Finance, Estates & Digital Committee

Date: 28th August 2025

Time: 09:00-12:00

Location: MS Teams

Agenda Number:	7.1	
Title:	Financial Performance – July 2025 (Month 4)	
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 4 the ICB is reporting a negligible year-to-date underspend of £0.1m and forecast breakeven position. Notwithstanding this there are variances at a programme level:
  - Mental Health – forecast overspend of £4.8m due to S117 placements and ADHD/Autism variable activity.

- Delegated primary care + POD – forecast underspend of £1.9m due to growth in lists being lower than forecast and material underspend in community pharmacy.
- Reserves – underspend due to non-recurrent actions of c£3.3m forecast.

- **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.

  Efficiency: currently on track both year to date (£0.4m over-performance) and forecast (£1.0m forecast overperformance).

  Risks and Mitigations: Net risk and mitigation scenarios range from a deficit of £10.7m to a surplus of £7.7m with our base case shows a small surplus of £0.9m (a marginal increase on the prior month of £0.6m) suggesting that the breakeven is still a valid forecast. The downside and upside scenarios remain consistent with the prior month.

System Finance

- **Revenue:** In Month 4 (July), at system level, a £1.4m deficit against plan was reported, meaning that at month 4, the system is showing a year-to-date deficit of £1.3m. This is a worsening in the position of £1.4m compared to the previous month, attributed wholly to the industrial action that took place in month. The forecast remains a breakeven position for the year for all NHS ICS organisations collectively and individually), however we are awaiting a refresh to forecasts.
- **Capital expenditure:** No issues have currently been reported by providers capital board are actively considering risk and alternative schemes should existing schemes slip (main risk is underspend not overspend). In terms of the ICB capital there is a potential £1.0m risk on Central Weston.
- **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 to be reported for M5 (originally anticipated for M4, however there have been delays in receiving these).

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:	Matt Backler – Interim Chief Finance Officer

Agenda item: 6.1

Report title: ICB Finance Report

Report on the financial performance for July 2025 (M04 – 2025/26)

1. Executive Summary

At month 4 the ICB is reporting both a year-to-date and forecast breakeven position. Notwithstanding this, there are variances at a programme level:

- Mental Health – forecast overspend of £4.8m:
  - £3.2m due to ADHD Right to Choose providers and
  - £1.7m due to S117 placements, offset by other underspends
- Community – forecast underspend of £0.06m, key variances include;
  - £0.9m overspend due to Discharge to Assess bed provision
  - £0.9m underspend due to delayed Anticipatory Care investment
  - £0.3m overspend due to increase community audiology activity
- Primary Care (A4-A7) – Forecast underspend of £1.864m (see section 4).

Efficiency delivery is forecast to be £50.9m, a £1.0m over-performance driven by primary care medicines optimisation. YTD delivery is £0.4m ahead of plan driven by All Age Continuing Care.

Net risk and mitigation scenarios range from a deficit of £10.7m to a surplus of £7.7m with our base case shows a small surplus of £0.9m (a marginal increase on the prior month of £0.6m) suggesting that the breakeven is still a valid forecast. The downside and upside scenarios remain consistent with the prior month.

In Month 4 (July), at system level, a £1.4m deficit against plan was reported, meaning that at month 4, the system is showing a year-to-date deficit of £1.3m. This is a worsening in the position of £1.4m compared to the previous month, attributed wholly to the industrial action that took place in month.

The forecast remains a breakeven position for the year for all NHS ICS organisations collectively and individually).

There is a potential emerging capital issue on Central Weston, this was live at the time of writing and further information can be provided to the Committee, this is up to £1.0m of risk. No other 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

Annual allocation has increased by £23.401m in month to £2,452.989m, the majority of which relates to funding for the Agenda for Change pay award (£12.929m). Other significant allocations include £6.5m additional funding for the Community Pharmacy Contractual Framework (CPCF), £2.0m for mid-year GP Practice contract changes, £0.7m in respect of the South West Secure Data Environment and £0.7m for PCT Fellowships.

In the below table the pay award funding was taken into reserves before being split out into programme areas.

Programme Area	Confirmed Initial ICB allocation £m	Prior Months Allocation Changes £m	Adjustments in Month		Baseline Allocation at 31-Jul-25 £m
			SDF/Other allocations £m	Internal Budget adjs £m	
Acute Contracts	1,232.664	1.124	*0.160*	*10.613*	**1,244.562**
Mental Health	238.952	0.389	*0.438*	*1.264*	**241.043**
Community Services	235.724	0.099	-	*1.213*	**237.036**
Delegated Primary Care	304.664	0.334	*4.842*	*2.147*	**311.987**
Medicines Management	167.573	0.076	*0.009*	-	**167.658**
Primary Care	37.327	0.000	*0.651*	-	**37.978**
Funded Care	140.696	-	-	-	**140.696**
Childrens Services	48.413	-	-	*0.511*	**48.924**
Support costs	9.377	0.535	*0.715*	-	**10.627**
Reserves	(2.977)	-0.699	*16.477*	*(15.749)*	**(2.948)**
Commissioning Budget	**2,412.412**	**1.858**	**23.292**	**-**	**2,437.562**
Running Costs	15.318	-	*0.109*	-	**15.427**
Total Allocation 2025-26	**2,427.730**	**1.858**	**23.401**	**-**	**2,452.989**

4. Financial position July 2025 (Month 4)

At month 4 the ICB is reporting a minimal year-to-date underspend and forecast breakeven position.

2025/26 July 2025 - Month 4	2025/26 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	1,244.562	420.380	419.567	**0.814**		1,244.886	**(0.324)**		A1
Mental Health	241.043	81.937	83.778	**(1.841)**		245.793	**(4.750)**		A2
Community	237.036	79.078	79.478	**(0.400)**		236.974	**0.062**		A3
Delegated Primary Care	311.987	103.995	103.064	**0.930**		310.082	**1.904**		A5/A6
Medicines Management	167.658	55.943	55.415	**0.528**		167.193	**0.465**		A7
Primary Care	37.978	12.661	12.805	**(0.143)**		38.494	**(0.516)**		A4
Funded Care	140.696	47.664	47.348	**0.316**		140.546	**0.150**		A8
Childrens	48.924	16.308	16.308	-		48.924	-		A9
Support Costs	10.627	3.846	4.059	**(0.214)**		10.900	**(0.273)**		A10
Reserves	(2.948)	(1.510)	(1.731)	**0.220**		(6.231)	**3.283**		-
Running Costs	15.427	5.126	5.274	**(0.148)**		15.427	**(0.000)**		A11
BNSSG ICB Surplus/(Deficit)	**2,452.989**	**825.428**	**825.365**	**0.062**		**2,452.989**	**-**		
Provider Surplus/Defict									
AWP	-	0.060	0.060	-		-	-		
NBT	-	(3.511)	(4.104)	**(0.593)**		-	-		
UHBW	-	(7.276)	(8.042)	**(0.766)**		-	-		
Provider Surplus/(Deficit)	**2,452.989**	**(10.727)**	**(12.086)**	**(1.359)**		**2,452.989**	**-**		
ICS Position	**2,452.989**	**836.155**	**837.451**	**(1.297)**		**2,452.989**	**-**		

Programme status to date

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

Acute (A1)

The Acutes position year-to-date for M4 is showing a net underspend of £(0.8m) due to various movements. The forecast is showing an overspend of £0.3m due to variable contract overspends, which the operational teams are working on to bring within budget.

Mental Health (A2)

The Mental Health, Learning Disabilities and Autism year-to-date position at M4 is overspent by £1.8m. Of this, £0.9m is on Placements due to increasing service user numbers and the ICB contributing on a ‘case-by-case’ than a global percentage basis to S117 local authority placement costs. £1.1m overspend is activity from ADHD Right to Choose Providers, whilst we work to get Indicative Activity Plans and affordability limits in place.

The forecast at M4 shows a net overspend of £4.8m. £3.2m of this is due to the manifesting run-rate impact overspend of ADHD Right to Choose Providers (this is inclusive of issues in the Children’s spend, which is currently being reported under Mental Health as the issue is being managed collectively, we will look to refine the reporting in future months). £1.7m is the run-rate impact of the ICB paying on a cost-

per-case basis for S117 packages rather than on a global percentage basis. Other underspends of (£0.1)m net off the overspends.

Community (A3)
The Community position is presenting an adverse variance of £0.4m year to date, and forecast underspend of £0.06m. There are key underlying variances to the reported position including;
Discharge to Assess beds costs are forecasting an overspend of £0.949m, mitigated by an agreed winter bed pressure contingency (Contingency total £1.8m; £1.2m planned, £0.6m urgent/emergency) from delays to Anticipatory Care investment, £0.949m underspend. The key drivers include, POM approved discharges (9) during June & July, and forecasting a portion of the planned mitigations over the winter period.

The overspend driven by Community Audiology has improved, but we have see continue increased in activity in addition to real terms growth of £0.5m allocated through the planning process. The forecast overspend is £0.329m (June, £0.546m)

Primary Care (A4)
The core funded Primary Care position is reporting an overspend to date of £0.14m and forecasting an overspend of £0.52m. The overspend is driven by a planning difference following a HMRC challenge with a provider, and an agreed financial support to enable the provider to transition to an employed model. The pace of transition is progressing faster than anticipated.

Primary Care Delegated (A5)
The Primary Care Delegated position is reporting an underspend of £0.623m to date and forecast £0.994m underspend. There are two variances caused by slower than forecast population growth (£0.520m favourable), and a variance between the published allocation for Additional Roles, and the 'cap' allocated to each PCN (£0.474m favourable).

Primary Care Delegated POD (A6)
The Primary Care Delegated POD position is reporting an underspend of £0.308m to date and forecast £0.921m underspend. The position is predominately due to Pharmacy underspending, which is due to two reasons;

- BNSSG has continued high number of 56 day prescribing post pandemic (other systems have reverted to 28-day prescribing).
- BNSSG is an exemplar nationally for Patient Group Direction (PGDs) which enables the supply or administrations a specified medicine to a group of patients without a prescription which in turn lowers pharmacy costs in our system.

Medicines Management (A7)
Medicines Management is reporting an underspend to date of £0.526m and forecast £0.465m underspend. The ICB has received two months invoicing (April & May) and the actual cost is less than the budget for those months.

There are a number of drug costs anticipated to increase (volume & price) over the course of the year, and as a result the year-to-date benefit has been forecast to remain at the end of the year.

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 £0.11m and the pay costs funded from other sources underspent by £0.15m generating a net underspend variance of £0.04m (admin overspending by £0.08m offset by an underspend on programme pay of £0.13m). Forecast is being refined in conjunction with line managers/budget holders and currently shows a small underspend however critically the funded establishment is overspent by £0.5m driven largely by underachievement of the significant vacancy factor. Admin pay is forecast to overspend by £0.25m which represents a risk to the ICB's duty to deliver within the prescribed running cost limit.

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	11.683	3.894	3.991	(0.097)	12.022	(0.339)
	Programme	11.892	3.964	3.976	(0.013)	12.070	(0.178)
Total funded Establishment		**23.575**	**7.858**	**7.967**	**(0.109)**	**24.091**	**(0.516)**
Other Funding source	Admin	0.915	0.305	0.292	0.013	0.825	0.089
	Programme	3.278	1.093	0.952	0.141	2.827	0.450
Total Other funded posts		**4.192**	**1.397**	**1.244**	**0.153**	**3.652**	**0.540**
Grand total		**27.767**	**9.256**	**9.212**	**0.044**	**27.744**	**0.023**

		Full year funding £m	YTD funding £m	YTD spend £m	YTD variance £m	Forecast Outturn £m	Forecast variance £m
Analysed by	Admin	12.597	4.199	4.283	(0.084)	12.847	(0.249)
	Programme	15.169	5.056	4.928	0.128	14.897	0.273
Grand total		**27.767**	**9.256**	**9.212**	**0.044**	**27.744**	**0.023**

5. Efficiencies

The total ICB savings plan is £50.9m 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 £19.8m.

Programme	SRO	YTD			Full year			Full year - RAG			
		Plan	Act	Var	Plan	FOT	Var	Blue	Green	Amber	Red
		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
All Age Continuing Care	R Shepherd	813	1,093	280	6,120	6,330	210	-	3,396	2,934	-
MHLDA placements	R Shepherd	36	17	(19)	886	808	(78)	-	-	808	-
High Cost Drugs	J Medhurst	1,015	1,108	93	2,198	1,783	(414)	-	1,108	675	-
Meds opt: Primary care	J Medhurst	2,088	2,180	92	5,155	6,454	1,299	-	4,776	1,678	-
Discharge programme	D Jarrett	1,113	1,113	-	3,338	3,338	0	-	3,338	-	-
Running cost	M Backler	376	376	-	1,129	1,129	-	-	1,129	-	-
ICB delivered		5,440	5,887	446	18,826	19,842	1,016	-	13,747	6,095	-
Contract efficiencies	M Backler	10,354	10,354	-	31,061	31,061	-	31,061	-	-	-
Total programme		15,794	16,240	446	49,887	50,904	1,016	31,061	13,747	6,095	-

Total efficiencies are £0.4m ahead of plan predominately driven by All Age Continuing Care where reductions in fact track case load is ahead of plan. The Meds optimisation schemes are both also marginally ahead of plan.

Full year forecast is an over delivery of £1.0m driven by primary care meds optimisation with forecast overperformance of £1.3m. This is partially offset by a forecast underperformance in high cost drugs due to a national delay in the release of a biosimilar.

6. Risks and mitigations

The finance team, in conjunction with budget holders maintain a detailed risk and mitigation schedule. Where a risk or mitigation become reasonably certain, both in terms of likelihood and value these are crystalised into the position.

A likelihood % is applied to each risk or mitigation across three scenarios, a base case which looks to test whether our overall forecast remains reasonable. We also then produce a reasonable upside and reasonable downside scenario. A summarised version of this is presented in the following table.

The scenarios range from a deficit of £10.7m to a surplus of £7.7m with our base case shows a small surplus of £0.9m, a marginal increase on the prior month of £0.6m suggesting that the breakeven is still a valid forecast. The downside and upside scenarios remain consistent with the prior month.

	Gross	Reasonable downside		Base case		Reasonable Upside	
	£'000	%	£'000	%	£'000	%	£'000
D2A	(2,663)	125%	(3,332)	37%	(997)	25%	(663)
HCDD	(3,500)	43%	(1,500)	25%	(875)	20%	(700)
All age continuing care	(3,700)	75%	(2,775)	50%	(1,850)	40%	(1,480)
Other variable activity	(3,000)	42%	(1,250)	23%	(700)	13%	(400)
MH/LD placements	(4,698)	70%	(3,279)	46%	(2,140)	36%	(1,705)
ADHD/Autism	(3,810)	60%	(2,286)	50%	(1,905)	25%	(953)
Delegated	5,839	25%	1,460	50%	2,920	67%	3,935
Meds Mgmt	1,000	25%	250	50%	500	90%	900
Other	2,058	-1%	(21)	123%	2,534	163%	3,344
Prior year/ reserves	3,210	65%	2,078	105%	3,380	168%	5,382
Total			(10,655)		866		7,660
Memo: Planning			(7,783)		-		6,310
Of which efficiency:	(7,705)		(7,048)		(3,109)		(1,799)
Planning			(7,783)		-		6,310
M3			(10,656)		601		7,942
M4			(10,655)		866		7,660

D2A – risk of requirement to open up additional beds, and savings plan under delivering. Some linked mitigation in the **anticipatory care** budget which is not yet fully committed.

HCDD – £1.25m risk in relation to additional growth, £0.5m savings delivery risk

All age continuing care – inherently risks areas, risk is based on current run rate and lower than planned savings delivery (particularly in the context of expected headcount reductions across the ICB).

Other Variable Activity – comprising mainly of Independent Sector ERF and Termination of pregnancy

Mental health / LD Placements – already recognised £1.5m FOT above budget, there is a risk these costs continue to rise. Risk comprises three elements, general growth in cost and number of placements, funding split with the local authorities and delivery of savings.

ADHD / Autism – Run rate in M1 was over £1m against a budget of £7m. Whilst we will attempt to control overspend through contractual mechanism there is a risk this will not be effective given waiting list size, resource available in ICB to manage and increasing number of providers.

Delegated – mitigation of £0.25m based on dental run rate. Remaining mitigation relates to delegated primary care underspend. Further detailed review of budget required to confirm potential benefit.

Medicines Management – Assumed delivery of savings stretch target

Other mitigations – Non-recurrent mitigations supporting the position.

7. System position

In Month 4 (July), at system level, a £1.4m deficit against plan was reported, meaning that at month 4, the system is showing a year to date deficit of £1.3m. This is a worsening in the position of £1.4m compared to the previous month, attributed wholly to the industrial action that took place in month.

The forecast remains a breakeven position for the year for all NHS ICS organisations collectively and individually).

8. Capital allocation

ICB Capital

The ICBs capital allocation is £6,873m in 2025/26. This is made up of a system transfer of £3.3m agreed in 2024/25 to support the Connexus PCN scheme, £2.081m ringfenced allocation for Primary Care BAU, and an in-year allocation of £0.242m for GPIT.

It has also been agreed that an additional £1.25m of system operational capital will be utilised by the ICB to support system priorities.

At month 4, the ICB is forecasting to utilise the allocation in full.

ICB Capital	Allocation	Forecast	Variance
Primary Care BAU Capital	2,081	2,081	-
In Year Primary Care BAU Capital	242	242	-
Plus transfer from Provider Allocation	3,300	3,300	-
System Priorities funded friom Provider Allocation	1,250	1,250	-
2025/26 Total ICB Capital Allocation	6,873	6,873	-

There is a potential emerging issue on the Central Weston case which may require up to £1.0m of further investment. This was a live issue at the point of writing and a verbal update can be provided to FED with further detail.

System Capital

The total system operational capital allocation is £99.964m. System providers have worked in collaboration to produce a capital plan that aims to fully utilise this large amount of capital available in 2025/26.

At month 4, the system is reporting full spend against the system capital allocation.

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.

9. Statement of Financial Position

The closing net asset position of the ICB is £111.1m, a year-to-date movement of £3.7m which is primarily driven by a decrease in payables of £11.1m and a small increase in debtors, offset by a reduction in cash of £10.8m.

At month end, the ICB's cash utilisation was ahead of plan by 1.42%. The ICB continues to predict a small shortfall of cash in 25/26 caused by late allocations in 24/25 that could not be drawn down.

Statement of Financial Position	Balance 31/03/2025 £m	Balance 31/07/2025 £m	Movement £m
Total Non Current Assets	3.101	2.953	(0.148)
Current Assets			
Cash & Cash Equivalents	0.377	(10.450)	(10.827)
Current Trade And Other Receivables	28.199	31.765	3.566
Total Current Assets	*28.576*	*21.315*	*(7.261)*
Total Assets	**31.678**	**24.269**	**(7.409)**
Liabilities			
Payables	(141.655)	(130.599)	11.056
Provisions	(2.429)	(2.429)	0.000
Lease Liability	(2.445)	(2.381)	0.064
Total Liabilities	***(146.529)***	***(135.409)***	***11.120***
Total Net Assets/(Liabilities)	**(114.851)**	**(111.140)**	**3.711**
Taxpayers Equity			
I&E Reserve - General Fund	(114.851)	(111.140)	3.711
Total Taxpayer Equity	**(114.851)**	**(111.140)**	**3.711**

NHSE monitor the ICB on the closing cash at bank balance compared to 1.25% of monthly drawdown, which for month 4 equated to £2.5m. The ICB met this target, with a closing cash at bank balance of £608k. The cash in ledger position shown above was £11m lower than cash at bank due uncleared receipts received on the final day of the month.

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.

This year, the ICB has paid an average of 2,700 invoices a month (increased from 2,600 a month in previous years) 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	97	112.193
	Total bills paid within target	96	112.192
	% bills paid within target	**98.97%**	**100.00%**
Non NHS	Total bills paid in month	2,695	92.600
	Total bills paid within target	2,671	91.789
	% bills paid within target	**99.11%**	**99.12%**

Type	Year to date	Number	£m
NHS	Total bills paid in year	530	461.827
	Total bills paid within target	525	461.820
	% bills paid within target	**99.06%**	**100.00%**
Non NHS	Total bills paid in year	10,222	297.634
	Total bills paid within target	10,133	291.158
	% bills paid within target	**99.13%**	**97.82%**

11. Recommendations

The committee are asked to note the financial position as of month 4.

Appendix 1 – Analysis of spend within programme areas

A1 – Acute

Acute Services	2025/26 Budget	YTD Budget	YTD Expenditure	YTD Variance		Forecast Outturn	Forecast Variance	
	£m	£m	£m	£m		£m	£m	
University Hospitals Bristol and Weston NH	542.400	180.615	180.626	(0.011)		542.474	(0.074)	
North Bristol NHS Trust	533.753	177.770	177.788	(0.018)		533.801	(0.048)	
South Western Ambulance Service NHS FT	59.749	19.916	19.916	-		59.749	-	
Independent Sector Treatment Centres	55.832	18.611	17.601	1.009		55.680	0.152	
Other Local Provider contracts (RUH, Glos,	19.444	6.481	6.508	(0.027)		19.525	(0.081)	
Low Volume Activity	8.709	8.648	8.649	(0.001)		8.709	-	
Non Contracted Activity	2.376	0.906	0.880	0.027		2.351	0.026	
Other Acute Spend (incl SWAG cancer)	22.299	7.433	7.598	(0.165)		22.598	(0.299)	
Grand Total	**1,244.562**	**420.380**	**419.567**	**0.814**		**1,244.886**	**(0.324)**	

A2 - Mental Health

Mental Health & Learning Disabilities	2025/26 Budget	YTD Budget	YTD Expenditure	YTD Variance		Forecast Outturn	Forecast Variance	
	£m	£m	£m	£m		£m	£m	
MH - AWP Core Contract	161.102	53.634	53.634	-		161.102	-	
Mental Health Placements	25.223	8.408	9.096	(0.688)		26.968	(1.745)	
Learning Disability and Autism	11.040	3.680	3.866	(0.186)		10.994	0.047	
Mental Health Community	10.345	3.448	3.441	0.007		10.379	(0.034)	
Improved Access to Psychological Therapie	12.776	4.259	4.259	-		12.776	-	
Dementia	6.263	2.088	2.088	-		6.263	-	
Crisis Services	3.959	1.320	1.295	0.025		3.934	0.025	
ADHD	6.800	3.314	4.387	(1.073)		9.968	(3.168)	
Mental Health Low Volume Activity	0.922	0.916	0.916	-		0.922	-	
Mental Health SDF	1.940	0.647	0.647	(0.000)		1.940	-	
MH - S12 Doctors Private Sector	0.673	0.224	0.151	0.074		548.54	0.124	
Grand Total	**241.043**	**81.937**	**83.778**	**(1.841)**		**245.793**	**(4.750)**	

A3 – Community

Community	2025/26 Budget	YTD Budget	YTD Expenditure	YTD Variance		Forecast Outturn	Forecast Variance	
	£m	£m	£m	£m		£m	£m	
Adult Community Contract	152.510	50.837	50.837	0.000		152.510	0.000	
Joint Commissioned	36.216	12.072	12.072	-		36.216	-	
Discharge to Assess Services	11.994	3.998	4.414	(0.416)		12.943	(0.949)	
Joint Commissioned D2A	0.578	0.193	0.193	-		0.578	-	
Patient Transport Services (PTS)	1.481	0.494	0.494	-		1.481	-	
Community Equipment	7.466	2.489	2.465	0.024		7.394	0.072	
Hospices	4.513	1.504	1.449	0.055		4.347	0.166	
BIRU	3.561	1.187	1.131	0.056		3.392	0.169	
In-Year Investments	0.713	0.238	0.212	0.025		0.637	0.076	
Anticipatory Care	7.246	2.415	2.415	-		6.297	0.949	
Health Inequalities	2.855	0.952	0.952	0.000		2.855	-	
Prevention Fund	1.495	0.522	0.522	0.000		1.495	-	
Other Community	6.409	2.179	2.324	(0.145)		6.830	(0.421)	
Grand Total	**237.036**	**79.078**	**79.478**	**(0.400)**		**236.974**	**0.062**	

A4 – Primary Care

Primary Care	2025/26 Budget	YTD Budget	YTD Expenditure	YTD Variance		Forecast Outturn	Forecast Variance	
	£m	£m	£m	£m		£m	£m	
NHS 111/Out of Hours	20.459	6.820	6.992	(0.172)		20.975	(0.516)	
Local Enhanced Services	8.536	2.845	2.809	0.037		8.536	-	
GP Forward View	2.998	1.001	1.001	-		2.998	-	
Other Primary Care	5.984	1.995	2.003	(0.008)		5.984	-	
Grand Total	**37.978**	**12.661**	**12.805**	**(0.143)**		**38.494**	**(0.516)**	

A5 – Primary Care Delegated

Delegated Primary Care	2025/26 Budget	YTD Budget	YTD Expenditure	YTD Variance		Forecast Outturn	Forecast Variance	
	£m	£m	£m	£m		£m	£m	
GMS/PMS/APMS Contracts	129.643	43.214	43.120	0.095		129.123	0.520	
Primary Care Networks DES	48.111	16.037	15.509	0.528		47.638	0.474	
Premises Costs	16.550	5.517	5.517	-		16.550	-	
Quality Outcomes Framework (QOF)	13.395	4.465	4.465	-		13.395	-	
Locum Reimbursement Cost	2.478	0.826	0.826	-		2.478	-	
Other GP Services	2.374	0.791	0.791	-		2.374	-	
Prescribing & Dispensing Fees	1.575	0.525	0.525	-		1.575	-	
Designated Enhanced Services (DES)	1.749	0.583	0.583	-		1.749	-	
Delegated Primary Care Reserve	-0.161	-0.054	-0.054	(0.000)		-0.161	-	
Grand Total	**215.714**	**71.904**	**71.282**	**0.623**		**214.720**	**0.994**	

A6 – Primary Care Delegated POD

Pharmacy, Ophthalmology and Dental (POD) delegation	2025/26 Budget	YTD Budget	YTD Expenditure	YTD Variance		Forecast Outturn	Forecast Variance	
	£m	£m	£m	£m		£m	£m	
Delegated Pharmacy	24.292	8.097	7.828	0.270		23.492	0.800	
Delegated Primary Dental	40.059	13.172	13.141	0.030		40.059	-	
Delegated Secondary Dental	18.259	6.267	6.254	0.013		18.167	0.092	
Delegated Community Dental	2.905	0.968	0.962	0.006		2.886	0.019	
Delegated Primary Care IT	1.838	0.613	0.614	(0.001)		1.838	-	
Delegated Ophthalmic	8.920	2.973	2.971	0.002		8.920	-	
Delegated Property costs	0.000	0.000	0.011	(0.011)		0.000	-	
Grand Total	**96.273**	**32.090**	**31.782**	**0.308**		**95.362**	**0.911**	

A7 – Medicines Management

Medicines Management	2025/26 Budget	YTD Budget	YTD Expenditure	YTD Variance		Forecast Outturn	Forecast Variance	
	£m	£m	£m	£m		£m	£m	
Prescribing	165.570	55.247	54.721	0.526		165.105	0.465	
Medicines Management staff costs	2.088	0.696	0.694	0.002		2.088	-	
Grand Total	**167.658**	**55.943**	**55.415**	**0.528**		**167.193**	**0.465**	

A8 – Funded Care

Funded Care	2025/26 Budget	YTD Budget	YTD Expenditure	YTD Variance		Forecast Outturn	Forecast Variance	
	£m	£m	£m	£m		£m	£m	
Adult Fully Funded CHC	69.484	23.106	23.317	(0.211)		70.026	(0.542)	
Adult Fully Funded PHB	11.443	3.813	3.814	(0.001)		11.443	-	
Adult Joint Funded	0.791	0.256	0.255	0.001		0.791	-	
CHC Assessment and Support	0.715	0.238	0.262	(0.023)		0.715	-	
Funded Care Pay	5.256	1.752	1.691	0.061		5.295	(0.039)	
Children's CHC	3.594	1.163	1.163	-		3.594	-	
Children's PHB	0.026	0.008	0.008	-		0.026	-	
Fast Track	18.223	6.447	5.958	0.489		17.492	0.731	
FNC	31.164	10.879	10.880	(0.001)		31.164	-	
Grand Total	**140.696**	**47.664**	**47.348**	**0.315**		**140.546**	**0.150**	

A9 – Children's Services

Children's Services	2025/26 Budget	YTD Budget	YTD Expenditure	YTD Variance		Forecast Outturn	Forecast Variance	
	£m	£m	£m	£m		£m	£m	
CCHP Contract	20.780	6.927	9.924	(2.998)		20.780	-	
Child & Adolescent Mental Health (CAMHS	18.001	6.000	6.000	-		18.001	-	
Childrens SDF	6.402	2.134	2.134	-		6.402	-	
Other	3.741	1.247	-1.751	2.998		3.741	-	
Grand Total	**48.924**	**16.308**	**16.308**	**-**		**48.924**	**-**	

A10 – Support Costs

Support Costs	2025/26 Budget	YTD Budget	YTD Expenditure	YTD Variance		Forecast Outturn	Forecast Variance	
	£m	£m	£m	£m		£m	£m	
Chief Medical Office	1.301	0.600	0.604	(0.003)		1.319	(0.018)	
Chief Nursing Office	2.466	0.822	0.778	0.044		2.471	(0.005)	
Estates	2.747	0.916	0.914	0.001		2.747	-	
Other Support Costs	0.470	0.157	0.285	(0.129)		0.597	(0.127)	
Performance and Delivery	1.070	0.357	0.373	(0.016)		1.188	(0.118)	
Projects	2.543	0.964	1.075	(0.111)		2.548	(0.005)	
R&D Team	0.030	0.030	0.030	-		0.030	-	
Grand Total	**10.627**	**3.846**	**4.059**	**(0.214)**		**10.900**	**(0.273)**	

A11 – Running Costs

Running Cost	2025/26 Budget	YTD Budget	YTD Expenditure	YTD Variance		Forecast Outturn	Forecast Variance	
	£m	£m	£m	£m		£m	£m	
Business, Strategy and Planning Directorat	3.772	1.237	1.372	(0.135)		3.674	0.098	
Chief Medical Office	0.643	0.214	0.211	0.003		0.679	(0.035)	
Chief Nursing Office	0.045	0.015	0.012	0.003		0.045	-	
Intelligence, Transformation and Digital Di	4.248	1.416	1.478	(0.062)		4.265	(0.016)	
Office of the Chair & Chief Executive	3.233	1.078	1.059	0.018		3.421	(0.188)	
People Directorate	1.523	0.512	0.473	0.039		1.346	0.177	
Performance & Delivery Directorate	1.963	0.654	0.669	(0.015)		1.998	(0.035)	
Grand Total	**15.427**	**5.126**	**5.274**	**(0.148)**		**15.427**	**(0.000)**	

Finance, Estates and Digital Committee (OPEN Session)

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

Present		Initials
Steve West	Finance, Estates and Digital Committee – Chair	SW
Matt Backler	Interim Chief Finance Officer	MB
John Cappock	Non-Executive Director, BNSSG ICB – Chair	JC
Deborah El-Sayed	Chief Transformation and Digital Information Officer, BNSSG ICB	DES
John Cappock	Non-Executive Director, BNSSG ICB	JC
Brian Stables	Non-Executive Director, AWP	BS
Jo Medhurst	Chief Medical Officer, BNSSG ICB	JM
Jeff Farrar	Chair, ICB	JF
Richard Gaunt	Non-Executive Director, NBT	RG
In attendance		
Pete Tilley	Interim Chief Finance Officer, AWP	PT
Helena Fuller	Deputy Director of Business & Planning, BNSSG ICB	HF
Dave Jarrett	Chief Delivery Officer, BNSSG ICB	DJ
Emily Parkinson	Strategy and Planning Coordinator, BNSSG ICB	EP
Susie McMullen	Head of Contracts: Childrens, Community and Primary Care	SM
Sebastian Habibi	Deputy Chief Transformation and Digital Officer	SH
Stewart Robinson	Joint Chief Systems and Product Officer, NBT and UHBW	SR
Sabrina Smithson	Executive PA - Note taker/admin, BNSSG ICB	SS

		Action
1	**Welcome and Apologies** The chair welcomed all to the meeting and noted no formal apologies were made.	
2	**Declarations of Interest** Brian Stables declared a standing interest related to Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) and confirmed he would not comment on related agenda items but would support Pete Tilley.	
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	**Items to discuss**	
5.1	**Programme of deep dives – AWP** PT began by confirming that Avon Wiltshire Partnership is currently delivering on its break-even plan, which aligns with the wider system's financial strategy. This position is underpinned by £10.1 million in non-recurrent system support to offset the Trust's underlying deficit. At Month 3, the Trust is forecasting to maintain this break-even position through year-end. However, he noted that the Trust continues to face structural challenges, particularly around the recurrent shortfall in funding for national pay awards. Due to AWP's higher proportion of pay-related costs compared to acute providers, the tariff uplift often fails to fully cover pay increases.	

While £2.3 million of this shortfall is already embedded in the underlying deficit, the impact of further adjustments—especially for Agenda for Change and medical staff—remains under review.
In terms of efficiency delivery, PT reported that 40% of the programme has been achieved on a recurrent basis, slightly below the planned profile of 44%. The remainder has been delivered through non-recurrent means. He acknowledged this as a concern, particularly given the implications for the 2026/27 financial year if recurrent delivery does not improve. The Trust is actively working to increase recurrent savings, particularly through corporate cost reductions and agency workforce transformation.

Capital expenditure is forecast to be fully utilised, including both internal and nationally allocated capital for safety programmes, crisis services, and step-down capacity. However, delays at Callington Road due to contractor liquidation have pushed some capital works into the next financial year.

PT then addressed key financial risks. These include the pay award funding gap, rising demand for adult acute inpatient beds—which has led to increased use of out-of-area placements—and immigration policy changes affecting healthcare support workers on visas. While recent updates have eased immediate concerns regarding visa regulations, the situation remains fluid. He also highlighted that any slippage in recurrent efficiency delivery would exacerbate pressures in 2026/27, making it imperative that the Trust delivers its planned efficiencies in full this year.

On workforce, the Trust has made significant progress in reducing agency spend—from £37 million to a projected £11 million this year—through tighter controls, reduced use of off-framework agencies, and targeted recruitment into substantive roles. The number of agency long-line contracts has dropped from 120 to 38, with further reductions planned. The Trust is also working to reclassify bank staff roles to better reflect their cost-effectiveness and contribution to service delivery.

PT also reviewed the Trust's internal controls and governance. Following a positive external peer review last year, AWP has maintained strong financial oversight through its savings board and enhanced vacancy controls. An annual review of financial controls is scheduled for Q3.

During the discussion, SW queried whether financial grip was being achieved at the expense of service quality. PT responded that the Trust continues to maintain safer staffing levels and is not compromising on quality. He explained that inpatient services are staffed to safe levels using substantive or bank staff rather than agency, and that community services are being strengthened to reduce inpatient demand.

JM added that the System Quality Group had recently recommended that AWP be removed from enhanced quality surveillance, indicating confidence in the Trust's service quality. She also raised two specific concerns: the potential impact of prolonged industrial action by resident doctors, and the profiling of £0.7 million in medical staffing efficiencies. PT acknowledged that while industrial action had minimal financial impact to date, it remains a risk. Regarding the medical staffing efficiencies, he clarified that the £0.7 million was not top-sliced but rather reprofiled to accelerate delivery, supported by ICB investment.

JC questioned the balance between recurrent and non-recurrent savings, noting a potential over-reliance on the latter. PT responded that the Trust had identified sufficient non-recurrent sources at the start of the year and is now working to increase recurrent delivery, particularly through corporate savings. He added that the Trust had not received scrutiny from external auditors on this point, as the non-recurrent sources were clearly identified and documented in the opening plan.
MB supported this view, noting that the Trust's exit run rate for recurrent savings aligns with its annual target. He also flagged the need to monitor medical agency spend and out-of-area placements through the Performance and Recovery Board. PT

	acknowledged this and confirmed that internal tracking is in place, with further updates to be shared through the appropriate governance channels. Finally, DES asked about the future of Section 117 responsibilities and whether AWP might assume a greater role. PT indicated that internal discussions were underway but emphasised the need for financial clarity before committing to such a shift. He stated that while the Trust is open to further conversations, any transition would require assurance that the financial risks are manageable. DES proposed that this be developed into a formal proposal over the next six months. In closing, SW commended PT for his transparency and the Trust's progress, noting the importance of sustaining both financial discipline and service quality.	
5.2	**Outputs from Planning Review and lessons identification process** EP began by explaining that the team had used a maturity scale to self-assess performance against a set of 20 system planning principles, which were agreed by the Board in December 2024. These principles were colour-coded from "not embedded" to "fully embedded" and tested with a wide range of planning colleagues across the system, including the internal ICB planning group. EP several priority areas for improvement. First, the principle of "planning for ourselves" emerged strongly from feedback, with a clear call for earlier timelines and clarity on expectations—even in the absence of national guidance. She emphasised the need to balance national objectives with local priorities, underpinned by robust metrics. Second, she highlighted the importance of aligning strategic documents such as the 10-Year Plan, Joint Forward Plan, and operational plans to create a coherent "golden thread." Third, she noted the need to clarify the H6 sign-off process, which had been a source of confusion in the previous cycle. The team also plans to proactively design an assurance tool to meet NHSE requirements, rather than reacting to them late in the process. EP also addressed feedback on delivery milestones and communications, acknowledging that duplication between benefits realisation and the "stop, slow, shift" framework had caused confusion. She outlined plans to streamline this and improve clarity around the role of the Strategy and Planning team, system partners, and governance structures such as the System Planners Network and planning days. As she concluded her presentation, SW thanked EP for a clear and well-structured paper, before inviting questions. JM was the first to respond, commending the focus on process but urging a stronger emphasis on outcomes. She reminded the group that the ICB's core purpose is to improve population health and reduce inequalities, and she noted that this was not sufficiently reflected in the current planning framework. JM suggested that the Strategic Health Inequalities Partnership (SHIP), chaired by Jeff Farrar, should play a more prominent role in challenging and shaping plans through a health inequalities lens. She also raised concerns about whether the current governance structures—particularly H6 and ODG—were equipped to make the difficult commissioning decisions needed to shift resources and address inequalities at scale. EP acknowledged JM's points and committed to incorporating them into the next iteration of the planning framework. DES then added her support for the review, praising the team's commitment to learning and improvement. However, she echoed JM's concerns and stressed the need for digital and data considerations to be embedded from the outset. DES highlighted that many initiatives still fail to plan for data collection, storage, and digital enablement, which undermines benefits realisation and long-term impact. She urged the team to ensure that digital infrastructure and data strategy are not afterthoughts but integral to planning from the start. EP agreed and noted that she had recently discussed this with Nic Saunders, and that further updates would be incorporated into the action plan.	

	DES also emphasised that without clear metrics and data, any plan risks becoming "a work of fiction." She called for a more rigorous approach to assurance, not just at the business case stage but during strategic planning itself. MB supported this view, noting that while detailed assurance is essential at the gateway stage, strategic planning must also be grounded in measurable outcomes. He added that the planning response would likely be framed around the "three shifts" and their enablers, reinforcing the need for robust digital and data foundations. JF then spoke to the evolving role of the ICB, noting that a transition group would be established following the appointment of the new Chief Executive on 8 August. This group would define a new vision and strategy, likely involving a shift in responsibilities to other partners. He stressed that future planning must be a joint endeavour with Gloucestershire from the outset—not a matter of presenting separate plans after the fact. In closing, SW summarised the discussion, thanking EP for her work and confirming that the committee supported the direction of travel. He noted that the feedback provided—particularly around health inequalities, digital infrastructure, and governance—would be essential in shaping the next phase of planning.	
	Finance Report	
7.1	**Review & Refresh Medium Term Financial Plan** MB began by reinforcing the importance of the system's current trajectory in achieving its recurrent savings target. He noted that the exit run rate of recurrent savings aligns with the overall target for the year, which is a positive indicator of financial sustainability. This observation supported PT earlier remarks on the balance between recurrent and non-recurrent efficiencies, and MB emphasised that the system appears to be on track to meet its financial goals. Finally, MB responded to a question about the impact of strategic commissioning on financial planning. He clarified that contracting remains a central component of the system's blueprint and that individual organisational accountability is likely to increase. This, he explained, would necessitate more rigorous contract monitoring and a greater emphasis on financial oversight than in previous years.	
7.2	**M3 ICB Revenue Finance Report inc System finance report** MB presented the finance report, highlighting the current break-even position both year-to-date and forecasted for the system. He noted that while the financial outlook appears stable, this is contingent on achieving the planned improvement in the underlying position. He cautioned that although the forecast deficit trajectory may not appear alarming at first glance, several underlying risks could significantly impact the financial position. One of the key risks identified was the increasing cost and demand associated with mental health placements. MB explained that the ICB is currently facing a £1.4 million forecast overspend in this area, with the potential for this to worsen due to both general growth in demand and ongoing disputes with the Local Authority over the percentage split of funding responsibilities. He noted that the LA is advocating for a 50% share, compared to the ICB's current 30%, which could expose the ICB to a £20+ million risk. Another major concern raised was the escalating financial pressure from ADHD and autism services under the Right to Choose framework. MB described this as the single biggest financial risk currently facing the ICB. He detailed the rapid growth in expenditure—from £1.8 million in 2022/23 to a projected £12 million in 2025/26—highlighting the lack of robust data, poor contractual oversight, and the challenge of managing providers not directly contracted by the ICB. He confirmed that a paper addressing this issue is being prepared for the Executive Team and suggested that a version should be brought to the committee for further scrutiny. In response, SW acknowledged the importance of maintaining focus on these risks, especially amid broader system changes. He emphasised the need for collective accountability to ensure delivery against financial targets.	

	JF added a critical update from a recent meeting with the regional director, noting that there is still an expectation from NHS England that redundancy costs associated with the 50% running cost reduction in ICBs be absorbed within existing budgets. He stressed that this is not feasible and flagged it as a significant risk, particularly given the absence of any confirmed central funding. MB agreed, noting that while the current forecast remains break-even, the balance of risks is shifting. He committed to sharing a slide summarising the updated risk profile and reiterated that the forecast is still appropriate, if mitigation efforts continue and are successful. SW concluded the discussion by praising the clarity of the finance report and reinforcing the importance of staying vigilant as the system navigates a period of transition and financial constraint.	
8	**Items to Note**	
8.1	**System DoFs Group** MB provided a summary of key updates from the Directors of Finance group noting there were no significant items beyond those discussed in other papers.	
8.3	**Strategic Estates** MB provided a brief verbal update on Strategic Estates, noting that there were no material issues to report at this time. He acknowledged that the accompanying paper had not initially appeared in the meeting pack but confirmed it had since been uploaded to Diligent. He assured the committee that all projects were progressing as planned and committed to ensuring the paper would be circulated post-meeting for full visibility. SW asked for confirmation that there were no issues requiring committee attention, to which MB confirmed there were none. Later in the meeting, JF raised a concern regarding the brief reference to Bristol Temple Quarter in the Strategic Estates paper. He highlighted the scale of the development—potentially 10,000 new homes and 5,000 additional students in the first phase, with further expansion expected at the adjacent Phillips Marsh site. JF emphasised the risk this posed to local health infrastructure, particularly GP and dental services, and acute care, if adequate health provision was not planned alongside the development. JF reported that he had raised these concerns at the Strategic Board chaired by the WECA Mayor, where he noted a strong focus on enabling development at any cost, with limited attention to the implications for public services. He stressed the importance of ensuring that health needs were not overlooked in Section 106 and Community Infrastructure Levy (CIL) negotiations, warning that failure to do so would leave the NHS to absorb the impact without adequate funding. JC acknowledged JF concerns and noted that Tim James had previously provided an update to the committee suggesting a shift in planning approach to better anticipate population growth. JF responded that, following that meeting, he had contacted Tim and learned that engagement with the council had been limited and at times resistant. He confirmed that his intervention at the Strategic Board had helped raise the profile of the issue. SW echoed JF concerns, particularly around the lack of revenue funding to support new infrastructure and agreed that the issue needed to remain on the committee's radar. He also referenced similar risks at other large-scale developments, such as Brabazon. BS declared a potential conflict of interest, noting that his wife is a senior manager with the lead design engineering partner for the Temple Quarter development. This was duly noted. JF concluded by urging that the risk be captured on the Strategic Risk Register and monitored through the Transition Committee.	

	Key Messages/Chair Conclusion: SW, at the end of the meeting acknowledged the key discussions and decisions, particularly: • The endorsement of the direction of travel for the transfer of the SRO role for Connecting Care to the Bristol NHS Group, with the understanding that further internal governance steps are required before formal approval. • The recommendation to proceed with the Graham Road and Horizon procurement process, while noting the need to manage potential conflicts of interest at board level. • The importance of maintaining oversight on financial risks, including Mental Health placements and ADHD/autism service pressures. • The need to track strategic risks such as the Bristol Temple Quarter development and its implications for health infrastructure. The emphasis on ensuring that transition risks related to the evolving role of the ICB are captured and managed effectively.	