Finance, Estates & Digital Committee

Date: **Thursday 27th November 2025**

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

Location: **MS Teams**

Agenda Number:	8.1	
Title:	Financial Performance – Oct 2025 (Month 7)	
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:

- ICB Finance Report – ICB level budgets, statutory duty to breakeven, and ICB savings
- 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 5the ICB is reporting a year-to-date and forecast breakeven position. Notwithstanding this there are variances at a programme level:
  - Mental Health, Learning Disabilities & Autism (A2) – forecast overspend of £4.9m:

        - £2.2m due to ADHD and Autism Right to Choose providers and
        - £3.0m mainly due to S117 placements, offset by other underspends
    - Primary Care (A4-A7) – forecast underspend of £5.1m.
        - £1.5m due to slow population growth & allocation methodology
        - £0.8m due to efficient use of Pharmacy services
        - £3.3m due to savings achievement & favorable drug pricing
    - Children's (A9) – Forecast overspend of £1.0m due to ADHD and Autism Right to Choose providers

- **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 (£1.9m over-performance) and forecast (£2.4m forecast overperformance).

  Risks and Mitigations: Net risks and mitigation scenarios range from a deficit of £12.2m (M6: £12.2m) to a surplus of £11.5m (M6: £12.5m) with our base case shows a small surplus of £1.6m (M6: £0.5), whilst this is a deterioration from the prior month this is driven by the inclusion of £9.8m in the base case for the system finance risk. Overall the position, in isolation from the wider system, is increasing confidence in the ability to deliver the financial plan of the ICB.

System Finance

- **Revenue:** YTD Month 7 (October), the system is showing a year-to-date deficit of £1.3m. The formal forecast remains a breakeven position for the year for all NHS ICS organisations collectively and individually). However, at the latest Performance and Recovery Board, underlying forecasts showed a system gap of £6.0m for controllable spend (rising to £10.3m including industrial action and transition costs) for which mitigations are not yet identified. PRB concluded that whilst the gap is significant we have reasonable confidence that we will be able to close this by end of the financial year.
- **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).
- **Cash**: overall the system maintains a healthy cash balance and does not anticipate needing cash support in year.
- **Next steps**: Recovery plans (UHBW and NBT) were presented to the October Performance and Recovery as per the agreed financial escalation framework – further actions were agreed to be completed ahead of the November PRB where improvements to the systems position are expected.

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 £1.4m, 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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Agenda item: 6.1

Report title: ICB Finance Report

Report on the financial performance for October 2025 (M07 – 2025/26)

1. Executive Summary

At month 7 the ICB is reporting both a year-to-date and forecast breakeven position. Notwithstanding this there are variances at a programme level:

- Mental Health, Learning Disabilities & Autism (A2) – forecast overspend of £4.9m:
  - £2.2m due to ADHD and Autism Right to Choose providers and
  - £3.0m mainly due to S117 placements, offset by other underspends
- Primary Care (A4-A7) – forecast underspend of £5.1m.
  - £1.5m due to slow population growth & allocation methodology
  - £0.8m due to efficient use of Pharmacy services
  - £3.3m due to savings achievement & favorable drug pricing
- Children's (A9) – Forecast overspend of £1.0m due to ADHD and Autism Right to Choose providers

Efficiency delivery is forecast to be £52.2m, a £2.4m over-performance driven by primary care medicines optimisation. YTD delivery is £1.9m ahead of plan driven by All Age Continuing Care and high cost drugs.

The scenarios range from a deficit of £12.2m (M6: £12.2m) to a surplus of £11.5m (M6: £12.5m) with our base case shows a small surplus of £1.6m (M6: £0.5), whilst this is a deterioration from the prior month this is driven by the inclusion of £9.8m in the base case for the system finance risk. Overall the position, in isolation from the wider system, is increasing confidence in the ability to deliver the financial plan of the ICB.

YTD Month 7 (October), the system is showing a year-to-date deficit of £1.3m. The formal forecast remains a breakeven position for the year for all NHS ICS organisations collectively and individually). However, at the latest Performance and Recovery Board, underlying forecasts showed a system gap of £6.0m for controllable spend (rising to £10.3m including industrial action and transition costs) for which mitigations are not yet identified. PRB concluded that whilst the gap is significant we have reasonable confidence that we will be able to close this by end of the financial year.

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

There were no allocation adjustments at month 7 due to the implementation of ISFE2. The ICB allocation remains unchanged at £2,463.655m

4. Financial position October 2025 (Month 7)

At month 7 the ICB continues to report a year-to-date and forecast breakeven position.

2025/26 October 2025 - Month 7	2025/26 Budget	Year To Date Budget	Year To Date Expenditure	Year To Date Variance		Forecast Outturn	Forecast Outturn Variance	
Programme Area	£m	£m	£m	£m		£m	£m	
Acute	1,246.375	734.043	733.764	**0.279**		1,244.773	**1.602**	
Mental Health	241.128	141.042	144.530	**(3.488)**		246.071	**(4.942)**	
Community	237.048	138.332	138.334	**(0.002)**		236.944	**0.104**	
Delegated Primary Care	316.298	185.171	183.903	**1.268**		314.500	**1.798**	
Medicines Management	167.533	97.122	95.450	**1.672**		164.820	**2.713**	
Primary Care	38.339	22.362	22.467	**(0.106)**		38.518	**(0.179)**	
Funded Care	140.732	82.940	81.951	**0.989**		139.248	**1.484**	
Childrens	48.924	28.539	29.350	**(0.811)**		49.925	**(1.002)**	
Support Costs	11.956	6.638	6.661	**(0.022)**		12.263	**(0.307)**	
Reserves	0.314	(1.055)	(1.404)	**0.349**		1.585	**(1.271)**	
Running Costs	15.008	9.126	9.256	**(0.130)**		15.008	**(0.000)**	
BNSSG ICB Surplus/(Deficit)	**2,463.655**	**1,444.262**	**1,444.262**	**-**		**2,463.655**	**-**	
Provider Surplus/Deficit								
AWP	-	0.009	0.009	-		-	-	
NBT	-	(2.830)	(3.480)	**(0.650)**		-	-	
UHBW	-	(7.664)	(8.318)	**(0.654)**		-	-	
Provider Surplus/(Deficit)	**2,463.655**	**(10.485)**	**(11.789)**	**(1.304)**		**2,463.655**	**-**	
ICS Position	**2,463.655**	**1,454.747**	**1,456.051**	**(1.304)**		**2,463.655**	**-**	

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 M7 is showing an underspend of (£0.2m). The forecast is showing an underspend of (£1.6m) against plan. This is primarily due to (£3.0m) underspend on the cost of High-Cost drugs compared to the plan. The plan was based on the horizon scan projection of new NICE TA drug costs introduced in 24/25. However enhanced pace of substituting these drugs with biosimilar drugs has resulted in a material reduction in manifesting spend in this year.

This forecast underspend is offset by forecast overspends on Independent Sector contracts £1.2m against agreed Indicative Activity Plans (IAP) and £0.2m on Activity based contracts . Contract management process is underway to address this issue to ensure that actual activity is in line with agreed IAPs.

Mental Health (A2)

The Mental Health, Learning Disabilities and Autism year-to-date position at M7 is overspent by £3.5m. Of this, £1.8m is on Placements due to increasing service user numbers, increasing Acuity through package costs and the ICB contributing on a 'case-by-case' than a global percentage basis to S117 local authority placement costs. £2m overspend is activity from Adult ADHD and Autism Right to Choose Providers, whilst we work to get Indicative Activity Plans and affordability limits in place.

The forecast at M7 shows a net overspend of £4.9m. £2.2m of this is due to the manifesting run-rate impact overspend of ADHD Right to Choose Providers. £3.0m is primarily mainly driven by the run-rate impact of the ICB paying on a cost-per-case basis for S117 packages rather than on a global percentage basis. These are offset by £0.3m of other underspends.

Please note that ADHD and Autism Right to Choose Providers' overspend on Children's services is reported separately within Children's Services area.

Community (A3)

The Community position is presenting breakeven year-to-date and forecast underspend of £0.101m. Whilst the forecast is overall favourable, there are a number of underlying variances including;

- Discharge to Assess Beds costs are forecasting an overspend of £0.025m. This excludes the mitigation supporting an agreed winter bed pressure contingency (£1.8m total; £1.2m planned, £0.6m urgent/emergency).

  This reporting also includes several pressures now supported by the in-year allocation, including;

- 17 beds due to close are still supporting patients discharged before the end of March 2025,
- POM had agreed 9 discharges during June & July
- £0.6m of the planned mitigations for the winter period.

There is an emerging pressure from 48 closed beds at UHBW, to the end of the year this is anticipated to cost £0.3m. The ICB is working with the partner (UHBW) to agree how this will be funded.

- Community Audiology, where increases in activity are contributing to a reported £0.226m overspend, in addition to real terms growth of £0.5m allocated through the planning process.

- Community Equipment is reporting a £0.202m underspend, this is significant as the ICB has been required to allocate, real terms growth each year to meet the equipment requirements for community discharges post pandemic (c.£2m increase 22/23 to 25/26, on c.£5m allocation from 22/23).

Primary Care (A4)
The core funded Primary Care position is reporting an overspend to date of £0.106m and forecasting an overspend of £0.179m. The overspend is primarily 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 £0.802m to date and forecast £1.001m underspend. There are two key variances, slower than forecast population growth (£1.022m 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 £0.467m to date and forecast £0.800m 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 £1.711m and forecast £2.773m underspend. The key favourable variances include.

- The ICB has received five months invoicing (April - Aug) 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 not all of the year-to-date benefit has been forecast to continue to the end of the year. The forecast is reporting £2.319m favourable, including the Edoxaban (Anticoagulant) incentive to encourage practices to safely switch eligible patients.
- There has been an improvement to the rebate income compared with the known rebates during the planning, which is reporting a favourable variance of £0.959m.

Children's Services (A9)
Children's services are reporting an overspend of £0.811m year to date and forecast £1.002m underspend.

The overspend is as a result of unmet demand for ASD & ADHD assessments. The national framework enables patients to to seek a diagnosis from qualified providers, performing activity which is additional to that which has been commissioned by the system under 'Right to Choose' (RtC).

Whilst funding was allocated to support this emerging pressure the level is activity forecast is significantly greater than the planning expectation (£0.3m which is three times the allocation of 2024/25). The ICB has implemented Indicative Activity Plans (IAPs) with the intention to manage the financial pressure. If this is unsuccessful, it is anticipated that the forecast overspend could increase by a further £0.5m

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 £0.28m and the pay costs funded from other sources underspent by £0.27m generating a net overspend variance of £0.01m (admin overspending by £0.25m partly offset by an underspend on programme pay of £0.24m).

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	12.193	7.113	7.407	(0.294)	12.474	(0.281)
	Programme	12.211	7.112	7.095	0.017	12.338	(0.126)
Total funded Establishment		**24.405**	**14.224**	**14.502**	**(0.278)**	**24.812**	**(0.408)**
Other Funding source	Admin	0.945	0.551	0.509	0.042	0.846	0.099
	Programme	3.349	1.954	1.726	0.228	2.932	0.417
Total Other funded posts		**4.294**	**2.505**	**2.235**	**0.270**	**3.778**	**0.516**
Grand total		**28.699**	**16.729**	**16.737**	**(0.008)**	**28.590**	**0.108**

		Full year funding £m	YTD funding £m	YTD spend £m	YTD variance £m	Forecast Outturn £m	Forecast variance £m
Analysed by	Admin	13.138	7.664	7.916	(0.252)	13.320	(0.182)
	Programme	15.561	9.065	8.821	0.244	15.270	0.290
Grand total		**28.699**	**16.729**	**16.737**	**(0.008)**	**28.590**	**0.108**

5. Efficiencies

The total ICB savings plan is £54.8m per the planning submission, internally this is £49.8m due to a presentational change within AACC (that did not effect bottom line budget). 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 £18.7m.

	YTD			Full year				Full year - RAG			
Programme	Plan £'000	Act £'000	Var £'000	Plan £'000	FOT £'000	Var £'000	Change £'000	Blue £'000	Green £'000	Amber £'000	Red £'000
All Age Continuing Care	1,645	2,466	821	6,120	7,529	1,409	636	-	3,331	4,198	-
MHLDAplacements	117	69	(48)	771	666	(105)	49	-	447	-	219
High Cost Drugs	1,522	2,184	662	2,198	2,860	662	(342)	-	2,184	675	-
Meds opt: Primarycare	2,824	3,304	480	5,155	5,635	480	(257)	-	3,854	1,782	-
Discharge programme	1,947	1,947	-	3,338	3,338	0	-	-	3,338	-	-
Running cost	659	659	-	1,129	1,129	-	-	-	1,129	-	-
ICBdelivered	8,714	10,629	1,916	18,711	21,157	2,446	87	-	14,283	6,655	219
Contract efficiencies	18,119	18,119	-	31,061	31,061	-	-	31,061	-	-	-
Total programme	26,833	28,748	1,916	49,772	52,218	2,446	87	31,061	14,283	6,655	219

Total efficiencies are £1.9m ahead of plan predominately driven by All Age Continuing Care where reductions in fact track case load is ahead of plan and High Cost Drugs.

Full year forecast is an over delivery of £2.4m driven by All Age Continuing Care.

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 £12.2m (M6: £12.2m) to a surplus of £11.5m (M6: £12.5m) with our base case shows a small surplus of £1.6m (M6: £0.5), whilst this is a deterioration from the prior month this is driven by the inclusion of £9.8m in the base case for the system finance risk. Overall the position, in isolation from the wider system, is increasing confidence in the ability to deliver the financial plan of the ICB.

	Gross	Reasonable downside		Base case		Reasonable Upside	
	£'000	%	£'000	%	£'000	%	£'000
D2A	(1,960)	162%	(3,180)	-2%	39	-21%	420
HCDD	(826)	75%	(620)	50%	(413)	25%	(207)
All age continuing care	(2,500)	75%	(1,875)	50%	(1,250)	40%	(1,000)
Other variable activity	(1,000)	50%	(500)	0%	-	0%	-
MH/LD placements	(1,800)	85%	(1,525)	58%	(1,050)	47%	(845)
ADHD/Austism	(3,131)	100%	(3,131)	75%	(2,349)	50%	(1,566)
Delegated	8,371	53%	4,426	73%	6,150	88%	7,366
Meds Mgmt	2,885	40%	1,154	70%	2,020	100%	2,885
Other	4,832	-10%	(465)	12%	591	29%	1,408
Prior year/ reserves	8,615	87%	7,538	89%	7,677	116%	9,990
System risk	(18,300)	69%	(12,650)	54%	(9,825)	38%	(7,000)
Total			(10,828)		1,589		11,450
Memo: last month			(12,165)		510		12,450
Of which efficiency:	(7,705)		(3,233)		1,477		3,084

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 – whilst this is an inherently risk balance, the M1-7 reporting is tracking below budget and the risk of overspend in this areas is reducing. However, there are savings plans profiled in the budget for H2 where the biosimilar national release is likely to be delayed.

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). We have had a further month of delivery in line with plan and positive signs on the case load looing forward.

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

Mental health / LD Placements – already recognised £3.0m 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. The profile has slightly worsened since M5.

ADHD / Autism – this relates to spend on Right to Choose providers. £3.2m has already been recognised in the forecast for Adults and CYP, which aligns to the assessment of IAPs issued when allowance is made for patients on existing pathways and new providers entering the market. A number of recovery actions are underway, however whilst we will attempt to control overspend through contractual mechanism there is a risk this will not be effective and further pressure will emerge given waiting list size, resource available in ICB to manage and increasing number of providers.

Delegated – potential significant underspend on delegated budgets, both dental, pharmacy and primary care. 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.

System risk – given the gap identified at UHBW and NBT, a system recovery plan is in development and an element of this has been recognised with the ICB risks and mitigations.

7. System position

On the 7th of October, Performance & Recovery Board was notified of a residual £13.9m risk to delivering this year's (2025/26) financial plan at system level (see Appendix 1).

This paper provides an update Performance & Recovery Board on the latest assessment of the systems unmitigated risk to delivering break-even financial position in 2025/26, and the key risks inherent in this assessment.

The revised assessment of unmitigated risk to delivering break-even is a deficit of £10.3m, the headline movements are articulated in the table below:

	£m
Previous risk to forecast out-turn	**(13.9)**
Improvement in ICB run rate	**2.5**
Variable over-performance on associate contracts shown in position	**2.7**
Costs of Industrial Action taken below the line	**1.4**
Transition Costs shown below the line	**1.3**
Revised assessment of controllable system deficit	**(6.0)**
Additional Risks (external factors)	
Revised assessment of Industrial action (following 2nd wave)	**(2.8)**
Risk of ICB unfunded transition costs	**(1.5)**
Current assessment of system Forecast deficit	**(10.3)**

A financial recovery package has been agreed between BNSSG ICB and Acute providers, to ensure an equitable approach to some of the emergent financial pressures impacting the system, most notably an under-writing of some of the escalation costs associated with no criteria to reside (where planned improvement trajectories have not been met), and a gain share on high-cost drugs to ensure benefit is reflected in both ICB and provider positions.

The ICB has also ensured that any national funding held in the ICB position is passed through to provers where appropriate.

The full impact at organisational level will continue to be worked through finance forums and the joint Directors of Finance Group.

Key Risks

1) In arriving at this latest forecast assessment, it should be noted that in addition to the significant financial recovery assumed within organisational positions (and as previously articulated to Performance & Recovery Board), there remains a significant level of risk relating to additional funding flows to the system from external (non BNSSG) partners (£11.5m in total).

- Assumed funding related to PFI residual interest (£6.3m)

- Forecast over-performance on variable elements of contracts with out of system commissioners (inter-system ICBs and NHSE Specialist Commissioning) is fully paid to providers (£5.2m)

2) The impact of known Industrial Action has been included in the current forecast out-turn assessment , however further action with no likely national finding solution will deteriorate the position further.

3) A detailed assessment of the ICB cost of commissioning changes and the funding that is made available to the system is underway. currently £1.5m of risk around unfunded costs has been included in the position.

With increased industrial action and likelihood that there will be pressures on transition costs within the ICB, careful consideration will need to be given as to whether breakeven is achievable as a system.

8. Capital allocation

ICB Capital

An additional transfer of £3.2m system operational capital to the ICB was agreed at the System Capital Board in November. This will support system priorities and ensure the system maximises the utilisation of the capital funding available in 25/26.

At month 7, the ICB is forecasting to utilise the allocations for both BAU and Estates in full, as follows:

ICB Capital - BAU	Original Plan	In Year Allocation	Current Plan	Forecast	Variance
Digital Technology Refresh	1,931		1,931	1,931	-
ARRS and PCN GPIT	100	242	342	342	
MIG Equipping	50		50	50	
2025/26 Total ICB Capital Allocation	2,081	242	2,323	2,323	-

ICB Capital - Estates	Original Plan	Agreed System	Current Plan	Forecast	Variance
Connexus / Wells Road	3,300	2,400	5,700	5,700	-
Central Weston VAT Liability	-	1,066	1,066	1,066	-
Thornbury HC	600	- 8	592	592	
Broadmead / Charlotte Keel	650	- 300	350	350	
2025/26 Total ICB Capital Allocation	4,550	3,158	7,708	7,708	-

System Capital

The total system operational capital allocation is £103.2m. System providers have worked in collaboration to produce a capital plan that aims to fully utilise the large amount of capital available in 2025/26.

At month 7, the system is reporting full spend against the system capital allocation.

The progress and risk of delivery of schemes is reported to the ICS Capital Board each month, and a schedule of additional/future year schemes has been compiled with the intention to direct any in year slippage to these schemes to fully utilise the allocation available.

9. Statement of Financial Position

The closing net asset position of the ICB is £100.7m, a year-to-date movement of £14.2m which is driven by an increase in payables of £93.2m, offset by an increase in debtors of £79.5m and an increase in cash of £28.2m. These large changes in working capital reflect the difficulties that the ICB has faced during the first month of running for our new ISFE2 ledger system.

Part of the increase in payables is caused by the problems faced in getting invoices processed for payment in the new system. The new system has not performed as expected or as described during training. The finance team are still identifying new issues and learning new information about how to use the system effectively. As a result, payments to providers in October were significantly lower than usual. To mitigate the cashflow risk to providers, the ICB made emergency payments to suppliers where necessary.

The balance of the increase in payables and the increase in debtors has been caused by the difficulties that the finance team has experienced in posting month end journals. Many of the balance sheet codes were not available, meaning that normal housekeeping journals could not be posted.

The lower-than-average supplier payments has contributed to the large cash balance at the end of the month.

Statement of Financial Position	Balance 31/03/2025 £m	Balance 31/10/2025 £m	Movement £m
Total Non Current Assets	3.101	2.843	(0.259)
Current Assets			
Cash & Cash Equivalents	0.377	28.533	28.156
Current Trade And Other Receivables	28.199	107.677	79.478
Total Current Assets	*28.576*	*136.210*	*107.633*
Total Assets	**31.678**	**139.052**	**107.375**
Liabilities			
Payables	(141.655)	(234.990)	(93.335)
Provisions	(2.429)	(2.429)	0.000
Lease Liability	(2.445)	(2.301)	0.145
Total Liabilities	***(146.529)***	***(239.719)***	***(93.190)***
Total Net Assets/(Liabilities)	**(114.851)**	**(100.667)**	**14.184**
Taxpayers Equity			
I&E Reserve - General Fund	(114.851)	(100.667)	14.184
Total Taxpayer Equity	**(114.851)**	**(100.667)**	**14.184**

At month end, the ICB's cash utilisation was ahead of plan by 3.24% or £46.6m. This is partly due to usual seasonal variation and partly because the ICB drew down cash to enable quarterly payments to be made to the Councils. Unfortunately, due to the technical issues experienced with the payments system in the new ledger, these invoices could not be processed in time for payment in month.

NHSE monitor the ICB on the closing cash at bank balance compared to 1.25% of monthly drawdown, which for month 7 equated to £1.75m. The ICB did not meet this target, with a closing cash at bank balance of £31.9m. This was due to the difficulties experienced in paying invoices on the new system as described above. The cash in ledger position shown above is £3.4m lower than cash at bank due to the timing of the final BACS run.

10. Better Payment Practice Code (BPPC)

The ICB is required to comply with the BPPC where all non-disputed invoices are to be paid within 30 days. The performance measure requires 95% or more of invoices, in terms of volume and value, to be paid within 30 days.

The ICB usually pays an average of 2,700 invoices a month, but in October, the ICB only paid 1,600 invoices. The ICB 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. However, we believe that these results are a result of the low level of payments made. We forecast that the issues faced with paying invoices in October will have a significant negative impact on BPPC compliance in future months.

Type	In month	Number	£m
NHS	Total bills paid in month	22	55.652
	Total bills paid within target	21	55.649
	% bills paid within target	**95.45%**	**99.99%**
Non NHS	Total bills paid in month	1,601	60.367
	Total bills paid within target	1,591	60.166
	% bills paid within target	**99.38%**	**99.67%**

Type	Year to date	Number	£m
NHS	Total bills paid in year	892	815.938
	Total bills paid within target	872	815.067
	% bills paid within target	**97.76%**	**99.89%**
Non NHS	Total bills paid in year	17,447	515.862
	Total bills paid within target	17,292	500.249
	% bills paid within target	**99.11%**	**96.97%**

11. Recommendations

The committee are asked to note the financial position as of month 7.

Appendix 1 – Analysis of spend within programme areas

Due to the implementation of ISFE2 we are unable to provide the detailed breakdown of spend in the current month's reporting. This is due to mapping issues between legacy ISFE1 coding and new ISFE2 coding. We anticipate being able to provide this for next month.

Appendix 2 – System view of unmitigated risk to forecast out-turn (as per Performance & Recovery Board paper 7th October 2025)

		UHBW	NBT	AWP	BNSSG ICB	ICS	Sirona
Forecast Surplus / (Deficit)							
Non-recurrent planning gap		(16.0)	(4.9)	0.0	(0.4)	**(21.3)**	
In-Year savings shortfall		(3.0)	(27.7)	(1.8)	0.0	**(32.5)**	(0.9)
Other In-Year deterioration v plan		(10.5)	(1.2)	(1.2)	0.0	**(12.9)**	
Emerging 2025/26 unplanned issues		(14.0)	(11.5)	0.0	(1.3)	**(26.8)**	(2.0)
PFI residual Interest Risk		0.0	(4.9)	(1.4)	0.0	**(6.3)**	
In-Year Controls / Financial Recovery Impact		23.5	30.6	3.0	1.4	**58.4**	2.6
Total Risk to Forecast out-turn		**(20.0)**	**(19.6)**	**(1.4)**	**(0.3)**	**(41.3)**	**(0.3)**
Additional Organisational Improvement							
Additional non-recurrent organisational mitigations		1.0	3.0		6.5	**10.5**	
Further mitigations (unidentified)			1.6			**1.6**	
Spec Comm 2024/25 retained funding (ERF)			2.0			**2.0**	
Patient Transport funding		0.3				**0.3**	
Agreed NHSE Risk Share					2.8	**2.8**	
2024/25 PFI funding					1.4	**1.4**	
Mitigated Deficit before additional funding		**(18.7)**	**(13.0)**	**(1.4)**	**10.3**	**(22.7)**	**(0.3)**
National Funding Flows							
PFI residual Interest Risk			4.9	1.4		**6.3**	
Retained Depreciation Funding		2.7			(2.7)	**0.0**	
Intra-System funding Flows							
25/26 ERF over-performance - BNSSG		0.8	7.1		(7.9)	**0.0**	
No Criteria to Reside (NCTR)		4.0	2.0		(6.0)	**0.0**	
ERF over-performance - Assumed reduction			(3.9)		3.9	**0.0**	
Income from Associate Commissioners (incl. Spec Comm)							
25/26 FOT ERF over-performance - Spec Comm		1.2	1.3			**2.5**	
25/26 FOT ERF over-performance - Associates			2.7			**2.7**	
ERF over-performance - Assumed reduction			(2.7)			**(2.7)**	
Total Risk to Forecast out-turn		**(10.0)**	**(1.6)**	**0.0**	**(2.4)**	**(13.9)**	**(0.3)**

Risk as a % of provide rincome		(0.8%)	(0.2%)	0.0%			(0.1%)
Risk as a % of ICB Allocation					(0.1%)	(0.6%)	

Finance, Estates and Digital Committee (OPEN Session)

Minutes of the meeting held on Thursday 25th September 2025, 09:00 – 10:30, via Microsoft Teams

Present		Initials
Steve West	Finance, Estates and Digital Committee – Chair	SW
Matt Backler	Interim Chief Finance Officer	MB
Deborah El-Sayed	Chief Transformation and Digital Information Officer, BNSSG ICB	DES
John Cappock	Non-Executive Director, BNSSG ICB	JC
Jo Medhurst	Chief Medical Officer, BNSSG ICB	JM
Richard Gaunt	Non-Executive Director, NBT	RG
Christina Gray	Director for Communities and Public Health, Bristol City Council	CG
In attendance		
Jenny Falco	Head of Contracts – Acutes and Mental Health, BNSSG ICB	JF
David Jarrett	Chief Delivery Officer, BNSSG ICB	DJ
Rhys Lewis	Digital and Business Intelligence – Executive Director, One Care	RL
Adwoa Webber	Head of Quality and Clinical Excellence, BNSSG ICB	AW
Nicole Saunders	Head of System Strategy & Planning, BNSSG ICB	NS
Sabrina Smithson	Executive PA - Note taker/admin, BNSSG ICB	SS

		Action
1	**Welcome and Apologies** The chair welcomed all to the meeting and noted formal apologies were received from Amy Webb – NSC and Brian Stables – AWP.	
2	**Declarations of Interest** No interests were declared beyond those recorded in the Declaration of Interest register.	
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.	
6	**Items to Discuss**	
6.1	**Digital Deep Dive: Primary Care** DES highlighted the longstanding and productive partnership between the ICB digital team and One Care. This collaboration has fostered a fully integrated approach, enabling both organisations to maximise constrained resources and build a foundation of trust and openness. DES noted that this partnership has positioned BNSSG as a leader in digital primary care innovation. RL, provided an annual update on digital developments in general practice. He outlined the scope of BNSSG general practice, which serves 1.2 million patients across 67 partnerships and 21 PCNs. RL acknowledged the inherent variation in general practice due to its structure as independent businesses but emphasised that this variation has been leveraged to drive innovation. One Care's role has been to support consistent, safe, and scalable digital adoption across practices. RL detailed the progress made in digital infrastructure, including secure networks, cloud-based telephony, and enhanced cyber resilience. Patient-facing tools have been embedded across practices, with widespread use of text messaging and NHS app	

	messaging. The region has proactively adopted online triage models, with many practices implementing total digital triage ahead of national requirements. A strong emphasis has been placed on promoting the NHS app, particularly for booking, prescriptions, and record access. Efforts to address digital exclusion have been strengthened through partnerships with voluntary sector organisations and patient participation groups. Activated patients have supported peers in navigating digital tools, and pilots have been conducted to test scalable innovations. Notably, automated patient registration has been implemented across most practices, significantly reducing administrative time and generating measurable cost savings. Ambient voice technology has also been piloted, demonstrating time savings in consultations and referral letter generation, with practices likely to self-fund these initiatives moving forward. Strategic partnerships have been instrumental, particularly with the University of the West of England (UWE). The Centre of Digital Excellence, hosted by UWE, serves as a real-world testbed for digital suppliers. A Knowledge Transfer Partnership has been secured to embed academic evaluation into practice. One Care has also been commissioned to lead ambient voice technology adoption across the Southwest, extending its impact beyond general practice to other health and social care providers. RL aligned these developments with the national 10-year plan, noting BNSSG's strong performance in digital telephony, online consultations, and triage. He highlighted ongoing work in population health, including the use of the Cambridge Mobility Score and a focus on continuity of care for high-risk patients. Research and innovation continue to be a priority, with BNSSG recognised as a leader in digital general practice. Looking ahead, RL identified key challenges including system integration, particularly with electronic patient records (EPRs), vendor variation due to practice independence, and a complex contractual environment. The impending closure of CSUs and the transition of GPIT infrastructure contracts present additional risks. The EMIS contract expiry in June 2026 and the need for clarity around N365 management were also flagged as areas requiring coordinated system support. RL concluded by emphasising the need to consolidate pilots into sustainable system-wide offers, embed standardised approaches across PCNs, and strengthen collaboration with Community, Acute, and Local Authority partners. He reiterated that ongoing investment, integration, and stability are essential to sustaining progress and unlocking the full potential of digital-first neighbourhood health models. SW commended the progress and stressed the importance of maintaining momentum during organisational change. He noted that effective digital transformation could alleviate pressure on acute services and influence public engagement with healthcare differently. Behavioural and cultural change among the population was identified as a critical factor in realising the benefits of digital innovation. DES expanded on the implications of the CSU closure, noting that the ICB retains statutory responsibility for GPIT delivery. She outlined plans to collaborate more closely with acute colleagues, particularly given that 80% of digital investment is directed toward acute services. The partnership model was reaffirmed as central to future success, with a call for system-wide collaboration beyond organisational boundaries. JC queried the extent of collaboration with Gloucestershire and the potential for scaling up. DES responded that Gloucestershire has taken a different approach, internalising digital delivery within the ICB and leveraging their acute trust for helpdesk support. While challenges have been noted, discussions are underway to explore joint or separate expressions of interest for future GPIT delivery, with governance and oversight remaining essential.	

	RL added that while informal relationships with Gloucestershire colleagues are developing, formal discussions will be guided by ICP leadership. He reiterated the importance of partnership working and invited further collaboration with system partners to drive innovation. SW closed the session by thanking RL for the presentation and reaffirming the importance of digital transformation in delivering safe, effective care and supporting strategic shifts across the system.	
6.2	**Review the Forward Work Planner** SW reconvened the meeting and introduced the review of the forward plan. He acknowledged that while the plan was largely unchanged, the group should remain responsive to emerging priorities. MB confirmed there were no immediate updates to the plan and invited feedback from the committee on any potential omissions. JM proposed the introduction of an annual audit to assess whether papers presented to the Committee sufficiently address health inequalities, using the newly published Health Inequalities Annual Report as a benchmark. She suggested this could serve as a formal assurance mechanism and noted that similar action in the past—such as requiring EQIAs—had led to improved compliance and awareness. SW welcomed the suggestion, noting that it would sharpen focus across the system. He recommended that the proposal be taken to the Executive Team and potentially the Board for broader discussion. JM agreed, suggesting that the approach should be adopted system-wide to ensure investment cases across all providers are evaluated through the lens of health equity. CG endorsed the proposal, describing it as an effective lever for embedding organisational values. She recommended that the audit focus on the organisation's core business and suggested that it be conducted by the same group that developed the Health Inequalities Report. CG also proposed the inclusion of a standing item on the forward plan to monitor organisation transition and its implications for board duties and responsibilities. SW agreed and noted the importance of ensuring that the Transition Board remains informed and aligned with these developments. MB supported the audit proposal and advised that its scope and timing be carefully considered. He recommended establishing clear expectations for how health inequalities should be factored into decision-making before conducting the audit, to ensure meaningful outcomes. JM added that the impact of the VCSE grant application process should also be reviewed, given its deviation from standard procurement guidance. She suggested this be scheduled for evaluation approximately 7–9 months into the following year. SW concluded the discussion by confirming that he and JM would work together to draft a proposal for the Board, with support from SS to incorporate the relevant points into the updated forward planner. SSS confirmed that the forward planner is reviewed every few months and that the proposed changes would be reflected in the next iteration. **Action – Proposal of annual Health Inequalities audit at committees' proposal be taken to the Executive Team and potentially the Board for broader discussion.**	**JM/MB**
7	**Finance Report**	
7.1	**M5 ICB Revenue Finance Report inc System finance report** MB opened the discussion by affirming that the ICB remains reasonably confident in its ability to deliver its financial position for the current year. He acknowledged the presence of significant risks and challenges but noted that current run rates and identified risks are covered by existing mitigations. Particular attention was drawn to overspending in ADHD, autism, and Section 117 services, which remain areas of concern. However, it was positively noted that high-cost drugs and Continuing Healthcare (CHC), which were major overspend areas in the previous year, are currently trending towards underspend.	

	This improvement was attributed to effective budgetary control and team efforts, although it was cautioned that these balances remain inherently volatile and sensitive to patient-level changes. Despite the ICB's relatively stable outlook, MB highlighted emerging concerns at the system level, particularly with North Bristol Trust (NBT) and University Hospitals Bristol and Weston (UHBW), both of which are facing significant financial delivery challenges. The Performance and Recovery Board (PRB) had previously identified a £10 million gap at NBT and a £15 million gap at UHBW, even after applying several mitigations, including assumptions of additional income. MB stressed the importance of triangulating system positions, especially where trusts anticipate income from the ICB that is not currently reflected in the ICB's financial outlook. Recovery plans are being developed by UHBW and NBT for the next PRB, but it is evident that these trusts alone will not be able to close the financial gaps. Consequently, system-level work is underway to assess positions, risks, and potential mitigations. The committee was formally advised of the challenging system-wide financial position. While the ICB remains in a relatively positive stance, pressures from demand-driven factors may impact its financial stability. SW acknowledged the early identification of these issues and confirmed that internal processes have been activated to conduct deep dives and cross-system reviews. He emphasised the collaborative efforts between the acute boards and the ICB to explore further solutions. In response to a query from JC regarding the forecast declaration for Q2 to the region, MB indicated that it is premature to provide a definitive forecast. The ICB continues to aim for a break-even position, and while this may not be achievable, current assessments do not warrant a deviation from this target. Trusts are refining their forecasts and recovery plans, and the ICB is reviewing its own position. Additional reviews are being requested from AWP and Sirona. MB confirmed that NHSE is aware of the risks and, despite the challenges, the ICB is not among the most severely impacted systems nationally. RG provided further context on provider-level issues, noting that half of NBT's shortfall stems from a technical accounting issue related to PFI interpretation, which may resolve over time. A significant driver of the current shortfall is the "no criteria to reside" metric, which remains at 22% across both organisations, compared to a budgeted assumption of 15%, contributing £8–10 million to the forecasted deficit. SW requested that future reporting include a breakdown of pressures and potential areas of focus, such as emergency department (ED) flow, which is currently exceeding expectations. MB confirmed that detailed recovery plans are being developed, including variance analysis and mitigation strategies. These efforts are being coordinated through the deputy's group and will be presented to the CFOs to ensure alignment and clarity. He reiterated the importance of triangulating assumptions, particularly those involving anticipated payments, and noted that discussions with CFOs are ongoing to address discrepancies and cost drivers. JM raised concerns about disparities in emergency admission data, highlighting significant differences in utilisation based on place and ethnicity. She advocated for more nuanced and targeted interventions within broader strategic plans, citing stark contrasts between affluent white populations and more deprived Black communities. SW added that international students often default to hospital visits due to unfamiliarity with local healthcare systems, suggesting that data-driven interventions could help address these patterns. The committee discussed the recurring challenges associated with "no criteria to reside" and flow issues, with JM suggesting a need for innovative approaches to break the cycle of ineffective repetition. RG supported this by referencing work on missed appointments in deprived areas, where lack of digital access and understanding of NHS systems contributes to disparities. Initiatives are underway to engage these communities more effectively. SW proposed the development of a heat map to illustrate public transport limitations, which further hinder access to healthcare services.	

	In closing, MB addressed transitional restructuring challenges, noting that NHSE requires assurance of operational and financial plan delivery before approving costs associated with transition. Treasury has confirmed that it will not fund restructuring costs this year, and while discussions for next year are ongoing, the ICB has communicated to staff that no consultation will occur before April due to financial constraints and national delays. The committee acknowledged the complexities involved and agreed to await further guidance.	
8	**Items to Note**	
8.2	**System DoFs Group** MB reported that joint meetings with Gloucestershire have been taking place periodically, which have proven helpful in maintaining momentum and fostering collaboration. However, he emphasised the importance of balancing joint engagement with the need for system-specific planning, given that BNSSG and Gloucestershire remain distinct entities with separate delivery responsibilities. Efforts are being made to ensure that meetings are purposeful and not held for their own sake. The challenge lies in maintaining alignment and shared progress while respecting the autonomy of each system's planning requirements. In addition to joint planning, work has been undertaken to review contract arrangements. Although not a formal contract reset, the exercise aims to clarify the contents of existing contracts and assess their alignment with national tariff and funding levels. This work is being conducted in collaboration with providers and is part of national reporting requirements. The objective is to ensure mutual understanding of what services are being commissioned, the associated costs, and how these compare to national benchmarks. This contract review process is expected to be a valuable step in aligning both sides on financial and service expectations. It will also inform the development of medium-term plans and contribute to broader strategic planning efforts. MB concluded by noting that these areas—joint system coordination and contract clarity—have been the primary focus of recent activity.	
8.4	**Digital Delivery Board** The committee received a verbal update from DES regarding digital and data developments across the system. She began by confirming progress on the transition of Connecting Care to the acute group, noting that a formal note had been sent to Neil Darvill, who confirmed it met his requirements for progressing within his organisation. The transition is scheduled for final approval at the November ICB board, with a preliminary review planned for October. RG was acknowledged for his engagement in the process. A one-off investment of £227,000 in cyber security was announced, to be spent by the end of the financial year. Although the funding is not ideally structured, it will enable advancement of the cyber strategy. Phil Wade from the hospital group and Chris Borman are leading this work, with the strategy also expected to be presented to the November ICB board. Nicole Saunders and her team were commended for their engagement with the Digital Delivery Board to ensure digital and data requirements are integrated into next year's planning round. While securing funding remains uncertain, it was emphasised that early visibility of digital needs is essential. A new workstream has commenced to support neighbourhood integration, aligning with earlier discussions on vertical integration. This initiative responds to a national requirement that 95% of complex adults must have an integrated care plan by 2027. The definition of "complex adults" remains unclear, and clarification has been requested. The workstream will assess existing resources and future investment needs, drawing on system-wide collaboration.	

	The dynamic population model, previously presented at a board seminar, has been updated with the latest ONS data. Work has also begun on incorporating children's data, supported by a new data agreement with the Centre. This agreement provides access to children's social care, education, and housing data, which will enhance the linked dataset and support population health management efforts for children. The Intelligence Centre re-procurement process is underway, with training initiated and a target to select an implementation partner by December. The chosen partner will work at risk to develop a business case for sign-off in March. In the Federated Data Platform and Secure Data Environment (SDE) space, BNSSG is leading nationally on the development of a system control centre. The Faculty AI product, used to monitor real-time data such as A&E and discharge activity, is being developed by Palantir based on BNSSG's specifications. Due to current limitations in the Palantir product, the existing contract has been extended. BNSSG also hosts the regional SDE, which is undergoing penetration testing under the leadership of Charlie Kenwood. CG raised a query regarding the definition of complexity in the context of integrated care plans, asking whether it referred to medical complexity (e.g., multiple conditions) or social complexity (e.g., homelessness, substance use). DES clarified that the current understanding points to medical complexity, though no formal definition has been provided. The team has requested further clarification to ensure appropriate care planning. CG suggested linking this work to the inequalities agenda previously presented by JM, which DES agreed would be beneficial.	
	Key Messages/Chair Conclusion: Steven West concluded the meeting by acknowledging that the agenda had been effectively covered and confirmed that no items had been missed. SW highlighted several areas of progress, including the primary care digital deep dive, which demonstrated the value of collaboration, and the health inequalities report, which he praised for its insightful approach and potential to drive meaningful action. He emphasised the importance of using data to inform decisions and suggested a follow-up conversation with JM regarding board-level messaging. SW also addressed the forward work programme, stressing the need to signal emerging issues to the Transition Board while continuing to make informed decisions as a finance, estates, and digital committee. He supported ongoing efforts to address financial pressures and encouraged continued planning despite limited guidance from national bodies, noting that proactive work has served the system well in previous years. Finally, SW cautioned that winter pressures may impact organisational capacity and decision-making, particularly in relation to financial management and the health inequalities agenda. He expressed confidence in the committee's ability to navigate these challenges and closed the meeting.	

Finance, Estates and Digital Committee (OPEN Session)

Minutes of the meeting held on Thursday 23rd October 2025, 09:00 – 10:30, via Microsoft Teams

Present		Initials
Steve West	Finance, Estates and Digital Committee – Chair	SW
Matt Backler	Interim Chief Finance Officer	MB
Deborah El-Sayed	Chief Transformation and Digital Information Officer, BNSSG ICB	DES
John Cappock	Non-Executive Director, BNSSG ICB	JC
Jo Medhurst	Chief Medical Officer, BNSSG ICB	JM
Richard Gaunt	Non-Executive Director, NBT	RG
Christina Gray	Director for Communities and Public Health, Bristol City Council	CG
Brian Stables	Non-Executive Director, AWP	BS
In attendance		
David Jarrett	Chief Delivery Officer, BNSSG ICB	DJ
Jamie Denton	Head of Finance – Primary, Community & Children's Services, BNSSG ICB	JD
Vicky Daniell	Senior Contract Manager - Primary Care, BNSSG ICB	VD
Susie McMullen	Head of Contracts: Childrens, Community and Primary Care, BNSSG ICB	SM
Tim James	Head of Strategic Estates, BNSSG ICB	TJ
Seb Habibi	Deputy Chief Transformation and Digital Officer	SH
Linda Frankland	Deputy Director of Finance, Sirona Care & Health	LF
Laks Khangura	Director of Finance, Sirona Care & Health	LK
Nicole Saunders	Head of System Strategy & Planning, BNSSG ICB	NS
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 formal apologies were received from Amy Webb – NSC and Brian Stables – AWP.	
2	**Declarations of Interest** No interests were declared beyond those recorded in the Declaration of Interest register.	
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.	
8	**Finance Report**	
8.1	**M6 ICB Revenue Finance Report inc. System finance report** The Chair invited MB to present the financial position of the ICB. MB reported that the ICB's financial outlook was positive, with notable improvements in areas that had previously presented challenges, such as high-cost drugs and continuing healthcare. Prescribing trends were also favourable. However, pressures remained in ADHD, autism, Right to Choose, and Section 117 services. These areas, while stabilised, continued to exert financial strain and were unlikely to recover their positions within the current year. Nonetheless, the ICB was forecast to deliver a significant surplus in isolation.	

	JM acknowledged the contribution of Debbie Campbell in managing the high-cost drugs portfolio, particularly in collaboration with the system chief pharmacist. The committee agreed that this recognition should be formally recorded in the minutes. Attention then turned to the broader system position. MB noted emerging financial gaps at University Hospitals Bristol and Weston (UHBW) and North Bristol Trust (NBT), with a combined shortfall of approximately £25 million prior to any ICB support. An anticipated £7.5 million benefit from the ICB had been factored into the system forecast, resulting in a residual gap of £13.9 million. Despite the absence of fully identified mitigations, the Performance and Recovery Board (PRB) had endorsed maintaining a break-even forecast, citing the scale of the system, timing within the financial year, and historical precedent. SW queried the overall system expenditure, which was confirmed to be approximately £2.3 billion. MB noted that while NHS England had reiterated the absence of additional funding, historical patterns suggested the potential emergence of year-end reserves. He cautioned, however, that other systems within the South West and nationally were in more precarious positions, which could affect the availability of regional risk reserves. The committee discussed the implications of maintaining system balance, particularly the need to restrict reinvestment of underspends at service level. MB confirmed that while individual cases would be assessed against quality and performance risks, the overarching priority was to address the system-wide gap.	
8.2	**Current System Forecast & Next Steps** The committee continued with a discussion on the system forecast and strategic planning. SW sought assurance that executive-level efforts were ongoing to drive necessary savings across the system. MB confirmed that actions were being managed through the PRB and that a further review was scheduled for November to assess the need for forecast adjustments. JM raised concerns about the recurring challenge of acute overspend and its impact on the ability to invest in prevention and community-based care. She advocated for a shift in financial strategy to enable reinvestment in general practice and enhanced local delivery schemes. SW concurred, acknowledging the systemic difficulty in redirecting resources to align with the ICB's core purpose. BS echoed these concerns, highlighting the need for clear communication to counter the perception that year-end bailouts were inevitable. He stressed the importance of focusing on recurrent savings and expressed apprehension about the compounded impact on the following financial year. MB responded by affirming that organisations were actively pursuing recovery plans and that peer reviews would be conducted to ensure robustness. He expressed concern about the underlying financial position, particularly the early indications of a £70 million shortfall across the two acute trusts. Efforts were underway to challenge these figures and refine the base case for the medium-term financial plan (MTFP), which would be presented to the committee in the following month. The committee explored mechanisms to incentivise behavioural change within the system, including risk and gain share arrangements. JM shared her experience with fund-holding models, which had successfully influenced clinical	

	decision-making and resource utilisation. She advocated for the early adoption of similar financial mechanisms within the neighbourhood care programme. SW proposed convening a joint seminar to further develop these ideas and ensure alignment with the clinical strategy refresh scheduled for 6 November. JM noted the opportunity to integrate financial planning with clinical strategy development, emphasising the importance of a unified approach. In closing, MB sought endorsement from the committee to proceed with a recommendation to the Transition Committee regarding the affordability of transitional costs. Based on PRB assessments and the current balance of risk, he deemed the proposal appropriate. SW supported the recommendation, noting the importance of continued risk mitigation.	
9	**Items to Note**	
9.2	**System DoFs Group** Update was received through item 8.	
	Key Messages/Chair Conclusion:	