NHS
Wiltshire
Clinical Commissioning Group

MINUTES OF FINANCE AND PERFORMANCE COMMITTEE MEETING
HELD ON TUESDAY 09 AUGUST 2016 AT 11:45hrs
AT SOUTHGATE HOUSE, DEVIZES

Present:		
Dr Peter Jenkins	PJ	Chair, CCG GP Chair
Peter Lucas	PL	Vice Chair, Lay Member
Simon Truelove	STr	Interim Accountable Officer
Steve Perkins	SP	Interim Chief Financial Officer
Christine Reid	CR	Lay Member
Jo Cullen	JCu	Director of Primary Care and Urgent Care/Group Director WWYKD
Dr Richard Sandford-Hill	RS-H	GP Chair, WWYKD
Dr Toby Davies	TD	GP Chair, SARUM
Ted Wilson	TW	Director of Community and Joint Specialist Commissioning/Group Director NEW
Dina McAlpine	DMcA	Director of Quality
Rob Hayday	RH	Associate Director of Performance, Corporate Services and Head of PMO
John Dudgeon	JD	Associate Director Information
Lucy Baker	LB	Deputy Director of Acute Commissioning
Sharon Woolley	SW	Board Administrator
Apologies:	MH	Director Planned Care /Group Director SARUM
Mark Harris	JR	Interim Integration Director
James Roach	DJN	Director of Planning, Performance and Corporate Services
David Noyes		
Dr Mark Smithies	MS	Secondary Care Doctor

Item Number	Item	Action
FIN/16/08/01	**Welcome and apologies for absence** PJ welcomed everybody to the meeting, in particular Sharon Woolley who has recently joined the CCG as the new Board Administrator. The above apologies were noted.	
FIN/16/08/02	**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/16/08/03	**Previous Minutes – 14 June 2016:** The minutes of the previous meeting were agreed as a true and accurate record with the following amendment:	

	FIN/16/06/03 – Amendment to sentence 'PJ welcomed everyone to the meeting, noting the above apologies.' **Matters Arising:** None. **Action Tracker**: **FIN/16/06/06 – DTOC AWP Out of Area Placements to be discussed at JCB 2.8.16:** JCu and TW reported that the DTOC discussion had been positive. TW will attend the Workforce Health and Care meeting with Wiltshire Council on 10.08.2016 which will discuss Domiciliary Care and the Help to Live at Home service contract that will commence in September. The issues relate to dementia beds, which will be an item on the September JCB meeting. Out of area placements are tracked weekly with DTOC and our providers. **CLOSED** Mental Health Out of Area Placement figures to be reported at next meeting and the Out of Hospital Board. **FIN/16/06/06 – Cardiology and Referral Support Services to be discussed at Planned Care Meeting 14.6.16:** Papers going to Clinical Exec Meeting (pm 9.8.16). Cardiology has its own work stream and the RSS has been linked to the STP. **CLOSED.**	**TW**
FIN/16/08/04	**Finance** • **M3 Update** The report builds upon the update given at the July Governing Body meeting. M3 shows a £2.9m pressure on acute hospitals. The provisional figures for M4 are currently showing pressures on the independent sector – some of this is planned activity repatriation (with the benefit still to be seen via acute slams) and some is linked to elective capacity constraints at main acutes due to non-elective pressures. • **Programme Areas** The table on page six of the report indicates the programme expenditure trends. The risk areas include the non-acute prescribing as prescribing forecast data has yet to be received. The work carried out to date has seen a reduction in the growth rate below national trends. • **Acute Positions** SP reported against the M3 headlines. **- SFT** Urgent care is the significant driver for their over-performance. A&E activity and finances remain higher than planned. This will be followed up next week in a meeting with the Trust. The planned care activity has risen and is linked to regular day admissions. Further details will be brought to the next meeting. JD reported that the way services, such as chemotherapy, are being recorded will have affected the figures. LB will discuss ITU activity and chemotherapy delivery with SFT at the contract meeting being held on 11.8.16. LB and JD to review the locality breakdown for sizeable elements of growth to determine if there are issues underlying this. The increase of out of hour's capacity at the Salisbury Walk in Centre should impact upon the hospital activity and will be monitored. M3	**JD** **MH** **LB/MH** **LB/JD**

	SLAM has stabilised, but non elective pressures remain along with increased first outpatient activity - the additional activity is likely to incur downstream cost pressures. **- RUH** Non-elective continues to be the main driver, with an annual spells growth of 12% with some activity funded in the plan. Short stay cases will be looked into further. A question on whether the Urgent Care Centre was bringing value for money was raised. This is an ongoing discussion item with BaNES CCG. GPs felt that young people are bypassing their GPs and going straight to A&E for a quicker appointment. A breakdown of figures are available which show the level of inappropriate attendances. There is also growth in ambulance delivery attendances. Acute hospitals need to be working with the CCG to identify the cost of these inappropriate attendance cases. Communication is vital between GPs and hospitals to ensure the associated cost message is given to patients. There is no incentive for A&E providers to turn them away. A primary care triage process should be considered at the front of all A&Es. This is in place at RUH, but it is not working adequately (and is the subject of discussions mentioned earlier with BaNES).	**JCu/SP**
	TW reported that the Treatment Escalation Plan (TEP) system has been implemented by all, except SFT. They wished to wait for the national TEP. LB will pursue this contractually with SFT as it should form part of the performance notice.	**LB**
	There is also the issue of non-attendance of GP appointments which has a significant cost associated. Patients can be removed from the list if they become regular non-attenders.	
	STr stated that primary care is key and the CCG investments are trying to support this. Technology pilots are in development across the three groups for the online symptom checker. This is being developed by Medivo and should help to increase primary care capacity. The Communications team have a number of campaigns running to help potential patients to realise what services they may need. The CCG needs to deliver on its QIPP schemes. STr requested that a list be drawn up of additional Primary Care Offer services being delivered as part of the funding stream.	**DN** **JCu**
	STr alluded to the financial pressures faced by the CCG and advised that plans must be devised to mitigate which will include tough decisions needing to be made. STr and DMcA left the meeting at 12:30. **- GWH** Overall position is more stable than prior year and does not show the same level of concerns as the other two main provider contracts. As per the RUH SLAM currently showing issues with maternity pathway costs – some of this is linked to phasing but also provider to provider cross charging which the CSU are reviewing. • **Financial Risks and Reserves** A contingency of 0.5% is held and has been applied. Department of Health has held back headroom funds to cover the overall NHS position as per the recent “NHS Financial Reset” document. A number of risks within the local health system are being managed.	

	Nationally the DH has agreed to a 40% increase in FNC rates from 1st April 2016 – communicated in July to CCGs. The impact of this is c£3m. NHSE expect CCGs to manage this and there is no additional funding to cover this. NHSE advise that the CCG should consider internal financial recovery. The table included in the report on page 11 lists the financial recovery plan options used for 2015/16. Some items are now classed as normal business and others were non recurrent. Discretionary spend needs to be controlled such as additional investments requested in the planned care programme board. General discussion was had on the options available covering an expansion to clinical priorities policies, deprescribing of drugs with limited clinical benefit, maximisation of the use of the new daisy unit as non-utilisation still incurs costs to the CCG under the agreement. Decommissioning should be considered, but options should not affect what is already being achieved and delivered. Internal and external resources should be considered. Following this discussion SP requested that a detailed list of financial recovery plan options to be brought to the next Committee meeting under the following work streams. 1. Expansion of clinical policies - LB 2. De-prescribing linked clinical effectiveness - JCu 3. CHC/FNC/specialist placements CQUIN review - DMcA 4. Repatriation of out of area placements into the Daisy - TW 5. Getting existing schemes performing An underspend has been forecast for the running costs of the CCG, but not at the level planned. **It was agreed to move to monthly meetings of the Finance and Performance Committee to support the monitoring of these programmes and the mitigation of the CCG's cost pressures.**	**LB/JCu/DMcA/TW**
FIN/16/08/05	**Projects Update** **QIPP** RH reported that the paper provided a snapshot of the QIPP position. A significant addition to the report is the break down into programme/project areas to relate to the £14.2m delivery plan, of which project registers are held for each and mapped against milestones and plans. To date there has been a mix of performance; but overall the QIPP target has not been met. The reports do not show the amount of the organisation's capacity being consumed to make a difference to the system and monitor progress. Concerns were expressed regarding the delivery of QIPP and the expected savings. Focus and prioritisation is needed on what we hold data for to ensure our services are making a difference, not just continuing to deliver as before. SP requested that an honest and frank assessment of QIPP schemes is needed to look at what is working, progressing and can realistically be delivered be undertaken with a view to stopping those that are not effective to free up capacity to resource the recovery actions discussed earlier. RSH asked to ensure that this does not inadvertently impact upon other services. Time constraints need to be communicated with the CSU. RH will take the QIPP for review and ratification to EMT.	**RH**

FIN/16/08/06	**Delivery of the Constitutional Targets Update** JD reported on delivery against constitutional targets as at the end of June (Q1 positions). Some slippage was known and planned for, but July would have been a challenge to bring targets back on track. RUH had a delivery trajectory for July, SFT and GWH are currently unknown. May Breaches: • 2 patients recorded as having to wait 52 weeks or more – but these were with out of county providers. • Cancer breached 2 standards: 2 week wait (tertiary provider) and 2 week breast symptoms (workforce issues). Recovery plan is in place and should realign targets by November. • 7 mixed sex breaches – all at SFT • A&E M3 figures not available – but provisional figures show that all 3 dipped. July A&E attendances have been the highest to date. • Ambulance responses against the 8 minute target is still below the 75% standard. • C. Difficile is only just green as there were breaches • Dementia Diagnosis has seen a slight increase for June, but still under target. NHSE are willing to discuss the national and local Dementia figures. • Community Services - 12 practices are below the average length of stay target. Additional support is being provided through the GP lead and locality groups. The activity shows most targets are being met against the NHSE plan. As part of the planning requirements the CCG included additional elective required by NHSE to meet their Indicative Hospital Activity Model System (IHAMS). The QIPP plan includes a target to directly match this. Areas of concern include the growth of non-GP referrals to acute hospitals and the control of the 'first seen' records. Growth needs to be understood and how this affects the CCG. This is to be looked at by the Audit and Assurance Committee. Completed pathways is lower than the planned levels and delivery on RTT is lower that targets overall.	**TW**
FIN/16/08/07	**Update on 2016/17 contracting requirements and links to STP management capacity** SP reported in the absence of ST and MH that the NHS Financial Rest document states that contracts should be agreed by December for 2016/17. SP and MH will be reviewing the baselines.. As part of freeing up management capacity across the STP single contracts are being looked into – currently for our main three providers but suggested this should be looked at wider. A fuller update on the contracting requirements will come to the next Committee meeting.	**MH**
FIN/16/08/08	**Any Other Business** There was no further business discussed and the meeting closed at 13:25 hrs	

Dates of Finance and Performance Committee Meetings 2016/17:

13 September 2016 (11.45 – 13.15)

11 October 2016 (11.45 – 13.15)
8 November 2016 (11.45 – 13.15)
6 December 2016 (10.00 – 12.00)
10 January 2017 (11.45 – 13.15)
14 February 2017 (11.45 – 13.15)
14 March 2017 (11.45 – 13.15)
11 April 2017 (11.45 – 13.15)