Finance and Performance Committee Meeting

Tuesday 23rd January 2018, 1.30 – 5.30 pm
St Paul's Church, Hammersmith, London W6 9PJ

Present

Name	Role and Organisation	Initials
Governing Body		
Nick Martin	Lay Member, Hammersmith and Fulham Governing Body (Chair)	NM
James Cavanagh	GP and Vice Chair, Hammersmith and Fulham Governing Body	JCa
Janet Cree	Managing Director, H&F Clinical Commissioning Group	JC
Tony Willis	GP and Governing Body member	TW
Andy Petros	Secondary Care Consultant	AP
Paul Skinner	GP and Governing Body member	PS
Neil Ferrelly	Chief Financial Officer, NWL CCGs	NF
Vanessa Andreae	Vice Chair and Practice Nurse, H&F Clinical Commissioning Group	VA

Name	Role and Organisation	Initials
Officers in attendance:		
Shelley Martin	Head of Finance, Hammersmith and Fulham CCG	SM
Sharon Robson	Associate Director, Acute Finance, H&F Clinical Commissioning Group	SR
Sue Roostan	Deputy Managing Director, H&F Clinical Commissioning Group	SRo
Toby Hyde	Associate Director, Strategy & Primary Care Hammersmith & Fulham CCG	TH
Carol Lambe	Head of Commissioning and Delivery, &F Clinical Commissioning Group	CL
Helen Lipinski	Project Manager, Commissioning and Delivery, &F Clinical Commissioning Group	HL
Davey Thomason	Associate Director – 3 Borough Better Care Fund Lead	DT
Margaret Kelly	Business Support Manager, H&F Clinical Commissioning Group (minutes)	MK

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1.	**Apologies**	
1.1	Apologies were received from Lewis Butler, Deputy Chief Finance Officer Strategy and Planning.	
2.	**Minutes of the Previous Meeting**	
2.1	The minutes of the previous meeting were approved as an accurate record of the meeting.	
3.	**Conflict of Interest**	
3.1	The previously acknowledged potential conflicts of GPs as commissioners and providers were noted.	
4.	**Matters Arising/Action Log**	
4.1	The outstanding actions were reviewed and discussed.	

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	Please refer to the actions table for updates. NM commented on the number of papers being presented to the committee for discussion and the detail of some reports and lack of an executive summary. NM said it would be helpful for all future reports to include on the cover sheet an executive summary of the key points of the paper and the decisions being asked of the committee.	
5.	**Corporate Risks Register (CRR) – Financial Risks**	
5.1	JC advised that Mark Jarvis, Head of Governance and Engagement, planned to undertake further review of the Corporate Risk Register (CRR) with more detailed assurance around updating the register and on risk management prior to further review and scrutiny by the Senior Management Team, to ensure the CCG risk management process was robust. Following this review process, an updated CRR would be provided to the committee. The committee **noted** the CCGs local Corporate Risk Register (CRR) and agreed to await the further work with presentation to the next committee	**MJ**
6.	**Month 9 Finance Report – 2017/18**	
6.1	SM introduced the report and explained that there were changes to the forecast outturn and underlying position. SM reminded members that at the last Governing Body meeting Philip Young, Lay member, asked what assurance the CCG had based on M9 data that the control total would be achieved in year. SM said at month 9 the CCG continues to report on plan, both year to date and forecast outturn, however, this relies on a significant level of non-recurrent underspends, including the release of £7.7m balance sheet gains. SM stated that in M9, the acute position had worsened overall by a total of £0.92m across all contracts, in particular for Imperial, Chelsea and Westminster (C&W), London North West Healthcare and Royal Brompton and Harefield Trusts. SM said that Continuing Healthcare (CHC) had deteriorated due to additional placements and showed a forecast worsening position of £0.2m. SM noted that the prescribing forecast has improved by £0.3m based on the data to October, although it still shows an overspend of approximately £1.12m. SM added that following an analysis of the impact of Generic Medicine Shortages and the price concessions and NCSO cost pressures, it showed in the position the year to date (YTD) impact was £0.78m, with a further worsening of £0.3m included as a risk. SM added that the data on prescribing pressures was being monitored closely by NHS England (NHSE), with a number of national returns being completed; however, there was no indication to date that additional funding would be received, but the CCG would continue to monitor the impact. SM advised the committee of movements in the forecast across programme areas and an overall significant deterioration, which has resulted in further balance sheet mitigations being required this month, increasing these from £6.7m to £7.7m. SM emphasised that this fully utilises the forecast available mitigations from the balance sheet, therefore no further deterioration in the forecast could be absorbed in this way. SM said that the risks and opportunities at month 9, showed a net risk of £0.56m, which showed a small improvement from M8. SM emphasised that maintaining this position had been enabled by the availability of support of £1.5m from within the Collaborative, made available by West London CCG to support H&F and CL CCGs. SM highlighted that the balance sheet mitigations had been brought into the position this month; however, between M10-M12 there would be limited or no balance sheet mitigations left to support the position.	

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	NM asked if there was a need for the CCG to utilise the collaborative support of £1.5M and whether this was certain to be available. SM said that H&F and CL CCGs were assured that the money would be available if required. JC emphasised that the support was available but was conditional on WLCCG achieving their control total. NF said it assumes that WLCCG would hit their control total. SM advised that previously H&F had achieved the control total without the use of collaborative support. She said that based on best estimates, a total of £3M would be available to support H&F and CL CCGs. JC confirmed that at the members' meeting GPs were informed of the significant changes in M9, and the severity of the internal position, with the CCG reliant on the collaborative to support the position. SM stated that at M9 the CCG was forecasting an underlying deficit of £4.16m, a worsening of £0.28m from month 8, due to changes in the forecast outturn. SM added that the full impact of the deteriorating position was not reflected in the underlying position, as it was partially offset by the full year effect and benefits from the CLCH transformation programme that was finalised last month and now included in the position. SM said that the risks associated with GP at Hand and C&W were estimates, which made it difficult to forecast the year-end position. SM noted that the GP at Hand acute risks had increased based on increases in list sizes reported in December 17. JC stated that the QIPP Delivery Group (QDG) had discussed the position and the need to keep highlighting it, both in debate with the Governing Body and through engagement with patient groups and Healthwatch. JC added that this follows on from earlier discussion and the agreement to use the CCGs comms and engagement plan to disseminate key messages early and to include this as part of future Joint Committee discussions going forward. The committee: • **Noted and discussed** the month 9 finance report.	
7.	**18/19 planning update**	
7.1	SM presented the report. SM said the previous report in November was based on M7; but this report sets out how the underlying position had moved based on the M9 forecast outturn and includes updates on the planning assumptions, the draft 18/19 plan and the implications of the QIPP target. SM stated that in terms of key messages, the M9 starting forecast showed a deficit of over £4m. Based on existing NHSE business rules, the CCG would be required to deliver an in-year break-even position in 2018/19. However, CCGs were awaiting the latest business rules and confirmation whether there might be some sector flexibility to adjust this target for individual CCGs, within the wider control total for NW London. NF said that some mitigations might become available, in the region of £0.5M, as system resilience may not be required, also due to prescribing changes. SM said that the CCG previously used the 17/18 plan for the tariff uplift. The central contracts team had provided an estimate of the uplift required for each NWL CCG, and for H&F this was a net 0.32%. However, more detailed work had been carried out to include the CNST premium in the uplift, which resulted in the estimate increasing to 0.82% for the acute providers and 0.63% for non-acute providers. SM highlighted this	

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	increased the cost modelled for contracts and added a further £1.09m to the planned expenditure for 18/19 and was included in the planning model. TW stated that the real demographic growth was greater and increasing, with 15% of acute costs associated with diabetes and a £10m cost pressure for London due to diabetes prevalence. TW said that the aim was to have this factored into QIPP. SM said that the CCG were using population estimates and a two-year plan but that the figures had not been refreshed. NF noted that the allocations were fixed for the next two years. SM stated that for the acute contracts it compares the M9 planning model; the forecast outturn and what it modelled as the costs of the acute contracts, and the baseline for the 18/19 process. SM said that for stage 1 the contract leads produced the 18/19 contract baselines, which represents the recurrent 17/18 outturn in 18/19 prices pre QIPP but includes 18/19 tariff changes and metric changes. SM noted that for stage 2 it includes activity growth and QIPP assumptions, to form the CCG contract offer. SM highlighted that the CCG planning model showed that the acute contract budgets were £0.47m below the baseline and indicated a significant difference to Imperial, £1.8m, whilst all other contracts were within budget. SM emphasised that the position does not adjust for this, and therefore this was an additional risk. SR explained that the Imperial gap was due to two more working days next year that would need to feed into the model (£400k gap) and the assumption changes set for Imperial around the non-elective codes, which the CCG assumes are non-recurrent for next year of £1.4m. SR added that the CCG would need to assume the PBR rules apply and would not get the money back next year. SR stated that the other contracts would need to include the two additional working days for next year. SM highlighted the difference in the way the modelling was undertaken in acute compared with the contracts team and the difficulty in pulling together the contract offers. NM questioned whether the coding issues at Imperial were now improving. SR clarified that the data issues were being addressed by the Trust and it was re-educating staff with the coding challenges; and activity was not increasing therefore should show a better run rate for next year. SM stated that the deterioration in the underlying position between M7 and M9, put significant pressure on the planning process, therefore the CCG QIPP target had increased from £14.7m to £18.6m (6.3%) of the CCG allocation, similar to the CCG's QIPP for 17/18. SM said that the current QIPP plan of £6.3m savings was prior to a risk adjustment for local schemes, therefore the impact of QIPP delivery following risk assessments shows that the total savings had reduced to £4m for the local schemes and NWL programmes. SM explained that the NWL Steering Group was in the process of reviewing schemes and 24 project initiation documents (PIDS) over a two-day period. Therefore we await the outputs to be factored into the plan to provide a clearer understanding of the remaining gap to be managed. SM highlighted that if you focus on the local schemes, it leaves a significant gap to bridge in order for the CCG to be able to submit a balanced plan. NM said that the level of QIPP savings to be delivered was very challenging. NF stated that it relates to the lower level of growth received and level of targets and the elements of QIPP required to fund headroom. NF stated that the CCG would receive additional growth monies if the deficit does not get back to breakeven, due to lack of balance sheet mitigations, with the modelling of each CCG position done to support CCGs to hit the control totals.	

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	The committee **noted** the draft financial plan for 2018/19 and the changes that have occurred since the previous report in November 2017 representing considerably greater challenges for the CCG	
8.	**NWL Sector Financial update**	
8.1	NF introduced the report which provided an overview of the STP financial performance and updates the committee on the month 8 YTD STP position and consequent forecast outturn. Furthermore, it provides a high-level summary and analysis of key issues and outlines the quality improvements and amount of QIPP to be delivered over the last four months of the year. The committee **noted** the M8 NWL Financial Report	
9.	**Imperial Contract Performance and trend analysis month 7 – 2017/18**	
9.1	SR introduced the report and advised the committee that at M8 there was a YTD unmitigated/mitigated variance of (£4.8m)/(£3.52m) respectively. SR advised the committee that the level of spend for non-electives was high over the past two months, in particular for Imperial, C&W and LNWT. SR reported an in month adverse movement of £998k, an adverse movement above trend of £638k. SR said that a draft agreement had been reached with the Trust to agree challenges for the rest of the year. SR said that the M9 data was awaited, but based on early estimates it showed a £2m lower spend across the 8 CCGs. SM stated that if you deducted QIPP year to date of £4.1m from the plan, the adverse variance would be replaced by a favourable variance of £571k. SR highlighted that year to date there were favourable variances against critical care of £886k; maternity of £251k, which were supporting the position but cannot be relied upon going forward, therefore are matched to plan and included in the forecast outturn. SR said that flu had a potential impact on the position with 43 beds funded at the Trust, but were unclear if sufficient capacity was planned. NM queried the non-elective activity and variance to plan of 10.3% and cost pressure of -£2,956,263 across the 8 Trusts. SR reported a pressure across the portfolio of providers and for Imperial this was impacted by coding. SR said the activity was correct but reported delays with data coming through the system. SR said that for Ambulatory or Outpatient Care the service changes would need to happen to address the non-electives concern and to deliver the QIPP savings. TW asked for further information around the non-elective areas. SR explained that non-electives showed a similar position to last year, but need to consider the transfer of data in and out between NHSE and CCGs. SR said that data was reported monthly by POD based on activity, the cost for last year and plan for this year and what was happening, and the impact of non-delivery of QIPP. SR noted that for outpatients the plan was lower than last year's outturn. SR reported QIPP of £30m included in the contract across the 8 NWL CCGs but highlighted the challenges in mobilising services over a 12-month period, and highlighted the lack of robust plans and lack of QIPP delivery. SR said that unidentified QIPP was a significant factor, and had an impact on the forecast overspend.	

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	NM asked how well Imperial and C&W were delivering their cost improvement (CIP) programmes. SR explained that the CCG were not sighted on their full plans. JCa said that going forward more realistic QIPP discussions would take place between CCGs and the Trusts with the development of Accountable Care Plans (ACP's) and what Acute Trusts plan to deliver. JCa said that the new Chief Executive at Imperial was very proactive and wanted to make the necessary changes and to focus on transformation to improve performance. NF said that he had spoken to Trusts and noted the work carried out by Hillingdon around the five outpatient specialities and the use of escalation beds to manage the pressures. The committee discussed the challenges ahead for Imperial to deliver the large QIPP schemes in 18/19. NF said that the £23m QIPP was also dependant on growth and the underlying deficit. TW said that to address the issue of people with a diabetes diagnosis going into hospital for diabetes related complications; and to reduce the £127m costs associated with these patients, that the diabetes team were looking at an integrated service and were keen to engage with Imperial Trust and shift activity out of acute. SR said that working with the Trust was crucial to address the capacity issues and to reduce costs. SR said it anticipated an improved M9 position. She reported that the forecast outturn predicts higher spend for the last four months of the year; therefore would need to be prudent and had included £800k to the run rate and £400k to critical care, to support the position. The committee **noted** the Imperial month 8 performance and trend analysis report	
10.	**Community Independence Service Contract Intentions 2018**	
10.1	TH presented the report and advised the committee that Central London (CL) CL CCG was the lead commissioner and CNWL, the lead provider, was working with WLMHT to provide the majority of capacity. TH noted that the paper drafted by CLCCG also included feedback from the Ops Group discussion. TH said the paper includes a list of proposals and a number of options for the 3 CCGs to consider when the existing service finishes. TH stated that H&FCCG recognised the importance of establishing the intentions of the Local Authority prior to agreeing a financial envelope for the 18/19 service, in order to identify any potential cost pressures and to reflect this in subsequent decisions with the provider. TH said the current CIS contract did not include any provision or extension clause, therefore if commissioners wanted CNWL to continue to deliver the service and the provider agreed; it would need to issue a Prior Information Notice (PIN) to fulfil procurement regulations, to extend the service from July 2018 to the end-March 2019. TH advised that any options to reduce funding into the service were not fully recognised in Hammersmith and Fulham therefore would need to work through the costs with the provider. TH stated that during the extension period; the Ops Group expressed a desire to work with the Integrated Care Partnership in Hammersmith and Fulham to bring together the CIS functions with Community and District Nursing; Primary Care Networks and associated Adult Social Care and voluntary sector teams.	

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	TH mentioned the positive work of CNWL and its partners in developing the service over the last 12 months. In particular; in establishing an effective workforce and forming joint working relationships with local authority services, also modelling service capacity to respond to demand and building and strengthening relationships with the Primary Care Coordinators/Navigators. TH advised members of the concerns across the three CCGs in particular around QIPP and the way the commissioners envisaged it would be delivered. TH said the CCG preferred option was option 3, to allow time to take the CIS service into a new phase of development, to integrate the service with community and district nursing and to work with the providers to deliver a new pathway of care and bringing together rapid response and discharge to assess with wider community nursing/care coordination services. TH advised members that by extending the CIS service with the existing provider would allow the CCGs enough time to scope the work. NM acknowledged the good work carried out by CNWL over the 12-month period in particular in the developing an effective workforce and establishing joint working relationships. TH acknowledged that it was a difficult and complex service to run. JCa said the experience his patients had of the service was positive, and acknowledged the importance of the service for those unstable patients at home. JCa said it was an expensive service and destabilising the workforce would be a concern and asked how value for money could be assessed. TH said that when the service was reviewed previously, there was a way to assess reductions in non-electives but did not know the figures. TH said the service also reduces pressure in the system. TW said people could be tracked through the whole system pathway, which would allow you to assess the impact on acute care and one option was to look at historic activity for similar groups. TH said that some work was carried out on the clinical audit around the right people to be seen and acknowledged that the H&F service differed to the service delivered to the other 2 CCGs, who had more of an acute case mix. TH agreed to review the data over the next 12 months as part of the review process to assess value for money. The committee: **Approved option 3**, to take the CIS service into a new phase of development, working with providers to deliver a new pathway of care and bringing together rapid response and discharge to assess with wider community nursing/care coordination services, Subject to: 1) Seeking agreement from the other 2 CCGs 2) Obtaining the views of the Local Authority and to clarify their funding position 3) To evidence value for money and return on investment in a more robust way 4) To work with the Integrated Care Partnership in Hammersmith & Fulham to bring together the CIS functions with Community and District Nursing, Primary Care Networks and associated Adult Social Care and voluntary sector teams. This programme of work would be a pre-requisite of the extension and allow the transition of the CIS into the Accountable Care Partnership from April 2019	
11.	**Primary Care Investment Programme – 18/19 Funding Implications**	
11.1	TH introduced the paper. TH said that the committee were asked to recommend for Chair's action, the approval of the 18/19 funding implications associated with the 17/18 PiDs totalling £588,201 (non-recurrent spend), approved through the investment programme as per the recommendation from the Primary Care Commissioning	

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	Committee. TH advised members that as the investment programme was on going and the costs outlined of £588,201 are at an upper limit, therefore the final costings would be confirmed through the PiD approvals and feed into the budget setting process for 18/19. TH noted that due to the timing of the investment programme in 17/18 and the nature of the projects submitted by networks, that some expenditure into 18/19 was inevitable. TH advised that although the budget setting process has yet to conclude for 18/19, that the CCG primary care allocation for 18/19 was set to increase by £1.6m next year and would be ring-fenced specifically for primary care. TH acknowledged some risks associated with the primary care budget in 18/19, such as rent and rates and the GP at Hand list size increases; however, felt there was likely to be sufficient headroom in the budgets to commit to this level of non-recurrent investment. JCa questioned whether the CCG would receive updates on the amount of money spent against the 17/18 budget. TH clarified that monthly updates, once finalised, would be provided to the CCG through the Primary Care Commissioning Committee to include what was delivered against the outcomes and the level of spend. JCa questioned the likelihood of the £1.3M budget being spent in 17/18. TH said this information was reflected in the proposals; and the CCG would go through due process to ensure the money was appropriately allocated. The F&P Committee **recommended** for Chair's action, the approval of the 18/19 funding implications associated with the 17/18 PiDs totalling £588,201 (non-recurrent spend), approved through the investment programme as per the recommendation from the Primary Care Commissioning Committee	
12.	**Homeless Health (EASL) Service**	
12.1	HL presented the Homeless Health (EASL) Service update. HL explained that the CCG currently commissions three services to work with the homeless population, and to reduce usage of unplanned services such as ambulances, A&E and non-elective admissions. HL noted the relatively small investment into these services, with evidence that the EASL and Groundswell services relieves pressures on NHS unplanned and crisis services, statutory mental health services and improve health outcomes for people with complex needs. HL acknowledged that evidencing the effectiveness of these services was challenging, due to the chaotic nature of the client group and the non-traditional approaches offered by the service, ranging from support and training for hostel staff to building capacity and 1:1 assessments and care planning. HL said that both services had provided case studies, which shows the impact of these interventions on the most challenging and chaotic service users, and these case studies have been used to draw up indicative savings created by their interventions. HL noted that the EASL service could offer some level of intervention to up to 600 service users per year, while Groundswell works with approximately 60, therefore it could be assumed that the overall savings offered by the service are far greater. HL said if the EASL and/or Groundswell services were decommissioned, the Local Authority (LA) had requested funding an extension to the contract(s) for a 5- month period from the 1st April 2018 to allow the LA to re-procure a new service whilst their	

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	local elections take place. HL noted this would be a cost pressure of £6250 for Groundswell and an additional £10,416 S75 cost for EASL. HL said the Peripatetic Nurse provides a nursing service to residents in four of the CCG largest / busiest Homeless Hostels, with the service delivered by CLCH. HL said that the Peripatetic Nurse Pilot demonstrated significant reductions in LAS callouts, unplanned inpatient admissions and A&E attendance and recently received a national award for 'Nursing in the Community' at the Nursing Times Awards. VA said the service was well regarded, and were looking to incorporate the service into the Out of Hospitals (OOH) provision, with the Primary Care Team taking a paper to the Primary Care Committee in due course, proposing that this service be moved to primary care and be funded through the OOH service. HL said that the EASL and Groundswell services are due to expire on the 31st March 2018 and deliver benefits in terms of unplanned care usage with net savings of £165k. HL said that hostel staff providing a conservative estimate of savings in the region of £30k, by using costed case studies and patients of highest need, due to the difficulties in tracking these patients. HL stated that the costs could be a lot higher if you take into account the level of work provided to this cohort of patients. NM said it was difficult to assess the impact of the service. JCa acknowledged his support for the service provided by the Peripatetic Nurse, who was irreplaceable. JCa also noted the difficulty in assessing value for money; however, given the small amount of investment required, considered it fundamental to invest in this section of the population. VA noted her involvement with the deep dive into the EASL and Groundswell services, which the LA took to PAC and planned to take to the Health and Wellbeing Board. SM said that investment for 18/19 was not included in the CCG 18/18 plan, but one way to fund these services for next year would be to include them as invest to save in the QIPP programme and track and monitor the return on investment. VA commented on the importance of the Peripatetic Nurse in establishing relationships with her cohort of patients. CL said that part of the Peripatetic Nurse role involves targeting hostels; making contact with new people coming in and focusing on the high users of unplanned services and through these interventions have generated significant savings. JCa queried how much of the budget for the OOH homeless initiative was spent. SRo explained that it planned to include perinatal into the OOH contract, with Groundswell part of S75 and as EASL was a pilot, the costs were non-recurrent. CL said that Groundswell and EASL could be an enabler of the non-elective work as this cohort of people were high non-elective users and this would allow the CCG to measure the savings. SRo said that the funding could be approved subject to the measurement being included as part of the non-elective work that contributes to the frequent attendees. The committee: 1. **Noted** the outcomes of the homeless health review 2. **Noted** the proposal that the Peripatetic Nurse (PPN) service is to be provided as	

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	part of the Out of Hospitals Service within the Enhanced Primary Care Contract (Paper to go to Ops and Primary Care Committee in February 3. **Approved** the request for recurrent funding of £25,000 for EASL and £15,000 for Groundswell as part of the Section 75 Agreement for 2018/19 onwards, subject to the measurement being included as part of the non-elective work and to feed into the frequent attendees 4. **Approved** the proposal that the Groundswell contract is incorporated into the Section 75 Agreement with the local authority 5. **Approved** the request that, in the event that the decision is taken by Finance & Performance Committee to decommission any Homeless Health Service, funding will be made available to allow H&F CCG and LBH&F to fulfil their notice periods with the services	
13.	**Community Direct Access Diagnostics Contract Extension**	
13.1	The committee n**oted** the community direct access diagnostics contract extension, and the recommended negotiation strategy with regard to the Indicative Activity plan (IAP) and Tariff	
14.	**Better Care Fund Plan 2017/19**	
14.1	DT presented the report and Q3 performance update. DT said the paper also provides an outline of the Three Borough Integration and Better Care Fund (BCF) Plan for 2017-19, and agreed budget and work priorities. DT said that the three-borough Integration and BCF Plan was assured by NHSE on the 27th October 2017 and would remain in place for 17/18, but the Local Authority (LA) continues to implement the 'move on' plans from the current arrangements. The committee noted that the full BCF budget requirements, including the Joint Commissioning S75 budgets reflected in the CCG Operating Plan Budget were being monitored as part of the 2-year BCF plan. DT advised the committee that the Q3 submission was reported to NHSE and the LA had submitted the better care template. DT noted that the CCG minimum contribution to health would further increase in 18/19 to 1.90% (£104k), which the CCG would need to bear in mind and build into the 18/19 position. DT noted that the total CCG contribution to the BCF in 17/18 was £31.779m (£1.05m of this was lodged funds), with the Joint Commissioning S75 contribution for specific health services of £11.235m. DT said the full year budget reflects the drawdown of monies previously lodged with the LA to support CIS, with £3.2m lodged in 2016/17, was to be used towards the transformation pot. However, due to the inability to undertake a full year of transformation work for existing BCF schemes, the money would now be used to deliver CCG non-recurrent QIPP savings. DT said that the iBCF additional funds that the LA would receive this year and over the next 2 years, should allow the CCG and the LA to develop a programme of transformation to establish recurrent QIPP savings from 18/19. DT noted that the new money as part of the Improved Better Care Fund (iBCF) and the agreement between Health and Social Care around how the monies were utilised was finalised as part of the BCF submission. DT said the main benefits to health would be to support hospital discharge and to reduce Delayed Transfers of Care (DToC); which were both integral to the success of CCG integration and the BCF Plan. DT said that the CCG was escalating the DToC work and initiatives for next year and the LA had produced a paper to take this forward, therefore the CCG should see some of the impact in 18/19.	

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	SRo noted that the discharge team and the DToC programme were working closely with the council on the placements. DT reported that the CIS scheme which sits under BCF, showed that for Q3 the rapid response (RR) activity was higher than the baseline contract, with over performance of 123 referrals against an in-month target of 75 referrals. DT said that CNWL had requested additional CCG contribution of £39,183 per month to pay for the increase in referrals, but the CCG had taken the decision not to pay the ramp-up payments, due to the failure of the provider in linking RR activity to a decrease in A&E and non-electives. DT said that the number of BCF schemes reduced in 17/18 with CIS the main area of the plan. DT said that fortnightly meetings were held between the CCG and the LA to determine what the CCG needed to do in order to establish its own identity going forward. DT said that the CCG had achieved the £1M QIPP savings this year but would need to decide how to underpin this for the savings put in for 18/19. SM clarified that finance were working on this and included £1M QIPP; however, this would need to be aligned to S75 as the biggest part of BCF. DT reported that the CCGs and LAs agreed to undertake a stocktake of contracts and placements to establish opportunity for efficiencies as S75 was the largest element of BCF. DT advised the committee that for H&F less money was available towards health; but money was available towards reablement, but questioned the costs and asked the LA how the reablement services add value for money. DT explained that as reablement monies were running out, this was flagged as a risk, therefore would need to determine with the LA whether it planned to fund this area going forward. DT noted that contract negotiation meetings with the LA would be held in the next few weeks. SRo said that BCF had the potential to deliver savings and would need to maintain relationships whilst at the same time conducting discussions. DT reported that a meeting was held with the managing directors to discuss BCF; in particular, how it planned to move from a three-borough contract to a 2 + 1 contract and to agree the CCG minimum contributions. SRo stated that the negotiation process would provide opportunities for more integrated ways of working, to obtain transparency and to allow relationships to be managed differently. DT said in March a refresh of the BCF budget would be provided to the committee, along with an update on how the plans would be taken forward by H&F. NF sought clarification of the £3.2M logged fund with the LA. DT explained that previously this money was allocated towards transformation and was logged with the LA in 16/17 and came back to the CCG to meet the QIPP savings, but needed to make the transformation changes to obtain the £1M in 18/19. The committee **noted** the Three Borough Integration and Better Care Fund Plan for 2017-19.	
15.	**Strategy and Transformation month 8 budget report – 2017/18**	
15.1	NF introduced the report. He reported an underspend of £1.6M against the M8 operational budget of £7.4M, predominantly due to consultancy and other cost pressures expected to arise in the last 4 months of the year in addition to strict control over recruitment to vacant posts and cuts in non-pay expenditure. NF said the S&T operational budget was forecasting an outturn of £12.5m, a £2.5m underspend against plan, with £2.1m of the S&T £12.5m budget pooled into a central consultancy and non-	

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	pay budget, and could only be drawn upon with approval of the budget owner. NF noted that a decision on the NHSE funding of £6M was yet to be finalised. NF said if S&T did not secure the full amount of money, further contingency plans would be required, with Keith Edmunds putting in place additional controls to reduce the consultancy budget, if NHSE monies were not secured. The committee noted that the S&T Team would not be asking CCGs for further contributions this financial year towards SOC1 and SOC2 consultancy costs therefore would be required to meet these costs from within the S&T budget. The committee **noted** the M8 YTD S&T Update	
16.	**CWHHE Joint Finance Working Group minutes – FOR INFORMATION**	
16.1	The committee noted the CWHHE Joint Finance Working Group minutes.	
17.	**Any other Business**	
17.1	NM advised the committee that at the Joint Committee a helpful discussion had been had on the issue of HFCCG Single Tender Waivers, hopefully clearing up any concerns. A discussion had also taken place about seeking further advice on the rent and rebates position and about attaining conveyancing advice from the Financial Authority.	
17.2	JC said concerning the outpatient programmes across North West London (NWL) that a programme update on the five areas would be brought back to the F&P committee following an initial Operational Group discussion. JC said in the first instance it would focus on how to reduce overall attendance, reduce the outpatient department and to provide an update on how to engage with members.	**JC**
17.3	JC informed the committee that it was Shelley Martin's last F&P Committee before she goes on maternity leave. JC advised members that the CCG had recruited Owen White, as interim Head of Finance for a six month period to manage the financial position. JC added that Owen had previous experience of working in the sector and will be taking up the post from next week to allow a handover with Shelley, prior to Shelley going on maternity leave. NF advised the committee that CWHHE had recruited John Leslie as the new Interim Director of Finance across the Tri-borough to replace Andrew Hyslop. NF said that John would be taking up the post from Monday 29th January, to allow proper handover. NF stated that in addition to Owen White, that John Leslie would support the committee and ensure consistent finance representation at future committee meetings. NF advised that he was managing the financial structures and processes across NWL CCGs and would be recruiting permanent staff to the structure. NM noted that this would be Shelley's last F&P Committee for some time. NM said on behalf of members of the Committee and wider CCG, thanked Shelley greatly for all her hard work over recent years and wished her very well during her period of maternity leave.	
	Date of next meeting: Tuesday 13th March, 3.00 - 5.30 pm, St Paul's Church, Hammersmith	