NHS
Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Group

Strategic Finance Committee Minutes of the meeting held on Friday 30th October 2020, 15:00-17:00, via Microsoft Teams

Open Minutes

Present		
*John Cappock	Strategic Finance Committee	JC **Chair**
*John Rushforth	Deputy Chair and Lay Member for Audit, Governance and Risk	JRu
*Sarah Truelove	Deputy CEO & Chief Finance Officer	ST
*Julia Ross	Chief Executive Officer	JRo
*Brian Hanratty	Clinical Lead	BH
Attended		
Lisa Manson	Executive Director of Commissioning	LM
Jonathan Lund	Deputy Chief Finance Officer	JL
Steve Rea	Associate Director of Programme Delivery	SR
Helena Fuller	Deputy Director of Commissioning	HF
Denise Moorehouse	Associate Director of Quality (Attended for Item 4.1 only)	DM
Lee Colwill	Head of Adult Continuing Healthcare (Attended for Item 4.1 only)	LC
Luke Baynes	Executive PA (Minute Taker)	LB
Apologies		
Jonathan Hayes	Clinical Chair	JH
Deborah El-Sayed	Executive Director of Transformation	

*Members of Committee who make-up quoracy.

	Item	**Action**
	This month's meeting was held via on online Video Conference due to the Covid-19 outbreak.	
3.0	**Declarations of Interest** There were no new declarations of interest	
3.1	**Open and closed Minutes from previous meeting** The minutes for the open and closed session had been circulated to the Committee in advance of the meeting and were approved.	

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3.2	**Action Log** The action log items were reviewed and updated accordingly.	
3.3	**CCG *Operating Budget M7-12*** The total CCG budget for M7-12 is proposed as £842,791k. Budgets for M7-12 have been aligned with Phase 3 Operational & Financial Plan submitted to NHSE/I. This plan has not yet been formally approved by NHS England/Improvement. The timeline and process for this is not yet known. This plan was developed as whole System Financial Plan; including system level prioritisation & principles for apportioning funds. The CCG has prepared a balanced financial plan; however the overall system plan has a £43.2m deficit, if not resolved nationally this may require the CCG to change its planned investments to support the wider system financial position. The CCG has identified £4.2m of gross financial risks to its plan; but also £4.2m of mitigations to offset this. The plan will be supported by £9,196k of savings targets designed to ensure the underlying position of the CCG remains aligned to the Long Term Plan. The wider system plan has further financial risks which could be mitigated by slippage & re-prioritisation of Phase 3 mitigation expenditure and provider capital expenditure, such as Elective Incentive Scheme penalties, AWP Provider Collaborative risk sharing. JL took the committee through the paper proposed to be approved and taken to Governing body. ST asked to discuss the deficit against the providers as it is a non-NHS operating income issue. If holding the deficit in one part rather than another is beneficial to the system even if it's disadvantage to the CCG is that supported. The Committee agreed it could be. Therefore the CCG needs to push other parts of the System to minimise the deficit. JC was concerned that if the CCG is put at disadvantage then are we being clear with where the responsibilities lie in this document. JRo said we are in a period of transition from where the CCG has control of	

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	the budget to where the system will be in control of the budget. The focus should be how we optimise income to the system and where the deficit does sit. The leaders for delivering saving plans are not always with the CCG. ST observed that we have a maturing level of relationships across the system and transparency between organisations to help with the deficit. JRo asked if we could change the way we have framed the public involvement in the plan. There has been a lot of engagement in the LTP, our operational plans were amended to Phase 3 and now this budget came off the back of Phase 3. **Action: Amend the document to include public involvement in line with the LTP.** JRu commented that part of the deficit comes from levels of growth we are allocated compared to what we experience. Previous discussions had about Primary Care (PC) allocations do not match the growth we see. JRu asked is the growth based on what growth will be or has been, and how has the model for Covid affected the plan. JL answered in terms of PC the budget is in line of national allocations. In year the growth is higher, but we have a plan in the current year with ARRS and General Practice (GP). We think saving can be made in PC to live within their allocation. The majority is non-recurrent saving and the growth is non-recurrent for example Pier Health. LM replied that the allocations in acute trusts are based on 19/20. The activity going through providers is now less based on Payment by Results (PbR) basis. In that sense we are managing growth although not in the way we wanted to do it. They have also been funded within the costs occurred during Covid. We have been diverting staff in doing one thing that we originally didn't fund them for but not in totality. In terms of budget setting we are, in effect, enabled to double run, with additional no-recurrent funding. JL explained with direct Covid costs there has been system funding envelope some of which flows to the CCG books and some with providers, but there could be a break glass on that in case of another peak. Otherwise we have to manage within the current annual financial envelope. We were told not to assume a second peak in the plan.	JL

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	JRo confirmed this was a national directive. The key assumptions of financial months 7-12 are all national. We are implementing what we have been given this year. ST added that an amendment to the paper is that we should not assume a significant second peak. Action: JL to amend narrative to reflect this key assumption JL in terms of costs we put in funding on a non-recurrent basis to keep elective going. The bottom line terms the costs base of the system will be unlikely to go up significant due to workforce and capacity constraints. It will be about meeting activity targets rather than playing out as a financial risk. BH asked why the Covid costs in PC Flu are zero, are we going to inject more people than are normally entitled, and is that a cost pressure . JL the costs of the vaccine itself would be reimbursed by Public Health England (PHE). BH asked about the system funding and the provider's annual leave accrual, does this happen every year or it because of Covid, and is there any other providers in the system to get the annual accrual. JL answered that annual leave accrual recognises the increased annual leave taken into the next year; this would not be expected as a CCG responsibility of any other provider. We have assumed it of the large providers in the system only. ST added in terms of that £43m it shows against their individual spend position. We are getting a sense nationally of the financial picture. Some providers say it is not actual so they do not count accrual. Some organisations have always have an annual leave accrual. Particularly this year people will not have taken so much leave. JC asked about the amendments, approach to saving, and oversight arrangements were there any questions. JRu asked what a directive is and what is a discretion. ST we are being told we need to implement 111 first. So we are taking account of that in this budget papers. Something will come back through Clinical Executive.	

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	JRu asked about South Gloucestershire avoidance admissions in the papers and why it wasn't presented for other local authorities. JL said that was a function of them coming forward with a specific initiative. JC in summary we are asking GB to approve the m7-12 budget with a for comment from key messages about the support in our intent to give best value for the population. JC asked of the committee are happy to approve this paper to go to GB JRu suggested a comment to recognise to put into the work to achieve this. Otherwise the rest of the committee agreed to approve the paper and send on to Governing Body.	
4.0	***CCG M6 Finance Report*** The CCG is reporting an YTD deficit against the prospectively adjusted allocation of £8.7m. This can be attributed to the following factors: 1. £4.5m adverse M6 Covid costs. £17.0m direct Covid-19 response costs to date off-set by an allocation adjustment of £12.5m covering M1 to M5; 2. £1.0m adverse Prescribing costs in September related predominantly to Cat M £0.25m, NCSO £0.28m and volume increase of £0.29m; 3. £1.5m adverse Technical & Accounting issues with the prospective baseline set by NHS England and mainly relate to service transfers between providers, beneficial impact of non-recurrent allocations relating to 2019-20; and creating provisions for new 20/21 Service Development Funds announced by NHS England 4. £1.7m adverse residual variances in September – main issues increasing expenditure in CHC as assessment restart, notably fast Track; and £700k overspend in Primary Care as a forecast underspend in ARRS is no longer likely to materialise based on latest workforce plans JL presented the paper that was distributed prior to the meeting. He highlighted that as of today we are not sure if we will get the £8.7m	

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	reimbursed, but we are expecting it, nonetheless we cannot definitely say it has been reimbursed. ST added that this is the last month of the retrospective claims basis. The information we received about m7-12m told us that we should have claimed for some funding such a maternity transformation funds As a CCG we are lower than other organisation in terms of our Covid costs.	
4.1	**CCG Savings Reports M5 and deep dive** • Month 6 2020/21 YTD and FOT position reported – see sections 2 and 3 below. There has been a deterioration of £562k to the forecast position compared to month 5 mainly due to the slippage on the Complex Individual Care Schemes. • Since last report the BNSSG Phase 3 plan has been completed. The financial implications on the CCG budgets and impact on savings requirements are described in the separate budget setting paper. • Work is now underway to confirm the recurrent financial savings impacts of the programmes, projects and mitigations that we have underway within the system – both those within existing system programmes and CCG Control Centres and those that have been developed as part of Phase 3. Whilst the financial framework for the NHS is not yet known for 2021/22 it is important to capture the areas that will support future financial sustainability. SR presented the paper which was distributed prior to the meeting. SR asked the committee about the forward planner for the deep dives for the remainder of the financial year. ST asked that the forward planner is brought back to the SFC at a later date JRo agreed and that the committee should being seeing potential responsibilities more often. JRo asked if the Planned and Urgent Care are unable to report then should it be taken out of the total at the bottom of the paper as this does not look right in presentation terms. JL said about the areas of control we need to have another look at Primary Care finance as there is an underlying deficit there. JC asked about the previous Public Health Management (PHM) deep dive	

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	that was brought to the committee last time. **Continuing Health Care Deep Dive** DM gave the presentation on the CHC deep dive which was distributed prior to the meeting. Control centre planned have been working to the target of £6.5m. Covid has had a huge impact on the ability of funded care. The year to date actual is £425K which is further than what was planned. The overall plan for CHC was ambitious at the outset without good detailed plans into schemes with milestones and deliverables against a month by month basis. Discuss of the meetings about is getting it on Verto with details and set is. Culturally within CHC there is not a sense this is Business as Usual (BAU), funding saving in operational plans has not been BAU way of working. LC briefed the committee on the planned programme schemes and what changes have been made in light of the deep dive. DM identified the new CCP approaches to future actions taken away from the deep dives. JRo commented that it is not about the money but provided the right service. This is a quality transformation as much as a financial. The CHC historically has not worked following best practise and that should not be the case. JRo was disappointed that the transformation plan is being pulled together due to the 18 months it has taken to get to this point and it now has to happen. This committee has to see that plan so there needs to be heavy pace now. JRu asked about the transformation programme is not designed to deliver saving this year at all, can we expect the programme will come through with saving of £3m next year, and when do you think we will start seeing real savings come through and what are the key risks to your saving deliveries. DM answered about the Transformation plan there has been a draft plan and now there is better ownership we will now deliver on this. We will start to see some savings coming through as we have already made some changes, for example the Fast Track will be £40k a month. The problem with a	

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	timeline is the LA must pick on the packages and reimburse. The schemes that are most at risk are the discrete schemes as they are difficult to provide reporting and assurance. BH asked if this on the CCG risk register. He also asked about the impact of Covid on the assessments evidence nationally of Covid leading to patients using high costs packages of care. DM was not aware of any national evidence in increases change for CHC. There is an issue with overproviding and leading to reduced capacity in the resulting in the system being unable to pick up other patients. It is not just about money it about making best use of resource across the system. JRo commented that the challenge for us is that we have to operate the Fast Track pathway true to the framework and increasingly we have to do this together with the LA. DM added that there is a joint authority funding panel to examine the level of support we should be providing when they don't meet the level of CHC. This is infantile in its maturity but at least we have a forum for those discussions. JC concluded that CHC should come back for another deep dive in three months' time **Action: to add CHC deep-dive to Forward Planner for January**	SR
4.2	**Review progress on integrating Health and Local Authority budgets and financial governance arrangements** Jon Lund gave a presentation that was distributed prior to the meeting. There have been not specific transactional changes to our funding with the LA. The response to Covid develops risks us heading in different directions. There is some initial thinking about principles in funding with the LA but these have not yet been shared with the LA. JRu asked about the principles in the third bullet point. We need to understand different needs but it is difficult if we accept that there will be differences in diverse areas and if there is a different in need. The equity is really important which includes a different level in diverse areas.	

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	JRo commented that the desktop review did not help very much. Under organisation structure the biggest difference is local politicians. We could do BCF very differently. The principles are all negative so what are the positive that will drive us in the principles. Bullet point 1 + 4 seem to be saying similar thing, plenty of other places have pooled budgets so is this due to will. JC suggested that all the intent is helpful particularly assuring resources but maybe focus on more on the desktop review before visiting the financial principles. ST said that is helpful information. It would be helpful to go back around the principles. JRo added it's a good idea, before agreeing principles we need to say what this is all about.	
5.0	**Review forward work programme** JC remarked that we had discussed the forward plan earlier in the meeting and the milestones stick with the financial and planning year. The committee was happy to adopt the current plan.	
5.1	**CRR & GBAF** ST said in light of the paper we took today for the risk M7-12M we need a review of the risk assigned. ST suggested putting the CRR first on the agenda at the next committee meeting **Action: Add to the agenda first and invite Sarah Carr to conversation.** JC stated that the three risks recommend for closure can go to GB next week as there were no concerns or issues.	LB

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	JC said in respect to the GBAF there were seven highlighted for oversight. The PHM has been discussed previously to be brought back in the near future. ST said looking at the agenda we have covered off most areas apart from the Children's services. JRo commented the funded care says it will go to Audit committee. ST concluded this is result of the external CHC review that has been done. Rosi Shepard is clear that this is coming back to the December meeting and was dropped in between the handovers of Nursing and Quality Directors.	
5.2	**Key Messages for Governing Body** • SFC are happy to endorse the proposals contained in the month 7-12 operating budget and in particular the intent to drive best value for our population through ongoing effective system working. The Committee wishes to congratulate all involved in preparing this in light of the particular challenges this year and wish to recognize the achievement. • Finances are showing a reasonably stable and reassuring position. We have clarity around the planning guidance in place for the remainder of this financial year. • Transformation work continues notwithstanding exceptional circumstances. SFC continues to see this as critical. For SFC purposes the target is £18M. • Deep dive continuing health care indicated challenges around culture, performance and ensuring that the resourcing balance is appropriate in all cases. The Committee will receive a further update at the end of January. • CRR and GBAF reviewed. Specifically SFC reviewed all risks and particularly those specifically related to our remit, reviewed risks	

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	recommended for closure, confirmed that CRR and GBAF are accurate reflection of risks. Specific SFC risks will be reviewed in more detail next month.	