Healthy Future

NHS Hammersmith and Fulham Clinical Commissioning Group

Item A0(i)

Finance and Performance Committee Meeting

Tuesday 23rd August 2016, 3.00 – 5.30 pm
St Paul's Church, Hammersmith

Governing Body members:		
Rohan Hewavisenti	H&F Clinical Commissioning Group – GP (Chair)	RH
Zohreen Ashraff	H&F Clinical Commissioning Group – GP	ZA
Clare Parker	Chief Officer, CWHHE	CP
Paul Skinner	H&F Clinical Commissioning Group – GP	PS
Sena Shah	H&F Clinical Commissioning Group – Practice Manager	SS
Eva Horgan	Deputy CFO, CWHHE	EH
Janet Cree	Managing Director, H&F Clinical Commissioning Group	JC

Officers in attendance:		
Helen Poole	Deputy Managing Director, H&F Clinical Commissioning Group	HP
Mark Jarvis	Head of Governance and Engagement, H&F Clinical Commissioning Group	MJ
Sharon Robson	Associate Director of Finance, H&F Clinical Commissioning Group	SR
Dilani Russell	Head of Collaborative Finance, CWHHE	DR
Bethany Golding	Patient & Public Engagement & Communications Manager	BG
Kerry Doyle	Head of Corporate Services, West London CCG	KD
Mark Neckles	Finance Control Team Manager, Hammersmith and Fulham CCG	MN
Margaret Kelly	Business Support Manager, H&F Clinical Commissioning Group (minutes)	MK

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1.	**Apologies**	
1.1	Apologies were received from Paul Skinner and Tony Willis.	
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.	**Transforming Care Plan (TCP) for people with Learning Disabilities, Autism & Challenging Behaviour**	
5.1	JW introduced the paper. She explained the current position as regards the possible match funding/approaches with NHSE. JW explained that there are two posts of money to centrally match fund and said that the other one related to SRS in Hertfordshire but required further detail on costs and risks and said that H&F CCG could be required to match the £13k funding required for their 2 patients. JW stated that CCGs are being asked to match fund a pot of money of £450k across the 8 CCGs to avoid readmissions and to monitor the low numbers in residential settings and by delivering the service at scale across the 8 CCGs it provides greater economies of scale and patient critical mass. She explained that the £450k is calculated based on 15 discharges with NHSE to match fund £30,000 for each inpatient reduction. She explained that the cost for H&FCCG in 2016/17 based solely on population was £40.6k, as opposed to £56,250k where the costs were calculated based on an equal split across the 8 CCGs. However, the proposed changes would need to go through the governance process across the other 7 CCGs to obtain their approval. JW said that an arrangement to allow the	

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	funding to follow the individuals has yet to be defined. JC commented on the requirement for CCG funding for years 17/18 and 18/19 but said that the CCG are still awaiting NHSE confirmation to match fund the two additional years. JC said that there are a significant number of patients being discharged which is challenging, and given their complexities there are difficulties in finding suitable local accommodation across the tri-borough. JW explained that a process was being developed to manage this cohort. JC acknowledged the value in working as 8 CCGs but said that a bespoke plan would need to be in place for each individual. The committee agreed to advocate the proposal based on population at a cost of£40.6k for 2016/17 but were unclear what could realistically be achieved over the next six months. The committee felt that the CCG could not commit to fund the 2017/18 and 2018/19 costs without being cited on the business case and going through a due diligence process and said that currently non-recurrent funds are not available. JW was not sure how much could accurately be achieved in 2016/17 and how to earmark funds not currently available and the lack of commitment from NHSE on match funding. KD from West London CCG attended the meeting on behalf of Louise Proctor, Managing Director, and asked for the West London CCG costs based on population. JW clarified that the West London CCG costs would be £43k but would require agreement from Brent CCG to fund the additional £15k costs. The committee **agreed** to advocate the TCP proposal based on the population at a cost of£40.6k for 2016/17 pending more detail being worked through and taking the outputs through the appropriate governance processes and obtaining commitment from NHSE to match fund the costs. The CCG could not commit to fund the 2017/18 and 2018/19 costs without being cited on the business case and going through a due diligence process given that non-recurrent funds are not available and obtaining commitment from NHSE to match fund the costs.	
6.	**Month 4 Finance Report – 2016/17**	
6.1	DR presented the month 4 finance position. She stated that the CCG is reporting a year to date surplus on plan and is forecasting delivery of the planned £2.72m surplus. She noted that whilst it is early in the financial year, there are some significant CCG pressures. The acute contracts are over performing by £1.74m year to date and show a worsening position of £0.86m from the previous month. The acute reserve have been released pro rata to the YTD spend and this has reduced the overspend to £1.21m. The forecast outturn based on this early position shows an overspend of £3.20m, after mitigations. DR noted that the continuing healthcare and physical disability placement budgets are continuing to face pressures and are overspending by £0.41m at month 4 due to highly complex care packages. The forecast based on the year to date client data shows an overspend of £1.02m. DR said that Funded Nursing Care is now showing a forecast overspend of £0.21m due to the weekly rate increase. DR reported that Primary Care is now showing a YTD overspend of £0.21m and forecast overspend of £0.40m and include the GP IT and Extended Hours cost pressures reflected in the ledger, having previously been included in risks and opportunities. She noted that these pressures have been partly offset by benefits on OOH Schemes and the Network Plan. DR stated that the YTD QIPP position is £0.23m below plan at month 4 and that the QIPP forecast of 21% under delivery is after using non recurrent measures of £2.69m. DR clarified that the YTD overspend across all areas is £1.92m and has required the release of reserves and contingency to manage the position. She noted that the mitigations have been released pro rata into the YTD position in relation to the forecast for acute, and this has enabled £1.09m to be made	

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	available to offset the pressure. The remaining balance has been managed through the release of balance sheet gains relating to the settlement of 15/16 final balances. DR said that in the most likely case the CCG has identified a net recurrent risk of £2.69m, mitigated by a net non-recurrent opportunity of £3.47m. The CCG has an overall likely opportunity of £0.78m and the range of risk is assessed to be an upside of £7.36m to a worsening in the forecast surplus of £6.28m. SR said that the assumptions in the year end position for Imperial and for other main contracts across NW London are becoming an issue and that we would need to understand what is driving this. JC said that we need due diligence and explained that the CCG are going through a financial and technical process with a line by line review of all contracts and for the QIPP element are reviewing the mitigations, risks, level of service demand and demand management. Furthermore, the CCG are reviewing the commissioning intentions to consider how services are delivered, whether the existing contracts offer value for money and if there are any overlaps. Additionally, to consider whether we continue with services in their existing form as non-recurrent monies will not be available in 2017/18. JC said that the H&P Operational Group are going through the Central London recovery plan alongside the demand management documentation and will share the headlines with this committee. It was noted that the clinical leads will be supporting the recovery position and as a CCG we need to look at having alternative pathways for services to deal with levels of demand. HP stated that the CCG have received the budget lines and would be undertaking monthly reviews with managers reviewing areas of over performance and said that for out of hospital services that the CCG would need to understand what can be accurately forecast and achieved. The committee **noted** the finance and activity position reported for H&F CCG at month 03	
7.	**Funding approved by Managing Director/Chair**	
7.1	HP informed the committee that the Operational Group had approved non-recurrent funding of £46,776 for a Tissue Viability Band 7 Clinical Nurse Specialist for the 8 month period from 1st August to 31st March 2017. She noted that the funding was provided until the end of Quarter 4 to ensure continuity of service in the leg ulcer clinics and to address safeguarding concerns in relation to pressure sores but may be reduced subject to earlier approval of the tri-borough business case which was planned to be presented at this Committee in September 2016. She emphasised that the new service would provide the opportunity for clinicians to be up-skilled. The committee **noted** the funding approved for Tissue Viability at the operational group of £46,776	
8.	**Imperial Contract Performance and trend analysis - month 3 – 16/17**	
8.1	SR presented the H& F performance at month 3 against the 2016/17 Imperial contract and agreed to share the portfolio at next month's meeting. SR reported that the unmitigated variance was £-552,357 however following applied adjustments that the mitigated variance had reduced to £-366,525 with the adjustments to close down by the end of September. SR stated that based in the £-366,525 over performance year to date (YTD) that the CCG forecast an over performance of £2m for the year. She reported an additional risk for RTT this year and said that the position had improved but the numbers were not included as we are awaiting the values. There are also additional costs to incur for drug spend increases and the junior doctor strike. She noted significant over performance in outpatients also for QIPP in regards to cardiology and respiratory and said that an element of NEL linked to QIPP had under achieved. SR said that discussion were taking place with the teams on the QIPP assumptions and would also be meeting with the collaborative and Trust to improve the QIPP position.	

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	SR reported that the forecast included additional costs which were added to the forecast to reflect lower spend in April due to lost capacity as a consequence of the 2 day junior doctors' strike. She said that over £1m would be included as credits for QIPP and that cardiology and respiratory were not deemed as high risk areas. It was noted that a 50:50 risk share was in place between H&F and Imperial on high cost drugs spend and a 50:50 gain share on switches to biosimilars with the CCG working collaboratively with the Trust towards the use of generic drugs. HP said that this forms part of Right Care and that H&F was an outlier for non-electives in particular for one particular drug which shows an adverse variance of £1m but said that the Head of Medicines Management had produced a paper with different drug options which the CCG were considering. ZA commented that as an organisation we should work more collaboratively with our Trusts. SR stated that the CCG were meeting the control total and achieved this through working with acute but need to stay on track and said that the main issue relates to RTT. JC stated that in regards to diagnostic RTT that the CCG should have a clearer picture of the underline growth but said that there is a backlog issue around data quality and improvement and that the Strategy and Transformation Team are doing some work in this area. SR explained that Sachin had produced the graphs which show the activity and costs and how we are achieving against the budgets and agreed to share the information with the wider CCG team. SR clarified that POD stood for "outpatient point of delivery". JC emphasised that there is an in-house skill set which supports Sharon Robson with IT. It focuses on usage to determine who is doing what and when, and are reviewing the cost of the profiles, making sure that the information is updated and captured as part of the overall CCG QIPP plan. The committee **noted and discussed** the month 3 report.	**SR**
9.	**Reset Presentation**	
9.1	DR presented the Reset Presentation. She explained that it includes a 7 point action plan that NHSE and NHS Improvement (NHSI) have published. She said that NHSE and NHSI are introducing new special measures to be used for providers and commissioners that fail to meet the financial discipline expected of the NHS and are basing its approach on the CCGs annual assessment of overall CCG performance. DR explained that H&F CCG need to implement a plan of action to deliver their control total in 2016/17 with the timelines to be issued in September. JC commented on the importance of the CCG in meeting the requirements and financial commitments, in particular with the move to accountable care partnerships (ACPs). VA commented on the £1.1m allocation and said that it does not resolve the activity problem going forward. DR clarified that the intention is that the money would be used to support people to manage the process. JC explained that in the month 4 finance report (slide 7) provides details of the 15/16 outturn which allows you to compare where costs have increased when compared with 16/17. JC explained that the operating plan guidance would be released in September and will include the assumptions required for next year's contracting round. The committee **noted** the Reset Presentation and proposed plans to dramatically cut the NHS annual deficit and support CCGs to stay within the public resources made available	
10.	**QIPP Month 4 Performance and Demand Management update**	
10.1	HP introduced the month 4 performance update. She reported that year to date we have delivered net savings of £816k against the plan of £969k which is an under performance of £153k and has an adverse variance of 16% and that the position is currently not mitigated by any additional schemes or	

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	non-current contingencies. HP said that the QIPP variance is largely driven by under performance against two planned care schemes and said that the Community Gynaecology scheme is reporting a gap of £52k. This is impacted especially by an increase in outpatient follow-up activity at Imperial. She noted that the Community Ophthalmology scheme is also reporting an adverse variance of £153k but as the service only went live on 18th April, so were expected some under delivery against our plan. HP confirmed that an in depth review of issues with Community Ophthalmology Service will be undertaken as a matter of urgency and that Hammersmith and Fulham was taking over as the lead commissioner for the service and were producing a detailed comprehensive plan to take this work forward. The analysis of GP referrals for QIPP impacting Outpatient Specialties in most cases shows a reducing trend this year and lower than the 15/16 levels. Also, RTT issue at Imperial for Ophthalmology, T&O, and Cardiology will impact the planned reduction in acute activity. HP explained that the year-end forecast performance is to deliver net savings of £3.47m against the plan of £7.79m, a gap of £4.32m. This is an improvement of £232k on M03 forecast largely due to change in investments. Taking non-recurrent contingencies of £2.69m, the QIPP gap is reduced to £1.63m. Currently there are no identified plans to cover the unidentified QIPP gap of £2.84m. HP explained that the demand management presentation was discussed at the Governing Body Seminar and explained that slides 16-21 includes the actions and said that some are already underway and some are proposed. She said that the CCG are proposing to develop them into the H&F Recovery Plan and review at the Operational Group monthly and bring the headlines to this committee alongside the QIPP report. PS commented on the great ideas in the plan and asked how does the CCG plan to prioritise them. HP explained that the CCG would need to look at the resource implications and have a balance between what the CCG must do and what the CCG wants to do and said that this would form part of the clinical discussion to refine the list and to look at return on investment. HP said that we need to get buy in from our GP members and focus on the quick win areas and monitor progress and the changes being made. RH questioned whether the process would be managed as a portfolio with key milestones and said that he was unclear what is happening with Community Ophthalmology. HP explained that information would be included with some narrative added to the plans with details of what is happening, the service leads, the lead for each action with robust project management. PS suggested getting the clinicians together and having a clinical lead from each network and to involve the CCG network managers to share new ideas. ZA commented on the diagnostics service being carried out by Imperial and the Trust also doing the follow-up and asked if this could be established at the triage stage. HP stated that we need to do as much work as possible prior to patients ending up in acute. ZA queried why the diagnostic figures were reducing at Chelsea and Westminster compared with Imperial given the same provider delivers the service and asked whether this was due to a difference in behaviour. HP said that there was an anomaly in the figures but if the service was not working, we need to consider why this was happening and look at how to alter GP behaviour. HP said that the CCG needs to understand what is causing the increase in demand. The committee: • **Noted** the month 4 QIPP performance update • **Noted** the presentation that was discussed at Governing Body seminar 16 August and the work	HP

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	underway on demand management	
11.	**Tender waiver and extension of tri-borough 111 contract**	
11.1	HP introduced the report. She stated that West London CCG is the lead commissioner for the tri-borough 111 service and approved the tender waiver to extend the current contract across the tri-borough for a further 21 months until 31st March 2018 at their June F&P committee. HP said that LCW provide an excellent service and the extended contract will provide the opportunity for service improvements and to achieve in-year efficiencies while the new service specification is developed. She noted that a 6 month notice period will also be included to allow for early termination should the procurement timetable be brought forward. The timeline will allow for any contract variation or re-tendering required following the outcome of the urgent care review. The committee **noted** the Tender waiver and extension of tri-borough 111 contract by West London CCG, the lead commissioner on behalf of the tri-borough	
12.	**CWHHE Workforce Report**	
12.1	HP presented the CWHHE workforce report. She asked the committee to note the apparent fall in sickness absence to zero but said it is unclear whether this is an accurate picture. She explained that a more robust process of validation of the monthly positive return is being implemented. She stated that reminder were sent to CCG of the change in process for reporting sickness and the documentation that needs to be completed once they return from sickness absence. HP said that the process will be overseen by the heads of service and the positive return signed off for submission by the Managing Director or, in her absence, by the Head of Governance and Engagement. She asked the committee to note that the CCG continues to have low levels of both interims and contractors but that these posts remain under constant review. HP said that the outcome of the data refresh has removed a significant number of historic posts which were listed as being vacant. Consequently future reporting will give a more accurate position of both the vacancy and turnover data. HP informed the committee that compliance levels for mandatory training has improved marginally. She noted that CCG colleagues received training from the HR department on how to use the electronic staff record system at a recent all staff meeting in order to address concerns that people had expressed over the difficulties they were having accessing and completing the training modules. She said that It is expected that mandatory training compliance will now see further improvement. The committee **noted** the CWHHE Workforce Report.	
13.	**Any Other Business**	
13.1	JC thanked members of the Quality Patient Safety and Risk Team, in particular Vanessa Andreae and Sena Shah for attending the Finance and Performance Committee for the ImBC and Transforming Care Plan (TCP) discussions. ZA asked if the CCG had an Annual Leave Policy and said that in general practice 2/3 weeks' notice was required for any leave requests to be granted. JC explained that MJ and MK have developed an annual leave tracker for governing body members and send regular reminders to members requesting their annual leave dates.	
The next meeting is scheduled for: Tuesday 27th September, 3.00 – 5.30 pm, St Paul's Church, Hammersmith		