Meeting of BNSSG ICB Board

Date: Thursday 4th September 2025
Time: 12:45 – 16:15
Location: Bristol Citadel Community Church and Family Centre, 6 Ashley Road, St Paul's, Bristol BS6 5NL

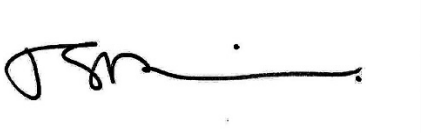
Agenda Number:	6.5	
Title:	Annual Report and Account 2024 - 25	
Confidential Papers	**Commercially Sensitive**	No
	Legally Sensitive	No
	Contains Patient Identifiable data	No
	Financially Sensitive	No
	Time Sensitive – not for public release at this time	No
	Other (Please state)	No
Purpose: Decision		
Key Points for Discussion:		
The production and publication of the Annual Report and Accounts (ARA) is a requirement of each ICB. The timetable for production is set by NHS England. In advance of the required submission by 23 June 2025, the ICB Board received a draft version of the Annual Report at its meeting in May and delegated responsibility to the Audit and Risk Committee (ARC) to approve the submission of the ARA with the necessary contributions included from the External and Internal Auditors. Following approval by the ARC, the submission was made on 19 June. ICBs are required to receive the Annual Report and Accounts at a meeting in public by the end of September. Following this Board meeting, the ARA will be published on the ICB website. There have been many contributors to the production of the document from individuals across the ICB, and external stakeholders including Directors of Public Health.		
Recommendations:	The Board is asked to receive the Annual Report and Accounts which have been approved by the Audit and Risk Committee.	
Previously Considered By and feedback:	The ICB Board delegated responsibility to ARC to approve the Annual Report and Accounts at its meeting in May 2025. ARC received updated versions of the documents at its meeting in June and submission to NHSE was made by the deadline of 23 June 2025.	

Management of Declared Interest:	All staff are required to declare interests, which are reported on the conflicts of interest register. Declarations of interest are considered at the start of each meeting. There are no conflicts of interest relating to this paper.
Risk and Assurance:	There are no risks related to the Annual Report and Accounts. However, failure to publish Annual Accounts would be a breach of the ICB's statutory duties. This risk is mitigated by this paper. The document does highlight risks and arrangements for risk management in the ICB.
Patient and Public Involvement:	The Annual Report and Accounts includes information regarding Consultation and Communication including Public Involvement during the period. The Annual Report meets the requirements to reference the ICB's response to its legal duties regarding public engagement. The Annual Report and Accounts will be published on the ICB website.
Financial / Resource Implications:	The publication of the Annual Report will be managed in-house with any costs associated being funded from existing budgets.
Legal, Procurement, Policy and Regulatory Requirements:	The publication of an Annual Report and Accounts is a legal requirement. Failure to publish would have an impact on the ICB.
How does this impact on health inequalities, equality and diversity and population health?	The Annual Report and Accounts includes information regarding health inequalities and the ICB's actions to reduce these during the reporting period. The document does not have health inequalities implications. The Annual Report meets the requirements to reference the ICB's response to its legal duties regarding health inequalities.
ICS Green Plan and the Carbon Net Zero target?	The Annual Report covers matters relating to sustainability and includes the mandated declarations.
Communications and Engagement:	The ICB Annual Report and Accounts will be published on the ICB website.
Author(s):	Rob Hayday, Chief of Staff
Sponsoring Director:	Shane Devlin, CEO

ICB Annual Report Template 1 April 2024 – 31 March 2025

Contents

PERFORMANCE REPORT



Shane Devlin

Accountable Officer

19 June 2025

Performance Overview

This performance overview provides a summary explaining what NHS Bristol, North Somerset and South Gloucestershire ICB does, the key risks faced in 24/25 and how the ICB performed against a range of measures. We describe performance in detail in the Performance Analysis section (p13).

Chair and Chief Executive's statement

We are pleased to present the 2024/25 Annual Report for the NHS Bristol, North Somerset and South Gloucestershire Integrated Care Board (BNSSG ICB). This report reflects the incredible dedication and collaboration across our health and care system during what has been another challenging and transformative year.

Over the past 12 months, we have worked tirelessly to improve outcomes for our 1.1 million-strong population. Together with our partners across the Healthier Together Integrated Care System, we have continued to focus on tackling health inequalities, improving access to services, enhancing the quality of care, and strengthening the sustainability of our health and care system.

The year has seen significant operational pressures, including increased demand across urgent, planned and mental health services, persistent workforce challenges, and the ongoing impact of the pandemic on service delivery and recovery. Despite this, we have achieved many notable successes. We delivered on key national targets such as eliminating 65-week waits for planned care by March 2025, sustained high diagnostic performance, and improved cancer diagnosis and treatment times. We have made tangible progress in enhancing community-based care, increasing virtual ward capacity, and reducing delayed discharges, helping more people to receive care closer to home.

Crucially, we have continued to put health inequalities at the heart of our decision-making. Our Strategic Health Inequalities, Prevention and Population Health Committee (SHIPPH) has driven forward work to ensure all system plans actively address the needs of our most underserved communities. This commitment is embedded in both our Joint Forward Plan and our day-to-day operational delivery.

Organisationally, this year marked the successful implementation of a major structural change to achieve required reductions in our running costs. We worked closely with our staff and partners to establish a new operating model that supports sustainable, high-quality delivery despite reduced resources.

Our performance has been underpinned by strong system leadership and collaboration. The positive feedback from NHS England's Annual Assessment is testament to the strength of our partnerships, our financial stewardship, and our joint commitment to improving population health and reducing health inequalities.

There is still much to do. As we move into 2025/26, we will continue to build on this year's progress. We remain focused on delivering our priorities: improving access and quality,

supporting our workforce, strengthening community services, embedding prevention, and delivering financial sustainability. We will also continue to evolve our integrated approach to ensure that people experience health and care services that work seamlessly around their individual needs.

We want to express our sincere thanks to our staff, system partners and the communities of Bristol, North Somerset and South Gloucestershire. Your hard work, resilience and collective spirit are what make our health and care system stronger and more compassionate.

Together, we will continue to strive for equitable, high-quality care for all.

Shane Devlin, CEO

Dr. Jeff Farrar QPM,OStJ, Chair

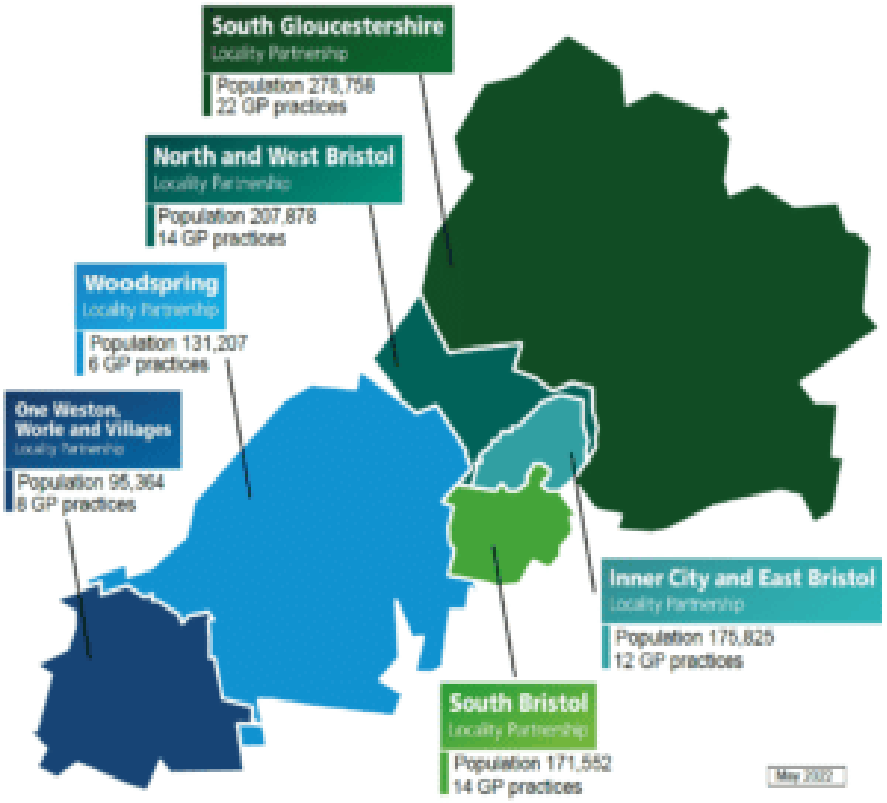
Performance Overview

About Bristol, North Somerset and South Gloucestershire Integrated Care Board

Bristol, North Somerset and South Gloucestershire Integrated Care Board (ICB) is a statutory NHS organisation that was established on 1 July 2022. We are responsible for developing the plans to meet the health needs of our population, managing the NHS budget and arranging for the provision of health services in our area. We are part of the local Integrated Care System, Healthier Together Partnership. Integrated Care Systems (ICS) bring together a range of partner organisations to help people stay happy, healthy and well for longer. Designed to ensure that health and care services join up around individual needs, Integrated Care Systems break down the boundaries between physical health, mental health and social care. Our ICS is made up of 10 partner organisations including the three Local Authorities in our area, the ICB, NHS Trusts, community providers, general practice and other partners. Locality Partnerships have been established within our ICS, working at a 'place' level and responding to the specific needs of local people. ICBs' to are expected to:

- Improve outcomes in population health and healthcare
- Tackle inequalities in outcome, experience and access
- Enhance productivity and value for money
- Help the NHS support broader social and economic development

Figure 1: Bristol, North Somerset and South Gloucestershire Integrated Care System



Population of 1.1 million served by:

- 1 Integrated Care Board planning NHS services
- 6 integrated locality partnerships
- 3 local authorities and Health and Wellbeing Boards
- 56 children's centres
- 278 care homes
- 1 GP Federation with 73 general practices and 20 primary care networks
- 1 Primary Care Out of Hours and 111 service
- 157 pharmacies
- 116 dentists
- 73 opticians
- 1 community care provider
- 1 Healthwatch
- 1 mental health trust
- 1 ambulance service trust
- 1 Academic Health Science Centre

Bristol, North Somerset and South Gloucestershire is home to about 1.1 million people and our diverse population has varied health needs. The numbers of people aged between 15 and 24 years old and people over the age of 60 years are growing, and the population predicted to increase most significantly over the next 25 years is those aged 85 and over. We are an ethnically diverse population, with Bristol having the greatest proportion of Black and Minority Ethnic (BME) people (16%) compared to South Gloucestershire (5%) and North Somerset (2.7%). There are significant pockets of deprivation across Bristol, North Somerset and South Gloucestershire, with around one in ten people living in a deprived area. Average life expectancy varies between those living in the most and least deprived areas by around six years, with some places seeing a 15-year difference.

Our priorities and plans for 25/26 are set out in our One Year Operational Plan. Our plan reflects spending commitments required by NHS England and also includes our local commitment to continue investing in our key transformation programmes, continued investment in Urgent Care and delivery of national targets.

We have continued to commit resources to reduce health inequalities. We have established our The Strategic Health Inequalities, Prevention and Population Health Committee (SHIPPH). This committee provides oversight, assurance and support for the Integrated Care System's efforts towards tackling health inequalities and embedding preventative approaches.

Our planning processes have ensured that plans include how they will reduce health inequalities and promote inclusivity. Plans also need to identify whether unintended health inequalities might emerge from them and, if this is the case how these will be tackled.

Our Joint Forward Plan (JFP) has been published. It sets the out the priorities for health and care until 2030 and how, as an Integrated Care System (ICS), we will deliver the national vison of high-quality healthcare for all, with equitable access, excellent experience and optimal outcomes. Our plan describes the steps we will take to:

- Deliver improvements in population health and wellbeing ambitions
- Describe the quality of services that reflect system intelligence, aiming at reducing inequalities
- Describe how the system will improve efficiency and sustainability of services

The plan builds on the work of our local Health and Wellbeing Boards, our Locality Partnerships and our 25/26 Operational Plan. Our Joint Forward Plan is refreshed annually to provide a five-year rolling plan. As our partnerships develop and the wider system matures our plans will increase in

depth and breadth. In 24/25 this has resulted in the development of our Healthier Together 2040 programme which has been established to support sustainable delivery of healthcare for targeted groups in our population.

You can view our JFP along with a summary of it here.

We set out the key enablers to support our ambitions and the work needed to take these forwards:

- Workforce
- Digital
- Population Health Management
- Research and Innovation
- Estates
- Finance and Procurement
- Health and Care Professional Leadership
- Medicines Optimisation

Throughout both our Operational Plan and our Joint Forward Plan we have embedded the triple aim (Section 14z43 NHS Act 2006 as amended by The Health and Care Act 2022), to ensure that we consider the effects of our decisions on:

- The health and wellbeing of local people
- The quality of services provided and arranged
- The sustainable and efficient use of resources

Our priorities and plans for 25/26 are set out in our One Year Operational Plan. Our plan reflects spending commitments required by NHS England and also includes our local commitment to continue investing in our key transformation programmes and delivery of national targets and developments.

ICB Organisational Change

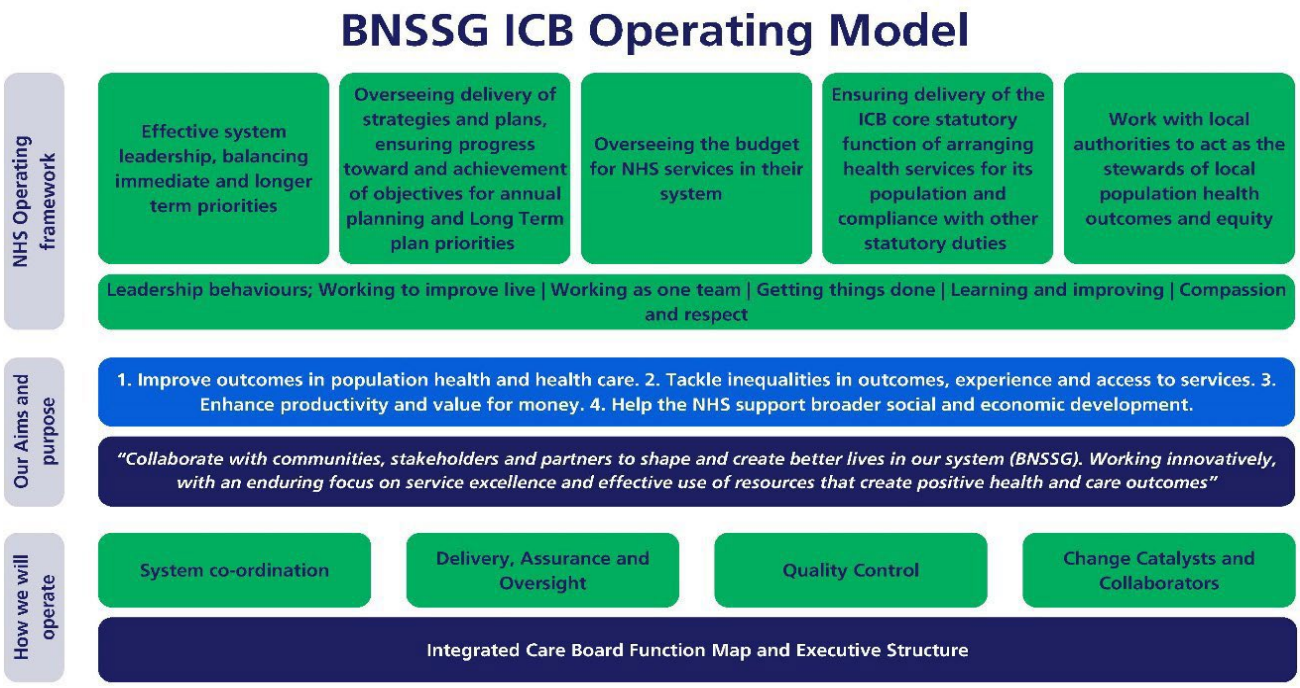
In April 2024, we completed our organisational changes to support the requirement to cut our running costs by the end of March 2025. We have achieved our running cost reductions and, through a process of consultation and working closely with our workforce, the Staff Partnership Forum and Staff Networks, we have implemented our new operating model for the ICB, new functions map and new directorate structure. The following Chief Officers lead the directorates:

- Business, Strategy and Planning – Sarah Truelove, Chief Finance Officer
- Chief Medical Office – Dr Joanna Medhurst, Chief Medical Officer

- Chief Nursing Office – Rosi Sheppard, Chief Nursing Officer
- Office of the Chair and Chief Executive – Shane Devlin, Chief Executive
- Performance and Delivery – David Jarrett, Chief Delivery Officer
- People – Jo Hicks, Chief People Officer
- Intelligence, Transformation and Digital – Deborah El-Sayed, Chief Transformation and Digital information Officer

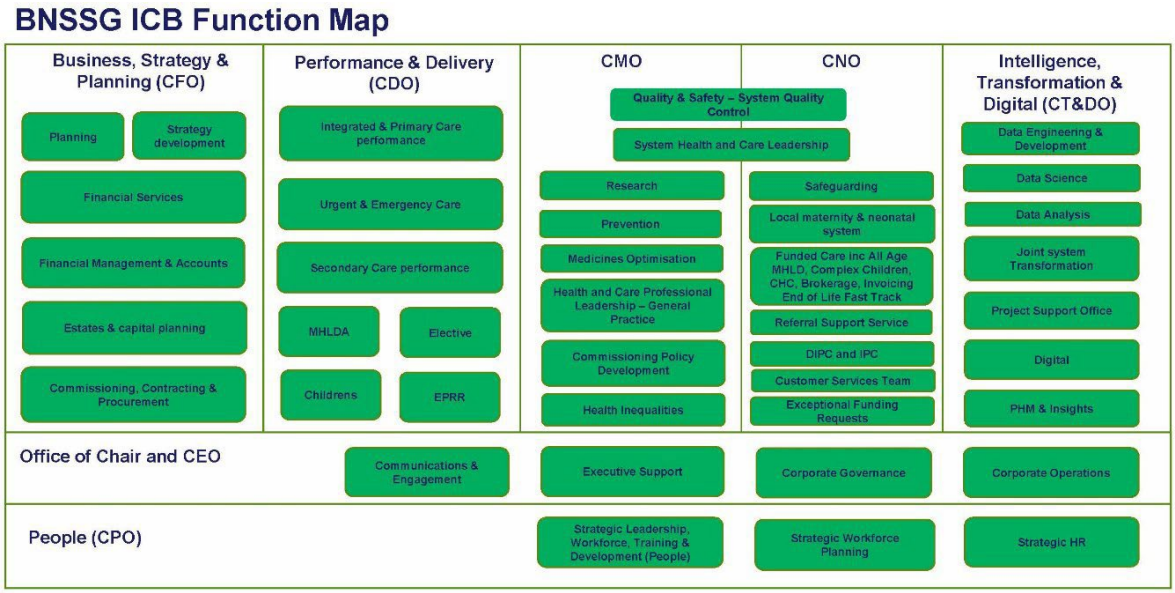
Details of our workforce can be found in the remuneration and staff report on page 158, and staff operate in service of our population in line with our operating model below:

Figure 2 – BNSSG ICB Operating Model



The functions of the ICB are shown below and the diagram describes which areas of work fall in each directorate. We continue to establish our team of teams approach to collaborative working to ensure we deliver ICB responsibilities with our reduced workforce.

Figure 3 – BNSSG ICB Function Map



In March 2025, the Government announced further changes to the NHS will take place in 2025. This includes the requirement for BNSSG ICB to reduce its costs. This will require further organisational change in 2025/2026.

Summary of key risks to delivering objectives

Our healthcare system continued to face significant challenges during 2024/25. Key risks reported through performance reports to the Board and highlighted on the ICB corporate risk and ICS strategic risk registers included:

- Addressing flow through our health and care settings to ensure that patients receive the care in the right settings.
- Improving performance across planned and urgent care, including ambulance and mental health services, to meet the demands placed on them.
- Mitigating the affects of the pandemic on service delivery, workforce and the delivery of long term plans while addressing recovery targets.
- Managing workforce pressures, right sizing our organisations with high quality staff, and reskilling and upskilling our existing workforce across health and social care.
- Access to Dental services remains a risk under our commissioning responsibilities delegated from NHS England.
- Risks relating to health inequalities and the risk of increasing health inequalities for specific groups were highlighted.

- Risks relating to Healthcare Associated Infections.
- The delivery of improved population health and financial sustainability.
- The continuing impact of ICB organisational restructuring impacting the capacity to make service changes for the population.
- Maintaining strong and collaborative relationships to deliver agreed priorities.
- The continued need to focus on cyber security measures.
- Risks associated with procurement and the new legislation.
- Risks associated with GP collective action

Mitigating actions were put in place to manage and reduce the likelihood of these risks materialising. More detail regarding performance and actions taken is provided in the Performance Analysis section of this report (p13).

Adoption of the going concern basis

Considering the going concern guidelines, the financial reporting and governance arrangements of the ICB, and the approach to developing operating plans for 2025/26, BNSSG ICB maintains that it remains a going concern. The annual accounts of the ICB are prepared on the assumption that the organisation is a going concern and that there is no reason it should not continue operating on the same basis for the foreseeable future. Further details can be found on page 115.

Summary of performance

Overview of how ICB performance is measured

The Regulatory and oversight framework is being revised in light of the 2022 Act. The performance of BNSSG continues to be assessed via the NHS Oversight Framework. This mechanism is used by NHS England, along with appropriate levels of support, to ensure that ICBs deliver services for their population.

The NHS Oversight Framework consists of five national themes with associated high-level metrics that reflect the ambitions of the NHS Long Term Plan and apply across Trusts and ICBs:

- Quality of care
- Access and outcomes
- Preventing ill-health and reducing inequalities
- People; finance and use of resources
- Leadership and capability
- Local strategic priorities.

Each ICB will be placed into a segment based on assessment against the NHS Oversight Framework. Bristol, North Somerset and South Gloucestershire ICB is currently in segment 3. The following table displays the segmentation descriptions at ICB and Trust level and the support needs associated with each segment

	Segment description		Scale and nature of support needs
	ICB	Trust	
1	Consistently high performing across the six oversight themes Capability and capacity required to deliver on the statutory and wider responsibilities of an ICB are well developed	Consistently high performing across the five national oversight themes and playing an active leadership role in supporting and driving key local place based and overall ICB priorities	No specific support needs identified. Trusts encouraged to offer peer support Systems are empowered to direct improvement resources to support places and organisations, or invited to partner in the co-design of support packages for more challenged organisations
2	On a development journey, but demonstrate many of the characteristics of an effective ICB Plans that have the support of system partners are in place to address areas of challenge	Plans that have the support of system partners in place to address areas of challenge Targeted support may be required to address specific identified issues	Flexible support delivered through peer support, clinical networks, the NHS England universal support offer (e.g. GIRFT, Right Care, pathway redesign, NHS Retention Programme) or a bespoke support package via one of the regional improvement hubs
3	Significant support needs against one or more of the six oversight themes Significant gaps in the capability and capacity required to deliver on the statutory and wider responsibilities of an ICB	Significant support needs against one or more of the five national oversight themes and in actual or suspected breach of the NHS provider licence (or equivalent for NHS trusts)	Bespoke mandated support, potentially through a regional improvement hub, drawing on system and national expertise as required (see Annex A)
4	Very serious, complex issues manifesting as critical quality and/or finance concerns that require intensive support	In actual or suspected breach of the NHS provider licence (or equivalent for NHS trusts) with very serious, complex issues manifesting as critical quality and/or finance concerns that require intensive support	Mandated intensive support delivered through the Recovery Support Programme (see Annex A)

In July 2024, NHSE provided BNSSG ICB with its Annual Assessment Letter for performance in 2023/24. Details can be found here:

https://nhs-icb.bisongrid.dev/wp-content/uploads/2024/09/6.1-Update-from-Bristol-North-Somerset-and-South-Gloucestershire-ICB-Annual-Assessment-Letter-2023-24-.pdf

The positive assessment reflected the ICB's performance in the following areas:

- System Leadership and Management
- Improving Population Health and Healthcare
- Tackling Unequal Outcomes, Access and Experience
- Enhancing Productivity and Value For Money
- Helping the NHS Support Broader Social and Economic Development

The assessment take into account the views of stakeholders. It concluded that the ICB had been working in compliance with its statutory duties. The ICB has built on its work in 23/24 to continue performing in 24/25 as is set out throughout this annual report.

Performance analysis

The following pages provide a more detailed summary of performance, key activities and programmes of work including:

- Work to improve the quality of services
- How we have worked to improve Safeguarding
- How we have engaged with people and communities
- Work to reduce health inequalities and promote equality across the local community and workforce
- Work with local Health and Wellbeing Boards
- Sustainable development
- A summary of our financial position. This is given in detail in the Annual Accounts section of the Annual Report (page 192)
- The actions to tackle fraud and bribery are described in the Governance Statement (page 153)

Through performance management we ensure services delivered and achieved good outcomes for our population and provide value for money. Performance is monitored and reported through:

- Finance: detailed financial plans are created to plan for patient care activity and outcomes, and to monitor the in-year performance of our providers
- Performance against NHS Constitutional Standards
- Performance in quality and outcomes: to ensure services are safe, patients have a positive experience of healthcare, and improvements in clinical outcomes are delivered

Performance of NHS Services 2024/25

The ICB is assessed on its performance against constitutional targets or national/regional targets which phase performance back towards constitutional targets e.g. 18 week standard which needs to be delivered for 92% of pathways by March 2029. These targets form the basis of the operational plan for 24/25 agreed with NHS England. Key constitutional targets relate to urgent care, planned care including elective, diagnostics and cancer care, mental health, learning disabilities and autism and community services.

Planned, Elective Care and Cancer Care

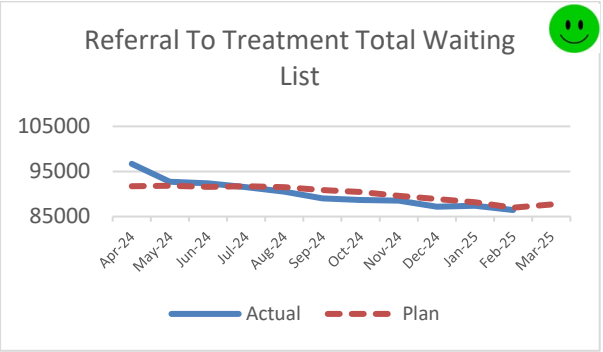
A summary of key elective performance targets and actual performance up to February 2025 is shown below. Further detail on performance delivery is shown later in this section.

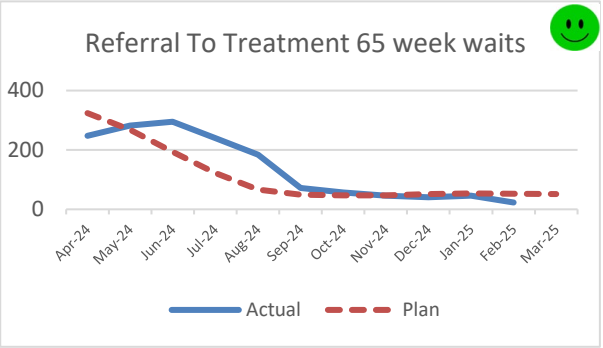
Key to symbols on the graphs which are explained in full below are:

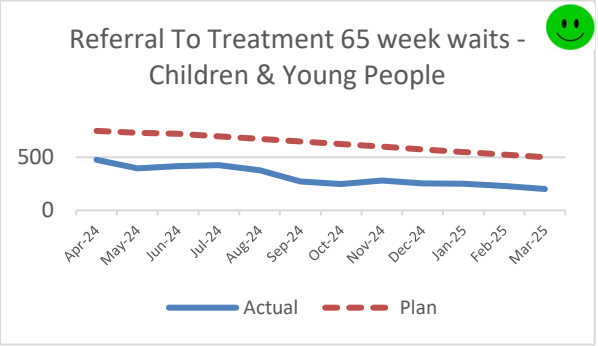
Achieving the operational plan

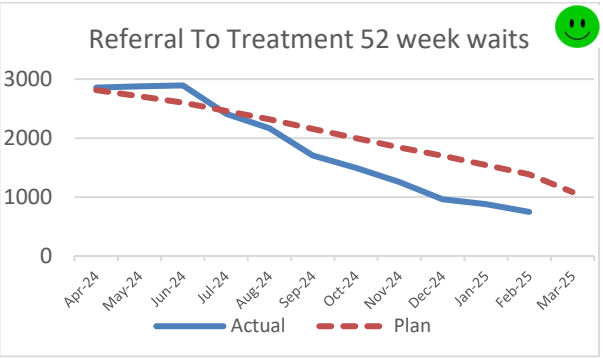
Slightly worse than operational plan

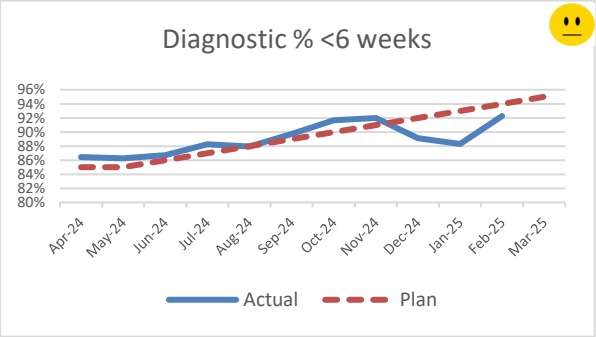
Did not achieve operational plan

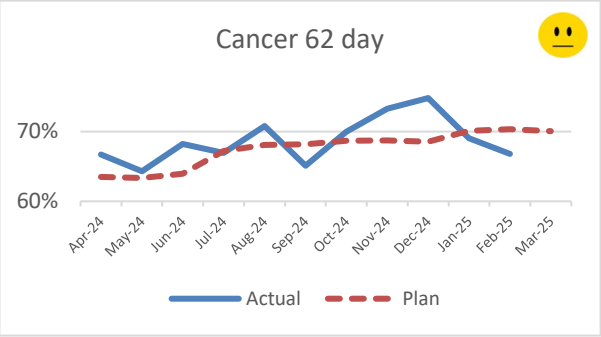


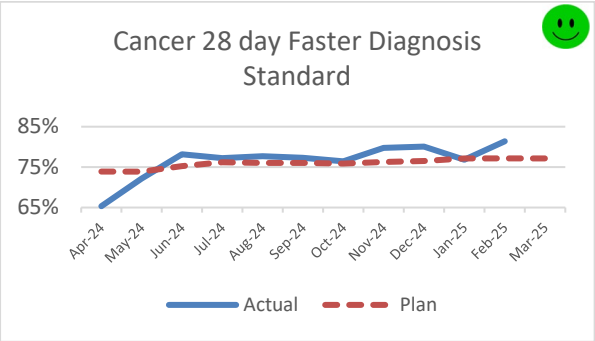












Elective care, including outpatients, cancer and diagnostics services in BNSSG were significantly impacted by the pandemic, causing backlogs of long waiting patients across many service areas. The elective programme over recent years has focussed on recovery, improving productivity and efficiency and progressing major strategic initiatives, that will support the sustainability of recovery.

Throughout 24/25 the focus remained on reducing the length of time people were waiting for appointments, tests and treatment; to reduce the volume of patients in the longer waiting cohorts; and address demand and capacity gaps across our elective, cancer, outpatient and diagnostic services. We delivered on our ambitions by holding ourselves to account for delivery of the commitments we made in our Operational Plan.

24/25 saw a number of significant milestone achievements, both from a strategic and operational perspective, including, the appointment of Joint Chief Executive for UHBW and NBT Hospital Group; the publication of the Joint Clinical Strategy and establishment of active delivery groups taking forward the first phase of transformation in Single Managed Services; the establishment of new estate and capacity in the form of two new Community Diagnostics Centres, offering diagnostic capacity closer to home; the construction of the Bristol Surgical Centre that will deliver 6,500 more operations a year for the population of BNSSG, opening in 2025; implementation and expansion of digital tools enabling effective and efficient ways of communicating with patients.

We delivered on our commitment to reducing long waiting times by increasing capacity and delivery opportunities through waiting list initiatives; utilising capacity available through our local independent sector (IS) providers, which included welcoming new IS providers into the BNSSG market; developing new ways of working, such as Community Appointment Days for physiotherapy; and working collaboratively across system partners to improve and develop pathways, such as a successful Teledermatology pilot that has brought together the skills across general practice and secondary care to ensure patients have images to accompany their referral provided closer to home, enabling triage to take place quickly and effectively.

We have delivered on our commitment to continually improve our services and look

for opportunities to improve effectiveness and efficiency, by maintaining our focus on ‘getting it right first time’ (GIRFT), including key metrics of theatre utilisation, day case rates, scheduling and booking efficiencies; increasing throughput on lists; approaching bed utilisation flexibly. As well as engaging in the national Further Faster programme, looking at clinic template and aligning across our system Trusts.

We have delivered on our commitment to developing services and improving system-wide clinical pathways and models of care, through for example the development of a Surgical Centre, built throughout 24/25 and due to open in 2025.

We have delivered on our commitment to ensuring patients receive the right care, in the right place by optimising demand management, developing shared system understanding of specialist advice and working collaboratively across system partners to define and agree the System Access Policy for Elective Care pathways, central to which is the commitment to patient choice.

We have maintained and driven forward our commitment to tackling health inequalities through a number of projects and initiatives across elective and cancer services. Work on missed appointments that started in 23/24 have developed throughout 24/25 and have been further enhanced through the progress in the digital and technological developments for patient communication and engagement with the expansion of the Trusts DrDoctor platform, a patient engagement portal.

Performance against our 24/25 Operational Plan

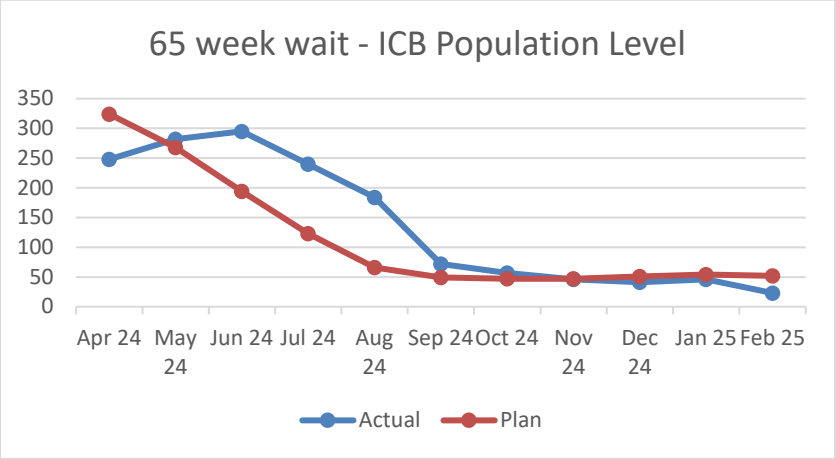
Our priorities to achieve by the end of 2024/2025 were:

- To treat all patients waiting 65 weeks or more on a RTT pathway
- To reduce the number of patients waiting 52 weeks or more on a RTT pathway
- To reduce the overall waiting list size for RTT pathways
- To increase to 95% the number of patients that receive their routine diagnostic test within 6 weeks of their referral
- To increase to 77% the number of patients that receive confirmation of a cancer diagnosis (or that cancer has been ruled out) within 28 days of their GP referring them on an Urgent Suspected Cancer pathway. This is called the Faster Diagnosis Standard (FDS).
- To increase to 70% the number of patients with a diagnosis of cancer, start treatment within 62 days of their GP referring them on an Urgent Suspected Cancer pathway.

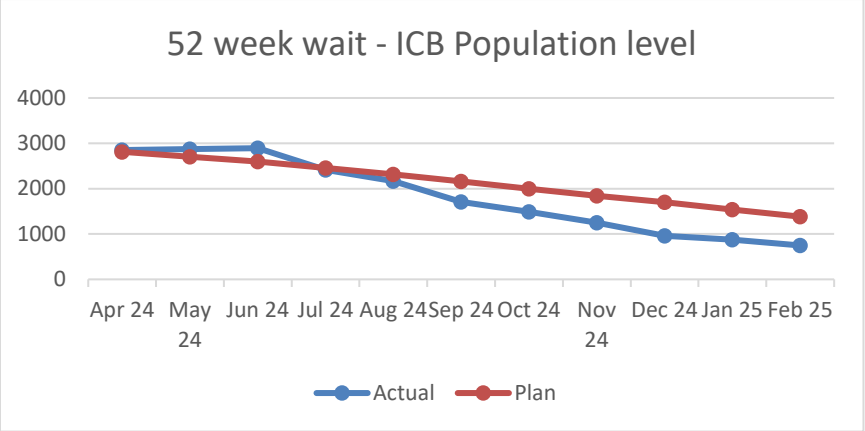
At the time of writing the latest validated data available was the end of February 2025 for some metrics and the end of March 2025 for others. Performance data

shows that:

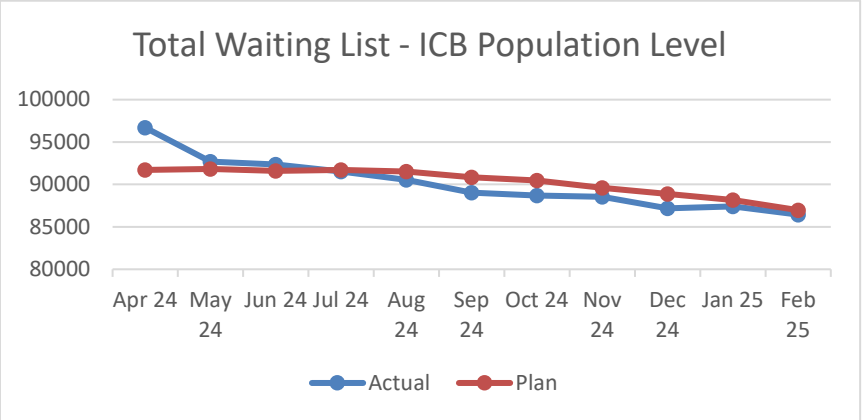
- The system has tracked on a weekly basis all patient pathways that were at risk of being over 65 weeks. BNSSG successfully treated all patients that had been waiting 65 weeks or more by the end of March 2025. The data below shows the performance trajectory to Feb 2025 and that achievement better than plan has been sustained since November 2024.



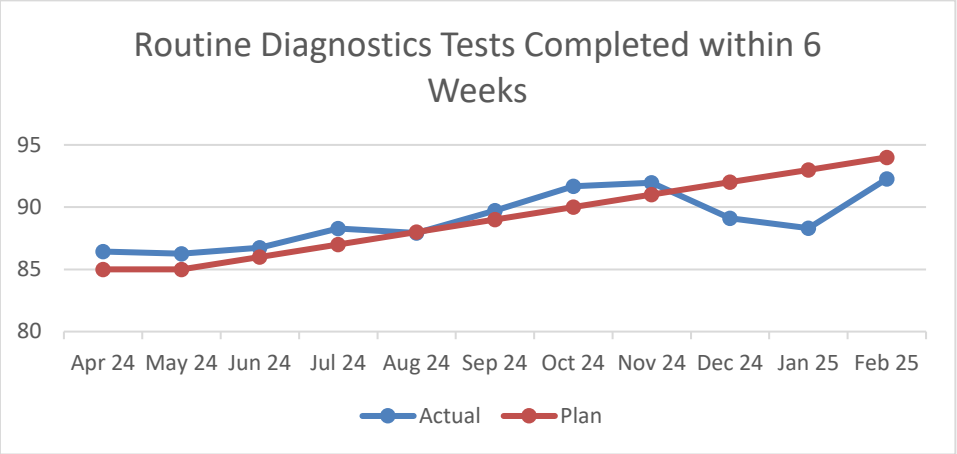
- The system successfully reduced the number of patients waiting greater than 52 weeks throughout 2024/5 and performed better than plan from July 2024 onwards



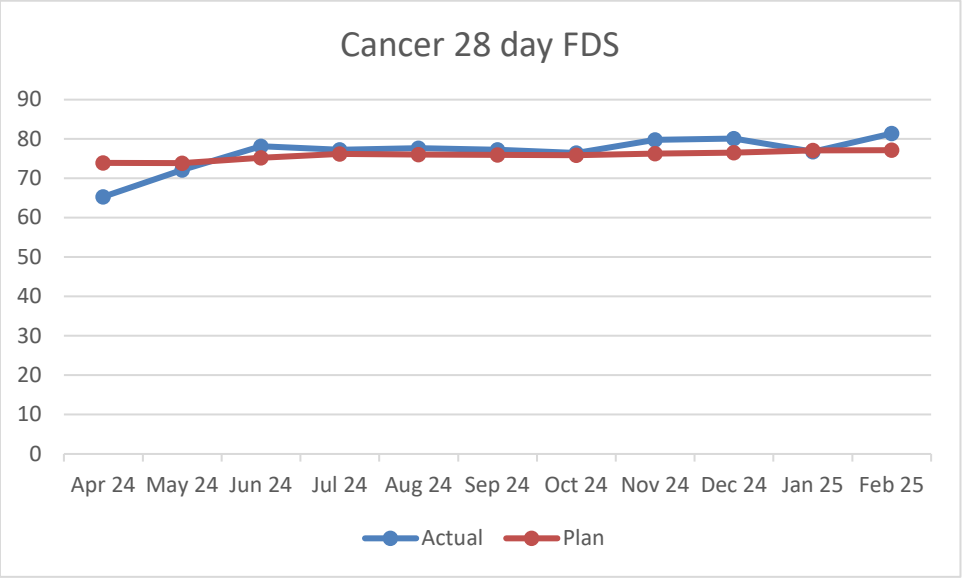
- The system successfully reduced the overall waiting list for Referral To Treatment pathways throughout 2024/5 and has maintained performance better than planned since July 2024.



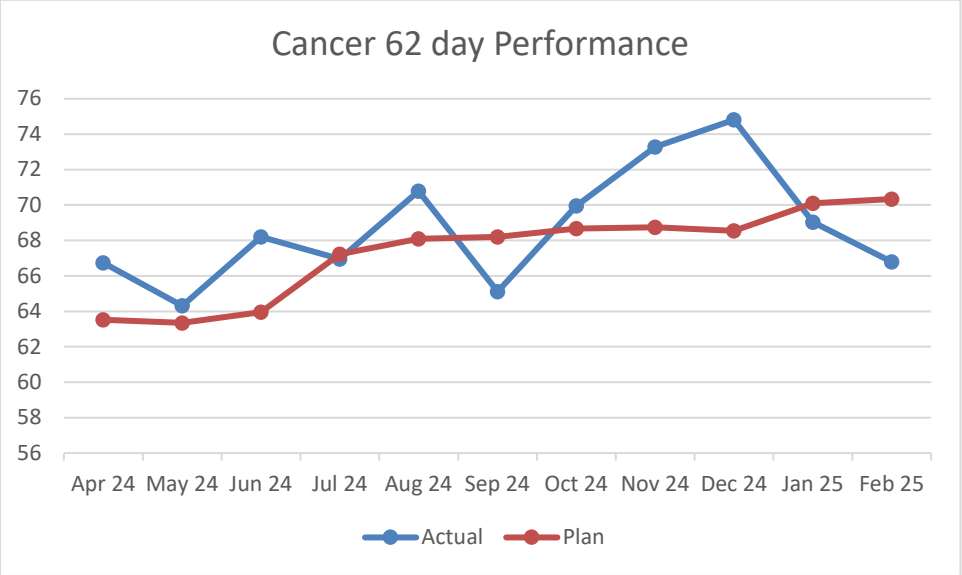
- As a system, we have maintained our high diagnostic performance and sustained a high benchmarked position across both the southwest and nationally throughout 24/25. At the time of writing, the most recent validated data (February 2025) shows over 92% of patients were waiting less than 6 weeks for their routine diagnostic test.



- As a system we have achieved the national ambitions for cancer performance against the Faster Diagnosis Standard the latest data available - February 2025 - shows that the system was exceeding the year-end 77% target, with an achievement of over 81%.



- The latest validated data for the 62-day Standard (February 2025) shows that the system is slightly behind the year-end 70% target, with an achievement of 67%. Forecast position for year-end however exceeds the 70% target.



Next Steps

In 25/26 we renew our commitments to delivery of our plans and meeting the NHS ambitions and Standards.

The overarching aim of elective programme performance from 25/26 is to shift focus from recovery and the stepping stones that have paved our recent years operational ambitions towards a return to the national constitutional standards for Referral to Treatment pathways, Diagnostics and Cancer, whilst maintaining our commitments

to our population around providing choice and driving down health inequalities where they exist.

We will develop a long-term system wide elective work-plan to coordinate and deliver on existing strategies, local and national including the Governments Reforming Elective Care paper. Our drivers will be to strive for equitable, accessible, timely elective care of the highest standard and provide choice; that demand and capacity is balanced sustainably; that our valued workforce develops and thrives and that our system performance achieves expectations and is resilient and sustained.

Elective commitments and priorities from 2025

The BNSSG Elective programme in 2025 and beyond commits to:

- Strategic Commissioning
- Developing the System Elective Care work-plan
- Supporting (and being supported by) the progression of the Group Hospital model
- Delivery of the Joint Clinical Strategy commitments
- Optimising the value of Single Managed Services (from the Group Hospital model) as a vehicle through which to address inequalities in access and outcomes
- Maintaining the reduction of Health Inequalities as a golden thread through all we do
- Developing pathways with partners to move activity into the community and closer to home
- Driving the digital agenda to improve patient experience and the quality of care delivered, with a focus on promoting the NHS app and opportunities for patient empowerment through digital tools.
- Addressing differential access to care and reducing variation
- Driving locality and community partnerships, improving anchor status and focussing on population health improvements
- Delivering estates and people strategies to support sustainability of services
- Informing System level capital priorities relating to elective care.

The priorities for BNSSG Elective programme in 2025 and beyond include:

- Delivery of surgical priorities including optimising the Bristol Surgical Centre and refurbishment of major operating theatres across the system.
- Maximising capacity and productivity of outpatient facilities, including reviewing and addressing unwarranted variation in specialty clinic templates in line with the NHSE GIRFT Further Faster programme intentions.
- Delivering improvements in perioperative care and assessments, with a particular focus on prehabilitation and patient optimisation to drive better patient experience, outcomes and productivity.
- Driving technological innovation and new ways of working, including maximising Robotic surgery across both Acutes.
- Delivering the benefits of the Single Managed Services through reinforcing resilience in the workforce, implementing shared rotas, and establishing shared patient tracking lists
- Firming up the sustainability of our pathways, which is in part dependent on the release of acute capacity. This will be achieved through collaborative, patient centred working, with our system partners to move services into the community and closer to home.
- Establishing robust plans and oversight over the delegation of Specialised Commissioning
- Establishing system principles and processes for managing the future innovative drugs and National Institute for Health and Care Excellence (NICE) Technology Appraisals (TA)
- Tracking growth in demand above population projection and seek solutions to growth in areas currently unmitigated

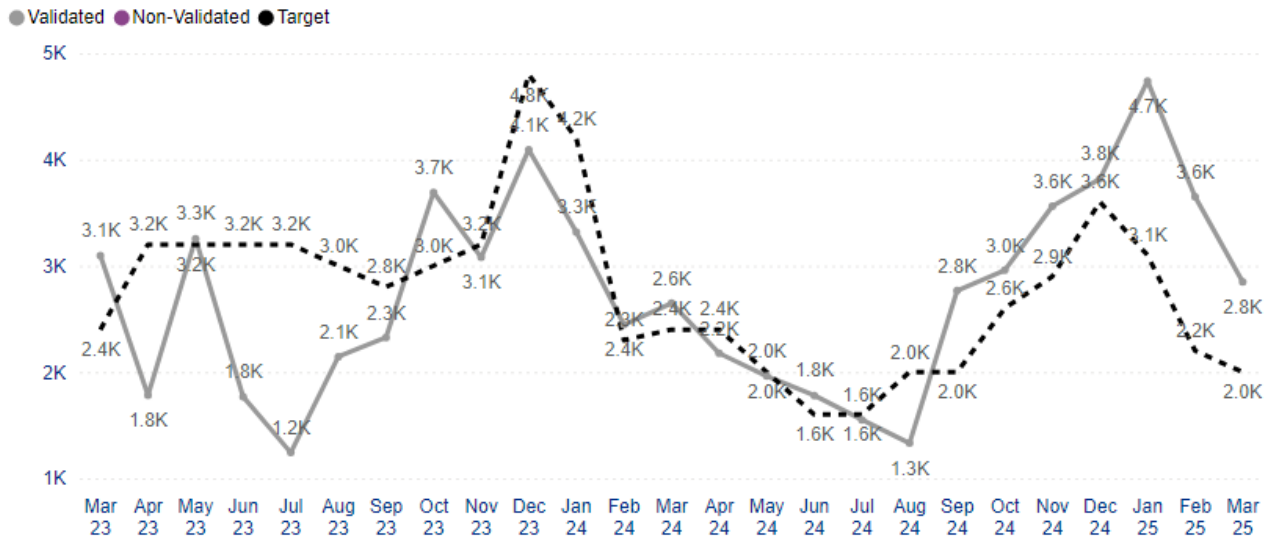
Urgent and Emergency Care

In 24/25 BNSSG built on its urgent care investments made in 23/24 with the introduction of a new Frailty-ACE (assessment and coordination for emergency and urgent care) service: a remote team of doctors, advanced nurse practitioners and social workers who work together to support paramedics on-scene with telephone advice, when the individual may otherwise be conveyed to hospital. The service keeps around 70% patients at home, with around half of that number avoiding any hospital admission over the next month.

BNSSG also remained at the forefront of systems tackling ambulance handover delays through increased use of temporary escalation spaces and ward-based escalation capacity to deal with surges in ambulance demand and maintain 'flow' through the hospital. As a result of these changes, ambulance handover delays in 24/25 were lower in the first half of the year than in 23/24; however, they increased significantly in the second half of the year.

This was driven by the impacts of an exceptionally high flu season, followed in the new year by very high levels of norovirus within BNSSG hospitals, both significantly above the levels seen in 23/24. These infectious diseases not only increase demand, but require careful management and control within the hospital bed base, which reduces the overall efficiency of those services through approaches that minimize the spread of infection, such as cohorting patients, and following intensive cleaning protocols.

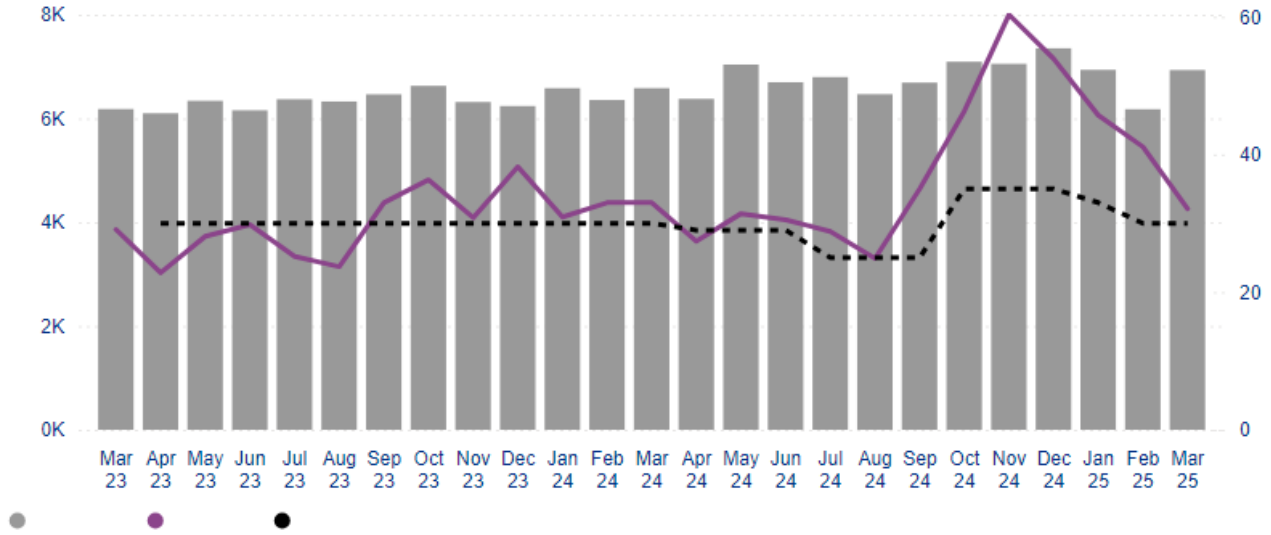
Figure 1: BNSSG ambulance handover delays – total time lost over 15 minute standard



In turn, this increase in handover delays negatively impacted our ambulance response times in the second half of the year, with 'Category 2' responses seen in an average of 38.4 minutes over the year, an increase from the 30.5 minutes

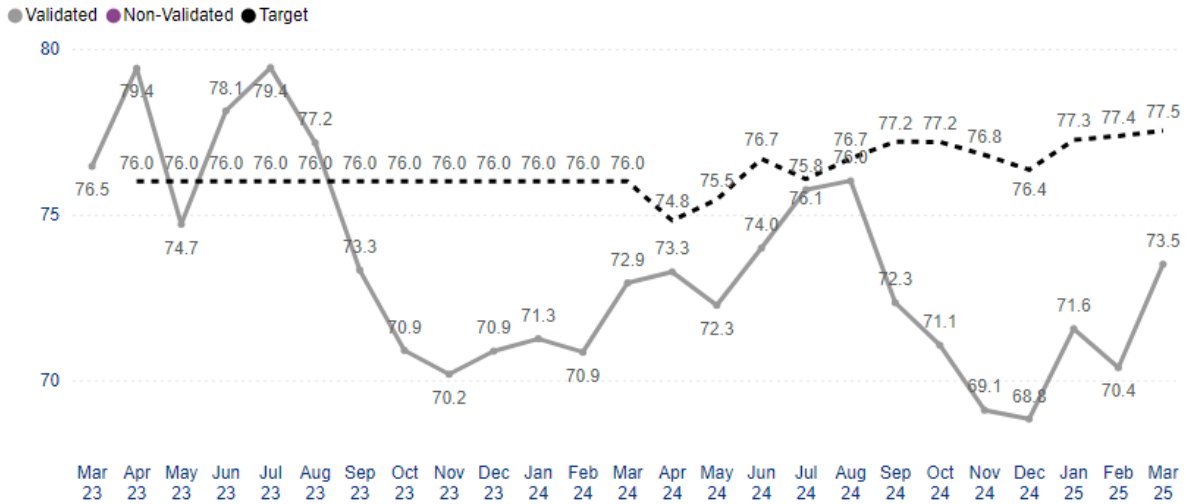
achieved in 23/24 and over the national standard for 24/25 of 30 minutes.

Figure 2: Category 2 ambulance response counts and average response times in BNSSG



The challenging winter demand impacted flow within the hospitals, with BNSSG missing its 4 hour performance trajectory in 24/25 despite improvements seen in the first half of the year, finishing at an average of 72% against the national target of 78%.

Figure 3: BNSSG all-types A&E - percentage of patients waiting less than four hours



Mental Health, Learning Disabilities & Autism

The table below shows our performance against NHS Operational Plan Targets for Mental Health, Learning Disabilities and Autism. Achievement against each measure is assessed as either Green, Yellow or Red with the reasons outlined.

Measure	Assessment	Reason
Adult CMH Services Access	Green	Improving trend - plan achieved
Dementia Diagnosis Rate	Green	Improving trend - plan achieved, better than national standard
SMI Physical Health Checks	Yellow	Local performance is better than the national standard but we have a discrepancy between our local data source, and the national data source which shows us below standard. This is reflected in this assessment
Perinatal Service Access	Green	Improving trend - plan achieved
TT Reliable Recovery Rate	Green	Slightly below stretch plan but better than national standard
TT Reliable Improvement Rate	Green	Plan achieved - better than national standard
CYPMH Access Rate	Yellow	Expect plan to have been achieved if missing data included
Inappropriate OAP (BNSSG)	Green	Plan achieved at year end.
LD&A Annual Health Checks	Green	Plan achieved
LDA Inpatients - Adults	Yellow	Worse than 23/24 - plan not achieved
LDA Inpatients - CYP	Red	Worse than 23/24 - plan not achieved

This year we have continued to work collaboratively as a system and with people with lived experience of mental health difficulties, to deliver better mental health for all. We are continuing to make progress against our BNSSG All Age Mental Health and Wellbeing Strategy 2024-2029, and have refreshed the Mental Health element of the BNSSG Joint Forward Plan 2025-2030 to reflect our strategy.

Our performance against key areas for the year 24/25 is set out below.

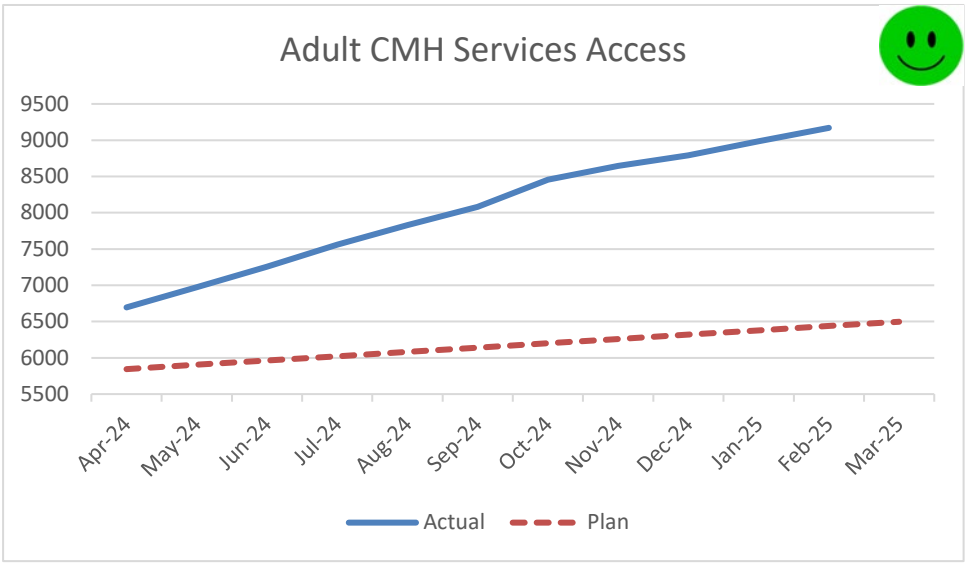
Key to symbols in graphs shown below:

 Better than last year but not achieving **national target.**

 Achieving **national target.**

Worse than last year and not achieving **national target.**

Adults and older people Community Mental Health (CMH) access



We have comfortably achieved the 24/25 national target for adults and older adults with Serious Mental Illness (SMI) accessing Community Mental Health services. This is due to the Community Mental Health Programme's focus on creating a place-based, integrated model of care (through Mental health and wellbeing Integrated Network Teams, MINT) and establishing a range of new services outlined below.

We have also been improving access to high-quality, evidence-based care by transforming services for people who need specialist support:

- **Eating disorders** services strengthened through early intervention support from AWP (FREED team) and charity SWEDA. Waits for psychological therapy have reduced by 75%, with nearly everyone referred being seen for an assessment within four weeks, with no wait for those with urgent needs. We have also established a new pathway between primary and secondary care to support the physical health needs of people with eating disorders.

- Specialist **Community Rehabilitation** team (AWP/Second Step) has led to a 74% reduction in the number of people in out of area rehabilitation wards.

- The new Sequoia Service is being provided to support people with **Personality Disorders** at a primary care level (AWP/Rethink Mental Illness).

- Established a new **Young People's Transitions** model of care (AWP / Off the Record) and a new **Student Mental Health service** is live (AWP, University of Bristol / UWE).

- **Physical health checks for people with Severe Mental Illness** have increased from 12% in 2022 to 81% in 2024.

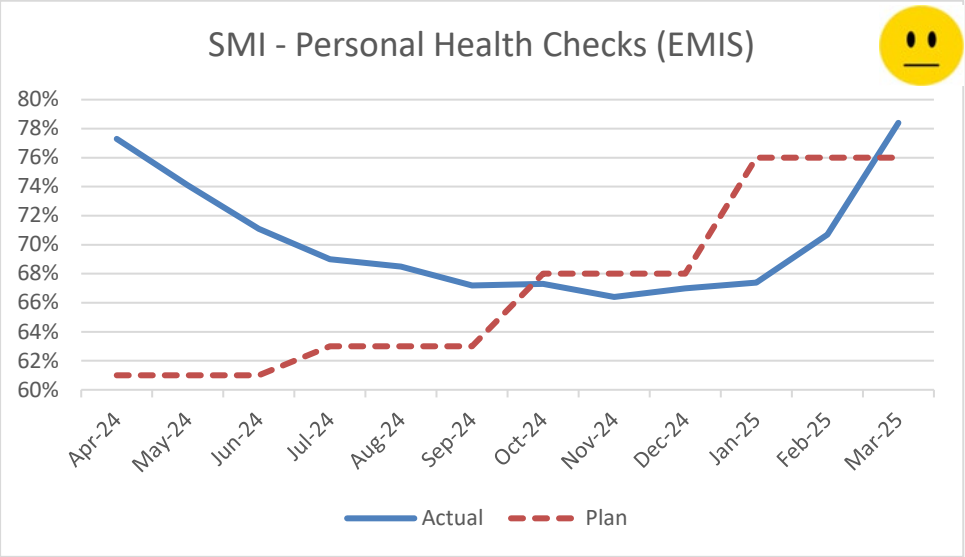
- Initiated a new **Mental Health, Accommodation and Care** programme, securing new investment to support people to move back into the community.

- **Integrated Access Partnership (IAP)** – a partnership of **AWP, BrisDoc and SWASFT, are working closely with Avon and Sommerset Police**, to support people in crisis – this has led to a 99% reduction in direction to attend Emergency Departments via 111, and a 60% reduction in direction back to GPs.

We are able to include a direct quote from an individual who has used the MINT service:

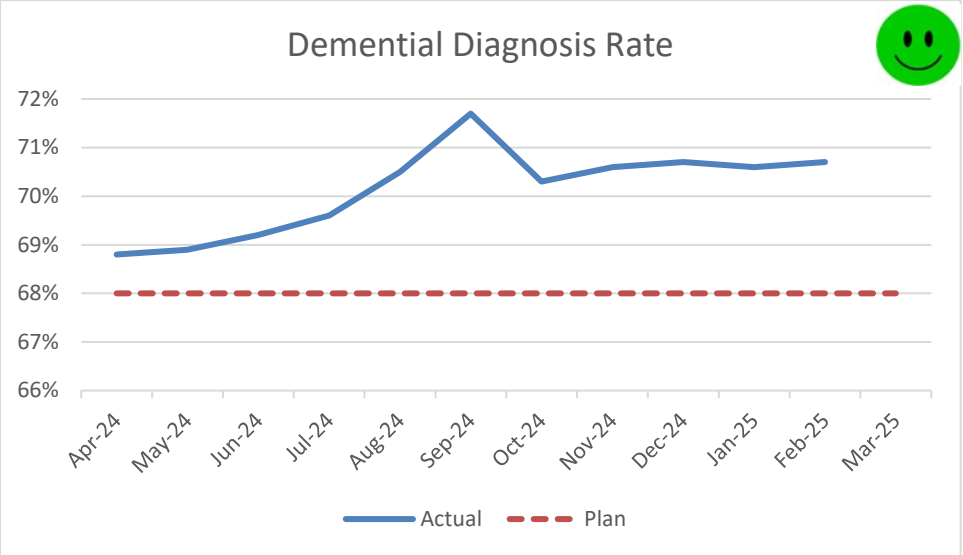
*"I am incredibly grateful for the support I received from MINT over the past several months…Thanks to MINT I now receive the right medications to help manage my conditions, which has made a tremendous difference in my daily life. Additionally, they arranged a support worker to assist me with claiming benefits, which has been invaluable in helping me navigate the system. The care, guidance and practical assistance I received have significantly improved my wellbeing and I deeply appreciate the dedication of the professionals who supported me. I would highly recommend MINT to anyone in need of mental health support. Their compassion and thorough approach ensure that people receive not only the right diagnosis, but also the necessary resources to move forwar*d".

Severe Mental Illness (SMI) physical health Improvement



Health data shows that people with the three mental health diagnoses that lead to them being categorised as having a 'Severe Mental Illness' (SMI) face a significant health inequality. They typically die between 15 and 20 years earlier than the general population and two out of three of these early deaths could have been prevented had the causes been identified and acted upon early enough. There is a national target to ensure that 75% of people with Severe Mental Illnesses receive a physical health check and appropriate follow-up each year. Following a significant improvement over the last four years, and exceeding the target in 2023/24, at the end of March 2025, 78.4% of people with SMI received a full annual physical health check. The numbers of people receiving follow-up to their health check are also showing improvement. We have a service which works specifically with people from particular minoritised ethnic groups (in inner city Bristol) that are presented with additional barriers to engaging with health services.

Dementia

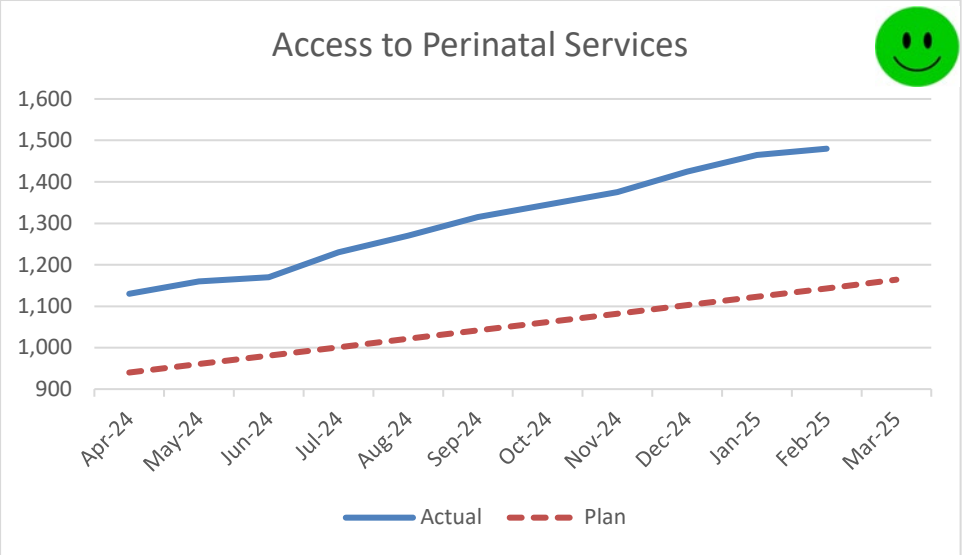


The number of people who receive a diagnosis of dementia has been significantly lower than the number of people estimated to actually have dementia. We have therefore been set a target over the past decade to increase the proportion of people who receive a diagnosis of dementia.

Out of the number of people (over 65 years) estimated to have dementia across the area, there is a national target for 68% to have a recorded diagnosis of dementia.

We have exceeded this target again with the Bristol and North Somerset services consistently surpassing it while the South Gloucestershire service shows improving performance. We will be working to bring about greater consistency across BNSSG.

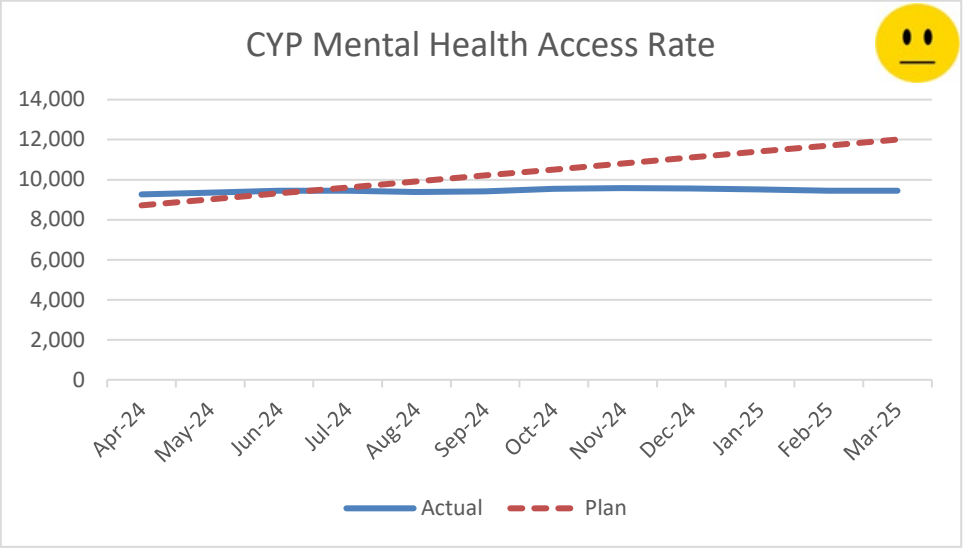
Perinatal Mental Health



It is estimated that up to 25% of women experience mental health difficulties in the perinatal period (from pregnancy to their child's second birthday). There is a national target that 10% of women who give birth in any year receive a specialist mental health service during this time.

Since the launch of the single point of entry (to perinatal mental health services) in January 2024, we have shown steadily improving progress which has now risen well above the target. In practice, this means that the number of women receiving a specialist perinatal mental health intervention is now properly recorded and increasing month by month.

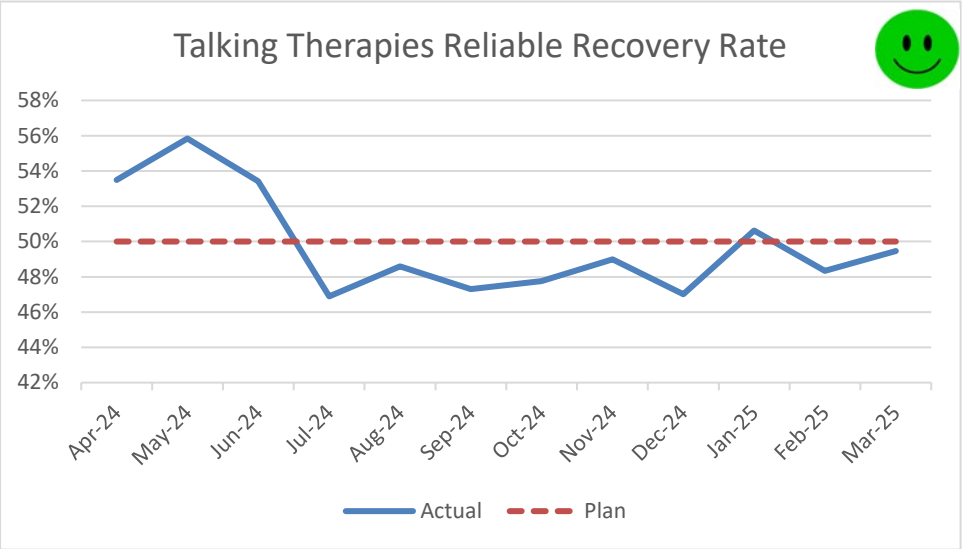
Children and young people mental health access



We remain below the national access target and improvement in this area remains a BNSSG priority with service level improvement plans. In 24/25 we have invested in the Child and Adolescent Mental Health Service (CAMHS). And Mental Health Support Teams (MHSTs) in schools has increased access to mental health support for children and young people. An enhanced transitions service for children moving on from CAMHS has been developed. The new service model will improve the provision of services for our young adults and provide a more supportive transition into adulthood.

A robust improvement plan has been developed with system partners to improve access and achieve the national ambition in 2025-26. Our improvement plan will focus on an increase in productivity and efficiency in our services this year. Key areas of focus in this plan are to increase access to Mental Health Support Teams (MHST) in schools through increased capacity of additional 'Wave 12' staff, a refreshed, consistent core offer and a communications campaign to increase referrals into the service, an online and digital therapeutic offer to increase accessibility and acceptability of the service for young people and their parent/carers, and by developing a plan to have MHST's in all our schools by 2029-30. We will focus on reducing variation in access across BNSSG and among all groups of young people and their families.

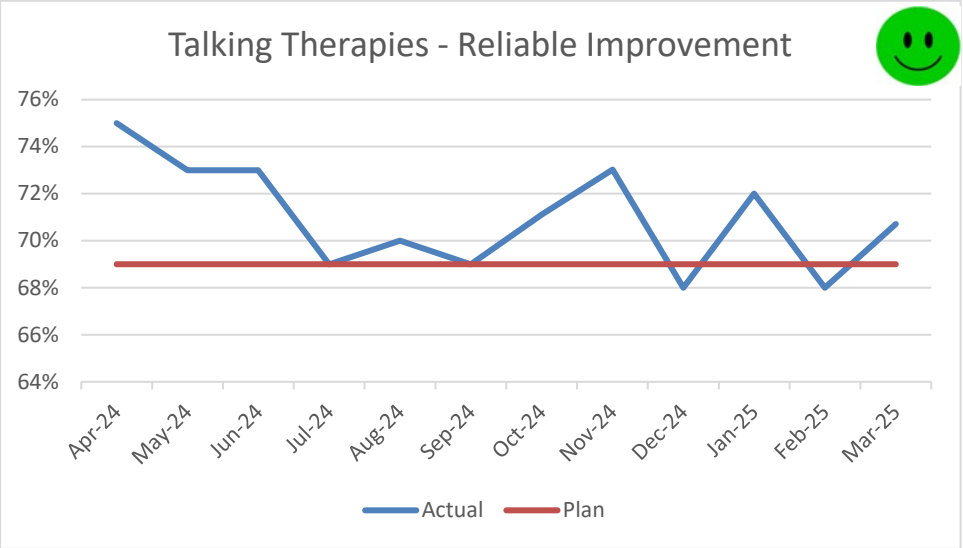
Talking Therapies



In 24/25 there was a change in the NHS Talking Therapies services target. The previous target focused on measuring access (1+ session) to the new target which focusses on courses of treatment completed (2+ sessions) and the % of patients who achieve reliable recovery and reliable improvement.

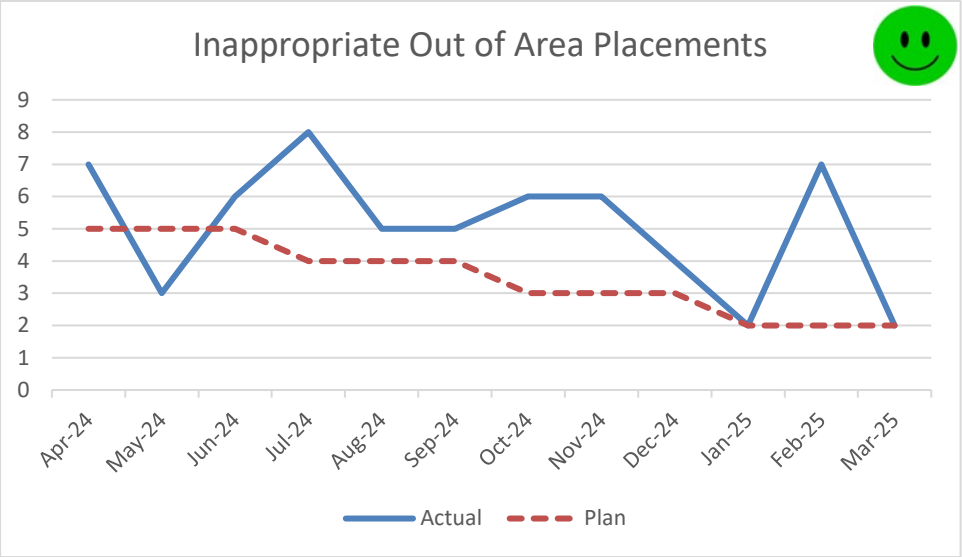
This year, our NHS Talking Therapies service in BNSSG delivered over 10,000 courses of treatment and narrowly missed their local target of completed courses of treatment. The service met the national ambition of 48% achieving reliable recovery and 67% achieving reliable improvement after a course of treatment. In addition, the service also met their local stretch target of 2% above the national ambition achieving 69% for reliable improvement after a course of treatment.

The service continues to consistently meet their national waiting time targets, and this year have significantly reduced their Step 3 waiting list for treatment (by 49.6% since July 2024) and have substantially reduced the % of longest waiters.



In 25/26 the service will increase their completed courses of treatment and maintain quality recovery rates, whilst further reducing their waiting lists and longest waits as a priority area of continuous improvement.

Inappropriate out of area placements for mental health



In 24/25 we achieved our target of reducing inappropriate out of area placements across BNSSG to 2 patients by March 2025. In 25/26 we plan to eliminate out-of-area placements completely.

People accessing Individual Placement Support (IPS)

IPS is a type of individually-focussed employment service (with well- evidenced success and sustainment rates) that provides specific support into paid employment to people with mental health difficulties. We have received significant funding to establish and expand our IPS provision over the last few years (with associated

targets for working with an increasing number of people). We have exceeded the national target of people receiving a service. While IPS works with secondary mental health teams all over BNSSG, it has now also started to work with people at a primary care level through the new/developing MINTs (Mental Health & Wellbeing Integrated Network Teams). This means that people with a wide range of mental health issues now have access to IPS employment support.

Although we have not had a performance target for this service in 24/25 this has been a key part of the NHS long term plan for mental health.

24/25 Mental Health Expenditure

As in previous financial years, BNSSG ICB achieved the Mental Health Investment Standard in 24/25. In 24/25, the ICB's Mental Health programme spend was 8.63% as a proportion of the overall ICB allocation as shown in the table below. This represents Mental Health spend in inpatient and community settings, across NHS and non-NHS providers including local authorities, voluntary sector and private sector providers.

Financial Years	**2023/24 £000**	**2024/25 £000**
Mental Health Spend	188,644	202,052
ICB Programme Allocation	2,154,499	2,340,683
Mental Health Spend as a proportion of ICB Programme Allocation	8.76%	8.63%

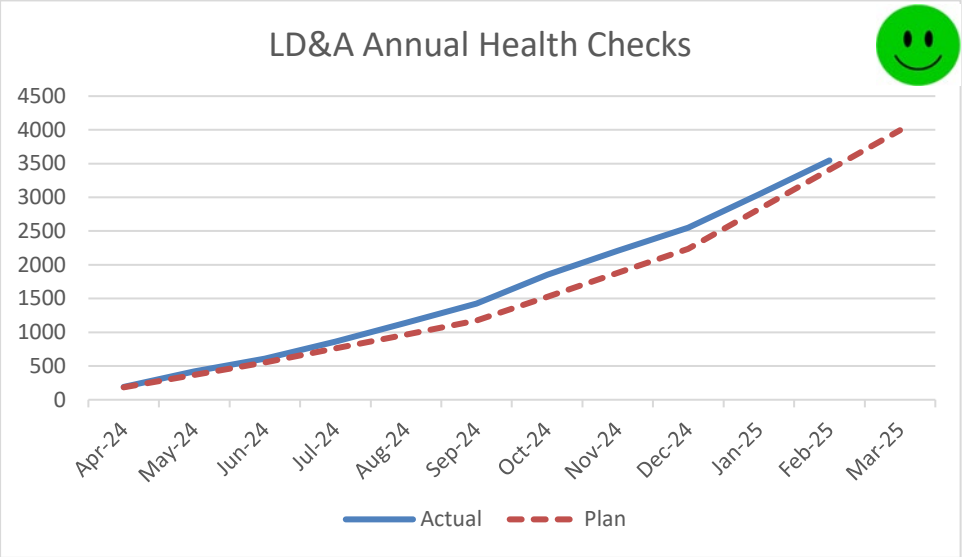
Learning Disability and Autism

We continue to work collaboratively in partnership with people with learning disabilities, autistic people, those with lived experience and with stakeholders from across the system. We want everyone with a learning disability and/or autism to live longer, healthier and happier lives. This means we need to ensure people are supported to have more choice, control and independence whilst always treated with dignity and respect. We believe it is important that these improvements are embedded via a rights-based approach, focusing on citizenship and belonging.

Learning Disability and Autism Annual Health Checks

To support our aims of improving people's health, our GPs keep a register of people

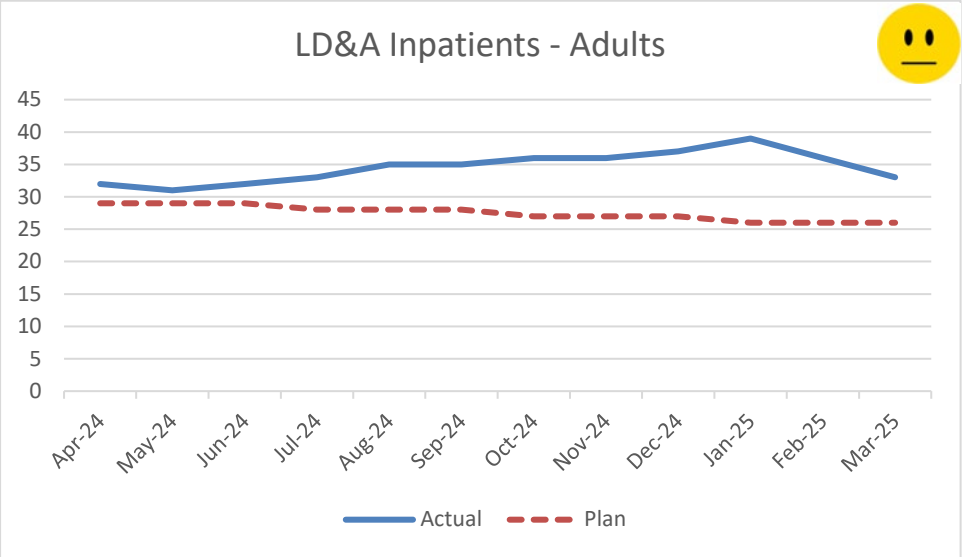
with a learning disability and autistic people as they are entitled to an annual preventative health check (AHC). Our target, set nationally, was for at least 75% to have an AHC and last year we achieved 87%, which means we have been delivering above our planned target every month. We fully expect to be able continue to on this trajectory in future.



Annual Health Checks are important as people with learning disabilities and/or autism often have several co-morbidities and generally have poorer health outcomes than the general population, dying many years earlier than would be expected. For example, men with learning disabilities die on average 23 years sooner than men in the general population, whilst women with learning disabilities die on average 27 years sooner. Adult men from minority ethnic groups with severe, profound and multiple learning disabilities often die even younger. Those living in the most deprived neighbourhoods also often die earlier compared to those in the least deprived neighbourhoods. We are working on ensuring these findings are reflected in projects which aim to improve care and support and to tackle the health inequalities experienced by people with learning disabilities and/or autism.

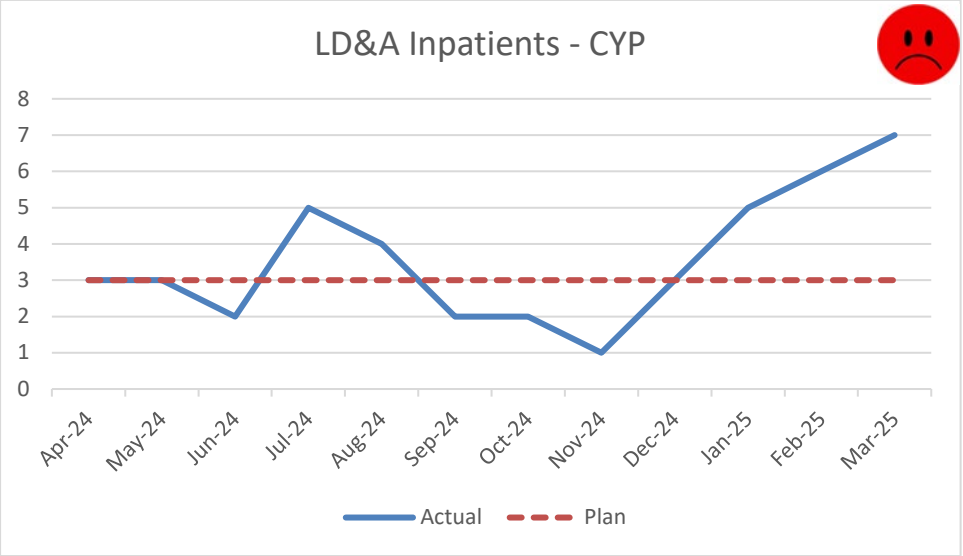
Reliance on inpatient care for adults with learning disabilities and autism

Although we continue to meet our annual health check targets month on month, further work is needed to improve our inpatient patient performance which is currently below target but is reflective of the demand and high complexity of the current cohort of people. This will be an area of prioritisation in 2025/26.



Reliance on inpatient care for children and young people with learning disabilities and autism

We have not met our performance target for children and young people using inpatient care, although the low numbers mean the performance rate is very volatile.



We have a range of improvements underway as a system to support prevention and to develop the right community provision across BNSSG which includes:

- new community housing opportunities to support discharge from hospital (for adult).
- Annual Health Checks for all young people over 14 years on the Learning Disability Register which helps identify conditions early and prevents adverse escalation
- an improved Dynamic Support Register (DSR) to flag young people and

adults at risk of inpatient admission to hospital

- digital Reasonable Adjustment flags on patient records so GPs and community clinicians are made aware of young people and adults who may need an alternative method of care

- a Keyworker Team which is working with young people at crisis points and successfully preventing hospital admission which we know often leads to poorer outcomes in the longer term.

Voice and Influence

Ensuring people with learning disabilities and/or autism have voice and influence is a key ambition for the ICB and we aim to ensure co-production is embedded in all our programmes of work. There remains a funding commitment to this process in order to build systems and forums for people with learning disabilities and/or autism to be equal partners in our different workstreams. We are keen to implement a pure co-production culture and are developing a robust and inclusive model across the system coordinated across health, care and educational partners.

Examples of involvement in 24/25 are set out below

- The adult ADHD transformation project has an expert by experience totally integrated in the project

- The C&YP Neurodiversity transformation project is being led by our 3 Parent carer Forums

- Our CeTR panels are largely made up of experts by experience

- We are funding our 3 Parent Carer Forums to provide engagement, insights and co-production to further develop support services around special educational needs and disability.

Learning Disabilities Mortality Review (LeDeR)

The annual report of LeDeR activities for 24/25 will be published in September 2025. The information which follows provides current information.

In 2023/24 BNSSG ICB experienced challenges in the capacity to meet the demand for LeDeR reviews. A focused effort to address the backlog was initiated and opportunities to procure a sustainable workforce were explored in order to improve performance in 2024/25. Previous annual reports are available on the ICB LeDeR webpage. The full LeDeR report provides a more detailed analysis of learning from LeDeR reviews and reports on learning and actions taken to enhance services

provided for people with a learning disability and/or autistic people.

During 2023/24, we reviewed our LeDeR governance structure to ensure a strong system approach to challenging health inequalities for our learning disability and autistic population. System partners are fully engaged with the LeDeR programme and there is dedicated commitment to challenge health inequalities and improve health outcomes for people with a learning disability and/or autistic people. Data, including themes and trends following LeDeR reviews, is now shared with our Mortality Group and Strategic Prevention Oversight Group to ensure strong oversight alongside our wider health inequalities work programmes.

We continued to invest in our improvement programme, which is co-produced by system partners and supported by colleagues from our voluntary and community sector and Experts by Experience. We developed ambitious plans, and through a culture of continuous improvement, we are proud of our achievements across the partnership, whilst recognising that there is more work to do.

Some of our key achievements in 2023/24 include our acute trusts driving education about constipation and our community provider committing to the new role of the Learning Disability Screening Practitioner. Primary care focus has been on raising awareness of the learning disability annual health check (AHC) and health action plan (HAP). We have also collaborated with the voluntary and community sector, with a focus on better understanding and reducing the barriers to accessing the primary care learning disability register and annual health checks for our citizens from an ethnic minority background. This collaborative project has highlighted the need for a system approach to achieve equal access to healthcare. Inequalities in housing provision, living in poverty and poor education, impacts access to healthcare. There is a focus on co-production to guarantee we commit to eliminating healthcare inequalities.

This report has allowed partners to showcase their outstanding efforts and demonstrates their dedication to enhancing the lives of our learning disability and autistic population. We extend our gratitude to everyone involved for their continuous dedication and hard work in serving this remarkable group of individuals.

Community Services

Across Bristol, North Somerset, and South Gloucestershire (BNSSG), adult and children’s community services are delivered by Sirona care & health. These services encompass specialist outpatient and home-based care, community rehabilitation beds, urgent community response, and place-based urgent care.

Performance Highlights 24/25

NHS@Home – Virtual Wards

Established in 2022/23, the NHS@Home service provides Virtual Ward care across BNSSG. Since its inception, the service has seen sustained growth, maintaining a caseload of over 100 patients. The service aims to achieve 80% occupancy of its target capacity of 165 patients.

Patient acuity levels have been higher than initially projected, influencing both the staffing model and future service planning. Approximately 50% of current provision supports 'step-up' interventions, offering a viable alternative to hospital admission and reducing the risk of harm and deconditioning associated with inpatient stays.

Improving Discharge pathways into the community

Discharge from acute care is supported by community-based care packages, provided at home where possible, or through bedded rehabilitation facilities when necessary. Integrated collaboration between community services, local authorities, and VCSE organisations has strengthened these pathways, resulting in:

- 200 additional acute beds freed up annually for patients requiring urgent or elective care, rather than being occupied by those awaiting discharge. This has allowed the system to absorb increases in demand for emergency admissions.

- A 25% reduction in the length of stay for patients experiencing discharge delays.

- 660 more patients each year recovering at home with care packages, reducing the need for bedded care by 72 community beds compared to 2022/23.

- The discharge improvement work has provided a renewed focus on the needs of the person with effective multi-disciplinary working with acute, community and local authority professionals, from hospital admission through to long-term recovery.

Specialist Community Services

Specialist services continue to adapt in response to rising referral volumes across most clinical areas. Key developments include

- Musculo Skeletal Physiotherapy services have reduced their waiting list through provision of 600 additional appointments, provided in collaboration

with Getting It Right First Time (GIRFT), a national improvement group.

- Community Dermatology has been shortlisted for the British Dermatological Nursing Group Innovation Award, recognising excellence in service innovation

- Additional capacity has been secured for the urgent **Heart Failure** diagnostic pathway in response to an increase in wait times for echocardiogram for those with suspected heart failure. There is a commitment to reviewing the system wide heart failure pathway in 25/26 to ensure access to treatment is timely.

Integrated Neighbourhood Teams

Community based nursing and therapy teams have responded to sustained high levels of demand, prioritising the most urgent needs such as facilitating hospital discharge to support pressures in our acute hospitals. At times, this has longer waits for routine at home follow up care.

Collaboration with acute trusts, local authorities, and VCSE partners is progressing well, focusing on coordinated, preventative support. The aim is to help people remain safe, independent, and well in their own homes for as long as possible.

Funded Care Services (Children's Continuing Care, individually funded Mental Health, Learning Disability and Autism, Adult CHC)

All Age Continuing Care

The Funded Care team is an 'all-age' team working alongside system partners to ensure individuals with highly complex needs continue to be met in the most appropriate environment. This includes children, young people and adults with both complex physical, psychological and mental health needs whose needs cannot be met with care and support from existing commissioned services and for whom a bespoke plan is required.

A priority of the team is to that ensure high quality, safe and effective care is delivered to our population. Work has been undertaken to reduce variation in approach including a change to internal process to decision making processes, so they are aligned to the Standing Financial Instructions in the ICB.

The Continuing Health Care (CHC) team is dedicated to commissioning care for the adult community who meet the eligibility criteria against the NHS CHC framework. A high performing team who, despite significant changes within the team, regularly overachieve against nationally mandated key performance indicators.

The Continuing Heath Care (CCC) team focus on Children and young people with complex health care needs. 2025 will see the adoption of similar key performance indicators that are in place for adults. The adoption of an all-age operating model, including an all-age senior management approach, will ease the transition to this reporting schedule in BNSSG ICB.

The team continue to work hard to ensure NHS funds are used to meet the identified care needs of this population and respond when they identify inappropriate use of funds. The team have worked with agencies such as the Counter fraud team to ensure appropriate action is taken when necessary.

Individually funded Mental Health, Learning disability and Autism

The team have been focussed on developing suitable conditions and environment for those in long term institutional care to have a successful and supported discharge. 2025 will see the opening of new residential provision (Oldland Common) for individuals with complex needs which will provide BNSSG with an opportunity to review how working differently and together can deliver improved outcomes for individuals.

The Key worker Team for Children and young people with LD and Autism continue to offer a service that prevents young people being admitted to Psychiatric Intensive Care Units (PICU). Work is underway to commission support from a health economist to identify the value this team delivers in terms of admission avoidance.

Primary Care including GP, Community Pharmacy, Dentistry and Community Optical Services

General Practice

24/25 saw the start of collective action by practices in response to concerns about the new contract, funding and workload. The ICB has worked collaboratively with Avon Local Medical Committee (LMC), our GP Federation (One Care), the GP Collaborative Board and system partners to support practices and review current service provision.

Significant work has continued to support monitoring and delivery of the contract,

reviewing our enhanced services and carrying out detailed procurements in line with the new framework for procuring healthcare services.

24/25 was also the second year of delivering the access improvement plan for general practice. Our practices and PCNs have continued to work hard to improve access for our patients. The ICB has supported all of our PCNs in their 6 monthly updates on capacity and access improvement plans to address population needs and evaluate impact. This has meant they all successfully received the related funding.

Our practices delivered 5.7% more appointments in 24/25 compared to 2023/24. This included:

- 40% of appointments same day, for those who are clinically appropriate, consistently maintained from previous years
- 83% of appointments within 14 days, consistently in line with the national average

This increase in appointments is a reflection of the demand in general practice rather than an increased workforce. Practices continue to be challenged to recruit and retain staff. The ICB, Training Hub, One Care and the LMC continue to support recruitment and retention initiatives and development of the workforce.

To further improve access to healthcare advice and meeting the needs of our population, along with workload for practices, we have supported:

- 100% of our practices being on cloud-based telephony, with 92% now having advanced functionality including call waiting and call back to support decreasing the 8am rush
- 72 practices offering online patient access to medical records
- 88% of practices in BNSSG now able to provide online registration for patients
- Embedding online consultations and total triage models as part of Modern General Practice
- Increased use of the NHS App to 62%, the national average being 59%. This is following the ICB commissioned project that has delivered a local communication campaign across GP practices, pharmacies and using social media platforms. In addition, delivering NHS app workshops
- Recruitment of 3 VCSE organisations to support digital inclusion (one for each locality)

- 87% of patients registered with practices referring to Pharmacy First – the highest performing ICB in the country for Pharmacy First referrals

- 30% increase in number of repeat prescriptions being ordered through the NHS App

- Improving the Primary/Secondary Care Interface with a monthly steering group and sub-groups focusing on culture, planned and urgent care

A dedicated multi-disciplinary team support delivering these improvements in access, resilience and quality across BNSSG. This intensive program includes looking at ways practices can improve access and get the best from their workforce. Providing hands-on support to practices where needed, along with toolkits and webinars to support improvements in practice.

The Training Hub continue to be vital in supporting recruitment and retention initiatives in general practice. 82% of Newly Qualified GPs completed the 2-year Fellowship Programme. 100% of Newly Qualified GP Fellows intend to continue working in general practice. 100% of General Practice Nurses (GPNs) (at the 6 and 12 month points of the Fellowship Programme) intend to continue working in primary care. In addition, as part of the Training Hub strategy, they are increasing education and supervisor capacity; maximizing apprenticeships and placements and supporting training for clinical and non-clinical staff.

Community Pharmacy

The Pharmacy First service continues to be a success and expand, averaging 13,000 referrals a month. BNSSG is the highest performing ICB in the country.

We have been working hard to continue to embed Pharmacy First but also engaging with practices to increase referrals to Community Pharmacy for blood pressure checks and contraception services. The work to increase Hypertension Case Finding is in conjunction with our communications team to attend some outreach events, for example Bristol Bears rugby games.

Work continues to expand our Patient Group Directions (PGDs) to allow specific registered healthcare professionals to supply or administer medicines to a pre-defined group of patients, without needing a separate prescription from a doctor.

Our Community Pharmacist Independent Prescriber (CPIP) pilot now has 2 out of the 3 sites live for minor ailments, This will enable more conditions to be completed by a Pharmacist rather than escalating to GP/111/UEC which will support the system and improve patient journey.

We have enabled capability in our digital system so referrals can be made in an efficient way which should help support making formal referrals to Community

Pharmacy easier. In addition, it enables access to the data in a timely way.

Our out of hours service and North Bristol Trust now have the ability to make electronic referrals to Community Pharmacy.

We continue to work in partnership with practices and our community services to get Designated Prescribing Practitioners for Community Pharmacists. Working with NHSE and Community Pharmacies to enhance pre-reg pharmacy technicians in Community Pharmacy. We currently have three student places funded.

Dentistry

Although our area is often above the regional averages for access there is significant variability and continued challenges with maintaining NHS service provision.

We acknowledge how important it is to improve access to NHS dental services for the local population and to identify plans which seek to reduce health inequalities. As such, the ICB has worked with stakeholders across local authorities, primary, community and secondary dental services, the Bristol Dental School and NHS England as well as undertaking a staff and public survey to facilitate the development of a local three-year Strategy.

The strategy is focused on the priorities for the next two years, but it is expected the work required will span three years given the scale of change required.

The strategy includes three aims:

- Promote good health across the entire BNSSG population
- Reduce health inequalities by increasing access to NHS dental provision
- Developing the workforce, retaining staff and attracting more applicants

This strategy was supported by the ICB Board in March 2025.

Significant progress has been made during 2024/2025. We have supported dental practices by increasing the minimum rate paid to providers above the national minimum of £28 to £30 to assist them with recruiting and retaining staff. In addition, we offered an enhanced rate to dental practices to deliver additional activity above 23/24 and we are now forecast to deliver in excess of 45,000 additional Units of Dental Activity. We offered a ‘golden hello’ bonus incentive payment of £20,000 per dentist to help practices that are struggling to attract people through the usual recruitment routes (8 places) and provided additional funding for NHS dental staff to complete continuing professional development to support staff retention.

We introduced new services such as the dental pilot for children in care/looked after and a new dental practice in Winterbourne opened in August 2024. We have

increased the provision of stabilisation services to ensure patients are able to access care that stabilises their oral health and reduces the likelihood of people going in and out of the urgent care system, or of receiving no treatment at all. 8 practices now provide in excess of 22 sessions per week and a procurement for 25/26 is due to be completed imminently.

We work closely with our Local Authorities and we have invested in oral health promotion. We introduced a supervised toothbrushing scheme in schools for 3–5-year-olds (nursery, and reception children), extending the number of settings to help more children, and we continue to support the First Dental Steps scheme where Health Visitors give oral health packs to parents of babies and siblings in targeted areas.

We have submitted a plan to deliver the 19076 additional urgent care appointments over and above the current baseline as part of the government's objective to deliver 700,000 appointments nationally and will be working throughout 2025/2026 to secure these services and support people to access these.

Access to dental services remains a significantly challenging area for our population and we anticipate this taking several years to recover, supported by national contract reform.

Community Optical Services

Our optometry practices are conveniently located across BNSSG. This enables the system to utilise both the clinical skills and specialist equipment that they possess to alleviate unnecessary pressures from overburdened secondary care services as well as GP practices who are often the first port of call for these patients.

We have re-established the BNSSG Eye Care Delivery Board working in partnership with Avon Local Optical Committee (LOC) along with primary and secondary care. This will help us review current provision and strategically plan for and monitor delivery of prioritised areas.

The Macular Pilot has been successful and received over 350 patient referrals, with 69% of patients avoiding a hospital visit by being referred through this route. Clinical decisions have been made within one working day of referral receipt, enabling patients to access treatment a week earlier than under the previous pathway. Feedback from community optometrists has been highly positive, highlighting both the faster patient access and the valuable educational feedback provided on each referral.

Safeguarding Children, Children in Care and Adults

BNSSG ICB is a statutory partner in all three Local Authority areas by various

configurations for the Safeguarding Children Partnership/Adult Boards/Community Safety Partnership arrangements. In line with the statutory guidance, and adherence to the NHSE Safeguarding Accountability and Assurance Framework (SAAF) the ICB has Designated Doctors for Safeguarding Children and Children in Care, Named GP's all age safeguarding, Designated Nurses/Professionals for Safeguarding Children in Care (CIC), Children and Adults. The ICB contributes to Annual Reports written by the Safeguarding Partnerships and Boards operating within the BNSSG footprint for 24/25 and these will be published during Autumn 2024 on the following five websites.

Welcome to the Keeping Bristol Safe Partnership website. (bristolsafeguarding.org)

Adult Safeguarding Board | Adult Safeguarding Board (nssab.co.uk)

Category: Adults | SafeguardingSouth Gloucestershire Safeguarding (southglos.gov.uk)

Childrens Safeguarding Board | Childrens Safeguarding Board (nsscp.co.uk)

Category: Children | SafeguardingSouth Gloucestershire Safeguarding (southglos.gov.uk)

Following the increase in statutory safeguarding reviews relating to serious youth violence at the end of 2023-24, a recommendation was made by the National Panel that a thematic review should be undertaken to combine the lines of enquiry in relation to peer on peer serious youth violence into one Child Safeguarding Practice Review (CSPR) from two of the three Rapid Reviews. An Independent CSPR reviewer was appointed at the beginning of Quarter 2 by Keeping Bristol Safe Partnership and time has been spent working with system partners to explore and identify systemic learning. It is anticipated that the findings will be published in Quarter 1 2025-6.

Also during Quarter 1 2024-5, the ICB safeguarding team collaborated with the dental commissioning team and NHS England South West Dental leads to design a model and offer that would improve access and meet the needs of children and young people in care in BNSSG. The ICB offered an Enhanced Contract to a small number of dental practices, that met a set of criteria including being a trauma informed practice, as part of a pilot which was then launched in Quarter 2.

A free prescription scheme for Care Leavers was also launched during Quarter 2 of 2024-5 which aims to ensure that this cohort can receive medication to support their health needs. This was originally a pilot, however has been extended for a further year into 2025-6 to evaluate its success and review how well it has been utilized.

There has been a focus during 2024-25 on ascertaining data to support of our BNSSG multi agency partnership arrangements to evidence need and trends. The

ICB have funded a data workstream in order that pseudonymized data could be pulled from GP records in relation to the use of Snomed costs relating to domestic abuse. This has enabled the ICB to have a more holistic view of how Snomed codes are being used by Primary Care GP Practices, how much safeguarding data is contacted within the Primary Care system and to allow the ICB to feed into local authority needs assessments to better triangulate information. In addition to this, the ICB safeguarding team have worked with health partners to agree a small set of metrics that can be shared directly with Safeguarding Children Partnerships to support their collaborative dashboards. This has included information and data in relation to children attending emergency departments and presenting with self-harm or injuries relating to potential serious youth violence, as well as numbers of children being referred to Child and Adolescent Mental Health Services.

Following on from the Local Government Association Review in 2023-24, the ICB safeguarding team established a Systemwide Safeguarding Transformation Programme during Quarter 2 of 2024-25 following support by System Executive Group. The first task of this programme was to form a Project Group that would produce a ‘Challenges and Opportunities’ statement identifying changes that could be made to deliver at BNSSG system level, local authority place based and then locality level. This was achieved by the end of Quarter 3 with a combined workshop and attendance from both Executive Directors and Project Group colleagues from across the three local authority areas and police. The top three opportunities from this statement are in progress and will complete by end of Quarter 1 in 2025-26.

A key priority for the ICB during 2024-25 was also to collaborate with the local authorities and police to agree the implementation of the new statutory guidance published in December 2023; ‘Working Together to Safeguard Children’. The ICB were required to identify a Lead Safeguarding Partner (LSP) and a Delegated safeguarding Partner (DSP) for each of the Safeguarding Children Partnerships, revise the multi agency safeguarding arrangements including the role of education, ensure that there is an effective early/family help offer in the partnership and ensure that practitioners and agencies were aware of changes. This was achieved by working with all three business managers of the partnerships and keeping our LSP and DSPs informed. As a result of this integration between Chief Executives in the system who are the identified LSPs, financial contributions into these arrangements were also discussed and amended for 2025-26, enabling Partnerships to create independent business support and data analyst functions.

The ICB Safeguarding Team have worked at pace during Quarter 3 and 4 of this financial year to recruit an Adult MASH Nurse into the team on a seconded basis to test a pilot with Bristol City Council. This had been a longstanding priority for Keeping Bristol Safe Partnership, however there had been delays owing to resource and capacity requirements. A health system governance board was established to support this pilot and assess the impact of this post, the postholder is a seconded

colleague from a health partner safeguarding team and therefore has a wealth of knowledge relevant to this ‘health coordination/facilitation role’. The pilot will end during Quarter 3 2025-26.

The ICB Safeguarding team have continued to work throughout the year with Primary Care in contributing to the statutory safeguarding review processes; Rapid Reviews, Child Safeguarding Practice Reviews, Safeguarding Adult Reviews, Domestic Homicide Reviews as well as audits. The team’s role has been to identify learning and best practice for both GP Practices but also multi agency working. Learning briefs from reviews and audits have been shared with GP Practices through various mediums; newsletter, one care bulletin, training and supervision sessions.

The Named Professionals for Primary Care alongside the Named GPs for all age safeguarding within the ICB safeguarding team have provided a number of training sessions to Safeguarding Link GPs who practice across the BNSSG area during this financial year including some Bitesize sessions that take place over lunch breaks to improve attendance. An All Age Safeguarding Conference for this cohort of staff was also held during 2024-25 for half a day with such positive feedback that a full day conference is planned for 20252-6 to enable networking across practices to take place and more practical case study conversations to take place to embed learning.

The ICB Safeguarding Team has provided the Outcomes, Performance and Quality Committee with a number of safeguarding reports illustrating the delivery of statutory duties, achievements undertaken by the team or system and risks known and understood by the ICB Safeguarding Team. There is also a direct reporting line into the Chief Nursing Officer as Executive Lead for Safeguarding in the organisation who regularly meets with the Designated Nurses/Professionals and Head of Safeguarding in terms of accountability of delivery against the statutory duties.

The ICB hosts a Strategic Health Safeguarding System Group. Safeguarding assurances have been sought from health partner organisations via quarterly reports and their own safeguarding annual reports. Bespoke Quality Schedules-Safeguarding Standards have been created for 2025-6 to ascertain specific information from each health partner to support our statutory safeguarding duties. In addition to these, two Safeguarding Statutory review Stocktake Days were hosted by the ICB safeguarding team for health partners during the year, one based on all learning from child related statutory safeguarding review undertaken in the last 12-18 months and another for adult related statutory safeguarding reviews; Safeguarding Adult Reviews and Domestic Homicide Reviews. These were well attended by our BNSSG health system partners and were a time for reflection of the identified learning from reviews and the recommendations completed or yet to be completed to improve practice.

As per SAFF guidance ICB workstreams have included the list below but is not

exhaustive.

- CP-IS
- FGM
- Prevent
- Working Together
- Modern Slavery and Human Trafficking
- Domestic Abuse
- Liberty Protection Safeguards/Mental Capacity Act

Confirmatory Statement that BNSSG ICB has followed the statutory assurance processes set out in the Safeguarding Accountability and Assurance Framework.

"All previous functions and duties of BNSSG CCG have now passed to the BNNSG Integrated Care Board (ICB) including commissioning responsibilities and contracts. Safeguarding duties have transitioned with BNSSG executive leads. BNSSG's core principles of Safeguarding children, young people and adults at risk in the NHS, including protecting the paramountcy of children, are sustained by adherence to the Safeguarding accountability and assurance framework "(SAAF) NHSE 2022

Children in Care

In line with statutory guidance, children should receive an initial health assessment within 20 working days of becoming a child in care to evaluate and meet their physical, emotional, and mental health needs. Performance against this metric has been challenging for some time owing to the timeliness of notifications from the local authority, capacity of community paediatricians to undertake the assessments and issues relating to children not being brought to their appointments. System partners continue to work together to address these challenges which is delivering an improvement in the timeliness of initial health assessments and an ongoing commitment to improve the timeliness of the review health assessments.

System partners have also been working together to agree an enhanced pathway for unaccompanied asylum-seeking children to provide expert support, reduce duplication of assessment and provide a more holistic approach for children. Specialist dental provision for children in care and free prescriptions for care leavers are also now commissioned to overcome disadvantages and improve health outcomes for this group of children.

Improve Quality

The ICB has a duty to ensure that safe, high quality, and effective health services for the people of Bristol, North Somerset and South Gloucestershire are in place as per section 14z34 of the National Health Service Act 2006 (as amended by the Health Care Act 2022). The ICB, internally, has standardised this oversight and monitoring by developing a Quality Management System, based on the principles of Quality Monitoring, Quality Oversight, Quality Assurrance and Quality Improvement and links in to the National Quality Board Escalation process. Our Outcomes, Quality and Performance Committee ensures comprehensive oversight and monitoring of the quality of services, providing assurance to the ICB Board. Highlighted below are some of the key indicators of quality and performance against these across our system.

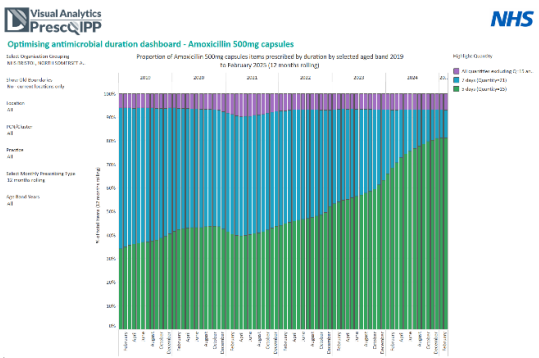
Infection, Prevention and Management (IPM)

Local leadership in infection prevention and control continues to be key in successful IP&M outcomes. We continued to support partner organisations, Adult Social Care (ASC), inclusion health settings and primary care colleagues with a continued focus on preventable infections. This was achieved by ensuring that updates to national guidance were implemented and understood as a system, by escalating risk when appropriate and by ensuring patient safety remained a priority for all. The Infection Prevention and Management Strategic Group (IPaMS) supports and enables delivery of the UK five-year Antimicrobial Resistance (AMR) National Action Plan (NAP) 2024-29 across BNSSG and ensures progress towards the 20-year vision to contain and control AMR. BNSSG together with the other systems in the South West region, have successfully implemented the South West Infection Prevention and Management Strategy (2024-2029) workstreams and work is ongoing to meet the improvement deliverables set benefiting the long-term health of the BNSSG population.

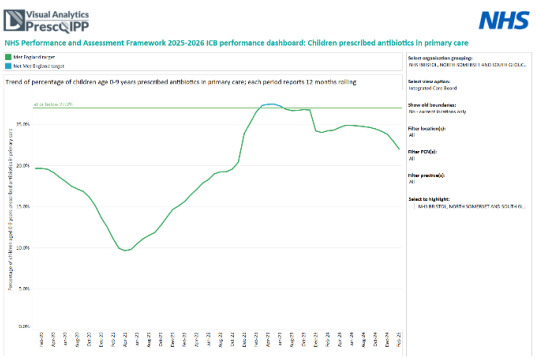
It has been a challenging year with infection outbreaks (COVID, RSV, Flu and Norovirus have been very visible within the healthcare system) and the emergence of measles which became prevalent during the winter period, however, as a system we have responded quickly and effectively for our service users. Participating in the South West IPC network and attending UKHSA events has allowed us to support our local partner organisations and primary care to prepare for possible increases in cases of High Consequence Infectious Disease (HCID). System IPC response pathways (SIRPs) developed with system partners to build on learning from infection threats where a dynamic system co-ordination and collaboration is required to respond, were implemented and revised in year and the aim is to maximise time and response by providing clear signposting for responsibilities and co-ordination and reduce duplication of effort. This partnership collaboration in developing local standards, achievement of initial HCID pathways for adults and infants/children and development of pathways for our more vulnerable cohorts of our population helps retain our focus on preventable infections.

Between 1st April 2024 and 31st March 2025, BNSSG compared favorably against the other six systems in the South West region for all Healthcare Associated Infections (HCAI), with the exception of MRSA. Despite this favourable bench marking across the region and nationally, rates were higher than our intended thresholds (except for Klebsiella species). BNSSG figures of incidence of Healthcare Associated Infections for 24/25 need to be seen within the wider context of regional and national increases of rates of infection post pandemic. The Clostridioides difficile (C.difficile) Infection (CDI) rate for the BNSSG system has steadily increased above South West and national benchmark rates since February 2023 and much learning is being undertaken both locally and within the region to understand drivers for this. We continued to strengthen a collaborative approach to learning from HCAIs across all BNSSG partner organisations in the health and care system and will aim to continue to compare favourably against the other six systems in the region in 2025/26, for all HCAI infections.

The system continues to support the appropriate prescribing of antibiotics through clear guidelines, education and promotion. In primary care prescribing benchmarks well, meeting both national targets for reducing overall prescribing and reducing broad spectrum antibiotic prescribing, one of 17 of 120 sub-ICBs to do so. A focus on the appropriate course length of antibiotics has continued during the year and BNSSG benchmarks highest nationally for 5-day courses of amoxicillin. Whilst prescribing in children is the lowest nationally we have seen an increase in prescribing since the Covid-19 pandemic, which is in line with a national trend, therefore this will be an area of focus for 25/26 supporting the National Action Plan on antimicrobial resistance target to reduce total antibiotic use in human populations. Secondary care trusts have initiated aligning guidelines during 24/25 whilst focusing on increasing the prescribing of access antibiotics (a World Health Organisation Category of antibiotics that are least likely to lead to resistance). A collaborative system wide approach has enabled good stewardship of antibiotic prescribing throughout the system.



Amoxicillin 5 day prescribing



% of children aged 0-9 prescribed an antibiotic

During 24/25 a Burden of Infections mapping process was completed, this included considering the impact of inequalities and will inform priorities as a system in 25/26 and going forward.

Patient Safety

The NHS Patient Safety Strategy (NPSS) NHS England » The NHS Patient Safety Strategy sets out how the NHS in England will achieve its safety vision to continuously improve patient safety. The strategy involves moving from the Serious Incident Framework to the NPSS. We have embraced this opportunity to improve patient safety through a patient safety culture and a patient safety system that is based on insights, involvement and improvement. We have:

- Supported our partners to adhere to the new Patient Safety Specialist priorities which include improving safety culture; implementing involving patients in patient safety; improving patient safety education and training and; addressing patient safety improvement, including the implementation of Martha's Rule in acute hospital trusts.
- Co-ordinated the design and delivery of new classifications (taxonomy) for patient safety information. This means that it will be much easier to identify the patient safety themes in our providers of health and care. We can then learn from them and support any work that is needed to improve care.
- Started to develop the BNSSG Patient Safety Incident Reporting Framework. This work will be completed during 2025/26
- Carried out quality visits to temporary escalation spaces. These are areas of a hospital where care is given in unplanned settings such as corridors. We visited to get assurance that they are safe and to agree any improvements needed. We do not want the use of these spaces to be considered as standard care. However, our hospitals are having to use them more regularly.
- Used the ICB's Quality Management System's escalation process, where appropriate, to respond to patient safety concerns

Patient Experience

During 2024/25, the ICB has continued to recognise the importance of local voices contributing to our work and has kept engaging with communities to design new services. A key challenge has been to use data to enhance patient experience. By

analysing patient feedback, we have identified themes and trends to drive improvements.

The Customer Services Team continued to gather feedback from patients through compliments and complaints, advice and liaison enquiries, MP enquiries, feedback from healthcare professionals, patient surveys and Healthwatch reports. The Customer Services Team will also be developing and improving how they gather patient feedback in 2025/26.

The ICB uses social media, including Instagram, X (formally Twitter) and Facebook, and monitor responses posted on the NHS Choices and Care Opinions websites. A customer satisfaction survey was sent to all patients who raised a complaint or general enquiry and this data was regularly reviewed with colleagues across the ICB.

During the first quarter of 24/25 the ICB received 808 contacts, 549 General Enquiries, 225 formal complaints, 11 Compliments and 23 MP/Councillor enquiries. In Q1 2 complaints to the Parliamentary and Health Service Ombudsman was outstanding form 2023/24

During quarter two of 24/25 the ICB received 736 contacts, 504 General Enquiries, 208 formal complaints, 11 compliments and 13 MP/Councillor. 0 complaints were reported to the Parliamentary and Health Service Ombudsman.

During quarter three of 24/25 the ICB received 724 contacts, 497 General Enquiries, 182 formal complaints, 14 compliments and 45 MP/Councillor complaints. 0 complaints were reported to the Parliamentary and Health Service Ombudsman.

During quarter four of 24/25 the ICB received 827 contacts, 546 General Enquiries, 211 formal complaints, 8 compliments and 62 MP/Councillor complaints 1 complaint was reported to the Parliamentary and Health Service Ombudsman.

Patient experience was used to improve how the ICB operated across the health system. Feedback and analysis of trends or themes were shared with the BNSSG ICB QOPC. to ensure that learnings were shared, and patient experience improved.

- The Customer Services Team continued to provide training for ICB staff regarding patient feedback, how this is used and why it is important to the ICB as service commissioners
- Customer Services have implemented regular meetings with key service providers within the ICB, to discuss feedback from patients and to facilitate a swifter and smoother process for people contacting the Customer Services Team.
- Customer Services continue to work alongside the Southwest HUB delivering all POD services and Primary Care complaints since the delegation of these services back to the ICB in 2023.
- Customer services continue to evolve the Clinical Review Team who met

weekly to discuss complex cases, processes and strategy with a view of giving the best possible patient experience.
- There were regular meetings with external providers to improve services and to facilitate a swifter and smoother process for patients and improve collaborative working.
- Learning and intelligence collected was used to inform and update policies and related documentation, to provide a fair and transparent service for patients.
- Customer services deliver complaints training to GP Practice Managers and frontline staff for all GP Practices within BNSSG.

Working with our people and communities

ICBs have a duty to engage with and involve members of the public as outlined in section 14z45 of the NHS Act 2006 (as amended by the Health Care Act 2022).

Across our integrated care system, and as an ICB and a partnership we are agreed that the communities we serve, the people who we provide health and care for, are at the heart of all that we do.

We know the vital impact and value that working with the diverse communities who live across Bristol, North Somerset and South Gloucestershire has. We will continue to work hard to ensure our communities' needs, aspirations, and priorities are reflected in our strategy and programmes of work. We are developing a Working with People and Communities Strategy which outlines that we will:

- Turn understanding of our population into action
- Ensure our decision-making is informed by insight and lived experience
- Make co-production everyone's business, and embed best practice.

These commitments have and will continue to guide our activity and decision-making.

Partner engagement

VCSE Sector – Strategic Developments, collaboration and progress

Healthier Together, our Integrated Care System (ICS), has greatly benefited from the expertise, connections, ambitions, and relationships of the Voluntary, Community and Social Enterprise (VCSE) sector. The contributions are fundamental to

improving the wellbeing and health of our population and communities. Our vision for working with the VCSE sector emphasises embedding VCSE in the ICS, creating a positive impact on wellbeing and health, tackling inequalities, and shaping policy and strategy. We cannot achieve our goals without the VCSE sector.

Achievements to date

Since the launch of the BNSSG VCSE Alliance in January 2024, we have witnessed remarkable progress in a relatively short period. The Alliance represents a significant positive change in Healthier Together, creating an interface between large public sector organisations and 8,000 VCSE organisations. This interface has enabled us to engage in strategic and system-wide discussions on crucial topics such as the wider determinants of health, the prevention of health conditions, and the VCSE sector's reach into excluded communities.

The VCSE Alliance has grown impressively, with hundreds of organisations joining and reaching across BNSSG into communities that are often considered 'hard to reach'. Over 100 VCSE Alliance Ambassadors have shown a keen interest in collaborating within our system. These Ambassadors are now involved in various parts of Healthier Together, including the SHIPPH subcommittee for health inequalities and prevention, the Integrated Care Partnership, the ICB Board, the Healthier Together 2040 plan, and the Women's Health Hub. Their diverse mindsets, approaches, and deep understanding of community needs are invaluable as we strive to improve people's health and wellbeing.

Another major development over the past year has been the introduction of the VCSE Brokerage Framework. We recognised that contracting with the NHS can be challenging for VCSE organisations due to highly regulated processes designed for clinical services procurement. To address this, we co-designed with the VCSE Alliance and partners a new process for making investments in VCSE activities in communities. The new Brokerage Framework is based on principles such as positive action, designing for smaller organisations, and a grant-first approach.

In the first six months, over 150 VCSE organizations joined the framework, with 40% being micro and small. We are currently testing the framework with health programmes such as Children & Young People's Wellbeing in North Somerset, Communities Against Cancer, Work Well West, and Prediabetes in South Bristol. These tests amount to nearly £800,000 in awards, and we are pleased to see innovative proposals resulting in new investments in VCSE organisations.

The VCSE's contributions to population health and community wellbeing are significant, though often under-recognised within formal system data and planning. Much of the sector's impact is reported directly to funders or communities themselves. The co-designed VCSE Brokerage Framework presents a powerful

opportunity to align outcomes, integrate insights, and embed community-rooted intelligence into the heart of system thinking and planning.

Developments such as Locality Partnerships and the holistic approach of Community First, which supports people before and after hospital, will benefit from VCSE engagement. The re-procurement of Community Mental Health services will address equity and integration, with VCSE organisations playing a fundamental role.

At the ICB staff away day in December, the Chief Executive's award for systems working was given to Ellie Oriel (VCSE Alliance Director) and Mark Hubbard (VCSE Lead, ICB) in recognition of their contributions and work with the VCSE sector. This acknowledgment highlights the visibility and value of our collaborative efforts.

Through our work together, we are creating the means for VCSE to deliver. The Alliance and Brokerage are now recognised as fundamental parts of enabling our ICS. Our collaboration with the VCSE sector has yielded significant achievements over the past year, and we are poised to seize the opportunities that lie ahead. The Alliance, Brokerage, Integration Strategy and ongoing ICB investments in VCSE developments are key components of our collective vision for VCSE in BNSSG.

Community and Public Engagement

This year we have successfully recruited 19 public contributors with lived experience into key areas of work. The role of public contributors is to use their experiences and knowledge and act as a 'critical friend', the 19 contributors are broken down into:

- Three Public Contributors for the new Strategic Health Inequalities, Prevention, and Population Health committee
- Two Perinatal Mental Health Lived Experience Advisers
- Two ADHD Service User group representatives
- Two Healthier Together 2040 Steering Group Public Contributors
- Two Smokefree Representatives – Smokefree Bristol, North Somerset, South Gloucestershire (BNSSG) Alliance
- Two lived experience communicators for Dynamic Support Register
- Two lived experience advisors for Dynamic Support Register
- Two representatives on our ICB Policy Group
- Two representatives for our Women's Hubs

Case studies

Stay Well This Winter Campaign

Our 'Stay Well This Winter' campaign focused on encouraging local people to adopt behaviours to protect their health and prevent avoidable winter illnesses likely to lead to hospital admission.

As part of the campaign, we produced a suite of videos featuring clinicians and local residents, each sharing a message linked to the campaign's core aims. Below are those featuring residents/community members:

- Boost your immunity - Stay Well This Winter – Salma, Caafi Health
- Flu vaccination in children - Stay Well This Winter – Kate and Arthur, Portishead residents
- Look out for others - Stay Well This Winter – Jill, Southmead resident
- Stay active - Stay Well This Winter – Maria, Community activator for Lockleaze Neighbour Trust

These personal stories helped make the campaign relatable and relevant to our local audience.

Remember When campaign

The Remember When campaign raised awareness of bowel cancer screening. Kitty Odel, a bowel cancer survivor from Bristol, shared with us her experiences of taking up her bowel cancer screening and spoke about how it saved her life because she had no symptoms prior to taking the screening, highlighting the importance of bowel cancer screening every two years.

Know your numbers campaign

We held two local blood pressure events:

- South Gloucestershire Food and Drink Festival
- 78 blood pressure checks, 16 people identified with high blood pressure
- Bristol Bears match
- 27 blood pressure checks, seven people identified with high blood pressure
- 30% of checks were carried out with people from core20plus population

26 social media posts regarding hypertension (know your numbers week and blood pressure events), with a total of 24,291 post impressions and 135 link clicks.

NHS Ten Year Plan – local engagement

In response to Lord Darzi's independent investigation report, released in September

2024, the Government is developing a 10 Year Plan for Health. This is a key part of the government's mission – "to build an NHS fit for the future" and responds directly to the Darzi report.

On 21 October 2024 a national conversation was launched called Change NHS – Help build a health service fit for the future.

The conversation plays a key role in the development of the 10-Year Health Plan, which will be launched in 2025. In addition to encouraging public and staff feedback via the national NHS change portal, local systems were asked to hold localised engagement events to help widen involvement and discuss the three shifts.

In BNSSG we held and ran the following local session and resulted in us speaking with 350 people.

- Six face-to-face events for the general public, including afternoon and evening sessions in Thornbury, Weston-super-Mare and Bristol
- One online event for the general public
- One online event for VCSE organisations
- 12 targeted events for Core20PLUS5 groups or organisations that represent those audiences, including victims of modern slavery, people that have been through the criminal justice system and the gypsy, roma travelling community.

Neurodiversity Transformation Programme and working with the Parent Carer Forums

Like many areas across the country, we have seen a significant increase in demand for autism and attention deficit hyperactivity disorder assessments. To help ensure children and families can be supported appropriately, work is underway on a transformation programme. The ICS is working closely with our three Parent Carer Forums in Bristol, North Somerset and South Gloucestershire to ensure all proposals are co- produced and to strengthen our mechanisms for engaging and involving the wider parent and carer community in this programme. The first concept currently being tested is a profiling tool that enables earlier identification of a child's needs and offers tailored strategies and guidance for families and schools. The profiling tool is conducted in the school setting with an education professional and the family to understand needs both in school settings and the home. The second concept which is due to be tested is an autism hub to provide informed advice and resources to families and young people. These will be tested in the community and underpinned by an MDT approach for families to discuss their child and signpost according to any required services and support. This approach will enable families and children to access appropriate support and

pathways, whilst understanding their child and their behaviour. Both concepts will be underpinned by a needs-led Charter which removes the need for a diagnosis before needs can be understood and met.

BNSSG Vaccination Programmes

The Bristol, North Somerset and South Gloucestershire (BNSSG) Integrated Vaccination Programme is funded and commissioned by NHS England (NHSE) and covers the BNSSG Integrated Care System (ICS). The programme is responsible for providing an efficient, cost-effective, easy access, safe, and high-quality vaccination service in convenient settings that are designed to meet the needs of the local population across BNSSG.

The BNSSG Integrated Vaccination Programme was previously selected by NHSE as one of 11 national vaccination demonstrator sites to contribute to informing and shaping vaccination transformation in line with the national ambitions set out in the NHSE Vaccination strategy NHS England » NHS vaccination strategy.

The National Vaccination Strategy builds on learnings from the Covid-19 vaccination programme, aiming to increase uptake of other immunisations and reduce vaccine-preventable diseases. It calls for every Integrated Care board (ICB) in England to develop vaccination services that are tailored and convenient for their local population, supplement existing vaccination offers with targeted outreach, and work in a joined-up, integrated way across the system. In BNSSG, we have already applied many of the principles contained within the Strategy, with our previous vaccination work on Measles, Mumps and Rubella (MMR) and Mpox uptake and this year, Human Papilloma Virus (HPV) uptake.

The BNSSG integrated vaccination outreach service is funded through NHSE Covid-19 vaccination access and inequalities (A&I) funding. The service contributes and complements the BNSSG system provision of delivering Covid-19 vaccines alongside other seasonal vaccines in multiple settings: care homes, community venues, community outreach clinics, inclusion health settings, universities, hospital hubs, GP surgeries and patient homes. The service is contracted until March 2026, with North Bristol NHS Trust (NBT) holding the contract currently. The vaccination outreach service is a system wide resource, complementing existing commissioned services, advocating and championing for reducing health inequalities, with a focus on underrepresented and underserved communities.

Our approach focuses on addressing inequalities in access, experience and outcomes by:

- Working with communities and groups most affected to understand and

address barriers to access and uptake of services and to build trust

- Ensuring our health and care provision is equitable and meets the needs of all our communities - different people and communities will need different approaches and levels of resource to meet their need

- Inclusive by design and advocates equitable access for the most marginalised health inclusion population groups, such as people who experience homelessness and Gypsy, Roma, and Traveller communities, and those not registered with healthcare providers across BNSSG

- Working in collaboration with system partners by using community assets and facilities to maximise vaccination uptake in underserved populations and reach into local communities, considering vaccination alongside wider health, care, or social issues

- Increasing health literacy that is culturally appropriate and that is in the preferred format of BNSSG communities

- Addressing the specific health inequalities experienced by Black, Asian, and other minority ethnic groups

- Programme takes an asset-based approach

This team continues to work in areas where there has been a reduced Covid-19 and flu vaccination offer from core services and community pharmacy, to ensure local communities have access to these vaccinations. The community clinics offer both a pre-booked and walk-in option for people to obtain these vaccinations where eligible.

Our hospital trusts continue to have vaccination hubs which focus on health care staff and inpatient Covid-19 and flu vaccinations. These are based at Southmead hospital, The Bristol Royal Infirmary and Weston hospitals and Callington Road hospital and its associated sites. Sirona also deliver vaccinations to their staff and inpatient units. These teams have adapted their approach and offer vaccinations all over the hospitals with roving teams, to improve access and save time for staff working on shift. Locally and nationally, vaccination uptake by health and social care staff are lower than targets set. However, BNSSG benchmarks better than national figures. Over the past few years there continues to be a steady decline in uptake in this cohort. Subsequently there will be a national focus on health and social care staff vaccination uptake for the Covid-19 and flu during Autumn 25/26. The outreach vaccination service will be utilised to attend and offer vaccinations to staff at some care homes to improve access for those social care staff that work long hours and can’t always get to a vaccination centre or GP.

Figure 4 – Covid uptake 24/25 by staff group:

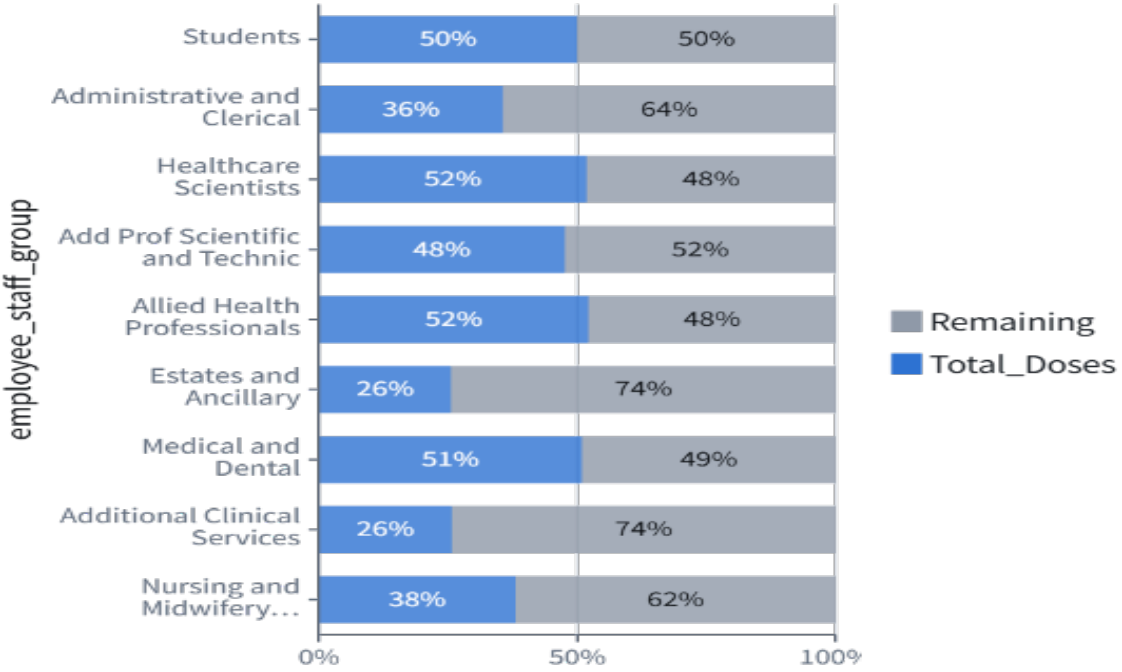
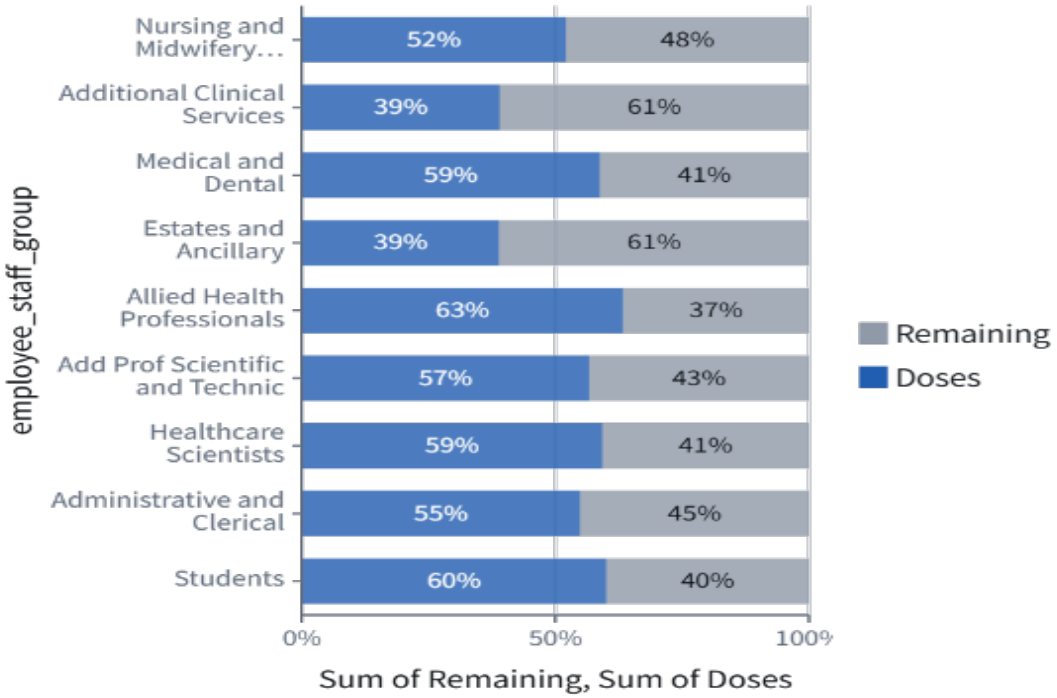


Figure 5 – Flu uptake 24/25 by staff group:



Staff vaccination rates for BNSSG system partners (FDP data):

Organisation	Frontline healthcare workers (HCW) on ESR – Covid update AW24/25	Frontline healthcare workers (HCW) on ESR – flu update AW24/25
North Bristol Trust	37.8%	49.5%
University Hospital Bristol and Weston Foundation Trust	40%	51.8%
Avon & Wiltshire Partnership	34.4%	46.9%

Our acute trust hospitals have also set up vaccinations in their maternity departments to ensure vaccination is accessible for pregnant people attending maternity services and appointments. Alongside Covid-19, flu and Pertussis vaccinations, the maternity services are also offering Respiratory Syncytial Virus (RSV) vaccinations to pregnant people. Starting in September 2024, the Government accepted the JVCI advise to start an RSV immunisation programme for older people and pregnant people, to protect infants. The link to the RSV Green Book, chapter 27a is here: Respiratory syncytial virus: the green book, chapter 27a - GOV.UK.

RSV data from the Federated Data Platform (FDP), dated 16/04/25:

	Eligible cohort	Doses administered	Percentage uptake
Routine cohort population and vaccinated			
National	327,002	101,505	31.04%
Southwest	35,663	13,376	37.51%
BNSSG	4,637	1,836	39.59%
Uptake for women currently in their 3rd Trimester			
National	147,373	53,006	36%
Southwest	12,210	5,162	42.3%
BNSSG	2,422	1,090	45%

During the AW24/25 flu campaign, BNSSG ICB offered BNSSG primary care networks (PCNs) additional funding to run additional flu clinics in the final months of the campaign for at risk cohorts. This work was proposed and co-ordinated through One Care, our GP Federation in BNSSG. This extra focus was in response to the then current system pressures and the predicted Flu surge and asked practices to increase Flu vaccination uptake by delivering more focussed outreach work in at-risk communities/cohorts. This work resulted in approximately 2410 flu vaccinations in this timeframe. From the learning of this project, we are taking this forward with offers to BNSSG PCNs to offer some additional activity to test new ways to increase Covid-19 and flu uptake in the Spring/Summer 25 (SS25) and Autumn/Winter 25/26 (AW25/26) campaigns. This is in its early stages but all PCNs have signed up to the offer some additional access and inequalities funding. An evaluation will be completed at the end of the project.

During our report in 23/24, we mentioned the BNSSG Integrated Vaccination Programme widened its remit to include other adult and childhood immunisations. During January to March 2025, we were awarded short term funding from NHSE to look at increasing HPV vaccination uptake in 16–25-year-olds. This was a collaborative piece of work across BNSSG, and we were able to ensure the work was taken into education settings throughout BNSSG. This work involved Sirona's school aged immunisations team offering additional catch-up clinics to sixth form students who may have missed previous HPV vaccinations, and this will continue into the new academic year in September 2025. We also worked with our student health service teams, based at the two universities in BNSSG. They looked at updating records for overseas students and invited students to additional vaccination clinics. Our Communications Lead worked across all these teams to ensure a consistent message was given and they will continue this engagement work alongside our three local authority teams as they look to increase awareness of HPV vaccination and cancer screening. This work is just being evaluated with further data outstanding, but nearly 200 HPV vaccinations were given by these teams with over

40 other vaccinations also being offered

Our previous work on MMR vaccination uptake, which NHSE funded in addition, saw us work collaboratively again in BNSSG. GP practices ran patient searches and sent out invites to vaccination, our vaccination outreach team ran vaccine clinics at local universities and colleges, and we offer community grants to our voluntary sector teams to raise awareness. In people aged 17-34 years, the results of this work increased the number of people double vaccinated with MMR by 3085. 1125 additional people showed as receiving a single dose of MMR vaccine and there was a 5316 reduction in non-MMR vaccinated people on data that NHSE Southwest ran. The outreach vaccination team delivered 185 first doses of the MMR vaccine and 76 2nd doses.

Our approach to vaccination continues to be through collaborative partnership working with the local voluntary sector, our communities, Local Authorities, Public Health Community Development team, general practice, community pharmacies, hospitals and the school aged immunisation service. We provide a more intense offer where need is higher, to improve outcomes and inequalities. We remain committed to building around strengths and assets in our local communities, co-producing solutions, and engaging with local organisations to raise awareness of all aged vaccines.

Insight continues to inform and develop the vaccination delivery model across BNSSG and at a hyper local level. Our communications have continued to build on this insight, offering audio translations of vaccination information for some languages such as Somali and Arabic where it is common for people not to be able to read their spoken language. Invitations to vaccination have also been sent out via text to some communities in their first language, and there are plans to extend this approach and share more widely in BNSSG.

Our approach is testament to the success we have achieved in our uptake figures in 24/25 compared to regional and national results. We recognise that there is more to do.

AW24/25 Covid-19 and Flu campaign data from the Federated Data Platform (FDP):

	Covid-19	**Flu**
Total vaccine doses administered in AW24/25 in BNSSG	213,080	312,396
Overall percentage uptake in AW24/25 comparison		
National	62.5%	50.93%
Southwest	71.9%	59.10%
BNSSG	74.3%	56.23%
Percentage uptake in ‘At Risk adults’ in AW24/25		
National	57.2 %	44.14%
Southwest	71.4%	48.87%
BNSSG	70.8%	48.93%
Percentage uptake in frontline healthcare workers on ESR in AW24/25		
National	20.8%	40.8%
Southwest	33.9%	48.5%
BNSSG	38.3%	50.2%
Percentage uptake for BNSSG care home staff (substantive) in AW24/25 (data from Capacity Tracker)	20%	13%
Percentage uptake for BNSSG home care staff (substantive) in AW24/25 (data from Capacity Tracker)	19%	15%
2-3 year old flu uptake percentage in AW24/25		
National	NA	41.81%
Southwest	NA	50.08%
BNSSG	NA	50.35%

Ensuring our decision-making is informed by citizen insight and lived experience

Partnership for Inclusion in Neurodiversity in Schools (PINS)

Meeting the needs of children with Special Educational Needs and Disabilities (SEND) in mainstream schools is the cornerstone to improving outcomes, parental confidence and delivering the financially sustainable SEND system. PINS is a programme designed to improve outcomes for neurodivergent pupils and those with special educational needs and disability in 45 of our Primary schools improving

inclusion and reducing exclusion. Our 3 parent carer forums have ensured our decision making is informed by insight and experience by:

- leading the initiative working strategically with the ICB to develop and deliver the project
- working with schools and parent carers to strengthen relationships between schools and their parent carers of neurodiverse children in their schools
- supporting the development of improved co-production with families to facilitate service design and delivery

Children and Young People

During 2024/25, the Children's Health and Care Improvement Group (HCIG), comprising BNSSG ICS Executive Directors, senior leaders, and health and care professionals, worked collaboratively to drive delivery against operational plan metrics and advance system-wide improvements aligned to the Joint Forward Plan.

Mental Health

Investment into the Child and Adolescent Mental Health Service (CAMHS) and Mental Health Support Teams (MHSTs) in schools has increased access to mental health support for children and young people. We remain below the National access target, however, and improvement in this area remains a key priority for BNSSG ICB.

A new paediatric acute eating disorders service was launched, supported by a joint weekly MDT with CAMHS and local authority involvement to deliver integrated care for children and young people.

An enhanced transitions service for children moving on from CAMHS was co-produced with young people with the aim of providing our young adults with a supportive transition into adulthood. The service has been set up and will be fully operational from June 2025.

Neurodiversity

A key challenge in BNSSG is the increasing need for autism assessments which significantly outweighs capacity. Investment and continued focus on reducing long waits in community services has resulted in the stabilisation of waiting lists and long waits. However, the scale of the gap between demand and capacity means that children and young people are still experiencing excessive waits for Autism and ADHD assessments. The BNSSG system neurodiversity transformation programme

has made significant progress in developing a needs-led approach to supporting children, young people and their families with the testing of profiling as an approach to the identification, planning and meeting of neurodiverse needs. A recovery plan, to implement a sustainable needs-led approach and eliminate long waits for Autism and ADHD assessments is now in development.

Investment in speech and language therapy for early years children is preventing children from falling further behind their peers whilst they are waiting for an autism assessment.

The Partnerships for Inclusion in Neurodiversity in Schools project has delivered bespoke support packages to 46 Primary schools across BNSSG aimed at improving the school's awareness, knowledge and confidence in meeting the needs of neurodivergent pupils thus improving inclusion and reducing exclusion.

The Autism Intensive Service (AIS), jointly re-commissioned by BNSSG ICB and Bristol, North Somerset and South Gloucestershire local authorities, continues to demonstrate improved and sustained quality of life and psychosocial wellbeing, reduced frequency and/or intensity of behaviours that challenge, and prevent exclusions from school or admissions for mental health support for most young people.

Around 75 children with a learning disability and/or autism now have a designated keyworker across BNSSG. The purpose of a keyworker is to ensure the child or young person, and their family have the support they need to prevent inpatient admissions to a child and adolescent mental health service (CAMHS). Inpatient numbers in BNSSG remain very low with inpatient admissions being avoided. Over the two and a half years that Keyworking has been in place in BNSSG, the team estimate c.£3.9m cost savings from avoiding unnecessary CAMHS inpatient admissions, acute admissions, and children going into care.

Special Educational Needs and Disabilities (SEND) and Safeguarding

All local area SEND inspection-related improvement plans have been completed and signed off. Bristol's Accelerated Progress Plan was signed off in October 2024, with strong evidence of improved co-production and engagement with parent carers.

Investment in system arrangements for safeguarding children, including consistent health input to safeguarding strategy meetings across BNSSG, capacity for adoption medicals and continued focus on initial and review health assessments for children in care have improved timeliness of assessments and strengthened overall safeguarding arrangements.

Community services

The transformation of Public Health Nursing was completed in 2024/25 and will continue to embed the benefits:

- The THRIVE Framework embedded so services offered are person-centred and needs-led

- More than 60 evidence-based pathways have been developed to support the delivery of the Healthy Child Programme and ensure an equitable and consistent service offer that has a focus on prevention, early intervention and reducing inequalities.

- The universal offer has been clarified so staff, families and system partners understand what services will be delivered, and a new website that was co-produced with children and young people has been created to ensure information and support is accessible to all.

- A single electronic record system will support the ability of the service to provide consistent, comparable, and good quality data to evidence performance and provide assurance.

- The Maternal Early Childhood Sustained Home Visiting (MECSH) programme has been launched to provide more intensive support to families at risk of poor outcomes, so families can receive the support they need at the intensity and scale that is proportional to their level of disadvantage

NHS England South West Health and Justice team commissioned BNSSG ICB to deliver the Vanguard Framework for Integrated Care to provide additional support to the most vulnerable children and young people in our community.

The Framework provides a set of guiding principles and practices which act as a template for trauma informed, integrated working. The aim is to provide preventative support for children exhibiting high risk and high harm behaviours. The BNSSG Vanguard is made up of 7 services who have embedded the framework principles and working in Trauma informed integrated way.

In the final year of funding, an independent evaluation is taking place demonstrating positive outcomes of reducing school exclusion, reducing risk taking behaviours and improving mental health and wellbeing. All providers are working on sustainability plans to continue the benefits of delivering the Framework of Integrated Care.

Acute services

The children’s acute services programme has continued to support patient flow and

provide additional capacity. This has resulted in a significant reduction in waiting time for elective care, with most paediatric specialties eliminating 65 week waits by the end of 2024/25. This focus is maintained in the 25/26 Joint Forward Plan, paying particular attention to cardiac surgery, dental and cleft that are facing specific risks and challenges.

The minor injuries stream and additional temporary space created for the Emergency Department is supporting waiting times for urgent and emergency care and achieving the national target of <78% patients seen within 4 hours by March 2025.

A system partnership, led by the Bristol Royal Hospital for Children, has set-up pilot sites for integrated care for children across three Primary Care Networks in BNSSG. Evaluation data, including excellent patient and staff feedback, supports the recommendation to continue this approach in other Primary Care Networks and supports the development of integrated neighbourhood health for children. The ICB is now developing a system-wide approach to developing neighbourhood health starting with a discovery phase to assess what we have already in place and inform our future ambitions and plans. Children and Young People are fully integrated within the scope of this work.

Maternity and Neonatal

Key Achievements and Focus Areas

Within BNSSG, we should be proud of our maternity services based at University Hospitals Bristol and Weston (UHBW) and North Bristol Trust (NBT), as both are high performing and among the few nationally rated ‘good’ by CQC. This is significant considering that 75% of maternity services nationally have been rated as ‘requires improvement’ or ‘inadequate’. Additionally, NBT’s safety rating has been upgraded from ‘requires improvement’ to ‘good’, making it one of only five maternity units in England to achieve this improvement. Both of our providers continue to have stillbirth rates lower than the national average of 4.0 per 1000 births (NBT 2.52 per 1000 births & UHBW 3.4 per 1000 births).

While these outcomes are positive, we remain committed to making further improvements in the quality and experience of care in our maternity and neonatal services across the NHS in BNSSG. We acknowledge that we still have underserved communities within our population. Therefore, improving outcomes and reducing inequity are the primary focus for the LMNS in 2025/2026.

Maternity & Neonatal Voice Partnership (MNVP) Development

Having the voice and views of the population we serve is integral to developing and improving maternity services. National MNVP guidance published in December 2023 clearly laid out a gold standard framework for a staffing model including roles and responsibilities. A key priority for 2024/2025 was to develop this within BNSSG in collaboration with acute maternity trusts and Healthwatch via The Care Forum (host organisation).

We now have a structure that replicates national guidance (strategic lead, trust liaison, community engagement, and neonatal specialist lead). BNSSG is the only ICB/LMNS within the South West to achieve this. We are currently developing a two-year strategic ambition framework focusing on improving equity and reducing inequalities.

Three Year Delivery Plan (TYDP)

The Three Year Delivery Plan (TYDP) lays out the strategic ambition for perinatal services. We have just entered year 3 of the TYDP and are progressing well. There is an additional shift in focus towards embedding programme capabilities (sustainability post-2026 for live projects) and benefits realisation (capturing and documenting benefits). The third and final year will commence in April 2025.

Maternity Incentive Scheme Year 6

Both Trusts achieved full compliance with all 10 safety actions for the second year in a row. NHSE have developed an implementation tool so that the LMNS can track evidence being submitted contemporaneously to ensure quality is assured. Year 7 has been published, and work has already begun to ensure compliance continues and will be monitored via the LMNS.

Saving Babies Lives Version 3

We continue to use the compliance tool provided by NHSE to ensure robust audit quality of evidence submitted. In 24/25 NBT has achieved 83% compliance compared to 77% last year. UHBW has achieved 90% compliance compared to 89% last year. We are working towards 100% compliance for next year with a focus on reducing smoking rates.

BNSSG LMNS Equity & Equality Action Plan

NHSE required all LMNS's to publish their Equity & Equality Action Plan, which was achieved in April 2024 and is available on the ICB website. A highlight report has been developed to capture system Equity & Equality achievements and share them with the system and region, showing our progress against all objectives. We will now work closely with the ICB Communications team to make an accessible, easy-read version for the public, which will be shared widely. Our MNVP is engaged in collecting feedback and in improving public perception of maternity services related

to improved outcomes.

Race and Health Observatory (RHO) Learning and Action Network

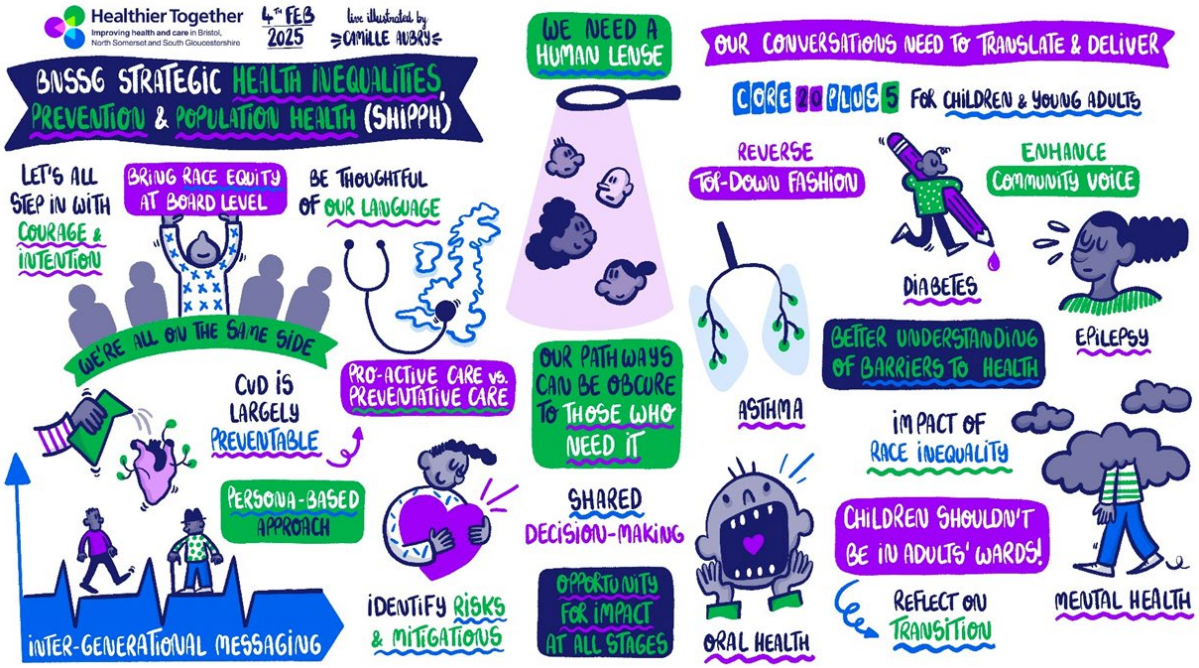
BNSSG is one of only 10 systems across England chosen to work with the RHO, aiming to reduce health inequalities and improve outcomes for Black and Asian mothers and babies. This 15-month project focuses on pre-term births and the disparity in antenatal interventions between our white and ethnic minority populations. During the project, we have worked collaboratively with trauma-informed anti-racist practitioners to gain the stories and experiences of Black mothers within our system who have lived experiences of pre-term birth to guide the focus of quality improvement with an anti-racist lens. There will be a celebration event this year to share our data and findings at local, regional, and national levels. BNSSG actively continues to support the Black Maternity Matters anti-racism training for perinatal staff to support the goal of improving outcomes and the experience of our global majority population within maternity and neonatal services.

Reducing Health Inequality and Inequalities

ICBs have a duty to reduce inequalities between persons with respect to their ability to access health services, and the outcomes achieved for them by the provision of health services as outlined in section 14z35 of the NHS Act 2006 (as amended by Health Care Act 2022). Under the Public Sector Equality Duty 2011 ICBs are required, in carrying out their functions, to have due regard to the need to eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Equality Act 2010; advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it and foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

There are many examples throughout this report of specific work that the ICB and its partners have done during 2024-2025 to promote equality and reduce health inequalities.

The SHIPPH Committee, newly established in 24/25, support the ICB discharge its responsibilities in regard to tackling inequalities. The minutes of this formal committee are reported to Open Board meetings. To assist with making the minutes accessible, pictograms of discussion held are included. An example is shown below:



Equality objectives

Under the Public Sector Equality Duty, the ICB is required to publish equality objectives that are based on an understanding of equality issues the ICB faces. In March 2025, the ICB Board agreed the following objectives which will be in place for three years (subject to review):

- **Workforce**

- To make recruitment practice more equitable, making year on year improvements in hiring outcomes for those from racialised communities as compared to 2023-24 disparity data.

- A year-on-year reduction in the disparity for colleagues from racialised communities and those with disabilities in relation to bullying, harassment and discrimination from managers and colleagues as reported in staff survey data in comparison to 2024 data.

- To increase the proportion of staff from racialised communities in Band 8a or above to 12% by April 2028.

- To continue to reduce the gender pay gap year on year, ensuring that the proportion of females within the upper quartile are comparable to overall organisation composition.

- **Cardiovascular disease**

Because cardiovascular disease (CVD) is one of the largest contributors to health

inequalities BNSSG ICB aims to improve the treatment of high blood pressure in our Black African and Caribbean populations so that 80% reach treatment targets by 2029. We will also reduce the gap between our Black African and Caribbean populations and our white population to within 3 percentage points.

- **Maternity**

To increase the administration of optimally timed antenatal steroids and magnesium sulphate in our population racialised as Black at risk of pre-term birth within BNSSG by March 2026

- **Ethnicity data recording**

Increase the completeness of ethnicity recording in the patient administration systems of University Hospitals Bristol and Weston NHS Foundation Trust, North Bristol NHS Trust and Avon and Wiltshire Mental Health Partnership NHS Trust to 80% for BNSSG patients by 2027.

The ICB Board will receive updates twice a year on the progress being made to achieve the objectives.

Resources for health inequalities

In addition to the 'business as usual' budgets that BNSSG ICB allocates to fulfil its responsibilities a health inequalities budget was allocated to its Chief Medical Officer. The funding was used as follows:

- Second year of funding to the six Locality Partnerships – each of them decided how to use it to reduce health inequalities in their area in response to their communities' needs.

- Support the increase in health and care needs of people within our communities and who are migrants. The funding is being used to support a range of services and statutory requirements.

Collecting, analysing and publishing information on health inequalities

In November 2023, NHS England advised, through the 'NHSE Statement', that all ICBs (and other relevant NHS organisations) should collect, analyse and publish certain information on health inequalities within or alongside their annual report. During 2024-25 we worked closely with the Directors of Public Health in each of our local authorities to develop a more robust format and support for fulfilling this requirement.

Some of the findings from the data we have been able to collect show that:

- A key objective for the NHS in 2023/24 was to recover elective (planned care in a hospital) activity levels to above those seen in the pre-COVID period, to address the growing elective care waiting list. We found that for adults, it is broadly similar across the deprivation quintiles. For children, outpatient activity remained below pre-pandemic levels. For admitted procedures, recovery has been noticeably slower in the most deprived quintile.

- People in BNSSG living in our most deprived areas are more likely to get a cancer diagnosis at a later stage.

- People who live in our 20% most deprived areas are 16% less likely to report recovery following talking therapies compared to the BNSSG average. Rates of talking therapies interventions are significantly lower than the BNSSG average for all other ethnic groups than White and Mixed or Multiple ethnic groups. For example, people in the Black African, Caribbean or Black British ethnic group are 40% less likely to report recovery following talking therapies. For people in the Asian or Asian British ethnic group, it's around 37%. We note that the differences observed by ethnicity are greater than for deprivation.

- Restrictive interventions are significantly higher in the most deprived quintile, and highest in the Black ethnic group.

- For high blood pressure

- Overall, more patients are achieving treatment targets, compared to two years ago, but a lower percentage of people living in our most deprived areas have a blood pressure reading at target than people living in our least deprived areas.

- People in the White ethnic group are the most likely to reach their blood pressure target. People in the broad Black ethnic group are the least likely to reach their target blood pressure.

During 2024-25, the ICB and the providers it commissions to deliver healthcare have been working both together and separately to address some of the findings. Some of the work is described in many other sections of this report. This work will continue over the coming years and the ICB Strategic Health Inequalities, Prevention and Population Health Committee will continue to seek assurance on the progress that is being made.

Women's health

We are improving access to and quality of women's health services for people who fall under the 'inclusion health' umbrella, specifically: migrants in vulnerable

circumstances, including asylum seekers and refugees; people facing multiple disadvantages; and Gypsy, Roma, and Traveler people. We have awarded 11 small grants to local organisations and community groups who have trusted relationships with people in the above groups. For example:

- Black Maternity Matters are working with people living in Ashley Community Housing to provide co-produced workshops on women's health topics.

- Bristol Refugee Rights are working in collaboration with Bridge View Medical practice to provide women's health sessions for people living in asylum seeker and refugee home office accommodation.

In November 2024, in a seminar session, the ICB Board undertook a deep dive on the strengthening of the work to tackle health inequalities with a focus on cardiovascular disease. Based on identified disparities, an ICB Equality Objective has been developed and ratified to focus on improving the treatment of hypertension in Black African and Caribbean communities.

Trauma-Informed Systems Programme

The BNSSG Trauma-Informed Systems Programme is based in the ICB as a dedicated resource to support the development of trauma-informed practice and trauma-informed systems change across BNSSG. Running through all aspects of the programme work is an active commitment to reducing health and social inequality, co-production and including the voice of lived experience, and integrating and contributing to evidence-base and best practice. Some key achievements over the year have included:

- Launched the BNSSG Trauma-Informed Practice Framework, a co-produced system-wide resource to improve understanding among individuals, teams, services and organisations of trauma and adversity, trauma informed approaches and how to embed into practice

- Co-produced an introductory trauma-informed practice e-learning module, due to go live in May 2025, that will form part of mandatory training for all ICB staff. This module will also be made available for use within the wider system.

- The Trauma-Informed Leadership event in July 2024, aimed to increase understanding of trauma-informed practice and the role of a trauma-informed leader and was attended by 58 national and regional leaders who hold senior positions across various sectors.

- Generated growing support for the Trauma-Informed Pledge for Partners, an opportunity for organisations, strategic groups and boards serving the people and communities of BNSSG to make an active commitment towards embedding a trauma-informed approach across services and systems. The pledge has already attracted support from over 35 ICS and wider system

partners to date including the ICB, Avon and Somerset Constabulary, Avon and Wiltshire Mental Health Partnership, our three local authorities, education providers, Voluntary Community and Social Enterprise organisations, University Hospitals Bristol and Weston and North Bristol NHS Trusts.

Medicines Optimisation

Medicines are the most common therapeutic intervention across our health service and the second highest area of NHS spending. To improve health outcomes and ensure the most efficient use of NHS resources medicines optimisation is vital and a golden thread throughout all care pathways.

Within BNSSG the Medicines Optimisation vision is to implement a person-centered, collaborative approach to get the best value from medicines, investing in medicines to improve patient outcomes, reduce avoidable harm and improve medicines safety whilst reducing health inequalities and ensuring equitable access to medicines.

This is achieved through safe and evidence-based prescribing, increasing patient empowerment through shared decision making whilst ensuring a sustainable pharmacy workforce.

A detailed implementation plan with key deliverables and milestones for the medicine's optimisation program is found in our Joint Forward Plan. Progress of the plan is monitored by the ICB medicines optimisation team and fed back to the Medicines Optimisation and Pharmacy System Leadership Group. The plan will continue to be reviewed, modified, and updated as we progress year on year. Within our plan, there are many aspects of routine work that is continued throughout the year to support system priorities.

In addition to this, the NHS England sets National Medicines Optimisation opportunities to enable ICBs to focus and deliver alongside their local medicine's optimisation priorities. Systems are asked to reach certain targets and systems are ranked based on their performance. BNSSG is ranked as the best in the country for reducing course length of antimicrobial prescribing and addressing low priority prescribing. The ICB has also made signification progress in the last 12 months regarding reducing carbon emissions with inhalers as part of the Optimising inhaler use to improve respiratory outcomes and reduce carbon emissions opportunity.

With regards to spend on medicines, the medicines optimisation team with system partners and finance undergo a horizon scanning each year to pre-empt the financial impact of either new drugs to the market approved through NICE or growth in use of existing medicines. Along with a plan for any possible savings/ efficiencies that can be made. This is done for both primary care prescribed drugs and the more

specialist prescribed medicines (high cost medicines, including some devices). Through reviewing this as well as ensuring clinical pathways are appropriate it enables BNSSG to be able to offer new medications and technologies to our patients

In 2024/25, the prediction for additional growth on primary care prescribing budgets was focused on new NICE TAs, license extension of existing medicines in diabetes, chronic kidney disease (CKD) and heart failure. With continued growth forecast in other areas such as treatment for ADHD and Menopause. Prescribers have been supported to choose the most cost-effective medicines such as diabetes medicines, Direct Oral Anticoagulants (DOACs), and best value biologics. In 24/25 growth has been almost as predicted and the savings plan has been achieved. In 24/25 approximately £160 million was spent on medicines within Primary Care. The medicines optimisation team supported with ensuring that this was spent appropriately, and financial balance was achieved with an underspend of approximately £3million, due to over savings plans doing better and the loss of patent sooner than anticipated on another of the DOACs which led to further savings in year.

There have been a range of medicines optimisation projects in primary care, aligning with system priorities that have included focusing on reviewing frailty patients prescribed overactive bladder (OAB) treatments to reduce anticholinergic burden, improving the number of patients treated to treatment targets with Cardiovascular disease (CVD) and projects focused on hypertension, lipid management and atrial fibrillation (AF) treatment optimisation which will further steer our prevention work in 25/26.

The hypertension project had several elements which included a patient survey of patients controlled and uncontrolled hypertension. Over 7,000 patients responded, key findings were:

- Awareness: 30.2-32.7% unaware of their current BP; 1/3 unaware of ideal BP
- Medication Adherence: Controlled patients more likely to take antihypertensives regularly; uncontrolled patients have more concerns about medication
- Knowledge Gaps: Over 1/3 felt benefits of BP control not well explained
- Home Monitoring: Nearly 25% monitor BP at home
- Review Attendance: Over 25% say they did not receive a review invite in the past year; controlled patients slightly more likely to attend reviews
- Patient Motivation: Most patients value BP control and are willing to attend reviews if invited

In addition, practices involved in the project were asked to work towards a 5% improvement in hypertension control, focusing on those with a previous cardiovascular event or significant co-morbidities. Over a 9 month period there was a BNSSG-wide average improvement of 3.64%. The average improvement of those practices involved in the project was 4.3% (which shows that those practices taking part in the PQS project made a bigger average improvement than those not taking part in the project). In addition, there was a 2.9% growth in the hypertension register in BNSSG (of 4246 patients).

Based on estimate of extrapolated data from Size of the Prize. A 3.64% improvement would lead to approximately 28 MI prevented, 42 strokes, 23 deaths and up to £780,000 saved over 3 years.

Ensuring safe use of medicines continues to be a key priority and areas of achievement in 24/25 have been embedding the ICB Medicines Safety Dashboard to support Primary Care practices to identify significant medication risks which could lead to medication related harm and potential hospital admissions. Areas of focus included anticoagulant and antiplatelet medication safety as well as reviewing patients on nephrotoxic combinations of medicines.

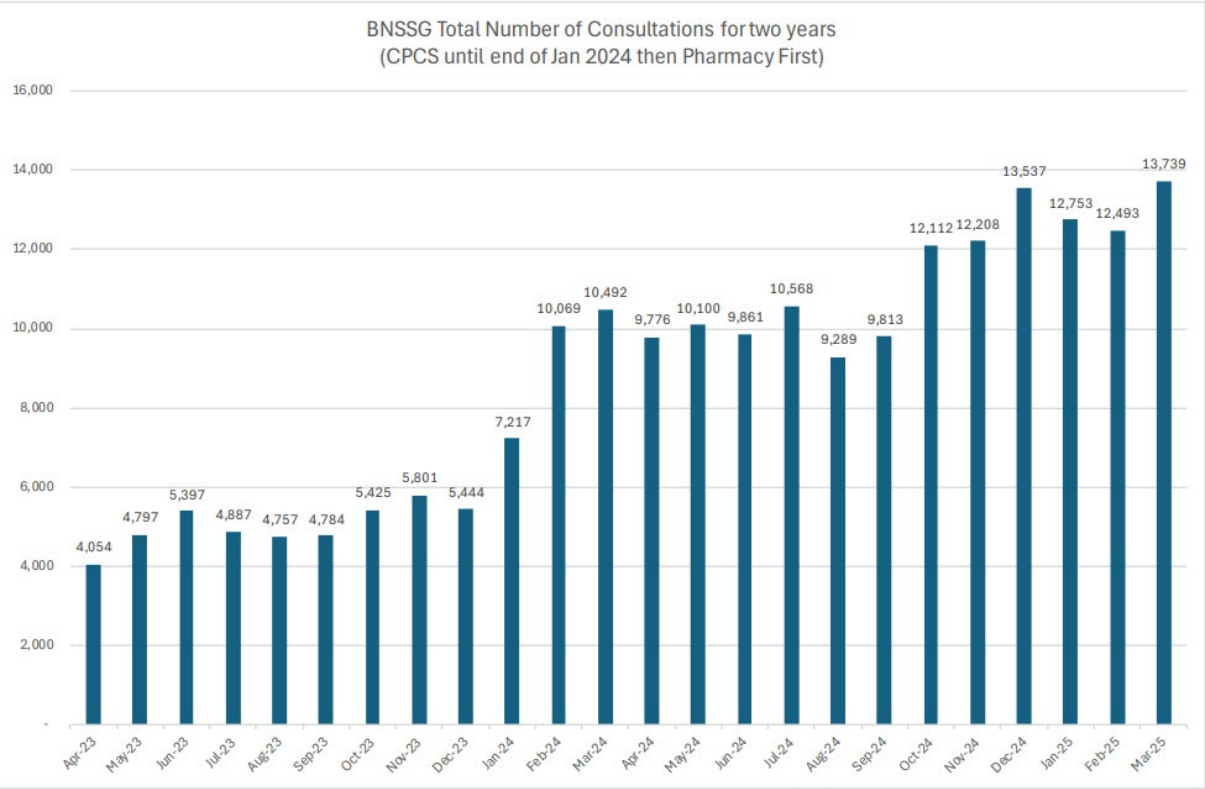
System-wide working groups continue to facilitate safer prescribing in areas such as anticoagulation, diabetes, prescribed drugs of dependence. A system-wide teratogenic medicines safety working group which focuses on central nervous system medications continues, and we have implemented and reviewed processes to improve patient safety around sodium valproate, meeting the requirements of the Valproate National Patient Safety Alert (NPSA) and other teratogenic medicines highlighted in MHRA safety alerts such as topiramate.

Work to support clinicians with the numerous national supply disruptions of medicines and shortages of medicines across the system has continued. Working with system colleagues have put in appropriate support and guidance to mitigate as much as possible the impact to patients. E.g., ADHD medication shortages and pancreatic enzyme replacement treatment (PERT).

Medicines feature in the sustainability/Green Plan for our system in which we are supporting the headline ambition to reduce the impact of medicines and medical devices on the environment. Some of the key headline aims include reducing the carbon footprint associated with anesthetic gases and metered dose inhalers. Desflurane, one of the highest carbon footprint inhaled anesthetic gases, has been completely decommissioned across the trusts, in line with the NHSE 2024 mandate and work continues to decarbonize other aspects of anesthesia within the trusts. In terms of inhalers, sustained action has been taken by the medicines optimisation team to encourage the use of greener inhalers.

Safeguarding the efficacy of antimicrobial continues to be a high priority for the system as detailed in the Infection, prevention and management section of the report.

Great progress has also been made in supporting patients to access care in the right place at the right time, by expanding the range of services that are available from community pharmacies. The Pharmacy First scheme is delivering approximately 13,000 consultations per month for Community Pharmacy, which frees up appointments in other parts of the system. Within BNSSG, GPs are referring the highest number of referrals to community pharmacy per month in England/100,000 patients. Local Enhanced Services (LES) using patient group directions (PGDs) continue to be utilized and community pharmacist roles expanded further.



In 24/25 we have expanded the specialist nurse led stoma service across the Integrated Care System to enable patients to have access to specialist stoma nurses for their prescribing of appliances and clinical queries improving their overall care. The stoma service is provided at both North Bristol Trust and University Hospitals Bristol and Weston NHS Foundation Trust.

From a digital perspective, and to support the shift from analogue to digital, there are many opportunities to adopt digital solutions to improve medication safety and provide efficiencies. The medicines related digital projects and ambitions align with the wider BNSSG Strategy. In 24/25 we have been successful in obtaining phase three funding of around £750,000 on a Technology for better care project from Health Foundation which will review a few different technologies as part of a personalised medicine support service, to improve patients' medication adherence. The pilot will continue throughout 25/26.

Through collaborative working with system colleagues there have been a number of

key successes in the management of high cost drugs and devices. Successful rapid adoption of biosimilar Ustekinumab across BNSSG through an Incentivisation Pace of Change (IPOC) agreement with Trusts resulted in above 90% uptake of biosimilar switch within 6 months – this has also supported the South West Region to be the fastest region in adopting biosimilar Ustekinumab. Regular biologic pathway and budget meetings with Gastroenterology, Rheumatology, Dermatology and Ophthalmology to support best use biologic, pathway development, horizon scanning and budget management have occurred through the year with the clinical teams. Updates to all biologic pathways have been undertaken in 24/25 to reflect best value biologic and new NICE Technology appraisals.

In line with NICE and NHS England guidance we have supported the adoption of hybrid closed loops in patients with type 1 diabetes working closely with our endocrinology colleagues through establishment of a working group. In addition, we have also worked closely with Bristol & West Purchasing Consortium (BWPC) to ensure that devices are ordered and purchased through the NHS Procurement Framework for best value devices. We are working towards updating local guidance for diabetes devices and development of a local diabetes device formulary to support best practice and cost-effective use.

We have continued to support the implementation of the weight management medicines in specialist weight management services (SWMS) and are planning the implementation of tirzapetide (Mounjaro) with primary care colleagues.

In preparation for the new Alzheimer's biologic medicines which will require a new pathway including diagnostics we have set up a working group to identify likely system requirements. This is also being considered within the wider context of the BNSSG dementia discovery project led by the ICB with system partners.

Research 2024/25

ICBs have a legal duty to facilitate and promote research relevant to health services and to use evidence obtained from research. Our research programme has an aim of creating and supporting health and care research that makes a difference to those who need it most.

Research Development

In 2024 BNSSG ICB was awarded £1.7m of Research Capability Funding (RCF) to invest in research development and supportive infrastructure. RCF supported 93 individuals across health, care and local university organisations who are developing research in areas of priority for our population.

42 applications for external research grants (21 preliminary stage & 21 final stage) to fund innovative improvement projects have been submitted, and a further 26 research development projects have been initiated that will lead on to grant applications in the near future.

We are proud to report that we have invested in, and are actively supporting, 11 early phase projects that have been initiated from research-naïve health and care delivery staff serving our most disadvantaged and under-represented communities.

Live Research Projects

BNSSG ICB supported 65 high quality research studies to open recruitment in our community health and care partner organisations. These projects encompass a breadth of health conditions and topics across many health and care settings, including general practice, local authority, community care, hospice, care homes and voluntary, community and social enterprise (VCSE).

Our portfolio of 33 externally funded research grants brought £46m into our health economy for innovative improvement projects that we deliver as the lead organisation in collaboration with multiple universities and health & care organisations, including VCSE partners. We are proud that this is the most of any ICB and is the 2nd highest amongst all NHS organisations in England.

A highlight of our year has been co-creating a novel contract with VCSE Partners who are members of the diverse Research Engagement Network (REN). This contract enables VCSE organisations to lead on and/or collaborate on NIHR portfolio research without the overhead costs of solicitors and lengthy contract negotiations. We will be promoting its use through various national networks so that the efforts of our local VCSE partners will benefit many other communities across the UK and increase the inclusivity of health and care research.

Evidence into practice

To support our use of evidence, the ICB has partnered with University of Bristol and UWE to establish an Impact Accelerator Unit. The Impact Accelerator Unit is dedicated to accelerating the use of evidence in our health and care services and we have been actively supporting the evidence from 12 of our research projects to be embedded into services and positively impact on the health of our population.

ICB Workforce Inequity

Across this year BNSSG ICB continues to focus on improving equity and inclusion within our workforce. Full, comprehensive reporting has been undertaken reviewing workforce race equality standard, workforce disability equality standard, gender and ethnicity pay gaps and a comprehensive workforce review in line with public sector equality duty. These have been reviewed at People Committee and Board level to ensure that senior leaders across the organisation are both aware and accountable.

There has been significant work undertaken in relation to the NHS sexual safety charter including policy creation, ensuring appropriate support is in place for staff and ensuring that all staff are aware of the behavioural expectations including an all

staff briefing in support of he national “We say No” campaign. We also continue to highlight Freedom to Speak up, including a “Speak Up, Speak Out” webinar available to all staff focused on inclusive culture, addressing and mitigating microaggressions, tools to challenge negative behaviours and understanding the roles of allies including practical approaches to allyship.

Additional policies, including flexible working and hybrid working, have been reviewed through an inclusive lens ensuring that they support our work to reduce pay gaps and improve staff experience.

In line with the NHS Equality, Diversity and Inclusion (EDI) Improvement plan high impact actions, our executive team all have specific and measurable EDI objectives to ensure that we create a culture that values and sustains a diverse workforce. Our board have undertaken seminar sessions focused on anti-racism and members of our executive team have undertaken a leadership focused anti-racism development programme delivered through Black Maternity Matters. Additionally, as an organisation we are undertaking an anti-racism train the trainer programme to enable effective development of all staff in this area.

We continue to work with our staff networks to improve the experience of colleagues with protected characteristics, including bi-monthly meetings of our Inclusion Council, chaired by our Chief Executive. Through this network engagement we have delivered a number of information and development sessions to staff including support for Disability History Month, a ‘Reclaiming Narratives’ session to support Black History month, a bring and share lunch to celebrate cultural heritage and identity, promotion to the “5 minute challenge” in support of Race Equity Week and the delivery of a Trans-awareness session that was open to all system partners. Our staff networks also provided support in ensuring diverse panels within our ‘Shaping Our Future’ organisational change programme.

A range of wider events have been delivered including Tea and Talk sessions with our Mental Health First aiders, suicide prevention and menopause support.

Within this year a significant office move was undertaken. Design plans were reviewed to support inclusive practice, and a full accessibility audit was undertaken. Individualised office inductions were undertaken in support of our wider reasonable adjustment provisions.

While there is still work to do we saw significant improvements related to staff experience of those with protected characteristics between 2023 and 2024 staff survey results. These include:

- For those with a disability, the organisation made reasonable adjustments to enable me to carry out my work (74.5% to 90.0%), not felt pressure from a manager to come to work when not feeling well enough (76.3% to 90%).
- For colleagues racialised as black or brown, colleagues are understanding and kind to one another (73.1% to 90), feel the organisation would address

any concerns I raised (53.8% to 70%).

- For LGBTQ+ colleagues; not experienced discrimination from manager / team leader or other colleagues (77.3% to 95%)

BNSSG was presented with a Lived Experience Charter Working Towards award in recognition of the work it is undertaking to support care experienced individuals into the workforce both organisationally and across the wider Health and Care system. We also continue to hold a bronze award as part of the Defence Employer Recognition Scheme.

ICS Workforce Inequity

ICS partners continued to work collaboratively throughout this year with regular meetings of the Equality, Diversity and Inclusion (EDI) Leads across the system to support system wide approaches where possible. This has included deep dive sessions including workforce race equality data and workforce disability equality data at a system level, anti-racism and a focus on learning and development activity. A system wide Workforce EDI report was delivered to both People Committee and Board to ensure awareness and accountability at senior levels.

Inclusive recruitment continues to be a focus, and this work has been embedded within the BNSSG One Workforce group ensuring that this becomes 'business as usual'. The system wide inclusive recruitment toolkit continues to be iterated to ensure best practice information sharing across the system.

Domain One of EDS continues to be a collaborative endeavour with a focus on Maternity, Cardiovascular services and Accessible Information Standard this year.

Where possible events are shared across the system, for example staff networks came together to celebrate Staff Networks Days and LGBTQ+ networks came together to celebrate Bristol Pride.

BNSSG has recruited a diverse range of members to its Independent Advisory Group on Race and Health Equity which will support both workforce and health inequity improvements across the system.

For much of this year BNSSG ICB continued to work with The Kings Trust (previously the Princes' Trust) to support young people from disadvantaged backgrounds into employment within the NHS and wider health and care system. During this time 93 young people participated in the scheme with 55 resulting job offers. Of particular note were an individual who progressed onto a Student Nursing Associate apprenticeship and one who progressed onto a Registered Nurse Degree Apprenticeship.

We also continued our work to support care experienced individuals into health and

care roles, engaging with young people to explore career pathways and supporting four individuals into traineeships at Weston College and providing a range of ringfenced apprenticeships, T-levels, volunteering and work experience placements. The programme, via Career Matters, also delivered Thrive Employer training to ensure employers can support care-experienced young people into the world of work. BNSSG achieved Working Towards for the Lived Experience Charter and the project manager won the South-West Integrated Personalised Care Award 2025 for this work.

In 24/25 BNSSG ICB ran events to promote Health and Care careers for young people including the Allied Health Professionals Day and Careers Discovery Day with a combined attendance of over 230 young people. Following the embedding of work experience programmes within NHS Employers across the system, we have continued to support work experience placements across wider partners, including our community provider who won a NHSE Gold Work Experience award and primary care.

BNSSG is a pilot for Workwell, a scheme to support working individuals at risk of long term sickness and those who are economically inactive due to ill health to enable them to return to work and thrive within the workplace. To date the programme has supported 412 individuals of which 39% have a disability, 35% unemployed and 49% in receipt of benefits.

Bristol, North Somerset and South Gloucestershire Locality Partnerships

BNSSG's six Locality Partnerships (Locality Partnerships - BNSSG Healthier Together) come together as equal partners across the public and voluntary & community sector around the needs of their local communities. They employ population health intelligence insights to identify and tackle local priorities, aiming to join up services, simplify pathways and support a shift to earlier support and intervention.

Examples of work:

BNSSG Approach to Falls: In 2024 a proposal was developed to respond to the many partner discussions; insights and population health data that highlighted falls as a priority across all six localities.

Funding was secured to deliver the three main strands of the approach which will begin delivering in 2025/26.

- **More Strength and Balance Classes** to increase capacity and ensure a core offer for falls prevention schemes across the BNSSG area. This will be done at place/neighbourhood level to support the development of local relationships to better reach those currently inactive and known to have the worse health and wellbeing outcomes.

- **Workforce Development**: Support training of the wider workforce of professionals to ensure capacity to provide classes exists within the system (it currently does not).

- **Asset Platform/Repository**: To develop a single BNSGG approach to sharing useful information on falls, so people, patients and staff can access a variety of up-to-date information on services and support in a place that is trusted and makes sense to them.

Mental health and wellbeing Integrated Network Teams (MINTs) aim to put people and communities at the center of mental health and wellbeing support. We are transforming community mental health services across BNSSG by bringing together new multidisciplinary teams to provide holistic support to individuals whose needs are not met by general practice alone but do not need secondary care support. . These changes will help people – wherever they live and whatever their background – to quickly access high-quality and personalised care, closer to home.

The localities have been working in partnership with the MINT Mobilisation Team to establish six MINTs across BNSSG. This year, each of the MINT Hubs have recruited teams including Hub Manager, Administrator, Psychologist, Social Worker, and Recovery Navigators in partnership with Local Authority, GPs and secondary care mental health staff and voluntary sector mental health partners and these teams how now been launched and are supporting people

Cardiovascular Disease Prevention: The BNSSG Cardiovascular Disease (CVD) Prevention was a one-year project, launched in March 2024, designed to address CVD risk factors across BNSSG through Locality Partnerships. Operating under a single model spanning all six localities, but tailored to meet specific-community need, the programme combined risk assessments and diagnostics with lifestyle advice and referrals. A key objective was to target vulnerable groups and tackle hyper-local health inequalities, ensuring inclusive support through collaboration with community groups and venues. The initiative aimed to raise awareness by engaging local volunteer community champions and delivering health events in community settings.

A total of 93 health events were delivered across BNSSG, with 15 events per locality, reaching 1,506 individuals. Of these events, 46 were specifically aimed at groups facing health inequalities, with an average attendance of 16 people per event. Throughout the programme, lifestyle advice was provided to 967 participants, 548 received blood pressure diaries, and 27 of the most vulnerable individuals were given free blood pressure monitors. Furthermore, 502 individuals were referred to GPs for continued support, indicating a strong focus on follow-up care and comprehensive health planning.

Inner City and East Bristol (ICE): in 24/25, ICE Locality secured funding to tackle health inequalities within its communities. This is being used to fund 7 organisations that demonstrated they could contribute to the delivery of the Partnership's data and

insight-driven priorities; reduce local health inequalities and demonstrate co-design with the communities served. ICE funded the following organisations:

- **Black Mothers Matter:** Will provide support to NHS professionals to offer better support to black people giving birth - through training, research and conferences, as well as delivering community sessions including 1:1 pairings with experts, providing resources and offering tailored guidance and signposting to further support.
- **Caafi Health:** Fruit and Vegetables on Prescription Project focusing on supporting local people in ICE who are at risk of food inequality by providing them with fruit and vegetables weekly, as well as providing healthy eating and cooking advice. This will target families living in poverty with children, those on benefits, with long-term health conditions and from minority ethnic groups.
- **Chinese Community Wellbeing Society:** The BAME Dementia Support Project focuses on four key areas to reduce the health inequalities gap within dementia services. This will be done through:
    1. Reducing the risk of developing dementia through promotion of 'healthy ageing'
    2. Supporting early diagnosis
    3. Improved post-diagnostic support and increased access to community care and health services
    4. Supporting carers
- **Open Minds Active CIC:** Movement in Nature Wellbeing Alliance will support women's mental and physical wellbeing through a range of nature-based interventions for some of Bristol's most marginalised citizens.
- **SARSAS:** offer monthly supportive drop-in spaces from their central Bristol space ('Drop In') and in ICE community venues ('Reach Out') for survivors of sexual violence and abuse (all genders).
- **St Werburghs City Farm:** Delivering a Volunteering, Skills & Wellbeing Programme providing practical courses, placements and activities for people experiencing mental health challenges and/or exclusion and marginalisation from the workplace.
- **Wellspring Settlement:** Gardening for Health project will support people to engage in nature-based interventions and activities to improve their physical and mental health by building links with partners as well as supporting people to connect through activities, groups, and services that meet the practical, social and emotional needs that affect health and wellbeing.

North and West Bristol: In 24/25 North and West Bristol Locality Partnership committed funding to implement an E**motionally Based School Avoidance (EBSA) Project** that will support children and young people (CYP), and their families, to improve their wellbeing and school attendance.

This will be done through providing new and strengthened support services and recruiting a specialist EBSA Link Worker, who will provide one-to-one support to CYP who are showing early signs of school avoidance or who have reduced or significantly reduced attendance, linking them into specialist wellbeing groups in schools and/or local community activity. This will include support for children with special educational needs and disabilities (SEND), and those from other groups

facing greater inequality.

The project will involve three partnered secondary schools in North and West Bristol along with their nine primary feeder schools. Schools will be chosen based on levels of multiple deprivation in their student population, allowing a focus on those facing the greatest health inequalities.

The North and West **Community Chronic Obstructive Pulmonary Disease (COPD) Project** aims to address this health inequality and improve the health and wellbeing of people living with COPD through three linked approaches:

1. Co-designed, multi-agency information sessions for the recently diagnosed
2. Group-based Peer support for people living with COPD or other lung health conditions and;
3. A COPD Passport to provide up-to-date information and guidance to people with COPD

Each element is designed to improve management of the condition, including helping people access the MyCOPD app, smoking cessation and pulmonary rehabilitation offers; signpost to support available in the community; warm homes advice; and foster connections with other people living with COPD. It is expected this project will begin to connect, strengthen and transform the 'COPD system' across North and West Bristol.

South Bristol: South Bristol LP launched the **Community Connectors Programme** to help people to optimise their own wellbeing and health, particularly as the population ages. Community Connectors help to address loneliness and isolation by supporting people to build social relationships and improve wellbeing.

In 2024, funding was secured to continue and expand the Community Connector Project, recognising the impact the offer is having on individual wellbeing and health, building social connections and opportunities; but also the roles that Community Connectors have in identifying and responding to health inequalities in communities by linking in supporting organisations through community groups and events.

Since 2023, The Community Connectors Programme has supported nearly 4,000 residents in BS3 and Knowle West, providing over 6,000 instances of support. Community Connectors are working with residents across Marksbury Road, Bedminster West, Inns Court and social housing complexes across BS3 and Knowle West.

Case Study:

Greg (name changed) has been attending on a regular basis and raised an interest in food and cooking, having a background in hospitality. We chatted to him about a

regular food offer at the Tuesday club, and he seemed keen to get involved. We supported Greg to complete his food hygiene training, and he now cooks a hot lunch for up to ten people at the club each week. Greg makes the decisions about what ingredients he needs to get and is responsible for filling in the paperwork and getting the food out in a timely manner.

Community Innovation Leads (CIL): This role fosters connections with voluntary and community sector (VCS) organisations and health and social care partners to build stronger, more connected and resilient communities.

Across both Swift (Swift PCN) and Connexus (Connexus PCN) Primary Care Networks (PCNs), the Community Innovation Leads have formed strong networks between multi-sector partners, seeking opportunities for collaboration to meet identified gaps in provision. The roles have been busy building relationships with each of the GP surgeries in the area, as well as building a network of community and primary care partners across Bristol identifying opportunities to bring service provision into the patch for the benefit of local residents' wellbeing and health in some of the most deprived wards in South Bristol and those communities experiencing multiple health inequalities.

For example, our Community Innovation Leads supported the Cardiovascular Disease Prevention Project by linking the provider into various community events and organisations to increase mobile health checks across 15 different South Bristol locations, and their work together allowed South Bristol to be the first locality to complete their checks for this program.

Other successes include:

- Developed relationships with 792 VCS organisations
- Identified 86 funding sources
- Connected 892 GP practices and VCS contacts to funding to support their work.

At the start of 2023, the South Bristol Locality Partnership recruited a Community Innovation Lead (CIL) to work in the Swift Primary Care Network (PCN), which covers

"Since Alice [Community Innovation Lead] started, the Social Prescribing team have all benefitted, from… really useful links and information and putting the information into manageable formats. She also has increased links being made with the community voluntary care sector and is working to bring together and connect the many wonderful organisations in our locality. Knowing she is working on all of this, is a great source of support to the work we do" **- Connexus PCN Social Prescribing Lead, Dec 24**

Weston, Worle and Villages:

Community Connection and Early Years Support

Community Connectors have been recruited in the South and Central wards of Weston. Their focus has been on supporting families with young children and helping to identify barriers that prevent people from accessing health and wellbeing services.

Supporting Children and Young People

The North Somerset Children & Young People Wellbeing Fund was launched this year through a new VCSE brokerage service. This fund combines contributions from the Locality Partnerships, North Somerset Council, and Sirona Health and Care. In Weston, funding has been awarded to projects promoting healthy weight in children and young people, with delivery starting in April 2025.

Improving Mental Health

The One Weston Mental Health Integrated Network Team (MINT) launched a new group called "Moving On After Trauma" (MOAT) in January 2025. The team also welcomed a new Youth Transitions Worker, jointly supported by Off The Record and AWP CAMHS, to help young people move between services. Plans are underway for a new peer support offer, co-funded by local partners, which will begin rolling out in 2025/26.

Ageing Well and Frailty Support

Funding has been secured for the new Falls and Fracture Screening and Prevention Service (FFSPS) through the Proactive Care Fund. This will become the first phase of the One Weston Community Frailty Hub, which is planned to go live on 1 May 2025. In the meantime, falls prevention classes have been extended, with funding in place beyond March 2025.

The Improving Ageing in North Somerset project delivered a comprehensive report on the State of Ageing in the area. Two new roles—a strategic VCSE lead and a coordinator—have been appointed to drive forward the Ageing Well work. These posts are part-funded by the Locality Partnership and the Big Lottery Fund.

Using Evidence to Shape Outcomes

The Theory of Change framework has been fully embedded in the way the partnership works. This helps focus on meaningful outcomes for local people.

New Projects and Innovation

Several new exploratory projects have been launched:

- A discovery phase to understand patterns in Emergency Department visits and admissions at Weston General Hospital.
- A project supported by the NHS Confederation to explore how primary and secondary urgent care connect locally.
- The Digital Vanguard/Brave AI programme, exploring how digital innovation can support care.

A new Local Authority Research Practitioner has also been recruited to help evaluate the impact of locality work. This role is jointly funded by the ICB and North Somerset Council.

Dementia, End of Life, and Community Engagement

The Dementia Community of Practice and the End of Life Community of Practice are now embedded in local working, ensuring community perspectives are part of service development. In May 2024, the Good Grief Festival brought together over 30 events in four days, creating space for local people to reflect and connect around the themes of grief, loss, and bereavement.

Woodspring:

Supporting Children and Young People's Mental Health

In 2024/25, we began running workshops across Woodspring to help parents support their children in managing anxiety. Alongside this, we created and widely shared information to help families find mental health support more easily.

We completed a pilot project in Portishead called Green Social Prescribing for Children and Young People, which aimed to reduce self-harm through connection with nature and community. Early results from this pilot have been positive. Building on this, we secured funding to start a new Green Social Prescribing project in Pill, focusing on supporting young people experiencing health inequalities. We have also begun planning further projects, with additional funding already in place to expand this important work.

We launched the North Somerset Children and Young People Wellbeing Fund through a new VCSE (Voluntary, Community and Social Enterprise) brokerage service. This fund combines support from North Somerset Locality Partnerships, North Somerset Council, and Sirona Health and Care to grow local social prescribing opportunities for young people and families.

Improving Community Mental Health

This year saw the launch of the Woodspring Mental Health Integrated Network Team. The team recruited key staff and began accepting referrals from specific sources.

We co-designed and successfully launched a Community Mental Health Small Grants Scheme to support peer-led community groups. At the same time, we continued our work to embed specialist community mental health services throughout the locality, making support more accessible and joined-up.

Building Community Support

We completed an evaluation of the North Somerset Together Virtual Hub and submitted a proposal for its future funding. Health inequalities funding enabled us to hire a Community Development Worker for the Pill area, helping to strengthen support at a local level.

In addition, we began work to establish a new Baby Clinic in Pill and to increase

Health Visiting services in the area. The Woodspring Locality Partnership also completed a successful cardiovascular disease outreach pilot, helping to raise awareness and support early detection.

Supporting Older People

We continued our commitment to building Age-Friendly Communities across Woodspring, ensuring older people feel valued, connected, and supported. Funding was identified to set up a new Complex Care Team to support those with the most complex needs.

Our work on falls prevention continued through the North Somerset Falls Collaborative, bringing partners together to reduce risks and respond effectively.

We also supported the “Improving Ageing in North Somerset” project, led by Voluntary Action North Somerset. This work is supported by new funding from the Locality Partnership and the Big Lottery Fund. In recognition of this ongoing work, North Somerset has now been approved as an official Age-Friendly Community.

Talking About End-of-Life Care

We have taken steps to encourage more conversations about end-of-life care in everyday, non-medical settings. Pilots to improve end-of-life pathways have been launched using a test-and-learn approach.

The Good Grief Festival, which offers a space for communities to explore grief and loss, was extended into Woodspring in 2024 and is now a regular part of our local offer. We have also established an End of Life Community of Practice to ensure this work remains embedded in our wider system.

Strategic Progress

The Theory of Change framework is now fully embedded in the way we work. It helps us focus on meaningful outcomes, not just activities.

We began work on the Woodspring Health Inequalities Strategy, with a particular focus on Pill. We have also contributed actively to the system-wide review of Locality Partnerships across North Somerset to help shape their future direction.

South Gloucestershire (SG):

In 24/25 the South Gloucestershire Locality Partnership committed Health Inequalities funding to sustain Health & Happiness Hubs projects:

- **Health & Happiness Hubs, SG wide** - Health and Happiness Hubs are for people with a long-term health condition who want to make positive changes to improve their health and happiness, they are held in community venues for 2hrs/week in each Primary Care Network (PCN) area. The Hubs take a preventative, de-medicalised approach to healthcare in community settings for people with one or more of the following conditions: hypertension / high blood pressure; Type 2 diabetes; issues with being overweight; chronic pain; anxiety or mild depression). People can also be seen by Outreach Care

Coordinators in their GP practices and can self-referral via the Southern Brooks website (Health and Happiness Hubs – Southern Brooks Community Partnerships).

- **Health & Happiness Hubs (HHHs) Outreach Activities (4PCN Leg Club) -** The Leg Club is a pilot in development that will provide community-based treatment, health promotion, education and ongoing care for people who are experiencing leg-related problems. It will provide support from specially trained nursing staff to people on a walk-in basis, in a non-medical setting, while volunteers provide holistic care. The overall goal is to improve wellbeing with faster healing and significantly lower recurrence rates through a holistic approach that aims to enable communities to connect and build resilience.

- **Health & Happiness Hubs Outreach Workers (Village Agents), SG wide -** Village Agents are trusted members of the community who help isolated people gain access to information and services that will enhance their wellbeing, safety or security. The emphasis is on independent living for as long as possible. Village Agents connect people with organisations that can offer support, specialised advice and practical assistance. The Village Agent as aims to be the 'go to' individual for local information as well as create new opportunities for individuals and groups to help each other.

- **Health & Happiness Hubs Outreach Workers (WARM), SG wide -** The WARM Service (When Advice Really Matters) run by Citizens Advice South Gloucestershire provides confidential, accredited and independent debt, benefits and welfare advice for those accessing primary care and VCSE health and wellbeing services because socioeconomic issues and financial hardship are impacting on their mental health.

Working with Health and Wellbeing Boards and the Health and Wellbeing Strategies

Health and Wellbeing Boards (HWB) are statutory functions of local authorities. The main duties of the HWB is to produce a Joint Needs Assessment, a population Health and Wellbeing Strategy and to provide local leadership to promote health and reduce inequality.

The ICB is a member of the three local authority HWBs of Bristol, North Somerset and South Gloucestershire, along with Healthwatch, Directors of Public Health, Directors of Children's Services and Directors of Adult services. Other members of the HWBB are NHS Trusts, Sirona, the Voluntary Sector.

Health and Wellbeing Boards are chaired by elected members who in turn sit on the system wide Integrated Care Partnership Board, representing their local place.

The Health and Wellbeing Boards contribute to the ICS Strategy and ICB Joint Forward Plan ensuring that the ICS system plans and vision, aligns closely with the local authority Health and Wellbeing Strategies.

HWBs work closely with the ICS Locality Partnerships. Each of the six Locality Partnerships in Bristol, North Somerset and South Gloucestershire is aligned to its local authority Health and Wellbeing Board.

This arrangement helps to knit together the wider NHS system, local authority place based activity with a strong community and neighborhood focus.

Bristol Health and Wellbeing Board

The Bristol Health & Wellbeing Board (HWB) has been chaired since May 2024 by Cllr Stephen Williams who is Chair of both the Health and Wellbeing Board and the Public Health and Communities Committee. Cllr Williams represents Bristol on the Integrated Care Partnership.

Colleagues from the NHS, community providers, the Voluntary Sector and ICB are members of the Board and are active contributors to the work programme. The Bristol Health and Wellbeing Board monitors progress against its statutory functions and key priorities which are set out in a Plan on a page. Priorities are informed by the Bristol Joint Strategic Needs Assessment, the ICB 'Our Future Health' needs assessment and Locality Health Needs Profiles as well as by One City and community engagement

Over the past year the Bristol Health and Wellbeing Board has received reports on sexual health, child health, the health of refugees and asylum seekers, fuel poverty, cost of living, immunizations, pharmacy services, healthy weight, stop smoking , dental services and oral health. Partnership programmes supported by the board include the Bristol Food Equality Strategy, Thrive at Night which aims to improve the mental health of those who work night.

The Bristol Health and Wellbeing Board is also a Board of the One City Partnership The One City Approach - Bristol One City and the Bristol Joint Health and Wellbeing Strategy is set within the context of the Bristol City Council “One City Plan”. Joint development sessions have been held with other one city boards on the health of Children and Young People, Domestic Violence, Mental Health, Healthy Homes standard and health and economic development.

The work of the Health and wellbeing Board partners was included in the 2024 Chief Medical Officers report on the Health of Cities Chief Medical Officer’s annual report 2024: health in cities - GOV.UK

Health and Wellbeing Board Meeting papers can be found on the Bristol City Council Health and Wellbeing Board site.

.

North Somerset Health and Wellbeing Board

The North Somerset Health and Wellbeing Board has been chaired by Councillor Jenna Ho Marris, Executive Member for Health, Homes and Equalities, since July 2023. David Moss, ICB Locality Director for North Somerset has been Vice Chairperson since July 2024. Cllr Ho Marris represents North Somerset in the Integrated Care Partnership.

Members of the Board include colleagues from the ICB, Locality Partnerships, UHBW (Weston General Hospital), Sirona, voluntary, community and social enterprise (VCSE) sector organisations, and Healthwatch, alongside Executive Members for North Somerset Council and the Directors of Healthy and Sustainable Communities, Children's Services, and Adults Services, with additional cross-council representation from the Environment, Assets and Transport Directorate and Corporate Services Directorate (Communities).

The Health and Wellbeing Board have had three meetings during 2024/25. The Board has focused on a variety of topics, including the pharmaceutical needs assessment, Better Care Fund, the system-wide approach to creating healthier places, and Locality Partnerships Review, with topic-based discussions including creative health and wellbeing, healthy ageing, and the place-based approach to tackling inequalities.

Over the past year, the Health and Wellbeing Board has monitored progress in development of the refreshed Joint Health and Wellbeing Strategy and prioritisation of linked investment, for instance through a stakeholder workshop and via discussion in Board meetings. The refreshed Joint Health and Wellbeing Strategy 2025-2028 and linked action plan were published in March 2025. The strategy is centred around five key approaches to improving health and wellbeing:

- **Prevention:** ensuring children have the best start in life and preventing ill-health throughout the life course.
- **Early intervention:** intervening as early as possible to address any health and wellbeing-related needs experienced during people's lives.
- **Holistic action and support:** implementing person-centred action on all factors that influence people's lives.
- **Healthy and caring communities:** empowering people and communities to be connected, healthy and resilient through strengths-based approaches, trauma-informed practice, and engagement and involvement.
- **Tackling inequalities:** prioritising action to ensure equality of opportunity in access to services, experience, and outcomes, to reduce inequalities between groups.

Objectives and actions are focused on seven priority theme areas: mental health and wellbeing; food, nutrition and oral health; tobacco, alcohol and drug use; being active; core determinants of health; and healthy places and communities.

The priorities set out in the strategy have been informed by the joint strategic needs assessment, topic-specific needs assessments, and stakeholder and public engagement, ensuring links to local, regional and national strategy. The strategy's approaches and guiding principles align with the ICS strategy. Further details are available here.

In addition to overseeing development of the refreshed strategy, the Board have overseen progress in implementation of the previous Joint Health and Wellbeing Strategy 2021-2024 via quarterly reports, focused around delivery of the action plan and the two-phased investment in health and wellbeing programmes. More broadly, the Board have supported development of the Communities Strategy, Mental Health and Wellbeing Strategy 2024-2029, and place-based approach to tackling health inequalities.

Meeting papers for the Health and Wellbeing Board are shared via North Somerset Council's website.

South Gloucestershire Health and Wellbeing Board

South Gloucestershire's Health & Wellbeing Board (HWB) is chaired by Cllr John O'Neill who has also been the Chair of the BNSSG Integrated Care Partnership in 2024-25.

Colleagues from the NHS, community providers, the Voluntary Sector and ICB are members of the Board and are active contributors to the work programme.

The South Gloucestershire Health & Wellbeing Board held four formal meetings in 2024-25, at which representatives from the ICB South Gloucestershire Locality Partnership have supported and participated in Board discussions.

Items have included:

- Quarterly deep dives into strategic objectives within the 2020-25 South Gloucestershire Joint Local Health and Wellbeing Strategy
- Annual review of the South Gloucestershire Joint Strategic Needs Assessment and Population Health Intelligence Portal
- Ratification of the South Gloucestershire Better Care Fund Plan 2024-25

- Refresh of the South Gloucestershire Pharmaceutical Needs Assessment

- Receipt of annual reports from the South Gloucestershire Safeguarding Adults Board and Children's Partnership, Drugs and Alcohol Partnership, Learning Difficulties Partnership Board and Health Protection Assurance Group

- Update on the planning for health services and review of the ICB's Locality Partnerships

- Receipt of Healthwatch reports

- Discussion about the development of the new South Gloucestershire Joint Local Health and Wellbeing Strategy for 2025-29, which will be signed off by the Health and Wellbeing Board on 1 May 2025.

The meeting papers can be viewed on the South Gloucestershire Council Health and Wellbeing Board site.

In addition, the Health and Wellbeing Board and ICB South Gloucestershire Locality Partnership held joint development sessions to further build relationships and develop joint priorities. There have been three sessions in 2024-25, one focused on housing and health, and the other two were around the development of the new South Gloucestershire Joint Local Health and Wellbeing Strategy for 2025-29.

The new strategy sets out:

- a shared vision for the Health and Wellbeing Board 2025-2029;

- how the Health and Wellbeing Board can use its unique role and membership to lead and advocate for health and wellbeing locally; and

- a shared commitment to developing how we work together to deliver that vision.

There are five strategic commitments to develop Health and Wellbeing Board ways of working and, each year, up to four annual focus areas to drive action.

ICB Locality Partnership colleagues have been instrumental in the development of the new strategy. The Locality Partnership Director was a member of the editorial group writing the strategy and co-delivered two workshops. This included an analysis of strengths, aspirations and opportunities related to each of the strategic commitments and year 1 areas of focus set out in the strategy.

Environmental matters

The Bristol, North Somerset and South Gloucestershire ICB Green Plan can be found at Healthier Together Integrated Care System Green Plan 2022-2025 - NHS BNSSG ICB. We remain committed to delivering our Green Plan.

The Green Plan focuses our system work over the forthcoming years as high standards of quality health and care are delivered whilst addressing the environmental impact this creates. Our sustainability vision is set out as one of our seven Integrated Care System (ICS) strategic aims:

“We will act as leading institutions to drive sustainable health and care by improving our environment, achieving net zero carbon by 2030; improving the quality of the natural environment; driving efficiency of resource use”

Our Deputy Chief Executive, Sarah Truelove, is the nominated ICB executive lead for sustainability and is a member of the Bristol, North Somerset and South Gloucestershire ICS Green Plan Steering Group which is expanding to cover the breadth of partner organisations in the system which is so crucial to driving change.

ICS partners across the system have been working to embed our ambitious sustainability goals and create a governance structure and delivery plan that

sees us working together to achieve our immediate and future goals. This year has seen the publication of the ICS revised Green Plan, setting out our sustainability commitments and outcomes and confirming our aim to be a leader in delivering sustainable healthcare for our region. All ICS partners have signed up to the Green Plan, aligning our efforts and amplifying our action and outcomes. The ICS has also developed a delivery plan to drive implementation and monitor progress against the Green Plan commitments.

The Green Plan sets out three clear outcomes that we are working towards;

1. Net zero carbon by 2030 across scope 1, 2 and 3 emissions sources.
2. Improve the environment by reducing waste, improving air quality and restoring biodiversity.
3. Create a BNSSG wide movement to support a culture change amongst, staff, citizens and businesses.

We have started the Green Plan refresh process engaging with stakeholders and reviewing what our actions will achieve against these outcomes and identifies the gaps we need to focus on

Throughout this year, North Bristol NHS Trust (NBT) and University Hospitals Bristol and Weston (UHBW) have worked together as one sustainability team along with colleagues from Sirona and Avon and Wiltshire Mental Health Partnership to achieve key milestones across the Green Plan work areas to deliver our net zero carbon goal and address the ecological emergency. The Green Plan and its associated Delivery Plan set out the actions we need to achieve across the Integrated Care System to get to net zero carbon by 2030. Through delivering our Green Plan we will build a healthcare service that improves the long-term health of our population and can deliver great care for generations to come.

One of our most notable achievements this year was the appointment of Dr Sanjoy Shah as the Joint Clinical Director for Green and Sustainable Healthcare for NBT and UHBW and Chair of the ICS Green Plan Steering Group. Sanjoy's experience as Deputy Chief Medical Officer, providing clinical leadership, will support us in embedding sustainability into our governance processes and will foster collaboration between clinical specialities across the system

The ICS is leading the way in delivering sustainable healthcare with Bristol, North Somerset and South Gloucestershire set to be the first Integrated Care System to sign the Why Weight Pledge aiming to support a food environment that is sustainable, affordable and enables healthy choices. NBT is the first NHS organisation to sign the Concordat for the Environmental Sustainability of Research and Innovation Practice and the Trust's trailblazing Neurospinal team also won the HSJ Towards Net Zero award for their world first Green Operating Day project, advocating for environmentally conscious decision making in neurosurgical procedures.

The ICB allocation of resources has recognised the need for capital to be ring fenced for decarbonisation and that this has been successfully applied to unlock grant funding. There has been initial assessment of carbon impacts in the supply chain in acute hospital trusts and mental health trusts; Social value and carbon reduction plan requirements have been integrating sustainability into procurement processes.

The Green Plan objectives are currently delivered through eight key workstreams that work across the ICS and which report progress up to the Green Plan Implementation Group and Green Plan Steering Group. This year we will be refreshing our Green Plan in line with national requirements and nominating executive and director-level leads for each Green Plan objective. The refocusing of our plan will support delivery Over the next few months, projects will be prioritised through the recently formed Sustainable Healthcare Collaboration which spans both Trusts and includes staff from both clinical and non-clinical settings.

Progress made against the Green Plan is reported below and is monitored monthly by the Green Plan Implementation Group. A Green Plan progress report is provided annually and was received by the ICB Board at its meeting in September 2024. The reported noted the progress against delivery of objectives, and areas of focus needed, and that ICB has been effective in leading system working embedding sustainability in capital prioritisation, Forward planning and Gateway processes for programmes of work. The ICB Board was also appraised of risks in the following areas: financial constraints, engagement, interdependencies with other sectors, competing priorities, impacts on patients if climate change adaptation is not delivered.

A further ICB Board update is scheduled for September 2025, In advance of that date, the template for use when preparing documents for the ICB Board has been updated to include specific mention of environmental impacts; the intention being to ensure environmental matters are factored into decision making.

The carbon reduction trajectory towards net zero of the main delivery plan workstreams is set out below. Our Delivery plan provides the detail of the carbon reductions that would be delivered by achieving the targets we have identified in our workstreams. To achieve net zero following the Science Based Targets Initiative approach we must reduce our emissions by 90% to 39,514 tonnes CO2e. The remaining 10% is to be addressed by offset schemes - investing in projects that result in permanent carbon removal and storage to counterbalance the residual 10% of emissions that cannot be eliminated.

Current actions will deliver carbon reduction of 257k tonnes CO2e, but this assumes there is capital funding available to decarbonise our buildings and

energy. The gap remaining from our current delivery plan is 98k tonnes CO2e for which we will need to identify further actions and funding. Without funding for buildings and energy decarbonisation the gap increases to 143k tonnes CO2e.

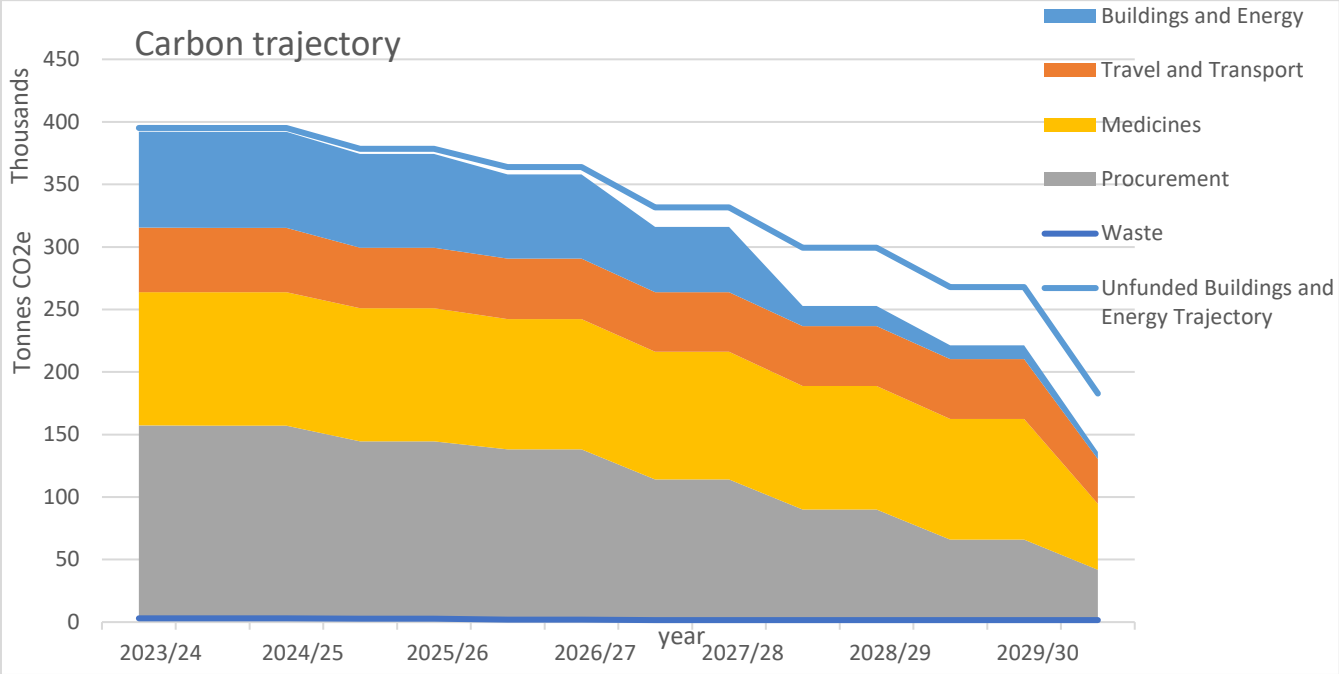


Figure 6 Carbon trajectory with current identified actions

	Tonnes CO_2e	Variance from carbon trajectory to meet target 90% emissions reduction (unfunded)	Carbon footprint goal 10% offset for net zero carbon
Current carbon footprint	395,140		
Carbon reduction required to meet NZC by 2030 (@90%)	Minus 355,626	0	39,514
Scenario 1 - Delivery Plan actions to achieve goal (assuming energy decarbonisation funded)	Minus 257,353	98,273	39,514
Scenario 2 - Delivery Plan actions to achieve goal assuming no funding available)	Minus 212,387	143,239	39,514

We have identified routes to net zero for our buildings and energy, and waste which are areas under our direct control but subject to achieving funding. Transport reductions are less in our control and dependent on working with partners across the ICP. Similarly, a substantial amount of our procurement is dependent on national approaches such as supplier carbon reduction plans and we are more limited in where we can influence them. Medicines requires further identification of reduction opportunities in reducing medicines waste

and targeting high impact areas such as inhalers, but as with wider procurement achieving net zero will be reliant on improving population health to reduce demand for pharmaceuticals and medical equipment.

Our delivery plan monitored by the Green Plan Steering Group sets out the detailed deliverables against the targets for each workstream area and by organisation. We have added RAG rated progress updates against targets and expected carbon reduction trajectories.

Our ICS carbon footprint includes the emissions of:

- Integrated Care Board:
- NHS Bristol, North Somerset and South Gloucestershire Integrated Care Board (BNSSG ICB)
- Healthcare Providers:
- Avon & Wiltshire Mental Health Partnership NHS Trust (AWP)
- General Practice providers
- North Bristol NHS Trust (NBT)
- Sirona care and health (Sirona)
- Southwestern Ambulance Service NHS Foundation Trust (SWASFT)
- University Hospitals Bristol and Weston NHS Foundation Trust (UHBW)

The carbon footprint includes scopes 1, 2 and 3 as described above. Annual data for 23/24 across all scopes is only available for the Acute hospital Trusts. However most of our carbon footprint is associated with the acute sector so we are able to use this a representative of our system.

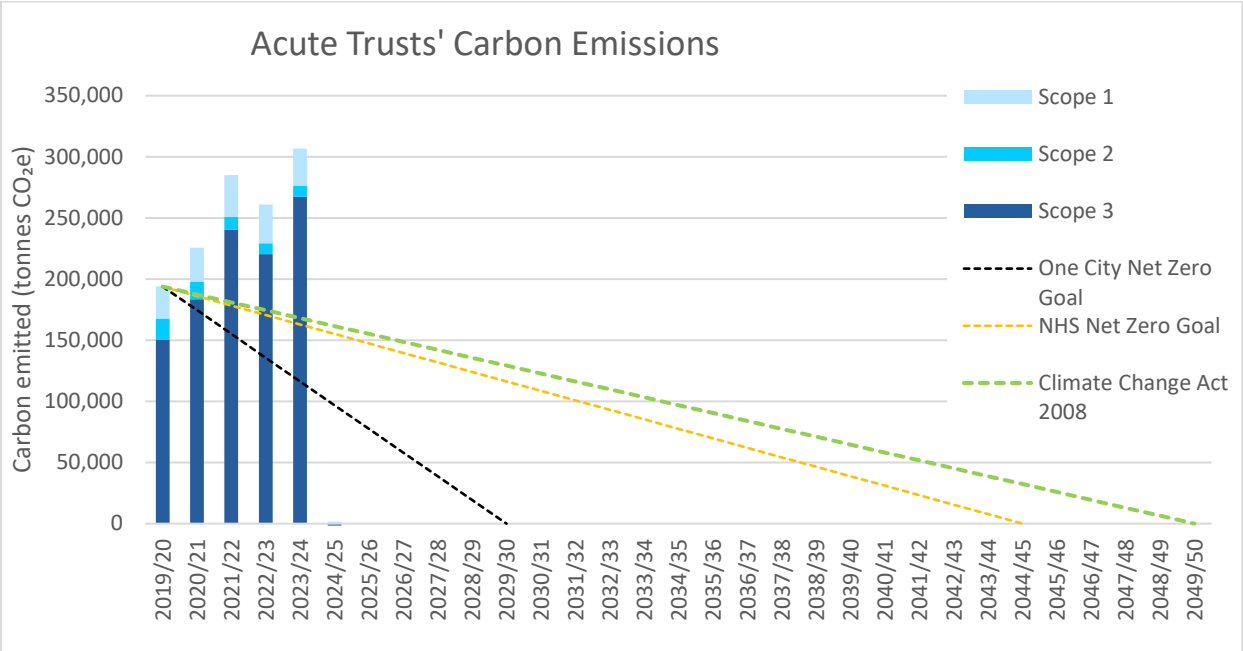


Figure 7 North Bristol and University Hospitals Bristol and Weston NHS Trusts' total carbon emissions for financial years 2019/20 to 23/24 compared with the carbon emissions trajectory required to achieve net zero carbon by 2030 as well as the trajectories to achieve the NHS Carbon Footprint Plus goal and the Climate Change Act 2008 target.

Our current approach to calculating our procurement carbon footprint is based on spend. This spend-based approach is flawed as it doesn't reflect where we are reducing carbon in our supply chain. The procurement footprint is particularly distorted by the increased spend during covid and high inflation.

Despite the emissions we have most control for, energy, water and waste showing an overall 4% carbon reduction in 23-24 compared with 22-23 We have seen a 21% growth impact from increased spend driven by inflation and activity (including investment in buildings and diagnostic equipment).

The carbon emissions reported in the table below cover the two acute hospital trusts that we have 23/24 annual data for.

Emissions Source	Unit	2021/22 Actual	2022/23 Actual	2023/24 Target	2023/24 Actual
Scope 1 (direct emissions)	tCO_2e	34,341	31,876	14,202	30,348
Scope 2 (indirect emissions from electricity)	tCO_2e	10,162	8,913	3,971	8,985
Scope 3 (indirect emissions)	tCO_2e	240,542	220,295	98,147	267,469
Total	**tCO_2e**	**285,044**	**261,083**	**116,320**	**306,801**
Energy					
Gas consumption	kWh	154,181,076	143,401,024		137,405,280
Oil Consumption	Litres	2,020,495	743,682		623,595
Electricity Consumption	kWh	47,861,589	46,091,982		43,390,423
Supply Chain					
Purchased goods and services (including upstream transport and distribution)	tCO_2e	186,226	177,616		224,120
Travel and Transport					
Trust owned Fleet	tCO_2e	358	352		411
Employee Commuting	tCO_2e	7,596	7,785		7,836
Waste					
Total Waste	Tonnes	6,350	6,564		6,679
	tCO_2e	2,767	2,739		2,522
Water					
Water volume	m3	692,744	625,348		618,789
Water volume and wastewater	tCO_2e	282	251		264

Figure 8 Acute Trusts carbon emissions

As of July 2024, we have 5 years and 5 months left to achieve net zero carbon goal to avoid the worst impacts of climate change hitting our health system. The figure below shows the future carbon taxation cost of our carbon footprint and how that reduces with our carbon reduction trajectory. This takes our delivery plan carbon reduction trajectory on the ICS carbon footprint from NHS England data and we have applied Treasury guidance to show the abatement cost of carbon for our system. The carbon value used to assess climate related risks and opportunities follows the high series valuation of greenhouse gas emissions.

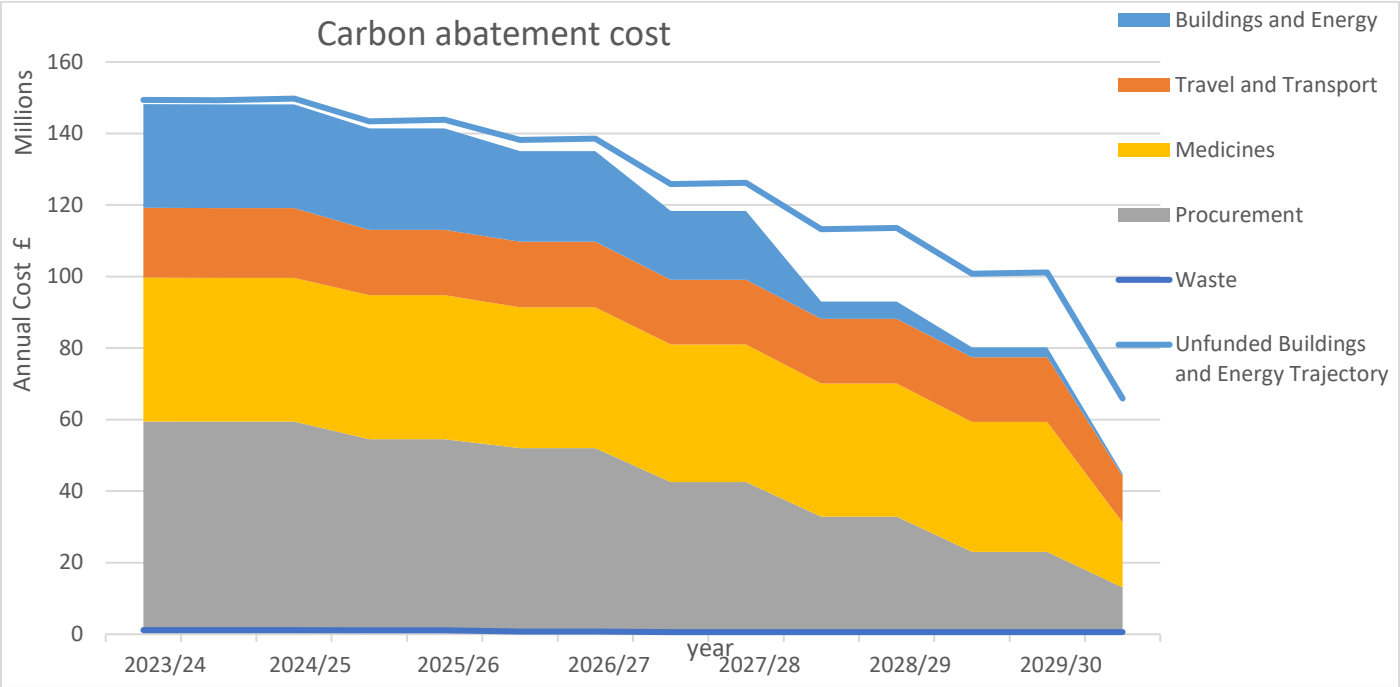


Figure 9 Carbon abatement cost for ICS carbon trajectory

The DHSC GAM has adopted a phased approach to incorporating the recommended Taskforce on Climate-related Financial Disclosures (TCFD), as part of sustainability annual reporting requirements for NHS bodies, stemming from HM Treasury's TCFD aligned disclosure guidance for public sector annual reports.

Local NHS bodies are not required to disclose scope 1, 2 and 3 greenhouse gas emissions under TCFD requirements as these are computed nationally, by NHS England.

TCFD recommended disclosures, as interpreted and adapted for the public sector by the HM Treasury TCFD aligned disclosure application guidance, will be implemented in sustainability reporting requirements on a phased basis up to the 2025-26 financial year.

However, where possible across the system (principally our acute trusts) we do calculate and publish this data to help track our progress against the Green Plan sustainability commitments. This data can be found in Section 3 of this document.

For 2024/25, the phased approach incorporates the disclosure requirements of the following ‘pillars’: Governance, Risk management, and Metrics and targets. These disclosures are provided below with appropriate cross referencing to relevant information elsewhere in the Annual Report and Accounts and in other external publications

Governance Pillar

The ICB Board are responsible for setting the strategic direction of the and monitoring performance against organisational objectives. In performing this role, the Board receive updates from the Green Plan Steering Group on the corporate level sustainability commitments in the Green Plan.

The Board are updated regularly throughout the year on climate related issues, specifically on progress against the Green Plan commitments and to approve the Green Plan annual report. Through this process, the Board are made aware of our successes as well as areas for improvement. In any given year, the Board may also be required to review and approve any updates made to the Green Plan. The Green Plan is due for an update during financial year 2025/26. The current Green Plan can be accessed here; Green Plan for Bristol, North Somerset and South Gloucestershire ICS: 2022 - 2025

Sustainability features in business case and project management governance through the use of sustainability impact assessment which features in project and programme gateway reviews.

To deliver the breadth and ambition of commitments set out in the Green Plan, the work has been broken down into separate workstreams that cover our main impact areas. These workstreams are;

- Net Zero Carbon
- Sustainable Procurement
- Food and Nutrition
- Travel, transport and clean air
- Biodiversity
- Healthier with nature
- Communications and engagement

This year has seen the introduction of the food and nutrition workstream and a delivery plan for this workstream will be developed.

Each workstream meets monthly to progress work against its delivery plans. These workstream meetings are chaired by the workstream lead and attended by relevant stakeholders from across the ICS. For example, catering leads and dieticians from both acute Trusts are invited to the food and nutrition workstream.

The workstreams report monthly to the Green Plan Implementation Group, overseen by the Head of Sustainability for the ICS. In turn, this group reports on a quarterly basis to the Green Plan Steering Group which is made up of Executive Directors from each partner organisation who in turn inform the System Executive Group.

Risk Management Pillar

Transition and physical climate related risks are listed in the Green Plan Steering Group risk register. In the ICB, as part of the Risk Management Framework which sets out arrangements for all reporting risks – including those relating to environmental matters - to the ICB Board on the Corporate Risk Register,

There are currently three risks that sit on the Green Plan Steering Group risk management register. Two of these risks relate to adaption on our estate. The acute trusts sustainability team have undertaken climate change scenario analysis for both sea level rise and heat. This involved mapping both sea level rise and maximum summer temperatures for our region in 2050 using publicly available resources from the Inter-governmental Panel on Climate Change. This assessment found that some facilities including Weston General Hospital are vulnerable to the future impacts of sea level rise through annual flooding. This will impact on patient care, staff availability and the physical estate. This is listed as is one of the two adaptation risks.

The second risk relates to the frequency of extreme weather events increasing with a focus on heavy rainfall, flooding and heatwaves. Adaptation is currently a climate related risk that is not regularly reported on to the Board either internally or through the ICS. There is no workstream for this work. It is recognised as a gap in current work and will be assessed at the next Green Plan refresh due to happen during financial year 2025/26.

The third risk is the financial investment required for the ICS to decarbonise, and the financial risks associated with not doing so through offsetting and carbon taxation. This risk is mitigated through the work undertaken to decarbonise our estate, waste and transport. In doing so, organisations have applied for and been successful in being awarded grant funding for decarbonisation through the Public Sector Decarbonisation Scheme. The system decarbonisation capital funding has been fundamental in providing the matched funding to enable the acceptance of these grants. We will continue to support organisations to apply for funding under the scheme as and when appropriate projects are ready to be progressed. The impact of future costs increases through the UK emissions trading scheme, taxation and offsetting have also been raised to organisation boards.

Green Plan workstream risks which focus on project delivery are escalated through the Green Plan governance process as appropriate, to ensure that they are managed.

Metrics and Targets

The ICS aims to have a comprehensive and transparent approach to reporting progress against its targets. The Green Plan sets out the range of metrics that are used to demonstrate progress against our commitments.

The Green Plan sets out both the timeframe for achieving our overall targets and the interim targets set over a 3 year period. It includes the targets set by NHS England that we are working towards and our own targets that are set to meet the needs of our local area and fit our ambition.

Our carbon emissions, waste, water and air quality impacts are publicly published in the Green Plan annual report. The data published is for this financial year and the previous two years to in order to show progression and trends in our performance.

All commitments are absolute reduction targets. The only amendment made is to adjust the spend data for the purchased goods and services category of scope 3 emission for inflation. This does not make the calculation methodology any more accurate but does level out the impact of inflationary cost increases in the data which do not reflect the carbon impact of the purchases made under this category.

The carbon emissions, rationale and calculation methodology used can be found by using this link; UHBW Carbon Reduction Plan 23-24

Targets, commitments and key performance indicators set out in the Green Plan and delivery plan are being reviewed as part of the Green Plan refresh process to be completed by July 2025. The reporting on progress and actions to address performance are included in the green plan annual report to the ICB board.

There is currently no specific climate change adaptation workstream and therefore we do not currently report on any adaptation related metrics. A set of suggested metrics for adaptation are set out in chapter 18 of the Green Plan but have not been progressed. This will be reviewed as part of the review of the Green Plan due to take place next financial Year (25-26).

Financial review

Basis

NHS England has directed, under the National Health Service Act 2006 (as amended), that ICBs prepare financial statements in accordance with the 'Group Accounting Manual (GAM)' issued by the Department of Health. The GAM is drafted to meet the requirements of the government financial reporting manual (FReM). The financial information included in this section of our annual report is taken from the financial statements for the period 1 April 2024 to 31 March 2025.

Overview of 24/25 financial framework

NHS financial arrangements for 24/25 continued to support a system-based approach to planning and delivery. Integrated Care Systems (ICSs) were issued with two-year revenue allocations spanning 23/24 and 2024/25, these were updated for nationally agreed changes such as pay award funding. Core ICB capital allocations for 22/23 to 24/25 had already been published and remain the foundation of capital planning for future years. ICBs and NHS primary and secondary care providers have been expected to work together to plan and deliver a balanced net system financial position in collaboration with other ICS partners

The 24/25 financial framework has continued with population-based funding with a move back to system fair shares allocations via convergence adjustments. Systems are expected to:

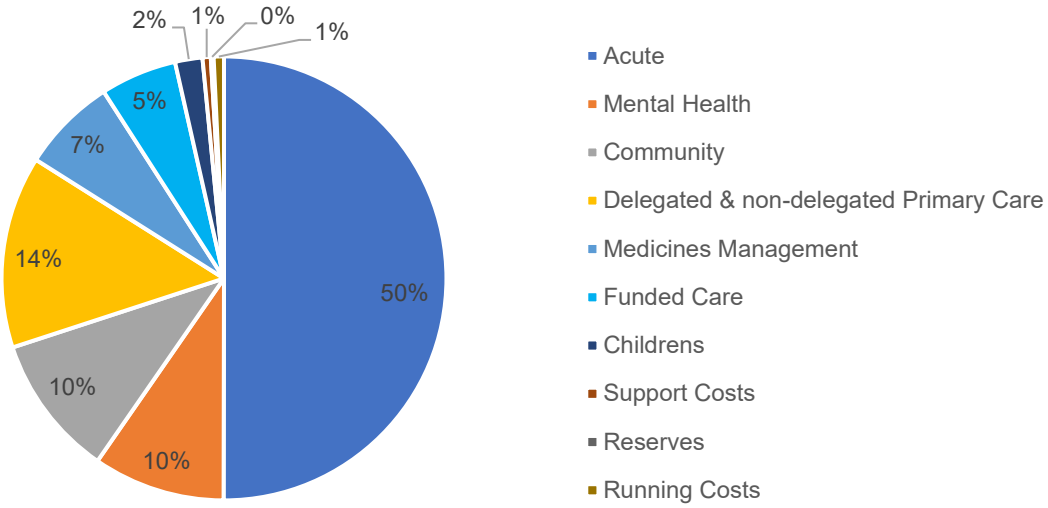
- deliver a balanced net system financial position for 24/25
- work together to develop impact assured plans that meet the minimum 2.2% efficiency target and raise productivity to levels that will deliver on the objectives set out in this guidance within allocated resources
- improve operational and clinical productivity, making full use of the opportunities highlighted through GIRFT, The Model Health System and other benchmarking and best practice guidance
- improve workforce productivity and reduce agency spend to a maximum of 3.2% of the total pay bill across 24/25 • release efficiency savings through reducing variation, optimising medicines value and improving the adoption of and compliance with best value frameworks.

Our local health system produced an operational plan for 24/25 which delivered a balanced net system financial position (and for each member

organisation individually). Monthly finance reports presented throughout 24/25 have reported progress against these plans, with analysis of any variances.

ICBs also have a duty to deliver financial balance independently of the ICS (section 223GC of the 2006 Act). This promotes careful financial management and reflects legislation that requires NHS England and ICBs to manage within a fixed budget. Additionally, we are required to ensure that we do not exceed our running cost allocation limit, which is published as part of ICB allocations.

The chart below sets out how the ICB planned to spend its revenue allocation for 24/25:



Financial duties

During the financial period 1 April 2024 to 31 March 2025, our performance against our financial duties is demonstrated in the table below:

Duty	Achieved
Maintain expenditure within the revenue resource limit	Yes
Ensure running costs are within the running cost resource limit.	Yes
Maintain capital expenditure within the delegated limit	Yes
Maintain expenditure within the allocated cash limit	Yes
Ensure compliance with the better payment practice	Yes

Analysis of Financial Performance

NHS Bristol, North Somerset and South Gloucestershire ICB has a statutory duty to maintain expenditure within the resource limits set by NHS England. Revenue expenditure covers general day-to-day running costs and other areas of ongoing expenditure. As demonstrated in the table below, the ICB has met its statutory duty to operate within its revenue resource limits for the period 1 April 2024 to 31 March 2025.

Analysis of Financial Performance 1 April 2024 to 31 March 2025	Programme costs	Running Costs	Total
	£'000	£'000	£'000
Total net operating cost for the financial year	2,340,681	17,512	2,358,193
Final in year revenue resource limit	2,340,683	17,536	2,358,219
Surplus/(deficit) in year	**2**	**24**	**26**

The table below sets out an analysis of how final expenditure compared to budget. This shows that whilst at an aggregate level the position is balanced there were a number of over and underspends reported with non-recurrent actions in reserves required to offset significant pressure observed in acute spend (driven by high cost drugs and devices and additional support required for North Bristol NHS Trust and University Hospital Bristol and Weston NHS Foundation Trust) as well as in funded care (as a result in growth in case list and constricted market leading to increased prices for care packages).

Financial performance 1 April 2024 to 31 March 2025	**Budget**	**Expenditure**	**Variance**
Programme Area	**£m**	**£m**	**£m**
Acute	1,179,797	1,194,389	(14,593)
Mental Health	226,363	226,296	68
Community	243,806	243,894	(88)
Delegated Primary Care	290,758	288,485	2,273
Medicines Management	163,486	160,716	2,770
Primary Care	39,637	39,263	375
Funded Care	130,986	139,299	(8,313)
Children's	46,937	47,001	(64)
Support Costs	14,080	13,069	1,011
Reserves	4,834	(11,730)	16,563
Running Costs	17,536	17,512	24
BNSSG ICB Surplus/(Deficit)	**2,358,219**	**2,358,194**	**26**
Provider Surplus/Deficit			
AWP	-	107	107
NBT	-	30	30
UHBW	-	42	42
Provider Surplus/(Deficit)	**-**	**179**	**179**
ICS Position	**2,358,219**	**2,358,015**	**205**

Reflected in the position above is the ICB efficiency programme which had a planned value of £33.0m, actual deliver exceeded this by £2.4m with a full year delivery of £35.4m.

Capital resource is made available for long-term spend such as new

buildings, equipment, and technology. We have been allocated £25.9m for capital which comprises:

- £0.4m for minor improvement grants in primary care
- £1.0m for GP information and technology
- £0.3m for Corporate Information Technology
- £16.2m for the redevelopment of the Thornbury Health Centre; and
- £8.1m for the Central Weston development

We have met our statutory duty to not exceed this resource for 2024/25, as demonstrated in the table below:

Analysis of Financial Performance 1 April 2024 to 31 March 2025	Total capital resource
	£'000
Total net capital cost for the financial year	25,910
Final in year capital resource limit	25,925
Surplus/(deficit) in year	**15**

Running Costs

NHS Bristol, North Somerset and South Gloucestershire ICB's was funded a total of £17.5m for the period 1 April 2024 to 31 March 2025 to support headquarters and administration costs.

Total expenditure recorded against running costs for the period 1 April 2023 to 31 March 2024 was £17.5m, ensuring that the ICB delivered against its financial duty to ensure that revenue administration resource use does not exceed the amount specified in Directions.

To facilitate the effective running of our organisation, we continue to review those functions which we provide in-house and those which are provided by South, Central and West Commissioning Support Unit (SCW CSU). The services commissioned via the SCW CSU cover human resources, business intelligence support, information technology and information governance support, procurement services support, care navigation services, GP IT services, and additional consultancy and project support.

Financial governance

NHS Bristol, North Somerset and South Gloucestershire ICB's Finance, Estates and Digital (FED) Committee and Board receive regular reports on

the financial performance of the ICB and the wider health system, which provide assurance and evidence of financial performance. Other reports include risk register reviews, financial plans and ad-hoc reports and information as required. We submit monthly and quarterly information to NHS England as part of the assurance process.

The FED Committee meets monthly to review the financial position and identify mitigating actions to ensure we strive to deliver to our financial targets.

We have an established Audit and Risk Committee whose role is centred on ensuring the adequacy and effectiveness of the organisation's overall internal control systems. The Audit Committee is an assurance committee of the ICB Board and comprises non-executive members. John Cappock chairs the ICB Audit and Risk Committee. Five meetings were held between 1 April 2024 and 31 March 2025, and considered: governance, risk management and internal control, internal audit, external audit, counter fraud and other assurance functions. Through the work of the Audit and Risk Committee, the ICB Board has been assured that effective internal control arrangements are in place. The ICB's annual accounts for the reporting period 1 April 2024 to 31 March 2025 are included on page 192 of this report. They describe how we have used our resources to deliver health services to residents of our local population. An explanation of the key financial terms can be found as an appendix at the end of the annual accounts.

Cash flow

NHS Bristol, North Somerset and South Gloucestershire ICB's cash position is reported monthly to the Finance Committee. Detailed monthly cash flow monitoring and forecasting is in place with NHS England.

Better Payment Practice Code

We are required to pay our non-NHS and NHS trade payables in accordance with the Confederation of British Industry (CBI) Better Payment Practice Code. The target is to pay non-NHS and NHS trade payables within 30 days of receipt of goods or a valid invoice (whichever is the later) unless other payment terms have been agreed with the supplier.

Our performance for the period 1 April 2023 to 31 March 2024 is summarised below:

	1 April 2024 to 31 March 2025 Number	1 April 2024 to 31 March 2025 £'000
Non-NHS Payables		
Total Non-NHS Trade invoices paid in year	31,747	857,922
Total Non-NHS Trade invoices paid within target	31,457	848,106
% of Non-NHS Trade invoices paid within target	***99.09%***	***98.86%***
NHS Payables		
Total NHS Trade invoices paid in year	1,265	1,324,977
Total NHS Trade invoices paid within target	1,230	1,322,719
% of NHS Trade invoices paid within target	***97.23%***	***99.83%***

The ICB achieved the required 95% target to pay NHS and Non-NHS trade payables within 30 days (unless other terms had been agreed).

Accounting Policies

Full details of the accounting policies used to prepare the accounts and summary financial statements can be found within Note 1 of the ICB's audited accounts (see Appendix 1).

ICB Board Members

Full details of the remuneration paid to Board members and senior employees are provided within the senior manager remuneration section [add link] of the remuneration and staff report, together with their pension entitlements and declarations of interest.

External Audit

Grant Thornton UK LLP is the appointed external auditor for NHS Bristol, North Somerset and South Gloucestershire ICB for the accounting period 1 April 2024 to 31 March 2025. The total fees payable to Grant Thornton UK LLP by the ICB for 24/25 were;

- £194,400 net of VAT to cover the cost of the statutory audit, value for money audit requirements and associated services for the ICB
- £16,200 net of VAT to cover the cost of assurance work carried out on the Mental Health Investment Standard (MHIS) compliance statement

for 23/24.

Governance Statement

The Chief Executive, as Accountable Officer, publishes an annual governance statement, confirming the systems for managing risk within NHS Bristol, North Somerset and South Gloucestershire ICB. This statement is supported by the Head of Internal Audit who provides an opinion on the overall arrangement for gaining assurance through the Assurance Framework and on the effectiveness of the controls in place to mitigate risks. A copy of the full governance statement can be found on page 125.

Operational Financial Planning 25/26

The NHS financial arrangements for 25/26 will continue to support a system-based approach to planning and delivery, with Integrated Care Systems (ICSs) in a single year settlement for 25/26 whilst we await the outcomes of the Comprehensive Spending Review being undertaken by the government. ICBs will continue to receive Service Development Funding (SDF) allocations to support the delivery of the national objectives set out in this guidance.

The core ICB capital allocations for 25/26 had already been published and remain the foundation of capital planning for future years. ICBs and NHS primary and secondary care providers are expected to work together to plan and deliver a balanced net system financial position in collaboration with other ICS partners.

It is in this context that systems have been asked to focus on the following priorities for 25/26[1]:

- **reduce the time people wait for elective care**, improving the percentage of patients waiting no longer than 18 weeks for elective treatment to 65% nationally by March 2026, with every trust expected to deliver a minimum 5% point improvement. Systems are expected to continue to improve performance against the cancer 62-day and 28-day Faster Diagnosis Standard (FDS) to 75% and 80% respectively by March 2026
- **improve A&E waiting times and ambulance response**

[1] NHS England » 2025/26 priorities and operational planning guidance

times compared to 2024/25, with a minimum of 78% of patients seen within 4 hours in March 2026. Category 2 ambulance response times should average no more than 30 minutes across 2025/26

- **improve patients' access to general practice,** improving patient experience, **and improve access to urgent dental care,** providing 700,000 additional urgent dental appointments

- **improve patient flow through mental health crisis and acute pathways,** reducing average length of stay in adult acute beds, **and improve access to children and young people's (CYP) mental health services**, to achieve the national ambition for 345,000 additional CYP aged 0 to 25 compared to 2019

In delivering these priorities for patients and service users, ICBs and providers are expected to work together with support from NHS to:

- **drive the reform that will support delivery of our immediate priorities and ensure the NHS is fit for the future.** For 25/26 we ask ICBs and providers to focus on:
  - reducing demand through developing Neighbourhood Health Service models with an immediate focus on preventing long and costly admissions to hospital and improving timely access to urgent and emergency care
  - making full use of digital tools to drive the shift from analogue to digital
  - addressing inequalities and shift towards secondary prevention

- **live within the budget allocated, reducing waste and improving productivity**. ICBs, trusts and primary care providers must work together to plan and deliver a balanced net system financial position in collaboration with other integrated care system (ICS) partners. This will require prioritisation of resources and stopping lower-value activity

- **maintain our collective focus on the overall quality and safety of our services**, paying particular attention to challenged and fragile services including maternity and neonatal services, delivering the key actions of 'Three year delivery plan', and continue to address variation in access, experience and outcomes

As set out in section 223M of the National Health Service Act 2006, each ICB and its partner trusts must exercise their functions with a view to ensuring that, in respect of each financial year:

- local capital resource use does not exceed the limit set by NHS England

- local revenue resource use does not exceed the limit set by NHS England

Furthermore, under section 223L of the 2006 Act (as amended) NHS England may set financial objectives for ICBs and their partner trusts, and each ICB and its partner trusts have a duty to seek to achieve those objectives. NHS England will set the objective that each ICB, and the partner trusts whose resources are apportioned to it, should deliver a financially balanced system, which may be referred to as a 'duty on breakeven'.

ICBs also have a duty to deliver financial balance individually (section 223GC of the 2006 Act). This is to promote careful financial management and to reflect legislation that requires NHS England and ICBs to manage within a fixed budget. Additionally, each ICB should ensure it does not exceed the running cost allocation limit, which will be published as part of ICB allocations.

The Bristol, North Somerset and South Gloucestershire health system has submitted an operational plan for 25/26 on 28 March 2025 to NHS England. The plan had been presented to the FED Committee, which had been given delegated permissions from the ICB Board. This draft operational plan submission delivers a break even revenue position for all NHS system partners. A revised plan was submitted on 30 April 2025 with no substantive changes.

Going concern

Within our accounts, we are required to make a clear disclosure that the individuals responsible for financial governance for NHS Bristol, North Somerset and South Gloucestershire ICB have considered this position, and that given the facts at their disposal, the ICB is a going concern. Where there are material uncertainties in respect of events or conditions that cast significant doubt upon the going concern ability of the ICB, these are disclosed as part of the disclosure notes supporting the annual accounts.

Having considered the going concern guidelines, the financial reporting and governance arrangements of the ICB, approach to the development of operating plans for 2025/26, as set out above, and the continued focus by the ICB and our local system partners to drive improvements to the financial position, NHS Bristol, North Somerset and South Gloucestershire ICB considers that it remains a going concern.

The annual accounts of the ICB are prepared on the basis that the organisation is a going concern and that there is no reason why it should not continue operating on the same basis for the foreseeable future.

ACCOUNTABILITY REPORT

SHANE DEVLIN

Accountable Officer

19 June 2025

Accountability Report

The Accountability Report describes how we meet key accountability requirements and embody best practice to comply with corporate governance norms and regulations.

It comprises three sections:

The **Corporate Governance Report** sets out how we have governed the organisation during the period 1 April 2024 to 31 March 2025 including membership and organisation of our governance structures and how they supported the achievement of our objectives.

The **Remuneration and Staff Report** describes our remuneration polices for executive and non-executive directors, including salary and pension liability information. It also provides further information on our workforce, remuneration and staff policies.

The **Parliamentary Accountability and Audit Report** brings together key information to support accountability, including a summary of fees and charges, remote contingent liabilities, and an audit report and certificate.

Corporate Governance Report

The Corporate Governance Report includes:

- The Members Report
- The Statement of Accounting/Accountable Officers Responsibilities and
- The ICB Governance Statement

We provide information about the ICB Board and Committees, explain there were no Personal Data Incidents between 1st April 2024 and 31st March 2025. We also include the ICB Modern Slavery Statement

ICB Board Members Report

The ICB Board membership is set out in our Constitution (Governance Handbook - NHS BNSSG ICB). In 24/25 there have been changes to our Constitution which were agreed by the Board and supported by NHSE. This has included a change to the number of Partner Members. The ICB Board is responsible for discharging the functions set out in legislation and our Constitution. Our Board is made up of:

- The Chair
- Chief Executive
- Chief Finance Officer/Deputy CEO
- Chief Medical Officer

- Chief Nursing Officer
- Five Independent Non-Executive Members (INEM) - non-executive Directors. Alison Moon has been appointed as the Senior Independent Director (SID) during 24/25 to meet constitutional requirements.
- Partner members – until February 2025 the Board comprised 9 partner members, there are now 8

The eight partner members bring the perspectives from:

- Acute and community mental health services,
- Acute secondary care and tertiary services
- Ambulance services
- Primary care and community services
- Costal, rural and urban communities

From 1st April 2024 to 31st March 2025 voting Board members were:

Name	Title	Tenure 2024/25	Attendance
Jeff Farrar	Chair of BNSSG Integrated Care Board	1st April 2024 – present	Ten of Eleven
John Cappock	Non-Executive Director, Chair of Audit and Risk Committee	1st April 2024 – present	Nine of Eleven
Jaya Chakrabarti	Non-Executive Director, Chair of People Committee	1st April 2024 – present	Nine of Eleven
Shane Devlin	Chief Executive Officer, BNSSG ICB	1st April 2024 – present	Eleven of Eleven
Ellen Donovan	Non-Executive Director Chair Quality and Performance Committee and Chair of Remuneration Committee	1st April 2024 – present	Ten of Eleven
Dominic Hardisty	Chief Executive Officer, Avon and Wiltshire Mental Health Partnership NHS Trust	1st April 2024 – present	Six of Eleven
Hugh Evans	Director of Adult Services, BCC	5th September 2024 – 2nd January 2025	Four of Five
Nick Hibberd	Chief Executive, Bristol City Council	16th January 2025 - present	One of Two
Maria Kane	Joint Chief Executive Officer, NHS North Bristol Trust and University Hospitals Bristol and Weston NHS Foundation Trust	1st April 2024 – present	Nine of Eleven
Jon Hayes	Chair of the GP Collaborative Board	1st April 2024 – 7th	Five of Seven

		November 2024	
Jacob Lee	Clinical Chair, GP Collaborative Board	20th November 2024 – present	Four of Four
John Martin	Chief Executive Officer, South Western Ambulance Service NHS Foundation Trust	1st April 2024 – present	Three of Eleven
Joanne Medhurst	Chief Medical Officer, BNSSG ICB	1st April 2024 – present	Ten of Eleven
Alison Moon	Non-Executive Director, Chair Primary Care Committee	1st April 2024 – present	Ten of Eleven
Stephen Peacock	Chief Executive, Bristol City Council	1st April 2024 – 30th June 2024	Three of Three
Dave Perry	Chief Executive, South Gloucestershire Council	1st April 2024 – present	Eight of Eleven
Sue Porto	Chief Executive Officer, Sirona care & health	1st April 2024 - May 2024	Two of Two
Julie Sharma	Interim Chief Executive Officer, Sirona care & health	July 2024 - present	Eight of Eight
Rosi Shepherd	Chief Nursing Officer, BNSSG ICB	1st April 2024 – present	Eight of Eleven
Sarah Truelove	Chief Financial Officer and Deputy Chief Executive, BNSSG ICB	1st April 2024 – present	Eleven of Eleven
Jo Walker	Chief Executive Officer, North Somerset Council	1st April 2024 – present	Seven of Eleven
Stuart Walker	Interim Chief Executive Officer, University Hospitals Bristol and Weston NHS Foundation Trust	1st Jan 2024 – 20th November 2024	Four of Seven
Steve West	Non-Executive Director – Finance, Estates and Digital	1st April 2024– present	Nine of Eleven

Participants regularly attending the ICB Board in 24/25 included

Name	Title
Mark Cooke	Director of Strategy and Transformation, NHS England
Deborah El-Sayed	Director of Transformation and Chief Digital Information Officer, BNSSG ICB
Aishah Farooq	Associate Non-Executive Director
Chris Head	VCSE Alliance Representative (April – to July 2024)
Jo Hicks	Chief People Officer, BNSSG ICB
Ruth Hughes	Chief Executive Officer, One Care
David Jarrett	Director of Primary and Integrated Care, BNSSG ICB

Fiona Mackintosh	VCSE Alliance representative (July 2024 to present)
Kevin Peltonen-Messenger	Chief Executive, The Care Forum (providing Healthwatch perspective) (19 February 2025 – present)
Vicky Marriott	Healthwatch Bristol, North Somerset and South Gloucestershire (to January 2025)

The ICB Board holds regular meetings in open and closed session. Members of the public are able to attend open meetings and can submit questions to the Board. In 24/25, the Board has come together to discuss matters in seminars to support their work to serve our population. Seminars have included the following subject areas:

- Health inequalities and our Public Sector Equality Duties
- Due diligence associated with the arrangements for taking on delegated commissioning responsibilities for specialised commissioned services.
- The Insightful Board guidance published by NHSE to board development.
- A committee effectiveness review meeting was also held in October 2024 between the ICB Executive team and the Independent Non Executive Members who chair the ICB Board and committee meetings.
- The Chair of the Board, supported by the Senior Independent Director, has completed appropriate activities to ensure that members of the Board meet the Fit and Proper Persons Test arrangements set out by NHSE. Appraisals have also been conducted.

Member profiles

For more details about our ICB Board members visit Our Integrated Care Board - NHS BNSSG ICB . Our Board holds meetings in public and we publish our Board papers on our website Events - NHS BNSSG ICB

Committees, including Audit Committee

Our ICB Board has seven committees that report to it. Their terms of reference can be found here Governance Handbook - NHS BNSSG ICB. In 24/25, we added the Strategic Health Inequalities, Prevention and Population Health Committee to the six which existed previously and which includes the mandatory Audit and Remuneration Committees. The Governance Handbook at the link provided does identify an eighth committee – The South West Joint Specialised Services Committee. This committee

has been added to the ICB on 1 April 2025 and does not therefore feature in this reporting period.

We provide more information about our committees, their membership and attendance details, in the Governance Statement on page 125.

Register of Interests

Details about the declared interests of ICB Board members and participants can be found at ICB register of interests - NHS BNSSG ICB

Personal data related incidents

A personal data breach is a breach of security leading to the accidental or unlawful destruction, loss, alteration, unauthorised disclosure of, or access to, personal data transmitted, stored or otherwise processed.

If we experience a personal data breach at the ICB, we need to consider the impact on the individual or group of individuals. We need to consider the likelihood and severity of the risk to people's rights and freedoms, following the breach. Once this assessment has been made following the ICBs Standard Operating Procedures, if it's likely there will be a risk then we will notify the Information Commissioner's Office (ICO). If it's unlikely then we will deal with the breach according to our policies, without reporting to the ICO.

In the period covered by this report, 1st April 2024 to the 31st of March 2025, no incidents were reported to the ICO.

Modern Slavery Act

NHS Bristol, North Somerset and South Gloucestershire ICB fully supports the Government's objectives to eradicate modern slavery and human trafficking but does not meet the requirements for producing an annual Slavery and Human Trafficking Statement as set out in the Modern Slavery Act 2015. Our Modern Slavery and Human Trafficking Statement can be read at Modern Slavery & Human Trafficking Statement - BNSSG ICB

Statement of Accountable Officer's Responsibilities

Under the National Health Service Act 2006 (as amended), NHS England has directed each Integrated Care Board to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of the BNSSG ICB and of its income and expenditure, Statement of Financial Position and cash flows for the financial year.

In preparing the accounts, the Accountable Officer is required to comply with the requirements of the Government Financial Reporting Manual and in particular to:

- Observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- Make judgements and estimates on a reasonable basis;
- State whether applicable accounting standards as set out in the Government Financial Reporting Manual have been followed, and disclose and explain any material departures in the accounts; and,
- Prepare the accounts on a going concern basis; and
- Confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced and understandable.

The National Health Service Act 2006 (as amended) states that each Integrated Care Board shall have an Accountable Officer and that Officer shall be appointed by NHS England.

NHS England has appointed the Chief Executive to be the Accountable Officer of BNSSG ICB. The responsibilities of an Accountable Officer, including responsibility for the propriety and regularity of the public finances for which the Accountable Officer is answerable, for keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the Integrated Care Board and enable them to ensure that the accounts comply with the requirements of the Accounts Direction), and for safeguarding the BNSSG ICB's assets (and hence for taking

reasonable steps for the prevention and detection of fraud and other irregularities), are set out in the Accountable Officer Appointment Letter, the National Health Service Act 2006 (as amended), and Managing Public Money published by the Treasury.

As the Accountable Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that BNSSG ICB's auditors are aware of that information. So far as I am aware, there is no relevant audit information of which the auditors are unaware.

As the Accountable Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that BNSSG ICB's auditors are aware of that information. So far as I am aware, there is no relevant audit information of which the auditors are unaware.

Governance Statement

Introduction and context

NHS Bristol, North Somerset and South Gloucestershire ICB is a body corporate established by NHS England on 1 July 2022 under the National Health Service Act 2006 (as amended).

The NHS Bristol, North Somerset and South Gloucestershire ICB ’s statutory functions are set out under the National Health Service Act 2006 (as amended).

The ICB’s general function is arranging the provision of services for persons for the purposes of the health service in England. The ICB is, in particular, required to arrange for the provision of certain health services to such extent as it considers necessary to meet the reasonable requirements of its population.

Between 1 April 2024 and 31 March 2025 the Integrated Care Board was not subject to any directions from NHS England issued under Section 14Z61 of the of the National Health Service Act 2006 (as amended).

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the BNSSG ICB’s policies, aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me in Managing Public Money. I also acknowledge my responsibilities as set out under the National Health Service Act 2006 (as amended) and in the BNSSG ICB’s Accountable Officer Appointment Letter.

I am responsible for ensuring that the BNSSG ICB is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity. I also have responsibility for reviewing the effectiveness of the system of internal control within the ICB as set out in this governance statement.

Governance arrangements and effectiveness

The main function of the Board is to ensure that the group has made appropriate arrangements for ensuring that it exercises its functions effectively, efficiently and

economically, and complies with such generally accepted principles of good governance as are relevant to it.

The ICB Board composition and attendance is described on page 118. The ICB Constitution sets out how appointments are made to the Board and the process for the joint nomination, assessment, selection and appointment of ICB partner members and role descriptions are on our website. Governance Handbook - NHS BNSSG ICB. In 24/25 the Board have agreed changes to the Board composition and the constitution. Due process has been followed and NHSE England have approved the Constitutional changes.

In support of the Constitution, the ICB maintains a range of governance documents that set out the arrangements we have in place to ensure we maintain a robust system of internal control Governance Handbook - NHS BNSSG ICB:

- Standing Orders
- Standing Financial Instructions
- Functions and decision map
- Scheme of Reservation and Delegation
- Committee Terms of Reference

Formal committees have been established by the Board, each is chaired by an Independent Non-Executive Member (INEM) - a non-executive director. The ICB began 24/25 with six committees and in this reporting period added a seventh committee - Strategic Health Inequalities, Prevention and Population Health Committee.

The ICB has also established the Independent Advisory Group reporting to the ICB. Recruitment has taken place to ensure that this group has sufficient capacity to deploy subject matter experts to bring challenge and the perspective of disadvantaged communities to the commissioning work of the ICB.

The following section identifies information about the remit of each committee, its membership and attendance. The Terms of Reference, which the committee keep under review, are listed in the Governance Handbook - NHS BNSSG ICB.

Audit and Risk Committee

The Audit and Risk Committee provides the ICB Board with an independent objective view of and assurance on controls and governance arrangements. The Committee is responsible for the oversight of financial reporting and disclosure and is chaired by a non-executive director who is a qualified accountant and has experience at Director of Finance level. Membership of the Committee and attendance at meetings are detailed in the table below. The Audit and Risk Committee provides assurance to the Board that an appropriate system of internal control is in place, so that:

- Business is conducted in accordance with the law and proper standards
- Public money is safeguarded and properly accounted for
- Financial statements are prepared in a timely fashion and give a true and fair view of the financial position for the period in question
- Economic, efficient and effective use of resources is secured
- Adequate arrangements are in place and reasonable steps are taken to prevent and detect fraud and other irregularities
- An effective system of integrated governance, risk management and internal control across the whole of the ICB's activities is established and maintained.

Name	Title	Attendance
John Cappock	Non-Executive Director, ICB Chair of Audit and Risk Committee	Five of five
Jaya Chakrabarti	Non-Executive Director, ICB Board	Five of five
Ellen Donovan	Non-Executive Director ICB Board	Four of five
Lorna Harrison	Non-Executive Director, Sirona	One of five
Alison Moon	Non-Executive Director, ICB Board	Three of five
Jane Norman	Non-Executive Director, UHBW	Zero of one
Anne Tutt	Non-Executive Director, UHBW	Two of three
Jo Walker	Chief Executive Officer, North Somerset Council	One of five
Steve West	Non-Executive Director ICB Board	Four of five

Remuneration Committee

The Remuneration Committee makes decisions on all aspects of remuneration and other allowances (including pension schemes) for employees not covered by Agenda

for Change terms and conditions and other individuals providing services to the ICB. The committee is also involved in decisions relating to organisational changes and the movement of affected staff.

The Remuneration Committee membership is drawn from the ICB Board non-executive directors and from ICB Board partner members when necessary. Routine membership and attendance are detailed in the table below:

Name	Title	Attendance
Ellen Donovan	Non-Executive Director ICB Chair of Remuneration Committee	Three of three
Jaya Chakrabarti	Non-Executive Director, ICB Board	Three of three
Jeff Farrar	Chair ICB Board	Three of three
Alison Moon	Non-Executive Director, ICB Board	Three of three
Steve West	Non-Executive Director ICB Board	Three of three

Outcomes, Performance and Quality Committee

Our Outcomes, Performance and Quality Committee and oversees and seeks assurance on the effective delivery of the ICB Operational Plan and that cohesive and comprehensive structures are in place for effective planning, management and improvement of outcomes, quality and performance. The membership and attendance at meetings are detailed in the table below. Details of performance matters can be found in the Performance Report from page 3.

Name	Title	Attendance
Ellen Donovan	Non-Executive Director ICB; Chair of Outcomes, Performance and Quality Committee; Chair of Remuneration Committee	Six of six
Sue Balcombe	Non-Executive Director, UHBW	Two of six
Hugh Evans	Executive Director, Adult & Communities, Bristol City Council	Three of six
Jacky Hayden	Non-Executive Director, Sirona	Two of two
Jon Hayes	GP Collaborative Board Chair (left November 2024)	Three of four
Jacob Lee	GP Collaborative Board Chair	One of two
Paul May	Non-Executive Director, Sirona (left November 2024	Three of four
Jo Medhurst	Chief Medical Officer, ICB	Four of six

Rosi Shepherd	Chief Nursing Officer, ICB	Six of six
Sarah Weld	Director of Public Health, South Gloucestershire Council	Four of six
Jeff Farrar	Chair, BNSSG ICB	Three of six
Alison Moon	Non-Executive Director, ICB	Six of six
David Jarrett	Chief Delivery Officer, ICB	Five of six

Finance, Estates and Digital Committee

The Finance, Estates and Digital Committee considers all draft strategic and financial plans prior to their submission to the Board for approval, including the financial plans associated with the Operational Plan, Joint Forward Plan and savings plans. The Committee monitors the longer term financial strategic direction of the ICB, the delivery of savings plans and the ICB's in year financial performance, identifying key issues and risks requiring discussion and decision by the ICB Board. The committee oversees the development of the ICB Estates Strategy and Digital Strategy and gains assurances that these strategies are embedded into the ICS financial framework. The membership and attendance at meetings are detailed in the table below.

Name	**Title**	**Attendance**
Steve West	Non-Executive Director ICB Chair of Finance, Estates and Digital Committee	Eleven of twelve
John Cappock	Non-Executive Director, ICB Board	Twelve of twelve
Deborah El Sayed	Director of Transformation and Chief Digital Information Officer, ICB	Eleven of twelve
Richard Gaunt	Non-Executive Director NBT	Five of twelve
Christina Gray	Director of Public Health, Bristol City Council	Seven of twelve
Jo Medhurst	Chief Medical Officer, ICB	Eight of twelve
Amy Webb	Section 151 Officer, North Somerset Council *(attendance from March 2024)*	Seven of twelve
Brian Stables	Non-Executive Director, AWP	Nine of twelve
Martin Sykes	Non-Executive Director, UHBW	Six of twelve
Rosi Shepherd	Chief Nursing Officer, ICB	Four of twelve
Sarah Truelove	Chief Financial Officer, ICB	Twelve of twelve

Primary Care Committee

The ICB has delegated authority for the commissioning of primary medical care, and has established a committee to oversee the contracting of general practice services. The committee provides assurance on the review, planning and procurement of primary care services delegated by NHS England to the ICB. The following services are now delegated to the ICB from NHS England:

- Primary Care Medical Services
- Primary Dental Services and Prescribed Dental Services
- Primary Ophthalmic Services
- Pharmaceutical Services and Local Pharmaceutical Services

Membership and attendance at meetings are detailed in the table below.

Name	Title	Attendance
Alison Moon	Non-Executive Director ICB Chair of Primary Care Committee	Six of six
Georgie Bigg	Healthwatch Bristol, North Somerset and South Gloucestershire	Two of six
Katrina Boutin	GP Collaborative Board Representative	Three of six
Dr Barbara Brown	Chair, Sirona	One of five
Ellen Donovan	Non-Executive Director ICB Board	Five of six
Jeff Farrar	Chair ICB Board	Three of six
John Hopcroft	Avon Local Optical Committee	Three of six
Matthew Jerreat	Clinical Chair of the Southwest Local Dental Network	Three of six
David Jarrett	Chief Delivery Officer, BNSSG ICB	Six of six
Matt Lenny	Director of Public Health, North Somerset Council	Four of six
Dr Joanne Medhurst	Chief Medical Officer, BNSSG ICB	Four of six
Dr Shaba Nabi	Chair, Avon Local Medical Committee	Four of six

Sarah Purdy	Non-Executive Director, NBT	Three of six
Hayley Richards	Non Executive Director, Sirona	One of one
Rosi Shepherd	Chief Nursing Officer, ICB	Three of six

People Committee

The People Committee is made up of the ICS People Committee and the ICB People Committee elements. The ICS People Committee oversees the development of the ICS People Strategy and Plan, monitoring its implementation across the system. The committee challenges and scrutinises workforce risks, ensuring mitigating actions are identified and implemented. The committee seeks assurance on the ICB's Equalities and Diversity Strategy and Equality Delivery Strategies. The ICB People Committee element ensures that the ICB has in place a robust People Strategy and monitors its implementation for the organisation. The membership and attendance at meetings are detailed in the table below.

ICS People Committee

Name	Title	Attendance
Jaya Chakrabarti	Non-Executive Director, ICB Board	Six of six
Ellen Donovan	Non-Executive Director ICB Board	Five of six
Alison Moon	Non-Executive Director, ICB Board	Five of six
Linda Kennedy	Non-Executive Director, UHBW	Six of six
Jo Hicks	Chief People Officer, BNSSG ICB	Six of six
Kelvin Blake	Non-Executive Director, NBT	Five of six
Rosi Shepherd	Chief Nursing Officer, BNSSG ICB	Four of six
Sonya Wallbank	Chief People Officer, Sirona	Two of five
Rebecca Helmsley	Chief People Officer, Sirona	One of six
Jan Baptiste Grant	Non-Executive Director, AWP	Five of six
Anil Patil	Non-Executive Director, Sirona	Three of four
Tim Cooper	Non-Executive Director, Sirona	Two of two
Lorraine Francis	Councillor for Eastville, BCC	One of one

Bryony Campbell	Executive Director, Transformation & Strategy, OneCare	Six of six

ICB People Committee

Name	Title	Attendance
Jaya Chakrabarti	Non-Executive Director, ICB	Three of three
Ellen Donovan	Non-Executive Director, ICB	Two of three (shared attendance with Alison Moon)
Alison Moon	Non-Executive Director, ICB	One of three (shared attendance with Ellen Donovan)
Jeff Farrar	Chair BNSSG ICB	Two of three
Shane Devlin	Chief Executive BNSSG ICB	One of three
Jo Hicks	Chief People Officer BNSSG ICB	Three of three
Sarah Truelove	Deputy Chief Executive/Chief Finance Officer BNSSG ICB	Two of three
Joanne Medhurst	Chief Medical Officer BNSSG ICB	None
Rosi Shepherd	Chief Nurse Officer BNSSG ICB	One of three
Deborah El-Sayed	Chief Transformation and Digital Information Officer BNSSG ICB	One of three
Dave Jarrett	Chief Delivery Officer BNSSG ICB	One of three

Strategic Health Inequalities, Prevention and Population Health Committee

The Strategic Health Inequalities, Prevention and Population Health Committee (SHIPPH) provides oversight, assurance and support for the ICS's efforts towards tackling health inequalities and embedding preventative approaches. While the committee is primarily focused on assurance, it also holds responsibility for the delivery of ICS Strategy Commitments to the following:

- Develop an overarching approach to prevention

- Developing a whole system approach to healthy weight
- Develop a whole system approach to Smokefree BNSSG (focused on reducing the harms from tobacco)
- Develop a whole system approach to alcohol and drugs

The membership and attendance at meetings are detailed in the table below.

Name	Title	Attendance
Jeff Farrar	Chair BNSSG Integrated Care Board (ICB)	Three of Three
Jo Medhurst	Chief Medical Officer BNSSG Integrated Care Board (ICB)	Three of Three
Deborah El-Sayed	Chief Transformation and Digital Information Officer BNSSG Integrated Care Board (ICB)	Two of Three
Rosi Shepherd	Chief Nursing Officer BNSSG Integrated Care Board (ICB)	Two of Three
Grace Burn	Public Contributor	One of Three
Samina Baig	Public Contributor	Two of Three
Lucy Heard	Public Contributor	One of Three
Amanda Threlfall	Public Contributor	Two of Three
Steve Nelson	Chief Executive Wesport	Two of Three
Mark Graham	Chief Executive For All Healthy Living	Three of Three
Anya Mulcahy-Bowman	Deputy Chief Executive Wellspring Settlement	Two of Three
Kevin Peltonen-Messenger	Chief Executive of The Care Forum	None of Three
Tracie Joliff	Chair ICB Independent Advisory Group on Race Equality	Three of Three

Christina Gray	Director of Public Health Bristol City Council	Three of Three
Matt Lenny	Director of Public Health North Somerset Council	Two of Three
Sarah Weld	Director of Public Health South Gloucestershire Council	One of Three
Katrina Boutin	Medical Director General Practice Collaborative Board	Three of Three
Richard Brown	Chief Officer Local Pharmaceutical Committee	None of Three
Mary Lewis / Su Monk	Chief Nurse and Allied Health Officer Sirona Care and Health representative	One of Three

ICB Decision Making Framework

The System Executive Group is made up of the ICS's delivery partners (NHS (including One Care), and Local Authority) Chief Executives, and is chaired by the ICB Chief Executive. This group continues to drive activity requested by the ICB Board, takes system decisions when required within delegated limits of the ICB Chief Executive, and is a forum for deeper discussions on system challenges or opportunities.

To support the delivery of our ICB functions and ambitions we have developed a series of principles with the System Executive Group which oversees the work of our Health and Care Improvements Groups (HCIG). HCIGs comprise representatives from organisations from across our Integrated Care System (ICS) who come together in service of the BNSSG population we serve and to progress the activities associated with our system plan. The principles recognise the complexities of working across the ICS where individual organisations will have their own governance arrangements to follow. They are intended to promote timely and responsive ways of collaborative working.

Our principles:

1. ICS Groups (operational or oversight) are collaborations of ICS partner representatives.

2. ICS Groups will make decisions by consensus that best serve our population, not the interest of individual ICS partner organisations.
3. Decisions made by ICS Groups will require action from ICS partners organisations.
4. It is ICS partner organisations' responsibility to ensure that the right people with the appropriate delegated authority attend ICS Groups to agree and action the decisions.
5. If ICS partner representatives do not have delegated authority to agree and action ICS group decisions, they must escalate through their organisation's governance processes.
6. Hierarchy of decision-making to be respected.

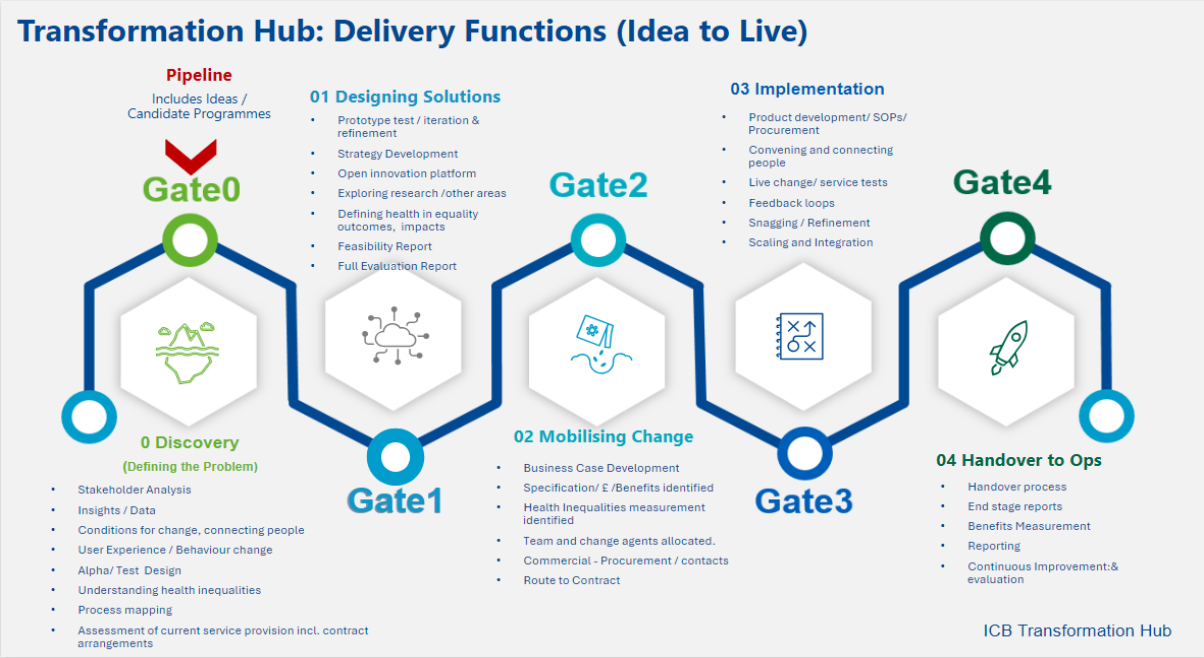
We have established four Health and Care Improvement Groups (HCIG) which provide system level oversight with representation from appropriate system partners. The four HCIGs are: Mental Health and LD&A , Children's Services , Acute Services , Community Services. Each has the following purpose:

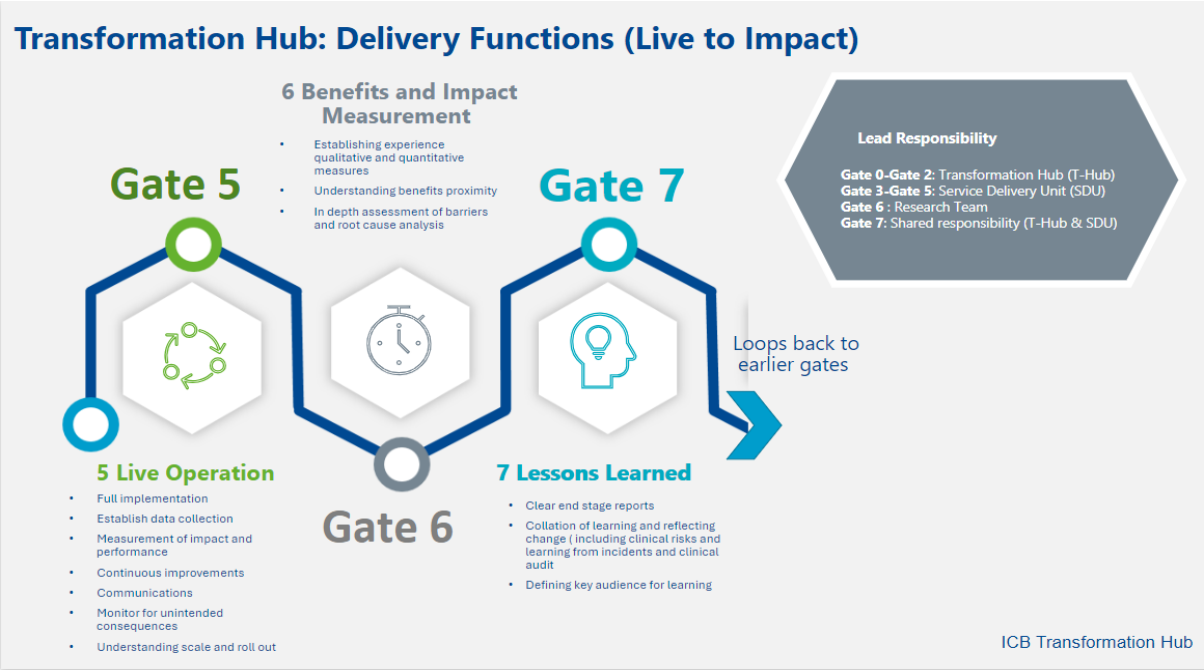
- To provide system oversight, ensuring system partners working together effectively, collaboratively and symbiotically
- Key role in ICS Operating and Decision-Making Framework in oversight of services and making recommendations relating to resource and strategic developments
- Delegated responsibility from ICB Board for achieving specific outcomes, strategic and in-year plan objectives in pursuit of the ICS' vision and mission.
- Commission ICB transformation and intelligence hub and SDUs against specific phases of Gateway delivery process,
- Align and deploy activity across the system and partner organisations to achieve ICS vision and mission and ensure all activity contributes to delivering health and care services that meet the needs of our population.
- Gatekeepers of the ICB transformation and intelligence hub, supported by an ICB gateway panel that will undertake quality assurance checks at each gateway.

The Lead ICB Executive for each HCIG can exercise decisions of this group on behalf of the ICB in accordance with delegated authority from ICB constitution, SFIs and schemes of reservation and delegation. All HCIG members will have delegated authority from their

employing organisations constitutions, SFIs and schemes of reservation and delegation. HCIGs are supported by Operational Delivery Groups and Service Delivery Units.

We have resourced a Transformation Hub which supports the delivery of work programmes through the application of structured methodology to ensure delivery of defined outcomes. This approach which utilises a series of gateways is shown below:





Our established Locality Partnerships have continued to drive collaboration in local areas and give us the structure required to be outcome focused. They also allow us to operate as a strategic and delivery partnership; founded on the principles of distributed leadership as well as rigorous and robust system oversight, assurance, and scrutiny; functioning through decisions that are timely, responsive and proportionate.

UK Corporate Governance Code

NHS Bodies are not required to comply with the UK Code of Corporate Governance.

Discharge of Statutory Functions

BNSSG ICB has reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislation and regulations. As a result, I can confirm that the ICBs is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions.

Responsibility for each duty and power has been clearly allocated to a lead Director. Directorates have confirmed that their structures provide the necessary capability and capacity to undertake all of the ICB's statutory duties supported where appropriate by resources commissioned from South Central and West Commissioning Support Unit (SCWCSU).

.

Risk management arrangements and effectiveness

The ICB has adopted risk management arrangements focused on the management of risk within the ICB and developed its Risk Management Framework which is kept under review and agreed by the Board with input from the Audit and Risk Committee. Our internal ICB risk management arrangements can be found in the ICB Governance Handbook Governance Handbook - NHS BNSSG ICB . This defines the structures for the management and ownership of risk within the ICB.

The Audit and Risk Committee seeks assurances on the ICB governance arrangements including financial governance and risk management. The ICB committees are responsible for the oversight and scrutiny of risks within their remit. Updates form committees are scheduled at each Board meeting and the non executive committee chairs provide updates and escalations where there is a gap in assurance.

The Board has agreed a series of risk appetite statements. In March 2025, the appetite of the Board for managed risk was increased to support the delivery of obligations set out in the Planning Guidance for 25/26 by NHS England.

The ICB Corporate Risk Register identifies risks to the achievement of the ICB objectives, highlights gaps in controls and assurances and details the mitigations to be implemented. Risks are identified through data analysis, external and internal audit reports and other regulatory reporting mechanisms, incident reporting, complaints and litigation, and staff concerns/whistle blowing. Risks are evaluated and assessed using a risk scoring matrix set out in the Risk Management Framework and are reported through Directorate and Corporate Risk Registers. Risk is embedded in the reporting arrangements to the Board as part of the standard paper template. Equality Health Impact Assessments are used to assist with the identification and mitigation of risks. Equality Health Impact Assessments also form part of the standard template for papers to the ICB Board and committees.

As part of the framework of control the ICB has in place processes for the reporting, investigation, management and learning from incidents. All serious incidents and risks are reported through incident reporting procedures. Incident reports and trends are used to identify risks, and this is referenced in the Risk Management Framework.

Our work with patients and members of the public ensures that our local people are involved throughout our planning and commissioning processes and these present the opportunity for public stakeholders to highlight relevant risks and engage in discussions around how to mitigate them.

In support of the Risk Management Framework, the ICB has adopted policies for managing conflicts of interest and gifts and hospitality, and tackling fraud and bribery. The ICB has established Standing Financial Instructions.

ICS System risk management

A system risk is defined as a risk that is held in common between health and care partner organisations which cannot be controlled or mitigated by individual partners in

isolation. The responsibility for ownership and management of system risks is shared across ICS partners.

The ICS Risk Management Framework developed describes the principles for identifying system risks, escalation protocols for system risks and supporting arrangements for health and care partners to use to better understand and manage actions to control and mitigate system risks.

The System Executive Group comprised of very senior leaders in organisations servicing the BNSSG population have established the ICS Strategic Risk Register. This provides oversight of risk which require attention to ensure the continued delivery of services. The ICS Strategic Risk Register is reported to the ICB Board.

Capacity to Handle Risk

The ICB's policy is to identify, minimise, control and, where possible, eliminate risks that could have an adverse impact on patients, staff and the organisation. As Accountable Officer I carry ultimate responsibility for all risks within the ICB. Our Risk Management Framework describe the governance structures and responsibilities for risk management within the ICB and across partners including the roles of the Board and its committees.

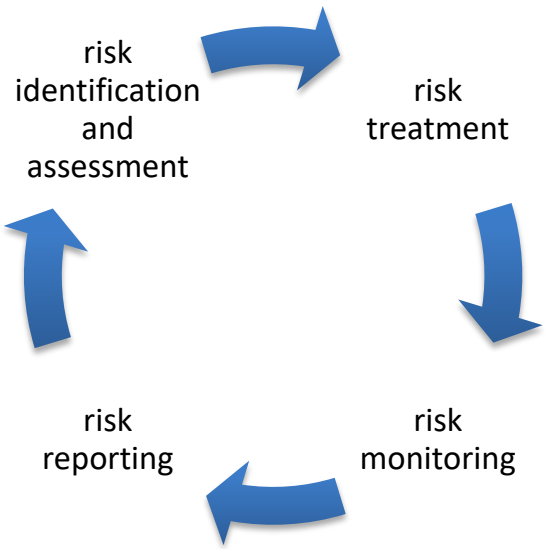
The ICB Board receives monthly reports on performance and quality, and finance providing timely, accurate data that supports the ICB Board in the assessment of risks, including risks to compliance with statutory obligations. The Board's regular review and interrogation of these reports and other ad hoc reports enables it to have robust and rigorous oversight of performance. The Health and Care Improvement Groups provide system wide fora for monitoring system risks and mitigations, and with the System Executive Group support the reporting of risks to the ICB Board.

Staff are required to undertake training for the management of risk where relevant. In addition to core risk management training, training sessions and e-learning was available for key topics such as health and safety, manual handling, basic life support, infection control, fire safety, conflict resolution and information governance. It is mandatory for employees to undertake training on an annual, bi-annual, or three-yearly basis, as appropriate to their role. Learning is drawn from good practice, performance

management, continuing professional development where relevant, audit and the application of evidence-based practice.

Risk Assessment

Risk assessment and management follows the steps described in the diagram below



Risks are identified and assessed using a risk-scoring matrix, risks are analysed, the actions required to mitigate them are identified and implemented and the impact of these mitigations is monitored. Risks are reported through Board reports and provision of the Corporate Risk Register. Major risks to governance, risk management and internal control in 24/25 are detailed at page 147 ‘Control Issues’.

Other sources of assurance

Internal Control Framework

A system of internal control is the set of processes and procedures in place in BNSSG ICB to ensure it delivers its policies, aims and objectives. It is designed to identify and prioritise the risks, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control allows risk to be managed to a reasonable level rather than eliminating all risk; it can therefore only provide reasonable and not absolute assurance of effectiveness.

The system of internal control is described through the Standing Orders, Scheme of Reservation and Delegation, and Standing Financial Instructions for the ICB. These ensure compliance with statutory requirements for the management of governance. Internal audit and the counter-fraud service provide an independent review of internal controls.

The risk assessment component of the internal system of control is contained in the Risk Management Framework as described previously.

The Board has a clear understanding of the key pressures facing the organisation. A key element of control is the provision of assurance through regular reporting including but not limited to:

• Audit and assurance reports

• Minutes of committees of the ICB and other key groups

• Strategic planning

• Reports on patient safety and quality of clinical care

• Performance management

• Financial management

The Board is also engaged in seminars to support its development. Procurement activities are carried out within the framework of control set out in legislation and regulation and the associated policy has been updated in 24/25. This update has taken into consideration the Provider Selection Regime (PSR). Arrangements are in hand for the ICB to publish its required PSR Annual Report covering the period from January 2024 to Match 2025. It is anticipated that this will be available from the end of July 2025.

The ICB has a range of policies relating to information governance, human resources, health and safety, human resource management, equalities and diversity, and emergency preparedness and resilience, all of which contribute to the internal control environment.

As Accountable Officer, I am responsible for reviewing the effectiveness of the system of control and for providing leadership and direction to staff. I hold responsibility for the governance and risk management frameworks. Other members of the Executive Team have lead responsibility for the specific systems of control that fall within their remit:

Deputy Chief Executive/Chief Finance Officer:

- Financial controls and financial risk

Chief Nursing Officer:

- Quality of services
- Patient safety and safeguarding
- Customer experience and complaints

Chief Medical Officer:

- Innovation and research
- Caldicott Guardian

The Director of Transformation/Chief Digital Officer:

- Management of information governance and related risks as the Senior Information Risk Officer (SIRO)

The role of all of our Executive Directors is to ensure that appropriate arrangements and systems are in place so that risks are:

- identified and assessed
- eliminated or reduced to an acceptable level
- effectively managed

Executive Directors ensure that staff comply with policies and procedures, and statutory as well as regulatory requirements.

Certain Executive Directors also hold nationally mandated portfolio responsibilities. These are published on our website:

- Children and young people (aged 0 to 25)

  Nominated ICB Executive: David Jarrett – Chief Delivery Officer

- Children and young people with special educational needs and disabilities (SEND)

Nominated ICB Executive: David Jarrett – Chief Delivery Officer

- Safeguarding (all-age), including looked after children

  Nominated ICB Executive: Rosi Shepherd – Chief Nursing Officer

- Learning disability and autism (all-age)

  Nominated ICB Executive: Rosi Shepherd – Chief Nursing Officer

- Down syndrome (all-age)

  Nominated ICB Executive: David Jarrett – Chief Delivery Officer

Executives and other Board Members are subjected to the Fit and Proper Persons Test arrangements. Following suitability checks, assurance has been provided to NHS England by the ICB Chair.

Conflicts of interest management

The ICB arrangements to manage actual and potential conflicts of interest include:

- Managing Conflicts of Interest and Gifts and Hospitality Policies which have been updated and approved by the ICB Board in 24/25 with input from the Audit and Risk Committee. These are included in the Governance Handbook.
- the appointment of a Conflicts of Interest Guardian – the chair of the Audit and Risk Committee
- an internal process requiring regular declarations to be made supported by a regular reminder system including as part of onboarding new staff.
- regular updates and reminders through the internal newsletter
- monthly updating of the register of interests on the ICB website
- regular audits undertaken by the Corporate Governance Team
- statutory and mandatory training. This includes the identification of the correct target audience that will be required to complete the two additional modules introduced by NHSE in January 2025.

Data Quality

The information used by the ICB Board and its Committees enables the ICB to carry out its responsibilities and discharge its statutory functions. Information is strategic operational, financial, or relates to outcomes, performance, quality and patient experience. The Board and its Committees are engaged in a continuous cycle of improvement with regard to the quality of the information received. The reports received underwent regular review and improvement. The Board found the quality of data to be acceptable and utilised the Insightful Board Guidance published by NHS England at a dedicated seminar in February 2025. No risks relating to the quality of data were highlighted between 1st April 2024 and 31st of March 2025.

Information Governance

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The NHS Information Governance Framework is supported by a Data Security Protection Toolkit (DSPT) and the annual submission process provides assurances to BNSSG ICB, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively.

For 23/24 the ICB submitted a standards not met assessment to NHS England in June 2024. Following the approval of an improvement plan by NHS England work commenced to meet the outstanding requirements. All improvements were completed by August 2024. NHS England accepted the improvements and the ICB status was updated to standards met.

In September 2024, the DSPT changed to adopt the National Cyber Security Centre's Cyber Assessment Framework (CAF) as its basis for cyber security and IG assurance. This was a commitment made in the Department of Health and Social Care's cyber security strategy 2030. This change has led to a requirement for the ICB to align to a new set of requirements in terms of Objectives, Principles and Outcomes. The ICB is expected to submit its final assessment to NHS England by 30th June 2025. Our internal Auditors are independently reviewing our assessment of compliance.

We place high importance on ensuring there are robust information governance systems and processes in place to help protect individuals' and business information. We have established an information governance management framework and have robust

information governance policies and processes in place. We have ensured all staff undertake annual information governance training and have implemented a staff information governance handbook and Acceptable Use of IT Policy to ensure staff are aware of their information governance roles and responsibilities.

There are also processes in place for incident reporting and investigation of serious incidents. We are continually developing information risk assessment and management procedures and a programme will be established to strengthen the existing information risk culture throughout the organisation.

Business Critical Models

An appropriate framework and environment were in place to provide quality assurance of business-critical models, in line with best practice recommendations of the 2013 MacPherson review into the quality assurance of analytical models.

Emergency Preparedness, Resilience and Response

The NHS needs to be able to plan for and respond to a wide range of incidents and emergencies which could affect health or patient care. These could be anything from extreme weather conditions, an infectious disease outbreak, a major transport accident, a cyber security incident or a terrorist act. This is underpinned by legislation contained in the Civil Contingencies Act 2004, the NHS Act 2006 and the Health and Care Act 2022. This work is referred to in the health service as emergency preparedness, resilience, and response or EPRR.

Since 1 July 2022, BNSSG ICB has been a Category 1 responder. Category 1 responders are required to comply with six duties.

- assess the risk of emergencies occurring and use this to inform contingency planning,
- put in place emergency plans,
- put in place business continuity management arrangements,
- put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency,

- share information with other local responders to enhance co-ordination,
- co-operate with other local responders to enhance co-ordination and efficiency,

To support our EPRR work, the Local Health Resilience Partnership is established and jointly chaired by David Jarrett, – Chief Delivery Officer, and Accountable Emergency Officer (AEO), NHS BNSSG ICB; and Matt Lenny – Director of Public Health, North Somerset Council.

NHS England (NHSE) undertake an annual review of compliance against the Core Standards of EPRR framework. This framework is applicable to all ICBs, it also involves ICBs' assurance of system partner. In November 2024, following 'confirm and challenge' meetings, NHSE confirmed that BNSSG ICB had achieved full compliance against 100% of the 47 core standards.

In the ICB, the Outcomes, Quality and Performance committee oversees the EPRR agenda.

Third party assurances

The ICB purchases services from the South Central and West Commissioning Support Unit which include HR, procurement, IT, and information governance support. Independent assurances on these services are provided through service auditor reports. Day to day assurance of the above services is achieved through regular performance meetings attended by senior members of staff from both organisations.

ISAE3402 Assurance Letters of Comfort are received and shared with the Chief Financial Officer, and the Internal Auditors. The internal auditor reviews are reported in the Head of Internal Auditor Opinion (HIAO) on page 233, and noted as follows.

- Finance and Accounting provided through NHS Shared Business Services. The opinion was qualified based on three controls where exceptions were identified in testing. However, these are not considered sufficient significant to impact on the ICB's HIAO.

- Dental payment process system, Electronic Staff Record (ESR) system, Prescription payments process system provided through NHS Business Services Authority. No exceptions were noted.
- Primary Care Support England (PCSE) Services provided by Capita. The opinion was qualified based on one control objective where exceptions were identified in testing however, these are not considered sufficiently significant to impact on the ICB's HIAO.
- Payroll and Non-Clinical Procurement services provided by the four NHS Commissiong Support Units (CSU) including South Central and West CSU. One opinion was given for this report covering all four CSUs. The opinion was qualified based on two control objectives where exceptions were identified in testing, relating to the Accounts Receivable areas of sales order requests and credit notes. These are not services provided to the ICB and are therefore do not impact on the ICB's HIAO.

Our External Auditors have noted the qualified opinions on various service auditor reports and observed that these relate to controls operating at the third party and not the ICB. The External auditors are satisfied that the ICB has appropriate compensating controls in place to mitigate against any increased area of risk.

Control Issues

The following control issues were reported to NHS England in the January 2025 Governance Statement return. More detail information about performance is provided in the Performance section of the Annual Report on page 3.

Finance, Governance and Control – Finance and Procurement

The ICB has an ongoing legal challenge following the completion of a Non-Emergency Patient Transport Service – Lot 1 (Haemodialysis Transport) & 2 (Planned Transport) legal challenge. Following the receipt of the challenge and the Particulars around the claim, the ICB has taken numerous actions to mitigate risks of not securing such a service. For example: the ICB sought counsel which resulted in the courts supporting the lifting of the contact award / mobilisation suspension, this did cause delay in mobilisation. Services have been secured due to the actions taken during and after mobilisation including actions taken to place an urgent award with our NHS partners. The legal

challenge remains in place and to support the challenge the ICB has completed the following in readiness for the potential up and coming court hearing:

- Case Management Conference held
- Response to the particulars of claim (PoC) and subsequent amended and re-amended PoC – Statement of Truth
- Review of ICB position of success of defence
- Disclosure Order agreed and actioned – all required and necessary disclosure documents have been secured, reviewed and disclosed
- Witnesses agreed and statements taken. All witness statements are due to be submitted on 20 January 2025
- Schedule of Loss submitted along with our Counter Schedule of Loss
- Expect court hearing to be during Q2/3 25/26

Quality and Performance – Children's Services

Referrals for children's community paediatrics, including ASD and ADHD assessments significantly exceed capacity resulting in significant waiting times for assessments. Mitigation includes a children's community services recovery plan, informed by NHS England's Intensive Support Team, who undertook a review of the clinical and administrative processes. Improvement actions fall into 2 main programme areas:

- System neurodiversity transformation - including an accelerated model testing neurodiversity profiling and a neurodiversity support team to identify and meet need earlier ; longer term sustainable change via neurodiversity community hubs to be tested from April 2025
- Tactical – including efficiency measures, waiting list management, building capacity and data/reporting.

Access to children's mental health services in BNSSG remains below the national target. Improvement actions include improved capture and reporting of contacts across providers, continued focused on recruitment and retention and provider level improvement plans with supporting trajectories

Quality and Performance – Mental Health and Dementia

Within Mental Health there continues to be a challenge to eliminating inappropriate out of area placements: A number of improvement actions are underway to further reduce OAPs, both below our local target and overall aim of zero. These include:

- A Transfer of Care Hub (TOC Hub) has been established in Nov 2024 and will support prevention, discharge and flow by closer working with Local Authority social care and housing teams.
- Protective inpatient capacity has been implemented improving flow with positive impact recorded in the first two months. This has slipped back with Winter Pressure increasing demand, and is being looked at again to maintain improvement.
- In 2025 Home Treatment will be enhanced through redesign to offer robust resilient home treatment where staff are not pulled away into crisis assessment. This is expected to provide greater opportunity to keep people out of hospital and support local bed availability where clinically appropriate.

The NHSE National Quality Board guidance and framework is embedded into the ICB's and System Quality Group's quality and patient safety governance and escalation framework. It is used with system partners where significant risk has been identified in relation to patient care and/or significant safeguarding issues. The ICB is currently monitoring Avon and Wiltshire NHS Trust in "Enhanced Surveillance Status" since the Trust received a Regulation 29a Notice in January 2023 due to safety concerns for inpatient wards for adults of working age. Further safeguarding and patient safety concerns have emerged and therefore an Improvement Board (chaired by BNSSG CEO) and an enhanced contractual quality group (joint chaired by BNSSG and BSW ICB's CNOs) is in place to support the trust and seek assurance on improvement activity. Deep dives using the new NHSE Early Warning Signs framework have also been undertaken in addition to an independent review of some services. AWP NHS Trust is currently in Segment 3 of the NHS System Oversight Framework

Quality and Performance – Ambulance Services

Ambulance services in BNSSG have consistently maintained good performance in Q1 and Q2, overachieving against mean handover and Category 2 response time targets. This improvement was driven largely by revised acute queueing protocols and use of temporary and bedded escalation capacity, including the 'continuous flow' approach, areas in which BNSSG is leading regionally.

However, this position has deteriorated in Q3 following sharp growth in ED activity in September and October, combined with related system flow issues, and a reduction in frontline ambulance capacity driven by internal cost savings initiatives in the ambulance service. Further deterioration in November and December has followed, driven by a surge in influenza nationally, markedly higher than winter 2023/24. In Q3 ambulance handover delays increased significantly, leading to a deterioration in Category 2 performance, peaking at 60 minutes in November.

In response to known issues with system flow, the ICB maintained £4.9m additional resourcing investment in SWAST to enable more ambulances and paramedics to respond to demand and mitigate some of the effect of handover delays. An additional £220k was invested by the ICB for Q4, alongside NHSE and SWAST internal contributions, to reverse the cuts to frontline resourcing seen in Q3, which will improve performance from the start of January.

Additionally for 24/25, BNSSG has established the new frailty-ACE service to provide ambulance crews with a remote multi-disciplinary team, made up of medical, nursing, and social work staff, to provide an alternative to conveying patients to hospital where a 'wraparound' community offer can a better outcome. As of January, this service has been mandated for use by the ambulance service under the 'call before you convey' directive.

More broadly, the system has invested circa £40m recurrently 23/24 in schemes which will improve system flow, including discharge to assess capacity and transformation, new transfer of care hubs, increased SDEC provision, expansion of virtual wards and 2-hour urgent community response, and Healthy Weston 2. These investments are monitored via the HCIGs and are subject to review within the 25/26 operational planning round.

Quality and Performance – Accident and Emergency Services

Footprint 4hr A&E performance in BNSSG gradually improved over Q1 and Q2, peaking at 76% in July and August. This has reduced in subsequent months to 69% in November and December. This deterioration has coincided with sharp growth in ED activity in September and October, combined with related system flow issues. Further deterioration in November and December was driven by a surge in influenza nationally, markedly higher than winter 2023/24.

Acute respiratory infection capacity in general practice was mobilised in late November and aims to mitigate the high impact of the seasonal respiratory disease seen this winter. The NHS@Home service has also increased its step-up pathways to support ED demand, which now accounts for more than half of the service's capacity. The 2 hour urgent community response teams have also over-delivered on commissioned capacity to support alternatives to hospital.

Review of economy, efficiency & effectiveness of the use of resources

The ICB undertakes a comprehensive range of contract monitoring, benchmarking and budget monitoring to ensure the robust management of resources.

The ICB Board has overarching responsibility for ensuring that the ICB has appropriate arrangements in place to exercise its functions effectively, efficiently and economically and in accordance with the principles of good governance.

Detailed performance, quality and finance reports, which included the use of comparative analysis to assess performance, are presented at each ICB Board meeting. These reports provide an overview of progress against key indicators and financial objectives.

The Audit and Risk Committee has oversight of internal and external audit, reviews financial and information systems and monitors the integrity of the financial statements. The Audit and Risk Committee receives regular reports from Internal and External Audit

as well as Counter Fraud. External Audit, as part of its audit plan, reviewed the ICB's governance arrangements to identify whether it had in place appropriate arrangements for securing economy, efficiency and effectiveness in its use of resources.

The ICB's Scheme of Reservation and Delegation and Standing Financial Instructions underpin the use of economic, efficient and effective resources. Both have been reviewed in 2024/25. These are supported by budgetary controls and other policies and procedures. The Internal Audit Reports relating to the main accounting process have provided assurance regarding these arrangements. Regular contract management processes are established with providers to link service quality, performance and financial management.

During 24/25, the ICB established an extraordinary Performance and Recovery Board chaired by the CEO to ensure delivery of the break-even position and resulting incentives agreed with NHS England. As a result of the achievement of the planned break-even position, the historic debt carried forward from predecessor CCGs will be written off in line with the financial framework set by NHS England.

The Finance Review on page 107 describes how we have delivered efficiency, our central management costs and our approach to planning.

Commissioning of delegated specialised services

BNSSG ICB signed a delegation agreement (DA) with NHS England and held full commissioning responsibilities for delegated services during the 24/25 reporting period.

To the best of ICB leadership's knowledge, the commissioning of all delegated services has been compliant with the 10 core commissioning requirements – as set out in the 24/25 Delegated Commissioning Assurance Guidance, published by NHS England – including the requirement that all conditions set out in the DA are being met.

Where there were known compliance issues, the ICB leadership has engaged with NHS England's regional leadership to notify and address such issues in a timely manner.

The ICB leadership is able to provide the necessary evidence of core commissioning requirements compliance, should NHS England or a third party (e.g. external auditors) ask for such evidence.

Delegation of ICB functions

Where the ICB has chosen to commission business functions from other organisations, services are managed against a service level agreement and subject to regular performance review and independent audit where applicable. The ICB commissions the South Central and West Commissioning Support Unit to provide a number of services. Feedback is gained on business, use of resources and responses to risk through independent assurance, principally Service Auditor Reports as described previously. The ICB receives general ledger services from Shared Business Services Limited, and payroll services from North Bristol Trust.

Counter fraud arrangements

The ICB's counter fraud arrangements are aligned with the NHS Protect Standards for Commissioners: Fraud, Bribery and Corruption.

The ICB's annual Counter Fraud Plan, focussing on risk-based prevention and deterrence, is overseen by the Audit and Risk Committee. A Counter Fraud Bribery and Corruption Policy, helping staff to understand in simple terms what fraud, bribery and corruption are and containing useful guides on how to identify fraud, together with details on how to report and how cases will be dealt with, is in place. The policy emphasises that it is the responsibility of all staff to work to prevent fraud and protect the assets of the NHS. The policy is supported by the Management of Conflicts of Interest and Gifts and Hospitality Policies. A Local Counter Fraud Specialist (LCFS) is contracted by the ICB to provide counter fraud training to all staff as part of the staff induction programme. Counter Fraud training is a mandatory element of the ICB's e-learning programme.

The Chief Finance Officer is responsible for overseeing and providing strategic management and support for all counter fraud, bribery and corruption work within the organisation, and is assisted by the Chair of the Audit and Risk Committee who is the Counter Fraud Champion. The LCFS works in consultation with the Chief Finance Officer to identify and report cases of actual or suspected fraud and ensure that learning identified from any subsequent investigation is implemented.

The Audit and Risk Committee receives regular reports and an annual report outlining compliance against each of the Government Functional Standard GovS 013: Counter

Fraud, and identifies risks to be addressed in the annual work plan overseen by the committee. Appropriate action is taken regarding any NHS Counter Fraud Authority (NHSCFA) quality assurance recommendations, in line with NHSCFA Standards.

Head of Internal Audit Opinion

Following completion of the planned audit work for the period 1 April 2024 to 31 March 2025 for the ICB, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the ICB's system of risk management, governance and internal control. The Head of Internal Audit concluded that the ICB has an adequate and effective framework for risk management, governance, and internal control. However, the work of our internal audit partner has identified further enhancements to the framework of risk management, governance and control to ensure that it remains adequate and effective.

During the period, Internal Audit issued the following audit reports which have contributed to the Head of Internal Audit Opinion.

Area of Audit	**Level of Assurance Given**
People Risks and People Committee	Reasonable Assurance
System Quality Assurance	Reasonable Assurance
Financial Controls	Substantial Assurance
Digital Strategy	Reasonable Assurance
Primary Care Commissioning Framework	Reasonable Assurance
Risk Management	Reasonable Assurance
Specialised Commissioning	Substantial Assurance
Financial Governance and Performance	Substantial Assurance

Cyber Assessment Framework (CAF)-aligned Data Security and Protection Toolkit (DSPT) Independent Assessment	High Risk Rating Medium Confidence Level

The activities associated with the findings of these audits and the agreed management actions are overseen by the Audit and Risk Committee with continued independent scrutiny provided by the Internal Auditors to ensure improvements are made.

No issues have been flagged by Internal Audit as significant control issues to be flagged as part of the Annual Governance Statement.

The full Internal audit findings can be found at page 233.

Review of the effectiveness of governance, risk management and internal control

My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, executive managers and clinical leads within the ICB who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their annual audit letter and other reports.

Our risk management framework provides me with evidence that the effectiveness of controls that manage risks to the ICB achieving its principles objectives have been reviewed.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the ICB Board, and Audit and Risk Committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place:

- The Audit and Risk Committee agreed an annual plan for Internal Audit focusing on areas of particular concern or risk. Reports were made to the Committee on audit findings, with assurance and recommendations. Discussions were held with the

External Auditors regarding audit plans, and regular reports from Auditors and Counter Fraud colleagues were made to the committee.

- Internal Audit and Counter Fraud provide assurances through their reports on various aspects of internal control to the Audit, Governance and Risk Committee. These reports also provide assurances and support for the work undertaken by the external auditors.

Conclusion

With the exception of the control issues identified and reported in the 24/25 Month 9 return to NHS England in January 2025, no significant control issues have been identified during the year.

Shane Devlin

Accountable Officer

19 June 2025

Remuneration and Staff Report

This Remuneration and Staff Report provides information about the remuneration of ICB directors and senior managers, and other matters such as compensation on early retirement or for loss of office, any payments to past directors, the fair pay disclosure and staff numbers and costs. The section also contains a report on staff sickness absence, key staff policies, staff engagement, and Freedom to Speak Up arrangements. This is in line with corporate governance best practice.

Remuneration Report

Senior managers proposed to be included within the ICB Annual Report for the year ended 31 March 2025:

Name	Title	ICB employee or like contract
Jeff Farrar	Chair of BNSSG Integrated Care Board	Y
John Cappock	Non-Executive Member, Chair of Audit and Risk Committee	Y
Jaya Chakrabarti	Non-Executive Member, Chair of People Committee	Y
Ellen Donovan	Non-Executive Member Chair Outcomes, Quality and Performance Committee	Y
Alison Moon	Non-Executive Member, Chair Primary Care Committee	Y
Steve West	Non-Executive Member – Finance, Estates and Digital Committee	Y
Aishah Farooq	Associate Non-Executive Member	Y
Shane Devlin	Chief Executive Officer, BNSSG ICB	Y
Deborah El-Sayed	Chief Transformation and Digital Information Officer, BNSSG ICB	Y
Jo Hicks	Chief People Officer, BNSSG ICB	Y
David Jarrett	Chief Delivery Officer, BNSSG ICB	Y
Joanne Medhurst	Chief Medical Officer, BNSSG ICB	Y
Rosi Shepherd	Chief Nursing Officer, BNSSG ICB	Y
Sarah Truelove	Chief Finance Officer and Deputy Chief Executive, BNSSG ICB	Y
Dominic Hardisty	Chief Executive Officer, Avon and Wiltshire Mental Health Partnership NHS Trust	N
Jon Hayes	Chair of the GP Collaborative Board	N
Jacob Lee	Chair of the GP Collaborative Board	N
Maria Kane	Joint Chief Executive Officer, North Bristol Trust and University Hospitals Bristol and Weston NHS Foundation Trust	N
Maria Kane	Chief Executive Officer, North Bristol Trust	N
Stuart Walker	Interim Chief Executive Officer, University Hospitals Bristol and Weston NHS Foundation Trust	N
Dave Perry	Chief Executive, South Gloucestershire Council	N
Jo Walker	Chief Executive Officer, North Somerset Council	N
Stephen Peacock	Chief Executive Officer, Bristol City Council	N

Hugh Evans	Executive Director for Adults & Communities, Bristol City Council	N
Nick Hibberd	Chief Executive Officer, Bristol City Council	N
Julie Sharma	Interim Chief Executive Officer, Sirona care & health	N
Sue Porto	Chief Executive, Sirona care & health	N
John Martin	Interim Chief Executive Officer, South West Ambulance Service NHS Foundation Trust	N
Mark Cooke	Regional Director, NHSE	N
Kevin Peltonen-Messenger	Chief Executive, The Care Forum	N
Vicky Marriott	Chief Officer, Healthwatch	N
Fiona Mackintosh	VCSE Alliance representative	N
Chris Head	VCSE Alliance representative	N
Ruth Hughes	Chief Executive Officer, One Care	N

Notes:

Mark Cooke, Kevin Peltonen-Messenger, Vicky Marriott, Fiona Mackintosh, Chris Head and Ruth Hughes are included as senior managers for the first time in 2024-25 for completeness. They attend Board meetings but are not voting members.

Remuneration Committee

The ICB has established a Remuneration Committee which makes decisions about the remuneration and allowances for Very Senior Managers (VSM) and persons in senior positions within the ICB. More information about our Remuneration Committee, including the membership can be found at the Governance Statement on page 127.

Entities are required to disclose:

a - The percentage change from the previous financial year in respect of the highest paid director, and;

b- The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole.

Two percentage figures will therefore be provided for each single total figure component, giving a total of four percentages to be disclosed for each financial year under this requirement. The calculation for salaries and allowances shall be based on the mid-point of the band for each salary and performance pay and bonuses payable.

The calculation for salaries and allowances is the total for all employees on an annualised basis, excluding the highest paid director, divided by the FTE number of employees (also excluding the highest paid director). The calculation in respect of performance pay and bonuses payable is the total for all employees, excluding the

highest paid director, divided by the FTE number of employees (also excluding the highest paid director).

Percentage change in remuneration of highest paid director

This statement is subject to audit by the external auditors and is covered by the Audit Opinion issued on the ICB's financial statements.

	Salary and allowances	**Performance pay and bonuses**
The percentage change from the previous financial year in respect of the highest paid director	5%	0%
The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole	5%	0%

The highest paid director in 2024-25 is Shane Devlin, ICB Chief Executive. The highest paid director in 2023-24 was also Shane Devlin, ICB Chief Executive. The percentage increase in salary relates to the Agenda for Change pay rise of 5% in 2024-25.

Shane Devlin did not receive performance pay in 2024-25 or in 2023-24.

Pay ratio information

This statement is audited by the external auditors and is covered by the Audit Opinion issued on the ICB's financial statements.

Reporting bodies are required to disclose the relationship between the total remuneration of the highest-paid director / member in their organisation against the 25th percentile, median and 75th percentile of remuneration of the organisation's workforce. Total remuneration of the employee at the 25th percentile, median and 75th percentile is further broken down to disclose the salary component.

The banded remuneration of the highest paid director / member in NHS Bristol, North Somerset and South Gloucestershire ICB at 31 March 2025 was £205,000 - £210,000 (2023/24: £190,000 - £195,000).

The relationship to the remuneration of the organisation's workforce for 2024-25 is disclosed in the below table (based on mid-point remuneration).

Table 1

2024/25	25th percentile pay ratio	Median pay ratio	75th percentile pay ratio
Total remuneration (£)	£36,483	£46,148	£56,454
Salary component of total remuneration (£)	£36,483	£46,148	£56,454
Pay ratio information	5.68:1	4.49:1	3.67:1

The relationship to the remuneration of the organisation's workforce for 2023-24 is disclosed in the below table (based on actual remuneration).

Table 2

	25th percentile pay ratio	Median pay ratio	75th percentile pay ratio
Total remuneration (£)	£34,581	£43,742	£54,151
Salary component of total remuneration (£)	£34,581	£43,742	£54,151
Pay ratio information	5.71:1	4.52:1	3.65:1

During the reporting period 2024/25, no employees received remuneration in excess of the highest-paid director/member (2023/24: none).

Remuneration ranged from £14,554 to £207,375 during the year ended 31 March 2025 (£13,861 to £192,436 during the year ended 31 March 2024).

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

Policy on the remuneration of senior managers

The policy on the remuneration of VSM, including members of the ICB Board is set using NHS England guidance. National remuneration guidance for VSM pay was applied for 2024-25.

Remuneration of Very Senior Managers

Advance approval of the Chief Secretary to the Treasury (CST) is required for remuneration packages at £150,000 or above. Where the ICB has VSM roles that fall into this category, business cases for the posts are completed, taking into consideration:

- Influence and impact of role
- The specialist nature of the role including the skills and experience required
- Labour market considerations
- Relevant supporting benchmarking data
- The package of the previous incumbent or any obvious comparators and
- Only when appropriate, biographical information

Table 3 Senior manager remuneration (including salary and pension entitlements) 2024/25

This statement is subject to audit by the external auditors and is covered by the Audit Opinion issued on the ICB's financial statements.

Name and Title	Note	2024-25					
		Salary (bands of £5,000)	Expense payments (taxable) (Rounded to the nearest £100**	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension-related benefits (bands of £2,500)	TOTAL (bands of £5,000)
		£000	£	£000	£000	£000	£000
Shane Devlin, Chief Executive Officer	6	205-210	-	-	-	50-52.5	255-260
Sarah Truelove, Chief Financial Officer and Deputy Chief Executive		170-175	-	-	-	-	170-175
Deborah El-Sayed, Chief Transformation and Digital Information Officer	6	145-150	-	-	-	20-22.5	165-170
Joanne Hicks, Chief People Officer	6	140-145	-	-	-	42.5-45	185-190
David Jarrett, Chief Delivery Officer	6	140-145	-	-	-	62.5-65	205-210
Joanne Medhurst, Chief Medical Officer	6	160-165	-	-	-	20-22.5	185-190
Rosalind Shepherd, Chief Nursing Officer	2	130-135	-	-	-	-	130-135
Non-Executives							
Jeffrey Farrar, Chair		65-70	-	-	-	-	65-70
John Cappock, Non-Executive Member, Chair of Audit and Risk Committee		15-20	-	-	-	-	15-20
Jaya Chakrabarti, Non-Executive Member, Chair of People Committee		15-20	-	-	-	-	15-20

Name and Title	Note	2024-25					
		Salary (bands of £5,000)	Expense payments (taxable) (Rounded to the nearest £100**	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension-related benefits (bands of £2,500)	TOTAL (bands of £5,000)
		£000	£	£000	£000	£000	£000
Ellen Donovan, Non-Executive Member Chair Quality and Performance Committee		15-20	-	-	-	-	15-20
Alison Moon, Non-Executive Member, Chair Primary Care Committee		15-20	-	-	-	-	15-20
Steve West, Non-Executive Member – Finance, Estates and Digital		15-20	-	-	-	-	15-20
Aishah Farooq Associate Non-Executive Member		-	-	-	-	-	-
Non-remunerated Senior Managers							
Dominic Hardisty, Chief Executive Officer, Avon and Wiltshire Mental Health Partnership NHS Trust	3	-	-	-	-	-	-
Jonathan Hayes, Chair of the GP Collaborative Board (to Nov 24)	3	-	-	-	-	-	-
Jacob Les, Chair of the GP Collaborative Board (from Dec 24)	3	-	-	-	-	-	-
Maria Kane, Joint Chief Executive Officer, North Bristol Trust and University Hospitals Bristol and Weston NHS Foundation Trust (from Sep 24)	3	-	-	-	-	-	-
Maria Kane, Chief Executive Officer, North Bristol Trust (to Aug 24)	3	-	-	-	-	-	-

Name and Title	Note	2024-25					
		Salary (bands of £5,000)	Expense payments (taxable) (Rounded to the nearest £100**	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension-related benefits (bands of £2,500)	TOTAL (bands of £5,000)
		£000	£	£000	£000	£000	£000
Stuart Walker Interim Chief Executive Officer, University Hospitals Bristol and Weston NHS Foundation Trust (to Sep 24)	3	-	-	-	-	-	-
Nick Hibberd, (from Feb 25) Chief Executive, Bristol City Council	3	-	-	-	-	-	-
Hugh Evans, Executive Director for Adults & Communities, Bristol City Council (from Sep 24 to Jan 25)	3	-	-	-	-	-	-
Stephen Peacock, Chief Executive, Bristol City Council (to Aug 24)	3	-	-	-	-	-	-
Jo Walker, Chief Executive Officer, North Somerset Council	3	-	-	-	-	-	-
Dave Perry, Chief Executive, South Gloucestershire Council	3	-	-	-	-	-	-
Julie Sharma, Interim Chief Executive Officer, Sirona Care & Health (to Jul 23 & from Sep 24)	3	-	-	-	-	-	-
Sue Porto Chief Executive, Sirona care & Health (from July 23 to Aug 24)	3	-	-	-	-	-	-
John Martin Interim Chief Executive Officer, South Western Ambulance Service NHS Foundation Trust	3	-	-	-	-	-	-
Mark Cooke	3	-	-	-	-	-	-

Name and Title	Note	2024-25					
		Salary (bands of £5,000)	Expense payments (taxable) (Rounded to the nearest £100**	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension-related benefits (bands of £2,500)	TOTAL (bands of £5,000)
		£000	£	£000	£000	£000	£000
Regional Director, NHSE							
Kevin Peltonen-Messenger Chief Executive, The Care Forum (from Feb 25)	3	-	-	-	-	-	-
Vicky Marriott, Chief Officer, Healthwatch (to Jan 25)	3	-	-	-	-	-	-
Fiona Mackintosh VCSE Alliance representative (from Jul 24)	3	-	-	-	-	-	-
Chris Head VCSE Alliance representative (to Jul 24)	3	-	-	-	-	-	-
Ruth Hughes Chief Executive Officer, One Care	3	-	-	-	-	-	-

***Note: Taxable expenses and benefits in kind are expressed to the nearest £100.*

Table 4 Senior manager remuneration (including salary and pension entitlements) 2023/24

This statement is subject to audit by the external auditors and is covered by the Audit Opinion issued on the ICB's financial statements.

Name and Title	Note	2023-24					
		Salary (bands of £5,000)	Expense payments (taxable) (Rounded to the nearest £100**	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension-related benefits (bands of £2,500)	TOTAL (bands of £5,000)
		£000	£	£000	£000	£000	£000
Shane Devlin, Chief Executive Officer	6	190-195	-	-	-	45-47.5	235-240
Sarah Truelove, Chief Financial Officer and Deputy Chief Executive		165-170	-	-	-	-	165-170
Colin Bradbury, Director of Strategy, Partnerships and Population (to Dec 23)	4, 5	125-130	-	-	-	-	125-130
Deborah El-Sayed, Chief Transformation and Digital Information Officer	4	135-140	-	-	-	-	135-140
Joanne Hicks, Chief People Officer	6	135-140	-	-	-	22.5-25	155-160
David Jarrett, Chief Delivery Officer	4	130-135	-	-	-	-	130-135
Lisa Manson, Director of Performance and Delivery (end date 30/09/23)	4	70-75	-	-	-	-	70-75
Joanne Medhurst, Chief Medical Officer	4	155-160	-	-	-	-	155-160
Rosalind Shepherd, Chief Nursing Officer	4, 6	130-135	-	-	-	30-32.5	165-170

Name and Title	Note	2023-24					
		Salary (bands of £5,000)	Expense payments (taxable) (Rounded to the nearest £100**	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension-related benefits (bands of £2,500)	TOTAL (bands of £5,000)
		£000	£	£000	£000	£000	£000
Non-Executives							
Jeffrey Farrar, Chair		65-70	-	-	-	-	65-70
John Cappock, Non-Executive Member, Chair of Audit and Risk Committee		15-20	-	-	-	-	15-20
Jaya Chakrabarti, Non-Executive Member, Chair of People Committee		15-20	-	-	-	-	15-20
Ellen Donovan, Non-Executive Member Chair Quality and Performance Committee		15-20	-	-	-	-	15-20
Alison Moon, Non-Executive Member, Chair Primary Care Committee		15-20	-	-	-	-	15-20
Steve West, Non-Executive Member – Finance, Estates and Digital		15-20	-	-	-	-	15-20
Non-remunerated Senior Managers							
Dominic Hardisty, Chief Executive Officer, Avon and Wiltshire Mental Health Partnership NHS Trust	3	-	-	-	-	-	-
Jonathan Hayes, Chair of the GP Collaborative Board	3	-	-	-	-	-	-
Maria Kane, Chief Executive Officer, North Bristol Trust	3	-	-	-	-	-	-

Name and Title	Note	2023-24					
		Salary (bands of £5,000)	Expense payments (taxable) (Rounded to the nearest £100**	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension-related benefits (bands of £2,500)	TOTAL (bands of £5,000)
		£000	£	£000	£000	£000	£000
John Martin Interim Chief Executive Officer, South Western Ambulance Service NHS Foundation Trust (from Jan 24)	3	-	-	-	-	-	-
Stephen Peacock, Chief Executive, Bristol City Council	3	-	-	-	-	-	-
Dave Perry, Chief Executive, South Gloucestershire Council	3	-	-	-	-	-	-
Sue Porto (from June 23) Chief Executive, Sirona care & Health	3	-	-	-	-	-	-
Julie Sharma, Interim Chief Executive Officer, Sirona Care & Health (to Jul 23)	3	-	-	-	-	-	-
Jo Walker, Chief Executive Officer, North Somerset Council	3	-	-	-	-	-	-
Stuart Walker Interim Chief Executive Officer, University Hospitals Bristol and Weston NHS Foundation Trust (from Jan 24)	3	-	-	-	-	-	-
Will Warrender, Chief Executive Officer, South Western Ambulance Service NHS Foundation Trust (to Dec 23)	3	-	-	-	-	-	-
Eugine Yafele, Chief Executive Officer, University Hospitals Bristol and Weston NHS Foundation Trust (to Dec 23)	3	-	-	-	-	-	-

***Note: Taxable expenses and benefits in kind are expressed to the nearest £100.*

Notes:

1. No senior manager waived his/her remuneration. No performance payments were made in 2024-25 or in 2023-24.

2. Rosalind Shepherd claimed partial retirement benefits during 2024-25. Therefore, her pension benefits disclosed in 2024- 25 are lower than those disclosed in 2023-24. She reduced her hours from 1 WTE to 0.7 WTE from January 2025.

3. These are non-remunerated posts.

4. Staff affected by the Public Service Pensions Remedy in 2023-24. Their membership between 1 April 2015 and 31 March 2022 was moved back into the 1995/2008 Scheme on 1 October 2023. Negative values are not disclosed in this table but are substituted with a zero.

Accrued pension benefits included in this table for any individual affected by the Public Service Pensions Remedy have been calculated based on their inclusion in the legacy scheme for the period between 1 April 2015 and 31 March 2022, following the McCloud judgment. The Public Service Pensions Remedy applies to individuals that were members, or eligible to be members, of a public service pension scheme on 31 March 2012 and were members of a public service pension scheme between 1 April 2015 and 31 March 2022. The basis for the calculation reflects the legal position that impacted members have been rolled back into the relevant legacy scheme for the remedy period and that this will apply unless the member actively exercises their entitlement on retirement to decide instead to receive benefits calculated under the terms of the Alpha scheme for the period from 1 April 2015 to 31 March 2022.

5. Colin Bradbury was made redundant on 27 September 2024 following the ICB’s restructure. Colin has been on secondment from the ICB since 11 December 2023 and is therefore not included within the disclosure of senior manager remuneration for 2024-25. However, Colin’s full salary and pension costs during his secondment were met by the ICB until 19 July 2024. Colin’s salary for the period April to

September 2024 was £69,023 including pay uplift arrears. Of this, £32,805 was recharged to Devon ICB relating to his secondment for the period 19 July to 27 September 2024.

Colin's redundancy package was agreed in line within HM Treasury rules at a value of £140,000. This value was paid to Colin in the October payroll. Colin's total pension related benefits increased by £33,966 during 2024-25.

6. All Pensions Related Benefits: The real increase in the value of pension benefits accrued during the year excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20 less the contributions made by the individual.

These values do not represent an amount that will be received by the individual. It is a calculation that is intended to convey to the reader of the accounts an estimation of the benefit that being a member of the pension scheme could provide.

The pension benefit table provides further information on the pension benefits accruing to the individual.

Factors determining the variation in the values recorded between individuals include but is not limited to:

- A change in role with a resulting change in pay and impact on pension benefits
- A change in the pension scheme itself
- Changes in the contribution rates
- Changes in the wider remuneration package of an individual.

Table 5 Pension benefits at 31 March 2025

This statement is subject to audit by the external auditors and is covered by the Audit Opinion issued on ICB's financial statements.

Name and Title	Notes	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2025 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2025 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2024	Real Increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2025	Employers Contribution to partnership pension
		£000	£000	£000	£000	£000	£000	£000	£000
Shane Devlin Chief Executive Officer		2.5-5	-	10-15	-	111	32	177	-
Deborah El-Sayed Chief Transformation and Digital Information Officer	2	0-2.5	-	45-50	120-125	1009	26	1120	-
Jo Hicks Chief People Officer		2.5-5	-	5-10	-	33	28	80	-
David Jarrett Chief Delivery Officer	2	2.5-5	2.5-5	50-55	130-135	960	64	1106	-
Joanne Medhurst Chief Medical Officer	2	0-2.5	-	45-50	115-120	1048	25	1164	-
Rosalind Shepherd Chief Nursing Officer	2	-	-	65-70	180-185	1745	-	136	-

Table 6 Pension benefits at 31 March 2024

Name and Title	Notes	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2024 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2024 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2023	Real Increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2024	Employers Contribution to partnership pension
		£000	£000	£000	£000	£000	£000	£000	£000
Shane Devlin Chief Executive Officer	1	2.5-5	-	5-10	-	45	35	111	-
Colin Bradbury Director of Strategy, Partnerships and Population	2	-	30-32.5	30-35	85-90	591	106	774	-
Deborah El-Sayed Chief Transformation and Digital Information Officer	2	-	32.5-35	40-45	115-120	783	128	1,008	-
Jo Hicks Chief People Officer		0-2.5	-	0-5	-	3	12	33	-
David Jarrett Chief Delivery Officer	2	-	32.5-35	40-45	115-120	696	176	960	-
Lisa Manson Director of Performance and Delivery	2	-	12.5-15	50-55	140-145	975	46	1,176	-
Joanne Medhurst Chief Medical Officer	2	-	35-37.5	40-45	110-115	816	128	1,048	-
Rosalind Shepherd Chief Nursing Officer	2	2.5-5	0-2.5	65-70	190-195	1,422	156	1,745	-

Notes:

1 The ICB has no pension liabilities for Sarah Truelove, Deputy Chief Executive and Jeffrey Farrar, ICB Chair. Neither of these employees are contributing to the NHS Pension Scheme

2 Staff affected by the Public Service Pensions Remedy in 2023-24. Their membership between 1 April 2015 and 31 March 2022 was moved back into the 1995/2008 Scheme on 1 October 2023. Negative values are not disclosed in this table but are substituted with a zero.

Accrued pension benefits included in this table for any individual affected by the Public Service Pensions Remedy have been calculated based on their inclusion in the legacy scheme for the period between 1 April 2015 and 31 March 2022, following the McCloud judgment. The Public Service Pensions Remedy applies to individuals that were members, or eligible to be members, of a public service pension scheme on 31 March 2012 and were members of a public service pension scheme between 1 April 2015 and 31 March 2022. The basis for the calculation reflects the legal position that impacted members have been rolled back into the relevant legacy scheme for the remedy period and that this will apply unless the member actively exercises their entitlement on retirement to decide instead to receive benefits calculated under the terms of the Alpha scheme for the period from 1 April 2015 to 31 March 2022.

3. Non-remunerated senior managers do not receive pensionable pay.

4. Rosalind Shepherd claimed partial retirement benefits during 2024-25. Therefore, her pension benefits shown as at 31 March 2025 are lower than those disclosed as at 31 March 2024.

5. Real increase in pension at pension age is calculated based on the increase between 1 April and 31 March, as adjusted for inflation.

6. Real increase in pension lump sum at pension age is calculated based on the increase between 1 April and 31 March, as adjusted for inflation.

Cash equivalent transfer values

A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme.

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.

The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real increase in CETV

This reflects the increase in CETV that is funded by the employer. It does not include the increase in accrued pension due to inflation or contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement).

Compensation on early retirement or for loss of office

This statement is subject to audit by the External Auditors and is covered by the Audit Opinion issued on the ICB's Financial Statements.

Colin Bradbury was made redundant on 27 September 2024 following the ICB's restructure. The package was agreed in line within HM Treasury rules at a value of £140,000. This value was paid to Colin in the October payroll.

Colin has been on secondment from the ICB since 11 December 2023. Colin's full salary and pension costs during his secondment were met by the ICB until 19 July 2024. Colin's salary for the period April to September 2024 was £69,023 including pay uplift arrears. Of this, £32,805 was recharged to Devon ICB relating to his secondment period from 19 July to 27 September 2024. During the period 1 April 2024 to 31 March 2025, Colin's total pension related benefits increased by £33,966.

No senior managers were made redundant during 2023-24.

No payments for compensation on early retirement were received by any senior managers in 2024-25 or in 2023-24.

Payments to past directors

This statement is subject to audit by the External Auditors and is covered by the Audit Opinion issued on the ICB's Financial Statements.

Colin Bradbury was Director of Strategy, Partnerships and Population prior to the ICB's restructure in 2023/24.

Colin has been on secondment from the ICB since 11 December 2023. Colin's full salary and pension costs during his secondment were met by the ICB until 19 July 2024. Colin's salary for the period April to September 2024 was £69,023 including pay uplift arrears. Of this, £32,805 was recharged to Devon ICB relating to his secondment period from 19 July to 27 September 2024. During the period 1 April 2024 to 31 March 2025, Colin's total pension related benefits increased by £33,966.

Staff Report

Number of senior managers, Staff numbers and costs

This statement is audited by the External Auditors and is covered by the Audit Opinion issued on the ICB's Financial Statements.

There was an average of number 81 Senior Managers in 2024-25 (2023-24, 94).

Table 7 Senior Manager numbers 2024-25

	Permanent			Other			Total		
Senior Managers (WTE)	**Female**	**Male**	**Total**	**Female**	**Male**	**Total**	**Female**	**Male**	**Total**
Very Senior Manager	5	2	7	-	-	-	5	2	7
Band 9	5	3	8	1	-	1	6	3	9
Band 8D	3	6	9	-	-	-	3	6	9
Band 8C	15	8	23	-	-	-	15	8	23
Band 8B	21	12	33	-	-	-	21	12	33
Total	**49**	**31**	**80**	1	-	1	**50**	**31**	**81**

Table 8 Senior Manager numbers 2023-24

	Permanent			Other			Total		
Senior Managers (WTE)	**Female**	**Male**	**Total**	**Female**	**Male**	**Total**	**Female**	**Male**	**Total**
Very Senior Manager	5	3	8	-	-	-	5	3	8
Band 9	5	3	8	-	-	-	5	3	8
Band 8D	3	2	5	1	-	1	4	2	6
Band 8C	21	14	35	-	1	1	21	15	36
Band 8B	21	11	32	3	1	4	24	12	36
Total	**55**	**33**	**88**	**4**	**2**	**6**	**59**	**35**	**94**

Staff numbers and costs

This statement is subject to audit by the External Auditors and is covered by the Audit Opinion issued on the ICB's Financial Statements.

This statement is audited by the External Auditors and is covered by the Audit Opinion issued on the ICB's Financial Statements, with the exception of any sex analysis.

The total staff costs for 2024-25 were £28,373,513 (2023-24 £28,421,674). The breakdown by cost, contract type and category is set out in the table below.

Table 9 Staff costs 2024-25

	Admin			Programme			Total		
	Permanent Employees	Other	Total	Permanent Employees	Other	Total	Permanent Employees	Other	Total
Employee Benefits	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Salaries and wages	9,459	261	9,720	10,902	729	11,631	20,361	990	21,351
Social security costs	1,109	-	1,109	1,169	-	1,169	2,278	-	2,278
Employer contributions to the NHS Pension Scheme	3,209	-	3,209	1,444	-,	1,444	4,653	-	4,653
-Apprenticeship Levy	92	-	92	-	-	-	92	-	92
Termination benefits	-	-	-	-	-	-	-	-	-
Gross employee benefits expenditure	**13,869**	**261**	**14,130**	**13,515**	**729**	**14,244**	**27,384**	**990**	**28,374**

Table 10 Staff costs 2023-24

	Admin			Programme			Total		
	Permanent Employees	Other	Total	Permanent Employees	Other	Total	Permanent Employees	Other	Total
Employee Benefits	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Salaries and wages	9,885	533	10,418	10,511	952	11,463	20,396	1,485	21,881
Social security costs	1,191	-	1,191	1,054	-	1,054	2,245	-	2,245
Employer contributions to the NHS Pension Scheme	2,739	-	2,739	1,313	-	1,313	4,052	-	4,052
Apprenticeship Levy	97	-	97	-	-	-	97	-	97
Termination benefits	-	-	-	147	-	147	147	-	147
Gross employee benefits expenditure	**13,912**	**533**	**14,445**	**13,025**	**952**	**13,977**	**26,937**	**1,485**	**28,422**

The total average number of staff was 416 in 2023-24 (2023-24, 444). The breakdown by staff category, contract type and sex is set out in the table below.

Table 11 Staff Numbers 2024-25

	Permanent			Other			Total		
Staff Category (WTE)	**Female**	**Male**	**Total**	**Female**	**Male**	**Total**	**Female**	**Male**	**Total**
Administrative and Clerical	178	60	238	6	5	11	184	65	249
Medical and Dental	2	2	4	1	-	1	3	2	5
Add Professional. Scientific and Technical	18	6	24	-	-	-	18	6	24
Nursing and Midwifery	53	4	57	-	-	-	53	4	57
Allied Health Professionals	-	-	-	-	-	-	-	-	-
Estates and ancillary	-	-	-	-	-	-	-	-	-
Senior Managers	49	31	80	1	-	1	50	31	81
Total	**300**	**103**	**403**	**8**	**5**	**13**	**308**	**108**	**416**

Table 12 Staff Numbers 2023-24

	Permanent			Other			Total		
Staff Category (WTE)	**Female**	**Male**	**Total**	**Female**	**Male**	**Total**	**Female**	**Male**	**Total**
Administrative and Clerical	188	65	253	5	3	8	193	68	261
Medical and Dental	3	1	4	1	-	1	4	1	5
Add Professional. Scientific and Technical	18	7	25	-	-	-	18	7	25
Nursing and Midwifery	54	5	59	-	-	-	54	5	59
Allied Health Professionals	-	-	-	-	-	-	-	-	-
Estates and ancillary	-	-	-	-	-	-	-	-	-
Senior Managers	55	33	88	4	2	6	59	35	94
Total	**318**	**111**	**429**	**10**	**5**	**15**	**328**	**116**	**444**

Staff composition

There were 494 staff (headcount) in 2023-24 (2023-24, 510). The breakdown by sex, seniority and contract type is set out in the table below.

Table 13 Staff composition 2024-25

	Permanent			Other			Total		
Senior Managers (headcount)	**Female**	**Male**	**Total**	**Female**	**Male**	**Total**	**Female**	**Male**	**Total**
Members of the governing body	3	3	6	-	-	-	3	3	6
Directors	5	2	7	-	-	-	5	2	7
Band 9	5	3	8	2	-	2	7	3	10
Band 8D	4	6	10	-	-	-	4	6	10
Band 8C	16	8	24	-	-	-	16	8	24
Band 8B	24	12	36	-	-	-	24	12	36
Other employees	298	83	381	13	7	20	311	90	401
Total	**355**	**117**	**472**	**15**	**7**	**22**	**370**	**124**	**494**

Table 14 Staff composition 2023-24

	Permanent			Other			Total		
Senior Managers (headcount)	**Female**	**Male**	**Total**	**Female**	**Male**	**Total**	**Female**	**Male**	**Total**
Members of the governing body	3	3	6	-	-	-	3	3	6
Directors	5	3	8	-	-	-	5	3	8
Band 9	5	3	8	-	-	-	5	3	8
Band 8D	3	2	5	1	1	2	4	3	7
Band 8C	22	14	36	-	1	1	22	15	37
Band 8B	24	12	36	4	1	5	28	13	41
Other employees	**304**	**83**	**387**	**12**	**4**	**16**	**316**	**87**	**403**
Total	**366**	**120**	**486**	**17**	**7**	**24**	**383**	**127**	**510**

Sickness absence data

The ICB has a detailed and robust Sickness Absence Policy. A range of services are available to support staff at work or returning to work. These services include access to Occupational Health and an Employee Assistance Programme, which includes access to counselling sessions. The People Resources team have worked with managers on best practice for managing sickness absence to. All managers are required to undertake return to work interviews with employees which are designed to support them in returning to work. Managers are also supported to undertake stress risk assessments to help identify and manage stress, are provided with support and guidance on making reasonable adjustments in the workplace and how to increase wellbeing amongst staff. All sickness absence is managed in line with the Managing Sickness Absence Policy.

The ICB has a portfolio of resources for staff to support health and well-being. These resources have been collated in one place to ensure that everyone can easily access all of the wide-ranging support available. This resource bank has been promoted to staff and managers to help them in signposting to the most appropriate resources if needed.

We are required to report annual sickness absence data for the calendar year.

The ICB had an average number of full-time equivalent members of staff (FTE) of 412 over the period 1st January 2024 to 31st December 2024. The full time equivalent possible working days available was 150,270. The data in the table below has been calculated by NHS Digital. ESR does not hold details of normal number of days worked by each employee. Average annual sick days per FTE has been estimated by dividing the estimated number of FTE-days sick by the average FTE and multiplying by 225 (the typical number of working days per year).

Table 15 Full Time Equivalent (FTE) Members of Staff

	Number of FTE staff (average)	Sum of FTE Days Sick	Sum of FTE Days Available	FTE sickness absence %	Average Annual Sick Days per FTE
NHS Bristol, North Somerset and South Gloucestershire ICB	**412**	**4,662**	**150,270**	**1.91%**	**7.0**

Staff turnover percentages

Bristol, North Somerset and South Gloucestershire ICB staff turnover is reported via the Electronic Staff Record (ESR). During the period 1st April 2024 to 31st March 2025, 70 members of staff joined the ICB, and 74 staff members left. Staff turnover measures the number of staff who leave an organisation during a period of time. The ICB staff turnover for the period 1st April 2024 to 31st March 2025 is 15.5% is based on a headcount of 74 leavers.

Whilst the turnover rate measures the outflow of people from an organisation and is expressed in terms of the number of people who leave over a period of time, the stability rate calculates the proportion of the workforce who remain employed for a specified period and measures how effectively the organisation is retaining staff. The ICB's stability index reports that 86% of employees were retained during the period 1st April 2024 and 31st March 2025.

Staff engagement percentages

Staff engagement is an important source of information about our staff and in the Autumn of 2024 the ICB participated in the Annual NHS Staff Survey. There were 351 responses, which equated to a response rate of 78% and demonstrated good staff engagement. The ICB response rate was higher with the national average of 74% for our national benchmarking group. The full Staff Survey can be found at NHS Staff Survey Results 2024. In relation to the theme of 'Staff Engagement' the ICB has achieved a score of 6.76 which is slightly higher than the national average for our national benchmarking group of 6.63. The results have been shared across the ICB and key themes incorporated within our Organisational Development Plan and Directorates will each develop local actions.

The ICB maintains staff engagement through a variety of routes including the following staff networks: Disabled staff network, LGBTQ+, EmPowered Network and parents and carers. It also hosted a Staff Awards event to recognise the contributions of many staff in various categories. Staff were instrumental in the nomination and selection process for different categories.

We have an Inclusion Council and a Staff Partnership Forum that meet bimonthly. We use a variety of communication methods to maintain staff engagement including the weekly Have We Got News for You sessions with the Chief Executive and the Voice, line manager briefing, staff drop in sessions, all staff away days and staff temperature checks and participation in the NHS National Staff Survey.

Staff policies

The ICB has an integrated approach to delivering workforce equality. Equalities issues are incorporated in policies covering all aspects of employee management ranging from recruitment to performance to discipline.

The ICB's duty is to operate in ways that do not discriminate against potential or current employees with any of the protected characteristics specified in the Equality Act 2010, and to support employees to maximise their performance including making any reasonable adjustments that may be required on a case-by-case basis.

The ICB has a Reasonable Adjustments Guide which supports employees and managers in making reasonable adjustments so that our staff are able to work comfortably and efficiently. Our guidance aims to help line managers and staff to have open conversations on what barriers staff maybe facing and how they can support in making reasonable adjustments within the ICB. This includes external support services from Access to Work and Occupational Health.

The ICB is disability confident which means it is committed to carrying out inclusive and accessible recruitment, offering an interview to disabled people, providing reasonable adjustments and supporting existing employees.

The ICB have been through a period of significant change and transition and throughout this reporting period, during this time we have reviewed our Organisational Change policy, Flexible Working Policy and Hybrid Working Policy, and in doing so it was our priority to actively engage staff in their development through our Staff Partnership Forum and Staff Networks.

We continue to review and develop staff policies. All staff policies are subject to consultation with staff and Trade Union representatives through the Staff Partnership Forum. All policies are developed to ensure the ICB is able to recruit and retain a diverse workforce whilst ensuring equal treatment of staff and meeting the organisation's duty of

care around staff health and safety at work. All policies have an Equality Impact Assessment to ensure they were not detrimental to staff on the basis of any protected characteristics as defined in the Equality Act 2010. The ICB regularly monitors the diversity of its workforce.

The ICB has a timetable for policy reviews and will continue to make updates in line with the review cycle. All HR policies will be reviewed in partnership with staff and Trade Union representatives through the Staff Partnership Forum, which continues to meet regularly and provides a constructive space for collaboration between staff representatives, and management.

The ICB signed the Sexual Safety in HealthCare Organisational Charter and is committed to a zero-acceptance approach to sexual misconduct. In October 2024, The Worker Protection Act (amendment of Equality Act 2010) came into force and created a duty on employers to take reasonable steps to stop sexual harassment in the workplace from colleagues and third parties. The ICB used the national NHS England Sexual Misconduct Policy framework to support the creation of the ICB's Sexual Safety Policy and its toolkit to ensure the ICB is taking the right steps to recognise, report and prevent sexual misconduct. The ICB has also adopted the national Pregnancy and Baby loss People Policy framework to provide support to staff at a difficult time who have experience baby loss and help managers and colleagues know how to support staff affected, with kindness and understanding.

Freedom to Speak Up

The ICB has in place policies to support staff when raising concerns, including the Freedom to Speak Up Policy, Fraud and Bribery Policy, and Bullying and Harassment Policy. Freedom to Speak Up was introduced by Sir Robert Francis following a 2015 review into NHS 'whistleblowing' processes. It incorporates whistleblowing and extends beyond that to develop cultures where concerns are identified and addressed at an early stage before people feel the need to 'blow the whistle'.

Freedom to Speak Up is hugely important to the ICB, we are committed to ensuring that a culture of speaking up is embedded throughout the organisation, and that effective processes are in place to support staff. The Freedom to Speak Up Policy provides a framework that supports a culture where staff feel comfortable to raise concerns. The policy gives guidance and advice to staff on raising a concern.

Trade Union Facility Time Reporting Requirements

The total number of employees who were relevant union officials during the period 1st April 2024 to 31st March 2025 was:

Table 16

Number of employees who were relevant union officials during the relevant period	Full time equivalent number
0	0

Other employee matters

In April 2024, the ICB completed its organisational changes to support the requirement to cut our running costs by the end of March 2025. Throughout this change process, there was constructive consultation and engagement with staff which has been positively recognised by the workforce and the Staff Partnership Forum.

In 24/25 The ICB launched its Hybrid Working Policy to support its move to new office premises in vacant Bristol City Council space alongside other NHS tenants. This has helped to reduce running costs.

In March 2025, the Government announced further changes to the NHS will take place in 2025. This includes the requirement for BNSSG ICB to reduce its costs which will have a bearing on the workforce.

Expenditure on consultancy

Consultancy expenditure was £481,000 in 2024-25 (2023-24 £289,000), and this can be analysed as follows:

Table 17 Consultancy Expenditure

Consultancy Category	2024-25 £'000	2023-24 £'000
Finance	15	41
Human Resources, Training and Education	29	18
IT/IS	9	-
Marketing and Communications	-	1
Organisation and Change Management	6	56
Programmes and Project Management	3	27
Property and Construction	-	-
Strategy	197	53
Technical	222	93
Total	**481**	**289**

Off-payroll engagements

NHS bodies are required to include disclosures about their off-payroll engagements, and the details for the ICB are set out in the tables below.

Table 18 Length of all highly paid off-payroll engagements

For all off-payroll engagements as at 31 March 2025 for more than £245* per day:

	Number
Number of existing engagements as of 31 March	4
for less than one year at the time of reporting	-
for between one and two years at the time of reporting	1
for between 2 and 3 years at the time of reporting	1
for between 3 and 4 years at the time of reporting	-
for 4 or more years at the time of reporting	2

*The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.

The ICB confirms that all existing off-payroll engagements have at some point been subject to a risk-based assessment as to whether assurance is required that the

individual is paying the right amount of tax and, where necessary, that assurance has been sought.

Table 19 Off-payroll workers engaged at any point during the financial year

For all off-payroll engagements between 1 April 2024 to 31 March 2025, for more than £245[1] per day:

	Number
Number of temporary off-payroll workers engaged	7
No. not subject to off-payroll legislation[2]	4
No. subject to off-payroll legislation and determined as in-scope of IR35[2]	-
No. subject to off-payroll legislation and determined as out of scope of IR35[2]	-
the number of engagements reassessed for compliance or assurance purposes during the year	-
Of which: no. of engagements that saw a change to IR35 status following review	-

[1] The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.

[2] A worker that provides their services through their own limited company or another type of intermediary to the client will be subject to off-payroll legislation and the Department must undertake an assessment to determine whether that worker is in-scope of Intermediaries legislation (IR35) or out-of-scope for tax purposes.

Table 20 Off-payroll engagements / senior official engagements

For any off-payroll engagements of Board members and / or senior officials with significant financial responsibility, between 1 April 2024 to 31 March 2025:

	Number
Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during reporting period[1]	-
Total no. of individuals on payroll and off-payroll that have been deemed “board members, and/or, senior officials with significant financial responsibility”, during the reporting period. This figure should include both on payroll and off-payroll engagements. [2]	14

Exit packages, including special (non-contractual) payments 2024/25

This statement is subject to audit by the external auditors and is covered by the Audit Opinion issued on ICB's financial statements.

Table 21 Exit Packages 2024-25

Exit package cost band (inc. any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s
Less than £10,000	-	-	-	-	**-**	**-**	-	-
£10,000 - £25,000	-	-	-	-	**-**	**-**	-	-
£25,001 - £50,000	-	-	-	-	**-**	**-**	-	-
£50,001 - £100,000	1	51,750	-	-	**1**	**51,750**	-	-
£100,001 - £150,000	1	140,000	-	-	**1**	**140,000**	-	-
£150,001 – £200,000	1	160,000	-	-	**1**	**160,000**	-	-
>£200,000	-	-	-	-	**-**	**-**	-	-
TOTALS	**3**	**351,750**	-	-	**3**	**351,750**	-	-
				Agrees to table 23 below				

Exit packages, including special (non-contractual) payments 2023/24

This statement is subject to audit by the external auditors and is covered by the Audit Opinion issued on ICB's financial statements.

Table 22 Exit Packages 2023-24

Exit package cost band (inc. any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s
Less than £10,000	-	-	2	14,554	**2**	**14,554**	-	-
£10,000 - £25,000	-	-	3	64,470	**3**	**64,470**	-	-
£25,001 - £50,000	-	-	5	170,865	**5**	**170,865**	-	-
£50,001 - £100,000	2	146,988	4	290,232	**6**	**437,220**	-	-
£100,001 - £150,000	1	128,000	2	266,458	**3**	**394,458**	-	-
£150,001 – £200,000	-	-	2	355,880	**2**	**355,880**	-	-
>£200,000	-	-	-	-	**-**	**-**	-	-
TOTALS	**3**	**274,988**	18	**1,162,459**	**21**	**1,437,447**	**-**	**-**

Redundancy and other departure cost have been paid in accordance with the provisions of The NHS Terms and Conditions of Service (Agenda for Change). Exit costs in this note are accounted for in full in the year of departure. Where Bristol, North Somerset and South Gloucestershire ICB has agreed early retirements, the additional costs are met by the ICB and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table above.

Analysis of Other Departures

Table 23

	Agreements	Total Value of agreements
	Number	£000s
Voluntary redundancies including early retirement contractual costs	-	-
Mutually agreed resignations (MARS) contractual costs	-	-
Early retirements in the efficiency of the service contractual costs	-	-
Contractual payments in lieu of notice	-	-
Exit payments following Employment Tribunals or court orders	-	-
Non-contractual payments requiring HMT approval	-	-
TOTAL	-	-

A – agrees to total in table 21

In 2023-24, there were 18 voluntary redundancies with a cost of £1.162m.

No non-contractual payments were made to individuals where the payment value was more than 12 months' of their annual salary. The Remuneration Report includes disclosure of exit packages payable to individuals named in that Report.

Parliamentary Accountability and Audit Report

BNSSG ICB is not required to produce a Parliamentary Accountability and Audit Report. Disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges are included as notes in the Financial Statements of this report at page 192. An audit certificate and report are also included in this Annual Report at page 250.

ANNUAL ACCOUNTS

Shane Devlin

Accountable Officer

19 June 2025

CONTENTS

Statement of Comprehensive Net Expenditure for the year ended 31 March 2025

	Note	2024-25 £'000	2023-24 £'000
Income from sale of goods and services	3	(38,450)	(36,118)
Other operating income	3	-	-
Total operating income		**(38,450)**	**(36,118)**
Staff costs	4	28,374	28,422
Purchase of goods and services	5	2,360,461	2,177,432
Depreciation and impairment charges	5	391	281
Provision expense	5	(4,031)	(3,397)
Other operating expenditure	5	11,338	8,355
Total operating expenditure		**2,396,533**	**2,211,093**
Net Operating Expenditure		**2,358,083**	**2,174,975**
Finance expense	7	119	31
Comprehensive Net Expenditure for the year		**2,358,202**	**2,175,006**

The notes on pages 198 to 232 form part of this statement.

Statement of Financial Position as at 31 March

	Note	2024-25 £'000	2023-24 £'000
Non-current assets			
Property, plant and equipment	8	600	448
Right-of-use Assets	9	2,502	2,576
Total non-current assets		**3,102**	**3,024**
Current assets			
Trade and other receivables	10	28,199	40,607
Cash and cash equivalents	11	377	174
Total current assets		**28,576**	**40,781**
Total assets		**31,678**	**43,805**
Current liabilities			
Trade and other payables	12	(141,655)	(141,065)
Lease liabilities	9	(298)	(150)
Provisions	13	(2,225)	(8,280)
Total current liabilities		**(144,178)**	**(149,495)**
Non-current liabilities			
Lease liabilities	9	(2,147)	(2,445)
Provisions	13	(204)	
Total non-current liabilities		**(2,351)**	**(2,445)**
Total Assets less Total Liabilities		**(114,851)**	**(108,136)**
Financed by Taxpayers' Equity			
General fund		(114,851)	(108,136)
Total taxpayers' equity		**(114,851)**	**(108,136)**

The notes on pages 198 to 232 form part of this statement.

The financial statements on pages 194 to 232 were approved by the Audit and Risk Committee on 19 June 2025 with delegated authority from the Board and signed on its behalf by:

Chief Accountable Officer
Shane Devlin

Statement of Changes In Taxpayers Equity for the year ended 31 March 2025

	Note	General fund reserves
Changes in taxpayers' equity for 2024-25		
		£'000
Balance at 1 April 2024		**(108,136)**
Changes in NHS Integrated Care Board taxpayers' equity for 2024-25		
Net recognised expenditure for the year		(2,358,202)
Net funding		2,351,487
Balance at 31 March 2025		**(114,851)**

	Note	General fund reserves
Changes in taxpayers' equity for 2023-24		
		£'000
Balance at 1 April 2023		**(125,976)**
Changes in NHS Integrated Care Board taxpayers' equity for 2023-24		
Net recognised expenditure for the year		(2,175,006)
Net funding		2,192,846
Balance at 31 March 2024		**(108,136)**

The notes on pages 198 to 232 form part of this statement.

Statement of Cash Flows for the year ended 31 March 2025

	Note	2024-25 £'000	2023-24 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial period		(2,358,202)	(2,175,006)
Depreciation and amortisation	5	391	281
(Increase)/decrease in trade & other receivables	10	12,408	(26,990)
Increase/(decrease) in trade & other payables	12	589	14,342
Provisions utilised	13	(2,025)	(1,624)
Increase/(decrease) in provisions	13	(4,030)	(3,397)
Net Cash Inflow (Outflow) from Operating Activities		**(2,350,869)**	**(2,192,394)**
Cash Flows from Investing Activities			
Interest received		118	31
(Payments) for property, plant and equipment	8	(265)	(210)
Net Cash Inflow (Outflow) from Investing Activities		**(147)**	**(179)**
Net Cash Inflow (Outflow) before Financing		**(2,351,016)**	**(2,192,573)**
Cash Flows from Financing Activities			
Grant in Aid Funding Received		2,351,487	2,192,846
Repayment of lease liabilities	9	(268)	(180)
Net Cash Inflow (Outflow) from Financing Activities		**2,351,219**	**2,192,666**
Net Increase (Decrease) in Cash & Cash Equivalents at 31 March		**203**	**93**
Cash & Cash Equivalents at the Beginning of the Financial Period		174	81
Cash & Cash Equivalents at the End of the Financial Year	11	**377**	**174**

The notes on pages 198 to 232 form part of this statement.

Notes to the financial statements

1 Accounting Policies

NHS England has directed that the financial statements of Integrated Care Boards (ICBs) shall meet the accounting requirements of the Group Accounting Manual (GAM) issued by the Department of Health and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2024-25 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards (IFRS) to the extent that they are meaningful and appropriate to Integrated Care Boards as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the ICB for the purpose of giving a true and fair view has been selected. The particular policies adopted by the ICB are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going Concern

These accounts have been prepared on a going concern basis.

On 13 March 2025 the government announced that NHS England and the Department for Health and Social Care will increasingly merge functions, ultimately leading to NHS England being fully integrated into the Department. The legal status of ICBs is currently unchanged.

Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated. If services will continue to be provided in the public sector the financial statements should be prepared on the going concern basis. The statement of financial position has therefore been drawn up at 31 March 2025, on a going concern basis.

1.2 Accounting Convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, inventories and certain financial assets and financial liabilities.

1.3 Better Care Fund

The Integrated Care Board and Bristol City Council, North Somerset Council and South Gloucestershire Councils have agreed to treat the Better Care Fund as a non-pooled fund. The terms of these are set out in the section 75 agreements. Both parties have chosen to contract with individual providers without reference to each other using their own sources of funding alone and it is for this reason that neither party considers they are operating a pooled budget.

1.4 Critical Accounting Judgements & Key Sources of Estimation Uncertainty

In the application of the Integrated Care Board's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. These are regularly reviewed. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period, or in the period of the revision and future periods if the revision affects both current and future periods.

1.4.1 Critical Judgements in Applying Accounting Policies

In applying the Integrated Care Board's accounting policies, management has not made any critical judgements that that have a significant effect on the amounts recognised in the financial statements.

1.4.2 Key Sources of Estimation Uncertainty

There are no other sources of estimation uncertainty that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year that require disclosure.

1.5 Operating Segments

Income and expenditure are analysed in the Operating Segments note and are reported in line with management information used within the Integrated Care Board.

1.6 Revenue

The Integrated Care Board's financial position is controlled by a limit on net expenditure rather than funding from DHSC. As such the Integrated Care Board's income from other activities is very limited with the most significant elements being R&D income, prescription fees and dental fees. Prescription and dental fees are recognised two months after the transaction takes place, with accruals made to estimate income for the last two months of the year. The Integrated Care Board does not enter into long term revenue contracts (most income arises from recharging past performance) and so the assessment indicates that there is no impact on income recognition from adopting IFRS 15.

Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred. Payment terms are standard reflecting cross government principles.

1.7 Employee Benefits

1.7.1 Short-term Employee Benefits

Salaries, wages and employment-related payments, including payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken.

The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.7.2 Retirement Benefit Costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities.

Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

For early retirements, other than those due to ill health, the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs are charged to expenditure at the time the Integrated Care Board commits itself to the retirement, regardless of the method of payment.

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

1.8 Purchase of Goods, Services and Other Expenses

The purchase of goods, services and other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.9 **Leases**

A lease is a contract, or part of a contract, that conveys the right of control the use of an asset for a period of time in exchange for consideration. The Integrated Care Board assesses whether a contract is or contains a lease, at inception of the contract.

1.9.1 **The Integrated Care Board as Lessee**

A right-of-use asset and a corresponding lease liability are recognised at commencement of the lease.

The lease liability is initially measured at the present value of the future lease payments, discounted by using the rate implicit in the lease. If this rate cannot be readily determined, the prescribed HM Treasury discount rates are used as the incremental borrowing rate to discount future lease payments.

Lease payments included in the measurement of the lease liability comprise

- Fixed payments;
- Variable lease payments dependent on an index or rate, initially measured using the index or rate at commencement;
- The amount expected to be payable under residual value guarantees;
- The exercise price of purchase options, if it is reasonably certain the option will be exercised; and,
- Payments of penalties for terminating the lease, if the lease term reflects the exercise of an option to terminate the lease.

The lease liability is subsequently measured by increasing the carrying amount for interest incurred using the effective interest method and decreasing the carrying amount to reflect the lease payments made. The lease liability is remeasured, with a corresponding adjustment to the right-of-use asset, to reflect any reassessment of, or modification made to, the lease.

The right-of-use asset is initially measured at an amount equal to the initial lease liability adjusted for any lease prepayments or incentives, initial direct costs or an estimate of any dismantling, removal or restoring costs relating to either restoring the location of the asset or restoring the underlying asset itself, unless costs are incurred to produce inventories.

The subsequent measurement of the right-of-use asset is consistent with the principles for subsequent measurement of property, plant and equipment. Accordingly, right-of-use assets that are held for their service potential and are in use are subsequently measured at their current value in existing use.

Right-of-use assets for leases that are low value or short term and for which current value in use is not expected to fluctuate significantly due to changes in market prices and conditions are valued at depreciated historical cost as a proxy for current value in existing use.

Other than leases for assets under construction and investment property, the right-of-use asset is subsequently depreciated on a straight-line basis over the shorter of the lease term or the useful life of the underlying asset. The right-of-use asset is tested for impairment if there are any indicators of impairment and impairment losses are accounted for as described in the "Depreciation amortisation and impairment" policy.

Peppercorn leases are defined as leases for which the consideration paid is nil or nominal (that is, significantly below market value). Peppercorn leases are in the scope of IFRS 16 if they meet the definition of a lease in all aspects apart from containing consideration. For peppercorn leases a right-of-use asset is recognised and initially measured at current value in existing use. The lease liability is measured in accordance with the above policy. Any difference between carrying amount of the right-of-use asset and the lease liability is recognised as income as required by IAS 20 as interpreted by the Financial Reporting Manual (FreM).

Leases of low value (value when new less than £5,000) and short-term of 12 months or less are recognised as an expense on a straight-line basis over the term of the lease.

1.10 **Cash & Cash Equivalents**

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Integrated Care Board's cash management.

1.11 **Provisions**

Provisions are recognised when the Integrated Care Board has a present legal or constructive obligation as a result of a past event, it is probable that the Integrated Care Board will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate as follows:

All general provisions are subject to four separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date, a nominal:

- short-term rate of 4.03% (2023-24: 4.26%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.
- medium-term rate of 4.07% (2023-24: 4.03%) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.

- long-term rate of 4.81% (2023-24: 4.72%) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.
- very long-term rate of 4.55% (2023-24: 4.40%) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received, and the amount of the receivable can be measured reliably.

A restructuring provision is recognised when the Integrated Care Board has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with on-going activities of the entity.

1.12 **Clinical Negligence Costs**

NHS Resolution operates a risk pooling scheme under which the Integrated Care Board pays an annual contribution to NHS Resolution, which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Integrated Care Board.

1.13 **Non-clinical Risk Pooling**

The Integrated Care Board participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Integrated Care Board pays an annual contribution to the NHS Resolution and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.14 **Continuing healthcare risk pooling**

Claims that have arisen since April 2013 with a retrospective element dating back to a maximum of 1 April 2013, have been assessed and, if appropriate, paid from the current year budget. Therefore, in each accounting period there may be some costs relating to previous years, but the budget has funding for this (based on historical spend being built into the baseline) which obviates the need for a provision. It is also very difficult to estimate the level of retrospective liabilities as cases are not known until a claim is made and an estimate cannot be made with any certainty.

1.15 **Impairment of financial assets**

Financial assets are recognised when the Integrated Care Board becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired, or the asset has been transferred.

Financial assets are classified into the following categories:
- Financial assets at amortised cost;
- Financial assets at fair value through other comprehensive income and ;
- Financial assets at fair value through profit and loss.

The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

1.15.1 **Financial assets at amortised cost**

Financial assets measured at amortised cost are those held within a business model whose objective is achieved by collecting contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables and other simple debt instruments. After initial recognition these financial assets are measured at amortised cost using the effective interest method less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

1.15.2 **Financial assets at fair value through other comprehensive income**

A financial asset is measured at fair value through other comprehensive income where business model objectives are met by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest. Movements in the fair value of financial assets in this category are recognised as gains or losses in other comprehensive income except for impairment losses. On derecognition, cumulative gains and losses previously recognised in other comprehensive income are reclassified from equity to income and expenditure, except where the ICB elected to measure an equity instrument in this category on initial recognition.

The ICB has not elected to measure any assets at fair value.

1.15.3 **Financial assets at fair value through profit and loss**

Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or at fair value through other comprehensive income. This category also includes financial assets and liabilities acquired principally for the purpose of selling in the short term (held for trading) and derivatives. Derivatives which are embedded in other contracts, but which are separable from the host contract are measured within this category. Movements in

the fair value of financial assets and liabilities in this category are recognised as gains or losses in the Statement of Comprehensive income.

The ICB has not elected to measure any financial assets / financial liabilities at fair value.

1.15.4 **Impairment of financial assets**

For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets, the Integrated Care Board recognises a loss allowance representing the expected credit losses on the financial asset.

The Integrated Care Board adopts the simplified approach to impairment in accordance with IFRS 9, and measures the loss allowance for trade receivables, lease receivables and contract assets at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2) and otherwise at an amount equal to 12 months expected credit losses (stage 1).

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds and Exchequer Funds assets where repayment is ensured by primary legislation. The Integrated Care Board therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally, Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's lengths bodies and NHS bodies and the Integrated Care Board does not recognise allowances for stage 1 or stage 2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

1.16 **Financial Liabilities**

Financial liabilities are recognised on the statement of financial position when the Integrated Care Board becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

1.16.1 Financial Liabilities at Fair Value Through Profit and Loss

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the Integrated Care Board's surplus/deficit. The net gain or loss incorporates any interest payable on the financial liability.

1.16.2 Other Financial Liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health and Social Care, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.17 Value Added Tax (VAT)

Most of the activities of the Integrated Care Board are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.18 Foreign Currencies

The Integrated Care Board's functional currency and presentational currency is pounds sterling and amounts are presented in thousands of pounds unless expressly stated otherwise. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March 2025. Resulting exchange gains and losses for either of these are recognised in the Integrated Care Board's surplus/deficit in the period in which they arise. The ICB has a small number of low value foreign currency transactions mainly relating to research and development.

1.19 Losses & Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had

the Integrated Care Board not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.20 **Gifts**

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

1.21 **Grants Payable**

Where grant funding is not intended to be directly related to activity undertaken by a grant recipient in a specific period, the Integrated Care Board recognises the expenditure in the period in which the grant is paid. All other grants are accounted for on an accruals basis.

1.22 **Contingent liabilities**

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Integrated Care Board, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

Where the time value of money is material, contingent liabilities are disclosed at their present value.

1.23 **New and revised IFRS Standards in issue but not yet effective**

IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021, adopted by the FReM from April 2025. The ICB is undertaking a review of all contracts for insurance clauses and has not identified any relevant contracts to date.

IFRS 18 Presentation and Disclosure in Financial Statements - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. The impact on the ICB is not yet known.

IFRS 19 Subsidiaries without Public Accountability: Disclosures - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. The impact on the ICB is not yet known.

2 Financial Performance

2.1 Financial duties

During the financial period 1 April 2024 to 31 March 2025, the Integrated Care Board met all its financial duties as demonstrated in the table below:

Duty	Achieved
Maintain expenditure within the revenue resource limit	Yes
Ensure running costs are within the running cost resource limit.	Yes
Maintain capital expenditure within the delegated limit	Yes
Maintain expenditure within the allocated cash limit	Yes
Ensure compliance with the better payment practice	Yes

2.2 Analysis of Financial Performance

The Integrated Care Board has a statutory duty to maintain expenditure within the resource limits set by NHS England.

Revenue expenditure covers general day-to-day running costs and other areas of ongoing expenditure. Capital expenditure covers investment in long term assets, including lease assets and IT equipment. As demonstrated in the table below, the ICB has met its statutory duty to operate within its capital and revenue resource limits for the period 1 April 2024 to 31 March 2025.

	2024-25		
	Target £'000	Performance £'000	Variance £'000
Expenditure not to exceed income	2,397,146	2,397,121	(25)
Capital resource use does not exceed the amount specified in Directions	477	469	(8)
Revenue resource use does not exceed the amount specified in Directions	2,358,219	2,358,202	(17)
Revenue administration resource use does not exceed the amount specified in Directions	17,536	17,520	(16)

3.1 Operating Income

	2024-25 Total £'000	2023-24 Total £'000
Income from sale of goods and services (contracts)		
Non-patient care services to other bodies - *note 1*	12,143	7,992
Prescription fees and charges	10,185	9,951
Dental fees and charges	13,795	12,826
Other contract income	2,327	5,349
Total income from sale of goods and services	**38,450**	**36,118**
Total Operating Income	**38,450**	**36,118**

Revenue in this note does not include cash received from NHS England, which is drawn down directly into the bank account of the Integrated Care Board and credited to the General Fund.

Revenue is totally from the supply of services. The Integrated Care Board receives no money from sale of goods.

Notes

1. £9.4m of this revenue figure relates to income for Research and Development from the Department of Health and Social Care (2023-24 £7.8m).

3.2 Disaggregation of Income – Income from sale of goods and services (contracts)

	2024-25			
	Non-patient care services to other bodies	Prescription fees and charges	Dental fees and charges	Other Contract income
	£'000	£'000	£'000	£'000
Source of Revenue				
NHS	151	-	-	889
Non NHS	11,992	10,185	13795	1,438
Total	**12,143**	**10,185**	**13795**	**2,327**

	2024-25			
	Non-patient care services to other bodies	Prescription fees and charges	Dental fees and charges	Other Contract income
	£'000	£'000	£'000	£'000
Timing of Revenue				
Point in time	12143	10,185	13795	2,327
Over time	-	-	-	-
Total	**12,143**	**10,185**	**13795**	**2,327**

	2023-24			
	Non-patient care services to other bodies	Prescription fees and charges	Dental fees and charges	Other Contract income
	£'000	£'000	£'000	£'000
Source of Revenue				
NHS	204	-	-	2,275
Non NHS	7,778	9,951	12,826	3,074
Total	**7,992**	**9,951**	**12,826**	**5,349**

	2023-24			
	Non-patient care services to other bodies	Prescription fees and charges	Dental fees and charges	Other Contract income
	£'000	£'000	£'000	£'000
Timing of Revenue				
Point in time	7,992	9,951	12,826	5,349
Over time	-	-	-	-
Total	**7,992**	**9,951**	**12,826**	**5,349**

4. Employee benefits and staff numbers

4.1 Employee benefits

	2024-25		
	Permanent Employees	Other	Total
	£'000	£'000	£'000
Employee benefits			
Salaries and wages	20,361	990	21,351
Social security costs	2,278	-	2,278
Employer contributions to NHS Pension scheme	4,653	-	4,653
Apprenticeship levy	92	-	92
Termination benefits	-	-	-
Gross employee benefits expenditure	**27,384**	**990**	**28,374**

	2023-24		
	Permanent Employees	Other	Total
	£'000	£'000	£'000
Employee benefits			
Salaries and wages	20,396	1,485	21,881
Social security costs	2,245	-	2,245
Employer contributions to NHS Pension scheme	4,052	-	4,052
Apprenticeship levy	97	-	97
Termination benefits	147	-	147
Gross employee benefits expenditure	**26,937**	**1,485**	**28,422**

There were no capitalised staff costs in 2024-25 or in 2023-24.

4.2 Average number of people employed

	Permanently employed Number	Other Number	Total Number
2024-25	403	13	416
2023-24	429	15	444

There were no whole-time equivalent people engaged on capital projects in 2024-25 or in the year ended 31 March 2023.

4.3 Staff annual leave accrual balances

	Permanent Staff £'000
Employee accrued benefits liability at 31 March 2025	177
Employee accrued benefits liability at 31 March 2024	198

The accrued benefits liability balance related to permanent staff only; no temporary or agency staff accrued annual leave benefits.

4.4 Exit packages agreed in the financial year

	2024-25					
	Compulsory redundancies		Other agreed departures		Total	
	No.	£	No.	£	No.	£
Less than £10,000	-	-	-	-	-	-
£10,001 to £25,000	-	-	-	-	-	-
£25,001 to £50,000	-	-	-	-	-	-
£50,001 to £100,000	1	51,750	-	-	1	51,750
£100,001 to £150,000	1	140,000	-	-	1	140,000
£150,001 to £200,000	1	160,000	-	-	1	160,000
Over £200,001	-	-	-	- -	-	-
Total	**3**	**351,750**	**-**	-	**3**	**351,750**

	2023-24					
	Compulsory redundancies		Other agreed departures		Total	
	No.	£	No.	£	No.	£
Less than £10,000	-	-	2	14,554	2	14,554
£10,001 to £25,000	-	-	3	64,470	3	64,470
£25,001 to £50,000	-	-	5	170,865	5	170,865
£50,001 to £100,000	2	146,988	4	290,232	6	437,220
£100,001 to £150,000	1	128,000	2	266,458	3	394,458
£150,001 to £200,000	-	-	2	355,880	2	355,880
Over £200,001	-	-	-	-	-	-
Total	**3**	**274,988**	**18**	**1,162,459**	**21**	**1,437,447**

There were no other agreed departures in 2024-25. The other agreed departures in 2023-24 all related to voluntary redundancies. There were no departures where special payments were made in 2024-25 (2023-24 Nil).

No payments were made relating to non-contractual payments in lieu of notice.

As a single exit package can be made up of several components, each of which will be counted separately in this table, the total number will not necessarily match the total number in the table above, which will be the number of individuals.

These tables report the number and value of exit packages agreed in the financial period. The expense associated with these departures may have been recognised in part or in full in a previous period.

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS terms and conditions of service (Agenda for Change). Please see the Annual Report for further details (section Compensation on early retirement of for loss of office).

Exit costs are accounted for in accordance with relevant accounting standards and, at the latest, in full in the year of departure.

No non-contractual payments were made to individuals where the payment value was more than 12 months of their annual salary. (2023-24 Nil).

The Annual Report includes the Remuneration Report, which includes the disclosure of exit payments payable to individuals named in that report.

4.5 Pension costs

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions.

Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities.

Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years”. An outline of these follows:

4.5.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period and is accepted as providing suitably robust figures for financial reporting purposes.

The valuation of the scheme liability as at 31 March 2025, is based on valuation data as at 31 March 2023, updated to 31 March 2025 with summary global member and accounting data. In

undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

4.5.2 Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (considering recent demographic experience), and to recommend the contribution rate payable by employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 to 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027.

The ICB offers the National Employment Savings Scheme (NEST) as an additional defined contribution workplace pension scheme to relevant employees. The ICB recognises contributions payable under this scheme as an expense during the year that it was incurred.

5. Operating Expenditure

	2024-25 Total	2023-24 Total
Purchase of goods and services	**£'000**	**£'000**
Services from other ICBs and NHS England	11,369	8,635
Services from foundation trusts	636,625	584,949
Services from other NHS trusts	674,133	627,726
Services from other WGA bodies	1,637	1,787
Purchase of healthcare from non-NHS bodies	564,030	505,230
Purchase of social care	10,427	8,681
General dental & personal dental services	44,471	41,745
Prescribing costs	154,325	149,512
Pharmaceutical services	29,741	29,183
General ophthalmic services	8,458	8,027
GPMS/APMS and PCTMS	207,276	193,923
Supplies and services – clinical	4,118	4,255
Supplies and services – general	48	239
Consultancy services	455	824
Establishment	4,853	5,843
Transport	36	34
Premises	3,821	4,878
Audit fees - *notes 1,2*	258	252
Other non statutory audit expenditure		
· Internal audit services	-	-
· Other services	-	-
Other professional fees - *note 3*	2,676	1,061
Legal fees	1,086	355
Education, training and conferences	618	293
Total Purchase of goods and services	**2,360,461**	**2,177,432**
Depreciation and provisions expense		
Depreciation	391	281
Amortisation	-	-
Provisions expense	(4,031)	(3,397)
Total Depreciation provisions expense	**(3,640)**	**(3,116)**
Other Operating Expenditure		
Chair and Non-Executive Members	164	164
Grants to Other bodies - *note 4*	159	150
Research and development (excluding staff costs)	10,183	8,041
Expected credit loss on receivables	832	-
Other expenditure	-	-
Total Other Operating Expenditure	**11,338**	**8,355**
Total Operating Expenditure	**2,368,159**	**2,182,671**

5. Operating Expenditure (continued)

Notes

1. External audit liability is capped at £2m.

2. External audit fees in 2024-25 were £215,100, net of VAT. This comprises £194,400 core services, and £16,200 for the 2024-25 MHIS audit. The ICB also received an additional, unbudgeted bill in 2024-25 for £4,500, net of VAT, in relation to the 2023-24 audit. In 2023-24, external audit fees were £210,000 in total, net of VAT. This comprised £180,000 for core services, £15,000 for the 2023-24 MHIS audit and a further £15,000 for the 2021-22 MHIS audit which had not been previously accrued.

3. Internal Audit services are provided by an external provider RSM Risk Assurance Services LLP and fees in 2024-25 were £75,348 net of VAT (2023-24 £71,760 net of VAT). This is included in Other professional fees.

4. Grants to other bodies reflects capital grants from NHSE to the community provider.

6.1 Better Payment Practice Code

Measure of compliance	2024-25 No.	2024-25 £'000	2023-24 No.	2023-24 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the period	31,747	857,922	31,150	772,437
Total Non-NHS Trade Invoices paid within target	31,457	848,106	30,716	745,444
Percentage of Non-NHS Trade invoices paid within target	**99%**	**99%**	**99%**	**97%**
NHS Payables				
Total NHS Trade invoices paid in the period	1,265	1,324,977	1,010	1,226,793
Total NHS Trade invoices paid within target	1,230	1,322,719	985	1,226,067
Percentage of NHS Trade Invoices paid within target	**97%**	**100%**	**98%**	**100%**

6.2 The Late Payment of Commercial Debts (Interest) Act 1998

In 2024-25, the ICB agreed a settlement with a supplier relating to disputed invoices, which included a payment of £1,720 relating to interest for late payment of debt. There were no payments made from claims under Late Payment of Commercial Debts (Interest) Act 1998 in 2023-24.

7. Finance Costs

	2024-25 Total £'000	2023-24 Total £'000
Interest on lease liabilities	118	31
Interest on late payment of commercial debt	1	-
Total finance costs	**119**	**31**

8. Property, plant and equipment

	2024-25 £'000	2023-24 £'000
Cost or Valuation opening balance	830	1,022
Additions purchased	265	177
Disposals	(116)	(369)
Cost or Valuation closing balance	**979**	**830**
Depreciation opening balance	382	638
Disposals	(116)	(369)
Charged during the year	113	113
Depreciation closing balance	**379**	**382**
Net Book Value closing balance	**600**	**448**
Purchased	600	448
Total at 31 March	**600**	**448**
Asset financing:		
Owned	600	448
Total at 31 March	**600**	**448**

All property, plant and equipment held by the ICB at 31 March 2025 and 31 March 2024 relate to Information Technology assets.

8.1 Economic lives

	Minimum Life (years)	Maximum Life (Years)
Information technology	1	5

9. Leases

9.1 Right-of-use assets

	2024-25 Buildings £'000	2023-24 Buildings £'000
Cost opening balance	3,160	520
Additions	-	2,640
ROU dilapidation	204	-
Assets derecognised	(520)	-
Cost closing balance	**2,844**	**3,160**
Depreciation opening balance	584	416
Charged during the period	278	168
Derecognised	(520)	-
Depreciation closing balance	**342**	**584**
Net Book Value closing balance	**2,502**	**2,576**

9.2 Lease liabilities

	2024-25 £'000	2023-24 £'000
Lease liabilities opening balance	(2,595)	(104)
Additions	-	(2,640)
Interest expense relating to lease liabilities	(118)	(31)
Repayment of lease liabilities (capital and interest)	268	180
Lease liabilities closing balance	**(2,445)**	**(2,595)**

All Right of Use Assets are leased from NHS Property Services.

The derecognised lease relates to the ICB’s former head office.

9.3 Lease liabilities - Maturity analysis of undiscounted future lease payments

	2024-25 Obligations Leased from NHS Property Services £'000	2023-24 Obligations Leased from NHS Property Services £'000
Within one year	(406)	(268)
Between one and five	(1,473)	(1,602)
After five years	(1,056)	(1,333)
Total	**(2,935)**	**(3,203)**
Effect of discounting	490	608
Included in:		
Current lease liabilities	(298)	(150)
Non-current lease liabilities	(2,147)	(2,445)
Total	**(2,445)**	**(2,595)**

9.4 Amounts recognised in Statement of Comprehensive Net Expenditure

	SoCNE 2024-25 £'000	SoCNE 2023-24 £'000
Depreciation expense on right-of-use asset	278	168
Interest expense on lease liabilities	118	31

9.5 Amounts recognised in cashflow

	SOCF 2024-25 £'000	SOCF 2023-24 £'000
Total cash outflow on leases under IFRS 16	268	180

10 Trade and other receivables

	2024-25 Current £'000	2023-24 Current £'000
NHS receivables: Revenue	5,910	4,760
NHS prepayments	-	744
NHS accrued income	684	1,020
Non-NHS and Other WGA receivables: Revenue	6,549	20,382
Non-NHS and Other WGA prepayments	403	1,267
Non-NHS and Other WGA accrued income	4319	769
Non-NHS and Other WGA Contract Receivable not yet invoiced/non-invoice	10,904	11,473
Expected credit loss allowance-receivables	(904)	(73)
VAT	324	263
Other receivables and accruals	10	2
Total Current trade & other receivables	**28,199**	**40,607**

The ICB had no non-current trade receivables at 31 March 2025 or at 31 March 2024.

The ICB had no prepaid pensions contributions at 31 March 2025 or at 31 March 2024.

10.1 Receivables past their due date but not impaired

	2024-25		2023-24	
	DHSC Group Bodies £'000	Non DHSC Group Bodies £'000	DHSC Group Bodies £'000	Non DHSC Group Bodies £'000
By up to three months	88	1,032	394	18,834
By three to six months	158	320	21	168
By more than six months	-	210	7	11
Total	**246**	**1,562**	**422**	**19,013**

10.2 Loss allowance on asset classes

	Trade and other receivables: Non DHSC Group Bodies	
	2024-25	2023-24
	£'000	£'000
Allowance for credit losses opening balance	(73)	(73)
Lifetime expected credit losses on trade and other receivables-Stage 2	(833)	-
Amounts written off	2	-
Allowance for credit losses closing balance	**(904)**	**(73)**

10.3 Provision matrix on lifetime credit loss

	31 March 2025		
	%	£'000	£'000
Non NHS Debt	**Lifetime expected credit loss rate**	**Gross Carrying amount**	**Lifetime expected credit loss**
Current	13	5,106	664
1-30 days	1	142	2
31-60 days	2	893	18
61-90 days	10	318	32
90-365 days	10	24	2
Greater than 365 days	100	186	186
Total expected credit loss		**6,669**	**904**

	31 March 2024		
	%	£'000	£'000
Non NHS Debt	**Lifetime expected credit loss rate**	**Gross Carrying amount**	**Lifetime expected credit loss**
Current	-	247	-
1-30 days	0.5	13,182	67
31-60 days	2	2	-
61-90 days	10	33	3
90-365 days	10	9	1
Greater than 365 days	100	2	2
Total expected credit loss		**13,475**	**73**

The Integrated Care Board did not hold any collateral against receivables outstanding at 31 March 2025 or at 31 March 2024.The bad debt provision includes a specific provision for known disputes.

11. Cash and cash equivalents

	2024-25 Total £'000	2023-24 Total £'000
Opening balance	174	81
Net change in period	203	93
Closing balance	**377**	**174**
Made up of:		
Cash with the Government Banking Service	377	173
Cash in hand	-	1
Cash and cash equivalents as in statement of financial position	**377**	**174**

12. Trade and other payables

	2024-25 Total £'000	2023-24 Total £'000
NHS payables: Revenue	3,851	2,494
NHS accruals	8,003	5,256
Non-NHS and Other WGA payables: Revenue	47,223	49,568
Non-NHS and Other WGA payables: Capital	-	-
Non-NHS and Other WGA accruals	79,381	80,654
Non-NHS and Other WGA deferred income	-	38
Social security costs	291	299
Tax	348	325
Payments on account	172	-
Other payables and accruals	2,386	2,431
Total Current Trade & Other Payables	**141,655**	**141,065**

The ICB had no non-current trade and other payables at 31 March 2025 or at 31 March 2024.

There are no liabilities included in the above for any person due in future years under arrangements to buy out the liability for early retirement over 5 years.

Other payables include £1,998,701 outstanding pension contributions at 31 March 2025 (£1,757,444 as at 31 March 2024).

13 Provisions

	2024-25			2023-24		
	Current	Non-current	Total	Current	Non-current	Total
	£'000	£'000	£'000	£'000	£'000	£'000
Current						
Redundancy	-	-	-	747	-	747
Legal claims	2,225		2,225	4,761	-	4,761
Other	-	204	204	2,772	-	2,772
Total	**2,225**	**204**	**2,429**	**8,280**	-	**8,280**

The ICB's created a non-current provision in 2024-25, relating to dilapidations on the ICB's Head Office ROU lease. The ICB had no non-current provisions at 31 March 2024.

	2024-25			
	Redundancy	Legal Claims	Other	Total
	£'000	£'000	£'000	£'000
Balance at 1 April 2024	**747**	**4,761**	**2,772**	**8,280**
Arising during the period	-	2,225	204	**2,429**
Utilised during the period	(225)	(1,800)	-	**(2,025)**
Reversed unused	(522)	(2,961)	(2,772)	**(6,255)**
Change in discount rate	-	-	-	**-**
Balance at 31 March 2025	**-**	**2,225**	**204**	**2,429**
Expected timing of cash flows:				
Within one year	-	2,225	-	2,225
Between one and five years	-	-	-	-
After five years	-	-	204	204
Balance at 31 March 2025	**-**	**2,225**	**204**	**2,429**

The movement in the Legal provision reflects changes in outstanding contract challenges.

The Other provision opening balance related to:
- £2,150k for General Practitioner service charge payments disputed with NHS Property Services. The ICB no longer considers that this provision is required, as no claims have been received.
- £622k for dilapidations associated with the old Head Office and a GP practice. The old Head Office has been vacated and the ICB no claim has been received relating to the GP practice.

The Other provision closing balance relates to dilapidations associated with the new Head Office.

	2023-24				
	Redundancy	**Restructuring**	**Legal Claims**	**Other**	**Total**
	£'000	**£'000**	**£'000**	**£'000**	**£'000**
Balance at 1 April 2023	**-**	**300**	**4,761**	**8,240**	**13,301**
Arising during the period	747	1,484	-	-	**2,231**
Utilised during the period	-	(1,624)	-	-	**(1,624)**
Reversed unused	-	(160)	-	(5,468)	**(5,628)**
Change in discount rate	-	-	-	-	**-**
Balance at 31 March 2024	**747**	**-**	**4,761**	**2,772**	**8,280**
Expected timing of cash flows:					
Within one year	747	-	4,761	2,772	8,280
Between one and five years	-	-	-	-	-
After five years	-	-	-	-	-
Balance at 31 March 2024	**747**	**-**	**4,761**	**2,772**	**8,280**

14. Financial instruments

14.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities.

Because the Integrated Care Board is financed through parliamentary funding, it is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Integrated Care Board has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Integrated Care Board in undertaking its activities.

Treasury management operations are carried out by the finance department, within parameters defined formally within the Integrated Care Board standing financial instructions and policies agreed by the Board. Treasury activity is subject to review by the Integrated Care Board and internal auditors.

14.1.1 Currency risk

The Integrated Care Board is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Integrated Care Board has no overseas operations. The Integrated Care Board therefore has low exposure to currency rate fluctuations.

14.1.2 Interest rate risk

The Integrated Care Board borrows from government for capital expenditure, subject to affordability as confirmed by NHS England. The borrowings are for 1 to 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Integrated Care Board therefore has low exposure to interest rate fluctuations.

14.1.3 Credit risk

Because the majority of the Integrated Care Board's revenue comes from parliamentary funding, the Integrated Care Board has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note.

14.1.4 Liquidity risk

The Integrated Care Board is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament. The Integrated Care Board draws down cash to cover expenditure, as the need arises. The Integrated Care Board is not, therefore, exposed to significant liquidity risks.

14.1.5 Financial Instruments

As the cash requirements of NHS England are met through the Estimate process, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body. The majority of financial instruments relate to contracts to buy non-financial items in line with NHS England's expected purchase and usage requirements and NHS England is therefore exposed to little credit, liquidity or market risk.

14.2 Financial assets

	Financial Assets measured at amortised cost	
	2024-25 Total £'000	2023-24 Total £'000
Trade and other receivables with NHSE bodies	2,551	2,747
Trade and other receivables with other DHSC group bodies	4,400	3,054
Trade and other receivables with external bodies	21,425	32,605
Cash and cash equivalents	378	174
Bad debt reserve	(904)	-
Total closing balance	**27,850**	**38,580**

14.3 Financial liabilities

	Financial Liabilities measured at amortised cost	
	2024-25 Total £'000	2023-24 Total £'000
Trade and other payables with NHSE bodies	(2,383)	(1,462)
Trade and other payables with other DHSC group bodies	(9,839)	(6,532)
Trade and other payables with external bodies	(128,622)	(135,005)
Finance lease obligations	(2,445)	-
Total closing balance	**(143,289)**	**(142,999)**

14.4 Maturity of Financial liabilities

	2024-25		
	Payable to DHSC	Payable to Other bodies	Total
	£'000	£'000	£'000
In one year or less	12,222	128,920	141,142
In more than one year		2,147	2,147
Total at 31 March 2025	**12,222**	**131,067**	**143,289**

	2023-24		
	Payable to DHSC	Payable to Other bodies	Total
	£'000	£'000	£'000
In one year or less	7,994	135,005	142,999
Total at 31 March 2024	**7,994**	**135,005**	**142,999**

15. Operating segments

	2024-25	2023-24
	Commissioning Healthcare	Commissioning Healthcare
	£'000	£'000
Gross expenditure	2,396,652	2,211,124
Income	(38,450)	(36,118)
Net expenditure	2,358,202	2,175,006
Total assets	31,678	43,805
Total liabilities	(146,529)	(151,941)
Net assets	(114,851)	(108,136)

15.1 Reconciliation between Operating Segments and SoCNE

	2024-25 £'000	2023-24 £'000
Total net expenditure reported for operating segments	2,358,202	2,175,006
Total net expenditure per the Statement of Comprehensive Net Expenditure	2,358,202	2,175,006

15.2 Reconciliation between Operating Segments and SoFP

	2024-25 £'000	2023-24 £'000
Total assets reported for operating segments	31,678	43,805
Total assets per Statement of Financial Position	31,678	43,805

	2024-25 £'000	2023-24 £'000
Total liabilities reported for operating segments	(146,529)	(151,941)
Total liabilities per Statement of Financial Position	(146,529)	(151,941)

16. Related party transactions

16.1 Details of related party transactions with other organisations

The Department of Health and Social Care is the parent department and is regarded as a related party. During the year to 31 March 2025 the Integrated Care Board has had a significant number of material transactions with entities for which the Department is regarded as the parent Department. For example:

- NHS England;
- NHS Foundation Trusts - significant parties University Hospitals Bristol and Weston NHS FT & South Western Ambulance FT;
- NHS Trusts - significant parties North Bristol NHS Trust and Avon & Wiltshire Mental Health Partnership Trust
- NHS Litigation Authority; and,
- NHS Business Services Authority.

The Integrated Care Board had several material transactions with other government departments and other central and local government bodies during the year to 31 March 2025. The transactions with Bristol City Council, North Somerset Council and South Gloucestershire Council have a net spend of £131.5m and the main services this relates to are: Better Care Fund and Other (£49.4m); Funded Nursing Care (£31.5m); and all groups of Complex Care clients (£50.6m).

	2024-25	2023-24	Movement
Local Authority	**£m**	**£m**	**£m**
Bristol City Council	46.3	40.2	6.1
North Somerset Council	22.9	25.1	-2.2
South Gloucestershire Council	62.2	52.5	9.7
Total	**131.5**	**117.8**	**13.7**

16.2 Details of related party transactions with individuals

During the year, a Board member at the ICB declared significance influence with a Board member of Avon & Wiltshire Mental Health Partnership Trust and a Board member of Royal United Hospitals Bath NHSFT. The ICB had the transactions set out in the table below with these organisations. All transactions with these organisations were conducted at arm's length and in the ordinary course of business.

	Avon & Wiltshire Mental Health Partnership Trust		Royal United Hospitals Bath NHSFT	
	2024-25	2023-24	2024-25	2023-24
	£'000	£'000	£'000	£'000
Expenditure	151,651	146,324	16,290	16,317
Income	1	80	0	0
Payables	393	315	305	390
Receivables	2,916	3,016	0	0

17. Partnership arrangements

The Integrated Care Board has partnership arrangements with Bristol City Council, North Somerset Council and South Gloucestershire Council for the delivery of the Better Care Fund for the provision of community and mental health services together with continuing and social care. The arrangements are made in accordance with S75 of the NHS Act 2006 and any surplus or deficits are the responsibility of the respective partners. Each of the partner bodies is responsible for managing the individual schemes for which they have lead responsibility.

The funding and expenditure for each BCF are:

Bristol City Council	**2024-25**	**2023-24**
	£'000	**£'000**
Funding provided to partnership budgets	41,131	38,928
Additional NHS contribution	1,340	1,332
ASC discharge funding	4,232	3,584
ICB funding to council for protection of adult social care	(21,384)	(20,239)
Expenditure from partnership arrangement	**25,319**	**23,605**

North Somerset Council	**2024-25**	**2023-24**
	£'000	**£'000**
Funding provided to partnership budgets	19,521	18,475
Additional NHS contribution	1,408	1,400
ASC discharge funding	2,059	1,735
ICB funding to council for protection of adult social care	(8,554)	(8,096)
Expenditure from partnership arrangement	**14,434**	**13,514**

South Gloucestershire Council	**2024-25**	**2023-24**
	£'000	**£'000**
Funding provided to partnership budgets	20,009	18,937
Additional NHS contribution	1,745	1,529
ASC discharge funding	2,201	1,868
ICB funding to council for protection of adult social care	(7,237)	(6,849)
Expenditure from partnership arrangement	**16,718**	**15,485**

18. Losses and special payments

In 2024-25, the ICB made a bookkeeping loss relating to a salary overpayment of £2,094 that was written off in the year. This was fully covered by the bad debt provision.

The ICB incurred no losses and made no special payments in 2023-24.

19. Contingences

Contingent Liabilities

	2024-25 £'000	2023-24 £'000
Continuing Healthcare	18	121

The Continuing Healthcare contingent liability relates to continuing healthcare claims back to 2018. The uncertainty relates to the eligibility of outstanding historic claims. Whilst possible, it has been deemed unlikely these amounts will be reimbursed.

20. Events after the reporting period

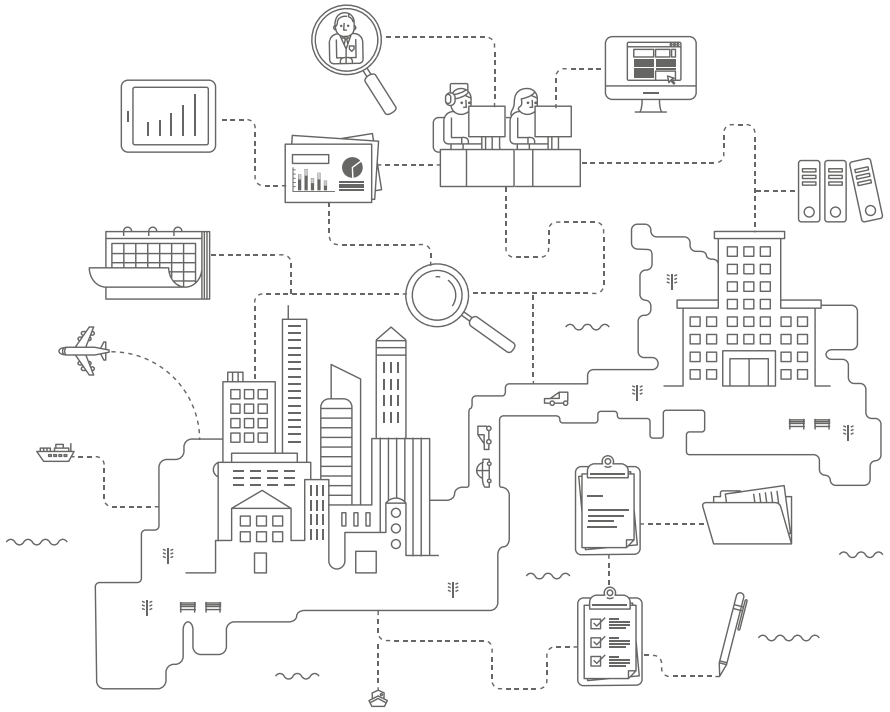
On 13 March 2025 the government announced that NHS England and the Department for Health and Social Care will increasingly merge functions, ultimately leading to NHS England being fully integrated into the Department. The legal status of ICBs is currently unchanged but they have been tasked with significant reductions in their cost base. Discussions are ongoing on the impact of these and the impact of staffing reductions, together with the costs and approvals of any exit arrangements. ICBs are currently being asked to implement any plans during quarter 3 of the 2025/26 financial year.

NHS BRISTOL, NORTH SOMERSET AND SOUTH GLOUCESTERSHIRE ICB

Annual Internal Audit Report for the 12 months ending 31 March 2025

13 June 2025

CONTENTS



THE ANNUAL INTERNAL AUDIT OPINION

The annual internal audit opinion is based upon, and limited to, the work performed on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes. For the 12 months ending 31 March 2025 the head of internal audit opinion for NHS Bristol, North Somerset and South Gloucestershire ICB is:

Annual opinion

Factors influencing our opinion

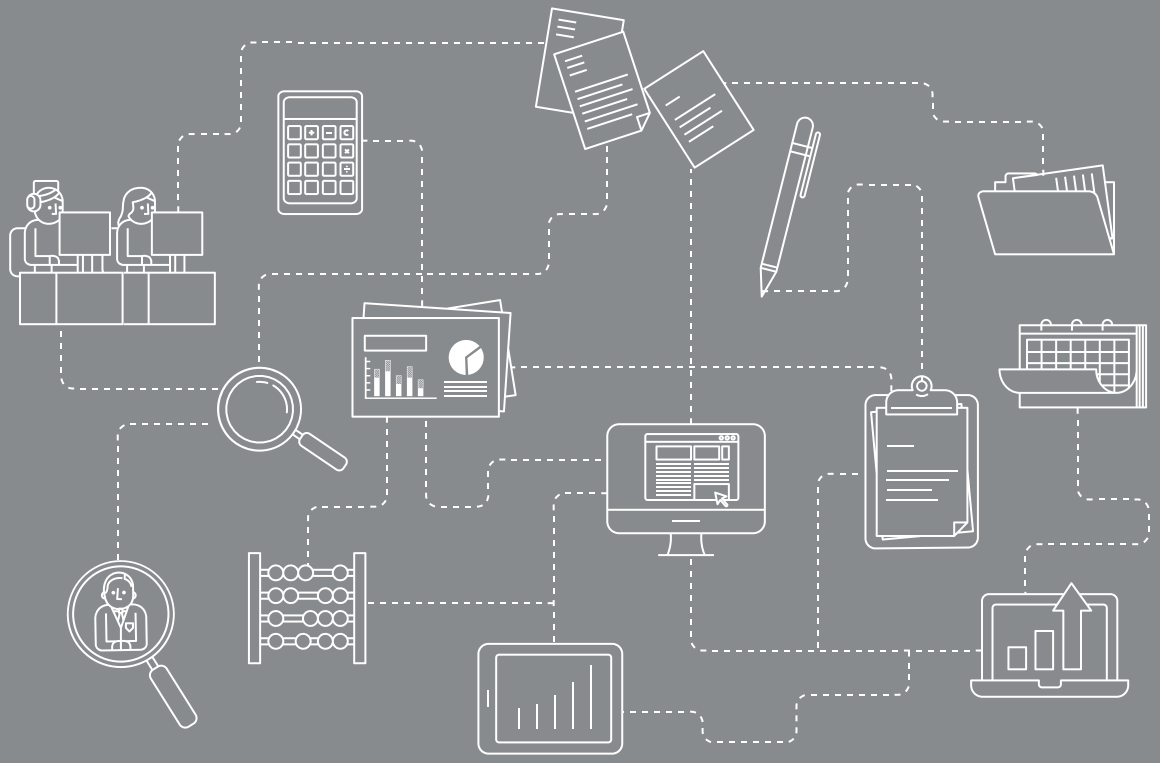
The factors which are considered when influencing our opinion are:

- inherent risk in the area being audited;
- limitations in the individual audit assignments;
- the adequacy and effectiveness of the risk management and / or governance control framework;
- the impact of weaknesses identified;
- the level of risk exposure; and
- the response to management actions and timeliness of actions taken.

It remains management's responsibility to develop and maintain a sound system of risk management, internal control, governance, and for the prevention and detection of errors, loss or fraud. The work of internal audit is not and should not be seen as a substitute for management responsibility around the design and effective operation of these systems.

Scope and Limitations

01



1 SCOPE AND LIMITATIONS OF OUR WORK

The formation of our opinion is achieved through a risk-based plan of work, agreed with management and approved by the audit committee, our opinion is subject to inherent limitations, as detailed below.

- Internal audit has not reviewed all risks and assurances relating to the organisation.
- The opinion is substantially derived from the conduct of risk-based plans generated from a robust and organisation-led assurance framework. The assurance framework is one component that the board takes into account in making its annual governance statement (AGS) to the Board.
- The opinion is based on the findings and conclusions of the agreed work which was limited to the area under review and agreed with management.
- Where strong levels of control have been identified, there are still instances where these may not always be effective. This may be due to human error, incorrect management judgement, management override, controls being by-passed or a reduction in compliance.
- Due to the limited scope of our audits, there may be weaknesses in the control system which we are not aware of, or which were not brought to our attention.
- The matters highlighted in this report represent only the issues we encountered during our work. It is not an exhaustive list of all weaknesses or potential improvements. Management remains responsible for maintaining a robust system of internal controls, and our work should not be the sole basis for identifying all strengths and weaknesses.
- This report is prepared solely for the use of the Board and senior management of Bristol, North Somerset and South Gloucestershire ICB.

Informing Our Opinion

02

2 FACTORS AND FINDINGS WHICH HAVE INFORMED OUR OPINION

A summary of internal audit work undertaken, and the resulting conclusions, is provided at appendix B.

We have undertaken 11 assignments as part of the 2024/25 internal audit plan. Of which, eight provided a positive assurance opinion (three substantial and five reasonable) and two were advisory.

The eleventh assignment, the **Cyber Assessment Framework (CAF)-aligned Data Security and Protection Toolkit Independent Assessment Report (11.24/25)** concluded with a **High** risk rating, defined as between two and four outcomes rated as not meeting minimum achievement levels required; and a **Medium** confidence level in the veracity of the self-assessment. We have raised three **High** and four **Medium** priority actions with management.

The results of our positive assurance opinion audits and advisory assignments are summarised below:

People Risks and People Committee (1.24/25)

Our work on People Risks and People Committee concluded with **reasonable assurance**. We confirmed that the ICB was actively engaged in system-wide workforce workstreams to deliver against the annual Workforce Plan, which aligns to NHSE's 10 People Functions and the Long Term Workforce Plan. We found the ICB was actively involved with regional level working through the South West Temporary Staffing Collaborative Board, with ICB representation in the three key workstreams developed to review and transform national rate cards for nursing, medical and mental health staff. Data driven workforce monitoring against the Workforce Plan was consistently reported through the ICS governance structure via the People Programme Board and ICS People Committee. However, weaknesses in the control framework to deliver workforce targets against the plan were identified around provider data reliability and timely returns, ongoing development and embedding of workstreams and the effectiveness of the ICS People Committee.

Population Health Management (PHM) and Health inequalities (2.24/25)

From our **advisory review** in this area we concluded that BNSSG ICB have provided a range of positive examples where they have utilised PHM approaches and have shown that they have well established PHM capabilities, a strong PHM Delivery Group and an effective PHM platform in the system-wide dataset. The ICB is on a journey with PHM as it looks to further strengthen the system-wide dataset and ensure that the insights from PHM analysis are actioned through engagement and co-production with identified groups. As a next step, we would encourage BNSSG ICB to continue to expand the PHM capacity within the system through training and wider sharing of successful examples of PHM projects, as well as to embed evaluation methods within projects and support decisions regarding resource allocation.

Financial Governance and Performance (Part 1) (3.24/25)

Our **advisory review** of Financial Governance and Performance completed in October 2024 concluded that from our review of the design of the control frameworks in place for financial governance and performance, including the Protocol, that the ICB has a robust and mature framework in place to continuously identify threats to achieving financial balance and subsequently implement measures to address weaknesses identified. To build on the good work already put in place, BNSSG should maintain its continued focus on evidence-based and realistic operational planning, underpinned by savings delivery plans and contingency planning to ensure it is best placed to meet the required in-year financial performance.

System Quality Assurance (4.24/25)

We concluded with **reasonable assurance** in the area of System Quality Assurance. Our review identified that system quality performance monitoring was a central focus in meetings across the quality governance structure, with performance metrics used to inform decision making across key areas such as Children's Services, Mental Health, Learning Disabilities & Autism, and Urgent & Emergency Care. The HCIG structure provided oversight, risk management, and improvement activities which facilitated escalation and ownership, and performance data was widely shared and consistently discussed, ensuring alignment and engagement across various groups and levels. However, we identified a few areas where the control framework and governance could be further enhanced.

Financial Controls (5.24/25)

Our audit of Financial Controls concluded with a **substantial assurance** opinion. Through reviewing and testing the design and operational effectiveness of selected ICB financial controls, we have concluded that there is a robust framework of controls to mitigate risk effectively with regards to the ICB's general ledger and scheduled payments. The ICB's control framework consists of first line controls such as the use of month-end timetables and reconciliations, and the effective use of second line controls. For example, self-approved journal entries are reviewed at month-end, scheduled payments are reviewed prior to payment, and ICB finance reports are presented each month to the FED Committee and monthly updates provided by the Committee to the ICB Board. We raised one low priority action for the ICB to begin to populate the action completed date for each action stated within the month-end timetable.

Digital Strategy (6.24/25)

Our audit of the ICB's Digital Strategy concluded with a **reasonable assurance** opinion. We identified that the ICB has a well-defined project management framework in place to ensure delivery of the projects that underpin the Digital Strategy itself, working through from project identification, prioritisation and monitoring and reporting following go-live. However, we have identified areas of improvement within this framework to ensure that sufficient consideration is given specifically to the level of resource available to deliver projects in a timely manner and that planned savings are realised.

Primary Care Commissioning Framework (7.24/25)

We concluded with **reasonable assurance** regarding the ICB's Primary Care Commissioning Framework. Through review of documentation provided, we verified 17 of the 20 self-assessed RAG ratings in our sample. Of the other three, BNSSG assessed two as green and it is our view that these should have been assessed as amber. The remaining item in our sample was assessed as amber by BNSSG and it is our view that it should have been assessed as green.

We found that there was a documented process for faster payments, that support was provided by the Southwest Community Commissioning Hub to ensure contractors were aware of the escalation process, and that correspondence was saved centrally in each contractor's file. We understood that the ICB may have rated itself as amber because the ICB had not needed to use the faster payments process and therefore had not tested the process.

Risk Management (8.24/25)

Our audit of Risk Management concluded with **reasonable assurance**. From our assessment of the design of the control framework the ICB has in place for corporate risk management, we recognise the improvements made since our previous audit in this area completed in June 2024. However, concerns remain over specific areas which have not improved. Most notably, the accuracy and completeness of the ICB Corporate Risk Register when compared with directorate risk registers, which sit directly below it in the

risk escalation / de-escalation chain. As raised last year, we would question whether based on the current level of resource that the ICB has the capacity to implement and embed an effective risk management framework for the ICB as well as overseeing the equivalent for the ICS.

Specialised Commissioning (9.24/25)

We concluded with **substantial assurance** over the area of Specialised Commissioning. At the time of this audit, governance and planning papers were in draft and are expected to have final approval in March 2025 for a go-live date from April 2025. Our findings are based on the draft papers available at the time of fieldwork. We identified a number of areas where adequate planning and governance controls are being put in place, as below. However further work is expected in developing these baseline arrangements following full implementation in April 2025.

Financial Governance and Performance (Part 2) (10.24/25)

Our second Financial Governance and Performance audit completed in March 2025 concluded with a **substantial assurance** opinion. Whilst we were not able to comment on whether the savings are achievable and that the ICB has identified all savings, we confirmed that there is a collaborative system-wise approach to identifying savings and continuously reviewing the financial position and forecast outturn. We also confirmed that actions were being taken in a timely manner (such as enactment of the Protocol) in order to best achieve financial breakeven and that these decisions and actions were subject to scrutiny and challenge throughout the ICB's governance structure.

As well as the headline findings discussed above, the following areas have helped to inform our opinion. A summary of internal audit work undertaken, and the resulting conclusions, is provided at appendix A.

Acceptance of internal audit management actions

Management have agreed actions to address most of the findings reported by the internal audit service during 2024/25.

Implementation of internal audit management actions

We have continued to track the progress in implementation of previously agreed management actions raised as part of our internal audit work. As at 31 March 2025:

- the ICB had implemented six **High** and 43 **Medium** priority actions during 2024/25;
- one **Medium** action from the 2021/22 Key Financial Controls audit regarding implementation of the ISFE2 finance system remained ongoing;
- one **Medium** action each from the 2023/24 Safeguarding and Funded Care audits also remained ongoing;
- 14 **Medium** and three **High** actions agreed in our 2024/25 reports were not yet due and will be monitored throughout 2025/26.

Working with other assurance providers

We reviewed the service auditors report ISAE 3402 for NHS Shared Business Services for it provision of Finance and Accounting Services. The opinion was qualified on the basis of three controls where exceptions were identified in testing. However, these are not considered sufficient significant to impact on the Trust/ICB's Head of IA Opinion.

We reviewed the service auditors report ISAE 3000 for NHS Business Services Authority for its provision and maintenance of the Electronic Staff Record system. No exceptions were noted.

We reviewed the service auditors report ISAE 3402 for NHS Business Services Authority for its Dental Payments Process system. No exceptions were noted.

We reviewed the service auditors report ISAE 3402 for NHS Business Services Authority for its Prescription Payments Process system. No exceptions were noted.

We reviewed the service auditors report ISAE 3402 for Capita for the Primary Care Support England (PCSE) services for processing GP, Ophthalmic and Pharmacy payments and pensions administration, operated on behalf of NHS England. The opinion was qualified based on one control objective where exceptions were identified in testing however, these are not considered sufficiently significant to impact on the ICB's Head of IA Opinion.

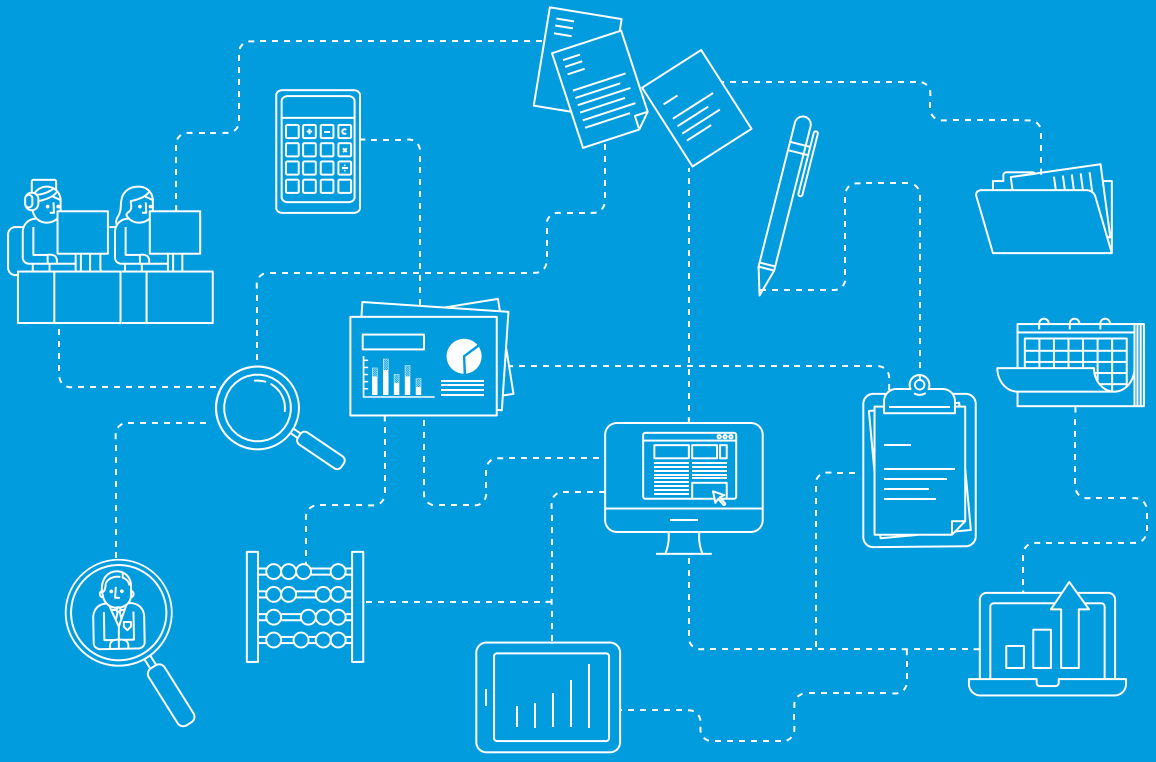
We reviewed the Type II Service Auditor Report, covering Finance, Payroll and Non-Clinical Procurement services provided by the four NHS CSUs for the period 1 April 2024 to 31 March 2025. For the ICB the Report covers the Payroll / Non-Clinical Procurement service South, Central and West CSU provided to the ICB during the period. One opinion was given for this report covering all four CSUs. The opinion was qualified based on two control objectives where exceptions were identified in testing, relating to the Accounts Receivable areas of sales order requests and credit notes. These are not services provided to the ICB and are therefore do not impact on the ICB's Head of IA Opinion.

Topics judged relevant for consideration as part of the annual governance statement

Based on the work we have undertaken on the ICB's system of internal control we have not identified any areas that need to be flagged as significant internal control issues. However, we have identified some areas where enhancements are required and in each of these cases management actions have been agreed, the implementation of which will improve the control environment. As part of developing an annual governance statement the ICB may want to consider findings from the partial assurance reports.

Our Performance

03



3.1 Wider value adding delivery

See below

Area of work	How has this added value?
Audit Chairs Forum	During 2024/25, the Audit Chairs Forum was established, in which there was discussion on a range of topics such as how ICBs, individual health bodies and ICSs can thrive through closer working, improved risk management, and alignment of objectives and ambitions across each ICS.
Benchmarking	We have shared benchmarking information with the ICB including our annual report on the outcomes of internal audit opinions and actions and results of our Data Security and Protection Toolkit audits across our NHS client base.
Sector briefings	We have issued a number of sector briefings during the year providing information on key developments, publications and guidance including, for example, our NHS - Emerging Issues briefings and the new Internal Audit Code of Practice Standards. This has provided committee members with insight into issue in the health sector and wider public sector.
Flexible annual planning approach	We worked closely with the Executive Team to revise the audit plan in year in order to meet the operational pressures of the ICB while ensuring sufficient coverage to allow for an audit opinion.
Collaboration and SME input	We have worked in collaboration with our Technology Risk Assurance colleagues, as appropriate in supporting the work undertaken at the ICB.
Webinar and event invitations	Representatives of the ICB have been invited to attend various RSM events and webinars during the year.

3.2 Conflicts of interest

RSM has not undertaken any work or activity during 2024/25 that would lead us to declare any conflict of interest. Internal audit remains independent and there have been no threats to our independence when delivering the audit plan during 2024/25.

3.3 Conformance with internal auditing standards

RSM affirms that our internal audit services are designed to conform to the Public Sector Internal Audit Standards (PSIAS) and the Global Internal Audit Standards.

Under PSIAS, internal audit services are required to have an external quality assessment every five years. Our risk assurance service line commissioned an external independent review of our internal audit services in 2021 to provide assurance whether our approach meets the requirements of the International Professional Practices Framework (IPPF), and the Internal Audit Code of Practice, as published by the Global Institute of Internal Auditors (IIA) and the Chartered IIA, on which PSIAS is based.

The external review concluded that RSM 'generally conforms* to the requirements of the IIA Standards' and that 'RSM IA also generally conforms with the other Professional Standards and the IIA Code of Ethics. There were no instances of non-conformance with any of the Professional Standards'.

* The rating of 'generally conforms' is the highest rating that can be achieved, in line with the IIA's EQA assessment model.

3.4 Quality assurance and continual improvement

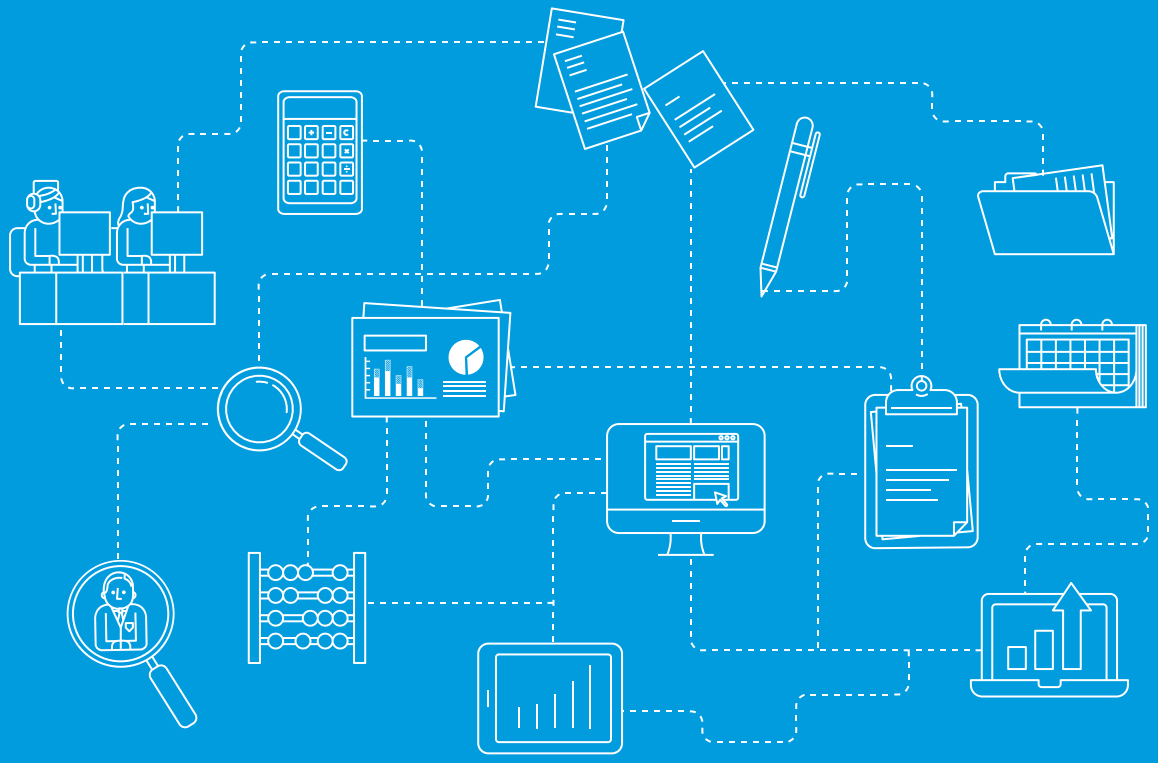
To ensure that RSM remains compliant with the PSIAS framework we have a dedicated internal Quality Assurance Team who undertake a programme of reviews to ensure the quality of our audit assignments. This is applicable to all Heads of Internal Audit, where a sample of their clients will be reviewed. Any findings from these reviews are used to inform the training needs of our audit teams.

As part of the Quality Assessment and Improvement Programme, none of your files were selected for Internal Quality Monitoring programme during 2024/25. From the results of the reviews undertaken across our client base, there are no areas which we believe warrant flagging to your attention as impacting on the quality of the service we provide to you.

In addition to this, any feedback we receive from our post assignment surveys, client feedback, appraisal processes and training needs assessments is also taken into consideration to continually improve the service we provide and inform any training requirements.

Appendices

04



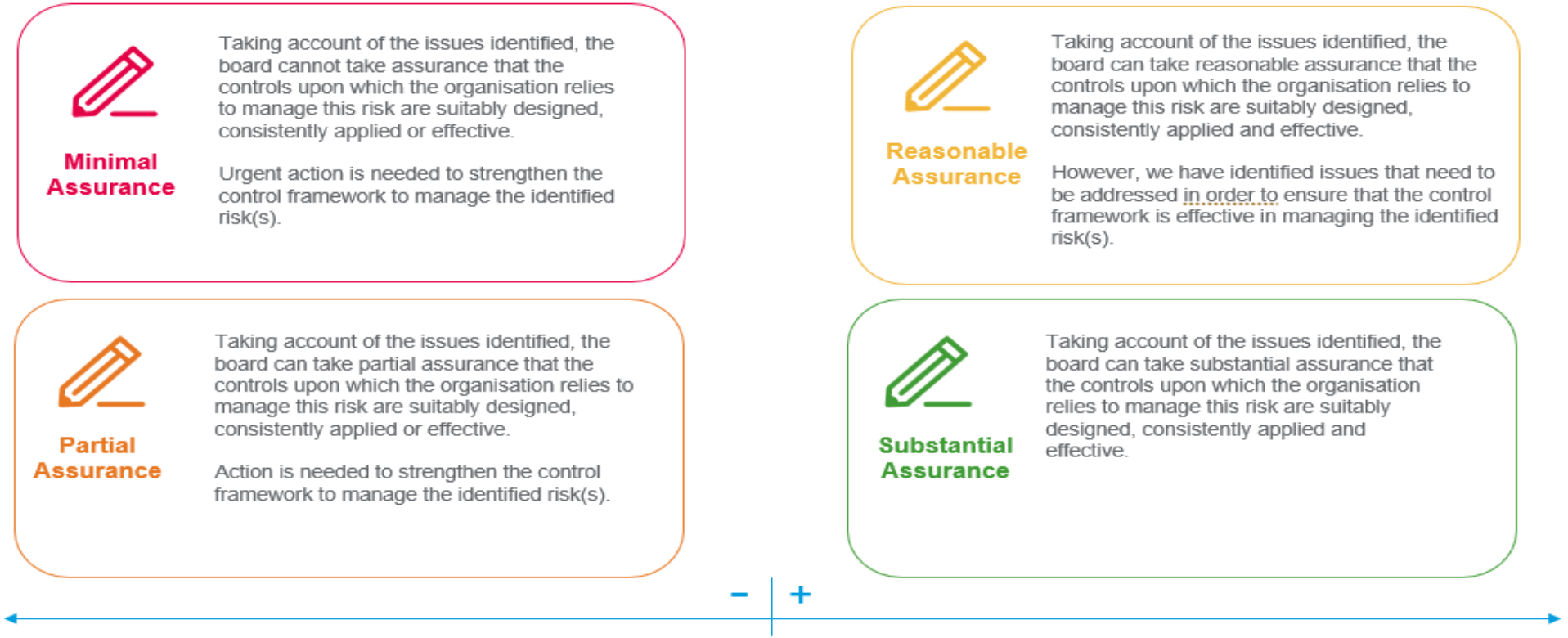
APPENDIX A: SUMMARY OF INTERNAL AUDIT WORK COMPLETED

All of the assurance levels and outcomes provided below should be considered in the context of the scope, and the limitation of scope, set out in the individual assignment report.

Assignment	Executive lead	Status / Opinion issued	Actions agreed			
			A	L	M	H
People Risks and People Committee	Jo Hicks	Reasonable Assurance	-	1	4	0
Population Health Management and Health Inequalities	Dr Joanne Medhurst	Advisory	6	-	-	-
Financial Governance and Performance (Part 1)	Sarah Truelove	Advisory	0	-	-	-
System Quality Assurance	Rosi Shepherd	Reasonable Assurance	-	0	4	0
Financial Controls	Sarah Truelove	Substantial Assurance	-	1	0	0
Digital Strategy	Deborah El-Sayed	Reasonable Assurance	-	2	2	0
Primary Care Commissioning Framework	David Jarrett	Reasonable Assurance	-	1	1	0
Risk Management	Sarah Truelove	Reasonable Assurance	-	0	5	0
Specialised Commissioning	David Jarrett	Substantial Assurance	-	0	0	0
Financial Governance and Performance (Part 2)	Sarah Truelove	Substantial Assurance	-	0	0	0
Cyber Assessment Framework (CAF)-aligned Data Security and Protection Toolkit (DSPT) Independent Assessment	Deborah El-Sayed	High Risk Rating Medium Confidence Level	-	0	4	3

APPENDIX B: OPINION CLASSIFICATION

We use the following levels of opinion classification within our internal audit reports, reflecting the level of assurance the board can take:



FOR FURTHER INFORMATION CONTACT

Nick Atkinson – Head of Internal Audit

Nick.Atkinson@rsmuk.com

Aled Price – Managing Consultant

Aled.Price@rsmuk.com

Independent auditor's report to the members of the Governing Body of NHS Bristol, North Somerset and South Gloucestershire Integrated Care Board

Report on the audit of the financial statements

Opinion on financial statements

We have audited the financial statements of NHS Bristol, North Somerset and South Gloucestershire Integrated Care Board (the 'ICB') for the year ended 31 March 2025, which comprise the statement of comprehensive net expenditure, the statement of financial position, the statement of changes in taxpayers' equity, the statement of cashflows and notes to the accounts, including material accounting policy information. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards in conformity with the requirements of Schedule 1B of the National Health Service Act 2006, as amended by the Health and Care Act 2022 and interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2024-25.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the ICB as at 31 March 2025 and of its expenditure and income for the year then ended;
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2024-25; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006, as amended by the Health and Care Act 2022.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law, as required by the Code of Audit Practice (2024) ("the Code of Audit Practice") approved by the Comptroller and Auditor General. Our responsibilities under those standards are further described in the 'Auditor's responsibilities for the audit of the financial statements' section of our report. We are independent of the ICB in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

We are responsible for concluding on the appropriateness of the Accountable Officer's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the ICB's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify the auditor's opinion. Our conclusions are based on the audit evidence obtained up to the date of our report. However, future events or conditions may cause the ICB to cease to continue as a going concern.

In our evaluation of the Accountable Officer's conclusions, and in accordance with the expectation set out within the Department of Health and Social Care Group Accounting Manual 2024-25 that the ICB's financial statements shall be prepared on a going concern basis, we considered the inherent risks associated with the continuation of services currently provided by the ICB. In doing so we have had regard to the guidance provided in Practice Note 10 Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2024) on the application of ISA (UK) 570 Going Concern to public sector entities. We assessed the reasonableness of the basis of preparation used by the ICB and the ICB's disclosures over the going concern period.

In auditing the financial statements, we have concluded that the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the ICB's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the Accountable Officer with respect to going concern are described in the relevant sections of this report.

Other information

The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. The Accountable Officer is responsible for the other information contained within the annual report. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements themselves. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office in November 2024 on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Governance Statement does not comply with the requirements of the Department of Health and Social Care Group Accounting Manual 2024-25 or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with the requirements of the Department of Health and Social Care Group Accounting Manual 2024-25; and
- based on the work undertaken in the course of the audit of the financial statements, the other information published together with the financial statements in the annual report for the period for which the financial statements are prepared is consistent with the financial statements.

Opinion on regularity of income and expenditure required by the Code of Audit Practice

In our opinion, in all material respects the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions in the financial statements conform to the authorities which govern them.

Matters on which we are required to report by exception

Under the Code of Audit Practice, we are required to report to you if:

- we issue a report in the public interest under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit; or
- we refer a matter to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the ICB, or an officer of the ICB, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we make a written recommendation to the ICB under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit.

We have nothing to report in respect of the above matters.

Responsibilities of the Accountable Officer

As explained more fully in the Statement of Accountable Officer's responsibilities, the Accountable Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions, for being satisfied that they give a true and fair view, and for such internal control as the Accountable Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accountable Officer is responsible for assessing the ICB's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the ICB without the transfer of its services to another public sector entity.

The Accountable Officer is responsible for ensuring the regularity of expenditure and income in the financial statements.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists.

We are also responsible for giving an opinion on the regularity of expenditure and income in the financial statements in accordance with the Code of Audit Practice.

Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below:

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the ICB and determined that the most significant which are directly relevant to specific assertions in the financial statements are those related to the reporting frameworks (international accounting standards and the National Health Service Act 2006, as amended by the Health and Care Act 2022 and interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2024-25).
- We enquired of management and the audit and risk committee, concerning the ICB's policies and procedures relating to:
  - the identification, evaluation and compliance with laws and regulations;
  - the detection and response to the risks of fraud; and
  - the establishment of internal controls to mitigate risks related to fraud or non-compliance with laws and regulations.
- We enquired of management, internal audit and the audit and risk committee, whether they were aware of any instances of non-compliance with laws and regulations or whether they had any knowledge of actual, suspected or alleged fraud.
- We assessed the susceptibility of the ICB's financial statements to material misstatement, including how fraud might occur, evaluating management's incentives and opportunities for manipulation of the financial statements. This included the evaluation of the risk of management override of controls and the cut-off risk in the ICBs non-block and non-NHS operating expenditure and its associated payables. We determined that the principal risks were in relation to:
  - Unusual journals (including journals posted by senior management and material post year end journals).
  - Manipulation of expenditure recognition using journals close to and after year end; and
  - Deliberate over recognition of expenditure in order to meet agreed year end targets
- Our audit procedures involved:
  - evaluation of the design effectiveness of controls that management has in place to prevent and detect fraud;
  - journal entry testing, with a focus on unusual journals as defined above,
  - challenging assumptions and judgements made by management in its significant accounting estimates in respect of the recognition of year-end manual expenditure accruals and related payable balances; and
  - assessing the extent of compliance with the relevant laws and regulations as part of our procedures on the related financial statement item.
- These audit procedures were designed to provide reasonable assurance that the financial statements were free from fraud or error. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error and detecting irregularities that result from fraud is inherently more difficult than detecting those that result from error, as fraud may involve collusion, deliberate concealment, forgery or intentional misrepresentations. Also, the further removed non-compliance with laws and regulations is from events and transactions reflected in the financial statements, the less likely we would become aware of it.
- We communicated relevant laws and regulations and potential fraud risks to all engagement team members, including management override of controls and the cut-off risk in the ICBs non-block and non-NHS operating expenditure and its

associated payables. We remained alert to any indications of non-compliance with laws and regulations, including fraud, throughout the audit.

- The engagement partner's assessment of the appropriateness of the collective competence and capabilities of the engagement team included consideration of the engagement team's:
  - understanding of, and practical experience with audit engagements of a similar nature and complexity through appropriate training and participation
  - knowledge of the health sector and economy in which the ICB operates
  - understanding of the legal and regulatory requirements specific to the ICB including:
    - the provisions of the applicable legislation
    - NHS England's rules and related guidance
    - the applicable statutory provisions.
- In assessing the potential risks of material misstatement, we obtained an understanding of:
  - The ICB's operations, including the nature of its other operating revenue and expenditure and its services and of its objectives and strategies to understand the classes of transactions, account balances, expected financial statement disclosures and business risks that may result in risks of material misstatement.
  - The ICB's control environment, including the policies and procedures implemented by the ICB to ensure compliance with the requirements of the financial reporting framework.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Report on other legal and regulatory requirements – the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources

Matter on which we are required to report by exception – the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the ICB has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2025.

We have nothing to report in respect of the above matter.

Responsibilities of the Accountable Officer

As explained in the Governance Statement, the Accountable Officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the ICB's resources.

Auditor's responsibilities for the review of the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under Section 21(1)(c) of the Local Audit and Accountability Act 2014 to be satisfied that the ICB has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in November 2024. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the ICB plans and manages its resources to ensure it can continue to deliver its services;
- Governance: how the ICB ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness: how the ICB uses information about its costs and performance to improve the way it manages and delivers its services.

We have documented our understanding of the arrangements the ICB has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In undertaking our work, we have considered whether there is evidence to suggest that there are significant weaknesses in arrangements.

Report on other legal and regulatory requirements – Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate for NHS Bristol, North Somerset and South Gloucestershire Integrated Care Board for the year ended 31 March 2025 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice until we have completed the work necessary in relation to the ICB's consolidation schedules, and we have received confirmation from the National Audit Office that the audit of the NHS group consolidation is complete for the year ended 31 March 2025. We are satisfied that this work does not have a material effect on the financial statements for the year ended 31 March 2025.

Use of our report

This report is made solely to the members of the Governing Body of the ICB, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the members of the Governing Body of the ICB those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the ICB and the members of the Governing Body of the ICB as a body, for our audit work, for this report, or for the opinions we have formed.

Beth Bowers

Beth Bowers, Key Audit Partner
for and on behalf of Grant Thornton UK LLP, Local Auditor

Bristol
19 June 2025