NHS
Derby and Derbyshire
Integrated Care Board

MINUTES OF THE SYSTEM FINANCE, ESTATES AND DIGITAL COMMITTEE

HELD ON TUESDAY 24 SEPTEMBER 2024 VIA MS TEAMS AT 1.30PM

Present:		
Jill Dentith	JED	Non-Executive Director, ICB (Chair)
Michelle Arrowsmith	MA	Chief Strategy and Delivery Officer/Deputy CEO (part)
Cath Benfield	CB	Strategic Finance Lead JUCD
Simon Burrows	SB	Deputy Chief Finance Officer, DCHS
Claire Finn	CF	Interim Chief Finance Officer, UHDB
Keith Griffiths	KG	Chief Finance Officer, ICB
Steve Heppinstall	SH	Chief Finance Officer, CRH
Tamsin Hooton	TH	Programme Director, Provider Collaborative, JUCD
David Hughes	DH	Director of Finance, ICB
Mike Naylor	MN	Director of Finance, EMAS
Stuart Proud	SP	Non-Executive Director, DCHS
James Sabin	JS	Director of Finance, DHcFT
Sue Sunderland	SS	Non-Executive Director and Audit Chair, ICB
Susan Whale	SW	Director of System PMO & Improvement
In Attendance:		
Debbie Donaldson	DD	EA to Keith Griffiths, (Minute Taker) ICB
Apologies:		
Chris Clayton	CC	Chief Executive Officer, ICB
Peter Handford	PH	Chief Finance Officer, DCHS
Ian Lichfield	IL	Non-Executive Director, UHDB
Lee Radford	LR	Chief People Officer, ICB

Item No.	Item	Action
FE2425/453	**Welcome, Introductions and Apologies** The Chair welcomed members to the meeting. Apologies were received from Lee Radford, Peter Handford, Ian Lichfield and Chris Clayton.	
FE2425/454	**Confirmation of Quoracy** The Chair declared that the meeting was quorate.	
FE2425/455	**Declarations of Interest** The Chair reminded Committee members of their obligation to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of the ICB. Declarations declared by members of the System Finance, Estates and Digital Committee are listed in the ICB's Register of Interests and included with the meeting papers. The Register is also available either via the Executive Assistant to the Board or the ICB website at the following link: www.derbyandderbyshire.icb.nhs.uk	

	No declarations of interest were made.	
FE2425/456	**Any points arising from previous ICB Board Meeting** The Chair highlighted the following: • The ICB Board Meeting and AGM was held on 19 September 2024. • There had been an interesting citizen story about falls prevention in Hartington. This was an example of good practice, and it was being considered as to how that could be replicated across the patch, noting that Hartington was quite a unique area. Keith Griffiths reflected on this presentation and reported that a very small amount of money (£10-20k) could make a big difference for charities/engage the community. • There had been a strategic update on Place from Michelle Arrowsmith/Dr Penny Blackwell. • There was a presentation on Dental Services from Michelle Arrowsmith. • Keith Griffiths had presented the Infrastructure Strategy. • Board had talked about the local landscape and position. It was noted that we were now 6 months into the year and in terms of finance, workforce, and efficiencies, there needed to be a continued focus from all organisations, bearing in mind that we had back loaded a lot of the financial planning into the last 6 months of the year. • Board had looked at the national position regarding the Darzi and CQC reviews.	
FINANCE		
FE2425/457	**M5 System Finance Report** Keith Griffiths reported that this paper presented the financial position of JUCD for the period ended 31st August 2024 (M05). It highlighted the key areas where there are I&E challenges, as well as summarising the capital position across the JUCD system. It was noted that with the national requirement for all systems to re-submit their plans on 12th June 2024, JUCD had submitted a revised financial plan to deliver a planned deficit of £50m, in line with the Revenue Financial Plan Limit set for the ICS. This report highlighted the System financial performance against the revised financial plan. • The System was expecting non-recurrent deficit support revenue allocation in 2024/25 of £50m, the funding for this was expected in October. • At M05 the system reported a YTD adverse variance of £3.7m against a plan of £41.9m. The annual forecast was to deliver the planned deficit of £50m by the end of the financial year. • The key drivers of the YTD position included:	

- Industrial Action Costs of £2m (UHDB and CRH) due to Junior Doctor strikes in June & early July. NHSE had indicated that there would be funding available for this pressure, but the value and timing had not yet been confirmed.
- Urgent & Emergency Care Demand Pressures of £1.3m (UHDB) resulting from remaining in OPEL 4 with Full Capacity Plan protocols in place.

- The forecast outturn (FOT) was expected to be in line with the £50m deficit plan; the YTD extrapolated run rate sees the outturn at a deficit of £109.5m. The required improvement of £59.9m in M06-M12 was detailed in a bridge chart on page 4. The following key deliverables would support achievement of the System financial target for 2024/25:

  - CIP actualisation including development of the £6.5m unidentified gap in efficiency plans and acceleration of £27.6m opportunities and £48.4m plans in progress.
  - Improvement to unplanned care pathway within UHDB resulting in the safe and urgent removal of unfunded additional enhanced capacity.
  - Maximisation of financial opportunity from the Elective Recovery Fund.
  - Reduction of variable pay and alignment of WTE and financial pay information.

- The DDICB had a System Review Meeting with region on 20 September 2024.
- The Derby and Derbyshire System was closest to plan than 9 out of the 11 Systems in the Midlands, however, there was still a need to deliver to plan.
- There was a slight variance from plan, and we needed to stay in that space to deliver £50m deficit.

David Hughes highlighted the following key workforce issues:

- We had a workforce of circa 30,000. The workforce numbers were lower than plan of around 550 WTE. At the same time, pay was overspending by about £4.4m (less than 1%). It was felt that this was an issue that we needed to get to the bottom of. Colleagues were working with the HR team with a view to try to understand what was in each other's numbers to hopefully address this.
- Claire Finn supported what David Hughes was stating but felt the pay award figures were slightly misleading. The pay award within some of the ICB information had not necessarily been adjusted. The report was showing that UHDB had a workforce variance of £2.9m – it was only a variance of £1m; this would be reflected in future months.
- In respect of agency the YTD spend was circa £15m which equated to 2.2% of the pay bill which was well below the ceiling of 3.2%.

	• This linked in with the first point around the workforce agency issue, at M6 the plan was to drilling into some of the issues that would help us reconcile between the two numbers. Keith Griffiths reported that there would be some funding flowing for the industrial action, the value of this income would be determined by a metric devised by NHSE. There would be some improvement in future months once that income was clarified. Stuart Proud asked the following three questions: • P11 slide – Run Rate Overview. There was a block of -£51.5m (called other risks) to the forecast. He wanted to understand what the additional risks to the forecast were, which were outside of the plan. He asked whether we could mitigate them and still live within the £50m or was it a risk around efficiency. • P13 slide showed the I&E position – the forecast for income was to be slightly higher than was in the plan, he assumed that was ERF related; was there a risk around this assumption. • Workforce – he had looked at what we were spending currently, and if we extrapolated substantive pay, then it looked like we were going to be spending overall about £140m more than we were currently spending (if we went by the forecast here). Was that down to either the pay award or that we were going to recruit to the 550 staff (that we have not currently recruited to). He asked whether we were certain that we needed these additional staff, and if we needed them was it because it related to our income issues. He added that agency did not also to appear to be reducing from the forecast, it was about the same if you extrapolated it. David Hughes responded to the above questions raised: • David Hughes reported that there were some limitations around the straight-line extrapolation of the YTD numbers and where that takes us. There was some expectation around additional funding, and reference had been made to that earlier, nevertheless, there was a significant variance of £56.9m; there would be a range of things that would happen to address that. Predominantly it related to the achievement of efficiency schemes in the second half of the year. It was hoped that the assurance that members needed would be gleaned from the session that was planned later in the agenda (next item). • As it stood, we had heavily backloaded plans, this did create risk. It was noted that if we were to keep on track, then there were things that we needed to address. • In respect of the specifics of the £51m, David Hughes agreed to take that question away and respond to members via email. • In respect of workforce, he acknowledged the point raised, that workforce did generate a positive contribution financially. • Income position – David Hughes agreed to share the detail of this offline with members via email.	DH DH

	• Keith Griffiths reported that UHDB had signed a contract negotiated with Staffordshire, which would generate extra income of £6m for UHDB in M5. It was noted that there was nothing coming out of the ICB that was growth in income. • Claire Finn reported that UHDB had agreed the contract with Staffordshire, and they had supported and acknowledged the level of UEC demand that we were seeing within the organisation currently. In terms of whether there was any upside, the agreement was in line with their planning assumptions. Previously UHDB had quoted that there was a risk around Staffordshire if they did not agree the contract assumptions that they were working on; that risk had now dissipated. • Claire Finn and David Hughes agreed to do a triangulation piece of work on the £51m to see what that income looked like. **System Finance, Estates and Digital Committee NOTED:** • **The YTD position and commitment to deliver in line with the submitted plan.** • **The expectation that the System will receive a non-recurrent deficit support allocation in 2024/25 effectively taking the position to breakeven, but this is repayable.** • **The risks and mitigations associated with delivery of the planned £50m deficit.** • **The risks associated with the capital plan including the IFRS16 risk and the DHcFT cost pressure in relation to the eradication of mental health dormitories.** **Considered action to oversee and accelerate the key deliverables to support the success of the System financial target for 2024/25:** • **CIP actualisation including development of the £6.5m unidentified gap in efficiency plans and acceleration of £27.6m opportunities and £48.4m plans in progress.** • **Improvement to unplanned care pathway within UHDB resulting in the safe and urgent removal of unfunded additional enhanced capacity.** • **Maximisation of financial opportunity from the Elective Recovery Fund.** • **Reduction of variable pay and alignment of WTE and financial pay information.** • **Mitigation of the £29.9m to £32.9m risk adjusted efficiency gap, to secure delivery of the financial plan.**	DH/CF
FE2425/458	**Formal Presentations from each organisation on risks and mitigations to ensure delivery of agreed 24/25 plans:** **UHDB:** Claire Finn highlighted the following:	

	• The Trust YTD planned deficit for M5 was £33m. The Trust reported an actual position of £36.9m, which was £3.9m adverse to plan (YTD at M4 was £2.7m adverse to plan). The in-month adverse variance was £1.2m. • The £1.2m pressure in M5 related to continued UEC pressures and excess inflation, as well as spend above plan in surgery theatre consumables and estates for water legionnaires checking services. These pressures were offset by continued substantive recruitment slippage against budgeted vacancies, and slippage against the planned multi-storey car park scheme. • The drivers of the YTD adverse variance of £3.9m were explained in greater detail on Slide 6 of her presentation but related to the one-off impact of junior doctor industrial action, excess non-pay inflation, additional capacity for UEC demand and challenging behaviours, and non-tariff drugs and devices including new hybrid closed-loop insulin pumps. These pressures were offset by continued and growing slippage against budgeted vacancies. • Slide 3 showed the trust's 2024/25 financial and efficiency plan. • The trust's planned deficit was £47.8m and was predicated on delivery of £62.7m of financial efficiencies. In M4 required efficiency delivery increased materially, and again in M5 and M9. • As of M5 the target of £17.4m had been achieved, • The red dotted line on Slide 3 was a straight-line extrapolation of YTD financial performance, it was expected that divisions would increase CIP delivery in the remaining months of the year to mitigate this trajectory. • The waterfall on Slide 4 illustrated the key variances to the trust's YTD plan at the end of M5 (August 2024): • Excess inflation (£1.9m): non-pay contract price increases above the 1.8% funded in national allocation uplifts. The largest of these pressures relates to NHS Blood and Transplant, with a contract uplift of 15%. • Industrial action (£1.5m): Junior doctor industrial action across June/July. • UEC capacity demand (£1.3m): UEC demand remained above planned levels, with A&E and non-elective activity circa 8-9% higher than the same period last year. This led to escalation capacity remaining open throughout June. Ward 312 was re-opened in August with no anticipated close date this financial year. • Non-tariff drugs and devices and hybrid closed-loop (HCL) insulin pumps: (£1.2m): Estimates of the costs and income for pass-through drugs and devices (including newly introduced hybrid closed-loop insulin pumps) show a £1.2m net pressure at M4. It was assumed that all high-cost drugs and devices would be fully funded by commissioners in-line with national guidance, however, there remains a risk to this as discussions are ongoing. • Challenging behaviour pathways (£0.5m): these costs related to increased staffing ratios for patients presenting with challenging behaviours. • MARS (£0.4m): several staff left the trust under a Mutually Agreed Redundancy Scheme, with gross redundancy and legal	

fees amounting to £0.5m. These costs had been partially offset by salary savings in M5 (and would continue to be offset further).
- Other, including investment slippage (£3.0m underspend): net of underspends relating to vacant posts within budgets and other small variances across all other areas.
- NHSE productivity analysis showed that between M3 2023/24 and M3 2024/25 (latest data available) inflation adjusted expenditure increased by 1.3%, WTE grew by 1.9% but cost weighted activity grew by 7.3%. This translated to an improvement in productivity of 5.9% over the period.
- The graph on Slide 5 illustrated this, with activity numbers (not Value Weighted Activity (VWA) in graph) for each POD having increased between 3% and 9.5% whilst total WTE had grown significantly less. Average activity growth by POD (by number, not VWA) was 7.2%, broadly in line with the growth in VWA.
- The risks at M5 were detailed in the diagram on Slide 6.

CRH

Steve Heppinstall highlighted the following:

- Risks to the plan were detailed on slide 2.
- Proposed phasing of mitigations was detailed on slide 3.
- Current transformation plans of £15.9m v £19.8m target, significant risk in some plans.
- Work continued to develop the pipeline and strengthen financial controls.
- Robust pay controls were in place, fortnightly CEO led vacancy panel, additional, strengthened processes to tackle nursing bank.
- Workforce numbers had reduced slightly from March and CRH were making headway on bank and agency.
- There were challenges around leadership capacity in the organisation which was being addressed.
- Operational pressures were significant and ongoing problems with lack of capital funding impacting on productivity and capacity.
- CRH had strengthened internal governance around key challenges such as fragile services.

DHcFT

James Sabin highlighted the following:

- DHcFT M5 YTD £3.8m deficit – on plan.
- FOT to achieve plan.
- CIP was behind plan YTD, there were no major concerns, QEIA processes concluded, 75% identified as recurrent.
- Agency was slightly above plan – (£0.9m under plan excluding complex AED patient, expenditure ceased at beginning of Sept)
- The delay to the Making Room for Dignity (MR4D) programme had extended some of the appropriate out of area (OOA) usage but this was contained and offset by delaying recruitment.

	• CQC Impact – Zonal observations put in place in response to CQC concerns on female acute wards. Unplanned cost pressure stands at £0.5m in 2024/25. • Transfer of high-cost patient – now transferred and no longer a pressure. Discussions ongoing re seeking reimbursement/ Provider Collaborative contribution. Unplanned costs stand at £1.14m in 2024/25. • Work continued on closing the CIP gap and progressing recurrent solutions. Inpatients and Childrens and CAMHS struggling. • Inpatient staffing: continued overspends linked to Acuity and Obs and safe staffing levels. • Acute OOA costs remained a key area of focus, and the required recovery trajectory increased as we moved into Q3. (Increased OOA offset by delays re MR4D increased pay costs) • Capital – MR4D cost pressure (national support ask for £7.5m outcome pending) and other system pressures linked to IFRS16 etc. remained unresolved. Need CDEL headroom and cash. • Medical locum expenditure remained high, and some key appointments needed to open the PICU and other new facilities. International recruitment being taken forward. • Strengthened Performance Management Framework. Across all clinical and corporate areas. • Some areas moved to monthly Executive led oversight meetings. • Increased focus of CIP oversight group. Executive oversight monthly and operational meetings fortnightly. • Another review of all vacancies excluding MR4D. (To close CIP gap and move NREC to REC) • Continuation of robust VCP process and consideration of recruitment pause. Everything via VCP including extensions and small increases in hours. Also, Medics not exempt. Removed expression of interest loophole. • Continue discussions re: additional contribution for patient with complex needs. • OOA/MR4D – manage risk and slippage. Increased OOA required delays in pay expansion. • Review non-pay expenditure. More focus on proactive forward planning. • Reliance on balance sheet flex in 24/25. • Very minimal investments. £20k this year post plan other than those CQC and safety driven. **DCHS** Simon Burrows highlighted the following: • At M5, the Trust reported a £0.800m deficit position against a planned deficit of £1.539m. (£0.739m favourable variance to plan) • The M5 efficiency position was achievement of £3.148m against a plan of £2.896m (109%). An over-performance of £0.252m. • The Trust had spent £0.541m on agency expenditure against planned expenditure of £0.503m. The increase had been driven	

by additional agency costs in support of pressures within the Urgent Treatment Centres.

- The Trust's cash balance at M5 was £30.5m, which was £8.9m above the planned cash balance. The main drivers of the higher cash balance were due to the underspending position against the 24-25 capital programme and more favourable financial performance than planned.
- At M5, the Trust had incurred £6.4m capital expenditure against a planned capital expenditure of £11.4m. This under performance was being seen against the Bakewell and Walton CDC with significant commitments forecast in September – November 2024.

Potential Risks to Delivery in 2024-25:

- Efficiency Delivery – £1.3m: Breakeven position reliant on residual CIP/SQIP gap being closed. Work continues with Financial Efficiency Sprint Group through 6 dedicated workstreams to identify in-year and multi-year delivery plans.
- Emergent Cost Pressures in Service Delivery - £1m: Operational pressures within Community Nursing and UTC provision. Redistribution of resourcing across Community Nursing teams in line with Safer Staffing Tools. UTC model reviewed – 24/25 plan assumed element of coverage of pressures.
- Non-Pay Inflation £1.1m: Rising inflation levels generating cost pressures to DCHS when renewing contracts/undertaking capital projects. No identified material pressures at M5. Continue to monitor closely.

Mitigations:

- Efficiency Delivery – continued focus and drive for delivery of recurrent schemes with Senior Leadership Team oversight and challenge. Focus on maintaining and improving delivery to required run rates to deliver planned outturn financial performance.
- Management of emergent cost pressures through operational escalation reporting framework and utilising resourcing across service lines/teams.

EMAS

Mike Naylor highlighted the following:

- M5 financial position surplus of £2.3m (vs a YTD planned surplus of £2.6m).
- The cost profile for EMAS was slightly different to other organisations. Main workforce was road technicians and paramedics and due to some recent pay band increases over the last 2-3 years their incremental dates were very much coterminous. There would be big increases in costs later in the year.
- EMAS had taken that service, extrapolated it up and then adjusted for known run rate changes so those increments could come down to £5m for the year.

- EMAS had taken a gain from the sale of Newark ambulance station.
- EMAS had anticipated a slowdown in sickness rates.
- EMAS has an efficiency of nearly £2m that they had not been able to bank yet because of handover delays.
- Potentially this would leave EMAS with £1m at year end.
- In terms of risk, within that assumption, they had got a contract variance currently. They did not have a contract in place for A&E.
- There was just over £6m of risk in relation to originating contract value.
- Risk of depreciation £1.5m – dependent on hitting targets.
- Activity and handover delays were the big things that would move the cost base during the year.
- Activity – there had been a big increase in 999 calls (4.4%). This year as part of EMAS efficiency drive and quality improvement they were taking more calls but where clinically appropriate and instead of automatically despatching ambulances, they were either signposting somewhere else or referring to their own internal clinical assessment teams. This had helped keep cost rises down.
- Non-recurrent savings were helping against their CIP currently.
- EMAS had £2m of unbanked CIP to help offset the handover delays.
- EMAS did not anticipate any arbitration regarding handover delays.
- Winter was imminent and CAT2 performance was a key assessment of NHS performance. EMAS tended to receive extra money in January/February for this, but this had not been taken into account currently.
- The agreement EMAS had with JUCD was that they would not reduce any resource out; they had the same hours and people out as they had in Q4 last year.

ICB

David Hughes highlighted the following:

- Slide 2 summarised the ICB's statutory financial duties and other key financial indicators as at M 05.
- The ICB had a total Revenue Resource Limit at M05 of £2.673 billion.
- Year-to-date surplus of £4.8m. This was £0.3m favourable variance to plan.
- The ICB had a planned surplus £23.8m.
- The ICB was forecasting to achieve the planned surplus £23.8m.
- ICB Running Cost Allocation was £17.8m and forecast to remain with the allowance.
- The ICB was forecasting to achieve its efficiencies (£47m). YTD £13.3m (£1m ahead of plan).
- The ICB was planning to achieve Mental Health Investment Standard (MHIS).

	• The ICB was achieving its key metrics in relation to cash and the Better Payment Practice Code.
	• The 2024/25 financial target is to achieve an in-year surplus of £23.8m.
	• The ICB was on course to achieve the planned surplus. However, this is not without risk.
	• Healthcare areas under budgetary pressure with adverse variances to plan were:
	  • Mental health & learning disabilities of £4.8m caused by increasing demand, out of area placements, and national policy.
	  • Continuing healthcare of £2.7m (£2m of anticipated uplifts and £0.7m brain injury caseload increase).
	  • Medicines of £2.9m mainly caused by prescribing volumes.
	• Mitigating the above were non-recurrent benefits:
	  • Dental (delegated services) £7m which was £1.5m above the original planned £5.5m benefit.
	  • Specialised commissioning (delegated services) £3.6m which was £2.6m above the original planned £1m benefit.
	  • Some non-recurrent fortuitous gains/balance sheet flexibility from last year.
	• At M05, the YTD efficiency delivery was £13.4m, a favourable variance of £1.1m.
	• The ICB was forecasting to achieve its full efficiency target of £47m by the end of the year. However, the efficiency programme was not without risk.
	• The efficiency programme was heavily weighted towards the later months.
	• The high-risk schemes identified, posed a risk to the ICB.
	• £32.3m/69% of the schemes were recurrent and £14.8m/31% were non-recurrent.
	• The ICB through groups, such as, the Executive Led Efficiency Group were identifying and developing replacement/ contingency schemes.
	• Contingency schemes included, GPIT, pay costs (targeted vacancy freeze and review of functions), a review of contracts (healthcare and non-healthcare), VAT claim, and assessment of S117 packages.
	• Efficiency risk of £12m had been factored into the financial position of the ICB. Should schemes further underachieve and replacement schemes not be identified, the financial gap would widen.
	• A BCF reduction of £6m was identified during the planning round. £3m of this reduction was included within the ICB's efficiency programme. The likely benefit was minimal.
	• Mental health and SDF reductions identified during the planning round totalled £4m and £2m, respectively. Unallocated SDF totalled £3.6m leaving a residual shortfall of £2.4m.
	• Based upon current performance, contract 'clawbacks' from community dentists was estimated to be circa £2m.
	• Prescribing price gains notified after month-end were estimated to improve the forecast outturn by £1m.	

	• The earmarked health inequalities funding (£5.2m) would not be spent as intended and instead used to support the financial position. • The residual risks and mitigations leave a financial gap of £7m. • Further actions were underway to address this shortfall. • The actions/next steps were being overseen by the Executive Led Efficiency Group. The group meets every Friday and has a wide-ranging Executive membership from across the organisation. Its aim was the continual development of additional/contingency efficiency schemes to ensure that we were optimising all the opportunities that we had available to us and to hold the organisation to account in respect of the original £47m worth of schemes. • Contingency schemes identified included, GPIT, pay costs (targeted vacancy freeze and review of functions), a review of contracts (healthcare and non-healthcare), VAT claim, and assessment of S117 packages. • Further areas of management intervention were being considered including, a time limited vacancy freeze, enhanced expenditure controls, delay or slippage of expenditure, retention/slippage of ICB specific allocations. • De-risk current efficiency schemes. To include detailed oversight by Executive Team. • Development of recurrent schemes where possible – more likely a benefit in 2025/26 and move away from non-recurrent schemes. The Chair thanked everyone for their presentations which gave an overview of where each organisation was. The Chair requested that the power point presentations be shared with members of this Committee. Keith Griffiths echoed his thanks to everyone for the transparency that had been shared. He reported that much material had been shared which he felt could be reviewed in more depth at the next Derbyshire DoFs meeting. He reminded colleagues of what the Chair of the ICB had reported at last week's Board meeting, which was that the only answer for the end of March 2025 was a System deficit of £50m. There were risks emerging and further assurance was required on the mitigations and the likelihood of some of those risks emerging in the range predicated. Keith Griffiths felt that we needed to come back to this on a monthly basis to see whether the risks were growing or diminishing and to look at the mitigations. Keith Griffiths highlighted the following: • We needed to be clear on what the road map to £50m deficit was. • We needed to crystalise for each organisation and get back to the original figures in the plan. • If we felt, at some point in the future, that was not going to be doable, then we needed to look at where we needed to go further in one or two areas to help mitigate pressures; we were not in that space yet.	DD

	• When we started looking at the costs in the two acutes, we had heard surge beds and mental health patients mentioned. • Keith Griffiths requested that the System be messaged in as to where Primary Care, 111, Social Care as well as Community, Mental Health together with Acute services were working together to derisk those pressures. We needed to understand whether there were flow issues in the two acutes that were causing cost pressures, primarily more in UHDB than CRH. • The ICB was seeing things come through such as Out of Areas and associated costs, this was one of those themes that working together across organisations on repatriation or managing demand/reviewing protocols could take some money out in different parts of the System. • The position should not all be all down to accountants to manage the balance sheet and tracking CIP; we needed to get connectivity across all organisations to derisk and ensure that there were no unintended consequences. • The Chair reported that we needed to work with NHSE to ensure that the money flowed in the right places at the right time so that we could then manage the delivery in terms of meeting targets. • James Sabin referred to productivity, he could see that UHDB had done some work on that already. He asked whether people were going back to 19/20 pre Covid or looking at productivity from 23/24; DHcFT had been doing some work on that but were looking at baseline data from 19/20. • James Sabin reported that he was sighted on the Investigation and Intervention (I&I) process that Nottingham was currently going through. He was starting to look at the data requests that came with that process to help inform internally of what was required, and to do improvements without being part of a formal I&I process. • James Sabin reported that some of the mitigations under spend slippage might be linked to capital schemes in terms of depreciation and capital charges. He knew that some of DCHS schemes were behind plan and may have some slippage, which would probably cause us another issue. • Stuart Proud reported that the presentations had highlighted a few common risks across Providers. He felt it would be good to get a sense of the scale of each of those common risks and what was the collective mitigation, which he believed Keith Griffiths would pick up at the next DoFs meeting. • Stuart Proud reported that he was concerned from listening to the presentations, of what was outside some of those other risks eg delivery on CIP. We had a huge mountain to climb, and we appeared to be slipping behind. He appreciated that everyone was working hard, but we needed a sense of realism at some point, which we needed to come back to. He was concerned that we were using things in terms of services to offset to balance plans, and we needed to be careful about that in future years, if not this year. • Stuart Proud felt assured that everyone had a 100% focus and grip on this, but regarding outcome he would put limited assurance on it in terms of where we are at. He appreciated	

	what the ICB Chair had said regarding the £50m deficit at year end, but if we had to deviate from that, and he sensed we may have to, then we needed to put a timescale on at what point we may have to do something differently. • Stuart Proud reported that we had pressures on Acutes around UEC, and we had things in our transformation plan with no financial numbers against them, we needed something in response as to how we were going to deal with that to fix it for the medium to long term. In the short term we were dealing with big pressures here and we were having to try and absorb them, so we needed a different solution and a different focus; he was not sure that the work we were doing now was doing the right things. • Michelle Arrowsmith reported that there was no doubt that the UEC side of things was operationally and clinically pressured, however, she felt that caution was required with what the data was informing us. She reported that her team was working with UHDB and CRH on what the data was telling us; different data sets were telling us different things – we needed one version of the truth. This work was, she hoped, starting to crystallise it for us. Michelle Arrowsmith highlighted the following: • A 24/25 Ops planning meeting had taken place with HRD's, DoFs and Ops. • A number of areas were highlighted where there were both sovereign organisations and System actions required particularly around UEC. • The Strategic Discharge Group were tasked to review length of stay for medically fit for discharge, and around longer waits on discharge particularly for the community beds which was causing a flow issue. However, there were a number of areas which internally organisations needed to clearly be looking at, such as UEC demand, and where demand was growing. • A fuller picture was hoped to be received by the end of the week. Michelle Arrowsmith felt we needed to be very careful about the UEC position; there were things that everyone could do from the Community Trust to Mental Health Trust and the two Acutes around the UEC in their own organisations, as well as what we needed to do in terms of taking some System actions. • Michelle Arrowsmith reported that we needed to be driving our elective performance, as we could generate income through the ERF; we needed to operationally balance the UEC and elective positions, although this could not be done in isolation. Meetings had been set up with DoFs, HRDs and COOs in order to help triangulate together, rather than just having a financial or operational lens. The Audit Chair highlighted the following: • She shared a lot of Stuart Proud's concerns about how we get from where we are, to where we needed to be at the end of the	

	year, and the risks that we were facing, particularly when the efficiencies were being back ended. • She agreed that we needed to be looking at what the alternatives were going to be if we could not deliver some of these critical elements. We needed to look at the difficult decisions if we could not bring some of these costs under control and if we could not progress with some of the transformation work. She asked what we were going to have to stop doing – this seemed to be the bit that was missing from the presentations received today. • Claire Finn suggested meeting with Michelle Arrowsmith to discuss some of the issues/points raised today. She did not disagree that there were things that could be done internally in terms of maximising flow as much as possible, put quite simply, the numbers that were coming through into the organisation at this point in time, would not be solved with some internal improvements around flow. She requested sight of the data that Michelle Arrowsmith was referring to regarding low acuity. She reported that we needed to work with System partners in making sure that we could reduce those attendances; these conversations needed to happen quickly as we would be running into winter and having to open additional escalation capacity. All those significant additional costs would be difficult to manage, which would not help us achieve a balanced position at year end. The Chair highlighted the following: • She thanked everyone for their presentations; she noted that we were in a difficult position, that there were some common risks and there were some collective mitigations that we could look at to help manage that across the System. She felt that assurance in terms of delivery over the next few months to year end was key. • She asked Keith Griffiths to firm up some assurances/highlight some of the key risks at his next meeting with Derbyshire DoFs, which would then be reported through to the various Boards. It was noted that we had to deliver, what was a very challenging agenda. • In terms of the Organisation/System level and the national picture, we needed to ensure that we made the most of our assets in all those arenas. • The Health Inequalities Funding was an issue, and it was one of the four core values of the ICB, we needed to think through the implications of that and noting that if funding was not put forward what the consequences of that would be. • She asked Michelle Arrowsmith to lead on the UEC issue, along with her colleagues, to give Committee some assurances/ highlight the risks at next month's meeting. • In terms of decommissioning, which was not where we wanted to be, we needed to confirm the arena for those conversations. • She requested a meeting with Keith Griffiths regarding how we wanted to alert colleagues as to what was needed/what	KG MA KG/JED

	assurances Committee was looking for at its next meeting, and what reporting mechanism would be used. **The System Finance Estates and Digital Committee NOTED the above presentations.**	
TRANSFORMATION/CONTINUOUS IMPROVEMENT		
FE2425/459	**Transformation Report** Susan Whale explained that this paper provided a summarised report on the System transformation programmes and efficiency delivery during Month 5 2024-25. The following was highlighted: • The overall position on the system financial efficiency programme delivery was shown in Table 1. • At M5 the transacted plans loaded to the ePMO totalled £47.7m against the cumulative M5 plan of £47.6m, an over delivery of £0.1m. This was an increase of £13.2m transacted since M4. • £20.9m of the transacted plans at M5 were recurrent efficiencies, 20% of the £102.7m recurrent plan submission for 2024-25. The phasing of planned recurrent efficiencies was heavily loaded towards the second half of the year. • Table 2 in the report showed the progress that has been made at Provider level in identifying efficiency schemes for 2024-25. This report from 18th September 2024 indicated a gap from plan of £18.5m (11%). • The proportion of target efficiencies which had been identified and uploaded to the ePMO varied by. • These figures showed the split between schemes which had been fully worked up into plans and those that remained as identified 'opportunities' within the ePMO where there was a greater risk to delivery. The £18.5m gap could be considered a 'best case' scenario as it assumed that all identified opportunities would be realised. Cath Benfield highlighted the following: • Actual CIP delivery as at 17 September 2024 was £47.5m which was 28% of the overall target for the year. • Forecast delivery of £86.4m in M6-12 with a further £17.2m in opportunities section but with a 24/25 value recorded. • Overall delivery best case of £151.2m leaving a gap of £18.5m or circa 11% of 24/25 target. • To meet a £169.7m target we need delivery of £122.2m (72%) in M6-12. • Based on the delivery risk rating in the ePMO, of that £122.2m £51.4m was red rated (42%), £30.0m was amber rated (24.5%) and £40.8m was green rated (33.5%). • This highlighted the level of risk within the CIP Plan based on what was currently detailed within the ePMO.	

	• The slide pack detailed risks by organisation. Susan Whale went on to highlight the following: • The scope for the ePMO review had now been approved within the System (included as Appendix 4). A workplan was now under development and would involve all key stakeholders. The intention was to prepare a report detailing the output of the review and recommendations for consideration, to an NHS Executives meeting in December 2024. • NHS IMPACT (Improving Patient Care Together) was launched in 2023 to support all NHS organisations to have the skills and techniques to deliver continuous improvement and it would inform the way we worked across services and create the conditions in which continuous improvement was the "go to" method for tackling clinical, operational, and financial challenges. • The JUCD NHS IMPACT workshop was held in June 2024 and brought together key System stakeholders to undertake a self-assessment of our System against the above components and "what good looks like" building on the individual Provider self-assessments undertaken last year. The output of the System self-assessment was shown in Table 3 of the report. The Chair reported that we were now in September, halfway through the financial year, and we still seemed to be struggling in terms of delivery against these challenging agendas. The Chair reported that we all needed to think through how we report some of this back to the ICB Board as well as our own organisations, highlighting the assurances we had, but also the specific risks that we had got. 43% of schemes were rated red at this stage and the fact was that most were back loaded in terms of delivery – we were not where we wanted to be. Steve Heppinstall referred to the NHS IMPACT and asked how we could reach into that - there were some important things there in terms of cultural approach and how, as Leaders, we needed to shape and embed the kind of continuous improvement in things we did. It was noted that there were some high impact things as part of that assessment that we could start to talk about in this forum and create an action plan. The Chair agreed with Steve Heppinstall's comments above and requested that a discussion be scheduled on the forward planner (at an appropriate time) for NHS IMPACT/Action Plan. Susan Whale/Tamsin Hooton to action. **The System Finance, Estates & Digital Committee NOTED the Transformation and Efficiency Report.**	SW/TH
FE2425/460	**Developing Our Understanding of Resource Distribution at a Programme and Place Level** Cath Benfield reported that she had taken an action to update	

	Committee around understanding resource distribution at a programme and Place level. The following was highlighted: • Significant work had been undertaken in 23/24 to develop a programme view of the system's £3bn gross spend. • This took an organisational agnostic lens on the System's financial position and associated challenges. • Detailed service mapping was undertaken, the resources allocated to programmes relate to direct, influenceable costs so corporate, estates cost for example were captured separately. Reports were shared with Delivery Boards. • Data capture was at a sufficiently granular level to support meaningful analysis. • Ability to capture workforce numbers based on ledger data so we could start to understand where our workforce aligned to programme area. • An initial update had been undertaken for 24/25 following the Q1 reporting period. • Some consolidation and mapping issues remained which continued to be worked through but not considered material in the context of the overall level of spend in the System. • Going forward we needed to agree how we better use this information, triangulate with workforce, activity data etc to support identification of opportunities for financial improvement alongside the work we wanted to progress on Place resource analysis. Cath Benfield highlighted what we were trying to achieve: • Better understanding, richer intelligence on the current financial resource distribution at Place level. • Positively support colleagues working at Place to drive change in service models and strengthen our "out of hospital capacity" in its widest sense. • Influence the way JUCD planning was undertaken and start to change the resource profile of our System. • Bring System partners along with us, recognising the operating and financial context makes this extremely challenging. • Identify areas where increased investment/redistribution to a place could deliver real benefits to the System in terms of patient outcomes, reduction in health inequalities, improve access and deliver better value through financial efficiencies. This aligned with work on a System wide Benefits Realisation approach. • Development of a financial framework which included an approach to risk and gain sharing to support these ambitions. Cath Benfield highlighted the initial pieces of work we needed to commission: • Building on the work undertaken to date to describe the System's £3bn gross spend by programme area, further analysis by Place to be initiated.	

	• Work up benchmarking information which considered spend per WTD population as an initial view. • Highlight experience to date of unintended consequences of current approach to planning and financial management on Place level services, developing a Place based risk and issues log. • Develop a framework and risk and gain share approach to support programmes of transformational change, support the System to have the confidence to do something different but with appropriate safeguards to recognise other System partner's priorities and risk profiling. • Work to triangulate spend at Place level with patient needs and current outcomes. • Ensure Place priorities were fed into and considered in the development of the principles upon which we would work up our financial plans for 2025/26. Keith Griffiths reported that this was an incredibly powerful piece of work. He was keen for this work to continue, he supported it and wanted to give it as much profile as possible with all our partners in the System, not just within the NHS. Keith Griffiths felt we needed to reflect on what had been shared and agreed to spend some time on it at the Derbyshire DoFs meeting tomorrow. It was noted that support was required to give Cath Benfield and her team a broader audience on this in the next few months. Michelle Arrowsmith reported that it needed to be presented to an NHS Executive Team Meeting; it was noted that she was happy to take this forward on behalf of the Committee. It was agreed that Keith Griffiths, Michelle Arrowsmith and Cath Benfield would have a conversation outside of this meeting to arrange this and then bring an update back to Committee. Tamsin Hooton highlighted the following: • We needed a framework as to how we use this information. • It was already planned that we would take this information into the Transformation Coordinating Group. Information would be triangulated with other sources which would show where we were spending our money. • We wanted to combine that with an analysis of what was in the Model Health System about our System opportunities and other data where we are outliers to start a conversation about what we should be doing differently. As a result, agree actions and outcomes. • We benchmarked as an outlier around high intensity users, with a benchmark excess spend of £32m, people were repeatedly using Urgent Care Pathways in our System. What was happening in our upstream services to deliver that? • This should play into that conversation together with the distribution of resources/current programme budgets and how we needed to shift that.	MA/KG/ CB

	• We were trying to support some of that conversation and bringing together the people that were working on those individual programmes and Delivery Boards. • This also needed exposure at a more senior System level. We needed to support those teams to come up with the right plans and focus on them, building them into current and then 2025-26 planning. The Chair highlighted the following actions required: • Keith Griffiths to pick this up with Derbyshire DoFs at their meeting tomorrow to have a further conversation. • Michelle Arrowsmith to lead/present to NHS Executive Team. • Cath Benfield to bring a very brief update paper back to Committee next month. • Keith/Chair to suggest that this presentation (in a slightly more refined form), be taken to a future Board Development session to ensure that it was seen as part of our overall Board priorities; it needed to be branded correctly when it was presented. **System Finance, Estates and Digital Committee NOTED the following:** • **This was still a developmental piece of work and we needed to build on the work done in the last financial year.** • **We continued to work on the principle that we needed information that was good enough but not aiming for perfection.** • **We needed to develop/use this information more systematically to support the ongoing identification of opportunities for improvement in our System which needed to include triangulation with non-financial data.** • **The work on Place level analysis was not as advanced as the programme level view. It was recommended that we start with the service lines that were being delivered/operationally managed at a Place level, to develop a consistent methodology for other services eg acute services.**	KG MA CB KG/JED
RISK MANAGEMENT		
FE2425/461	**Risk Report** David Hughes presented the Risk Report, as at September 2024, the System Finance, Estates and Digital Committee were responsible for 5 ICB Corporate risks. David Hughes highlighted the following two risks: **Risk 21:** *There is a risk that contractors may not be able to fulfil their obligations in the current financial climate. The ICB may then have to find alternative providers, in some cases at short notice, which may have significant financial impact.*	

	David Hughes reported that we were not seeing/hearing from any GP contractors wishing to hand back their contracts. This risk was currently scored at 12. Michelle Arrowsmith reported that she had started to see dental hand back of contracts and indeed some Providers had started to hand back contracts or not going forward to tender. David Hughes suggested if that was the case, we needed to have a more generic form of words for this risk, as currently it concentrated on GPs. It was noted that the score for this risk was a little on the high side, but members agreed that the score of 12 should remain unchanged. David Hughes agreed to broaden out the risk description of Risk 21 with the help of Michelle Arrowsmith and colleagues. **Risk RL07**: Risk that ownership of the financial challenge is not shared by all System partners in equal measure alongside performance, quality, and safety. This risk was currently scored at 16 and was previously owned by Simon Crowther. David Hughes asked Committee whether they wanted to keep it, or whether it should be closed. It was noted that there had not been many updates or mitigations added to this risk, and David Hughes was struggling to see the benefit of it. Claire Finn agreed, as it was clearly a System risk, she felt that it was odd that it had been lead by Simon Crowther at UHDB. Keith Griffiths reported that when this risk was identified there had been concern about ownership and accountability of the financial challenge. The governance around this was now quite different and the world had moved on. He felt that if we were to keep RL07, at a score of 16, this was not a true representation of where we were now. The Chair asked members whether we needed to keep RL07 on the register, and if so, what score should it be. Keith Griffiths proposed that RL07 be closed and removed from the register. It was noted that Committee members agreed with this suggestion. **System Finance, Estates and Digital Committee AGREED:** • **Risk 21: score of 12 should remain unchanged. David Hughes to broaden out the risk description of Risk 21 with the help of Michelle Arrowsmith and colleagues.** • **RL07 be closed and removed from the register.**	DH/MA DH

FE2425/462	**Board Assurance Report** David Hughes reported that two strategic risks had been identified which were the responsibility of the System Finance, Estates and Digital Committee: Strategic Risk 4 - *There is a risk that the NHS in Derby and Derbyshire is unable to reduce costs and improve productivity to enable the ICB to move to a sustainable financial position and achieve best value from the £3.4 billion available funding.* The risk score currently remained at a very high 20, aligning to the corporate finance risks 06A and 06B within the ICB's Corporate Risk Register. Committee agreed that there should be no change to the current risk score. Strategic Risk 10 - *There is a risk that the system does not identify, prioritise, and adequately resource digital transformation in order to improve outcomes and enhance efficiency.* This risk was scored at a high 12. Given the current financial environment and planning outturns, alongside some continuing national funding streams, no change to the current risk score was proposed. It was noted that updates for Q2 were highlighted in blue, and that meetings had also taken place during Q2 with the relevant Leads to review and update the relevant gaps and actions. **The System Finance, Estates and Digital Committee AGREED that no changes were to be made to the scores for Board Assurance Framework Strategic Risks 4 and 10 for the final position for Q2 2024/25.**	
MINUTES AND MATTERS ARISING		
FE2425/463	**Minutes from the Meeting held on Tuesday 27 August 2024** The minutes from the meeting held on Tuesday 27 August 2024 were agreed as a true and accurate record.	
FE2425/464	**Action Log from the meeting held on Tuesday 27 August 2024** The action log was reviewed.	
CLOSING ITEMS		
FE2425/465	**Any Other Business** **Update on Revenue Deficit Allocation 2024/25** David Hughes presented a paper giving an update on the Revenue Deficit Allocation for 24/25.	

	It was noted that NHSE circulated an email to finance teams on 17 September in respect of the expectation of Revenue Support Allocation funding of £50m to move the JUCD System plan from £50m deficit to break-even. The key messages in that communication were: • The October (M06) allocations would contain the 24/25 non-recurrent deficit support revenue allocation of £50m for JUCD. Receipt of the funding would then enable all Systems to deliver a breakeven position for the year. • ICB's would receive this as cash allocation. • It was expected that Provider cash support applications would reduce. • Any providers requesting working capital borrowing from this point could expect a greater level of scrutiny than had been the case up to now. Next steps to access this funding and the JUCD response had been detailed in the main body of the report. This included the profiling over the year. The agreed split by Provider and impact this had on individual organisational plans was highlighted in the table on page 2 of this report. It was noted that of the £50m, £14.5m would go to CRH and £35.5m would go to UHDB; this had been agreed with System partners and followed the demand for cash. It was noted that phasing needed to be agreed between the finance teams, and repayment arrangements would also need to be firmed up – last year the repayments were a year in arrears. The agreed split of the deficit support allocation retained deficits in three of the JUCD Provider positions and a surplus in the ICB position. The ability for the System to go further than this – to redistribute surpluses in cash terms resulting in all organisational plans being break-even – was predicated on the overall System position being delivered with real surpluses in cash terms being generated. This would require all System partners achieving their agreed plan and supporting a System wide approach to identify cash releasing mitigations against our efficiency challenge including the planning gap of £18m which was taken into the ICB position to align our overall System plan to £50m. The System was not yet in a position to confirm this, and as such there were no confirmed cash surpluses which could be distributed at this time. **The System Finance, Estates and Digital Committee NOTED the update on Revenue Deficit Allocation for 2024/25.** **Review of ICB Committees:** The Chair reported that there was to be a review of all ICB Committees. A paper was to be presented to ICB Board in November 2024 detailing the changes and an update would be presented to this Committee thereafter. There was no further business.	

FE2425/466	**Escalations to Other Committees** The Chair reported that an Assurance Report would be prepared giving key highlights from today's meeting and forwarded for inclusion within the next ICB Board agenda pack.	
FE2425/467	**Finance, Estates and Digital Committee Forward Planner** The Committee forward planner for 2024-25 was noted.	

ASSURANCE QUESTIONS	
1.	Has the Committee been attended by all relevant Executive Directors and Senior Managers for assurance purposes? **YES**
2.	Were the papers presented to the Committee of an appropriate professional standard, did they incorporate detailed reports with sufficient factual information and clear recommendations? **YES**
3.	Has the committee discussed everything identified under the BAF and/or Risk Register, and are there any changes to be made to these documents as a result of these discussions? **YES**
4.	Were papers that have already been reported on at another committee presented to you in a summary form? **YES**
5.	Was the content of the papers suitable and appropriate for the public domain? **YES**
6.	Were the papers sent to Committee members at least 5 working days in advance of the meeting to allow for the review of papers for assurance purposes? **NO**
7.	Does the Committee wish to deep dive any area on the agenda, in more detail at the next meeting, or through a separate meeting with an Executive Director in advance of the next scheduled meeting? **NO**
8.	What recommendations do the Committee want to make to the ICB Board following the assurance process at today's Committee meeting? **AN ASSURANCE REPORT WOULD BE PREPARED FOR THE ICB BOARD.**

DATE AND TIME OF NEXT MEETING
Date: Tuesday 22 October 2024
Time: 1.30pm
Venue: MS Teams