NHS
Wiltshire
Clinical Commissioning Group

FINANCE COMMITTEE MEETING

Held on 9 September 2014
At Southgate house

Present:

Dr. Stephen Rowlands (SR)	Chair
Deborah Fielding (DF)	Accountable Officer
Simon Truelove (ST)	Chief Finance Officer
Steve Perkins (SP)	Deputy Chief Finance Officer
Peter Lucas (PL)	Lay Member
Christine Reid (CR)	Lay Member
Ted Wilson (TW)	Group Director NEW
Jo Cullen (JC)	Group Director WWYKD
Mark Harris (MH)	Group Director (SARUM)
Dr.Toby Davies (TD)	GP Chair SARUM Locality Group

Doreen Wiltshire (notes)

FIN/14/09/01 Welcome and Apologies

SR welcomed the members to the meeting
Apologies were received from Jacqui Chidgey-Clark

FIN/14/09/02 Declaration of Interest

There were no declarations of interest to note

FIN/14/07//03 Minutes of the last meeting

The minutes dated 08.07.14 were agreed.

FIN/14/07/04 Update on CCG Financial position including the Current Reserves position

SP presented the previously circulated paper which set out the month 4 position, providing an update on the CCG's reserves and how they will be applied to mitigate emerging pressures.

At month 4 the year end picture already shows significant financial pressure on non-elective activity and day cases, which if not addressed will create financial stress going forward. Activity performance is 4% above planned level. The CCG also continues to underperform against a number of performance access targets.

Month 4 surplus of £1.8m is in line to achieve the forecast to deliver the £5.3m year end surplus, inclusive of the £11.6m QIPP delivery and 99.99% cash reserve use.

Planned Care, Performance and expenditure:
Information is based on SUS data containing un-coded activity costings, which will change.

Planned care spells are 3.9% above 2014/15 planned levels and 1.9% above 2013/14 comparators level. (All acutes). Both Out patients and follow up appointments are above planned level.

Current areas of over performance are:
GWH - Oncology, specialities which might revert to specialist commissioning, ENT and Urology.
RUH - Haematology and Respiratory Medicine – Critical Care is disputed, and duplication of costs.
SFT - Gastroenterology, General Medicine and Ophthalmology. Some activity may move to specialist commissioning when recoded. There are a number of challenge areas in growth and activity.

Urgent Care, Performance and expenditure:
M3 non-elective activity was 11.1% above 2015/15 planned level (8.9% above 2013). .
Emergency activity is 11% above prior year comparators at the 3 main Acutes.
The average non-elective length of stay reduction of 0.3 days has helped support the increase in non-elective bed days, and the extra unplanned and non-elective demand.

The extra demand in non-elective activity presents a challenge for both commissioners and providers. What can the GPs do to break the trend increase the CCG need to reconsider where we are to deliver the service. The message has to be relayed to everybody that we are in a difficult place. If we don't deliver this year, it will compound into next year. If the CCG cannot deliver the 1% surplus we will probably be back on monthly review by the Area Team. If the CCG do not deliver QIPP this year the compound into next year, and getting back on track will be almost impossible.

Extra non elective demand presents a challenge for both commissioners and providers, both the CCG and Acutes are struggling financially.
In response to QIPP plans our main providers adjusted their non-elective capacity, but due to demand there has been a need for them to use escalation capacity, supported by costly agency staff. Some of the non-elective activity is only paid at 30% to the Acutes. Significant activity and readmissions has an impact on the whole Health Community.

If pressure is more than mitigation area, what can we do to pull back?
CR asked what can the Group Directors do?
QIPP needs to deliver, top areas of over performance need identifying and , the activity audit data needs to be understood.

Over activity under achievement initiatives need to be addressed, look at managing contracts and cost of activity rather than activity. The CCG cannot correct historical backflow, it is a struggle to change care and professional workforce overnight, but the cash base activity needs to be supressed. The CCG need to work hard on implementation working jointly with the Council. The Acutes can only reduce beds if trends change.

The 100 day challenge has numerous alternatives in place but they are not being used. TD felt that more could be done in the Care Homes, offering End of Life education, and training of dealing early with family pressures and

expectations. Communications need to relay the messages to Practices, and Care Agencies with positive marketing 'Think before you ring'.

Non-Acute Commissioned Services, Performance and Expenditure:
Two areas of adverse movement are Community Services (maternity services) and Local Enhanced Services.

Access and Performance:
A number of targets not being met, and require further investigation and challenge through the contract performance route.

NBT are being challenged on the 52 weeks wait target, this is being challenged and penalties will be administered for the failure of this target.

CCG has received charges from Property Services which are currently in dispute (a meeting is being arranged to resolve) to support cash flows within the system the CCG will be making a payment on account in respect of charges received to date.

ACTION: **The Finance Committee are asked to note the financial position at Month 4**

FIN/14/07/05 Update on Current QIPP and project delivery:

The CCG need to make sure QIPP delivers.

Support change agenda process is good but application is struggling. Actions need to be captured to measure success, used properly will help project leaders performance manage. The toolkit is there to support delivery there is expertise available to help. Some of the milestones were good but not correct at the beginning. Project plans do not take into account delays. Missed milestones need to be rescheduled, extra resources obtained. Buigger and better milestones can be built in to help with tracks, and RAG pressures can be split.

Group Directors were asked to identify the projects where delivery can be quickly driven forward. Accurate and timely information will help to recognise what is on and not on track and enable resources to be redirected as necessary. New schemes are required, and growth needs to be challenged.

The CCG are expecting to see real improvement on the investment into the Community Integrated Teams. During the first quarter of this financial year there has been a real change to manage people out of hospital.

Care Home admissions for the over 75 are down, but activity is still rising, this is a worrying trend. GWH are making a new effort with managers to keep the over 75 out of Hospital Care. 111 are working to reduce admissions to A & E but their calls are going up. The Better Care Fund should help improve DTOC, and Social Care placements, issues need to be addressed with Wiltshire Council. Issues with contractors Mears have had an impact

Planned Care is behind with delivery, there are no plans to mitigate. SFT need to be driven.

PL asked if there was enough support being provided, are there things which could be done but are not, because of lack of support.
TD mentioned the lack of Social Care, and Physiotherapy appointments (4 month wait).

FIN/14/07/06 Initial Financial view for 2015/16

In September 2013 the Governing Body adopted the CCG medium term financial plan for 2015/16. Refinements have been made using updated national planning assumptions, and this forms part of the 5 year plan agreed in January 2014 by the Governing Body.

in September 2013 which takes into account national planning requirements, changes to allocations, local issues such as specific developments and recurrent forecast outturn issues (inc, QIPP under delivery) at month 4.

The starting point for updated 2015/16 plan is to take the updated recurrent commitments/contracts and to adjust them for the recurrent impact of the forecast outturn positions at month 4.

SP presented the previously circulated paper setting out the planned 2015/16 position based on 2014/15 Month 4 forecast outturn position.
Non acute care budgets (inc. prescribing) associated with these QIPP targets are not reporting financial outturn pressures, and by implication are delivering QIPP.
Acute care budgets are reporting significant pressures, in particular related to non-elective activity, and by implication are not delivering QIPP challenges.

With reduced reserves to mitigate under delivery, increased 2015/16 QIPP programme is required to deliver financial performance. Contingent reserves held are not able to mitigate the full level of QIPP required for financial balance.

The current position is based on national assumptions is relation to inflation CRES and resource growth, which are subject to change, and if decreased will have cost pressure impact.

What more can the CCG do to get every practice engaged with the 100 day plan sign up to see it work and get delivery? GPs together, are best placed to work with the change performance, cluster localities need to engage all the GPs and encourage joint working. The Practices need to get the best out of the care co-ordinators, and manage electives by better pathway designs, use TCOP incentives.

Help and support is available for sign up in principle to use the Challenge Fund Money, either small amounts split for 1 off pilot. CCG fund match may be difficult, savings will have to match funding. TD said it will be difficult to release people to do the ground work, there is a shortage of Locums (168 vacancies).

ACTION: The Finance committee were asked to note the 2015/16 financial summary.

FIN/14/07/07 2014-15 QIPP Recovery Plan:

Everybody needs to recognise their responsibility to deliver.
Leaders need to own and use the toolkit available, if used properly it will help the project leads to support delivery. Actions need to be captured to deliver the projects, to enable success and the financial impacts to be measured.
To convey the realistic position it is important to have the milestones right, with tracker help bigger and better milestones can be built. JoC and DN are working on the Primary Care milestone which has yet to be captured. The PMO office is available with support and training if required.

ACTION: Recovery Plans to be included as a topic on the GP Away Day Agenda.
ACTION; Incremental to be included on the Recovery Plan

FIN/14/07/08 Any Other Business

The next schedule Finance meeting is not until November, ST proposed that an extra meeting he held in October for further discussion and update. Directors to invite their locality Chairs to attend.
*(post meeting note: the meeting date has been set for 14.10.14***)**

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FINANCE COMMITTEE MEETING

Held on 14 October 2014
At Southgate house

Present:

Dr. Stephen Rowlands (SR)	Chair
Deborah Fielding (DF)	Accountable Officer
Simon Truelove (ST)	Chief Finance Officer
Steve Perkins (SP)	Deputy Chief Finance Officer
Peter Lucas (PL)	Lay Member
David Noyes (DN)	Director Planning, Performance and Corporate Services
Christine Reid (CR)	Lay Member
Ted Wilson (TW)	Group Director NEW
Jo Cullen (JC)	Group Director WWYKD
Mark Harris (MH)	Group Director (SARUM)
Dr.Toby Davies (TD)	GP Chair SARUM Locality Group
S Burrell (SB)	GP Chair NEW Locality Group
Anna Collings	GP NEW Locality Group
Helen Osborn	GP chair WWYKD Locality Group

Doreen Wiltshire (notes)

FIN/10/10/01 Welcome and Apologies

SR welcomed the members to the meeting
Apologies were received from Jacqui Chidgey-Clark

FIN/10/10/02 Declaration of Interest

There were no declarations of interest to note

FIN/12/10//03 Minutes of the last meeting

The minutes dated 9 September 2014 were agreed.

FIN/10/10/04 Update on CCG Financial position including the Current Reserves position

SP presented the previously circulated paper which sets out the month 6 position. The position indicates that contingent reserves are nearly fully applied to mitigate over performance and non delivery of QIPP.

Month 6 position shows a total overspend of £10.2m a deterioration of £1.2m since month 5. Recurrent over performance will flow into the 2015/16 financial position and will result in an increased QIPP challenge above the estimated £15.8m value. Contingent reserves held are not able to mitigate the full level of QIPP that is required for financial balance.

SARUM Financial position and Action plan was circulated.
The forecast is an overspend of £2.52m (+2.5%).
Within the figure the SFT contract is showing a CCG determined forecast overspend of £2.609m. This position is reliant of actions being successful and

forecasting adjustments totalling £1.919m. There are further opportunities to mitigate this position of £685k if all actions are successful.
SFT have openly stated that they are no achieving their own Cost Improvement Programme and the CCG overspend in supporting them financially

SARUM has the lead responsibility for the planned care programme with QIPP target of £2.740m, there are plans for £1,573,337 leaving £1,166,663 unplanned. The current forecast is an achievement of £632,449, there are actions in place to make further £587.089 savings.
The question raise was what could be actioned on to take the risks away.
Growth variance against the criteria plan requires actions.
Speak with the Clinicians regarding outpatient procedures being charged as day cases, as epidural injections are still being coded as day cases.
Regular attenders and type of activity need to be investigated, together with reducing the number of follow up appointments. Deep dive is required to get to the bottom of what is really happening, sharing the information with GPs is vital.

RUH
PPA has a sizable overspend .

Prescribing has a forecast overspend, and part of the mitigation is to work with practices targeting niche areas.

GWH
GWH being a smaller contract there are so many challenge issues. The overall forecast outturn is £1.5m allowing for slippage the expectation is £1m. The Frail Elderly programme is due to commence in November.

Optimising Community Team will have 20 additional staff by January so hopefully some of the savings target should be realised in the latter part of the financial year.

A meeting has been arranged with Property Services to discuss the legal responsibilities and potential cost implications.

CHC
RUH are fast tracking patients out, but at the moment there are operational issues with one of the providers.
Legacy issues pre PCT £2m has already been allocated to the legacy pool this year, but the claims for nursing care are larger than expected, and cannot be reclaimed from NHS England. Underspend on Mental Health and Learning Disabilities are helping support CHC financially.

There is still a lot of reliance on TCOP to achieve, at the moment it is not working to full effect. Robust contract management is needed to deliver to the maximum, not leaving anything exposed.

SB pointed out that it is difficult to see detail above the bigger picture, and high cost drugs are difficult to counteract, could the information department provide more detailed information. The GP are struggling to get behind it all, could there be clarity of detail where increases and hot spots are, is it all age

related? Understanding the information presented is very time consuming for GPs. Chairs need help with identifying where to look for details, could it be presented to understand, ammunition is required to feed back at the locality meetings.

ST felt that all the information is out there in reports supplied by the Information Team.
The Practices need to manage the problem, their admissions need to be changed from unplanned to planned and patients need to be discharged quicker. RTT operational problems require the clinicians to link with the CCG.
Clinician expertise input is required to keep demand out, the Acutes are not coping.
Consultants need to justify why admission rates are up. There are more patients who are staying longer.
Resources are not able to cope with demand, to minimise risk the next round of contract negotiations need to be braced tightly. There is only one allocation of money for all the Wiltshire patients.
SFT have money from the CCG for cost improvement programme.
WCCG are penalised by Dorset and Hants stance of block contract.

FIN/10/10/05 **Recovery Plan 2015/15;**

Each of the group Directors gave an update on their recovery plans.
The frail and elderly unit is due to commence in November , this should hopefully see a reduction in admissions. Directors are looking at readmissions, service redesign pathways for opportunities to make identified savings.
There needs to be a change in culture, extras need to be curtailed and not rewarded.
Optimising Community Teams, should have 20 additional staff by January, this should achieve savings target for last half of the year.

TD said that there are things which can be done not happening fast enough. Discussions need to be harder and firmer. May be penalties are needed, reduce income for high activity. Vision needs to be shared between Acutes, to reach the point of joint ownership and responsibility.

DF said that each group should take 2 main targets in addition to the contractual and existing levels to manage 1 DGH. Provide a table of initiatives to stop activity, manage activity and finance.

Action: **The committee need to be give confidence how GWH is managing their contract, there is no ability to see that it is happening. Look at shadowing the template used by Mental Health presentation.**

ST said with only 5 months left, does the CCG think the control target can be delivered by year end.

Group directors were asked what figure they thought achievable.
TW felt that GWH could achieve half of QIPP slippage (£1m) may be more, but any spikes cannot be foreseen.

SB felt that perception does not give a view of what is going on, cannot understand admission is static but LOS is going up Information is needed for

comparison,i.e. HRG codes numbers, proper control of data to have evidence to check challenge.
There is a daily spike of patients presenting between 4pm – 7pm, who are being admitted.

Action: Information Department to look at trends, and give heads up to get slants, to understand the right messages are getting through.

Action: Physical visibility of medicines management team at practices, as there has been a shift back since the incentive scheme ceased.

PL told the emphasised the severity of the financial situation. The framework need to be scrutinised, without evidence relevant support cannot be provided. The financial situation is serious and assurances need to be addressed.

Action: GP s to be invited to attend the Finance Committee meetings.

Date of the next meeting 11.11.14