NHS
Wiltshire
Clinical Commissioning Group

NOTES OF WILTSHIRE CLINICAL COMMISSIONING GROUP
FINANCE MEETING
HELD ON 10 March 2015
THE CONFERENCE ROOM, SOUTHGATE HOUSE

Present:

Dr Steve Rowlands	SR	Chair WCCG
Deborah Fielding	DF	Accountable Office
Simon Truelove	ST	Chief Financial Officer
Steve Perkins	SP	Deputy Chief Financial Officer
Peter Lucas	PL	Lay Member (Vice Chair)
Peter Jenkins	PJ	
David Noyes	DN	Director Planning, Performance and Corporate Services
Jo Cullen	JC	Group Director WWYKD
Mark Harris	MH	Group Director SARUM
Ted Wilson	TW	Group Director NEW
Dr Toby Davies	TD	GP Chair SARUM Group

Apologies:
Christine Reid

FIN/15/03/01	**Welcome and apologies for absence** SR welcomed everybody to the meeting noting the apologies above.	**ACTION**
FIN/15/03/02	**Declarations of Interests** 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 the Wiltshire Clinical Commissioning Group (CCG). No declarations of interest were raised.	
FIN/15/03/03	**Previous Minutes of the meeting held on 13 January 2015** The minutes were agreed as an accurate record. **Action Tracker** 11.11.14/04 The 3 location configuration has been agreed, with another round of national recruitment going ahead . Recruitment issues and staff turnover has meant that some investments have been used for the provision of expensive agency staff, 6% on top of post. There is a Time line trajectory of 3 months, headway staffing for step up beds. 7 day affordability – GWH has requested £1.3m extra for ward staff, therapists etc. they are expecting 7 day working but do not envisage extra agency costs. . Workforce being a big risk to the system and has been placed on the risk register. Job satisfaction and a more effective better place to work could lure people back, but the students are taking up placements in the bigger towns. The CCG needs to gain assurance of the workforce strategy. DF said that there are many factors involved, professional and non-professional people need to be encouraged to get back into the system. People if trained are going elsewhere, are we getting the right people in the first	

	instance. **Action: Recruitment plans to be shared with ST and SP.** TCOP – The Panel are due to meet the last week in March to agree KPIs and activity, there will be no impact this ear across the board. James Drury has requested a step change in delivery from now until the end of April in Non-elective QIPP, BCP and TCOP.	
FIN/15/03/04	**Update on the Financial Recovery Plan, incorporating the month 11 financial position** ST updated the members on the Financial Recovery Plan which was agreed by the CCG in January and shred with NHSE Some of the assumptions in the plan have come to fruition SP presented the previously circulated paper which sets out the month 11 position. The reported shortfall as of M8 £1.3m has decreased to £200k. ISTC – The ISTC is a legacy contract, the change in accounting reporting, has seen little benefit to the CCG, , the utilisation by other Commissioners has increased, which means that there is nothing to offset our overperformance, currently being charged at tariff + 30%. Normal tariff charges are due to start 1.11.16 in line with the new contract which S Glos are leading on. Our RSS, level has not increased but others are utilising more. Some of the out of area placements, expected to have been brought back into County have not been achieved leading to deterioration in the variance. Review of the BCP expenditure - the current assumption of reducing the contributions by £1.5m has been reduced by £203k. There is volatility in the 3 acute providers in planned and non electives The CCG are experiencing difficulties in closing off the year end figures with the acutes reluctant to sign off end of year deals. SFT have been given backing evidence but are not prepared to move on the end of year agreement. ST has written to Malcolm Cassells and will meet with him next week to discuss the SLAM position. There are further pressures around prescribing, the flu vaccination costs were greater this year. The CCG has minimal reserves as Headroom has been utilised. QIPP needs to be delivered. There is no flexability, the CCG needs to keep more committed funds to uncommitted. The CCG are £2m shortfall of the controlled target of £5.3m, (£700k if agreement can be made with the acutes). Support is needed, including clinical. The CCG has reported to NHSE the residual risk position of £700k above the £2m currently reported. It is envisaged that the residual risk can be mitigated within the current assumptions enabling the CCG to deliver the revised surplus of £3.3m DF told the committee that a letter has been received today from NHSE reiterating the position, the essence is thinking about additional investment. PL felt that better evidence is needed regarding investment results, there being no complete system measuring the success, although he felt comfortable with investments and confident of seeing future recovery in	

	2015/15 and significant savings next year. If we run projects the investment needs to get desirable returns. Projects where investment gets the desirable return, needs to be pursued, but where does the assurance come from. This will be an item for discussion at Clinical Executive this afternoon. SARUM locality GPs have agreed to give back £225k of their SLA monies, hopefully NEW and WWYKD will consider their position to help. TCOP – Every project needs clear strands, and any not working needs to be reverted back the originals The question was raised why commit headroom to BCP and TCOP **ACTION: The Committee were asked to note the position of the current progress on the FRP and to acknowledge the residual risks in the financial position.**	
FIN/15/03/05	**2015/16 Draft Finance and Activity Plan** SP presented the budget setting out the process for 2015/16 financial year. The budgets represent the funding made available, the investment priorities and QIPP requirements as outlined in the 5 year strategic plan and recent planning submission to NHSE. Budgets have been set based upon confirmed and anticipated allocations for 2015/16 , and are consistent with previous years, allowing for national tariff adjustments. There is a degree of uncertainty surrounding the national tariff assumptions, the CCG are currently working on 2014/15 roll over. 2015/15 two options are Default Tariff Rollover where(DTR) CQUIN is lost or Enhanced Tariff Option (ETO) which would mean a greater share of marginal rate 70% cost against 30% currently. The CCG will hold back 0.5% of contingency reserve to mitigate emerging issues , but may require further actions to reallocate resilience funding. The plan is based on the ETO model. 1% surplus, 1% headroom 10% reduction in running costs 10%. Mental Health investment equivalent to growth is ring fenced. 1% potential hidden demographic pressure**.** A quarter of the QIPP savings need to be achieved in the first 3 months of the new financial year. BCF funding has been set aside for BCF in line with the required £27.1 level of funding. **Action: The finance Committee is asked to recommend the 2015/16 process and budgets to the Governing Body for adoption** Planned Care Trends still remain a financial challenge backing evidence has been sent to SFT, a few areas have been agreed but this is not reflected in SLAM. Gastro work has commenced with consultant discussions and planned care specialities, the outcomes will be shared down the line. This years round of contract negotiations need to explicit. The first instance is to get the Acutes to accept the plan, followed by the contracts to be signed in the first quarter of the year.	

	Process timeline from NHSE is from the 1-17 April mediation and negotiation, from 17April onwards arbitration. Mental Health will have no reserves as £1.6m is to ring fenced . There will be no additional spend until solutions found to some problem areas. Resilience contingency money, the message this year is to maintain reserves. The whole context is around delivery a forward view is necessary. . Non Electives – the CCG need to deliver reduction and savings, in the role as commissioner capacity need to be reduced. To invest money into Community and Primary Care activity needs to reduce. Communication to practices is important. ST asked the committee if it felt that vital messages were getting through to the practices, and offered to attend the locality meetings to reiterate the financial position and the expected support required, TD felt that direct communication would be good, highlighting that only a small reduction is required across the patch, 1 avoidable admission per practice per week would make all the difference. The best place for large group turnout to relay the information would be the locality meetings **Action: ST to give presentations at the locality meetings.**	
FIN/15/03/06	**2015/16 QIPP Plan** DN outlined to the committee the 2015/16 Delivery Plan showing an overview of QIPP schemes. Each project has been scoped and sized and QIPP savings included in the financial plans. The plan shows assessed points at which financial benefits would be delivered for each scheme. TCOP – During 2014, 13 schemes were supported and funded on an ongoing basis, subject to successful delivery of admissions avoidance. The new financial year should quickly see some benefits of investment. BCF – Key factors are avoidable admissions, and reducing the length of stay in acutes. The latter is very dependent on working closely with local authorities. Medicines Management – Reduction in overall spend, where cost effective options are available. CHC – Reduces activity through better management and inappropriateness of referrals. Elective Care – Review effectiveness of clinical procedures and consider those classed as having little or no clinical effectiveness. Non elective – Improvement of access to secondary care, and reduction in inpatient stays, and patients being seen and charged as ambulatory care. QIPP delivery is still below target, delivery is fundamental to the financial stability of the CCG. Clinicians need to be engaged with delivering programmes/projects which they have been involved in developing. Projects have been derived from clinical expertise although not every project has savings. High level scoping project achievement has set out the milestones. Any duplication of BCF and TCOP needs to be avoided **Risks –** • Provider over performance, against assumed reduction in admissions. • Mental Health pressure out of area continues, investment is in place. There is a potential £2.2m pressure if out of area placements continue. • Prescribing, potential cost pressure, especially around Primary	

	Care prescribing • Capital Grant dependent on community equipment, NHSE expect pull back. • Marginal Rate fund additional resilience Each project risk will be reported via the Integrated Performance Report and will be monitored by the PMO methodology. Project workbooks supporting the delivery of each scheme will be reviewed at the monthly review meetings. Savings need to be delivered from the word go. Milestones are dependent on risk assessments. PL asked if there could be evidence of clinical engagement and direct ownership of the schemes.	
FIN/15/03/07	**Any Other Business** **Contracts:** This new year's negotiations need to explicit. The first instance is to get the Acutes to accept the plan, followed by the contracts to be signed in the first quarter of the year. NHSE contract process timeline is from the 1-17 April mediation and negotiation, from 17April onwards arbitration. Mental Health will have no reserves as £1.6m is to ring fenced . There will be not additional spend until solutions to some problem areas Resilience contingency money, the message this year is to maintain reserves. The whole context is around delivery a forward view is necessary. Non Electives – the CCG need to deliver reduction and savings, in the role as commissioner capacity need to be reduced. To invest money into Community and Primary Care activity needs to reduce. Communication to practices is important. ST asked the committee if it felt that vital messages were getting through to the practices, and offered to attend the locality meetings to reiterate the financial position and the expected support required. TD felt that direct communication would be good, highlighting that only a small reduction is required across the patch, 1 avoidable admission per practice per week would make all the difference. The best place for turnout to relay the information would be the locality meetings **Action: ST to give presentations at the locality meetings.** ST to relay the message to the Health and Wellbeing Board , is how realistic is the BCF, the CCG are taking up the extra costs as the Council are not spending enough, and packages of care are being removed. ST said the important message to all is that the CCG are a bit off target but still in surplus not in a deficit position. **Action: Directors to invite and encourage their locality chairs to attend future Finance Committee meetings.**	