NHS
Wiltshire
Clinical Commissioning Group

MINUTES OF FINANCE AND PERFORMANCE COMMITTEE MEETING HELD ON TUESDAY, 7 JULY 2015 AT 11:45hrs AT SOUTHGATE HOUSE, DEVIZES

Present:

Peter Lucas	PL	Chair, Lay Member
Christine Reid	CR	Vice Chair, Lay Member
Dr Peter Jenkins	PJ	GP Chair, WCCG
Deborah Fielding	DF	Chief Officer
Simon Truelove	STr	Chief Financial Officer
David Noyes	DJN	Director of Planning, Performance and Corporate Services
Steve Perkins	SP	Deputy Chief Financial Officer
John Dudgeon	JD	Head of Information
Dr Richard Sandford-Hill	RS-H	GP Chair, WWYKD
Jo Cullen	JCu	Group Director, WWYKD
Dr Simon Burrell	SB	GP Chair, NEW
Ted Wilson	TW	Group Director, NEW
Dr Naz Kamal	NK	GP, Sarum
Mark Harris	MH	Group Director, Sarum
James Roach	JR	Interim Integration Director
Dr Mark Smithies	MS	Secondary Care Doctor
Rob Hayday	RH	Associate Director, Performance and Planning and Head of PMO
Diana Hargreaves *(minutes)*	DJH	Board Administrator

Apologies:

Dr Toby Davies	TD	GP Chair, Sarum

Item Number	Item	Action
FIN/15/07/01	**Welcome and apologies for absence** PL welcomed everybody to the meeting.	
FIN/15/07/02	**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/15/07/03	**Previous Minutes** Finance and Performance meeting held 9 June 2015. **The minutes were agreed as an accurate record.** **Matters Arising** None. **Actions** **FIN/15/06/04** - SP - On the agenda. **COMPLETE**. **FIN/15/06/04** - JD - On the agenda. **COMPLETE**. **FIN/15/06/05** - RH - Included in the report. **COMPLETE**. **FIN/15/06/05** - DF/JCu - Conversation took place. Work in progress as greater understanding of the data coming through. Keep as a live item. **FIN/15/06/05** - RH - Included in the report. **COMPLETE**. **FIN/15/06/05** - RH - Included in the report. **COMPLETE**. **FIN/15/06/05** - RH - Included in the report. **COMPLETE**.	**DF/JCu**
FIN/15/07/04	**M2 Finance Reporting Pack** SP took the Members through the report stating that, at the end of month 2, the CCG is currently forecasting delivery of its 1% surplus. The table at 3.1a) GWH shows that elective inpatients and elective day cases are a significant risk. MH said that GWH have a sizeable backlog and waiting list and they are not targeting the correct part of the waiting list: they are overspending on the wrong type of activity. The CCG is in discussion with GWH on this issue. One of the overspend elements in the GWH position related to maternity pathway payments. SP explained that this is being reviewed further due to the impact of the maternity pathway charging by GWH and any associated pre-payment. It was reported at 3.1b) that Circle were carrying out inpatient day case activity faster than outpatient activity. The provider has grown year on year and taken up the market share from other providers. Circle are running their waiting list faster than we would like them to in the contract. However, recent discussion with Circle suggests that they are approaching maximum capacity and their waiting times are now increasing: therefore further acceleration of volumes is not expected. STr asked whether the finance managers were visiting individual practices, so that practices were aware of the financial position. MH replied saying that, in Sarum, practices were aware as monthly information packs were send out to them. STr reiterated the need for the finance managers to visit individual practices. NK reported that the Sarum city practices were doing well with the reduction of non-elective activity and it was important to understand the reasons for this, to share with less successful practices. PJ had visited one of the Sarum practices that had asked for help with their non-elective activity and the clinician to clinician discussion had proved valuable. SP reported that SFT had no waiting list problems and the movement in the overspend was positive. However, referrals were up by 6.5% and	

	there was growth in consultant referrals across specialities. The CCG is challenging this through the performance meetings. *TW joined the meeting at 12:17hrs.* Members discussed the progress that GPs have made with distinguishing between necessary and unnecessary referrals: an example of this is that activity at the Salisbury walk-in centre is down by 7% this year. The federations had been formed to improve the quality of primary care and to support exemplar management techniques, so the CCG should be having the discussions with the federations in order to standardise best practice across the system. Members agreed that this would be a good idea in 6-9 months' time, but to start at practice level for now. It was decided to draft a structure to support these discussions and this would be an agenda item for the next Clinical Executive meeting - Explanation of Variation and Support for Practice Visits. *NK left the meeting at 12:37hrs.* STr informed Members that NHSE are pleased with what the CCG is achieving but they are not seeing the return on investment, which is the big challenge. Contracts have not yet been signed and so there is the opportunity to build activity into the contracts with a financial cap, although it was agreed that this would not be accepted by the providers. It would be important to look at all the pathways and be explicit with providers about what we require from them, including controlling the flow of the acutes' elective activity. The Exec team would work on an internal recovery plan, to be brought back to next month's meeting, to demonstrate that the trends are going in the right direction. *SB joined the meeting at 12:40hrs.*	**DJH** **Exec team**
FIN/15/07/05	**M3 Financial Position Update** SP informed Members that the position was currently being worked through and there was no update at this time.	
FIN/15/07/06	**Status on CCG Projects and QIPP Delivery Plan 2015** DJN introduced the paper describing the status of the projects supporting the delivery of QIPP in 2015/16. Month 1 data shows that there are shortfalls in the delivery of financial savings associated with QIPP and urgent remedial action is required to correct this position. In the Summary Level QIPP Performance – Month 1 the Effective Planned Care YTD savings figure should read £30k and not c£90k. DF raised a concern about the PMO RAG status report which showed some workstreams as red but with a high percentage attributed to them. RH explained that the percentage was the Directors' confidence of delivery. The next report will have the column separated out with specific text in the headers, for greater clarity. Members agreed that when a project was red-ragged, the project's owner needed to explain the reasons to this Committee, who would then support. Any workstream that was not on course to deliver QIPP by the end of the year should be reported to this Committee.	**Project Directors**

FIN/15/07/07	**Status on the Delivery of the Constitutional Targets and key activity and access indicators** JD introduced the paper updating the Committee on the current performance at April 2015 on delivery of constitutional targets set by NHSE. The key issues for the CCG are waiting times and waiting list size, activity levels in March, referrals and ambulance response times.	
FIN/15/07/08	**Better Care Fund Update** JR introduced the paper updating Members on the current Better Care Plan 2015/16 position, adding that he would be attending this meeting each month to continue the updates. JR explained that P4P was an acronym for Pay-for-performance, an umbrella term for initiatives aimed at improving the quality, efficiency, and overall value of health care. These arrangements provide financial incentives to hospitals, physicians, and other healthcare providers to carry out such improvements and achieve optimal outcomes for patients. JR continued saying that the P4P indicator, reduction in G&A non-elective admissions, had been rebased to actual 2014 admissions, which took the reduction in admissions from the originally submitted 978 to 1,048. Members requested that future reports included an evaluation of the effectiveness of the existing schemes.	**JR**
FIN/15/07/09	**Any Other Business** There was no further business discussed and the meeting closed at 13:47hrs.	

ITEMS FOR INFORMATION - The following papers are for information only and will not be discussed at the meeting. Printed copies can be made available to members. Should you have any questions regarding any of the papers, please contact the author.

Date of next Finance and Performance Committee Meeting: 11 August 2015 at 11:45hrs

NHS
Wiltshire
Clinical Commissioning Group

FINAL MINUTES OF FINANCE AND PERFORMANCE COMMITTEE MEETING HELD ON TUESDAY, 11 AUGUST 2015 AT 11:45hrs AT SOUTHGATE HOUSE, DEVIZES

Present:

Peter Lucas	PL	Chair, Lay Member
Christine Reid	CR	Vice Chair, Lay Member
Dr Peter Jenkins	PJ	GP Chair, WCCG
Deborah Fielding	DF	Chief Officer
Simon Truelove	STr	Chief Financial Officer
John Dudgeon	JD	Head of Information
Dr Richard Sandford-Hill	RS-H	GP Chair, WWYKD
Jo Cullen	JCu	Group Director, WWYKD
Dr Simon Burrell	SB	GP Chair, NEW
Mark Harris	MH	Group Director, Sarum
James Slater	JS	Associate Director, Commissioning
Diana Hargreaves *(minutes)*	DJH	Board Administrator

Apologies:

Dr Toby Davies	TD	GP Chair, Sarum
Steve Perkins	SP	Deputy Chief Financial Officer
David Noyes	DJN	Director of Planning, Performance and Corporate Services
James Roach	JR	Interim Integration Director
Dr Mark Smithies	MS	Secondary Care Doctor
Ted Wilson	TW	Group Director, NEW
Rob Hayday	RH	Associate Director, Performance and Planning and Head of PMO

Item Number	Item	Action
FIN/15/08/01	**Welcome and apologies for absence** PL welcomed everybody to the meeting, noting the apologies above.	
FIN/15/08/02	**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/15/08/03	**Previous Minutes** Finance and Performance meeting held 7 July 2015. **The minutes were agreed as an accurate record and there were no Matters Arising.** **Actions** **FIN/15/06/05 – COMPLETE.** **FIN/15/07/04 – BOTH COMPLETE.** **FIN/15/07/06 – COMPLETE.** **FIN/15/07/08** – Carry forward to the next meeting.	
FIN/15/08/04	**M3 Finance Reporting Pack** STr introduced the report, advising Members that the CCG continued to forecast the delivery of the control total of £5.5m as at the end of month 3: however, this position was only being sustained by the use of contingency, headroom and slippage on investments, to offset overspends in acute care and prescribing. STr advised that the CCG was experiencing significant pressure on acute care, which was forecast to overspend by £4.45m by the end of the financial year, based on month 2 activity levels. This was as a result of elective and non-elective activity exceeding the 2015/16 plan. The pressure on elective activity was as a result of additional RTT activity, with electives being 4.3% over plan at month 2. Non-electives were exceeding last year's activity by 1.5%. The non-elective activity plan was even worse as the plan was anticipating non-elective to reduce activity by 4% on last year, as per the QIPP plan. STr also presented the current financial risks that had not been accounted for in the forecast outturn. This included gross risks of £9.9m, which after operational actions, would be mitigated to £2.5m. STr continued by saying that the CCG only had £1.0m of financial reserves in which to mitigate the residual risks, leaving the CCG exposed to potential risk of £1.43m, which would still need to be managed, to deliver the CCG control total if it came to fruition. STr reiterated that, if there was no improvement on the trajectories for the elective and non-elective QIPP plans, the delivery of the CCG control total would not be delivered, as there were not sufficient reserves to mitigate the overspend. STr stressed that it was essential that the QIPP targets were delivered, in order to deliver the control total and a return on the significant investment that had been made on the TCOP and BCF schemes: otherwise failure to deliver the control total would trigger the need to deliver a financial recovery plan, as well as managerial intervention from NHSE. Debate then ensued between the Members, with the clinical leaders stressing the need for the CCG management to be patient, as it was felt that the TCOP and BCF plans would start to deliver, albeit in a longer timeframe than this financial year. Further debate occurred on the elective pressures. SB described how NEW Group had convened separate meetings with GWH and BMI to explore the possibility of fixing the rate of interventions based on public health data: the organisations were keen on the idea of working to specific numbers. It was suggested that the same approach could be beneficial with Circle and other independent providers. Again, STr	

questioned whether there could be any impact in-year. The clinicians, however, felt it would potentially be longer than this financial year.

CR asked whether the waiting list position was anomalous. MH replied that there was a benchmark of how much activity should be carried as backlog without affecting the ability as a Trust to deliver, but that GWH in particular had a backlog far in excess of this position, which was a rump of additional activity they were seeking to be funded for, over and above the contract level. There was a lack of confidence in some of the processes and information at GWH which were being tackled through a number of focused groups. This issue also affected RUH, but to a much lesser extent, and was not an issue at SFT.

STr said that it would take much longer than 6 months to see an effect on elective care plans, as all of the local acute hospitals had significant waiting lists, or as STr described them 'Order Books', which would need to be reduced before seeing any impact from pathway redesign. The clinicians felt that, for some specialties, there was a need to generate primary care clinics, manned by consultants wanting to see a reduced surgical intervention. GPs would refer patients with specific conditions to these clinics in order to ensure that all appropriate clinical options had been sought before sending on to an acute hospital for surgical intervention. Again, STr asked whether these clinics could be set up this year to support the in-year financial position: it was felt that it was too early to tell whether anything could be set up this year.

DF said that announcements from Monitor were undermining the position of the CCG by requesting that all Trusts resubmit their financial plans in order to deliver a balanced plan. This had come about from the national position on provider finances, which was forecasting a potential £2 billion deficit for 2015/16. This would mean that Trusts would be expecting to receive more income from the CCGs by undertaking more operations, resulting in over-performance on their contracts. Given that the CCG had cost-per-case contracts with most of its local providers, the risk for further overspend in the CCG would be increased. The clinicians felt that the only way to mitigate this risk was to cap the income for providers or restrict the number of operations for particular specialties. STr advised that it would be very difficult to get the providers to sign up to some form of block contract or cap, when the CCG to date had not managed to reduce demand. MH was congratulated for doing an excellent job.

Members commented:

- Picking up on SB's experience with the provider meetings, clinician to clinician discussion was the way forward
- Difficult to manage the referrals with multiple providers
- Ensure that contract challenges stick to discourage providers from populating data with patients' multiple episodes
- Ensure that there is an appropriate charge for provision
- Concern about the accuracy of the activity coming out of the providers, further exacerbated by GWH's Head of Information Services having left and SFT losing their Deputy Head of Information Services

CR asked how much money was outstanding from challenges made to providers. MH reported that the CSU had, on the CCG's behalf, challenged £753K for Months 1 and 2. So far providers had accepted £142K. A challenge tracker was in place and once providers had responded, the CSU reported back what was accepted, agreed as no

	longer a challenge or still in dispute, to be escalated. The key areas of challenges ongoing related to : • Patient misallocated (where providers argued that their data was more accurate) • Interventions not normally funded (where providers did not follow the Clinical Policies or challenge their application in relation to NICE guidance). MH commented that, although the strike rate for INNF was not high, this was in the context of much less activity happening and so the QIPP scheme was over-delivering against its target. PL reiterated the need for greater traction on the QIPP schemes in order to support the delivery of the CCG's control total. Members agreed to focus their attention on delivery, conscious of the challenges they faced.	
FIN/15/08/05	**M4 Financial Position Update** STr updated Members on early indications on the month 4 financial position, stating that, although the CCG was still forecasting the delivery of the 1% surplus against its available resources, further pressure on acute care would mean a deterioration in the forecast by £1.3m. Additional pressures on the integrated equipment budget (£120k), funded nursing care (£200k), Circle Health (£260k) had been reported and could only be mitigated by assuming slippage on the mental health investments of £900k and releasing all of the residual reserves. This would mean that the residual risks of £1.4m would have to covered from mitigating actions, instead of being offset by reserves, which would increase the likelihood of not delivering the control total given the poor delivery of QIPP targets in 2015/16. Members discussed the worrying trend with Circle's year on year increase in market share, leading to a significant overspend forecast. There was also a concern about quality at Circle, of which DMcA was aware, and the CCG had planned to visit the provider in the near future. The Committee discussed: • the CCG's lack of control over the independent providers' waiting lists and the speed at which money was spent • 30% of first outpatient visits were not GP-referred and, once a patient was in the acute provider, the CCG again had no control Following the discussion at the last Governing Body Seminar about new models of care for Planned Care, MH would bring a fleshed-out action report to Clinical Executive to put into the CCG commissioning intentions. • SB said that practices who were outliers for particular activity areas were willing to engage with the CCG and there had been discussion in Clinical Executive about the variation in quality in primary care. DF asked who was progressing the actions that had come out of this discussion. To discuss outside this meeting. PL restated the need for increased delivery of the QIPP schemes, asking colleagues to consider what further actions could be taken going	**MH** **Group Directors**

	forward.	
FIN/15/08/06	**Status on CCG Projects and QIPP Delivery Plan 2015** STr introduced the report and asked each of the Groups to talk through progress with the workstreams on the project spreadsheet. JCu said that the TCOP panel had met on 28 July and the returns from the 19 TCOP schemes varied in the range of information included. There were some concerns about return on investment in 4/5 areas. SB commented on the change from a reactive to a proactive approach to the workstreams, which would take some time to embed. Shortfalls in delivery, where a scheme was not working, were being flagged up to the project managers, which was very encouraging. DF was concerned that the BCF had nothing registered against savings and there was little focus in the schemes around reducing non-elective activity. The BCF was due to finish in March 2016 but STr believed that it would continue in some form. MH went through the project spreadsheet, informing Members of progress against the workstreams, adding that all three acute providers had now signed their contracts. **Better Care Plan Update** JRo had submitted a BCP Update which the Committee were unable to discuss, as JRo did not attend the meeting. STtr will feed back any comments to JRo at the next monthly internal review meeting: • To pass on Members' concerns about JRo's 85% confidence level of delivering on the BCF workstreams in the QIPP table, against a RAG status of red	
FIN/15/08/07	**Status on the Delivery of the Constitutional Targets and key activity and access indicators** JD introduced the report, detailing the current status of delivery against the constitutional targets and pointing out the key issues: • Waiting times • Waiting list size • Activity levels in June • Referrals • Ambulance response times JD reported that, although ambulatory activity was up slightly, it was not as much as other CCGs, apart from Swindon. There was a workshop being held tomorrow with colleagues from the 111, OOH and ambulance services, where the impact of staffing issues on services would be discussed.	
FIN/15/08/08	**Any Other Business** There was no further business discussed and the meeting closed at 13:39hrs	

ITEMS FOR INFORMATION - The following papers are for information only and will not be discussed at the meeting. Printed copies can be made available to members. Should you have any questions regarding any of the papers, please contact the author.

Date of next Finance and Performance Committee Meeting: 8 September 2015 at 11:45hrs