NHS
Enfield
Clinical Commissioning Group

Minutes of the

FINANCE AND PERFORMANCE COMMITTEE MEETING
Committee Room, Holbrook House

Wednesday 29th March 2017
1.00pm - 4.00pm

Members present:		
Dr Alpesh Patel	AP	Clinical Vice Chair of the Governing Body and Chair of the Finance Committee
Karen Trew	KT	Qualified Finance Member (External) Acting
Rob Whiteford	RW	Chief Finance Officer
Mark Eaton	ME	Director of Recovery
Jahan Mahmoodi	JM	Clinical Director
Professor Robert Elkeles	RE	Secondary Care Member
In attendance:		
Arati Das	AD	Deputy Chief Finance Officer
Ed Nkrumah	EN	Head of Performance and Informatics
Keith Spratt	KS	Head of Acute Contracting
Deborah McBeal	DMB	Deputy Chief Officer
Christiana Fadipe	CF	Executive Assistant (minutes)
Apologies:		
Sarah F. Thompson	ST	Chief Officer
Sarah Rothenberg	SR	NCL POD Deputy Director (Enfield MDT)

Item No.	Item	Action
1.	**Welcome and Apologies for Absence** AP welcomed everyone present and introductions were made. Apologies for absence from Sarah Rothenberg, NCL POD Deputy Director (Enfield MDT) and Sarah Thompson, Chief Officer KT placed on record on behalf of the committee her thanks to AP for chairing and improving the Committee and for his excellent work. RW seconded this. The Chair expressed his intention to reorder the agenda items to allow invited attendees and staff to present their item(s) and leave the meeting. (**Note:** For ease, the minutes will be noted in the order agenda items were presented. Items 11 and 14 would move up the agenda.)	
2.	**Declarations of Interest** The Declaration of Interest form was circulated and completed by members and attendees. ME declared an interest in the action log – number 197 concerning IR35. He left the meeting during consideration of this item. AP (Chair) declared a conflict of interest with items 13 and he left the meeting for these items. RE chaired.	

3.	**Minutes of the Previous Meeting** The minutes of the meeting held on 22 February 2017 were approved as an accurate record with the exception of the following item: 12. PAU Consultant Report: resolved item should read *'RESOLVED: It was recommended subject to continuing further engagement*	
4.	**Action Log from 22nd February 2017** The Committee agreed that the following completed actions be removed from the action log: 194, 195, 199 Updates were provided for the following actions: **189** - AP advised that the report was expected and the action is now closed. **196 -** AP advised that the request has been deferred to April 2017. **205 -** AP advised that this is on the Governing Body agenda. **206 -** AP advised that further consultation has been completed **193** – EN queried the detail of this action point and the item from which it has arisen. He suggested that it had been agreed and the item should be changed to 'in progress' and verbal feedback would be given by Graham MacDougall, Director Strategy & Partnership in Aprils meeting.	
5.	**Matters Arising** **Finance, Risk Update** AD presented the Finance, Risk Update (Agenda item 4, App G) which provided an update on the changes in financial risks following the last reported position. RW explained the scores had been changed in order to be more accurate in the context of non-financial risks. The committee was pleased with the clear format and agreed to use the same going forward. **Recommendation:** The committee endorsed the revised risk ratings.	
6.	**M11 Finance & Contracts Report** RW presented the Finance and Contracts Report M11. A year to date deficit of £7.7m and the forecast year-end deficit of £7.7m were reported, both being in line with plan. The CCG has received a formal notification of £3.6m risk share funds from North Central London CCG's from the £4.9m previously anticipated. The opportunities to identify the £1.3m shortfall are still under discussion. RW confirmed that a year-end agreement with St Bartholomew's Hospital has been concluded. The major risk not included in the forecast is £1.3m NCL income which may not be actioned in month 12. The CCG has agreed to release, in line with national instruction, £3.9m of accrued by uncommitted funds and will therefore improve its position in month 12. It was observed that acute expenditure is static with agreement having been reached on North Middlesex University Hospital NHS Trust (NMUH) and progress having been worked on closing the position with Royal Free London (RFL).	

	The acute raw position net of known errors was a forecast overspend of £7.9m. Spend of £1.5m has been added to this based on a prudent assumption for Referral to Treatment (RTT) costs, claims mitigation and adverse impact of smaller contracts. These adjustments increase the forecast overspend to £9.3m. This overspend has then been reduced by using out acute contracting contingency of £2.9m, £6.3m from the 15/16 RFL close down and other unused accruals and recognising a benefit of £0.8 on non-SLA acute commitments. RW advised that whilst there is an overspend of £400k the key message was that there is virtually zero risk compared to several months ago. Questions and comments were invited KT queried how many contract query notices had been issued and what actions are being taken to resolve these issues. KS explained there were two contract queries notices issued. Chase Farm staffing level issue is an ongoing problem and a formal procedure has been started due to the staffing levels not matching the service specification. The second contract query was due to recruitment issues, as several vacancies are not filled. AP asked the reason for the unfilled vacancies. JMah explained this may remain an issue because of the differential in hourly rates. KT enquired why the data presented on GP referrals differs from the deep dive. In response, KS advised that the GP transformation data previously presented may not correlate with the monthly GP referral by ERS reported within appendix 1 because the analyst was performed on a different set of data which excluded MSK and Bypass. KS confirmed there is no service reason for the decrease, and the figures presented may be influenced by the implementation of locality commissioning systems for GP's. It was agreed that further analysis and a deep dive will be completed and brought back to this meeting.	**KS**
7.	**QIPP** ME presented the QIPP report Month 10 which provided a summary of progress on the QIPP/Recovery programme for review and approval. ME highlighted that the programme risks include: • A lack of experienced resources either within Enfield or across NCL to deliver the scale of QIPP challenge required puts the programme at risk. This is now being addressed following approval of the resourcing business case in February 2017 by the F&P Committee. • The pace of change associated with the STP for NCL is slower than that required for Enfield and as such places additional pressure on our local programme caused by the NCL programme acting as a 'sea anchor'. • The need to bring more QIPP into the contracts with Acute Providers over and above the already large requirement within the STP makes it highly likely we will receive 'push back' from providers. • A lack of clarity around the mechanisms for amending contracts post 31st March 2017 and, any revenue that may be raised through contract challenges in the new contract arrangements puts the £1.5m of 'Non-Recurrent Efficiencies' at risk. ME updated that the numbers since preparing the report have changed and explained that the final value of QIPP in acute contracts is £11.6m. Questions and comments were invited	

	KT queried what schemes are not secured and what strategy is in place to ensure they are delivered. ME explained that a number of schemes were removed, namely: • ENT • Stoke readmission • Ambulatory Patients, replaced with Community Care Admissions Avoidance • GP See and Direct • NCL prostate cancer follow-up AP queried what is happening around NCL in regard to QIPP's. ME explained that Enfield CCG is the only CCG rated as green and we have the most agreed acute QIPP within contracts in NCL. Enfield CCG currently have £3.0m unidentified against a £24.0m target which is good when compared to neighbouring CCGs. AP asked what the year-end target implication for NCL's red and amber rated QIPP's are. RW explained the STP team felt the risk across the NCL CCG was around £39m-£40m. This means that a balanced plan cannot be realistically set without using reserves. This results in the QIPP values being artificially inflated. AD highlighted that against the £11.6m QIPP, the STP has £3.5m overall as an investment. AD remarked that it has been clarified with the PMO team that these funds will not go directly to acute providers. ME was pleased to confirm the recruitment of previously agreed interims and transformation leads to the transformation team. The recruitment of clinical leads is taking place. ME presented the following documents for approval: • role descriptions for SRO's CRO's and Project Managers • changes to the Business Case approval process • the revised full business case template • the new summary business case template • the highlighted report template • the TPG Terms of Reference (TOR) **Recommendation : The committee approved the above items** AP asked whether there is anything within the omitted document that will be contentious? In response to the AP, ME noted that the role descriptions for SRO's CRO's and Project Managers document was accidently omitted from this report. He advised there is nothing contentious within the document outside of the normal role descriptions for SRO's or CRO's and that these had been independently reviewed and approved by Directors and also by Drs Mahmoodi and Abedi independently. ME noted that schemes identified as high risk will be reviewed at the next F&P committee once approved by the Weekly Directors Meeting on 4th April 2107.	
8.	**Integrated Performance & Quality Report** EN presented the March 2017 Integrated Performance & Quality Report. He explained that, whist the RRT and the performance in January was compliant, there were some data quality issues in February. The data submitted to unify by BMI was incorrect which is likely to bring our position to 92%. This was raised as a significant issue. EN advised that NHS England were notified of a rectification plan.	

There were three 52 week breaches. These are being tracked closely with Imperial and RFL to ensure that there are treatment plans in place. EN noted that there is still some risk around long term staffing.

Enfield CCG did not achieve the 6 weeks diagnostic with standard in January, noting performance of 31%. This was attributed to issues at NMUH relating to colonoscopy and gastroscopy and RFL non-obstetric ultrasound pathway. The main issue at NMUH relate to capacity constraints. The Trust is on track to recover by March 2017. Performance is being monitored fortnightly.

EN advised that there was one breach of the two week wait target in January. In January the 62 day performance was 83.3% and will be monitored closely for Q4. EN noted that to ensure the CCG achieve the quality premium we need to achieve 85%.

EN advised that LAS have not met their trajectories since July 2016 with performance in Enfield and neighbouring boroughs consistently among the worst in London. The proposed contract for 2017/18 has a minimum target for category A and category C calls of 60% within response times.

The IAPT recovery rate remains an issue. A letter of concern has been forwarded regarding IAPT performance of the BEHMHT and a recovery plan is in place.

ME asked how diagnoses are recorded? EN explained that there is an issue around how diagnoses are reported at the beginning of treatment and the chances of getting the correct score by the end of the treatment not being aligned.

AP asked who is responsible for scoring patients? EN explained that that everyone is expected to be scored before and after treatment.

EN highlighted the following:

- Quality premium position (Page 5) feedback from medicines management highlighted that the antibiotics KPI (Local 4b) is now a medium risk
- Median wait by specialty tabled (Page 6, appendix 5) demonstrates RTT Median waits at local Trusts by specialty. This showed overall NMUH have the best median wait across hospitals

AP asked when does the clock start?

JMah explained that according to the RTT guidance v13, RTT starts at the point from when the referral is made by the GP. EN asked members to note the average ERS triage time in Q3 is 2.9 days, which measures from the time the referral reaches ERS. EN advised that the new ERS system is being piloted and rolled out to other services with the hope that there will be a noticeable decrease in triage times.

RW queried why the Enfield CCG C Difficile scores were so high compared with those from individual acute providers.

EN explained that provider position of C Difficile infection cases is attributed to both acute and CCG accounts for the YTD position for Enfield CCG of 81.

EN noted that between Kings Oaks and Cavell implemented a systems. This has resulted in RTT being reported incorrectly. The problem was identified; resources have been allocated to resolve the issue and there is an opportunities to resubmit data.

Furthermore, EN advised a request was made for assurance and there is a potential of a contract performance notice.

	EN introduced the Benchmarking Network, CCG Functions Project; Pilot, item 8, appendix F (ii). EN informed that the NHS Benchmarking Network are exploring a benchmarking exercise looking at CCG configurations, i.e. how CCG's work together, performance, and activates. The aim is to collect data that is not in the public domain in order to develop a benchmark for the NHS. EN agreed to bring back to this meeting once data has been submitted.	**EN**
9.	**Authorisation of Business Cases: System Resilience Investment Plan 2017/18** This was deferred to Aprils meeting.	**GMacD**
10.	**IR35 update: Non-clinical and Clinical Staff** ME expressed a declaration of interest and left the meeting for this item. **Non-Clinical Staff** AD advised we have made good progress. JP confirmed of 21 people 20 have been through compliance checks and the last one will be completed this week. She noted that for people who are inside IR35 confirmation will be required from relevant agencies KT enquired if any issued has been identified on implementation of IR35? AD explained that due to the process commencing quite early no issues were noted. AD noted that the latest version of the tool had more questions and as a result more people are inside IR35. JP confirmed that finance has provided a standard email to circulate to agencies with a request for further information to provide assurance. AD advised no payment will be made until assurance has been confirmed and noted that all budget holders were informed a number of weeks ago. AP noted the review of the tool was provided and that there was a latest version of the tool. He asked if we have recorded when the tool changes occurred and responses people made to ensure there are consistent across a board because some of the terms are open to interpretation. He asked how the CCG will assure that those who have completed the tool submitted the same response where the same responses were applicable and a record of the said responses have led to about outcomes. Furthermore, whether the processes of completing the tools were the same as local CCG's and NCL. AD advised that there was no public statement from HMRC to indicate the test is now harder, however the latest version may have more questions and as a result more people have been placed inside. JP advised that the line managers have taken responsibility in completed the tool to ensure consistency. RW asked that a record of all compliance checks using the tools is completed to ensure consistency is applied in all areas. **Clinical staff:** **There was a comprehensive and lengthy discussion regarding the application of IR35 to Clinical Lead roles. This focussed on clinical leads in ERS as a practical example.** Agreement was reached to issue a letter on IR35 to affected staff. It was noted that the application of IR35 may cause significant service delivery issues with GP triaging in ERS. JMah and DMcB were asked to discuss the potential for this and mitigations with Dr Janet High. AP delegated the wording of the IR35 letter to RW/AD & JMah and asked for the wording of the letter should include the things the committee considered and the option decided. **ACTION: IR35 Letter to be drafted by RW/AD & JMah**	**AD** **RW/AD & JMah**

	ACTION: JMah & DMcB to have a discussion with Dr Janet High, Governing Body Member explore management plan if there is significant service impact	**JMah / DMcB**
11.	**NCL: Financial Strategy 2017 -21** RW presented the next iteration of the Financial Strategy 17/18 - 20/21 which was previously agreed by Governing Bodies in September 2016. RW highlighted four key components: • The creation of an NCL investment pool that takes 1% of each CCG's allocation to be set to aside for investment priorities. • The creation of an NCL risk reserve, which takes 0.5% of the allocation – national non recurrent 'set aside'. • The collective management of contracts which set out options for the financial management of variance on acute contract, including (a) Variances sit where they fall based on activity over/under performance (b) full pooling with variances shared pro-rata across all acute contracts (c) Partial pooling e.g. on a provider specific basis, or with agreed tolerance. Or pooling dependent on driver of the variance. • Repayment of Legacy Debt. Questions and comments were invited: KT asked what feedback was received from NCL? RW feedback that Barnet Finance Committee has concurred in principle, however, would like to see worked examples. It was observed that the report will be taken to other CCG Finance Committees during March and April 2017. AP noted concerns about the vast discrepancies between CCG's allocations and queried whether some CCG's are contributing enough funds. AP felt we should work towards getting to more even position more quickly. AP suggested that he would not be against the pooling of Primary Care funds if the equalisation was reviewed more objectively. **Resolved** The committee noted the report and endorse the ongoing work **ACTION: Comments and feedback regarding the Financial Strategy 17/18 – 20-21 should be communicated via email or face-2face to RW by mid-April.** **ACTION: To remove (page 6, 3.1, item 5) "External assessment"**	**ALL** **RW**
12.	**Fully Delegated Commissioning of GP Services** KT left the meeting at 4pm. DMcB presented the Fully Delegated Commissioning of GP Services and asked the committee to approve the memorandum of understanding. It was observed that the F&P committee do not want to hold up the signing process. However the committee placed on record the implication of the significant omissions and areas still to be completed.	

	Recommended **The committee approved the memorandum of understanding for signing by the Chief Officer subject to the missing information being completed.**	
13.	**Confirmation to roll forward local Primary Care Commissioning Schemes Whist Single Offer is Being Prepared** AP left the meeting for this item due to a conflict of interest. DMcB provided a verbal update on the development of the single offer Primary Care across Enfield. This would provide the opportunity to commission at scale from our providers for the whole Enfield population. This was discussed extensively at the most recent Governing Body meeting. DMcB recommended that existing schemes remain in place by default until new arrangements are in place. **Resolved** The committee approved the proposal that existing schemes should by default remain until there is an alternative feasible option.	
14.	**GP Referral and Outpatient Report** AP returned to the meeting. The Committee agreed to defer this item to next meeting	
15.	**Locality Clinical Leads; Referrals – Next steps re: referrals** . The Committee agreed to defer this item to next meeting	
16.	**CSU SLA Agreement** JP reported that SLA, CSU was signed off for a two year period and cost savings are planned for c£300k. There is flexibility within the agreement and 6 month notice period, which can be invoked at any time.	
17.	**Forward Planner** The committee agreed to discuss at the next meeting.	
18.	**Any Other Business** GP Pilot at North Middlesex Hospital A&E Department DMcB presented a report on the pilot at North Middlesex Hospital A&E department. This provides GP streaming services. This has been extremely successful in supporting the North Middlesex University Hospital NHS Trust to reduce pressure on the busy emergency department and at the same time allow them to undertake the improvements needed. The Trust has now confirmed that it is ready to work without the support of the pilot and is introducing a nurse streaming element within the department from 1 April so that the pilot can be stood down from 31 March. DMcB noted ECCG will continue working with the NMUH and Haringey CCG to support the introduction of the new model of care for A&E departments recommended by NHS England. Questions and comments were invited KT asked whether there are financial consequences terminating the pilot? DMcB explained that there is no financial implication. The committee placed on record their disappointment at the cessation of the pilot but felt there was no practical alternative.	

	Resolved The committee noted the report and endorsed the recommendation to end pilot on 31st March 2017. The committee placed on record their thanks to DMcB and her team for their hard work.	
19.	**Date & Place of next meeting** 26th April 2017 at 11.30 - 14.30pm, Committee Room, Holbrook House	