Healthy Future

NHS Hammersmith and Fulham Clinical Commissioning Group

Finance and Performance Committee Meeting

Tuesday 29th September, 3.00 – 5.30 pm
St Paul's Church, Hammersmith

Governing Body members:		
Rohan Hewavisenti	Lay member (chair)	RH
James Cavanagh	Acting Joint Vice Chair and GP, H&F Clinical Commissioning Group	JC
Tony Willis	H&F Clinical Commissioning Group – GP	TW
Paul Skinner	H&F Clinical Commissioning Group – GP	PS
Keith Edmunds	Chief Finance Officer, CWHHE	KE

Officers in attendance:		
Helen Poole	Deputy Managing Director, HFCCG	HP
Shelley Martin	Head of Finance, HFCCG	SM
Sharon Robson	Associate Director of Finance	SR
Noreen Groves	Head of PMO, Project Business Planning, HFCCG	NG
Jenny Platt	Strategic Lead for Integrated Care and Joint Commissioning	JP
Toby Hyde	Head of Strategy, HFCCG	TH
Margaret Kelly	Business Support Manager, HFCCG (minutes)	MK

Item	Agenda Item /Discussion	Action Owner
1.	**Apologies**	
1.1	Apologies were received from Susan McGoldrick, Zohreen Ashraff, Janet Cree and Helen Troalen.	
2.	**Minutes of the Previous Meeting**	
2.1	The minutes of the previous meeting were approved as an accurate record of the meeting.	
3.	**Conflict of Interest**	
3.1	The previously acknowledged potential conflicts of GPs as commissioners and providers were noted.	
4.	**Matters Arising/Action Log**	
4.1	The outstanding actions were reviewed and discussed. Please refer to the actions table for updates.	
5.	**Month 5 Finance and Activity Report – 2015/16**	
5.1	SM introduced the month 5 Finance and Activity Report. She informed the committee that the CCG has reported a year to date surplus of £2.92m, which is on plan and is forecasting delivery of the planned £9.15m surplus. She noted that the acute contract position is over performing by £4.22m in the year to date and is forecast to be a £8.55m overspend at year-end, which is a worsening of £0.81m from the previous month. Acute reserves of £1.83m have been released in full and reduce the full year overspend to £6.72m. Month 05 now reflects forecast over performance on continuing care of £1.1m across adult placements and both EOLC and dementia referrals. This had previously been included in the risk analysis but the trend has been continuing therefore the overspend has now been brought into the position. Further non-recurrent benefits of £1.32m have been released this month as work progresses on finalising the position against our 14/15 year end accruals. There are still a number of balances to be finalised and an assessment of the further benefit is included in the risk and opportunities breakdown. Overall, the forecast overspend remains above the level the CCG can mitigate through releasing investment slippage, acute reserves, QIPP reserve and contingency. The delivery of the planned surplus remains contingent on receiving £1.8m support from within the Collaborative. She noted that that the uncommitted funds are available to support further investments, that at month 5 the forecast assumes further schemes will be developed, and the remaining balance will be committed over the remainder of the year. It was noted that at month 5 there is £1.656m in uncommitted reserves. SM stated that we need to check the investment proposals currently being developed to ensure these are on track and review the list of potential investments to ensure we have captured everything.	

Item	Agenda Item /Discussion	Action Owner
	The committee raised the following questions: • JC asked how the CCG compares with last year. SM explained that last year we had more money uncommitted. • JC commented that there will be cost pressures for next year around extended hours and that new proposals are being presented at Ops weekly and asked what formal process is in place. SM stated that we are reporting the recurrent and non-recurrent position to show how we address future year's budgets and are firming this up which leaves us with a balancing position of £1.37m but we need to decide how we use this money for the remainder of the year. JC asked if this money could be used next year for winter pressures and extended hours. SM said that she had concerns around the level of funding still available at this stage of the year and anticipate that the money available will be higher than the £1.37m • TW commented that last year we had more money to spend and managed to spend it and asked if we had more planned expenditure. SM explained that last year we were able to offer support to the collaborative. • TW commented that H&F has been an outlier in spending on Imperial and asked whether this is still the position when compared with the other CCGs. SR clarified that H&F has the highest overspend with £2m more exaggerated spend in the last 2 months and mainly around critical care but an audit will be carried out as there are wider issues. Last year we also had a block contract but this year we have fewer blocks in place. • RH asked when these investments which are in the pipeline are due to come to this committee for approval and when these schemes are due to commence. SM explained that this piece of work will be mapped out for month 6 to include the timeline for each project and the likely spend for each scheme. HP stated that this piece of work would be reviewed monthly to address any slippage. HP said that SystmOne is one area that needs to be reviewed and plans to meet with Farid to review the projects and likely spend. • KE said that if CCG are spending non-recurrent monies then it should be focusing on areas with cost pressures such as child healthcare costs. In month 6 a review will be undertaken across the five CCGs and we should use the reserves on areas this year that will benefit us in future years, and said that we need to spend the non-recurrent monies this financial year on areas that will deliver real value. • HP said at October's 'Breaking the Cycle' event a collaborative session will be delivered on recurrent and non-recurrent monies with each CCG looking at potential areas to secure investment. • RH queries the running costs on slides 11 and 12 and asked why the figures are exactly the same as budgeted and whether they are accrued to budget. SM said that in most cases they are fixed and accrued to budget. RH asked if there are any staff variances and questioned the staff costs coming in on budget. SM agreed to provide further detail and provide a breakdown of the costs by cost centres. **Action: To provide further detail on the running costs and breakdown the costs down into cost centres** The committee **discussed and noted** the month 5 Finance and Activity Report.	**SM**
6.	**Imperial Contract Performance and Trend Analysis – month 4**	
6.1	SR presented the Imperial Contract Performance and Trend Analysis at month 4 and focused particularly on the specific pressure areas of outpatient procedures, day case and electives and non-electives. She informed the committee of the following: • At month 4 the H&F position deteriorated above trend with £4m overspend with £1.1m in mitigations and adjustments. The overspend is due to exceptional high critical care and excess bed day costs along with an increase in maternity charges which will be covered by funding transferring from EHT but we should be able to maintain this position in month 5. • The year-end forecast is adversely affected by the adverse in month movement, but the forecast does not assume the high in month critical care and excess bed days will continue. Where appropriate challenges have been raised against the in-month charges with challenges raised to the trust on a monthly basis as per an agreed timeline. • Further work is required to understand the position better and the full year impact and whether any of the YTD spends relates to 18 weeks RTT work or Ophthalmology back log work. If so, then the scale and value needs to be estimated. SR reported that the budget was calculated based on 2014/15 month 6 position and included seasonality and growth and said that for next year we should look at the latest data and determine what works for us. • The CCG has already recovered £800k back from the trust in challenges but the trust have yet to respond to a number of other challenges such as A&E case mix and breaches. • Money has been set aside in reserves to fund additional RTT work but we need to see the demand and capacity to determine whether the position is overstretched and then make an assessment. • CIS is not delivering what we expected but we have the risk share. • The majority of cost pressure is on volume with the trust doing more activity than planned. • The stress-testing audit is complete. As soon as data is received, we can put forward a challenge. • We have not yet challenged critical care; we are awaiting the draft audit. • Non-electives, we do not have challenges on this area. • SR noted that if there are problems in Trauma and Orthopaedics then there could be problems in other areas, e.g. the	

Item	Agenda Item /Discussion	Action Owner
	trust are badging clinics as non-electives, but the charges are the same. • SR noted that the revised M4 forecast outturn is £69,261758k. The key discussions were as follows: • JC said that there is a 12% month on month over performance at Imperial with critical care and A&E the main areas and that we need greater engagement from the trust to sort these issues out. • RH queried the adverse mitigated variance of £1.275m (slide 3a) and said it was higher than the planned price of activity. SR explained that the average cost of a spell is higher than planned and said that 20% of activity could be more complex therefore will cost more and will not be part of the run rate. She noted that for example, there is notable pressure against Thoracic procedures and disorders of (£321k) such as pulmonary disease; pneumonia related spells and bronchitis related spells, with the primary proactive code driving up the spells with activity lower than the planned average price but volumes are significantly higher. The committee **noted** the month 4 Imperial Contract Performance and Trend Analysis	
7.	**Increase in Proactive Care in Care Homes service - Medical Cover in Care Homes**	
7.1	JP introduced the paper on proactive care in the Care Homes service and explained that following review of the evaluation, the CCG decided in April 2015 to extend the Pilot for a further 6 months to allow for the wider review of medical cover into care homes to take place. In June 2015, the F&P Committee approved the business case and the non-recurrent funding for 18 months to take forward the four work streams. As part of this approval, the funding was agreed at £182,000 per annum against which it was noted that the pilot model had delivered around £215,000 of overall savings following its first year evaluation. CLCH have indicated that the costs of the services, which were originally agreed in 2013, were not subject to on-cost as the service was classed as a pilot. As the service is continuing as part of the main CLCH and is no longer a pilot therefore is subject to on-costs. Furthermore, the modelling presented in the business omitted a £10,000 budget for social care to be part of the MDT delivery team. It was noted that the future delivery of the service under its current model with CLCH requires both H&F and West London CCGs to continue the service jointly. West London CCG has agreed the revised costs to continue the service with CLCH. • The revised costings have been discussed with CLCH and negotiations have taken place jointly with West London CCG to ensure that contingencies have been removed and overheads have been kept the minimum level. The three different funding options were presented with option 1 the preferred option, which was to maintain the current delivery of the service model and avoid any reduction in pharmacy support, which could risk the ongoing delivery of the KPIs, and the savings achieved. It was noted that the pharmacy input has delivered circa £106,000 of confirmed savings in its first year evaluation but the risk for the CCG is the additional non-recurrent cost pressure. The following questions and comments were raised by the committee: • TW asked why CLCH undercut the costs of the pilot. JP explained that it was initially an ICP service with an independent provider and a lot has changed since this service. • TW commented that having a pharmacist as part of the service model adds real value and was keen for this post to be maintained. • RH asked what level of savings is predicted in future years. JP explained that the service is part of QIPP for this year and as we are at the start of the programme, we have not set the trajectory yet and do not have the recurrent total for the six months of the pilot. She also noted that there has not been an initial target set for the medicines management review. • RH queried if the additional funding for this programme is already part of our reserves. SM clarified that investment of £110k is included in non-recurrent investment therefore these costs would be covered. • RH queried the psychiatric nurse costs and asked whether the total costs equated to £300k. JP agreed to check if the figures were accurate and whether they include WLCCG costs. • KE asked what would happen to the service after March 2017. JP explained that we would need to review our nursing home model of care and wrap this service up with bigger provision. She said that WLCCG are progressing whole systems in a different way and plan to move this service into their model much quicker. We can look at what they have done and consider doing something similar. **Action: To review the psychiatric nurse costs** The committee **approved option 1** the recommendation for additional non-recurrent funding for 18 months of £82,122 to enable the delivery of the Proactive Care Home model, with a caveat that the psychiatric nurse costs are clarified	 **JP**

Item	Agenda Item /Discussion	Action Owner
8.	**Winter marketing and GP 7 day services marketing**	
8.1	SM presented the paper on marketing winter and GP services, which the committee are asked to note that the funding was approved by Clare Parker, which was within the delegated limits. The funding is to enable CWHHE to deliver a series of locally focused communications and engagement campaigns to achieve a number of key objectives. The long-term benefits of the campaign would result in fewer people attending A&E, the UCC and acute hospitals for illnesses or injuries that can be treated in primary care, the pharmacy, and by self-care. The key discussions were as follows: • RH asked if NHSE are undertaking any marketing campaigns on a national basis. HP clarified that this local campaign is to complement the national and London campaigns. • TW queried how we evaluate the impact of this campaign. It was suggested that we could look at questionnaires, opinion polls and assess the levels of increased uptake. SM agreed to feed this back to the collaborative. **Action: To consider how the Winter marketing and GP 7 day services marketing can be evaluated** The committee **noted** the Winter marketing and GP 7 day services marketing Business Case.	**SM**
9.	**Prime Ministers Challenge Fund Programme Executive (PMCF PE) Update (29 September)**	
9.1	HP provided a verbal update from the PMCF Programme Executive Group. She reported the following main updates: • There is a mixed picture on progress with members of the group expressing the view that the highlights were not detailed enough therefore this needs to be taken on board by the Interim CMO. • **CIS:** – the level of engagement with practices needs to be progressed further with the seven practices. There are two GP leads, one has limited availability and the other is the urgent care lead. • **Telephony Systems out of call pilot**: Three of the eleven practices selected have started to offer patients an alternative to face to face appointments, with one third of appointments for repeat prescriptions, also some appointments for bloods, dermatology referrals and medicine reviews. • **Out of Hospital Services**: the Federation stated that by the end of September 2015 all out of hospital services should be offered to patients, however many practices have not yet started or are behind plan. The Federation Chief Executive holds weekly calls with practices and is looking at best practice and the use of SystmOne templates. It was noted that there are planned monthly contract monitoring meetings of the Federation, which are now underway. • **On-line registrations:** the average for H&F is 10%, therefore shows limited improvement. Patients are being asked to bring in photo ID. This is done as part of the registration with letters sent to patients. • **Tranche 2 sustainability funding £65k:** This has been reviewed; with a pilot now in place with five practices. Patients are being contacted and offered an alternative consultation. The learning will be disseminated to allow other practices to use it with a standard operating procedure to be implemented. The key discussion was as follows: • SM said we need to look at any underspend in budget due to the 3-4 week delays in getting contracts signed off and in getting services up and running. HP agreed to pick this up as part of the six monthly reviews in early 2016 once any issues with services have been resolved. **Action: To review the Out of Hospital budget as part of the six monthly review to determine whether there are any underspends in budgets due to the delay in getting contracts signed off and delays with the commencement of services** The committee **noted** the PMCF verbal update from the September meeting.	**HP**
10.	**QIPP Month 5 Performance update 15/16**	
10.1	NG introduced the month 5 QIPP report and reported that year to date we have delivered savings of £1,904k against the plan of £1,776k, an over delivery of savings by 7%. This includes non-recurrent mitigations of £483k, which offsets the gap of £355k on the planned schemes. NG reported on the areas of exception as follows: • **CIS scheme:** we have not seen the required level of NEL admissions. NEL activity at Imperial has increased to date. Engagement work is taking place with practices to drive up performance. • **A&E Activity:** We have seen larger than planned reductions in HRGs related to A&E activity, resulting in over delivery of savings by £212k year to date • **BCF Schemes:** work is still on-going to determine the likely achievable savings related to Nursing & care home and s75 contracts review schemes, resulting in reported gap of £136k • **Ophthalmology:** There is slippage in go live date with the Community service. The service should go live at the Charing Cross site on the 5th October 2015 and at Parkview in January 2016.	

Item	Agenda Item /Discussion	Action Owner
	• **Gynaecology:** activity in the Community is close to our expectation but a material increase at ChelWest is being investigated for possible recording issue or increase in demand. • **Out of Hospital services:** These services went live in July/August and we are benefiting from the reduced tariff agreed with In-Health, as contract is pending sign off. The In-Health service should start this Thursday. • **Excess Bed Days:** It shows an increase in all procedures, targeted work needs to take place and review this at speciality level. The forecast financial performance before mitigations is a gap of £1,508k, which is an adverse movement of £327k on last month's forecast as a result of key changes. NG said that there is work to do on this year's QIPP schemes, in reviewing the targets and variances and understanding how long it takes to get schemes up and running. We have already started our planning for next year's QIPP schemes and will be working with our providers on the long-term schemes to realise the benefits. The following points emerged in discussion: • RH asked if we have achieved the actual ophthalmology savings of £296k due to a general reduction in acute. NG clarified that this was an error and would have the report amended. • KE asked what is happing in regards to proactive care. NP clarified that this is not one of our QIPP schemes for 2015/16 but have nursing homes linked to the Better Care Fund, which differs. This area will be discussed as part of the 2016/17 QIPP scheme with Jenny Platt and we will look to identify some KPI's for this area. • JC commented that if it were not for out of area we would not have achieved our QIPP schemes. RH commented that the CCG has also used mitigations to achieve the targets. SM explained that what out of area means is that there is a reduction in non-electives and that there are a number of challenges raised but not finalised with trusts across NWL that we are not the lead commissioner for with a greater number of challenges raised this year. • KE asked for clarity on the non-recurrent QIPP contingencies. SM explained that this is our QIPP reserves for non-delivery of QIPP and that this is held in reserves alongside our general contingencies to mitigate under delivery but what we have not done is applied it at scheme level. RH said that what we are saying is that QIPP has not delivered but we have released contingencies to mitigate the under delivery. SM clarified that the contingency is a non-recurrent mitigation. **Action: To amend the QIPP report Year End Forecast page to specify "forecast" activity and savings rather than "actual"** The Committee **noted** the QIPP month -performance update.	NG
11.	**CIS update**	
11.1	TH presented the CIS update. Her reported that the engagement work with practices in 2015/16 to achieve the increase in the number of referrals builds upon the previous work undertaken which has seen a gradual net trend of an increasing number of GP referrals into the service. Work has also been undertaken to encourage engagement from wider sources with approximately 40% of rapid response referrals being received from hospital, other community services, social services and other services. While this further work is undertaken to understand why the anticipated benefits are not being realised, actions already being taken as part of a recovery plan for 2015/16 include both direct work with the CIS and wider plans under the Whole Systems programme to support the required reduction in NEL activity. TH stated that currently there is a huge variation with GP engagement with some GP practices. Some practices have high non-electives but are not referring into CIS, which is a big issue, there are also some practices referring a lot but inappropriately and others do not fully understand the service. There are plans for increasing the number of appropriate referrals into the service and making tangible improvements to the service to facilitate improved care and transitions between the CIS and core services. Increasing the number of appropriate referrals is being progressed by: • Network meeting attendance to update practices on service developments and highlight appropriate cases for referral along with discussion and feedback from practices to identify any barriers or improvements. • Further development of alternative referral routes including a focus on the falls pathway with LAS. • Targeted engagement work with the GP Federation through PMCF to work with practices with low referrals and higher levels of admission to reduce the levels of variation between practices and ensure eligible patients are offered access to the service. TH informed the committee that work is underway on whole systems in primary care. It has appointed a programme manager to work with the CCG and Federation and with 6-10 practices to do some design work with an initial cohort of patients. As part of the work programme it will look at what infrastructure is in place in these GP practices and what support	

Item	Agenda Item /Discussion	Action Owner
	is available to support their risk patients' e.g. additional nursing support. The committee raised the following points: • TW said that the PMCF has been tasked to do some work on this and one of the aims of the network plan is to reduce non-electives and the CIS is one of the tools to assist in achieving the reduction in non-electives. • JC commented that as we are not tasked to performance manage GPs should we seek NHSE performance management support. TH suggested that we do not pass this to NHSE. He said that detailed information around CIS referrals and other performance data on areas such as diabetes could be pulled together on a practice-by-practice basis to look at wider performance and have a performance dashboard for each practice. • RH asked whether the plan is to share the performance dashboard with each practice and whether this would make a difference in driving up performance. TH said that the Federation e-mailed out some practice data on non-electives and referrals into the CIS service and were told that the data was not accurate, therefore it is difficult to know whether sharing the data will have an impact but we need to try to influence behaviour in general practice. • RH commented that non-electives continue to increase. • NG asked if provider data is being reported. TH clarified that CLCH are providing data and we need to track the performance of the service. • JC commented that there are a number of ill patients in the CIS service which is evidenced by their long length of stay and that levels in A&E are increasing. TH said that nationally there is a debate on this and the level of contribution from social care. • TW suggested there is an increase in in non-medical support around social prescribing that does not require costly medical staff and could provide this in a co-ordinated and more coherent way involving carers and staff who know what is going on. • KE asked whether the flu jab would make a difference. It was stated that for last year there was no evidence to suggest the flu jab does make a difference but are not sure in terms of the older age groups. It was suggested using some non-recurrent funding to do some targeted work. **Action: To discuss with Vanessa Andreae whether we should use some non-recurrent funding to provide the flu jabs to those ill patients with long lengths of stay in CIS and see if it makes a difference** The committee **noted and discussed** the CIS update	 **TH**
12.	**Integrated Performance and Quality Month 4 Report – 15/16**	
12.1	JC introduced the month 4 Integrated Performance and Quality Report for 2015/16. He noted the following: Detailed work is underway with Imperil on the areas of underperformance such as RTT, Cancer and A&E 4-hour performance. • **RTT 18 week's performance** – Imperial sustained their achievement of the 92% incomplete pathway standard in M4. For the specialities that are challenged to meet 18-week RTT targets (ENT, general surgery, T&O and urology), speciality level demand and capacity assessments and delivery plans will be presented by 30 September with the aim of agreeing plans to achieve and sustain speciality level performance. C&W continued to achieve the RTT aggregate targets in M4 and performance against the speciality level incomplete targets is good with all specialities either achieving or within 5% of target. • **Cancer** – HFCCG did not achieve the 2-week wait breast symptomatic standard, the 31-day standard or the 62-day GP referred standard. For the breast symptomatic and 31 day standards H&F CCG are meeting the standards year to date and all NWL providers are meeting the standards trust-wide both in-month and year to date, as such at this point no remedial action is required. Failure of the 62 day GP referred standard was a result of 4 patient breaches, with three reported at Imperial. Imperial also failed the 62 day GP referred standard trust-wide but have provided individual breach analysis and exception reports. The breach reports are being reviewed with early indications that both internal trust issues and complex pathways shared with other trusts have contributed to these breaches. • **A&E**- Performance against the 95% A&E national standard at Imperial has been the focus of attention from the Systems Resilience Group (SRG). Substantial efforts have been made to drive up performance for 4-hour waits and tackle underlying factors, resulting in an improving trend in monthly performance. Following the achievement of the 95% standard in M3 performance dipped in M4 due to the high volume of patients in early July, which affected bed flow. • **LAS Handover** – At Imperial there were 169 breaches of the 30-minute handover standard in M4 but no breaches of the 60-minute handover target. The trust is preparing an audit of the 30 minute breaches, to confirm what proportion of these are genuine, and will be reporting the results to September's CQG. At C&W, there were 23 breaches of the 30-minute standard for M4; this continued the improving trend in recent months. The following point emerged in discussion: • KE asked what the LAS are saying about the Imperial audit and challenge of the 30-minute handover standard. JC said that Imperial receives the HAS data and that the LAS operational staff should know whether the data is reliable and noted that	

Item	Agenda Item /Discussion	Action Owner
	only Imperial are challenging the data. The Committee **noted** the month 4 Integrated Performance and Quality Report.	
13.	**Any Other Business**	
13.1	No other business was discussed.	
The next meeting is scheduled for: Tuesday 27th October, 3.00 – 5.30 pm, St Paul's Church, Hammersmith		