is doing. RB asked if Rob Jakeman should be invited back. IM said it is very important to understand the management structure for accountability this will be discussed further at the Audit meeting tomorrow.

Training Sessions - feedback was asked for which was due to come back in April 2016 not March as stated on the report.

Committee Review - first 12 months of operation:

1. Develop an agenda programme for 2016, RB will put that together and bring to next meeting as Draft, please give any items you would like included to RB.(AMBER)
2. Attendance at meetings is being monitored.(BLUE)
3. Constructive challenging in meetings, Terms of Reference to be reviewed under AOB (BLUE)

6 KEY FINANCIAL ISSUES

6.1 Month 11 Report and QIPP Report: JI gave a brief update, the full report will go to Governing Body at the end of the month, the ledger closed w/e 11/3/16. The position at month 11 is similar to that of month 10, YTD surplus of £800K. It was around £700K last month so a slight improvement but is behind plan and the FRP trajectory. Significant adverse variance with regards to QEH contract and prescribing. A similar prescribing increase to other CCG's (£300-£400k increase). CH said there was a change in prices for a number of drugs in January but awaiting January's figures, JI also suggested that Christmas prescribing may have also played a part. Risk and Mitigations have been reviewed with NHS England, three scenarios were given last month

- Reporting a balanced view (as directed by NHS England)
- Worst case scenario, or
- Most likely case.

JI flagged up that Risk and Mitigation doesn't include clinical academic reserve, this wasn't provided for last year either. MP asked how it was funded last year if we didn't make a contribution. SC clarified that nothing changes. RB thanked JI for his overview.

HDL questioned prescribing patterns, Norfolk has the highest proportion of dispensing GP's and very high dispensing costs. This potentially creates a conflict of interest. HDL has asked what assurances there are that there is no poor prescribing by a dispensing practice to increase their income. IM responded saying that the variances between practices is high but dispensing practices are extremely professional, there is the potential that NHS England can serve notices on any practices over prescribing. HDL asked if practices that are high prescribers are they dispensing practices. IM said there is a sanction to take if the practice is a high prescriber. The biggest problem is for practices having capacity to implement changes, some GP's refrain from changing as they think it is clinically unwise, but others may not have the time capacity to implement those changes. MP said that a detailed audit would substantiate this as practices have a limited

resource. SC said there had been a deep dive 18 months ago by an independent company but no trends were found. **DC**

SC said it may be an idea to take an objective look at some practices who are high prescribers to satisfy the assurances needed. IM said another assurance is the joint committee. RB spoke about the conflicts of interest committee and invited Debbie Craven to look into this subject back in February, the conclusion was that there is no evidence of conflicts of interests amongst GP members of the CCG team. The Audit committee will consider in more detail.

CLINICAL ACADEMIC RESERVE UPDATE: ****FOI EXEMPT SECTION****

IM asked about prior approval processes (pg 3) JI stated that Prior Approval changes were put in place July 15 and updated Dec 15. Validation is needed for what is now happening. MP asked if they are submitting requests for prior approval and how many, also are the thresholds correct. SC asked if there are any reductions in procedures, JI stated that there were not.

JI stated that thought needs to go into how to improve and tighten the Prior Approval QIPP Project going forward. IM asked who clinically was included in this? It was clarified that it is Dr Mark Funnell. There is £649k in the QIPP programme for next year. CC said the referral pathways need to be looked at, she will sit with AJ and MF to map an exercise to do this. CC stated that the burden of proof would shift to the provider and only be funded once the CCG were assured.

IM to speak to Dr Mark Funnell about clinical input in this area and how it will operate going forward. JI said benchmarking that was done last year still stands and numbers done for N&N are substantially different from QEH. JI offered an update of this at next meeting.

CR asked about sanctions on prescribing, how often are they used? IM said the sanction is an NHS letter but has only been used once, currently there is an established prescribing saving incentive scheme. FRP give incentives at an individual practice level.

RB asked that given we have Feb figures what is the estimate of where we will be at end of March, JI estimated that if we deliver a surplus of £1m it would be good, we are still working as hard as we can to deliver the 1% surplus, this does depend on prescribing as variable and the QEH and their position for 2015/16. JI needs to go back to QEH but it may be a fix slightly higher.

RB asked for clarification of IM's point of prior approvals, some of the under recovery is being offset by higher recovery on penalties, RB asked if £716k was a firm number and JI confirmed that it is. RB - forecast total of £5m against the original of £7.8m, therefore should we be looking in the regions of £15-£16m for next year to allow for headroom and likely delivery.

IM contract penalties - will there be any decision on penalties after January, JI said a letter had been received saying that constitutional type penalties in Q4 should not be spent but retained by CCG to improve their financial position or given back to the providers to improve their positions. IM clarified that it won't support our bottom line.

6.2 **2015/16 FRP Update:** JI noted that YTD variance and risks are submitted to NHS England. In month 10 the scale of risk faced exceeded mitigation a net circa of £1m. NHS England have asked that we resubmit our financial recovery plan with updated risks.

CAR is not covered in this risk, JI waiting for formal feedback. The revised recovery plan shows other opportunities to maximise the yield that we should have for this year. JI also stated that there has been positive progress with continuing healthcare. SC asked on the dashboard under item 26-28 programme 'progress contract variation delivered on contract spend'? CHC assessment service are we going to spend that in the year, JI said it may have been committed to another provider but £20k may come back, SC does not anticipate that being spent. IM plan with QEH in claims process, what has the learning been and what are the actions going forward. Minor schemes is there the possibility to stretch these.

Virtual wards covering Cambridge patients, what is happening with this? JI said that data confirms patients out of West Norfolk and how many of those patients are social care, going forward we need much tighter reporting on virtual wards and thought needs to go into a better way forward. The QEH issue - West and North have adopted the pilot enhanced claims process, the North CCG have yielded a higher number, JI said we have had issues with the CSU contract management locally, Helen Hughes will be taking this forward. Claims are still open and there is a dialogue ongoing, there are over £1m claims that haven't been closed. IM said this would be a high priority area and benchmarking can be done against North Norfolk, JI said the process is being pushed forward for next year to get those claims closed down. MP asked if North Norfolk commissioned through CSU too, CC said it was a different trust who have responded differently. CC said a big difference was the commissioner attribution, N&N can be re-attributed to NHSE as they have a much bigger element of commissioning saturation.

SC asked if there was an evaluation of the process, JI said there wasn't currently. RB asked if this was a data challenge for QIPP 2016/17 JI confirmed that it was. Performance and capacity issues have come through within CSU. IM said further questions need to be asked to gain further assurance, and to map out the process and where the accountability sits between CSU and CCG committees. EKM asked if the paper would tie in with new year contracting? IM will discuss this later on. (RB asked if there was an update from QEH and negotiations that are taking place, for the current financial year? JI said an offer had been sent with a difference between the two of £1.6m, there is an element of negotiation with a forecast position of £700k-£800k although QEH may not come down to that level.(FOI))

6.3 Update on 2016/17 Planning

RB advised that there was a preliminary paper from JI and asked JI for his key points; the paper is going to the governing body in March for final approval of budgets for 2016/17. There are regular meetings for the financial plans to discuss risks and QIPP. JI stated that one of the national changes is around the current risk reserve, there has been a fundamental change going forward, 1% has to be set aside but we are not allowed to touch it – possibly due to huge deficit within providers nationally. If we deliver targets then there will be further discussion with regards to possibly spending it. Melvin asked if it could be used elsewhere, JI advised that the wording surrounds SDP Footprint Norfolk & Waveney. RB understands that this would be set aside and it may be used for deficits for other areas outside of those that may be seen in WNCCG position.

IM asks if there is an update regarding the QEH and their possible bailout. QEH has £6m offered to them to bring their deficit from £12m to £6m but in return they would have to commit to trajectories around performance. CC said trajectories are still to be agreed with the commissioners, they have now asked that the A&E meeting for June has been pushed back to July. IM clarified that trajectories are purely with regards to current national standards.

IM asked if the sanctions process has been agreed? CC confirmed that they will come under standard contract and there will be automatic penalties for any constitution standard missed and non-compliance, they can potentially be fined twice. CC advised that transformation money is linked to achieving their key performance targets plan and they get access to their transformational money. IM suggested that it could be put into the public domain that funding is being put into the Acute Hospital and funding is being given to them centrally. JI stated that the level of payment is linked to the Carter Report on efficiencies that each individual provider can make. JI added in terms of Risks that the readmissions credit (if patients are readmitted within 30 days then we don't pay for a proportion of their treatment again) is in the region of £500-£600k, this may not be available next year. The readmissions credit did fund services in the community to support patients on discharge from hospital and to reduce them being readmitted. CC to take this forward and brief JI.

RB asked about the pressures of growth £7.5m for Acute Services (pg 2), JI said it was a reasonable estimate 1.1% activity growth nationally, 2.4% for QEH demographic growth. Contract value has gone up to 2.5-3%.

7 2016/17 QIPP

7.1 2016/17 QIPP Planning Overview

JI invited Amanda Johashen, Philip Riedlinger and Maggie Carter into the meeting and also Lucy Blood who is standing in for Debbie Craven. RB asked for an overview of the top 5 points of the QIPP scheme. Maggie Carter (MC) handed out the Scheme Overview report.

AJ advised that the phase 1 plan needs significant revision after risk assessments, this exercise is being done towards the end of this week. There is a huge workforce challenge with regards to how the QIPP is performance managed and resourced going forward.

HDL asked how many people are involved directly with achieving a QIPP plan, AJ advised that it was a combination of substantive and interim staff.

PR has been delivering training to staff and has recognised that some people have had project management experience and want to up skill them so the QIPP scheme can be spread more evenly. PR advised that roles and responsibilities will become clearer.

RB said the scale of the challenge is £8.7m net so far, but more is needed, delivery is running at 50% in the current year. RB said an estimate of £15m would be a figure to go forward with. AJ recognises that clinical support and buy in is needed with a clear line of communication with clinical colleagues to get the right level of input. Dr Mark Funnell is supporting AJ. Ownership is also important for this scheme, Phil added that another piece of work which is called 'in the day job' could be considered in QIPP terms. CC stated that streams of work are QIPP, Transformation of work and Business as usual and they are getting moved in the right direction. RB asked to focus on resourcing, we need to come up with a level of resources that will support and deliver this programme, are there resources in mind? AJ said there needs to be a project resource per scheme who needs to understand how to engage with those responsible and have access to a senior responsible person, along with Business Intelligence and Finance and Communications support. CC said this needs to be done within the wider context. FRP is an example and is done by external people, this is not necessarily the most efficient way to do it. CC said it would be detrimental to resource QIPP separately.

MP asked what the gap is and what the cost is? CC stated that workload tracking happened last week and a decision should be made by next week. SC clarified that individuals need to know what to 'drop' to focus on this. PR said re-prioritisation and up skilling will take this scheme a long way. MC advised that the ownership does lay with individuals. RB is looking for assurance that we have the right people doing the right jobs

at the moment, CC and MC agreed with this and asked AJ to input her view into this. JI said this is more behind than where we should be. CC suggested that there was no need to bring in temporary QIPP support and to secondment people instead who are already familiar with CCG, economy and QIPP. RB asked JI why we are in this position, JI said it comes down to how busy people are. AJ added that this is a hard scheme and how it is approached. There is an opportunity to link in to wider scale programmes which should be done earlier, along with linking with clinical partners. CC said it may be down to lack of engagement. SC asked for focus on the projects that need our improvement and track the changes.

HDL asked if people would be appraised on this? It was confirmed that they would be and SC added that it would be discussed with Governance Team as it would need to be included in PDR. EKM confirmed that the timings of PDR's were conducted on an individual annual basis. IM said this has been a helpful discussion and the structure will be discussed further at the Audit meeting, it comes down to finding different ways of working.

CC asked if QIPP would be in the objectives for clinical leads too? IM advised that it would be worked towards. AJ said the plan needs to be signed off by the governing body imminently. HDL asked for clarification that the aim is for £15-£16m plan. PR advised that we are looking for 75% success rate on projects. JI clarified that there is a difference between QIPP target and aspirations.

7.2 Better Care Fund Renegotiation

JI explained that in 2015/16 £11m was put into BCR, £2m was put into Social Services for maintenance but it has become apparent that we do not need to do this. Social care is expecting £7m across all the CCG's to continue into next year, to reduce this could have an impact on healthcare. SC is attending a meeting this afternoon regarding Risk Share.

IM asked who would be managing the BCF key figures, JI said he has been doing it up to now with support from NHS England and discussions have been led by County Council. IM recognises that JI's work is now split between 2 CCG's. JI advised that section 75 finishes 31/03/16 so no commitment to make any payment to the BCF. HDL pointed out that Norfolk CCGs had contributed more than other regions in 15/16 as they had been faithful to the original NHSE guidance NCC is taking the position that the "protecting social services care packages" is recurrent. CC said there was a minimum financial requirement.

7.3 – Prescribing Quality Scheme

LB was standing in for Debbie Craven and highlighted that the scheme will run from March – December to realise the savings within the year. 50% of financial incentive will be paid in first quarter. The scheme will be individualised to the practices to get maximum engagement. Payment made to practices will be weighted against the amount of savings. MP asked if there was claw back if they don't deliver, LB said the payment will only be made at the end of the year if they have made the savings – LB clarified that the 50% payment is allocated to them but paid at the end of the year.

IM highlighted that the important element is multiple medications in long term conditions, LB advised that it has been established and now it can be built on through the coming year. RB asked about conflicts of interest and medicine reviews, LB said medication reviews are now across the board. IM asked to make sure that care home matrons are involved with medication reviews with the pharmacists. MC recognised that LB's department has not had as much support with this work but they do now have additional resource. RB said there would be just over a £1m saving but this does not tie up with the planned investment, RB asked what would it be different this year to the delivery compared with last year? LB said the individualisation of delivery would help the practices, more pharmacist support increases the work and speed that it is done. IM said the targets are moving targets due to the prices of drugs, the long term solution would be to make sure the practices have a fluid and dynamic process. RB asked what the deliverability factor would be? LB said this is

what is done day to day and they understand the system so it is achievable. LB left the meeting.

7.4 CHC Optimisation

SC explained that CHC optimisation has two parts, SC is leading on new CHC pathway implementation. Patient assessments take place out of the hospital whilst the patient is recovering. 28 days of care is paid for whilst the patient is recovering. It is early days for the scheme which was implemented on 4th Jan, now it is reviewed fortnightly with key people who are delivering it. HDL asked why is 28 days chosen, is there evidence that it is relevant? SC clarified that it is up to 28 days, a month after discharged most people reach their optimum recovery if no ongoing care is needed. The clinical condition of each patient would influence this. RB asked that net saving £750k with an investment of £24k, RB asked if Robert Jakeman should be involved with this area? SC confirmed that he would be. CC asked that when patients are out after 28 days where do they go? SC said it was based on needs, nursing home care has been negotiated. IM asked what the impact this has on beds at QEH and the flow has not shown any benefit. SC responded that CHC patient numbers are small, so impact on total flow is limited but the LOS for CHC patients is significantly reduced. HDL asked what the deliverability would be on this, SC said it is already implemented, data capture and monitoring is ongoing.

7.5 CHC and Non-CHC Individual Patient Placements

RB asked if the sharing of information between organisations is an issue, MC stated that it is not. The planned investment and net saving stands at TBA on the report, MC said the work has been done with Adrian Bellamy. MC has discussed baseline savings with Adrian but he is currently off sick. RB asked who the clinical lead would be as there will be the need for a clinical review. MC clarified that the clinical lead would be Tony Burgess. CR asked if CCG was responsible for out of area treatments? E.g. mental health, LD, JI said not for mental health, the trust picks up some mental health, there are some patients who go to specialist treatment locations.
MC left the meeting.

7.6 Acute Data Challenge Process

JI said a decision point is needed soon, it should be established as business as usual but needs to be monitored. RB asked who is working on the proposal for next year. JI said he would expect it to be worked up within the next month (first couple of weeks of April) and the team is ready to process information. CC said we need to work out what we get for enhanced services from our SLA.

RB asked JI if we should be relying on what the lead commissioner does for the N&N, JI confirmed that we do. HDL asked what happens if providers do not engage with the process, would that pose a problem? CC said there is an issue with the payment cycle, CC proposes moving to SUS to pay on evidence. RB said there are lots of risks identified, PR said risk mitigation does need some improvement. RB said the content of workshops looks very good. PR will report back on feedback received at the next meeting. IM asked if roles and responsibilities could be explored at tomorrow's meeting. CR said in the current year there are planned savings of £1.5m for data challenge, is there enough challenge for the level of savings. JI responded to say that NEL said 1-2% of contract value.
PR and AJ left the meeting.

8 Performance Matters By Exception

CC highlighted constitutional standards, ambulances, A&E and metrics around mental health. CC has closed contract forms on QEH but they can be re-issued on 1/4/16. Remedial action plan included Ambulance and A&E, if not on a full trajectory by April, then we will be issuing contracting sanctions.

IM said more work is to be done with the remedial action plan, performance remains poor. Performance for A&E has dipped to 64% for 4 hour A&E. NHS England are taking great interest in this issue.

CC reforming the SRG care system, getting the flow. Key issues to think about are 7 day working for all our services.
IM said getting business as usual is challenging.
RB will read CC's report outside of the meeting and feedback to her, JI, HDR, CH and CR will also be copied in.

9 Feedback from Contracting Executive March 16
******FOI EXEMPT ITEM******

10 CSU Performance Monitoring
RB asked what performance against the KPI's are? JI said staff contract management and finance have been the main issues. There are however, areas that work well. CSU role in relation to what it does for CCG needs to be brought to discussion tomorrow. CC asked what % of management allowance is to be spent on CSU? JI said approximately 25%.
HDL stated that Great Yarmouth and Waveney do not use CSU's for some areas of work.

11 AOB
Cathy Hudson has reminded RB that Terms of Reference need to be reviewed, but due to time restraints today could individual's feedback comments to RB so he can collate them and bring an updated copy to the next meeting. Comments are needed by the end of the month.

RB said he would like to thank JI on behalf of the committee for everything he has done for the CCG and the support given to RB, he has done a tremendous job and his commitment is incredible. CR is coming into the role.

RB also thanked CC and said her experience and insight has been invaluable.

Also a welcome to CH into his role.

12 Date of Next Meeting:
There being no further business the meeting closed at 1pm.

The next meeting of the Finance and Performance Committee will take place on Wednesday April 20th 2016 at 10am.