NHS
Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Group

Strategic Finance Committee Minutes of the meeting held on Friday 25th September 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
Christopher Davies	Associate Director Business Intelligence	CD
Steve Rea	Associate Director of Programme Delivery	SR
Helena Fuller	Deputy Director of Commissioning	HF
Rachel Anthwal	Head of Contracts – Non Acute	RA
Niall Prosser	Deputy Director of Commissioning – Planning and Performance	NP
Kate Lavington	Head of Transformation (Integrated and Urgent Care)	
Luke Baynes	Executive PA (Minute Taker)	LB
Apologies		
Jonathan Hayes	Clinical Lead	JH

*Members of Committee who make-up quoracy.

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

	Item	Action
3.1	**Action Log** The action log items were reviewed and updated accordingly.	
4.0	**CCG M5 Finance Report** JL presented the report that was circulated prior to the meeting. - The financial framework, initially for the first four months but now extended to six months of 20/21, was changed to allow the NHS to respond to COVID. The regime means our initial allocation has been changed but with the expectation that our actual costs will be met by further allocation adjustments. The key changes are: - the CCG allocation having been set for Apr-Jul has now been extended for M5 & 6 given the extension of the current financial regime - the revised allocations broadly represent run rate expenditure from 19/20 continuing into 20/21 ie. there is no investment funded, but equally no requirement to recover underlying overspends - Funding for ISTC contracts commissioned nationally has been clawed back. Funding has been reset for NHS providers to represent the value of the nationally calculated block payments - Retrospective true-up m1-4 have received allocations. M5 has an adverse variance of £4.3, £1.5 further Covid related costs which are now slowing down. We slightly understated prescribing position last month but there has been an overspend. The costs have gone up for transformation program with NHSE retrospectively funding for transformation funds. The underlying costs of the CCG are quite stable and no major issues to report this month.	
4.1	**CCG Savings Reports M5 and deep dive** SR presented the paper that was circulated prior to the meeting - This paper provides an update to the 2020/2021 deliverables and savings position as at month 5 (April - August 2020). . - Month 5 2020/21 YTD and FOT position reported – see section 2 below. There has been a slight deterioration of £200k to the forecast position compared to month 4 due to the slippage on the Complex Individual Care Schemes. - Focus over the last few weeks has been on supporting the process	

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	for submission of the BNSSG Phase 3 Plan, including development and prioritisation of provider and system transformation plans that seek to maximise productivity and value, and therefore positively impact the system recovery trajectories. At the time of writing this work is still in progress. - A review meeting is scheduled for 23 September where consideration will be given to the developing role of Turnaround Steering Group, noting the accountabilities and responsibilities of system groups (such as HT Steering Groups) in terms of programme delivery and the CCG role of understanding population needs and use of PHM, alongside existing functions such as delivery oversight of plans from a CCG perspective. - The risk mitigations have been updated to reflect present circumstances. - SR recommend CHC colleagues to give the deep dive next month. ST commented that this is a significant cultural shift for the organisation from a transactional to a more value perspective. JRo asked about complex individual care as we have only achieved £400k savings and how certain are we going to deliver on the £6,500k forecast. JL confirmed that the funded care team will come back next month to explain the positon and actions being taken to mitigate. The underlying spend on CHC has come down because of Covid due to mortality, and changed assessments on hospital discharge. Therefore any savings saving underdelivery should not significantly affect the CCG's financial position this year. JRo asked if the CHC transformation programme does not work because what is going on in Covid. ST explained that she doesn't think it needs to be suspended. There are challenges because of the team as they have to catch-up on the assessment. Potentially we need to make sure that they are on top of those transformation changes. JRu we have forecast £15m of saving out £18m. What are doing with the £3m SR confirmed these are unmitigated circumstances so we are taking in the phase 3 planning at the moment. There are a number of changes coming along that will change the efficiency of the system and many things are not included in the plan yet.	

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	ST from a CCG perspective the in-year position is deliverable within the overall system envelope, we do know yet the financial regime for 21/22. We are still testing what out of the recovery work will have implications for next year.	
4.1a	**Urgent and Integrated Care** NP gave the presentation which was distributed prior to the meeting. BH expressed that from his experience sitting on the NHS 111 clinical leads group he agreed in principle where this was to go. The positive news of reducing ED attendances does need to be aligned with increasing capacity issues and cost issues in the community. JRu questioned the confidence of the capacity to deliver and not spreading ourselves to thinly. He also asked if is this will be knocked sideways if Covid is not brought back under control. NP said that there are clearly a growing number of Covid cases regionally and nationally. Any large scale growth would delay transformational change which is a risk that sits with what we do. There is scope and capacity to deliver the full range, but it is something we regularly monitor, this is partially why we have introduced the maturity assessment for our schemes. JC thanked NP for the update and there were no other comments from the committee.	
4.2	**Confirmed financial framework for Phase 3 and BNSSG financial plan** ST gave the presentation which JL distributed during the meeting. We are currently planning for recovery, involving in NHS 111First and the Mental Health Business Case, and what we can deliver and the value of those schemes. There is £32m funding available to go against mitigation, which will require a financial governance regime. JL added for the large acute providers the expectation of their spend for the remainder year is less than compared to the average in the same financial	

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	period last year, which frees up funding for reinvestment. ST continued the regional final submission is now 5th October. We are expecting these mitigation will recover most area of activity to expected levels. Outpatients still has very high levels of activity which have been impacts by IPC measures and the other area affected is Non-Obstetric Ultrasound (NOUS). JRo asked about the bed deficit in relation to urgent care, if activity in the elective space increases, what thinking has been done to join that back up. ST said there is further thinking about bed deficit. What is built into the financial plan there is money in for Winter planning. The Capacity and Impact Cell have been discussing the bed deficit. LM we trying to get the beds that the acutes have closed to re-open, as there have been no resources come through to support community in other ways. JRo commented that we have never had ended up with a balanced position on beds through Winter. We need to make sure we are joining back up our recovery expectation and management of Winter and non-elective. ST expressed that more planning information has come out this afternoon that we will be going through in more detail. From a CCG perspective the key issues are that level of prescribing growth looked right, but Primary Care (PC) allocation was not quite right. The PC allocation is a timing issue and we should get that through. In terms of the prescribing growth it is short, but we have intact contingencies. JL observed that prescribing growth and CHC assessment restarting planning assumptions are that we will not make any saving so that is another source of mitigations. One significant area in the system financial envelope is SWAST because their baseline funding in the Dorset allocation. LM highlighted that is being picked up in the AJCC on Monday as part of the phase 3 planning.	
4.3	**Covid-19 management letter** JC asked if this will go back to audit committee in due course.	

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	ST confirmed that audit committee it will just be considered at SFC. BH was assured by the letter.	
4.4	**CCG Capital Report M5** JL presented the paper which was distributed before the meeting. JC asked are we implementing pre-Covid plans that were deferred or has there been a stock take, has that changed any of the capital planning thinking. JL advised in terms of the major schemes they have not been majorly impacted. The minor areas have been impacted more. The Minor Improvement Grants (MIG) funding has not come back. There probably won't be a financial consequences of investing primary care estate and IT. JRu asked are we ready to respond if new opportunities spring up from capital investment. ST conformed she had spoken to Tim James that morning to take this forward over the next few weeks, We understand that the primary care team is not being scaled down nationally so this could mean there potentially going to be work done in this area. BH expressed one of the big barrier issues to developing IPC's would be estates so was thankful of ST's comments.	
4.5	**Review annual planning / contracting approach to include commissioning intentions (Procurement pipeline)** LM gave a verbal update on the procurement pipeline. The proposal is to not issue commissioning intention as we move into an Integrated Care Service (ICS) in November. The programme of work being looked at is contract arrangements as issued by NHSE. There were no questions on this item	
4.6	**Population Health Management & Value Programme - Actuarial and Financial modelling inputs and forecasts** CD gave the presentation that was distributed prior to the meeting.	

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	JC asked about the savings of the programme and if the information has worked. ST said one of the discussions we had this week was using this information to asses frailty. JRu asked how we quantify outcomes across so many different activities; however you measure outcomes in one area you need that methodology in other areas. How do we spend our resources on those with special protected characteristics etc. There will not be one way to segment the population and we will have to take most of those into account. CD agreed with JRu and explained there is not one size fits all and there different segmentation approaches. This example we used forces data into groups and this is an illustrative example. Members of The Business Intelligence modelling team published a paper on using segmented approach so we are very aware of this approach. JRo acknowledged we are talking about health inequalities and how this data will help intervene with the health inequalities across the system, it needs to bring in the local authorities as it is not completely health based. Unfortunately we are not talking costs, as we are talking spend, and there is a massive piece of work to do in costs across the system. ST understood the costing issue is imperfect. We are looking at it what it will cost the CCG not the provider at the moment. Kate Herrick from UHBW is taking the lead for the system on the workstream on the PHM project; This is positive to understanding costs across the system. ST added the outcomes are procuring a platform to capture the outcomes which has been delayed because of Covid. CD said we were considering bringing in a health economist to look at other ways to capture outcomes from the data we have. JRu asked when we are talking about outcomes is there a time dimension to that, ie an immediate outcome which has an ongoing time benefit. CD answered the cost of the intervention is measured against the benefit of to the life of the patient as that is where we get the value from.	

	Item	Action
5.0	**CRR** ST said we have covered off the lack of understanding the financial position going forward. The conversation about savings we need to keep under review.	
5.1	**Key Messages for Governing Body** • Committee discussed and endorsed the recommencement of the integrated community equipment procurement for submission to GB • Finances are showing a reasonably stable and reassuring position. We now 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 of which £15M is identified in the forecast at this stage. • The Committee received a presentation on population health management. This offers scope to provide a more focussed understanding of whether or not population needs are being met through our actions. SFC encouraged further development of this thinking and aligning with the transformation work. SFC received updates on Urgent and Emergency Care programme, capital programme and the planned approach to contracting for 20/21. • The Committee reviewed management responses to the internal audit Covid review letter and reviewed the CRR.	