NHS
Bristol, North Somerset and South Gloucestershire
Integrated Care Board

BNSSG ICS System Finance Report

Month 9 – December 2023

Finance, Estates & Digital Committee

Thursday 25th January 2024

Shaping better health

Executive Summary – Key Messages

Month 9 – December 2023

1a) Overall Financial Position (year to date)

At the end of December (month 9), the system has reported an overall **year to date (YTD) adverse variance against plan of £4.4m** (YTD plan = £11.7m deficit, YTD actual = £16m deficit). This represents a combined provider adverse variance against of plan of £6.8m, and an ICB favourable variance to plan of £2.4m.

Key Drivers – positive/ (adverse) variance to plan:

Impact of Industrial Action	**(£7.5m) adverse**	**M9**	**last month**
• of which direct costs (notably backfill costs at premium rates)		(£0.7m)	£0.0m
• of which lost income due to reduced elective activity		(£6.8m)	(£5.4m)

Other key variances to plan	**£3.1m favourable**	**M9**	**last month**
• Year to Date Efficiency Plan Under-Delivery		(£9.4m)	(£8.3m)
• Temporary Staffing Costs		(£3.3m)	(£2.3m)
• ICB Primary Care Prescribing		(£2.0m)	(£2.7m)
• ICB Funded Care placements		(£8.6m)	(£7.7m)
• Slippage on investments & POD services underspend		£17.2m	£14.9m

1b) Forecast out-turn

As reported to FED last month the system received an additional £18.4m funding allocation to support financial pressures and risks, including (but not limited to industrial action), and submitted a financial forecast for the second half of the financial-year that maintained a forecast break-even out-turn position at both constituent provider and for the combined system.

Continued industrial action in December and January has adversely impacted the system's financial position and forced a deterioration in the reported forecast out-turn position to a combined system deficit of £5.6m

Our working assumption is that this 'uncontrollable' deficit will not impact the write-off of the historic accumulated ICB debtor impact the element of next year's capital allocation linked to current year revenue performance. An update will be provided to FED next month when formal communication is received from the national team, clarifying this position.

Executive Summary – Key Messages (cont.)

2) Savings Delivery

- Whilst at the end of December, the system is reporting **delivery of 82% of its year-to-date efficiency plan (£9.4m below plan)**, performance at constituent organisational level is varied, with the three provider organisations under-delivering against year-to-date savings plans, and varying degrees to which non-recurrent actions are supporting under-delivery against the recurrent savings programme.

- The ability to recover this under-delivery, whilst also identifying and delivering against a higher planned level of savings in the remainder of the year will continue to be a significant focus from all system partners.

- Directors of Finance are collaborating to ensure there is a consistent approach to measuring and reporting on the forecast delivery of savings across all constituent organisations. For example, the risk to likelihood of planned savings; the assumption of recurrent and non-recurrent full year impacts; and month and year of attribution of specific savings schemes

3) Changes to Capital Allocation and Reporting of Leases (IFRS16)

- As notified by NHSE England in December, Systems will now be monitored and expected to manage their operational capital expenditure against their total system operational capital allocations **including the incremental impact of IFRS 16**. (N.B. this is different from the approach taken during 2022/23 and to date in 2023/24 where providers and systems have been monitored against their system operational capital allocations before the incremental impact of IFRS 16).

- Each system has been allocated a share of £615m national CDEL uplift. BNSSGs share of this is £8.8m, increasing the total capital allocation to £84.1m. Based on this initial allocation, the ICB is currently forecasting a £20.9m overspend against the system capital envelope.

- £12.1m of the IFRS 16 impact relates to 'intra DHSC' leases and is therefore not expected to score against the systems capital envelope, once the lease values are agreed with the counter-party. However, this still leaves a potential £8.8m overspend, before receipt of any national contingency funding.

- Where there are significant IFRS 16 pressures and providers / systems may be able to access a national contingency fund, where certain criteria can be met. Soft intelligence from NHSE Regional team suggests there is reasonable likelihood this risk will be mitigated. In the event of an in-year overspend materialising, at this stage no guidance is available whether this would become repayable in future years.

Executive Summary – Key Messages (cont.)

4) Additional risks to delivery of forecast out-turn

- The system is reporting 2 additional areas of financial risk over and above the reported £5.6m forecast out-turn deficit (£9.2m gross risk in total):
- £7.7m combined acute provider risk associated with delivery of elective activity plans in the remainder of the year, and linked to national elective recovery funding, mitigated through delivery of operational and divisional recovery plans
- £1.5m ICB risk associated with managing the costs of Funded Care placements mitigated by continued monitoring of the delivery of savings, ensuring the assumptions and outputs are tested and triangulated, and development of standard report for monitoring and forecasting requirements.

5) Next Steps

- Constituent organisational Directors of Finance will continue to direct respective Boards to focus attention and action on delivering recurrent savings plans, and where possible over the coming period of likely increased emergency activity, continue to place emphasis on elective activity delivery, recognising the importance of delivering against restated elective recovery targets, to maximise the level of elective recovery income the system earns. These are both key deliverables in the remainder of this year that will ensure the system achieves breakeven in line with 2023/24 Operational Plan and gives the system the best possible opportunity to deliver breakeven (excluding the impact of Industrial Action as previously referenced) in 2024/25.
- Continued enactment of the actions as set out in the Financial Forecast Outturn Change Protocol, including development of the processes to support a ‘double-lock’ within the system for any investments above £50,000 with sign-off required by both the organisation and the system.
- Continued dialogue with regional NHS England colleagues to explore opportunities to access additional capital resource, including the national contingency and minimise the risk of any overspend against the notified capital allocation.

Consequences of failure to deliver 23/24 Financial Plan

- The ICB was established with an **accumulated brought-forward debt of £117m** derived from net historical clinical commissioning group (CCG) overspends. If the system and ICB achieve breakeven in 2023/24 (having achieved this in 2022/23), the historic debt will be written off. **Failure to deliver this breakeven requirement will have the balance reinstated and it will therefore become repayable**
- In-Year deterioration from the planned break-even position triggers several conditions for both ICB and providers within the system:
    - **Provider: double-lock sign-off process for any investments above £50,000** with sign-off required by the organisation and the system
    - **System: triple-lock sign-off process for any investments above £100,000** with sign-off required by the organisation, system and NHSE regional team
    - Additional reporting requirements to NHSE/I
    - Further **restrictions on recruitment, agency, consultancy and bank usage** may be imposed at the discretion of the regional team
    - **Capital funding restrictions**
        - C. £5m reduction in system capital funding
        - limited access to national capital funding streams

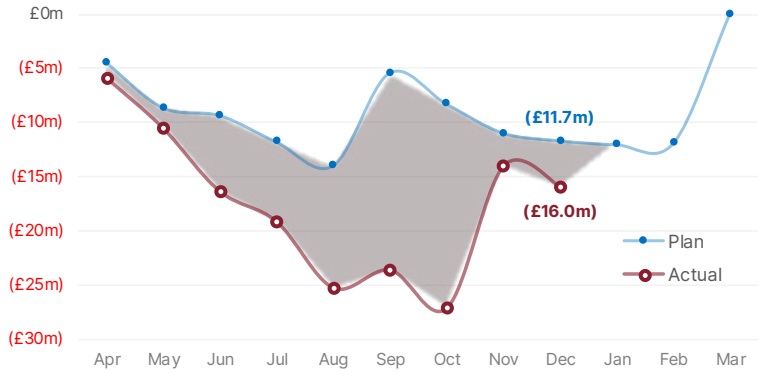
1. System Financial Performance Overview

Month 9 – December 2023

Financial performance
Forecast surplus / (deficit) v plan
(£5.6m)

Organisation	Plan	Actual	YTD Variance	FCST Variance
UHBW	(£8.0m)	(£9.6m)	(£1.6m)	**(£3.1m)**
NBT	(£3.6m)	(£8.0m)	(£4.3m)	**(£2.4m)**
AWP	£0.0m	(£0.9m)	(£0.9m)	**(£0.1m)**
NHS Providers	**(£11.7m)**	**(£18.4m)**	**(£6.8m)**	**(£5.6m)**
BNSSG ICB	£0.0m	£2.4m	£2.4m	**£0.0m**
Total System	**(£11.7m)**	**(£16.0m)**	**(£4.4m)**	**(£5.6m)**
Previous Month		(£3.1m)		£0.0m

YTD Cumulative Surplus / (Deficit)
Year to Date surplus / (deficit) v plan
(£4.4m)



System Risk
Unmitigated risk as a % of ICB allocation
0.0%

Gross Risk	(£9.2m)
Gross Mitigations	£9.2m
Net Unmitigated Risk	**£0.0m**
Net Risk as a % of ICB allocation	**0.0%**

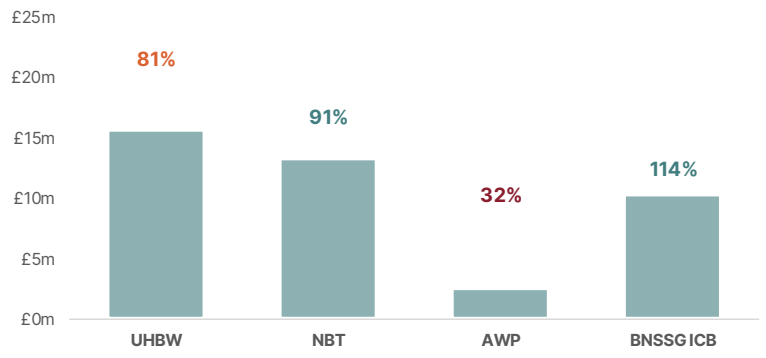
Risk adjusted forecast out-turn **(£5.6m) deficit**

Previous Month £0.0m

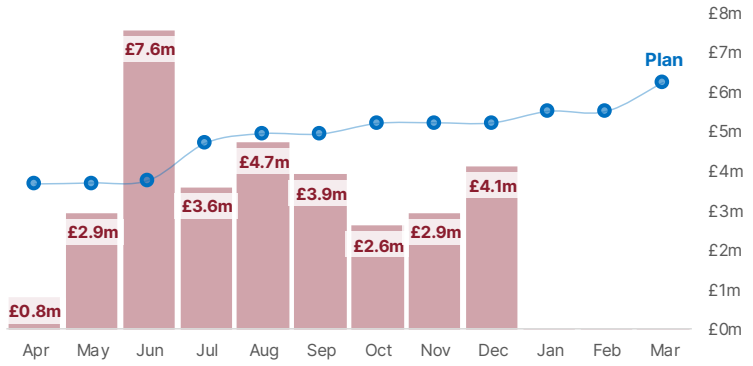
Efficiency Delivery by Organisation
Year to date delivery v plan
(£9.4m)

Organisation	Plan	Actual	YTD Variance	FCST Variance
UHBW	£19.5m	£15.8m	(£3.8m)	**(£6.1m)**
NBT	£14.7m	£13.4m	(£1.3m)	**(£2.2m)**
AWP	£8.2m	£2.7m	(£5.6m)	**£0.0m**
NHS Providers	**£42.5m**	**£31.8m**	**(£10.7m)**	**(£8.3m)**
BNSSG ICB	£9.2m	£10.4m	£1.2m	**£1.7m**
Total System	**£51.6m**	**£42.2m**	**(£9.4m)**	**(£6.6m)**
Previous Month		(£8.2m)		(£7.7m)

Efficiency Delivery by Organisation
Year to date delivery v plan
82%



System RECURRENT Efficiency
Monthly delivery v plan
80%



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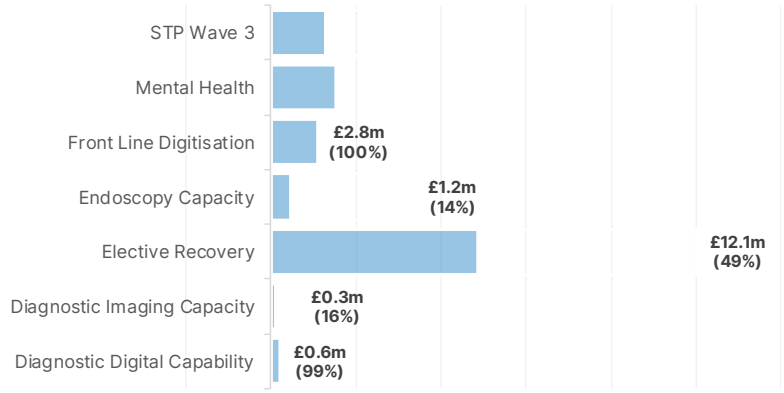
2. System Financial Performance Overview (2)

Month 9 – December 2023

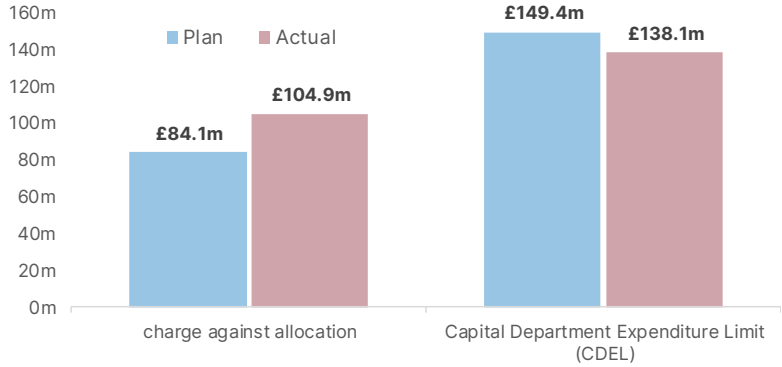
Full Year Charge Against capital Allocation — (£8.8m)
Forecast variance to plan

Combined Provider & ICB operational allocation	£75.3m
IFRS 16 CDEL uplift allocation	£8.8m
Operational Capital Allocation (including IFRS 16 uplift)	**£84.1m**
Provider Forecast Expenditure	(£72.0m)
BNSSG ICB Capital Grants & Acquisitions	(£3.5m)
Provider Forecast Lease expenditure (IFRS16)	(£29.5m)
Charge against Capital Allocation	**(£104.9m)**
less IFRS 16 Intra DHSC group adjustments	£12.1m
Variance to allocation	**(£8.8m)**

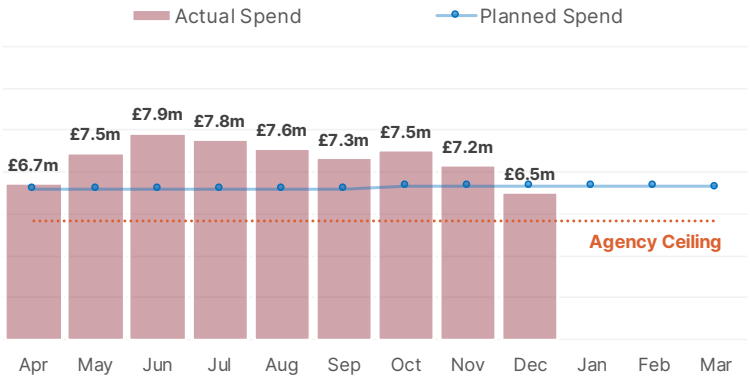
National Capital Funding Sources — £25.8m 52%
Forecast % spend of national funding



Forecast Capital Expenditure v Plan
Forecast Variance to capital plan



System Agency Expenditure — £6.4m
YTD Over / Underspend (-) v Plan

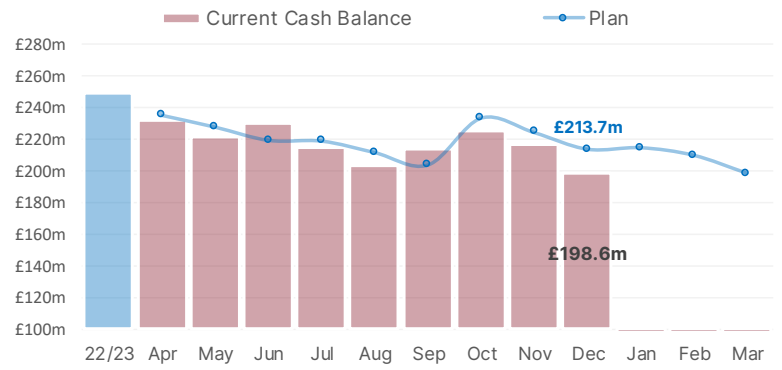


Better Payment Practice Code (BPPC) — 2
Number of organisations missing BPPC target

Target = 95%

Organisation	Current Month %	Current Month Achieved?	Year to Date %	Year to Date Achieved?
UHBW	90.3%	N	90.3%	N
NBT	91.5%	N	92.3%	N
AWP	93.4%	N	98.7%	Y
BNSSG ICB	99.1%	Y	98.1%	Y
System Average	**93.6%**	**N**	**94.9%**	**N**

Cash Balances — -£15.1m
Cash and cash equivalents year to date variance v plan



3. Key Financial Performance Indicators

Month 9 – December 2023

	Year to Date						Forecast			Variance by Organisation			
	System	previous month		UHBW	NBT	AWP	BNSSG ICB	System	previous month		UHBW	NBT	AWP	BNSSG ICB
1.1 Overall Variance from Plan														
variance to plan	**-£4.4m**	-£3.1m	↓	-£1.6m	-£4.3m	-£0.9m	£2.4m	**(£5.6m)**	£0.0m	↓	-	-	-	-
1.2 Net Unmitigated Risk														
Net Unmitigated Risk								**(£5.6m)**	**£0.0m**		assessed at system level			
(as a % of ICB allocation)								0.0%	0.0%	←				
2. Efficiency plan delivery														
2.1 Annual Efficiency Plan (recurrent & non-recurrent schemes)														
Variance v plan (£)	**-£9.4m**	-£8.2m		-£3.8m	-£1.3m	-£5.6m	£1.2m	**-£6.6m**	-£7.7m		-£6.1m	-£2.2m	£0.0m	£1.7m
% delivery	**82%**	82%	↓	81%	91%	**32%**	**114%**	**91%**	90%	↑	77%	91%	**100%**	**114%**
2.2 Recurrent Efficiency Plan														
Variance v plan (£)	**-£8.1m**	-£7.0m		-£4.8m	-£1.3m	-£3.2m	£1.2m	**-£8.9m**	-£9.6m		-£7.5m	£0.0m	-£3.2m	£1.7m
% delivery	**80%**	81%	↓	**58%**	91%	**45%**	**114%**	**85%**	84%	↑	**55%**	**100%**	**60%**	**114%**
3. System capital														
3.1 Capital Departmental Expenditure Limit (CDEL)														
Variance v plan (£)	**-£17.2m**	-£9.2m		£5.5m	-£23.4m	£0.8m	-	**-£11.3m**	-£5.0m		£7.4m	-£14.8m	-£3.9m	-
% delivery	**83%**	89%	↓	79%	**60%**	**142%**	-	**92%**	97%	↓	**117%**	80%	**105%**	-
3.2 Charge against Capital Allocation (including impact of IFRS16)														
Variance v plan (£)								**-£8.8m**	-£22.2m	↑				

4. Key Financial Performance Indicators (2)

Month 9 – December 2023

	Year to Date						Forecast		Variance by Organisation			
	System	previous month		UHBW	NBT	AWP	BNSSG ICB	System	previous month	UHBW	NBT	AWP	BNSSG ICB
4. Workforce													
4.1 Agency Expenditure v Plan													
Variance v plan (£)	**£6.4m**	£6.5m		-£4.2m	£2.7m	£7.9m	-	**£5.3m**	£9.7m	-£4.7m	£0.0m	£9.9m	-
Variance v plan (%)	**11%**	12%	↓	-14%	21%	38%	-	**7%**	12%	0%	0%	31%	-
4.2 Agency Expenditure v Agency Ceiling													
Variance v agency cap (£)	**£13.6m**	£12.9m		assessed at system level				**£15.1m**	£19.5m	assessed at system level			
Variance v agency cap (%)	**26%**	28%	↓					**22%**	28%				
5. Liquidity(cash)													
5.1 Cash Balances v Plan													
Variance v plan (£)	**-£15.1m**	-£7.7m		-£0.6m	-£37.8m	£23.3m	-	**-£41.6m**	£19.4m	-£5.1m	-£42.6m	£6.0m	-
Variance v plan (%)	**5%**	5%	←	-1%	-52%	67%	-	**-21%**	10%	-5%	-47%	67%	
6. Other Key Financial Indicators													
6.1 Mental Health Investment Standard													
minimum investment achieved	**Y**	Y	←										
6.2 ICB Running Cost Allowance													
Planned Expenditure within allowance	**Y**	Y	←										

5. System Financial Risk

Month 9 – December 2023

Organisation / System-wide	Description of Risk	Liklihood	Impact before mitigations £'000K	Mitigations £'000K	Description of mitigating actions being taken by the system	Financial Impact after mitigations £'000K	Prior Month Net Risk £'000K
ICB	Funded Care demand	Medium	(£1.5m)	£1.5m	non-recurrent balance sheet flexibility	£0.0m	£0.0m
Acute Providers	Elective Activity earnings	Medium	(£7.7m)	£7.7m	Continued Divisional Recovery Plans / Delivery of H2 plan	£0.0m	£0.0m
System Wide	Impact of Indutcrial Action to end of Septmber on cost base and ESRF activity income	Removed	£0.0m	£0.0m	National H2 Funding settlement	£0.0m	£0.0m
ICB	Prescribing run-rate	Removed	£0.0m	£0.0m	Risk removed	£0.0m	£0.0m
System Wide	Winter Pressures / Discharge to Assess risk pool	Removed	£0.0m	£0.0m	Risk removed	£0.0m	£0.0m
System Wide	Microsoft 365 license	Removed	£0.0m	£0.0m	Risk removed	£0.0m	£0.0m
	Total Gross (Risk) / Mitigations		**(£9.2m)**	**£9.2m**	**Total Net Risk**	**£0.0m**	**£0.0m**

Gross Risk as a percentage of ICB allocation	-0.4%	Net Risk as a percentage of ICB allocation	0.0%

Appendix 1

System I&E Summary

(ICB & Combined Provider)

	YTD Plan £m	Actual £m	Variance £m	Full-Year Plan £m	Forecast £m	Forecast Variance £m
ICB Revenue Resource Limit	**£1,638.4m**	**£1,638.4m**	**£0.0m**	**£2,141.6m**	**£2,141.6m**	**£0.0m**
BNSSG ICB Expenditure						
Acute Services	(820.4)	(821.5)	**(1.1)**	(1,070.5)	(1,073.1)	**(2.6)**
Mental Health Services	(172.8)	(173.2)	**(0.4)**	(229.8)	(230.2)	**(0.4)**
Community Health Services	(175.2)	(175.1)	**0.1**	(221.7)	(221.8)	**(0.1)**
Continuing Care Services	(85.6)	(94.2)	**(8.6)**	(114.0)	(125.9)	**(11.9)**
Primary Care Services	(138.2)	(139.9)	**(1.7)**	(184.2)	(185.9)	**(1.7)**
Primary Medical Services	(136.8)	(137.0)	**(0.2)**	(175.9)	(176.0)	**(0.1)**
Delegated Dental, Ophthalmic and Pharmacy Services	(64.1)	(57.7)	**6.4**	(85.7)	(77.1)	**8.6**
Other Commissioned Services	(8.8)	(8.7)	**0.1**	(11.8)	(11.5)	**0.2**
Other Programme Services	(3.3)	(3.5)	**(0.3)**	(6.6)	(6.4)	**0.2**
Reserves / Contingencies	(18.8)	(10.5)	**8.2**	(22.6)	(14.8)	**7.8**
Total ICB Programme Expenditure	**(1,623.9)**	**(1,621.5)**	**2.4**	**(2,122.7)**	**(2,122.7)**	**0.0**
ICB Running Costs	(14.5)	(14.5)	**0.0**	(18.9)	(18.9)	**0.0**
Total ICB Net Expenditure	**(1,638.4)**	**(1,636.0)**	**2.4**	**(2,141.6)**	**(2,141.6)**	**0.0**
ICB surplus / (deficit)	**£0.0m**	**£2.4m**	**£2.4m**	**£0.0m**	**£0.0m**	**£0.0m**
Combined Provider I&E						
Operating income from patient care activities	1,602.2	1,646.5	**44.3**	2,145.4	2,211.0	**65.5**
Other operating income	137.9	167.1	**29.2**	182.5	218.5	**36.0**
Total Operating Income	**1,740.1**	**1,813.6**	**73.5**	**2,327.9**	**2,429.5**	**101.6**
Substantive staff including on-costs	(1,003.2)	(1,001.5)	**1.7**	(1,323.2)	(1,342.2)	**(19.0)**
Bank staff including on-costs	(46.8)	(81.6)	**(34.8)**	(63.2)	(107.5)	**(44.3)**
Agency / contract	(60.5)	(66.4)	**(5.9)**	(80.8)	(86.1)	**(5.3)**
Other Staff Costs	4.4	2.0	**(2.3)**	5.9	5.5	**(0.3)**
Other Operating Expenditure	(594.1)	(652.2)	**(58.1)**	(802.9)	(860.4)	**(57.5)**
Total Operating Expenditure	**(1,700.2)**	**(1,799.6)**	**(99.4)**	**(2,264.2)**	**(2,390.6)**	**(126.4)**
OPERATING SURPLUS / (DEFICIT)	**39.9**	**13.9**	**(25.9)**	**63.7**	**38.8**	**(24.9)**
Net Finance Costs	(54.1)	(116.3)	**(62.2)**	(72.1)	(133.2)	**(61.1)**
Other Adjustments to Financial Performance	2.6	83.9	**81.3**	8.4	88.8	**80.4**
NHS Provider surplus / (deficit)	**(£11.7m)**	**(£18.4m)**	**(£6.8m)**	**£0.0m**	**(£5.6m)**	**(£5.6m)**
SYSTEM FINANCIAL PERFORMANCE	**(£11.7m)**	**(£16.0m)**	**(£4.4m)**	**£0.0m**	**(£5.6m)**	**(£5.6m)**

Appendix 2.1

System Capital Summary

(Forecast Variance to Capital Allocation)

	Combined Provider £m	ICB £m	System TOTAL £m
System Level Capital Envelope Analysis			
2023/24 Capital Allocation (excluding Prior Year Revenue Performance allocation)	68.5	1.7	**70.2**
Confirmed Prior Year Revenue Performance Allocation	5.1	0.0	**5.1**
Less transfer to the ICB Allocation	(1.8)	1.8	**0.0**
2023/24 Total Capital Allocation (Indicative)	**71.8**	**3.5**	**75.3**
IFRS 16 CDEL uplift allocation	8.8	0.0	**8.8**
2023/24 Total Capital Allocation (including IFRS 16 CDEL uplift)	**£80.6m**	**£3.5m**	**£84.1m**
Provider Forecast Expenditure (owned assets)			
Routine maintenance (non-backlog)	10.9	-	**10.9**
Backlog Maintenance	15.7	-	**15.7**
New Build	15.2	-	**15.2**
Equipment	6.7	-	**6.7**
Plant and machinery	18.6	-	**18.6**
Fire Safety	2.5	-	**2.5**
IT	9.1	-	**9.1**
Sub total before donations and leases	**78.7**	**0.0**	**78.7**
less Donations	(3.7)	-	**(3.7)**
Less PFI capital (IFRIC12)	(3.0)	-	**(3.0)**
plus IFRS16 Leases	29.5	-	**29.5**
Provider Charge against Capital Allocation (including impact of IFRS 16)	**£101.5m**	**£0.0m**	**£101.5m**
ICB Summary			
GPIT	-	1.1	**1.1**
Other Capital Acquisition	-	0.3	**0.3**
Improvement Grant	-	0.6	**0.6**
Other Capital Grant	-	1.5	**1.5**
ICB Charge against Capital Allocation	**£0.0m**	**£3.5m**	**£3.5m**
less IFRS 16 Intra DHSC group adjustments	(12.1)	0.0	**(12.1)**
(Over) / Underspend v Capital Allocation	**(£8.8m)**	**£0.0m**	**(£8.8m)**

Appendix 2.2

Provider Capital Detail

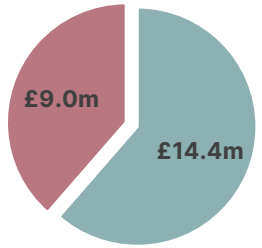
	YTD Plan £m	Actual £m	Variance £m	Full-Year Plan £m	Forecast £m	Forecast Variance £m
Internally Funded (owned assets)						
Routine maintenance (non-backlog)	7.7	3.3	4.5	10.8	10.9	(0.1)
Backlog Maintenance	5.1	14.7	(9.6)	6.9	15.7	(8.8)
New Build	14.5	11.2	3.3	19.4	15.2	4.2
Equipment	2.6	6.0	(3.4)	3.5	6.7	(3.2)
Plant and machinery	14.9	8.1	6.8	19.9	18.6	1.2
Fire Safety	1.9	0.7	1.2	2.5	2.5	0.0
IT	7.4	6.1	1.3	11.1	9.1	2.0
Fleet, Vehicles & Transport	0.0	0.0	0.0	0.0	0.0	0.0
Other	0.0	0.0	0.0	0.0	0.0	0.0
sub total	**54.1**	**50.1**	**4.1**	**74.0**	**78.7**	**(4.7)**
less donations	(0.2)	(2.5)	2.3	(0.2)	(3.7)	3.5
less disposals	0.0	(0.2)	0.2	0.0	(0.2)	0.2
less PFI capital (IFRIC12)	(1.5)	(2.2)	0.7	(2.0)	(3.0)	1.0
Charge against Capital Allocation (before impact of IFRS 16)	**£52.5m**	**£45.3m**	**£7.2m**	**£71.8m**	**£71.8m**	**£0.0m**
IFRS16 Leases						
Routine maintenance (non-backlog)	9.3	7.4	2.0	9.3	7.8	1.5
Other	0.0	14.9	(14.9)	3.7	15.8	(12.1)
Plant and machinery	3.5	3.7	(0.2)	4.7	5.8	(1.1)
Fleet, Vehicles & Transport	0.1	0.1	(0.0)	0.1	0.1	0.0
Total Internally Funded	**12.9**	**26.1**	**(13.1)**	**17.8**	**29.5**	**(11.7)**
Total Charge against Capital Allocation (including impact of IFRS 16)	**£65.4m**	**£71.3m**	**(£5.9m)**	**£89.6m**	**£101.3m**	**(£11.7m)**
PFI capital charges (e.g. residual interest)						
PFI capital charges (e.g. residual interest)	7.8	8.3	(0.5)	10.3	11.0	(0.7)
National Programme Funding						
Critical Cybersecurity Infrastructure Risks	0.0	0.0	0.0	0.0	0.2	(0.2)
Diagnostic Digital Capability Programme	0.2	0.0	0.2	0.6	0.6	0.0
Diagnostic Imaging Capacity	0.3	0.0	0.3	1.6	0.3	1.4
Elective Recovery/Targeted Investment Fund	18.7	2.1	16.7	25.0	12.1	12.9
Endoscopy - Increasing Capacity	4.2	0.0	4.2	8.5	1.2	7.3
Front Line Digitisation	0.5	0.0	0.5	2.8	2.8	(0.0)
Mandate Transfer - National	0.0	0.0	0.0	0.0	1.6	(1.6)
Mental Health	1.9	1.2	0.7	4.7	3.8	0.9
Screening - Diagnostics Programme	0.0	0.0	0.0	0.0	0.1	(0.1)
STP Wave 3	3.0	2.0	1.0	6.2	3.2	3.0
UEC Capacity	0.0	0.0	0.0	0.0	0.0	0.0
Total National Programme Funding	**28.9**	**5.2**	**23.6**	**49.4**	**25.8**	**23.6**
Total Capital Departmental Expenditure Limit (CDEL)	**£102.0m**	**£84.8m**	**£17.2m**	**£149.4m**	**£138.1m**	**£11.3m**

Appendix 3.1

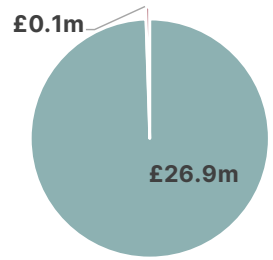
Efficiency Delivery (Provider)

Provider Pay Efficiencies	YTD Plan £m	Actual £m	Variance £m	Delivery %	Full-Year Plan £m	Forecast £m	Variance £m	Forecast Delivery %
Agency - price cap compliance	2.4	1.4	(1.0)	60%	3.3	1.9	(1.4)	58%
Agency - eliminate off framework supply	1.0	0.1	(0.9)	11%	1.4	0.6	(0.9)	40%
Establishment reviews	4.9	6.1	1.3	127%	8.7	7.9	(0.8)	91%
E-Rostering	0.1	0.0	(0.0)	48%	0.1	0.0	(0.0)	50%
Digital transformation	0.0	0.0	(0.0)	0%	0.0	0.0	0.0	100%
Service re-design - pay	5.7	1.2	(4.6)	20%	8.6	2.1	(6.4)	25%
Other - pay	0.2	0.2	(0.0)	96%	0.3	0.8	0.5	303%
Unidentified - pay	0.7	0.0	(0.7)	0%	1.0	0.7	(0.3)	70%
Total Provider Pay Schemes	**15.0**	**9.1**	**(5.8)**	**61%**	**23.4**	**14.4**	**(9.0)**	**61%**
Provider Non-pay Efficiencies								
Medicines optimisation	2.0	2.3	0.3	115%	2.7	3.5	0.8	129%
Procurement (excl drugs) -non-clinical	2.8	1.4	(1.4)	49%	3.8	2.9	(0.9)	76%
Procurement (excl drugs) - medical and clinical	7.3	3.5	(3.8)	48%	9.9	5.5	(4.3)	56%
Estates and Premises transformation	1.6	1.6	(0.0)	99%	2.2	2.2	(0.1)	97%
Fleet optimisation	0.1	0.0	(0.0)	43%	0.1	0.1	(0.1)	39%
Pathology & imaging networks	0.8	1.0	0.2	131%	1.3	1.6	0.3	123%
Corporate services transformation - non-pay	0.0	5.4	5.3	17930%	0.1	5.5	5.3	4871%
Digital transformation	0.1	0.0	(0.0)	37%	0.3	0.4	0.2	163%
Service re-design - Non-pay	1.5	1.1	(0.4)	72%	2.0	1.1	(0.9)	54%
Other - Non-pay (balance - please provide description)	0.3	0.2	(0.1)	81%	0.4	3.0	2.6	677%
Unidentified - non-pay (please provide commentary)	3.0	0.0	(3.0)	0%	4.0	1.1	(2.9)	27%
Total Provider Non-Pay Schemes	**19.3**	**16.4**	**(2.9)**	**85%**	**26.8**	**26.9**	**0.1**	**101%**
Provider Income Efficiencies								
Income Private Patient	0.1	0.3	0.1	191%	0.3	0.9	0.6	350%
Income Overseas Visitors	0.1	0.1	0.0	152%	0.1	0.1	0.0	100%
Income Non-Patient Care	7.7	5.6	(2.0)	73%	11.2	7.2	(4.0)	64%
Income Other (balance - please provide description)	0.3	0.2	(0.1)	79%	0.5	3.5	2.9	664%
Unidentified - Income (please provide commentary)	0.0	0.0	0.0	-	0.0	1.0	1.0	100%
Total Provider Income Schemes	**8.2**	**6.2**	**(1.9)**	**76%**	**12.1**	**12.6**	**0.5**	**104%**
Total Combined Provider Efficiencies	**£42.5m**	**£31.8m**	**(£10.7m)**	**75%**	**£62.3m**	**£53.9m**	**(£8.3m)**	**87%**

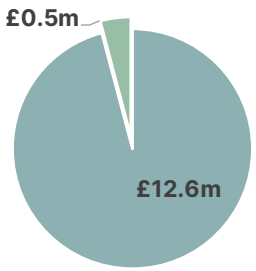
Provider pay



Provider non-pay



Provider income



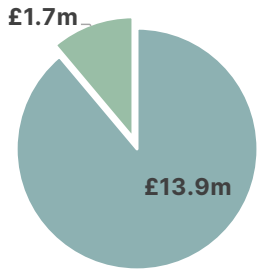
Shaping better health

Appendix 3.2

Efficiency Delivery (ICB & System total)

ICB Efficiencies	YTD Plan £m	Actual £m	Variance £m	Delivery %	Full-Year Plan £m	Forecast £m	Variance £m	Forecast Delivery %
All-age Continuing Care - Commissioning/Procurement	2.3	1.9	(0.4)	83%	3.1	3.0	(0.1)	98%
Primary Care Prescribing	2.0	4.8	**2.7**	236%	2.7	5.9	**3.2**	221%
Non-NHS Procurement	2.8	2.8	**0.0**	100%	3.7	3.7	**0.0**	100%
Running cost review	0.4	0.4	**0.0**	100%	0.5	0.5	**0.0**	100%
ICB efficiency impacting providers outside system:	0.5	0.5	**0.0**	101%	0.7	0.7	**0.0**	101%
Unidentified	1.1	0.0	(1.1)	0%	1.5	0.0	(1.5)	0%
Total ICB Efficiencies	**£9.2m**	**£10.4m**	**£1.2m**	**114%**	**£12.2m**	**£13.9m**	**£1.7m**	**114%**
TOTAL System Efficiencies	**£51.6m**	**£42.2m**	**(£9.4m)**	**82%**	**£74.4m**	**£67.8m**	**(£6.6m)**	**91%**

ICB

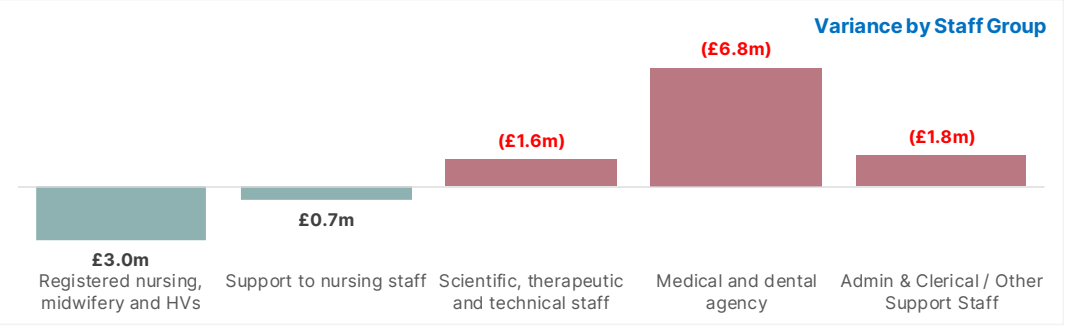


Appendix 4

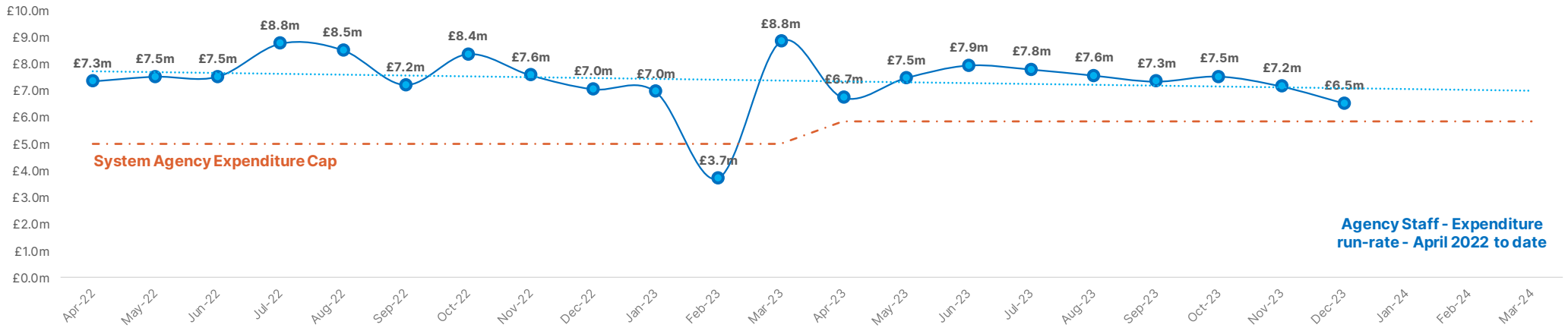
System Agency Staff Expenditure

&

Performance v Agency Ceiling



	Year to Date		Forecast	
Plan	£59.7m		£79.7m	
Year to Date / Forecast Spend	£66.0m		£85.0m	
Variance to Plan	**(£6.4m)**	**11%**	**(£5.3m)**	**7%**
Variance to System Agency Ceiling	(£13.6m)	26%	(£15.1m)	22%
Target Agency Spend as a % of Total Pay	4.7%		4.7%	
Actual Agency Spend as a % of Total Pay	5.8%		5.6%	



Staff Group	YEAR TO DATE Plan £m	Actual £m	Variance £m	Variance %	UHBW £m	NBT £m	AWP £m	FORECAST Plan £m	Forecast £m	Variance £m	Variance %	UHBW £m	NBT £m	AWP £m
Registered nursing, midwifery and HVs	41.5	38.5	**3.0**	-7%	4.5	2.3	(3.9)	55.4	49.8	**5.5**	-10%	5.0	5.4	(4.9)
Support to nursing staff	6.8	6.0	**0.7**	-11%	0.3	1.0	(0.5)	9.0	7.6	**1.4**	-16%	0.4	1.3	(0.3)
Scientific, therapeutic and technical staff	0.9	2.5	**(1.6)**	178%	(0.6)	(1.0)	(0.0)	1.2	3.1	**(1.9)**	167%	(0.7)	(1.2)	(0.1)
Medical and dental agency	9.1	15.9	**(6.8)**	74%	(0.5)	(3.8)	(2.4)	12.3	20.3	**(8.0)**	65%	(0.6)	(4.1)	(3.3)
Admin & Clerical / Other Support Staff	1.3	3.1	**(1.8)**	134%	0.4	(1.2)	(1.1)	1.8	4.1	**(2.3)**	129%	0.5	(1.4)	(1.4)
Total Agency Spend	**59.7**	**66.0**	**(6.4)**	**11%**	**4.2**	**(2.7)**	**(7.9)**	**79.7**	**85.0**	**(5.3)**	**7%**	**4.7**	**0.0**	**(9.9)**
Agency costs as % of gross staff costs					**3.6%**	**4.5%**	**13.7%**					**3.7%**	**3.9%**	**13.4%**

Appendix 5 Statement of Financial Position

	UHBW			NBT			AWP			BNSSG ICB		
	March 2023 £m	Current Month £m	Movement £m	March 2023 £m	Current Month £m	Movement £m	March 2023 £m	Current Month £m	Movement £m	March 2023 £m	Current Month £m	Movement £m
PFI / LIFT Assests	0.0	0.0	**0.0**	294.7	0.0	**(294.7)**	35.9	34.7	**(1.2)**	0.0	0.0	**0.0**
Other property, plant and equipment	577.1	570.4	**(6.8)**	188.8	491.9	**303.1**	142.3	143.7	**1.4**	0.0	0.0	**0.0**
Leased Assets	99.2	112.8	**13.6**	8.7	9.4	**0.7**	17.5	19.4	**2.0**	0.0	0.0	**0.0**
Receivables due	1.8	1.8	**0.0**	1.4	1.4	**0.0**	0.2	0.2	**0.0**	0.0	0.0	**0.0**
Other non-current assets	20.0	17.5	**(2.5)**	17.6	16.6	**(1.0)**	2.1	1.9	**(0.2)**	0.5	0.5	**(0.0)**
Total non-current assets	**698.2**	**702.5**	**4.4**	**511.2**	**519.3**	**8.1**	**198.0**	**199.9**	**1.9**	**0.5**	**0.5**	**(0.0)**
Inventories	15.0	16.9	**1.8**	10.0	10.0	**(0.0)**	0.2	0.2	**(0.0)**	0.0	0.0	**0.0**
Receivables due	68.1	52.2	**(15.9)**	68.0	70.0	**1.9**	20.9	18.4	**(2.5)**	18.3	17.2	**(1.1)**
Cash and cash equivalents	128.0	102.3	**(25.7)**	104.0	59.4	**(44.6)**	17.0	36.3	**19.3**	0.1	(1.5)	**(1.5)**
Other current assets	(4.8)	(5.0)	**(0.1)**	(10.7)	(10.7)	**(0.0)**	0.0	0.0	**0.0**	0.0	0.0	**0.0**
Total current assets	**206.4**	**166.5**	**(39.9)**	**171.4**	**128.7**	**(42.7)**	**38.2**	**54.9**	**16.8**	**18.4**	**15.8**	**(2.7)**
Trade and other payables	(164.4)	(124.4)	**40.0**	(121.9)	(73.7)	**48.2**	(37.9)	(53.8)	**(15.9)**	(131.5)	(129.5)	**2.0**
Borrowings	(12.5)	(12.9)	**(0.3)**	(17.1)	(27.3)	**(10.3)**	(3.0)	(1.4)	**1.6**	(0.1)	0.0	**0.1**
Provisions	(0.3)	(0.4)	**(0.1)**	(4.1)	(3.9)	**0.1**	(3.7)	(3.7)	**0.0**	(13.3)	(10.8)	**2.5**
Other liabilities	(8.5)	(25.7)	**(17.2)**	(17.2)	(38.2)	**(21.0)**	0.0	0.0	**0.0**	0.0	0.0	**0.0**
Total current liabilities	**(185.7)**	**(163.3)**	**22.5**	**(160.2)**	**(143.2)**	**17.0**	**(44.6)**	**(58.9)**	**(14.3)**	**(144.9)**	**(140.2)**	**4.6**
Borrowings	(133.3)	(141.1)	**(7.8)**	(355.2)	(576.3)	**(221.0)**	(50.5)	(84.4)	**(33.9)**	0.0	0.0	**0.0**
Other non-current liabilities	(3.9)	(3.7)	**0.1**	(6.8)	(7.1)	**(0.3)**	(1.2)	(1.1)	**0.1**	0.0	0.0	**0.0**
Total non-current liabilities	**(137.2)**	**(144.8)**	**(7.6)**	**(362.0)**	**(583.4)**	**(221.4)**	**(51.7)**	**(85.5)**	**(33.8)**	**0.0**	**0.0**	**0.0**
Total net assets employed	**£581.7m**	**£560.9m**	**(£20.7m)**	**£160.4m**	**(£78.7m)**	**(£239.0m)**	**£139.9m**	**£110.5m**	**(£29.4m)**	**(£126.0m)**	**(£124.0m)**	**£2.0m**
Public dividend capital	326.6	326.2	**(0.4)**	469.1	472.0	**2.9**	141.4	144.4	**3.0**	0.0	0.0	**0.0**
Income and expenditure reserve	143.6	122.9	**(20.7)**	(376.7)	(618.1)	**(241.4)**	(79.5)	(110.1)	**(30.7)**	0.0	0.0	**0.0**
Revaluation reserve	111.3	109.7	**(1.7)**	68.0	68.0	**0.0**	77.9	76.2	**(1.7)**	0.0	0.0	**0.0**
I&E Reserve General Fund	0.0	0.0	**0.0**	0.0	0.0	**0.0**	0.0	0.0	**0.0**	(126.0)	(124.0)	**2.0**
Other reserves	0.1	0.1	**0.0**	0.0	0.0	**0.0**	0.0	0.0	**0.0**	0.0	0.0	**0.0**
Total taxpayers' and others' equity	**£581.6m**	**£558.8m**	**(£22.8m)**	**£160.4m**	**(£78.1m)**	**(£238.5m)**	**£139.9m**	**£110.5m**	**(£29.4m)**	**(£126.0m)**	**(£124.0m)**	**£2.0m**

Finance, Estates and Digital Committee OPEN Minutes
Thursday 23rd November 2023, 09:00 – 12:00, Microsoft Teams

Members (Quoracy: 3 members required, including one of ICB Non-Executive members; and one of Chief Executive or Chief Finance Officer)		**Initials**
Steve West	Finance, Estates and Digital Committee – Chair	SW
Sarah Truelove	Deputy CEO & CFO – ICB (item 5.0 only)	ST
Deborah El-Sayed	Director of Transformation and Chief Digital and Information Officer	DES
Jo Medhurst	Chief Medical Officer – ICB	JM
John Cappock	Non-Executive Director – ICB	JC
Christina Gray	Director of Public Health - BCC	CG
Nina Philippidis	S151 Officer – SGC	NP
Brian Stables	Non-Executive Director - AWP	BS
Rosi Shepherd	Chief Nursing Officer – ICB	RS
Attending		
Jon Lund	Deputy Chief Finance Officer - ICB	JL
Dominic Hardisty	Chief Executive – AWP (item 5.0 only)	DH
Paul Roy	Research Manager – ICB (item 6.1 only)	PR
Dan Offord	Head of Digital Delivery – ICB (item 8.1 only)	DO
Rachel Smith	Exec PA (Note Taker)	RSm

	Item	**Action**
1.0	**Apologies for Absence** Apologies were received from Shane Devlin, BNSSG ICB; Dave Jarrett, BNSSG ICB and Martin Sykes, UHBW.	
2.0	**Declarations of Interest** Two members declared a conflict of interest: • Item 5.0, Brian Stables (BS) had a conflict of interest for item 5.0 of the open agenda (AWP Saving Plan Delivery 2023/24). BS was Chair of the AWP Audit and Risk Committee and would not comment on the discussions. • Item 6.1, Steve West (SW) had a conflict of interest for item 6.1 of the open agenda (Research Grants and Research Capability Funding Financial Governance Arrangements, due to his role as Pro-Vice Chancellor of UWE.	
3.0	**Minutes of the previous meeting** The minutes of the meeting held on 26 October 2023 were agreed to be a true and accurate record of the meeting.	
4.0	**Actions from Previous Meeting** The action log was reviewed and updated accordingly.	
	To discuss	
5.0	**AWP Saving Plan Delivery 2023/24** A paper was circulated to the committee prior to the meeting; Steve West (SW) invited Dominic Hardisty (DH) to provide assurance on behalf of the AWP Board that plans were on track, due to concerns around potential drift, leading to implications towards the end of the financial year and reiterated the ICB had accountability responsibility at system level. DH advised that the slides that were shared were just for information, rather than assurance, and assurance around delivery of the plan was provided to AWP's Finance Performance Committee and the Trust Board. A separate assurance meeting could be arranged for this committee if required. DH summarised / highlighted as follows: • current forecasts and trajectories indicate achievement of £8m recurrent savings, leaving a residual £3m still to be delivered, • The significant financial challenge for AWP in 2023/24 was known at the start of the year and the challenge would be around timing of delivery of recurrent savings, rather than reliance on system support and non-recurrent savings.	

	• CIP plans were stood down due to the unexpected S29A notice in February 2023, which required a significant proportion of leadership capacity to develop the CQC response by June 2023. This resulted in a 6 month delay against plan, leading to reliance on non-recurrent savings and drawing on reserve resources to achieve break even, which may have implications for future years. • Concerns around delivery of forecast outturn for 2023/24, the run rate at year end and plans for future savings. • A key focus in Q3 was out of area placements (private sector outside of BNSSG / BSW and also out of Trust but within area). There were currently 0 out of area placements and there was a planned trajectory to reduce out of area placement beds (down to 12) by the end of 2024, which was supported by an appropriate bed base. • Reduction of agency usage was also a key focus: the new safer staffing processes implemented over the past 6 – 8 weeks (and would be in all establishments from 1 December 2023) and improved processes around agency approval would show a significant reduction in agency costs over the last 3 months. • Significant investment in international recruitment, with 150 nurses from India joining the Trust. The international recruitment was expected to reduce the agency expenditure within 6 months and the Trust was exploring the possibility of extending the NHS element of the funding into next year. • A longer range Transformation plan was also under development for 2024/25; AWP had identified a number of specific projects to reduce the cost base but which would improve quality and staff experience. Further work was required around mobilisation and timeframes but it was hoped to reach a decision around this in January 2024. Stakeholder engagement was also important to minimise any potential risks related to organisational reputation, quality or operational flow. • Potential areas / opportunities for system support including: - Opening discussions around allocation and management of the MHIS in each system - MH agency usage in acute hospitals (due to concerns around over-skillmixing and use of expensive agencies) - Sustainability of AWP services provided to the SW Provider Collaborative - Alignment of physical and mental health in the community - Benchmarking opportunities - Parity of esteem in capital allocations SW queried where the international nurses would be based; DH advised they would all be working on wards initially. A trial was underway around a small number of international nurses moving into the community, having worked on wards for a year. Christina Gray (CG) welcomed the international recruitment model but queried whether there were any plans for local recruitment / apprenticeships and links to the system workforce plan, in addition to develop staff to enable them to work across the system and have a clearly defined pathway for career progression. DH confirmed local recruitment and apprenticeships were ongoing but believed more could be done. CG also referenced the BNSSG system Mental Health strategy, which was currently out for consultation, and the opportunities to align the system strategy with AWP's own strategy, in order to address some of the issues currently being experienced by AWP. The Trust's People Strategy was in the process of being refreshed and the refresh would include bolstering of all opportunities to align strategies. CG also highlighted the Community Mental Health Framework, which was the transformation enabler at locality level and may be able to stabilise some of the issues raised. DH advised that the CMH framework had been designed to address the deficit in care more than the deficit in provider setting, so was a slightly different driver. DH also highlighted that slight reductions in referrals had been reported. Furthermore, in relation to the issues around bed occupancy by those patients waiting for social care packages / housing, CG suggested DH liaise with the LA Directors of Adult Services and offered support to broker these conversations, if that would be useful. DH welcomed the offer of support to enable a co-production approach to support discharges. In relation to the leadership capacity required to develop the s29A response, John Cappock (JC) a asked if, in hindsight, anything could have been done differently, and also queried the challenges around straddling two ICBs and whether all avenues around system working and sustainability had been exhaustively highlighted elsewhere.	

	The complexities and challenges around system working were recognised and DH highlighted the importance and value in developing and investing in relationships and alliance strategies. In terms of organisational leadership / resilience, DH confirmed that a recent well-led development review had identified organisational capacity as an area for review. Significant work had been undertaken regarding executive capacity and capability and a formal development programme for middle management was also being planned. Sarah Truelove (ST) raised concerns regarding the workforce element and suggested that it would be appropriate for the AWP People Strategy to be presented to the ICS People Committee once completed, due to the implications around this year's savings plan. There were further concerns around the significant number of vacancies in AWP at present, which necessitated the high reliance on agency staff which was not replicated in other Mental Health Trusts, and clarification was sought around system support that could be provided and whether consideration was required around escalation of the issues to the ICB Board. DH was confident that there was the right level of engagement and did not feel escalation was required at this point. AWP had identified reasons behind recruitment challenges, which included the current clinical and operational model, particularly around bed numbers on the wards. The most recent staff survey had shown improvements year on year over the last 4 years but still only scored as an "average" organisation in which to work, thereby indicating further work needed to be done, particularly around organisational culture. In terms of the refreshed People Strategy, DH confirmed there was more scope and opportunity to be more creative, particularly in relation to people with lived experience and the voluntary sector. SW welcomed the update and ensuing discussion, noting it was a work in progress, particularly around the workforce needed to develop the care pathways and the care approaches which radically needed to change and would require wider system support. Education pipelines were also key, due to the year on year reduction in the number of people choosing to work in the mental health profession. The potential risks to the year end position were also acknowledged.	
	To Approve	
5.2	**Implementation of the Forecast Outturn Protocol in BNSSG – SOP** Jon Lund (JL) presented the protocol which had been developed by the system DOFs, following NHSE's development of a protocol earlier in the year for instances whereby a system or organisation wanted to deteriorate from its planned financial position, and the ICB took the opportunity to develop a similar protocol. The protocol details the approach to manage financial risk and financial deterioration in the system. The protocol, which emphasised the importance of peer to peer support and engagement, has also been endorsed by the system Chief Executives group. BS proposed an amendment to the wording in that if a potential deterioration was identified, organisations could seek peer review and support at an earlier stage than detailed in the version presented. JL agreed to amend the wording but was keen to ensure ownership was kept within organisations as much as possible. The Committee approved the recommendation for onward presentation of the protocol to the ICB Board.	
6.1	**Research Grants and Research Capability Funding Financial Governance Arrangements** A paper was circulated to the committee prior to the meeting; Paul Roy (PR) provided a summary around the current process in place for approval of research grants and sought FED assurance for the new arrangements which proposed the all research -related contracts can be signed by the Chief Finance Officer (CFO), following existing due process around contract assurance. The majority of the funding came with the contracts and therefore the actual amount to be funded by the ICB for the majority of grants was typically less than £10,000. It was noted that all contracts currently go through their own sign off processes before ICB approval is requested. CG highlighted the significant research programmes within the local authorities, and the well-established networks between universities, Bristol Health Partners and NIHR, and queried whether this should also be included / referenced in the proposal. PR confirmed that as the ICB already hosted local authority projects, it would be possible for the ICB CFO to sign off any research projects, following the proposed process. BS sought clarification around the audit trail methodology for the signed contracts and that there would be no expectation for the CFO to breach SFIs.	

	JC queried whether the proposal been reviewed by the Counter Fraud team and whether there were any HMRC implications (in relation to payments to research participants). PR advised that Counter Fraud advice would be sought, following FED committee approval. **Action: JL to liaise with the Finance Department to seek reassurance for the Committee around any process that may be required.** JL also advised that work was ongoing within the Strategy Team to develop a policy for payment to people with Lived Expertise. PR also advised that participants contributing their experience and knowledge are actually reimbursed for their time, rather than being paid, and all research participants received a standard letter which explained their HMRC obligations and also similarly for those in receipt of universal credit. PR also confirmed that there was only a system in place for those with bank accounts but not yet for those who preferred payment in cash, but this was under development to ensure the ICB was able to offer an equitable service for participation, inclusion and opportunities. It was noted that food vouchers for certain outlets were also offered as payment. Jo Medhurst (JM) highlighted that this was linked to a World Health Organisation (WHO) statement concerning payment to people for research and co-design input and also supports the ICB's focus on reducing health inequalities. The Committee supported the recommendation for onward presentation to the ICB Board**.**	**JL**
6.3	**Standing Financial Instructions (SFI) Update** JL presented the updated SFIs for approval, and highlighted that a clean version had been circulated, in addition to a version with tracked changes, for ease of review. The SFIs had been reviewed and updated following the ICB's transition from a CCG in 2022, and the following key changes were highlighted within the cover paper. RS advised that in relation to the sections 8.2.6 and 8.2.7 (Commissioning of packages of care), a snapshot of the ICB's very high cost cases to enable a second tier of oversight and appropriate check and challenge by the committee. BS advised that he had forwarded a number of queries to ST and these were being worked through. In response to a query from CG, JL advised that the NHS Directors of Finance (DOFs) had discussed aligning governance processes with the Local Authorities and would be happy to share the SFIs once approved. RS also advised that in terms of the high cost care cases, these were processed through a joint funded panel and would be keen to explore joint commissioning arrangements where appropriate, in order to develop a system-wide approach. The SFIs would be kept under review as a working document, with specific items highlighted as appropriate between reviews. JL would amend the SFIs to include a reference to the Research Protocol; SW would review the amendment on behalf of the Committee. The Committee supported the recommendation for onward presentation to the ICB Board, following the Chair's final review.	JL
	Finance Report	
7.0	**M7 Finance Report ICB & System (incl Capital)** A paper was circulated to the committee prior to the meeting. JL reported that an extraordinary Board meeting was held on 21 November 2023 to reset the financial framework for the current year and receipt of additional non-recurrent funding targeted around the industrial action which provided assurance that a balanced financial position would be reported at the end of 2023/24. From a system-wide perspective, the challenges facing the acute sector were noted and were one of the drivers behind the protocol presented at item 5.2. This approach had been welcomed by both NBT and UHBW and the support offered by the system had been positively received. In terms of M7, there were no material changes to report and the mitigations in place to support the challenges around AWP's savings plan (as discussed at item 5.0), funded care and prescribing were noted. SW asked for an update on reducing prescribing costs; JL reported that there had been lots of work to assure the ICB to drive the costs down and a benchmarking exercise highlighted that the prescribing spend per head in BNSSG was lower than anywhere else in the region, which indicated robust controls were in place.	

	Work undertaken around prices and price inflation had also provided assurance that the overspend was inflation driven, and beyond the control of the ICB, with no signs of a lack of controls or actions. In response to a query from CG, JL advised that the 30% reduction in ICB running costs did not take effect until 1 April 2024 and would not be referenced until the new financial year. JL also highlighted that the redundancy costs associated with the Voluntary Early Redundancy Scheme (VERS) launched by the ICB in October had been set aside in the budget this year. The scheme would not create any pressure and the ICB was on track to deliver the 30% reductions. JL assured that committee that the ICB was very aware of the financial pressures and the actions that needed to be taken to mitigate any risks. BS reported on a proposal in AWP to implement an18 month revolving financial forecast, particularly for cost improvement plans and queried whether the ICB had considered something similar. JL advised that financial recovery and productivity gains had been discussed in detail at an ICB Planning Day in November and had helped in locking down the current year financial position early in order to enable a clear focus on the next wave of recovery, and allow a longer lead in time to get to the position of an 18 month forecast.	
	To Note	
8.0	**Receive update from System DoFs Group** No further comments to add to the discussion at item 7.0.	
8.1	**Receive update from System Digital Delivery Group** A paper was circulated to the committee prior to the meeting and Deborah El-Sayed (DES) drew attention to section 2 which drew out the areas of focus in the development of the Digital Strategy and the reduced funding that would be available, which would require careful management to ensure the strategy is delivered in the most meaningful and impactful way. The following was also highlighted: • work was ongoing to prioritise the high impact / time critical projects that were aligned to clinical and operational priorities and it was noted that the Full Business Case may identify different priorities but there was a keenness to on a smaller number of areas which will make a difference within the boundaries of the financial allocation. • CDIOs had been asked for proposals around developing and embedding leadership, particularly in the cyber security space, with clinical leadership directed towards each of the work packages that will drive through discovery requirements and into the deployment phase. • There was also a strong appetite to develop system resilience around cyber leadership, and the Cyber Security sub-group had taken this away to develop a proposal around this. • Recruitment for a Shared Data and Planning Platform (SDPP) Programme Director was underway to provide core leadership to drive this work forward. • Meeting arranged with SIROs and Caldicott Guardian to identify the requirements to develop a data sharing framework. • NHSE has awarded the Federated Dedicated Data Platform contract to has been awarded to Palantir. The ICB is part of the overarching engagement with local systems and exploring the possibility of being an early adopter to understand the functionality. • Procurement process for the HSCN has concluded, resulting in a continuation of services for GP Practices within BNSSG and for the ICB. The clear update report was welcomed.	
8.2	**Receive update from System Estates Steering Group** JL provided a verbal update: • work was continuing around the development of a capital prioritisation framework for the system and discussions were ongoing regarding this being major agenda item for a Board Seminar. An update would also be presented to the Committee in advance of the Board Seminar session. • Development of the Estate and Infrastructure strategy was progressing well, with good engagement from all organisations. It was agreed that it would be helpful for the committee to receive an update particularly in relation to timelines; JL to discuss offline with ST.	

Any Other Business		
	Key messages for ICB Board • Helpful discussion regarding AWP financial position, noting the need for more work to be done at system level to support the development of new pathways. The AWP Workforce agenda was also at a critical point.	
Next Meeting - Thursday 21st December 2023 – 09:00-12:00		

NHS
Bristol, North Somerset and South Gloucestershire
Integrated Care Board

Finance, Estates and Digital Committee OPEN Minutes
Thursday 21 December 2023, 09:00 – 12:00, Microsoft Teams

Members (Quoracy: 3 members required, including one of ICB Non-Executive members; and one of Chief Executive or Chief Finance Officer)		**Initials**
Steve West	Finance, Estates and Digital Committee – Chair	SW
Sarah Truelove	Deputy CEO & CFO – ICB	ST
Jeff Farrar	ICB Chair	JF
Richard Gaunt	Non-Executive Director – NBT	RG
Martin Sykes	Non-Executive Director – UHBW	MS
Nina Philippidis	S151 Officer – SGC	NP
Deborah El-Sayed	Director of Transformation and Chief Digital and Information Officer	DES
Attending		
Jon Lund	Deputy Chief Finance Officer - ICB	JL
Tim James	Head of Strategic Estates *(item 6.0 and 6.1 only)*	TJ
Tim Kempster	Consultant, Community Health Partnerships *(item 6.0 and 6.1 only)*	TK
Seb Habibi	Deputy Director of Transformation *(item 8.1 only)*	SH
Sophiya Wilson	Estates Project Support Officer *(item 6.0 and 6.1 only)*	SW
Rachel Smith	Exec PA *(Note Taker)*	RS

		Action
1.0	**Apologies for Absence** Apologies were received from Brian Stables, AWP; John Cappock, ICB; Christina Gray, Bristol City Council, and Jo Medhurst, ICB.	
2.0	**Declarations of Interest** There were no declarations of interest.	
3.0	**Minutes of the previous meeting** The minutes of the Open and Closed sessions held on 23 November 2023 were agreed as an accurate record of the meeting.	
4.0	**Actions from Previous Meeting** The action log was reviewed and updated accordingly.	
5.0	**Items for Approval** There were no items for approval.	
To Discuss		
6.0	**Infrastructure Strategy Update** Sarah Truelove (ST) explained that this session had been scheduled to enable a focus on estates and the ICS Infrastructure, which would also be presented to the next Board Seminar session on 4 January 2024. The national operational planning guidance had not yet been received but it was anticipated that it would include the requirement to develop an ICS Infrastructure Strategy, which would then be used to inform the comprehensive spending review that would be expected to take place following the next General Election. Typically with capital allocation, focus usually centred on the larger projects, rather than addressing the significant issues in some of the underlying infrastructure. Capital funding is allocated to the system as a whole, resulting in a prioritisation process to agree the allocations and this needs to be completed through the lens of aligning with the ICS strategy. This was further complicated by the different prioritisation processes in each of the partner organisations, which made it more difficult to translate to the wider system, but also the differing risks in each of the organisations which had to be resolved. Martin Sykes (MS) reflected that from his experience, there seemed to be more acceptance to do things differently, including working together to allocate resources and the importance of identifying and owning risks, in order to make the appropriate investment decisions.	

		Action
	Steve West (SW) agreed, highlighting that the starting place for any investment decision should always be against organisational / system priorities and ambitions / programmes of work. Resources simply could not be allocated to any projects / initiatives that did not address any of the identified risks. Richard Gaunt (RG) also highlighted the impact on patients whose procedures are cancelled due to equipment requiring repair or out of contract support, and the importance of ensuring that patient impact was at the heart of any decision. Tim Kempster (TK) presented the proposed structure for the strategy and advised that whilst not all of the tasks defined in the strategy would be completed by the end of March, it was intended to identify the tasks for completion by that point. It was noted that official guidance had not yet been published regarding the required content, but the strategy would be structured in such a way that it would provide an overview of the whole system, the scope, intent and methodology of the strategy, in addition to being accessible and concise. The strategy would be highly technical in parts but would highlight any gaps in maturity within the system. ST has previously expressed concern that the March 2024 deadline was tight, particularly for those systems who had not started to develop their strategy, especially in terms of proceeding through the required governance processes. ST acknowledged that whilst work on thew BNSSG strategy was progressing well, there was still significant work to do. TK highlighted the infrastructure planning principles to be followed whilst developing the strategy, which included: ➢ Objectives – statement of intent ➢ Adoption of 3 core principles: - Utilisation of assets - Prioritise investment options - Secure funding ➢ Efficiency ➢ Options appraisal ➢ Infrastructure ➢ Data strategy ➢ Tool sets and processes SW highlighted the importance of ensuring the strategy was developed in partnership with unitary authorities and other big owners of infrastructure assets in order to fully utilise assets, purely because it would not be possible to fund every project. Sustainability and the net zero carbon deadline were also key factors. TK welcomed the comments raised, all of which would be considered, along with other examples including as location of workforce and digital transformation opportunities but stressed that it was important to ensure that the scope was not expanded so far as to limit the ambition to deliver. MS queried whether the strategy could be more ambitious or aspirational, and whether a different approach could be taken in terms of building the infrastructure strategy around the future clinical ambition. TK welcomed the challenge and acknowledged that the strategy was possibly limited in its ambition due to the system constraints in terms of ability to deliver. Deborah El-Sayed (DES) agreed with the need for swift agreement of priorities and the system clinical strategies had already identified areas for development, which were already supported by good fundamental building blocks. From the digital perspective, thinking had turned to how the infrastructure component of the Digital Strategy aligned with this work, and developing the linkages between Digital and Transformation to positively impact and reduce the reliance on beds in buildings by different ways of working. Well defined and embedded foundations would provide significant opportunities for innovation but the complexities around this were noted. TK acknowledged the comments regarding the strategy's ambition and the importance of securing buy-in, motivation and engagement in the strategy. Tim James (TJ) also welcomed the comments regarding full utilisation of existing functions / assets and appropriate asset disposal, which must be supported by a suitable evidence base to enable prioritisation. TJ also recognised the need to ensure the system was co-ordinated to develop a baseline position and therefore be able to respond to and support the clinical strategies as they emerge and are developed.	

		Action
	Ensuring the physical estate (i.e. buildings) were fit for purpose to support the ever-evolving clinical strategies and delivery models longer term highlighted the importance of having clarity around the clinical strategies. SW suggested it may be useful for the NHS to take some learning from industry / private sectors around their infrastructure / estates planning, which is undertaken on a more modular level, rather than designing a new building each time. TK referenced other different ways of thinking whereby patients were seen as a "customer base" and the strategy built around delivering to the customer and meeting their needs more effectively. In terms of financing, ST updated on some of the work underway with the national team around the poor value for money that comes from capital allocations, due to the it is allocated, the short nature of the funding available and the short timescales in which to apply for funding which further exacerbates the challenge. Jon Lund (JL) shared an updated slide around the infrastructure funding and financing strategy and highlighted the continued uncertainty around regarding capital funding sources available to the ICS over a 10 – 20 year horizon. Due to this uncertainty, the development of a set of reasonable financial planning assumptions and scenarios plan should be developed (by the system Directors of Finance) and published alongside the infrastructure strategy. The Key Assumptions included: ➢ Future healthcare demand - Reasonable assumption that demand may be felt more in the community over the coming years, rather than in hospitals. Information from the New Hospitals Programmes also assumes a real term reduction in hospital demand but some level of growth and need should still be assumed, especially for multi-morbidity and mental health patients. - Demographic demand will vary by locality based on housing plans - Real-terms demand will vary by provider; - Demand for key-worker accommodation may change [in response to a query from SW, ST advised that NBT were currently running a pilot scheme with the private sector around asset utilisation]. - Demand for complex care housing and some inpatient services may increase due to repatriation for out of area placements. ➢ Revenue, Cash and Counting - Revenue affordability: revenue funding assumed to grow by 1.7% over the long term, and the healthcare demand is forecast to grow at the same level. - NHS Accounting: JL clarified that capital funds allocated could not be accumulated and spent at a later date, therefore a longer term capital / annual pipeline plan would be needed. The ICS would also be required to apply to the DOH for capital programme funds. - Cash availability ➢ Sources of Capital Funding: JL advised that the DOFs would develop a list of reasonable assumptions for the different funding sources - Outside of scope of CDEL and off balance sheet - Outside of scope of CDEL and on balance sheet (government and non-government grants / charitable donations) - Capital funding (to be aligned to both Infrastructure Strategy and Digital Strategy) - In scope of CDEL and on balance sheet (ie disposals / national programmes) Nina Philippidis (NP) highlighted the Section 106 funding and the need for this to be negotiated, in order to fully understand the needs for new developments, especially as all of the current funding has been fully allocated and more housing developments are being planned, all of which require additional GP provision. It was also assumed that Bristol City Council and North Somerset Council were in a similar position. NP also queried how the needs of the areas are being aligned with the 10 year capital plan, and sought assurance that the thinking was being joined up. TJ acknowledged NP's comments and confirmed he had the details of the historical agreements, and these would be built into the plans. Also fundamental to this would be for all Local Authorities to set out their housing growth plans in order to plan for the assumed pressures on health of any new developments over the next 10 years and for the ICS to advise a suitable response in terms of S106s.	

		Action
	JL referenced the plans to engage and negotiate with non-NHS stakeholders and advised that a significant period time for this would be required, due to the number of people to be kept informed and would therefore need to be part of the strategy itself, by way of a set of reasonable assumptions to enable suitable planning time. JL concluded with a slide which detailed, for context, the DoH's capital budget and outturn, dating back to 2010 and up to 2025. Previously, there had been a capital budget but this subsequently transferred to revenue but ultimately, the NHS capital budget has been increased and uplifted and there was the assumption that it would remain at that level going forward. It was also assumed that a significant portion of funding would be consumed by the Hospitals programme funding, which BNSSG may not be able to access to this would also need to be considered. ST felt there was more that could be done as a system to make the best use of the resources available and also S106. ST thanked members for the helpful discussion, which would support further planning for the Board Seminar in January.	
6.1	**Capital Prioritisation Process** TJ provided an update on the 2 year capital prioritisation plan (2023/24 and 2024/25), which would hopefully lead to the development of a 10 year plan which would cover both operational and strategic requirements. The 2022/23 process had been challenging; organisations were invited to bid for funding against the CDEL, some of whom struggled with the process which did not align with their internal processes / timelines. A significant proportion of the funding was ultimately allocated to community schemes. Lessons had been learned from the 2022/23 process and a new process was developed, to include the establishment of a Process Design Working Group which had representation from partner organisations. The new process was based around assessing risk across the system to ensure investment was targeted to the highest priority risks, with separate prioritisation processes to differentiate between critical risk schemes, strategic capital schemes and Net Zero schemes (with the latter being led by the Green Plan Steering Group). It was the intention for the strategic capital schemes to be at the centre of the Infrastructure Strategy and work had commenced with partner organisation to collate information regarding their timelines / processes to ensure alignment with the ICB timelines and to also agree the definition of a critical risk scheme. The limited CDEL budget was challenging but the proposed critical risk schemes included: ➢ Major diagnostic equipment replacement ➢ Critical backlog maintenance ➢ Fire safety ➢ Replacement of life expired AHUs ➢ Ward refurbishment ➢ Replacement of high-risk estate The process itself had been complex, particular as the internal processes within the UHBW and NBT were very different, with UHBW following a very structured process, and NBT taking a more dynamic and discussion-based approach. The process had also been supported by the respective DOFs but ultimately, it was felt that the ambition for a 10 year plan by March 2024 was unachievable, due in part to concerns raised by the acute Trusts regarding budget allocation for 2024/25 and these discussions continued. A system-level decision would be taken around whether the risks in the acute Trusts were manageable and whether any changes to the funding allocations could be made. Work was also underway to define our ambitions for the future (in terms of investments) and areas in which to deliver new models of care, changes in service provision and address poor infrastructure, whilst ensuring alignment as a system and maintaining an understanding of one another's challenges within organisations. In terms of next steps over the coming months: ➢ Confirmation of the 2024/25 CDEL allocation.	

		Action
	➢ Agreement of the priority schemes for the next 5 – 10 years, which would form part of the Infrastructure Strategy, noting that this would be an iterative process, and would include the following steps: 1. Organisational filter 2. Organisational prioritisation 3. Collaborative prioritisation 4. System prioritisation Examples of strategic schemes had also been identified by the Estates Steering Group, and it was anticipated that a level of sub-prioritisation would also be required: 1. Schemes that address major risks to delivery of system objectives; 2. Schemes that support improved productivity, efficiency, commercial opportunity and research; 3. Schemes that facilitate new models of care / patient pathways. There would also be scoring criteria to be followed for each scheme. NP asked if there was any benchmarking or learning from other systems that could be adopted; TJ was aware of approaches taken by some ICBs but that typically, providers were responsible for managing their own allocations, rather than take a system approach. NP suggested it may be useful to include a statement to that effect, highlighting to the ICB Board that BNSSG were at the forefront of an important but difficult challenge. In response to a query from DES, NP advised that the process within the Local Authority was very different in that they are required to submit business cases through the Combined Authority, ahead of regional prioritisation. It was agreed that it would be useful for the ICB to have sight of the local authority priorities / agreed business cases to ensure alignment, particularly in relation to transport and climate-based investments; this information should be easily accessible from the Combined Authority. TJ also highlighted the need to develop a shared system policy for capital to ensure complete transparency from all organisations around how it is allocated and spent, and also, where possible to standardise or harmonise processes. Looking forward to the Board Seminar, Jeff Farrar (JF) advised that it would not be possible to have the same level of discussion. The session would need include a summary of the current position, where we need to be and why, and to also be clear around the consequences of inaction and the required outputs of the session. ST and TJ would discuss the plan for the seminar outside of the meeting, and agree on appropriate pre-reading to be circulated ahead of the seminar.	
	Finance Report	
7.0	**M8 Finance Report ICB & System inc Capital ICB Savings report** ST reported on the additional funding received for the Industrial Action. The costs and lost income associated with the IA would continue to be recorded separately, with systems advised to assume the national funding would continue but to note that it had not been confirmed where the funding would come from (previous funding was as a result of DHSC underspend). A paper was circulated to the committee prior to the meeting. In terms of the ICB financial position, a further deterioration in the funded care placement spend had been reported; work was underway to explore the extent to which the savings on high cost packages are impacting the run rate. Learning disability placements were also being removed from the Discharge To Assess (D2A) pathways, which was a significant focus for the system. There was evidence that and increased number of people were going into nursing home placements (sometimes with an NHS funding contribution) and more people coming out our nursing homes with an enhanced package of care, which was counter to the ICS strategy (for more people to be moved on to a Home First pathway). Lower prescribing costs were also reported in M8 (£1m lower than M7) and a new cheaper anti-coagulant was also available, the results of which would start to come through in January 2024. Overall, the ICB remained on target to break even. In terms of providers, the implication of the IA funding was complex to work through but would ultimately show a benefit to the system. The UHBW financial position had also improved over the last couple of months, with improvements reported on agency staffing and increases in elective activity income.	

		Action
	The action taken to escalate the UHBW position to the system did appear to be having an impact. NBT were not improving at the same rate but remained on plan. Agency spend also remained high but recovery plans were in place and were still projecting a breakeven position. AWP remained on track, although high levels of agency staff and high levels of investment underspend were noted. A comprehensive forecast for year end would be produced after M9. In terms of the overall forecast position, the ability to maintain elective income through winter will be key in terms of the year end financial position. NP welcomed the positive position but queried the narrative regarding *maintaining* the financial position between M7 and M8, and whether a more adverse position would have been reported if the IA funding had not been received. ST advised that it had been challenging as only verbal assurances had been provided regarding the forthcoming IA funding but national confirmation was awaited. The system took the approach of maintaining focus on elements within its control, rather than the distraction of the IA costs. In future instances, it may be prudent to take a more proactive role with the national team and escalate earlier issues that require a resolution. The IA funding had been cited as a mitigation in the forecast year end position, but this would not have been possible if the IA funding had not been received. It was also essential to continue to signal the financial challenges through in-year reporting. JL reported a change in in accounting and budgeting within capital around IFRS 16 (related to accounting for leases). A plan detailing the planned spend on leases or 2023/24 had been submitted to the DOH, but the national budget for this was not finalised until M8. The ICB received significantly less funding than has been spent but the national approach is that DHSC would request bids for funding against a contingency budget. This was not felt to be a performance risk at this stage but it was important to bring it to the Committee's attention, due to the potential risk of failure against this metric. It did also indicate a level of uncertainty regarding future funding for leases for the ICB to be aware of for future planning for buildings with leases, and that less capital funding may be available in future years. Escalation to the ICB Board was not required at this point.	
	To Note	
8.0	**System DoFs Group Update** ST reported that the majority of the discussions within the DOFs group focussed on capital prioritisation (as discussed at item 6.2) and H2 planning, but with no specific update to highlight to the Committee.	
8.1	**System Digital Delivery Board (DDB) Update** A paper was circulated to the Committee prior to the meeting and Seb Habibi (SH) highlighted the following: ➢ Work continued on the Collaborative Worklist, developed by Orion Health, which enabled partner organisations to access shared data to support discharge planning. The D2A Operational Delivery Group had also approved a 12 month licence extension for this work to continue, which would provide continuity and the opportunity develop the functionality to respond to feedback. ➢ The DDB had also provided feedback on the proposed programme scope and phasing assumptions for the Digital Strategy portfolio going into 2024/25; useful feedback had also been received from the Clinical Informatics Cabinet which would assist in aligning digital priorities with clinical operational priorities. ➢ A Shared Data and Planning Platform (SDPP) Programme Director had been appointed and a new Information Governance Project Board would also be established to enable the programme to come out of "reset", with the appropriate governance processes implemented to support the programme moving forward. ➢ Proposals to establish a Data Sharing Charter were endorsed; this would provide a framework for data sharing between organisations. A workshop was held in November, which brought together clinical operations leads, information governance leads, SIROs, Caldicott Guardians from a wide range of partner organisations. Investment in data sharing was critical, due to the heavy reliance of services on data sharing and sharing of boundaries.	

		Action
	➢ The workshop enabled full system working to agree the charter and provided a shared understanding of case law, which was regularly evolving. Feedback from lawyers was that there were no other systems taking such a co-ordinated approach, with good, robust foundations and the involvement of both clinical and data colleagues provided a platform to build these strong foundations. SW reflected on the mental health needs of University students and the challenges around data sharing across multiple systems; SW and DES would discuss further outside of the meeting. ➢ An extraordinary DDB had been convened for 16 January 2024 to approve the business case for the re-procurement of Connecting Care, which would be presented to the Committee in January 2024.	
8.2	**Receive update from System Estates Steering Group** No further comments to add to the discussion at items 6.0 and 6.1.	
	Any Other Business	
9.1	**S151 Officer Representation** NP had secured a new role within Gloucestershire County Council and Amy Webb (North Somerset Council) had agreed to join the Committee from February 2024.	
	Key messages for ICB Board ➢ Important to continue to track and monitor progress against the financial position. ➢ National updates regarding IA funding ➢ Pre-reading to be developed for the Infrastructure Strategy session at the Board Seminar in January 2024.	
Next Meeting - Thursday 25 January 2024 – 09:00-12:00		