Finance, Estates & Digital Committee

Date: **26th June 2025**

Time: **09:00-12:00**

Location: **MS Teams**

Agenda Number:	6.1	
Title:	Financial Performance – May 2025 (Month 2)	
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 2 the ICB is reporting a negligible year-to-date underspend of £0.1m and forecast breakeven position.
- **Financial Duties:** The in-month assessment of delivery against the ICB's financial duties are three on plan (maintain expenditure within the revenue limit, running costs and better payment practice code, capital expenditure and cash limit) with one at risk (maintain expenditure within the revenue limit) which is driven by the inherent level of risk to delivery of the plan.

- **Risks and Mitigations:** Our net risk and mitigation position is a small surplus and this has improved from the prior month such that we are now confident in delivering the breakeven plan. Our current modelling suggests a reasonable downside and upside case showing a range of a £7.7m deficit to a £6.3m surplus.

System Finance

- **Revenue**: The ICS is reporting a £1.7m deficit at M2, this is driven by UHBW with a deficit of £1.9m. The underlying cause is under-delivery of efficiency, assurance has been provided through performance and recovery board that this does not represent a material risk at present.
- **Capital expenditure**: No issues have currently been reported in capital expenditure however capital board are actively considering risk and alternative schemes should existing schemes slip (main risk is underspend not overspend).
- **Cash**: overall the system maintains a healthy cash balance and does not anticipate needing cash support in year.
- **Next steps**: Detailed review of forecasts and risk and mitigations post Q1.

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 £1.7m, which relates to provider deficits related to under delivery of CIPs
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 2025/26. 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: 6.1

Report title: ICB Finance Report

Report on the financial performance for May 2025 (M02 – 2025/26)

1. Executive Summary

At month 2 the ICB is reporting a negligible year-to-date underspend of £0.1m and forecast breakeven position.

Our net risk and mitigation position is a small surplus and this has improved from the prior month such that we are now confident in delivering the breakeven plan. Our current modelling suggests a reasonable downside and upside case showing a range of a £7.7m deficit to a £6.3m surplus.

The ICS is reporting a £1.7m deficit at M2, this is driven by UHBW with a deficit of £1.9m. The underlying cause is under-delivery of efficiency, assurance has been provided through performance and recovery board that this does not represent a material risk at present.

No issues have currently been reported in capital expenditure however capital board are actively considering risk and alternative schemes should existing schemes slip (main risk is underspend not overspend).

2. Financial duties and financial performance metrics

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

Duty	RAG	Position
Maintain expenditure within the revenue resource limit *(Section 4)*	A	Although the ICB is reporting a breakeven year to date and forecast position, however the plan contains material levels of risk and as such an Amber risk rating is considered appropriate.
Ensure running costs are within the running cost resource limit. *(Section 4)*	G	Running costs are currently forecast to be within budget, we are expecting savings from the nationally mandated reductions and are assuming any transition costs are funded.
Maintain capital expenditure within the delegated limit *(Section 8)*	G	The capital programme is £7.1m, we currently do not anticipate any major risks around spending to this level.
Maintain expenditure within the allocated cash limit *(Section 9)*	G	Whilst there was an in-month issue due to some queries on larger invoices we do not anticipate any issues as a matter of course.
Ensure compliance with the better payment practice code *(Section 10)*	G	Performance target requires 95% of non-disputed invoices to be paid within 30 days. The ICB continues to meet the target.

3. Revenue allocation

The total allocation is £2,427m of which £168m is non-recurrent (£86m ERF £13.9m CDC and £20.6m SDF being the most significant balances).

There have been no material movements in the allocation compared to the original budget as at M2, with the only change being formal confirmation of £7.0m for depreciation (was included in plan).

4. Financial position May 2025 (Month 2)

At month 2 the ICB is reporting a negligible year-to-date underspend of £0.1m and forecast breakeven position.

2025/26 May 2025 - Month 2	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	1,232.664	205.444	205.444	-		1,232.664	-		A1
Mental Health	238.952	39.825	39.674	**0.152**		238.952	(0.000)		A2
Community	235.724	39.287	39.287	-		235.724	-		A3
Delegated Primary Care	304.664	50.777	50.337	**0.440**		304.664	-		A5/A6
Medicines Management	167.573	27.929	27.937	(0.008)		167.573	-		A7
Primary Care	37.327	6.221	6.222	(0.001)		37.327	-		A4
Funded Care	140.696	23.964	23.973	(0.009)		140.696	-		A8
Childrens	48.413	8.069	8.069	-		48.413	-		A9
Support Costs	9.377	2.022	2.011	**0.011**		9.377	-		A10
Reserves	(2.977)	(0.496)	(0.060)	(0.436)		(2.977)	-		-
Running Costs	15.318	2.543	2.543	-		15.318	-		A11
BNSSG ICB Surplus/(Deficit)	**2,427.730**	**405.585**	**405.437**	**0.148**		**2,427.730**	**-**		
Provider Surplus/Defict									
AWP	-	0.030	0.030	-		-	-		
NBT	-	(2.530)	(2.478)	**0.052**		-	-		
UHBW	-	- 6,273.00	(8.149)	(1.876)		-	-		
Provider Surplus/(Deficit)	**2,427.730**	**(8.773)**	**(10.597)**	**(1.824)**		**2,427.730**	**-**		
ICS Position	**2,427.730**	**414.358**	**416.034**	**(1.676)**		**2,427.730**	**-**		

There are some variances YTD at a programme level, however this is driven by budget phasing at this stage will all areas forecasting to deliver on budget.

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 – however at M2 all areas are on plan.

Forecast Outturn

The ICB continues to forecast a breakeven position.

A detailed risk and mitigation plan is kept by finance in conversation with budget holders and the net risk/mitigation position is a modest surplus – see “Risk and mitigations section”.

Payroll overview

Included in the financial position are the pay costs, as summarised below. The funded establishment is currently overspent with a variance to date of £0.12m and the pay costs funded from other sources underspent by £0.08m generating a net overspend variance of £0.05m (£0.08m over on admin costs and £0.03m under on programme). Forecast is included in the below table but should be used with caution as it is very early in the financial year to predict with any certainty, particularly amidst the current uncertainty around ICB structures.

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	11.748	1.958	2.043	(0.085)	12.062	(0.313)
	Programme	11.747	1.958	1.997	(0.040)	12.077	(0.330)
Total funded Establishment		**23.496**	**3.916**	**4.040**	**(0.124)**	**24.139**	**(0.643)**
Other Funding source	Admin	1.136	0.189	0.187	0.002	1.039	0.098
	Programme	3.118	0.520	0.445	0.075	2.644	0.474
Total Other funded posts		**4.254**	**0.709**	**0.632**	**0.077**	**3.682**	**0.572**
Grand total		**27.750**	**4.625**	**4.672**	**(0.047)**	**27.821**	**(0.071)**

		Full year funding £m	YTD funding £m	YTD spend £m	YTD variance £m	Forecast Outturn £m	Forecast variance £m
Analysed by	Admin	12.885	2.147	2.230	(0.082)	13.100	(0.216)
	Programme	14.865	2.478	2.442	0.035	14.721	0.144
Grand total		**27.750**	**4.625**	**4.672**	**(0.047)**	**27.821**	**(0.071)**

5. Efficiencies

The total ICB savings plan is £54.8.0m per the planning submission. Within the total savings target there is £31.0m 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. The residual balance for ICB led delivery is £23.7m.

	Status	Risk	YTD			FOT		
			Plan	Actual	Var	Plan	FOT	Var
Contracted national efficiency	Implemented	B	5,177	5,177	-	31,061	31,061	-
Funded care	Developed	R	929	929	-	10,538	10,538	-
Primary Care Prescribing	Developed	G	492	492	-	3,001	3,001	-
Primary Care Prescribing (DOA	Developed	G	549	549	-	2,385	2,385	-
Discharge to Assess Beds	Developed	A	557	557	-	3,339	3,339	-
S3 - MH placements	Developed	A	62	62	-	373	373	-
S3 - LD placements	Developed	A	129	129	-	771	771	-
High Cost Drugs Savings (NBT)	Developed	A	159	159	-	952	952	-
High Cost Drugs Savings (UHB	Developed	A	208	208	-	1,246	1,246	-
Running costs	Developed	G	188	188	-	1,129	1,129	-
ICB local plan			8,449	8,449	-	54,795	54,795	-
Balance of savings to plan			1	-	(1)	1	-	(1)
Submitted plan			8,450	8,449	(1)	54,796	54,795	(1)

All schemes are currently reporting to plan. The ICB has established a Savings Board which met during May to sign off Project Definition Documents (PDDs) for each saving scheme. There are some minor follow up actions to be completed but otherwise all schemes have been approved. The savings Board will review progress

against milestones, KPIs and financial delivery each month and is intended to be the main assurance vehicle (reporting into FED) for the ICB. This is Chaired by the CEO.

6. Risks and mitigations

The following risks and mitigations were set out as part of budget setting, these have been reviewed by at month two and no material changes have been noted. A full review will be undertaken as part of the system review following Q1 (for M3 reporting).

Risks

- **Funded care** - driven by delivery of the savings target (particularly in the context of expected headcount reductions across the ICB) and whether growth rates have been fully captured in the context of the total budget being c£2.0m less than 24/25 FOT. A downside risk is estimated at £6-7m.
- **HCDD** - this has been fully funded against Month 8 horizon scanning. However, prior experience suggests that the increasing baseline usage of NICE TA drugs could pose a developing financial risk. This needs to be monitored through ongoing forecasting processes with Medicines Optimisation and through system-level performance and governance groups. If we assume a similar level of overspend to 24/25 this would be around £3.5m.
- **ERF** the mechanisms in place should protect against risk (including diagnostics) however it is possible the cap will be abolished pending the outcome of the NHS Payment system consultation.
- **ADHD and Autism**. This will depend on approach with payment limits as with ERF but for example one of our providers is planning on adding c £3m to their activity with us without the cap.
- **Discharge to assess** - 25/26 budgets for planned beds only. There is therefore a risk that system pressures will result in further beds being opened as we have observed in 24/25 with an overspend of c£4.0m, a downside risk is this level of overspend is required again. This is partially mitigated by the anticipatory care budget not yet being fully committed.
- **Children's** as a result of reduction in SDF funding available there is up to £0.5m unfunded pressure for which mitigations are not fully developed.
- **Mental health SDF** gap in budget of c£1.5m compared to prior commitments as a result in a national cut to the SDF. We expect this to be mitigated by a review of the services and start dates. The Mental Health Finance Oversight Group is overseeing the delivery of savings required.
- **Mental health planning gap -** a non-recurrent savings target of £3.2m was applied in 24/25 of this £2.0m has been restored however the residual balance of £1.2m remains as an expectation and there is currently no identified source to cover this.
- **Mental Health placements -** both from a volume but also a share of cost perspective with local authorities looking to increase the contribution health are paying. We have moved to individual case splits since December 2024 and early analysis shows our cost may be increasing by 50% on cases examined. We have estimated the risk value at £3-5m for 25/26.

- **Forensic adults, CAHMs tier 4 –** A number of LD&A service users currently within Spec Comm and South West Provider Collaborative funding responsibility are expected to step down into ICB funding responsibility. This is to support a NHSE trajectory to ensure more service users are moved into relevant community settings. However, currently the budget does not follow the discharge/step down of patients. The ICB finance team is actively seeking any supporting information on costs from NHSE to quantify the potential financial risk to the ICB. We are currently seeing a single patient costing £35k per week which the Collaborative are refusing to take. Two service users at this level represent around £2.5m.

Mitigations

- **Contingency** - The ICB has uncommitted contingency of £2.5m as part of the 25/26 budget
- **ERF contingency** - £2.0m held as contingency in ERF for Right to Choose providers entering the market, it is possible this is not all fully utilised, estimated at 50%.
- **ERF** the mechanisms in place should protect against risk (including diagnostics) however it is possible the cap will be abolished pending the outcome of the NHS Payment system consultation. Outside of this, in particular the NBT contract has grown significantly with the Bristol Surgical Centre and it is feasible that activity will lag behind plans presenting a financial (if not operational) mitigation. It is not possible to effectively quantify this at present.
- **Anticipatory care** budget of £2.0m not fully committed at present (aligned to D2A risk)
- **Meds management savings** - Potential stretch of c£1.0m to Medicines management savings target.
- **Non-recurrent benefits** – historically we have seen non-recurrent benefits arise during the year, a reasonable assumption may be around £4.0m.

Net position

The table below sets out an illustrative reasonable downside and upside case showing a range of a £7.7m deficit to a £6.3m surplus. Whilst gross risks are c£27.2m compared to gross mitigations of £16.5m there is greater likelihood of the mitigations crystalising. Therefore, given the range this suggests the base case of breakeven is a reasonable assumption for the Forecast outturn. Notwithstanding this the risks and mitigations will need to be managed carefully throughout the year.

	Gross	Reasonable downside		Reasonable Upside	
	£'000	%	£'000	%	£'000
Funded care	(7,000)	50%	(3,500)	20%	(1,400)
HCDD	(3,500)	50%	(1,750)	20%	(700)
ERF cap	tbc		tbc	-	tbc
ADHD & Autism	(3,000)	50%	(1,500)	20%	(600)
D2A	(4,000)	50%	(2,000)	20%	(800)
Childrens	(500)	25%	(125)	20%	(100)
MH SDF	(1,500)	25%	(375)	20%	(300)
MH planning gap	(1,200)	50%	(600)	20%	(240)
MH placements	(4,000)	50%	(2,000)	20%	(800)
Forensic adults/CAHMS tier 4	(2,500)	33%	(833)	20%	(500)
Total Risks	**(27,200)**	**47%**	**(12,683)**	**20%**	**(5,440)**
Contingency	2,500	100%	2,500	100%	2,500
ERF contingency	2,000	10%	200	75%	1,500
ERF underspend	5,000	10%	500	50%	2,500
Anticpatory care	2,000	10%	200	75%	1,500
Non-recurrent benefits	4,000	25%	1,000	75%	3,000
Meds m'ment savings stretch	1,000	50%	500	75%	750
Total Mitigations	**16,500**	**30%**	**4,900**	**71%**	**11,750**
Total			**(7,783)**		**6,310**

7. System position

The ICS is reporting a £1.7m deficit at M2, this is driven by UHBW with a deficit of £1.9m. The underlying cause is under-delivery of efficiency – however this is based on an efficiency profile tactically balanced to the first part of the year to help drive delivery in the organisation – this has been discussed at Performance and Recovery Board where assurance was sought and received that this did not represent an issue at this stage. This position occurred at M1 and delivery was in line (in month) for M2.

Forecast remains a breakeven position for the year for all NHS ICS organisations collectively and individually). A detailed update to forecast (and risk and mitigations) will occur post Q1.

8. Capital allocation

System Capital

The total system operational capital allocation is £99.722m, made up as follows:

Provider Capital		
2025/26 Capital Allocation (Indicative)		72,072
2024/25 Revenue Fair Shares Allocation Adjustment		13,103
2025/26 Revenue Fair Shares Allocation Adjustment		12,466
Less transfer to the ICB Allocation	-	3,300
2025/26 Total Provider Capital Allocation		**94,341**
ICB Capital		
2025/26 Capital Allocation		2,081
Plus transfer from Provider Allocation		3,300
2025/26 Total ICB Capital Allocation		**5,381**
2025/26 Total Charge against Capital Allocation (including impact of IFRS 16)		**99,722**

System providers have worked in collaboration to produce a capital plan that aims to fully utilise the large amount of capital available in 2025/26.

The progress and risk of delivery of schemes will be reported to the ICS Capital Board each month, and a schedule of additional schemes is being compiled with the intention to direct any in year slippage to these schemes.

A BNSSG ICS multi year capital plan will be produced in the following months to show the effect any in year schemes will have in future years. This will also allow for any future schemes to be brought forward in the event of any in year slippage.

In addition to the system capital allocation, national funding is available in 2025/26 for capital schemes that address national priorities. BNSSG ICS has received initial approval for the national schemes as follows:

National Programme Funding	
Return to Constitutional Standards	22,146
Estates Safety (Critical Infrastructure Risk)	22,495
Mental Health: Reducing Out of Area Placements	885
Primary Care Utilisation Fund	1,740
Total National Programme Funding	**47,266**

Funding for these programmes has not been agreed on a multi year basis, and as such, any impact the progression of these schemes will have on future capital allocations available will be reflected and continuously updated within the multi year BNSSG ICS Capital Plan.

ICB Capital

The ICBs capital allocation is £5.381m in 2025/26. This is made up of a system transfer of £3.3m agreed in 2024/25 to support the Connexus PCN scheme, and £2.081m ringfenced allocation for Primary Care BAU.

In addition to this, the Primary Care Utilisation & Modernisation Fund provides an allocation of £1.74m to BNSSG ICB. The fund aims to enhance the use of existing

infrastructure, create additional capacity for the GP workforce, and increase the number of patient appointments available. Plans for the use of this funding have been submitted to NHSE for approval.

Funding for the ringfenced GP BAU allocation has increased from the previous financial year, with the split of intended use also changing. A comparison between years is shown below:

Primary Care BAU	2024/25	2025/26
MIG - ICB allocation	300	-
Corporate Refresh	273	15
GP - BAU Refresh	941	1,916
GP - ARRs and PCN	76	100
MIG equipping	71	50
	1,661	**2,081**

There is no requirement for Estates MIG funding in 2025/26 due to both the system pre commitment transfer of £3.3m and the creation of the Primary Care Utilisation Fund of £1.74m.

There is very little requirement for Corporate Refresh funding in 2025/26. This is because there are sufficient laptops in stock and on issue that are within their warranty period. The impending changes to the size and structure of BNSSG ICB mean that the number of laptops that are required will also reduce. Once the organisational changes have taken place, a forecast of future capital requirements will be required. Whilst the funding for Corporate Refresh will need to increase again in future years, the intention is that the demand for capital to refresh laptops for fewer staff is reduced in the future.

In addition to this there are no anticipated digital developments for the recently refurbished offices at 100 Temple Street, also negating any capital request for the Corporate Refresh.

This has allowed for a greater allocation towards the GPIT Capital Refresh in 2025/26. The refresh programme has identified a high volume of hardware that has reached the end of its serviceable life and will need to be replaced. Completing this refresh in 2025/26 will reduce the capital requirement for this work in the forthcoming years.

9. Statement of Financial Position

The closing balance sheet at month 2 was £94.286m compared to 2024/25 closing position of £114.851m. The £20.566m movement is mainly driven by a reduction in payables. Please note that the full balance sheet position has not been included as SBS do not post the year end rollover position until month 3.

The closing cash at bank position for month 2 was £7,319m. NHSE monitor the ICB on the closing cash at bank balance (1.25% of monthly drawdown), which for month 2 equates to £2.475m. The ICB missed this target by £4.844m due to queries on invoices which meant that they were not paid in the month anticipated.

10. 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 has met its target for the value of NHS and Non-NHS invoices for the year to date and in month position, as set out below.

Type	In month	Number	£m
NHS	Total bills paid in month	79	126.896
	Total bills paid within target	78	126.896
	% bills paid within target	**98.73%**	**100.00%**
Non NHS	Total bills paid in month	2,728	75.343
	Total bills paid within target	2,700	71.627
	% bills paid within target	**98.97%**	**95.07%**

Type	Year to date	Number	£m
NHS	Total bills paid in year	200	240.473
	Total bills paid within target	199	240.473
	% bills paid within target	**99.50%**	**100.00%**
Non NHS	Total bills paid in year	5,095	143.748
	Total bills paid within target	5,039	138.278
	% bills paid within target	**98.90%**	**96.19%**

11. Recommendations

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

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 NH	536.556	89.426	89.426	-		536.556	-	
North Bristol NHS Trust	529.877	88.313	88.313	-		529.877	-	
South Western Ambulance Service NHS FT	59.354	9.892	9.892	-		59.354	-	
Independent Sector Treatment Centres	54.491	9.082	9.082	0.000		54.491	-	
Other Local Provider contracts (RUH, Glos,	19.316	3.219	3.219	-		19.316	-	
Low Volume Activity	8.820	1.470	1.480	(0.010)		8.820	-	
Non Contracted Activity	2.203	0.367	0.357	0.010		2.203	-	
Other Acute Spend (incl SWAG cancer)	22.047	3.675	3.675	(0.000)		22.047	-	
Grand Total	**1,232.664**	**205.444**	**205.444**	**(0.000)**		**1,232.664**	**-**	

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	161.079	26.847	26.847	-		157.577	3.502	
Mental Health Placements	25.223	4.204	4.204	-		25.283	(0.060)	
Learning Disability and Autism	11.057	1.843	1.691	0.152		10.997	0.060	
Mental Health Community	9.996	1.666	1.666	-		10.085	(0.089)	
Improved Access to Psychological Therapie	12.774	2.129	2.129	-		12.774	-	
Dementia	6.223	1.037	1.037	-		6.223	-	
Crisis Services	4.108	0.685	0.685	-		4.055	0.053	
ADHD	6.800	1.133	1.133	-		6.800	-	
Mental Health Low Volume Activity	0.916	0.153	0.153	-		0.916	-	
Mental Health SDF	0.103	0.017	0.017	-		3.477	(3.373)	
MH - S12 Doctors Private Sector	0.673	0.112	0.112	-		765.63	(0.093)	
Grand Total	**238.952**	**39.825**	**39.674**	**0.152**		**238.952**	**0.000**	

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	151.475	25.246	25.246	-		151.475	-	
Joint Commissioned	36.216	6.036	6.036	-		36.216	-	
Discharge to Assess Services	11.858	1.976	1.976	-		11.858	-	
Joint Commissioned D2A	0.578	0.096	0.096	-		0.578	-	
Patient Transport Services (PTS)	1.481	0.247	0.247	-		1.481	-	
Community Equipment	7.466	1.244	1.244	-		7.466	-	
Hospices	4.483	0.747	0.747	-		4.483	-	
BIRU	3.538	0.590	0.590	-		3.538	-	
In-Year Investments	0.708	0.118	0.118	-		0.708	-	
Anticipatory Care	7.397	1.233	1.233	-		7.397	-	
Health Inequalities	2.836	0.473	0.473	-		2.836	-	
Prevention Fund	1.450	0.242	0.242	-		1.450	-	
Other Community	6.240	1.040	1.040	-		6.240	-	
Grand Total	**235.724**	**39.287**	**39.287**	**-**		**235.724**	**-**	

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	20.459	3.410	3.410	-		20.459	-	
Local Enhanced Services	8.536	1.423	1.423	-		8.536	-	
GP Forward View	2.347	0.391	0.391	-		2.347	-	
Other Primary Care	5.984	0.997	0.999	(0.001)		5.984	-	
Grand Total	**37.327**	**6.221**	**6.222**	**(0.001)**		**37.327**	**-**	

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	128.497	21.416	21.416	-		128.497	-	
Primary Care Networks DES	47.670	7.945	7.945	-		47.670	-	
Premises Costs	16.550	2.758	2.758	-		16.550	-	
Quality Outcomes Framework (QOF)	13.395	2.232	2.232	-		13.395	-	
Locum Reimbursement Cost	2.416	0.403	0.406	(0.003)		2.416	-	
Other GP Services	2.374	0.396	0.396	-		2.374	-	
Prescribing & Dispensing Fees	1.562	0.260	0.260	-		1.562	-	
Designated Enhanced Services (DES)	1.404	0.234	0.234	-		1.404	-	
Delegated Primary Care Reserve	-0.517	-0.086	-0.086	-		-0.517	-	
Grand Total	**213.351**	**35.559**	**35.561**	**(0.003)**		**213.351**	**-**	

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	19.450	3.242	3.193	**0.049**		19.450	-	
Delegated Primary Dental	40.331	6.722	6.722	-		40.331	-	
Delegated Secondary Dental	17.895	2.983	2.983	-		17.895	-	
Delegated Community Dental	2.886	0.481	0.481	-		2.886	-	
Delegated Primary Care IT	1.831	0.305	-0.022	**0.327**		1.831	-	
Delegated Ophthalmic	8.920	1.487	1.420	**0.067**		8.920	-	
Delegated Property costs	0.000	0.000	0.000	-		0.000	-	
Grand Total	**91.313**	**15.219**	**14.776**	**0.443**		**91.313**	**-**	

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	165.485	27.581	27.585	(0.004)		165.485	-	
Medicines Management staff costs	2.088	0.348	0.352	(0.004)		2.088	-	
Grand Total	**167.573**	**27.929**	**27.937**	**(0.008)**		**167.573**	**-**	

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	69.484	11.546	11.527	**0.020**		69.484	-	
Adult Fully Funded PHB	11.443	1.906	1.906	-		11.443	-	
Adult Joint Funded	0.791	0.128	0.128	-		0.791	-	
CHC Assessment and Support	0.715	0.119	0.160	**(0.041)**		0.715	-	
Funded Care Pay	5.256	0.876	0.864	**0.012**		5.256	-	
Children's CHC	3.594	0.579	0.579	-		3.594	-	
Children's PHB	0.026	0.004	0.004	-		0.026	-	
Fast Track	18.223	3.298	3.298	-		18.223	-	
FNC	31.164	5.507	5.507	-		31.164	-	
Grand Total	**140.696**	**23.964**	**23.973**	**(0.009)**		**140.696**	**-**	

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	20.447	3.408	3.408	-		20.447	-	
Child & Adolescent Mental Health (CAMHS	17.630	2.938	2.938	-		17.630	-	
Childrens SDF	6.359	1.060	1.060	-		6.359	-	
Other	3.976	0.663	0.663	-		3.976	-	
Grand Total	**48.413**	**8.069**	**8.069**	**-**		**48.413**	**-**	

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	1.301	0.300	0.289	**0.011**		1.301	-	
Chief Nursing Office	2.466	0.603	0.587	**0.016**		2.466	-	
Estates	2.747	0.458	0.458	-		2.747	-	
Other Support Costs	0.470	0.078	0.104	**(0.026)**		0.470	-	
Performance and Delivery	1.070	0.178	0.185	**(0.007)**		1.070	-	
Projects	1.293	0.374	0.370	**0.004**		1.293	-	
R&D Team	0.030	0.030	0.017	**0.013**		0.030	-	
Grand Total	**9.377**	**2.022**	**2.011**	**0.011**		**9.377**	**-**	

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 Directorat	3.663	0.600	0.649	**(0.049)**		3.663	-	
Chief Medical Office	0.643	0.107	0.107	**0.000**		0.643	-	
Chief Nursing Office	0.045	0.008	(0.001)	**0.008**		0.045	-	
Intelligence, Transformation and Digital Di	4.248	0.708	0.699	**0.009**		4.248	-	
Office of the Chair & Chief Executive	3.233	0.539	0.535	**0.004**		3.233	-	
People Directorate	1.523	0.254	0.202	**0.052**		1.523	-	
Performance & Delivery Directorate	1.963	0.327	0.352	**(0.025)**		1.963	-	
Grand Total	**15.318**	**2.543**	**2.543**	**0.000**		**15.318**	**-**	

Finance, Estates and Digital Committee (OPEN Session)

Minutes of the meeting held on Thursday 24th April 2025, 09:00 – 12:00, via Microsoft Teams

Present		Initials
Steve West	Finance, Estates and Digital Committee – Chair	SW
Deborah El-Sayed	Chief Transformation and Digital Information Officer, BNSSG ICB	DES
John Cappock	Non-Executive Director, BNSSG ICB	JC
Sarah Truelove	Deputy CEO & Chief Finance Officer, BNSSG ICB	SaT
Brian Stables	Non-Executive Director, AWP	BS
Jeff Farrar	Chair, ICB	JF
Joanne Medhurst	Chief Medical Officer, ICB	
In attendance		
Matt Backler	Operational Director of Finance, BNSSG ICB	MB
Neil Kemsley	Director of Finance and Information, UHBW	NK
Steward Walker	Hospital Managing Director, UHBW	SW
Kerrie Darvill	Intelligence Centre Programme Director, ICB	KD
Tim James	Head of Strategic Estates, ICB	TJ
Vicky Ledbury	Senior Contract Manager (Children's & Community), ICB	VL
Helena Fuller	Deputy Director of Business, Strategy and Planning, ICB	HF
Seb Habibi	Deputy Chief of Transformation and Digital, ICB	SH
Sabrina Smithson	Executive PA - Note taker/admin, BNSSG ICB	SS

		Action
1	**Welcome and Apologies** Apologies were received from Martin Sykes - UHBW, Christina Gray – BCC, Richard Gaunt – NBT, John Cappock – ICB,	
2	**Declarations of Interest** - An interest was declared on behalf of UHBW & NBT committee members for the NEPTS Procurement. These committee members did not receive the papers for Item 6.1 and had sent apologies in advance of the committee, so no further action was taken. - BS Declared an interest in the UHBW Deep dive due to family member working at UHBW. No action from the Chair was taken during the meeting.	
3	**Minutes of the Previous meeting** The minutes from the previous meeting were reviewed and approved.	
4	**Actions from previous meetings and matters arising** The action log was reviewed and updated accordingly.	
5	**Item for Discussion**	
5.1	**Programme of deep dives: UHBW** SW provided an overview of the current financial environment, and the significant progress made despite challenges. He highlighted the importance of headcount reductions and agency reductions, acknowledging the impact on real people's jobs. NK then outlined key points from the financial plan, including the £53 million savings target and the maturity of cost improvement schemes. Concerns were raised by BS regarding the split between recurrent and non-recurrent savings and the phasing of the Cost Improvement Programme (CIP). NK responded that approximately £40 million of the savings identified are recurrent, and the phasing has	

	been adjusted to avoid a significant ramp-up in the second half of the year. The discussion also touched on the importance of maintaining a balance between immediate financial targets and long-term sustainability. SaT acknowledged the significant progress in financial planning despite challenges and noted the impact of workforce reductions. She also inquired about whether the latest submission from divisions showed an improvement to which NK confirmed further progress. The £53 million savings target with a focus on recurrent savings was highlighted as a key point. Additionally, the committee discussed the importance of ensuring that the workforce reductions are managed sensitively to minimise the impact on staff well-being. The overall sentiment was one of cautious optimism, recognising the challenges ahead but also the robust plans in place to address them.	
5.2	**BNSSG Information Sharing Charter** DES introduced the BNSSG Information Sharing Charter, highlighting its importance for integrated care and collaboration across the system. KD provided an update on the progress, noting that most organisations have approved the charter, with a few pending approvals expected soon. JF expressed concerns about the potential impact of future ICB configurations on the charter. KD reassured that similar initiatives are being adopted elsewhere, and the charter can be adapted as needed. The committee discussed the importance of simplifying Information Governance and enhancing collaboration. The adaptability of the charter to future changes in ICB configurations was noted. AW suggested that the Executive Summary could be clearer in terms of the principles and objectives of the charter. KD agreed to incorporate this feedback into the communications plan. The committee also discussed the practical steps needed to implement the charter, including the need for clear communication and training for staff across the organisations involved. The importance of building trust and ensuring that all parties understand the benefits of the charter was emphasised. The committee agreed that moving forward with the charter was a critical step in improving information sharing and collaboration across the system.	
5.4	**Review Financial Performance content for ICB Annual Report** MB presented the initial draft of the financial performance section for the ICB Annual Report. The draft included elements from previous reports and highlighted the comprehensive coverage of financial performance. SaT suggested minor tweaks, such as including all non-executive members in the audit committee section. The committee provided overall positive feedback on the draft, noting its comprehensive nature and the minor adjustments needed for accuracy. The discussion also touched on the importance of ensuring that the financial performance section accurately reflects the achievements and challenges of the past year. The committee acknowledged the hard work that had gone into preparing the draft and the importance of presenting a clear and accurate picture of the ICB's financial performance. The final version of the report will include the latest financial data and any additional feedback from the committee. The goal is to provide a transparent and informative account of the ICB's financial activities over the past year. JM pointed out an editing error in the going concern section of the report, which was noted for correction.	
	Finance Report	
7.1	**M12 NHS System Revenue & Capital Finance Report** MB provided an overview of the Month 12 ICB Revenue Finance Report, noting that the ICB achieved its break-even plan. He highlighted the risks for the next financial year, particularly in mental health placements and ADHD/autism services.	

	The committee acknowledged the achievement of the break-even plan for the year and identified risks for the next financial year. The discussion also included a review of the financial controls in place and the steps being taken to mitigate the identified risks. The committee discussed the importance of maintaining financial discipline and ensuring that the ICB remains on track to achieve its financial targets. The need for ongoing monitoring and reporting was emphasised, with a focus on identifying and addressing any emerging issues promptly. The committee also highlighted the importance of clear communication with stakeholders about the ICB's financial position and plans.	
8	**Items to Note**	
8.1	**System DoFs Group** SaT provided an update on the System Directors of Finance (DoFs) Group, noting the positive discussions with new Section 151 officers and the agreement on next steps for joint focused work. The committee acknowledged the importance of collaboration and the need for a coordinated approach to financial management across the system. The next steps will involve further discussions and planning to build on the progress made and address any outstanding issues.	
8.3	**Digital Delivery Board** DES presented the update from the Digital Delivery Board, covering several key projects. She highlighted the progress on the Dental Electronic Referral service, the pause in the Procurement of the Intelligence Centre, and the success of the Connecting Care Target. She also mentioned the pilot of the AI and productivity tool, Copilot, and the upcoming Digital Maturity Assessment. SW inquired about the tracking of project status and the efforts to remove obstacles causing delays. DES confirmed that these issues are being monitored and addressed. The committee discussed the progress on key digital projects, the pilot of the AI and productivity tool, Copilot, and the upcoming Digital Maturity Assessment. The importance of digital innovation and the role of technology in improving Healthcare delivery were emphasised. The committee also discussed the challenges and opportunities associated with implementing new digital initiatives.	
	Key Messages/Chair Conclusion: SW summarised the key messages for the ICB Board: - Productive deep dive discussion around UHBW and the group structure, noting the importance of understanding governance and future operations. - Agreement to move forward with the Information Sharing Charter, emphasising the need to maintain momentum without a large public announcement. - Estates overview was a comprehensive piece of work that prioritised and prepares projects for future funding, recognising the team's efforts in creating a long-term, ten-year plan. - Financial performance and annual report, noting the absence of surprises and the successful delivery of expected outcomes. He mentioned the positive learning from the procurement process and the detailed documentation that supports selecting the right provider. SW concluded by acknowledging the overall good work done during the meeting, thanking colleagues and the support teams for their contributions.	

Finance, Estates and Digital Committee (OPEN Session)

Minutes of the meeting held on Thursday 22nd May 2025, 09:00 – 10:30, via Microsoft Teams

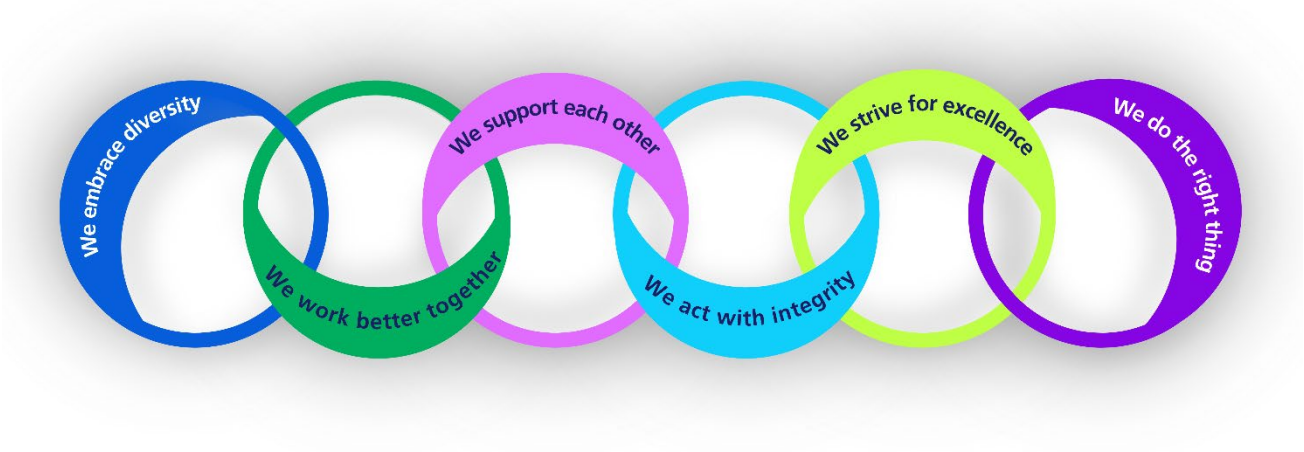
Present		Initials
Steve West	Finance, Estates and Digital Committee – Chair	SW
Deborah El-Sayed	Chief Transformation and Digital Information Officer, BNSSG ICB	DES
John Cappock	Non-Executive Director, BNSSG ICB	JC
Sarah Truelove	Deputy CEO & Chief Finance Officer, BNSSG ICB	SaT
Brian Stables	Non-Executive Director, AWP	BS
Jeff Farrar	Chair, ICB	JF
Richard Gaunt	Non-Executive Director, NBT	RG
Amy Webb	Director of Corporate Services/ S151 Officer, NSC	AW
Christina Gray	Director for Communities and Public Health, Bristol City Council	CG
In attendance		
Matt Backler	Operational Director of Finance, BNSSG ICB	MB
Elizabeth Poskitt	Chief Finance Officer, NBT	EP
Sabrina Smithson	Executive PA - Note taker/admin, BNSSG ICB	SS

		Action
1	**Welcome and Apologies** Apologies were received from Rosi Shepherd – BNSSG ICB, Joanne Medhurst – BNSSG ICB and Martin Sykes – UHBW.	
2	**Declarations of Interest** No interests were declared	
3	**Minutes of the Previous meeting** The minutes from the previous meeting were reviewed and approved.	
4	**Actions from previous meetings and matters arising** The action log was reviewed and updated accordingly.	
5	**Item to Approve**	
5.1	**BNSSG Procurement Policy** The committee received a comprehensive update on the annual review of the procurement policy. A key point of discussion centred on the integration of social value into procurement processes. CG highlighted the potential of procurement as a lever for delivering Social benefit and reducing Health In-equalities. She referenced the work undertaken by Bristol City Council (BCC) and recommended that the ICB engage with BCC procurement lead who has expertise in embedding Social Justice principles into commercial decision-making. DES supported this perspective, noting that while social value questions are included in procurement scoring, suppliers often struggle to provide meaningful responses. DES advocated for improved guidance and evaluation frameworks to ensure that commitments to local employment and community benefit are both measurable and enforceable. The policy was approved in principle, subject to minor tracked changes and further consultation with Local Authority (LA) partners. The final version will be circulated for the committees review and recommended to the board for formal adoption.	

	The committee reaffirmed its commitment to continuous improvement, ensuring that procurement remains a strategic tool for achieving both financial and social outcomes. ***Actions:*** - *Amendments were received from BS outside of the meeting to be actioned by Helena Fuller (author of the policy) and circulated to the committee prior to Board.* - *SaT to work with HF on the development of SOPS for contract management by linking with BCC Procurement lead.*	SaT/HF
6	**Item to Discuss**	
6.1	**Programme of deep dives – North Bristol Trust (NBT)** The committee welcomed a detailed financial presentation on the Trust's approach to delivering recurrent savings and managing Financial Sustainability. EP Advised NBT has set a savings target of £40 million for 2024/25, representing 5% of its budget. Of this, 4% has been delegated to departments, with the remaining 1% managed centrally by the Executive Team. EP highlighted that NBT tracks only recurrent savings, deliberately excluding non-recurrent items from its formal savings tracker, to ensure long-term financial resilience. This approach, while more stringent, is designed to avoid reliance on one-off measures that do not contribute to structural efficiency. EP continued the Trust has implemented a robust governance framework, including a Financial Sustainability Board, Department Performance Reviews, and Escalation Triggers for underperformance. A digital tracker system is used to monitor progress, although some schemes had defaulted to March delivery due to system settings. Departments have been instructed to reprofile these schemes to reflect realistic timelines. SaT and AW queried the apparent back-loading of savings into the final month of the year. EP clarified that this was a data artifact and assured the committee that corrective action was underway. BS suggested extending visibility to 15 months to support long-term planning, a recommendation that was well received. The presentation also highlighted key initiatives, including Agency Cost Reduction, Commercial Income Generation, and Productivity Improvements. Notably, NBT is exploring joint commercial ventures with University Hospital Bristol and Weston (UHBW) and leveraging its in-house legal team to support contract negotiations. The Trust is also focusing on headcount reduction, supported by a structured Quality Impact Assessment (QIA) process to safeguard patient care. The committee expressed strong assurance in NBT's strategy, commending the clarity, transparency, and maturity of its financial planning. Members acknowledged the challenges ahead but were encouraged by the Trust's proactive stance and commitment to sustainable delivery.	
7	**Items to Note**	
7.1	**System Directors of Finance (DoF) Group** SaT reported on the DoF Group activities and presented a system-wide view of financial performance at month 1. The system is slightly off plan due to slippage at UHBW, which will be reviewed in June. NBT has shown strong progress in maturing savings schemes, with a shift from high-risk to fully developed plans. The presentation included a comparison of the initial and final savings plans, highlighting the improvement in the maturity of savings schemes. The committee were encouraged by the progress and the focus on ensuring that savings plans are realistic and achievable. The importance of maintaining momentum and addressing any slippage promptly was emphasised.	

	SaT reported planning is underway for a joint DoF session with Gloucestershire to support Medium-Term Financial Planning. The group is preparing for the upcoming Comprehensive Spending Review (CSR) and 10-Year Health plan to inform a refreshed Financial Strategy. The importance of collaboration and shared learning across the ICBs was emphasised. The committee was informed of ongoing efforts to align financial planning with strategic objectives and ensure that resources are allocated effectively to meet future challenges.	
7.3	**Digital Delivery Board** DES provided updates on digital initiatives. The Senior Responsible Officer (SRO) transfer for Connecting Care is delayed due to financial liability concerns, but progress continues. A new training platform for Connecting Care has launched with positive feedback. The Work Anywhere project is addressing bandwidth issues to support flexible working in GP practices. Future planning includes defining the ICB's digital commissioning role post-transition. RG noted that providers are also increasing focus on digital, with a new digital committee being established. The committee acknowledged the critical role of digital initiatives in driving efficiency and improving service delivery.	
	Key Messages/Chair Conclusion: SW expressed appreciation for the contributions of all attendees, particularly acknowledging the efforts of the Executive Teams and colleagues navigating complex challenges. He stressed the importance of maintaining momentum and collaboration, especially considering the evolving system architecture and the need to preserve effective practices.	

Procurement Policy



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Complete the blank cells in the table below. The rest will be added by the corporate team once the policy approved and before it is added to the website.	
Policy ref no:	
Responsible Executive Director:	Sarah Truelove, Deputy Chief Executive
Author and Job Title:	Helena Fuller, Deputy Director of Business Strategy and Planning Samuel Naxton, Associate Director of Procurement, NHS South, Central and West
Date Approved:	
Approved by:	
Date of next review:	1 April 2026

Policy Review Checklist

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

	Yes/No/NA	Supporting information
		Patient and Public Involvement Strategy and Policy
Has the lead Executive Director approved the policy?	Yes	Sarah Truelove
Which Committees have assured the policy?	Yes	Corporate Policy Review Group Finance, Estates and Digital Committee
Has an implementation plan been provided?	N/A	However, the ICB will be made aware of the policy via all internal communication routes (i.e. HWGNFY). Any advice in relation to the policy can be accessed within the Business Strategy and Planning Directorate (BSP)
How will the policy be shared with staff?		Staff –Bespoke training has previously been provided through the SCW procurement team. Further awareness training and updates will be established thorugh 25/26 Patients and public – through ICB website publication
Will an audit trail demonstrating receipt of policy by staff be required; how will this be done?	No	Not required for this Policy
Has a DPIA been considered in regards to this policy?	Yes	Yes via the comments made about IG at CPRG.
Have Data Protection implications have been considered?	Yes	Yes via the comments made about DP at CPRG.

Version		Date	Consultation

Table of contents

Contents

Procurement Policy

1 Preface

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

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

1.1 Summary Points

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

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

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

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

1.2 BNSSG ICB Values

This Policy is aligned with BNSSG ICB Values:

- We act with integrity.
- We support each other.

- We embrace diversity.
- We work better together.
- We strive for excellence.
- We do the right thing.

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

2 Relevant to / Target Audience

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

SECTION A - Introduction

3 Introduction and Purpose

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

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

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

This Procurement Policy will ensure that all procurements undertaken:

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

c) Treats providers in a transparent, proportionate, and non-discriminatory manner with equality of treatment a core requirement.
d) Provides the best possible value for money.
e) Maintains high standards of public trust and probity in its use of public funds.
f) Uses best practice as standard and is aligned to the ICB Procurement Standard Operating Procedures (SoP).
g) Complies with long and short-term objectives of the ICB.
h) Does not engage in anti-competitive behaviour.
i) Providers and suppliers understand their obligations under UK Data Protection Legislation (UK GDPR and Data Protection Act 2018)
j) Embeds social justice into commercial decision-making by integrating ethical considerations, fairness, and social impact assessments into the decision-making process.

It is noteworthy that the ICB understands and manages security and IG risks to information, systems and networks supporting the operation of essential functions that arise as a result of dependencies on external suppliers.

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

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

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

4 Scope of the Procurement Policy

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

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

5 Definitions

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

6 Roles and responsibilities

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

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

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

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

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

In addition, please seek advice as early as possible from the Data Protection Officer or IG Consultant to understand the necessary IG requirements. For IT/Cyber requirements please seek advice from the Intelligence, Transformation and Digital Lead

There is a need and a requirement for multiple skills and resources to commission / procure services, therefore, to support embedding a team of teams multi-disciplinary approach taking advantage of the skills and capacity across directorates within the ICB it is pivotal that the ICB sets lines of responsibility and accountability for the commissioning of the services being secured. It is recognised that for some procurements advice and support will be provided and that maybe appropriate, however for large, complex and sensitive procurements and to ensure that all team members understand their roles and responsibilities within the programme/project for each phase of a procurement and that this is adapted to best deliver successful delivery of tasks leading to service commencement, contract management and service

delivery performance - the table below looks to identify the core management responsibility and skill required to support / complete the work as part of the team working within the procurement that will deliver the requirements to secure the commissioning of required services:

Procurement Delivery Element	**Primary Lead / Responsible for delivery**	**Secondary contribution / advice / support - where required**
Finance and Budget allocation	Finance - BSP	Budget Holder – all Directorates
BI / Activity	BI - Digital – Transformation/Digital Information	Head of Delivery – Performance and Delivery
Communications and Engagement	Communications and Engagement team - OCCE	Planning – BSP Heads of – PD Contracting - BSP
Quality Impact Assessment	Quality team – CNO Directorate	
Equality Health Impact Assessment	HR Business Partner - CPO team	Quality / Clinical Effectiveness team – CNO/CMO Directorate
Question development, evaluation, moderation	Procurement lead with contributions from secondary leads…..	Finance - BSP Quality – CNO Service Delivery – PD Comms / Engagement – OCCE Meds Opt - CMO
Procurement Risk management	Overseen by the SRO and procurement lead	
Contract drafting and contract review	Health Care – BSP Contracting Team Non-Clinical – Responsible Directorates contract holder/manager	Contract review covers several areas (see section 3 page 11) and therefore covers all directorates e.g. - Specification - Secondary Care / Primary Care / VCSE sector challenges including performance - Contract length and alignment - Financial contract modelling and total contract values.

		- Activity/spend analysis - Key Performance Indicators - Lessons Learned e.g., Previous procurements, , Stakeholder and Market 'End User' feedback.
Procurement Route	Health Care – BSP Contracting team / CSU Non-Clinical – Responsible Directorates contract holder/manager / CSU	Procurement Oversight Group to support
Procurement process	CSU	Overseen by contract holder
Governance routes for approval for procurements / contract award in line with SFIs	Contract holder/manager - All Directorates	
Mobilisation	Health Care – BSP contracting team / PD Non-Clinical – Contract holder/manager	
Contract management	Contract holder/manager - All Directorates	
IG, IMT, Digital	IG / Digital – Transformation/Digital Information	
Contract reviews and following SFIs, Procurement Policy Contracting SoP, Grant award SoP, Procurement SoP and completing the Contract register	Contract holder/manager - All Directorates	

7 Ethical Framework principles for decision-making

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

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

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

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

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

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

SECTION B – Procurement Direction and Influences

8 Public Procurement Legislation and Policy influences

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

Legislation

- Section 75 of the Health and Care Act 2022 – "Co-operation by NHS bodies and local authorities".
- Health Care Services (Provider Selection Regime) Regulations 2023
- The Public Contracts Regulations 2015 ('PCR 2015') which are amended by The Public Procurement (Amendment etc.) (EU Exit) Regulations 2020 ('PPAR 2020').
- Public Services (Social Value) Act 2012
- Health and Care Act 2022
- The Procurement Act 2023
- Equality Act 2010.
- National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 (as amended)

Policy / Guidance

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

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

Procurement exercises for health care services which commenced before 1 January 2024 are required to conclude under the Public Contract Regulations 2015. The Public Contracts Regulation 2015 will be replaced on 24th February 2025 for new procurements (excluding healthcare services) by the Procurement Act 2023.

Any new procurements that commence once the Procurement Act 2023 is in place (excluding regime for healthcare services) must be conducted by reference to the Act only, whilst those that were commenced under the previous legislation (the Public Contracts Regulations 2015 (PCR) must continue to be procured and managed under that legislation.

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

8.1 NHS Provider Selection Regime (PSR)

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

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

The PSR replaces the:

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

The PSR will **not** apply to the procurement of goods or non-health care services (unless as part of a mixed procurement), irrespective of whether these are procured by Relevant Authorities. The PSR is introduced by regulations made under the Health and Care Act 2022. In keeping with the intent of the Act, the PSR has been designed to:

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

8.2 Procurement Act 2023

The Procurement Act 2023 will apply from 24th February 2025 for non-healthcare procurements. The Procurement Act 2023 replaces the Public Contracts Regulations 2015 (detailed below), the Concessions Contract Regulations 2016 and the Utilities Contract Regulations 2016.

The key benefits of the Procurement Act include:

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

The Procurement Act condenses the 7 procurement procedures highlighted at section 13.2 into the following 3 procedures:

1) **Open Procedure (a one stage process).** This is a single stage procedure whereby any interested party can submit a tender and the ICB will decide whom to award the contract to on the basis of that tender.
2) **Competitive Flexible (Multi-stage procurement process).** This provides flexibility for the ICB to design a competitive tendering procedure where it considers appropriate for the purpose of awarding the public contract.

   There are some circumstances where the ICB can only use the competitive flexible procedure; these include:

   a) Where it wishes to limit the number of suppliers before inviting tenders.
   b) When procuring a dynamic market
   c) When reserving a public contract to supported employment providers or public service mutuals.

   Note, Framework contracts can be established under either the open procedure or the competitive procedure.

3) **Direct Award (including urgency requirements).** A public contract is awarded without a competitive tendering procedure and the public contract is placed directly with the supplier of the ICBs choosing. Under the Procurement Act, a transparency notice must be published before a contract is directly awarded. The function of the transparency notice is to inform stakeholders that a contracting authority intends to directly award a contract and ensure that there is transparency relating to this decision. It provides an opportunity for interested parties to consider the justification for direct award.

Guidance Documents

The Cabinet Office has developed comprehensive guidance documents that cover all aspects of the Procurement Act 2023 and are intended to provide technical guidance and help with interpretation and understanding. These can be accessed from the following link: https://www.gov.uk/government/collections/procurement-act-2023-guidance-documents

The guidance documents should be read in conjunction with the Procurement Act 2023 and its associated regulations and are aimed at procurement practitioners and commercial policy leads across the ICB and its partners.

8.3 Public Contracts Regulations 2015 (PCR 2015)

The Public Contracts Regulations 2015 (the 2015 Regulations) detail the required processes for conducting public procurement non-Healthcare services procurements through to 24th February 2025, or for healthcare services procurements formally commenced prior to 1 January 2024. The 2015 Regulations require that certain procedures must be followed by relevant public bodies when awarding contracts above specified financial thresholds. The 2015 Regulations must be complied with for the procurement of non-healthcare services until replaced under the Procurement Act 2023.

Providers raising a complaint against the 2015 Regulations will sometimes look to resolve a complaint/challenge via correspondence with the ICB (see s16) and/or if the provider remains unsatisfied with the outcome, they may decide to issue court proceedings. There are general time limits that a provider can issue court proceedings as specified in regulation 92 but generally proceedings must be started within 30 days beginning with the date when the provider first knew or ought to have known that grounds for starting the proceedings had arisen.

8.4 Integrated Working

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

procurement obligations are fulfilled.

8.5 The Health and Care Act 2022

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

8.6 Equality Act 2010

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

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

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

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

- decision-makers must be made aware of their duty to have due regard to the identified needs.
- the Duty must be fulfilled both before and during consideration of a particular policy and involves a "conscious approach and state of mind".
- it is not a question of ticking boxes, the Duty must be approached in substance, with rigour and with an open mind, and a failure to refer expressly to the Duty whilst exercising a public function will not be determinative of whether due regard has been had.
- the Duty is non-delegable.
- the Duty is continuing.
- it is good practice for an authority to keep a record showing that it has considered the identified needs.

8.7 Public Services (Social Value) Act 2012

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

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

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

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

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

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

The ICB has developed a Green plan (latest version - Green Plan for Bristol, North Somerset and South Gloucestershire ICS: 2022 - 2025) which headlines the ambition for the ICB when considering procurement and its supply chain. This recognises the positive impact that can be leveraged from a collaborative approach to procurement, to ensure social, responsible, and environmental commitments are at the heart of decision making that will drive towards a net zero procurement and supply chain by 2030. The ICB will have an ethical approach at the centre of our procurement decisions, recognising that our need to procure to deliver our health service should never be at the detriment of others and commissioners will work to ensure that is the case. The ICB will look to:

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

8.9 ICB Ethical Framework

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

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

make decisions.

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

9 Fraud, Bribery and Corruption

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

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

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

9.1 Fraud Act 2006

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

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

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

9.2 Bribery Act 2010

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

- Bribing another person.

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

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

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

The Economic Crime and Corporate Transparency Act (ECCTA) is a UK law aimed at enhancing transparency in the corporate sector and strengthening the nation's business environment. It was passed in 2023 and includes changes to Companies House and the legal framework to combat economic crime and fraud. One of its key aims is to improve the accuracy and trustworthiness of information on company registers.

Key aspects of the ECCTA:

- **Enhanced Transparency:**

The Act aims to improve the transparency of UK companies and other legal entities by giving Companies House more power to tackle economic crime.

- **Data Quality:**

The Act includes provisions to improve the accuracy and trustworthiness of information on company registers, including powers to query and challenge information, new rules for registered office addresses, and new objectives for the registrar.

- **Combating Economic Crime:**

The Act introduces new measures to combat economic crime, such as the "failure to prevent fraud" offence and the expansion of powers for Companies House.

- **Company Law Changes:**

The Act introduces changes to UK company law, including a new role for Companies House in tackling economic crime and supporting economic growth.

- **Phased Implementation:**

The reforms are being implemented in a phased manner to allow for the development of resources, systems, and secondary legislation to support the changes.

There is also the Data Security and Protection Toolkit and any concerns or advice needed in this area should be raised / sought by the Intelligence, Transformation and Digital Lead

SECTION C – Practical processes and guidance

10 Procurement Approach / Decision to Tender

10.1 ICB Constitution and applicable financial thresholds

Where the ICB wishes to award a contract for goods or services, it must consider which of the relevant pieces of legislation is applicable and the value of that contract opportunity to determine the appropriate procurement approach. Attention should also be given to the ICB's Constitution. All procurement activity will be undertaken in accordance with Standards of Business Conduct including conflicts of interest – section 6 of the NHS Constitution.

Procurement routes to market

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

Non-Healthcare:

Total Contract Value Threshold for Non-Healthcare contract (inclusive of VAT)	***Minimum Type of Procurement Required***	***Applicable Governance/legislation***
Up to £5k (inclusive of VAT)	No formal requirement for external procurement process	ICB Constitution: which describes the authority for approval of single tender waivers. This process can be found in the ICBs Standing Financial Instructions (SFIs)

Total Contract Value Threshold for Non-Healthcare contract (inclusive of VAT)	***Minimum Type of Procurement Required***	***Applicable Governance/legislation***
Between £5k and £50k (inclusive of VAT)	Quotations should be obtained from at least 3 suppliers/individuals. (Single Tender Waiver should only be used in exceptional circumstances and must be reported to Audit Committee)	Procurement Policy: which describes the award of contract without competition (see s13.4). NHSE: Managing conflicts of interest in the NHS.
Between £50k and £214,904 (inclusive of VAT)	Competitive tender required. (Single Tender Waiver should only be used in exceptional circumstances and must be reported to Audit Committee) The ICB can consider an open (advertised) or closed (framework or local approved supplier list) approach to market.	
Above £214, 904 (inclusive of VAT)	Full open (advertised) or closed (framework) tender required. Advice and guidance from SCW Procurement Team, including if full tender cannot be undertaken.	Public Contracts Regulations 2015. Procurement Act 2023 taking effect from 24th February 2025 NHSE: Managing conflicts of interest in the NHS.

Healthcare Contracts:

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

10.2 Decision whether to competitively tender

The tables above and the additional guidance within this policy should be applied in the first instance to indicate the correct approach to procurement in any event that be it under the Provider Selection Regime (Healthcare) or Procurement Act 23 (Goods and Services). In relation to healthcare contracts, there is no 'one size fits all' approach, and regard will have to be given in each instance to how the ICB can best meet the needs of the population, ensuring that the quality of services and the efficiency with which they are provided is improved (for example in terms of whether a new contract that would attract procurement law obligations needs to be awarded, or whether the ICB's requirements can be met in other.

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

In instances of particular urgency where it is necessary to award a contract without competitive tendering, and there is not time to follow the standard governance and approval process, it will be necessary to seek approval from the appropriate officer within the ICB aligning / adhering to the ICBs SFIs and to ensure that advice is obtained from the procurement and/or legal teams in accordance with the relevant scheme of delegation, in the form of a signed waiver document.

The ICB approval of the procurement strategy and readiness to proceed shall be managed through the ICB governance processes and shall include preparedness,

contract value and contract length plus any extensions.

10.3 Engaging the Procurement Team

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

11 Route to Market

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

SECTION D – Provider Selection Regime (Healthcare procurements Only)

12 Provider Selection Regime (Healthcare procurements Only)

The Provider Selection Regime (PSR) applies to all new healthcare procurements commenced after the 01 January 2024. NHSE has provided statutory guidance that sits alongside the PSR regulations to support the ICB/commissioners understand and interpret the regime. Commissioners must note that, under the PSR regulations, the threshold for PSR to apply is £0 (zero). A summary of key aspects of the PSR is detailed below.

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

1) **Direct Award processes (A, B and C):** These involve awarding contracts to providers when there is limited or no reason to seek change from the existing provider; or to assess providers against one another, because:
    a. the existing provider is the only provider that can deliver the health care services (direct award process A)
    b. patients have a choice of providers, and the number of providers is not restricted by the ICB (direct award process B)
    c. the existing provider is satisfying its existing contract, will likely satisfy the new contract to a sufficient standard, and the proposed contracting arrangements are not changing considerably (direct award process C).
2) **Most Suitable Provider process:** This involves awarding a contract to providers without running a competitive process, because the ICB can identify the most suitable provider.
3) **Competitive process:** This involves running a competitive process to award a contract including the formulisation of framework agreements.

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

Accreditation of Independent Sector Healthcare Providers: The ICB is required to follow PSR when procuring health care services, in accordance with NHS England Provider Selection Regime statutory guidance and Patient Choice Guidance. In relation to Accreditation of providers the ICB will follow the Direct Award B process as this facilitates the effective operation of choice by ensuring that prospective providers, including those that do not have a contract with an ICB or NHSE England, have an opportunity to be included on the list of providers from which patients are offered a choice of provider. The ICB will undertake all the necessary due diligence activities to assess whether the provider is qualified to offer the services and be awarded a contract. The ICB/Commissioners are advised to liaise with SCW procurement team to seek advice on following the relevant assessment / criteria that are required to comply with the process.

12.1 Making decisions under the Provider Selection Regime

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

Commissioners will need to comply with defined processes in each of the provider selection routes to market to evidence their decision-making, including record keeping and the publication of transparency notices. As such advice from the SCW Procurement Team should always be sought when considering the most appropriate route to market and a member of the Business, Strategy and Planning Directorate (BSP) should be involved as early as possible in the commissioning process to ensure they have a full understanding of the requirements of the service and to advise on the procurement process.

12.2 Key and Basic Selection Criteria

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

Key Criteria
Quality and Innovation
Value
Integration, Collaboration, and service sustainability

Improving access, reducing health inequalities, and facilitating choice
Social Value

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

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

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

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

12.3 Transparency Requirements

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

12.4 Mixed Procurements

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

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

  And

- The ICB is of the view that the other goods or services could not reasonably be supplied under a separate contract. This means that the ICB is of the view that procuring the health care services and the other goods and services separately would, or would be likely to, have a material adverse impact on the ICB's ability to act in accordance with the procurement principles.

12.5 Modifications of contracts and framework agreements during their term

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

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

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

Modifications are NOT permitted when:

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

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

12.6 Standstill Period and Receiving Representations

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

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

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

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

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

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

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

12.7 Abandonment

The ICB may decide to abandon any procurement under PSR at any time before an award is made (and not award a contract or conclude a framework under that provider selection process), providing this decision is transparent, fair and proportionate.

After deciding to abandon a process, the ICB is expected to notify providers that are aware they were being considered for the award of a contract or framework agreement (for example, in response to a tender under the competitive process).

The ICB must also submit for publication a notice of their decision on the Find a Tender Service (FTS). This notice must be submitted within 30 days of the decision to abandon process or if the decision was made during the standstill period, then within 30 days after the end of the standstill period.

The ICB must also keep a record of their reasoning for abandoning a provider selection process, including a clear decision-making record that has been approved by the relevant signatories within the ICB and in accordance with the ICB's Standing Financial Instructions (SFI).

12.8 Record Keeping

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

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

All contracts and awards made will be held on the ICBs Contract register – see ICBs contracting SoP for further details. Please note that there is a requirement to ensure suppliers/providers security and data protection requirements are included as records. This includes Data Security and Protection status and completion date, plus any IT/cyber certification

12.9 Urgent Requirements

There are limited circumstances where the ICB may need to urgently award or modify contracts to address immediate risks to patient or public safety.

These circumstances include where:

- a new service needs to be arranged rapidly in an unforeseen emergency or local, regional or national crisis (for example, a pandemic)
- urgent quality or safety concerns pose risks to patients or the public and necessitate rapid changes
- an existing provider is suddenly unable to provide services under an existing contract (for example, it becomes insolvent or suddenly lacks critical workforce) and a new provider needs to be found

In urgent situations, the ICB may make the following decisions without following normal PSR guidelines:

- re-award contracts held by the existing provider(s)
- award contract(s) for new services
- award contract(s) for considerably changed services
- make contract modifications (without limitation)

An urgent award or modification must only be made by the ICB when all the below apply:

- the award or modification must be made urgently
- the reason for the urgency was not foreseeable by and is not attributable to the ICB
- delaying the award of the contract to conduct a full application of the regime would likely pose a risk to patient or public safety
- the ICB must not use the urgent award or contract modification provisions if the urgency is attributable to the ICB not leaving sufficient time to make procurement decisions and run a provider selection process i.e. poor planning is not an acceptable reason for using these provisions.

Utilising an urgent modification or award under PSR does not negate the need for full ICB governance and in these circumstances you:

- are expected to limit the contract term or contract modification term to that which is strictly necessary. This is advised to be long enough to address the urgent situation and to conduct a full application of the PSR for that service at the earliest feasible opportunity. For this reason it is imperative that you alert the Procurement Oversight Group (POG) of your intentions immediately so that the long-term procurement activity can be planned and resourced appropriately.
- are expected to utilise a contract term of no longer than 12 months and, if longer you must justify and record this decision.
- must keep records of your decision-making, including the justification for using an urgent award and a clear decision-making record that has been approved by the relevant signatories within the ICB and in accordance with

the ICB's Standing Financial Instructions (SFI).

- must be transparent about your decision by issuing an urgent award notice or urgent modification notice via the Find a Tender portal.

SECTION E – Public Contract Regulations 2015 and Procurement Act 2023 (Non-Healthcare Procurements)

13 a) Public Contract Regulations 2015 (Goods and Non-Healthcare Service Procurements)

Public sector procurement is subject to national procurement rules and regulations, and procurement activity must be conducted consistently, accurately, and effectively. Public Contract Regulations 2015 are no longer valid from 24th February 2025. They must only be considered and/or applied to procurement processes that have not been concluded by the 23rd February 2025.

All procurement processes that commence from the 24th February 2025 must be in accordance with the Procurement Act 2023 (for goods or non-healthcare services) or the Provider Selection Regime 2023 (for healthcare services).

If the ICB / Commissioner chooses to use a Framework that commenced prior to the Procurement Act 2023, (i.e. the Framework was set up under the Public Contracts Regulations 2015), that is still a live Framework, they must continue to apply the Public Contracts Regulations 2015.

For these procurement processes that still fall under the Public Contracts Regulations 2015, the ICB / Commissioner is advised to liaise with SCW Procurement Team.

13 b) Procurement Act 2023 (Procurement Regulations 2024), Non-healthcare Procurement

The Act introduced from the 24th February 2025 considers and reflects value for money, competition and objective criteria in decision-making. Therefore, it is important for the ICB to have regard to delivering value for money, maximising public benefit, acting with transparency, acting with integrity as well as consideration to the particular barriers facing SMEs and what can be done to overcome them.

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

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

The procurement procedures available for use under the Act are detailed at section 8.2 Other key areas of the Act include:

Estimating Value of Contracts and Procurement Threshold

The Procurement Act requires the ICB to estimate the value of contracts, in accordance with a methodology set out in Schedule 3, and restricts manipulation of the estimated value of a contract in order to avoid requirements in the legislation. By following the methodology, the ICB can estimate the value of a contract and thereby determine whether the contract is above or below the relevant thresholds as detailed in Schedule 1 (key thresholds summarised below):

Type of contract	Thresholds (including VAT): 1 January 2024 to 31 December 2025
Utility works contract	£5,372,609
Utility contract that is not a works contract, a defence and security contract or a light touch contract	£429,809
Concession works and services contract	£5,372,609
Works contract	£5,372,609
Contract for the supply of goods or services (which may be mixed contracts that contain some works elements) to a sub-central government authority not within any other row	£214,904

Light Touch Contracts

Light touch utilities contract	£884,720
Light touch concession contract	£5,372,609 (1 January 2024 to 31 December 2025)
All other light touch contracts	£663,540

Mixed Procurements

The ICB may need to be able to award contracts that are not always 100% goods, 100% services or 100% works. Contracts can therefore comprise a mixture of two or more different categories. Section 5 of the Act sets out the rules on determining when a mixed contract will become a public contract. This is because a mixed contract may comprise two or more elements that, if procured separately, would have different applicable thresholds. Section 5 also provides clarity on applying the rules on thresholds to situations where a contract contains mixed elements, where at least one is above, and one is below the relevant thresholds.

Frameworks

Frameworks that are public contracts are most likely to be awarded following a competitive tendering procedure and will either be deemed as a standard framework or an open framework. The Procurement Act 2023 (Act) defines a framework as a: 'contract between the ICB and one or more suppliers that provides for the future award of contracts by the ICB to the supplier or suppliers.' (section 45(2)). This means that a framework sets out the provisions under which future contracts for the supply of goods, services and/or works are to be awarded.

The Act defines an open framework as a: 'scheme of frameworks that provides for the award of successive frameworks on substantially the same terms' (section 49(1)).

Calling off against a Framework must be in accordance with the process and terms set out within the Framework. When the ICB awards a call-off contract using a Framework, the relevant notices defined in Appendix 7 must be followed, with the exception of a tender notice, which is not required.

Conflict of Interest

The Procurement Act 2023 (Act) requires the ICB, when carrying out a 'covered procurement', to have regard to a number of objectives, which include acting, and being seen to act, with integrity (section 12(1)(d) of the Act). The integrity of a procurement may be compromised if it is influenced by external or private interests. Alongside the procurement objectives, the Act includes specific provisions dealing with conflicts of interest when carrying out a covered procurement (Part 5 of the Act).

A conflict of interest arises in a procurement context where there is a conflict between the interests of a person acting in relation to a procurement and those of the procurement itself. These conflicts of interest need to be managed effectively to ensure that the public can trust the ICB to carry out public procurement responsibly and impartially. It also helps to encourage suppliers to participate in procurements, providing confidence that they will be treated fairly and that there will be genuine competition.

When conflicts of interest are not identified and effectively mitigated, there can be far-reaching consequences. It can lead to accusations of fraud, bribery and corruption, legal challenges and the undermining of public confidence in the integrity of public institutions. The Act requires the ICB to identify and keep under review actual and potential conflicts of interest. The ICB must also mitigate conflicts of interest and address circumstances which are considered likely to cause a reasonable person to wrongly believe there to be a conflict or potential conflict of interest ('perceived conflict of interest'). ICB staff are required to complete conflicts of interest and declaration of interest training as part of the statutory and mandatory training package.

Modifying a Competitive Procurement

During the course of a competitive tendering procedure, it may be necessary to make amendments or clarifications to information in the tender notice or associated tender documents to deal with circumstances that were not anticipated. Modifications during a procedure may be necessary for a number of reasons. For example, it could be that a supplier has raised a clarification question which requires an amendment to the associated tender documents, or something was omitted from the tender notice. Any modifications must be made in accordance with section 31.

Transparency Notices

The Act places an increased focus on the ICB to be transparent when undertaking procurement activities to ensure that procurement information is publicly available not only to support competition, but to provide the public with insight into how their money is spent. A table of all the transparency notices covered under the Act and when publication is required is detailed in Appendix 7.

Award of Contract without competition (Direct Award)

A Direct award is when a public contract is awarded without a competitive tendering procedure and the public contract is placed directly with the supplier of the ICBs choosing. There are limited circumstances in which the ICB is permitted to award a public contract to a supplier without first running a competitive tendering procedure. Consequently, a competitive tendering procedure is the default for most public procurements. The ICB may only directly award a public contract when section 41 (and one or more of the justifications in Schedule 5), section 42 or section 43 apply.

Under the Procurement Act 2023 (Act), a transparency notice must be published before a contract is directly awarded. The function of the transparency notice is to inform stakeholders that the ICB intends to directly award a contract and ensure that there is transparency relating to this decision. It provides an opportunity for interested parties to consider the justification for direct award.

14 Form of Contract

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

15 Award of Contract

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

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

For all relevant procurement procedures conducted under the PCR Regulations 2015, Provider Selection Regime and the Procurement Act 2023 the ICB will operate a standstill period, reflecting best practice and will align to the respective procurement regulations between announcing the contract award decision and entering into the contract. For clarity, the minimum standstill period for the respective procurement regulations is detailed below:

- PCR Regulations 2015 – A minimum of 10 calendar days after intention to award a contract is sent electronically to bidders e.g., via an e-Tendering Portal.
- Provider Selection Regime – A minimum of 8 working days after intention to award a contract is published.
- Procurement Act 2023 – A minimum of 8 working days beginning with the day on which a contract award notice is published in respect of the contract. Note: The ICB will need to factor in all of the bank holidays in England, Wales, Scotland and Northern Ireland when calculating the standstill period.

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

16 Complaints and Dispute Procedure

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

- Bidders/contractors
- A member of the public

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

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

SECTION F - Additional Considerations

17 Data Protection Impact Assessment

Where any new service is required, it will be necessary for a data protection impact assessment (DPIA) to be completed. The project lead should liaise with the SCW information governance lead and/or ICB Data Protection Officer to complete a DPIA prior to selection of provider which should be updated once the provider is identified. DPIAs are completed to ensure the ICB understands and manages security and Information Governance risks to information, systems and networks supporting the operation of its functions that arise as a result of dependencies on external suppliers.

This includes the ability to

Understand the general risks suppliers may pose to ICB essential function(s).

Know the extent of your supply chain that supports your essential function(s), including sub-contractors.

Understand which contracts are relevant and you include appropriate security and data protection obligations in relevant contracts.

Awareness of all third-party connections and have assurance that they meet your organisation's security and IG requirements.

The approach to security and data protection incident management considers incidents that might arise in your supply chain.

Have confidence that information shared with suppliers that is necessary for the operation of your essential function(s) is appropriately protected from well-known attacks and known vulnerabilities.

Know international data transfers to suppliers are covered by a legal protection.

Please seek advice as early as possible from the Data Protection Officer or IG Consultant to understand the necessary IG requirements. For IT/Cyber requirements please seek advice from the Intelligence, Transformation and Digital Lead

17.1 Equality Health Impact Assessment

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

The ICB EHIA template can be found here:

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

17.2 Quality Impact Assessment

A Quality Impact Assessment should form part of any service commissioning process, especially when there is likely to be a change to the way in which a service

is delivered or a change in provider. As with both tools above, a similar process should be completed for a quality impact assessment. The project lead should liaise with the ICB Quality Team.

The ICB QIA template can be found here:

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

17.3 Code of Conduct and Conflicts of Interest

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

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

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

17.4 Voluntary and community sector/Small and Medium Enterprises Support

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

17.5 NHSE Integrated Support and Assurance Process (ISAP)

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

17.6 NHSE Consultancy spending approval criteria for providers

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

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

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

17.7 Accessible Procurement

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

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

17.8 IR35 and Employment Assessment

The ICB has a responsibility to ensure appropriate procedures are in place to meet with HMRC requirements regarding, amongst other things, appropriate payment of tax. This is particularly relevant to procurement when the ICB engages with self-employed individuals, individuals via their own limited company (known as a Personal Services Company) or a partner in a partnership. HMRC introduced the Check Employment Status for Tax (CEST) service in 2017 to help employers (or hirers) and workers to determine how the work being done should be dealt with for tax purposes.
The following link provides further details to support:
https://www.gov.uk/government/publications/check-employment-status-for-tax-cest-2019-enhancement/check-employment-status-for-tax-cest-usage-data

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

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

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

- Not having to work under direct supervision or control of the end client.
- Having control over how / where / when to complete the work.
- Has no access to holiday pay or sickness benefits.

- A fixed fee is agreed by the employer for the work, regardless of how long it takes to complete.
- Financial risk e.g., having to correct errors in their own time and at their own expense.
- Being able to propose a substitute agent or person to complete the work.

17.9 Integrated Care - Working with People and Communities

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

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

18 The Procurement Oversight Group

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

20 Training and Awareness

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

All commissioning staff throughout the ICB should know enough about procurement to know to seek help when they encounter related issues; they must also be able to give clear and consistent messages to providers and potential providers about the

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

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

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

SECTION G – Policy Governance

21 Consultation

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

22 Recommendation and Approval Process

This policy is to be scrutinised by the Finance Estates and Digital Committee pending approval by the Board in line with the Scheme of Reservation and Delegation.

23 Communication/Dissemination

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

24 Implementation

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

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

25 Monitoring Compliance and Effectiveness of the Document

The Audit Governance and Risk Committee will oversee compliance with aspects of

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

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

26 Document Review Frequency and Version Control

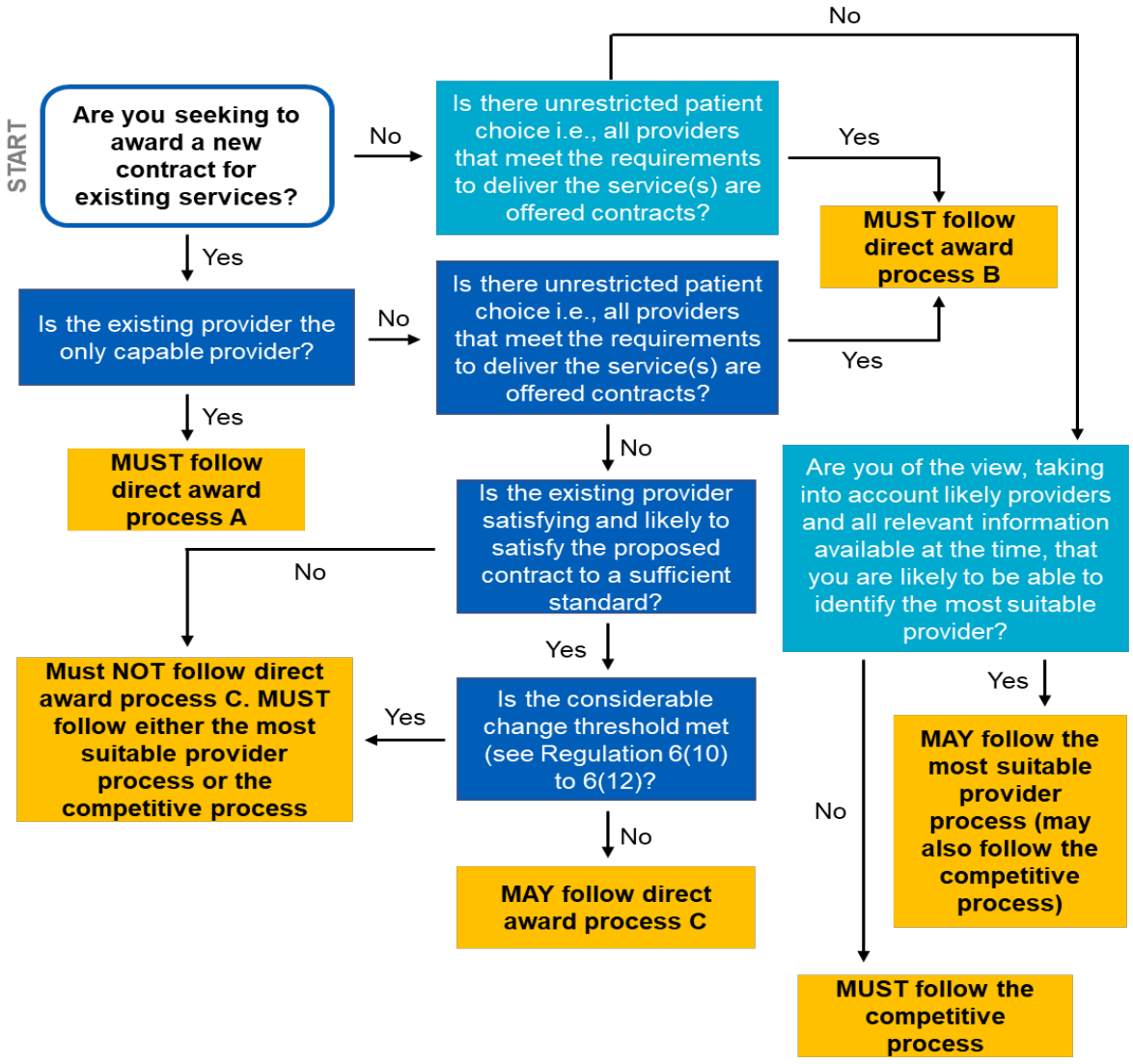
This policy will be reviewed every two years or earlier if appropriate, to reflect any changes to legislation or guidance that may occur. Necessary changes throughout the year will be issued as amendments to the policy. Such amendments will be clearly identifiable to the section to which they refer,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

Appendix 1: Provider Selection Regime – Decision Flow Chart

"Getting to the Right Decision"

NEED TO PROCURE A HEALTHCARE SERVICE?

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



Overview of decision-making approach to PSR process

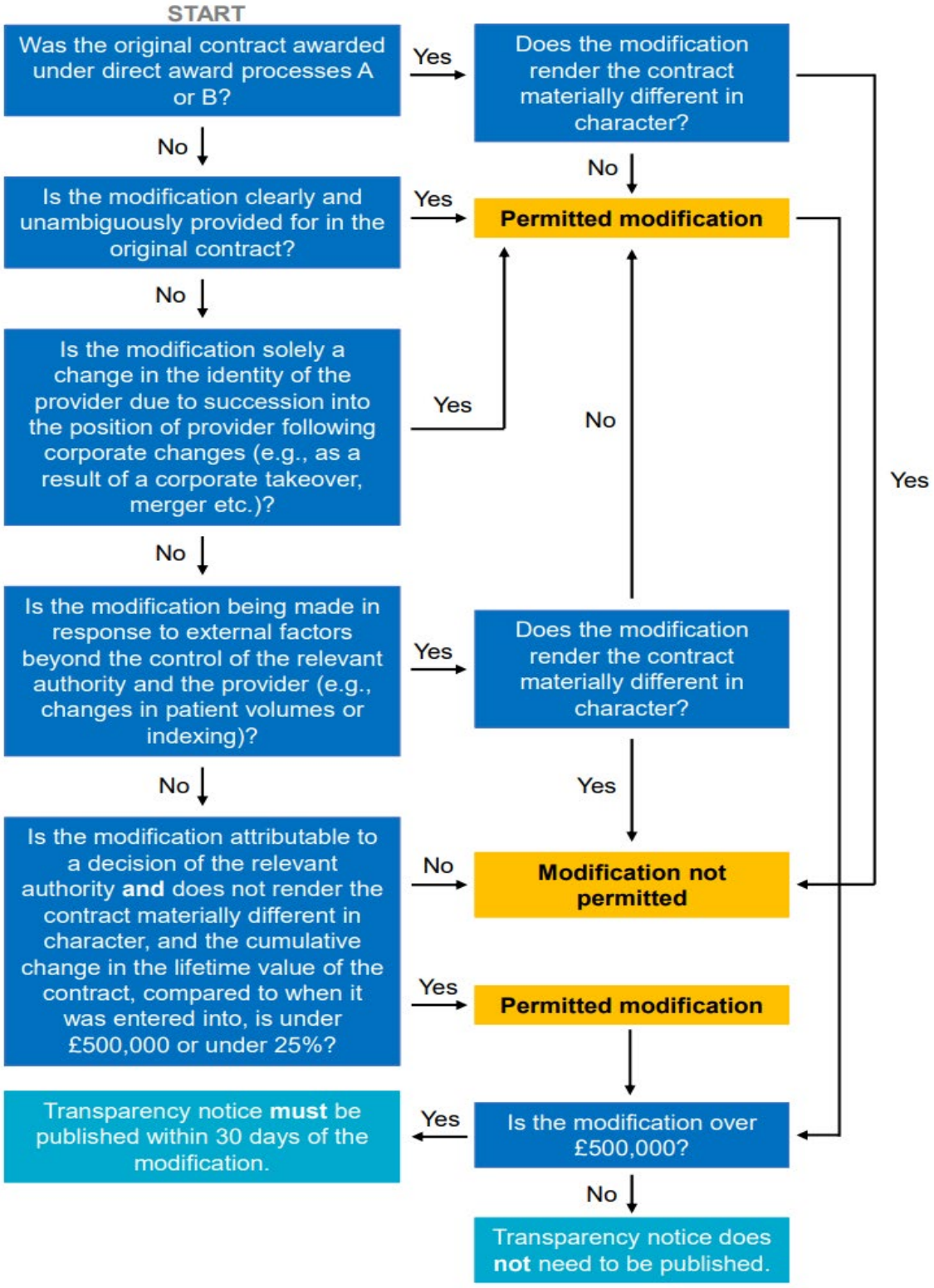
Direct Award A	Continuation of existing arrangements –there is no realistic alternative to the existing provider (for example for Type 1 and 2 urgent and emergency services). Not used to establish framework agreement. **Must** be used if applicable. Transparency award notice published within 30 days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

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

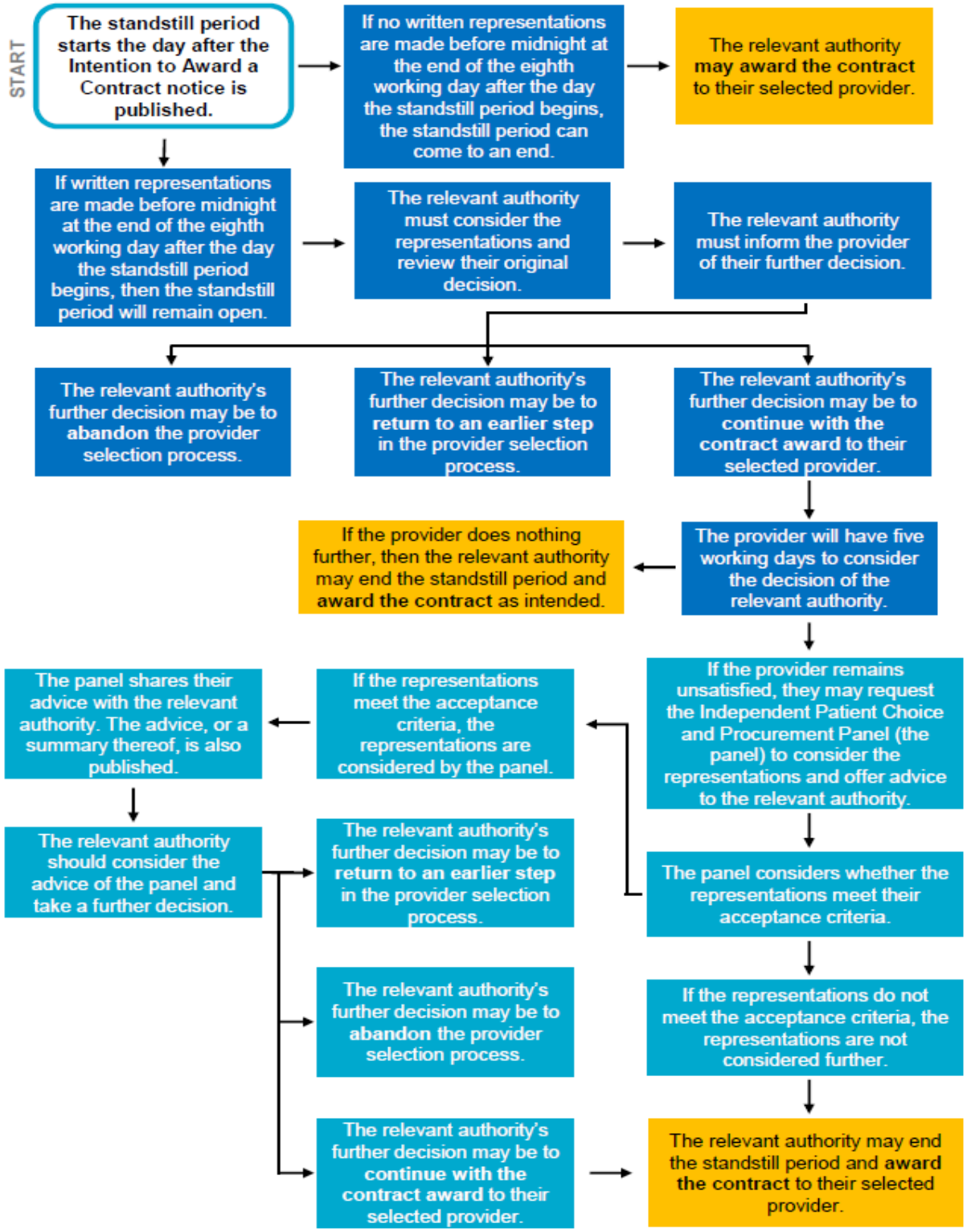
PSR Process	A	B	C	MSP	Competitive
Details on intended approach (PIN)				Notice published at least 14 calendar days before assessing providers	Optional
Contract Notice for procurement					On FTS website
Internal record of decision-making process & rationale					
Responding to unsuccessful bidders				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

Notice required
Internal Record
Outcome Letter

Appendix 3: PSR Contract Modifications Flow Chart



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



Appendix 5: Procurement Process Table (non-healthcare)

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

CONTRACT THRESHOLD VALUE	PROCUREMENT PROCESS
Up to £5k Total Contract Value	No Formal Requirement (Quotations Advised)
Between £5k and £50k Total Contract Value	3 Formal Quotations need to be obtained. (Single Tender Waiver signed by CEO required if quotations cannot be obtained)
Between £50k and £214,904 (inc. VAT) Total Contract Value	Competitive tender required. (Single Tender waiver signed by CEO required if competitive tender cannot be undertaken) The ICB can consider an open (advertised) or closed (framework or local approved supplier list) approach to market.
Above £214,904 (inc. VAT) Total Contract Value	Full open (advertised) or closed (framework) tender required. (*Advice and guidance from **SCW Procurement team,** including if the view is that a full tender cannot be undertaken*) **Legislation:** Public Contracts Regulations 2015/Procurement Act 2023 from 24/02/25

Appendix 6: Common Procurement Processes (Procurement Act 23) - Guidance

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

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

Appendix 7: Procurement Act 2023 – Table of Transparency Notices

The following table sets out the publication requirements that apply to notices that should be 'published when required' on the central digital platform (Find A Tender Service). Exemptions to publication may apply so please seek advice and guidance from the NHSE SCW procurement team as appropriate.

Notice Name / Reference	Publication Requirement
Pipeline notice (UK1)	Mandatory (for organisations where spend is £100m+ PA) 12-month forward-look at planned procurements £2m+ value
Preliminary market engagement notice (UK2)	Mandatory where pre-market engagement is anticipated or has taken place (or, explain in the tender notice reason for not publishing)
Planned procurement notice (UK3)	Optional and best practice advises the market of an upcoming procurement. A qualifying planned procurement notice can reduce tender timescales to 10 days
Tender Notice (UK4)	Mandatory when undertaking an open or competitive flexible procedure (including to establish a framework and award a contract under an existing dynamic market) or a regulated below-threshold procedure
Transparency Notice (UK5)	Mandatory when undertaking a direct award (publish prior to award)
Contract Award Notice (UK6)	Mandatory communicates the outcome of the procurement and (commences standstill prior to awarding a contract open or competitive flexible procedure)
Contract Details Notice (UK7)	Mandatory details of the awarded contract (including the redacted contract, for public contracts £5m+ and KPI information)

Notice Name / Reference	Publication Requirement
Contract Payment Notice (UK8)	Mandatory details of payments over £30,000 made under a public contract (quarterly)
Contract Performance Notice (UK9)	Mandatory to report: a. annual KPI scores for public contracts valued £5m+ b. poor supplier performance / breach of contract (within 30 days of event)
Contract Change Notice (UK10)	Mandatory prior to a qualifying modification taking place (copy of modified contract for public contracts over £5m)
Procurement Termination Notice (UK12)	Mandatory where, after publishing a tender or transparency notice, the process is terminated without awarding a contract
Dynamic Market Notice (UK13 TO16)	Mandatory when advertising, establishing, changing or terminating a dynamic market
Payments Compliance Notice (UK17)	Mandatory details of contracting authority performance against 30- day payment terms (twice annually)
Contract Termination Notice (UK11)	Mandatory when a public contract ends