*Oxfordshire*
*Clinical Commissioning Group*

**Oxfordshire Clinical Commissioning Group**
**Board Meeting**

| **Date of Meeting: 26 May 2016** | **Paper No: 16/44b** |
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| **Title of Presentation:** Finance Committee, 1 March 2016. |
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| **Is this paper for** (delete as appropriate) | **Discussion** | | **Decision** | | **Information** | ✓ |
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**Purpose and Executive Summary (if paper longer than 3 pages):**

The meeting had been called to gain assurance on the ongoing development and deliverability of the CCG financial plan for 2016/17. The Director of Finance presented a detailed draft financial plan and the key messages at this stage of the contract round were as follows:

- Oxford University Hospitals Trust (OUHFT) – The revised baseline was £303m after adjustments for specialised commissioning, high cost drugs and devices, and activity over-performance, giving a cost pressure of c£7m moving into 2016/17. OUHFT first draft proposal was £320m and OCCG's draft offer based on the affordable envelope was £310m, taking into account £11m of savings.
- OCCG has assumed a 1.9% increase in activity in its modelling but national planning assumptions were higher.
- CQUIN would again be payable to OUHFT in 2016/17 but could be linked to the transformation initiative.
- Activity with London providers had increased 10%.
- SCAS had submitted an unaffordable proposal with a c£1.7m pressure for OCCG.
- £3.4m has been set aside for Prime Minister's Challenge Fund.
- OCCG had allocated £9.35m as the Better Care Fund contribution and if extra funding were required, this would have to come from existing budgets and not be new spend.
- The mental health outcome based contract was a 5 year, flat cash contract but there had been an increase in-year of £1.4m due to national allocations, some of which had now been made recurrent in the funding for 2016/17.
- The funding of community services cost pressures as a result of demographic growth was discretionary. OHFT had flagged a £2m cost pressure ahead of contract negotiations.
- Provision had been made for development costs at Townlands Hospital, £1.7m, of which £0.6m was included for dual running costs of the new services.
- Reserves were £16.8m, meeting national business rules and including a £7m transformation fund.

The Committee agreed that the solution to the cost pressures on OCCG's commissioning budget lied in system-wide transformation, as the biggest driver of cost was activity and that GP federations would need to support primary care, which would have to be sustainable before taking on activity from secondary care.

The Committee wanted to understand the reason for the increase in elective waiting lists and cost pressure. The Committee explored the 2015/16 over-performance in Orthopaedic elective activity across the NHS and independent providers and the opportunity for greater management of demand and waiting lists as a system.

Next steps would be to discuss the financial plan at the next Board workshop, looking at other pressures outside the plan and demand management of secondary care referrals in primary care.

**Financial Implications of Paper:** The financial implications are set out above.

**Action Required:**
There are no actions for the Board arising from this meeting. Board members have been invited to attend the Management Team meeting on 22nd March to participate in a discussion on the 2016/17 financial plan.

The detailed work of the Finance Committee provides further assurance to the Board that OCCG is managing its finances effectively and in accordance with the financial plans and budgets approved by this Board.

Board members are asked to consider if they are receiving sufficient information in the Board's finance report and through the minutes of Committee meetings, to assure themselves in relation to OCCG's financial performance.

| **NHS Outcomes Framework Domains Supported** (please delete tick as appropriate) | |
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| | Preventing People from Dying Prematurely |
| | Enhancing Quality of Life for People with Long Term Conditions |
| | Helping People to Recover from Episodes of Ill Health or Following Injury |
| | Ensuring that People have a Positive Experience of Care |
| | Treating and Caring for People in a Safe Environment and Protecting them from Avoidable harm |

| **Equality Analysis completed** (please delete tick and attach as appropriate) | Yes | No | Not applicable ✓ |
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| **Outcome of Equality Analysis** | | | |

| **Author:** Duncan Smith, Lay Member and Chair of the Finance Committee. | **Clinical Lead:** Joe McManners, Clinical Chair. |
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**MINUTES:**

**Finance & Investment Committee**

**01 March 2016, 12.00 – 14.00**

**Conference Room B, Jubilee House**

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| **Present:** | Julie Anderson (JA), Clinical Director, South West locality | Gareth Kenworthy (GK), Director of Finance |
| | Mike Delaney (MD), Lay Member | Paul Park (PP), Deputy Clinical Chair |
| | Roger Dickinson (RD), Lay Vice Chair | David Smith (DS), Chief Executive |
| | Diane Hedges (DH), Director of Delivery and Localities | Duncan Smith (EDS), Lay Member for Finance – Chair |
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| **In attendance:** | Ros Kenrick (RK) – Minutes Secretary | |
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| **Apologies** | | |
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| | | **Action** |
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| 1. | **Declarations of Interest**<br>There were no new declarations of interest. | |
| 2. | The Chair had called the meeting to gain assurance on the ongoing development and deliverability of the CCG financial plan following the Board workshop in January. This would be in preparation for the next workshop in March. As part of this, focus would need to be on any gaps in the savings plans which would need to be addressed and the progress on reaching contract agreements with providers.<br><br>Papers relating to the agenda items had been circulated prior to the meeting, but it was decided instead to concentrate on the draft, detailed financial plan that was presented by the Director of Finance.<br><br>• Oxford University Hospitals Trust (OUHFT)<br><br>Contract Value for 2015/16 was £292m – there had been amendments in-year for specialised commissioning and adjustments reflecting over performance (high cost drugs and devices and activity overperformance). The baseline was now modelled at £303m, a cost pressure of £7m moving into 16/17. 2016/17 tariff impact showed the move from DTR (14/15 prices) to 16/17 prices in one step. The net change was minor, but still a pressure. | |

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| | OCCG had assumed a 1.9% increase in activity, but national planning assumptions were higher. In addition, OUHFT's figures reconciled with neither.<br>2016/17: OUHFT first draft proposal (from the national contract tracker) was for £320m. OCCG's draft offer based on the affordable envelope was £310m taking into account £11m QIPP savings. Under the national payment framework, OUHFT had to deliver £19m efficiency savings, half of which should have been delivered in 15/16 in preparation of the unwinding of the DTR tariff.<br><br>In discussion on whether the CCG was planning to contract for an appropriate level of acute activity, the question was asked "Had there been an increase in elective care waiting lists?"<br>**Action 16.25: Director of Delivery and Localities to investigate**<br>CQUIN: A key impact of the move away from the DTR tariff was that CQUIN would now become payable. The CCG was not in a position to retain an OUH CQUIN reserve to meet this cost due to affordability; all available resources were committed to the contract to fund activity. The £7m could be linked to the transformation initiative as part of contract negotiations to mitigate the impact of it becoming payable. The local 2 per cent of CQUIN might be deemed to be discretionary, but this would be an extremely contentious approach even if allowed by guidance. In the OHFT block contract, CQUIN had been guaranteed as a condition of agreement.<br><br>Orthopaedics: OUHFT had under-performed and Ramsay Independent Treatment Centre (ISTC) and the Manor over-performed. Overall activity on orthopaedics had not gone up, but had been redistributed. Committee members wondered whether OUHFT could sub-contract with the other providers under a risk share agreement. This might have implications for patient choice.<br><br>Other lines of the Financial Plan were reviewed as follows:<br><br>• London providers had a 10 per cent increase this year. There were no identifiable trends. The figures move from year to year.<br>• SCAS had submitted an unaffordable proposal again. The risk to the CCG was c£1.7m. Commissioners were likely to seek mediation/arbitration to resolve this.<br>• Primary care block net figure was £3.2m.<br>• PMCF has been provided for at £3.4m. Federations were beginning to test this figure by pushing for £5m.<br>• Out of Hours: overspend was due to the 111 re-procurement costs. The Committee was not confident in the figure.<br>• Continuing Healthcare would always present a risk to the plan, being volume-based cost. OCCG had allocated the baseline £9.35m to OCC to continue next year as the BCF contribution. If extra funding were required, this would have to come from existing budgets and not be new spend. It was felt that OCCG | **DH** |

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| | did not receive much assurance on the value for money of this transfer, but there would be a high risk to withdrawing the funding because that would leave adult social care with an extra £9.35m pressure. OCCG would need to be assured, given the difficulties of last year. OCC had taken £5m from next year's nursing and care home budget, but had added less than £5m to the home care budget. Could OCCG commission these services directly?<br>• The contribution to the CHC national risk pool was forecast to reduce by £2.4m and this benefit has been reflected in the plan.<br>• MH OBC was a 5 plus 2 year flat cash contract. There had been an increase in mental health spend of £1.4m due to national allocations in-year, some of which had now been made recurrent in the funding for 16/17. The Committee noted that the same rigour as used in other contracts needed to be applied to mental health contracts.<br>• Community Health: extra costs around demographic growth were discretionary because of the block contract. OHFT had flagged a £2m cost pressure ahead of contract negotiations.<br>• DToC money was non-recurrent, but there could be a legacy cost that would not have been considered in the budget.<br>• GPIT was now a core allocation of £1.8m.<br>• Townlands costs planned for were £1.7m. £600k was included for dual running costs of the services.<br>• Running Costs Budget – the population increase in Oxfordshire had resulted in a £860k increase to the allocation. This would be held as a reserve.<br>• Reserves were £16.8m non-recurrent of which 1 per cent was held and £7m ring fenced for transformation. NHSE required a 2 per cent risk reserve, 1 per cent of which could be used for bail outs of failing trusts across OCCG's planning footprint. The footprint was currently seen as covering Berkshire, Buckinghamshire and Oxfordshire.<br>Lay Vice Chair reported that the national audit committee chairs' meeting had discussed footprints and how CCGs were unhappy with these. NHSE would take this back to consider.<br>£7m of the reserve was as yet not committed.<br><br>• The solution to the cost pressures on the CCG and the Trusts would lie in system-wide transformation. The biggest driver was activity. How could demand be limited?<br>• Federations would need to support primary care which would have to be sustainable before taking on secondary care work.<br>• Should the PMCF money be spent in different ways? What should be prioritised and where should OCCG invest?<br>• OCCG was in the first wave of the RightCare initiative. Discussions revolved around spend versus outcomes. Was this compatible with the other areas of work in the Transformation | |

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| | Board?<br><br>• Next steps would be to discuss at the next Board workshop, looking at other pressures outside the plan; holding a high level discussion on how primary care could avoid making acute referrals and how this could be funded; looking at the implications of all discussed here.<br>• The CCG Executive meeting on 22 March would also discuss these issues and Board members would be invited. | |
| 3. | **Date of Next Meeting**<br>The next meeting was scheduled for 24 March 2016, 09:00 -11:30, Conference Room B, Jubilee House | |