NHS
Guildford and Waverley
Clinical Commissioning Group

MINUTES

Name of meeting	**Commissioning, Finance and Performance Committee**	
Date and time	21st February 2017	
Venue	Boardroom, Dominion House	
Chairman	Darren Watts (DW)	GP Member and Vice Chair (Clinical)/Prescribing Lead GWCCG
Members	Phelim Brady (PB)	Lay Member Patient and Public Engagement (Deputy Chair)
	Jacqui Burke (JB)	Lay Member for Corporate Governance & Audit Chair
	Dominic Wright (DWr)	Chief Executive GWCCG
	Karen McDowell (KMc)	Chief Finance Officer/Deputy Chief Officer
	Jonathan Inglesfield (JI)	Medical Director - Commissioning
	Vicky Stobbart (VS)	Executive Nurse, Director of Quality & Safeguarding
	Justine Hall (JH)	GP Member
Attendees	David Eyre-Brook (DEB)	Chair GWCCG
	Ray Wagner (RW)	Interim Deputy Director, Clinical Commissioning
	Julie George (JG)	Consultant in Public Health
	Niki Baier (NB)	Director of Contracts (Attendance for items 6,15, 18 &19 only)
	Anna Vigurs (AV)	Quality & Performance Analyst (Attendance for Item 7 only)
	Carina Joanes (CJ)	Lead Commissioning Pharmacist, Surrey Downs CCG (Attendance for item 13 only)
	Anna Larkham (AL)	Community Nutritional Management Specialist, GWCCG (Attendance for Items 10 & 11 only)
	Diane Woods (DWo)	Associate Director Commissioning Mental Health & Learning Disabilities for the Surrey CCG Collaborative (Attendance for item 5 only)
	Hannah Yasuda (HY)	Interim Head of Planned Care (Attendance for item 18 only)
	Rachel McEwen (RM)	Management Accountant & Minute Taker

Apologies Members	Sian Jones (SJ)	GP Member
Apologies non members	David Howell (DH)	Head of Performance & information, Senior Quality & Performance Analyst
	Vicki Taylor (VT)	Deputy Chief Finance Officer

NB: Those present at this meeting should be aware that their names will be listed in the notes of the meeting which may be released to members of the public on request under Freedom of Information requirements.

	DISCUSSION AND NEW ACTIONS	BY WHOM	DEADLINE
1.	**Welcome and apologies for absence** Apologies for absence were noted as above. **Quoracy** As the required quorum was met, the Chair declared the meeting open.		
2.	**Declaration of Conflicts of Interest** Chair declared that the Clinical Members have a conflict pertaining to Item 17, Appendix 12 as this paper relates to Procare Health Ltd which requires a decision. All agreed for PB to Chair this agenda item and for the Clinical Members to provide clinical input but not take part in the decision. Clinical members did not leave the meeting and following discussion of this item non-clinical members were asked for a decision. There is a further potential conflict regarding Item 14, GP in A&E as this also relates to Procare Health Ltd. However this item is not for decision and is a verbal update only. There were no further declarations from the membership and those in attendance in relation to the agenda.		
3.	**Action Log** Please see action log.		
4.	**Minutes from the 17th January 2017** All agreed that the minutes were an accurate representation of the meeting.		
5.	**New Mental Health Commissioning Arrangements** DWo and VS presented the new mental health and commissioning arrangements to the committee. DWo highlighted a key risk that the sharing of information about existing Commissioning Support Unit staff who may TUPE (Transfer of Undertakings Protection of Employment) across to G&WCCG has delayed the consultation going out		

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	and the recruitment to a new structure. PB queried whether this will be cost neutral. VS confirmed this was correct and there would be no redundancies. There are currently vacancies due to staff turn around. JG queried how Social Care will be included in the structure; DWo confirmed that Executive members and Team Leaders in Social Care have been invited to the relevant meetings. The next step in the process is for the contract to be signed in March 2017. JB asked for a paper on how the invoices arrangements have transitioned for the next Audit Committee. **Action 1: KMc** **Recommended Actions** **The Committee noted the presentation and the highlighted risks**. *AV joined the committee at 1.25 pm*	**KMc**	**14/3/17**
6.	**Performance Report Month 9** This report focuses on month 9 data of the 2016/17 financial year, December 2016, unless otherwise indicated. The CCG's performance against the NHS Constitution standards has deteriorated at month 9 compared to month 8 with a reduction in green metrics to 10 (down 3). The number of red metrics has increased to 4 (up from 0); whilst the number of amber metrics, 1, has decreased (by 1). The performance at Royal Surrey County Hospital NHS Foundation Trust (RSCH) has stayed broadly the same at month 9 from its month 8 position, with 12 green metrics (up 1), 6 red metrics (up 1) and 1 amber metric (down 1). Performance at South East Coast Ambulance Service NHS Foundation Trust (SECAmb) has declined at month 9, having improved at month 8 for the first time since month 4. All three metrics are RAG rated red (up 1 from month 8). AV explained that currently the CCG is unlikely to achieve Quality Premium (QP) as there are two constitution measures which is SECAmb and the 4 hour wait which will not be achieved. However there is a caveat as this relates to Q3 and 4. KMc asked AV to query with NHS England if the CCG would receive QP if financial balance is not achieved.		

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	Action 2: DH (AV has now left CCG) **Recommended Actions** **The committee noted the areas of adverse performance and the actions identified to rectify.** *AV left the meeting at 1.40 pm*	**DH**	**14.3.17**
7.	**Finance Report Month 10** The financial position at M10 is a YTD deficit of £7.9 m against the plan to break even. This is a deterioration against plan of £2.8m since M9. The CCG have now received a control total deficit of £8.5 m for the full year forecast which is still a high risk position. To achieve this position, the CCG is heavily reliant on the mitigations in place to materialize, further delivery of QIPP in Q3 and Q4 and no further pressures or other movements in the position. The CCG have experienced a number of pressures in the financial year which are mainly due to slippage on QIPP and Acute over-performance, other issues are the national FNC pressure which are now all reflected in the position There are currently year end negotiations taking place with RSCH, Ashford and St Peters and Frimley Park Hospital. All mitigations need to be considered in order for the CCG to deliver against its current control total, the CCG will continue to work on stretch of QIPP delivery and joint work with the main acute provider to cap the risk for the remaining part of the year. **Recommended Actions** **The committee reviewed and noted the report and the risks highlighted.**		
8.	**Service Transformation Report M10** The net savings target for the service transformation programme is £12.8m. The YTD target at 31 January is £10m with a reported performance of £5.4m resulting in a variance of £4.6m. This represents a 54% delivery year to date. The forecast for the full year is £9m resulting in a shortfall of £3.8m against plan (70% performance). The forecast outturn includes transactional efficiencies which will have an impact of 2017/18 due to the non-recurrent nature of some mitigations. This report has been discussed in detail in the QIPP Delivery and Assurance Group (QDAG) meeting.		

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	Although the position is adversely performing against the plan, the significant amount of work in development and mobilisation of these projects has been noted by NHS England. **Recommended Actions** **The committee reviewed and noted the report and the risks highlighted.** *CJ joined the meeting at 2 pm*		
9.	**Project Mandate for Managing Anticoagulant Prescribing in Primary and Secondary Care due to high cost** CJ highlighted that there has been a significant and continuing increase in the issue of expensive New Oral Anticoagulants (NOACs) between April 2016 and October 2016. Together with a consultant Cardiologist at the RSCH the Medicines Management team have worked collaboratively to maximize the use of NOACs with lowest acquisition costs in both Primary and Secondary Care. There was a discussion on why these expensive NOACs are favorable in both the primary and secondary care and agreed that this could be due to marketing. Currently there is no data to suggest that certain NOACs are better than Warfarin which is more cost effective. Committee agreed further exploration of the reasons for extensive issue would be followed up. **Recommended Actions** **The Committee noted the paper** *AL joined the committee at 2.05 pm.* *CJ left the meeting at 2.15 pm*		
10.	**Enteral Feeding Dietetic Service Proposals and accompanying EIA and Decision Briefing for Procedure to manage Enteral Feeding Invoicing** This Decision Briefing has been discussed at the Medicines Optimisation Group (MOG) meeting with agreement for Option (1) for the invoices to be reviewed by the dietetic team at RSCH and submitted the CCG (Adults) or Childrens Community Service (Childrens) for payment.		

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	JB sought assurance of the dietetics 'buy in' to the service. AL explained that the dieticians have been involved throughout the process and are keen for these patients to be monitored efficiently and for governance arrangements to be improved. JB queried whether the CCG's finance team had provided input into the suggested invoice process, KMc agreed to check. **Action: KMc to discuss with the Finance Team** Chair agreed that there is currently no service for these patients and therefore this service will improve patient care. The Enteral Feeding Dietetic Service Proposals and accompanying EIA paper was also discussed in MOG and option 2 for the dietetic service to be commissioned and hosted by the RSCH with a 1.0 wte dietician (band 6) and a dietetic assistant (band 3) has been recommended. The dietician post will be an integrated post across both adults and children. **Recommended Actions** **All agreed with the MOG suggestions; however the governance and flow of invoices as well as funding sources should be agreed first. KMc to discuss with Finance Team.** *AL left the meeting at 2.40 pm* *NB and HY joined the committee at 2.34 pm*	**KMc**	**14.3.17**
11.	**PoLCE Thresholds** Following a discussion on the changes proposed by another CCG, it was agreed that JI should discuss with the Surrey Priorities Committee with a view to standardising the policy. **Recommended Actions:** **The Committee discussed the implications of differing PoLCE thresholds and agreed these should be referred for recommendations by the Surrey Priorities Committee.**		
12.	***Due to the GP Members' conflict of interest it was agreed that PB would Chair this item and the Clinical Members who have declared an interest (DW, JI, JH, (SJ apologies for this meeting)) will provide clinical input with any decision being made by the non GP Members of the Committee.***		

	DISCUSSION AND NEW ACTIONS	BY WHOM	DEADLINE
	Referral Support Service (RSS) Options Paper The RSS service was extended to the 30th September 2017 with a further review on the service to take place. NB highlighted that Procare will need to be informed of the decision to continue or not by the 31st March 2017. NB explained that should the contract be re-negotiated, it will be at a lower cost with more specific and detailed KPIs incorporated into the contract. All contracts from 2017/18 will be a 2 year contract. There has been an increase in referrals (73% based on CCG data) and, of the referrals sent to secondary care, 50% of are sent to the RSCH. The main benefit has been the engagement by Primary Care and the level of referrals via e-referral however it hasn't converted into any changes or reduced the flow of referrals. Currently Primary Care upload the referrals onto e-referral and then forward to the RSS; if RSS is discontinued the referral will be forwarded to the relevant provider instead. JH also noted that many departments in the hospital already triage the referrals. RW noted that the RSS can be a valuable resource and an effective tool in information gathering. KMc explained that Procare have already agreed that the RSS will be refocused once the CCG offers guidance on what is required. NB agreed that should the service be continued there will be a re-negotiation of the service specification which will come back to this committee for approval. PB asked all non GP Members to determine how this item should be taken forward. All non GP Members agreed that, should the service continue, the service specification and direction of the RSS should be re-focused. All non GP members agreed that NB should discuss the new financial envelope and revision of the KPIs further with Procare, with a decision deferred to the next committee (March). **Action NB** **Recommended Actions** **The Non GP Members agreed for NB to discuss further the KPIs and the new financial envelope with Procare and agreed to discuss at the next committee.**	**NB**	**14.3.17**

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13.	**Procurement Update** There was a commercially sensitive discussion regarding the outcome of the adult community health services procurement. In accordance with the level of delegated authority and in view of the potential conflict of interest, this would be referred to the Governing Body part 2 meeting on the 28th February 2017.		
14.	**Contract Management Update** There has been significant over performance across all acute contracts and there are on-going discussions regarding year end agreements. All milestones in 2017/18 Contracting Round have been achieved. **Recommended Actions** **The committee noted the contents of the report and actions being undertaken to monitor performance and requirements of 2017/18 contracting round**. *DMc joined the committee at 3.15 pm* *NB and HY left the committee at 3.20 pm*		
15.	**Learning Disabilities Intensive Support Service Update** The Deacon unit has now opened and there is a weekly MDT meeting to discuss the referrals that have been issued and the path which they take (Urgent or Non Urgent). So far seven (7) admissions have been avoided due to the triage referral service. *DMc left the committee at 3.30 pm*		
16.	**Review of Terms of Reference** All agreed that the ToR were an accurate representation. No changes are required at this time.		
17.	**Clinical Members have declared an interest in Procare Health Ltd however this item is not for decision and is a verbal update only** **GP in A&E** KMc explained that there will be a business case that will be discussed in this Committee. Should this service continue next year then a decision should be made in the next 2 weeks due to GP rotas.		

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	Clinical Members noted that to ensure indemnity cover, the GP who takes part in this service, would require an honorary contract with the RSCH. Following a discussion all agreed that a full review of the service should take place including the data, whether slots were filled and how cost effective the service was.		
18.	**Better Care Fund Update** Value for money analysis is taking place on the services provided by BCF. KMc asked for this piece of work to be completed before the next BCF meeting on the 9 March 2017 and for a paper to be discussed in the 21 March 2017 CFP committee. **Action 4: RW**	**RW**	**09/03/17**
19.	**Risk Paper** JB noted that there has been no change in commentary since the previous month. Although this risk may still be the same, it should be noted that it is reviewed each month. KMc and RW confirmed that the risk has been updated recently and would ensure this is presented to the Committee.		
20.	**Minutes from QIPP Delivery and Assurance Group meeting 17th January 2017** The Committee noted the minutes.		
21.	**Minutes from Medicines Optimisation Group meeting on the 10th January 2017** The Committee noted the minutes.		
22.	**Top 3 Risks** 1. Community Contracts 2. Finance 3. SECAmb		
23.	**AOB** None		
	Signed and agreed by Darren Watts, Chair:		
	Minutes agreed for publication by Karen McDowell, Chief Finance Officer:		

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Date of next meeting: Tuesday 21st March 2017, 1 – 3.30 pm			