FINAL MINUTES

Name of meeting	**Commissioning, Finance & Performance Committee**	
Date and time	**15 August 2017, 1-3.30pm**	
Venue	**Boardroom, 3rd Floor Dominion House, Woodbridge Road, Guildford, Surrey**	
Chairman	Darren Watts (DW)	Vice Chair (Clinical)/GP Member
Members	Phelim Brady (PB)	Lay Member Patient and Public Engagement (Deputy Chair)
	Matthew Tait (MT)	Joint Accountable Officer
	Jonathan Inglesfield (JI)	Medical Director - Commissioning
	Jacqui Burke (JB)	Lay Member Corporate Governance and Audit Chair
	Vicky Stobbart (VS)	Executive Nurse, Director of Quality & Safeguarding
	Justine Hall (JH)	GP Member
In Attendance	David Eyre-Brook (DEB)	Chair
	Annette Keen (AK)	Senior Strategic Transformation & Commissioning Lead
	Jane Chalmers (JC)	Interim Deputy Director Clinical Commissioning GWCCG
	Vicki Taylor (VT)	Deputy Chief Finance Officer
	Adam Binnie (AB)	Senior Information Analyst **(Item 5 only)**
	Gillian Barnes (GB)	Head of Contracts **(Items 11 & 12 only)**
	Kristina Clegg (KC)	PA & Note Taker
Apologies - Members	Sian Jones (SJ)	GP Member
	Karen McDowell (KMc)	Chief Finance Officer & Deputy Chief Officer
Apologies - Attendees	David Howell (DH)	Head of Performance & Information, Senior Quality & Performance Analyst
	Julie George	Public Health Consultant, SCC
	Niki Baier (NB)	Director of Contracts

No.	Discussion & new Actions	By Whom	Deadline
1	**Apologies for absence** Apologies were received as noted as above. JI introduced Hannah Copeland, new GP Registrar.		
2	**Declaration of Conflicts of Interest** Chair asked if those present had any new or further declarations in addition to those noted on the register circulated. None were received. JH noted that she remained a non-voting member but would commence employment at Woodbridge surgery 21.8.17 and her voting rights at this Committee would be reinstated. Chair then noted the following conflicts: Item 8 - Cranleigh Village Hospital Trust (CVHT) – JI It was agreed JI would detail the conflict when the item was taken, with consideration of the proposed handling - to remain in the meeting and take part in the discussion. Item 11 - GP in A&E – all GP members GP members were all members of Procare. It was agreed they should be involved in the discussion and decision, having considered the material impact which was not deemed to be significant. Item 13 - Phyllis Tuckwell Memorial Hospice Grant Agreement - DEB DEB would leave the meeting for the item.		
3	**Action Log** Please see action log. **Item 13 &14 RSS** – RSCH and Procare to agree a way forward for RSS to continue. Phil Ridsdill-Smith (PRS), as CEO of Procare Health Ltd, and Paula Head, Chief Executive RSCH, are meeting 16.8.17. DEB has asked PH to update CCG on outcome of that meeting. ***(Please see pdf document attached for latest update – circulated to practices 16.8.17***) This item will remain open on the Action Log, with an update for 19.09.17 CFP meeting.	**DEB**	
	Item 8 LCS Budgets – VT is working on this. Item to remain open with an update to be provided at 19.9.17 CFP meeting.	**VT**	
	Item 16 – CFP Terms of Reference/Quoracy CFP Chair met with Director of Governance and Conflict of Interest Guardian 15.08.17 to discuss handling of the declared	**EN**	

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	interests of GP Member practices with respect to their Procare Health Ltd affiliation. EN to prepare a proposal for 19.9.17 CFP. **Item 5 – Performance Report M2** – item to remain open pending update from Ben Hill/Rory Collinge for 19.9.17 CFP		
	A Risk Pooling Agreement was circulated with the meeting papers (omitted from the July meeting papers) and Chair advised this item would be discussed under item 6 on the agenda – Finance Report **Action 1: To review calculation of first quarter risk pool figures and governance – JB, VT, Hannah Hamilton (HH) & Martin Hedley, Lay member for Finance at RSCH to discuss outside of this meeting and report to September meeting**	**JB, VT, HH & Martin Hedley**	**12.9.17**
4	**Draft Minutes of June & July 2017 meeting** No changes or amendments were raised. **The Committee approved the Minutes**		
5	**Performance Report M3** AB noted general improvement. Two exceptions reported at CCG Level: ➢ Diagnostics – Amber ➢ 1 case of community acquired MRSA Improved position on ECHOs at RSCH and on track to deliver the recovery trajectory in line with the contract performance notice issued to the Trust. Urodynamics – no diagnostic test procedures were carried out in June due to shortage of trained staff and unforeseen leave. Back log starting to be addressed including re-triage of video referrals by Consultant Urologist. VS has requested a QIA from Louise Stead, Director of Nursing at RSCH. AB noted that a contract performance notice had been issued due to the continuing underperformance for this modality and a meeting has been requested by the Head of Performance at RSCH.		

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	Cancer 62 day waits – x1 GWCCG patient over 62 days due to late onward referral by RSCH Ambulance Handovers – significant improvement in comparison with the same period last year. SECAMB have a new handover policy that is being rolled out across all acute providers and an update on the progress and impact of this change will be included in Performance Report for September. Handover nurse at RSCH funded by CCG from Winter pressures money; RSCH are expected to pick up funding from March 2018. **Action 2: Item to remain open and return to September meeting for update.** Quality Premium – control deficit will be the measure so unlikely to result in any QP premium for CCG **Action 3: AB to amend C. Diff target for RSCH to green** Issues around SECAMB staffing, culture of harassment and bullying which have been widely reported were raised - these have been noted and are to be discussed at Quality & Clinical Governance Committee. **Recommendation:** **The Committee is asked to note the areas of adverse performance and the actions identified to rectify** **The Committee noted the areas of adverse performance and the actions identified to rectify**	 **BH** **AB**	 **12.09.17** **12.9.17**
6	**Finance Report M4** VT presented the Finance paper and the financial position for month 4. - as at the end of July, a deficit of £2.8m which is in line with the plan. - forecast for the year is delivery of the planned deficit of £8.4m. Although the position is balanced at month 4, there have been a number of pressures predominantly within acute services and driven by the over performance on the main acute provider contract. VT noted that the risk pooling arrangement was in place with the main acute provider and the CCG had to account for the full amount to be transferred to the CCG in both the year to		

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	date and forecast positions reported**.** This position is agreed on a monthly basis with the Trust The current run rate is not forecast to continue at the same rate as Q1 and a reduction in expenditure is expected through QIPP delivery and deep dives into acute spend at some of the smaller providers. This poses a risk to the CCG if costs do not reduce and savings are not delivered against the QIPP programme. VT noted that in order to ensure financial balance at Month 4, the position relied upon a number of actions including the use of underspends across other CCG budgets, for example IAPT where the year to date activity was lower than planned. In addition, it was noted that any investments that had not be committed in the first 4 months had been released to balance the position. VT flagged that continued increases, or even continuation of the current run rate position, would mean the CCG would be unable to balance to the plan of an £8.4m deficit. JB noted the potential risk in releasing funding to offset acute performance in order to balance the bottom line. Discussion took place regarding the release of funds to do this and it was confirmed that although underspends had been used as mitigation, these were real underspends within the year to date position and it is only if this position continues to decline that the CCG will face further risk. VT noted that the under-spend that had been banked were illustrated in the table on page 6 of the report. CCG have reported 75% delivery against the QIPP programme year to date and a forecast of 76%. Running costs are performing well and delivering an under spend which delivers against the corporate efficiency target. A question was asked as to whether NHSE had responded about the unbalanced plan and the requirement to meet the control total. VT noted that KMc had been raising this matter on a regular basis with NHSE and the latest response is that the control total deficit will not change, however they understand that we are reporting against the financial plan submission of an £8.4m deficit.		

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	It was also noted that although the QIPP requirement to deliver the planned deficit is £8.6m, the CCG are continuing to pursue savings of £13m which would be required to deliver against the control total deficit. MT noted that the CCG should expect formal notification from NHS E regarding the control total - to date this has not been received. Following a question from DEB about the risk pool agreement with RSCH – VT confirmed that at Q1 the CCG needed the full year to date share of the risk pool. Clarification was sought on the agreement and it was confirmed that every quarter £1m can be drawn down to be directed to whichever organisation needs it. If both need it, it will be shared on a proportionate basis so that the risk in both organisations is equalised. It was confirmed at M4, the CCG needed the risk pool and this position had been agreed with RSCH. JB noted in the report there was reference to deep dive work on acute providers and asked for clarity about where and when this would be reported. VT confirmed that the outcome of the work would be brought to the next meeting of CFP. **Action 4: NB to prepare Deep Dive Report for presentation at September CFP meeting.** **Recommendation:** **The Committee is asked to note the report** **The Committee noted the report**	**NB**	**12.9.17**
7	**Service Transformation Report M4** Following a question from PB on analysis of the capped expenditure programme, it was confirmed JC and JW have undertaken an analysis, with a report to be forwarded to MT imminently. Some schemes will be for 2017-18, some will be 'pump primed' for 2018-19. JW has identified three items common across all three CCGs. Following a question regarding possible gains from the schemes, it was noted it was difficult to quantify but there were opportunities in-year including transactional opportunities. For example, there could be opportunities around POLCE thresholds. VS and her team will carry out QIAs once targets identified across the three CCGs.		

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	By the next meeting in September the intention is that there are 'real' in year opportunities which will be in the process of being worked up as part of the 17-18 QIPP plan. **Action 5: JC/Jane Williams (JW) to provide update on Capped Expenditure Programme to September meeting** **Recommendation:** **The Committee is asked to note the report** **The Committee noted the report**	**JC/JW**	**12.9.17**
8	**Update on Cranleigh Village Hospital Development (CVHD)** Chair asked JI to explain the nature of the identified conflict in relation to the CVHT item. As JI is a member of a GP practice in Cranleigh - if the service as referred to in the paper went ahead, his practice would provide medical cover for the beds with financial benefit. The Committee considered the potential materiality which was felt to be not significant at this stage to warrant exclusion. Chair recognised JI's interest as a potential conflict in the future, but not material to warrant exclusion at this stage and the discussion would benefit from his input – all agreed. The purpose of this item was to: (a) give an update on the current position in relation to CVHT developing the hospital site and (b) to clarify the CCG's response to CVHT's request for support of its proposals. DEB drew the committee's attention to pages 4 and 5 - the Considerations and Appendix E – Schedule of Heads of Terms which CVHT would like the CCG to agree to, before a public meeting they have planned for September 2017. Background information was given on the village hospital in Cranleigh which had faced the threat of closure in late 1990s, leading to formation of CVHT in 2010 and fund raising (c£2m) to build new facilities. It was noted that Surrey PCT had previously made a commitment in very general terms for some local beds; the CCG is now requested by CVHT to be a key stakeholder. A detailed discussion ensued: (i) In response to a question from MT as to what role CCG was asked to play in development, it was clarified this		

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	was CCG support for their proposal to offer the CCG ten community beds for use by the wider population, with the cost cited at £365k per annum. (ii) Clarification of what the CCG had agreed to date was provided with reference to: Appendix D (November 2016) of the paper referred to an Executive discussion, with the conclusion drawn that support was given in principle, but without expectation of CCG committing any additional funding. This was in the context of the current financial climate and the CCG not being in a position to support the Heads of Terms. Formal communication of this to CVHT had not been established. However a signed statement - Appendix A (by previous Accountable Officer (AO) in May 2017) - supported the re-provision of community beds. (iii) The statement which CVHT had subsequently released in June 17 (Appendix B) was not however consistent with what had been signed off in May 2017. The CCG had written to CVHT informing them that they did not recognise the statement released and seeking confirmation that prior agreement would be sought for any future statements with CCG implication. Whilst this had been acknowledged with an apology and agreement, re-issue of the June statement had not taken place and would be followed up. **Action 6: JC to follow up (iii) above**	**JC**	**10.10.17**
	(iv) JB referred to the questions which she had raised in an email to the Chair and Commissioning team. JC noted that Ben Hill had attended the last 2 or 3 CVHT meetings and would be best placed to respond to these for the September meeting. **Action 7: BH to address questions raised by JB** The Chair summarised the key points requiring further clarification as follows: (a) An explanation of how the cost of 10 community beds had been calculated to arrive at £365k. (b) A number of elements in the Heads of Agreement specifically regarding use of vacant community designated beds by supplier	**BH**	**10.10.17**

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	(c) How the ten (10) additional beds at CVHT would: fit the CHC model of services (a discussion was indicated with Surrey Downs CCG before such an options could be progressed); (d) fit into the overall CCG strategy for provision of community beds across the CCG's footprint; (e) The need for due diligence on HCOne as a prerequisite to any formal partnership working agreement being established. **Action 8: JC and BH to address key points above requiring further clarification** A meeting is scheduled to take place on 31.8.17 with CVHT and HCOne. Chair noted the Committee's reservations and the need for a full business case, plus supporting documentation and clarity of governance arrangements, to return to CFP for further consideration. A public meeting is provisionally scheduled for September but is still subject to confirmation. DEB suggested a letter to Robin Fawkner-Corbett, Chair of CVHT to advise that the CCG would not be in a position to sign the Heads of Terms pending resolution of these issues. This approach was supported. PB noted from the paper presented, no compelling case had been made for the CCG to invest. An update on this would be scheduled for September's CFP meeting with a thorough review of the project before any consideration of a full business case from CVHT. Those present agreed the importance of clarifying the position with CVHT. **Action 9: JC to draft a letter for DEB to send to Robin Fawkner-Corbett as noted above.** JB asked if Andrew Carne at RSCH could be copied in on any correspondence. *2.15pm JH left the meeting and re-joined at 2.20pm*	**JC/BH** **JC**	**10.10.17** **11.9.17**
9	**Commissioning Intentions** AK presented the paper re Commissioning Intentions, outlining the CCG's proposed approach. Policy, performance and strategic direction issues for GWCCG and STP will all be taken into account in developing commissioning and contracting intentions. The need to ensure engagement with all key stakeholders to identify their issues, concerns and priorities for		

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	the commissioning and contracting intentions was highlighted. The paper also makes reference to key timescales taking into account the earlier timeline than for the previous year's planning and the need to issue commissioning and contracting intentions, and reflect in contractual notices to providers, by end of September to ensure full 6 months' notice is in line with requirements set out in the national standard contract; To that end AK noted one correction to the timeline: *Extract from Timeline – 'Share with providers, contract drafting, contract negotiations'* Following discussion with NB – above will need to be brought forward to December 2017. Meeting to address inter-dependency with the STP – what commissioning intentions might be identified strategically across Surrey Heartlands were planned, as the STP have committed to produce system wide commissioning intentions as part of the devolution process. Chair asked about the timescale for CFP and GB meetings and how AK intended to engage with Primary Care, recognising the need for their greater involvement. AK reported that plans to attend Locality Workshops (one on 24.8.17), Locality Meetings (September) and Practice Council (next meeting September) were in place. This approach was preferred over the suggestion to arrange individual practice meetings. MT noted that we would need to engage GPs on their own interests – e.g. out of hospital models and how they are developed, community services development. The conversation with primary care/GPs needs to include realistic options. VS observed that the paper would need to be amended to include key meetings with stakeholders and sign off dates on the timeline. **Action 7: Update on the milestone plan to develop the boarder commissioning plan including key dates for CFP and GB signoff to be provided at September meeting** **Recommendation:** **To support the proposed process for developing the GWCCG commissioning and contracting intentions; and**	**AK**	**12.9.17**

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	note the inter-dependency with STP commissioning intentions being developed collaboratively across Surrey Heartlands. **The committee acknowledged the deadline for issuing the contracting and commissioning notices letter to providers and that work should progress to engage stakeholders in this process.** **An updated milestone plan as per above and progress report to be presented to the September CFP.**		
10	**Better Care Fund** AK presented this paper. A discussion took place on the original BCF agreement which, it was considered, did not compare favourably from a health perspective to other areas. In some larger county councils there have been reductions in services e.g. sexual health and alcohol which will have significant impact on health budgets and a greater level of scrutiny and challenge will be sought going forward There was a need to consider if the health economy were challenging robustly enough the funding to ensure health services were not impacted. In particular stakeholders had questioned the process for approval of iBCF plans. It was acknowledged that the plans had been through the required governance process with the Surrey Health and Social Care Integration Board and therefore the recommendation to approve was supported; however it was noted that this body represents commissioners and in future there should be greater visibility of these plans, particularly in view of Surrey Heartlands focus on devolution including joint commissioner and provider investment decisions. It was noted that the paper appeared to be largely focussed on the aging population and that there was little or no mention of diabetes or obesity; also no mention of East Surrey's contribution to patient/public engagement It was highlighted that a recent internal audit of the BCF fund had been conducted at SCC. Recommendations would need to be reviewed and acted on by the Local Joint Commissioning Group. **Action 8: AK to share report with CCG audit chair and provide an update on progress with implementation of recommendations and performance of work streams**	**AK**	**12.9.17**

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	within the locality BCF plan **Recommendation:** **The Committee is asked to (i) approve the plan and (ii) consider the timeframe for next internal update to CFP** **The Committee approved (i) the plan and (ii) considered the timeframe for next update to CFP**		
11	**GP in A&E Business Case** Chair noted the conflict with GPs as members of Procare but it was recommended that GP Members could participate in the discussion and decision making – there were no objections to managing the conflict in this way. *2.45pm Giles Mahoney (GM), RSCH joined the meeting* JC presented the previously circulated business case. JC stated that RSCH has received £1m to provide a facility for GPs working in A&E. • The request to CFP is for a non-recurrent investment of £85,107 to fund the GP element of the model – this would be for a period of six (6) months (October 17 to March 18); • The business case has been developed with input and challenge from CCG colleagues; • There is still some debate nationally about the benefits of the GP in A&E model and this is reflected in the fact that it is, at this stage, non-recurrent funding to fully evaluate the first 6 months. KPIs will be agreed over the next few weeks and there will be a full evaluation of the scheme in Q4 with, if appropriate, a re-presented business case for a recurrent investment for 2018-19 and beyond. GM noted that RSCH was looking only for the GP costs to be shared between organisations. There was a detailed discussion which covered the following areas: (a) how a model would work and what tariff would be applied when a patient is streamed through A&E to see a GP.		

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	(b) whether Crown Indemnity would cover GPs were working for the Trust. Procare and RSCH has agreed that RSCH would sub-contract with Procare which would cover this issue. However this was disputed by the CFP Chair who had checked this and understood this cover would not be available. GM said that he would raise this issue for clarification with Phil Ridsdill-Smith (PRS) on 16.8.16. GM further noted that there would be full EMIS access for those GPs working in A&E which should help to lower the indemnity figure. The need to exercise caution was emphasised by GP and committee members around this issue. (c) DEB observed that the model would only work if GPs were preventing admissions; if the number of admissions does not reduce, then GP in A&E would be ineffectual. KPIs would need to be agreed to demonstrate this and a shift in approach. (d) JB sought clarity on the financials and asked how any financial benefit would be released. In response to a question about whether the benefit would be shared between RSCH and CCG, this was confirmed and would be made a condition. JC added that it was a stated condition of the CCG in supporting the initial capital proposal that, where the activity assumptions are exceeded and therefore greater than the anticipated savings identified in the business case, the commissioner work with RSCH to share these savings. This had been included on page 9 of the business case. **Recommendation:** **The Committee is asked to approve (1) The operational model outlined in Option 4 is the most suitable for our local context; (2) The GP element of the service will be initially funded to operate for a 6 month period and this element will be funded equally by the CCG and Trust. This is a cost of £170,215, shared 50/50 so the non-recurrent investment from the CCG will be £85,107; (3) It notes that the service will be thoroughly evaluated and the system**		

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	benefits will be explored so that if it can be proved sustainable a proposal for recurrent funding will be brought to CFP for consideration in March 2018 **The Committee approved (1), (2), (3) & (4) above with the proviso that they would be given an update on KPI development at the next CFP meeting in September 2017.** *2.45pm Gillian Barnes joined the meeting* *3pm Giles Mahoney left the meeting* *3pm DEB left the meeting* *3.10pm JC left the meeting and returned at 3.15pm*		
12	**Mental Health Voluntary Sector** GB presented this paper to the Committee. Main points were identified and Committee is asked to ratify the approach for the renewal of the Voluntary Sector Contracts as shown below: **(i)** Employment Support and Retraining Agency (ESRA) - The ESRA contract is £35,829 compared with the RF contract which is £759,682.80, meaning going out to procurement would not be cost effective. (ii) Citizens' Advice – Epsom and Ewell, Guildford, Runnymede and Spelthorne - If there are no other providers in the market providing these specialist services, it would not be cost effective to run a re-procurement exercise. The Prior Information process will identify whether testing the market would be appropriate. (iii) Travel Matters - Travel Matters was commissioned on the understanding the service would become self-sustaining. The NEH&FCCG paper presented in May 2016 proposed local commissioning at a reducing level until safe to be de-commissioned. **Recommendation:** **Committee is asked to (i) Approve extension to Employment Support and Re-training contract; (ii) approve Prior Information Notice to test the market for the three Citizens Advice Contracts and (iii) to note proposals to address the Travel Matters contract** **The Committee approved (i), (ii) and (iii) above.**		

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13	**Phyllis Tuckwell Memorial Hospice Grant Agreement** Chair noted a conflict for DEB who withdrew from the meeting for this item and took no part in the discussion. The formal Grant Agreement with PTHC terminated on 31st March 2017 and agreement of a new grant arrangement remains outstanding. NHS Guildford and Waverley CCG, as lead commissioner, has continued the monitoring of payments into the 2017-18 financial year to ensure services run as Business As Usual (BAU). Committee noted a good, clear and concise paper and commended GB on her presentation of the facts in support of the case. **Recommendation:** **(1) Agree a new grant agreement with PTHC from 1 April 2017** **(2) Agree the duration of the PTHC Grant Agreement so it is concurrent with Beacon Contract with PTHC for two years from 1 April 2017 to 31 March 2019** **(3) Incorporate a 2.1% inflationary uplift in the PTHC Grant Agreement from 1 April 2017 to 31 March 2019** **The Committee approved (1), (2) and (3) as above**		
14	**Stroke Update** DEB provided the following verbal update on Stroke services: • The Stroke Committees in Common (CiC) is scheduled for 7th September 2017. • Frimley Health Care are proposing a revised networked model in which RSCH provides an ASU (Acute Stroke Unit) - as they currently do in the transition phase - and/or enhanced rehabilitation as part of the stroke care pathway. Clarity on this is expected with a view to its presentation to NHS E assurance panel for scrutiny and approval to take forward as an option. • Regarding flows – SECamb has been asked to instruct their staff to take patients to the nearest HASU. This is expected to move the split of G&W patients from the current 95% towards Frimley to around 70/30. This is important to ensure that Ashford & St. Peters (ASP) Hyper Acute Stroke Unit (HASU) remains viable.		

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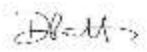
15	**Top 3 Risks** The Top3 risks were noted as: (i) Continued over-performance at RSCH (ii) Stroke - timescales (iii) Cranleigh Village Hospital Trust		
16	**AOB** There being no further business the meeting closed.		
Signed and agreed by Darren Watts, Chair 			
Minutes agreed for publication by Karen McDowell, Chief Finance Officer / Deputy Accountable Officer 			
Date of next Meeting 19 September 2017 2017, 1-3.30pm			