Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group

Strategic Finance Committee Minutes of the meeting held on Friday 26th June 2020, 13:00-15:00, 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
Attended		
Jonathan Lund	Deputy Chief Finance Officer	JL
Steve Rea	Associate Director of Programme Delivery	SR
Helena Fuller	Deputy Director of Commissioning	HF
Rebecca Dunn	Deputy Director of Transformation	RD
Emma Brown	BI Manager	EB
Andrea O'Connell	Independent Consultant, CHC Transformation Programme	AC
Lee Colwill	Head of Adult Continuing Healthcare	LC
Padma Ramanan	Head of Finance – Partnerships and Mental Health	PR
Sabrina Smithson	Executive PA (Minute Taker)	SS
Apologies		
*Jonathan Hayes	BNSSG Clinical Chair	
*Julia Ross	Chief Executive Officer	JRo
Lisa Manson	Executive Director of Commissioning	LM

*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. **Declarations of Interest** There were no new declarations of interest or declarations of interest relevant to the agenda. **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
	Action Log The action log were reviewed and updated accordingly. **BNSSG Stroke Programme** The papers were circulated to the committee prior to the meeting. RD & EB highlighted their recommendations for the committee: • That the work completed on the baseline position is assured by the Strategic Finance Committee, following completion of a detailed costing exercise with system partners • That the deficit position on the baseline is noted • That support is given to the next phase of the programme, which will determine the financial impact of the proposed future state provision and appropriate contracting mechanisms to support this The following questions arose: JRu asked regarding the deficit, how the level of spend on stroke compares to the national benchmark or peer groups. RD advised the national baseline would be reviewed as an action – ACTION. RD confirmed that the Programme does not intend to a develop a service model that is unaffordable and therefore understanding the baseline cost for comaprison was vital. JL noted their currently appears to be an inconsistency between UHB and NBT and the activity levels quoted in terms of beds don't correlate. RD advised the CCG have noted this, but they are different services within these providers so there are significant discrepancies. RD suggested working with the CCG Finance team on this. JC asked are the CCG looking at have system resource to consolidation. RD confirmed. We were looking at contractual models before Covid but we have not taken this forward since March due to Covid-19 and this will be reported back through the Governing Body. JC asked regarding the clinically led solution, would it be more a business led solution as opposed to clinical. RD answered we would like to have both, but until this is mapped out it is difficult to say. DES noted we need to have consideration to the whole patient pathway cost and not just focus on the Heath-related cost, to make sure we're not too short sighted. ST noted the conversations with the clinical group and noting the CCG need to keep discussing the best outcomes for sources available	RD RD/ST

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	within those conversations. JRu asked if part of this work looking at prevention as well. RD reported the CCG are not looking out of scope now. It was suggested the baseline should be reviewed again further at an STP DOF meeting – ACTION **CCG Finance Report – Month 2** A presentation was circulated to the committee prior to the meeting. JC asked is the expectation that covid-19 funds will be refunded. JL answered yes, but the exact mechanism that that will happen is yet to be confirmed. ST advised the committee, the CCG have been testing with colleagues across the South West that our position is similar and BNSSG are actually presenting lower covid-19 costs and a lower deficit. JRu interjected does that take into account the different levels of covid-19 activity. ST advised that many costs were associated with preparation for covid-19 as much as actual infection costs, for example everyone had to implement discharge programmes in hospitals. JL reported the CCG manages our internal accounts against our existing internal operational plan; as well as the Covid finance regime so we can ensure we're not losing sight of underlying financial position. JRu asked about the Prescribing variance. JL stated it was still being debated nationally regarding which costs should be directly attributable to covd-19. The top-up of funding expected won't be just based on covid however and therefore we still expect to have additional costs funded. JRu asked how Primary Care costs are being captured and managed. JL confirmed it was covered by same process as for other providers. DES asked after the NHS 111 costs and if the increase in calls was Covid related? JL confirmed and advised of the expectation of this to go down. **System Finance Report** The presentation was circulated to the committee prior to the meeting. The following questions and discussions arose: JC asked if the variances reported were indicative of the leadership in different organisations; ST advised we could not draw that conclusion as they provide different services which have been impacted differentially by covid-19. JRu asked where Sirona and local authorities were captured in the report.	

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	ST stated Sirona finances were effectively included directly in the CCG income and expenditure positon. Local Authorities were currently excluded and advised the CCG are carrying out work with the local authorities to bring this in JRu asked are Track and Trace costs part of this reporting. JL advised No, that's all managed and funded nationally. **CCG Savings Reports – Month 2** A presentation was circulated prior to the meeting. SR highlighted the following areas: • 2019/20 final savings position confirmed (£39.6m) • Lessons learned review completed with key reasons of non-delivery explained. • Engagement with providers is improving. JL noted an observation that there are a number of projects that are delivering savings now, but at took a while to deliver, for example outpatients/high cost drugs. It seemed to be the speed of implementation that was over-ambitious not the scheme itself. JC stated the key reasons about over-estimation were helpful, and continued to ask have the CCG done an estimation or analysis of how much this has cost us. SR confirmed a report will be submitted to future Committees. JC further queried the over-estimation impact can bring on big capital programmes, is there anything we can foresee here. SR Confirmed yes this is also being reviewed and to be reported to future committees. DES reported the challenges the CCG find with turnaround projects and defining agile business cases are difficult. We are looking at the gateway outcomes and we need to make sure we have those structures in place. JRu noted the £30m savings was a commendable achievement. JRu asked has work been done on the culture of the organisation, and then explained the CCG sometimes is over-ambitious or not ambitious enough and this links back to culture and will we be addressing this? ST noted this and advised there are active conversations taking place on how well we have allocated resources to things that are our highest priority and how do we take the learning from that into our business as usual. - **Complex Individual Care** A presentation was circulated to the committee prior to the meeting. LC, AC & PR highlighted the following areas: • The Complex Individual Control Centre plans have 6 identified	

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	schemes to support a Control Savings of £6.5m. • Several of these schemes are on hold/delayed due to Covid-19. • To further support the £2.9m unidentified saving schemes a workshop was held with managers in the team to identify further potential cost saving schemes. • All schemes identified need to be worked up and further support is required from both the PMO and also Finance team. All managers will need to be trained on Verto and would also like more understanding of the budget. • The transformation plan for CHC that has been developed will support savings as detailed in NHS England's Strategic Improvement Programme Menu of Opportunities, which includes: - Standardised processes. - Standardised commissioning and contracting. - Use of dashboards to track performance and address areas of concern. - Peer review. - Consistency of decision making/reducing unwarranted variation. - CHC seen as part of integration agenda. - Timely and proportionate care package reviews. ST stated in the forecast it reports all savings will be delivered and asked is this a realistic report. AC answered we are looking to restart CHC assessments in July and there is training in place for this. Looking at innovative ways to do assessments and reviews. The CCG will re-review this in September. PR added the M2 forecasting assumption of delivering savings, later than usual this year is the actual impact of April and May, in August-September, we will be clearer. JRu asked in regards to big projects and not over-estimating, is there a slight anxiety we might over analyse and how do we prioritise. AC answered we need to sort out things such as E-xec contract. We will priorities those with the greatest impact financially. **Covid-19 Phase 3 Annual Operating Plan** ST Reported for M5-12 there are discussions with the national team and we're expecting the phase 3 planning guidance in July 2020. The CCG will get a fixed financial envelope at system level for M5-12, they are aiming to bring back some financial control within the NHS. This will empower systems to work together and not just at an organisation value and really interact with the systems.	

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	Covid cost will be reviewed nationally and then we will get an allocation for our system. As BNSSG have been spending less it might be an advantage, There will be a 'break-glass' clause in the event of a second spike or local lockdown. ST concluded the main concern is what will happen with the hospital discharge scheme and not doing CHC assessments, as we would have done previously. ST further reported the CCG won't need to agree contracts with anyone but we need to think how the governance will work making decisions around a system financial envelope. **To review progress on setting Integrated Care Partnership budgets and financial governance arrangements** ST reported the Governing Body signed of the ICP next phase paper; Julia Ross has been speaking to stakeholders to scope out this. The Finance team has continued to undertake development work to support the move to Integrated Care Partnerships. • At May SFC a review of Primary Care budgets was undertaken, to understand what was discretionary vs core spending; and what spending could be allocated or apportioned at practice level, PCN level, locality level vs whole population level ST asked the committee for their initial thoughts to contribute and review at a later stage: DES noted in regards to Mental health, there are new reporting systems such as 'radar' and it might be worth checking in with other systems on how they are getting on with the pricing around certain activity milestones for someone like e.g. Section 3. JRu asked if what the CCG are considering is delegating authority for spending at locality level, how do we ensure we are not getting in-equality in cohorts depending on where you live? The CCG need re-assurance on this as this is something we have worked on. JRu further noted the decision making regarding spend of resources was not clear and how will that affect the board for locality and will there be a conflict of interest? JRu's last note was the nature of population to be taking into account and the difference in the voluntary sector offer in certain communities. JC asked what assurances do we have about the locality expertise and ultimately where does the liability stop? If this doesn't work are we comfortable with the control we are giving away. JRu added delegation of authority required sufficient support for people to do the work.	

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	ST concluded the next couple of weeks will see the first draft of thinking and further feedback can be provided outside of the committee. **GBAF & CRR** Noted by committee. JRu asked for some columns to be re-reviewed in terms of dates – ACTION **Key Messages for Governing Body** • The financial environment remains unclear and it is anticipated that this will continue to be the case for a good part of this financial year. Covid related overspends are currently forecast. It is anticipated that these will be reimbursed but the formulae for doing so remain under discussion. • Stroke programme work was endorsed. This is intended to come to GB in October. • SFC reviewed system finance report and deliverability of savings and discussed lessons learned and scope to make changes to deliver these. • Early thinking on integrated care system budgets and financial governance was discussed and some initial ideas shared. SFC will build on these. • CRR and GBAF reviewed and considered appropriate.	JL