Meeting of the ICB Board

Date: 16th January 2025
Time: 09:30-12:00
Location: Virtual, via Microsoft Teams

Agenda Number:	7.3.1		
Title:	Financial Performance – November 2024 (Month 8)		
Confidential Papers	**Commercially Sensitive**	~~Yes~~/No	
	Legally Sensitive	~~Yes~~/No	
	Contains Patient Identifiable data	~~Yes~~/No	
	Financially Sensitive	~~Yes~~/No	
	Time Sensitive – not for public release at this time	~~Yes~~/No	
	Other (Please state)	~~Yes~~/No	
Purpose: For Information			
Key Points for Discussion:			

The assurance report covers:

1. ICB Finance Report – ICB level budgets, statutory duty to breakeven, and ICB savings
2. System Finance Report – overall NHS sector of ICS, key performance metrics of System Oversight Framework and statutory duty to breakeven in year.

ICB Finance

- **Financial performance:** At month 8 the ICB is reporting a year-to-date breakeven position *(breakeven in month 7)* and continues to report a forecast (FOT) breakeven position. However, there have been a number of changes at the programme area level, with acute care worsening in particular. There is very little headroom in the delivery of the FOT.

- **Financial Duties:** The in-month assessment of delivery against the ICB's financial duties are two on plan (running costs and better payment practice code) with three at risk (maintain expenditure within the revenue limit, capital expenditure and cash limit) which is driven by the risk to delivery of the plan and from late notification of capital schemes.

- **Risks and Mitigations:** There are three mitigated risks associated with delivering forecast outturn assumptions, local authority social care costs and funded care and placements. One risk was closed in month, patient transport procurement, as the cost pressures are now reported in the financial position.

System Finance

- **Revenue YTD**: The system reported an overall year to date deficit against plan of £10.0m in line with the prior month. Variance driven by under-delivery of efficiency and elective activity levels.
- **Revenue FOT**: the system is maintaining a breakeven forecast which whilst stretching is believed to be deliverable.
- **Efficiency**: £51.4m delivered - £14.0m under-delivery (79% of overall plan being delivered) with a £93.1m (92%) forecast.
- **Capital expenditure**: forecast of £164.6m representing a potential £5.5m over-commitment which relates to IFRS16 expenditure. In 2023/24, any IFRS 16 variance was managed at a regional level.
- **Cash**: overall the system maintains a healthy cash balance and does not anticipate needing cash support in year.
- **Next steps**: Detailed route to breakeven developed by mid-January.

Recommendations:	To note the year-to-date financial position and the emerging risks and mitigations.
Previously Considered By and feedback:	ICB Finance report – summary to ICB Extended Leadership Team System Finance Report – System DoF's Group.
Management of Declared Interest:	Declarations of interest stated in meeting and recorded in Committee minutes.
Risk and Assurance:	In the current month the system reported a year-to-date deficit of £10.m, which relates to provider deficits related to under delivery of CIPs, elective recovery performance and pay costs.
Financial / Resource Implications:	This paper presents the financial position of NHS Bristol, North Somerset and South Gloucestershire ICB and ICS. The financial performance of the system is monitored via the Performance and Recovery Board where local and national escalation processes will be applied to system partners as appropriate.
Legal, Policy and Regulatory Requirements:	BNSSG is required not to exceed the cash limit set by NHS England, which restricts the amount of cash drawings that the ICB can make in the financial year. The ICB must also comply with relevant accounting standards. The ICS are required to breakeven on a cumulative basis for the financial year 2024/25. If the system finance was to

	report an adverse forecast outturn to plan, then NHS England may enact additional financial controls
How does this reduce Health Inequalities:	Annual operating plan and savings & transformation projects require assessments to be completed during the planning stages to ascertain whether there are positive, negative or neutral impacts on health inequalities.
How does this impact on Equality & diversity	Annual operating plan and savings & transformation projects require assessments to be completed during the planning stages to ascertain whether there are positive, negative, or neutral impacts in relation to the Protected Characteristics.
Patient and Public Involvement:	BNSSG ICB has given a firm commitment that where annual operating plan and savings & transformation projects look to deliver services in a different way specific patient and public involvement programmes will be carried out to ensure direct involvement.
Communications and Engagement:	The financial position of the ICB is subject to regular reporting and review by the Finance Estates and Digital Committee and public Governing Body. In addition, the ICB has regular meetings with NHSE to review performance throughout the year. Planning, Savings and Transformation project leads are working with communication representatives to facilitate engagement with patients, the public and stakeholders when appropriate. Their feedback is sought on a number of proposals which aim to improve services and increase efficiency.
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Sponsoring Director / Clinical Lead / Lay Member:	Sarah Truelove, Deputy Chief Executive and Chief Finance Officer

Agenda item: 7.3.1.1

Report title: ICB Finance Report

Report on the financial performance for November 2024 (M8 – 2024/25)

1. Executive Summary

At month 8 the ICB is reporting a year-to-date breakeven position *(breakeven in month 7)* and continues to report a forecast breakeven position. However, there have been a number of changes at the programme area level – in particular the acute forecast outturn (FOT) has worsened by £3.4m to a £.2m overspend (as a result of variable activity overperformance being recognised for high cost drugs and non-ERF independent sector), this has been offset by improvements in the reserves position through a combination of the forecast drugs overspend no longer being held against this figure and a further deployment of general reserves.

There is very little scope to deviate from the assumptions in the FOT and therefore there is increased risk of not delivering the breakeven position. In line with the system forecast outturn change protocol the ICB will introduce programme review meetings where the lead director, budget holder, contract manager and head of finance will meet with the Chief Executive Office and Deputy Chief Executive Officer and Chief Finance Officer for services considered to be in escalation. We have also agreed a number of actions relating to the acute spend.

The ICS is reporting a year-to-date deficit of £10.0m attributable to the acute provides with AWP and ICB breaking even in line with the prior month. A The main drivers are savings underperformance (£14.0m YTD) and ERF delivery behind plan. Full year forecast is a breakeven however there is significant risk being managed to deliver this.

The next step agreed at the Performance and Recovery Board is a detailed forecast exercise based on the M8 numbers and development.

Capital is expected to deliver inline with the allocation received.

2. Risks and mitigations

The risks and mitigations associated with the delivery of the ICB financial position, as continue to be reported in the directorate risk register, are summarised in the table below.

Risks	Mitigations	Open/Closed
Non delivery of forecast outturn assumptions could impact the delivery of a breakeven position.	Forecast outturn change protocol enacted with the step up of programme review meetings between the Deputy Chief Executive and Chief Finance Officer and the Executive programme lead and key stakeholders.	Open

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.	Open
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.	Open

3. Financial duties and financial performance metrics

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

Duty	RAG	Position
Maintain expenditure within the revenue resource limit *(Section 5)*	A	Although the ICB is reporting a breakeven year to date and forecast position there is no scope for further cost pressures or investment commitments. The ICB must ensure the assumptions within the forecast position are delivered in order to secure a breakeven position at year end.
Ensure running costs are within the running cost resource limit. *(Section 5)*	G	The running costs are ahead of plan by £0.044m due to timing issues but is forecasting to breakeven by year end. 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.
Maintain capital expenditure within the delegated limit *(Section 7)*	A	The 2024/25 capital programme is £25.8m; £1.7m ICB allocation, £6.9m system CDEL prioritised capital and £17.3m Wave 4 national funds (based on the assumption Thornbury and Central Weston are approved). The delay in NHSE approving the ICB allocations may impact the delivery plan for year end. The ICB continues to liaise with NHSE and key stakeholders on Central Weston, Connexus and Thornbury Health Centre to agree governance and funding mechanisms.
Maintain expenditure within the allocated cash limit *(Section 8)*	A	Cash draw down at the end of month 8 is ahead of monthly profile by 1.5%, after adjusting for the closing cash balance. The noncash transactions impacting the financial position (e.g. release of provisions) and anticipated NHSE allocations impact the year-to-date cash requirement.
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 continues to meet the target.

4. Revenue allocation

The annual allocation has increased by £16.1m in month to £2,291.3m. The majority of allocations received in month related to ERF overperformance (£14.5m), this funding has previously been included in expected allocation to offset observed performance at relevant providers. Other significant allocations were received in respect of the Talkin Therapies (£0.4m) and NHSE funding for ambulance service (£0.4m).

Programme Area	Confirmed Initial ICB allocation £m	Prior Months Allocation Changes £m	Adjustments in Month		Baseline Allocation at 30-Nov-24 £m
			SDF/Other allocations £m	Internal Budget adjs £m	
Acute Contracts	1,090.937	47.469	*14.416*	*0.000*	**1,152.822**
Mental Health	220.492	5.361	*0.483*	*0.011*	**226.347**
Community Services	223.013	11.642	*0.013*	-	**234.668**
Delegated Primary Care	269.848	11.399	*0.131*	-	**281.378**
Medicines Management	163.374	0.062	*0.001*	-	**163.437**
Primary Care	34.965	4.354	*0.123*	*0.075*	**39.517**
Funded Care	130.812	0.174	-	-	**130.986**
Childrens Services	44.154	2.857	-	-	**47.012**
Support costs	8.279	3.642	-	-	**11.920**
Reserves	(15.689)	2.362	*0.966*	*(0.086)*	**(12.447)**
Commissioning Budget	**2,170.185**	**89.321**	**16.133**	**-**	**2,275.639**
Running Costs	15.528	0.150	*0.000*	-	**15.678**
Total Allocation 2024-25	**2,185.713**	**89.471**	**16.133**	**-**	**2,291.317**

5. Financial position November 2024 (Month 8)

At month 8 the ICB is reporting a year-to-date and forecast breakeven position.

2024/25 November 2024 - Month 8	2024/25 Budget	Year To Date Budget	Year To Date Expenditure	Year To Date Variance		Forecast Outturn	Forecast Outurn Variance		Appendix Ref
Programme Area	£m	£m	£m	£m		£m	£m		
Acute	1,152.822	784.519	793.658	(9.139)		1,166.602	(13.780)		A1
Mental Health	226.347	150.983	154.064	(3.080)		230.081	(3.734)		A2
Community	234.668	156.587	157.153	(0.566)		235.638	(0.970)		A3
Delegated Primary Care	281.378	191.218	190.992	**0.226**		280.395	**0.983**		A5/A6
Medicines Management	163.437	108.979	106.997	**1.982**		160.483	**2.954**		A7
Primary Care	39.517	26.516	26.552	(0.037)		39.569	(0.052)		A4
Funded Care	130.986	87.324	91.745	(4.421)		136.412	(5.426)		A8
Childrens	47.012	31.340	31.082	**0.258**		46.620	**0.392**		A9
Support Costs	11.920	7.512	7.818	(0.306)		12.581	(0.661)		A10
Reserves	(12.447)	4.600	(10.483)	**15.082**		(32.742)	**20.295**		-
Running Costs	15.678	10.040	10.040	(0.000)		15.678	-		A11
BNSSG ICB Surplus/(Deficit)	**2,291.317**	**1,559.616**	**1,559.616**	(0.000)		**2,291.318**	**-**		
Provider Surplus/Defict									
AWP	-	-	-	-		-	-		
NBT	-	(2.451)	(6.110)	**(3.659)**		-	-		
UHBW	-	-	(6.318)	**(6.318)**		-	-		
Provider Surplus/(Deficit)	**2,291.317**	**(2.451)**	**(12.428)**	(9.977)		**2,291.318**	**-**		
ICS Position	**2,291.317**	**1,562.067**	**1,572.044**	(9.977)		**2,291.318**	**-**		

Although the year-to-date position is reporting a breakeven position there continues to be overspends over £1m in the acute (£9.1m), funded care (£4.4m) and mental health (£3.1m) programme areas.

The adverse variances are offset by over delivery of savings within medicines management (£1.9m), slippage on investments and release of provisions and reserves (combined £15.1m).

Programme status to date

The programme areas are rated on variance from budget with ,1% rated green, between 1% and 2% amber and over 2% red. The programme areas with amber and red ratings are reported below.

Acute (A1)
The Acutes budget year-to-date is overspent by £9.2m, this has deteriorated by £3.4m from the prior month, this deterioration is as a result of activity in the independent sector that is outside the scope of ERF (£1.0m but represents a YTD figure), £0.3m on the ambulance contract and the residual £2.1m relating to high cost drugs which had previously been shown as a risk against reserves.

The forecast position is an overspend of £13.8m. Main drivers for the year-to-date and forecast overspend in the SWASFT ambulances contract, overspend in high cost drugs and overperformance in variable diagnostics activity.

Overspend in variable diagnostic activity is being monitored for activity and finance patterns through the Elective Recovery Operational Delivery Group meetings led by the ICB Performance Team.

Mental Health (A2)
The year-to-date position presents an overspend of £3.08m which includes section 117 placements of £1.8m and ADHD patient choice of £1.2m.
The year-to-date charges from local authorities are due to ongoing growth in service user numbers and an increase in existing package costs. This remains a significant area of concern over rising costs which the ICB does not directly have control over.

The forecast position is showing an overspend of £3.7m attributable to s117 placements of £2.7m and the impact of Patient Choice on ADHD and Autism £1.8m.

Work is underway with budget holders to test funding arrangements are reviewed to ensure patients get timely reviews and the ICB ensure value for money.
The finance team is working with the budget holder and local authorities to reconcile the data and ensure the charges and forecast assumptions are complete and accurate.

Funded Care (A8)
The year-to-date position presents an overspend of £4.4m *(£4.0m in month 7*). The position was expected to improve as the full savings plan is implemented but has seen an increase to the adverse variance by £0.4m. The adverse position is predominately attributable to an increase of eligible patients in receipt of care under Adult Fully Funded CHC (LD).

The forecast assumptions continue to anticipate an improvement over the remainder of the year as the full savings plan (£6.5m budgeted and £6.7m forecast) for 2024/25 is implemented. The year-to-date position includes savings delivered from all of the eight schemes planned for implementation this financial year (year-to date achievement, £3.26m).

The forecast overspend has seen an increase in month of £1.4m from £4.0m to £5.4m. The run rate through to the year-end includes the delivery of £3.5m from saving schemes. There is concern that the reported forecast could worsen if the impact of the savings schemes is less than anticipated, further work is underway to assure the reported position, and to explore options to provide further mitigation.

Support Costs (A10)
The year to date and forecast overspends continue to be driven by higher than budgeted charges from NHS Property Services and Community Health Partnerships in respect of the ICB's programme estates and void spaces. The forecast is based on charges received for the first two quarters of the financial year, work is continuing between finance and estates teams to investigate to ensure these charges are accurate and appropriate. Further charges have been received in M7 relating to the procurement challenge legal fees which were not budgeted for.

Forecast Outturn

The ICB continues to forecast a breakeven position. M7 has seen small favourable movements in most programme areas however these have been offset by the significant worsening of the funded care position as detailed above.

There is very little scope to deviate from the assumptions in the FOT and therefore there is increased risk of not delivering the breakeven position. In line with the system forecast outturn change protocol the ICB will introduce programme review meetings where the lead director, budget holder, contract manager and head of finance will meet with the Chief Executive Office and Deputy Chief Executive Officer and Chief Finance Officer to explain the main drivers of the financial position and what recovery actions will be taken, where necessary. These will be stood up formally during November.

System position

The ICS is reporting a year-to-date deficit of £10.0m attributable to the acute provides with AWP and ICB breaking even in line with the prior month. A The main drivers are savings underperformance (£14.0m YTD) and ERF delivery behind plan. At a combined provider level income is £52.5m ahead of plan YTD (£70.9m FOT) with pay costs (£25.7m YTD, £33.9m FOT) and non-pay (£36.8m YTD and £37.0m FOT) exceeding planned levels.

The next step agreed at the Performance and Recovery Board is a detailed forecast exercise based on the M8 numbers and development.

The current forecast outturn is breakeven across the system however local financial recovery actions are in place at the acute providers and phase two of the forecast outturn change protocol has been triggered including the engagement of external peer review to provide assurance on financial delivery arrangements.

The Performance and Recovery Board received an update of the system forecast assessment and peer review feedback on the acute providers self-assessments. The

next step agreed at the Board is a detailed forecast exercise based on the M8 numbers and route to breakeven, this work is expected to conclude during January.

Full details of the financial position are reported in the attached System Finance Report.

Failure to deliver the system breakeven position will result in intervention by NHS England through the appointment of mandated management consultants to improve the financial performance through imposing spending controls, increased monitoring and control arrangements from NHSE with less autonomy within the system and reduced access to revenue and capital funding in 2025/26.

Capital is expected to deliver in-line with the allocation received.

Payroll overview

Included in the financial position are the pay costs, as summarised below. The funded establishment is currently underspent with a variance to date of £0.5m and the pay costs funded from other sources overspent by £0.3m generating a net underspend variance of £0.2m (£0.2m over on admin costs and £0.4m under on programme). The management accounts team continue to work with the people directorate and line managers to confirm the funding sources of all externally funded posts to ensure funding or recharge arrangements in place.

Source of funds	Admin/ Programme	Full year funding £m	YTD funding £m	YTD spend £m	YTD variance £m	Forecast Outturn £m	Forecast variance £m
Funded Establishment	Admin	11.485	6.699	6.717	(0.018)	11.673	(0.188)
	Programme	11.607	6.770	6.253	0.517	11.133	0.474
Total funded Establishment		**23.091**	**13.470**	**12.970**	**0.499**	**22.806**	**0.285**
Other Funding source	Admin	1.307	0.797	0.974	(0.177)	1.595	(0.288)
	Programme	1.986	1.134	1.244	(0.110)	2.185	(0.199)
Total Other funded posts		**3.293**	**1.932**	**2.218**	**(0.286)**	**3.780**	**(0.487)**
Grand total		**26.384**	**15.402**	**15.188**	**0.213**	**26.585**	**(0.202)**

		Full year funding £m	YTD funding £m	YTD spend £m	YTD variance £m	Forecast Outturn £m	Forecast variance £m
Analysed by	Admin	12.792	7.497	7.691	(0.194)	13.268	(0.477)
	Programme	13.592	7.905	7.497	0.407	13.317	0.275
Grand total		**26.384**	**15.402**	**15.188**	**0.213**	**26.585**	**(0.202)**

6. Efficiencies

The total ICB savings plan is £33.0m per the planning submission. Within the total savings target there is £11.4m of provider commissioning efficiencies which 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.

2024/25 Month 8	YTD planned net saving £ms	YTD actual net saving £ms	YTD Variance £ms	Planned Net Saving £ms	FOT Net Saving £ms	Variance to Plan £ms
ICB savings plan						
Running Costs/Support costs	2.0	2.0	-	3.0	3.0	-
Funded Care	4.3	3.3	(1.1)	6.5	6.7	0.2
Medicine Optimisation	3.5	6.5	3.0	5.3	7.9	2.6
Transformation Savings	1.7	1.1	(0.7)	2.6	2.7	0.1
Contract savings	2.8	2.8	-	4.2	4.2	-
Total ICB savings plan	**14.4**	**15.7**	1.3	**21.6**	**24.5**	**2.9**
Commissioning efficiencies						
NHS Providers inside system	7.0	7.0	-	10.6	10.6	-
NHS Providers outside of system	0.5	0.5	-	0.8	0.8	-
ICB Total Savings (per submission)	**22.0**	**23.3**	**1.3**	**33.0**	**35.9**	**2.9**

At month 8 the ICB efficiency delivery was £15.7m against a plan of £14.4m, ahead of plan by £1.3m. The funded care and medicines optimisation profiles have been set at scheme level with a number of funded care schemes profiled to deliver later in the financial year. Transformation savings schemes are assessed against investment plans to establish the net investment and savings impact for this financial year and the impact on future savings assumptions – YTD savings are £0.7m behind plan but are forecast to recover by year end.

The medicine optimisation schemes continue to over deliver year to date (£3.0m) and forecast due to additional savings on direct oral anticoagulants (Apixaban).

As reported in section 5 the funded care savings delivered to month 8 are now from all eight schemes planned for implementation this financial year, however YTD delivery is £1.1m behind plan, forecast to recover to a slight over-delivery.

7. Capital allocation

The ICB's total capital expected allocation is £25.8m (; £1.7m recurring allocation, £6.9m 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 £17.2m for national schemes £2.8m for Central Weston and £14.4m for Thornbury Health Centre (noting the full allocation is not yet approved pending business case review – however has been included here for completeness).

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	(0.300)	-
Central Weston	GP	2.580	-	2.580
Central Weston	Sirona	1.000	1.500	2.500
Thornbury (system contribution)	Local authority	-	1.800	1.800
Connexus PCN	GP	3.000	(3.000)	-
Total system prioritisation		**6.880**	-	**6.880**
Other Capital Sources				
Wave 4 STP - Thornbury	Local Authority	1.123	13.277	14.400
Wave 4 STP - Central Weston	Tbc	-	2.826	2.826
Total other capital sources		**1.123**	**16.103**	**17.226**
Total ICB capital allocation (excl. IFRS16)		**9.664**	**16.136**	**25.800**

In October the ICB received approval for the recurrent allocation schemes and therefore delivery plans are being finalised and profiled with expenditure not expected to be incurred until quarter 3 or 4.

The Central Weston development continues to advance with the ICB in active liaison with NHSE and the key stakeholders of the development.

The site search and proposed plans for Connexus PCN have been finalised and the ICB are in contact with Regional and National NHSE colleagues to confirm governance requirements and funding mechanisms. We are now not expecting any material spend in year due to timing constraints.

The Thornbury Health Centre project board meets on a monthly basis, the business case has been submitted to NHSE and we are awaiting final approval. Full value is expected to be £16.2m as we have now included the VAT risk (which we continue to look to challenge) resulting in a contribution from the ICB of £1.8m re-allocated from Connexus due to timing slippages on that project.

There are a number of risks around delivery in year and we are working with system partners on a detailed forecast and collective mitigations should these become necessary.

8. Statement of Financial Position

The closing net asset position of the ICB is £116.8m, a year-to-date movement of £8.6m which primarily represents:

- a decrease in working capital balances of £15.2m (comprising a decrease in debtors of £12.3m and a small increase in creditors of £2.9m).
- this is offset by a release of provisions of £5.8m (no change from m6)
- an increase in cash of £0.8m

Statement of Financial Position	Balance 31/03/2024 £m	Balance 30/11/2024 £m	Movement £m
Total Non Current Assets	3.024	2.967	(0.057)
Current Assets			
Cash & Cash Equivalents	0.174	0.960	0.787
Current Trade And Other Receivables	40.608	28.356	(12.252)
Total Current Assets	*40.781*	*29.316*	*(11.465)*
Total Assets	**43.805**	**32.283**	**(11.522)**
Current Liabilities			
Payables	(141.065)	(144.012)	(2.947)
Lease Liability	(2.595)	(2.537)	0.059
Provisions	(8.280)	(2.497)	5.784
Total Current Liabilities	***(151.941)***	***(149.046)***	***2.895***
Total Net Assets/(Liabilities)	**(108.136)**	**(116.762)**	**(8.627)**
Taxpayers Equity			
I&E Reserve - General Fund	(108.136)	(116.762)	(8.627)
Total Taxpayer Equity	**(108.136)**	**(116.762)**	**(8.627)**

NHSE monitor the ICB on the closing cash at bank balance compared to 1.25% of monthly drawdown, which for month 8 equated to £2.2m. The ICB narrowly missed this target, with a closing cash at bank balance of £2.4m. The cash in ledger position shown above was £1.4m lower than cash at bank due to the timing of the final BACS run of the month.

At month end the ICB's cash utilisation was ahead of plan by 1.54%. The ICB has drawn down cash ahead of profile due to the timing of anticipated allocations from NHSE. The ICB actively monitors the cashflow forecast and has identified that the cash run rate to year end is lower than the year-to-date position.

9. Better Payment Practice Code (BPPC)

The ICB is 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 continues to meet the BPPC target for all

10. Statement of Financial Position

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Current Trade And Other Receivables	40.608	28.356	(12.252)
Total Current Assets	*40.781*	*29.316*	*(11.465)*
Total Assets	**43.805**	**32.283**	**(11.522)**
Current Liabilities			
Payables	(141.065)	(144.012)	(2.947)
Lease Liability	(2.595)	(2.537)	0.059
Provisions	(8.280)	(2.497)	5.784
Total Current Liabilities	***(151.941)***	***(149.046)***	***2.895***
Total Net Assets/(Liabilities)	**(108.136)**	**(116.762)**	**(8.627)**
Taxpayers Equity			
I&E Reserve - General Fund	(108.136)	(116.762)	(8.627)
Total Taxpayer Equity	**(108.136)**	**(116.762)**	**(8.627)**

NHSE monitor the ICB on the closing cash at bank balance compared to 1.25% of monthly drawdown, which for month 8 equated to £2.2m. The ICB narrowly missed this target, with a closing cash at bank balance of £2.4m. The cash in ledger position shown above was £1.4m lower than cash at bank due to the timing of the final BACS run of the month.

At month end the ICB's cash utilisation was ahead of plan by 1.54%. The ICB has drawn down cash ahead of profile due to the timing of anticipated allocations from NHSE. The ICB actively monitors the cashflow forecast and has identified that the cash run rate to year end is lower than the year-to-date position.

11. Better Payment Practice Code (BPPC)

The ICB is 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 continues to meet the BPPC target for all NHS and Non-NHS invoices, as set out below.

Type	In month	Number	£m
NHS	Total bills paid in month	79	108.435
	Total bills paid within target	76	108.434
	% bills paid within target	**96.20%**	**100.00%**
Non NHS	Total bills paid in month	2,712	67.546
	Total bills paid within target	2,700	67.482
	% bills paid within target	**99.56%**	**99.91%**

Type	Year to date	Number	£m
NHS	Total bills paid in year	871	860.772
	Total bills paid within target	849	859.662
	% bills paid within target	**97.47%**	**99.87%**
Non NHS	Total bills paid in year	20,530	578.921
	Total bills paid within target	20,352	570.743
	% bills paid within target	**99.13%**	**98.59%**

12. Recommendations

The committee are asked to note the financial position as of month 8.

Appendix 1 – Analysis of spend within programme areas

A1 – Acute

Acute Services	2024/25 Budget	YTD Budget	YTD Expenditure	YTD Variance		Forecast Outturn	Forecast Variance	
	£m	£m	£m	£m		£m	£m	
University Hospitals Bristol and Weston NHS FT	503.622	336.424	340.012	(3.588)		509.020	(5.398)	
North Bristol NHS Trust	484.102	322.330	324.893	(2.563)		487.996	(3.895)	
South Western Ambulance Service NHS FT	57.325	38.216	40.207	(1.990)		60.310	(2.985)	
Independent Sector Treatment Centres	39.680	33.980	34.647	(0.667)		40.680	(1.000)	
Other Local Provider contracts (RUH, Glos, Somerset)	18.984	12.656	12.656	-		18.984	-	
Low Volume Activity	8.098	8.098	8.125	(0.027)		8.098	-	
Non Contracted Activity	0.920	0.614	1.079	(0.465)		1.637	(0.717)	
Other Acute Spend (incl SWAG cancer)	40.091	32.200	32.039	0.161		39.876	0.215	
Grand Total	**1,152.822**	**784.519**	**793.658**	(9.139)		**1,166.602**	(13.780)	

A2 - Mental Health

Mental Health & Learning Disabilities	2024/25 Budget	YTD Budget	YTD Expenditure	YTD Variance		Forecast Outturn	Forecast Variance	
	£m	£m	£m	£m		£m	£m	
MH - AWP Core Contract	149.917	99.737	99.737	-		149.917	-	
Mental Health Placements	22.090	14.727	16.188	(1.462)		23.858	(1.768)	
Learning Disability and Autism	10.052	6.701	7.106	(0.404)		10.632	(0.580)	
Mental Health Community	5.488	3.659	4.355	(0.696)		6.539	(1.051)	
Improved Access to Psychological Therapies (IAPT)	12.505	8.337	8.281	0.056		12.422	0.084	
Dementia	6.077	4.051	3.957	0.095		5.935	0.142	
Crisis Services	3.970	2.646	2.063	0.583		3.095	0.875	
ADHD	2.889	1.926	3.156	(1.230)		4.738	(1.850)	
Mental Health Low Volume Activity	0.880	0.880	0.896	(0.016)		0.896	(0.016)	
Mental Health SDF	11.730	7.820	7.820	-		11.277	0.453	
MH - S12 Doctors Private Sector	0.750	0.500	0.505	(0.005)		773.02	(0.024)	
Grand Total	**226.347**	**150.983**	**154.064**	(3.080)		**230.081**	(3.734)	

A3 – Community

Community	2024/25 Budget	YTD Budget	YTD Expenditure	YTD Variance		Forecast Outturn	Forecast Variance	
	£m	£m	£m	£m		£m	£m	
Adult Community Contract	152.618	101.746	101.579	0.167		152.354	0.264	
Joint Commissioned	33.187	22.125	22.125	-		33.187	-	
Discharge to Assess Services	10.883	7.255	8.689	(1.434)		13.168	(2.285)	
Joint Commissioned D2A	2.475	1.650	1.650	-		2.475	-	
Patient Transport Services (PTS)	6.618	4.412	4.676	(0.264)		7.015	(0.397)	
Community Equipment	6.948	4.632	4.783	(0.151)		7.174	(0.226)	
Hospices	4.359	2.906	2.842	0.064		4.263	0.096	
BIRU	3.440	2.293	2.265	0.028		3.398	0.042	
In-Year Investments	2.462	1.753	0.820	0.933		1.063	1.399	
Anticipatory Care	3.385	2.257	2.257	-		3.385	-	
Health Inequalities	1.775	1.183	1.042	0.141		1.563	0.212	
Prevention Fund	1.327	0.885	0.687	0.198		0.997	0.330	
Other Community	5.191	3.490	3.738	(0.248)		5.595	(0.405)	
Grand Total	**234.668**	**156.587**	**157.153**	(0.566)		**235.638**	(0.970)	

A4 – Primary Care

Primary Care	2024/25 Budget	YTD Budget	YTD Expenditure	YTD Variance		Forecast Outturn	Forecast Variance	
	£m	£m	£m	£m		£m	£m	
NHS 111/Out of Hours	19.639	13.093	13.188	(0.095)		19.782	(0.143)	
Local Enhanced Services	7.501	5.001	5.020	(0.020)		7.506	(0.005)	
GP Forward View	5.619	3.917	3.913	0.004		5.619	-	
Other Primary Care	6.758	4.505	4.432	0.074		6.663	0.095	
Grand Total	**39.517**	**26.516**	**26.552**	**(0.037)**		**39.569**	**(0.053)**	

A5 – Primary Care Delegated

Delegated Primary Care	2024/25 Budget	YTD Budget	YTD Expenditure	YTD Variance		Forecast Outturn	Forecast Variance	
	£m	£m	£m	£m		£m	£m	
GMS/PMS/APMS Contracts	115.312	76.875	76.532	0.343		114.797	0.515	
Primary Care Networks DES	38.328	28.844	28.786	0.059		38.277	0.051	
Premises Costs	17.082	11.388	11.481	(0.093)		17.230	(0.148)	
Quality Outcomes Framework (QOF)	14.867	9.911	9.911	-		14.867	(0.000)	
Locum Reimbursement Cost	2.350	1.567	1.560	0.007		2.339	0.011	
Other GP Services	2.110	1.407	1.478	(0.071)		2.248	(0.138)	
Prescribing & Dispensing Fees	1.562	1.041	1.041	-		1.562	0.000	
Designated Enhanced Services (DES)	1.330	0.887	0.836	0.051		1.253	0.077	
Delegated Primary Care Reserve	-0.583	-0.388	0.026	(0.415)		-0.000	(0.582)	
Grand Total	**192.358**	**131.532**	**131.650**	**(0.119)**		**192.573**	**(0.215)**	

A6 – Primary Care Delegated POD

Pharmacy, Ophthalmology and Dental (POD) delegation	2024/25 Budget	YTD Budget	YTD Expenditure	YTD Variance		Forecast Outturn	Forecast Variance	
	£m	£m	£m	£m		£m	£m	
Delegated Pharmacy	20.356	13.910	13.447	0.463		19.708	0.648	
Delegated Primary Dental	38.302	25.535	25.535	-		38.302	(0.000)	
Delegated Secondary Dental	18.211	12.140	12.520	(0.379)		18.211	-	
Delegated Community Dental	2.859	1.906	1.906	-		2.859	(0.000)	
Delegated Primary Care IT	0.406	0.270	0.017	0.253		0.040	0.366	
Delegated Ophthalmic	8.887	5.925	5.918	0.007		8.703	0.185	
Delegated Property costs	0.000	0.000	0.000	-		0.000	-	
Grand Total	**89.020**	**59.686**	**59.342**	**0.344**		**87.822**	**1.198**	

A7 – Medicines Management

Medicines Management	2024/25 Budget	YTD Budget	YTD Expenditure	YTD Variance		Forecast Outturn	Forecast Variance	
	£m	£m	£m	£m		£m	£m	
Prescribing	161.441	107.648	105.729	1.920		158.633	2.808	
Medicines Management staff costs	1.996	1.331	1.268	0.062		1.850	0.146	
Grand Total	**163.437**	**108.979**	**106.997**	**1.982**		**160.483**	**2.954**	

A8 – Funded Care

Funded Care	2024/25 Budget	YTD Budget	YTD Expenditure	YTD Variance		Forecast Outturn	Forecast Variance	
	£m	£m	£m	£m		£m	£m	
Adult Fully Funded CHC	61.466	40.977	43.761	(2.783)		63.903	(2.437)	
Adult Fully Funded PHB	11.000	7.334	7.065	0.269		10.659	0.342	
Adult Joint Funded	0.730	0.487	0.499	(0.012)		0.785	(0.056)	
CHC Assessment and Support	0.542	0.362	0.346	0.015		0.698	(0.156)	
Funded Care Pay	5.237	3.491	3.178	0.313		5.063	0.174	
Children's CHC	4.214	2.809	3.052	(0.243)		4.385	(0.171)	
Children's PHB	0.665	0.443	0.012	0.431		0.020	0.645	
Fast Track	17.228	11.486	12.869	(1.383)		19.184	(1.955)	
FNC	29.903	19.935	20.963	(1.028)		31.715	(1.812)	
Grand Total	**130.986**	**87.324**	**91.745**	**(4.421)**		**136.412**	**(5.426)**	

A9 – Children's Services

Children's Services	2024/25 Budget	YTD Budget	YTD Expenditure	YTD Variance		Forecast Outturn	Forecast Variance	
	£m	£m	£m	£m		£m	£m	
CCHP Contract	18.364	12.242	12.577	(0.335)		18.866	(0.502)	
Child & Adolescent Mental Health (CAMHS)	16.559	11.040	10.641	0.399		15.959	0.600	
Childrens SDF	6.932	4.622	4.533	0.089		6.799	0.133	
Other	5.156	3.436	3.331	0.105		4.996	0.161	
Grand Total	**47.012**	**31.340**	**31.082**	**0.258**		**46.620**	**0.392**	

A10 – Support Costs

Support Costs	2024/25 Budget	YTD Budget	YTD Expenditure	YTD Variance		Forecast Outturn	Forecast Variance	
	£m	£m	£m	£m		£m	£m	
Chief Medical Office	1.251	0.834	0.837	(0.003)		1.312	(0.062)	
Chief Nursing Office	2.375	1.583	1.545	0.038		2.385	(0.010)	
Estates	2.407	1.604	1.755	(0.150)		2.668	(0.261)	
Other Support Costs	0.513	0.342	0.672	(0.330)		0.769	(0.256)	
Performance and Delivery	1.003	0.669	0.639	0.030		0.980	0.023	
Projects	4.215	2.375	2.248	0.128		4.310	(0.095)	
R&D Team	0.157	0.105	0.123	(0.018)		0.157	-	
Grand Total	**11.920**	**7.512**	**7.818**	**(0.306)**		**12.581**	**(0.661)**	

A11 – Running Costs

Running Cost	2024/25 Budget	YTD Budget	YTD Expenditure	YTD Variance		Forecast Outturn	Forecast Variance	
	£m	£m	£m	£m		£m	£m	
Business, Strategy and Planning Directorate	4.518	2.600	2.464	0.136		4.241	0.278	
Chief Medical Office	0.595	0.397	0.375	0.022		0.586	0.009	
Chief Nursing Office	0.050	0.033	0.014	0.019		0.050	-	
Intelligence, Transformation and Digital Directorate	4.353	2.902	2.983	(0.081)		4.475	(0.122)	
Office of the Chair & Chief Executive	3.218	2.146	2.277	(0.132)		3.336	(0.117)	
People Directorate	0.989	0.660	0.587	0.073		1.005	(0.016)	
Performance & Delivery Directorate	1.954	1.303	1.340	(0.037)		1.986	(0.031)	
Grand Total	**15.678**	**10.040**	**10.040**	**(0.000)**		**15.678**	**0.000**	

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

NHS
Bristol, North Somerset and South Gloucestershire
Integrated Care Board

BNSSG System Finance Report (November 2024) M8

Finance, Estates & Digital Committee

19th December 2024

Key Messages

1. Overall Revenue Performance

- At the end of November (month 8), the system reported an overall **year to date deficit against plan of £10.0m** (planned deficit £2.4m, actual deficit £12.4m).
- In month therefore, there has been no movement to the position that was reported in the previous month.
- At system level, the two key drivers of this deficit continue to be under-delivery against planned savings targets, and under-performance against planned levels of elective activity.
- The impact of Industrial Action previously included in the YTD position (£1.8m) was funded by NHS England in M6.
- Total worked WTE numbers (including temporary staff) continue to be in excess of funded levels and this is driving a year to date overspend of £25.7m against total pay budgets.
- The system has maintained its forecast break-even position by the end of the financial year in line with plans submitted to NHS England

2. 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 a **£14m under-delivery against plan at the end of November, with 79% of planned efficiencies delivered** (£51.4m actual delivery v planned £65.3m).
- The forecast for total system efficiencies is 92% of plan at M8.
- 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 some corporate savings, which is in-part contributing to the year-to-date under delivery.

3. 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 this plan is driving part of the reported financial deficit.

Key Messages (2)

4. Capital Expenditure

- The system has submitted a capital expenditure plan 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.
- In addition, the system is planning to spend £43.7m on nationally funded capital programmes
- At Month 8 total capital expenditure is forecast to be £164.6m. The system has a potential £5.5m over-commitment against notified allocations relating to IFRS16 expenditure. In 2023/24, this was managed at a regional level and will continue to be monitored during the year.

5. Cash

- There is planned reduction in the overall system cash position of c.£82m in 2024/25, from a balance of £184m at the end of March 2024, to a planned balance of £101m at the end of the financial year.
- Current cash balances are £14.9m higher (c.10.4%) than planned levels at the end of November.
- Whilst it was not anticipated that any organisation would require cash support in this financial year at planning, 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 (c.£13m) does not come with additional cash resource, and that there is a lengthy process that must be followed for organisations requesting additional cash support from NHS England. Therefore, cash support for capital may be required in year.

System Key Financial Performance Indicators (1)

	In Month	YTD TOTAL (NHS)	Prior Month		UH Bristol & Weston	North Bristol Trust	Avon & Wiltshire Partnership	NHS Provider Sector	BNSSG ICB
1. Year to Date Financial Performance		A			A	A	G	A	G
Actual Surplus / (Deficit)	(£0.0m)	**(£12.4m)**	(£12.4m)		(£6.3m)	(£6.1m)	(£0.0m)	**(£12.4m)**	£0.0m
variance to plan	**(£0.0m)**	**(£10.0m)**	(£10.0m)	↓	**(£6.3m)**	**(£3.7m)**	**(£0.0m)**	**(£10.0m)**	£0.0m
variance (% of turnover)		**(0.3%)**	(0.3%)		**(0.7%)**	**(0.5%)**	**(0.0%)**	**(0.5%)**	0.0%
variance (% of ICB Allocation)		**(0.6%)**	(0.7%)		-	-	-	-	-
2. Forecast Surplus / (Deficit)									
Forecast Surplus / (Deficit)	-	**£0.0m**	£0.0m	←	**£0.0m**	**£0.0m**	**£0.0m**	**£0.0m**	**£0.0m**
3. Risk to Forecast Out-turn		G			G	G	G	G	G
Net Unmitigated Risk		**£0.0m**	£0.0m		£0.0m	£0.0m	£0.0m	**£0.0m**	**£0.0m**
Net Unmitigated Risk (%)		**0.0%**	0.0%		0.0%	0.0%	0.0%	**0.0%**	**0.0%**
4. Year to Date Savings Delivery		R			R	R	G	R	G
Savings Delivery (£)	£8.3m	**£51.4m**	£43.1m		£19.3m	£10.1m	£6.2m	**£35.5m**	£15.8m
Savings Delivery v plan	**-£0.4m**	**-£14.0m**	-£13.6m		**-£7.9m**	**-£7.1m**	**-£0.3m**	**-£15.3m**	**+£1.3m**
Savings Delivery (%)	96%	79%	76%	↑	71%	59%	96%	70%	109%
Savings Delivery as a % of turnover		**2.0%**	1.9%		2.2%	1.5%	2.4%	**2.0%**	0.0%
5. Forecast Savings Delivery		G			R	G	G	A	G
Forecast Savings Delivery (£)		**£93.1m**	£95.1m		£30.7m	£28.7m	£9.0m	**£68.4m**	£24.8m
Forecast Savings Performance v plan		**-£8.3m**	-£6.3m		**-£10.5m**	**+£0.0m**	**-£0.7m**	**-£11.2m**	**+£2.9m**
Forecast Savings Delivery (%)		92%	94%	↓	74%	100%	93%	86%	114%

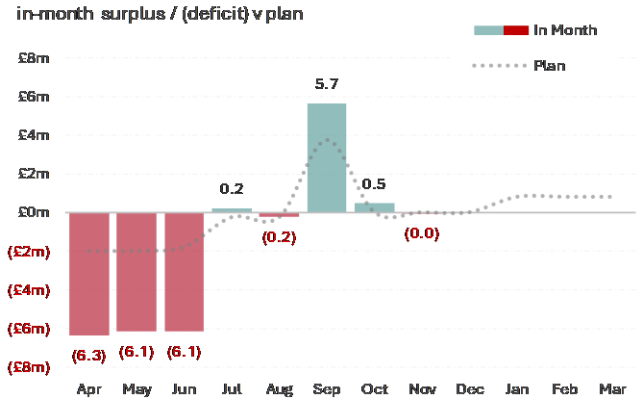
System Key Financial Performance Indicators (2)

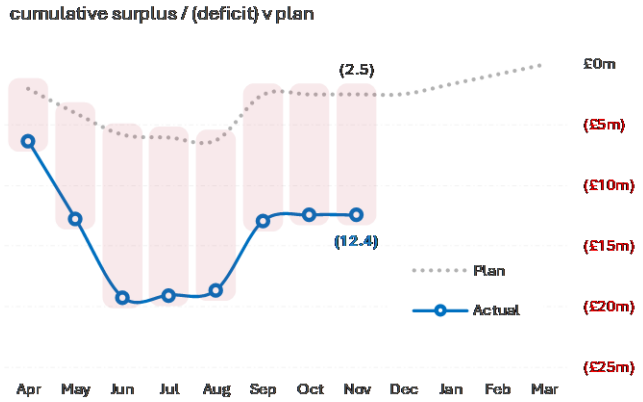
	In Month	NHS TOTAL	Prior Month		UH Bristol & Weston	North Bristol Trust	Avon & Wiltshire Partnership	NHS Provider Sector	BNSSG ICB
6. Charge against Capital Allocation (excluding impact of IFRS 16)		G			G	G	G	G	G
Total System Operational Capital Allocation		**£81.9m**	£81.9m		£38.1m	£32.1m	£3.1m	**£73.3m**	£8.5m
Forecast Charge Against Capital Allocation		**£81.9m**	£81.9m		£38.1m	£32.1m	£3.1m	**£73.3m**	£8.5m
Forecast variance to allocation		£0.0m	£0.0m	←	**£0.0m**	**£0.0m**	**£0.0m**	**£0.0m**	**£0.0m**
Forecast variance to allocation (%)		**0.0%**	0%		0.0%	0.0%	0.0%	**0.0%**	0.0%
7. Charge against Capital Allocation (with impact of IFRS 16)		A							
Total System Operational Capital Allocation		**£100.3m**	£100.3m						
Forecast Charge against Capital Allocation (including IFRS 16)		**£105.8m**	£105.8m		£47.4m	£43.0m	£6.9m	**£97.3m**	£8.5m
Forecast capital overspend v plan		+£5.5m	+£5.5m	←					
Forecast variance to allocation (%)		**5.5%**	5.5%						
8. Current Cash Balance		G			G	R	G	G	-
Planned cash balance	(£21.6m)	**£143.1m**	£164.7m		£80.1m	£42.6m	£20.3m	**£143.1m**	-
Current cash balance	(£4.8m)	**£158.0m**	£162.8m		£88.3m	£34.8m	£34.9m	**£158.0m**	-
Year to date variance to plan	+£16.8m	+£14.9m	-£1.9m	↑	+£8.2m	-£7.9m	+£14.6m	+£14.9m	-
Year to date variance to plan (%)		**10.4%**	-1%		10.3%	-18.5%	71.8%	**10.4%**	-
9. Better Payment Practice Code (BPPC) - 95% target					A	A	G	-	G
Total Bills paid within 30 days (in-month)		**95%**	95%	←	92%	93%	99%	-	98%
Total Bills paid within 30 days (year to date)		**95%**	95%	←	90%	91%	99%	-	98%

System Financial Performance Overview

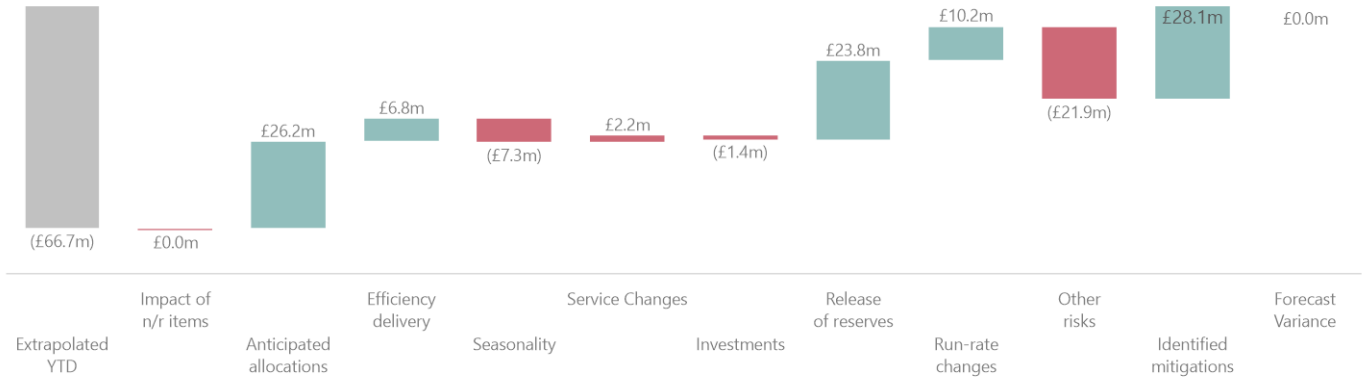
1. FINANCIAL PERFORMANCE: **YTD Variance : -£10.0m** A **In-Month Variance : -£0.0m** G **Forecast Suplus / (Deficit) : £0.0m** G

Organisation	YTD Plan	YTD Actual	YTD Variance to Plan	YTD Variance (%)	Forecast Surplus / (Deficit)
UHBW	0.0	(6.3)	(6.3)	-0.7%	0.0
NBT	(2.5)	(6.1)	(3.7)	-0.5%	0.0
AWP	0.0	(0.0)	(0.0)	-0.0%	0.0
Provider Total	**(2.5)**	**(12.4)**	**(10.0)**	**-0.5%**	**0.0**
BNSSG ICB	0.0	0.0	0.0	0.0%	0.0
NHS Total	**(2.5)**	**(12.4)**	**(10.0)**	**-0.3%**	**0.0**
Sirona	0.0	0.0	0.0		0.0
System Total	**(£2.5m)**	**(£12.4m)**	**(£10.0m)**	**-0.3%**	**£0.0m**





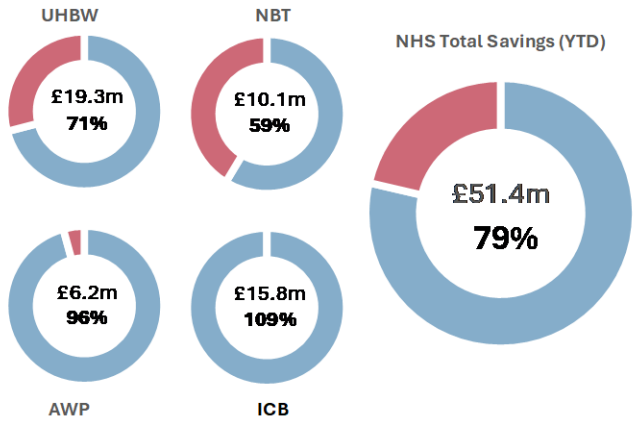
2. RUN-RATE BRIDGE - Extrapolated Year to Date Variance to Forecast Variance

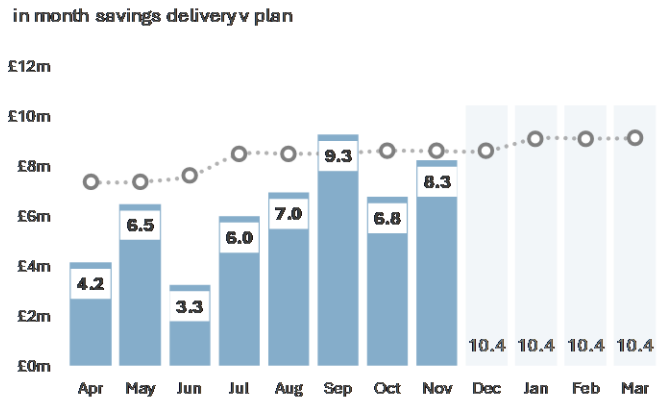


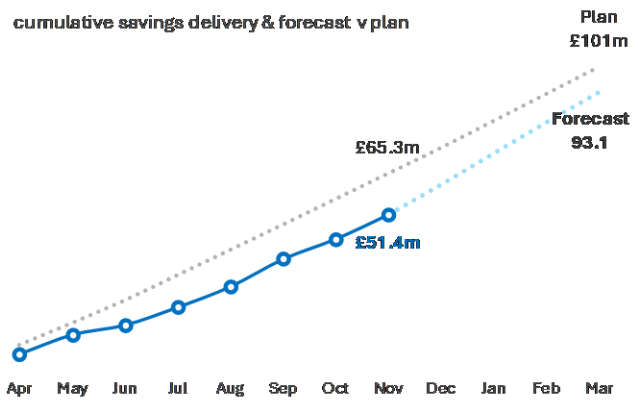
Extrapolated YTD	**(£66.7m)**
Impact of n/r items	£0.0m
Anticipated allocations	£26.2m
Efficiency delivery	£6.8m
Seasonality	(£7.3m)
Service Changes	£2.2m
Investments	(£1.4m)
Release of reserves	£23.8m
Run-rate changes	£10.2m
Other risks	(£21.9m)
Identified mitigations	£28.1m
Forecast Variance	**£0.0m**

System Financial Performance Overview (2)

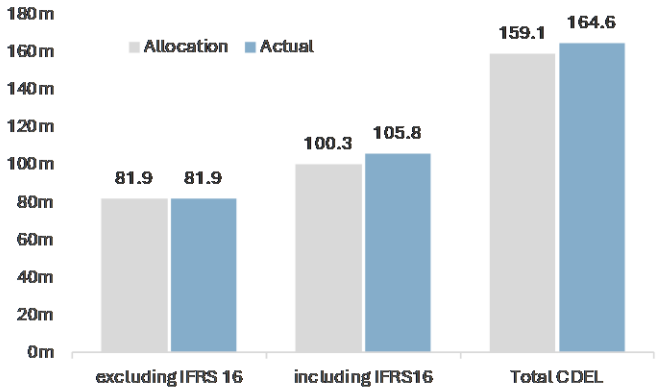
3. EFFICIENCY DELIVERY: YTD £51.4m (79% of plan) R | Avg. Monthly Savings (YTD): £6.4m | required to hit forecast: £10.4m | Forecast : £93.1m (92% of plan) G



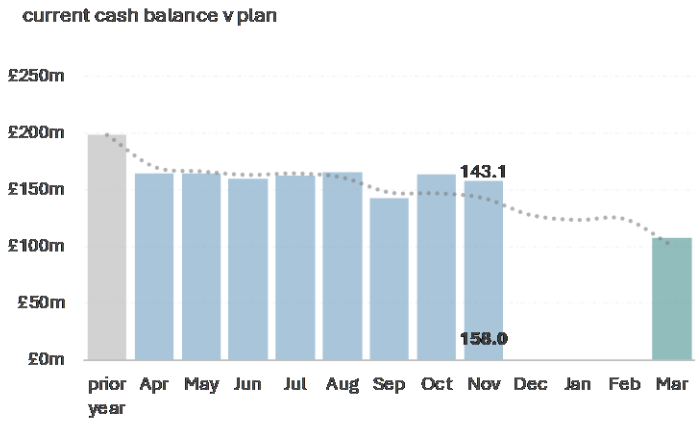




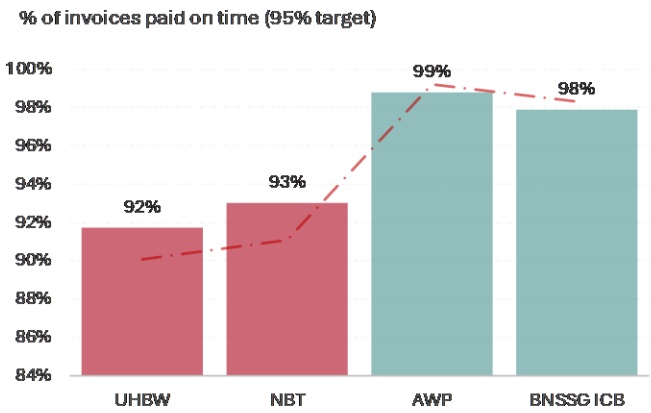
4. CHARGE AGAINST CAPITAL ALLOCATION +£5.5m G



5. CURRENT CASH BALANCE: YTD Variance : £14.9m G



6. BETTER PAYMENT PRACTICE: No. of Orgs missing target: 2



System Income & Expenditure Summary

(NHS Providers)

	YTD Plan £m	Actual £m	Variance £m	Full-Year Plan £m	Forecast £m	Forecast Variance £m
Combined Provider Income Sources						
NHS England	(533.4)	(562.7)	29.3	(797.2)	(828.3)	31.1
Integrated Care Boards	(920.6)	(942.2)	21.6	(1,380.6)	(1,406.1)	25.5
Other patient care income	(95.2)	(80.3)	(14.9)	(139.8)	(120.2)	(19.6)
Total income from patient care activities	**(1,549.1)**	**(1,585.1)**	**36.0**	**(2,317.6)**	**(2,354.7)**	**37.1**
Other operating income	(145.8)	(162.3)	16.5	(219.8)	(253.6)	33.8
Total Provider Operating Income	**(1,694.9)**	**(1,747.4)**	**52.5**	**(2,537.4)**	**(2,608.3)**	**70.9**
Combined Provider Expenditure						
Substantive staff including on-costs	959.1	992.1	(33.1)	1,433.4	1,478.7	(45.2)
Bank staff including on-costs	83.1	86.4	(3.3)	125.9	133.7	(7.8)
Agency / contract	39.8	30.8	9.1	59.9	41.7	18.3
Other Staff Costs	(0.6)	(2.2)	1.6	(0.9)	(1.7)	0.8
Other Operating Expenditure	581.7	612.3	(30.7)	872.6	912.7	(40.1)
Total Provider Operating Expenditure	**1,663.1**	**1,719.5**	**(56.4)**	**2,490.9**	**2,565.1**	**(74.1)**
Operating Surplus / (Deficit)	**(31.9)**	**(27.9)**	**(3.9)**	**(46.5)**	**(43.2)**	**(3.3)**
Net Finance Costs	(68.0)	(64.3)	(3.7)	(88.9)	(85.3)	(3.6)
Other Adjustments to Financial Performance	97.4	79.9	17.6	135.3	128.5	6.8
NHS Provider surplus / (deficit)	**(2.5)**	**(12.4)**	**(10.0)**	**0.0**	**0.0**	**0.0**
Total ICB Allocation	**(1,559.6)**	**(1,559.6)**	**0.0**	**(2,291.3)**	**(2,291.3)**	**0.0**
BNSSG ICB Expenditure						
Acute Services	788.9	798.3	(9.4)	1,159.4	1,173.6	(14.2)
Mental Health & LD Services	166.6	169.2	(2.6)	249.8	252.8	(3.0)
Community Health Services	167.9	168.4	(0.5)	251.6	252.5	(0.9)
Continuing Care Services	87.3	91.7	(4.4)	131.0	136.4	(5.4)
Primary Care Services	130.7	128.6	2.0	195.7	192.7	3.0
Other Programme Services	5.1	5.4	(0.3)	8.3	8.9	(0.6)
Other Commissioned Services	7.2	7.3	(0.1)	10.8	11.1	(0.2)
Delegated Primary Medical Services	131.8	131.7	0.1	192.8	192.6	0.2
Delegated Dental, Ophthalmic and Pharmacy Servi	59.4	59.3	0.1	88.6	87.8	0.8
ICB Running Costs	10.0	10.0	0.0	15.7	15.7	0.0
Reserves / Contingencies	4.6	(10.5)	15.1	(12.4)	(32.7)	20.3
Total ICB Net Expenditure	**1,559.6**	**1,559.6**	**0.0**	**2,291.3**	**2,291.3**	**(0.0)**
ICB surplus / (deficit)	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**(0.0)**
System Operating Surplus / (Deficit)	**(2.5)**	**(12.4)**	**(10.0)**	**0.0**	**0.0**	**(0.0)**

Efficiency Delivery

YTD & Forecast by Scheme

	YTD Plan £m	Actual £m	Variance £m	% delivery		Full-Year Plan £m	Forecast £m	Forecast Variance £m	% delivery	
Provider Pay Schemes										
Pay - Agency Cost Reduction	10.9	12.8	1.9	118%		16.6	18.2	1.6	109%	
Pay - E-Rostering / E-Job Planning	5.9	4.9	-0.9	84%		8.8	7.5	-1.3	85%	
Pay - Corporate services transformation	1.8	0.4	-1.4	23%		2.7	0.6	-2.1	23%	
Pay - Service re-design	5.5	4.8	-0.6	88%		8.2	7.6	-0.6	92%	
Pay - Other	2.9	2.5	-0.4	87%		4.4	3.5	-0.9	80%	
	26.9	**25.5**	**-1.4**	**95%**		**40.7**	**37.4**	**-3.4**	**92%**	
Provider Non-Pay Schemes										
Non-Pay - Medicines efficiencies	1.0	1.2	0.2	116%		1.6	2.4	0.8	153%	
Non-Pay - Procurement	6.3	3.1	-3.2	49%		9.6	7.8	-1.8	81%	
Non-Pay - Net zero carbon	1.9	1.0	-0.9	51%		3.0	1.3	-1.7	42%	
Non-Pay - Service re-design	5.3	0.1	-5.3	1%		8.0	0.2	-7.8	3%	
Non-Pay - Other	4.1	3.4	-0.8	82%		6.3	5.5	-0.8	88%	
	18.8	**8.8**	**-10.0**	**47%**		**28.5**	**17.3**	**-11.2**	**61%**	
Provider Income Schemes										
Provider Income	6.8	5.9	-0.8	88%		10.3	13.7	3.3	132%	
	6.8	**5.9**	**-0.8**	**88%**		**10.3**	**13.7**	**3.3**	**132%**	
NBT re-phasing adjustment	(1.6)	(4.6)	-3.0							
Total provider efficiencies	**50.8**	**35.5**	**-15.3**	**70%**	R	**79.6**	**68.4**	**-11.2**	**86%**	A
ICB efficieny programme										
Demand Management (referrals)	0.0	0.0	0.0	-		0.0	0.0	0.0	-	
Evidence based interventions	3.0	3.0	0.0	100%		4.5	4.5	0.0	100%	
All-age Continuing Care	4.3	3.3	-1.1	76%		6.5	6.7	0.2	104%	
Medicines efficiencies	3.5	6.5	3.0	186%		5.3	7.9	2.6	150%	
Running cost review	2.0	2.0	-0.0	100%		3.0	3.0	0.0	100%	
Establishment reviews	0.0	0.0	0.0	-		0.0	0.0	0.0	-	
Other	1.7	1.1	-0.7	62%		2.6	2.7	0.1	104%	
Unidentified	0.0	0.0	0.0	-		0.0	0.0	0.0	-	
Total ICB efficiencies	**14.5**	**15.8**	**1.3**	**109%**	G	**21.8**	**24.8**	**2.9**	**114%**	G
TOTAL SYSTEM EFFICIENCIES	**65.3**	**51.4**	**-14.0**	**79%**	R	**101.4**	**93.1**	**-8.3**	**92%**	G

System Capital Department Expenditure Limit (CDEL)

System Capital Allocation	system plan £m	Allocation adjustments £m	Revised System CDEL limit £m	Forecast £m	Forecast Variance to CDEL limit £m
2024/25 Capital Allocation (provider)	68.0		**68.0**		
Less transfer to the ICB Allocation	0.0		**0.0**		
Prior Year Revenue Performance Allocation	2.5		**2.5**		
23/24 Revenue Surplus Bonus	0.1		**0.1**		
24/25 Revenue Fair Shares Adjustment	11.2		**11.2**		
Total System Allocation (before IFRS16)	**81.9**	**0.0**	**81.9**		
Operational Capital Allocation to Organisations					
UHBW	36.7	1.4	**38.1**	38.1	+0.0
NBT	27.7	4.5	**32.1**	32.1	-0.0
AWP	9.0	(5.9)	**3.1**	3.1	+0.0
BNSSG ICB	8.5	0.0	**8.5**	8.5	+0.0
Total Charge against Capital Allocation (excluding impact of IFRS 16)	**81.9**	**(0.0)**	**81.9**	**81.9**	**+0.0**
Impact of IFRS16 (plan)					
Capital expenditure on lease remeasurements	10.0	(10.0)	**0.0**	4.3	+4.3
Capital expenditure on right of use assets	19.7	(19.7)	**0.0**	19.7	+19.7
IFRS 16 CDEL uplift allocation	0.0	18.4	**18.4**	0.0	-18.4
Total impact of IFRS 16	29.7	**(11.3)**	**18.4**	**24.0**	**+5.5**
Total Charge against Capital Allocation (including impact of IFRS 16)	**111.6**	**(11.3)**	**100.3**	**105.8**	**+5.5**
National Programme Funding (PDC)					
Diagnostic Digital Capability Programme	0.3	0.2	**0.5**	0.5	-0.0
Elective Recovery/Targeted Investment Fund	20.4		**20.4**	20.4	0
Mental Health	17.6		**17.6**	17.6	-0.0
STP Wave 3	3.0		**3.0**	3.0	+0.0
Front Line Digitisation	0.0	2.2	**2.2**	2.2	0
Total National Funding (PDC)	41.4	**2.4**	**43.7**	**43.7**	**-0.0**
PFI capital charges (e.g. residual interest)					
PFI capital charges	15.1		**15.1**	15.1	0
Total System CDEL	**168.0**	**(8.9)**	**159.1**	**164.6**	**+5.5**

System Capital Expenditure

Year to Date & Forecast by Category

	UHBW Actual £m	NBT Actual £m	AWP Actual £m	BNSSG ICB Actual £m	System TOTAL Actual £m	UHBW Forecast £m	NBT Forecast £m	AWP Forecast £m	BNSSG ICB Forecast £m	System TOTAL Forecast £m
Internally Funded (owned assets)										
Routine maintenance (non-backlog)	1.2	0.0	0.4		**1.6**	7.8	0.0	3.6		**11.3**
Backlog Maintenance	2.4	1.1	0.0		**3.5**	4.8	5.1	0.0		**10.0**
New Build	1.8	0.4	0.0		**2.2**	12.4	18.1	0.0		**30.5**
Equipment	3.5	0.0	0.0		**3.5**	7.2	0.0	0.0		**7.2**
Plant and machinery	0.0	0.5	0.0		**0.5**	0.0	8.1	0.0		**8.1**
Fire Safety	1.1	0.0	0.0		**1.1**	2.5	0.0	0.0		**2.5**
IT	0.6	0.7	0.0	0.0	**1.3**	5.3	2.7	1.1	1.1	**10.2**
Fleet, Vehicles & Transport	0.0	0.0	0.0		**0.0**	0.0	0.0	0.0		**0.0**
Other	0.0	0.0	0.0		**0.0**	0.0	0.0	0.0	7.5	**7.5**
Sub-Total	**10.7**	**2.6**	**0.4**	**0.0**	13.7	**39.9**	**34.1**	**4.7**	**8.5**	**87.2**
less donations	(0.4)	(0.3)	0.0		**(0.7)**	(1.9)	(0.5)	0.0		**(2.4)**
less disposals	0.0	0.0	0.0		**0.0**	0.0	0.0	0.0		**0.0**
less PFI capital (IFRIC12)	0.0	(0.1)	(0.2)		**(0.3)**	0.0	(1.5)	(1.6)		**(3.0)**
Charge against Capital Allocation (before IFRS 16)	**10.3**	**2.2**	**0.2**	**0.0**	12.7	**38.1**	**32.1**	**3.1**	**8.5**	**81.9**
Capital expenditure on lease remeasurements	4.3	0.0	0.0		**4.3**	4.3	0.0	0.0		**4.3**
Capital expenditure on right of use assets	0.0	0.1	0.3		**0.4**	5.0	10.9	3.8		**19.7**
Total impact of IFRS 16	**4.3**	**0.1**	**0.3**	**0.0**	4.7	**9.3**	**10.9**	**3.8**	**0.0**	**24.0**
Total Charge against Capital Allocation (including IFRS	**14.6**	**2.3**	**0.5**	**0.0**	17.4	**47.4**	**43.0**	**6.9**	**8.5**	**105.8**
PFI capital charges (e.g. residual interest)										
PFI capital charges	0.0	9.4	0.6		**10.0**	0.0	14.1	0.9		**15.1**
National Programme Funding (PDC)										
Diagnostic Digital Capability Programme	0.0	0.0	0.0		**0.0**	0.2	0.3	0.0		**0.5**
Front Line Digitisation	0.0	0.0	0.0		**0.0**	0.4	0.0	1.8		**2.2**
Elective Recovery/Targeted Investment Fund	0.0	7.3	0.0		**7.3**	0.0	20.4	0.0		**20.4**
Mental Health	0.0	0.0	3.3		**3.3**	0.0	0.0	17.6		**17.6**
STP Wave 3	0.0	0.0	1.8		**1.8**	0.0	0.0	3.0		**3.0**
Total National Programme Funding	**0.0**	**7.3**	**5.0**	**0.0**	12.3	**0.6**	**20.7**	**22.5**	**0.0**	**43.7**
Total Capital Department Expenditure Limit (CDEL)	**14.6**	**19.0**	**6.1**	**0.0**	39.7	**47.9**	**77.8**	**30.3**	**8.5**	**164.6**

Statement of Cash Flows (SoCF)

	UHBW			NBT			AWP		
	YTD Plan £m	Actual £m	Variance £m	YTD Plan £m	Actual £m	Variance £m	YTD Plan £m	Actual £m	Variance £m
Operating surplus/(deficit)	**(1.3)**	**0.6**	**1.9**	**25.5**	**20.6**	**(5.0)**	**7.6**	**6.7**	**(0.9)**
Non-cash income and expense:									
Depreciation and amortisation	28.9	29.0	0.1	19.3	16.9	(2.4)	5.8	5.9	0.1
Impairments and reversals	10.0	0.0	(10.0)	0.0	0.0	0.0	0.0	0.0	0.0
Income recognised in respect of capital donatior	(1.2)	(1.1)	0.1	(0.3)	(0.3)	0.0	0.0	0.0	0.0
(Increase)/decrease in receivables	(4.7)	1.7	6.4	(2.4)	(12.3)	(9.9)	(3.5)	(7.4)	(3.8)
Increase/(decrease) in trade and other payables	(17.3)	(14.0)	3.3	(2.4)	(15.3)	(12.9)	3.7	18.8	15.1
Other	0.0	8.9	8.9	4.7	6.7	2.0	(2.5)	(0.2)	2.3
Net cash generated from / (used in) operations	**14.5**	**25.2**	**10.7**	**44.4**	**16.4**	**(28.0)**	**11.1**	**23.8**	**12.7**
Cash flows from investing activities									
Purchase of property, plant and equipment	(17.1)	(21.9)	(4.8)	(41.6)	(20.3)	21.3	(15.6)	(12.7)	2.9
Interest received	2.3	3.9	1.6	1.3	2.4	1.1	0.4	1.3	0.9
Purchase of intangible assets	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Other	1.2	1.1	(0.1)	0.3	0.3	(0.0)	0.0	0.0	0.0
Net cash from/(used in) investing activities	**(13.6)**	**(16.9)**	**(3.3)**	**(40.0)**	**(17.6)**	**22.4**	**(15.2)**	**(11.4)**	**3.8**
Cash flows from financing activities									
Net Public dividend capital	0.0	0.0	0.0	13.8	11.9	(1.9)	9.0	6.9	(2.1)
Loans from Department of Health and Social Ca	(2.9)	(2.9)	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Other loans	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Capital element of lease liability repayments	(5.2)	(4.7)	0.5	(0.9)	(1.2)	(0.3)	(1.2)	(1.0)	0.1
Interest	(2.0)	(1.8)	0.2	(25.2)	(25.3)	(0.0)	(3.8)	(3.8)	(0.0)
PDC dividend (paid)/refunded	(7.0)	(7.3)	(0.3)	0.0	0.0	0.0	(1.6)	(1.6)	0.0
Other	0.0	0.0	(0.0)	(12.2)	(12.2)	(0.0)	(2.3)	(2.3)	(0.0)
Net cash from/(used in) financing activities	**(17.1)**	**(16.7)**	**0.4**	**(24.5)**	**(26.7)**	**(2.2)**	**0.1**	**(1.9)**	**(2.0)**
Increase/(decrease) in cash and cash equivale	**(16.2)**	**(8.4)**	**7.8**	**(20.0)**	**(27.9)**	**(7.9)**	**(4.0)**	**10.6**	**14.6**
Cash and cash equivalents at start of year	96.3	96.7	0.4	62.7	62.7	0.0	24.3	24.3	0.0
Cash and cash equivalents at end of period	**80.1**	**88.3**	**8.2**	**42.6**	**34.8**	**(7.9)**	**20.3**	**34.9**	**14.6**

Statement of Financial Position (SoFP)

	UHBW			NBT			AWP			BNSSG ICB		
	March 2024 £m	Current £m	In-Year Movement £m	March 2024 £m	Current £m	In-Year Movement £m	March 2024 £m	Current £m	In-Year Movement £m	March 2024 £m	Current £m	In-Year Movement £m
Non-current assets												
PFI/LIFT assets	0.0	0.0	0.0	302.2	298.4	(3.8)	34.3	34.3	0.0	0.0	0.0	0.0
Other property, plant and equipment	547.2	542.4	(4.8)	210.3	221.6	11.4	147.9	151.8	3.9	0.4	0.4	(0.0)
Right of use assets	111.1	109.0	(2.1)	9.7	8.6	(1.1)	18.8	18.2	(0.6)	2.6	2.5	(0.1)
Receivables due	1.5	1.5	0.0	1.1	1.1	0.0	0.2	0.2	0.0	0.0	0.0	0.0
Other non-current assets	18.0	16.1	(1.9)	15.1	12.7	(2.4)	1.8	1.4	(0.5)	0.0	0.0	0.0
Total non-current assets	**677.8**	**669.1**	**(8.7)**	**538.4**	**542.4**	**4.0**	**203.1**	**205.8**	**2.7**	**3.0**	**2.9**	**(0.1)**
Current assets												
Inventories	16.7	18.5	1.8	11.7	11.9	0.2	0.1	0.2	0.1	0.0	0.0	0.0
Receivables: due	71.4	68.2	(3.2)	59.5	72.3	12.8	16.7	24.0	7.4	40.6	26.0	(14.6)
Cash and cash equivalents	96.7	88.3	(8.4)	62.7	34.8	(27.9)	24.3	34.9	10.6	0.2	(8.6)	(8.8)
Other non-current assets	(6.4)	(5.0)	1.4	(9.6)	(10.2)	(0.6)	0.0	0.0	0.0	0.0	0.0	0.0
Total current assets	**178.4**	**170.1**	**(8.3)**	**124.2**	**108.7**	**(15.5)**	**41.1**	**59.1**	**18.0**	**40.8**	**17.4**	**(23.4)**
Current liabilities												
Trade and other payables	(9.1)	(4.2)	4.9	(4.9)	(5.5)	(0.5)	(5.0)	(1.7)	3.3	(141.1)	(119.8)	21.3
Borrowings	(13.3)	(13.5)	(0.1)	(23.6)	(23.6)	0.0	(1.4)	(2.2)	(0.8)	0.0	0.0	0.0
Provisions	(0.4)	(0.3)	0.1	(4.4)	(0.6)	3.8	(3.7)	(3.7)	(0.0)	(8.3)	(3.5)	4.8
Other liabilities	(151.3)	(151.9)	(0.6)	(105.4)	(100.3)	5.1	(33.4)	(52.2)	(18.8)	(2.6)	(2.6)	0.0
Total current liabilities	**(174.2)**	**(169.9)**	**4.2**	**(138.4)**	**(130.0)**	**8.4**	**(43.6)**	**(59.8)**	**(16.3)**	**(151.9)**	**(125.9)**	**26.1**
Non-current liabilities												
Borrowings	(139.1)	(134.8)	4.3	(571.8)	(584.9)	(13.1)	(85.0)	(83.6)	1.5	0.0	0.0	0.0
Other non-current liabilities	(3.4)	(2.0)	(2.8)	(6.2)	(6.6)	(8.8)	(1.2)	(1.1)	16.4	0.0	0.0	0.0
Total non-current liabilities	**(142.5)**	**(136.8)**	**5.7**	**(578.0)**	**(591.5)**	**(13.5)**	**(86.3)**	**(84.7)**	**1.6**	**0.0**	**0.0**	**0.0**
Total net assets employed	**539.5**	**532.4**	**(7.1)**	**(53.7)**	**(70.4)**	**(16.7)**	**114.3**	**120.4**	**6.1**	**(108.1)**	**(105.5)**	**2.6**
Financed by												
Public dividend capital	333.5	333.5	0.0	485.2	497.1	11.9	151.0	158.0	6.9	0.0	0.0	0.0
Income and expenditure reserve	113.5	106.4	(7.1)	(610.8)	(639.4)	(28.6)	(113.7)	(113.0)	0.7	0.0	0.0	0.0
Revaluation reserve	92.4	92.4	(0.0)	71.9	71.9	0.0	77.0	75.4	(1.5)	0.0	0.0	0.0
Other	0.1	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
I&E Reserve General Fund	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	(108.1)	(105.5)	2.6
Total taxpayers' and others' equity	**539.5**	**532.4**	**(7.1)**	**(53.7)**	**(70.4)**	**(16.7)**	**114.3**	**120.4**	**6.1**	**(108.1)**	**(105.5)**	**2.6**

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Integrated Care Board

Finance, Estates and Digital Committee (OPEN Session)

DRAFT Minutes of the meeting held on Thursday 27 June 2024, 09:00 – 11:30, via Microsoft Teams

Present		**Initials**
Steve West	Finance, Estates and Digital Committee – Chair	SW
Brian Stables	Non-Executive Director, AWP	BS
Christina Gray	Director of Public Health, BCC	CG
Deborah El-Sayed	Chief Transformation and Digital Information Officer, BNSSG ICB (until 10am)	DES
Jeff Farrar	Chair, BNSSG ICB	JF
Jo Medhurst	Chief Medical Officer, BNSSG ICB	JM
John Cappock	Non-Executive Director, ICB (until 10.20am)	JC
Sarah Truelove	Deputy CEO & Chief Finance Officer, BNSSG ICB	ST
Present		**Initials**
Catherine Cookson	Associate CFO, BNSSG ICB	CC
Rob Ayerst	Associate CFO, BNSSG ICB	RA
Seb Habibi	Deputy Chief Transformation & Digital Officer, BNSSG ICB	SH
Kerrie Darvill	Intelligence Centre Programme Director (item 5.3 only)	KD
Rachel Smith	Executive Assistant (notes)	RS

		Action
1.0	**Apologies for Absence** Apologies were received from Rosi Shepherd, BNSSG ICB; Richard Gaunt, NBT and Amy Webb, North Somerset Council.	
2.0	**Declarations of Interest** There were no declarations of interest for the Open session.	
3.0	**Minutes of the previous meeting** The minutes of the Open session held on 23 May 2024 were agreed as an accurate record of the meeting.	
4.0	**Actions from Previous Meeting / Matters Arising** The action log was reviewed and updated accordingly. Sarah Truelove (ST) highlighted an issue arising from the external audit report related to the governance processes in place for awarding grants; work was underway to shore up the processes and an update would be reported back to this committee in August or September and highlighted to the Audit and risk Committee accordingly. In response to a query from Jeff Farrar (JF), ST also confirmed that two incidents had been identified, the second occurred in 21/22 and would have been presented to the appropriate CCG committee (as was in place at the time).	
	For Discussion	
5.3	**Intelligence Centre (formerly the Shared Data and Planning Platform) Update** Deborah El-Sayed (DES) introduced the item and highlighted the trailblazing work being led by Kerrie Darvill (KD) and her team around Federated Data Platforms (FDP) and Shared Data Environments (SDE) to test how the infrastructure will work for ICBs.	

		Action
	KD shared a slide deck and highlighted the following: ➢ Vision statement: narrative to be revised to provide clarity around the overarching programme aims. ➢ Benefits overview of the Intelligence Centre (IC) programme; significant examples highlighted include: • Intelligent decision-making: how data is used and decisions made in a transparent and robust way. • ICS processes and data: the digital technology required to facilitate and enable joint working and turn data into knowledge. • Single Data Front Door: to make the use of intelligence simple and standardise processes • Shared version of the truth: to ensure transparency around data to ensure it is used in the right way. • Safe and secure ➢ Data from the unitary authorities is also being linked in via a data leads group comprised of BI leads from all provider organisations to provide their input. ➢ Transition from SDPP to the IC, including 1. Redefining the aims and objectives 2. Rescoping the programme workstreams 3. Redesigning the programme governance and roles / responsibilities 4. Review of programme content 5. Reconsidered design methodology with senior product owners ➢ IC Key Capabilities, with product owners for each of the following areas: 1. Plan: to improve data processes to support planning and commissioning 2. Perform: improving data availability to support performance activities and reduce variation 3. Prevent and Predict: data interpretation improvements and understanding population needs. ➢ Two additional elements also at play: a. System-wide data sharing agreement to facilitate the IC b. Applied Research capability enables and informs the IC ➢ Focus areas to date: • Communications and engagement plan • Scope and requirements • Information Sharing Charter • FDP proof of concept – currently being worked through by the Information Governance Committee; to be presented to FED in due course • System architecture approach ➢ High level programme timeline, culminating in the OBC being presented to the ICB Board in September 2024 ➢ Top risks a. Public concern: managed via a strong public engagement exercise b. Stakeholder input c. FDP review: potential impact on timescales Christina Gray (CG) welcomed the clear presentation and advised that her Public Health colleagues were keen to be engaged and help shape the product. CG also shared similar concerns around the risks highlighted, particularly in light of the cyber incidents affecting a number of hospitals in London.	

		Action
	Jo Medhurst (JM) queried whether there were any concerns relating to firewalls / penetration tests / governance and safety processes of the organisations signing up to the Information Sharing Charter that may affect clinical care delivery, and how this would be managed. KD acknowledged the challenges around this; she advised that the Information Governance Committee would be used to seek assurance from provider organisations and work would continue around standardisation of processes. KD also reported on the toolkit processes that each of the providers would need to complete; these would also be assessed to identify the level of assurance within each of the organisations. John Cappock (JC) suggested it may also be useful for KD to discuss this with Sarah Smith, Counter Fraud Lead for the ICB. KD was invited back to a future meeting in due course to provide a tutorial / demonstration once available.	
	For Approval	
6	There were no items for approval in the Open session	
	Finance Report	
7	**M2 System Finance Report** Catherine Cookson (CC) presented the M2 ICB Finance report; the following key updates were highlighted: ➢ The ICB's initial allocation is just over £2.1bn, in line with plan. ➢ A relatively light review was undertaken of the M2 financial position with a £0.267m deficit reported ➢ Funded care a key area of concern due to the level of maturity of some savings plans. Meetings held during June to agree a recovery plan for the savings plans, which are reviewed on a monthly basis with the CFO and CNO. ST further assured the committee on the ongoing discussions around the savings plans, ensuring the right level of engagement within the system in the discussions. ➢ Capital: ICB capital allocations submitted to NHSE in June; Delivery plans to be finalised once NHSE approval received. ➢ Cash: planned reduction against the cash allocation and will continue to be monitored closely. There are no concerns at the time and the ICB continues to work with provider organisations to maximise cash allocations to enable them to benefit from any investment opportunities. ➢ As part of the M3 reporting, deep dives will be undertaken on each programme area. Rob Ayerst (RA) presented the M2 System Finance report; the following key updates were highlighted: ➢ A planned deficit of £9.5m was reported at the end of M2, broken down as follows: • AWP reported a breakeven position • NBT reported a £2.9m variance (solely represents slippage on delivery of their savings plan), • UHBW reported a £6.3m variance (slippage on savings delivery and lower than planned levels of elective activity leading to lower than assumed elective recovery) • ICB reported a variance of £300k (linked to slippage on delivery of the funded care savings plan). • Two key drivers of the deficit: under-delivery of savings as a system (approximately 60% of M2 savings were delivered by the end of M2) but this was expected. The second driver related to under-performance against planned levels of elective activity.	

		Action
	➢ Next steps included detailed revenue and capital reviews and capital FOT reviews by all system providers. As discussed earlier in the meeting, there was also the expectation that the Escalation Framework would be applied wider within organisations, where appropriate, to support recovery from a financial and performance perspective. ➢ Revisions to national finance regime in terms of the ICS delivering a break-even plan in 23/24 and submitting a balanced financial plan for 24/25 resulted in received of an additional £13m linked to revenue performance. The system has prioritised the use of the additional expenditure and by following a risk-based approach, has allocated a proportion to ensure the highest operational capital risks are addressed, and would be discussed by the system DOFs, ahead of being presented to the ICB Board for approval. There was a high level of confidence that the position would be recovered by the end of the financial year. CG queried the omission of Primary Care or Sirona within the system financial overview, as it would be useful to receive information pertaining to GPs / Pharmacies and community services etc; RA advised that these were embedded within the overall ICB position, as part of standard reporting. It was noted that the reporting would be developed during 24/25 to include KPIs for Sirona as per the statutory requirement to report on NHS organisations as a system, which Sirona had offered voluntarily. ST clarified that a breakdown of the areas CG highlighted were included, but only at a very high level. Primary Care providers were not required to report their financial position to the ICB; the only potential financial impact on the ICB by Primary Care providers would be following an S96 declaration whereby emergency funding was required. A deep dive into Primary Care could be provided for a future meeting if this would be useful. ST also advised that work was underway with the Section 151 officers in each of the Local Authorities to show the LA position, in order to present a full system position in totality. RA advised that he would aim to include further detail within the M3 report, but M4 may be more feasible. SW reflected that it was important to be clear on the purpose of including the extra information, and not generating work unnecessarily.	
	To Note	
8.1	**System DoFs Group** ST reported the following update: ➢ Philip Kiely, Deputy COO, UHBW, presented an update on the UHBW Elective Investment Review. ➢ The DOFs also received a presentation from NBT on their approach to grip and control; UHWB were reviewing a similar approach for UHBW. ➢ Interim feedback from the AWP financial review was positive and would be presented to the AWP Improvement Board on 28 June 2024 ➢ The focus of the next Performance and Recovery Board on 5 July 2024 would be planning for 25/26 and the need to seek clarity earlier in the process on the areas of focus in 25/26. A rolling programme would be developed to support the main areas of focus.	
		Action
8.2	**Digital Delivery Board Update** Seb Habibi presented the report and highlighted the following: ➢ Progress on key asks from the Learning Disabilities Programme, whereby a Reasonable Adjustments Digital Flag (RADF) is added to patient records to provide key prompts to identify adjustments needed to ensure an improved personal experience.	

	The ICB, in collaboration with One Care, Sirona and the NHSE regional team have developed a local solution which has been commended by the NHSSE SW Learning Disabilities and Autism Team. The RADF would be nationally mandated in 2024. ➢ Technology Enabled Care: application funding approved, with the ICB signing an agreement with NHSE for c£502k in June 2024. A delivery plan has been developed and approved by the Discharge to Assess (D2A) programme Board who would oversee delivery on behalf of the system. The funding would realise benefits in the form of reduced length of stay, re-admissions and social care packages. ➢ Federated Data Platform – proof of concept: as discussed earlier in the meeting, work was underway with the national team to test the ICB-level offer for Federated Data Platforms, which would support delivery of the Intelligence Centre (IC) objectives. ➢ Living well with COPD' digital health pilot: provisional data from NBT reported a 20% reduction in non-elective admissions in the target cohort. The ICB Gateway Panel has undertaken a review of the options for continuation of the pilot and advised that a "do minimum" option be developed to enable the target cohort who have already been onboard to be optimised ahead of the winter period. It was hoped that further investment would improve the return on investment, generate further learning and inform a business case for a more sustainable model. ➢ The UHBW Digital Strategy has been published, in addition to a refresh of the NBT Digital Strategy. ➢ Dr Luke Koupparis has been appointed as vice-Chair of the BNSSG Clinical Informatics Cabinet. ➢ Draft BNSSG Information Sharing charter approved by the Digital Delivery Board ➢ Careflow Connect community contract: recovery actions agreed by the DDB relating to the risk around expiry of the Careflow Connect Clinical communications system contract in August 2024.	
8.3	**System Estates Steering Group** ST provide the following update: ➢ Work continued on the ICS Infrastructure Strategy; a draft would be presented to the ICB Board on 4 July 2024, and to seek Board approval to delegate authority to the FED Committee to approve the final strategy ahead the submission deadline (31 July 2024). ➢ Clear position emerging on work required in South Bristol and Inner City Bristol around Primary Care estates; to be presented to FED in due course.	
	Any Other Business There was no other business.	
	Date of Next Meeting Thursday 25 July 2024 – 09:00-12:00, MS Teams	

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Finance, Estates and Digital Committee (OPEN Session)

Minutes of the meeting held on Tuesday 1 October 2024, 2pm – 4pm, via Microsoft Teams

Present		Initials
Steve West	Finance, Estates and Digital Committee – Chair	SW
Brian Stables	Non-Executive Director, AWP	BS
Deborah El-Sayed	Chief Transformation and Digital Information Officer, BNSSG ICB	DES
Jeff Farrar	Chair, BNSSG ICB	JF
Jo Medhurst	Chief Medical Officer, BNSSG ICB	JM
John Cappock	Audit Committee Chair, BNSSG ICB	JC
Richard Gaunt	Non-Executive Director, NBT	RG
Sarah Truelove	Deputy CEO & Chief Finance Officer, BNSSG ICB	ST
In attendance		
Catherine Cookson	Associate CFO, BNSSG ICB	CC
Julie Northcott	Deputy Director, Public Health, Bristol City Council (for Christina Gray)	JN
Rachel Smith	Executive Assistant (notes)	RS

		Action
1	**Welcome and Apologies** Apologies were received from Rosi Shepherd, BNSSG ICB; Amy Webb, North Somerset Council and Christina Gray, Bristol City Council.	
2	**Declarations of Interest** There were no declarations of interest for the Open session.	
3	**Minutes of the Previous meeting** The minutes of the Open session held on 22 August 2024 were agreed as an accurate record.	
4	**Actions from previous meetings and matters arising** The action log was reviewed and updated accordingly.	
5	**Items for Approval**	
	There were no items for approval in the Open Session.	
6	**Items for Discussion**	
	There were no items for discussion in the Open Session.	
7	**Finance Report**	
7.1	**Finance Report** *The M5 report was noted but not discussed in detail* Sarah Truelove (ST) introduced the report and advised that the position for M5 had improved slightly from M4, with a system deficit of £18.6m against a planned deficit of £6.2m. As reported at the last meeting, organisations continued to work through the Forecast Outturn (FOT) Protocol to seek a decision from the ICB Board in November to either amend the FOT or support the measures being put in place to deliver a breakeven position.	

		Action
	The risk of not delivering a break-even position remained but a significant amount of work had been undertaken to date. The peer review of the acute Trusts continued, with the outputs to be presented to the Performance and Recovery Board on 14 October 2024. The output from that discussion would also inform the proposal to be presented to FED on 24 October ahead of the ICB Board in November. It was positive to note that there were no outstanding risks to the position and significant work had been undertaken to ensure there was no mis-match of assumptions in terms of balance agreements between the Trusts. There had been a good level of engagement across the system to date, and from all teams. The loss of financial incentives for 25/26 as a result of not delivering a break-even plan were significant; this would be in addition to a potential loss of autonomy over decision-making within the system. It was noted that the work continued and a further update would be presented to the next meeting, with additional measures identified by the system CFOs to further strengthen the position to deliver a break-even plan. Jeff Farrar (JF) highlighted the contrasting pictures between the improved quality and performance reporting and the deteriorating financial position. The potential national intervention was also a concern and JF queried whether there was any further leverage that could be used, particularly in relation to the risk of losing financial incentives in 25/26. ST acknowledged the challenge and reiterated the strong level of engagement in the Trusts. ST also highlighted that when compared to M2, most of the variances then have plateaued so the impact of the action were starting to materialise. It was also reiterated that the 25/26 savings plans would be developed earlier than in previous years to ensure work on these could start from April 2025. The planning process for the 25/26 plans would be launched on 22 October 2024, at a system-wide workshop. Delivery of a balanced plan in both 24/25 and 25/26 would almost guarantee a break-even plan for 26/27, ideally without national intervention. In response to a query from JC, ST advised that it was expected that a vacancy freeze would be one of the recommendations to be presented to the Board in November, following the culmination of the FOT protocol work. Richard Gaunt (RG) welcomed the plans to commence planning for 25/26 earlier than previously, given the time it can take for savings to materialise. RG also acknowledged the workforce challenges; it was positive to note the reduction in agency usage but using bank staff to cover sickness also had an impact. JC enquired whether any further guidance had been received from DHSC in term of financial plans for 25/26; ST reported that it was the expectation that pay awards would be honoured but from a revenue perspective, 25/26 would be challenging. A multi-year capital settlement may be announced in the Autumn budget, which would provide a longer term view of funds and ensure funds could be used more effectively. ST again reiterated that should a break-even plan not be delivered, £23m in capital resource and revenue would be lost, in addition to the loss of financial autonomy. Steve West (SW) asked whether any system had successfully addressed the issues in the acute sector regarding flow. ST referenced No Criteria To Reside (NCTR) and whilst the numbers in BNSSG remained high, when reviewing every other non-elective measure, BNSSG was one of the best performing systems. It was a significant challenge and there was more that could be done regarding admission avoidance rather than just focussing on discharge. Jo Medhurst (JM) highlighted the work underway to develop a business case to focus on admission avoidance and back door flow, which would require the re-allocation of funds from the acutes to different parts of the system. This was a behavioural issue within organisations which needed to be addressed as a system, so as to bring about the greater good for the BNSSG population, rather than focussing on organisational sovereignty.	

		Action
	DES highlighted a paper being presented to the ICB Board on the Transformation and Improvement approach and the need to change mindset to focus on what changes can be made. DES also reported on 3 retrospective reviews undertaken around impacts on flow in response to the accumulation of various elements – a small number of delayed discharges, sickness etc and the need to think about data differently. The issues around organisational sovereignty were discussed and this should be escalated to the ICB Board for discussion to bring about a resolution for this issue. ST also highlighted the ICB's regulatory responsibilities and whether the Board should consider revising the level of authorisation for any kind of spend, due to the significant risk of not delivering CIP plans, particularly with the significant gap at M6.	
8	**Items to Note**	
8.1	**System CFOs Group** As highlighted in the previous item, the discussion focussed on the FOT protocol, in addition to capital policy discussions, as part of the infrastructure strategy development.	
8.2	**Digital Delivery Board [to include NHS App Deep Dive]** DES reported that in terms of the savings plan for Digital, £170k of savings were still to be identified but there were a number of significant opportunities to be explored further to bridge the gap. DES was also scheduled to meet with the system CFOs to enlist their support in terms of a number of digital developments. A more detailed update would be presented to the ICB on 3 October 2024. DES highlighted the NHS App deep dive papers, which indicated significant variability in terms of usage but presented positively overall. The papers had been uploaded to Diligent [but not discussed] and would be presented to the ICB Board on 3 October, as part of the Digital update.	
8.3	**System Estates Steering Group** The System Estates Steering Group's main focus had been the completion of the ICS Infrastructure strategy.	
	Date of Next Meeting Thursday 24 October 2024 – 09:00-12:00, MS Teams	

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Finance, Estates and Digital Committee (OPEN Session)

Draft Minutes of the meeting held on Thursday 24 October 2024, 9am – 11.30am, 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
Christina Gray	Director of Public Health, Bristol City Council	CG
Deborah El-Sayed	Chief Transformation and Digital Information Officer, BNSSG ICB	DES
Jo Medhurst	Chief Medical Officer, BNSSG ICB	JM
John Cappock	Non-Executive Director, BNSSG ICB	JC
Richard Gaunt	Non-Executive Director, NBT	RG
Sarah Truelove	Deputy CEO & Chief Finance Officer, BNSSG ICB	ST
In attendance		
Catherine Cookson	Associate CFO, BNSSG ICB (item 7.1 only)	CC
Debbie Campbell	Chief Pharmacist, BNSSG ICB (Item 5.5 only)	DC
Jon Standing	Director of Pharmacy, UHBW (Item 5.5 only)	JS
Kerrie Darvill	Intelligence Centre Programme Director , BNSSG ICB (Item 5.4)	KD
Padma Ramanan	Head of Finance (Mental Health & Acute Services), BNSSG ICB (Item 5.5)	PR
Seb Habibi	Deputy CTDIO, BNSSG ICB	SH
Shane Devlin	CEO, BNSSG ICB	SD
Rachel Smith	Executive Assistant (notes)	RS

		Action
1	**Welcome and Apologies** Apologies were received from Rosi Shepherd, BNSSG ICB and Brian Stables, AWP.	
2	**Declarations of Interest** There were no declarations of internet for the Open session.	
3	**Minutes of the Previous meeting** The minutes of the Open session held on 1 October 2024 were agreed as an accurate record.	
4	**Actions from previous meetings and matters arising** The action log was reviewed.	
5	**Items for Discussion**	
5.4	**Intelligence Centre Finance Update** Deborah El-Sayed (DES) introduced the report and explained that FED would receive monthly reports to ensure regular financial oversight of the development of the FBC, including the ongoing benefits realisation work, ahead of FBC approval in March / April 2025.	

		Action
	Amy Webb (AW) reflected on previous discussions where further work had been requested by FED ahead of the OBC being presented to the ICB Board. John Cappock (JC) confirmed AW's reflections and advised that it had been clearly communicated to the ICB that further work was required regarding around benefits realisation, and in particular, the system benefits in view of the significant financial investment. DES had acknowledged the challenge regarding the benefits identified in the OBC and that steps were being taken to identify the system-wide benefits. DES also reported that a number of stakeholder workshops were in the process of being arranged to draw out the system-wide benefits, including one with the three Local Authorities. AW further queried the plans to procure a delivery partner before the benefits had been fully identified, and which would incur further expenditure. Kerrie Darvill (KD) confirmed that the contract with the selected procurement partner would not be signed until the benefits had been fully identified but the process had to start, in order to meet the required timescales. KD provided further assurance in that the FBC would not be approved if the benefits were not acceptable, and would be presented to FED prior to final approval being sought by the ICB Board. Progress updates on the identification of the benefits would also be included within the monthly updates presented to FED. Christina Gray (CG) suggested that the scope, aims and ambitions could be further strengthened and defined, ensuring the ability to respond flexibility to changes within the system. Sarah Truelove (ST) proposed that the draft FBC should be brought to FED for initial review a month before being presented for approval; this would allow time for further review / amendments before the final FBC is presented for approval. This was agreed. The following was highlighted from the update report: ➢ Formal agreement nationally to utilise the Federated Data Platform technology. ➢ Target Operating model (TOM): the process to determine roles and responsibilities within the Intelligence Centre (IC), including the resources that will be required and who would manage the system. ➢ FDP+ Tools: procurement process to secure an implementation to commence imminently to support the benefits realisation work that is required for the FBC. ➢ Financial Assessment: OBC forecast position noted and confirmation of the forecast £1.389m underspend noted. A review of resources confirmed all expenditure was in-line with 24/25 savings expectations. Finalised budgets for future years would be produced following once the FDP+ planning work had taken place with the selected procurement partner. The changes from the OBC forecast (July 2024) to the current position (October 2024) were noted. ➢ Next steps include: • Mini-procurement underway to source additional support to progress to FBC stage. This will include further work on the Target Operating Model and the benefits realisation. • Monthly updates to continue to be presented to FED ST clarified that with regard the £1.4m underspend, this may be re-prioritised within the programme due to benefits slippage in other areas. The committee also noted that as any digital investment were dependent upon delivery of savings, there may be difficult decisions to be made around programmes that cannot be progressed and the associated funding re-directed to the IC. This would also be linked to the updated Medium Term Financial Plan (MTFP) which would be presented to the next FED and ICB Board meetings to ensure a full understanding of the opportunities, challenges and potential consequences that are to be considered going forward.	

		Action
	CG queried the inclusion of a £4m investment from North Somerset Council; AW confirmed that this was grant funding from the ICB that NSC was holding on behalf of the 3 local authorities. In terms of 25/26 and 26/27 investment, it was expected that the budget scheduled for 30 October 2024 may provide some clarity around spending for the 25/26 and the remainder of 24/25. It was also the expectation that the Comprehensive Spending Review in March 2025 would bring further clarity for 26/27 but the final outcome may not be confirmed until summer 2025. The recommendations were summarised and noted; the complexities were acknowledged but it was essential that the ICB Board were presented with a very clear picture of the proposals within the FBC, particularly in terms of re-prioritisation of funding.	
5.5	**High Cost Medicines and NICE Technology Appraisals (TAs)** Debbie Campbell (DC), Jon Standing (JS) and Padma Ramanan (PR) were welcomed to the meeting to provide an update on the high cost drugs and devices (HCDD). The following was highlighted: ➢ Summary of the M5 position, including the total 23/24 budget, total 23/24 outturn, total 23/24 outturn variance, 24/25 M5 forecast position and 24/25 M5 forecast variance. ➢ Current overspend of £6.1m noted; due primarily to the NICE TA increases and a higher demand for some categories of drugs and devices. ➢ NBT: forecasting a year-end overspend of £619k (over 50% of which relates to diabetes technologies). ➢ UHBW : currently forecasting a year-end overspend of £3.8m, in a number of areas, including Dermatology (£700k), Ophthalmology (£720k) and Home TPN (high tech homecare) (£997k). These areas were particularly affected due to the growth of numbers in pathways, which subsequently increases drug choice. ➢ Areas of risk for 24/25 include weight management, Diabetes, pathway growth (pathology, gastroenterology, rheumatology and ophthalmology), renal and alopecia treatments ➢ 25/26 horizon scanning includes dementia drugs (for mild / moderate cases of Alzheimers) and a new diagnostic pathway, a new Diabetes drug to delay the onset of Type 1 Diabetes, and weight management (delivery to patients expected to start in July 2025 but the funding of this is currently unknown) ➢ Plans in place include: • National recognition of the growth in HCDD, and the risks to be addressed by all ICBs. • Greater clinical involvement in supporting the budget through regular speciality meetings in dermatology, gastroenterology, rheumatology and ophthalmology. • Incentivising Pace of Change (IPAC): financial incentive for accelerated adoption of biosimilars; one such change in Diabetes may deliver a full year effect of £4m in savings. • Inaugural meeting held of the NICE TAs Stewardship Group to support decision making on the implementation of NICE TAs, in consideration with local priorities. Sub-groups may also be established to focus on specific areas and ensure wider representation across the system, to be able to further drive improvements and reduce health inequalities for the local population. • Regional horizon scanning and implementation mapping • NHSE to apply for NICE funding variations to extend implementation period from 90 days and provide further direction on clinical prioritisation.	

		Action
	It was noted that this was extremely challenging and that NICE TAs had effectively doubled over the last 5 years. Issues were further exacerbated by lack of clarity around funding and the challenges faced by clinicians to implement the new drugs once approved by NICE, with some drugs taking 9 years to implement. In terms of benefits realisation, the responsibility lay largely with local systems to identify any benefits, rather than a central approach being taken by DHSC, who only undertook short-length studies. It was noted, however, that there were discussions underway around a potential change to the current process. Jo Medhurst (JM) reflected on the weight management drug example, with a 9 year implementation plan for 3m eligible patients; the cost was not the only issue but also the infrastructure required to support the implementation period as this could overwhelm general practice. Whilst it was an exciting development, there were potentially significant effects on the morbidity profile of the patients who were eligible. A wider system shift would be needed, including a review of the impact on elective waiting lists for some procedures for patients on the new weight loss and diabetes pathways. Jon Standing (JS) commented that pathway control was also important, as more drugs were added to pathways. Close grip and control was needed around how the drugs are used sequentially within the pathway and it was positive to note that BNSSG had been trailblazing a digital platform to support this. A second element to this was in relation medical devices as these do not flow through Pharmacy depts the same was as drugs, thereby resulting in less grip and control, from a clinical usage and procurement perspective. Thirdly, traditional cost improvement plans and adherence to contract prices was also key; the South West was trailblazing nationally in relation to achieving greater savings in lots of different areas, when compared nationally. Consideration would be given as to whether it would be useful for this to be discussed at a future Board Seminar.	
5.6	**Review Forward Work Programme Q3 / Q4** ST presented the forward work programme for the remainder of the year; all of the planned finance deep dives had taken place as planned but given the financial position ST suggested it would be useful to receive a further deep dive around Funded Care – this was agreed. An increased focus on Digital would also be useful. CG queried whether FED should receive updates / lessons learned particularly in relation to areas such as the Patient Transport award and the recent insolvency case, and to provide assurance around the mitigations in place for issues like this. CG also queried whether a local authority representative from social care should be in attendance for certain deep dive topics, ie funded care, particularly if the discussions were ultimately leading to a decision. ST advised that FED was an assurance committee, rather than a decision making group, whose responsibility was to receive the required assurance on behalf of the ICB Board that processes and plans in place were robust. AW advised that the S151 officers had regular discussions with ICB Executives and was comfortable with the current process but acknowledged that it was important to ensure the appropriate consultation and engagement has taken place prior to a decision. JC queried whether Sirona featured in discussions / agenda items sufficiently and whether additional scrutiny should be given to Sirona. SW and ST to reflect and discuss offline.	SW/ST
5.7	**Corporate Risk Register and Directorate Risk Register (DRR)** ST presented for information the Corporate Risk Register (CRR) and Directorate Risk Register (DRR) to provide oversight of the relevant risks on the CRR and also to raise awareness of risks currently held at Directorate level. Within the Business, Strategy and Planning Directorate (BSP), led by ST, the Directorate Senior Leadership Team review the DRR at their monthly. The review entails appropriate and timely progress updates and any emerging risks and issues.	

		Action
	ST also highlighted those risks that had been escalated to this committee previously and were also referenced in the monthly Finance Report to ensure FED had oversight of the actions which underpinned the risks. Specific areas of risk would also be included within the FED forward work programme as required. AW suggested that it would be useful, within the risk narrative, to include a brief update on any changes / movements since the previous version. This was agreed and would be fed back to Nic Saunders. ST also clarified that the individual sub-Committees of the ICB Board were responsible for reviewing the risks on the CRR that were within their area of responsibility.	
6	**Items for Approval**	
6.1	**Standing Financial Instructions** Catherine Cookson (CC) presented the refreshed Standing Financial Instructions (SFIs) for review and ratification for onwards approval by the ICB Board. The main highlights were noted: ➢ Tracked version included within the papers to easily identify the amendments ➢ New Grant Agreement SOP and follow up actions from the internal audit recommendations. ➢ Thresholds for competitive tendering so simplify the procurement process slightly. ➢ An updated section on waiver circumstances, ensuring that all contracts with optional extensions are included on the Single Tender Waiver (STW) register. ➢ Discussions underway to explore opportunities for digitally recording minutes of meetings. The SFIs to be presented to the Board for ratification would contain further clarity around this, due to the ongoing discussions. JC queried whether the issues around supporting Due Diligence aspects when issuing grants should be acknowledged within the SFIs as part of the audit trail to provide assurance that all of the necessary checks have been made. FED approved the revised SFIs for onward approval by the ICB Board.	
7	**Finance Report**	
7.1	**M6 System Finance Report** As presented to the last Performance and Recovery Board meeting, there had been continued improvement in terms of variances. In addition, funding had been received to cover the costs of the industrial action which also positively affected the variance. The actual deficit reduced considerably in M6, from £18.6m to £12.9m, which was extremely encouraging. Challenges remained in terms of the ICB position; whilst a breakeven position was still forecast, there were some fluctuations and concerns regarding funded care and mental health placements. A further issue around diagnostic activity had also recently come to light; further analysis was underway to understand the driver behind the increase. In line with the FOT change protocol, the ICB is to introduce the same processes that were expected of the provider organisations. SD and ST are to meet with the Executive Team, budget holders, contract managers and finance managers to identify and resolve the drivers behind the deterioration.	
8	**Items to Note**	
8.1	**System CFOs Group** ST reported that the main areas of focus for the CFOs had been developing the papers for the Performance and Recovery Board and also Finance Staff Development, with a system-wide session being arranged for January. A live-stream broadcast for Finance Staff Development to provide team updates is also under development, and will take place in December.	

		Action
	A communications plan was also being developed for staff and stakeholders to ensure consistent messaging in relation to financial performance. ST, Dave Jarrett and Shane Devlin had also attended the local Authority HOSP / HOSC meetings over the last month to provide an update on the financial performance.	
8.2	**Digital Delivery Board** Seb Habibi (SH) presented the update and highlighted the following: ➢ Key parameters for the programme include £1.2m recurrent investment which was expected to leverage c£2.6m of cash releasing savings. Due to the time delay between the investment and the benefits realisation, there would be a gap of £1.m at year end. ➢ Programme / project status noted, which showed improvements on previous reports. The programme was still in recovery and the financial outlook has improved, largely due to performance in Connecting Care. Significant risk remains for future years and the mitigations for these were noted. ➢ The programme FOT would continue to be updated on a monthly basis, and the risks and mitigation review every month DES also highlight a further risk related to the due diligence underway for the handover of Connecting Care as a number of the smaller contracts for different elements of the Connecting Care functionality were approaching renewal. A STW process may be followed but it was noted that renegotiating the contracts may bring about associated inflationary costs which will need to be considered for 25/26 planning. This has also been raised nationally.	
8.3	**System Estates Steering Group** ST presented the highlight report and explained that future reports would include updates on the key capital projects.	
	Date of Next Meeting Thursday 28 November 2024 – 09:00-12:00, MS Teams	

Classification: Official

Bristol, North Somerset and South Gloucestershire
Integrated Care Board

Publication approval reference:
Agreed by ICB Board 07 November 2024

BNSSG Integrated Care Board

Standing Financial Instructions

Version 4.0

7 November 2024

Contents

1. Purpose and statutory framework

1.1.1 These Standing Financial Instructions (SFIs) shall have effect as if incorporated into the Integrated Care Board's (ICB) constitution and Governance Handbook. In accordance with the National Health Service Act 2006, as amended by the Health and Care Act 2022, the ICB must publish its constitution.

1.1.2 In accordance with the Act as amended, NHS England is mandated to publish guidance for ICBs, to which each ICB must have regard, in order to discharge their duties.

1.1.3 The purpose of this governance document is to ensure that the ICB fulfils its statutory duty to carry out its functions effectively, efficiently, and economically. The SFIs are part of the ICB's control environment for managing the organisation's financial affairs as they are designed to ensure regularity and propriety of financial transactions.

1.1.4 SFIs define the purpose, responsibilities, legal framework and operating environment of the ICB. They enable sound administration, lessen the risk of irregularities and support commissioning and delivery of effective, efficient, and economical services.

1.1.5 The ICB is established under Chapter A3 of Part 2 of the National Health Service Act 2006, as inserted by the Health and Care Act 2022 and has the general function of arranging for the provision of services for the purposes of the health services in England in accordance with the Act.

1.1.6 Each ICB is established by order made by NHS England for an area within England, the order establishing an ICB makes provision for the constitution of the ICB.

1.1.7 All members of the ICB, its Board, and all other officers should be aware of the existence of these documents and be familiar with their detailed provisions. The ICB SFIs will be made available to all officers on the Hub and internet website.

1.1.8 Should any difficulties arise regarding the interpretation or application of any of these SFIs, the advice of the Chief Executive Officer or the Chief Finance Officer must be sought before acting.

1.1.9 Failure to comply with the SFIs may result in disciplinary action in accordance with the ICBs applicable disciplinary policy and procedure in operation at that time.

2. Scope

2.1.1 All officers of the ICB, without exception, are within the scope of the SFIs without limitation. The term officer includes, permanent employees, fixed term contract employees, secondees, agency and contract workers.

2.1.2 Within this document, words imparting any gender include any other gender. Words in the singular include the plural and words in the plural include the singular.

2.1.3 Any reference to an enactment is a reference to that enactment as amended.

2.1.4 Unless a contrary intention is evident, or the context requires otherwise, words or expressions contained in this document, will have the same meaning as set out in the applicable Act.

3. Roles and Responsibilities

3.1 Staff

3.1.1 All ICB officers are severally and collectively, responsible to their respective employer(s) for:

- abiding by all conditions of any delegated authority;
- the security of the statutory organisations property and avoiding all forms of loss;
- ensuring integrity, accuracy, probity, and value for money in the use of resources; and
- conforming to the requirements of these SFIs

3.2 Accountable Officer

3.2.1 The ICB constitution provides for the appointment of the Chief Executive Officer by the ICB chair. The Chief Executive Officer is the Accountable Officer for the ICB and is personally accountable to NHS England for the stewardship of the ICBs allocated resources.

3.2.2 The Chief Finance Officer reports directly to the ICB Chief Executive Officer and is professionally accountable to the NHS England regional finance director.

3.2.3 The Chief Executive Officer will delegate to the Chief Finance Officer the following responsibilities (see also section 4 – Annual Reporting and accounts) in relation to the ICB:

- preparation and audit of annual accounts;
- adherence to the directions from NHS England in relation to accounts preparation;
- ensuring that the allocated annual revenue and capital resource limits are not exceeded, jointly with system partners;
- ensuring that there is an effective financial control framework in place to support accurate financial reporting, safeguard assets and minimise risk of financial loss;
- meeting statutory requirements relating to taxation;

- ensuring that there are suitable financial systems in place (see Section 5 – Financial Systems and Processes),
- meets the financial targets set for it by NHS England;
- use of incidental powers such as management of ICB assets, entering commercial agreements;
- the Governance statement and annual accounts & reports are signed;
- developing the funding strategy for the ICB to support the Board in achieving ICB objectives, including consideration of place-based budgets;
- planned budgets are approved by the relevant Board;
- making use of benchmarking to make sure that funds are deployed as effectively as possible;
- executive members (partner members and non-executive members) and other officers are notified of and understand their responsibilities within the SFIs;
- specific responsibilities and delegation of authority to specific job titles are confirmed;
- financial leadership and financial performance of the ICB;
- identification of key financial risks and issues relating to robust financial performance and leadership and working with relevant providers and partners to enable solutions; and
- the Chief Finance Officer will support a strong culture of public accountability, probity, and governance, ensuring that appropriate and compliant structures, systems, and process are in place to minimise risk.

3.3 Audit and risk assurance committee

3.3.1 The ICB Board (Board) and Accountable Officer should be supported by an Audit and Risk committee, which should provide proactive support to the Board in advising on:

- the management of key risks;
- the strategic processes for risk;
- the operation of internal controls;
- control and governance and the governance statement;
- the accounting policies, the accounts, and the annual report of the ICB;

- the process for reviewing of the accounts prior to submission for audit, management's letter of representation to the external auditors; and the planned activity and results of both internal and external audit.

3.3.2 In accordance with ICB Constitution the Board shall formally establish an Audit and Risk Committee, with clearly defined terms of reference and following guidance from the NHS Audit Committee Handbook to perform the following tasks:

a. ensuring there is an effective internal audit function established by management, that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit and Risk Committee, Chief Executive Officer and Board;

b. reviewing the work and findings of the External Auditor appointed by the ICB and considering the implications of and management's responses to their work;

c. to assure itself that the ICB has adequate arrangements in place for counter fraud, bribery and corruption (including cyber security) that meet NHS Counter Fraud Authority's (NHSCFA) standards and shall review the outcomes of work in these area;

d. reviewing the findings of other significant assurance functions, both internal and external to the organisation, and considering the implications for the governance of the organisation;

e. ensuring that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board;

f. reviewing financial and information systems and monitoring the integrity of the financial statements and reviewing significant financial reporting judgments;

g. reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives;

h. monitoring compliance with ICB Constitution, Standing Financial Instructions and Prime Financial Policies;

i. reviewing schedules of losses and compensations and making recommendations to the Board;

j. reviewing schedules of assets and liabilities;

k. reviewing the annual report and annual financial statements prior to submission to the Board focusing particularly on:

    - the wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee;

- changes in, and compliance with, accounting policies and practices;
- unadjusted mis-statements in the financial statements;
- major judgmental areas;
- significant adjustments resulting from audit.

l. reviewing the annual financial statements and recommend their approval to the Board;

m. reviewing the External Auditors' report on the financial statements and the annual management letter;

n. conducting a review of the ICB's major accounting policies;

o. reviewing any incident of fraud or corruption or possible breach of ethical standards or legal or statutory requirements that could have a significant impact on the ICB's published financial accounts or reputation;

p. reviewing any objectives and effectiveness of the internal audit services including its working relationship with External Auditors;

q. reviewing major findings from internal and External Audit reports and ensure appropriate action is taken;

r. reviewing 'value for money' audits reporting on the effectiveness and efficiency of the selected departments or activities;

s. reviewing the mechanisms and levels of authority (e.g. ICB Constitution, Standing Financial Instructions, Delegated limits) and make recommendations to the Board;

t. reviewing the scope of both internal and External Audit including the agreement on the number of audits per year for approval by the ICB delegated Board;

u. investigating any matter within its terms of reference, having the right of access to any information relating to the particular matter under investigation;

v. reviewing waivers to ICB Constitution and its procurement activities;

w. reviewing hospitality and sponsorship registers;

x. reviewing the information prepared to support the Annual Governance Statement prepared on behalf of the Board and advising the Board accordingly;

y. establish an auditor panel as a sub group of the Audit and Risk Committee to ensure the contract arrangements, including the procurement and selection, with the External Auditors is appropriate.

3.3.3 The minutes of the Audit and Risk Committee meetings shall be formally recorded by the Corporate Services and Operations team and submitted to the Board. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to the full Board, or require executive action. The Committee will report to the Board annually on its work in support of the Annual Governance Statement, specifically commenting on the fitness for purpose of the Assurance Framework, the completeness and embeddedness of risk management in the organisation and the integration of governance arrangements.

3.3.4 Where the Audit and Risk Committee considers there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the Committee wishes to raise, the Chairman of the Audit and Risk Committee should raise the matter at a full meeting of the Board. Exceptionally, the matter may need to be referred on to NHS England and/or the Department of Health and Social Care.

3.4 Finance, Estates and Digital committee

3.4.1 The Finance, Estates and Digital Committee (FED) is accountable to the Board. The Board shall approve and keep under review the terms of reference for the FED Committee, including information on the membership of the FED Committee. The chair of the FED Committee will be an Independent Non-Executive Member.

3.4.2 The minutes of the FED committee meetings shall be formally recorded and submitted to the Board under the direction of the Chief Finance Officer. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to the full Board or require executive action.

3.4.3 The FED Committee shall support the Board through its purpose;

- To contribute to the overall delivery of the ICB's objectives by providing oversight and assurance to the Board in the development and delivery of a robust, viable and sustainable system financial strategy and operational plan. This includes:
    - financial performance of the ICB
    - financial performance of NHS organisations within the ICB footprint
- Providing financial advice to the Integrated Care System Partnership Board to enable the development of a financially sustainable Strategy;
- Develop financial strategy and plan for the ICB with due regard for the Strategy of the Integrated Care System Partnership Board and associated Health & Wellbeing Boards.

3.4.4 The Board has delegated authority to the FED Committee as described in the Reservation and Delegation Scheme:

- Strategy and Planning
    - Recommend annual, medium-term and Long-Term financial plans to the Board.
    - Recommend the approach for resource allocation to the Board.
- Regulation and Control
    - Prepare Standing Financial Instructions (SFIs)
    - Oversight of procurement exercises in line with section 8.2 and make recommendations to the Board.

4. Annual reporting and accounts

4.1 Reporting

4.1.1 The Chief Executive Officer, on behalf of the Board will ensure the ICB, in each financial year, prepares a report on how it has discharged its functions in the previous financial year.

4.1.2 An annual report must, in particular, explain how the ICB has:

- discharged its duties in relating to improving quality of services, reducing inequalities, the triple aim and public involvement;
- review the extent to which the Board has exercised its functions in accordance with its published 5 year forward plan and capital resource use plan; and
- review any steps that the Board has taken to implement any joint local health and wellbeing strategy.

4.1.3 The Chief Finance Officer will ensure, on behalf of the Accountable Officer and Board that the ICB is in a position to produce its required monthly reporting, annual report, and accounts.

4.1.4 NHS England will give annual directions to the ICB as to the form and content of an annual report.

4.1.5 The ICB must give a copy of its annual report to NHS England by the date specified by NHS England in a direction and publish the report.

4.2 Internal audit

The Chief Executive Officer, as the Accountable Officer, is responsible for ensuring there is appropriate internal audit provision in the ICB. For operational purposes, this responsibility is delegated to the Chief Finance Officer to ensure that:

- all internal audit services provided under arrangements proposed by the Chief Finance Officer are approved by the Audit and Risk Committee, on behalf of the Board;
- the ICB must have an internal audit charter (as set out in the Internal Audit plan). The internal audit charter must be prepared in accordance with the Public Sector Internal Audit Standards (PSIAS);

- the ICB internal audit charter and annual audit plan, must be endorsed by the ICB Accountable Officer, Audit and Risk Committee and Board;

- the head of internal audit must provide an annual opinion on the overall adequacy and effectiveness of the Board's framework of governance, risk management and internal control as they operated during the year, based on a systematic review and evaluation;

- the head of internal audit should attend Audit and Risk Committee meetings and have a right of access to all audit and risk assurance committee members, the Chair and Chief Executive of the ICB.

- the appropriate and effective financial control arrangements are in place for the ICB and that accepted internal and external audit recommendations are actioned in a timely manner.

4.3 External audit

The Chief Finance Officer is responsible for:

- liaising with external audit colleagues to ensure timely delivery of financial statements for audit and publication in accordance with statutory, regulatory requirements;

- ensuring that the ICB appoints an auditor in accordance with the Local Audit and Accountability Act 2014; in particular, the ICB must appoint a local auditor to audit its accounts for a financial year not later than 31 December in the preceding financial year; the ICB must appoint a local auditor at least once every 5 years and

- ensuring that the appropriate and effective financial control arrangements are in place for the ICB and that accepted external audit recommendations are actioned in a timely manner.

5. Financial systems and processes

5.1 Provision of finance systems

5.1.1 To be read in conjunction with section 16 – Digital.

5.1.2 The Chief Finance Officer is responsible for ensuring systems and processes are designed and maintained for the recording and verification of finance transactions such as payments and receivables for the ICB.

5.1.3 The systems and processes will ensure, that payment for goods and services is made in accordance with the provisions of these SFIs, related procurement guidance and prompt payment practice.

5.1.4 The required accounting system for use by ICBs is the Integrated Single Financial Environment ("ISFE"), which is due to be updated to ISFE2 in April 2025.

5.1.5 Access will be granted to ICB employees to enable users to perform core accounting functions such as to transacting and coding of expenditure/income in fulfilment of their roles.

5.1.6 The Chief Finance Officer will, in relation to financial systems:

- promote awareness and understanding of financial systems, value for money and commercial issues;
- ensure that transacting is carried out efficiently in line with current best practice;
- ensure that the ICB meets the required financial and governance reporting requirements as a statutory body by the effective use of finance systems;
- enable the prevention and the detection of inaccuracies and fraud, and the reconstitution of any lost records;
- ensure that the financial transactions of the authority are recorded as soon as, and as accurately as, reasonably practicable;
- ensure publication and implementation of all ICB business rules and ensure that the finance team is appropriately resourced to deliver all statutory functions of the ICB;
- ensure that risk is appropriately managed;

- ensure identification of the duties of officers dealing with financial transactions and division of responsibilities of those officers;

- ensure the ICB has suitable financial and other software to enable it to comply with these policies and any consolidation requirements of the ICB;

- ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes; and

- where another health organisation or any other agency provides a computer service for financial applications, the Chief Finance Officer shall periodically seek assurances that adequate controls are in operation.

6. Planning, Budgets and Budgetary Control

6.1 Planning

6.1.1 Prior to the start of the financial year the Chief Finance Officer, on behalf of the Accountable Officer, will prepare an Annual Plan for approval by the Board and NHS England.

6.1.2 The annual plan will be developed in line with the ICS's Medium Term plan and the NHS Long term plan objectives and will:

a. be in accordance with the aims and objectives set out in the ICB's strategy;

b. ensure the achievement of the ICB statutory duty to breakeven, within the ICS's duty to breakeven;

c. accord with workload and manpower plans;

d. be prepared within the limits of available funds;

e. identify potential risks.

6.1.3 The approved annual plan will be the basis for setting the detailed budget plan and delegated budgets to approved budget holders.

6.1.4 The Chief Finance Officer will ensure that financial performance is monitored against budget and plan and communicated to appropriate Boards and Committees.

6.1.5 All budget holders must provide information as required by the Chief Finance Officer to enable budgets to be compiled.

6.2 Budgetary control and reporting

6.2.1 The Chief Finance Officer is

- responsible for maintaining policies and processes relating to the control, management and use of resources across the ICB;

- will delegate the budgetary control responsibilities to budget holders through a formal documented process.

6.2.2 The Chief Finance Officer will ensure:

- the promotion of compliance to the SFIs through a financial governance framework;
- the promotion of long-term financial heath for the NHS system (including ICS);
- budget holders are accountable for obtaining the necessary approvals and oversight of all expenditure incurred on the cost centres and subjective code combinations they are responsible for;
- the improvement of financial literacy of budget holders with the appropriate level of expertise and systems training;
- that the budget holders are supported in proportion to the operational risk; and
- the implementation of financial and resources plans that support the NHS Long term plan objectives.

6.2.3 In addition, the Chief Finance Officer should have financial leadership responsibility for the following statutory duties:

- that of the ICB, in conjunction with its partner NHS trusts and NHS foundation trusts, to exercise its functions with a view to ensuring that, in respect of each financial year,
    - local capital resource use does not exceed the limit specified in a direction by NHS England;
    - local revenue resource use does not exceed the limit specified in a direction by NHS England.
- the duty of the ICB to perform its functions as to secure that its expenditure does not exceed the aggregate of its allotment from NHS England and its other income; and
- the duty of the ICB, in conjunction with its partner trusts, to seek to achieve any joint financial objectives set by NHS England for the ICB and its partner trusts.

6.2.4 The Chief Finance Officer and other Chief Officers should also promote a culture where budget holders and decision makers consult their heads of finance in key strategic decisions that carry a financial impact.

6.3 Budget holder responsibilities

6.3.1 Each Budget Holder is responsible for ensuring that:

a. they sign off their budget, as approved through the approved annual plan, at the start of the year and provide accurate forecasts of out-turn during the course of the year;

b. the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised, subject to the rules of virement;

c. no permanent employees are appointed without the approval of the Chief Executive Officer other than those provided for within the available resources and manpower establishment as approved by the Board;

d. any likely overspending or reduction of income which cannot be met by virement is not incurred without the prior consent of the following delegated officers within the % of budget set up below;

a.	Head of Finance	< 1%
b.	Deputy Chief Finance Officer	>1% and <2%
c.	Chief Finance Officer	>2% and >5%
d.	CFO and CEO	>5%.

To be escalated to Board on a case by case basis, following oversight by FED and also other Board committees with specific responsibility for the assurance of the service being commissioned.

e. Full variance analysis from budgeted plan and corrective actions must be provided;

f. they participate in finance training to develop the skills and knowledge necessary to discharge their financial management duties;

g. they use the ICB's finance systems as required;

h. where matters of financial control risk are identified, they are communicated to the ICB finance team as a matter of urgency;

i. they are accountable for their budgets and financial performance, even where contracts are negotiated on behalf of the ICB by another institution;

j. they take responsibility for ensuring that new members of staff are paid the correct salary and for making sure that final payments to and from employees are correct;

k. ensuring that the prices paid for goods are correct, represent value for money, that procedures are followed to prevent fraud and that all invoices are appropriately authorised and that the goods and services received are correct;

l. aware of the ICB's medium term plan and the impact of in year commitments on future years' planning assumptions

m. they are available to work with the auditors and respond to questions or recommendations.

6.3.2 The Executive Team is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the Annual Plan and a balanced budget.

6.4 Virement

6.4.1 Virements cover all budget transfers carried out in the financial year apart from those enacting the Annual Plan.

6.4.2 Delegated limits for virement are

a. NHS England for the whole ICB unlimited value: this includes all allocation changes consequent budget changes and any change required to meet Integrated Single Financial Environment (ISFE) reporting requirements;

b. Board for the whole ICB unlimited value: this includes Annual Operating Plan and any business cases/proposals agreed by the Board;

c. >£500k and <£1m Chief Executive Officer and Chief Finance Officer; includes any committee that approves expenditure where the Chief Executive Officer or Chief Finance Officer or their appointed nominee is present;

d. >£250k and <£500k Chief Finance Officer includes any committee that approves expenditure where the Chief Finance Officer or their appointed nominee is present;

e. >£25k and <£250k Chief Officer for their directorate~~;~~

f. >£10k and <£25k Assistant Chief Officers for their directorate~~;~~

g. <£10k Budget Holder for their service.

6.4.3 Approval in line with the delegated limits will be evidenced through the budget virement form signed by those with delegated authority (as per 6.4.2) or meeting minutes. Evidence of NHS England directed changes will be in the form of allocation reconciliation, email directing the change or guidance published by NHS England.

6.4.4 All budget journals will be supported by the approvals noted in 6.4.3 and processed and signed by an authorised member of the management account team.

6.4.5 The finance team will make the following technical adjustments as they become necessary:

a. Contract value adjustments

b. Corrections

c. Phasing

d. Reallocation of unused budgets back to reserves

6.5 Reserves

6.5.1 Reserves cover all expenditure budgets not currently allocated to a budget holder and are held centrally.

6.6 Capital expenditure

6.6.1 The general rules applying to delegation and reporting shall also apply to capital expenditure.

6.7 Monitoring returns

6.7.1 The Chief Finance Officer is responsible for ensuring that the appropriate monitoring forms are submitted to the ICB's designated external regulators.

7. Income, banking arrangements and debt recovery

7.1 Income

7.1.1 An ICB has power to do anything specified in section 7(2)(a), (b) and (e) to (h) of the Health and Medicines Act 1988 for the purpose of making additional income available for improving the health service.

7.1.2 The Chief Finance Officer is responsible for:

- ensuring order to bank practices are designed and operated to support, efficient, accurate and timely invoicing and receipting of cash. The processes and procedures should be standardised and consistent across the NHS system by working with the Shared Services provider; and
- ensuring the debt management procedures reflects the debt management objectives of the ICB and the prevailing risks.

7.1.3 The ICB shall follow the Department of Health and Social Care costing manual in setting prices for NHS service agreements.

7.1.4 The Chief Finance Officer is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health and Social Care or by Statute. Independent professional advice on matters of valuation shall be taken as necessary.

7.1.5 All employees must inform the management accounts team promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

7.2 Banking

7.2.1 The Chief Finance Officer is responsible for ensuring the ICB complies with any directions issued by the Secretary of State with regards to the use of specified banking facilities for any specified purposes.

7.2.2 The Chief Finance Officer is responsible for ensuring the ICB complies with any directions

7.2.3 The Chief Finance Officer will ensure that:

- the ICB holds the minimum number of bank accounts required to run the organisation effectively. These should be raised through the government banking services contract; and

- the ICB has effective cash management policies and procedures in place.

7.3 Debt management

7.3.1 The Chief Finance Officer is responsible for the ICB debt management policies and procedures.

7.3.2 This includes:

- debt management policies and procedures that covers end-to-end debt management from debt creation to collection or write-off in accordance with the losses and special payment procedures;

- ensuring the debt management policies and procedures covers a minimum period of 3 years and must be reviewed 12 months to ensure relevance and provide assurance;

- accountability to the Board that debt is being managed effectively;

- accountabilities and responsibilities are defined with regards to debt management to budget holders; and

- responsibility to appoint a senior officer responsible (Head of Financial Services) for day-to-day management of debt.

7.4 Security of cash

7.4.1 The Chief Finance Officer is responsible for:

a. approving the means of officially acknowledging or recording monies received or receivable;

b. the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines;

c. prescribing systems and procedures for handling cash and negotiable securities on behalf of the ICB.

7.4.2 Official money shall not under any circumstances be used for the encashment of private cheques or IOUs.

7.4.3 Any cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received.

7.4.4 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the ICB is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the ICB from responsibility for any loss.

8. Procurement and purchasing

8.1 Principles

8.1.1 The Chief Finance Officer will take a lead role on behalf of the ICB to ensure that there are appropriate and effective financial, contracting, monitoring and performance arrangements in place to ensure the delivery of effective health services.

8.1.2 The ICB must ensure that procurement activity is in accordance with the legislation and regulation as described in the ICB's procurement policies for healthcare and goods and services and associated statutory requirements whilst securing value for money and sustainability. The Procurement policy can be found on the ICB's website and the Hub.

8.1.3 The ICB must consider, as appropriate, any applicable NHS England guidance that does not conflict with the above.

8.1.4 All revenue and non-pay expenditure must be approved, in accordance with the ICB business case policy, prior to an agreement being made with a third party that enters a commitment to future expenditure.

8.1.5 All officers must ensure that any conflicts of interest are identified, declared and appropriately mitigated or resolved in accordance with the ICB standards of business conduct policy.

8.1.6 Budget holders are accountable for obtaining the necessary approvals and oversight of all expenditure incurred on the cost centres and subjective code combinations they are responsible for. This includes obtaining the necessary internal and external approvals which vary based on the type of spend, prior to procuring the goods, services or works.

8.1.7 The ICB shall undertake any contract variations or extensions in accordance with Public Contracts Regulation 2015 (goods and services) and/or The Health Care Services (Provider Selection Regime) Regulations 2023 and the ICB procurement policy.

8.1.8 The award of grant agreements must be in accordance with NHS England guidance and model agreement as referenced in section 13.4.

8.1.9 Retrospective expenditure approval should not be permitted. Any such retrospective breaches require approval from any committee responsible for approvals before the liability is settled. Such breaches must be reported to the Audit and Risk committee.

8.1.10 The ICB will consider obtaining expert support as appropriate to ensure compliance when engaging in tendering procedures.

8.2 Authorisation to procure

8.2.1 Providing all the conditions and circumstances set out in these Standing Financial Instructions and the Procurement policy (on Hub) have been fully complied with thresholds for the formal **authorisation to procure** for tenders and competitive quotations or commission pilot schemes are based on the type of procurement:

- Commissioning of Health Care Services (8.2.5)
- Commissioning of packages of care (8.2.6)
- Non-health care procurements - running costs (8.2.7)
- Non- health care procurements – excluding running costs (8.2.8)

8.2.2 The contract life cycle value excludes VAT. For commissioning of packages of care the procurement value represents the annual cost of the package.

8.2.3 Officers with delegated responsibility include their delegated deputies.

Commissioning of Health Care Services

8.2.4 To be read in conjunction with section 8.13 - Healthcare Service Agreements and the Procurement policy.

8.2.5 The formal authorisation to procure is delegated as follows:

• £100k	Designated budget holder
• >£100k and <£1m	Lead Chief Officer
• >£1m and <£5m	Chief Finance Officer **or** Chief Executive Officer
• >£5m	ICB Board following oversight by FED and other Board committees with a specific responsibility for the service being contracted.

Commissioning of packages of care

8.2.6 The Chief Nursing Officer will develop a commissioning policy for individual funded care packages. The formal authorisation to procure is delegated as follows (values represent annual costs of packages of care) and will follow an escalation process:

- £130k — Designated budget holder *(level 1 and 2 of policy)*
- >£130k and <£260k — As above plus Complex Care panel (level 3)
- >£260k and <£520k — As above plus High cost panel *(level 4)*
- >£520k and <£750k — As above plus Chief Nursing Officer *(level 5)*
- £750k and <£1m — As above plus Chief Finance Officer **or** Chief Executive Officer
- >£1m — Specially convened panel including Chief Nursing Officer, Chief Finance Officer, Chief Executive and a Non Executive member *(level 5)*

8.2.7 Care packages must be reviewed on an annual basis and subject to the same authorisation process.

Non-healthcare procurement – running costs

8.2.8 The formal authorisation to procure is delegated as follows:

- <£50k — Designated budget holder
- >£50k and <£500k — Lead Chief Officer
- >£500k and <£1m — Chief Finance Officer **or** Chief Executive Officer
- >£1m — ICB Board following oversight by FED and other Board committees with a specific responsibility for the service being contracted.

Non-healthcare procurement – excluding running costs

8.2.9 The formal authorisation to procure is delegated as follows:

- <£100k — Designated budget holder
- >£100k and <£1m — Lead Chief Officer

- >£1m and <£5m — Chief Finance Officer **or** Chief Executive Officer
- >£5m — ICB Board following oversight by FED and other Board committees with a specific responsibility for the service being contracted.

8.3 Route to procurement

8.3.1 The ICB Procurement policy and Procurement SOP; available on the Hub set out the route to procurement in line with current legislation and regulations. The delivery of all healthcare and goods and services, including transformation and pilot schemes, will be contracted through the following routes;

- Quotations: Competitive and non-competitive (8.4)
- Competitive tendering (8.5)
- By exception, waiving of quotations and competitive tendering (8.6)

8.4 Quotations: Competitive and non-competitive

8.4.1 For **Healthcare** quotations are required where formal tendering procedures are not adopted and where the intended expenditure or income exceeds or is reasonably expected to exceed £5k but not exceed £50k over the **lifetime of the contract.**

8.4.2 For **non healthcare** quotations are required where formal tendering procedures are not adopted and where the intended expenditure or income exceeds, or is reasonably expected to exceed £5k but not exceed the Public Contract Regulation threshold level (October 2024 £139,688) over the **lifetime of the contract**.

8.4.3 Competitive Quotations

a. Quotations should be obtained from at least 3 firms/individuals based on specifications or terms of reference prepared by, or on behalf of, the ICB;

b. Quotations should be in writing;

c. All quotations should be treated as confidential, should be retained for inspection and used to populate the contract register (see section 8.10.2);

d. Those with delegated authority should evaluate the quotation and select the quote which gives the best value for money. If this is not the lowest quotation for a payment made by the ICB, or the highest for a payment received by the ICB, then the choice made and the reasons why should be recorded in a permanent record.

e. For **non-healthcare quotations** the competitive quotations should be used to raise a procurement order through the financial system.

8.4.4 No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the ICB (8.2) and which is not in accordance with Standing Financial Instructions except with the authorisation of either the Chief Executive Officer or Chief Finance Officer.

8.4.5 Non-Competitive Quotations

Non-competitive quotations in writing may be obtained in the following circumstances:

a. the supply of proprietary or other goods of a special character and the rendering of services of a special character, for which it is not, in the opinion of the Responsible Officer, possible or desirable to obtain competitive quotations;

b. the supply of goods or manufactured articles of any kind which are required quickly and are not obtainable under existing contracts;

c. where the goods or services are for building and engineering maintenance the responsible works manager must certify that the first two conditions of this SFI applies.

8.4.6 Where three quotes cannot be obtained or non-competitive quotations applied a Single Tender Waiver document must be completed following the process as set out in section 8.6.

8.5 Competitive tendering

8.5.1 **Non-healthcare** related services

The ICB shall ensure that competitive tenders are invited for non-healthcare related contracts where the intended expenditure or income exceeds, or is reasonably expected to exceed the Public Contract Regulation threshold level (October 2024 £139,688) over the lifetime of the contract, including:

- the supply of goods, materials and manufactured articles;
- services including all forms of management consultancy services (other than specialised services sought from or provided by the Department of Health and Social Care);
- the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); for disposals.

8.5.2 **Health Care** Services

To be read in conjunction with section 8.13 - Healthcare Service Agreements and the latest version of the Procurement Policy (available on the Hub).

8.5.3 Where the ICB elects to invite tenders for the supply of healthcare services the ICB Constitution and these Standing Financial Instructions shall apply as far as they are applicable to the tendering procedure.

8.5.4 Exceptions and instances where formal tendering need not be applied

Formal tendering procedures need not be applied (see section 8.6) where:

a. the estimated expenditure or income does not, or is not reasonably expected to, exceed £50k (contract life cycle); or

b. where the supply is proposed under special arrangements negotiated by the Department of Health and Social Care in which event the said special arrangements must be complied with;

c. regarding disposals as set out in Standing Financial Instructions No. 8.6.

8.5.5 Where competitive tendering has not been applied or exceptions taken a Single Tender Waiver document must be completed following the process as set out in section 8.6.

8.6 Waiving of tendering procedures

8.6.1 Formal tendering procedures may be waived in the following circumstances:

a. in very exceptional circumstances where the Chief Executive Officer decides that formal tendering procedures would not be practicable or the estimated expenditure or income would not warrant formal tendering procedures;

b. where the requirement is covered by an existing contract, including any optional extension periods;

c. where the Cabinet Office framework agreements are in place and have been approved by the Board;

d. where a consortium arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the consortium members;

e. where the timescale genuinely precludes competitive tendering, but failure to plan the work properly would not be regarded as a justification for a single tender;

f. where specialist expertise is required and is available from only one source;

g. where specialist activities covered under a grant agreement are available from only one voluntary community and social enterprise organisation;

h. when the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate;

i. there is a clear benefit to be gained from maintaining continuity with an earlier project. However, in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering;

j. for the provision of legal advice and services providing that any legal firm or partnership commissioned by the ICB is regulated by the Law Society for England and Wales for the conduct of their business (or by the Bar Council for England and Wales in relation to the obtaining of Counsel's opinion) and are generally recognised as having sufficient expertise in the area of work for which they are commissioned;

k. where allowed and provided for in the Capital Investment Manual.

l. where current contract arrangements are transitioned to the new financial system (ISFE2)

8.6.2 The waiving of competitive tendering procedures should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure.

Where it is decided that competitive tendering is not applicable and should be waived, the fact of the waiver and the reasons should be documented and recorded in an appropriate ICB record and reported to the Audit, and Risk Committee at each meeting.

8.6.3 Fair and Adequate Competition. Where the exceptions set out in 8.5.4 apply, the ICB shall ensure that Invitations To Tender (ITT) are sent to a sufficient number of firms/individuals to provide fair and adequate competition as appropriate, and in no case less than three firms/individuals, having regard to their capacity to supply the goods or materials or to undertake the services or works required.

8.6.4 List of approved firms. The ICB shall ensure that the firms/individuals invited to tender (and where appropriate, quote) are among those on appropriate frameworks or that are otherwise confirmed as qualified. Where in the opinion of the Chief Finance Officer it is desirable to seek tenders from firms not on the approved lists, the reason shall be recorded in writing to the Chief Executive Officer.

8.6.5 Items which subsequently breach thresholds after original approval. Items estimated to be below the limits set in these SFIs for which formal tendering procedures are not used which subsequently prove to have a value above such limits shall be reported to the Chief Executive Officer and be recorded in an appropriate ICB record.

8.6.6 Where tendering procedures have been waived a single tender waiver form needs to be completed (available from the Corporate and Operations team) and signed as noted below and attached to the requisition, before being reported to the Audit and Risk Committee.

- >£5k and <£100k Lead Chief Officer
- >£100k and <£1m As above plus Chief Finance Officer
- >£1m As above plus Chief Executive Officer
- >£5m As above plus ICB Board

8.7 Disposals (cross reference to SFI 14.2)

8.7.1 Where competitive tendering or quotation procedures shall not apply to the disposal of:

a. any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive Officer or their nominated officer;

b. obsolete or condemned articles and stores, which may be disposed of in accordance with the supplies policy of the ICB;

c. items to be disposed of with an estimated sale value of less than £1,000;

d. items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract;

e. land or buildings concerning which Department of Health and Social Care guidance has been issued but subject to compliance with such guidance.

8.8 Personnel, agency, or temporary staff contracts

8.8.1 The Chief Executive Officer shall ensure compliance with instructions issued by Department of Health and Social Care and NHS England. The Chief Executive Officer shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts and put in place any necessary arrangements in relation to vacancy control before recruitment and to manage risks associated with organisational change.

8.8.2 Where a role is as a Board Member or senior official, these must be in line with the 2012 HMT Review of Tax Arrangements for Public Sector Appointees, the HMT guidance "Managing Public Money" instructions from the Department of Health and Social Care for the reimbursement of Board members and senior officials, and the ICB Constitution.

8.8.3 Board appointments will be made in accordance with the Fit and Proper Person (FPP) test requirements.

8.9 Authorisation of contracts and grants

8.9.1 Providing all the conditions and circumstances set out in these Standing Financial Instructions have been fully complied with the formal authorisation and awarding of a contract or grant agreement is delegated to the following staff within +/- 10 percent of the authorised tender value as follows (contract life cycle inc. VAT):

- <£100k — Designated Budget Holders
- >£100k and <£1m — Lead Chief Officer
- >£1m and <£5m — Chief Executive Officer or Chief Finance Officer
- >£5m — ICB Board

8.9.2 All tenders that will be, or are forecast to be, greater than, the authorised tender value by +/- 10 percent or exceed the designated budget holder shall be escalated to the next level.

8.10 Signing of contracts and grant agreements

8.10.1 Providing all the conditions and circumstances set out in these Standing Financial Instructions, including the authorisation and awarding of contracts and grant agreements in section 8, have been fully complied with the formal signing of a contract is delegated as follows:

- <£100k — Designated budget holders
- >£100k and <£1m — Lead Chief Officer

• >£1m and <£500m	Chief Executive Officer **or** the Chief Finance Officer. Formal authorisation must be put in writing.
• >£500m	Chief Executive Officer **and** Chief Finance Officer

8.10.2 All signed contracts and grant agreements must be recorded in the ICB's contracts register in line with the ICB Contract Management standard operating procedure.

8.11 Contract variations

8.11.1 All contract variations and all supporting documents including the Signing Assurance Form (SAF) must be signed by the delegated officer roles who signed the original contract.

8.12 Compliance requirements for all contracts and grant agreements

8.12.1 The Board and delegated officers may only enter into contracts or grant agreements on behalf of the ICB within the statutory powers delegated to it by the Secretary of State and shall comply with:

a. the ICB's Constitution and Standing Financial Instructions;

b. directives and other statutory provisions, so long as they continue to apply as a matter of law;

c. such as part of the NHS Act 2006 the NHS Standard Contract Conditions, section 75 agreements, General Medical Services and Alternative Primary Medical Services as are applicable;

d. Care Quality Commission guidance;

e. contracts with foundation trusts must be in a form compliant with appropriate NHS guidance;

f. where appropriate contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited;

g. in all contracts and grant agreements made by the ICB, the Board shall endeavour to obtain best value for money by use of all systems in place. The Chief Executive Officer shall nominate an officer who shall oversee and manage each contract and grant agreement on behalf of the ICB.

8.13 Healthcare Service Agreements (cross reference with SFI 8.2.4 and 8.5.2)

8.13.1 Service agreements with NHS providers for the supply of healthcare services shall be drawn up in accordance with current legislation and guidance and administered by the ICB. Service agreements are not contracts in law and are not enforceable by the courts. However, a contract with a Foundation Trust, being a Performance Based Contracts, is a legal document and is enforceable in law.

8.13.2 The Chief Executive Officer shall nominate officers to commission service agreements with providers of healthcare in line with a commissioning plan approved by the Board.

9. Contracting/Tendering Procedure

9.1 Invitation to tender

9.1.1 Invitation to tender should be undertaken in conjunction with the SCW procurement team and the relevant legislation, as referenced in section 8.1.

9.1.2 Where e-tendering is not used, all invitations to tender shall state the date and time as being the latest time for the receipt of tenders.

9.1.3 All invitations to tender shall state that no tender will be accepted unless

- submitted in a plain sealed package or envelope bearing a pre-printed label supplied by the ICB (or the word "tender" followed by the subject to which it related) and by the latest date and time for the receipt of such tender addressed to the Chief Executive Officer or nominated manager;

- that tender envelopes/ packages shall not bear any names or marks indicating the sender. The use of courier/postal services must not identify the sender on the envelope or on any receipt so required by the deliverer.

9.1.4 Where an e-tendering software package is used the supplier's response will be completed on-line and uploaded to a secure mailbox until the opening time.

9.1.5 Every tender for goods, materials, services or disposals shall embody such elements of the NHS Standard Contract Conditions as are applicable. This will also include services procured collaboratively with local authorities and other partners. Recognising services may be contracted under a local authority's contract.

9.1.6 Every tender must have given, or give a written undertaking, not to engage in collusive tendering or other restrictive practices.

9.2 Receipt and safe custody of tenders

9.2.1 The Chief Executive Officer or their nominated representative will be responsible for the receipt, endorsement and safe custody of tenders received until the time appointed for their opening.

9.2.2 The date and time of receipt of each tender shall be endorsed on the tender envelope/package.

9.2.3 An audit log within the e-tendering system will record the date and time the offer documents are received.

9.3 Opening tenders and register of tenders

9.3.1 Where e-tendering is **not** used:

a. As soon as practicable after the date and time stated as being the latest time for the receipt of tenders, they shall be opened by two senior officers/managers designated by the Chief Executive Officer and not from the originating department.

b. The originating department will be taken to mean the department sponsoring or commissioning the tender.

c. A member of the ICB Executive team will be required to be one of the two approved persons present for the opening of tenders estimated above £500k (contract life cycle). The rules relating to the opening of tenders will need to be read in conjunction with any delegated authority set out in the ICB's Scheme of Reservation and Delegation.

d. The involvement of finance staff in the preparation of a tender proposal will not preclude the Chief Finance Officer or any approved senior manager from the finance team from serving as one of the two senior managers to open tenders.

e. The Executive team will be authorised to open tenders regardless of whether they are from the originating department provided that the other authorised person opening the tenders with them is not from the originating department.

f. The ICB's Company Secretary or equivalent role will count as a Director for the purposes of opening tenders.

g. Every tender received shall be marked with the date of opening and initialled by those present at the opening. Where an electronic tendering package is used the details of the persons opening the documents will be recorded in the audit trail together with the date and time of the document opening.

h. A register shall be maintained by the Chief Executive Officer, or a person authorised by them, to show for each set of competitive tender invitations dispatched:

- the name of all firms or individuals invited;
- the names of firms or individuals from which tenders have been received;
- the date the tenders were received and opened;
- the persons present at the opening;
- the price shown on each tender;

- a note where price alterations have been made on the tender and suitably initialled.

Each entry to this register shall be signed by those present. A note shall be made in the register if any one tender price has had so many alterations that it cannot be easily read or understood.

i. Incomplete tenders, i.e., those from which information necessary for the adjudication of the tender is missing, and amended tenders i.e., those amended by the tenderer upon their own initiative either orally or in writing after the due time for receipt, but prior to the opening of other tenders, should be dealt with in the same way as late tenders (section 9.5 below).

9.4 Admissibility

9.4.1 If for any reason the designated officers are of the opinion that the tenders received are not strictly competitive (for example, because their numbers are insufficient or any are amended, incomplete or qualified) no contract shall be awarded without the approval of the Chief Executive Officer.

9.4.2 Where only one tender is sought and/or received, the Chief Executive Officer and Chief Finance Officer shall, as far practicable, ensure that the price to be paid is fair and reasonable and will ensure value for money for the ICB.

9.5 Late tenders

9.5.1 Tenders received after the due time and date, but prior to the opening of the other tenders, may be considered only if the Chief Executive Officer or nominated officer decides that there are exceptional circumstances i.e. dispatched in good time but delayed through no fault of the tenderer.

9.5.2 Only in the most exceptional circumstances will a tender be considered which is received after the opening of the other tenders and only then if the tenders that have been duly opened have not left the custody of the Chief Executive Officer or their nominated officer or if the process of evaluation and adjudication has not started.

9.5.3 While decisions as to the admissibility of late, incomplete or amended tenders are under consideration, the tender documents shall be kept strictly confidential, recorded, and held in safe custody by the Chief Executive Officer or their nominated officer.

9.5.4 Accepted late tenders will be reported to the Board.

9.6 Acceptance of formal tenders

9.6.1 Any discussions with a tenderer which are deemed necessary to clarify technical aspects of their tender before the award of a contract will not disqualify the tender.

9.6.2 The most economical advantageous tender, if payment is to be made by the ICB, or the highest, if payment is to be received by the ICB, shall be accepted unless there are good and sufficient reasons to the contrary. Such reasons shall be set out in either the contract file, or other appropriate record. It is accepted that for professional services such as management consultancy, the lowest price does not always represent the best value for money. Other factors affecting the success of a project will be included in the criteria section of the invitation to tenders and may include:

- experience and qualifications of team members;
- understanding of client's needs;
- feasibility and credibility of proposed approach;
- ability to complete the project on time.

9.6.3 Where other factors are taken into account in selecting a tenderer, these must be clearly recorded and documented in the contract file, and the reason(s) for not accepting the lowest tender clearly stated.

9.6.4 No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the ICB (section 8.2) and which is not in accordance with these instructions except with the authorisation of the Chief Executive Officer.

9.6.5 The use of these procedures must demonstrate that the award of the contract was:

- not in excess of the going market rate / price current at the time the contract was awarded;
- that best value for money was achieved.

9.6.6 All tenders should be treated as confidential and should be retained for inspection.

9.7 Tender reports to the ICB Board

9.7.1 Reports to the Board will be made on an exceptional circumstance basis only.

10. Staff costs and staff related non pay expenditure

10.1 Remuneration and terms of service

10.1.1 In accordance with ICB Constitution the Board shall establish a Remuneration and Terms of Service Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting. (See NHS guidance contained in the Higgs report).

10.1.2 The Committee will operate within the scheme of delegation agreed and agreed terms of reference:

a. advise the Board about appropriate remuneration and terms of service for the Chief Executive Officer, Executive Senior Managers (ESM) other officer members and clinical leads employed by the ICB including:

   - all aspects of salary (including any performance-related elements/ bonuses)
   - provisions for other benefits, including pensions and cars
   - arrangements for termination of employment and other contractual terms;

b. Advise the Board on the remuneration and terms of service of officer members of the Board and members (and other senior employees) to ensure they are fairly rewarded for their individual contribution to the ICB - having proper regard to the ICB's circumstances and performance and to the provisions of any national arrangements for such members and staff where appropriate;

c. monitor and evaluate the performance of individual officer members and members of the Board;

d. advise on and oversee appropriate contractual arrangements for staff including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate.

10.1.3 The Committee shall keep the Board informed of their activities and decisions made within scope of their remit as detailed in the agreed terms of reference. Minutes of the Board's meetings should record information discussed.

10.1.4 The Board will consider and need to approve proposals presented by the Chief Executive Officer for the setting of remuneration and conditions of service for those employees and officers not covered by the Committee.

10.1.5 The ICB will pay allowances to the Chair and non-Executive Members of the Board in accordance with instructions issued by the Secretary of State for Health and Social Care.

10.2 Funded establishment

10.2.1 The staffing plans incorporated within the annual budget will form the funded establishment.

10.2.2 The funded establishment of any department may not be varied without the approval of the Chief Executive Officer or their nominated deputy.

10.3 Staff appointments

10.3.1 No officer or member of the Board or employee may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration:

a. Without approval from the ICB vacancy control panel, and

b. unless it's within the limit of their approved budget and funded establishment.

10.3.2 The Board will approve policies presented by the Chief People Officer for the determination of commencing pay rates, condition of service, etc. for employees.

10.4 Processing payroll

10.4.1 The Chief Finance Officer is responsible for:

a. specifying timetables for submission of properly authorised time records and other notifications;

b. agreeing with HR policies for the final determination of pay;

c. making payment on agreed dates;

d. agreeing methods of payment;

10.4.2 The Chief Finance Officer will issue instructions regarding:

a. verification and documentation of data;

b. the timetable for receipt and preparation of payroll data and the payment of employees and allowances;

c. maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;

d. security and confidentiality of payroll information;

e. checks to be applied to completed payroll before and after payment;

f. authority to release payroll data under the provisions of the Data Protection Act;

g. methods of payment available to various categories of employee and officers;

h. procedures for payment to employees and officers;

i. procedures for the recall of payments~~;~~

j. pay advances and their recovery including salary sacrifice;

k. maintenance of regular and independent reconciliation of pay control accounts;

l. separation of duties of preparing records and handling cash;

m. a system to ensure the recovery from those leaving the employment of the ICB of sums of money and property

10.4.3 Appropriately nominated managers have delegated responsibility for:

a. submitting time records, and other notifications in accordance with agreed timetables;

b. completing time records and other notifications in accordance with the Chief Finance Officer's instructions and in the form prescribed by the Chief Finance Officer including approval of expenses;

c. submitting termination forms in the prescribed format immediately upon knowing the effective date of an employees or officer’s resignation, termination or retirement. Where an employee fails to report for duty or to fulfil obligations in circumstances that suggest they have left without notice, the Chief Finance Officer must be informed immediately;

10.4.4 Regardless of the arrangements for providing the payroll service, the Chief Finance Officer shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangement are made for the collection of payroll deductions and payment of these to appropriate bodies.

10.5 Contracts of employment

10.5.1 The Board shall delegate responsibility to an officer for:

a. ensuring that all employees are issued with a contract of employment in a form approved by the Board and which complies with employment legislation; and

b. dealing with variations to, or termination of, contracts of employment. This includes cases subject to disciplinary rules and procedure and where suspension is under review in line with the delegation of authority as detailed in the Disciplinary policy.

11. Non pay expenditure

11.1 Delegation of Authority

11.1.1 The Board will approve the level of non-pay expenditure on an annual basis and the Chief Finance Officer will determine the level of delegation to budget managers.

11.1.2 The Chief Finance Officer will set out:

(a) the authorised managers who are authorised to place requisitions for the supply of goods and services;

(b) the maximum level of each requisition and the system for authorisation above that level.

11.1.3 The Chief Finance Officer shall set out procedures on the seeking of professional advice regarding the supply of goods and services in accordance with NHS England guidance.

11.2 Choice, Requestioning, Ordering, Receipt and Payment for Goods *(see overlay with SFI 8 and 9)*

11.2.1 Requisitioning

Providing all the conditions and circumstances set out in these Standing Financial Instructions have been fully complied the requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the ICB (please refer to section 8 for thresholds, tendering, quotations, contracts and waivers and section 9 for tendering procedures).

11.2.2 In so doing, the advice of the ICB's adviser on supply shall be sought. Where this advice is not acceptable to the requisitioner the Chief Finance Officer or the Chief Executive Officer shall be consulted, in line with section 9.6.4.

11.2.3 System of Payment and Payment Verification

The Chief Finance Officer shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

The operational Scheme of Reservation and Delegation sets out levels of delegated authority for payment authorisation in the following instances:

a. Budget already approved by the Board e.g. payments to NHS bodies arising from agreement of NHS Contracts.
b. Payments to NHS bodies where there is no contract in place.

11.2.4 The Chief Finance Officer will

a. prepare procedural instructions or guidance within the Scheme of Delegation on the obtaining of goods, works and services incorporating the thresholds;

b. be responsible for the prompt payment of all properly authorised accounts and claims;

c. be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable;.

d. be responsible for ensuring a timetable and system for submission of accounts to the Audit and Risk Committee;

e. be responsible for issuing instructions to employees regarding the handling and payment of accounts within the Finance Department;

f. be responsible for ensuring that payment for goods and services is only made once the goods and services are received. The only exceptions are set out in 11.2.5 below.

11.2.5 Duties of Managers and Officers

Managers and officers must ensure that they comply with all the conditions and circumstances set out in these Standing Financial Instructions (specifically the delegations and processes set out in sections 8 and 9) no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Chief Finance Officer on behalf of the Chief Executive Officer;

a. all goods, services, or works are ordered via the Oracle I-Procurement Purchase to Pay system or on an official order except works and services executed in accordance with a contract and purchases from petty cash or cash equivalent;

b. verbal orders must only be issued by exception - by an employee designated by the Chief Executive Officer and only in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked "Confirmation Order";

c. orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

- goods are not taken on trial or loan in circumstances that could commit the ICB to a future uncompetitive purchase;
- changes to the list of members/employees and officers authorised to certify invoices are notified to the Chief Finance Officer;

d. where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by NHS England SW Region and the Department of Health and Social Care;

e. no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to the Chief Executive Officer or employees, other than:

- isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;
- conventional hospitality, such as lunches in the course of working visits.

This provision needs to be read in conjunction with Section 6 of the ICB Constitution and the principles outlined in the national guidance contained in HSG 93(5) "Standards of Business Conduct for NHS Staff"; the Code of Conduct for NHS Managers 2002; and the ABPI Code of Professional Conduct relating to hospitality/gifts from pharmaceutical/external industry; the Bribery Act 2010 and the relevant ICB policies.

f. purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Chief Finance Officer;

g. petty cash records are maintained in a form as determined by the Chief Finance Officer.

11.2.6 Prepayments

Prepayments are only permitted where exceptional circumstances apply. In such instances:

a. the financial advantages outweigh the disadvantages. Prepayments will constitute payments made in advance for periods greater than one month;.

b. the appropriate officer member of the ICB must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the ICB if the supplier is at some time during the course of the prepayment agreement unable to meet its commitments;

c. the Chief Finance Officer will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the EU public procurement rules, so long as they continue to apply as a matter of law, where the contract is above a stipulated financial threshold);

d. the budget holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate Chief Officer or Chief Executive Officer if problems are encountered.

The finance team will assess all prepayments and take a judgement on monthly adjustments based on a de minimis value of £100k.

11.2.7 Official Orders

Official orders must be made via the Oracle I-Procurement Purchase to Pay system. Where paper-based ordering systems are retained, they must:

- be consecutively numbered;
- be in a form approved by the Chief Finance Officer;
- state the ICB's terms and conditions of trade;
- only be issued to, and used by, those duly authorised by the Chief Finance Officer.

11.3 Joint Finance Arrangements with Local Authorities and Voluntary Bodies

11.3.1 Payments to local authorities and voluntary organisations made under the powers of section 75 or 256 of the NHS Act 2006, as amended, shall comply with procedures laid down by the Chief Finance Officer which shall be in accordance with that Act.

11.3.2 Section 75 and 256 agreements are authorised by the Chief Finance Officer.

12. Research and development

12.1 Objective

12.1.1 To provide specific instruction to research and development and reference to general financial instructions and processes governing this area.

12.2 General

12.2.1 The undertaking of commercial or NIHR-funded research and disbursement of by associated Research Capability Funding by ICB employees (substantive or honorary) shall be strictly in accordance with the ICB's policies and strategies on research management and governance and shall be subject to approval accordingly.

12.2.2 The Standing Financial Instructions apply equally when undertaking externally funded research activity within the ICB, particularly:

- Section 6 Planning, Budgets and Budgetary Control
- Section 7 Income, banking arrangements and debt recovery
- Section 8 Procurement and purchasing
- Section 9 Contract Tendering Procedure
- Section 10 Staff costs and staff related non pay expenditure
- Section 11 Non pay expenditure
- Section 14 Fraud, bribery and corruption
- Section 16 Gifts and donations
- Section 17 Retention of Documents
- Section 18 Risk Management, legal and insurance.

12.2.3 The principles governing probity and public accountability shall apply equally to work undertaken through externally funded research.

12.3 Research Applications

12.3.1 All applications for research funding and disbursement of Research Capability Funding, including entering into RCF Collaboration Agreements require approval from the Chief Finance Officer or a designated deputy. This applies to applications to both NHS funders and to non-NHS organisations, such as charitable bodies and research councils.

12.3.2 All other documents* relating to research will require approval from the Chief Medical Officer or a designated deputy, once all the necessary checks have been carried out, including finance checks where applicable, and advice from The Research

and Knowledge Mobilisation Advisory Committee which reports to the BNSSG ICP Research and Innovation Steering Committee and the ICB Outcomes, Quality & Performance Committee.

**other documents include research contracts with funding bodies, grant collaboration agreements, commercial research contracts, site agreements, sub-contracts with participating organisations, contract variations and contract amendments.*

12.4 Intellectual Property

12.4.1 The agreement covering any undertaking of research shall recognise the ICB's policies governing Intellectual Property rights. Where there is any lack of clarity this shall be resolved prior to undertaking the project.

13. Capital Investments, security of assets and Grants

13.1 Capital investment

13.1.1 The Chief Finance Officer is responsible for:

- ensuring that at the commencement of each financial year, the ICB and its partner NHS trusts and NHS foundation trusts prepare a plan setting out their planned capital resource use;
- ensuring that the ICB and its partner NHS trusts and NHS foundation trusts exercise their functions with a view to ensuring that, in respect of each financial year local capital resource use does not exceed the limit specified in a direction by NHS England;
- ensuring that there is an effective appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;
- ensuring that there are processes in place for the management of all stages of ICB capital schemes, that will ensure schemes are delivered on time and to cost;
- ensuring that capital investment is not authorised without evidence of availability of resources to finance all revenue consequences; and
- for every ICB capital expenditure proposal, the Chief Finance Officer is responsible for ensuring there are processes in place to ensure that a business case is produced.
- the accountability of ICB property assets and for managing property.

13.1.2 The ICB shall ensure there is a property governance and management framework, which

- confirms the ICB asset portfolio supports its business objectives; and
- complies with NHS England policies and directives and with this standard.

13.1.3 Capital commitments typically cover land, buildings, equipment, capital grants to third parties and IT, including:

- authority to spend capital or make a capital grant;
- authority to enter into leasing arrangements.

13.1.4 Advice should be sought from the Chief Finance Officer or nominated officer if there is any doubt as to whether any proposal is a capital commitment requiring formal approval.

13.1.5 The approval of a capital programme shall not constitute approval for expenditure on any scheme. Providing all the conditions and circumstances set out in these Standing Financial Instructions have been fully complied with approval of capital schemes may be given by the following staff to the total value of (contract life cycle excl. VAT):

- <£500k Chief Finance Officer.
- >£500k and <£5m Chief Executive Officer and the Chief Finance Officer.
- >£5m the Board.

13.1.6 Disposals of surplus assets should be made in accordance with published guidance and should be supported by a business case which should contain an appraisal of the options and benefits of the disposal in the context of the wider public sector and to secure value for money. (see section 14.2).

13.2 Asset registers

13.2.1 The Chief Executive Officer is responsible for the maintenance of registers of assets, taking account of the advice of the Chief Finance Officer concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted once a year.

13.2.2 The ICB shall maintain an asset register recording fixed assets. The minimum data set to be held within these registers shall be as specified in the Capital Accounting Manual as issued by the Department of Health and Social Care.

13.2.3 Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

a. properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;

b. stores, requisitions and wages records for own materials and labour including appropriate overheads;

c. lease agreements in respect of assets held under a finance lease and capitalised.

13.2.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

13.2.5 The Chief Finance Officer shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

13.2.6 The value of each asset shall be depreciated using methods and rates as specified in the Capital Accounting Manual issued by the Department of Health and Social Care.

13.3 Security of assets

13.3.1 The overall control of fixed assets is the responsibility of the Chief Finance Officer.

13.3.2 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Chief Finance Officer. This procedure shall make provision for:

a. recording managerial responsibility for each asset;

b. identification of additions and disposals;

c. identification of all repairs and maintenance expenses;

d. physical security of assets;

e. periodic verification of the existence of, condition of, and title to, assets recorded;

f. identification and reporting of all costs associated with the retention of an asset;

g. reporting

13.3.3 . All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Chief Finance Officer.

13.3.4 Whilst each employee and officer have a responsibility for the security of property of the ICB, it is the responsibility of the Board and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with agreed procedures.

13.3.5 Any damage to the ICB's premises and equipment, or any loss of equipment, stores or supplies must be reported in accordance with the procedure for reporting losses.

13.3.6 Where practical, assets should be marked as ICB property.

13.4 Grant agreements

13.4.1 The Chief Finance Officer is responsible for providing robust management, governance and assurance to the ICB with regards to the use of specific powers under which it can make capital or revenue grants available to;

- any of its partner NHS trusts or NHS foundation trusts; and
- to a Local Authority or voluntary organisation, by way of a grant or loan.

13.4.2 The ICB can award grant funding to a voluntary organisation where the ICB supports the activities of that organisation because they complement the services that the ICB commissions (for example, grant funding to contribute to a hospice) or align to the ICB's statutory functions and strategies.

13.4.3 By awarding a grant agreement the ICB is not commissioning services from the organisation but supporting the activities of that organisation: the grant agreement is not a contract for services, and so grant funding does not oblige the recipient to provide services to the ICB and the ICB cannot, through grant funding, compel a body to provide services.

13.4.4 A grant agreement should not be granted on an unconditional basis. The ICB must be assured that any funding will be used strictly for the purposes for which it was given, and that the activities provided by the recipient to those who benefit from its activities are appropriate to receive public funds and is an economic and effective use of resources.

13.4.5 The overall responsibility of the grant agreement is delegated to approved budget holders (section 6). The delegated budget holder must ensure grant agreements are established in line with NHS England guidance on the use of model grant agreements as set out in the ICB's Grant Agreement Standing Operating Procedure.

14. Losses, special payments and disposals

14.1 Losses and Special Payments

14.1.1 HM Treasury approval is required if a transaction exceeds the delegated authority, or if transactions will set a precedent, are novel, contentious or could cause repercussions elsewhere in the public sector.

14.1.2 The Chief Finance Officer will support a strong culture of public accountability, probity, and governance, ensuring that appropriate and compliant structures, systems, and process are in place to minimise risks from losses and special payments.

14.1.3 The ICB must act in accordance with the guidance and delegated limits in relation to losses and special payments, as set out in NHS England guidance.

14.1.4 NHS England has the statutory power to require an integrated care board to provide NHS England with information. The information, is not limited to losses and special payments, must be provided in such form, and at such time or within such period, as NHS England may require.

14.1.5 As part of the compliance and control procedures, ICBs must submit an annual assurance statement confirming the following:

- details of all exit packages (including special severance payments) that have been agreed and/or made during the year;
- that NHS England and HMT approvals have been obtained before any offers, whether verbally or in writing, are made; and
- adherence to the special severance payments guidance as published by NHS England.

14.1.6 All losses and special payments (including special severance payments) must be reported to the ICB Audit and Risk Committee and NHS England noting that ICBs do not have a delegated limit to approve special payments.

14.1.7 For detailed operational guidance on losses and special payments, please refer to the ICB losses and special payment guide.

14.1.8 Any employee or officer discovering or suspecting a loss of any kind must either immediately inform their Chief Officer who must immediately inform the Chief Executive Officer and the Chief Finance Officer or inform an officer charged with responsibility for responding to concerns involving loss. This officer will then appropriately inform the Chief Finance Officer and/or Chief Executive Officer.

14.1.9 Where a criminal offence is suspected, the Chief Finance Officer must immediately inform the police if theft or arson is involved. In cases of fraud and corruption or of anomalies which may indicate fraud or corruption, the Chief Finance Officer must inform the relevant LCFS and Operational Fraud Team (OFT) in accordance with Secretary of State for Health and Social Care's Directions.

14.2 Disposals

14.2.1 The Chief Finance Officer must prepare detailed procedures for the disposal of assets including condemnations and ensure that these are notified to managers.

14.2.2 When it is decided to dispose of a ICB asset, their Chief Officer or authorised deputy will determine and advise the Chief Finance Officer of the estimated market value of the item, taking account of professional advice where appropriate.

14.2.3 All unserviceable articles shall be condemned or otherwise disposed of by those duly authorised for that purpose by the Chief Finance Officer (likely to be ICB employee or SCW CSU)

14.2.4 The Condemning Officer shall satisfy themselves as to whether there is evidence of negligence in use and shall report any such evidence to the Chief Finance Officer who will take the appropriate action.

14.2.5 All property or land disposals will require approval by the Board

15. Fraud, bribery and corruption (Economic crime)

15.1 Overview

15.1.1 The ICB is committed to identifying, investigating and preventing economic crime.

15.1.2 The ICB Chief Finance Officer is responsible for ensuring appropriate arrangements are in place to provide adequate counter fraud provision which should include reporting requirements to the Board and audit committee, and defined roles and accountabilities for those involved as part of the process of providing assurance to the Board. These arrangements should comply with the NHS Requirements the Government Functional Standard 013 Counter Fraud as issued by NHS Counter Fraud Authority and any guidance issued by NHS England and NHS Improvement.

15.2 Suspected fraud

15.2.1 The Chief Finance Officer must notify the NHS Counter Fraud Authority (NHS CFA), normally via the Local Counter Fraud Specialist (LCFS) and the External Auditor of all frauds.

15.2.2 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Chief Finance Officer must immediately notify:

a. the Board, and

b. the External Auditor.

15.2.3 Within limits delegated to it by the Department of Health and Social Care, the Board shall approve the writing-off of losses.

15.2.4 The Chief Finance Officer shall be authorised to take any necessary steps to safeguard the ICB's interests in bankruptcies and company liquidations.

15.2.5 For any loss, the Chief Finance Officer should consider whether any insurance claim can be made.

15.2.6 The Chief Finance Officer shall maintain a Losses and Special Payments Register in which write-off action is recorded.

15.2.7 No special payments exceeding delegated limits shall be made without the prior approval of the Department of Health and Social Care.

15.2.8 All losses and special payments must be reported to the Audit and Risk Committee at every meeting.

15.3 Recovery of fraud losses

15.3.1 Initially, recovery of any losses arising from fraudulent activity are followed up by Shared Business Services (SBS) using their recovery policy. Recoveries would be reported to the LCFS to be recorded on the national NHS CFA case management system and included in the LCFS annual report to Audit, and Risk Committee

16. Digital Financial data

16.1 Responsibilities and duties of the Chief Finance Officer

16.1.1 The Chief Finance Officer is responsible for the confidentiality, accuracy and security of the computerised financial data of the ICB whether this is in house or hosted in an outsourced arrangement, and shall:

a. devise and implement any necessary procedures to ensure protection of the ICB's data, programs and computer hardware for which the Chief Finance Officer is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the UK Data Protection legislation (Date Protection Act 2018 and UK GDPR);

b. ensure that users are adequately trained on finance systems

c. ensure that reasonable controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

d. ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;

e. ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as the Chief Finance Officer may consider.

Please also refer to section 5 – Financial systems and processes.

16.1.2 The Chief Finance Officer shall ensure that new financial systems and amendments to current financial systems are developed in a controlled manner. Information Governance assurance is confirmed, and the system is thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.

16.1.3 The Chief of Staff or equivalent role shall publish and maintain a Freedom of Information (FOI) publication scheme or adopt a model publication scheme approved by the Information Commissioner. A publication scheme is a complete guide to the information routinely published by a public authority. It describes the classes or types of information about the ICB that are made publicly available.

16.2 Responsibilities and duties of other Chief Officers and Officers in relation to computer systems of a general application

16.2.1 In the case of computer systems which are proposed General Applications *(i.e. normally those applications which the majority of ICBs in the Region wish to sponsor jointly)* all responsible Chief Officers and employees will send to the Chief Transformation and Digital Information Officer:

a. details of the outline design of the system including Information Governance and Data Protection Impact Assessment (DPIA) considerations;
b. in the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement.

16.3 Contracts for digital services for financial applications with other health bodies or outside agencies

16.3.1 The Chief Finance Officer shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

16.3.2 The Chief Financial Officer will ensure the necessary due diligence checks are undertaken to ensure the third-party provider is compliant with Data Protection laws and National Data Guardian standards.

16.3.3 Where another health organisation or any other agency provides a computer service for financial applications, the Chief Finance Officer shall periodically seek assurances that adequate controls are in operation.

16.4 Requirements for computer systems which have an impact on corporate financial systems

16.4.1 Where computer systems have an impact on corporate financial systems the Chief Finance Officer shall need to be satisfied that:

a. systems acquisition, development and maintenance are in line with corporate policies such as an Information Technology Strategy;
b. data produced for use with financial systems is adequate, relevant, accurate, complete and timely, and that a management (audit) trail exists;
c. only relevant staff have access to such data;
d. such computer audit reviews as are considered necessary are being carried out.

17. Gifts and donations

17.1 Acceptance of Gifts

17.1.1 The Chief Finance Officer shall ensure that all staff are made aware of the ICB policy on acceptance of gifts and other benefits in kind by staff which will be in line with the Bribery Act 2010.

17.1.2 This policy follows the guidance contained in the NHS England Policy for Managing Conflicts of Interest 2017; the Code of Conduct for NHS Managers 2002; and the ABPI Code of Professional Conduct relating to hospitality/gifts from pharmaceutical/external industry and is also deemed to be an integral part of these ICB Constitution and Standing Financial Instructions.

17.1.3 Further details can be found in the in the ICB's Gifts and Hospitality Policy and the ICB Constitution.

17.2 Granting of Gifts

17.2.1 The ICB will not present gifts to third parties without the consent of the Chief Executive Officer, as this does not fall within the functions of the ICB as set out in the ICB Constitution.

17.3 Donations

17.3.1 The ICB do not hold charitable funds and are therefore unable to accept monetary donations.

18. Retention of records

18.1 Overview

18.1.1 The Chief Executive Officer shall be responsible for maintaining archives for all records required to be retained in accordance with Records Management Code of Practice for Health and Social Care 2023.

18.1.2 The records held in archives shall be capable of retrieval by authorised persons.

18.1.3 Records held in accordance with NHS Code of Practice - Records Management 2006, shall only be destroyed at the express instigation of the Chief Executive Officer. Detail shall be maintained of records so destroyed.

19. Risk Management, legal and insurance

19.1 Risk management

19.1.1 The Chief Executive Officer shall ensure that the ICB has a programme of risk management, in accordance with current Department of Health and Social Care assurance framework requirements, which must be approved and monitored by the Board. The programme of risk management shall include:

a. process for identifying and quantifying risks and potential liabilities;

b. engendering among all levels of staff a positive attitude towards the control of risk;

c. management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;

d. contingency plans to offset the impact of adverse events;

e. audit arrangements including; internal audit, clinical audit, health and safety review;

f. a clear indication of which risks shall be insured;

g. arrangements to review the risk management programme.

19.1.2 The existence, integration and evaluation of the above elements will assist in providing a basis to make a statement on the effectiveness of internal control within the Annual Report and Accounts as required by current Department of Health and Social Care guidance.

19.2 Legal

19.2.1 This section applies to any legal cases threatened or instituted by or against the ICB. The ICB should have policies and procedures detailing:

- engagement of solicitors / legal advisors;
- approval and signing of documents which will be necessary in legal proceedings; and
- Officers who can commit or spend ICB revenue resources in relation to settling legal matters.

19.2.2 Claims will be approved for defence documents and or offers of settlement in line with legal advice and NHS Resolution advice as per delegated amounts;

- Under the value of £50k the Chief of Staff or delegated deputy.
- Over £50k and less than £500k the Chief Finance Officer and relevant Chief Officer.
- Over the value of £500k up to £1 million the Chief Finance Officer or Chief Executive Officer.
- Over the value of £1 million the Chief Executive Officer, Chief Finance Officer and with the advice of the Chair of Audit, Governance and Risk.

19.3 Insurance

19.3.1 The Board shall decide if the ICB will insure through the risk pooling schemes administered by the NHS Resolution or self-insure for some or all of the risks covered by the risk pooling schemes. If the Board decides not to use the risk pooling schemes for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme this decision shall be reviewed annually.

19.3.2 ICBs are advised not to buy commercial insurance to protect against risk unless it is part of a risk management strategy that is approved by the Accountable Officer. However, the exceptions when ICBs may enter into insurance arrangements are;

a. insuring motor vehicles owned by the ICB including insuring third party liability arising from their use;

b. where the ICB is involved with a consortium in a Private Finance Initiative contract and the other consortium members require that commercial insurance arrangements are entered into;

c. where income generation activities take place. Income generation activities should normally be insured against all risks using commercial insurance. If the income generation activity is also an activity normally carried out by the ICB for a NHS purpose the activity may be covered in the risk pool. Confirmation of coverage in the risk pool must be obtained from the NHS Resolution. In any case of doubt concerning a ICB's powers to enter into commercial insurance arrangements the Chief Financial Officer should consult the Department of Health and Social Care.

19.3.3 Where the Board decides to use the risk pooling schemes administered by the NHS Resolution the Chief Finance Officer shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Chief Finance Officer shall ensure that documented procedures cover these arrangements.

19.3.4 Where the Board decides not to use the risk pooling schemes administered by the NHS Resolution for one or other of the risks covered by the schemes, the Chief Finance Officer shall ensure that the Board is informed of the nature and extent of the risks that are self-insured as a result of this decision. The Chief Finance Officer will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses which will not be reimbursed.

19.3.5 All the risk pooling schemes require Scheme members to make some contribution to the settlement of claims (the 'deductible'). The Chief Financial Officer should ensure documented procedures also cover the management of claims and payments below the deductible in each case.