NHS
Haringey
Clinical Commissioning Group

Minutes
Meeting of the Haringey Clinical Commissioning Group Finance and Performance Committee
22 March 2016 at 1.00pm
Meeting Room 7 River Park House

Present:

Dr John Rohan	JR	GP Governing Body Member, North East Lead and Chair of the Finance and Performance Committee, Haringey CCG
Lucinda Beesley	LB	Interim Director for QIPP, Haringey CCG
Dr Dina Dhorajiwala	DD	GP Governing Body Member, West, Haringey CCG
David Maloney	DM	Chief Finance Officer, Haringey CCG
Sarah Price	SP	Chief Officer, Haringey CCG
Adam Sharples	AS	Governing Body Lay Member, Haringey CCG
Jill Shattock	JS	Director of Commissioning, Haringey CCG
In attendance:		
Ernie Gartrell	EG	Associate Director of Contracting NEL CSU
Linda Roast	LR	Minutes

1.	**INTRODUCTION**	Action
1.1	**Apologies for Absence**	
1.1.1	Apologies were received from Dr Sherry Tang.	
1.2	**Declarations of Interest**	
1.2.1	There were no declarations of interest.	
1.3	**Chair's Introduction and Opening Remarks**	
1.3.1	Dr John Rohan welcomed all present.	
1.4	**Minutes of the Previous Meeting**	
1.4.1	The Committee agreed both the minutes of the meeting held on 28 January 2016 and notes of the teleconference on 1 March 2016 as an accurate record.	

1.5	**Matters Arising and Action Log**	
1.5.1	Action 28/01/16 – 01: Completed.	
2.	**Financial Report – Month 11**	

2.1	David Maloney presented a report on the CCG financial position as at the end of February 2016 (month 11). An appendix to the report set out the financial position as at month 11 for each main budget line. The financial position for month 11 had been subject to discussion at the Committee's teleconference meeting at the beginning of March. The Integrated Contract Monitoring Report, produced by the CSU, included detail of acute contract performance and was provided for discussion in conjunction with this report. David Maloney advised that the CCG was reporting a breakeven position against its budget for the year end to date.	
2.2	David Maloney reported that the run rate had increased marginally in month 11 to £17.5m and mainly reflected an increase of £0.4m at NMUH. The net acute overspend reported at month 11 was £2.1m and this was partly offset by the application of recurrent and non-recurrent mitigations. The CCG's financial position included the receipt of agreed income from the NCL Risk Share Fund. Non-acute budgets were overspending by £1.3m at month 11. This was mainly due to significant financial pressures relating to Continuing Healthcare. Running cost budgets were performing to plan. A key remaining area of risk related to the closure of acute contracts for 2015/2016, particularly in relation to Whittington Health, with invoices raised by the trust that were in excess of the capped contract agreed value. With Haringey's support Islington CCG, as lead commissioner, were in discussion with the Trust to agree a year-end position but future implications were a consideration. Negotiations were continuing with other major acute providers with close down of 2015/2016 positions nearing completion. Close down with RFH was expected before year end.	
2.3	The current overspends at Barts (£2.1m) and RFL (£2.2.m) were raised. David Maloney explained that the transfer of cardiology activity from UCLH was largely driving the overspend at Barts and had not been cost neutral due to higher activity at Barts. A year end agreement was now in place. There had been a number of issues with data activity submissions by RFL over the last months. It was understood that the latest submission had corrected some of these issues but there was still some uncertainty on data quality. Negotiations to agree a year-end position were being led by Barnet CCG. It was acknowledged that the overspends by Barts and RFL appeared disproportionate for Haringey and the overspend at Barnet Chase Farm/RFL was significant on an NCL-wide basis.	
2.4	The Committee had been previously advised of an unexpected invoice raised by Community Health Partnerships (CHP) for £0.6m in respect to charges for Hornsey Neighbourhood Health Centre. As an inexplicably high sum, of which the CCG had received no prior notification, this invoice had been disputed on 10 November. David Maloney reported that he had met with CHP representatives last month and it was understood that the issue would be resolved. The table in section 9 of the report set out the current assessment of key financial risks and mitigations.	
2.5	The Committee **NOTED** the finance report for month 11.	
3.	**CCG MDT Integrated Contract Monitoring Report (Finance and Contract updates)**	

3.1	Ernie Gartrell presented the ICMR and noted that key financial issues had been covered by David Maloney's report on the position at month 11. Following the audit in relation to emergency readmissions at NMUH resolution of an agreed percentage was required. This had been discussed with the Chief Finance Officer for the Trust and it was anticipated that the Trust would request a further audit. Ernie Gartrell recommended proceeding to mediation as this was likely to find on the CCG's behalf. This was not however the case with ambulatory care where, in the absence of a national tariff, indicative rates had been subject to local agreement. Contract Performance Notices (CPN) had been issued to NMUH on a monthly basis in relation to failure to achieve standards in emergency care, diagnostics and cancer. Performance had been subject to close monitoring with Remedial Action Plans (RAP) in place for each standard. Sarah Price advised that improvements had been made in relation to diagnostic and cancer standards. An overarching Improvement Plan would replace the current RAP for emergency care. An Activity Query Notice had been issued due to increases in day case activity but a particular rise in relation to Trauma and Orthopaedics appeared to have subsequently abated. It was likely the AQN would be withdrawn.	
3.2	There continued to be work on data quality at RFL. A CPN regarding RTT had been issued and Barnet CCG had requested a revised trajectory. It was anticipated that the RTT standard would not be achieved until March 2016. CPNs had been issued to UCLH in respect to underperformance against cancer and diagnostic standards.	
3.3	Details of the close down of 2015/2016 contracts were as previously reported by David Maloney. Negotiations for 2016/2017 contracts were underway and the CSU was in the process of co-ordinating first contract offers to providers. With the exception of RFL and UCLH, Haringey had agreed first cut offers for all NCL contracts.	
3.4	The Committee **NOTED** the Integrated Contract Monitoring Report and contract updates.	
4.	**QIPP Update**	
4.1	Lucinda Beesley outlined the position in relation to CCG QIPP performance for 2015/2016 which, with further progress to reduce the previous shortfall, was now almost fully on target. Issues to highlight included problems in relation to mobilisation of the community gynaecology service at Whittington Health, with the result that six months notice had now been served on this contract. It was noted that there had also been quality issues regarding the community urology service at WH and Enfield CCG were to lead a review regarding re-procurement. The priority was now the agreement of PIDs and associated work in relation to QIPP schemes in 2016/2017, ensuring a focus on quality and improved monitoring. Schemes had been identified to the required value of £10m. However, in acknowledging there would be factors to potentially affect full achievement, a risk assessment had been undertaken. This had resulted in a probable estimate of around £6m of QIPP delivery. Work was underway to prepare additional schemes to introduce. Areas of joint working were being discussed with the Local Authority and there had been discussion with the Clinical Cabinet for further ideas and areas of focus. Lucinda Beesley noted capacity challenges but emphasised that progress was very good. Questions and comments were invited.	

4.2	Sarah Price noted that the contracting round for 2016/2017 would be difficult. The acute providers were resistant to demand management and reluctant to have numerous small schemes. Lucinda Beesley noted that analyses and preparation of PIDs required a great deal of work but starting at a high point should enable negotiation to the level wanted.	
4.3	The Committee **NOTED** the progress of QIPP schemes for 2015/2016 plus work underway for 2016/2017 and **NOTED** the minutes of the QIPP Delivery Group meeting held on 23 February 2016.	
5.	**Integrated Contract Monitoring Report - Performance**	
5.1	Jill Shattock reported that the Integrated Contract Monitoring Report provided an overview of the performance of the CCG and its main providers in relation to finance, performance and key quality indicators. A supporting narrative was provided to highlight key issues and challenges.	
5.2	Jill Shattock outlined key performance issues. As discussed earlier in the meeting, performance against diagnostic and cancer wait standards at NMUH had improved. However, there continued to be significant challenges regarding A&E performance and waiting times had deteriorated. A great deal of work was underway on a system wide basis in order to understand and address the associated issues and to support and monitor improvement. A Programme Director for Emergency Care, with experience of work on similar issues elsewhere, had been appointed. Following review of the previous trajectory for recovery a final report was awaited on the action proposed for realistic, deliverable and sustained improvement from year end and through 2016/2017. A data pack available gave an indication of the problem issues and included patients spending too much time in A&E, the A&E department being very separate/isolated from the rest of the hospital and insufficient clinical seniority available on a 24 hour basis. The SRG would oversee and support improvement work receiving a fortnightly update on progress and monthly review of four key workstreams - the Emergency Department (triage and decision making etc); re-establishing short stay assessment; wards (earlier discharges etc); and “out of hospital” (schemes/services etc). There would be an SRO assigned to each workstream with associated governance arrangements put in place and the agreement of milestones for delivery. Jill Shattock added that it was understood that NMUH had also now appointed a new Clinical Director for ED but this had not yet been formally confirmed. Questions and comments were invited.	

5.3	Dr John Rohan queried current LAS performance. Jill Shattock confirmed that this continued to be challenging and performance had fallen behind trajectory for January 2016. Commissioners, LAS and the CQC had agreed an improvement plan and this was monitored at the Clinical Quality Group. Sarah Price reported that LAS was seeking further additional funding which COs had discussed and did not support. Work on recruitment was being taken forward as a priority with up-banding of paramedics in London to be equal to other areas. Dr Paul Jenkins was the NCL lead on a London-wide group. David Maloney emphasised that LAS had previously received additional funding of £25m from CCGs and £8m from NHSE which had been dependent on service improvement. Internal Auditors had confirmed that this funding had been spent but performance had not improved and the service was now requesting more. Adam Sharples noted that the Committee had previously requested a report from Brent CCG, as lead commissioner. Jill Shattock advised that the CQC action plan had been circulated and also examples of the regular update reports received from Brent CCG. She agreed to circulate the latest of these progress reports for information.	
5.4	**ACTION 22/03/16 – 01** To circulate the latest update report re LAS as received from Brent CCG.	**JS**
5.5	The Committee **NOTED** the findings of the Integrated Contract Monitoring Report (performance).	
6.	**2016/2017 Financial Allocations**	
6.1	David Maloney presented a report, as prepared for the Governing Body, outlining progress in setting the CCG's 2016/2017 Financial Plan. This built on the previous report regarding financial allocations presented to the Governing Body in February and also reflected points raised in previous discussion by the Finance and Performance Committee. The total allocation for 2016/2017 was £350.4m as previously reported and included a running cost allocation of £6.3m. The budget setting process used the forecast outturn position for 2015/2016 adjusted for non-recurrent items. Work to then formulate expected expenditure in 2016/2017 took account of a number of factors. The impact of the 2016/2017 tariff would increase CCG expenditure by approximately 2% and this would represent half of the increase to the CCG allocation. Additionally, provision had been made for both demographic and non-demographic growth; an estimate for inflation not covered by the tariff; contingency at 0.5% of budget; and budgetary provision for services identified as national financial priorities (GP IT, CAMHS and BCF). David Maloney highlighted that national guidance was for CCGs to leave 1% of overall budget as uncommitted on a non-recurrent basis. Following discussion of the CCG's financial position with NHSE, a "holding" position had been agreed for the CCG to commit this 1% to cover its contribution to the Healthy London Partnership, funding for NCL transformation, CHC retrospective claims and contribution of costs in respect to the RFL acquisition of Barnet and Chase Farm Hospital. This represented a total sum of £3.4m. However, this was contrary to guidance and a further conversation with NHSE this week would confirm the way forward. It was acknowledged that, if agreed, this exception would not necessarily be on an on-going basis. The overall financial gap was estimated at £10m and the implementation of a significant QIPP plan would be required for the CCG to set a balanced budget.	

6.2	David Maloney explained that the intention was to set a breakeven financial plan for 2016/2017 and Operating Plan submissions to date had shown a breakeven position. This was not however consistent with NHS Business Rules for CCGs which stipulated delivery of a surplus equivalent to 1% of overall budget. There were a number of financial risks to delivery of the 2016/2017 Financial Plan as explained in the report. These included any deterioration in the underlying position; the negotiation of contracts with providers to be in line with CCG affordability envelopes; management of activity within contracted levels; delivery of a significant QIPP Plan; and the 1% uncommitted reserve issue as previously discussed. The next steps in the timetable for the 2016/2017 planning round were detailed in the report and the deadline for final submission of the Operating Plan on 11 April 2016 would be challenging. Progress would be discussed with the Governing Body later this week, including the process for approval and sign off. Committee members would be provided with progress updates.	
6.3	David Maloney reported that, in managing delivery of the financial plan, NHSE advised working with colleagues in other NCL CCGs but it was discussed that this could present difficulties. The revised national formula for allocations was intended to move CCGs further towards target which had implications for Camden in particular.	
6.4	David Maloney advised that if contracts with providers were not agreed by 25 April negotiations would proceed to arbitration. It was therefore aimed to agree contracts prior to the final Operating Plan submission on 11 April. It was agreed that the position regarding the 1% uncommitted reserve needed to be resolved by 11 April and would be discussed with David Slegg. Sarah Price suggested there also needed to be discussion of the approach to QIPP, the scale of which was significant and would be very challenging. Lucinda Beesley emphasised good progress had been made with PIDs but there were some issues related to ownership by Project Managers and proposals needed to be realistically deliverable. The Right Care programme presented a risk. Sarah Price agreed that the amount of work and associated time required in relation to Right Care represented a risk against delivery of savings in year.	
6.5	Adam Sharples asked if CCGs all needed to look at where there could be restrictions. Sarah Price confirmed that there was review in this respect however, much was already bound into contracts and Trusts were failing to achieve greater efficiency. Dr John Rohan agreed and the key issue was reducing acute referrals, hospital attendance and admissions wherever appropriate to do so. Haringey had a previous record of good performance but it was agreed many issues now needed an NCL approach in order to achieve any further progress.	
6.6	Committee members would be informed of progress and advised at the earliest opportunity should there be any change to the proposal to set a breakeven financial plan for 2016/2017.	
6.7	The Committee **NOTED** progress made in setting the CCG's 2016/2017 Financial Plan.	
7.	**Risk Register Review**	

7.1	David Maloney presented an extract of the Risk Register, containing the risks for which the Finance and Performance Committee had lead responsibility of oversight. This included details of the mitigations and assurances in place as well as progress against the planned actions. Changes were highlighted for ease of reference. David Maloney noted that in nearing year end the level of financial risk for 2015/2016 had reduced. As discussed, work was now underway on budget setting for 2016/2017 and risk for the coming financial year would be reflected in the Risk Register. Jill Shattock provided assurance that the risk in relation to quality and performance at NMUH was subject to constant review.		
8.	**ANY OTHER BUSINESS**		
8.2	There were no other items of business.		
9.	**DATE OF NEXT MEETING**		
9.1	It was noted that the next meeting of the Committee would be on 19 May at 1pm.		
9.2	Thursday 19 May 2016 (An earlier "virtual"/teleconference meeting to be arranged if necessary prior to the submission of the Operational Plan)	1.00 - 3.00pm	