Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

Minutes of a Meeting of the AWP NHS Finance and Planning Committee

Held on 20th February 2015 at 9.30 am in Conference Room, Jenner House, Wiltshire

These Minutes are presented for **Approval**

Members Present

Lee O'Bryan (LOB) – Chair
Sue Hall (SH) – Director of Resources
Kristin Dominy (KD) – Director of Operations
Tony Gallagher (TG) – Trust Chair
Barry Dennington (BD) – Non-Executive Director
Iain Tully (IT) – CEO
Dick Beath (DB) – Head of Financial Planning
Fiona Bell (FB) – Head of Programme
Amanda Willis (AW) – Head of Contracting and Procurement
Kerry Geoghegan (KG) – Head of Business Planning
Peter Wilson (PW) – Head of Business Development

Staff In attendance

Alexander Lauder-Bliss (ALB) – Governance and Risk Coordinator
Will Hall (WH) – Interim System Clinical Director, Bristol Mental Health
Melanie Corish (MC) – Bed Management Consultant
Sarah Branton (SB) – Interim Bristol Managing Director, Bristol
Jenny Macdonald (JM) – Managing Director, South Gloucestershire
Sam Maunder (SM) – TDA
Nicky Mowatt (NM) – TDA

FP/14/131- Apologies

1. Apologies were received and accepted from Emma Roberts and Pippa Ross-Smith.

FP/14/132 – Declaration Of Members' Interests

1. In accordance with Trust Standing Orders (s7.1) members present were asked to declare any conflicts of interest with items on the committee meeting agenda.
2. No interests were declared.

FP/14/133 – Minutes/Summary of the Meeting on 23 January 2015

1. The minutes of the previous meeting, held on 23 January 2015, were **approved** and taken as accurate.

FP/14/134 – Matters Arising

1. The Committee reviewed the Matters Arising and actions as below.
2. In terms of Finance Report, SH updated that South Gloucestershire were contractually obliged to pay the bill, as had been confirmed by the CSU. Payment

had not yet been received. It was agreed that the item would be kept open until the end of the financial year.

3. In terms of the forecast, SH stated that turnover rates had been included in the ESEC paper of the current week. She explained that a target for the reduction of turnover had been set, as part of the Trust's objectives. TG added that ESEC had agreed to target a 2% reduction, to approximately 13%. He noted that Secure services affected the figures. TG had asked ESEC to consider the numbers without the inclusion of Secure services, for benchmarking purposes.
4. SH updated that she had written to the Bristol CCG, to ask for a copy of the gateway review of the Bristol tender. She had not yet received a response. The item was kept open.
5. Action point 5 was incomplete and would be kept open.
6. The Chair proposed that action point 7 would be reviewed at the end of the Committee meeting, and signed off if sufficient assurance had been given.
7. In terms of workforce and rostering assumptions, SH and KD had undertaken work to ensure that all rosters were reviewed. The action to review was ongoing.
8. Action point 10 was signed off.
9. On the authorisation process for bad debts, SH understood that the action had been taken to the Audit and Risk Committee on Monday 16 February. The Chair asked that SH ensure Audit and Risk had reviewed the action, from a control point of view, and that she was satisfied with the control processes.
10. Action point 13 was ongoing, and action point 14 was signed off.
11. On action point 15, SH updated that impairment would be assumed in the following year's budget.
12. KD confirmed that action point 16 had been completed and was being taken to Board in the following week.
13. The Committee **approved** the Matters Arising with the above amendments.

FP/14/142– Otsuka Partnership: Full Business Case

1. The Chair requested that the Otsuka Partnership item was moved further up on the agenda.
2. WH presented the system structure, a significant portion of which was designated to Primary Care. He noted that some services had begun transitioning in October 2014, and that some services would not be launched until April 2015.
3. WH gave an overview of the 18 organisations involved in running the services. There were approximately 25 teams operating across the system.
4. During the tendering process, the team had realised that a significant change in partnership would be necessary to successfully manage and lead the system. The team had met with Otsuka in October 2013. An ecosystem assessment had been undertaken in 2014. In December 2014, a presentation had been made to the Board and it had been agreed that a full business case would be prepared.
5. WH emphasised that the purpose of the partnership was to enable teams, services

and the system to change its behaviour and to analyse and improve the processes it followed. He outlined that the following tools were in use to enable the changes: care pathway; predictive analytics; system dashboards and 'alerts'.

6. WH emphasised that it was necessary to find a 'leaner' way of working. He expressed his confidence that the relationship with Otsuka could be developed to ensure that the system was highly patient-focused and could reflect the core values of the Trust.
7. WH stated that the total Trust investment in the relationship constituted £1.2 million. Internal support costs constituted £225,000. The ecosystem assessment had been undertaken at no cost to the Trust.
8. The Chair agreed that the partnership was the correct strategic approach to take. He asked that the Executive team undertake further due diligence in respect of the numbers. IT confirmed that the Executive team had looked at and were satisfied with the numbers. He proposed that the Trust commit to the partnership, on the condition that the contract was reviewed and given further consideration.
9. BD asked for a view on the total cost of software tools ownership, for the following five years, taking into account further development, customisation and maintenance. SH replied that the system had not been tested, and would be developed in-year. She confirmed that the principles around the risk share would be agreed.
10. KD expressed her agreement with the partnership. She asked that the strategy be tested for its applicability to the rest of the organisation. SB added that initial reviews showed the partnership could have significance across the Trust and the wider NHS. TG emphasised that the current decision was to be made in respect of Bristol only.
11. TG stressed that due diligence needed to be undertaken before a proposal was taken to Board. The Chair confirmed that he and SH would complete the due diligence.
12. The Chair summarised that there were four actions to take forward: to review the contractual arrangements; to overview the detailed financials; to review the sources of funding and to review phasing. **– ACTION Chair**
13. SH estimated that a decision could be made circa December 2015 as to whether or not the proposal could be brought forward. The Chair noted that the activity could be included for discussion in the fortnightly call with Bristol.
14. It was agreed that a public announcement about the partnership could be made after the contract had been signed.
15. The Committee resolved to **note** the reports and **approve** the business case.

FP/14/135 – Finance Report

1. SH presented the Finance Report for M10.
2. SH stated that the finance report was comparatively more positive than previous reports, which was reflective of the work that had been undertaken in-year. At month 10, the Trust was showing a surplus and was £25,000 behind plan.

3. The significant issue which had been discussed in the previous month had been around the risk to the Trust's forecast position at year-end. Management actions had been implemented in-month and had been successful. The Trust was now able to reduce the pressure on its forecast by £1.2 million. Further, the team was confident that the Trust would deliver its surplus of £750,000.
4. Areas where rostering practice was not being followed had been identified, and a number of changes to the Bank office had been implemented. A significant reduction in agency usage had since been realised. The cost of agency locums had been reviewed and reduced via the redistribution of the clinical workforce. Hayley Richards had reviewed the possibility of introducing 'bank locums'. The use of pharmacy agency staff had been terminated.
5. Two items had been put through the Revenue I&E account, but should have been put through as capital. Some estates work had been re-prioritised in line with the CQC action plan.
6. SH turned to the income statement. Page four showed an increase in income, in-month, of £753,000. The majority of variance in income, in-month, pertained to out-of-area income. This was offset within non-pay. There was additional income for LIFT activity in Bristol and BANES. There was additional capacity in Swindon.
7. Expenditure variants offset income variants, the majority of which were sat within pay costs. This was explained by the increase in agency and pay, and was in line with the forecast.
8. Table 7 showed that recruitment levels were not high enough. SH added that there had been an additional seven starters within Specialised Services.
9. SH stated that out-of-area remained high within the Trust and that the spend remained high. Table 10 of the report showed that, with the exclusion of out-of-area, income, expenditure and contingency figures, the Trust would break even. A significant variance would be realised if the use of out-of-area was stopped. Further, pay was overspending in-year.
10. The Chair highlighted that service quality, vacancies and the use of agency staff were areas of concern. He asked SB how concerned she was about service quality. SB confirmed that service quality was a concern. She explained that Bristol had attempted to ensure that agency staff were performing assessments frontline, rather than holding caseloads. Further, work had been undertaken with VCS partners, who had provided assurance that targets would be met. Service managers were currently working to understand the exit plan, in terms of agency use. JM updated that discussions had been held at Senior Management Team around the possibility of changing the way bank staff were paid. The Chair requested clarification of statutory requirements for when Agency were made substantive. **– ACTION SH**
11. TG asked that an update be given at the next Committee meeting around rostering and avoiding 'peaks', specifically to show the difference that controls had made. KD added that Employee Strategy and Engagement Committee had asked for a deep dive around rostering policy. **– ACTION KD**
12. TG asked that the Committee undertake a deep dive into the cost and benefits of bed closures. He noted that this was a cross-reference issue from the Quality and

Standards Committee.

13. SH turned to the agreement of balance exercise, which had been realised as an issue at month nine. There was one discrepancy with the Swindon CCG. The balance had been agreed but remained in dispute. SH added that the Trust did not plan to take the matter to arbitration. She confirmed that the issue constituted a risk to the Trust's bottom line position.
14. In terms of cash position, the Trust was significantly behind in-month. This largely pertained to unpaid invoices for CQC work and was replicated in the capital plan. TG asked for the capital plan to be revisited to differentiate between incremental and non-incremental activity. The Chair agreed. **– ACTION SH**
15. TG asked if it was necessary for the Committee to approve the figure for medical equipment. SH explained that there was allocation within the capital programme for medical equipment, and that the allocation needed to be agreed by F&P. She suggested that she could propose a change to the scheme delegations. **– ACTION SH**
16. The Committee resolved to **approve** the Finance Report and the recommendations provided to the Committee.

FP/14/136 – CIP Report M10 (Including Other Savings Projects)

1. FB presented the CIP Report and provided two additional pages for all Committee members that outlined work done in regards to Pharmacy as requested from the previous meeting.
2. As of February, the headline delivery figure was £5,855 against the plan of £5,839. At month 10, approximately 82% of the programme had been delivered, and progress indicated that the plan would be met. There was a year-end forecast for 100% delivery, which was £7.076 million.
3. FB stated that the initial target set for the cost reduction programme was £1.7 million. The programme to date had delivered £1.261 million, which was slightly ahead of the forecast. FB noted that the Procurement and Pharmacy programmes were reported on a monthly basis, in arrears. The current forecast for the year-end position was £1.4 million, which would leave the Trust approximately £315,000 under the plan.
4. The current position for Procurement had improved. Procurement was now reported on a monthly basis. I&T were set to achieve their target. FB suggested that the cost reduction programme be 'more fluid' than CIP, in order to relieve cost pressures.
5. FB updated on the Pharmacy programme. Historically, the Pharmacy budget had struggled year-on-year, and had undergone cost pressures. Pharmacy had moved in-house 18 months previously, which had a significant impact. FB emphasised that the Pharmacy programme's focus was about the cost of drugs and spend, rather than people within the organisation. She added that, whilst drug spend was being monitored, localities also had Pharmacy savings plans within their CIP programmes. FB turned to the Pharmacy summary on page 12. The current projected spending was circa £710,000. £262,000, year-to-date, had been removed from the budget as part of the CIP programme. The forecast for removal

from budget was £334,000 by year-end. The team were confident that the targets would be met. The project cost reduction was £376,000. FB stated that there was no longer overspend in Pharmacy.

6. The target for Pharmacy at the start of the year had been set at £689,000, as a result from; being able to buy drugs cheaper, more in-house delivery and switching to memory service drugs. FB explained that the target had been changed to £500,000 at Q2 because the programme had been under-delivering. The average for Pharmacy's reduction in spend over the year was £160,000 per month.
7. FB updated that the 'reduction in FP10 spend' and 'memory' items had delivered ahead of the plan.
8. In terms of CIP delivery, the year-to-date position was £262,000 and the year-end position was £334,000.
9. IT noted that significant improvements had been realised within the last two years.
10. The 2015/16 programme had undergone several iterations. The net figure was £8,769 on the first cut, and the figure had reduced to £6,941 by the fourth cut. This had created a gap of £1.8 million from the initial project, assuming that requirements remained the same.
11. The targets that had been allocated to individual budget areas and Trust-wide schemes had been finalised, to help close the gap from the LDUs. There was approximately 6% of 'pull-through' from 2013/14, and FB was confident that the first few months would deliver. LDU plans were much further developed and had been started sooner. Trust-wide schemes would potentially be back-ended, to provide a balance of local delivery at the front-end of the programme, and Trust-wide delivery at the tail-end of the programme.
12. TG noted that the team had agreed to rolling, two-year plans. He suggested that the 2016/17 impact and gap be reviewed at the current date rather than in August. KD agreed. The Chair requested that the team to accelerate the two-year plan.
13. FB summarised that she was confident around delivery, and anticipated that the gap would be breached. This would be brought out with the end of year paper. The Chair noted that this did not detract from accountability.
14. TG asked for greater coherence and cross-referencing between different Committees.
15. The Committee resolved to **note** the report.

FP/14/137 – Budget-Setting Progress Update

1. SH presented the Budget-Setting Progress Update paper and updated that the tariff from NHS England and Monitor proposed two new options, which the Trust were required to decide on by 4 March. One option would allow the Trust to have CQUIN funding, and the other option did not allow CQUIN funding. SH noted that the ideal tariff would grant the Trust CQUIN funding. The current budget and paper were based on the tariff as it had originally been set out, with an income reduction of 1.9% and an assumed uplift of 0.35%.
2. A further assumption had been made around the cost reduction programme of

8.7%, which was higher than the 3.8% efficiency rate that was set in the tariff. This level of savings may not be necessary.

3. A number of other cost reduction plans had been identified, which were cost pressures that had been identified during the budget-setting process. These had been outlined in page three of the paper.
4. SH outlined that, historically, the Trust had used CQUIN into its bottom line by a different percentage every year. The Board had agreed the percentage. Current working assumptions were that additional costs would be incurred for all schemes. The CQUIN schemes had yet to be agreed with commissioners.
5. An additional £1.8 million had been included in the budget-setting for safer staffing. It was being agreed that the CCGs would fund the safer staffing.
6. SH outlined that, to reach an Operating surplus of 1%, it was possible to reduce the current target from £2.7 million to £1.9 million, effectively putting an additional £860,000 into the bottom line. TG suggested that investors could be asked what areas could be invested in, at the value of £860,000, which would either result in additional savings in subsequent years or increase care in subsequent years.
7. SH outlined another decision around the development of 'Daisy' in Wiltshire. It was possible to fund the venture internally rather than apply for a loan. This had been discussed with the TDA, who were content with the proposition. The decision would reduce the planned cash balance. TG suggested that the Trust should use cash balances rather than keep them; the Chair agreed. TG questioned the Trust's confidence around the disposal programme. SH agreed that further clarification and assurance was necessary.
8. BD asked if and how safer staffing was tied to specific definitions of numbers of beds, utilisation and capacity. KD replied that the safer staffing model had been designed from the wards upwards, in terms of the number of beds the wards had, the acuity of the ward environment and what constituted running a 'safe' environment from the perspective of the ward manager, modern matron and the triumvirate. This was then entered into a 'ward calculator', to determine the cost of the service with the figures collected. KD added that the modelling had been completed against an 85% occupancy versus 100% occupancy. The numbers had been shared with and agreed by the Quality and Standards Committee in September. KD added that the ward environments and agreed staffing levels were reviewed every six months, as part of the safer staffing reporting to NHS England.
9. The Committee resolved to **approve** the report.

FP/14/138 – Quality and Performance Report

1. KD presented the Quality and Performance report for M10.
2. KD highlighted that there was a predominant issue within Bristol. It had recently been agreed that a new control mechanism would be adopted, which was aligned to the Monitor system. Bristol would be required to produce a recovery plan to be achieved within one month. KD highlighted that Bristol's approach to sustainability was of major importance.
3. KD acknowledged concerns around waiting times in memory clinics. She updated

that there had been a reduction in the performance in Somerset, which related to an increase in the number of referrals. Discussions were being held with commissioners to determine how to address the issue.

4. KD noted that Swindon had been asked for information around their recovery plan, in relation to their indicators. This information had been presented and reviewed by the triumvirate. Swindon was now required to demonstrate sustainability in relation to its performance indicators.
5. Processes for ensuring delivery against CQC action plans were well-embedded. The first Week in Focus had been undertaken, the actions of which had been fed into the Quality and Standards Committee earlier in the week. Two programmes were being run in March, in Swindon and Wiltshire.
6. TDA colleagues were joining the team in the following week, accompanying a deep dive into the issues affecting out-of-area treatments.
7. The Chair asked the MDs present how the 'check and challenge' process worked. JM outlined that, in South Gloucestershire, the triumvirate performed 'walkabouts', whereby they visited teams unannounced and rated quality against a Trust-wide checklist. This was fed back to the service and team managers. Executive walkabouts had also been undertaken, and feedback had been provided formally and informally. Further, quality was discussed during every meeting held by the team. Every two weeks, the team came to Jenner House, met with another locality, and challenged and questioned how assurance was provided around service quality.
8. TG noted that the number of referrals to the North Somerset team had increased by 50%. He asked for an explanation of the cause of the increase. TG further proposed that the Committee re-review reference costs, at cost-level and activity-level. The Committee agreed.
9. The Committee resolved to **approve** the report.

FP/14/139- Annual Operating Plan

1. KG presented the Annual Operating Plan for approval.
2. KG updated that draft annual operating plans for 2015/16 had been submitted, as per the TDA requirements. It was aligned with the TDA guidelines on content. Further, a range of documentation, including an overarching summary, had been resubmitted to the Finance and Planning Committee in the current month, following its initial submission in January. A range of activity, finance and workforce information was being compiled, alongside checklists.
3. The operating plan for 2015/16 picked up the second year of last year's two-year operating plan. A lot of detail had been pulled through into the plan. KG noted that there had been changes around the commissioning landscape and the market which had impacted growth plans, etc. KG emphasised that the market had changed, in that there had been a reduction in formal tender opportunities. There were opportunities for development of the contract with the current commissioners.
4. The growth and loss of business for 2014/15 had been articulated, and the impact

for 2015/16 had been analysed.

5. The team had identified comprehensive risks within the commissioning arrangements for 2015/16, which generally related to funding arrangements. Quality risks, commissioning intention risks and financial and business risks had been identified, as was required by the TDA. Financial risks remained broadly the same as outlined in the operating plan of 2014/15.
6. Work had been undertaken with the LDUs in relation to workforce, and specifically around developing the understanding of CIPs. The work was currently ongoing.
7. The operating plan had also been submitted to the ESEC and Quality and Standards Committees. The operating plan would be presented at the February Board meeting and would subsequently be submitted to the TDA. The plan would return to the Finance and Planning Committee in March, for final sign-off for the March Board meeting. SH updated that ESEC had scheduled a seminar, which localities would attend, to review localities' detailed workforce plans. This would ensure that the Committee were in line with other Committees and Trust strategy.
8. The Board resolved to **approve** the Plan with recommendation that more assurance was needed around mitigating the financial risks. **– ACTION KG**

FP/14/140 – Daisy Outline Business Case

1. DB presented the Daisy Outline Business Case for approval.
2. DB outlined that the partnership with the third sector had been instigated in October 2013. Discussions with Priory had subsequently been undertaken around the wider LD pathway. Discussions were ongoing with independent advisors.
3. DB outlined the recommendations given following the options appraisal: to build a five-flat Daisy model for a maximum of nine occupants; the Trust were to source the funding for the capital build; the Trust were to sub-contract the running of the operation to Priory, and were to sub-contract Priory to build and manage the unit.
4. DB clarified a point within the paper: 'This focus is being served by allowing Priory to run the Daisy, whilst the Trust can carry on its role'.
5. The Chair described the business case as creative and acknowledged that there was significant demand. He added that the business case was in line with the Trust being a specialist provider.
6. SH clarified that the financial impact outlined in the paper was based on the initial model which had been proposed to the CCG. Negotiations were continuing, and the Trust were being asked to reduce the cost where possible. DB updated that the CCG had been advised that costs would be reviewed after one year.
7. PW noted the recent, post-Winterbourne changes around the non-closures of assessment and treatment units. IT agreed, and emphasised that although the build would be a hospital, it would also be the service users' own home. He updated that discussions were being held with Priory around how it was possible to develop a more community-orientated model. SH noted that the design of the build was significantly different from previous models. Further, the staff who would work in Daisy were social and community staff, rather than purely clinical.

8. PW relayed feedback from potential service users that the 'localness' of the build and the proposed environment were positive. He relayed criticism that the 'home for life' appeared to be a 'ward for life' and that there was a need for more social care. SH confirmed that the social element was being developed. She added that Priory were able to provide social and community staff. DB noted that the build needed to be listed as a hospital and provide clinical care, but was also required to give social support.
9. BD noted that safer staffing analysis had not been included in the paper. DB confirmed that this would be added before final sign-off.
10. SH updated that a transitioning team had been appointed to connect with the initial service user, to ensure ongoing relationship-building.
11. TG suggested that the broader issue of risk needed to be clarified, and suggested that a risk analysis needed to be undertaken. The Chair agreed that further assurance was required. **– ACTION DB/SH**
12. DB outlined that the paper, including modifications, needed to be sent to the TDA. The team would then continue to build a full business case, to present to the Board in March, and negotiations with Priory would continue. DB confirmed that the contract would not be signed until the business case had been presented to the March Board meeting.
13. The Committee resolved to **approve** the business case.

FP/14/141 – Acute Care Pathway Presentation

1. MC attended the meeting to present the Acute Care Pathway Presentation.
2. MC explained that work was being undertaken to analyse the data within Trust-operated systems. She outlined the following key findings:
    - The Trust had a commission bed base which was in the lower quartile, against national benchmarking data, for adult acute beds. This meant that commissioners commissioned a lower-end number of beds for their weighted mental health populations. The bed base for older adult acute beds was around the median, as measured against national benchmarking data.
    - Lengths of stay, for all types of bed within the Trust, were at the 'longer end' against benchmarking data.
    - MC explained that having a lean bed base meant that all elements of the system was required to work extremely effectively, so that demand could be managed. It was necessary for the Trust to have optimised care, efficient systems and processes, in inpatient wards as well as pathways, and clear exit routes for those service users who were not able to be discharged to their homes.
3. MC outlined that there was a fundamental problem with exit routes, and that a significant number of service users became 'delayed transfers of care'. This issue had consumed approximately 11,500 bed days between December 2013 and November 2014, which equated to 100% of the out-of-Trust placements for older adults. MC highlighted that the Trust was reliant on local authority colleagues and

the availability of onward placements to enable service users to be discharged. The cost of this issue, which was shared between the Trust and its commissioners, constituted approximately £5 million per annum.

4. A recommendation was to discuss the problem with partner or colleague organisations, and to look for potential leverage elsewhere. MC noted that the problem was not unique to the Trust, but was a common problem nationwide.
5. MC outlined a further key finding around personality disorders. The Trust admitted a number of people with personality disorders who, once they were admitted, seemed to stay in care for a significant period of time. Evidence and best practice suggested that admitting people with personality disorders should be avoided if at all possible and, when people were admitted, admissions should be time-limited if at all possible. MC stated that longer admission times, and the environment of acute inpatient units, had a detrimental effect on people with personality disorders, and increased their risk of suicide by 40%.
6. MC said that, if the Trust could work with commissioners to establish a robust, community-based, Personality Disorders Pathway, and implement appropriate policy and procedures, to prevent admissions where possible and to time-limit all admissions, and to limit the number of admissions per year, the organisation could save approximately 2,800 bed days. MC emphasised that the individuals in question were high risk, and that there would be consequences to applying the policy.
7. Further work was being undertaken to reduce the length of stay for service users in general. This required a more standardised approach to those admitted to a ward environment. There were standard guidelines around treatment for conditions in inpatient units, as well as standardised approaches to good ward quality in mental health services. This included, for example, each individual receiving one-to-one care across the ward. A primary reason for this was ward size; in a lot of cases, Trust ward sizes were above the recommended number of beds. MC highlighted that the number of beds per ward significantly impacted both service users and staff. She recommended that work be done to assess the estate and consider the opportunity for reducing ward sizes.
8. MC noted that the Trust's high use of agency staff meant that it was difficult to adopt and sustain best practice on the ward.
9. It was further necessary to increase staff capacity in-ward. Wards that had reduced their bed numbers saw staff becoming 'more liberated'. Staff were able to spend therapeutic, one-on-one time with patients.
10. MC recommended working through the localities to address the recommendations. She emphasised that it would be useful to reinforce the locality structures with fixed term resources.
11. The Chair asked MC to outline the next steps. MC replied that the Trust needed to agree which elements of the Pathway it wanted to adopt, and to consequently develop a detailed programme of work to cover approximately 18 months.
12. TG noted that length-of-stay was only addressed as an issue when it became 'unmanageable'. He suggested that the issue be addressed sooner. TG further suggested that the Board would have a high-risk appetite for putting facilities or

programme managers at risk, in relation to commissioners not providing funding until after the first year. He asked that the Trust think 'out of the ordinary' and adopt different approaches to address the problems.

13. IT updated that he had asked for a clear outline of immediate actions, planned actions and actions going forward. He emphasised that, from a measurement point of view, it was necessary to develop a clear outline of what was to be expected in terms of lengths of stay, admission times and investment terms, etc.
14. KD agreed that there were elements of the proposed operational practice that were 'necessary' for the Trust to undertake. She anticipated that the changes would bring 'standardised benefits' across the organisation as a whole, which would improve patient care in any event. KD suggested that work should begin with the four project work streams, as outlined on page 26 of MC's report. She agreed with MC that it would be beneficial to begin by working with one locality and subsequently rolling out the model.
15. TG noted that the Committee had identified potential additional revenue spends, potential additional capital spends and a potential impact on the Trust's estate strategy. He suggested that the estate strategy and capital plan be revisited in light of the proposed model. Further, the impact to the annual operating surplus needed to be determined and presented to Board. TG added that a PMO capability needed to be developed and applied to the model in the first instance.
16. The Chair emphasised that the Committee were in support of the model.

FP/14/143- A.O.B.

1. In terms of the TDA oversight return and monitor compliance, SH confirmed that there were no changes.
2. There were no changes to the Board statement.
3. The Finance and Planning Terms of Reference had been shared with the Committee and was up-to-date. This also applied to the draft Work Plan.
4. SH clarified that, paragraph 4.1.2 of the Commercial Tendering Report was not reflected of the current position and would be removed from the report. SH explained that the team were in discussion with a number of parties who may or may not be bidding towards Wiltshire Community tenders. Discussions were further being held with the three acute Trusts who were potentially going to pull together a single bid for the tender. SH confirmed that discussions had been held with Medvivo around a potential tender. She said that the paragraph in question suggested that the Trust were partnering exclusively with Medvivo. SH confirmed that this was not the case. The Chair agreed that the paragraph could be withdrawn and rewritten.
5. PW noted that the Daisy model, Operating Plan and inpatient review would impact on the decision to open a new ward.