Agenda item: 7.1

Report title: ICB Finance Report

Report on the financial performance for May 2024 (M2 – 2024/25)

1. Executive Summary

The ICB's initial allocation is £2,185.713m, in line with the annual plan submission.

At month 2 the ICB reported a £0.267m deficit to plan which is entirely related to unidentified savings in funded care at the end of month 2. During June the Executive Team approved the funded care savings plan which is expected to address the current variance.

A detailed forecast will be undertaken in all programme areas at month 3 and reported to Committee in July.

2. Risks and mitigations

The risks and mitigations associated with the delivery of the ICB financial position are summarised in the table below.

Risks	Mitigations
The financial challenge faced by local authorities could impact social care costs in the ICB leading to unfunded cost pressures	Continued engagement with Local Authorities and commitment to work together to reduce the overall costs.
Funded care and placements – management of in year costs and development and delivery of savings plans	Savings plan approved by the Executive team during June. Regular meetings between Deputy Chief Executive and Chief Finance Officer and Chief Nursing Officer to monitor performance.
Unfunded inflationary pressures leading to an increase in costs over and above funded inflation levels	Monitor the year-to-date inflationary pressures and impact within the overall financial position, including the investment reserves.

3. Financial duties and financial performance metrics

The in-month assessment of delivery against the ICB's financial duties are three on plan (green) and two at risk (amber).

Duty	RAG	Position
Maintain expenditure within the revenue resource limit *(Section 5)*	A	The ICB is reporting an adverse variance of £0.267m against a year-to-date budget of £362.789m. The variance relates to unidentified savings in funded care
Ensure running costs are within the running cost resource limit. *(Section 5)*	G	The running costs are on plan. The ICB continues to actively review the required reduction in running costs allocations with a focus on identifying the required non pay reductions in 2025/26

Duty	RAG	Position
Maintain capital expenditure within the delegated limit *(Section 7)*	G	The 2024/25 capital programme is £8.541m; £1.661m ICB allocation and £6.880m system CDEL prioritised capital. The ICB capital schemes have been submitted to NHSE for approval.
Maintain expenditure within the allocated cash limit *(Section 8)*	G	Cash draw down at the end of month 2 is ahead of monthly profile by 0.06% (£13.174m) however the closing cash position was £21.644m due to delay in receiving and authorising of local authority invoices and the receipt of cash inflows ahead of forecast.
Ensure compliance with the better payment practice code *(Section 9)*	A	Performance target requires 95% of non-disputed invoices to be paid within 30 days. The ICB met the value target however did not meet the target for the volume of NHS paid (93.4%)

4. Revenue allocation

The initial allocation received at month 2 was in line with the ICB's financial plan as summarised below.

Programme Area	Confirmed Initial ICB allocation £m
Acute Contracts	1,090.937
Mental Health	243.278
Community Services	223.013
Delegated Primary Care	269.848
Medicines Management	163.374
Primary Care	34.965
Funded Care	130.812
Childrens Services	21.369
Support costs	8.279
Reserves	(15.689)
Commissioning Budget	**2,170.185**
Running Costs	15.528
Total Allocation 2023-24	**2,185.713**

5. Financial position May 2024 (Month 2)

At month 2 the ICB reported a year-to-date deficit of £0.267m. The senior finance team undertook a high-level review of the month end position identifying exceptional reporting items. A detailed month end and forecast position will be undertaken for month 3 and reported in the June report.

2024/25 May 2024 - Month 2	2024/25 Budget	Year To Date Budget	Year To Date Expenditure	Year To Date Variance	
Programme Area	£m	£m	£m	£m	
Acute	1,090.937	180.473	180.473	-	
Mental Health	227.206	37.721	37.721	-	
Community	223.013	37.169	37.169	-	
Delegated Primary Care	269.848	44.975	44.975	-	
Medicines Management	163.374	27.229	27.229	-	
Primary Care	34.965	5.828	5.828	-	
Funded Care	130.812	21.802	22.069	(0.267)	
Childrens	37.441	6.240	6.240	-	
Support Costs	8.279	1.380	1.380	-	
Reserves	(15.689)	(2.615)	(2.615)	-	
Running Costs	15.528	2.588	2.588	-	
BNSSG ICB Surplus/(Deficit)	**2,185.713**	**362.789**	**363.056**	**(0.267)**	
Provider Surplus/Defict					
AWP	-	-	-	-	
NBT	-	(3.976)	(6.904)	(2.928)	
UHBW	-	-	(6.322)	(6.322)	
Provider Surplus/(Deficit)	**2,185.713**	**(3.976)**	**(13.226)**	**(9.250)**	
ICS Position	**2,185.713**	**358.813**	**349.830**	**(9.517)**	

The year-to-date adverse variance is due to the impact of unidentified savings schemes within funded care (see section 6 below).

System position

As reported in the above table the ICS is reporting a year-to-date adverse variance of £9.517m, £0.267m for the ICB and £9.250m with the providers. The Deputy Chief Executive and Chief Finance Officer has met with the providers to understand the drivers of the adverse variances and obtain assurance on corrective actions, which will be reported through the Performance and Recovery Board.

6. Efficiencies

The total ICB savings plan is £35.693m, £32.967m per the planning submission and an additional £2.727m in funded care due to the final exit run rate from 2023/24. The savings are split £24.300m within the ICB and £11.393m of provider commissioning efficiencies.

2024/25 Month 2	YTD planned net saving £ms	YTD actual net saving £ms	YTD Variance £ms	Planned Net Saving £ms
ICB savings plan				
Running Costs/Support costs	0.504	0.504	0.000	3.022
Funded Care	1.533	1.266	(0.267)	9.200
Medicine Optimisation	0.875	0.875	-	5.252
Digital Savings	0.433	0.433	-	2.600
Contract savings	0.704	0.704	-	4.226
Total ICB savings plan	**4.050**	**3.783**	(0.267)	**24.300**
Commissioning efficiencies				
NHS Providers inside system	1.762	1.762	-	10.574
NHS Providers outside of system	0.137	0.137	-	0.819
Total savings	**5.949**	**5.682**	(0.267)	**35.693**

At month 2 the ICB efficiency delivery was £3.783m against a plan of £4.050m. The overspend on funded care within the financial position (section 5) has impacted the year-to-date and forecast delivery of savings in funded care. The savings programme had not been fully developed at month 2 with the variance reflecting the year-to-date impact of the unidentified savings schemes. During June the Executive Team has approved the funded care savings plans which is expected to address the current variance.

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

7. Capital allocation

The ICB's total capital allocation is £8.541m; £1.661m recurring allocation and £6.880m prioritised from system Capital Departmental Expenditure Limit (CDEL) for additional minor improvement grants, capital grants to Sirona and GPs as part of the Central Weston development site and £3.000m to Connexus PCN practice developments.

2024/25 Schemes	Asset Owner	Capital Allocation £m	Planning Virement	Capital Allocation £m
Minor Improvement Grant (MIG)	NHS England	0.331	-	0.331
MIG Equipping	NHS England	0.038	0.033	0.071
GPIT - BAU refresh	NHS England	0.942	-	0.942
GPIT - additional roles & PCN	NHS England	0.076	-	0.076
IT Corporate Refresh	BNSSG ICB	0.274	-	0.274
ICB Capital Allocation		**1.661**	**0.033**	**1.694**
System prioritisation schemes				
Additional MIG	NHS England	0.300	(0.149)	0.151
Central Weston	GP	2.580	-	2.580
Central Weston	Sirona	1.000	1.500	2.500
Connexus PCN	GP	3.000	(1.384)	1.616
Total system prioritisation		**6.880**	**(0.033)**	**6.847**
Total ICB capital allocation (excl. IFRS16)		**8.541**	**-**	**8.541**

The planning virements between schemes relates to the slippage in 2023/24 on the Sirona Central Weston scheme which is being funded in 2024/25 from the Connexus PCN allocation and the balance on additional MIGs, which was reassessed to £0.184m before the virement of £0.033m to MIG equipment.

All ICB capital allocations must be submitted to NHSE for approval. The ICB capital allocations and additional MIG schemes were submitted in June. Once approval is received the delivery plans will be finalised and profiled to deliver in the latter part of the financial year with expenditure not expected to be incurred until quarter 2.

The Central Weston business case has been approved by NHSE with the Head of Strategic Estates and Associate Chief Finance Officer liaising with NHSE regarding the mechanism for transferring the funds which are forecast for September (month 6) and December (month 9).

8. Statement of Financial Position

The closing balance sheet at month 2 was £93.780m compared to 2023/24 closing position of £108.136m. The £14.355m movement is the net of an increase in cash of £20.966m and reductions in working capital balances and other movements of £6.529m and £0.080m respectively.

The closing cash at bank position for month 2 was £21.644m. NHSE monitor the ICB on the closing cash at bank balance (1.25% of monthly drawdown), which for month 2 equates to £2.063m. The ICB missed this target due to £12m of local authority invoices where were either disputed or not received on a timely basis and higher than forecast cash inflows as invoices were paid ahead of payment terms.

9. 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 has met its target for the value of NHS and Non-NHS invoices for the year to date and in month position. The volume of payments was met for Non-NHS supplies however below target for NHS payments due to delays in approving disputed CSU invoices. The ICB is confident this will improve as the financial year progresses as budget holders have been reminded to put disputed invoices on hold.

Type	In month	Number	£m
NHS	Total bills paid in month	99	103.495
	Total bills paid within target	89	102.485
	% bills paid within target	**89.90%**	**99.02%**
Non NHS	Total bills paid in month	2,514	60.366
	Total bills paid within target	2,460	58.686
	% bills paid within target	**97.85%**	**97.22%**

Type	Year to date	Number	£m
NHS	Total bills paid in year	197	198.260
	Total bills paid within target	184	197.170
	% bills paid within target	**93.40%**	**99.45%**
Non NHS	Total bills paid in year	5,019	141.240
	Total bills paid within target	4,942	135.861
	% bills paid within target	**98.47%**	**96.19%**

10. Recommendations

The committee are asked to note the financial position as of month 2.

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BNSSG System Finance Report (May 2024)

Finance, Estates & Digital Committee

Thursday 27th June 2024

Key Messages

Overall Revenue Performance

- All organisations in the system have submitted a break-even plan for 2024/25, although identified net unmitigated risk of £5.8m on submission of plans to NHS England.
- At the end of May (month 2), the system reported an overall **deficit against plan of £9.5m** (year to date plan £4m deficit, year to date actual £13.5m deficit).
- At system level, the two key drivers of this deficit are under-delivery against planned savings targets, and under-performance against planned levels of elective activity.

Efficiency Delivery

- The systems total efficiency plan for 2024/25 is £101.4m (of which £91.8m is planned to be delivered on a recurrent basis).
- There is significant **under-delivery against plan at the end of May, with only 60% of planned efficiencies delivered**.
- It should be noted that whilst plans are phased equally across the year (broadly in 12ths), there is a recognition that this is not reflective of likely delivery of corporate savings, which is in-part contributing to the year-to-date performance.
- Expenditure levels related to the use of agency staff continue to fall, and the system is delivering in line with plan at the end of Month 2. In totality, the system has planned to reduce agency staff expenditure by c.30% compared to 2023/24.

Elective Recovery

- Elective Recovery targets for 2024/25 have been confirmed by NHS England, are in line with the targets set for each system in 2023/24 (prior to the impact of industrial action). This equates to a target of c.103% (of 2019/20 activity baselines) for the system.
- Financial plans assumed a level of performance over and above this target, and failure to deliver in line with plan in the first two months of this year is driving part of the reported financial deficit.
- Further work is underway to understand the impact of national changes to the calculation of baselines (and therefore targets), on planned levels of elective recovery funding, and further updates will be provided to future meetings.

Key Messages (2)

Capital Expenditure

- The system has submitted a capital expenditure for 2024/25 totalling £168m, of which £41.4m is funded through national allocations over and above the systems Operational Capital allocation.
- Planned spend counting against the systems Operational Capital Allocation (excluding IFRS16 expenditure) is £81.9m, in line with the total notified allocation.
- At planning stage, the system has a potential £2.4m over-commitment against it's notified allocation relating to IFRS16 expenditure. In 2023/24, this was managed at a regional level, and will continue to be monitored during the year.

Cash

- There is planned reduction in the overall system cash position of c.£82m in 2024/25, from a balance of £183m at the end of March 2024, to a planned balance of £101m at the end of the financial year.
- The cash position will continue to be monitored closely, noting that the additional operational capital the system received as an incentive for delivering a break-even plan in 2024/25 does not come with additional cash resource.

Next Steps

- Financial and Operational performance is monitored through the recently established BNSSG Performance & Recovery Committee. Through this committee, all organisations have signed up to an 'escalation framework' to ensure that processes and governance is in place to ensure organisations have a planned approach to recovering deviations from planned operational and financial performance.
- In following this approach, and based on the performance reported at Month 2, it is anticipated that a number of specific divisions within organisations will be subject to local application if the escalation framework, and supported to ensure there are plans in place to recover to planned trajectories.
- As part of the Month 3 reporting process, all organisations will undertake an updated to forecast out-turns for 2024/25 on both revenue and capital positions, and activity trajectories.
- Continued dialogue with regional NHS England colleagues to explore opportunities to access additional capital resource, including the national contingency and minimise the risk of any overspend against the notified capital allocation.

System Financial Performance Overview

1. Forecast Surplus / (Deficit)

£0.0m breakeven

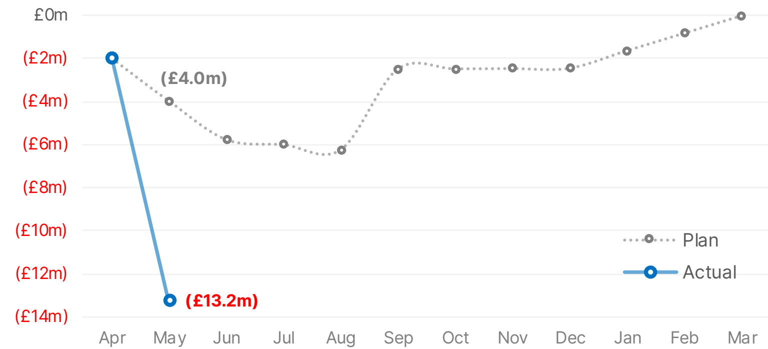
Forecast surplus / **(deficit)** v plan

Organisation	Plan	Actual	YTD Variance	FCST Variance
UHBW	£0.0m	(£6.3m)	(£6.3m)	**£0.0m**
NBT	(£4.0m)	(£6.9m)	(£2.9m)	**£0.0m**
AWP	£0.0m	£0.0m	£0.0m	**£0.0m**
NHS Providers	**(£4.0m)**	**(£13.2m)**	**(£9.2m)**	**£0.0m**
BNSSG ICB	£0.0m	(£0.3m)	(£0.3m)	**£0.0m**
Total System	**(£4.0m)**	**(£13.5m)**	**(£9.5m)**	**£0.0m**
Previous Month			-	-

2. YTD Cumulative Surplus / (Deficit)

£9.5m variance to plan

Year to Date surplus / **(deficit)** v plan



3. Risk to Forecast Outturn

-0.2%

Unmitigated risk as a % of ICB allocation

Gross Risk	(£29.7m)
Gross Mitigations	£23.9m
Net Unmitigated Risk	**(£5.8m)**
Net Risk as a % of ICB allocation	**-0.2%**
Risk adjusted forecast out-turn	**(£5.8m) deficit**
Previous Month	£0.0m

4a. YTD Efficiency Delivery

£6.6m below plan

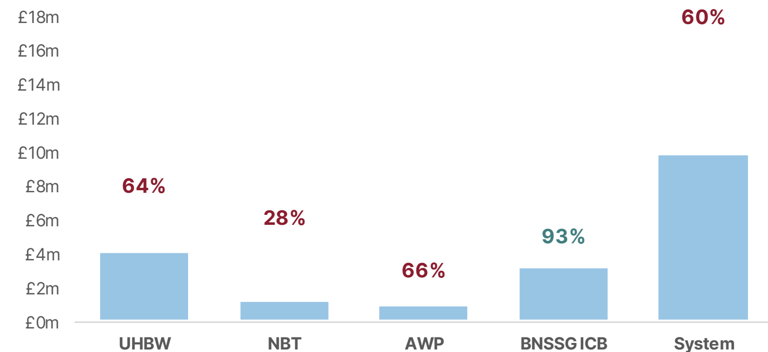
Year to date delivery v plan

Organisation	Plan	Actual	YTD Variance	FCST Variance
UHBW	£6.6m	£4.2m	(£2.4m)	**£0.0m**
NBT	£4.7m	£1.3m	(£3.4m)	**£0.0m**
AWP	£1.6m	£1.1m	(£0.6m)	**£0.0m**
NHS Providers	**£12.9m**	**£6.6m**	**(£6.3m)**	**£0.0m**
BNSSG ICB	£3.6m	£3.4m	(£0.3m)	**£0.0m**
Total System	**£16.5m**	**£10.0m**	**(£6.6m)**	**£0.0m**
Previous Month			-	-

4b. YTD Efficiency Delivery by Org.

60%

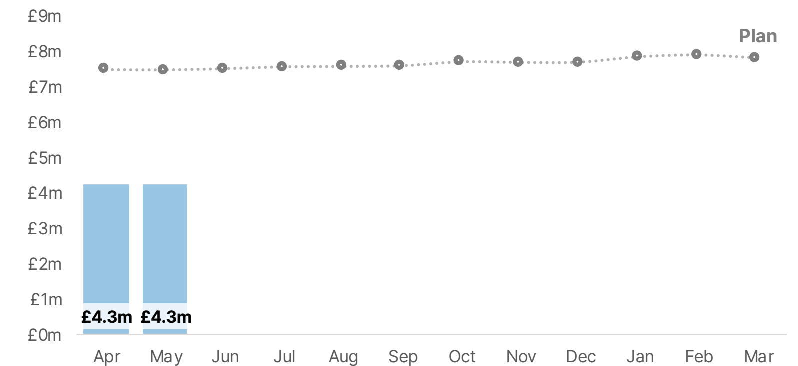
Year to date delivery v plan



4c. System RECURRENT Efficiency

57%

Monthly delivery v plan



System Financial Performance Overview (2)

5. System Agency Expenditure

3.6%

Agency Costs as a% of Total Workforce Expenditure

Organisation	Plan	Actual	YTD Variance	Costs as a% of Total Workforce
UHBW	£2.4m	£2.8m	£0.5m	2.4%
NBT	£3.1m	£1.9m	(£1.2m)	2.0%
AWP	£4.4m	£4.8m	£0.4m	10.1%
NHS Providers	**£9.9m**	**£9.6m**	**(£0.4m)**	**3.6%**

6. Full Year Charge Against capital Allocation

£2.4m overspend

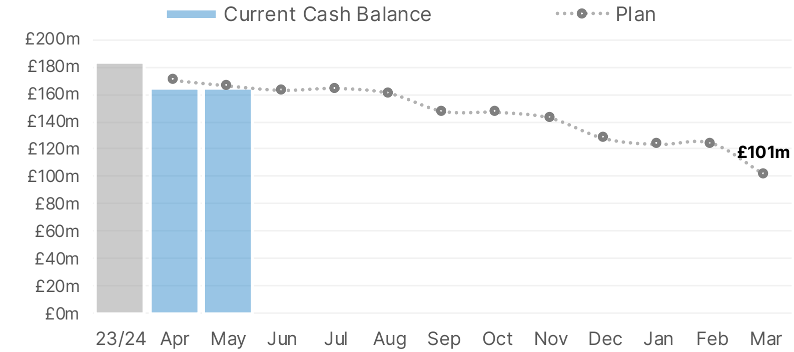
Forecast variance to plan

Combined Provider & ICB operational allocation	£81.9m
IFRS 16 CDEL uplift allocation	£17.3m
Operational Capital Allocation (including IFRS 16 uplif	**£99.2m**
Provider Forecast Expenditure	(£73.3m)
BNSSG ICB Capital Grants & Acquisitions	(£8.5m)
Provider Forecast Lease expenditure (IFRS16)	(£19.7m)
Charge against Capital Allocation	**(£101.6m)**
Forecast Variance to capital allocation	**(£2.4m)**

7. Cash Balances

£2.2m under plan

Cash and cash equivalents year to date variance v plan



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Finance, Estates and Digital Committee Minutes OPEN
Thursday 25 April 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
Christina Gray	Director of Public Health, BCC (until 10.45am)	CG
Brian Stables	Non-Executive Director, AWP	BS
John Cappock	Non-Executive Director, ICB	JC
Attending		
Jon Lund	Deputy Chief Finance Officer, ICB	JL
Denise Moorhouse	Deputy Chief Nurse, ICB (Item 5.2 only)	DM
Tim James	Head of Strategic Estates, ICB (Item 5.5 only)	TJ
Rachel Smith	Executive Assistant, ICB (notes)	RS

		Action
1.0	**Apologies for Absence** Apologies were received from Richard Gaunt, NBT; Rosi Shepherd, ICB; Amy Webb, North Somerset Council; Jo Medhurst, BNSSG ICB; Deborah El-Sayed, ICB; Martin Sykes, UHBW.	
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 28 March 2024 were agreed as an accurate record of the meeting. Steve West (SW) confirmed that where items required quoracy, those matters were referred onto Shane Devlin to ensure an appropriate audit trail of the required actions.	
4.0	**Actions from Previous Meeting** The action log was reviewed and updated accordingly.	
For discussion		
5.2	**Deep Dive: Funded Care Programme** Denise Moorhouse (DM) presented the deep dive and shared a slide deck which have been developed following a recent quarterly NHSE reporting meeting. The ICB was required to make eligibility decisions against the national framework and the quarterly reporting provided the opportunity to interrogate national and regional benchmarking data; it was noted that the ICB had been clustered with ICBs where the socioeconomic population data was similar. The following key points were highlighted: ➢ BNSSG ICB was above the 95th percentile in the number of new referrals received for Continuing Health Care (CHC) funding per 50k population when compared with comparator sites. The regional team were assured that assessments were being completed within the required 28 day period. The ICB received a high number of referrals which required screening and the benchmarking place the ICB in the middle for the numbers of individuals identified as eligible for CHC care. ➢ Conversion rates also benchmarked favourably compared against the regional and national benchmark. ➢ Funded Nursing Care (FNC) levels (the tariff paid for nursing home residents deemed s needing a level of nursing care rather than residential care) were also high, with significant increases from Q2 2022/23 onwards, resulting in a £3.1m overspend against the FNC budget in 2023/24. The ICB was obligated to contribute to the total cost of care for those funded by local authorities, social care budgets or self-funders, under the FNC tariff. This is an area over which the ICB has no control. Initial investigations identified that the cohort of individuals in receipt of LA funded care was stable but significant growth has been reported in self-funders in nursing homes, for which the ICB has to pay the FNC element. This may be multi-factorial and a deep dive into the Discharge to Assess (D2A) impact on FNC growth was being considered. SW queried whether monitoring mechanisms were in place for individuals receiving FNC and sought assurance that the increase was not being driven by private care home providers receiving FNC funding but not providing the required level of care.	

		Action
	SW declared a personal interest in relation to a family member who was in receipt of FNC (outside of BNSSG) but the care being received was not at the expected level. DM was not able to comment on individual cases but suggested a discussion to express concerns. DM also provided assurance that all individuals who were eligible for FNC in nursing homes were assessed in situ. Jon Lund (JL) reflected that it was the expectation that D2A assumes lower demand for bed-based care and mor demand for home-based car so the indication in the benchmarking indicator was contra to the assumption. More work was required to understand the implications for residential and nursing care funded by the local authorities. In response to a further query from JL, DM advised that the most significant impact from the pandemic was around end of life care and individuals avoided going into nursing homes. It was also noted that nursing homes were not admitting regularly during the pandemic and whilst covid could be attributed to some of the reporting metrics but possibly not to the increase in self-funders. DM also explained that the self-funding cohort would no longer be self-funding (due to lack of money) and would become the responsibility of the local authority; and a modelling exercise would be required to understand the short, medium and longer term impact of this on the wider system. Christina Gray (CG) agreed on a system-wide approach to manage self-funded individuals and queried the origin of some of the comparators included within the presentation, as she had not seen them previously. CG also suggested it would be useful to have a clearer understanding of the demographics of the population; it was acknowledged the majority were older people in residential nursing homes but CG queried the number of younger adults with complex care needs. DM advised that there was a CHC cohort for children and work was underway to review those reaching adulthood as life expectancy has improved significantly, and the impact of this on planning across social care and health. Nursing homes were unable to take individuals under the age of 60 and there were a number of CHC packages offered in the community, some of which were very complex. The challenge for the ICB was to establish the sustainability of offering the complex care packages in the community and a commissioning policy was being developed to support this and agree the system direction of travel. The presentation also detailed updated on a number of schemes identified to deliver the savings plan for 2024/25 (c£8m), including the actions to be taken, the intended impact and any risks / requirements. These were split into two sections – action for the ICB and actions whereby system support would be needed: **ICB Actions** ➢ Reduce the size of the main CHC caseload ➢ Higher level of scrutiny and standardised approach for all newly eligible cases ➢ Care package efficiency and reducing high-cost agency use ➢ Offer a variable inflationary uplift to care providers [COMPLETED] ➢ Maintaining Fast Track reviews ➢ Reducing choice of location of care for Fast Track CHC **ICS Actions** ➢ Enhanced Care in care homes ➢ Transforming Care Funding ➢ Resolving housing delays CG reflected that it would be useful to have sight of the granular detail related to housing – the who, what and why etc, in order for her to raise it with housing colleagues, not only within BCC but also North Somerset and South Gloucestershire. DM advised that through the work of the Transformation team, they had clearer sight of the current cohorts and could also anticipate the future cohorts from the younger population. DM also reflected on useful conversations with BCC and was not aware of the same level of conversations with NSC and SG but a system-wide Away Day had been scheduled which would hopefully present more of the data. It was noted that the current financial position reduced the ability to invest in LD but without investment, the growth in complex care would continue so further strategic work was required in this area. The upcoming away day would also provide the opportunity for a wide discussion on housing / accommodation needs, ensuring the right housing was in the right place for individuals who needed it. SW thanked DM for a helpful, comprehensive overview and reiterate the importance in the need for cross-system working with unitary authorities to build upon the modelling and work already undertaken.	

		Action
5.4	**Corporate Risk Register** Sarah Truelove (ST) introduced the report and provided an update on two risks on the Corporate Risk Register which had been assigned to FED for oversight: a. Central Weston Development: the decision for the ICB to take on the head lease (subject to NHSE approval) would enable this risk to be mitigated and closed. ST advised that a decision was awaited from the regional team and ST has also discussed with the regional Director of Finance to ensure his team understood the imperative of granting approval. b. Mental Health Community Health Redesign and Procurement: following agreement of a 2 year extension in November 2023, concerns around capacity have been raised in relation to completing the work and also the procurement. Discussions continue and a meeting with AWP scheduled for w/c 29 April 2024. A prioritisation exercise to agree the areas to be progressed initially would also be undertaken and would likely include the dementia and perinatal pathways. There was a risk to the procurement and one of the mitigations for this included keeping the market appraised of the current situation and anticipated timelines.	
5.5	**Infrastructure Update** Tim James (TJ) presented the update and reported that NHSE had issued guidance around the development of a joint ICS infrastructure strategy. The expectation was for a first draft to be submitted by 31 May, with the final strategy submitted by 31 July 2024. Both the initial draft and final strategy would be reviewed by the Regional Estates team prior to submission, and it was the expectation that the strategies would be used to support the HMT Comprehensive Spending Review (CSR), scheduled for Autumn 2024. From the ICS perspective, the infrastructure strategy provided the opportunity for a system approach to develop an integrated system Estates function. The strategy would follow three key principles: 1. Utilise our assets: understand what we already have, use it fully and efficiently, or dispose of it; 2. Prioritise our investment options: develop our evidence-base and identify our priorities; 3. Secure funding: make sure we are bringing in as much funding as we can. To support the development of the strategy, a number of workshops were held with system partner, involving representatives from workforce, digital and medical equipment teams. The challenge around this work was recognised, given the number of different organisations involved but good progress has been made to date. The final strategy would be an iterative document and would be reviewed annually. There were a number of gaps still to be worked through and this work was ongoing: 1. Capital Prioritisation – Annual CDEL Allocation 2. Capital Prioritisation – Strategic Schemes 3. Condition of Existing Estate (Core, Flex, Tail) 4. Housing Growth The draft strategy was expected to fulfil NHSE's expectations, but with the possible inclusion of further ambitions to include not only the development the integrated system Estates function but also more cohesion and integration between digital and equipment elements. ST reiterated that the ICB was in a good position with the draft strategy, and that it was important to be in a position to inform the CSR for the next 3 years. ST also echoed TJ's comments regarding the key ambition to develop a much clearer view of the current position, opportunities and challenges for the next 10 years. In terms of the future direction of travel, it was recognised that there was further work required but the strategy would ensure a stable point from which to start. SW welcomed the update and the work completed to date which has started to set the approach for further integration. CG and John Cappock (JC) commended the update and the work undertaken to date. TJ also confirmed the sequencing and timelines for the governance routes ahead of sign off ahead of the final submission were also being developed.	
	To Approve	
6.2	**Review Financial Performance content for ICB Annual Report** JL introduced the 2023/24 financial review which had been included within the draft ICB Annual Report that had been submitted to NHSE and auditors, noting that there would be an opportunity for further refinement ahead of the final submission. The Annual Report would be a public document and comments / reflections were sought around the content and the tone.	

		Action
	JC welcomed the report but suggested alterations to the content related to the organisation's approach to risk and how these have been managed. JC further reflected on whether the section could begin with highlighting the achievements of the core financial duties, for ease of reading, followed up in the latter pages with the detail. Brian Stables (BS) suggested a section which highlights the challenges and the significant work undertaken to achieve a break even position, to avoid the illusion that it had been a clear path; this was echoed by SW. It was agreed for editorial changes to be made ahead of the final submission and that the paper did not need to return to the committee for approval.	
	Finance Report	
7.1	**M12 Finance Report ICB & System inc Capital ICB Savings Report** ST advised that the full system Finance report was not yet finalised (due to the extended timetable in relation to the annual accounts cycle) but would be presented to the ICB Board on 2 May 2024. JL presented the Finance Report and highlighted the following: ➢ All breakeven targets were achieved at year end. Key messages in-month highlighted CHC funding and prescribing trends were as in previous months and the Elective Services Recovery fund was subject to a number of last minute changes from NHSE but these were resolved with no adverse or positive financial consequences. It was noted that guidance was awaited in relation to how the Elective Service Recovery Fund would operate in 24/25. ➢ Accounts were closed based on an estimate of year-end activity for electives – the benefits of this were expected to be received in the next financial year but would not affect the planning assumptions. ➢ The draft ICB Annual Report, which includes the annual accounts, was also submitted within deadline on 23 April.	
	To Note	
8.1	**System DoFs Group** ST reported that the operational planning continued to be the main area of focus but also highlighted the ongoing work by One NHS Finance in developing a talent management strategy. This would be applicable for all staff B8c and above and would be rolled out across the whole Finance team. The strategy would ensure that individuals who wish to progress in NHS Finance would have access to the relevant opportunities and also enables succession planning for critical roles. ST also reflected on the continued motivation ad momentum to stay with a balanced financial plan and the significant achievement of the historical deficit write off, which was as a result of a combined effort across the system.	
8.3	**System Estates Steering Group** The main focus of the Estates Steering Group was the development of the ICS Infrastructure strategy ST: overed as part of infrastructure strategy, and also the progression of the key worker accommodation, with wide system support.	
	Any Other Business The committee congratulated JL on his upcoming secondment to the RUH as interim Chief Finance Officer.	
	Date of Next Meeting Thursday 23 May 2024 – 09:00-12:00, MS Teams	

Healthier Together
Improving health and care in Bristol, North Somerset and South Gloucestershire

NHS
Bristol, North Somerset and South Gloucestershire
Integrated Care Board

Finance, Estates and Digital Committee (OPEN Session)

Minutes of the meeting held on Thursday 23 May 2024, 09:00 – 11:00, via Microsoft Teams

Present		**Initials**
Steve West	Finance, Estates and Digital Committee – Chair	SW
Amy Webb	Director of Corporate Services / S151 Officer – North Somerset Council	AW
Brian Stables	Non-Executive Director, AWP	BS
Deborah El-Sayed	Chief Transformation and Digital Information Officer	DES
Jeff Farrar	Chair, BNSSG ICB	JF
John Cappock	Non-Executive Director, ICB	JC
Martin Sykes	Non-Executive Director, UHBW	MS
Richard Gaunt	Non-Executive Director, NBT	RG
Sarah Truelove	Deputy CEO & CFO, ICB	ST
In attendance		
Glyn Howells	Chief Finance Officer, NBT	GH
Kerrie Darvill	Intelligence Centre Programme Director (item 5.3 only)	KD
Seb Habibi	Deputy Chief Transformation and Digital Officer (item 8.2 only)	SH
Tim James	Head of Strategic Estates, ICB (item 5.2 only)	TJ
Rachel Smith	Executive Assistant (notes)	RS

		Action
1.0	**Apologies for Absence** Apologies were received from Jo Medhurst, BNSSG ICB; Rosi Shepherd, BNSSG ICB; and Christina Gray, BCC.	
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 25 April 2024 were agreed as an accurate record of the meeting, following one minor grammatical amendment.	
4.0	**Actions from Previous Meeting** The action log was reviewed and updated accordingly.	
	Items for Discussion	
5.2	**BNSSG ICS Strategic Capital Prioritisation Process** Following the announcement of the forthcoming general election, and the potential impact on the Comprehensive Spending Review (CSR) scheduled for Autumn 2024, Sarah Truelove (ST) advised that the infrastructure strategy currently under development would be strengthened to ensure the highest priority areas were clearly articulated (as the Infrastructure strategies would be used to inform the CSR). ST also explained that the regional Finance Capital Lead would attend a Directors of Finance (DOFs) meeting in early June to discuss the capital prioritisation process and to provide clarity on both the capital and cash regimes for 24/25 and 25/26. Tim James (TJ) explained that, in a different approach from last year, the BNSSG ICB capital allocation process would be split into 3 categories, all of which would have separate prioritisation processes:	

		Action
	- Stream 1: critical risk schemes (CDEL) – funded by the system to address the high-impact risks to staff / patient safety, operational safety and operational risks. - Stream 2: Strategic capital schemes (no funding source) – to address lower-level risks or significant opportunities for the delivery of system strategic and operational benefit that unlikely to be funded via Stream 1. The agreed list of priorities to be included within the Infrastructure Strategy and revenue investment would be required for schemes to progress to business case stage. System partners would be asked to work together to agree the priorities - 5 from the acute sector and 5 from integrated / community care, and rated from one to 10 within the strategy. - Stream 3: Net Zero Schemes - £3m allocated for investment in sustainability schemes which contribute to reducing carbon emissions, improving local air quality, and staff/patient health. A template had been developed to aid the prioritisation and would include pass / fail criteria, and a scoring matrix to be applied to each scheme. The timeline for the prioritisation of the schemes ahead of the 31 July submission deadline was noted. It was also noted that the strategy was an iterative document and would continue to develop as the acute joint working and the primary and community care strategies mature and different priorities may emerge. In response to a query from Deborah El-Sayed (DES) regarding digital and data components and costs of schemes, TJ confirmed that the template included a specific section related to interdependencies, costs and digital requirements. TJ would share the template with DES for review / comment. Steve West (SW) reiterated the importance of the critical and ongoing contribution to green agendas, smart buildings (with the data and ability to control smart buildings) and continued close working relationships with planners and unitary authorities. Martin Sykes (MS) welcomed the approach but queried whether a more strategic, longer term view of schemes could be taken, i.e. schemes to be implemented in years 3 and 5 to provide more of a road map for system investments, rather than a piece meal approach. ST advised that a longer term approach was the aspiration but that this may not be possible in the first year. Work was being progressed via the System Estates Group, the Acute Provider Collaborative and Healthier Together for 2040 to support further iterations of the infrastructure strategy and ensure the ICS was in the best possible position to have a coherent strategy to support future system bids for capital funding. ST also highlighted the section within the prioritisation template regarding scheme affordability to minimise options appraisals being undertaken for schemes that would never be affordable. Brian Stables (BS) referenced the weighting within the prioritisation scoring criteria, particularly in relation to productivity and efficiency, and whether it was too low. ST acknowledged this and advised that it had been debated in some detail whilst the template was being developed. TJ advised that it may not be possible to alter the weighting percentages at this point but would review it further. SW referenced ST's earlier comment that the strategy would be iterative and also the challenge around investing capital whilst ensuring improvements, of which productivity would be part. The Digital component would ensure efficiencies, delivery of effective and better quality care, and reducing health inequalities were captured accurately.	
5.3	**Information Governance Update** Kerrie Darvill (KD) was welcomed to the meeting to provide an Information Governance (IG) update and highlighted the following:	

		Action
	<u>ICS IG Partnership working</u>: • Development of a system-level approach to IG processes and documentation, with clear, robust arrangements. Current arrangements involved system partners working with their own IG specialists, which added extra complexity and confusion, due to different interpretations of national standards and delays in signing up to sharing agreements. Furthermore, the national direction of travel was for joint controller arrangements, and less IG systems in use. • Establishment of two new groups: - a new monthly IG committee, to bring together system IG leads and data protection officers, to oversee assurance activities regarding robust practices in the use of patient / staff information and to support the delivery of quality patient outcomes and clinical safety adherence. - a new SIRO group from across partner organisations who would meet twice a year and have focussed discussions on agreed topics, share areas of learning and best practice and advise on system-wide IG improvement priorities. <u>BNSSG Information Sharing Charter</u>: • The new IG Committee would provide the required governance to oversee the BNSSG Information Sharing Charter, which had been developed to cover all types of information sharing set out in 4 key purposes in the "Data Saves Lives" national strategy: - For the direct care of individuals. - To improve population health through the proactive targeting of services. - For the planning, funding and improvement of services. - For the research and innovation that will power new medical treatments and/or the improvement of delivery to existing treatments and procedures. • The charter would simplify sharing arrangements across the ICS, enhance care provision and maintain compliance with relevant legal and regulatory obligations. • There will be a process going forward for organisations to sign up to the charter, including the requirement to meet a set of standards before they can join. • Multiple workshops have been held with providers to develop the charter and there is strong support of the proposed direction of travel. <u>ICB IG requirements and support arrangements</u>: • KD has undertaken a review of ICB roles and responsibilities to map the IG activities to be undertaken and a gap analysis would also be completed. <u>Risk Implications</u>: • Risk sharing and liabilities: entering into the Information Sharing charter will require IG risks to managed as a system. A policy would be developed to mitigate this, and would be shared with all partners. A number of other ICS' have already begun / been through the process so there were examples that could be studied. • Resistance to change (by organisation): a strong and clear communication and engagement plan would be required. • Public Concern around data usage: public communications and engagement are yet to take place but it was essential to ensure the Information Sharing Charter was understandable across the population, and that there was a mechanism for queries. • ICB Management Resources: robust processes to be in place to manage the new ways of working; this would be supported by the mapping exercise that would be undertaken to support identification and allocation of resources.	

		Action
	In terms of next steps: • First meeting of the IG Committee scheduled for 30 May would review the Terms of Reference and the Information Sharing Charter. • Information Sharing Charter to be ratified by the Digital Delivery Board • Development of a communications and engagement plan to be presented to the Intelligence Centre Programme Board in June 2024. • Completion of IG requirements vs resources gap analysis • Launch of the Information Sharing Charter – date TBC BS sought assurance that organisations would not be required to lower their current arrangements when they sign up to the Information Sharing Charter. KD confirmed that all organisations currently have the required documentation and processes to ensure compliance with the toolkit, and the documentation would be reviewed and standardised as the new IG Committee is established, whilst ensuring compliance with national standards. The new arrangements would also enable peer to peer challenge and be strengthened. BS also queried the IG SIRO group membership as AWP had been omitted; KD advised this was an error and would be amended. DES reflected that in terms of the Caldicott principles, there was a duty to share and at times, this is not achieved, with data not shared adequately. The new arrangements would strengthen this approach to deliver the high quality of care that is needed to keep people safe and integrated across the across the system. DES also confirmed that the Caldicott guardians had been involved from the outset, along with the Directors of Public Health at the local authorities, to ensure this is driven from not only a data and digital perspective, and from clinical perspective. KD advised that significant work was required in primary care and this would be supported by the appointment of a clinical lead; a recruitment process was currently underway. JF enquired whether the Information Commissioners office had been updated on the intention to implement a system-wide approach. KD confirmed that direct engagement had not taken place but would make contact to inform them of the plans to ensure a clear audit trail. DES advised that the ICB had engaged significant legal counsel, and also with DHSC and the central IG teams in NHS England but not directly with the IC office. SW referenced an ongoing project within universities and AWP and the sharing of data, specifically around students in crisis and that the universities would need to be included in any system working to ensure full use of the data sharing agreements.	
	Items for Approval	
6	There were no items for approval in the Open session.	
	Finance Report	
7	**M12 System Finance Report** ST presented, for completeness, the full M12 finance report which had not been available for the last meeting, due to financial timetabling, and the following key updates were highlighted: ➢ The challenges encountered in achieving a break-even position for year-end and the challenges ahead for 24/25 and 25/26, particularly in relation to the cash regime around capital. Additional measures have been implemented to track and monitor performance via the Performance and Recovery Board. ➢ Efficiency Delivery against plan was 81%; recurrent shortfalls are expected to be delivered in 24/25. ➢ Annual audit currently underway.	

		Action
Items to Note		
8.1	**System DoFs Group** Covered under item 7; the main focus of the DOFs centred on managing the 23/24 year end and the ongoing operational planning process.	
8.2	**Digital Delivery Board** DES presented the first Digital Strategy Quarterly Report and highlighted the following: • Overall status of the portfolio RAG rated yellow (experiencing obstacles), with the majority of programmes at a "not started", "inception" or "planning" stage. Projects currently at implementation stage either started last year or at pace in-year. • The impact of the ICB restructure and ongoing recruitment in OneCare has resulted in delays in initiating some projects. • Review of all proposals underway ensuring operational and clinical feedback is sought. • Key achievements were highlighted by exception, with some showing encouraging signs that the digital health model of care was working for patients and starting to have a positive impact, particularly for higher risk patients. • Digital Strategy Planning investments and savings for 24/25 were noted, along with the key drivers of savings to deliver financial returns on the investments. The main driver of savings for this year, in financial terms, would be from the Living Well with COPD Digital Health Hub Pilot, which was showing very encouraging signs. It was noted, however, that NHSE provided £700k funding for this 6 month pilot and a business case had been developed for continuation of the pilot. The continued challenges around short-term pilots was also recognised and was felt to be a retrograde step, which did not encourage innovation. • Recovery actions would be required to support One Care to progress the NHS App Digital Inclusion Project, which had been developed to increase usage of the NHS App. • Key risks / issues and associated mitigations were summarised. The investments approved by the ICB Board were contingent on savings delivery but it had already been acknowledged that these would not be achieved and mitigations would be required. The main mitigation was the expected underspend in the SDPP Programme, as detailed in the plan. The risks would be reviewed throughout the year and it was acknowledged that some of the expenditure may need to be slowed, re-allocated or deferred to offset any savings shortfall. Three projects had already been highlighted where progress could be slowed or expenditure deferred which would enable scope for savings delivery. Every mitigation opportunity would be reviewed to ensure benefits are delivered, in addition to the savings. In response to a query from Amy Webb (AW), Seb Habibi (SH) would share the detail behind the scale of programme investment and how they were delivering against the proposed savings. AW also queried whether it would be possible specific North Somerset data in relation to system benefits and specific targeting in relation to NHS app usage / digital inclusion; SH would share the report. SW acknowledged the difficulties in benefits realisation for digital initiatives.	
8.3	**System Estates Steering Group** Covered under item 5.2.	
	Any Other Business There was no other business.	
	Date of Next Meeting Thursday 27 June 2024 – 09:00-12:00, MS Teams	