NHS
Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Group

Strategic Finance Committee Minutes of the meeting held on Friday 21st August 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
*Brian Hanratty	Clinical Lead	BH
Attended		
Lisa Manson	Executive Director of Commissioning	LM
Helena Fuller	Deputy Director of Commissioning	HF
Rob Ayerst	HT Finance Lead	RA (Item 4.0 & 4.1)
David Moss	Head of Primary Care Contracts	DM (Item 4.4)
Neil Turney	Transformation Manager – Mental Health & Learning Disabilities	NT (Item 4.5)
Sabrina Smithson	Executive PA (Minute Taker)	SS
Luke Baynes	Executive PA (Minute Taker)	LB
Apologies		
*Julia Ross	Chief Executive Officer	JRo
Jonathan Lund	Deputy Chief Finance Officer	JL
Jonathan Hayes	Clinical Lead	JH
Deborah El-Sayed	Executive Director of Transformation	DES
Steve Rea	Associate Director of Programme Delivery	SR

*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.	
2.0	**Declarations of Interest** There were no new declarations of interest JRu & JC declared interest in the Mental Health paper in accordance with their roles at universities. LM confirmed Health Education England had stated the specifics within the paper so it cannot be varied.	
3.0	**Minutes from previous meeting** The minutes for the open session had been circulated to the Committee in advance of the meeting and were approved.	

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3.1	**Action Log** The action log items were reviewed and updated accordingly.	
3.2	**SFC Committee Effectiveness Survey Results** The committee noted the survey and welcomed the exercise. JC asked if the SFC minutes and discussions were escalated to the CCG Exec Team. ST advised they were in sight of these through Governing Body paperwork and circulated action logs (if allocated action).	
4.0	**CCG M4 Finance Report incl Forecast outturn** A paper was circulated to the committee prior to the meeting. ST highlighted of the key messages from the paper and the chair noted that the information was consistent with last month's report. With that, the following queries arose: JRu asked if the CCG make good of the promises made and delivers the savings at the level we think we will achieve, will it come in on target. ST advised the CCG are pulling together the forecast outturn so we can compare it to expect spend. The forecast suggests in the last 6 months we will incur Covid cost of £10.5m and remaining cost variances of £10.1m.There will be a national look at COVID costs and a fixed financial envelope will be issued to systems so the CCG feels secure in that regard, as we benchmark low against other systems. The technical issues (£0.9m) are related to block contracts (nationally set) but we expect these will be corrected. ST added other issues include COVID related prescribing and Category M, slippage on CHC savings and the Mental Health (MH) Investment Standard pressure. There is £6.5m of contingency so we think prescribing and CHC slippage will be covered and prioritisation decisions will have to be made against the MHIS so the CCG can deliver a break-even position. BH advised Primary Care has become agitated about COVID cost with practices being allocated £3per patient, and continued to ask if the CCG is liable for any COVID costs within Primary Care. ST advised all costs up to M3 have been fully reimbursed. Once we get past month 6 we will have a fixed financial envelope for the whole system based on what has been spent on COVID nationally allocated to your population. BH queried if this was localised LM interjected and advised the CCG have had a challenge process to ensure equity across all the practices. JRu asked with the COVID funding, will it be based on level of spend nationally and distributed based on population as BNSSG have spent less ST confirmed that to be the case and explained this should mean the system has some extra funding to go towards system recovery.**System M3 Finance Report** A presentation was circulated to the committee prior to the meeting. RA	

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4.1	highlighted parts of the presentation and the following discussion took place: RA explained that Healthier Together is a month behind the CCG's position that was just presented in the previous item. This report shows how BNSSG compares to the rest of the region and BNSSG COVID spend is the lowest in the region for spend per head of population. There is a lack of clarity around the fixed financial envelopes being allocated across the system. Based on the presentation over the first 3 months of the year and compared to the South West average we spent £5m less. Potentially given a COVID envelope if this was at the average level of spend for the SWest we might be get £10m extra which would be over and above what we are spending on COVID which will help us restoring services in phase 3. **Progress report on Phase 3 Financial Plan** ST provided the following verbal update in regards to Phase 3 Financial Plan. - The financial envelopes for the system will for providers will be based on blocks - what they have been getting and CCG allocation. - Things outstanding is additional costs for flu, 111 FIRST we know we will get MH Investment standard funding and Primary Care Transformation funding. - COVID allocation and hospital discharge programme will be charged to a separate pot outside of the system envelope. 4.3 - Single system return – financial template and financial envelope so working with providers to get ahead in understanding the cost base and cost requirement for the remainder of the year across the system. - Complexities for provider block contracts are being reviewed. Looking at the draft for first 4 months. - The Financial envelope will be released within the next 2 weeks. - Yesterday there was some guidance of an incentive scheme for systems which we are working through and understanding the proposal. The scheme allows systems to earn more resource if activity can be delivered above the levels set in the phase 3 planning guidance and if deliver below these levels have 25% removed to reflect lower non-pay costs. In high level terms we're trying to piece this together so we can try to get an idea of what the envelope will be. JC asked what the deadlines are for these ST confirmed 4th September is first submission. BH asked what happened if the CCG faced a significant second wave. ST advised there is a break-glass clause so we would go back to the first regime. LM added the providers staffing expenditure has been different within COVID. LM asked RA if the CCG are including the Local Authorities. RA confirmed that the submission is just for the NHS system, but we need to ensure that	

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	we monitor this and ensure costs are recharged where appropriate. JC asked in regards to assurance and not expecting financial envelope until 02nd Sept, is there anything we can do to provide assurance. ST advised there will be a discussion at GB but the tactic proposed for the first submission is to say what we can do within the current run rate and not making assumptions about additional COVID resource until we have the chance to look at the envelope. JRu asked after the numbers for benchmarking. There is a strong correlation between cost per case and cases per population. What drives these costs. ST answered there it is unclear what the clarity of correlation is currently and it might very well be coincidence. The big variances for providers are with workforce and in the CCG spend there is a range for hospital discharge and some of the issues with national procurement and PPE. LM added the CCG is well provided for, we have a stronger positon in regards to our acute response because of the levels of critical care beds within the system.	
4.2	**CCG Savings Report M4** JRu asked what is the number that the CCG is trying to hit, is our planned actual saving £15.6m, and what are we asking the committee to get assurance on. We are trying to keep the focus particularly in the areas not covered by nationally determined blocks and delivering the transformation set out in the long terms plan. ST advised if you discount planned care and urgent care it is the £18m but we are forecasting 15.6m.	
4.4	**To review progress on setting indicative Integrated Care Partnership budgets and financial governance arrangements** A presentation was circulated to the committee prior to the meeting. ST & DM highlighted parts of the paper and the following discussion took place: The committee were asked to consider the following 1. Defining Scope and Scale of ICPs - Availability of Cost, Activity & Outcome data 2. Develop a Maturity Matrix to enable delegated financial responsibility 3. How ICP development links to ICS development and overall CCG financial governance 4. Proposed Project governance structure BH noted the Kings Fund slides were helpful for general debate and practice; the CCG need to focus back on these for system delivery. BH continued to advise he was in favour of the locality and the CCG are on the right pathway. LM noted the MH Community framework will help getting the work into a live and tangible example, part of it is starting small and bringing	

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	the learning back into parts of it to support the ICP's to be successful. JC asked after timescales for this. DM confirmed community MH is April 2022, so the CCG have autumn and spring to carry out the work. BH stated the CCG should continue with work on frailty and same day urgent care as localities can really help with these work streams. JRu stated the CCG should be mindful of being hung up on structure and protocol as we're trying to manage a cultural shift and collaborating for the benefit of patients. We need framework on how all these things link together, so long as the net outcome is better for the patient. JRu continued to suggest if the CCG are proposing doing this across the patch then a set of principles for all to comply with would be really helpful. JRu continued the gateways for autonomy, agree targets, agree information and agree reporting. We need to be assured we can track and reserve the right to step in. JC endorsed getting colleagues together and asked what is intended from the OD programme. DM advised for General Practice and PCN there is a significant OD strand including attendance at the Peloton programme and locality away days.	
4.5	**Mental Health In Schools recurrent funding pick up** A paper was circulated to the committee prior to the meeting. LM highlighted parts of the paper and the committee confirmed CCG Direct Award to CCHP for 3 +1 years with a review point at 3 years to confirm evaluation of the service.	
5.0	**GBAF/CRR** JC noted the GBAF had no significant changes. ST reported the CCG Exec Team are refreshing this and bringing to GB the week after next. The CRR was noted, particularly the challenges associated with the uncertainty in the financial framework going forward.	
5.1	**Key Messages for Governing Body** We continue to operate under the guidance issued which initially covered the period April – July. This has been extended to the end of September. Further formal guidance continues to be awaited to cover the remainder of this financial year although some informal guidance has been provided by colleagues at regional level. Operational planning is continuing notwithstanding this and the proposed cautious approach to this will be shared with the September GB meeting. The Committee considered the outcome of its recent effectiveness review. The Committee received an update on COVID specific costs and their recovery, all of which appears to be on track and being recouped a month in	

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	arrears. Efficiency and transformation work continues again notwithstanding current exceptional circumstances. SFC continues to see this as critical work and supports the focus this is getting. Integrated care partnership budgets and governance arrangements were considered and suggestions made about taking these forward. Mental Health Schools bid options were considered and the preferred 3 year + 1 was endorsed. The CRR and GBAF were reviewed and considered appropriate at this stage.	