NHS
Northumberland
Clinical Commissioning Group

Minutes of the Resources and Performance Committee
11 March 2016

Members Present:

Karen Bower (KB)	Lay Governor, Resources and Performance (Chair)
Steve Brazier (SB)	Lay Governor, Audit and Conflicts of Interest
Dr Paul Crook (PC)	Governing Body Secondary Care Doctor
Dr John Unsworth (JU)	Governing Body Nurse

In attendance:

Rob Robertson (RR)	Chief Finance Officer
Julie Ross (JR)	Chief Operating Officer
John Warrington (JW)	Business Director Finance and Contracting
Stephen Young (SY)	Strategic Head of Corporate Affairs
Faye Smeaton (FS)	Business Support
Matthew Plummer (MP)	Price, Waterhouse, Cooper (observing)
Cameron Waddell (CW)	Director, External Audit, Mazars LLP (observing)
Jim Dafter (JD)	Senior Manager, External Audit, Mazars LLP (observing)

RP/16/11 Agenda Item 1 – Apologies for absence

There were no apologies for absence.

RP/16/12 Agenda Item 2 - Declaration of conflicts of interest and Quoracy

No conflicts of interest were declared and the meeting was quorate.

RP/16/13 Agenda Item 3 - Minutes from the previous meeting

The minutes of the previous meeting were agreed as a true and accurate record.

The following matters arising were discussed:

Waiting lists for psychological therapies – KB requested an update regarding waiting times. JR explained that a contract meeting was held between Northumberland Clinical Commissioning Group (CCG) and Talking Matters Northumberland (TMN) as a result of patients experiencing lengthy waiting times after referral to the service. A written assessment has been produced and shared with the Local Medical Committee (LMC). JR reported that the CCG are confident that appropriate actions are now in place to reduce waiting times and dropout rates. Bi-monthly update calls are scheduled and the contract remains in escalation until issues are resolved.

JR noted that TMN do not have a presence in Coquetdale and that TMN are considering how they can put support into the area. The LMC are still reporting lengthy waiting times but have noted that improvements are beginning to emerge.

KB asked whether there were any financial implications as a result of lengthy waiting times. RR confirmed that there are no implications for the CCG and that the contract outlines that there will be no financial penalties for TMN within the first year while they work to clear the inherited backlog.

Handover delays – JU asked for an update regarding handover delays at the Northumbria Specialist Emergency Care Hospital (NSECH). JR explained that a report was presented to the Health and Wellbeing Board (HWBB) on 10 March 2016, which confirmed that NSECH have put a number of actions in place to reduce delays. Reductions in delays have been seen as a result, however JR noted that this coincides with a reduction in attendances. During the weekend of 5 March 2016, attendances at NSECH increased and delays also increased as a result, to eight hours at the peak.

JR noted that a system-wide meeting is arranged for w/c 14 March 2016, which will follow a 'drain's up' event at NSECH. The system-wide meeting will look in detail at the issues at NSECH and review the actions in place to reduce delays.

PC asked whether there had been any further action regarding the sharing of protocols. JR confirmed that protocols have been re-circulated to the North East Ambulance Service (NEAS) to improve understanding regarding the use of base sites for urgent care. JR explained that the number of ambulance attendances is not higher than last year, however the number of walk-in patients is considerably higher and largely consists of non-urgent cases. JU felt that a focus on demand management is required in order to ensure that maximum resources are in place at the busiest times, similar to the PACS approach for primary care.

JG asked how walk-ins are dealt with and why they create such an impact on handover delays. JR explained that walk-in patients take up beds, which are then not available for ambulance patients. JG asked whether the current volume of patients was planned for during the planning stages of NSECH. JR responded that GP urgent cases were expected and planned for but that NSECH was not originally designed to receive walk-in patients.

JR reported that there was a strong focus on ambulance performance at the HWBB meeting and concern regarding handover delays. JR had explained to HWBB that although ambulance performance is not at the required level, issues at NSECH are contributing to this.

RP/16/14 Agenda Item 4 Action Log

There were no actions to review.

RP/16/15 Agenda Item 5 Performance report received by JLEB in February 2016

RR reported that David Lea (DL) is working with practices to gain a fuller understanding of the level of choice cancer symptomatic patients are offered in order to receive an appointment within two weeks. DL has spent time in surgeries observing the booking process. This has revealed that, at times, patients may be offered two separate appointments but they may be on the same day and towards the end of the 14 day window. Concerns about the level of patient choice on offer have been raised with Northumbria Health Care Foundation Trust (NHCFT). DL will now work with a larger group of practices to define sample data to be shared with NHCFT.

JU noted that good progress has been made to gain an understanding of cancer waiting times and stated that there is a need to continue to push at the root cause of the problem in order to improve the quality of patient care.

RR noted that the Cancer Network has expressed an interest in DL's waiting time analysis. KB asked whether any national comparators exist and RR responded that while this information is available it is extremely difficult to access. SB asked whether the waiting time information presented was year to date or month on month. RR confirmed that the data is monthly but agreed to bring year to date figures to the next Committee meeting.

Action RP/16/15/1 RR to include year to date cancer waiting time figures in the next performance report to the Committee.

PC queried why the table on page two of the performance report shows IAPT performance for Northumberland Tyne and Wear Trust (NTW) as well as for the CCG. RR responded that the dashboard shows provider level performance separately to CCG performance as not all provider activity is related to the CCG.

RP/16/16 Agenda Item 6 – Financial performance report received by JLEB in February 2016

RR explained that the month 10 finance report received by the Joint Locality Executive Board (JLEB) in February 2016 had outlined a c£2million risk to achieving a break-even position at year end. RR noted that this position has now changed, with an overspend of £2.5million now expected, as the pressures in the main acute contracts will not be mitigated by the end of the year.

RR attributed the in-month movement to the North East Commissioning Support Unit (NECS) no longer being able to progress an agreement regarding the return of funding related to the contract renewal for the COIN IT network.

RR outlined the key areas of financial risk as follows:

- **Slippage in the prescribing programme.** A session was held in October 2015 to identify additional programme savings in-year. Actions were initiated immediately and benefits achieved as a result, which have previously been reviewed by the Committee.

- **Mental health and learning disability pressures related to high cost packages.** The CCG has worked with other CCGs across the north east regarding the risk share following changes to the commissioners guidance in 2013. Previously, responsible commissioners were linked to the local authority regarding 117 aftercare, however they are now linked to registered GP practices. This meant that CCGs could charge each other for the provision of care. This resulted in an increased net cost to Northumberland CCG, which was raised in the early part of the year, with a risk share agreed as a result and mitigations identified to create benefits for the CCG. Risk share agreements may also be arranged for future years, dependant on any further guidance changes.
- **QIPP delivery.** The CCG is forecasting that it will deliver 90% of cost improvements. The Better Care Fund (BCF) is not delivering the anticipated savings and the risk share has been enacted in full.
- **Acute contracts.** The CCG is experiencing significant pressures within the NUTH contract. This particularly relates to non-elective activity, excluded drugs and devices, outpatient procedures and day-case activity. The CCG's initial year-end offer has been rejected by NHCFT, and further work on forecast outturn is under way in order for a revised offer to be made. The CCG is currently in negotiation with NHCFT regarding the level of contract over-performance due to be paid in-year. This position was discussed with JLEB members at their business meeting in February 2016; discussions with NHCFT will continue. RR noted that more detailed contract performance information is included as an appendix to the report.

RR reported that cash targets continue to be met and there are no issues regarding better practice payments.

JU asked whether outpatient procedures were the primary reason for increased use of the NICE approved drugs. RR confirmed that this was the case. JU asked whether NUTH provides ambulatory care and RR confirmed that they do, but only for a small number of conditions. JU asked how much of the £405k could have moved to ambulatory care had the patient been seen at NSECH. RR said that further work is required to investigate patient level data in order to understand this.

SB asked whether period 10 data is likely to show contract spending coming under control. RR said that period 10 is likely to show slight stabilisation at NUTH and increases at NSECH.

KB asked why the finance report shows increased spend for the NHCFT acute contract compared to the previous report. RR explained that this spend had previously been shown in the 'other acute' budget line as part of the BCF but has now been moved into individual acute lines where pressures are expected to materialise.

JU queried why an overspend is showing against the NHCFT community contract when this is a block contract. RR explained that this is related to spending on property and IT which is funded from running costs.

KB noted that there has been substantial change to the commissioning reserves and running costs since the last report. RR explained that this was due to allocations in

year and the receipt of significant funding related to Vanguard which is shown in commissioning reserves, and that the allocation increase can be seen in Appendix 2 of the JLEB report.

PC asked why there had been a change in the budget line for latent TB. RR explained that funding received in error had now been removed.

KB noted that the finance report sent to JLEB had asked the Board to consider the risks and agree mitigating actions; however the extract of the JLEB minutes does not note any mitigating actions being discussed. RR confirmed that no additional mitigations had been agreed; however the existing actions had been reinforced.

RP/16/17 Agenda Item 7 – 2015/16 Forecast to year end

JR and RR gave a presentation regarding:

- The financial position for 2015/16.
- The 2015/16 recovery plan assessment.
- The 2016/17 system-wide recovery plan.

RR said that the CCG is forecasting a £2.5million overspend at year end and the risk of this had been reported throughout the year. He noted that some of the work undertaken in 2015/16 will deliver savings in future years rather than between January and March 2016 as expected.

90% of QIPP cost improvement targets will be delivered as discussed earlier in the meeting. RR stated that work continues to reduce costs even in areas where this has already been achieved.

RR said that the projection for 2016/17 is to achieve an £840k underspend by year end. RR explained how the 2016/17 financial plan is built up by adding demographic and non-demographic pressures, tariff inflation, pre-commitments, NHS England business rules and QIPP. The total QIPP challenge is currently £17m, (of which £9m is recurrent and £8m non recurrent). The CCG will receive an additional allocation increase in 2016/17 related to delegated primary care. This will be discussed further at the April 2016 meeting of the Primary Care Co-Commissioning Committee.

JR explained that the challenge to achieving financial recovery is that, although the numbers of referrals are low, costs remain high across the system and there is an over-reliance on beds. She noted that NHCFT will need to lower costs if spend is going to be reduced. This is reinforced by the information contained within the Carter report.

The CCG has submitted QIPP information to NHS England, alongside noting that changes are required in the system. A meeting has been arranged between NHCFT, NTW and the local authority to consider reducing spend.

SB asked whether there was any part of Right Care that is not being taken forward. JR said that a national Right Care workstream has been established which provides guidance to CCGs regarding which elements to focus on.

JR outlined some key questions that need to be considered in relation to financial recovery:

- Does the CCG need to consider changes to the way maternity services are delivered?
- Are community hospital beds sustainable?
- Should all four urgent care points (excluding NSECH) be open 24/7?

PC asked whether NSECH could cope with additional pressures if the base sites were closed at night. JR noted that the number of walk-ins is low at night and so felt that the impact would not be substantial.

JR explained that, while the CCG has been operating a Programme Management Office (PMO) style function throughout 2015/16, there has not been an official PMO in place. However, financial recovery meetings have been ongoing throughout the year on a fortnightly basis.

JR said that a more formal PMO will now be established, led by SY, and that streams of care will be stood down in favour of focusing on spending reductions. There will be regular updates reported to this committee and the Integration board.

Action RP/16/17/1 JR and KB to discuss the impact of PMO creation and the financial recovery plan on the Resources and Performance (R&P) Committee's forward plan.

JR stressed the importance of ensuring that work to recover the financial position does not threaten delivery of ACO/PACS.

KB highlighted the potential for uncertainty amongst staff regarding the creation of the ACO and asked what is being done to ensure staff retention. JR explained that the majority of CCG staff will move to the ACO, with some being retained within the local authority. RR said that the ACO is an attractive prospect for staff as it represents the future of the NHS and is being promoted as such. SY noted that staff retention is on the risk register. KB asked when the CCG will know which staff will go to the ACO/local authority. JR expected this to happen in September or October 2016.

SB asked whether any assurance could be provided that the CCG's plans will dovetail with those of NHCFT. JR explained that a system-wide plan is in development, with a meeting planned for 17 March 2016 to finalise this.

JW explained that the reason for referrals being within the second lowest quintile, yet costs being within the top quintile is specific to electives. He noted that there is a need to put a system in place which centres around shared decision making and focuses on considering the risks and benefits of surgical procedures.

PC asked what proportion of electives are generated by internal referral. RR said that there are high levels within some specialities but not between different specialities.

Action RP16/17/2 Financial recovery to be the focus of a future Governing Body development session.

PC stated that there will always be difficulties with community models due to the geographical nature of Northumberland. JR said that formal consultations are always carried out regarding changes to services. KB asked whether there has been any reduction in the number of patients attending hospitals over the border. JR confirmed that numbers have reduced, but that patients will always be taken to the nearest hospital in emergency situations.

RP/16/18 Agenda Item 8 – Review of R&P Committee 2015/16

KB thanked Committee members for their responses to the R&P Committee review questionnaire and outlined the four main areas for discussion which had emerged from the responses:

- **Focusing on outcome based KPIs**. KB felt that the Committee already reviews outcomes and asked whether members felt that reports need to focus on this more explicitly. JR said that the Committee receives standard reports in line with the procedures outlined in the CCG's constitution. JR also noted that the Kings Fund have been commissioned to develop health outcomes related to the creation of the ACO and that these will need to be tested in 2016/17.
- **Timeliness of data.** KB noted that there is only so much control regarding when data is available. JG noted that she had investigated the possibility of receiving more up to date data with JR and RR and come to the conclusion that the data received by committees is the most up to date available. RR said that, moving forward, cost base information should be more recent and noted that the current PBR reporting schedule has caused some frustration.
- **JLEB minutes.** KB said that responses had noted a lack of understanding from JLEB minutes regarding what has happened or changed as a result of discussion. SY said that JLEB minutes have been reconfigured and should now clearly outline the issue, debate and decisions arising out of the meetings. JU asked whether the full set of JLEB minutes should be circulated to lay members, however the Committee felt that receiving excerpts of the minutes alongside the relevant report is helpful and were also cautious of becoming overly involved in operational issues.
- **Availability of comparative information.** RR explained that Right Care will provide national data for benchmarking purposes but noted the difficulties in accessing data for other rural areas. SB agreed that rural data is difficult to obtain. RR said that Chief Finance Officers (CFOs) across the north east have requested routine benchmarking from NECS and noted that he plans to continue to push for this.

Action RP/16/18/1 SB to investigate whether a list of assurance and data sources is available from internal audit.

JG said that it would be useful to produce an improvement plan based on the responses to the R&P review.

Action RP/16/18/2 JR to bring a report to the next committee meeting outlining proposed actions as a result of the R&P review.

RP/16/19 Agenda Item 9 – Any other business

There was no further business to discuss.

RP/16/20 Agenda Item 10 – Date and time of next meeting

Friday 13 May 2016 0930, Ashington meeting room, County Hall.