FINAL MINUTES

NHS
Wiltshire
Clinical Commissioning Group

MINUTES OF FINANCE AND PERFORMANCE COMMITTEE MEETING
HELD ON TUESDAY 11 OCTOBER 2016 AT 11:45hrs
AT SOUTHGATE HOUSE, DEVIZES

Present:

Peter Lucas	PL	Vice Chair, Lay Member
Tracey Cox	TC	Interim Accountable Officer
Steve Perkins	SP	Interim Chief Financial Officer
Christine Reid	CR	Lay Member
Dr Mark Smithies	MS	Secondary Care Doctor
Dr Richard Sandford-Hill	RS-H	GP Chair, WWYKD
Dr Toby Davies	TD	GP Chair, SARUM
Dr Andrew Girdher	AG	GP Co-Chair, NEW
David Noyes	DJN	Director of Planning, Performance and Corporate Services
Jo Cullen	JCu	Director of Primary Care and Urgent Care/Group Director WWYKD
Mark Harris	MH	Chief Operating Officer
Rob Hayday	RH	Associate Director of Performance, Corporate Services and Head of PMO
John Dudgeon	JD	Associate Director Information
James Roach	JR	Interim Integration Director *(joined the meeting at 12.35hrs)*
Lucy Baker	LB	Interim Director of Acute Commissioning *(joined the meeting at 12.15hrs)*
Sharon Woolley	SW	Board Administrator

Apologies:

Dr Peter Jenkins	PJ	Chair, CCG
Ted Wilson	TW	Director of Community and Joint Specialist Commissioning/Group Director NEW
Dr Anna Collings	AC	GP Co-Chair, NEW
Dina McAlpine	DMcA	Director of Quality

Item Number	Item	Action
FIN/16/10/01	**Welcome and apologies for absence** PL chaired the meeting in the absence of PJ and welcomed attendees. The above apologies were noted.	
FIN/16/10/02	**Declarations of Interest** Members were reminded of their obligation to declare any interest they may have on any issues arising at the meeting which might conflict with the business of Wiltshire CCG. **There were none declared.**	

FIN/16/10/03	**Minutes of the meeting held on 13 September 2016:** The minutes of the meeting held on 13 September 2016 were agreed as a true and accurate record. **Action Tracker**: **FIN/16/08/03 – AWP/DTOC Mental Health Out of Area Placement Figures:** TW had briefed members and circulated information to PJ, PL and CR. **COMPLETED** **FIN/16/08/04.2 – SFT ITU Activity and Chemotherapy Delivery:** MH confirmed that chemotherapy delivery had been raised at the SFT contract meeting. A structure audit was being undertaken next week. This remained a continued pressure for SFT. The audit results would provide the intelligence needed to review delivery. These would be brought to the November Finance and Performance Committee meeting. **ONGOING** **FIN/16/08/04.3 – Locality Breakdown Sizeable Elements of Growth:** JD reported that activity figures had been cut by locality for further analysis. The locality pressures were included in the finance report to be discussed under item five. **COMPLETED** **FIN/16/08/04.4 – Review RUH Urgent Care:** SP was to continue discussions with BANES to establish their intentions and confirm if notice would be given on the contract. (TC confirmed that BANES CCG had given notice). Conversations for the 2016/17 contract confirmed there would be no change in this year's position. This would not bring any additional funding pressures. **COMPLETED** **FIN/16/08/04.5 – Discuss Implementation of TEP System with SFT:** MH confirmed that this had been raised at the SFT contract meeting and was now on their tracker for review. **COMPLETED** **FIN/16/08/04.6 – Update on Technology Pilots for Online Symptom Checker:** DJN reported that the online symptom checker was not yet a finished product, interaction with other IT systems was being investigated. Pilots were to commence in selected practices over the next six to nine months. DJN recommended that the pilots run to then see the outcomes and impacts. A report would come back to a future Finance and Performance Committee meeting when available. **COMPLETED** **FIN/16/08/06.0 – Discuss National and Local Dementia Figures with NHSE:** TW had discussed with NHSE. Dementia figures are now on track to meet the national target. **COMPLETED** **FIN/16/09/03.0 – A&E and Ambulance Pressure Areas taken to A&E Delivery Board Meeting:** Pressure areas had been cut by locality, and a deep dive was underway at SFT which would be reviewed by the Urgent Primary Care team and discussed with SFT. Outcomes would go to the Local Delivery Board. **COMPLETED** **FIN/16/09/03.1 – Non-GP Referral Counting to be Standardised Across all Three Acutes and FIN/16/09/03.2 – Standardising Non-GP Referral Counting to be Discussed with BANES:** Actions were connected. JD reported that the counting issue had been raised with RUH, the only Trust who had different recording to track the RTT pathway. It would be stressed to RUH that the GP growth was a more important activity to record for the CCG. **COMPLETED** **FIN/16/09/05.1 – Short Stay Cases to be Raised Through Primary Care Route**	**LB**

	and Local Delivery Board: COMPLETED **FIN/16/09/06.0 – Prescribing Scheme Timescales to be added to FRP:** Dates added. **COMPLETED** **FIN/16/09/06.1 – Current Primary Care Investments to be Reviewed:** Reviewed and included in the FRP. **COMPLETED** **FIN/16/09/06.2 - CHC SPP and S117 Saving Costs to be Identified:** Included in FRP. **COMPLETED** **FIN/16/09/06.3 - Repatriation of WCCG patients to Utilise Daisy Unit:** TW and SP had discussed this and progression was being made. **COMPLETED** **FIN/16/09/06.4 – FRP Monitoring Mechanism:** Included in FRP paper. **COMPLETED** **FIN/16/09/07 – Contracting Requirements Governance Arrangements Update:** Agenda item. **COMPLETED** **FIN/16/09/08.0 - TCOP Progress and Performance Update:** Update to be provided following the Primary Care Oversight Board meeting in November. **ONGOING** **FIN/16/09/08.1 – BCF Evaluation Against Rationalisation Exercise:** Agenda item. **COMPLETED** ACTION: FIN/16/10/03 - Update on Online Symptom Checker to be brought to future Finance and Performance Committee Meeting following the six to nine month pilots with selected practices.	**JCu** **DJN**
FIN/16/10/04	**Matters Arising** There were none.	
FIN/16/10/05	**Financial Position** SP reported that the financial position was in line with NHSE requirements. Table 3 of the report indicated the movements in position, the main area being FNC and the increase in programme reserves to mitigate. The variance in Mental Health related to previous year issues, not reductions in funds for the service. The evaluation of AWP found underperformance, resulting in reduced payment. Mental Health had also seen lower placement activity levels. Deep dives were underway with the three Acutes. SFT had subcontracted to Ramsay to assist with the increase in NEL activity. Costs would be looked into to ensure there was no double payment. ACTION: FIN/16/10/05.0 - SFT elective activity payments to be reviewed to ensure no double payment from sub-contracting. • **SFT** There was an increase in uncoded activity, which would have a timing impact and, when validated, potentially a cost pressure. SFT would be working through this. NEL remained the main issue. Excess bed days had also increased, which brought a significant cost. This increase was due to a mixture of DTOC and staff capacity causing bed blocking. JCu confirmed that the STP Urgent Care work stream would be looking into this and reviewing data.	**SP**

	Increased A&E activity would form part of the deep dive and be reported against at the November Finance and Performance Committee meeting. Next month figures indicated that uncoded activity would continue to be an issue due to the capacity and backlog. Extra codes could be implemented. This was not a new issue. It was also noted that A&E activity levels were reduced, but an increase in maternity activity would bring a cost pressure. The impact of the change in Salisbury Walk in Centre hours would be reviewed against A&E activity. ACTION: FIN/16/10/05.1 – A&E activity pressures and SWIC impact to be reviewed and reported to the November Finance and Performance Committee meeting. • **RUH** NEL activity continues to be over plan. The spike in EL activity is to be analysed. It was NHSE's responsibility to ensure RTT delivery, but as the commissioner, the CCG was to ensure it is actioned and that providers had capacity. LB confirmed that activity was being re-directed and the benefit of this should be seen in September activity reports. • **GWH** NEL activity had increased and costs were over plan by £70k (not £700k as stated in the report). High cost drug costs had spiked significantly and maternity activity continued to increase. Chippenham locality a significant pressure point for NEL activity (reflected in increases at RUH as well). M5 showed an improvement in position, especially around A&E and NEL activity. **Financial Risks and Reserves** Delivery of the FRP actions remained a financial risk to the overall position. The work on clawing back the Continuing Care Services from debtor Swindon Borough Council continued. DMcA had sought advice from SCCG and Legal Advice to escalate this to gain movement. **The Committee received and noted the report.**	**JCu**
FIN/16/10/06	**Financial Recovery Plan** SP presented the updated FRP. The table on page 5 of the paper gave an overview of the schemes, the savings achieved to date and the planned savings. This monitoring mechanism highlighted activity and any reductions in projected savings and would be used to record adjustments and actual savings. Ongoing, the progress would be amalgamated into the financial position paper. MH requested that the approach needed, the narrative and forecast was added to the report, and that phasing it into QIPP was considered. RH confirmed that inclusion in QIPP was being looked into. An update was provided on each work stream by the relevant Director/Lead. • **Expansion of Clinical Policies** MH was confident that the action taken regards the Patella Resurfacing Policy would bring the expected savings. The Refreshed Injections Policy action was still to take forward. The current policy would first be reinforced, then revised. • **Primary Care Schemes**	

	JCu reported that majority of actions are on track with additional capacity brought in. Detailed plans had been implemented by the Meds Management Team. The prescribing budget had been split, causing some synchronisation issues, but this would be brought back on track. Children's drugs, especially those used in treatment of ADHD, would be raised with Virgin Care to see what savings could be made. Primary Care Offer (PCO) budgets had been reviewed using the actuals from Q2, and would be sent to the Oversight Board in November. PCO was developed to build resilience, and schemes across localities should demonstrate added value and show commitment throughout the year. SP informed members that through the external audit value for money was looked at to ensure appropriate use of funds. This funding was agreed, at clinical exec, to commission additional capacity and it needs to be evidenced – if not the unused monies will be clawed back.. The WCCG's role was to manage expectations and its principals. AG felt that as part of the three year PCO programme, part of the process should be to support schemes to succeed. If achievements were not as planned in November, the CCG should look at what was required to get them back on track and evaluate the work together. It should be ensured that all requirements were in place from the start and that resources were being fully utilised. Funds could be recouped at a later date if there was initial slippage, as long as the scheme added value and funds were being used for the specified purpose. SP agreed that commissioning leads needed to work with practices to support successful delivery, however if additional capacity costs had not been incurred then the funding would be retained. • **CHC/FNC/Specialist Placements and CQUIN Review** No verbal update given due to DMcA being absent. • **Repatriation of Out of Area Patients into the Daisy Unit** No verbal update given due to TW being absent. • **Getting Existing QIPP Schemes Performing** LB reported that the ophthalmology triage pilot commenced on 1 October 2016. The Planned Care PIFU had been initiated with providers. The medical specification had been agreed, with cardiology being undertaken first. MH reported that the clinical policies element was indicating a saving however it had been found that this saving was being double counted with QIPP and so would be removed from the list. Overall, it was felt that current activity should continue to be maximised, focus maintained, risks adjusted and the forecasts reviewed before identifying any additional actions. Feedback from the recent Q2 Assurance meeting was that NHSE were content with the CCG's current position and that this should be maintained. **The Committee received and noted the update on the Financial Recovery Plan.**	
FIN/16/10/07	**2017/18 Financial View** The operational planning guidance from NHSE had been received on 22 September 2016, which included the nine priority areas and required alignment with the STP. SP explained that the 2017/18 financial view paper outlined the national view, and an alternative local view.	

	The draft operational plan was to be submitted by 24 November, with two year provider contracts signed by 23 December. The local NHS providers were aware of the timescales. The risk reserve was to be in place to support the overall national system. In 2017/18, 50% of CCG's headroom budgets were to contribute to this. The remaining 50% of WCCG headroom funds could be used to support service redesign and should be used effectively. The MTFP included the national and STP allocation assumptions and anticipated growth up to 2021/22. This had been refined to provide a local view. A standard demographic increase of 0.6% per annum had been assumed. Table 6 indicated the agreed new investments expected in 2017/18 and 2018/19. The assumed FNC impact was included. Table 7 and 8 presented the challenges for the next five years for the national and local view. The £14.5m local QIPP figure would be a challenge. Table 9 showed the QIPP targets reconciled, with table 10 listing suggested areas to look at and the scale of the ambition needed. Even with the identified QIPP target areas, there remains a shortfall and challenge. PL questioned the persistent overspend of NEL activity and how this could be rectified. The expected full year impact identified was ambitious. SP explained the high cost outturn was reflected in the position and included growth on top if the level was held to contract and growth contained this would be a significant achievement. The BCF and TCOP had helped to contain elderly patient growth. Admissions to hospital had become more complex. A case mix control needed to be realistic. The main areas of risk to the position were shown on page 8 of the paper. The impact of HRG4+ was being modelled. There had been no direct mapping for HRG4 to HRG4+. Unforeseen cost pressures could arise and sensitivity modelling showed the impact. The clinical negligence uplift percentage has not yet been released; an assumption had been included BCF may require an increased contribution; this has not yet been confirmed. Position, linked to STP, based on M4 positions and would need to factor in updates. SP asked for the Committee to agree the direction of travel and the local plan assumptions. It was noted that if WCCG were to agree the local plan, this would have to match the STP assumptions and have the agreement of the STP partners. MH and SP would review the suggested QIPP target areas, consider possible de-investments and the use of non-tariff based services. Overall, growth in activity needed to be curtailed and benchmarking put into place. The financial plan needed to be reasonable, but fluid and would inform the operational plan. **The Committee agreed the 2017/18 financial plan and the local model and assumptions.** ACTION: FIN/16/10/07 – Review the suggested 2017/18 QIPP targets, consider possible de-investments and the use of non-tariff based services.	**SP/MH**
FIN/16/10/08	**Status on CCG Project Milestones for QIPP Delivery 2016/17** DJN reported that a deep dive of the QIPP report had been undertaken and continuation of schemes had been discussed. It was acknowledged that QIPP was to support the financial recovery plan and that schemes needed to perform. Targets were not as expected to date, but work was underway where possible to resolve this. This would be addressed through the operational plan.	

	Although targets overall were not currently being met, those over achieving schemes were helping to offset some underperformance. Each scheme is monitored through a dashboard and the report generated by the CSU. The paper indicated scheme status. CR questioned if QIPP delivery benchmarking was available. DJN explained that QIPP was hard to compare due to the split in transformational and cost avoidance schemes. To date, WCCG had delivered 30% of its transformational schemes. The report format could be improved. TC felt the existing reports were hard to navigate. BANES had recently reviewed their approach, which now clearly indicated the month's achievements and those schemes off target. MH and DJN would review the report in due course. The processes and mechanisms were already in place, but the production of the correct content would be needed to better inform the report. ACTION: FIN/16/10/08 – Using the BANES report, the QIPP report format to be revised and relaunched at an appropriate timescale. **The Committee received and noted the QIPP update.**	**MH/DJN**
FIN/16/10/09	**Update on 2016/17 Contracting Requirements and Links to STP Management Capacity** **a) Governance Arrangements** Item not discussed at meeting and to be brought to the next meeting.	
FIN/16/10/10	**Better Care Fund Update and Evaluation** The BCF presentation had been circulated with the meeting papers for information. JR covered a number of slides in his report. Elderly NEL activity had seen good success with growth curtailed. When comparing 2015/16 to 2016/17, it clearly indicated a challenging year, especially for DTOC. CQC reviews had impacted on provider availability as had a service provider transfer. Intermediate discharges had been restricted. The co-location of health and social care at front of the building was to be implemented. Urgent care at home was now at full capacity. The staffing model was to be changed. Rehab Support Workers for domiciliary care were to be brought in to increase capacity. Domiciliary care would be re-prioritised to maximise the offer. A review would be held with patients every two weeks to encourage the move from care to telecare. Hospitals were notably busier with more complex issues. A better contractual management and staffing structure was in place. Q3 position was good and a better buy in had been received from the acutes at discharge. MS questioned Wiltshire Health and Care integration. JR reported that they had been better engaged, aligning staff to the discharge teams. The comprehensive assessment roll out in Salisbury had been delayed. Wiltshire Health and Care have assured that they are responsible for all care within seven days and pathways were in place. It has been reported that care providers were not reacting early enough. Work was underway with Wiltshire Health and Care to address the workforce issue.	

	AG felt that there were still not enough avenues in place to reduce hospital admission. Ongoing unmet need should be mapped and achievements shared with GP's. The BCF input into QIPP was raised. JR reported that scheme progress and actions were detailed in the monthly Integrated Performance Report. The Committee felt further, specific BCF detail was needed. JR highlighted that some disinvestment work and areas of opportunities were being looked into. The BCF Information Governance Group were aware of the potential impact. ACTION: FIN/16/10/10.0 – Wiltshire Health and Care workforce issues to be addressed and report provided to the Finance and Performance Committee. ACTION: FIN/16/10/10.1 – BCF QIPP schemes to be evaluated and report provided to November Finance and Performance Committee meeting.	**TW/JR** **JR**
FIN/16/10/11	**Locality Data and Case Review** Using the locality data supplied by JD, TD had commenced the review of the 600 patient cases reported against the three acutes to look at the case mix of the short length stays. Initial findings had found that A&E activity had increased for those patients who had joined a practice in the last 18/24 months. Patients would be targeted and educated about the pressures faced by A&E. ACTION: FIN/16/10/11 – Analysis of locality data to continue and report to be provided to November Finance and Performance Committee meeting.	**TD**
FIN/16/10/12	**Delivery of the Constitutional Targets Update** JD reported on delivery against constitutional targets as at August 2016, although it was noted that some data for August was not available. Breaches had been recorded for the RTT incomplete pathways, diagnostic test waiting times, mixed sex accommodation and ambulance response times. Although still under target, dementia diagnosis had seen an upward trend over the last four months. This would be discussed further at the Area Team Review meeting. RTT was raised at the recent Q2 Assurance meeting and was noted as an action for the CCG to address.	
FIN/16/10/13	**Any Other Business** There was none. The meeting was closed at 13:40hrs	

Dates of Finance and Performance Committee Meetings 2016/17:

8 November 2016 (11.15 – 13.15)
6 December 2016 (10.00 – 12.00)
10 January 2017 (11.15 – 13.15)
14 February 2017 (10.00 – 12.00)
14 March 2017 (11.15 – 13.15)