NHS
Bristol, North Somerset and South Gloucestershire
Integrated Care Board

Procurement Policy

DOCUMENT CONTROL

Please complete the table below: *To be added by corporate team once policy approved and before placing on website*	
Policy reference no:	
Responsible Executive Director:	Sarah Truelove, Deputy Chief Executive
Author and Job Title:	Helena Fuller, Deputy Director of Business and Planning Samuel Naxton, Associate Director of Procurement, NHS South, Central and West
Date Approved:	
Approved by:	
Date of next review:	1 April 2025

The purpose of the Procurement Policy is to ensure all procurement undertaken on behalf of NHS Bristol, North Somerset, and South Gloucestershire Integrated Care Board:

- Provides the best possible value.
- Is undertaken in a transparent and non-discriminatory manner with equality of treatment a core requirement.
- Is compliant with all regulatory frameworks including local and national legislation.
- Uses best practice as standard.
- Complies with long and short-term objectives of the Integrated Care Board.

Policy Review Checklist	Yes / No / N/A	Supporting information
Has an Equality Impact Assessment Screening been completed?	No	Individual procurements will consider all equality impacts and may include the need for further consideration of equality impacts, dependant on services commissioned
Has the review taken account of latest Guidance/Legislation?	Yes	Public procurement obligations are defined in Section B – Procurement Direction and Influences.
Has legal advice been sought?	Yes	External advice sought pre-adoption
Has HR been consulted?	No	Not required for this Policy
Have training issues been addressed?	Yes	To be provided by procurement team and guides for managers / Standard Operating Procedure developed.
Are there other HR related issues that need to be considered?	No	Not required for this Policy
Has the policy been reviewed by Staff Partnership Forum?	No	Not required for this Policy
Are there financial issues and have they been addressed?	No	Although this Policy is concerned with ICB expenditure, it does not raise any specific financial issues
What engagement has there been with patients/members of the public in preparing this policy?	N/A	Not required for this Policy
Are there linked policies and procedures?	Yes	ICB Constitution (Standing Financial Instructions), ICB Detailed Financial Policies, ICB Contracting Standing Operating Procedure, ICB Procurement Standing Operating Procedure and ICB Patient and Public Involvement Strategy and Policy

Policy Review Checklist	Yes / No / N/A	Supporting information
Has the lead Executive Director approved the policy?	Yes	Sarah Truelove
Which Committees have assured the policy?		Corporate Policy Group Finance, Estates and Digital Committee
Has a Policy implementation plan been provided?	N/A	However, the ICB will be made aware of the policy via all internal communication routes (i.e. HWGNFY). Any advice in relation to the policy can be accessed within the Business Strategy and Planning Directorate
How will the policy be shared with? • Staff? • Patients? • Public?		Staff – through integration with the ICB's overall training plan, and bespoke training as provided through the SCW procurement team. Patients and public – through ICB website publication
Will an audit trail demonstrating receipt of policy by staff be required; how will this be done?	No	Not required for this Policy
Have Data Protection implications been considered?	Yes	Yes via the comments made about IG at CPRG.

Contents

1 Preface

This policy sets out the framework as to how NHS Bristol, North Somerset and South Gloucestershire Integrated Care Board ("the ICB") procurement decisions should be undertaken. All managers and staff (at all levels) are responsible for ensuring that they are viewing and working to the current version of this procedural document. If this document is printed in hard copy or saved to another location, it must be checked that the version number in use matches with that of the live version on the ICB website.

All ICB procedural documents are published on the ICB website and communication is circulated to all staff when new procedural documents or changes to existing procedural documents are released. Managers are encouraged to use team briefings to aid staff awareness of new and updated procedural documents. All staff are responsible for implementing procedural documents as part of their normal responsibilities and are responsible for ensuring they maintain an up-to-date awareness of their contents.

1.1 Summary Points

This document outlines how the ICB will make decisions regarding the procurement of the goods and health care services it commissions. Procurement seeks to positively influence and support the ICB's strategy, transformation and transition plans utilising the principles in this policy.

The objective of this document is to ensure that in relation to the procurement of healthcare services the ICB acts with a view to:

- Securing the needs of the people who use the services.
- Improving the quality of the services.
- Improving efficiency of the services.
- Ensuring that services provided are accessible.
- Ensuring its procurement activities are undertaken transparently, fairly, proportionately, and where appropriate through integrated service delivery.

And in relation to the procurement of all goods and health care services that the ICB complies with the law, regulations and published guidance and its own standing orders.

1.2 BNSSG ICB Values

This Policy is aligned with BNSSG ICB Values:

- We act with integrity.
- We support each other.
- We embrace diversity.
- We work better together.

- We strive for excellence.
- We do the right thing.

The appropriate use of procurement ensures a robust process framework exists within which the ICB's values can be achieved, including in relation to the ICB's obligations regarding acting with integrity through appropriate expenditure of public money, through embracing diversity in relation to the commissioning of services, and striving for excellence in how services are commissioned within BNSSG.

2 Relevant to / Target Audience

The policy, associated framework and guidance applies to all staff within the ICB and specifically to the decision-making bodies who make commissioning decisions regarding new, alternative or renewal of contracts for services or goods. This policy is to be read alongside the ICBs Standing Financial Instructions and Scheme of reservation and delegation.
https://bnssg.icb.nhs.uk/about-us/governance/governance-handbook/#module-9

SECTION A - Introduction

3 Introduction and Purpose

Procurement is the act of obtaining or buying goods or services and covers all spend undertaken within the Integrated Care Board (ICB). Spend within the ICB is wide ranging and may be the purchase of information technology hardware, legal services, healthcare services or human resource, but every element of spend is regulated by the internal Standing Financial Instructions, internal policies and external regulations and guidance.

The principal aim of procurement undertaken by NHS organisations is to deliver essential goods and services and improve patient outcomes, while increasing value from every pound spent. The ICB will ensure it uses the most appropriate mechanism (procurement process) and legislation available to secure goods, resources, services and works.

The purpose of this policy is to outline the procedures to be followed when obtaining goods or services on behalf of the ICB, either by outlining the processes, or by providing links to further information and support.

This Procurement Policy will ensure that all procurement undertaken:

a) Complies with relevant national legislation, policy, and guidance, the ICB Constitution, Standing Orders, Schemes of Reservation and Delegation and Standing Financial Instructions.
b) Acts with a view to deliver against the needs of the local population.

c) Treats providers in a transparent, proportionate, and non-discriminatory manner with equality of treatment a core requirement.
d) Provides the best possible value for money.
e) Maintains high standards of public trust and probity in its use of public funds.
f) Uses best practice as standard and is aligned to the ICB Procurement Standard Operating Procedures (SoP).
g) Complies with long and short-term objectives of the ICB.
h) Does not engage in anti-competitive behaviour.
i) Providers and suppliers understand their obligations under UK general data protection regulations (UKGDPR)

This policy sets out existing legal framework for procurement by public bodies in the UK and will be updated in line with any changes to UK legislation.

In all cases, procurement decisions will be taken within the parameters and limitations of the existing legal framework. Alongside this, the ICB recognises the general progression toward greater integration of services in the context of integrated models of care and will ensure that any such developments as they relate to procurement will be considered and integrated into ICB procurement practices as necessary.

Note:- the Procurement SoP will operationalise the policy and this will cover areas of innovation adoption and adaptation, stakeholder management, conflict of interest management, market engagement management that be it via the PSR or the PCR, it will also determine how we look to embed commercial intelligence throughout the ICB.

4 Scope of the Procurement Policy

This policy applies to all spend (goods, services, people, clinical and non-clinical) undertaken on behalf of the ICB. All services commissioned including those delegated to the ICB and/or yet to be delegated fall in scope of this policy.

This policy must be followed by all personnel working for, or on behalf of the ICB including staff on temporary or honorary contracts, pool staff, students, Independent Contractors, Sub-Contractors, and representatives from other external bodies.

5 Definitions

This document is a policy. Any abbreviations used in the document will be written in full in the first instance.

6 Roles and responsibilities

The Deputy Chief Executive Chief Finance Officer is the responsible officer for this policy and the contracting and procurement function. The Finance, Estates and Digital Committee is responsible for the adherence and monitoring compliance with this policy under delegated authority from the ICB Board.

The procurement function is supplied by NHS South, Central & West Commissioning Support Unit (SCW) and relevant advice and training will be provided by competent individuals supporting any procurement.

All ICB staff are responsible for consulting with either the ICBs Business, Strategy and Planning Directorates contracting team or the SCW CSU procurement function in matters contained within this policy. This includes due consideration of matters affecting equality and diversity and ensuring that the services that are being procured are accessible. Section D (Additional Considerations) identifies tools to support decision making such as Data Protection Impact Assessment (DPIA), Equality Impact Assessment (EIA), Quality Impact Assessment (QIA) and section 8.7 the consideration of delivering a Greener NHS, working towards a 'net zero national health service.

When jointly commissioning / securing services on behalf of the ICB/ICS system, all ICB staff must engage with all partners involved prior to launching the procurement process.

Please seek advice as early as possible from the ICB Business, Strategy and Planning Directorate contracting team or the SCW Procurement Team if you are uncertain which procurement regulations apply and need to be followed. A member of the Business, Strategy and Planning Directorate contracting team and or the SCW CSU procurement team should be involved as early as possible in the commissioning process to ensure they have a full understanding of the requirements.

7 Ethical Framework principles for decision-making

The ICB at all times seeks to work within an Ethical Framework in relation to its decision making. This includes:

Principle 1 – Rational: Decision-making is rational and based upon a process of reasoning.

Principle 2 – Inclusive: Decisions should be arrived at through a fair and non-discriminatory process.

Principle 3 – Take account of the value secured: Decisions will take account of the outcomes we will achieve (for example population health, quality of health, survival rate, extent of recovery, people's experience, safety) for the resources that we use (for example the amount we pay for a service, salaries, investment in equipment and buildings). This is what we call "value".

Principle 4 – Transparent and open to scrutiny: Decisions and the way they are made should be transparent and easily understood. The information provided to decision makers should be fully documented together with the process followed and the degree of consensus reached.

Principle 5 – Promote health for both individuals and the community: Decisions about things that promote health and avoid people becoming ill will be considered alongside things that will cure illness and other interventions. There may be times when it is appropriate to target specific demographic groups or health issues in order to reduce inequalities in health outcomes.

SECTION B – Procurement Direction and Influences

8 Public Procurement Legislation and Policy influences

Procurement within the NHS is governed by various pieces of legislation, policy and guidance which are to be considered when executing the ICBs' statutory duties, such as:

Legislation

- Section 75 of the Health and Care Act 2022 – "Co-operation by NHS bodies and local authorities".
- Health Care Services (Provider Selection Regime) Regulations 2023
- The Public Contracts Regulations 2015 ('PCR 2015') which are amended by The Public Procurement (Amendment etc.) (EU Exit) Regulations 2020 ('PPAR 2020').
- Public Services (Social Value) Act 2012
- Health and Care Act 2022
- The Procurement Act 2023 – note will be replacing PCR 2015 in October 2024
- Equality Act 2010.

Policy / Guidance

- Cabinet Office Guidelines and Procurement Policy Notes
- Crown Commercial Service Guidance
- NHS Constitution
- Strategy and Guidance documents from regulatory bodies such as NHS England and the Department of Health and Social Care
- Commissioning decisions made by the ICB.
- Relevant case law as it develops through the judicial system.
- NHSE Managing Conflicts of Interest: Revised Statutory Guidance

The ICB is required to follow two separate procurement regimes –
(1) a specific regime for healthcare services (see s8.1 – Provider Selection Regime (PSR)) and
(2) a regime for all other procurements (see s8.2 - Procurement Act 2023).

Where the ICB has already started a procurement exercise before 01 January 2024 then these will be required to conclude under the Public Contract Regulations 2015.

The Public Contracts Regulation 2015 is intended to be replaced on 1 October 2024 by the Procurement Act 2023. This update will be reflected in a subsequent version of this Policy.

For clarity, a contract award process for healthcare services is considered to have started under the Public Contracts Regulation 2015 if any of the following began **before** 01 January 2024:

- a contract notice has been submitted to the UK e-notification service for publication in accordance with the Public Contracts Regulations 2015
- the ICB has contacted any provider to:
  - seek expressions of interest or offers in respect of a proposed contract, **or**
  - respond to an unsolicited expression of interest or offer received from that provider in relation to a proposed contract.

Please seek advice from the ICB Business, Strategy and Planning Directorates contracting team or the SCW Procurement Team if you are uncertain which procurement regulations apply and need to be followed.

8.1 NHS Provider Selection Regime (PSR)

The Provider Selection Regime (PSR) comes into force on 01 January 2024 and is set out in the Health Care Services (Provider Selection Regime) Regulations 2023. The PSR sets rules for procuring healthcare services in England by organisations termed Relevant Authorities. Relevant Authorities are:

- NHS England
- Integrated care boards (ICBs)
- NHS trusts and NHS foundation trusts
- Local authorities and combined authorities.

The PSR replaces the:

- Public Contracts Regulations 2015, when procuring health care services
- National Health Service (Procurement, Patient Choice, and Competition) Regulations 2013

The PSR will **not** apply to the procurement of goods or non-health care services (unless as part of a mixed procurement), irrespective of whether these are procured by Relevant Authorities. The PSR is introduced by regulations made under the Health

and Care Act 2022. In keeping with the intent of the Act, the PSR has been designed to:

a) introduce a flexible and proportionate process for deciding who should provide health care services.
b) provide a framework that allows collaboration to flourish across Systems.
c) ensure that all decisions are made in the best interest of patients and service users.

8.2 Procurement Act 2023

The Procurement Act 2023 is expected to go-live from 01 October 2024. Once implemented the Procurement Act 2023 will replace the Public Contracts Regulations 2015 (detailed below), the Concessions Contract Regulations 2016 and the Utilities Contract Regulations 2016.

The key benefits of the Procurement Act include:

- Creating a simpler yet more flexible commercial system whilst ensuring that ICB procurement activity remains compliant with regulations.
- Provides opportunity to open up ICB public procurements to new entrants such as small businesses and social enterprises so that they can compete and win more public contracts.
- Enables tougher action to be undertaken on underperforming suppliers and exclude those suppliers who pose unacceptable risks.
- Embeds transparency throughout the commercial lifecycle so that the spending of taxpayers' money can be properly scrutinised.

The Procurement Act will also condense the 7 procurement procedures highlighted at section 13.2 into the following 3 procedures:

1) Open Procedure (a one stage process)
2) Competitive Flexible (Multi-stage procurement process)
3) Direct Award (including urgency requirements)

This Policy will be revised to reflect these procedures once further detail is known during the implementation stage notice period, which is scheduled between April to October 2024.

Public Contracts Regulations 2015 (PCR 2015)

The Public Contracts Regulations 2015 (the 2015 Regulations) detail the required processes for conducting public procurement non-Healthcare services procurements through to 1 October 2024, or for healthcare services procurements formally commenced prior to 1 January 2024. The 2015 Regulations require that certain procedures must be followed by relevant public bodies when awarding contracts above specified financial thresholds. Providers raising a complaint against the 2015 Regulations will sometimes look to resolve a complaint/challenge via correspondence with the ICB (see s16) and/or if the provider remains unsatisfied with the outcome,

they may decide to issue court proceedings. There are general time limits that a provider can issue court proceedings as specified in regulation 92 but generally proceedings must be started within 30 days beginning with the date when the provider first knew or ought to have known that grounds for starting the proceedings had arisen.

8.3 Integrated Working

The ICB is a member of the BNSSG Integrated Care System (ICS). Although the ICB remains accountable in law for its own public procurement decision making, there are times where an integrated approach to procurement with other ICS members will be appropriate. This could be with the ICB as either a lead or associate Contracting Authority. Where the ICB is an associate to other ICS members' procurement activity, it will remain incumbent on the ICB to ensure that its procurement obligations are fulfilled.

8.4 The Health and Care Act 2022

The Health and Social Care Act 2022 establishes a legislative framework to support ICB collaboration and partnership working to integrate services for patients. The Act enables the ICB and its partners to consider and determine the best system arrangements adopting a population health approach aimed at improving the health and wellbeing of the local population; integration within the NHS (between different NHS organisations) and integration between the NHS and local government (and wider partners).

8.5 Equality Act 2010

The main Public Sector Equality Duty (PSED) is comprised of three areas/functions, set out in section 149(1) of the Equality Act 2010 ("the Act"):

The ICB will, in the exercise of its procurement functions, have due regard to the need to:

(a) eliminate discrimination, harassment, victimisation, and any other conduct that is prohibited by or under this Act.
(b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it.
(c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

'Due regard' itself is broadly defined in the following ways:

- decision-makers must be made aware of their duty to have due regard to the identified needs.
- the Duty must be fulfilled both before and during consideration of a particular policy and involves a "conscious approach and state of mind".
- it is not a question of ticking boxes, the Duty must be approached in substance, with rigour and with an open mind, and a failure to refer expressly

to the Duty whilst exercising a public function will not be determinative of whether due regard has been had.
- the Duty is non-delegable.
- the Duty is continuing.
- it is good practice for an authority to keep a record showing that it has considered the identified needs.

8.6 Public Services (Social Value) Act 2012

The Public Services (Social Value) Act 2012 places requirements on commissioners to consider the economic, environmental, and social benefits of their approaches to service provision and procurement. Social Value when incorporated effectively, will help to reduce health inequalities, drive better environmental performance, and deliver more value from procured products and services.

Commissioners should consider social value during the needs assessment and service design phase before any procurement starts so they can inform the shape of the procurement and the design of the services required. In particular, the Act requires commissioners to make the following considerations at the pre-procurement stage:

(a) how what is proposed to be procured might improve the economic, social, and environmental well-being of the relevant area.
(b) how, in conducting a procurement process, it might act with a view to securing that improvement.
(c) whether to undertake a consultation on these matters.

In addition commissioners are required to include a minimum 10% weighting attributed to the evaluation criteria as detailed in Procurement Policy Note 06/20 – 'taking account of social value in the award of central government contracts'.

8.7 Greener NHS – Delivering a 'Net Zero' National Health Service

When considering service redesign and procurement the process should also consider the health service's commitment to 'delivering a 'Net Zero' National Health Service. Net Zero has been embedded in legislation, through the Health and Care Act 2022. This places a duty on the ICB to contribute towards statutory emissions and environmental targets.

The ICB has developed a Green Plan which headlines the ambition for the ICB when considering procurement and its supply chain. This recognises the positive impact that can be leveraged from a collaborative approach to procurement, to ensure social, responsible, and environmental commitments are at the heart of decision making that will drive towards a net zero procurement and supply chain by 2030. The ICB will have an ethical approach at the centre of our procurement decisions, recognising that our need to procure to deliver our health service should never be at

the detriment of others and commissioners will work to ensure that is the case. The ICB will look to:

- Drive the supply chain to net zero.
- Use our spend as a positive influence in our community.
- Promote a fair, diverse, and inclusive supply chain.

8.8 ICB Ethical Framework

The ICB has developed a formal Ethical Framework for Decision-Making (see section 7) to describe the principles that will underpin how commissioning decisions are made. The purpose of the Ethical Framework for Decision-Making is to describe the principles that will guide how the ICB:

- Makes commissioning decisions on behalf of and with its population.
- Is consistent across all levels of commissioning from strategic planning through to deciding on individual funding requests and meeting the requirements of the NHS Constitution
- Makes it clear to the public that we have a framework within which we make decisions.

The ICB will consider the application of the Ethical Framework in its procurement decision-making processes.

9 Fraud and Bribery and corruption

The ICB is committed to reducing and preventing fraud, bribery and corruption in the NHS and ensuring that funds stolen by these means are put back into patient care. During the development of this policy document, consideration has been given to how fraud, bribery or corruption may occur in this area. We have ensured that our processes will assist in preventing, detecting, and deterring fraud, bribery and corruption and considered what our responses to allegation of incidents of any such acts would be.

In the event that fraud, bribery or corruption is reasonably suspected, and in accordance with the Local Counter Fraud, Bribery and Corruption Policy, a referral will be made to the ICB's Local Counter Fraud Specialist for investigation. The ICB reserves the right to prosecute where fraud, bribery or corruption is suspected to have taken place. In cases involving any type of loss (financial or other), the ICB will take action to recover those losses by working with law enforcement agencies and investigators in both criminal and/or civil courts.

Procurement is a particularly high-risk area in terms of fraud and bribery. It is important that all ICB staff are aware of the risks and can recognise and report fraudulent activity. All staff should also be aware that the ICB has a zero-tolerance approach to Fraud and Bribery as highlighted within the Fraud and Bribery policy and detail provided at Corporate Induction.

9.1 Fraud Act 2006

The Fraud Act 2006 created a criminal offence of Fraud and defines three ways of committing it:

- Fraud by false representation *(e.g., an external fraudster purporting to be a genuine supplier to arrange payment to a bank account)*.
- Fraud by failing to disclose information *(e.g., a company director failing to disclose criminal convictions)*; and
- Fraud by abuse of position *(e.g., an employee creating fictitious suppliers with payments to their own bank accounts)*

In these cases, an offender's conduct must be dishonest, and their intention must be to make a gain or cause a loss (or the risk of a loss) to another.

9.2 Bribery Act 2010

The Bribery Act 2010 defines bribery as the giving or taking of a reward in return for acting dishonestly and/or in breach of the law. There are four main classifications of bribery:

- Bribing another person.
- Being bribed.
- Bribing a foreign public official; and
- Failure to prevent bribery (Corporate offence).

Any offering, promising, giving, requesting, agreeing to, receiving, or accepting of any bribe is strictly forbidden by any employee when conducting business on behalf of the ICB or when representing the ICB in any capacity and is contrary to the Bribery Act2010.

Any suspicions or concerns of acts of fraud or bribery can be reported confidentially to the Local Counter Fraud Specialist online via https://www.reportnhsfraud.nhs.uk or via the NHS Counter Fraud Authority (NHSCFA) Fraud and Corruption Reporting Line on 0800 0284060. All calls are dealt with by experienced trained staff and any caller who wishes to remain anonymous may do so.

SECTION C – Practical processes and guidance

10 Procurement Approach / Decision to Tender

10.1 ICB Constitution and applicable financial thresholds

Where the ICB wishes to award a contract for goods or services, it must consider which of the relevant pieces of legislation is applicable and the value of that contract opportunity to determine the appropriate procurement approach. Attention should also be given to the ICB's Constitution. All procurement activity will be undertaken

in accordance with Standards of Business Conduct including conflicts of interest – section 6 of the NHS Constitution.

The table below summarises the potential routes to market in accordance with the potential value of the contract (calculated over the full term of the contract) and the requirements of the PCR 2015 Regulations and other relevant legislation for non-healthcare contracts and Healthcare Services (Provider Selection Regime) Regulations 2023 for healthcare contracts. In certain circumstances the procurement route specified below might not be appropriate. In such circumstances written approval must be sought from the Chief Finance Officer. Potential routes to market are described in section 11 as a reference guide.

Non-Healthcare:

Total Contract Value Threshold for Non-Healthcare contract (inclusive of VAT)	***Minimum Type of Procurement Required***	***Applicable Governance/legislation***
Up to £5k (inclusive of VAT)	No formal requirement for external procurement process	ICB Constitution: which describes the authority for approval of single tender waivers. This process can be found in the ICBs Standing Financial Instructions (SFIs) Procurement Policy: which describes the award of contract without competition (see s13.4).
Between £5k and £50k (inclusive of VAT)	Quotations should be obtained from at least 3 suppliers/individuals. (Single Tender Waiver should only be used in exceptional circumstances and must be reported to Audit Committee)	

Total Contract Value Threshold for Non-Healthcare contract (inclusive of VAT)	***Minimum Type of Procurement Required***	***Applicable Governance/legislation***
Between £50k and £214,904 (inclusive of VAT)	Competitive tender required. (Single Tender Waiver should only be used in exceptional circumstances and must be reported to Audit Committee) The ICB can consider an open (advertised) or closed (framework or local approved supplier list) approach to market.	NHSE Managing conflicts of interest: revised statutory guidance.
Above £214, 904 (inclusive of VAT)	Full open (advertised) or closed (framework) tender required. Advice and guidance from SCW Procurement Team, including if full tender cannot be undertaken.	Public Contracts Regulations 2015, in anticipation of the Procurement Act 2023 taking effect from 1st October 2024 NHSE Managing conflicts of interest: revised statutory guidance.

Healthcare Contracts:

Total Contract Value of Healthcare contract/s	***Minimum Type of Procurement Required***	***Applicable Governance/legislation***
No set threshold values.	Route to market to be determined on a case-by-case basis in consultation with the SCW Procurement Team and Procurement Oversight Group (see s18). Transparency Notices published in Find Tender Service as required according to route to market (see Appendix 2).	Healthcare Services (Provider Selection Regime) Regulations 2023 Health and Care Act 2022 ICB Constitution: which describes the authority for approval of single tender waivers. This process can be found in the ICBs Standing Financial Instructions (SFIs) NHSE Managing conflicts of interest: revised statutory guidance.

10.2 Decision whether to competitively tender

The table above and the additional provider selection regime process guidance at Appendix 1 for healthcare contracts should be applied in the first instance to determine the correct procurement process approach.

In relation to healthcare contracts, there is no 'one size fits all' approach, and regard will have to be given in each instance to how the ICB can best meet the needs of the population, ensuring that the quality of services and the efficiency with which they are provided is improved (for example in terms of whether a new contract that would attract procurement law obligations needs to be awarded, or whether the ICB's requirements can be met in other.

This will need to be routinely considered as part of the commissioning process and the rationale behind any decision, whether or not, to competitively tender a contract should be fully documented, having obtained advice in all such instances from the Procurement Team and/or the Procurement Oversight Group. Such decisions should be transparent and must be signed-off by the relevant ICB committee(s).

In instances of particular urgency where it is necessary to award a contract without competitive tendering, and there is not time to follow the standard governance and approval process, it will be necessary to seek approval from the appropriate officer

within the ICB aligning / adhering to the ICBs SFIs and to ensure that advice is obtained from the procurement and/or legal teams in accordance with the relevant scheme of delegation, in the form of a signed waiver document.

The ICB approval of the procurement strategy and readiness to proceed shall be managed through the ICB governance processes and shall include preparedness, contract value and contract length plus any extensions.

10.3 Engaging the Procurement Team

A member of the Business, Strategy and Planning Directorate and or procurement team should be involved as early as possible in the commissioning process to ensure they have a full understanding of the requirements of the service and to advise on the procurement process, considering best practice and timelines as required.

11 Route to Market

A variety of procurement and tendering options are available by which the ICB can secure the required service. The advice of the SCW Procurement Team **should** be sought to ensure that the appropriate route is selected when procuring healthcare (see s12) and non-healthcare services (see s13), in compliance with all relevant legal and regulatory requirements.

SECTION D – Provider Selection Regime (Healthcare procurements Only)

12 Provider Selection Regime (Healthcare procurements Only)

The Provider Selection Regime (PSR) applies to all new healthcare procurements commenced after the 01 January 2024. NHSE has provided statutory guidance that sits alongside the PSR regulations to support the ICB/commissioners understand and interpret the regime. A summary of key aspects of the PSR is detailed below.

The ICB can follow three provider selection processes to award contracts for health services. These are:

1) **Direct Award processes (A, B and C):** These involve awarding contracts to providers when there is limited or no reason to seek change from the existing provider; or to assess providers against one another, because:
    a. the existing provider is the only provider that can deliver the health care services (direct award process A)
    b. patients have a choice of providers, and the number of providers is not restricted by the ICB (direct award process B)

c. the existing provider is satisfying its existing contract, will likely satisfy the new contract to a sufficient standard, and the proposed contracting arrangements are not changing considerably (direct award process C).

2) **Most Suitable Provider process:** This involves awarding a contract to providers without running a competitive process, because the ICB can identify the most suitable provider.
3) **Competitive process:** This involves running a competitive process to award a contract including the formulisation of framework agreements.

Direct Award processes A and B must be used where they apply. Where these processes are not mandated, commissioners may choose whether to use Direct Award process C, the Most Suitable Provider process, or the Competitive process, subject to the specific conditions of those processes (for example Direct Award process C cannot be used if services are changing considerably, as defined in the regulations).

12.1 Making decisions under the Provider Selection Regime

The regime will need to be applied as part of the commissioning process whenever contracts for healthcare services are coming to an end, changing considerably, or being awarded for the first time. A decision flow chart and overview of the decision-making approach to PSR process is provided at Appendix 1 to support commissioner understanding of the processes.

Commissioners will need to comply with defined processes in each of the provider selection routes to market to evidence their decision-making, including record keeping and the publication of transparency notices. As such advice from the SCW Procurement Team should always be sought when considering the most appropriate route to market.

12.2 Key and Basic Selection Criteria

If commissioners decide to follow the Direct Award C, Most Suitable Provider or Competitive process as a viable route to market then 'key criteria' and 'basic selection criteria" need to be considered, as detailed below:

Key Criteria
Quality and Innovation
Value
Integration, Collaboration, and service sustainability
Improving access, reducing health inequalities, and facilitating choice
Social Value

All of the key criteria must be considered. The relative importance of the criteria is not pre-determined and there is no prescribed hierarchy or weighting for each criterion with the exception of Social Value which must be a minimum of 10% weighting (see s8.6). The total percentage of the key criteria should equal 100%.

The relevant authority must also assess providers against the basic selection criteria and is expected not to award a contract to a provider that does not meet these. These may relate to:

Basic Selection Criteria
The provider's ability to pursue a particular activity e.g., membership of professional organisation or hold a specific authorisation
Economic and financial standing e.g., minimum turnover, indemnity insurance
Technical and professional ability e.g., level of experience, not having conflicting interests

Furthermore, the relevant authority should not award a contract to a provider that meets the exclusion criteria.

12.3 Transparency Requirements

The PSR is designed to encourage transparency and consequently commissioners will need to be transparent in their decision making to ensure that there is proper scrutiny and accountability of decisions made about NHS services. Appendix 2 provides a summary of the transparency steps required for each of the provider selection processes.

12.4 Mixed Procurements

The PSR must not be used for the procurement of goods or non-healthcare services alone. However, when a contract comprises a mixture of in-scope health care services and out of scope services or goods the ICB may use the PSR to arrange those services when both of the below statements are true:

- The main subject matter of the procurement is health care services. This means that the health care service element must be more than 50% of the value of the contract.

  And

- The ICB is of the view that the other goods or services could not

reasonably be supplied under a separate contract. This means that the ICB is of the view that procuring the health care services and the other goods and services separately would, or would be likely to, have a material adverse impact on the ICB's ability to act in accordance with the procurement principles.

12.5 Modifications of contracts and framework agreements during their term

There will be situations where contracts or framework agreements need to be modified to reflect/account for changes to services/circumstances during their term. Depending on circumstance, permitted modifications can be made without following a new provider selection process, but in some cases will require the publication of transparency notices. Appendix 3 provides a process flow chart to support commissioners.

Modifications are permitted if one of the following parameters is met:

- Clearly and unambiguously provided for in the original contract.
- Solely a change in the identity of the provider
- Made in response to external factors beyond the control of the ICB and the provider, such as changes in patient or service user volume in indexing; but do not render the contract materially different in character.
- Attributable to the ICB, does not render the contract materially different in character, and the change in the lifetime value of the contract, compared to its value when it was entered into, is UNDER £500k or represents less than 25% of the original contract.
- Attributable to the ICB, does not render the contract materially different in character, and the change in the lifetime value of the contract, compared to its value when it was entered into, is OVER £500k and represents less than 25% of the original contract value.
- Made to a contract that was originally awarded under the Direct Award Process A or Direct Award Process B and the modification does not render the contract materially different in character.

Modifications are NOT permitted when:

- the change is attributable to a decision made by the ICB, and
- if the changes render the contract materially different, or
- where the changes are over £500,000 and represent over 25% of the original contract value.

The provision for modification should not be used to circumvent PSR regulations when a contract ends and a new one is awarded. ICB staff should seek contracting / procurement advice from either the Business, Strategy and Planning Directorates contracting team or SCW when intending to modify a contract.

12.6 Standstill Period and Receiving Representations

A standstill period must be observed once a notice of intention to make an award to a provider under Direct Award process C, the Most Suitable Provider process, or the Competitive Process has been published (see process chart at Appendix 4). This includes concluding a framework agreement or awarding a contract based on a framework agreement following a mini competition.

The standstill period follows a decision to select a provider and must end before the contract can be awarded. It gives time for any provider who might otherwise have been a provider of the services to which the contract relates to make representations if unhappy with the decision; and for the ICB to consider those representations and respond as appropriate. The ICB where possible will ensure that decisions are reviewed by individuals not involved in the original decision. Where this is not possible, the ICB will ensure that at least one individual not involved in the original decision is included in the review process.

The standstill period must last for a minimum period of eight (8) working days (ending at midnight on the eighth day) and any provider representation must be made during this period. If any representations are received during this period, then the standstill period will remain open until the ICB provides any requested information, considers the representations, and makes a further decision.

The end of the standstill period must be at least five (5) working days after the ICB has communicated its decision to the provider. The minimum five (5) 'working days' notice allows for providers that remain unsatisfied about the response given by the ICB to their representations to seek the involvement of a PSR review panel. The PSR review panel will provide independent expert advice to the ICB with respect to the review of PSR decisions during the standstill period.

Where the PSR review panel accepts a representation for review, it will endeavour to consider it and share advice, or a summary of its advice, with the provider and the ICB within 25 working days. However, this timeframe is indicative and contingent on the engagement and timely responses of the provider and the ICB throughout the review process.

The PSR review panel may consider whether the ICB complied with the Regulations and may provide advice to the ICB. Following consideration of advice, the ICB will make an informed decision about how to proceed. SCW Procurement will support commissioners during the standstill period, receiving a representation and associated processes and when communicating the ICB's decision outcome aligned to PSR regulations. The decision outcome may include:

- entering into a contract or concluding the framework agreement as intended.
- going back to an earlier step in the selection process,
- abandoning the provider selection process, and

- starting a new process.

12.7 Record Keeping

The ICB must keep records of their considerations throughout the award process. These records may be requested for review prior or post contract award. Records must include:

- The relative importance of each of the key criteria and the rationale for their relative importance and how the basic selection criteria were assessed.
- Name and address of the provider
- The decision-making process followed to select a provider.
- The rationale for the decision
- For mixed procurements, how the procurement meets the requirements for mixed procurement.
- Details of the individual/individuals making the decision
- Any declared or potential conflicts of interest for individuals involved in decision making and how these were managed.

All contracts and awards made will be held on the ICBs Contract register – see ICBs contracting SoP for further details.

SECTION E – Public Contract Regulations 2015 (Non-Healthcare Procurements)

13 Public Contract Regulations 2015 (Non-Healthcare Procurements)

Public sector procurement is subject to national procurement rules and regulations, and it is therefore critical that procurement activity is conducted consistently, accurately, and effectively. Where commissioners wish to purchase Supplies, Services or Works which are over the relevant public procurement thresholds (see s13.1) they must also consider the definitions of Supplies, Works and Services that are as follows: -

- **“Supplies"** contracts are essentially those for the supply (including purchasing, leasing, and installation where appropriate) or hire of products.
- **"Works"** is the execution and/or design of works, working being defined as "the outcome of building or civil engineering, works taken as a whole that is sufficient of itself to fulfil an economic and technical function".
- **"Services"** includes, for example, services such as maintenance of equipment, transportation, consultancy, technical services, etc.

13.1 Procurement Thresholds

When commissioners are calculating the estimated value of a contract to determine whether the procurement regulations apply, the contract value estimation should be inclusive of Value Added Tax (VAT). Contracts must not be artificially broken down to avoid the application of the regulations. The threshold values are detailed below:

Category	Type of Contract	Threshold from 1 January 2024 (inclusive of VAT)
The Light Touch Regime (Public Contract Regulations 2015) Applies to health care, social care, education, cultural and certain services listed at Schedule 3 to the PCR 2015 where procurements commenced before PSR regulations are enacted i.e., 01/01/24.	**Services** (Schedule 3 (The Light Touch regime).	£663,540
Fully regulated (Public Contracts Regulations 2015) Applicable to non-healthcare procurements commenced before 01/10/24 and subject to full implementation of the Procurement Act 2023.	Services and Supplies (sub-central contracting authorities)	£214,904
	Works	£5,372,609

The Light Touch Regime
The regime is only applicable to those services listed at Schedule 3 to the PCR 2015 (the "light touch regime") of which the contract value exceeds the threshold of £663,540 inclusive of VAT. Any services which are not within the Light Touch Regime are subject to the full rigour of the PCR 2015 (as amended by The Public Procurement (Amendment etc.) (EU Exit) Regulations 2020) and case law around the procurement rules.

Calculating Contract Values
While contract values are to be calculated inclusive of VAT for the purposes of assessing whether thresholds are exceeded, guidance in PPN 10/21 states that contract values

inputted into Contract Notices and Contract Award Notices should continue to be stated exclusive of VAT.

13.2 Procurement Procedures

The following procedures apply when awarding non-healthcare contracts when their value exceeds set thresholds, and the procurement has commenced prior to 1st October 2024. Alternatively, an ICB may choose to use a procurement process similar to any of the below processes under the 'Competitive process' of PSR. A procurement process table is provided at Appendix 5 to support commissioners.

Below are the most common routes to market, all of which the ICB may utilise as and when appropriate. A summary of the most used processes with detail of when they would be appropriate is also provided in Appendix 6.

Open procedure:
In the Open Procedure all applicants who respond to the Contract Notice will be invited to submit a tender for the contract opportunity. If there are a small number of providers who are likely to express an interest, and all are expected to be technically competent and financially robust, this process should be considered. It means that bidders do not have to pre-qualify for inclusion in the procurement, but that they submit information in terms of financial standing and technical expertise at the same time as submitting their bid.

Restricted procedure:
The Restricted Procedure is used where the ICB wants to restrict the number of bidders who will be issued with the Invitation to Tender. A qualification requirement, usually in the form of a selection questionnaire (SQ) allows the ICB to assess the suitability of bidders prior to the bidders submitting a bid. This can make the process more manageable and cost-effective by reducing the number of bidders able to submit tenders and help to ensure that only bidders with the requisite capability and capacity are invited to tender.

Competitive dialogue procedure (CD):
This process should only be used in limited circumstances when the ICB's needs cannot be met without adaptation of readily available solutions. This might be where the tender process would include the development of design or innovative solutions and/or where there is a need for negotiation due to the complexity, evolving specification, legal or financial profile of the services required. If such circumstances exist the ICB will consider using a process that allows for a dialogue with bidders (post advertisement), rather than asking for bids in response to a defined specification.

Competitive Procedure with negotiation (CPN):
This allows the ICB to award a contract based on an initial tender but also enables the ICB to negotiate with bidders who submitted an initial tender, and any subsequent tenders, until it decides to conclude those negotiations. The ICB cannot negotiate

following final offers.

Innovation Partnership Procedure:
This is a procedure designed to allow contracting authorities to establish a long-term partnership for the development and subsequent purchase of a new, innovative product, service or works. The ICB should note that its ability to use this procedure is limited and may only apply if the ICB is seeking innovative ideas where solutions are not already available on the market.

Framework Agreement:
The ICB may wish to consider whether it can use an established framework agreement which has been tendered in accordance with the procurement rules. Purchasing from a framework agreement can save procurement costs and time.

Various existing frameworks are available for the ICB to use such as the Crown Commercial Service (CCS) to purchase goods or services without a full local tender. Each framework will have its own ordering process to follow but the timescales and transaction costs are usually far lower than running a full procurement.

The terms and conditions applicable to any subsequent call-off contract are defined by the particular framework agreement and may not be compatible with the NHS standard contract and therefore advice must be sought from the framework owner prior to conducting a mini-competition.

If the ICB are considering using a framework agreement it should ensure that:

- it is entitled to use the framework agreement and it follows the correct processes to appoint a provider.
- its requirements fall within the scope of the pre-established framework agreement.
- The term of the framework agreement has not expired.

Alternatively, the ICB could consider setting up its own framework agreement for its requirements. This could be a framework of multiple providers or a single provider and would need to be advertised in accordance with the PCR 2015.

Any Qualified Provider (AQP) (UK NHS Initiative only) (for Light Touch Regime services only commenced prior to 01 January 2024):
AQP describes a set of system rules (accreditation framework) whereby for a prescribed range of services, any provider that meets the cost and quality criteria laid down by the Commissioner can compete for business within the market, without direct constraint by the commissioner. AQP is a procurement route that encourages competition between providers of routine or other services, where activity is driven solely by Service User choice.

Under AQP, any provider assessed as meeting rigorous quality requirements who can deliver services to NHS prices and under the NHS Standard Contract is able to deliver

the service. Providers have no volume guarantees and patients will decide which providers to be referred.

Assessment of the AQP option should include consideration of the characteristics of the service, the local healthcare system, whether the service lends itself to patient choice, an analysis of the current market, how much competition and choice there is now and how much is required and any barriers to market entry. Once an AQP procurement is advertised, providers are assessed using a consistent qualification process and will qualify if they can:

- meet the quality requirements.
- meet the Terms and Conditions of the NHS Standard Contract.
- accept the NHS price for the service; and
- Provide assurance that they are capable of delivering the service requirements that have been set.

13.3 Contract Variation Process

It may be possible to use this option to secure incremental change to the service provided. When procuring a service, the ICB should consider potential modifications it may wish to make during the term of the contract and state this in the initial procurement and contract documents. The PCR 2015 provide clarity about the extent to which a contract can be amended after award, including where transparency notices need to be published (see Regulation 72 of the 2015 Regulations).

Permissible grounds for amendment include:

- the existence of suitable "clear, precise and unequivocal" review clauses in the contract.
- a need for additional supplies or services where a change of supplier is impossible and would cause significant inconvenience, or a need for additional deliveries due to unforeseen circumstances (both subject to 50% maximum non-cumulative increase in initial contract value).
- where a new supplier replaces the existing supplier because of insolvency or genuine restructuring.
- where the amendment, irrespective of its value, is not substantial (below the relevant procurement threshold and represents a cumulative variation of 10% of the initial contract value for service and supply contracts and 15% of the initial contract value for works contracts).

The following circumstances are likely to be regarded non-permitted variations and as such will require a new contract:

- the contract is materially different from the one initially concluded.
- the scope of the contract is extended considerably.
- other providers would have been interested in bidding for the contract if the change had originally been part of the specification when the service was originally procured.

- the contract would have been awarded to a different provider if the change had originally been included in the original service specification.
- the change involves genuinely new services not originally within the scope of the specification covered by the contract.
- there is a significant change in the value of the contract.
- the modification changes the economic balance of the contract in the favour of the contractor; or
- a new contractor replaces the one to which the ICB had initially awarded the contract, save for where that replacement occurs due to a universal or partial succession of the initial contractor including through a takeover, merger, acquisition, or insolvency and does not modify the overall nature of the contract.

The ICB may be subject to challenge if it uses a contract variation inappropriately. Therefore, commissioners should always take appropriate procurement advice before following this route.

13.4 Award of Contract without Competition (Direct Award)

Where the ICB determines through analysis of the market and proportionate and transparent engagement with potential providers that the service is only capable of being provided by one provider e.g., for technical, economic reasons, or there is an urgent clinical need, commissioners may consider proceeding with an award of contract without competition. This is where a contract is awarded to a single provider or a limited group of providers.

The law in this regard is complex and carries a risk of challenge from providers who believe they should have been given the opportunity to compete for the service. It is important that, if the ICB decides to take this route, it clearly records the rationale for the decision. Failure to plan adequately or not leaving enough time to tender is unlikely to be accepted as an urgent clinical need. Advice from the Procurement Team should be obtained in every event. Where a service is put in place for reasons of urgency or safety, the ICB should consider this as an interim step and plan to undertake a competitive and/or a compliant procurement process as soon as possible.

Commissioners should ensure there is evidence and an options appraisal in place that led to the decision to direct award. The ICB is required through statute to provide assurance that service providers are the most capable of delivering the service outcomes through efficient and effective process and operational management. The ICB should retain an audit trail of its decision-making process and associated governance approval e.g., completion of a signed Single Tender Award/Waiver form and justification paper prior to award of contract aligned to the relevant procurement threshold. Direct awards must also be compliant with Regulation 32 of PCR 2015.

14 Form of Contract

The ICB will ensure that the appropriate standard form national contract is used for all contracts for NHS funded health and social care services that the ICB let. Where non-healthcare contracts are awarded then the standard appropriate version of the NHS Terms and Conditions for the Supply of Goods and/or Services should be used, with the exception of procedures through an existing framework contract.

15 Award of Contract

The ICB will approve the award of contracts in accordance with the ICBs Scheme of Delegation as set out in the ICB Constitution and the ICBs Standing Financial Instructions.
https://bnssg.icb.nhs.uk/about-us/governance/governance-handbook/#module-9

The contract award recommendation will include the contract term plus any extension period to be approved by the appropriate Committee of the ICB Board.

For all relevant procurement procedures conducted under the PCR Regulations 2015 and Provider Selection Regime the ICB will operate a standstill period, reflecting best practice and will align to the respective procurement regulations between announcing the contract award decision and entering into the contract. For clarity, the minimum standstill period for the respective procurement regulations is detailed below:

- PCR Regulations 2015 – A minimum of 10 calendar days after intention to award a contract is sent electronically to bidders e.g., via an e-Tendering Portal.
- Provider Selection Regime – A minimum of 8 working days after intention to award a contract is published.

If in doubt on how long to allow for a standstill period, please seek advice from the SCW Procurement Team.

16 Complaints and Dispute Procedure

The ICB's approach to contestability means that it may pursue a wide range of routes to secure new and existing services. The ICB has developed the processes that will be followed within the ICB that enable any potential dispute relating to a procurement process or outcome from any procurement to be resolved in an open and transparent manner. The ICB will utilise a dispute resolution process to address and resolve any complaint in relation to competition and procurement received from either:

- Bidders/contractors
- A member of the public

This will at first require writing to the ICB Accountable Officer, as described in the dispute resolution process.

In regard to the ICB receiving any Provider Selection Regime representations it has been agreed that those representations received by BNSSG will be reviewed by NHS BSW ICB. Note that it has been agreed that BNSSG ICB will review BSW ICBs representations in return. If the provider remains unsatisfied following the review the provider can then make representation to the NHSE Independent Patient Choice and Procurement panel.

SECTION F - Additional Considerations

17 Data Protection Impact Assessment

Where any new service is required, it will be necessary for a data protection impact assessment (DPIA) to be completed. The project lead should liaise with the SCW information governance lead and/or ICB Data Protection Officer to complete a DPIA prior to selection of provider which should be updated once the provider is identified. DPIAs are completed to review security accreditations, processes and procedures to identify and mitigate risks.

17.1 Equality Impact Assessment

With any new service, compliance with the Public Sector Equality Duties 2011 will be demonstrated through a robust Equality Impact Assessment (EIA) process, ensuring that due regard is given to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited in under the Equality Act 2010) and those who do not share it.

The ICB EIA template can be found here:

https://thehub.bnssg.icb.nhs.uk/library/equality-health-inequality-impact-assessment-ehia-template/

17.2 Quality Impact Assessment

A Quality Impact Assessment should form part of any service commissioning process, especially when there is likely to be a change to the way in which a service is delivered or a change in provider. As with both tools above, a similar process should be completed for a quality impact assessment. The project lead should liaise with the ICB Quality Team.

The ICB QIA template can be found here:

https://thehub.bnssg.icb.nhs.uk/library/quality-impact-assessment-template/

17.3 Code of Conduct and Conflicts of Interest

In addition to the register of interests held by the ICB, the ICB needs to be able to recognise and manage any actual or potential conflicts of interest (COIs) which arise in relation to any procurement undertaken. Conflicts could arise where the ICB commissions healthcare/non-healthcare services, in which a member of the ICB has a financial, or other interest. Measures should be taken to identify and manage COIs at every stage of procurement to ensure and protect the integrity of the process. SCW Procurement will refer to the advice and guidance published by NHS England.

Clear records that show an audit trail of how COIs have been identified and managed as part of a procurement process will be kept, including:

- Declaration of conflict of interest for bidders / contractors
- Declaration of interests for ICB members and employees
- Register of procurement decisions and contracts awarded.

17.4 Voluntary and community sector/Small and Medium Enterprises Support

The ICB will aim to support and encourage voluntary and community sector and small and medium enterprise suppliers in bidding for contracts. The Procurement Team will work with service commissioners to ensure that procurement processes promote equality and do not discriminate on the grounds of age, race, gender, culture, religion, sexual orientation, or disability.

17.5 NHSE Integrated Support and Assurance Process (ISAP)

The ICB must consider this process for all novel and complex contracts. The ultimate decision on whether the ISAP should apply to a complex contract is at NHS England's discretion. Therefore, Commissioners should engage with their regional NHSE team as early as possible to establish whether a procurement or other arrangement would benefit from going through the ISAP. If ISAP is applicable a rigorous assurance process will be followed, with support of the SCW procurement team working alongside NHSE.

17.6 NHSE Consultancy spending approval criteria for providers

The ICB must consider the process and guidance when looking to commission consultancy services. Consultancy contracts over £50,000 (including irrecoverable VAT and other costs e.g., expenses) will require prior approval from NHSE. The approval process only applies to contracts that are accounted for as revenue

expenditure and does not currently apply to contracts accounted for as capital expenditure.

For further information and/or guidance on the process to be followed please contact the NHSE regional team or email england.consultancy@nhs.net direct.

17.7 Accessible Procurement

The ICB has a keen awareness of its accessibility and disability obligations as both an employer and a commissioner of services. When procuring digital systems the ICB will use NHS England's Digital Technology Assessment Criteria (DTAC). The DTAC is a national standard assessment that should be used when introducing any new digital technology into the NHS and includes usability and accessibility assessments such as Web Content Accessibility Guidelines compliance.

For requirements where use of the DTAC is not a mandatory requirement, the ICB has developed a Software Accessibility Checklist through its Disability Staff Network, and this will be used on a case-by-case basis.

17.8 IR35 and Employment Assessment

The ICB has a responsibility to ensure appropriate procedures are in place to meet with HMRC requirements regarding, amongst other things, appropriate payment of tax. This is particularly relevant to procurement when the ICB engages with self-employed individuals, individuals via their own limited company (known as a Personal Services Company) or a partner in a partnership.

Characteristics that may result in being inside IR35 legislation include the following:

- Having to work under direct supervision or control of the end client.
- Having to work at a set location or to set hours.
- Having to formally request leave or seek permission for absence.
- Having an hourly, daily, or weekly rate of pay
- Being paid for overtime, or to correct unsatisfactory work.
- Is unable to provide a substitute i.e., the work must be carried out by the contractor.
- Is able to be moved from task to task or to another location without arranging a new contract.

Characteristics that may result in being outside IR35 legislation include the following:

- Not having to work under direct supervision or control of the end client.
- Having control over how / where / when to complete the work.
- Has no access to holiday pay or sickness benefits.
- A fixed fee is agreed by the employer for the work, regardless of how long it takes to complete.
- Financial risk e.g., having to correct errors in their own time and at their own expense.

- Being able to propose a substitute agent or person to complete the work.

17.9 Integrated Care - Working with People and Communities

The ICB acknowledges that integrated care provides an opportunity to collaborate with partners to improve services and how money is spent. Commercial procurement due diligence activities may provide an opportunity for the ICB to meet its public involvement legal duties and the new 'triple aim' of better health and wellbeing, improved quality of services and the sustainable use of resources. Therefore, the ICB will consider, where appropriate, when looking to procure goods and services the following:

- Health needs assessment
- Stakeholder engagement activities
- Provider market engagement activities
- Undertaking consultation/public consultation where required
- Addressing health inequalities by understanding communities' needs and developing service specifications leading to proposed solutions with them.
- Opportunities for collaboration with partners – including local authorities, social care providers, Healthwatch/Patient Participation Groups and voluntary, community and social enterprise organisations.

18 The Procurement Oversight Group

To support this policy, it is proposed that the ICB establishes a Procurement Oversight Group. The Procurement Oversight Group's main purpose is to ensure procurement policy and processes are delivered appropriately to secure quality value for money services through procedures which are transparent, fair, and non-discriminatory. The group will have oversight of the commercial procurement pipeline to ensure procurement activity is planned and managed in a proactive way as well as ensuring a register of procurement decisions and contracts awarded are published on the ICBs website. Once established the full terms of reference for the Group will be made available on the ICB procurement webpage.

19 Training and Awareness

No mandatory training is required to comply with this policy. However, all ICB staff and others working with the ICB will need to be aware of this policy and its implications. It is not intended that staff generally will develop procurement expertise, but they will need to know when and how to seek further support.

All commissioning staff throughout the ICB should know enough about procurement to know to seek help when they encounter related issues; they must also be able to

give clear and consistent messages to providers and potential providers about the ICB's procurement intentions in relation to service developments. Awareness of procurement issues will be raised through organisational development and training sessions as necessary by the SCW procurement team.

Decision makers such as procurement evaluation panel members will have access to appropriate levels of training regarding procurement matters commensurate with their responsibilities. This will include general awareness of regulatory obligations and how to seek further support, advice, and guidance.

Each evaluation panel will receive evaluation and moderation training prior to starting the process. If training has not been undertaken the individual will not be involved in the evaluation and moderation process.

SECTION G – Policy Governance

20 Consultation

This policy was completed following consultation with the relevant internal stakeholders and groups including required ICB committees.

21 Recommendation and Approval Process

This policy is to be approved by the Finance Estates and Digital Committee under delegated authority of the ICB Board.

22 Communication/Dissemination

Following approval ICB staff will be made aware of the policy through the ICB website, the ICB voice communication and the weekly staff communication briefing.

23 Implementation

This policy is a revision of an existing policy and as such requires no specific implementation over and above the communication and dissemination highlighted in section 19 (Training and Awareness) and section 22 (Communication / Dissemination).

Target Group	Implementation or Training objective	Method	Lead	Target start date	Target End date	Resources Required
BNSSG Staff	Awareness	Presentation at HWGNFY	BSP Directorate	May 24	June 24	None
BNSSG Staff	Awareness and adherence	Share link to ICB Website and procurement training to reinforce adherence to	SCW / BSP Directorate	Ongoing	Ongoing	SCW / contracting

		policy at the start of each procurement				

24 Monitoring Compliance and Effectiveness of the Document

The Audit Governance and Risk Committee will oversee compliance with aspects of this policy through its review of the award of contract without competition requests and annual review of the Procurement Decision register. Audits of the procurement function will periodically be commissioned as appropriate as to ensure compliance with this policy.

Any areas of concern or non-compliance identified in any review must result in the production of an action plan. This will be reviewed by the appropriate committee/group. Actions will be recorded in the committee/group minutes.

25 Document Review Frequency and Version Control

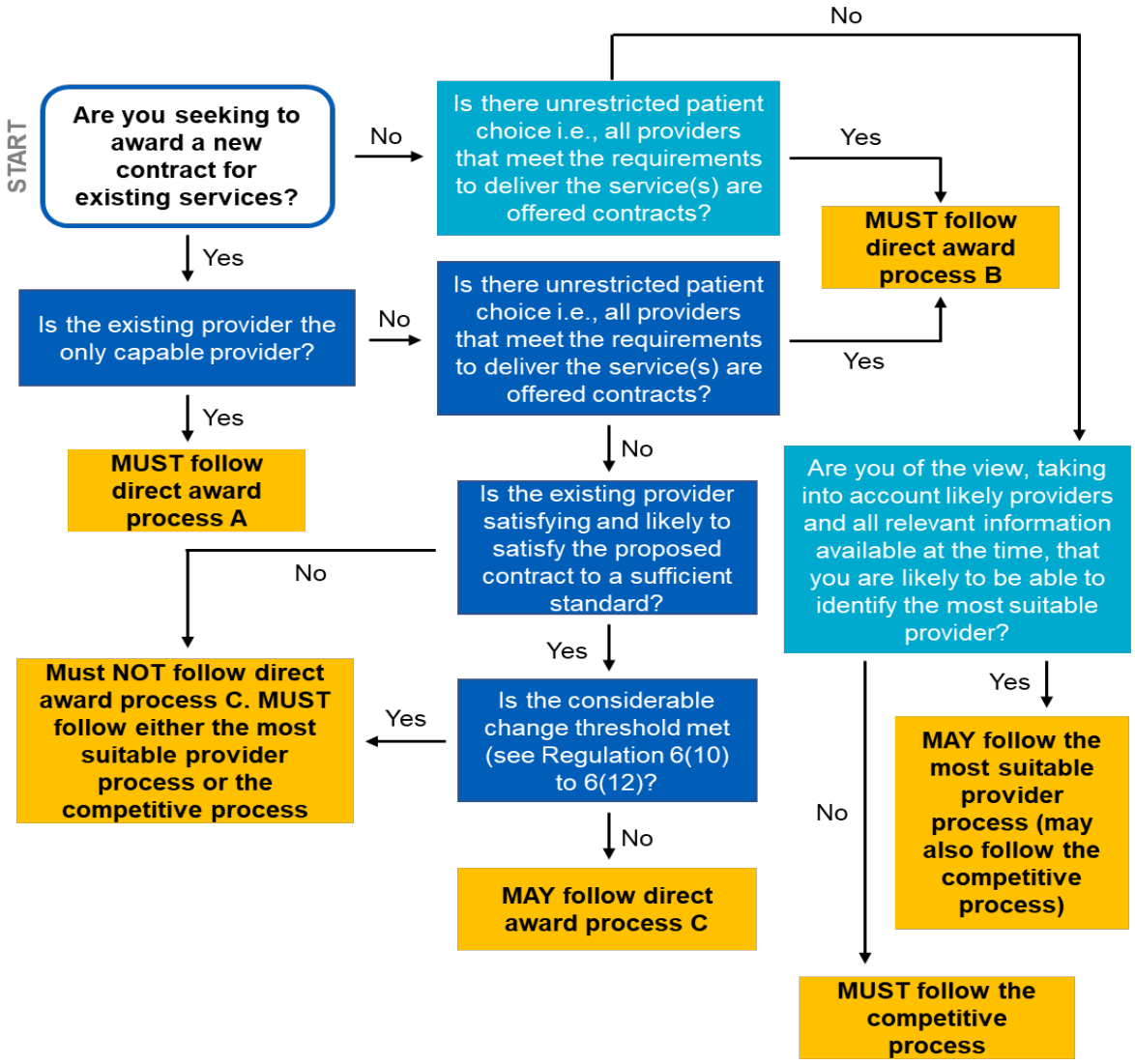
This policy will be reviewed every two years or earlier if appropriate, to reflect any changes to legislation or guidance that may occur. Necessary changes throughout the year will be issued as amendments to the policy. Such amendments will be clearly identifiable to the section to which they refer, and the date issued. These will be clearly communicated via the ICB newsletter.

Appendix 1: Provider Selection Regime – Decision Flow Chart

"Getting to the Right Decision"

NEED TO PROCURE A HEALTHCARE SERVICE?

SCW will support all procurements on a case-by-case basis – ICB procurement leads are to contact SCW in all cases to understand whether substantive procurement support is required.



Overview of decision-making approach to PSR process

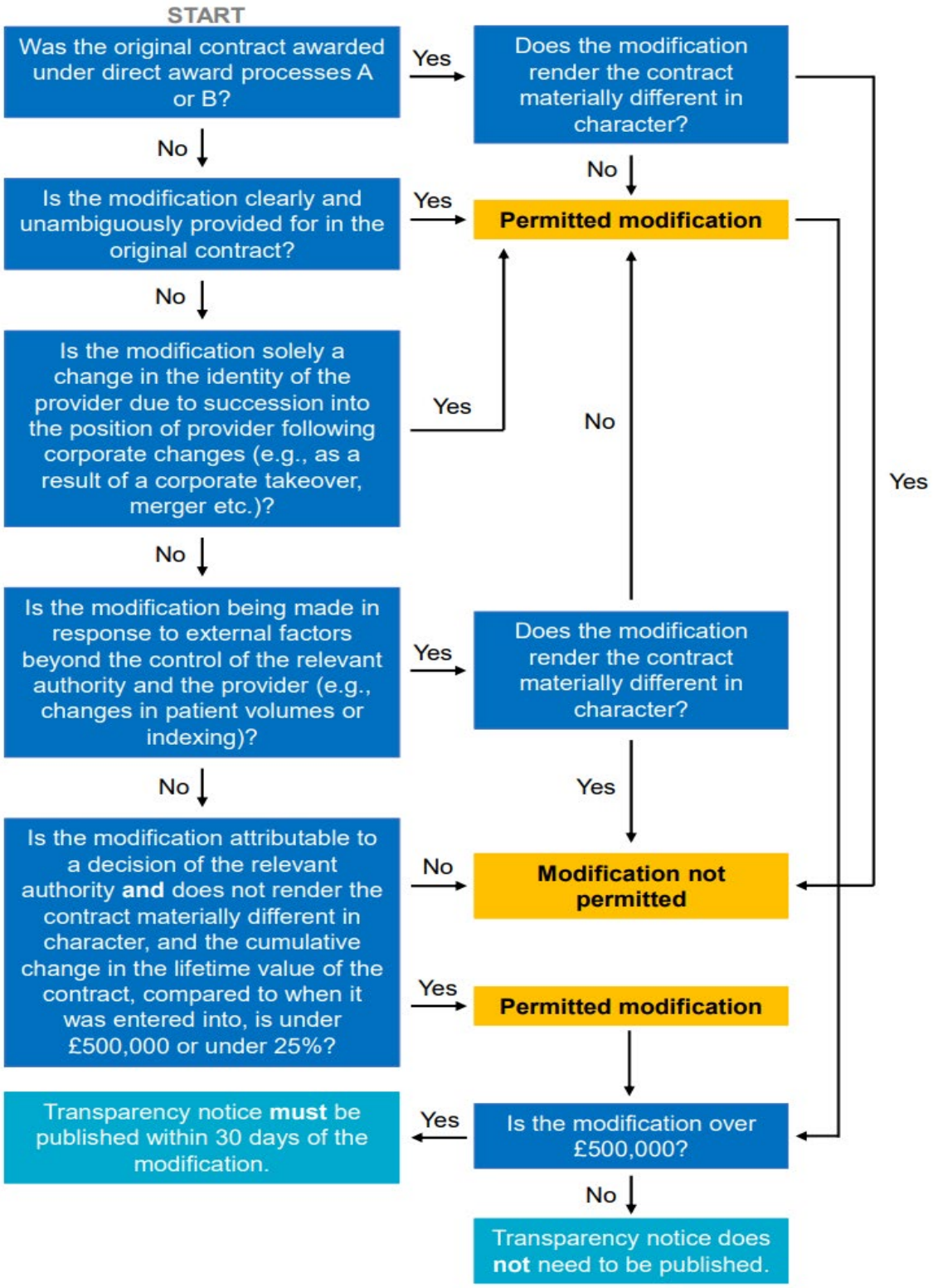
Direct Award A	Continuation of existing arrangements –there is no realistic alternative to the existing provider (for example for Type 1 and 2 urgent and emergency services). Not used to establish framework agreement. **Must** be used if applicable. Transparency award notice published within 30 days of contract award.
Direct Award B	The ICB wishes to provide, or currently provides an 'unrestricted patient choice' service (for example, consultant led elective care services). The number of providers cannot be restricted. Providers utilise Expression of Interest process. Contracts issued to all eligible providers. **Must** be used if applicable. Transparency award notice published within 30 days of contract award.
Direct Award C	Existing provider for the healthcare services, and their contract is ending – ICB decides by assessing key decision-making criteria that the provider is doing a sufficiently good job (satisfying original contract and is likely to satisfy new contract to a sufficient standard) and the service is not changing considerably (change is over £500,000 and is over 25% of the original lifetime value of the contract). Not required to follow Direct award processes A or B above. Cannot be used to establish a framework. Key and Basic Selection criteria to be considered. 8 working day standstill period must be observed. Multiple transparency notices published.
Most Suitable Provider	Identifying the most suitable provider when the decision-maker wants to use a new provider or for new/considerably changed arrangements and considers that it can identify the most suitable provider without a competitive process. Thorough knowledge of the provider landscape is crucial and goes beyond just knowing provider base. Not required to follow Direct Award process A or B and does not wish or cannot follow Direct Award Process C. Cannot be used to establish a framework. Key and Basic Selection criteria to be considered. 8 working day standstill period must be observed. Multiple transparency notices published, including allowing interested providers to ask to be considered as the 'most suitable provider'.
Competitive	Competitive procurement process. Not required to follow Direct Award process A or B. Does not wish to or cannot follow Direct Award process C and does not wish to use or is unable to identify the most suitable provider using the Most Suitable Provider route. Competitive route is required to establish a framework. Key and Basic Selection criteria to be considered. No financial thresholds. 8 working day Standstill period must be observed. Multiple transparency notices published.

Appendix 2: Summary of the Transparency steps under the Provider Selection Regime

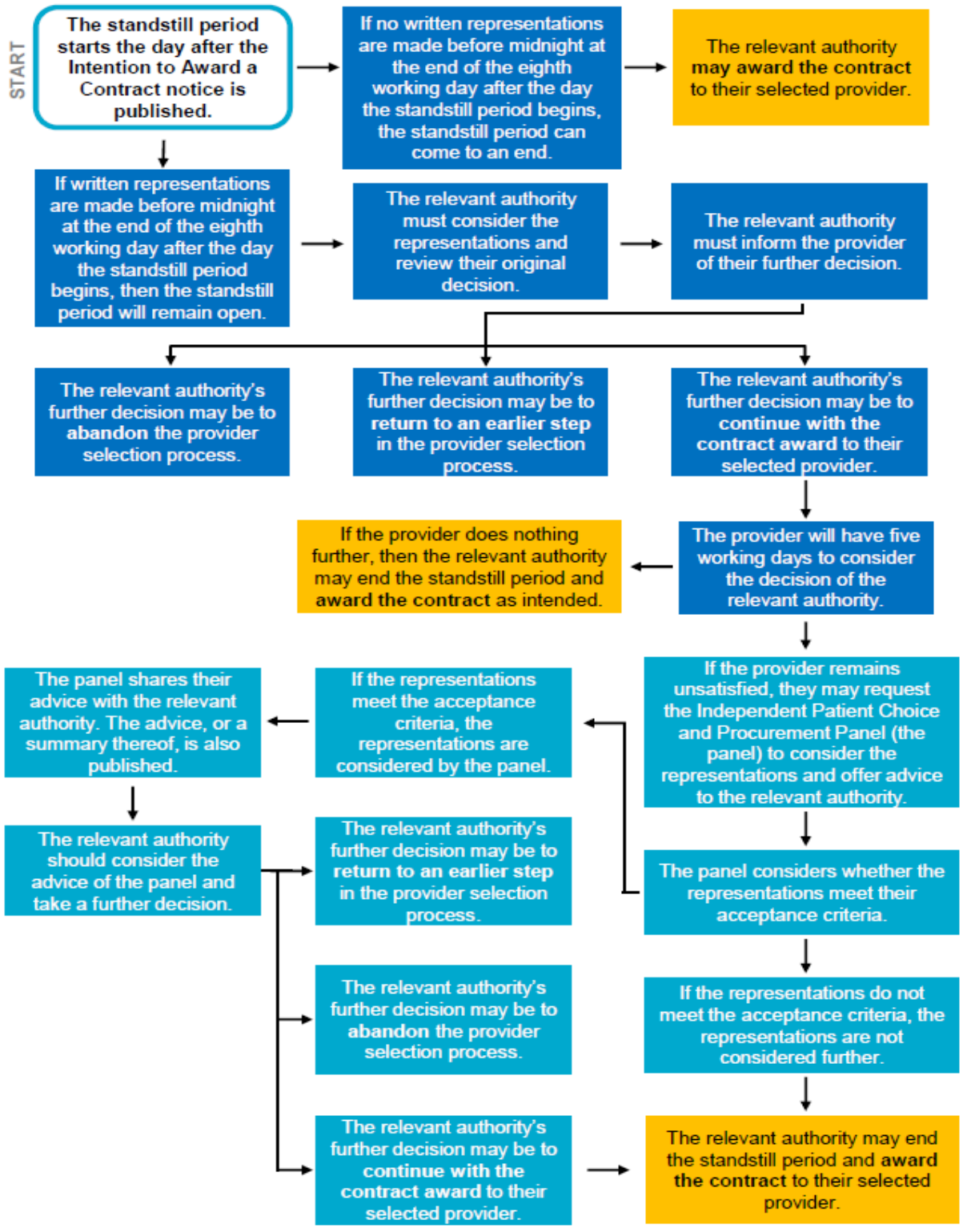
PSR Process	A	B	C	MSP	Competitive
Details on intended approach (PIN)				Notice published at least 14 calendar days before assessing providers	Optional
Contract Notice for procurement					On FTS website
Internal record of decision-making process & rationale					
Responding to unsuccessful bidders					
Intention to Award			On FTS website	On FTS website	On FTS website
Standstill & Resolution period (If representation received within 5 working days standstill period remains open until resolution)			8 working day Standstill Indicative 25 working days for Panel review 5 working days for bidder to consider final outcome	8 working day Standstill Indicative 25 working days for Panel review 5 working days for bidder to consider final outcome	8 working day Standstill Indicative 25 working days for Panel review 5 working days for bidder to consider final outcome
Confirmation of Award (CAN)	Within 30 days	Within 30 days	Within 30 days	Within 30 days	Within 30 days
Contract Modification	Within 30 days of modification	Within 30 days of modification	Within 30 days of modification	Within 30 days of modification	Within 30 days of modification

Notice required
Internal Record
Outcome Letter

Appendix 3: PSR Contract Modifications Flow Chart



Appendix 4: Provider Selection Regime – 'Standstill Process' Flow Chart



Appendix 5: Procurement Process Table (non-healthcare)

SCW will support all procurements on a case-by-case basis. ICB procurement/commissioning leads are to contact SCW in all cases to understand whether substantive procurement support is required.

CONTRACT THRESHOLD VALUE	PROCUREMENT PROCESS
Up to £5k Total Contract Value	No Formal Requirement (Quotations Advised)
Between £5k and £50k Total Contract Value	3 Formal Quotations need to be obtained. (Single Tender Waiver signed by CEO required if quotations cannot be obtained)
Between £50k and £214,904 (inc. VAT) Total Contract Value	Competitive tender required. (Single Tender waiver signed by CEO required if competitive tender cannot be undertaken) The ICB can consider an open (advertised) or closed (framework or local approved supplier list) approach to market.
Above £214,904 (inc. VAT) Total Contract Value	Full open (advertised) or closed (framework) tender required. (*Advice and guidance from **SCW Procurement team,** including if the view is that a full tender cannot be undertaken*) **Legislation:** Public Contracts Regulations 2015

Appendix 6: Common Procurement Processes (PCR2015) - Guidance

Below are three common procurement processes used and detail of when they would be appropriate. The type of process used to procure a service or goods should be decided in conjunction with the Procurement Team. These processes do not apply to healthcare service processes commenced on or after 1st January 2024.

Average length	Process type benefits	Process type risks
Open: - Suitable for simple procurements where the requirement can be clearly defined, i.e., purchase of goods.		
4 months plus mobilisation	-Only use if service specification is detailed and fully understood, i.e., service required is already known as no room for negotiation. -Ideal for limited markets when few responses are expected. -No Pre-Qualification Questionnaire restriction phase so can save time.	-Potential for numerous submissions if market is not properly understood. -Doesn't allow restriction and therefore any organisation can bid, and we are obliged to evaluate their bid. This will take a lot of time. -Can stifle innovation with restrictive specifications.
Restricted: - Suitable when you want to pre-qualify organisations and you are able to state the service requirement in detail as there is no room for negotiation following receipt of the bid.		
6 months plus mobilisation	-Designed for procurements where the service specification is fully understood and defined. -Allows restriction of bidders moving through to the Invitation to Tender (service delivery assessment) phase, therefore saving evaluation time at the Invitation to Tender phase.	-Pre-qualification stage takes additional time to complete. -Can be seen as burdensome by some bidders. -Can stifle innovation with restrictive specifications.
Competitive Dialogue / Competitive Procedure with Negotiation: - Appropriate where the specification is incomplete and will require negotiation, or where the solution is likely to be complex and will need dialogue to conclude the tender.		
9 months plus mobilisation	-Allows a better understanding of the specification and scope through dialogue, which in turn can lead to better outcomes and reduced risk. -Process allows more certainty around the bidder selection as you will have worked with them through dialogue. -Can lead to real innovation of services which are outcome driven. -Allows negotiation around requirements. -Allows restriction of bidders to the negotiation phase.	-Lengthy complicated process -Risk of price escalation when bidder truly understands the cost implications. -Loss of competition once preferred bidder is selected and therefore potential for difficult further negotiations before agreement on contract and price.

Bristol, North Somerset and South Gloucestershire
Integrated Care Board

Report title: ICB Finance Report

Report on the financial performance for March 2024 (M12 – 2023/24)

1. Executive Summary

The final allocation for the ICB is £2,175.014m; initial allocation of £2,000.957m with prior month increases of £166.236m and additional allocation in March of £7.820m.

The ICB is reporting a small surplus at year-end of £0.008m (*0.0004% of allocation*) with the system reporting a surplus of £0.074m. The system has delivered a breakeven or better position which should result in the accumulated historical debt of £117m being written off. Failure to achieve this would have resulted in the debt being reinstated and repayable, and restrictions implemented by NHS England on investments and additional reporting requirements.

Funded care, medicines management, acute (diagnostics and high cost drugs & devices) and mental health, learning disabilities & autism reported overspend positions which are mitigated by a significant underspend within the primary care pharmacy, ophthalmology and dental (POD) delegated allocation in addition to deferred investment reserves and inflation allocations.

2. Financial duties and financial performance metrics

The ICB delivered against all statutory financial duties.

Duty	RAG	Position
Maintain expenditure within the revenue resource limit *(Section 5)*	G	The ICB is reporting a small surplus of £0.008m against an allocation of £2,175.014m
Ensure running costs are within the running cost resource limit. *(Section 5 and appendix A8)*	G	The ICB has a running cost budget per the allocation of £20.515m. At year end there is a small underspend of £0.002m.
Maintain capital expenditure within the delegated limit *(Section 7)*	G	The 2023/24 capital programme is £6.677m; £1.961m ICB allocation, £1.800m system CDEL prioritised capital and reforecast £2.916m IFRS16 office lease. The ICB's underspends on non IFRS16 allocations have been utilised by the acute providers.
Maintain expenditure within the allocated cash limit *(Section 8)*	G	At year end the ICB had drawn down all of the £2,192.846m cash allocation
Ensure compliance with the better payment practice code *(Section 9)*	G	Performance target requires 95% of non-disputed invoices to be paid within 30 days. The ICB's annual performance is above the target.in NHS and Non-NHS volumes and values.

The ICB also expects to meet the requirement of Mental Health Investment Standard.

The ICB underspent on delegated POD services allocation and some small cases of Service Development Fund (SDF) allocations. The ICB overspent marginally on delegated primary care allocation and core programme allocation.

3. Revenue allocation

The allocation increased by £7.820m in month to £2,175.014m with the high value allocations in month relating to final ERF (£4.712m), primary care transformation and access recovery plan (£1.794m), 2024/25 allocations for redundancy provisions at 31 March 2024 (£0.586m) and direct oral anticoagulants (DOACs) rebate (£0.345m). The internal budget moves in month primarily relate to the cancer alliance funds, secondary dental Elective Recovery Fund and aligning support costs and reserves.

Programme Area	Confirmed Initial ICB allocation £m	Prior Months Allocation Changes £m	Adjustments in Month		Baseline Allocation at 31-Mar-24 £m
			SDF/Other allocations £m	Internal Budget adjs £m	
Acute Contracts	1,028.154	62.495	*4.712*	*5.702*	**1,101.063**
Mental Health	222.826	9.114	-	*0.090*	**232.030**
Community Services	193.862	18.342	*0.012*	*0.494*	**212.711**
Delegated Primary Care	255.137	13.425	*1.448*	*(0.467)*	**269.542**
Medicines Management	154.112	1.145	*0.341*	-	**155.598**
Primary Care	36.369	2.941	*0.132*	*0.085*	**39.527**
Funded Care	113.997	0.150	-	-	**114.147**
Childrens Services	20.523	0.752	-	*0.003*	**21.279**
Support costs	6.935	2.100	*0.589*	*(2.238)*	**7.386**
Reserves	(49.384)	54.034	*0.236*	*(3.669)*	**1.216**
Commissioning Budget	**1,982.530**	**164.498**	**7.470**	**-**	**2,154.499**
Running Costs	18.427	1.738	*0.350*	-	**20.515**
Total Allocation 2023-24	**2,000.957**	**166.236**	**7.820**	**-**	**2,175.014**

4. Financial position March 2024 (Month 12)

At year end the ICB is reporting a small surplus of £0.008m *(0.0004%).*

2023/24 March 2024 - Month 12	2023/24 Budget	Expenditure	Variance		Appendix Ref
Programme Area	**£m**	**£m**	**£m**		
Acute	1,101.063	1,104.222	**(3.159)**		A1
Mental Health	232.030	232.968	**(0.938)**		A2
Community	212.711	211.768	**0.943**		A3
Delegated Primary Care	269.542	260.391	**9.151**		A5/A6
Medicines Management	155.598	156.816	**(1.219)**		A7
Primary Care	39.527	39.139	**0.388**		A4
Funded Care	114.147	127.948	**(13.800)**		A8
Childrens	21.279	20.696	**0.583**		A9
Support Costs	7.386	6.929	**0.457**		A10
Reserves	1.216	(6.384)	**7.600**		-
Running Costs	20.515	20.513	**0.002**		A11
BNSSG ICB Surplus/(Deficit)	**2,175.014**	**2,175.006**	**0.008**		
Provider Surplus/Defict					
AWP	-	0.006	**0.006**		
NBT	-	0.019	**0.019**		
UHBW	-	0.041	**0.041**		
Provider Surplus/(Deficit)	**-**	**0.066**	**0.066**		
ICS Position	**2,175.014**	**2,175.072**	**0.074**		

The programme areas are reported by summary headings in Appendix 1.

While the overall position is break even there continues to be offsetting movements within programme areas. The adverse variances over a million pound are in acute (£3.159m), medicine management (£1.219m) and funded care (£13.800m) which have been funded by favourable variances in delegated primary care (of which £4.500m was managed release of earmarked reserve and allocation contingency and £4.651m was contract under delivery) and reserves (£7.600m).

Programme status at month 12

The programme areas are rated on adverse variance to budget with below 1% rated green, between 1% and 2% amber and over 2% red. The only programme area with a variance of more than 1% was Funded Care.

Funded Care (A8)

The overspend continues to primarily relate to increase in activity and costs for adult fully funded continued health care (£9.582m) and personal health budgets (£2.996m), and funded nursing care (£3.108m). Increasing activity and the complexities of cases, notably for people with learning disabilities, are the main drivers for the overspend.

The finance team has developed an activity and cost dashboard which will support the Funded Care team develop a 2024/25 savings programme to mitigate demand and price growth, incorporating the Transformation programme on Learning Disabilities

System position

As reported in the above table the ICS is reporting a year end surplus of £0.074m, £0.008m for the ICB and £0.066m with the providers.

Payroll overview

Included in the financial position are the pay costs, as summarised below. The funded establishment continued to be underspent with a variance of £1.255m and the pay costs funded from other sources overspent by £0.579m generating a net underspend variance of £0.579m (£0.163m over on admin costs and £0.742m under on programme).

Source of funds	Admin/ Programme	Full year budget £m	YTD budget £m	YTD spend £m	YTD variance £m
Funded Establishment	Admin	13.202	13.202	12.789	0.413
	Programme	11.745	11.745	10.902	0.843
Total funded Establishment		**24.947**	**24.947**	**23.692**	**1.255**
Other Funding source	Admin	0.071	0.071	0.647	(0.575)
	Programme	1.327	1.327	1.428	(0.100)
Total Other funded posts		**1.398**	**1.398**	**2.074**	**(0.676)**
Grand total		**26.346**	**26.346**	**25.766**	**0.579**

		Full year budget £m	YTD budget £m	YTD spend £m	YTD variance £m
Analysed by	Admin	13.273	13.273	13.436	(0.163)
	Programme	13.073	13.073	12.330	0.742
Grand total		**26.346**	**26.346**	**25.766**	**0.579**

5. Efficiencies

The total ICB savings plan as per the annual plan submission is £22.035m, £6.975m within the ICB and £15.060m of commissioning efficiencies.

2023/24 Month 12	Planned net saving £ms	Actual net saving £ms	Variance £ms
ICB savings plan			
Running Costs/Support costs	0.534	0.534	-
Funded Care	3.000	3.380	0.380
Primary Care	0.750	0.750	0.000
Medicine Optimisation	2.691	6.926	4.235
Total ICB savings plan	**6.975**	**11.590**	**4.615**
Commissioning efficiencies			
NHS Providers inside system	9.827	9.827	-
NHS Providers outside of system	0.719	0.719	-
Non NHS provider	3.705	3.705	-
Profiling reconciliation to NHSE return	0.809	0.720	(0.089)
Total savings	**22.035**	**26.561**	**4.526**

At year end the ICB efficiency delivery was £4.526m above plan and continued to be driven by the medicine optimisation projects optimising primary care prescribing, diabetes- value for money and national procurement of DOACs and the funded care projects recovery of continued health care backlog and personal heath budgets. The funded care projects were offset by under delivery on exit high-cost agency packages.

The commissioning efficiencies reflect the savings achieved through passing through the 1.1% efficiency factor via contact price uplifts each year. These savings are all fully delivered via baseline contract and budget changes.

6. Capital allocation

The ICB's total capital allocation, including IFRS16, is £6.677m, with in year expenditure of £4.805m. The £1.872m underspend is a result primarily of delay to Central Weston scheme, as well as underspend on corporate IT due to Shaping Our Future and the office accommodation move and a change in the discount rate when accounting for the IFRS16 asset associated with the lease of 100 Temple Street.

2023/24 Schemes	Asset Owner	Capital Allocation £m	Virement	Capital Allocation £m	YTD Budget £m	YTD Expenditure £m	YTD Variance £m
Minor Improvement Grant (MIG)	NHS England	0.313	(0.115)	0.198	0.198	0.198	-
MIG Equipping	NHS England	0.039	0.054	0.093	0.093	0.093	-
GPIT - BAU refresh	NHS England	0.941	(0.151)	0.790	0.790	0.790	-
GPIT - additional roles & PCN	NHS England	0.094	0.115	0.209	0.209	0.209	-
IT Corporate Refresh	BNSSG ICB	0.273	-	0.273	0.273	0.176	(0.097)
GPIT - gigabit acceleration	NHS England	0.151	0.151	0.302	0.302	0.302	-
Shared Care records	Sirona	0.150	-	0.150	0.150	0.150	-
ICB Capital Allocation		**1.961**	**0.054**	**2.015**	**2.015**	**1.918**	**(0.097)**
System prioritisation schemes							
Additional MIG	NHS England	0.300	(0.054)	0.246	0.246	0.246	-
Central Weston	Sirona	1.500	-	1.500	1.500	-	(1.500)
Total ICB capital allocation (excl. IFRS16)		**3.761**	**-**	**3.761**	**3.761**	**2.164**	**(1.597)**
IFRS 16 capital uplift							
Property lease	BNSSG ICB	2.916	-	2.916	2.916	2.641	(0.275)
Total ICB capital allocation (incl. IFRS16)		**6.677**	**-**	**6.677**	**6.677**	**4.805**	**(1.872)**

The underspend on the Capital Department Expenditure Limit (CDEL) for the Corporate IT and Central Weston schemes has been utilised by the acute providers in the system to ensure capital spend is maximised across BNSSG.

7. Statement of Financial Position

The closing net asset position of the ICB is £108.136m, an in-year movement of £17.840m

Statement of Financial Position	Balance 31/03/2023 £m	Balance 31/03/2024 £m	Movement £m
Total Non Current Assets	0.488	3.024	2.536
Current Assets			
Cash & Cash Equivalents	0.081	0.174	0.093
Current Trade And Other Receivables	18.338	40.596	22.258
Total Current Assets	*18.419*	*40.770*	*22.351*
Total Assets	**18.907**	**43.794**	**24.887**
Current Liabilities			
Payables	(131.478)	(141.053)	(9.575)
Lease Liability	(0.104)	(2.595)	(2.491)
Provisions	(13.301)	(8.280)	5.021
Total Current Liabilities	***(144.883)***	***(151.929)***	***(7.046)***
Total Net Assets/(Liabilities)	**(125.976)**	**(108.136)**	**17.840**
Taxpayers Equity			
I&E Reserve - General Fund	(125.976)	(108.136)	17.840
Total Taxpayer Equity	**(125.976)**	**(108.136)**	**17.840**

The in-year movements primarily relate to;

- Non-current assets *(£2.536m increase)* - the capitalisation of the lease for 100 Temple Street, as per IFRS16.
- Current trade and other receivables *(£22.258m increase in current assets)* – the ICB raised full year invoices in quarter 4 to the Local Authorities which were still outstanding at year end.
- Payables *(£9.575m increase in current liabilities)* - accruals relating to primary care POD services delegated in year.
- Lease liability *(£2.491m increase in liabilities)* – the corresponding lease liability for 100 Temple Street, as per IFRS 16
- Provisions *(£5.021m decrease in liabilities)* – release of provisions no longer required

NHSE monitor the ICB on the closing cash at bank balance with a target of 1.25% of monthly drawdown, which for month 12 equates to £1.866m. The ICB achieved this target with a closing cash at bank position and cash in ledger position of £0.174m.

During March NHSE increased the ICB's cash limit by £21.434m to £2,192.846m reflecting the ICB's additional cash requests to meet cash commitments arising from the under drawing of cash in previous years. As a result, the ICB met its target to maintain expenditure within the allocated cash limit.

8. 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 ICB pays an average of 2,600 invoices a month, and invoices paid in March returned to this level. The ICB met the BPPC target for all NHS and Non-NHS invoices for the year.

The ICB did not meet the in-month BPPC target for the value of non-NHS invoices paid on time. The target was missed due to delays at the approval stage for two high value invoices.

Type	In month	Number	£m
NHS	Total bills paid in month	58	112.946
	Total bills paid within target	58	112.946
	% bills paid within target	**100.00%**	**100.00%**
Non NHS	Total bills paid in month	2,576	64.045
	Total bills paid within target	2,545	56.445
	% bills paid within target	**98.80%**	**88.13%**

Type	Year to date	Number	£m
NHS	Total bills paid in year	1,010	1,226.793
	Total bills paid within target	985	1,226.067
	% bills paid within target	**97.52%**	**99.94%**
Non NHS	Total bills paid in year	31,150	772.437
	Total bills paid within target	30,716	745.444
	% bills paid within target	**98.61%**	**96.51%**

9. Recommendations

The committee are asked to note the financial position as of month 12.

Appendix 1 – Analysis of spend within programme areas

A1 – Acute

Acute Services	2023/24 Budget	2023/24 Expenditure	2023/24 Variance	
	£m	£m	£m	
University Hospitals Bristol and Weston NHS FT	480.426	485.159	(4.733)	
North Bristol NHS Trust	465.064	465.574	(0.510)	
South Western Ambulance Service NHS FT	50.746	50.746	-	
Independent Sector Treatment Centres	49.432	49.432	-	
Other Local Provider contracts (RUH, Glos, Somerset)	17.915	18.240	(0.325)	
Low Volume Activity	8.067	8.073	(0.006)	
Non Contracted Activity	0.908	1.590	(0.681)	
Other Acute Spend (incl SWAG cancer)	28.504	25.407	3.097	
Grand Total	**1,101.063**	**1,104.222**	(3.159)	

A2 - Mental Health

Mental Health & Learning Disabilities	2023/24 Budget	2023/24 Expenditure	2023/24 Variance	
	£m	£m	£m	
MH - AWP Core Contract	140.462	137.460	3.001	
Mental Health Placements	20.981	22.349	(1.368)	
Child & Adolescent Mental Health (CAMHS)	15.428	15.148	0.280	
Learning Disability and Autism	7.132	8.403	(1.272)	
Mental Health Community	6.120	8.314	(2.194)	
Improved Access to Psychological Therapies (IAPT)	12.160	12.071	0.089	
Dementia	5.848	5.710	0.138	
Crisis Services	2.969	1.690	1.279	
ADHD	0.871	3.461	(2.590)	
Mental Health Low Volume Activity	0.877	0.901	(0.024)	
Mental Health SDF	18.528	16.988	1.541	
MH - S12 Doctors Private Sector	0.655	0.474	0.181	
Grand Total	**232.030**	**232.968**	(0.939)	

A3 – Community

Community	2023/24 Budget	2023/24 Expenditure	2023/24 Variance	
	£m	£m	£m	
Adult Community	135.025	133.882	1.143	
Joint Commissioned	32.284	32.284	-	
Discharge to Assess Services	12.642	13.384	(0.742)	
Patient Transport Services (PTS)	7.218	6.303	0.915	
Community Equipment	6.058	6.956	(0.898)	
Hospices	4.598	4.528	0.070	
BIRU	3.994	3.232	0.763	
In-Year Investments	4.670	4.621	0.048	
Other Community	6.222	6.578	(0.356)	
Grand Total	**212.711**	**211.768**	0.943	

A4 – Primary Care

Primary Care	2023/24 Budget	2023/24 Expenditure	2023/24 Variance	
	£m	£m	£m	
NHS 111/Out of Hours	18.766	18.778	(0.012)	
Local Enhanced Services	7.621	7.366	0.255	
GP Forward View	5.541	5.537	0.004	
Other Primary Care	7.599	7.458	0.141	
Grand Total	**39.527**	**39.139**	**0.388**	

A5 – Primary Care Delegated

Delegated Primary Care	2023/24 Budget	2023/24 Expenditure	2023/24 Variance	
	£m	£m	£m	
GMS/PMS/APMS Contracts	106.245	106.095	0.150	
Primary Care Networks DES	41.466	41.444	0.022	
Premises Costs	16.472	16.294	0.177	
Quality Outcomes Framework (QOF)	14.382	14.371	0.011	
Locum Reimbursement Cost	1.976	2.217	(0.241)	
Other GP Services	1.894	2.121	(0.227)	
Prescribing & Dispensing Fees	1.545	1.370	0.175	
Designated Enhanced Services (DES)	1.452	1.351	0.101	
Delegated Primary Care Reserve	-1.572	-1.031	(0.541)	
Grand Total	**183.861**	**184.234**	**(0.373)**	

A6 – Primary Care Delegated POD

Pharmacy, Ophthalmology and Dental (POD) delegation	2023/24 Budget	2023/24 Expenditure	2023/24 Variance	
	£m	£m	£m	
Delegated Pharmacy	20.769	19.759	1.009	
Delegated Primary Dental	36.883	29.624	7.259	
Delegated Secondary Dental	16.043	16.043	-	
Delegated Community Dental	2.684	2.684	-	
Delegated Primary Care IT	0.464	0.018	0.447	
Delegated Ophthalmic	8.839	8.030	0.809	
Grand Total	**85.682**	**76.157**	**9.524**	

A7 – Medicines Management

Medicines Management	2023/24 Budget	2023/24 Expenditure	2023/24 Variance	
	£m	£m	£m	
Prescribing	153.753	155.007	(1.254)	
Medicines Management staff costs	1.844	1.809	0.035	
Grand Total	**155.598**	**156.816**	**(1.219)**	

A8 – Funded Care

Funded Care	2023/24 Budget	2023/24 Expenditure	2023/24 Variance	
	£m	£m	£m	
Adult Fully Funded CHC	52.890	62.479	(9.588)	
Adult Fully Funded PHB	8.515	11.512	(2.996)	
Adult Joint Funded	0.791	0.670	0.121	
CHC Assessment and Support	0.689	0.429	0.260	
Funded Care Pay	4.899	4.718	0.182	
Children's CHC	3.674	3.872	(0.199)	
Children's PHB	0.657	0.632	0.025	
Fast Track	17.592	16.089	1.503	
FNC	24.440	27.548	(3.108)	
Grand Total	**114.147**	**127.948**	**(13.801)**	

A9 – Children's Services

Children's Services	2023/24 Budget	2023/24 Expenditure	2023/24 Variance	
	£m	£m	£m	
CCHP Contract	18.207	17.685	0.522	
Other	3.072	3.011	0.061	
Grand Total	**21.279**	**20.696**	**0.583**	

A10 – Support Costs

Support Costs	2023/24 Budget	2023/24 Expenditure	2023/24 Variance	
	£m	£m	£m	
Chief Medical Office	0.995	1.017	(0.022)	
Chief Nursing Office	2.687	2.515	0.172	
Estates	2.576	2.790	(0.214)	
Other Support Costs	(1.791)	(2.276)	0.485	
Programme pay recharges	0.509	0.581	(0.073)	
Projects	1.163	1.254	(0.092)	
R&D Team	0.299	0.249	0.049	
Transformation, Data & Digital Directorate	0.950	0.799	0.151	
Grand Total	**7.386**	**6.929**	**0.457**	

A11 – Running Costs

Running Cost	2023/24 Budget	2023/24 Expenditure	2023/24 Variance	
	£m	£m	£m	
Business & Planning Directorate	6.635	6.237	0.398	
Chief Medical Office	0.834	0.719	0.115	
Chief Nursing Office	0.055	0.010	0.045	
CSU	1.092	1.273	(0.181)	
Integrated & Primary Care Directorate	2.194	2.267	(0.073)	
Office of the Chair & Chief Executive	4.403	4.714	(0.311)	
People Directorate	0.545	0.770	(0.226)	
Performance & Delivery Directorate	1.445	1.483	(0.038)	
Strategy Directorate	0.576	0.401	0.174	
Transformation, Data & Digital Directorate	2.737	2.639	0.098	
Grand Total	**20.515**	**20.513**	**0.002**	

NHS
Bristol, North Somerset and South Gloucestershire
Integrated Care Board

Finance, Estates and Digital Committee OPEN Minutes
Thursday 22 February 2024, 09:00 – 12:00, Microsoft Teams

Present		**Initials**
Steve West	Finance, Estates and Digital Committee – Chair	SW
Sarah Truelove	Deputy CEO & CFO – ICB	ST
Amy Webb	Director of Corporate Services / S151 Officer – North Somerset Council	AW
Brian Stables	Non-Executive Director – AWP	BS
Christina Gray	Director of Public Health - BCC	CG
Deborah El-Sayed	Chief Transformation and Digital Information Officer	DES
Jeff Farrar	ICB Chair	JF
Jo Medhurst	Chief Medical Officer - ICB	JM
John Cappock	Non-Executive Director - ICB	JC
Richard Gaunt	Non-Executive Director – NBT	RG
Attending		
Jon Lund	Deputy Chief Finance Officer - ICB	JL
Helena Fuller	Deputy Director of Planning – ICB (item 6.1 only)	HF
Cath Lewton	Senior Administrator - ICB	CL

		Action
1.0	**Apologies for Absence** Apologies were received from Nina Philippidis, South Gloucestershire Council; and Rosi Shepherd, ICB. Amy Webb (AW) was welcomed to her first meeting; AW had replaced Nina Philippidis as the Section 151 representative.	
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 25 January 2024 were agreed as an accurate record of the meeting.	
4.0	**Actions from Previous Meeting** The action log was reviewed and updated accordingly.	
	To Discuss	
5.1	**24/25 Operating Plan Progress Report** Sarah Truelove (ST) introduced the report and advised that NHSE had not yet published the final planning guidance but to mitigate this, informal draft guidance and financial allocations were published on 12 February 2024. It was positive to note that the work already undertaken by the ICB was consistent with the informal draft guidance and this work would continue ahead of the submission deadline of 21 March. NHSE had also requested a highlight report against key indicators is submitted on 29 February 2024, ahead of the March submission, which was hoped to the initial and final submission, but it was acknowledged that there may be some minor amendments to be made for the final submission deadline (2nd May 2024). There were a number of issues which still required a resolution before the 21st March submission from a performance perspective, and a further planning day with system partners had been scheduled for 14 March 2024. ST highlighted the A&E 4 hour target as key area of focus, in addition to learning disabilities and autism, and the reduction in the reliance on inpatient care; the complexities around this was noted. ST also reported on the challenges around the maturity and delivery of partner organisations' savings plans and discussions continued to identify the required savings for the system. It was important to note that there was no new funding and there would be difficult decisions to be made in terms of what could be continued in order to deliver the required efficiencies. Areas of high risk or those with safety issues to be addressed would require previously funded areas to be reviewed and re-prioritised accordingly.	

		Action
	ST highlighted the encouraging progress that was being made with health inequalities and the significant work happening in a number of areas, including elective care. ST also highlighted a current example of system working, led by the system Chief Nursing Officers (CNO) to identify those areas with quality and safety issues. The remit of the review included reviewing the issues, actions taken to date, funding allocations and identification of the key priorities, and take a system approach of address the areas of highest risk. Steve West (SW) queried the read-across of this with the ongoing workforce challenges. The NHS Workforce Plan contained significant ambitions and expectations for organisations to meet, and the challenges around limited / no funding available to meet these. Linked to this was the current high levels of agency and backfill expenditure across the system which needed to be reduced but it was positive to note that the ICB did over-deliver in 2023/24 in terms of the system workforce plan. ST highlighted that, in terms of workforce, the challenge for the system was more effective utilisation of the workforce, noting that this was also impacted by recruitment challenges particularly within community services. The system Chief People Officers (CPO), CNOs and CFOs were also scheduled to meet to discuss the issues behind the system workforce, to bring about a re-balance to support delivery of the system's top priorities. Workforce retention has also showed signs of improvement within the system. SW also highlighted early signs of reductions in student applications in UWE in a number of fields including nursing, midwifery, Allied Health Professionals and medicine. Following the discussion at the last meeting, ST confirmed that written confirmation regarding funding for the Industrial Action was still awaited but there had been verbal confirmation that funding would be allocated in respect of the December and January IA had been received. In response to a query from Christina Gray (CG), Jon Lund (JL) confirmed that the Key Performance Indicators (KPIs) listed within the document were a subset; confirmation of the complete list of KPIs would be included within the final planning guidance. ST further clarified that the list of KPIs included within the paper were those which NHSE had asked organisations to focus on for 2024/25 within the allocated resource envelope. For Primary Care, systems have been asked to continue to improve access to primary care, improve community services and focus on waiting times, again, within the allocated resources. JL updated on the governance process to ensure adherence of the Standing Financial Instructions and approval of the plan ahead of submission: - "Flash update report" to be submitted by 29 February; - HCIG Chairs to approve the key metrics of the relevant areas of the plan; - ICB Board would be asked on 7 March to delegate responsibility to the ICB CEO to submit the draft plan to NHSE on 15 March; NHS provider partner boards would also be asked to provide similar delegation to the CEOs; - ICB Board on 7 March would be asked to delegate responsibility to FED Committee to approve an interim budget on 28 March; this would then be ratified at the ICB Board Seminar on 4 April. Jeff Farrar (JF) echoed the comments previously made and the improvements already made in a number of areas since becoming an ICB. Whilst there were still a number of challenges, JF's discussions with NHSE indicated there was reassurance in the approaches being taken. The financial position would always be challenging and the ICB must remain responsive to national pressures.	
5.2	**Review 24/25 Forward Work Programme** ST presented the initial work programme for 2024/25 and advised that this would be expanded to include: - Procurements (schedule currently being developed by the Contracting team) - Digital / Estates strategic items (and ensure these are inter-linked with Finance to improve efficiencies and effectiveness) Regular items included: - Planning cycle - Medium Term Financial Plan reviews - Infrastructure strategy updates - Capital prioritisation - Financial governance - Devolving revenue and capital budgets	

		Action
	It was important to ensure FED had oversight around work required to meet the ICB's strategic aims and objectives and to also maintain a proactive approach to the ICB Strategy. Deborah El-Sayed (DES) confirmed that there were a number of items linked to the Digital Portfolio that needed to be included within the work programme following Board approval; these included quarterly reviews and benefits oversight. DES also advised that there was agreement at the last ICB Board meeting that all programmes of work were to ensure digital and data components were fully embedded and each business case developed as part of the Digital Portfolio would be reviewed to ensure these were adequately covered. Having this check and balance approach would ensure business cases could be de-risked as they progressed through the approvals process. CG referenced the item related to reviewing progress around the integration of Health & Local Authority budgets and financial governance arrangements. It was recognised that this was a complex area, with different organisational rules and policies and it was agreed to amend "integration" to "alignment". ST also provided assurance that discussions were ongoing with regard to alignment of planning processes, with a longer term lens, especially as planning cycles start at different points in different sectors. CG also suggested it may be useful to include high-level infographics within future finance reports, which detailed the various funding allocations / streams and resources across the system. CG also highlighted the appropriateness of some of the procurement items that were scheduled to be discussed the HCIGs, due to potential providers and other organisations who would be present in the meetings. ST advised that it would be the responsibility of the respective HCIG Chair to manage this via the Conflicts of Interest process. John Cappock (JC) reflected that the work programme may not accurately reflect the discussions around Digital and Estates and that it would be important to ensure there was adequate time in the FED Committee meetings dedicated to these areas. AW welcomed the opportunity to be involved in mapping the locality authority view from the finance perspective, particularly as similar discussions had been taking place within SGC. AW also referenced recent discussions at the fortnightly S151 Officer meetings regarding forward planning of financial decisions and it would be useful to ensure clarity around governance arrangements for those decision making points. JL reflected that whilst mapping of the social care and local authority spend with the NHS spend would be useful, the complexities around this could not be under-estimated but would include this item on the work programme. SW suggested it would be helpful for the item narrative to be such that it enabled engagement with wider communities, rather than just the ICB and its committees. This would also clearly demonstrate the joined up approaches being taken and the gains being made in terms of improvements and investments. It was agreed for ST, JL and DES to discuss the work programme off-line and to ensure a wider focus to include Digital and Estates item. An updated work programme would be brought back in due course.	JL ST / JL / DES
	To Approve	
6.1	**Provider Selection Regime Approach** Helena Fuller (HF) presented the paper which outlined the steps to be taken by the ICB to award contracts under the new Provider Selection Regime (PSR) which came into force on 1 January 2024. The PSR applies to all healthcare procurements commenced after 1 January 2024 and also applied to any contract modifications and contract awards. The paper detailed the 5 different provider selection processes to be followed when awarding contracts for healthcare services). The paper also included a flowchart design to support the relevant authorities in reaching the right decision in terms of which selection process is to be followed. Three of the 5 processes were direct awards, and the remaining 2 were the most suitable provider process and a competitive process. It was noted that since the new PSR came into effect, all existing contracts held within the Business, Strategy and Planning Directorate had been reviewed and those which were due to end on 31 March 2024 have been assessed in accordance with the PSR guidance and a PSR category assigned. FED were asked to support the recommendation proposed in the paper to support the assignment of Direct Award A and B contracts for 1 April 2024 for onward progression to the ICB Board for approval as part of the ICB Planning report submission.	

		Action
	Once approved by the ICB Board, the award notice would then be published in the public domain. In response to a query from DES, HF confirmed that contract terms and expected deliverables would be published. CG asked how the ICB would ensure value for money and that the contracts would optimise prevention and address inequalities; HF advised that there was the flexibility to make amendments to the contracts in terms of health inequalities and the monitoring of this would be managed through the system governance processes (i.e. Service Delivery Units, HCIGs and regular contract review meetings) to ensure services were being delivered in line with the contract. JC welcomed the proposed approach and queried how this would impact the existing Sirona contract. HF advised that Sirona was awarded a 10 year contract in 2020 following a competitive process so the PSR process would not yet apply. The contract would continue as is but the new PSR would be followed when the current contract was coming to the end, with involvement from across the wider system. AW asked if the paper could be shared with her Local Authority colleagues; ST advised that there was a high-level paper developed for the ICB Board that could be shared; HF to forward to AW, and to CG. JL queried how the PSR process would be applied with Primary Care contracts; HF advised that the process would be the same but they would not be classified as either a Direct A or B Award applied but the key criteria would be worked through and the appropriate process followed. HF advised that to support partners and provider organisations through the changes, a number of events were held across BNSSG so raise awareness. In addition, the ICB Procurement Policy has been reviewed and updated accordingly and would be presented to FED in March 2024. In response to a query from Brian Stables (BS), HF confirmed that contracts that were coming to an end would not simply be rolled over and that the procurement process would be followed for all contracts to ensure best value for money and that all contracts were awarded appropriately. FED approved the recommendations within the report.	HF
	Finance Report	
7.1	**M10 Finance Report ICB & System inc Capital ICB Savings Report** JL presented the Finance Report and highlighted the following: ➢ A forecast deficit of the system's financial position of £6.496m, attributable to the impact of the industrial action – confirmation of funding is still awaited from DHSC and NHSE. The risk, therefore, is that the system will not deliver a break-even position at year end and there are no local mitigations available. ➢ The ICB is reporting a break-even position year-to-date and a forecast breakeven position for year-end. ➢ Overspends continue in funded care, acute, medicines management and support costs, which are mitigated by underspends in other areas. ➢ Delivery of savings continues to challenge and remains a focus of discussion in terms of financial planning for 2024/25 for both the system and organisations. ➢ Agency spend continues on a downward trajectory, due to vacancies being filled with substantive staff and the success of the international recruitment programme. ➢ Notable cost savings benefits from a newly available and highly prescribed coagulant. ➢ Significant underspend in the dental budget but this may change following the recent announcements regarding plans for the retention of dentists. In response to a query from BS, ST advised that the impacts of cash utilisation were yet to be seen, but that this was also linked to the level of savings delivery, although it was noted that 82% of savings have been delivered recurrently across the system. ST further clarified that cash forecasts were included within the programme of work being progressed by the DOFs and Deputy DOFs over the coming months. BS also suggested it may useful tom include within the 2024/25 work programme items related to forecast outturn for income, expenditure and capital. ST advised that it was important to ensure a wider system view was taken, and that individual organisations would be feeding that into their own Board meetings and reviews. AW queried the slippage on investments (£19.3m) and any associated implications; JL advised that this related to revenue investments i.e. plans to invest in producing health inequalities and prevention; for which there was an underspend in this financial year.	

		Action
	The budgets would be reinstated to enable the investments to be made so the savings and overspends incurred elsewhere in the budget have to be removed. Richard Gaunt (RG) raised concerns regarding CIP targets for 2024/25; ST referenced her earlier comments and concerns regarding the ongoing discussions around the identification of savings and the maturity of savings plans. A number of the plans were still in the scoping stage and these needed to progress in order to enable credible discussions with the national team regarding the ability to meet the ICB's financial obligations. SW suggested that in order for FED to seek and be able to provide more assurance regarding the financial position across the whole system, this could be achieved via the Executive and Non-Executive Director paths to enable a joined up view and provide overall system assurance. ST highlighted a risk related to IFRS16 and the requirement for the ICB to obtain CDEL cover for the ICB's relocation to 100 Temple Street. Whilst confirmation of the CDEL resource had not been confirmed nationally, verbal assurance had been received. It remained a risk as the ICB could potentially overspend on its CDEL allocation for the current financial year and it would be removed from next year's allocation. CG highlighted the areas of underspends and queried whether budgets were allocated correctly and whether they should be adjusted. ST advised that it was the purpose of the MTFP to highlight those areas where investments should be adjusted.	
	To Note	
8.1	**System DoFs Group** ST reported that the main of focus for the DOFs was forward planning and ensuring consistency across the organisations. DOFs are looking at risks and mitigations, inflation issues and any other cost pressures in order to reach a real system view.	
8.2	**Digital Delivery Board** DES presented the update report and highlighted the following: ➢ Work underway to review clinical governance from the clinical digital perspective. ➢ Agreement of lead provider for the 10 projects as approved by the ICB on 1 February. DES clarified that where NBT was listed as the lead provider, this was a joint arrangement with UHBW, as their digital functions were connected. ➢ Negotiations have commenced with Orion Health to agree the points of clarification as part of the Connecting Care procurement. There were no concerns around the planned timeline.	
8.3	**System Estates Steering Group** ST reported that the last Estates Steering Group meeting was stood down, due to an Infrastructure Strategy Workshop scheduled for the same day. Good progress is being made on the Infrastructure Strategy and an update would be brought back to the Committee in due course.	
	Date of Next Meeting Thursday 28 March 2024 – 09:00-12:00, MS Teams	

NHS
Bristol, North Somerset and South Gloucestershire
Integrated Care Board

Finance, Estates and Digital Committee Minutes OPEN
Thursday 28 March 2024, 09:00 – 12:00, Microsoft Teams

Present		**Initials**
Steve West	Finance, Estates and Digital Committee – Chair	SW
John Cappock	Non-Executive Director - ICB	JC
Attending		
Jon Lund	Deputy Chief Finance Officer - ICB	JL
Tim James	Head of Strategic Estates (Item 5.1 only)	TJ
Helena Fuller	Deputy Director of Business & Planning – ICB (item 6.1 only)	HF
Rachel Smith	Executive Assistant (notes)	

The meeting was not quorate but it was agreed to proceed. Items requiring a decision would be referred to the CEO for approval.

		Action
1.0	**Apologies for Absence** Apologies were received from Deborah El-Sayed, ICB; Brian Stables, AWP; Rosi Shepherd, ICB; Amy Webb, North Somerset Council; Sarah Truelove, ICB; Christina Gray, Bristol City Council; Jo Medhurst, ICB; Richard Gaunt, NBT.	
2.0	**Declarations of Interest** There were no declarations of interest.	
3.0	**Minutes of the previous meeting** The minutes of the Open session held on 22 February 2024 were agreed as an accurate record of the meeting.	
4.0	**Actions from Previous Meeting** The action log was reviewed and updated accordingly.	
	To Approve	
5.3	**BNSSG Procurement Policy** Helena Fuller (HF) presented the policy, following its annual review and drew the Committee's attention to the following: • The Procurement Act of 2015 will become the Procurement Act of 2023, and go live in October 2024. • Significant elements of the policy have remained, including the ICB values, the requirement to adherence to public procurement legislation and policy, the ICB ethical framework, delivering Net Zero and the ICB's commitment to reducing and preventing Fraud, bribery and corruption. • The policy is clear that in relation to procurement of healthcare services, the ICB acts to secure the needs of the people it serves, within the law and ICB SFIs, and that all transactions are undertaken in a clear, fair and transparent manner. Key changes / additions include: • The drive for integration and working as a system and ensuring all ICB staff engage with all partners involved prior to launching a procurement process. • Clarity around seeking advice from the ICB Contracting team or the South, Central and West (SCW) Procurement Team for guidance on which procurement regulation is to be applied. • Guidance on Provider Selection Regime (PSR) which came into force on 1 January 2024, including a flowchart to support the decision making on which provider selection process is to be followed, and a flow chart to support the Commissioner during any contract modifications (including what can and cannot be modified). • Standstill period section expanded due to requirements under the PSR. • A section on record keeping, detailing what must be recorded throughout the award process, especially as records may be requested for review prior to the contract award. • Procurement thresholds to be considered for non-healthcare procurements, including supplies, works and services. This is different to the PSR which has no financial thresholds within it.	

		Action
	• Establishment of a Procurement Oversight Group to ensure the procurement policy and processes are managed and planned proactively to secure quality and value for money, and that the Contracts Register is published on the ICB website. The full Term of Reference would be added to the ICB website in due course. • Procurement SOP to be developed, which will not only align with the Procurement policy, but also with the Contracting SOP and the ICB SFIs. The Procurement SOP, which will also align with the Gateway process, will operationalise the policy and cover innovation, adoption and adaption, stakeholder management, conflict of interest management, and market engagement management. HF advised that under the ICB Scheme of Reservation and Delegation, the amended policy would not be presented directly to the ICB Board but that Committee Chairs be requested to recommend the policy to the ICB Board, if approved, and subsequently reported in the ICB Board meeting minutes. SW commended HF on the very clearly presented paper, particularly as organisations are increasingly challenging procurement outcomes and the need to ensure the ICB's processes and record keeping are robust enough to withstand scrutiny and challenge. SW also reflected on the difficulties in recruitment of procurement staff; HF echoed the difficulties and highlighted the importance in embedding commercial intelligence across and within the ICB. SW queried whether all partner organisations across the system would be implementing a similar policy and if there is a community of practice and sharing across the system. HF confirmed that the contracting function across the system did meet regularly to share knowledge and learning and also reported that the ICB ran a series of workshops and training sessions for the PSR across the system, in addition to arranging sessions to share lessons learned from procurement processes. JC welcomed the revised policy and incorporation of the learning taken from previous procurements. JC reflected on the training and awareness to support the process further and the possibility of identifying a specific cohort of people whose procurement skills could be developed. JL also welcomed the policy, and in response to JC's query regarding training, advised that as part of the "Shaping Our Future" consultation, Standard Operating Procedures and standard ways of working would be developed in mitigation to the reduction in staff numbers, along with training for staff to increase capability. In accordance with the ICB Scheme of Reservation and Delegation, the Committee approved the policy but as the Committee was not quorate, SW would liaise with the CEO ahead of the ICB Board meeting to advise him of their approval, for inclusion within the CEO's report for the ICB Board.	
	To Discuss	
6.1	**2024/25 Programme of Deep Dives** SW explained the background behind the requirement for a programme of deep dives, developed to provide assurance to the Board around the system financial position. JL presented the programme that had been developed, based on a high-level assessment of the greatest risks and where ICB-level support may be required. Funded Care had been identified as the first area for a deep dive, as it was the biggest individual risk for the ICB. The acute sector had been identified for subsequent months, due to the ongoing work to finalise the operational plan and based on their current financial positions and levels of risk. Deep dives on Elective Care and whole system benchmarking opportunities for 2025/26 savings programmes would follow in August and September. JC and SW approved the proposed approach and sequencing; JL would draft a communication to be sent regarding the deep dives, which would be shared with Committee members prior to circulation.	JL
	Finance Report	
7.1	**M11 Finance Report ICB & System inc Capital ICB Savings Report** JL presented the Finance Report and highlighted the following: ➢ The ICB continues to report a year to date and forecast breakeven position for the year. ➢ NBT reported further deterioration, which has been mitigated in-year but would compromise the level of flexibility going into the new financial year.	

	To Note	
	➢ Retrospective funding has been received for the industrial action that took place in December, January and February. A deficit was technically reported in M10 as the funding had not been received at that point. ➢ From an ICB perspective, the run rate of funded care has stabilised but was not yet reducing. The underspend in Dentistry continues and there have been further benefits in savings in prescribing, as reported in previous months. ➢ Challenges continue at a national level with a high level of scrutiny on all budget plans. ➢ Collaborative working with NBT enabled the purchase of IT equipment in-year to offset ICB underspend on Capital due to slippage on Central Weston project, thereby eliminating the risk of a loss in capital funding.	
8.1	**System DoFs Group** JL reported that discussions continued around plans for 2024/25. An extraordinary DOFs meeting was held on 27 March to review and discuss the changes in workforce pre-pandemic to date, in terms of staffing numbers, usage, funded budget changes, to help to identify the most obvious areas of focus. The consensus view of the DOFs was fundamentally that the choices and investments were made were appropriate and are now delivering the benefits. Examples include revision of the urgent care pathways to support de-escalation and reducing escalation capacity. The DOFs were collating their conclusions to present to the System Executive Group, in addition to this Committee.	
8.2	**Digital Delivery Board (DDB) Update** Seb Habibi (SH) presented the update report and highlighted the following: ➢ A digital incident occurred 22 – 26 February resulting in slow internet connection speed / breakdown which affected 3 GP practices. Whilst it was fortunate that the incident occurred over a weekend, it did expose a lack of understanding within the ICB of the supply chain and appropriate escalation procedures. The ICB was working with the CSU to implement lessons learned from the incident to improve resilience and to also develop an interim incident response protocol which would enable a co-ordinated and informed response for any similar events that may occur in the future. ➢ An issue had been escalated to the DDB regarding the sharing of maternity data between Trusts and the local authorities. The Trusts have concluded that they not able to share the data but discussions continue between the LAs and Trusts to identify alternative options. ➢ The DDB endorsed proposals from the Clinical Informatics Cabinet (CIC) to: • Revise their Terms of Reference to strength the role of the CIC in Digital system governance; • Appointment of new Chair and Vice-Chair; • Conduct a strategic review of the Digital Strategy. ➢ A reset of the Shared Data and Planning Platform (SDPP) has concluded and a revised OBC would be developed for Board approval in September. ➢ The 12 month Forward Plan for Digital Issues was presented, and includes items for assurance and deep dive items. The Forward Plan was noted by the Committee.	
8.3	**System Estates Steering Group** JL reported that work continued around the Central Weston project and further workshops have bene held to develop the ICB Infrastructure Strategy. It was noted that a national deadline was still awaited around the requirements for the Infrastructure Strategy but it was noted that propositions from the Labour Party around capital infrastructure investments may be more generous than currently. Sarah Truelove and Tim James had also been meeting with local authority colleagues to discuss their plans for housing / capital estates projects.	
	Date of Next Meeting Thursday 25 April 2024 – 09:00-12:00, MS Teams	