NHS
Bristol, North Somerset and South Gloucestershire
Integrated Care Board

Finance Report

Report on financial performance for March 2023

Created by
Jon Lund
Catherine Cookson

Contents

1. Executive summary

- The ICB annual allocation is £1,943.961m, after receiving additional allocation in month 12 of £13.687m, mostly related to prescribing costs, independent sector elective recovery and hospital discharge reimbursement.

- The ICB outturn is £1,943,958 against the allocation which resulted in a surplus of **£0.003m**. The providers reported a combined surplus of £0.346m which resulted in an ICS surplus of £0.349m.

Financial Duties	Target	Plan	Forecast Variance RAG	Explanation
Maintain expenditure within the revenue resource limit	Outturn is better than or equal to plan	Under new NHS financial regime break-even is required	G	At year end the ICB's outturn position is a small surplus of £0.003m.
Maintain expenditure within the allocated cash limit	Cash drawdown is less than or equal to MCD	ICB will manage within Cash Limit	G	The total cash drawdown for the year was £1,932.309m against an allocation of £1,943.693m (£11.384m / 0.006% under).
Maintain capital expenditure within the delegated limit	Expenditure less than or equal to plan	ICB will manage within Capital resource limit	G	The capital allocations had a small underspend at year end.
Ensure running costs are within the running cost resource limit	Expenditure less than or equal to plan	ICB will contain spend within Running Costs Allocation	G	The annual running cost allocation was £20.798m with spend of £19.291m.
Ensure compliance with the better payment practice code	Greater than or equal to 95% by number & value	ICB will achieve payment target throughout year	G	The non disputed invoices paid within 30 days are in line with target.

2.1 Agreed Revenue Allocation

Programme Area	CCG final allocation as at 30.06.22	Confirmed Initial ICB allocation	Prior Months Allocation Changes	Adjustments in Month 12		Baseline Allocation at 31-Mar-23
				SDF/Other allocations	Internal Budget adjs	
	£m	£m	£m	£m	£m	£m
Acute Contracts	236.024	711.148	56.459	*4.065*	*(0.488)*	**1,007.207**
Mental Health	53.575	160.137	0.317	-	*(0.561)*	**213.467**
Community Services	46.667	142.001	10.785	*2.747*	*6.874*	**209.075**
Delegated Primary Care	39.436	118.485	8.896	*0.086*	*(0.013)*	**166.890**
Medicines Management	36.088	108.264	0.792	*0.297*	*4.000*	**149.442**
Primary Care	10.525	31.243	1.633	*(0.002)*	-	**43.398**
Funded Care	24.707	74.121	1.802	-	*1.000*	**101.629**
Childrens Services	4.703	14.111	1.290	-	*0.889*	**20.993**
Support costs	1.666	4.758	12.586	-	*2.234*	**21.244**
Reserves	2.831	7.029	(9.676)	*6.495*	*(14.684)*	**-8.005**
Central allocation adjustment	(7.125)	7.125	-	-	-	-
Commissioning Budget	**449.097**	**1,378.422**	**84.883**	**13.687**	*(0.749)*	**1,925.340**
Running Costs	4.879	13.728	(0.735)	-	*0.749*	**18.621**
Total Allocation 2022-23	**453.976**	**1,392.150**	**84.148**	**13.687**	**0.000**	**1,943.961**

The ICB received an additional £13.687m allocation in Month 12, with the allocation relating to;

- £5.376m independent sector elective activity
- £4.906m prescribing costs
- £2.676m hospital discharge retrospective reimbursement
- £1.165m unconsolidated pay offer
- £2.564m other allocations
- (£3.000m) clawback of allocations

2.2 Financial Position as at March 2023 (Month 12)

March 2023 - Month 12	2022/23 Budget	2022/23 YTD Budget	Expenditure	Variance		Report Ref
Programme Area	**£m**	**£m**	**£m**	**£m**		
Acute	1,007.207	1,007.207	1,008.616	(1.408)		2.3
Mental Health	213.467	213.467	212.829	0.638		2.5
Community	209.075	209.075	209.149	(0.075)		2.6
Delegated Primary Care	166.890	166.890	167.673	(0.783)		2.7
Medicines Management	149.442	149.442	150.162	(0.721)		2.7
Primary Care	43.398	43.398	40.296	3.102		2.7
Funded Care	101.629	101.629	106.521	(4.892)		2.8
Childrens	20.993	20.993	20.721	0.272		2.9
Support Costs	21.243	21.243	22.205	(0.962)		2.10
Reserves	-8.003	-8.003	-13.506	5.503		2.10
Running Costs	18.621	18.621	19.291	(0.670)		2.10
BNSSG ICB Surplus/(Deficit)	**1,943.961**	**1,943.961**	**1,943.958**	**0.003**		
Provider Surplus/Defict	-	0.000	0.346	0.346		
ICS Position	**1,943.961**	**1,943.961**	**1,944.304**	**0.349**		
				-0.02%		

The ICB's outturn position is a small surplus of £0.003m, which when consolidated with the providers positions generates an ICS surplus of £0.349m.

The outturn position is primarily driven from overspends in funded care due to inflationary pressures and complex high cost packages, acute overspends on the South West Ambulance Service NHS FT contract and in the Brain Injury Rehabilitation Unit and the vacancy control factor within support costs and running costs which are offset by underspends in unallocated reserves and the minors investment within primary care-core.

2.3 Acute Commissioning – provider analysis

Acute Services	Budget	YTD Expenditure	YTD Variance	
	£m	£m	£m	
University Hospitals Bristol and Weston NHS FT	439.076	439.231	(0.155)	
North Bristol NHS Trust	435.065	435.115	(0.050)	
South Western Ambulance Service NHS FT	45.518	46.229	(0.711)	
Independent Sector Treatment Centres	42.380	42.302	0.078	
Other Local Provider contracts (RUH, Glos, Somerse	16.944	16.940	0.004	
Low Volume Activity (previously NCA)	9.196	8.829	0.367	
Other Acute Spend (incl SWAG cancer)	19.028	19.969	(0.941)	
Grand Total	**1,007.207**	**1,008.616**	**(1.408)**	

Key issues

The acute outturn is an adverse variance of £1.4m, a decrease of £3.106m compared to M11 reported forecast outturn. The reduction is primarily due to the independent sector elective recovery fund allocations received in month 12.

The underperformance is driven by South West Ambulance Service NHS FT (SWAST) contract and other acute spend. The SWAST contract continues to overspend as the additional risk share funding mechanism has been triggered due to failure to achieve sufficient reduction in ambulance handover delays. The other acute overspend relates to the Brain Injury Rehabilitation Unit (BIRU) where there has been an increase in non standard costs for stroke, operational escalation levels and increased bed costs due to demand.

2.4 Acute Commissioning – Point of Delivery Month 11

The year to date activity reported by the trusts and independent sector is the contract management software (SLAM) activity data for month 11.

The actual cost of activities for the month are shown in the trend graphs on page 10 and include the point of delivery trends from prior financial years. The table on page 11 reports the year to date comparison for the equivalent period in 2019/20.

A&E Attendances The cost of ED attendances to date is £48.1m with M11 spend being the lowest of the year to date and lower than the average monthly run rate from April to January 2023.	**Non Elective Inpatient** The cost of activities to date is £210.3m. The cumulative cost to date is slightly less than for the same period in 2019/20. For the comparable period there has been a 7.9% cost reduction in >1 length of stay (LOS) day spells and a 97.3% cost increase in the 0-1 day LOS spells.
Outpatient Attendances The cost of activities to date is £87.12m. This is 15.4% below the comparable period in 2019/20 and a decrease of 10% in the daily run rate compared with January.	**Daycase and Elective Inpatient** The cost of activities to date is £126.7m, which is £0.86m lower than the comparable period in 2019/20. The cost of activity is 14.9% higher than in January and the number of spells is up by 8.1%.

API - *there is no API performance reported for this period*

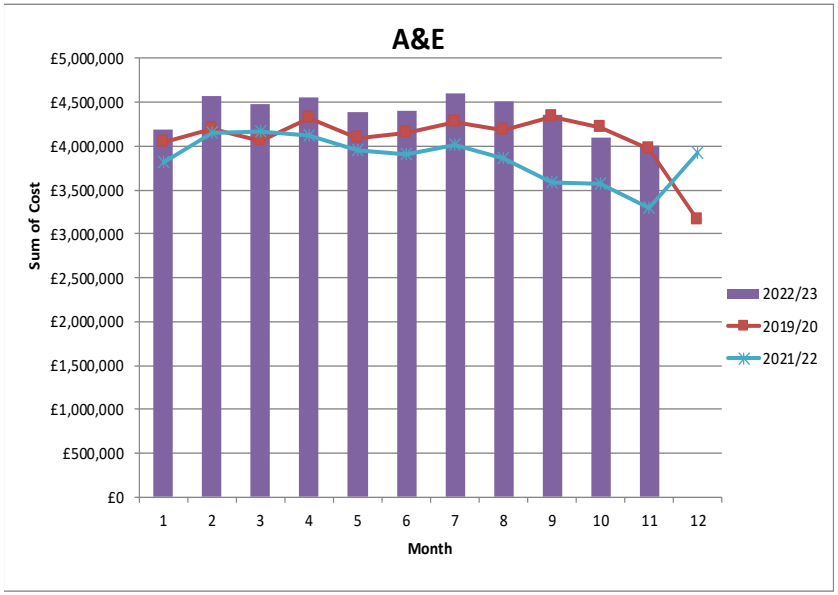
CQUINS - *there is no CQUIN performance reported for the period*

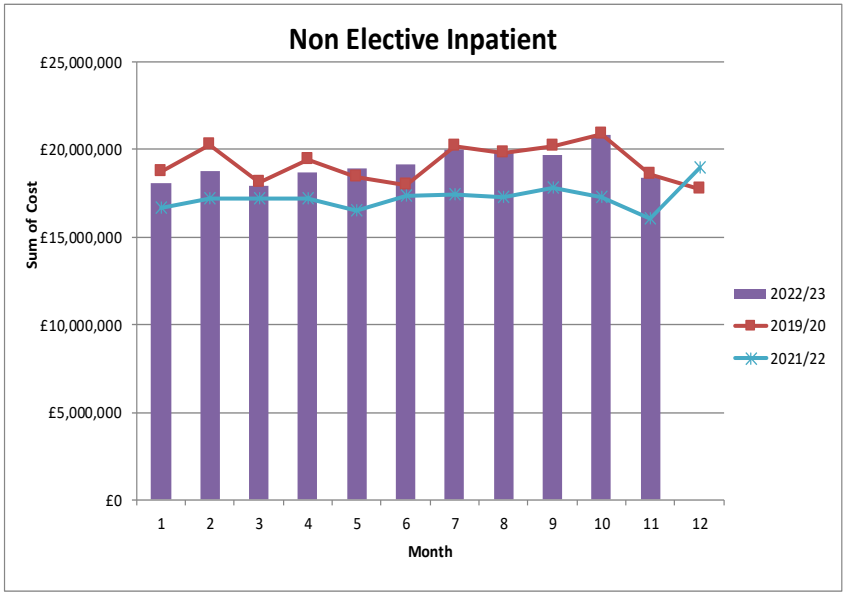
Savings *– there are no planned or urgent care savings planned for the reporting period. Savings have been assumed in the block payments with the NHS providers*

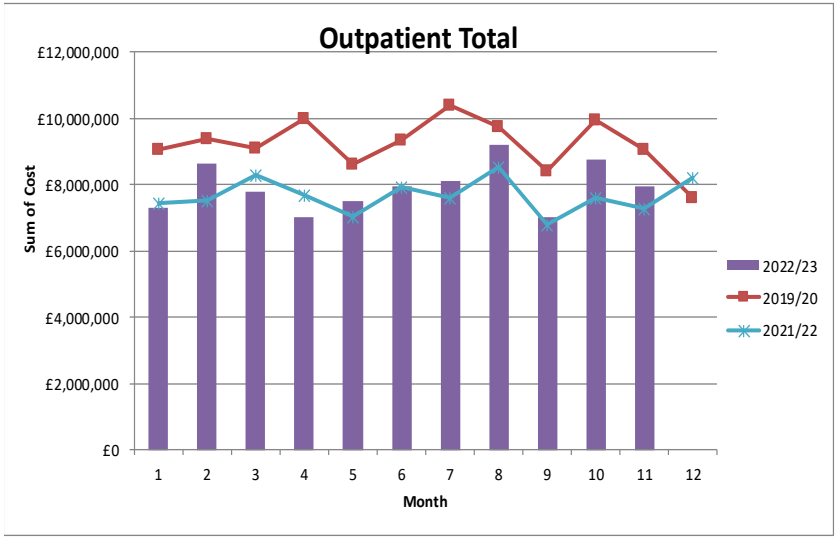
Elective Recovery Fund – *The YTD allocation is £30.1 and the planned clawback of £6.0m at M11 will be retained by the Trusts.*

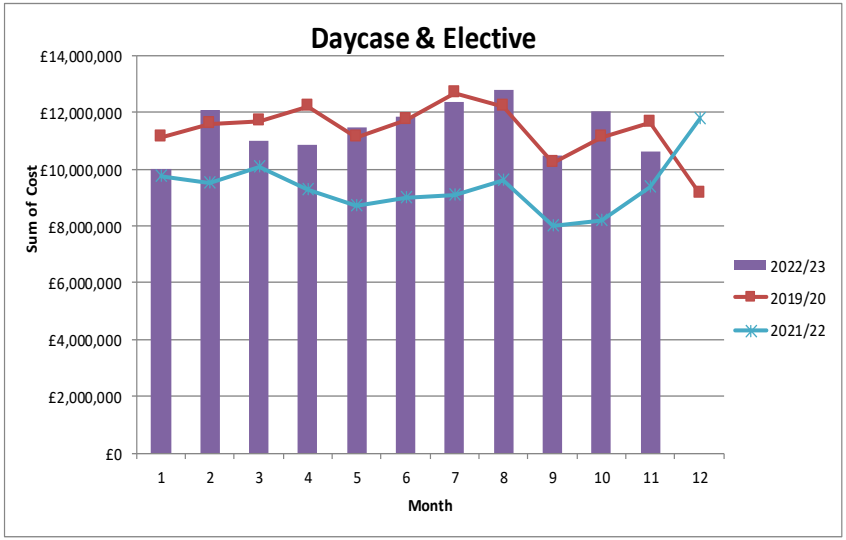
2.4 Acute Commissioning – Point of Delivery Trends

(a month in arrears)









2.4 Acute Commissioning

Point of Delivery performance Month 11 2022/23 compared with 2019/20. (*SLA Monitoring datasets are provided after the monthly accounts closedown deadline)*

	Activity				£'s			
	2019/20	2022/23	(Decrease)	(Decrease) %	2019/20 £m	2022/23 £m	(Decrease) £m	(Decrease) %
A&E	261,891	256,697	-5,194	-2%	£45.8	£48.1	£2.3	5%
Emergency Inpatient	100,090	110,556	10,466	10%	£199.0	£183.3	-£15.6	-8%
Emergency Short Stay	21,117	31,392	10,275	49%	£13.7	£27.0	£13.3	97%
Elective Inpatients	16,807	16,472	-335	-2%	£54.3	£53.2	-£1.1	-2%
Day Case	88,211	84,870	-3,341	-4%	£74.0	£73.5	-£0.5	-1%
Outpatient First	238,895	227,204	-11,691	-5%	£38.7	£33.2	-£5.6	0%
Outpatient Follow Up	477,337	419,042	-58,295	-12%	£40.0	£32.3	-£7.6	-19%
Outpatient Procedure	144,960	121,784	-23,176	-16%	£24.3	£21.6	-£2.7	-11%
Critical Care	14,363	16,669	2,306	16%	£18.2	£20.6	£2.4	13%
Diagnostic Imaging	116,425	114,206	-2,219	-2%	£11.2	£12.5	£1.3	11%
Direct Access	4,411,350	4,462,544	51,194	1%	£23.3	£22.0	-£1.3	-5%
Drugs and Devices					£33.3	£36.0	£2.7	8%
Maternity	36,724	35,622	-1,102	-3%	£55.3	£53.0	-£2.4	-4%
Rehabilitation	36,993	19,534	-17,459	-47%	£11.6	£6.8	-£4.7	-41%
Other	261,147	268,006	6,859	3%	£33.6	£21.3	-£12.3	-37%
Total Year to Date					**£676.3**	**£644.5**	**-£31.8**	**-5%**

Note 1 : North Bristol NHS Trust (NBT) rolled out a new Electronic Patient Record (EPR) system in July and this has impacted the SLA Monitoring (SLAM) reports. This is being actively reviewed in meetings with NBT via the Data Quality Group. Detailed reviews continue to be undertaken with key stakeholders and further updates will be provided until resolved. Whilst NBTs data quality is improving there are still data queries that are being reviewed through the data quality group and any correction to this data will potentially impact the comparison between periods in future reports.

The table above compares the aggregate expenditure by point of delivery (PoD) at month 11 in 2019/20 (uplifted to 2022/23 price base) and 2022/23 and the change (decrease) in absolute and percentage terms. The comparison with monthly expenditure trends in 2019/20 and 2021/22 for the key PoDs is shown in the graphs on the previous page.

Due to block funding arrangements, the 2022/23 figures do not represent the block values paid to all acute care providers but provides an indication of the impact on the income providers would expect to receive under payment by results when compared to the previous year.

2.5 Mental Health & Learning Disabilities

Mental Health & Learning Disabilities	Budget	YTD Expenditure	YTD Variance	
	£m	£m	£m	
MH - AWP Core Contract	127.661	127.605	**0.055**	
Mental Health Act	18.188	19.919	**(1.731)**	
Child & Adolescent Mental Health (CAMHS)	13.931	14.750	**(0.819)**	
Learning Disabilities	9.443	7.377	**2.065**	
Mental Health Community	6.004	6.015	**(0.011)**	
Improved Access to Psychological Therapies (IAPT)	10.906	10.674	**0.232**	
Dementia	8.422	8.654	**(0.232)**	
Crisis Services	2.253	1.599	**0.654**	
ADHD	1.447	2.710	**(1.262)**	
Mental Health Low Volume Activity	0.908	0.865	**0.044**	
Mental Health SDF	12.639	11.448	**1.192**	
Other Mental Health spend	1.664	1.214	**0.451**	
Grand Total	**213.467**	**212.829**	**0.638**	

Key issues

The underspend is the net position of underspends in mental health Service Development Funds (SDF) and learning disabilities (LD) placements due to workforce recruitment, mobilisation delays in new services and an underspend in planned LD commitments offset by overspends in Attention Deficit Hyperactivity Disorder (ADHD), MH Placements, Section12 Doctors and Child & Adolescent Mental Health Services (CAMHS).

2.6 Non-Acute Contracts

Non-Acute Contracts	Budget	YTD Expenditure	YTD Variance	
	£m	£m	£m	
Adult Community	134.534	132.768	**1.766**	
Joint Commissioned	25.014	34.416	**(9.402)**	
Discharge to Assess Services	13.130	10.961	**2.169**	
Patient Transport Services (PTS)	6.129	7.434	**(1.305)**	
Community Equipment	5.331	5.210	**0.120**	
Hospices	4.559	4.344	**0.215**	
Virtual Wards	3.128	2.632	**0.496**	
Other Community	17.250	11.383	**5.866**	
Grand Total	**209.075**	**209.149**	**(0.075)**	

Key issues

There have been significant additional allocations to support discharge capacity. Adult Social Care (ASC) Discharge funding is reported in the year to date position in line with the ASC reporting framework. The full allocation of £8.3m has been utilised by the end of the financial year and in addition the reimbursable Hospital Discharge Fund introduced has supported an allocation of £2.676m, funding additional P1 & P3 capacity.

The underlying overspend in the discharge to assess service, due to an increase in bed demand over the winter period, has been mitigated through forecast underspends in virtual wards and other community spend.

As previously reported, the patient transport contract activity was enhanced for the 2022/23 financial year with an expectation the service will improve patient experience with a potential offsetting financial benefit within acute provider budgets. Contractual underperformance continues to be under review with the provider and an assessment of the expected improvements and benefits is continuing.

2.7 Primary Care – including Medicines Management

Primary Care	Budget	YTD Expenditure	YTD Variance	
	£m	£m	£m	
Delegated Primary Care	166.890	167.673	(0.783)	
Prescribing	147.765	148.639	(0.873)	
NHS 111/Out of Hours	22.322	20.285	**2.037**	
Local Enhanced Services	9.159	8.680	**0.479**	
GP Forward View	6.742	6.589	**0.153**	
Medicines Management staff costs	1.676	1.524	**0.152**	
Other Primary Care	5.174	4.742	**0.432**	
Grand Total	**359.729**	**358.131**	**1.598**	

Key issues

The delegated primary care position now includes the additional roles reimbursable scheme (ARRs) allocation. The key drivers of the £0.783m overspend are, overdue post pandemic rent reviews, unprecedented prescribing fees, and a number of non-recurring costs experienced this financial year.

The Primary Care-Core position includes the minors investment which had an underspend of £2.037m due to recruitment issues within the Clinical Assessment Service (CAS) and clinical navigators.

The prescribing outturn includes cost pressures for category m drugs (drugs that are readily available) which have contributed to an overspend of £0.873m after receiving an allocation of £4m.

2.8 Funded Care

Funded Care	Budget	YTD Expenditure	YTD Variance	
	£m	£m	£m	
Adult Fully Funded CHC	44.875	48.274	(3.399)	
Adult Fully Funded PHB	8.289	8.277	0.011	
Adult Joint Funded	0.940	0.814	0.126	
CHC Assessment and Support	5.060	4.476	0.584	
Children's CHC	4.253	4.289	(0.036)	
Children's PHB	0.702	0.680	0.022	
Fast Track	15.260	16.743	(1.484)	
FNC	22.250	22.966	(0.717)	
Grand Total	**101.629**	**106.521**	**(4.892)**	

Key issues

Inflationary pressures in the care home and domiciliary care market have increased the costs of care packages. Continuing pressure on Local Authority budgets have increased the number of cases being referred for determining eligibility and / or seeking additional support for complex and high cost packages of care.

The demands and pressure remain high into 2023/24 planning and will continue to be short and medium term issues, the funded care team continue to explore opportunities for increased efficiencies and to mitigate financial risk.

2.9 Children's Services

Children's Services	Budget	YTD Expenditure	YTD Variance	
	£m	£m	£m	
CCHP Contract	18.542	18.846	(0.304)	
Other	2.451	1.876	0.575	
Grand Total	**20.993**	**20.721**	**0.272**	

Key issues

The net underspend of £272k is due to slippage on planned investments due to workforce recruitment challenges and delays in service mobilisation.

2.10 Running Costs & Other Support Costs

Running Costs & Other Support Costs	Budget	YTD Expenditure	YTD Variance	
	£m	£m	£m	
ICB running costs	18.621	19.291	(0.670)	
Support Costs & Reserves	13.240	8.700	4.541	
Grand Total	**31.861**	**27.991**	**3.870**	

Key issues

The running cost allocation for the year was £20.798m with some of the allocation coded to programme areas. The year to date expenditure of £19.291m is less than the allocation. The overspend against the budget allocated to running costs is the underachievement on the pay vacancy factor.

The underspend on support costs and reserves primarily relates to ICB allocations and contingency to mitigate risks identified in provider and ICB budget lines not utilised in the year.

2.11 Efficiencies

Control Centre	2022/23 Month 12		
	YTD planned net saving £ms	YTD actual net saving £ms	YTD Variance £ms
Running Costs/Support costs	0.375	0.375	-
Funded Care	3.000	2.113	0.887
Medicine Optimisation	4.404	4.433	(0.029)
Mental Health	1.579	1.971	(0.392)
Total	**9.358**	**8.892**	**0.466**

Summary overview of current month position

The total ICB control centre savings target for the year is £9.358m, with a further £3.761m of system based savings. The ICB efficiency delivery was £8.892m, with the detailed review of the savings programme reported in the separate paper, ICB Savings report.

Notes

Project Management of Running cost/Support cost and other system based efficiencies are not included in the scope of PMO Savings Report.

NB. For NHSE reporting purposes we also add the savings achieved through passing through the 1.1% efficiency factor to non-NHS providers (including Sirona) via contact price uplifts each year. This equates to £3.4m annual savings, hence a target of £12.8m. These savings are all fully delivered via baseline contact and budget changes.

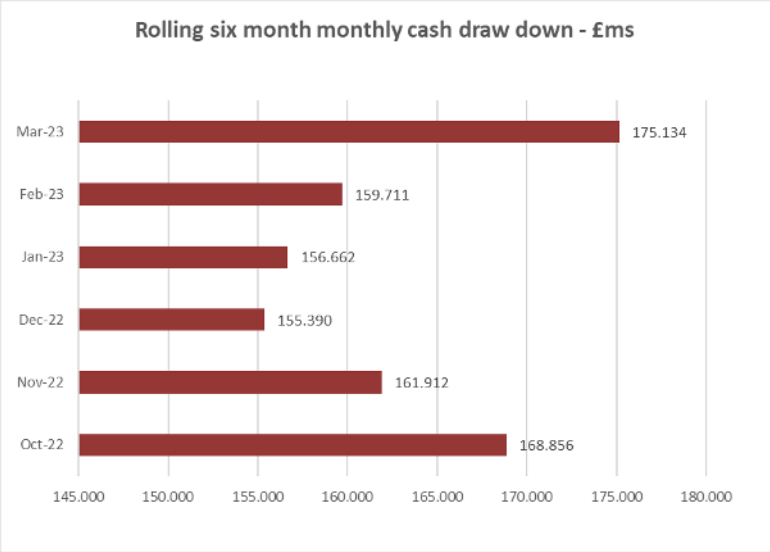
2.12 ICB Capital allocations

Approved Schemes	Asset Owner	22/23 Revised Operational Capital Allocation	YTD Budget	YTD Expenditure	YTD Variance	
		£m	£m	£m	£m	
Minor Improvement Grant (MIG)	NHS England	0.118	0.118	0.117	0.001	
MIG Equipping	NHS England	0.038	0.038	0.037	0.001	
GPIT - BAU refresh	NHS England	0.941	0.941	0.940	0.001	
GPIT - additional roles & PCN	NHS England	0.288	0.288	0.282	0.006	
IT Corporate Refresh	BNSSG ICB	0.273	0.273	0.273	-	
GPIT - additional roles	NHS England	0.457	0.457	0.457	-	
Community based falls	Sirona	0.188	0.188	0.188	-	
Total		**2.303**	**2.303**	**2.294**	**0.009**	

The capital allocations had a small underspend at year end.

2.13 Statement of Financial Position

Statement of Financial Position	Balance 31/03/2022 £m	Balance 31/03/2023 £m	Movement £m
Total Non Current Assets	0.283	0.488	0.205
Current Assets			
Cash & Cash Equivalents	0.046	0.081	0.035
Current Trade And Other Receivables	11.968	18.338	6.370
Total Current Assets	*12.014*	*18.419*	*6.405*
Total Assets	**12.297**	**18.907**	**6.610**
Current Liabilities			
Payables	(117.877)	(131.478)	(13.601)
Lease Liability	-	(0.104)	(0.104)
Provisions	(9.016)	(13.301)	(4.285)
Total Current Liabilities	***(126.893)***	***(144.883)***	***(17.990)***
Total Net Assets/(Liabilities)	**(114.596)**	**(125.976)**	**(11.380)**
Taxpayers Equity	(114.596)	(125.975)	(11.379)
I&E Reserve - General Fund			
Total Taxpayer Equity	**(114.596)**	**(125.975)**	**(11.379)**



Statement of Financial Position

There is a year to date negative movement on the balance sheet of (£11.379m) which is primarily due to an increase in creditors of (£8.880m), which is partly offset by an increase in debtors of 1.684m. The increase in creditors is due to backdated Sirona invoices which were still being validated in March.

Provisions have also increased due to additional liabilities raised by NHS Property Services and the unconsolidated pay offer for system partners.

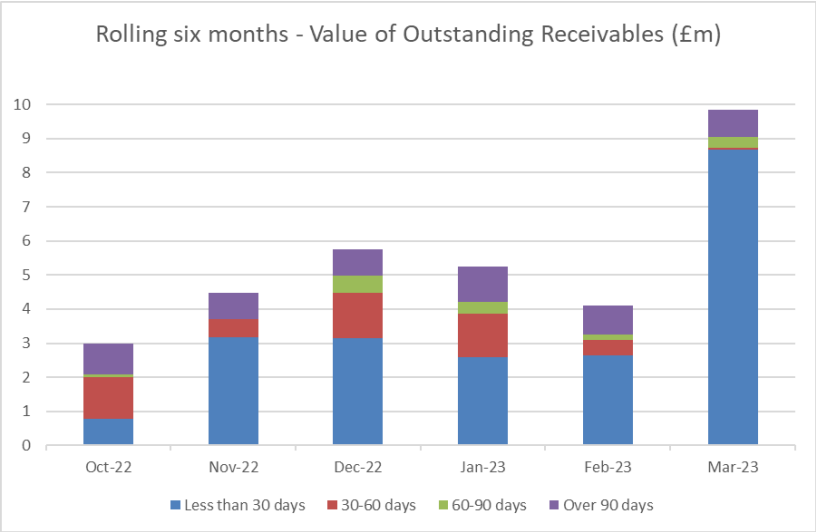
See the cash position below and the aged balances report in section 2.14.

Cash position

At 31 March, the total cash utilised was £1,932m against a full year allocation of £1,943m. Therefore, the annual cash drawdown was £11m less than the total allocation.

The closing cash balance was £0.080m (£0.081m in February) and was within NHSE target of 1.25% of monthly funding (£1.788m).

2.13 Statement of Financial Position (continued)

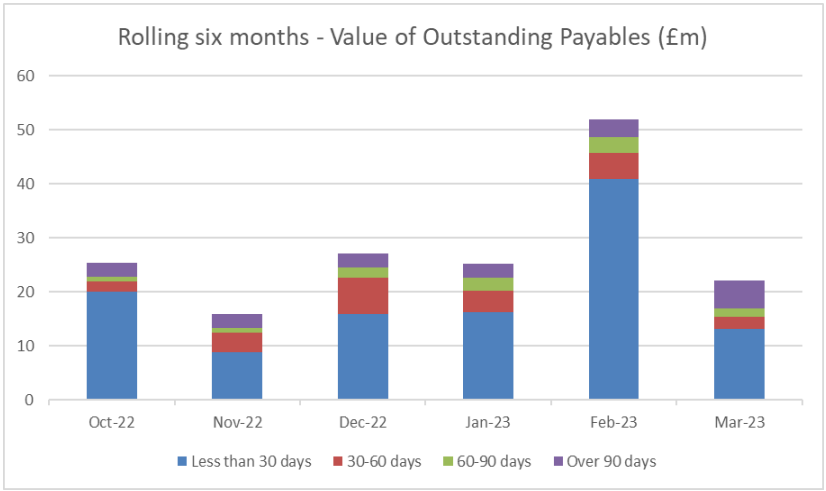


Aged Receivables

At 31 March, there were 101 receivable invoices outstanding with a value of £9.837m (50 and £4.107m in February).

The increase in debtors was driven by a large number of invoices raised in month (less than 30 days category). The 30-60 day category has continued to see reductions in the value outstanding.

2 invoices remain outstanding in the >90 days category which have been put on hold while funding mechanisms are clarified.

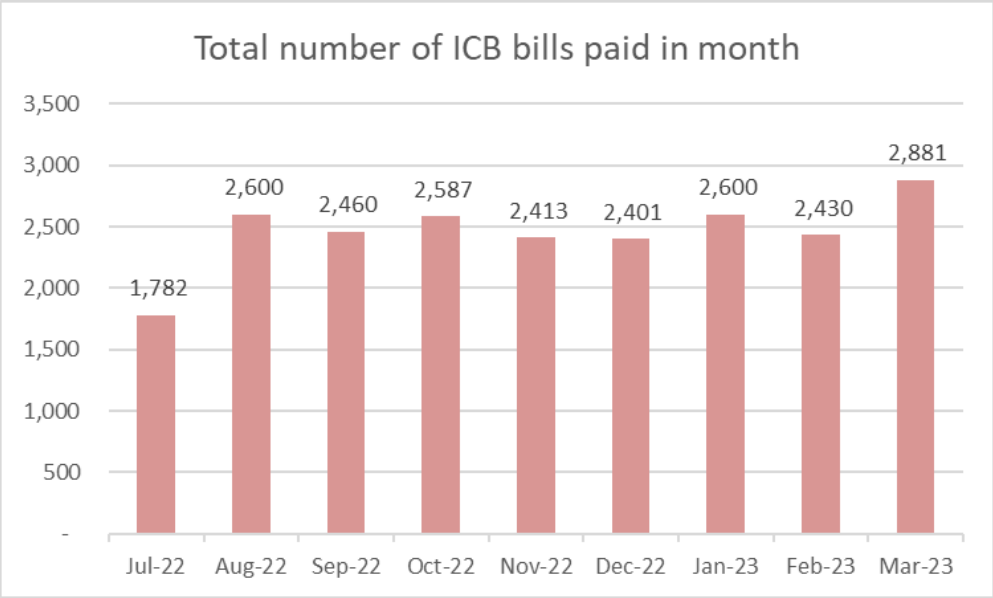


Aged Payables

At 31 March there were 1,165 invoices outstanding totalling £22,093m (1,334 and £51.962m in February). The invoices received in February relating to March were processed in month.

The majority of the invoices are in the 0-30 day category and within the performance target of the Better Payment Practice code (BPPC). There are 671 aged invoices totalling £8,902m. Of these, 561 invoices are marked as disputed with a value of £7,011m.

2.14 Better Payment Practice Code



Better Payment Practice Code (BPPC)
The ICB are required to comply with the BPPC where all non disputed invoices are to be paid within 30 days. The performance measure requires 95% or more of invoices, in terms of volume and value, to be paid within 30 days.

The performance target was reset at the 01 July 2022 with the establishment of the ICB.

The ICB paid an average of 2,462 invoices a month and continues to meet the BPPC target for all NHS and Non NHS invoices.

Year to date Payment performance (Mar 2023)	Number	£m
Total bills paid in year	824	853.412
Total bills paid within target	816	853.379
% bills paid within target	**99.03%**	**100.00%**
Total bills paid in year	21,330	505.337
Total bills paid within target	20,946	496.651
% bills paid within target	**98.20%**	**98.28%**

Finance, Estates and Digital Committee Minutes Thursday 23rd March 2023, 10:00-12:00 via teams

Members (Quoracy: 3 members required, including one of ICB Non-Executive members; and one of Chief Executive or Chief Finance Officer)		**Initials**
Steven West	Finance, Estates and Digital Committee Chair	SW
John Cappock	Audit Committee Chair	JC
Sarah Truelove	Deputy Chief Finance Officer and Chief Finance Officer	SaT
Deborah El-Sayed	Executive Director for Transformation and Digital	DES
Brian Stables	Non-executive Director - AWP	BS
Richard Gaunt	Non-executive Director – NBT	RG
Joanne Medhurst	Medical Director ICB	JM
Nina Philipiddis	S151 Officer - SGC	NP
Christina Gray	Public Health	CG
Attending		
Jeff Farrar	ICB Chair	JF
Jon Lund	Deputy CFO – ICB	JL
Sabrina Smithson	Exec PA (Note Taker)	SS
India Barrett	GMTS Graduate	IB
Jenny Norman	Digital Programme Lead – ICB	JN
Brian Roberts	Channel 3 Consulting	BR
Denise Moorhouse	Deputy Director of Nursing and Quality - ICB	DM
Lee Colwill	Head of Business – Office of CNO/CMO – ICB	LC

Number	Item	Action
2.0	**Declarations of Interest** ***To consider declarations of interest and conflicts of interest arising from this agenda***	
3.0	**Minutes of the previous meeting** The minutes were agreed as a true and accurate record.	
4.0	**Actions from Previous Meeting** The actions were reviewed and updated accordingly.	
	To Approve	
5.1	**Central Weston Full Business - Relocation of Graham Road Surgery to new Weston Rugby Club Development** The papers were circulated to the committee prior to the meeting. ST & TJ attended and highlighted areas of the papers and the following discussion/questions arose: SW commended the work/paper and noted a question on the bureaucracy surrounding this and asked could something be done nationally as it feels like it is disproportionate to the value of the capital. JM queried the narrative around parking and transport links as this was not included/clear in the paper. TJ reacted this has been reviewed and to ease the concern there will be 30 spaces created, which is around 25 spaces more than before. The Rugby club need some discussions about their parking. There are also bus routes and the train station which are all accessible for patients.	

	BS examined a table within the document for sensitivity analysis on capital spend and asked are we happy that IFRS16 has been adopted and TJ confirmed this has been worked through with NHSE. CG & NS confirmed PH and the LA's have been very closely involved in the project and it would be advantageous to include this in the paper. DES complimented the document and commented on the benefits piece and offered the PHM and Insights team alongside the work that was underway with PH so that we can start to find ways to measure some of the benefits. Committee approved for item to be escalated to Board.	
5.2	**Approve interim & final budgets 23/24** The papers were circulated to the committee prior to the meeting. ST & JL attended and highlighted areas of the papers and the following discussion/questions arose: NP questioned the ownership and detailed there are a lot of changes late in the day, so there needs to be assurance on how this is going to work in practice. ST reported that all the CEO's were called together and agreed to take this approach. Plans are now being developed for an event in April/May with exec teams across the system to go through the position in detail and ensure that everyone is clear on the delivery requirements and commitment to lead the plan as well. ST stated the risk is we go back and forth with NHSE in Q1, which means we have lost the whole quarter which makes delivery even less likely. ST added we have ensured we are clear to each organisation they understand, what is expected of them. We have an appendix in the paper, which we are strengthening in terms of making sure it is clear for each of the statutory boards that this is the envelope that they are working within. CG praised the allocation for Health Inequalities and had 2 further questions. 1. Was around the money we have been trying to identify. 2. Regarding prevention, this was associated with long term conditions and have we been looking how to support the system forensically as it needs to be reflected to the budgets, which is not clear in the paper. CG continued dentistry is pivotal for PH interventions. The only NHS dental care that we have in place, is for the most vulnerable and that is limited, which leads to further problems. CG continues this is NHS system budget and we are in a system which is co-dependent, particularly with adult social care, there's a Newton Europe report that has been done that has identified £20million potential savings for the system that we need to feed in. ST responded initially to the LA cross charges and explained Bristol City Council (BCC) have approached the ICB wanting to shift the balance of funding to the ICB from BCC for S117 so that potentially is a risk of £4.7m which is included in the risks section of the paper. The mitigation would have to be a reduction in the funding for health inequalities and anticipatory care. We have an underlying deficit as a system that we are trying to reduce and not invest. ST continued we have assumed a small amount of slippage on those. JL added NHS received a specific additional allocation of £7.2m to support hospital discharge. The interface with adult social care is broader than just hospital discharge, but that was a specific targeted intervention from national government of which, some came to the NHS. That has been allowed for within the budget, so we are planning to commit that towards the discharge processes. That's on top of the c£12m of investment into discharge to assess (D2A) that was made in previous years budgets. In addition to that, the process of how we deploy that is	

	subject to a joint planning and prioritisation process between adult social care teams and the NHS. JL continued one of the other uncertainties of that is there has also been a grant allocation to LA's of around £4m across the 3 and how we deploy that is subject to a joint planning and prioritisation process between adult social care teams and the NHS. JC endorsed the approach and then challenged the next steps. ST reported a paper is going to Board on Operational Plan and the key message is ownership and delivery around the underlying position. There will be some cliff-edge in 24/25 and we need to take every action we can in 23/24. NP requested the £4m worth of discharge funding was addressed in a LA meeting the following day. JL confirmed. JM referred to CG's points and reported the 3 DPH's have been doing work on health improvement and prevention group. Prevention is becoming increasingly important in the NHS; however, we need to work within our budgets. So, a Risk and Ethics Advisory Forum has been created and led by a professor of Ethics so that we can have some very robust judgments as multi professionals around the risks and ensuring the greatest allocation of resource to the greatest benefit. SW concluded there are several areas that we need to know the key assumptions, principles, risk and mitigations. To note the draft balance, primary ophthalmic and dental budgets, there has been a long debate about this. But the assumptions that are built into the paper are getting us ready for the formal delegation on the 1st of April 2023 to note the service developments greater than £1m per annum that require approval from the ICB. CG questioned if there was an LA representative at the Directors of Finance meeting hosted by Sarah Truelove. ST advised not, however there is a fortnightly meeting with the LA S151 Officers. CG declared interest as an employee of BCC and elaborated if we are operating as a system we are signing off an NHS budget with inherent pressures and we need to be saying something about the interdependency with particular LA partners. SW asked for this to be addressed in the meeting the next day and concluded this does work both ways, we are trying to work as a system and therefore all parts of the system need to be engaged in both directions. CG further examined, are the LA's DOF's comfortable with the paper/proposal as the paper did not read as the whole ICP. SW agreed both this will be raised at the board because it is now getting to the intricate details what we are doing as a system. JF noted the recommendations to go to the board and the 3 CEO's from the 3 LA's will be present. FED committee needs to ensure it has given some rigor and some recommendations. The Budget was agreed to be recommended to the ICB Board.	
	To Discuss	
6.0	**CHC Savings Deep Dive** A paper was circulated to the committee prior to the meeting. DM & LC attended and highlighted areas of the papers and the following discussion/questions arose: NP confirmed there are similar cases within the LA's with ad hoc £1m cases coming through. NP questioned how we are linking in the system on these cases so we are	

	not running the risk of shifting costs around and if these discussions are taking place, can the LAs be involved. DM responded we work daily with LA's and will continue to do so. There is a tension across both sectors because, the LA would have had the hospital route as a final destination, which is no longer available. We do work with the LA and there is work going on around the housing to support these patients who either are coming out of hospital, or we cannot admit to hospital. That has cost implications not from a capital perspective, but also from a care cost. JM reported we have set up a multi-disciplinary ethical group which includes the directors of PH and the reason is to take it away from individual cases, to extrapolate this up and to look at this as an ethical decision in the breadth of commissioning of health and care services. This topic would go to the REAF group for a for a good multidisciplinary review to bring forward a set of recommendations. DM flagged a growth in LD and in children. Children who come through continuing care, the cost per case is increasing so the conversation around the decision making and the framework will help with some of this growth. DM asked about the forecasting around budget setting for next year and looking at the activity and performance over the last year. The 8% growth needs to be considered and working together so there is confidence of that methodology. We are looking at something in the region of £120m forecast spend next year. ST replied it is challenging as CHC costs have suddenly started to increase in the last month. There is not funding within the allocation for that level of growth so we need to look at what are the choices. That is part of the gap that we had as a system that we're covering non recurrently in terms of the inflation issues. CG observed the Ethical Decision framework is one aspect, but this is an area we cannot be doing in silos and urged the work is joined across the system. SW concluded the work needs to be cross system so it will be addressed outside the committee meeting. A piece of work is required that helps us understand what we are going to do as a system. **ACTION – DM/LC to meet with Rosi Shepherd to consider what we want to ask REAF to consider.**	
	Finance Report	
7.0	**Report on the financial performance** **ICB Savings Reports** **M11 NHS System Revenue & Capital Finance Report** The reports were circulated to the committee prior to the meeting. ST, highlighted areas of the papers to the committee. Due to time restrictions no further discussion took place.	
	To Note	
8.0	**Receive update from System DoFs Group** ST reported all the work over the past few weeks has been aligned with operational plan and budget setting. We are trying to protect time for Finance Staff	

	Development, and this has been positive and more staff seeking sponsorship also with more sponsors in place. SW asked how we are looking in comparison to other ICB's in the patch. ST replied there are many areas that are much worse. The SW is doing the best out of the regions. Out of the 7 systems, 4 will get to balance for 23/24 and there are 2 are still reviewing further discussions are on-going, Devon won't get to balance but has a much improved position from previous years. ST continued there are significant challenges everywhere and we are meeting with the national team to go through the inflation issue.	
8.1	**Receive update from System Digital Delivery Group** **-MTDP** Then committee noted the MTDP.	
Any Other Business		
The committee agreed the length of the meeting would be extended to 3 hours moving forward. **Key messages for ICB Board** 1. Important to deliver planned savings plans for 23/24 2. Important that we ensure that we share budget assumptions across ICS system and get visibility and agreement at ICB 3. Work to continue developing a consolidated plan to pull together capital investments and workforce investment to deliver the plan focused on reducing health inequalities		