Healthy Future

NHS
Hammersmith and Fulham
Clinical Commissioning Group

Finance and Performance Committee Meeting

Tuesday 26th January, 3.00 – 5.30 pm
St Paul's Church, Hammersmith

Governing Body members:		
Zohreen Ashraff	H&F Clinical Commissioning Group – GP (Chair)	ZA
James Cavanagh	Acting Joint Vice Chair and GP, H&F Clinical Commissioning Group	JC
Paul Skinner	H&F Clinical Commissioning Group – GP	PS
Tony Willis	H&F Clinical Commissioning Group – GP	TW
Janet Cree	Interim Managing Director, HFCCG	JaC
Eva Horgan	Deputy Chief Finance Officer, CWHHE	EH
Helen Poole	Deputy Managing Director (Deputising for Janet Cree, Managing Director)	HP

Officers in attendance:		
Shelley Martin	Head of Finance, H&F Clinical Commissioning Group	SM
Sophie Ruiz	Senior Network Co-ordinator, H&F Clinical Commissioning Group	SRu
Sharon Robson	Associate Director of Finance, HFCCG	SR
Julie Scrivens	Head of Planned Care and Mental Health, HFCCG	JS
Catherine Williams	Interim Head of Business Planning, HFCCG	CW
Margaret Kelly	Business Support Manager, HFCCG (minutes)	MK

Item	Agenda Item /Discussion	Action Owner
1.	**Apologies**	
1.1	Apologies were received from Susan McGoldrick, Rohan Hewavidenti and David Hill.	
2.	**Minutes of the Previous Meeting**	
2.1	The minutes of the previous meeting were approved as an accurate record of the meeting pending the removal of the word interim from EH's title.	
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.	**Network Plan End of Year Position 14/15 and proposal for Respiratory and Gynaecology performance assessment**	
5.1	SRu presented the network plan end of year position for 14/15 and the proposal for Respiratory and Gynaecology performance assessment. She asked the committee to note the final assessment of network plan year 4 and network achievement against all components with the exception of Gynaecology and Respiratory and that to date a total of £813,019.43 has been paid to practices for Network Plan achievement. In 14/15, practices needed to ensure that 100% of referrals for Gynaecology and Respiratory were routed to the relevant Single Point of Access for these services. However, due to the ongoing issues with capturing accurate performance data all Practices were issued with a Patient Level Clinical Audit, which included first outpatient hospital attendance data for Respiratory and Gynaecology for 14/15 and were asked to undertake a clinical audit with respect to routine GP initiated hospital attendances identified. Practices were advised that the clinical audit should make clear the clinical justification for practice referrals. Appendix B provides information in relation to the audit outcomes and shows that in total 20 Practices undertook the clinical audits as requested. For gynaecology, 18 Practices confirmed that over 80% of acute attendances either had been to the SPA for triage or had provided appropriate clinical justification. When compared with performance information as derived from business intelligence (last 12 months rolling data available), 6 practices reported % utilisation of greater than 50% of performance reported as per BI. For respiratory, 14 Practices confirmed that over 80% of acute attendances had either been to the SPA for triage or had provided appropriate clinical justification, but 2 Practices did not perform an audit as there were no acute routine attendances recorded.	

Item	Agenda Item /Discussion	Action Owner
	In total, there is £78,000 available for this component (£34k per service) with a total of £30,628 in process payments that have been made to Practices to support behaviour change required. SR presented the 3 proposed options to support payment for practices for referring appropriately to acute services and for utilising the Single Point of Access for both Respiratory and Gynaecology. The preferred option was Option 1, which provides appropriately remuneration to practices. It was noted that there is high utilisation rates for both services based on the availability of data. Those practices achieving 80% or over according to either the audits undertaken / business intelligence report will receive 100% of reward payment available; and practices achieving between 60 - 79%, will receive 50% of reward payment available. The Total payable under this option is as follows: - Gynaecology: £17,316 (26 practices will receive payment) - Respiratory: £12,828 (16 Practices will receive payment) The following points emerged in discussion: • ZA asked if data is now accurate. It was stated that Imperial are putting in place a mechanism for SPA and we are working closely with the primary care team on the respiratory data. A SystmOne mobilisation solution for gynaecology is not in place as yet but the trust are using a manual work around and are confident they can provide us with the information we require. • EH noted that table 1 did not include the QIPP savings required by the CCG and asked for the figures to be shared and asked how much of the total investment we will accrue for to deliver the network plan at year-end. SR clarified that the CCG has accrued for the total investment of £1,233,599. • JaC stated that we would need to ensure we realise the benefits and not to continue to invest in services that fail to deliver and would need to take into consideration the measurement of benefits realised for 16/17. • JaC commented that non-electives have not been realised but there would need to be a greater focus on non-elective admissions and prescribing for next year. • PS commented that some practices continually fail to deliver the network plan for areas such as gynae and respiratory and asked if there is any correlation with other areas of the network plan. SR clarified that some practices are not performing across the network plan due to workforce issues. PS said if senior members of the practice are not engaged then the necessary changes will not occur. SRu explained that the focus for year 6 of the network plan would be on low performance across a number of areas and plan to link with the Federation on how practically this can be achieved. • JaC stated that value for money would need to be assessed. • PS commented that successful practices should have financial recognition. • TW queried what the CCG can do to support those practices that are under performing to encourage them along a sensible pathway and whether it was worth highlighting the gaps and asking the Federation to work with these practices. The committee: • Formally **noted** the payments made for 2014/15 achievement • **Approved the recommendation of Option 1** payments for Gynaecology and Respiratory SPA utilisation **Action: To provide the QIPP Savings required by the CCG for the Network Plan End of Year Position 14/15**	**SR**
6.	**Month 9 Finance Report – 15/16**	
6.1	SM presented the month 9 finance report for 15/16. She explained that at month 9 the CCG is reporting a year to date surplus of £6.87m, and is forecasting delivery of the planned £9.15m surplus. Acute contracts are over performing by £6.83m in the year to date and now forecast to be a £9.04m overspend at year-end, which are a worsening position of £1.78m from month 8 and mainly a worsening Imperial position of £1.23m. Acute reserves have been released and mitigate the overspend in part, but overall the forecast over performance for acute is £6.61m. The CCG has received the Quality Premium funding relating to 2014/15 achievement, which is a non-recurrent allocation of £0.47m. Given there is significant investment slippage in 2015/16 it has been assumed this fund will not be utilised in year and is instead used to support the CCG overspend, largely in acute. The Parity of Esteem reserve in Mental Health has been reviewed this month. There are no further planned investments likely to impact in this financial year and so the reserve has now been released and is again supporting the CCG overspend. Overall, the CCG is continuing to absorb the acute overspend and there are no calls this month on the Collaborative risk share for support. However as the acute overspend is significant and with the under delivery of QIPP this raises concerns for 2016/17 given the position is being balanced through non-recurrent measures. The underlying position has worsened by £0.36m this month reflecting the slippage in the Mental Health investments and	

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<tr><th>Item</th><th>Agenda Item /Discussion</th><th>Action Owner</th></tr>
<tr><td></td><td>overall the CCG is £1.43m adrift of the planned position for 2015/16. It is important to note this assumes the spend on RTT activity within acute is non-recurrent. An update on the acute position going into 2016/17 will be included once the baselines for the contracting round become available.

The key points raised were:
• JC queried how much of the Imperial over performance is Hammersmith and Fulham CCG liable for. EH explained, that H&F CCG will pay towards any additional activity delivered under Payment by Results (PBR). It was noted that the trust's overspend is approximately £30m and that it receives one third of its income from the CCG and how they manage their budgets and expenditure is their responsibility.
• TW stated that it was not clear why people end up in hospital and asked what proportion of people attends Imperial for surgical procedures and the proportion that attend for medical treatment such as long-term conditions, which the CCG has more control in preventing. SR explained that the contracts team receive patient level data and can look at the background to the diagnosis and could schedule a workshop to review the key information.
• JC commented that the NHS spends 4% extra each year and the CCG receives a 1% uplift (approx. £332m) and forecast a £370m outturn. JaC stated that we need to have an understanding of the Imperial baseline and said that we must have an open and transparent conversation with the trust to understand the true position. SR stated that in terms of benefits that the outcome is £370m prior to the changes and we should secure this year's outcome across the board but with no non-recurrent funding available next year to address any potential gaps and over performance that we need to think collective as CCGs how we plan to manage the position.
• JC commented that the RTT rates are falling. SR explained that information around year-end is shared in line with the forecast. In regards to QIPP, we have taken out just under £2m but need to ensure it delivers next year under the PBR contract, which will prove a challenge, but need to work on setting a reasonably affordable plan for next year. She noted that the RTT rates are falling and we are not meeting T&O and may struggle to deliver RTT next year.
• TW asked if QIPP savings are being delivered elsewhere in the country. HP explained that when the CCG joins the wave 1 NHS RightCare Programme on Monday that the focus will be on reducing variations and maximising the value that patients will receive from investment and will identify priority areas which offer the best opportunities and look at any outliers.
• As part of the programme, it plans to review case studies that have worked elsewhere and will consider schemes that could be adopted locally for the 16/17 QIPP programme.

The committee noted the month 9 Finance and Activity Report</td><td></td></tr>
<tr><td>7.</td><td>Imperial Contract Performance and Trend Analysis month 8 – 15/16</td><td></td></tr>
<tr><td>7.1</td><td>SR introduced the month 8 Imperial Contract Performance and Trend Analysis and reported the following key highlights:

• The CCG has a M8 YTD unmitigated overspend of £6.782m, after mitigations and adjustments of £1.724m the mitigated overspend is £5.058m. This is an adverse in month movement of £1.162m.
• In month, there was an adverse movement above trend of £605k with notable movements against Critical Care of £226k, Non-elective £128k and Daycase and Electives of £85k.
• The Q1 closedowns have concluded, with a small number of items still outstanding. The agreed Q1 credits agreed and closed down are yet to be reflected in the position. The Q2 closedown is underway; the process of closing down should be a lot quicker as the principles have been agreed in Q1.
• Critical care audit outcome has resulted in a material financial challenge, the challenge of £5.5m was sent to the Trust in December for all CCGs for M1-M8. At M8 and in the Forecast no yield has been assumed, although an opportunity of £0.5m is recognised across all CCG's.
• Reserves are held for in year RTT and Ophthalmology backlogs. Further work is required to understand the full year impact and whether any of the YTD spends relates to 18 weeks RTT work or Ophthalmology back log work.

The committee noted the month 8 Imperial Contract Performance and Trend Analysis update</td><td></td></tr>
<tr><td>8.</td><td>Financial Planning 16/17 – 20/21</td><td></td></tr>
<tr><td>8.1</td><td>EH presented the financial planning for 2016/17 to 2020/21 and said that the completed plans would need to come back to the committee for greater discussion.

The following key highlights were noted:
• The planning guidance has been released. It stipulates that an additional 1% must be planned for non-recurrently but must not be committed to at the start of the year. Previously CCGs have been required to earmark 2% of funding non-recurrently but there was no requirement for this to be uncommitted. This will put further pressure on the model, depending on how non-demographic growth is managed and how S&T contributions are decided.
• The allocated growth for H&F is outlined for the next 5 years on page 3 of the report. It shows growth of 1.4% allocated to the HFCCG for 16/17. This will make it difficult for the CCG to deliver the high level of QIPP given the low allocations.
• In regards to allocations and distance from targets it shows that H&F is currently 11.3% off target for 15/16. It was noted</td><td></td></tr>
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Item	Agenda Item /Discussion	Action Owner
	that the methodology was revised for 2016/17 and shows that H&F starts 2016/17 as 8% over and ahead of the other CCGs therefore would need to look at areas to make cut backs. • The HFCCG non-recurrent contribution towards the running of the Strategy and Transformation (S&T) Team and contribution towards Harrow and other CCGs was £7.7m in 15/16. The finance team are looking to see if the H&F contributions could be reduced for 16/17, as the CCG will struggle to make the £3.5m recurrent funding into next year. • There is approximately £9.7m QIPP savings required with Shelley and her team currently working on the figures, which are based on a poor underline position, but the figures may change and we need to look at how we can bridge this gap. It was noted that a significant proportion of the QIPP for 2016/17 remains unidentified at this stage in the year. • The CCG will need to consider how it funds growth for 16/17, as the £1.4m allocated uplift for next year will not cover the growth. • There is a tighter timetable to agree this and get the QIPP plans and planning model agreed which will feed into the Implementation Business Case (IMBC). The following points emerged in discussion: • TW commented that there is a huge amount of work that needs to happen on patient activation and getting patients engaged with self-management and will not see the changes until this occurs, in areas such as long-term conditions, and in reducing non-elective admissions etc. EH said that this is being looked into as part of QIPP for areas such as weight management but public health does not sit with us and as commissioners, we need to look at how to engage more effectively with the Local Authority (LA). HP said that the S&T Team have plans to look into these areas and that we should capitalise on this and consider schemes that can deliver quick wins. JaC stated that we would need to work differently but cannot afford to invest in areas that will not realise the benefits, deliver value for money and achieve savings and would need to do this consistently. • A breakdown of the S&T contribution was requested. EH explained that each CCG contributes to the S&T budget, which equates to approximately £30m in total across the eight CCGs with £10m to be returned to the CCGs. Whether the £10m should be retained by the CCGs and reduce the S&T budget is currently being discussed or should be linked to outputs towards QIPP delivery instead of being used as an enabler. HP stated that we do not want a consultancy type S&T but to have a team that is more embedded into the CCG. EH clarified this would form part of the collaboration board discussions on Thursday. • EH discussed the Part C redistributed funding between CCGs, which will be redistributed to those CCGs that have the greatest financial difficulties and asked for views on the H&F contribution of £3.5m. SM explained that this figure was agreed at a point in time when the CCG was in a different financial position. JaC said that the CCG should expect this figure to reduce. HP asked how much of this figure is based on financial difficulties. EH explained that it includes a number of areas such as distance in achieving targets and takes into account financial difficulties. HP stated that we would need to understand how the calculations are reached and how much is applicable. EH said that figures on non-demographic growth are available for sharing and can look at what is sensible and meaningful at the next meeting. • JaC asked about the 16/17 timescales and said that the initial feedback was around the operational plans. EH said that the timescales are ambitious and that things may alter with the NWL Financial Strategy. The decision-making will be made across the eight CCGs and the F&P will be kept briefed. A financial Strategy discussion will be had at the Collaboration Board this month and would be signed off at the March Governing Body but would be shared with the F&P Committee for discussion prior to sign off. • The committee agreed that the financial strategy/planning should be discussed in greater detail at the 9th February extra F&P Committee and be taken to the end of February F&P Committee for recommendation to the March Governing Body for final signoff. The committee **reviewed and considered** the assumptions used to underpin financial planning 2016/17 to 2020/21 and asked for a further discussion to be had on the financial planning at the extra F&P Committee on the 9th February	
9.	**QIPP 15/16 – month 9 performance update**	
9.1	HP introduced the month 9 QIPP report and stated that year to date; we have delivered net savings of £2,385k against the plan of £3,635k, under delivery of £1,250k (34% adverse variance). However, taking non-recurrent mitigations of £825k into account, the variance improves to 12% under delivery. Key assumptions to note: • The NEL scheme reports a gap of £379k to-date • Likely savings from BCF schemes Nursing & Home Care and s75 contracts are now confirmed. There will be no savings this year from nursing and home care • The go live date for Community Ophthalmology to be confirmed due to IT issues around data quality and pending agreement over core quality schedule. The QIPP forecast has been revised this month to show that no savings would be delivered this year • The acute Gynaecology activity has reduced each month; however, it is still higher than our QIPP plan with small savings of £16k reported, which is extrapolated to year-end but is offset by the greater cost of the community service but will	

Item	Agenda Item /Discussion	Action Owner
	consider the evaluation • The forecast for the Out of Hospital schemes is revised based on review of actual activity to M08 against the F&A plan submitted by GP Federation. This has resulted in adverse movement of £184k on year-end forecast. There is lack of engagement with the GP engagement days and issues in getting the education events set up at C&W and Imperial, which needs escalation to the contracts team • The forecast for NEL activity associated with Out of area providers has improved by £56k based on SUS data • The CIS direct referral pathway has been signed off at CQG The committee **noted and discussed** the month 9 QIPP report	
10.	**Business Planning update 16/17**	
10.1	HP presented the business planning update for 16/17 which includes a summary of the guidance and explained that the CCG are required to submit two separate but connected plans, which are: • A five year Sustainability and Transformational plan (STP0), a place based and driving the 5 Year Forward View • A one year Operational Plan for 2016/17, organisational-based but consistent with the emerging STP She noted that the guidance stipulates nine 'must do's' that the CCG must deliver. The development of the 5-year STP Plans and Operational Plan is being led by the Strategy and Transformation (S&T) Team. She noted that the S&T Team are working collaboratively with the CCG to produce the one-year operational plan for 2016/17. The CCG is required to submit its first STP footprint on the 29th January and the first draft of the 16/17 operational plans on the 8th February as per the national guidelines. She informed the committee that the CCG must achieve financial balance across the system and adopt a more system wide approach. SM noted that this is included in the financial outturn. HP noted that the CCG must detail what has been achieved and what it plans to achieve and noted that leads have been identified to take this work forward. The committee **noted** the requirements and timetable for delivery of2016/17 Business Plans	
11.	**Planned Care deep dive**	
11.1	JS introduced the 15/16 Planned Care deep dive and explained that planned care consists of a portfolio of 21 services, which integrate with the Out of Hospital (OOH) contracts and link in with local and national strategies. It has a total annual budget of £9.7m with block contracts of £4.38m and CLCH are the primary and largest contract holder. It lists the areas that are achieving and the services that are over performing. She noted that the CCG are in the process of mobilising and procuring new services and plan to commission 19 services in 2016/17. The key points raised were as follows: • JC asked what services are delivering and achieving the QIPP savings. JS stated that Gynae could deliver if the CCG gets the service correct and has confidence that the new Cardio and Respiratory service would deliver and with a new MSK provider envisage that the service would be delivered more consistently. HP explained that the CCG are looking at the original business cases to determine whether they are delivering the benefits. JS stated that the go live date for Ophthalmology has been further delayed. • ZA asked what the lessons learnt are from services such as Ophthalmology as we need approval of the processes. JS explained that the mobilisation of ophthalmology should have been managed more tightly and have closer management. • ZA stated that in regards to in-health that the endoscopy figures are high and asked how it plans to address this in the future. JS clarified that the indicative plan for endoscopy was not set correctly but was set using 2012/13 data, however have used NICE guidance and made pathway changes to allow clinicians to access the service. It was queried whether we should be commissioning some of the diagnostic services such as Ambulatory Blood Pressure Monitoring but should continue with ECG and deliver the service in a primary care setting. • TW questioned whether the support we put into the services deliver the pathway changes. JS explanted that the support is put in to manage the transition and upscaling. JaC commented that many resources are provided in planned care for small gains and that a great deal of work needs to happen and to get practices signed up to the process but should consider how services could be delivered more effectively going forward. To look at the business case benefits and primary care work programme and if we are focusing in the right way to achieve the benefits with limited resources, but require wider support from the network team, and should use the members meeting to bring about changes in behaviours, to deliver the outputs and improved quality of care. • EH commented that many planned care business cases are consultant led care models. If consultant led would be a set price, and need to consider who are the patients and how to direct to different services therefore may need to look at using different types of models in the future that are not all consultant led. JAC said that services would need to be linked against the Right Care Programme and to redirect the team in a different way. To look at doing this across the collaborative abut due to limited resources should consider how we utilise the shared central contracts team more effectively across the 5 or 8 CCGs, to maximise the benefits for patients, and start the planning process for the next 4 to 5 years. • JS commented that there must be closer working with the OOH contracts and greater linkage with the GP Federation to understand what is going on. JaC suggested using the clinical leads to problem solve and support the CCG in a more	

Item	Agenda Item /Discussion	Action Owner
	targeted way. HP suggested increasing clinical leadership for the QIPP programme sooner rather than later. The committee **noted** the deep dive report and update for the Planned Care portfolio and considered the areas which the committee would be particularly interested in focusing on for future deep dives	
12.	**Clinical procurement lessons learnt**	
12.1	JS presented the clinical procurement lessons learnt and explained that following contract award papers presented at previous F&P and Governing Body meetings, some questions were raised about the weighting of clinical versus quality scoring in clinical procurements. The slides were presented at the 1st December Governing Body seminar; and outline the lessons learned from recent clinical procurements, and options for scoring methodology in the future. The discussions that followed the presentation and the key points are detailed in this paper, which include the six recommendations. She noted that the decision of the group would then be used to inform all future clinical procurements. The following points emerged in discussion: • ZA commented that in having a clinical lead for mental health it has assisted the commissioners in getting papers through the F&P and governing body. • JC queried the role of the governing body sponsor and asked how it differs from the clinical lead role. JS clarified that the sponsor would be on the governing body and would update the rest of the members on progress of the project and provide assurance to their clinical colleagues and support papers moving through the governance processes. JaC said that the individual would have a level of responsibility and understanding to assess the service to determine its value. • PS asked if governing body members would have the time to dedicate to this role. JaC stated that it would need to define the role and time required for this role and governing body expectations. JS said that governing body members would need to take more scrutiny and have a certain level of detail to respond to any future questions about the service. • JS commented that in having a local clinical lead for each of the procurements it will allow them to get more involved in service re-design and in the development of service specifications prior to formal procurements. • JS stated that in having specific tender questions written by and marked solely by the patient representatives, the procurement process would be supported in a managed way and we should consider the value of having bidder presentations with patients on the panel. It was queried whether the CCG should have patients setting and marking the questions solely as we do not want to provide them with a greater role but need to ensure they have equal input. • JS explained that in order to manage conflicts of interest that the CCGs plans and overall Strategy would need to be taken to the Investment Committee. • ZA queried what plans the CCG has in the pipeline and what the timeline for new business case proposals to come to the F&P committee for consideration and asked are we looking at this in the context of what we have already approved. SM said that in the F&P month 9 pack (slides 13 and 14) it includes details of all investment proposals in the pipeline and those currently in development. JS stated that if we know what is in the pipeline we need to know the totality and when contracts are due to expire as certain services might be closely linked. The committee **noted** the discussion points and **endorsed** the recommendations from the clinical procurements presentation given to the Governing Body Seminar with a caveat that the sponsor role is defined	
13.	**Any Other Business**	
13.1	Comments from Rohan on the papers ZA noted the following comments from Rohan on the F&P papers: 1. **Procurement** - I am comfortable with options 1 and 4 as they are clear and transparent. Options 2 and 3 end up giving finance a much higher weighting. 2. **Financial plans** – it would be useful to have an explanation of the "metrics". What they are and how they affect plans. For reducing spend, it would be useful to have some options of where we could reduce spend or examples of over capitated spend and need to bear in mind that historically we haven't hit QIPP. No other business was discussed.	
The next meeting is scheduled for: Tuesday 23rd February 3.00 – 5.30 pm, St Paul's Church, Hammersmith		