Oxfordshire
Clinical Commissioning Group

Oxfordshire Clinical Commissioning Group
Board Meeting

Date of Meeting: 25 May 2017	**Paper No: 17/39b**

Title of Paper: Minutes of the Finance Committee, 20 April 2017

Paper is for: (please delete tick as appropriate)	**Discussion**		**Decision**		**Information**	✓

Purpose and Executive Summary:
The Committee draws to the attention of Board members, the following:

2017/18 financial performance:

- Following the release of the 1.0% reserve, the closing position included an additional £8.0k surplus above the planned target of £12.9m, as previously reported.
- There were a number of late movements (Month 12) that concerned the Committee and justified the CCG's prudent in-year approach, when considering releasing reserves. The movements included:
    - Oxford university Hospital's activity relating to waiting numbers and times
    - Specialised Commissioning issues, i.e. paediatric insulin pumps and critical care
    - Royal Berkshire NHS Foundation Trust contract
    - Oxfordshire County Council pooled budgets
- Non-recurrent funding allocations totalling c£4.0m were received from NHS England over the year and late notifications, resulted in difficulty in committing and accounting for the some of the allocations in-year. The Committee referred the matter to the Audit Committee for review.
- NHSE had provided advice on how the slippage on the GP Access Fund could be accounted for in 2017/18 and the funds were allocated against various schemes within the CCG. The Committee requested that a paper on how GP Access Funds were spent was prepared and members of the Committee discussed the advantages of ring-fencing a sum in 2017/18, equal to 50% of the slippage, to be used to meet pressures on primary care.
- The formal review of the Month 12 report would take place at the end of May.

Primary Care Streaming in A&E: Designed to help hospitals to meet their A&E targets, the Committee was briefed in relation to the emerging service model, and workforce and financial risks associated with rolling out this government policy. The Committee expressed some anxiety that the model may increase demand through

A&E and wanted to better understand the evidence base for this service model.

Non-Elective Growth Analysis: The Committee received the analysis and recommended that a scoping paper for a clinically led coding audit into non-elective activity should be commissioned.

Savings Plan: Progress had been made on establishing governance arrangements, Risk Mitigation Delivery Group and appointing staff to the project management posts. The Committee heard that the first focus area was primary care demand management (planned care) and the partners were looking at the 'Consultant Connect' model. The Committee were concerned that this option was being pursued, rather than a preferred in-house, Oxford University Hospital solution, which it understood was not on offer currently. The Committee expressed concerns in relation to the level of deliverable benefits, particularly if there was an issue with clinical support.

Thames Valley 111 Integrated Urgent Care Contract: The Committee approved the award of contract to the Thames Valley 111 Partnership (South Central Ambulance Service and a number of community providers).

Transformation Programme: The Committee requested that it reviewed the financial modelling, IM&T and Estates planning at its June meeting, ahead of the Board's decision on phase 1 of the transformation plans and the phase 2 consultation commencing.

Financial Implications of Paper:
As set out above.

Action Required:
The detailed work of the Finance Committee provides further assurance to the Board that OCCG is managing its finances effectively and in accordance with the financial plans and budgets approved by this Board. Board members are asked to consider if they are receiving sufficient information in the Board's finance report and through the minutes of Committee meetings, to assure themselves in relation to OCCG's financial performance.

OCCG Priorities Supported (please delete tick as appropriate)	
✓	Operational Delivery
✓	Transforming Health and Care
✓	Devolution and Integration
✓	Empowering Patients
✓	Engaging Communities
✓	System Leadership

Equality Analysis Outcome:
Not Applicable

Link to Risk:
Finance Committee is responsible to the Board (in conjunction with the Audit and Quality Committees) for reviewing the risks relating to the business and activities of the CCG and ensuring the levels of risk and mitigations of those risks are appropriate and are properly recorded in the Risk Register of the CCG.

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Date of Paper: 8 May 2017

MINUTES:

Finance Committee

20 April 2017, 10:00-12:00

Meeting room 7, Jubilee House, Oxford

Present:	Duncan Smith (EDS), Lay Member for Finance – Chair	Roger Dickinson (RD) Lay Vice Chair
	Mike Delaney (MD), Lay Member	Julie Dandridge (JD), Deputy Director of Delivery and Localities; Head of Primary Care and Localities [Deputising for Diane Hedges]
	Dr Julie Anderson (JA), Clinical Director, South West Oxfordshire Locality	Dr Paul Park (PP), Deputy Clinical Chair and Chief Clinical Information Officer
In attendance:	Elena Thorne (ET) – Minutes	James Limehouse (JL), Senior Commissioning Manager – Urgent Care – for item 5
	Jenny Simpson (JS), Deputy Director of Finance	
	Matthew Staples (MS), Thames Valley Urgent & Emergency Care Network Manager and Thames Valley 111 Integrated Urgent Care Procurement Programme Manager – for item 7	Lukasz Bohdan (LB), Head of Portfolio Management Office – for item 4 [Deputising for Hannah Mills]
Apologies	Diane Hedges (DH), Chief Operating Officer and Deputy Chief Executive	Gareth Kenworthy (GK), Director of Finance
	David Smith (DS), Chief Executive	

		Action
1.	**Declarations of Interest / Quorum** The Chair welcomed everyone to the meeting and declared the meeting **quorate**. Paul Park (PP) declared an interest through being a GP partner and it was noted by the Chair.	
2.	**Minutes of the previous meeting** The minutes of the meeting held on 23 March 2017 were approved as an	

	accurate record of the meeting subject to the following amendments: - **Action 16.95** – amend responsibility for the action from RD to RA (Rod Anthony). Update the action tracker accordingly. - **Item 9** Effectiveness of the Finance Committee – add the wording to reflect the review of the Terms of Reference (ToR): *The Committee received the papers on "Draft Annual Report from the Finance Committee to the Board" and "Finance Committee Efficiency and Performance Self-Assessment Checklist". The Committee reviewed the Terms of Reference, and members were requested to provide their individual feedback to the Deputy Director of Finance.* The Chair of the Finance Committee referred to the item within the ToR, namely: '*To monitor winter resilience processes and performance having regard to the findings and recommendations of the Quality Committee in respect of the assessed impact on patient and service safety and quality'* and suggested it was no longer relevant and **should be removed from the document (Action 17.01)** - **Item 5** Annual Operational Plan and Budget – amend OUHFT contract value from £321k to £321m. - **Item 6** Savings Plan – frame the below text into an action point: *More radical actions may be required to close the financial gap, and it was agreed that **the executive team would produce a paper with granular information on other opportunities available to mitigate the risk. (Action 17.02)*** **Matters Arising** The Action Tracker was noted and updated as follows: **Action 16.75 – Provide an update on Section 75 negotiations outside the meeting.** **Action 16.94 –** the Committee noted the progress reported by Julie Dandridge (JD). **Considering the seriousness of the financial risks involved, the Finance Committee recommended that a paper should be prepared by the Chief Executive for review by the Audit Committee and then OCCG Board (Action 17.03).** Julie Anderson (JA) questioned whether it was possible for the CCG to use its previous over-delivered surplus to relieve RTT pressures. The Deputy Director of Finance responded that the CCG was only authorised by NHSE to draw down £1.0m per annum over the course of 4 years. Views were expressed that once there was a detailed understanding of the RTT financial implications, the Trust's capacity to deal with the problem and the uniqueness of the case to Oxford University Hospitals Foundation Trust (OUHFT), discussions would be required with the regulators on how this activity should be funded and over what period.	**JS** **DS** **DS** **DS**
3.	**Annual Operational Plan and Budget** The Deputy Director of Finance provided a verbal update on the 2017/18	

	outturn position as at 20 April. The full Month 12 Finance Report would be available in May. The following key points were noted: • The closing position included an additional £8.0k surplus above the planned target of £12.9m, as previously reported. • There were a number of movements in Month 12, including OUHFT activity around RTT and specialised commissioning issues, i.e. paediatric insulin pumps and critical care. • Royal Berkshire NHS Foundation Trust (RBFT) contract showed a significant adverse variation – this was partially due to the long stay issue reflected in Month 11, as well as a further accrual (c£900k) submitted on the Trust's month 12 accrual statement, which was submitted past the national deadline. At the time of the meeting, no backup information to substantiate the accrual of £900k had been received. Committee members expressed their frustration with RBHT, in respect of the timing of the notification, a significant financial risk, against a contract that had been under-performing all year. • Further movements occurred in the Pooled Budgets. The LD and Physical Disability (PD) pools improved but the Older People pool deteriorated significantly. **The Chair of the Finance Committee requested that an explanation should be provided for the movements in the Pooled Budgets reflected in Month 12. (Action 17.04)** • Non-recurrent funding allocations totalling c£4.0m were received from NHSE throughout the year. Some were not received until the first quarter leading to difficulties in spending in the year of allocation. In some systems, providers had treated the funds as payments in advance, which would then result in agreement of balances mismatches with their CCG. **The Chair of the Finance Committee requested that a schedule of non-recurrent payments from NHSE and their allocation should be reviewed by the Audit Committee. (Action 17.05)** • NHSE had provided advice on how the slippage on GP Access Fund (GPAF) could be accounted for in 2017/18 and the funds were allocated against various schemes within the CCG. **The Chair of the Finance Committee requested that a paper on how GP Access Funds were spent was prepared and members of the Committee discussed the advantages of ring-fencing a sum in 2017/18, equal to 50% of the slippage, to be used to meet pressures on primary care. (Action 17.06)** The formal review of Month 12 report would take place during the Finance Committee meeting on 23 May 2017.	**JS** **JS** **JS**
4.	**Primary Care A&E Streaming** **Primary Care Streaming in A&E** Julie Dandridge (JD), Deputy Director of Delivery and Localities and Head of Primary Care and Localities attended the meeting on behalf of Diane	

	Hedges and presented the paper on Primary Care Streaming in A&E. It was detailed that: • The aim of the streaming was to help hospitals to meet their A&E targets. The paper represented an early version of the bid prepared in April 2017 and was brought to the Finance Committee for an update and to provide prior warning about the financial risks involved. • The bid for infrastructure funding for the Horton General Hospital was turned down due to concerns that Primary Care streaming in Horton would make the A&E unviable. A further call with NHSE to clarify this position this positon was expected. • Further information was requested in relation to the John Radcliffe Hospital bid, which was currently being provided. The deadline for delivery of Primary Care streaming was 1 October 2017. • There were a number of risks involved, such as workforce (GPs) recruitment and the financial challenge of ensuring that this service development was revenue neutral. Although preliminary indications showed minor savings to the CCG, further work on developing the model had to be done to ensure the staffing and activity assumptions were as accurate as possible. • JA commented that recruiting sufficient staff to work in A&E was an unlikely. If it did attract GPs willing to work out of hours/irregular hours, it was likely that it would reduce the workforce for other Oxfordshire out of hours services. In addition, she questioned whether this was a sensible approach at the time when the CCG was struggling to find additional workforce to support GP practices. Referring to the financial aspect of the bid, PP noted that the model lacked support of the Royal College of Emergency Medicine due to insufficient levels of patients going through A&E to achieve a breakeven position. Although capital funding was available from the NHS, there was no additional revenue funding available. In response to the question from the Lay Member, JD confirmed that this was a mandated service, although it was hoped that there may be some flexibility in how it could be delivered. Comments made by the Lay Members raised concerns that: - Workforce delivery did not feel believable, considering the risks; - The streaming was addressing the current symptom rather than the various causes. The causes should be addressed by the transformation work being done by the CCG. - Streaming would encourage the population to access A&E services rather than regular GPs/pharmacists/community services, thus undermining investments in the community and primary care services. The Chair of the Finance Committee summarised the discussions and **suggested the significant risks (financial and workforce) identified should be included within the risk registers (Action 17.07). Further,**	**JD(CM)** **PP**

	evidencing the service and financial model was working well in Luton and Dunstable would be beneficial (Action 17.08).	
5.	**Non-Elective Growth Analysis** James Limehouse (JL), Senior Commissioning Manager – Urgent Care, attended the meeting to present the paper on "Non-Elective Growth Analysis". The information was requested following the Finance Committee meeting on 27 February 2017, and it was sourced through *Urgent Care Data Report* from SLAM. JL indicated that: • Growth in activity levels was present throughout 2016-17, with particular spike in November/December 2016. • Some growth could be explained by coding issues in ambulatory assessment units. • Referring to significant year-on-year growth in WD (Treatment of Mental Health Patients by Non-Mental Health Service Providers), JL confirmed this was already being monitored and challenged with OUHFT. • The information was being taken forward to the Finance & Information Working Group within OUHFT in order to review it in greater detail. • The paper was intended as a starting point for further investigation. JA commented that patients going through A&E could be counted more than once by SLAM and expressed the view that the Trust was exploiting the legitimate ways to maximise coding and thereby activity income. PP added that a level of growth could be attributed to the genuine increase of activity; however, the percentage growth was exponentially rapid which would indicate a coding issue. In response to the question from the Chair of the Finance Committee on what could be done to understand the roots of the problem, JA suggested that NHS data should be accessed in order to establish the number of times individual patients were counted. Furthermore, individual GP practices might be able to help where pseudo anonymised patient data could be used to see how a bill was being raised. **Action (17.09) – The Finance Committee recommended that a scoping paper for a clinically led coding audit into NEL activity should be prepared and signed off by Diane Hedges and the relevant clinical directors. The paper should set out the objectives, sample sizes and the investigation areas (5-10 with the largest increases).** The paper should be circulated to the Finance Committee members for information.	**DH/ Clinical Directors**
6.	**Savings Plan** Lukasz Bohdan (LB), Head of Portfolio Management Office, attended the meeting to present the paper on "System Risk Mitigations – Programme Update". The Committee was asked to note the work underway, risks identified and mitigations in place. The following key points were made:	

	• Progress had been made on establishing governance arrangements, Risk Mitigation Delivery Group (RMDG) and appointing staff to PMO posts. • Risk mitigation measures were being prioritised, and the first focus area was around primary care demand management, where efforts were being made with Consultant Connect solution aimed at reducing referral rates from primary to secondary care. • The preferred option (3) with in-house solution provided in totality by OUHFT could not be progressed due the lack of commitment from the Trust. The solution accepted by RMDG was Option 1, utilising the Consultant Connect service. The Group recognised this was not the best solution; however, it was the only available option at the time. The Planned Care Team was in talks with other health systems and trusts about sourcing consultants. JA expressed the view that Consultant Connect option should be approached with caution in terms of the claims that it could cut referral rate by 50%, as not all calls made by GPs to secondary care were to do with referrals. Furthermore, Consultant Connect targeted high referral areas, and Oxfordshire had traditionally had low referral rates. Should the model be set out outside OUHFT setting, there was potential for lack of clinical confidence from GPs. PP supported JA's comments and added that Consultant Connect would work better in urgent care rather than planned care. It was critical for consultants to have access to patient records and not be in the position where a rushed decision had to be made, so an email services was more appropriate. Finally, if Consultant Connect was to be rolled out, it had to be targeted to certain specialities. Having access to the local consultant was deemed critically important to GPs. The Lay Member expressed concerns that the CCG had to work with the least preferred options, particularly taking into account the lack of clinical support around it. The Chair of the Finance Committee summarised the discussions and specifically referred to the Kings Fund evidence-base in Canada and New Zealand, where referrals to secondary care had reduced significantly following the integration of community and primary care services, with secondary care specialists working within the integrated teams. What appeared key in these models was the access to same day appointments. **It would be beneficial to obtain assurances from the Chief Executive or the Clinical Chair, that the governance model had clinical leadership in place and it was empowered to make decisions. (Action 17.10)** Referring to the second initiative outlined in Paper 3 (Reduction/change in mode of delivery for follow up appointments), **the Chair of the Finance Committee noted that it would be beneficial to understand what the constraints were (Action 17.11).**	**DS/JMcM** **LB/HM**

	Reflecting on the background of Care Home support item, the Chair noted that the initiative had not been fully rolled out. **The Committee felt that further feedback was required from the Chief Operating Officer to provide an update on Care Home support and how the new arrangements were being taken forward. Should there be a need to remodel the Care Home support initiative, the revised business case proposal would need to be presented to the Finance Committee. (Action 17.12)** JA expressed a point of view on Care Homes, that it was important to keep the primary care engaged with nursing homes residents. It was important to make the current arrangements work better, and increased funding might be needed with around Care Home support training service, out-of-hours admissions, IT support (N3 network, accessibility of records). JA noted that the new model was likely to be more expensive and could result in disengagement of primary care from Care Homes. Summing up, JA expressed the view that the Savings Plan was not likely to deliver savings. The Committee noted the work being done on prioritised mitigations and risks identified. It felt assurances were required around governance arrangements, clinical leadership along with better understanding of the blockages experienced with partner trusts.	**DH**
7.	**Thames Valley 111 Integrated Urgent Care Contract Award Recommendation** Matthew Staples (MS), Thames Valley Urgent & Emergency Care Network Manager and Thames Valley 111 Integrated Urgent Care Procurement Programme Manager, attended the meeting to present the paper on "Thames Valley 111 Integrated Care Contract Award". The Committee was asked to approve the award of the contract and the Directory of Services business case. MS referred to the previous approval of the contract within the same financial envelope by the Finance Committee in September 2016 to Care UK, who had subsequently withdrawn from the procurement. Further work was done with the reserve bidder – a co-production of SCAS and 3 community trusts across the Thames Valley, which resulted in a new service specification, including significant enhancements over the existing 111 service. In addition, service development plans across 5 years had been agreed, along with quarterly strategic review meetings. MS explained the current provisions for the Directory of Services and highlighted that current arrangements within the CSU were not fit for purpose. The new model would result in an annual savings of £12,500. In response to the question from the Lay Vice Chair, MS responded that the new contract for 111 Integrated Care Services had increased by £400k compared to the previous contract, and the financial envelope was signed off by all Directors of Finance in January 2016, as previously reported. The new contract would offer broader clinical input, including multi-	

	disciplinary skill mix and the enhanced management of calls. The Lay Member referred to the reasons behind awarding the contract to Care UK, whose case was superior to SCAS and questioned whether the new services to be received would be broadly the same as currently provided by SCAS. MS responded that although the services were broadly similar, they were enhanced owing to SCAS partnerships and synergies with community trusts. While recognising the improved service specification from SCAS, PP questioned whether commissioners had any concerns about the Trust's ability to deliver the new service specification. MS confirmed that the commissioners had gone through a robust process to agree contract penalties for non-achievement, which would be re-invested into the underperforming services during the first two years. In addition, quarterly strategic meeting would be aimed at monitoring the progress. The Finance Committee resolved to **APPROVE** the award of the Thames Valley NHS 111 Integrate Urgent Care service contract to the Thames Valley 111 Partnership. The Finance Committee resolved to **APPROVE** the Directory of Services business case. **It was requested that an update was provided to the Finance Committee in 6-7 months' post the contract start date, in relation to benefit realisation (Action 17.13).** **It was requested than a brief paper summarising the contract award should be provided to the members of the CCG Board (Action 17.14).**	**MS/ET** **MS**
8.	**Work plan** The Finance Committee reviewed the work plan and noted delays in Learning Disability contract, however the Deputy Director of Finance confirmed the project team was working towards contract mobilisation date of 1 July 2017. The Committee requested that items on the Transformation Plan (financial model, IM&T and Estates) be brought forward to the meeting on 22 June 2017.	
9.	**Any Other Business** The Chair of the Finance Committee thanked Julie Anderson for her contributions to the work on the Committee. The Committee reflected on the effectiveness of the meeting, and the following key points were made: • clinical input into the Committee discussions was extremely useful; • referring to the paper on Non-Elective Growth Analysis, the Lay Vice Chair felt the paper was not at the stage where it should have been brought to the Finance Committee. JA agreed and added it showed the lack of clinical input.	

	• The Lay Member agreed that Consultant Connect and A&E streaming papers also required further development prior to submission to the Finance Committee, although recognising the tight timetable in relation to the later and valuing the opportunity to make an earlier input into consideration of the options. • JD added that more clarity was required on the reasons why papers were being brought to the Finance Committee. • JS suggested that it was essential that all papers had a cover sheet, as this prompted the author to articulate what the Finance Committee was being asked to do. • The Chair of the Finance Committee expressed concerns around the Savings Plan, which would be escalated to OCCG Board.	