NHS
West Norfolk
Clinical Commissioning Group

Agenda Item: 18.81

MINUTES OF THE FINANCE & PERFORMANCE MEETING HELD ON FRIDAY 27th July AT 10.00 AM, MEETING ROOM 2, KING'S COURT, CHAPEL STREET, KING'S LYNN

Members:	Tim Bishop	(TB)	Governing Body Lay Member & Chair
	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
	Melvyn Peveritt	(MP)	Practice Representative (Vida Healthcare)
	John Webster	(JBW)	Accountable Officer (*Joined at 10.18am*)
Non-voting Participants:	Rebekah Mercer	(RM)	Deputy Director of Operations
Attendees:	Catarina Hamlet	(CH)	Admin Support (Finance)

18.59	**APOLOGIES**	**ACTION**
	Ross Collett (RC) Director of Operations Emma Kriehn-Morris (EKM) Deputy Chief Finance Officer Dr Imran Ahmed (IA) Governing Body GP Member	
18.60	**REGISTER OF INTEREST**	
	TB stated he was chairing the meeting on an interim basis and introduced Karl Fenlon as the new Lay member for Finance, and asked all members to introduce themselves. TB asked if any of the committee had any updates to the register of interest which has been circulated. **No additional declarations were required beyond those on the register.**	
18.61	**CONFIRMATION OF ANY PART OF THE AGENDA THAT IS EXEMPT UNDER THE FREEDOM OF INFORMATION ACT**	
	Nothing to note	
18.62	**MINUTES OF THE PREVIOUS MEETING HELD ON 22nd June 2018**	
	All minutes of the previous meeting which was held on 22nd June 2018 have been approved by the Committee with the exception of the dates on page 6, HM asked for an amendment on the sentence below: *"The current financial plan is that we repay this debt in full and move back to a normal business rule in year, which would mean the CCG would need to get to a 1% surplus*	

	position (around £3m), HM's view was that the £9m repayment in the 2019/20 plan was not realistic." Should be changed for 19/20, CH to update the minutes. With this update, the minutes are **APPROVED.**	**CH**
18.62	**ACTION LOG / MATTERS ARISING**	
	Action no. 04/18 – Report has been completed, this is to be added to agenda for the next F&P meeting. This will remain open. **Action no 10/18 –** HM informed the group that the BMI contract is not yet signed as there is an outstanding issue regarding CQUIN. The remaining contracts (Vida, St. James & Southgates) will be signed by the 31.07.18 **Action no 11/18 –** Discussed on agenda **Action no 12/18 –** Discussed on agenda **Action no 13/18 –** Discussed on agenda **Action no 14/18 –** Discussed on agenda **Action no 15/18 –** RM advised the committee that draft proposal will be submitted to the A&E operational group the following week and an update will be shared at the next F&P meeting.	
18.64	**FINANCE AND PERFORMANCE ANNUAL WORK PLAN AND TERMS OF REFERENCE**	
	Annual work plan HJM said that the changes and expectations on the budgets, and business case approval. TB asked if the committee were happy with these changes, all **APPROVED**.	
18.65	**STATUTORY DUTIES (INC FINANCIAL MANAGEMENT AND VALUE FOR MONEY)**	
	GBAF This item was discussed, agreed and approved at the last meeting 22.06.17.	
18.66	**INTEGRATED PERFORMANCE REPORT**	
	Performance Reporting RM introduced the GP dashboard. The figures are based on month two data. RM also confirmed that the figures within the report are weighted by population so it is a fair comparison by Practice. There is further development of the dashboard being undertaken that will provide further context for future reports. HDL highlighted previous work that she had undertaken in the field of education that enabled "value add" to be	

	drawn from a variety of reports and that CCG Director of Commissioning and HDL will be meeting a former colleague in mid August. Further updates to follow on the "value add" work at future meetings. **A&E** RM explained slide five of the presentation. QEH A&E performance was noted to have improved in June to 91.92% RM explained that whilst performance in early July was positive the recent heatwave had contributed to an increase in attendances and a subsequent reduction in performance. RM explained the purpose of the joint improvement plan (to be shared at the next meeting) RM explained that there were a number of workstreams contained within the plan and that delivery of the actions would support the Trust in the delivery of their A&E trajectory. RM explained that a key workstream contained within the plan was regarding improvements to discharge processes including the discharge to assess project. The delivery of discharge to assess would reduce the number of long term decisions made regarding patient's long term care made in a hospital setting and improve flow from hospital. JBW reminded the committee that the CCG is pressing the QEH to achieve the national requirements but also to work towards the winter plan to get less community delays for West Norfolk; this will be discussed at a future meeting. HDL reminded the group about a concern raised at a previous meeting regarding staff annual leave at the QEH. RM informed the committee that the Trust is currently relying heavily on Agency and Bank Staff but were actively engaged in recruiting substantive staff to vacancies. **Cancer 62 Day Target** RM explained that although performance for May had improved to 84.3% versus the national target of 85% there were concerns regarding the sustainability of achievement of 62 day performance. RM explained that patients that breached the 62 day standard were only reflected in the 62 day performance statistic when they were treated. RM explained the current concern related to a backlog of patients awaiting either diagnosis or treatment that had already breached 62 days. RM explained that whilst the CCG had received a remedial action plan and trajectory from the Trust in response to the Contract Performance Notice, the Trust has "over-performed" against the trajectory and clearance of the 62 day backlog has not been achieved. This had been escalated to NHSE and an escalation call was booked between the Trust, CCG, NHSE and NHSI. MB asked why they were waiting for the 62 days to hit, and also if the CCG is aware of the 'real' numbers. RM assured MB that the CCG were aware of the number of patients currently within the backlog and that fortnightly meetings were being held with the Trust to monitor performance.	**HDL/ RC**

	JBW explained that the CCG was committed to working with the Trust and regulatory partners to work towards the resolution of this issue. The QEH had explained that they believed the reason for the back log was an increase in GP 2 week wait referrals. The CCG felt that the cause was multifactorial and that further understanding of the issues was required. MP made a point to the committee about the possibility of the patient not having 62 days to wait for the treatment. MB asked what the report set up was for '104' breach; JBW responded that NHSE requires all CCGs to inform them when they hit 104 days. TB asked if the issues discussed are considered for review at the Quality committee. SJW confirmed they were, NL assured that going forward this would also be reported publically. TB asked if there were pathways for particular groups as Urology is being analysed and controlled all the way through; RM confirmed that there was work ongoing regarding improvements within specific pathways and that the CCG was represented at both Norfolk and Cambridgeshire and Peterborough STP wide cancer meetings. TB asked if there any escalation discussions about patients who had breached the target and raised a concern about prostate cancer. TB also asked if the Trust is struggling within this or other specialties. RM replied that there were challenges within Urology and treatment times at the tertiary centre and that the required recovery plan would contain actions to improve waiting times HDL asked if there is anything that could be learnt from these events, for example good practices on Urology elsewhere. RM said that there are good practice guidelines and model pathways published nationally and that the service improvement work underway at the QEH and across the STP compared the services nationally to these guidelines in order to identify opportunities for improvement. JBW said that where individuals were resistant to change best practice evidenced guidelines were a good motivator for change. TB asked JBW and RM to provide the committee with an update from the meeting scheduled with the QEH. **<u>Diagnostics</u>** RM presented slide seven and explained that the reduction in performance was predominantly associated with the DEXA. RM explained that a backlog of scans had now been cleared although the scanner was still housed in a temporary location. RM shared with the committee that a meeting is planned for the following month with the local osteoporosis group and QEH to agree the steps required to locate the scanner within the main building. KF asked about the previous procurement and the learnings from the failed contract. RM said that regarding this specific contract, there had unfortunately been an extremely short notice cessation of service with very little in the way of penalties which could be applied. HDL felt that there is a need to create a continuity plan in case a contract ends without previous warning. KF stated that it was clear there was a lack of mitigation. RM	**JBW/RM**

	explained that the situation was a national one as the company had decided to cease its diagnostic division without giving the period of notice required within the contract. RM made it clear that the CCG learned from this particular contract and how they are working to avoid similar situations in the future. TB said that the voluntary sector is fragile and asked if there any mitigations in place if the provider goes into liquidation i.e. did the CCG have a plan in place if or when this happens. **DTOC** RM explained that there had been a change in the format of the DTOC data presented in the pack and that the CCG were working with the QEH to present the information in a consistent way. RM explained that work continued with the QEH to develop and improve the process by which DTOCs were allocated as it was felt that there was an under representation of social care DTOCs. TB felt the numbers are not accurate, and asked if the patients are not being transferred to social care, what was happening to them. RM explained that the process of allocating a social care attributable DTOC was a two stage process detailed within the Social Care Act and that currently the second part of the process was not applied consistently. This resulted in patients being discharged to social care provided care, but without being classified as a DTOC. **RTT** RM presented slide nine and explained that the CCG were currently not satisfied with the remedial action plan provided by the QEH to recover 18 week performance as it was not felt to be realistic. The current recovery trajectory had been achieved in May but missed in June and had been escalated to SPRG. The committee was informed that fortnightly meetings were held between the Trust and the CCG regarding both RTT and Cancer to ensure that regular dialogue was maintained regarding progress. **Mixed sex accommodations breaches** The committee was informed that due to Estates issues the QEH had experienced breaches of the target in ITU for the last 2 years. In order to mitigate the issue the QEH had procured screens but due to the ceiling layout these screens did not reach fully from floor to ceiling. A further assessment of the mitigating actions will take place, but no date for resolution was given as yet. **Dementia** RM explained that the ongoing issue was that the rate of diagnosis of dementia was not keeping up with the attrition rate. In response to the issues the Commissioning team were putting together a strategy to support care homes in the diagnosis of Dementia in their residents. Monthly escalation calls with NHSE are also in place. MP asked if there was accurate data that confirmed these issues with dementia patients in care homes, RM explained that the CCG had a practice view of the number of patients that were expected to be diagnosed with dementia and that diagnosis rates in care homes were felt to be lower than the expected rate. .	**HJM**

IAPT (Access and Recovery)

RM shared the latest figures regarding IAPT. TB asked if the recovery data is reflecting its successful outcomes as this was a struggle in the past. HJM asked if the additional investment has been considered for the current year budget. RM confirmed this is the case. HJM asked when would there be results from the investment; RM advised that there was a recovery trajectory in place. TB asked if this is picked up by the other CCGs, do they have the same levels of concern. RM advised that the IAPT performance was monitored across the STP by the Lead Commissioner, South Norfolk CCG.

CYP Eating Disorders

RM said that there was no published data for Q4 but advised the committee of the ongoing issue with recruitment to this service. RM also explained that referral numbers were small and this has an impact on the percentage performance.

HJM asked if CCG should include performance data from other providers such as EEAST and IC24 in the Finance and Performance pack. This was AGREED by the committee. RM will ask for this data to be included.

Finance and Activity Reporting

HJM reminded the committee that the CCG has an allocation of £277m and a plan to spend £279m this year so there is £2m deficit. There is also an accumulated debt £5.8m from prior years. Therefore the year will end with a total of £7.8m deficit before the application of commission sustainability funding of £2m which is entirely dependent of the CCG achieving their financial plan.

£1m of the reserves have been utilised in the month 3 position and the CCG is forecasting the utilisation of £6m by year end in 2018/19, leaving a £4.9m as available reserve for RTT, QIPP and others. HJM reminded the committee of the annual net QIPP target of £11.57m. For month three the CCG officially reported £10.8m which is 93.6% and believe this forecast will be downgraded within the following months.

In terms of key risks, month two acute data is a month behind and CCG have adverse variances with NNUH and Addenbrooke's £0.85M. NNUH is the biggest part of it with £500k of a combination of daycase (possibly related to RTT), vascular, and critical care and is under investigation.

Addenbrooke's forecast adverse variance of £300k but there is not much information; there is a risk as the contract is under block with the lead commissioner.

There is £700K for unplanned investment via the STP and JSCC for winter resilience. The CCG has set aside £400K which was not included in the initial budget. HJM asked JBW if there was confirmation if these values would be kept in the system or if they need to leave. JBW confirmed there will be a debate the following week and he will update HJM accordingly.

	The other £300k includes a review of mental health services and a demand and capacity system wide review, and others should represent good value across the STP. HJM advised that the delivery of QIPP was the single biggest financial risk and flagged large variances in prescribing (based on latest pricing) where the projection is over £500k overspend and risk of £1m. The CHC projection of £1m underspend is based on NCCP who are providing the service, and although this is a risk, this should be reduced. **QEH** HJM pointed out for the two main risks: ➢ Year End 17/18 - with £1m gap, £500k being the CCG exposure, although the latest offer appears to have mitigated that risk. ➢ 18/19 starting financial gap £11.8m, now at £6m, following due diligence work on removing unsupported QIPP and ongoing negotiations on the application of APA thresholds. Discussions on the Activity Performance Adjustments (APA) are ongoing. It is currently likely that we will have come to an agreement on the actual setting of thresholds. However the application of financial penalties is under dispute and currently with CEO escalation. The next step is likely to be External Expert Determination in line with the contract. In the event that the CCG loses this dispute, the recourse would be to follow service condition 28 and manage performance via contract query notices which is a much more complex process to manage and would not guarantee the savings. KF asked if there were more contracts with the same interpretation issues, HJM explained that it is unusual for a contract not to have similar types and terms. For example, A&E conversion rate is one part, the other part is the follow up ratios and day case patients; However HJM has never seen the A&E conversion rate applied, in another acute hospital, what is more usual is for there to be local tariffs in place for very short stay admissions. HJM discussed the Grant Thornton audit report and how the Trust was invited to comment on it which they have declined to do. JBW spoke to Jon Green from the QEH who advised that the QEH is not doing anything different from other Trusts nationwide. The CCG will write to the Trust with regards to these audit results, and the potential implications going into 2019/20. The committee requested that the final audit be presented at the next committee. HJM also said that NHSE have directed Norfolk CCGs to agree block contracts with providers; the QEH were, to date, not engaging in any discussions regarding a block contract. HJM and JBW discussed how to approach this the proposal will be a Minimum Income Guarantee of £102.1m with a maximum income cap of £107.1m. The midpoint of	

£104.6m being the proposed updated contract value. The low point being the projected QEH forecast based on an unadjusted Q1 run rate.

TB asked HJM if NHSE has approved this proposal; HJM said that NHSE were aware and supported the proposal.

HJM said that the QEH's current plans do not appear to be viable. TB asked what will be the repercussions for the following years. HJM said that the plan was to improve on the demand and capacity modelling and work closer to ensure better alignment going into 2019/20. Examples of actions are below:

- Planning for next year to assess system demand and capacity
- Developing plans to jointly own QIPP and CIP schemes
- To apply the Grant Thornton audit outcomes.

HJM said that for noting, the Finance Report has been revised and asked if the new format was helpful and accepted by the committee. Everyone agreed and accepted the new format.

QIPP Reporting

RM explained that slippage against target had occurred predominantly within the transformational QIPPs and that this had been due to difficulties in engaging clinical resource and engagement from both Primary Care and Acute Care.

RM advised there are regular Operational Group meetings where the QIPP Lead Managers discuss any risks and concerns, potential slippage and resulting mitigations. Urgent matters are then escalated to the weekly Programme Board. Schemes which had been escalated to date included:

- Procedures of Limited Clinical Value
- Respiratory
- CHD
- Gastroenterology

HJM informed the committee that whilst the CCG will persevere with the problematic schemes as there is still a process to follow with BMI for these schemes; it would be a risk adjustment. KF asked to confirm the net values and if it would be possible to discuss the five higher value schemes with HJM separate to this meeting. HJM confirmed the values and agreed to discuss with KF.

TB asked for updates from the business case for frailty and care homes. RM said that both schemes are in progress and explained how care home schemes have been simplified. Urgent actions include GPs alignment with care homes, training and medicines management; a business case was going to Programme Board and CLEX in August and if agreed the risk will be adjusted.

As an urgent action the CCG made two bids of £100k each to get Deloittes support for a QIPP revision, delivery and field support. This support will cease in November 2018

	and advised the committee of the following options as possible plans. Further details will be shared at the next meeting. • Optum (Support company) • Recruit pharmacist leads (Other CCGs have recruited directly as the success rate was high) • Ask CSU to do the work and recruit directly; discussions are in place and they will then put a proposal to CCG next week shortly. There will be a proposal for another option by JSCC; this was recently approved and Deloittes will look at all STP based on Great Yarmouth & Waveney as they have recruited the leads themselves and the result has been very successful; having STP support was encouraging. HJM said that the big focus will be on the acute sector. SJW said there is a bi-monthly meeting with the QEH and the focus is on primary care. It was identified that the medicines management team have been trying to engage with GP's as a result. A report was created and will be presented at CLEX for future actions. SJW said that the medicines management policy has been revised following NSHE standards, and was due for approval at the next CLEX meeting. In case of non-engagement, escalation has been discussed and agreed it would show as below: Email from primary care commissioning ↓ To Clinical Lead ↓ CLEX ↓ NSHE JBW assured the Committee that this process will be followed.	
18.67	**CONTRACTUAL PERFORMANCE INCLUDING CSU**	**ACTION**
	<u>STP Update</u> JBW said that there appears to be an emerging issue about engagement; JBW is preparing a paper to be submitted to Governing Body in August that may have a 'knock-on' effect not only across the CCG but also the others CCG's. KF asked whether social care and other organisations would merge the same way. JBW explained that this will include all organisations and the path for this re-organisation will be difficult and quite demanding. MB asked if this funding was within the budget and what impact will that have on the CCG projects and financial plans. JBW said this will be discussed at future meetings.	
18.68	**ANY OTHER BUSINESS**	**ACTION**

	There was no other business The next meeting of the Finance and Performance Committee will take place on Thursday 23rd August 2018 at10 am in Meeting room 2, Kings Court, Chapel St, Kings Lynn	