WEST LEICESTERSHIRE CLINICAL COMMISSIONING GROUP

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Minutes of the Extraordinary Public Board Meeting
Tuesday 24 April 2018
WLCCG Headquarters, Woodgate, Loughborough, Leicestershire LE11 2TZ

Present:

Dr Chris Trzcinski	Vice-Clinical Chair (in the chair)
Mr Steve Churton	Deputy Chair Lay Member
Dr Chris Barlow	Locality Lead, South Charnwood
Mr Ket Chudasama	Director of Performance and Corporate Affairs
Mr Spencer Gay	Chief Finance Officer
Dr Geoff Hanlon	Locality Lead, North Charnwood
Dr Mike McHugh	Public Health Consultant
Dr James Ogle	Locality Lead, Hinckley & Bosworth
Mr Ian Potter	Director of Primary Care
Mr Toby Sanders	Managing Director
Dr Nil Sanganee	Locality Lead, North West Leicestershire
Dr Y B Shah	Locality Lead, South Charnwood

In Attendance:

Mr Wayne Rabin	Interim Communication and Engagement Lead
Ms Rose Uwins	MLCSU, Communications team
Ms Alison Moss	Committee Clerk (minutes)

Action

WL/18/076 Welcome and Apologies for Absence

In the absence of Professor Lakhani, Dr Trzcinski chaired the meeting. Apologies for absence were received from Professor Mayur Lakhani, Mr Ray Harding, Ms Gillian Adams, Dr Peter Cannon, Ms Nicky Harkness, Ms Tamsin Hooton and Mrs Caroline Trevithick.

The Chair noted that the meeting was quorate with 9 voting members. There were no members of the public.

The Chair changed the agenda and item WL/18/079 – Capacity Plan Approval was taken before item WL/18/078 - Financial Plan Approval.

WL/18/077 Declarations of Interest

The following declarations were noted:
WL/18/078 - Financial Plan Approval - All GPs and Dr Mike McHugh declaration only
WL/18/079 – Capacity Plan Approval - All GPs declaration only
WL/18/080 – Performance Trajectories - All GPs declaration only
WL/18/081 – Operational Plan Refresh - All GPs declaration only.

WL/18/078 Financial Plan Approval

All GPs declared an interest in WL/18/078.

Mr Gay introduced the Financial Plan which had been developed by LLR CCGs. The plan was based on Month 12 outturn and built bottom up involving contract leads and management accountants wherever possible. The QIPP saving required

to meet the CCG's financial target was £20.4M.

Mr Gay noted that the financial plan aligned with WLCCG's strategy, maintaining the Federation QIPP and support for locality working, MCP, etc. The plan was less about investment and largely about QIPP savings.

The QIPP saving schemes were listed at Appendix 2 and included schemes with zero value. It was anticipated that during the year some schemes would need to be developed and deliver savings to provide a contingency against slippage on other schemes. Mr Gay noted that the Board decisions needed to be consistent with the financial plan.

Mr Gay reported that the PMO had supported delivery and ensured a clinical sign off. Professor Lakhani and Mrs Trevithick were undertaking the Quality Impact Assessments on the schemes and had completed two thirds.

Mr Gay referred the Board to the risks outlined in the report noting that there had been assumptions about contractual values and the finer detail needed to be worked through. There were significant risks regarding Cat M and NCSO medicines. The planning assumptions were that the NCSO pressures would abate and there would be no price change for CAT M drugs.

Mr Gay noted that the delivery of QIPP schemes had achieved £16.5M savings, against a target of £18M. The target of £20M in 2018/19 exceeded any previous achievement. It would be important to align management resources to support delivery and strengthen the PMO.

Mr Churton asked whether the assumption that the overspend in 2017/18 would not be repaid in 2018/19 was reasonable. Mr Gay felt that it was as the overspend had been agreed with NHSE in Month 10 and if the assumption was incorrect WLCCG would have been informed.

Dr Hanlon asked what had been decided regarding the Federation QIPP and Mr Churton reported that it had been considered at Procurement and Investment Committee where more information had been requested and it would be reconvene later that day. Dr Hanlon asked whether the Board could assume the savings would be delivered as the Federation QIPP had yet to be agreed. Mr Gay said that for the plan to be realised every line would need to be delivered and it was hoped the Federation QIPP would over deliver. He added that he was not asking the Board to approve every line but to approve the overall QIPP plan as a reasonable plan to aim for.

Dr Hanlon asked whether he Integrated Locality Teams were going ahead. Mr Potter said it was part of the Federation QIPP.

Dr Shah sought clarification regarding paragraph 12 of the report which noted that the combined financial challenge for LLR CCGs was £58M. It was noted that this referred to the savings required of CCGs and was separate to the financial challenge faced by the trusts which was circa £50-60M.

Dr Shah referred to the assumption that the final half of the required £3 per head of the population (primary care transformation fund) had been included in the plan. Mr Gay confirmed that it was part of the Federation QIPP, as was the case in 20171/8 and included in the £2M allocation which at present was non-recurrent.

Mr Sanders acknowledged that this had been a very difficult planning round and

given the national funding settlement and assumptions of growth, the QIPP target was high. He noted that the Board would be required to consider 'the least worst things to do' and there would be difficult decisions in the future. He added that delivery of the plan would be critical and there was a reliance on collaborative working which heightened the need to align resources at an executive level.

Mr Chudasama said that work was underway to deliver a communication plan for the financial plan. Letters had already been sent to voluntary sector groups to highlight the potential risk to funding.

Dr McHugh noted the need to consider the proportion of funding allocated to mental health and to determine what was in and out of scope. Mr Gay noted that NHSE would be monitoring the spend and it would be reported to Board.

It was RESOLVED to:

- **APPROVE** the financial plan for 2018/19

WL/18/079 Capacity Plan Approval

All GPs declared an interest in WL/18/079.

Mr Gay introduced the report seeking approval of the final Capacity Plan 2018/19. A draft plan had been submitted to NHS England (NHSE) on 8th March 2018 in line with national deadlines. There were discrepancies between the assumptions relating to growth made by WLCCG and those presented by NHSE. Analysis of local data meant that WLCCG was above national minimum in some areas but below some in other areas. The net effect would be an increase in activity and therefore impact on the financial plan.

Mr Sanders tabled an email he had sent to NHSE regarding the Capacity Plan and noting that the Financial Plan had not been amended in light of NHSE's directive regarding activity levels. The email noted that WLCCG would need some time to work through the implications before revising the Financial Plan. Mr Sanders said the email confirmed the discussion he, and Mr Gay, had with NHSE and the assurance that no escalation process would be instigated at this time.

Mr Gay noted that the revised Capacity Plan would mean additional costs and therefore a higher QIPP target. Once contracts had been agreed there would be a process to verify the level of activity and financial costs. The potential additional expenditure was c£2M.

Mr Sanders said it was disappointing that NHSE had taken the stance that it had. He understood that a number of CCGs had reduced activity in their plans to ensure the plan was affordable which had led to NHSE requiring the use of national estimates. This had not been the case for WLCCG which had modelled the activity on local data, an understanding of recent trends and service redesign.

It was noted that the process of agreeing contracts with UHL had been based on agreed levels of activity and this would have to be adjusted.

As the financial year progressed, NHSE would be monitoring the activity and note if WLCCG was off target. If the activity was below target, for RTT, NHSE would direct WLCCG to pay for additional activity in line with the Capacity Plan.

Mr Sanders noted that if WLCCG did not accept the instruction from NHSE it would lead to an escalation process.

Mr Gay noted that the revision to the Capacity Plan created problems for financial planning and would impact upon the Federation QIPP.

Dr Shah asked about the anticipated growth for Accident and Emergency. Mr Gay noted that the growth of 3.2% had been offset by the ED QIPP. It was noted that growth could be negative as, in some areas, growth expected for 2017/8 had not materialised.

Dr Shah asked what 'other referrals' referred to and it was noted it included 'consultant to consultant referrals'. He thought that the growth was unrealistic and that more controls over 'other referrals' were needed. It was noted that the national assumptions predicted a much higher growth in non-elective activity.

Mr Sanders noted that activity levels were not routinely reported to Board and agreed to ensure regular reports. Dr Trzcinski thought it would be useful to compare activity against targets an historic performance. **SG**

It was RESOLVED to:

- **NOTE** the methodology used to produce the final capacity plan for 2018/19
- **AGREE** the capacity plan for 2018/19.

WL/18/080 Performance Trajectories

All GPs declared an interest in WL/18/080.

Mr Chudasama introduced the report which noted that as part of the 2018/2019 planning round, CCGs were required to submit targets and trajectories for a number of Key Performance Indicators to NHSE. These included a number of Constitution, Mental Health, Primary Care, 'Other Commitments' and LD Patient indicators. The Board was asked to approve the trajectories and the Quality Premium.

Appendix A outlined the submission for RTT, diagnostic and test and cancer indicators. All constitutional indicators were shown as meeting the national standards with the exception of four Cancer targets.

Mr Chudasama noted a small change from the papers circulated regarding RTT. WLCCG was not planning to achieve the 92% target as the focus was on the waiting list size. However, at the quarterly assurance meeting NHSE requested CCGs plan to achieve both RTT and waiting list size commitments. Therefore, CCB had agreed a target of 92% from November 2018. It was now proposed that WLCCG achieve 92% RTT in March 2019, although UHL was not planning to achieve 92% during 2018/19. The risk was that if CCGs were held to account by NHSE for not achieving RTT and UHL did not have the capacity and CCG was under its elective plan levels, WLCCG may be asked to secure elective capacity from elsewhere at further cost.

The target for A&E was 90% rising to 95% which was a risk given historical performance.

Mr Chudasama tabled updated information on LD In-patient numbers which indicated a slight increase for the numbers with a length of stay over 5 days.

With respect to the quality premium, it was recommended that the local priority remained as the 'percentage of patients returning to usual place of residence

following hospital treatment for stroke'. The proposal was to extend the target from 65% to 75%. Mr Chudasama said this would be would be ambitious.

Mr Churton asked that if WLCCG was achieving 83% currently how 75% was a stretch target. Mr Chudasama said that it did not refer to a full year's data and there was no reason to believe it would be different but there could be an adverse impact from other developments for example stroke beds.

It was thought that NHSE might require a higher target given the level of current performance.

It was noted that LCCCG had opted for a quality premium for a structured diabetes programme and ELRCCG had adopted a target for the 12 month follow up on dementia.

Mr Churton said that it felt safe to retain the existing indicators. Mr Gay thought that it was cautious as the guidance had been issued late and there had not been an opportunity to discuss it fully. As it was linked to payment it needed to be achievable. There would be further discussion at Finance and Planning Committee about quality premium in more detail but the Board would support the recommendation in the paper and await NHSE feedback

The Board had a discussion about the difficulty in achieving constitutional targets that had failed in previous years and the benefit of submitting trajectories that showed WLCCG would achieve them .

Mr Sanders noted that the targets were national constitutional targets which the CCG was mandated to achieve. It was not possible to plan to fail the targets at the outset. The CCG needed it use its best endeavours to achieve the constitutional targets.

It was noted that the recommendation had been to exclude the trajectories relating to A&E and out of area placements as the trajectories had been submitted by other CCG's on WLCCG's behalf. Mr Chudasama noted that the trajectories still needed to be agreed by WLCCG.

Mr Chudasama noted that WLCCG was commissioning enough activity but there was a risk that the providers could not meet the targets. Mr Gay said that the Board should agree the quality premium on the basis that further work would be undertaken locally.

It was RESOLVED to:

- **APPROVE** the trajectories
- **APPROVE** the 18/19 local indicator and target for the Quality Premium.

WL/18/081 Operational Plan Refresh

All GPs declared an interest in WL/18/081.

Mr Gay gave a verbal update on the Operational Plan noting that it would be updated to align with the capacity Plan, Financial Plan and Performance Trajectories. He anticipated the change would be minimal.

It was noted that NHSE did not require an operational plan to be submitted and the plan could change into a delivery plan.

It was RESOLVED TO

- **NOTE** the update on the Operational Plan.

WL/18/082 Any Other Business

There was no other business.

WL/18/083 Date of Next Meeting

The next meeting of the West Leicestershire Clinical Commissioning Group will be Held on Tuesday 8 May 2018, time to be confirmed, at WLCCG Headquarters, Woodgate, Loughborough, Leicestershire LE11 2TZ.