NHS
West Norfolk
Clinical Commissioning Group

Agenda Item: 18.81

MINUTES OF THE FINANCE & PERFORMANCE MEETING HELD ON FRIDAY 23rd August AT 10.00 AM, MEETING ROOM 2, KING'S COURT, CHAPEL STREET, KING'S LYNN

Members:	Karl Fenlon	(KF)	Governing Body Lay Member & Chair
	Dr Imran Ahmed	(IA)	Governing Body GP Member (Left at 12pm)
	Michelle Barry	(MB)	Governing Body Lay Member
	Rev Hilary De Lyon	(HDL)	Lay Member, Audit Chair & WNCCG Deputy Chair
	Howard Martin	(HJM)	Chief Finance Officer
	Ross Collett	(RC)	Director of Commissioning and Delivery
Non-voting Participants:			
Attendees:	Catarina Hamlet	(CH)	Admin Support (Finance)

18.69	**APOLOGIES**	**ACTION**
	Emma Kriehn-Morris (EKM) Deputy Chief Finance Officer John Webster (JBW) Accountable Officer Melvyn Peveritt (MP) Practice Representative (Vida Healthcare)	
18.70	**REGISTER OF INTEREST**	
	No additional declarations were required beyond those on the register.	
18.71	**CONFIRMATION OF ANY PART OF THE AGENDA THAT IS EXEMPT UNDER THE FREEDOM OF INFORMATION ACT**	
	Nothing to declare	
18.72	**MINUTES OF THE PREVIOUS MEETING HELD ON 27th July 2018**	
	The committee requested some changes on the minutes as per below: ➢ Page 3, second paragraph, "supporting the Trust on their trajectory". RC to liaise this with RZM and return to CH with the updates. ➢ Page 6, problem with the punctuation, advised revision ➢ Page 5, misspelled the word "fully" ➢ Page 5, Mitigations for the contracts ➢ Punctuation KF minutes were accepted with amendments but formal sign off is delayed awaiting the return of the missing members to assure their comments are taking into account.	RC CH CH CH

18.73	**ACTION LOG / MATTERS ARISING**	
	04.18 – HM presented an outline of the Grant Thornton report summary, agreed to share the report same day. It was accepted that the report supported the CCG position and the matter will be taken forward to consider the financial impact in discussion with the trust for future periods and will be considered elsewhere for its clinical impact. **Action complete.** **10.8** – Significant progress has been made on issues with contracts. The issue with BMI contract has been resolved. Contract wavers for Vida, St James and Southgates practices remain outstanding. **15.18** – Urgent Care plan summary shared today 23rd of August, updated to be brought forward at next meeting. **16.18** – Included on performance report. **Action complete.** **17.18** – To be included on performance report. Update for next month regarding Cancer. **Action complete.** **18.18** – To share with Practices has requested by MP. **Action complete.** Missing from the action log: ➢ **Missing action for HJM regarding mitigation for ending for contracts due to going into administration** **CH** ➢ **HDL and RC meeting with Prof Goldstein, feedback to be given in August F&P meeting.** **CH** KF said the action was completed as it was for HDL to begin communications with Prof Harvey Goldstein and asked if this type of analytical data report should be implemented nationwide through NHSE instead of WNCCG. HDL said that this was a way of developing what WNCCG was already working on to improve the measure of value or casemix from Primary Care. RC confirmed and agreed with the closure of the action. RC will continue the development of this work but this is not a subject that will be discussed at F&P.	
18.74	**Risk Register**	
	HJM advised the Committee there were no changes for GBAF. HJM advised on the Corporate Risk Register changes that reflected in four areas with an increased risk, RC said that despite the number of actions the WNCCG has taken to avoid risk, these risks will continue to be monitored as part of the Integrated Performance report. HJM commented on the new risk Community Providers and Social Care and advised this should be revised as the wording of the Risk title did not seem correct. **Action: RC will to review this risk**. The Committee accepted the report, with the risk 2.5 to be considered for the next meeting.	**RC**

18.75	INTEGRATED PERFORMANCE REPORT	

Performance

GP dashboard

RC presented the dashboard and clarified that the dashboard is not a ranking of practices but a way of comparing the use of resources between practices. Further development of the dashboard is being undertaken to improve the understanding the use of resources generated by Primary care.

HDL asked if the WNCCG should consider changing the heading as the current one is not clear about the ranking of use of resources and this may have a negative effect on the practice.
The committee has discussed this subject thoroughly and have decided to keep the heading as this dashboard will have future changes. The CCG assured the committee that if the heading had any negative impact on Practices, action would be undertaken immediately.

A&E

RC asked the committee to note that A&E performance changes on a daily bases, therefor the performance report will only capture a snapshot in time which will be out of date. Previous week performance has deteriorated, NHSE are aware of this as the CCG monitors performance on a daily basis and share a data with NHSE.

The WNCCG measures the actions taken to address urgent care performance through a joint improvement plan with QEH.

A key area of focus for QEH is the NHSI “SAFER” Programme which if embedded would improve flow through the hospital positively impacting the A&E performance.

The WNCCG continues to challenge the Trust about the implementation of “SAFER”.

KF asked if staffing was a key issue. RC agreed with KF acknowledging that QEH has a heavy reliance on Bank and Agency staff. SJW highlighted that the vacancy rate at the Trust is 25% and this is a high.

RC assured the committee that WNCCG is implementing a range of schemes and support to improve performance at QEH. Examples include winter schemes starting in November and QIPP. All of these initiatives are intended to reduce or redirect demand.

MB asked if the Trust were now coding accurately, and if so would this have a negative impact on the performance. RC replied this could correct.

KF asked if the Trust behaviours have changed regarding the coding, HJM said that one example was the conversion rate from A&E has decreased from 40% to 30% but WNCCG will be unable to confirm if this is a coding change until WNCCG have at least two months data.

KF asked if the issue was just the coding, RC said it was not the only issue.

KF asked if this performance change could be associated with an increase of patients, RC acknowledge that performance Is potentially affected by an increase in patients but currently NEL (Non Elective) admissions are decreasing.

KF asked if the hot weather had any impact on A&E and RC acknowledge this could have cause a peak on attendances but any subsequent deep in performance is compounded by a lack of staff or inexperience staff.

KF enquired as to whether QEH has appropriate protocols in place to deal with peaks in demand thereby avoiding a drop in performance. RC advised that the trust does have some protocols in place but it is not always clear whether staff are aware or are following these protocols.

HDL said that for the last seven years she has been involved with the QEH, her main concern has been management team turnover which impacts performance.

Diagnostics
RC informed there were no issues to report and they have improved.

DTOC (Delay Transfer of Care)
RC explained there are recurrent issues related to reporting of DTOCs which inflates the figures thereby inaccurately reflecting poor performance. RC advised that the WNCCG has agreed with the trust that they will follow the national guidance for reporting which will produce and accurate reflection of performance. In addition the WNCCG is taking a range of actions to improve discharge.

RTT – (Referral to Treatment Times)
RC advised there is a deteriorating position at the trust.

If the position continues deteriorate the trust will not meet its current trajectory to achieve the NHSE planning guidance.

There is a recovery plan in place that is monitored fortnightly at a joint meeting with the QEH.

IA asked if the trajectory is takes account of Winter pressures when elective procedures are often cancelled due to emergency admissions. RC advised that winter pressures were taken into account as part of the plan and trajectory.

KF asked if the WNCCG expects performance to decline over winter and therefor does tis risk the trust not meeting the requirements of the planning guidance. RC reiterated that winter pressures are factored into the plan but the WNCCG does have additional mitigations that it could deploy if performance drops below trajectory. This would involve moving or offering patients an alternative provider for that treatment. The Trust, however, will be accountable for any subcontracting of patients to other providers including the provision of transport.

KF asked whether the WNCCG accepts performance below the target of 92%. RC explained that the trust has to meet the requirements of the planning guidance which relates to waiting list size and not the NHS constitution target of 92%.

Mixed sex accommodation
KF asked if the WNCCG found it acceptable that the trust continues to see MSA breaches. RC explained that is not acceptable, but there are mitigating factors to do with the estate that is preventing the trust from meeting the requirements of MSA primarily in ITU.

SJW highlighted that the quality team are focussing in any MSA breaches that are not in ITU as there are no mitigating factors relating to these breaches.

Dementia
RC said the trust is not meeting the target. There is an action plan to engage with the practices and a GP lead to assist the practices with the identification of Dementia patients. The team are working towards the post-diagnosis support to assist the patient and family plan the next steps.

IA raised a concern to the committee regarding Dementia diagnosis, he feels there is delay on these and this may have severe repercussions for the patient, their family, GP and carers.

HDL informed the Committee that she would be meeting with Dr Devulapali and the NSFT chair and that she would mentioned this subject.

KF asked if the WNCCG should review the current action plans to be assured that they will deliver the desired outcomes. RC advised that the plans have been approved by NHSE and that he was confident that we were taking appropriate action.

IAPT (Access & Recovery)
RC advised that have been great improvement towards the target but the WNCCG remains cautious regarding the sustainability of current performance as NSFT has a limited capacity and can often shift attention to other parts of the STP which results in a drop in performance, This is the subject of a current contract performance notice.

FINANCE REPORT
HJM started by advising the Committee that the report was reflecting a deficit of £1.8m but in fact was £2m. This is because the CCG has received the quarterly share of the commission sustainability fund in Q1 for the amount of £200k. HJM explained there is a plan to spend £279m against the allocation of £277m.

The full £2m is wholly dependent on the delivery of the finance plan. HJM reminded the Committee that the CCG has a cumulative deficit of £5.8m that will need to be repaid in future years, adding 1% surplus at £3m meaning a total of £9m to be recovered in future years.

HJM said the CCG is still forecasting the delivery of the plan for month four and has posted the year to date position that is aligned with the plan. He informed the committee that there was an utilisation of £1.9m of the reserves and forecasting £7.3m by the year-end. There is an increase over £1.2m regarding the values reported in month three, and the two key drivers are:

- 500K for Continuing Health Care
- £700K and £800K for Intermediate Care Beds between (HJM raised his concern to this as the CCG has a £1m QIPP associated to some of these beds decommission)

HDL

KF asked where the intermediate care beds are being provided, RC responded that there are 98 contracts for the Beds and it was is a large number for the CCG geographic size.

KF asked if the purchase of the additional beds was associated to the QEH overflow. RC disclosed these beds are for rehabilitation and reablement, to restore patient's independence post hospital the CCG had to purchase 129 additional beds to relieve pressure on the hospital, but the was a concern that patients did not get the service for the intermediate care.

KF asked where these beds are allocated. RC said it was across the West and East between public and private provider. Within the QIPP scheme there is recognition to:

- Reduce spot beds purchase,
- Ability to decommission, (Being a risk)
- An arrangement with Norfolk County Council that provides a less complex end of rehabilitation, to shift 10 beds from the CCG.

KF asked what was the amount allocated to this QIPP. HJM replied there were £800k overspend and £1m as a risk.

IA asked if reducing the bed stock was the best solution considering the QEH pressure at the present month, expecting to deteriorate for winter, not disregarding the NHSE pressure towards the CCG. RC said that was a risk. The CCG is under pressure by the regulator NHSE regarding moving patients inappropriately, and said there are mitigations in place:

- Dialogue with Norfolk County Council (Meeting booked to resolve the bed's relocation)
- Clawback funding from Cambridge and Peterborough (RC will draft a letter to HJM to inform the expenditure last year for their patients)

Further negotiations with Cambridgeshire and Peterborough CCG will take place to agree payment for their patients.

IA asked why WNCCG is getting the pressure from NHSE and no other CCG's. RC replied that WNCCG is the lead commissioner. HJM said the priority in situation of extreme pressure, quite often Finance becomes second priority.

KF asked HJM if he had taken the £1m out of the QIPP, he replied that this was not taken yet but will be wound down in future months.

HJM explained the Reserves Utilisation on slide 20, and pointed out that £3.6m was available as contingency against material risks, amongst them are:

- Intermediate Care Bed QIPP
- RTT (£1.5m risk)

This is £1.2m less than was available in month three.

KF said that given the size of the values, risk is increasing financially.

HJM shared a paper with the committee that reflected the respective position between QEH and CCG. On the 30th of July the CCG offered QEH fixed values being £102 as minimum and £107m as maximum pay for the contract, the Trust submitted a counteroffer of £109.7m on the 20th of August and the CCG has declined this offer on the 22nd of August.

	 Peer Review Paper - WNCCG - 230818 .pdf HJM informed the committee that he and Roy Jackson (QEH Director of Finance) were called to a Peer Review Process and explained the Key Financial Risk paper he had prepared to share at the meeting that would justify the CCG position. The Committee discussed the paper and KF commended the work done on the paper and supported HJM on this paper and the CCG position. KF asked what would be the following steps from this meeting. HJM said the outcome will be shared with to STP and after would escalate to Paul Watson.	**RC**
18.76	**STP UPDATE**	
	JBW on annual leave, updates by next meeting.	
18.77	**ANY OTHER BUSINESS**	**ACTION**
	The next meeting of the Finance and Performance Committee will take place on Friday 21st September 2018 at 2.30pm.	