Fit for the Future
Working together to keep people well

Health & Care Executive

Date : Monday 21st November 2016
Time : 2.30-4.30pm
Venue: Boardroom, Peterborough City Hospital

MINUTES

Present :
David Astley (DA) Independent Chair, STP - Chair
Tracy Dowling (TD) Accountable Officer, CCG
Matthew Winn (MW) Chief Executive, CCS
Stephen Graves (SG) Chief Executive, PSHFT
Lance McCarthy (LM) Chief Executive, HHCT
Roland Sinker (RS) Chief Executive, CUH
Aidan Thomas (AT) Chief Executive, CPFT
Stephen Posey (SP) Chief Executive, Papworth
Jonathan Dunk (JD) Chief Finance Officer, CCG
Alex Gimson (AG) CAG Chair, STP
Liz Robin (LR) Director of Public Health for Cambridgeshire & Peterborough
Wendi Ogle-Welbourn (WO-W) Corporate Director: People and Communities, PCC
David Roberts (DR) Clinical Chair, SPC
Scott Haldane (SH) Interim Programme Director, SDU/Finance Director, CPFT

In Attendance:
Mark Millar (MM) FPPG Chair, STP
Roy Clarke (RC) Finance Director, Papworth
Roy Jackson (RJ) Finance Director, HHCT
Caroline Walker (CW) Finance Director, PSHFT
Simon Wood (SW) NHSI
Joel Harrison (JH) Finance, Analytics and Evaluation Director, SDU
Jessica Bawden (JB) Director of Corporate Affairs, CCG
Paul Dinkin (PD) McKinsey
Will Taylor (WT) McKinsey
Catherine Boaden (CB) Head of System Strategy and Leadership, SDU
Laura Gaylor (LG) Programme Governance Manager, SDU – Mins

Apologies:
Gary Howsam (GH) Clinical Chair, CCG
Joanna Yellon (JY) Locality Director Cambridgeshire and Norfolk, NHSE

	Agenda	Actions
1.	**Operational Planning and Contracting Update** SH opened the meeting by outlining the key objective for the session which was to agree a QIPP figure and an overall level of demand management for 2017/18 that was suitably realistic, achievable and challenging to HCE members and could serve as a basis for operational plans and contracting. HCE members were asked to discuss the consequences of the figure, agree the QIPP target and determine any preparation required before presenting it to NHS England on 24th November. PD and McKinsey colleagues provided the HCE with information and analysis to	

inform the decision. These included:

1.The scale of the challenge – the gap posed by initial Control Total offers
2.The total scale of opportunity – pointing out that current STP gets back to current levels of peer performance over 5 years, by which time peer performance will doubtless have improved (and leaves the CCG financial position worse next year than this year)
3.The current value of worked-up plans (and an indication of their implementation readiness)
4.The potential impact of different demand management scenarios on individual providers' income and activity
5.A set of actions that, if implemented, could increase the ability to deliver as a system
6.The investment that would be required to deliver initiatives and improve delivery capability and capacity.

The whole system challenge for 17/18 is £44m (made up of £18m for the CCG and £26m for the providers).

AT entered the meeting at 2.50pm.

In order to achieve its 17/18 proposed Control Total, the CCG's QIPP requirement is £53m (5.4%). £35.3m has been identified as the QIPP level that could be achieved in 17/18, based on FYE from 16/17 QIPP and new 17/18 QIPP, however there is a £17.7m gap to meet the proposed CCG Control Total.

External benchmarking suggests that the STP submission of £35m QIPP will lead to below the current median peer level performance. There are savings opportunities identified in acute and non-acute if we compare ourselves to other systems. We are performing at less than peer average for both elective and non-elective care. AG referred to a letter sent from the CAG to the CCG (Copied to HCE members) and commented that the CAG have identified that there is more focus needed on non-elective savings opportunities.

The HCE discussed the issue regarding pace of delivering the saving opportunities. Savings are being identified across all areas of spend. £37.3m has already been identified either as full year effect of 16/17 schemes or additional new initiatives being developed. This included £16m of savings in process of more detailed development, which includes initial best practices for acute savings where engagement with clinicians is needed on operational detail and non-acute savings where process has begun to identify further opportunities.

Using best practice turnaround methodology, current initiatives have been assessed against an implementation readiness framework. £11.9m out of £37.3m of savings identified are at L2 and L3 against this framework (the L-based Gateway criteria were defined in the reference slide discussed by HCE)..

TD entered at 3pm.

PD presented a step-by-step approach of assessing the impact of QIPP scenarios on providers and outlined where and why this piece of QIPP impact modelling differs from the STP in approach and assumptions. The slides provided a step through the methodology and outputs of assessing the impact on providers at POD level on income and activity. The level of cost was not shown in this document due to lack of data. The FPPG are currently working through the differing views on how to conclude on this.

PD presented the new figures which had used more detailed, and more up-to-date, bottom up solutions than the original STP submission. The original QIPP scenario for the STP submission was £27m, of which £20.1m is in acute settings. The new QIPP modelling has two scenarios (1) £35m based on subsequent QIPP, of which £24.2m is in acute settings; (2) £53m based on closing the proposed CCG control total, assumed 60% (£31.8m) of which in acute settings.

Tariff changes will have an impact on QIPP savings as there are currently differences between provider tariffs. Changes to the tariff which took place last week will ensure uniformity across the system. SG noted the impact of the changes to CNST presented an additional challenge to the providers and would need to be considered in future modelling.

It was **noted** that the balance of savings had shifted significantly towards non-elective savings compared to the STP plan. That shift was welcomed but it was recognised that it had gone too far and work would be done to reduce the proposed non-elective savings back to the recommendation from the CAG of 7.5% (or 3.5% net after the projected demand growth of 4%) and increase the value of elective and outpatient savings.

McKinsey presented the different QIPP distribution by POD between the original STP plan and QIPP scenario modelling due to top-down vs. bottom-up approach. JH noted the growth doesn't reflect the real time growth. There is an overall 0.5% net effect against 16/17 FOT.

The two QIPP modelling scenarios, £35m and £53m total QIPP, result in 1.8% and 3.4% net reduction in acute activity vs. 2016/17 forecast outturn respectively.

Due to the remodelling the CCG actual schemes which have been developed have had a higher waiting on non-elective and this is why there is a greater shift in reduction (9%). The HCE were asked if they were comfortable with that size of shift. AG summarised the view from the CAG in a letter to TD, which outlined that the CAG recommends the savings come from non-elective and not elective services. AG noted that there are a number of investments which were not highlighted in the presentation. LR noted the lack of prevention strategies within the discussion which could also be implemented rapidly.

Investment in new ways of working will be required to increase clinical ownership, accountability, and pace of delivery. PN outlined the shared approach to implementing schemes and enabling changes in leadership and capability. New 17/18 QIPP initiatives require c. £20m of investment in order to generate annual gross savings of c. £33m. LR noted that prevention investments need to align with CAG and LA. WO-W raised concerns to work together with the LA to join up to achieve savings not only for 17/18, but that could be built on in following years.

PN presented the modelled two QIPP scenarios: (1) £35m as per STP submission; (2) £53m in meeting the proposed CCG control total. The HCE were asked to discuss as for the CCG to deliver a stable (£17.4m) deficit in 17/18 would require £37.5m QIPP. The HCE **agreed** to commit to target of £37.5m resulting in a stable year on year CCG position. The group discussed the importance of setting up the system to deliver an achievable target, and having details of lead in times by schemes with times of returns of investments.

Action: WO-W to review LA investment business cases and share with the HCE. **WO-W**

The group discussed the ambitious target and the need to achieve a realistic pace of delivery. AG noted that some clinicians are sceptical about the feasibility and there is a

need to invest in projects and in delivery. Engagement with patients, public and staff is also required.

SG raised concerns around the PSHFT/HHCT full business case and the need to understand implications on the provider bottom line. The HCE **agreed** there needs to be a consistent message in preparation for the meeting with Paul Watson on 24 November. AT, SG, AG, WO-W, TD, SH & DA confirmed their attendance at the meeting.

Action: SH to coordinate a pre-meet teleconference prior to meeting with Paul Watson on 24 November. **SH**

2. Structures and Reporting for Delivery Mode
SH confirmed the SDU are meeting with LM to discuss reporting and tracking proposals and will present at the next HCE meeting in December. MW noted that there is a process needed to track provider CIP and to track back the £37.5m.

3. Local Digital Roadmap
The Local Digital Roadmap (LDR) was circulated to the HCE prior to the meeting. The LDR was submitted to NHSE on 18 November. The HCE **agreed** to endorse the LDR. The HCE noted thanks to Claire Tripp for her work on the LDR.

4. FPPG and CAG Key Discussions and Conclusions
This item was not discussed due to key discussions noted earlier in the meeting.

5. Actions from the last meeting
This item was not discussed.

6. Review status of key deliverables
This item was not discussed.

7. Review key programme risks and issues
This item was not discussed.

8. Agree agendas for the next HCE meetings
The HCE **agreed** to review December meetings following meeting with Paul Watson on 24 November.

9. AOB
The STP was published prior to the HCE meeting taking place and there has been a number of media interviews completed already.

The meeting closed at 4.35pm

Date of next meeting: Tuesday 13th December, 3-4.30pm, Teleconference

Author: Laura Gaylor, Programme Governance Manager, November 2016