NHS
Guildford and Waverley
Clinical Commissioning Group

FINAL MINUTES

Name of meeting	**Commissioning, Finance & Performance Committee**	
Date and time	**19 September 2017, 1.00-3.30pm**	
Venue	**Boardroom, 3rd Floor Dominion House, Woodbridge Road, Guildford, Surrey**	
	Name	*Title*
Chairman	Darren Watts (DW)	Vice Chair (Clinical/GP Member
	Matthew Tait (MT)	Joint Accountable Officer
	Karen McDowell (KMc)	Chief Finance Officer/Deputy Chief Officer
	Jonathan Inglesfield (JI)	Medical Director - Commissioning
	Sian Jones (SJ)	GP Member
	Jacqui Burke (JB)	Lay Member for Finance, Audit & Corporate Governance
	Vicky Stobbart (VS)	Executive Nurse, Director of Quality & Safeguarding
	Justine Hall (JH)	GP Member
In Attendance	David Eyre-Brook (DEB)	Chair GWCCG
	Vicki Taylor (VT)	Deputy Chief Finance Officer
	Niki Baier (NB) **agenda items 6,8,9,10 only**	Director of Contracts
	David Howell (DH) **agenda item ~~5~~ only**	Head of Performance & Information, Senior Quality & Performance Analyst
	Adam Binnie (AB) **agenda item ~~5~~ only**	Senior Information Analyst
	Rachel Mackay (RM) **agenda items 12 & 13 only**	Head of Medicines Optimisation
	Julie George (JG)	Public Health Consultant, SCC
	Karen Simmonds (KS)	SCC
	Kristina Clegg (KC)	PA & Note Taker
	Phelim Brady (PB)	Lay Member Patient and Public Engagement (Deputy Chair)

Apologies in Attendance	Jane Chalmers (JC)	Interim Deputy Director Clinical Commissioning GWCCG
	Annette Keen (AK)	Senior Strategic Transformation & Commissioning Lead

No	Discussion & New Actions	By Whom	Deadline
1	**Apologies for absence** Apologies were noted as above. Chair made introductions for the benefit of Karen Simmonds (Deputy to Julie George). Sian Jones (GP member) had been noted under apologies on the agenda but was present at the meeting.		
2	**Declaration of Conflicts of Interest** Chair asked if anyone present wished to make any declarations in addition to those noted on the Register– none were declared. Procare Health Ltd – a meeting had been held between EN, JB and DW to discuss GP Members' declarations of interest with regard to their practices' affiliation with Procare and how it affected their participation in decision making. Information had been sought and received from the Chief Executive of Procare to provide more detail on the interest; this would be included in the Register of Interests for openness and transparency. This matter would be kept under review. ***1.10pm JI, DH and AB joined the meeting*** ***1.15pm NB and VT joined the meeting***		
3	**Action Log** See Action Log. **Item 5** – to remain open until response received from Rory Collinge. **Item 7** – AK to follow up, KMc will chase.		

No	Discussion & New Actions	By Whom	Deadline
	Item 8 – closed – Chair requested this item to be re-opened and Deep Dive review to return to October CFP meeting. Audit report was not around healthcare spending but on the County Council's own spending – reasonable level of assurance in audit terms re focus and accountability for spending but focus on social care not healthcare. JB noted that there may be gap in the assurance around healthcare. JB noted that Annette Keen had said that a different type of monthly report re BCF would be produced in future but this has not yet been provided. KMc – need to revert to SCC Internal Audit and request audit is undertaken across whole BCF (has happened every year previously). Deep dive reviews have been carried out on all health and social care spend with SCC colleagues and also identified schemes to be dis-invested and re-invested in reserve contingency for new schemes. KMc – would be helpful to bring back to this Committee reports on work already undertaken. **Action 1: Reports/audits/deep dive review work already undertaken to be re-presented at October CFP**	**AK**	**9.10.17**
4	**Draft Minutes of August meeting** The Chair took the Committee through the Minutes and addressed all points for clarification as set out in the drafting notes. It was noted by the Chair that subject to the changes noted here, the Minutes were agreed.		
5	**Performance Report M4** **CWT 62 DAY** With regards to 62 Day from Urgent GP referrals, this is the first time since February 2016 the Trust has moved to amber from red under the national thresholds. A letter was sent by the Regional Medical Director for the South of England to the Cancer Alliance Clinical Leads, Clinical Network Cancer Leads and NHS Trust Medical Directors for the South Region on the 4th September thanking them for the their support and work to date to support recovery of the 62 Day Cancer Standard. The national and regional expectation is that the South of England is to achieve 85% delivery in aggregate from September.		

No	Discussion & New Actions	By Whom	Deadline
	AMBULANCE HANDOVERS SECAmb's Reduced Hospital Turnaround Project continues to progress well and concerns surrounding the new handover procedure are being addressed. Performance monitoring of A&E Departments continues and SECAmb are aiming for 100% compliance from Acute Trusts and A&E Departments in adopting the New Conveyance Handover and Transfers of Care Procedure by the 29/09/2017. A question was raised re the impact of the ambulance handover nurse. DH noted that this had produced a positive impact but was still not a 24 hour a day, 7 days a week post and was still being funded solely by the CCG from Winter pressures money. It was felt that the CCG should do some work on the capacity of the handover nurse and the issue of funding. There was a also a query as to whether SECAMB should contribute to the funding of this post. JB asked if this was something which could become an STP scheme. MT replied that there were some areas where the STP overlaps already. SECAMB keen to look at bidding for transformation monies to apply to see and treat options. **Action 2 – BH to discuss increasing capacity of the handover nurse and funding of the post with RSCH also to follow up with SECAMB re contribution to funding.** **DIAGNOSTICS** **Cardiology – Echocardiography update:** The Trust has made a significant improvement in clearing the backlog and this is the lowest the backlog has been since April 2016. In July there were a record number of procedures carried out for this modality and the overall snapshot of the waiting list is the lowest it has been since January 2015. This has been achieved through a continued effort of additional ad-hoc and weekend outpatient clinics and outsourcing or activity. JI wished it noted that the improvement noted above was due to pressure being maintained by CCG officers **Urodynamics – Pressures and Flows:** Following the June return in accordance with General Condition 9.4 in the NHS Standard Contract, the CCG issued the Trust with a contract performance notice with regard to the continuing underperformance in relation to the delivery of Urodynamic activity. In month 4 the waiting list increased again to 57.		

No	Discussion & New Actions	By Whom	Deadline
	A Support nurse has now been recruited to work alongside Clinical Nurse Specialist and RSCH now have a recovery tracjectory in place to improve diagnostic performance for this modality. All of the back log are standard urodynamic tests. Chair noted the significant positive impact the CCG has had on performance by raising Contract Query Notices with the provider and thanked the team. **C. Difficile** JB and DH had been in discussions regarding the M1 position for C.diff at RSCH. DH explained that the annual threshold of 21 is split across 12 months allowing 1.75 cases per month – RSCH had 2 cases in April which had been rated red by CCG and green by the acute. AB had contacted the Head of Performance at RSCH to ask for the annual phasing of the threshold so the CCG could align this to the Trust for consistent reporting. AB was advised that the Trust have not phased the target and is split equally over the 12 months. The Trust had launched a new scorecard in April 17 and think their rating was reported incorrectly. In M3 they also had 2 cases and rated themselves as red. DEB asked if Dementia prevalence rates should be included in this report. **Action 3: DH to provide a report to CFP as above.** ***1.30pm DH and AB left the meeting*** **Recommendation** **Committee is asked to note the areas of adverse performance and the actions needed to rectify** **Committee noted the areas of adverse performance and the actions needed to rectify**		
6	***2.03pm MT joined the meeting*** **Finance Report M5** Month 5 financial position is a deficit of £4.1m against the plan of £3.5m resulting in a £640k over spend against the plan. Main driver of over performance is acute services predominantly main acute provider contract including slippage against the service transformation programme. There is a significant increase in costs compared to the same period last year.		

No	Discussion & New Actions	By Whom	Deadline
6 cont	Forecast remains on plan to deliver the £8.4m deficit with significant risks noted. CCG has received an allocation reduction of £4m in respect of IR rules which is currently being discussed and disputed with NHS E as the CCG do not accept this position. It is expected a further adjustment will be made but this is currently reported as a mitigated risk for the CCG. Entitlement to earn the Quality Premium will be based on the control total and not on the CCG plan of £8.4m Risk Pooling Agreement in place with RSCH – full amount used for CCG position at M5. At M6 there will be a deep dive of CCG numbers Page 9 - a question was raised re day cases and electives. NB confirmed that there was a stream of work under way by the commissioning team, looking at where patients had been treated i.e. as a day case or in an OPD clinic; on the basis of that work NB confirmed that a challenge has been submitted. **Recommendation** **The Committee is asked to note the report** **The Committee noted the report** **Financial Framework/Budgets 2017/18** • Paper presents the budget and financial framework for 17/18 plans. • Finalises the position previously reported to committees in December to March 2017. • Plan is for CCG to deliver a deficit of £8.4m with a QIPP requirement of £8.6m. • Key assumptions in plan described in the paper and an assessment of risks faced by the CCG. Agree paper to go to next GB meeting in September. **Recommendation** **Committee is asked to note the Financial Framework and budgets for 2017/118 and to agree which GB meeting should approve the contents of the paper** **Committee noted the Financial Framework and budgets for 2017/118. It was agreed that the Financial Framework and Budgets shoul go to September Part II GB meeting**		

No	Discussion & New Actions	By Whom	Deadline
6 cont	**Contract Management Update** The key areas of concern continue to be: Non Elective performance, particularly at RSCH although there are increases at Frimley Health due to the changes in Stroke activity. Outpatient activity, particularly at BMI Mount Alvernia, but across a number of providers relating to specialities where RSCH RTT performance is below expected levels A Clinical Audit has been undertaken which will be presented as a separate document, but will inform the content of the next Contract Management Update in October		
7	**Service Transformation Report M5** KMc noted that this was a headline report and that the full report goes to the QIPP Delivery Group meeting (QDAG). Capped Envelope Approach – it was noted that CEO at the RSCH is supportive of threshold reductions but this requires continued focus. KMc confirmed that RSCH had been fully involved in the discussions and that, once it had been decided which schemes would be taken forward, they will be subject to a Quality Impact Analysis (QIA) before proceeding. **Recommendation** **Committee is asked to:** **(1) CFP is asked to note progress to date** **(2) CFP is asked to note the change in the forecast savings against plan from 76% in M4 to 67.8% in M5** **(3) CFP is asked to note plans for further development of additional QIPP schemes for 2017/18** **(4) CFP is asked to note the top 2 risks to achievement of the QIPP plan** **Committee noted (1) to (4) above** ***2.10pm VT left the meeting***		
8	**Current Operating Process for IFRs** From a patient perspective, it was suggested that a simplified version of the policy document for use by patients should be drafted and reviewed by a public engagement group.		

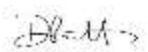
No	Discussion & New Actions	By Whom	Deadline
	This policy will return to CFP in March 2018 for 18/19 contracts. SDCCG have ratified policy. GWCCG are last CCG to ratify. **Action 4: NB will feedback the concerns of this Committee to the IFR Management Team at Surrey Downs CCG for a 'patient friendly' version of the policy to be produced.** **Recommendation** **Committee is asked to formally approve the revisions made to the Operating Process for Dealing with IFRs** **Committee formally approved the revisions made to the Operating Process for Dealing with IFRs**	**NB**	**10.10.17**
9	**NHS 111 Procurement/IUC Integrated Urgent care Service** NWSCCG lead this procurement. Management leads are AK and NB. Clinical Lead DEB. A report on progress regarding this procurement was presented to committee with a series of recommendations relating to the next steps. In relation to each recommendation, the CFP members sought clarification on particular points Recommendation 1 – Committee asked if sub-group had considered and ruled out financial penalties for under-performance? Recommendation 2 – Committee asked if we had been clear in the contract re circumstances under which +3 would/would not apply? Recommendation 3 – Committee asked an expert VAT opinion had been obtained? **Action 5: NB to feed back to Lyn Reynolds, NHS111 Procurement Consultant re Recommendation 1-3 above**	**NB**	**10.10.17**

No	Discussion & New Actions	By Whom	Deadline
	Recommendation **Committee is asked to:** **(1) The BI/Finance sub-group further explore the available payment mechanisms and make a recommendation** **(2) The contract Term is 5 years with an option to extend once for a period of up to 3 years** **(3) The NHS Standard Contract compliant with APMS requirements is used and Commissioners do not dictate the commercial arrangements between Providers** **(4) The Pre-market Bidder Engagement Restricted route to Market is undertaken and CCG Associates will provide adequate management resources to assist the procurement process.** **(5) Release of the first draft service specification to the market/key stakeholders for comment, feedback and further development as part of the pre-engagement restricted route to market process for this procurement** **Committee agreed to recommend (1) to (5) above to GB for approval *(Reason for recommendation to GB is that the contract value is above the threshold for approval by CFP)***		
10	**Procurement Board - Update** **Adult Community Health Services** • ACHS Procurement completed bidder evaluations 18.9.17, following presentations by prospective bidders. • Anonymised Report is being prepared to go to GB. • COIs – Following discussions between EN and JB, and based on the anonymity of the report, consideration is being given to whether GP Members may take part in approving the ratification report i.e. in confirming assurance that the process has been followed as laid out and delegated. • Situation has been clarified with legal advisers		
	Children's CHS Procurement Challenge • Agreed dates in diary to seek resolution via mediation • Provisional case management Hearing date set for the end of October 2017 if no agreement reached.		

No	Discussion & New Actions	By Whom	Deadline
	Mental Health Contracts – Citizens Advice Bureau A PIN has been issued with regard to the expiration of the CAB contracts, response are expected by 22 September with an update being presented to the next Procurement Programme Board. Dependent on the responses received, a further procurement may be required. **Recommendation** **Committee is asked to note the Procurement Board Update** **Committee noted the Procurement Board Update**		
11	**Quality Impact Assessment (QIA) Policy (Revised)** Revisions requested by EMT: QIA Group should be authorised to approve where possible; EMT to provide escalation route. Main changes top of page 2: • *The role of the Executive Management Team amended to be the escalation route by exception.* • *The role of the Quality Impact Assessment Group has been strengthened so that they have delegated authority to perform the assessments and to escalate cases to the Executive Management Team when the mitigated risk is still considered high (15 and above).* • *The categories for the impact assessment process has been overhauled to make the process more streamlined and straightforward to complete* • *Instructions have been added for those assessments where risks exceed 15* **Action 8: Helen Collins to change the word 'Committee' to the word 'Team' in bullet point 2 (as shown above) on the revised QIA Policy** **Recommendation** **Committee is asked to approve the revisions to the QIA Policy** **Committee approved the revisions to the QIA Policy**	**HC**	**10.10.17**

No	Discussion & New Actions	By Whom	Deadline
12	*2.35pm Rachel Mackay and Carina Joannes joined the meeting* **Primary Care Locally Commissioned Services for Direct Oral Anticoagulants initiative and annual review specification** Chair noted no COIs for GPs as this item relates only to the service specification. Conflicts were addressed when business case was submitted in June 2017. Business case was agreed at June2017 CFP meeting. Paper has returned to CFP for final sign off of service specification. Reviewed by Medicines Management Team and by JI from a clinical perspective • CFPC were asked to approve the proposed service specification subject to a minor amendment: CURRENTLY*: Practices are encouraged to include their practice code and to tick 'share with CCG' so learning can be shared (anonymously) with the local area.* CHANGE TO*: Practices are encouraged to include their practice code -so learning can be shared (anonymously) with the local area.* • The LCS has been reviewed by the LMC who have proposed a higher payment within the service • CFPC agreed the content of the service specification and have referred to EMT to finalise the price to be paid within the service. An update report on this will be provided to CFP in 18 months To be added to agenda for EMT meeting 21.9.17 **Recommendation** **To agree the content of the Direct Oral Anticoagulants (DOACs) initiation and annual review Locally Commissioned Service for Primary Care.** **Committee agreed the content of the Direct Oral Anticoagulants (DOACs) initiation and annual review Locally Commissioned Service for Primary Care.**		

No	Discussion & New Actions	By Whom	Deadline
13	**Impact to CCG of the Cost Improvement Programme (CIP) & Transformational Programme for Medicines Management at RSCH** • CFPC were asked for a decision on whether the Medicines Management Team should engage further with the RSCH CIP. The programme had been badged as a transformation programme with the aim to find joint savings across the health economy. • The purpose of the briefing is to highlight the implications of the programme to the CCG, which is being led by an external management consultant who has a remit to make significant savings within Pharmacy for the Trust. • The decision made by CFPC was for Mathew Tait / David Eyre-Brook to speak to Paula Head to see if this piece of work is a work stream within the wider Transformation Programme Board. *2.50pm KMc left the meeting* *2.53pm KMc rejoined the meeting* *3.05pm Rachel Mackay and Carina Joannes left the meeting* **Recommendation** **Committee is asked to note the recommendation** **Committee noted the recommendation**		
14	**Cranleigh Village Hospital Trust (CVHT) Update** • SCC and GWCCG will support a 20 bedded unit of an 80 bed nursing home. There has been no statement on what the beds will be used for. • No step up or step down facility. • CHC (Continuing Health Care) would be logical. • No detailed discussions have yet taken place with SDCCG as lead - JC and BH have been tasked with this. • Revised planning application is to be submitted by CVHT and HCOne and seeking GWCCG support. • A question was asked re whether the CCG is now being sighted on any/all communications issuing from CVHT. It was confirmed that the Chair of CVHT, Robin Fawkener-Corbett (RFC) was now channelling communications through GWCCG's Communications Manager. **BH to pick up actions re CVHT as a matter of priority.** **Action 9: VS to speak to Eileen Clark, Acting Clinical Director & Chief Nurse, Surrey Downs and update BH**	**VS**	**10.10.17**

No	Discussion & New Actions	By Whom	Deadline
	Action 10: BH to speak to SDCCG • Liz Uliasz at SCC is preparing a joint statement **Action 11: DEB to share CCG letter to CVHT with VS and MT**	**BH** **DEB**	**10.10.17** **10.10.17**
15	**QDAG Minutes August 2017** **Recommendation** **Committee is asked to note the Minutes** **Committee noted the Minutes**		
16	**Clinical Forum Group Decisions & Action Notes August 2017** **Recommendation** **Committee is asked to note the Decisions and Action Notes** **Committee noted the Decisions and Action Notes**		
17	**MOG Minutes July 2017** **Recommendation** **Committee is asked to note the Minutes** **Committee noted the Minutes**		
18	**Top Risks** 1. Continued over-performance at RSCH 2. Transformative working with RSCH 3. CVHT 4. £4m INR £4m allocation adjustment regarding Identification Rules (IR)		
19	**AOB** • Observation of deadlines for Action Log Updates & Submission of Papers • Attendance & Quoracy for next meeting – no apologies or absences were given for October meeting	-	
Signed and agreed by Darren Watts, Chair 			
Minutes agreed for publication by Karen McDowell, Chief Finance Officer / Deputy Accountable Officer 			

No	Discussion & New Actions	By Whom	Deadline
Date of next Meeting 17 October 2017 2017, 1-3.30pm			

***QUORUM AND VOTING**

Non clinical members may not exceed clinical members when decisions are being taken.

A quorum shall comprise of half the membership (5/10), and include the following:

- Committee Chair (clinical) or Deputy Chair (lay)
- Lay member (may be covered by Deputy Chair)
- either the Chief Finance Officer or the Chief Officer (Accountable Officer).
- Three Clinical Representatives clinical (may include Committee Chair)
- Non clinical members should not exceed clinical members[1], either as part of the quorum or the wider membership where decisions are being taken.

All members, as specified in Section 4 above, have voting rights and any decisions put to a vote at a Committee meeting shall be determined by a majority of the votes of members present assuming quoracy is met. In the case of an equal vote, the Committee Chair shall have a second and casting vote.

[1] Clinical membership comprises Medical Director (Commissioning), GP Clinical Representatives and Executive Director, Nursing, Quality and Safeguarding