



NHS Bristol, North Somerset and South Gloucestershire ICB Annual Report

1 April 2025 – 31 March 2026

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PERFORMANCE REPORT

A handwritten signature in black ink, appearing to read 'Shane Devlin', with a long horizontal stroke extending to the right.

Shane Devlin

Accountable Officer

16 June 2026

Performance Analysis

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 (page 17)

Chair and Chief Executive's statement

We are delighted to present this year's Annual Report for NHS Bristol, North Somerset and South Gloucestershire Integrated Care Board (BNSSG ICB) which reflects on a year of significant challenge, change and progress for our organisation.

During the last 12 months we have seen a rising demand for services, sustained financial and workforce pressures and a rapidly changing national policy context. Against this backdrop we continue to forge ahead, and our focus has remained clear: to improve outcomes for local people, reduce inequalities, support safe and high-quality care, and make the best possible use of public resources.

There is much in this report that demonstrates what can be achieved through partnership. We have made important progress in elective care, diagnostics and cancer services, including reductions in long waits, strong diagnostic performance and the opening of the Princess Royal Bristol Surgical Centre, which is increasing elective capacity for local people. Our urgent and emergency care system has also delivered improvements, including better ambulance handover performance and reduced Category 2 ambulance response times, despite continued pressures.

We have also seen improved access and innovation through projects like Pharmacy First, increased availability of urgent dental care appointments and strong flu and Covid-19 vaccination uptake.

A defining feature of the year has been listening to, and working with, our communities. We have strengthened involvement and co-production, including work with children, young people and families to shape children's community health services, our partnership with Parent Carer Forums on things like the neurodiversity transformation project, and the growing role of the voluntary, community and social enterprise (VCSE) sector in planning and delivery.

Reducing health inequalities remains one of our most important responsibilities. Our Population Health and Strategic Commissioning Plan provides a strong foundation for the years ahead, setting out shared ambitions for healthy lives, health equity and best value.

Looking to next year, we do so with both realism and confidence during what is a pivotal time for Integrated Care Boards. For us locally this means continuing our work to bring NHS Gloucestershire and NHS BNSSG ICBs together and supporting our colleagues through change, while maintaining our focus on delivery. We are deeply grateful to our teams across the ICBs and to partners across health, care, local government and the VCSE sector for their professionalism, resilience and continued commitment to improving services.

On behalf of the Board, we would like to thank everyone who has contributed to the work described in this report. Together, we will continue to build a health and care system that is more inclusive, preventative, sustainable and responsive for the people we serve.

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

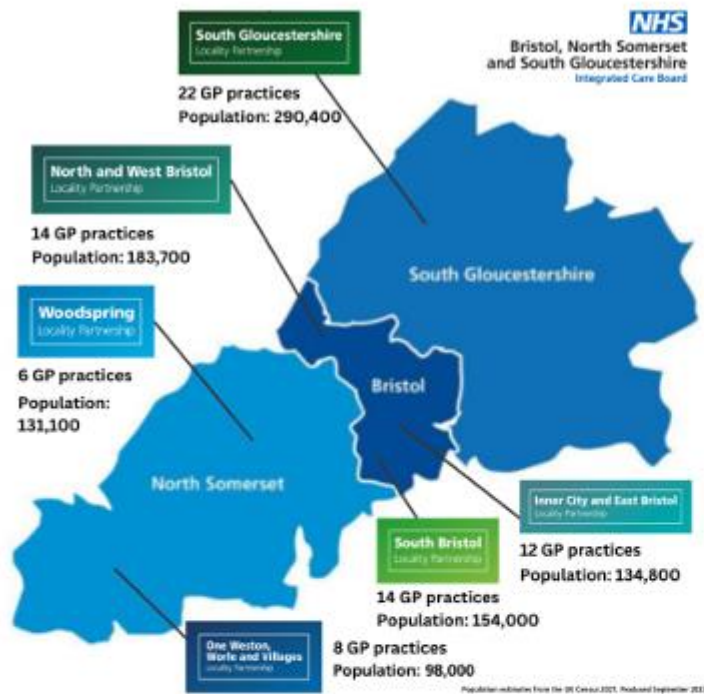


Figure 1 – Map of Locality Partnerships.

Population of one million people served by:

- Six Integrated Locality Partnerships
- Three local authorities and Health and Wellbeing Boards
- 56 children's centres
- 278 care homes
- One GP federation and one GP Collaborative with 78 general practices and 20 primary care networks
- One of each Medical, Dental, Optometry and Pharmacy Committees.
- One Primary Care 24/7 and 111 service
- 169 pharmacies
- 114 dental practices
- 79 opticians
- One community care provider
- One Healthwatch
- One mental health trust
- One ambulance service trust
- One Academic Health Science Centre
- Two acute hospital trusts
- Hundreds of voluntary and community sector enterprise partners

Bristol, North Somerset and South Gloucestershire is home to about one 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 ethnic minority communities (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 were 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. During 2025/26, our recently established 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 and racial equity. 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 Population Health and Strategic Commissioning Plan has been published. It sets out our priorities for health and care until 2031 and how, as an Integrated Care System (ICS), we will deliver the national vision of high-quality healthcare for all, with equitable access, excellent experience and optimal outcomes. Our plan has also been shaped in close alignment with Gloucestershire ICB, reflecting our shared ambition that, from 2027 onwards, there will be a single, integrated strategy and operating model across the wider footprint as the new, merged Integrated Care Board takes shape

Over the next five years, we are determined to close the unacceptable gaps in health outcomes that persist between communities, ensuring that where people live, work and grow no longer determines the quality or length of their lives. In pursuit of that, we have three Strategic Ambitions to unite us over the coming years - Healthy Lives, Health Equity and Best Value.

The plan builds on the work of our local Health and Wellbeing Boards, our Locality Partnerships and our 26/27 to 29/30 Medium Term Plan. Our Strategic Commissioning Plan is refreshed annually to provide a five-year

rolling plan. As our partnerships develop and the new system matures our plans will increase in depth and breadth.

You can view our Strategic Commissioning Plan along with a summary of it [here](#).

The Plan sets out the vision and strategic ambition, the population health needs for BNSSG, the commissioning intentions for the period and outlines how we will develop a strategic commissioning approach.

Our priorities and plans for 26/27 are set out in Year 1 of our 3-year Medium Term 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 to support delivery of the 10 Year Health Plan.

Figure 2 Integrated Care Strategy on a page



This Strategy is jointly owned by local authority, NHS and voluntary and community sector enterprise (VCSE) partners. By the same token, it will be delivered jointly by these three sets of partners who collectively make up our ICS. This jointly owned system strategy outlines the challenges and opportunities to meet the needs of the people living in Bristol, North Somerset and South Gloucestershire (BNSSG) at a population level over the next five years. The strategy development was led by the principles and approaches set out in the BNSSG Strategic Framework which was published

in December 2022. Contained in the strategy is a mandate for system change, with an increased focus on prevention and addressing health inequalities. The strategy has been developed from several important sources. It includes public views, including those who have used our health and social care services, information showing our communities' local health and social care needs, such as the Joint Strategic Needs Assessment, and the insights of practitioners working in our organisations.

BNSSG ICB continuing to operate in a changing environment

In March 2025, with the ICB emerging from its reorganisation completed in 2024, the Health Secretary set out a new direction for the NHS - one focused on delivering locally driven services through a revised national operating model. This new model repositions Integrated Care Boards (ICBs) as streamlined, strategic commissioners.

On the 1st April 2025 Jim Mackey, Chief Executive of NHSE wrote to all Trust and ICB Chief Executives and Chairs to define a new round of changes. The letter clearly indicated that the existing roles, functions, responsibilities and structures of ICBs would need to change. Much of 2025-26 has been spent on preparation for the changes and supporting the workforce to serve our population while facing the uncertainty of another round of organisational change.

Following this announcement, NHS England published the Model ICB Blueprint. Developed jointly with system leaders, the Blueprint provides further detail on the responsibilities of ICBs, stating that the central aim of ICBs is to ensure funding is used in the most effective way to improve population health, reduce inequalities, and improve access to high quality services, through a strategic commissioning approach. It reaffirms that ICBs in England are collectively responsible for four core objectives:

- Improving population health and reducing health inequalities
- Ensuring consistently high-quality care
- Driving productivity and value
- Enhancing social and economic impact

These objectives are supported by the 10-Year Health Plan for England: Fit for the Future, which sets out three major shifts in health and care:

- From hospital based to community focused services
- From analogue to digital delivery
- From reactive sickness care to proactive prevention

At the heart of the 10-Year Health Plan is the development of neighbourhood

health that brings care closer to communities, reduces fragmentation, and improves patient experience. The plan reiterates the essential role of ICBs in leading strategic commissioning, delivering the three shifts and championing neighbourhood health models.

In November 2025, NHS England also published the Strategic Commissioning Framework, providing further clarity on how strategic commissioning should operate in practice. All ICBs are expected to begin adopting this approach from April 2026.

While the Blueprint initially outlined 18 functions for potential transfer out of ICBs, later national updates confirmed that most of these functions should remain within ICB at least in the short to medium term.

Taken together, these national developments define a new model for ICBs—one that repositions their central role as strategic commissioners. This model will continue to evolve through collaboration, system engagement, and future guidance. The NHS Confederation Document – Pioneers of Reform, proposes the following process for strategic commissioning:



Alongside this change to purpose, NHS England announced a new resource envelope for ICBs, requiring them to halve their running and programme costs to improve efficiency and reduce duplication.

NHS England and the Chief Executives of ICBs in the Southwest came together to determine how this funding challenge could be met. It was agreed that bringing neighbouring ICBs together, in clusters and then mergers, would help create 'economies of scale', alongside efficiencies and deliver the new resource envelope for ICBs.

NHS Gloucestershire ICB and NHS Bristol North Somerset and South Gloucestershire (BNSSG) ICB submitted a proposal to cluster, which was later agreed.

For NHS Gloucestershire and BNSSG ICBs the new resource envelope,

(£19.00 per head of weighted population), means a reduction from c£65.7m to £32.7m; and a total reduction of £33m. This will require all areas of both organisations to reduce staff numbers and improve efficiency.

To support the clustering arrangements and the resulting organisational changes, NHS England appointed the existing BNSSG ICB Chair to also be the Chair of Gloucestershire ICB. ICBs constitutions were changed by NHS England to permit a CEO to be appointed as Accountable Officer for more than one ICB. Following a competitive process, Shane Devlin, BNSSG CEO was appointed as Cluster CEO.

In January 2026, a new jointly appointed executive team was announced. The following appointments will serve on the Boards of both BNSSG and Gloucestershire ICBs.

- Chief Clinical Leadership and Delivery Officer (Nursing) – Rosi Shepherd
- Chief Clinical Leadership and Delivery Officer (Medical) – Dr Ananthakrishnan Raghuram MBE
- Chief Finance and Corporate Services Officer – Cath Leech
- Chief Population Health Improvement Officer – Dr Joanne Medhurst
- Chief Transformation, Organisational Development and People Officer – Jo Hicks
- Chief Strategic Commissioning Officer – David Jarrett.

Non-executive directors (NED) have also been jointly appointed with NHS Gloucestershire ICB and will serve the cluster. All Chief Officers and NEDs form part of the Joint Transition Committee that was established in September 2025 to support the governance of the transition arrangements affecting the organisation. Details of the Joint Transition Committee can be found on page 158.

Changes in our workforce continue to be managed in line with our organisational changes policies and with the support of our Staff Partnership Forum and Staff Networks. The impact of any proposed changes to workforce is being considered with a strong focus on equality, diversity and inclusion to minimize any adverse effects on individuals and the overall demographic.

Details of our workforce can be found in the remuneration and staff report on page 183, and staff operate in service of our population in line with our operating model below.

2025-26 BNSSG ICB Operating Model

Whilst recognising the scale of change during 2025-26, the BNSSG ICB operating model has remained broadly stable and is set out as follows:

BNSSG ICB Operating Model

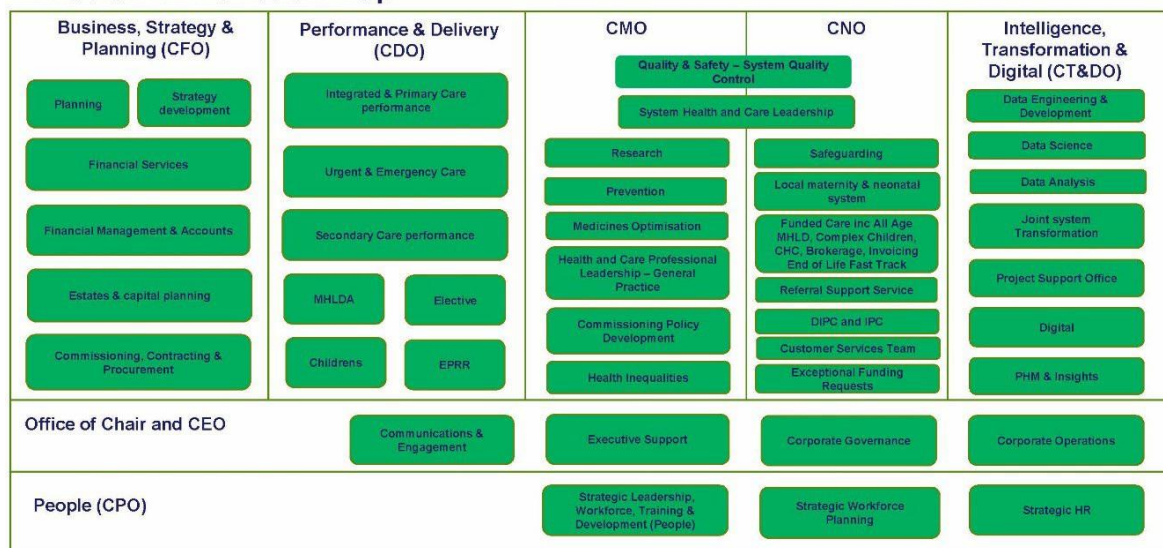


Health and Care Professional Leadership

Within BNSSG, we have cross organisational, system-wide working in health and care leadership and this leadership is integral to the function and delivery of our ICB. The Health and Care Professional Executive (HCPE) in BNSSG provides leadership and advice on health and care matters, focusing on improving outcomes and quality for residents. The HCPE aims to provide a professional interface for local and regional change proposals, offer strategic advice on health and care matters, review and endorse policies, and oversee strategic transformation activities.

2025-26 BNSSG ICB Functions Map

BNSSG ICB Function Map



The functions of the ICB are shown below and the diagram describes which areas of work fall in each directorate. We have continued to establish our team of teams approach to collaborative working to ensure we deliver ICB responsibilities with our reduced workforce, and this will continue to be a major focus and included in our organisational development.

The workforce of BNSSG ICB has operated within the structure above with staff organised into 7 directorates. The appointment of 5 new Chief Officers to lead the new clustered organisation will have an impact on the way the staff are organised. This will be clarified following the outcome of staff consultation which was launched on 23 March 2026 and will run for 45 days. The full implementation of the changes is not anticipated to be complete until September 2026

Summary of key risks to delivering objectives

Aside from the impact of further organisational change, our healthcare system continued to face significant challenges during 2025/26. Key risks reported to the Board and highlighted on the ICB corporate risk registers have included the following areas:

Directorate	Risk Areas
Chief Medical and Chief Nursing	GP Collective Action
	PHM Data Sharing Agreement affecting immunisation data
	Specialised Supported Housing Capacity
	Funded Care Budget

Directorate	Risk Areas
Intelligence, Transformation and Digital Directorate	Cyber Security
	Clinical Safety Risk Management Arrangements for Digital Systems
	Top 3 IG risks
People	Employee Relations linked to Shaping Our Future
	Oliver McGowan Mandatory Training Long Term Sustainable Plan
	Organisational Change 25-26
Business, Strategy and Planning	Central Weston Development
	ADHD and Autism Variable Activity
	Elective Variable Activity
	Acute Trusts forecast position
Performance and Delivery	Procurement Activity
	Recruitment and retention of Locality Partnership Teams
	Capacity within the Locality Partnership Teams
Office of the Chair and Chief Executive	Impact of NHS Reforms on ICB Performance
	Neurodiversity P3 Waiting List

In addition, the Board has received updates to the ICS strategic risk register which has included the following risk areas: partnerships and relationships, system flow and risk of harm, tackling health inequalities, workforce and capacity for change, financial management and investment, and the impact of the NHS reforms on ICS performance and strategic working arrangements.

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 (page 17).

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, 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 136.

Summary of our performance

Overview of how ICB performance is measured

The performance of BNSSG continues to be assessed by NHS England via the [NHS Oversight Framework](#). The new model, introduced for 25/26, is a mechanism 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 scoring and non-scoring domains as indicated below:

Domains and sub-domains
Access to services – elective care – cancer care – urgent and emergency care – mental health care
Effectiveness and experience of care
Patient safety
People and workforce
Finance and productivity
Improving health and reducing inequality (non-scoring) – improving population health – primary prevention – inequalities

Unlike in previous years, ICBs were not allocated

For ICBs, a set of metrics and system considerations have been selected by NHS England to reflect the NHS priorities and operational planning guidance, system performance and longer-term strategic priorities. However, under the new Oversight Framework, ICBs were not be segmented in 2025/26 due to the significant changes they have been experiencing.

This means these metrics will not be scored to inform segmentation, but they will be reported as contextual information to be used in strategic planning and improvement conversations. Although ICBs were not segmented, their leadership capability will be assessed through the annual assessment of ICBs, which reviews how well each ICB is performing its statutory duties

In July 2025, NHSE provided BNSSG ICB with its Annual Assessment Letter for performance in 2024/25. Details can be found here:

<https://bnssghealthiertogether.org.uk/wp-content/uploads/2025/08/5-Chief-Executive-Officers-Report-ICB-Board-September-2025.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 takes into account the views of stakeholders. It concluded that the ICB The ICB has demonstrated a strong and evolving commitment to fulfilling its statutory duties during 2024–25, with clear evidence of strategic leadership, collaborative system working, and a growing maturity in its approach to integrated care. The conclusion also recognised the challenges associated with the organisation changes and associated reduction in costs which lay ahead.

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 224)
- The actions to tackle fraud and bribery are described in the Governance Statement (page 178)

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 2025/26

Planned, Elective Care and Cancer Care

A summary of key elective performance targets and actual performance up to February 2026 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



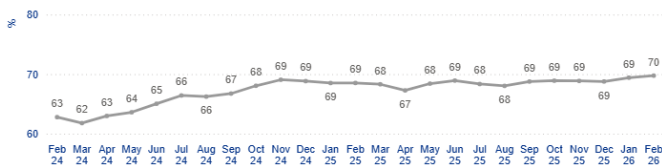
Slightly worse than operational plan



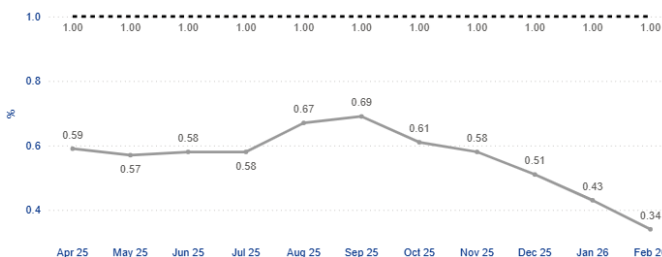
Did not achieve operational plan

RTT Metrics: ICB level

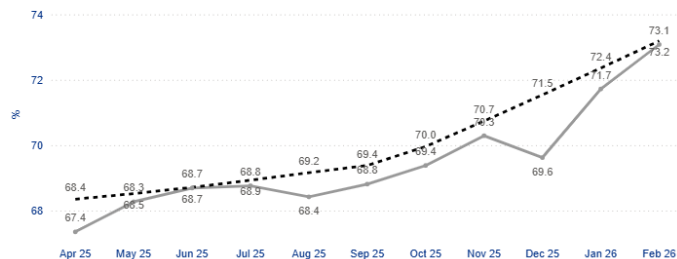
RTT Performance (March 2026 target 74%) 😞



% RTT Waits >52 weeks waiting. (March 2026 target <1%) 😊



% waiting <18 weeks for 1st Outpatient appointment (Feb 2026 target 73%) 😊



Elective care, including outpatients, cancer and diagnostics services in BNSSG have demonstrated significant recovery in 2025/2026.

The system focus remained on reducing the length of time people were waiting for appointments, tests and treatment 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.

2025/2026 saw a number of significant milestone achievements, both from a strategic and operational perspective, including, the progression of the Hospital Group, which will merge, will become as a single organisation called Bristol NHS Foundation Trust from 1 July 2026. In August 2025, The Princess Royal Bristol Surgical Centre opened its doors providing additional elective capacity for local people, meaning shorter waits for treatment, improved patient experience and outcomes, improved capability for productivity, and a cornerstone of the future delivery of elective care in BNSSG.

We further 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, MSK and podiatry; and working collaboratively across system partners to improve and develop pathways including Advice and Guidance between General Practice and Secondary Care specialists. This links closely to our commitment to ensuring patients receive the right care, in the right place and is underpinned by 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 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.

Digital development and expansion has made important strides in 2025/26 and is already demonstrating improved communication and interaction with patients both administratively and clinically and in 2026, patients will be able to initiate changes to their appointments in the NHS App.

We have maintained and driven forward our commitment to tackling health inequalities through a number of projects and initiatives across elective and cancer services.

Performance against our 25/26 Operational Plan

Our priorities to achieve by the end of 2025/2026 were:	<u>Performance position as at February 2026 (latest available data at time of writing)</u> (graphs can be found earlier in the section)
To increase the RTT performance at the ICB level to 74%	February 2026 data shows performance at the ICB level is 70%. This is expected to improve further in March data after an intensive 'sprint' of activity, supported by additional funding from NHSE, took place.
To reduce the number of patients waiting 52 weeks or more on a RTT pathway to less than 1% of the total RTT waiting list	We have consistently maintained far less than 1% of our total RTT waiting list being people that have waited >52 weeks for their treatment. In February 2026, people waiting over 52 weeks was 0.34% of the total waiting list.
To increase the % of people waiting less than 18 weeks for their 1st Outpatient appointment	In February 2026 we achieved our plan of 73% of people waiting less than 18 weeks for their first outpatient appointment.
To increase to 95% the number of patients that receive their routine diagnostic test within 6 weeks of their referral	We have throughout 2025/2026 maintained position as the top ranked ICB in England for DM01 (Diagnostics) performance and in February 2026 achieved 94.6%
To increase to 80% 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. (FDS)	With the exception of January 2026, our FDS performance has been high. In February 2026 performance was 78.6% and is forecast to meet the 80% target in March 2026.
To increase to 75% 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.	62 day has been more challenged in 2025/26, but has recorded improvements and reduction in variance to plan in February 2026. It is forecast that the performance position in March will be slightly below our operational plan ambition.

Next Steps

Our overarching aim across elective care, diagnostics and cancer care in BNSSG, remains to drive quality service delivery and high performance, ensuring the system upholds patients' rights around choice and access.

Our overarching priority is a return to constitution standards across elective, cancer and diagnostic pathways.

In 26/27 we renew our commitments to delivery of our plans and meeting the NHS ambitions and Standards. We will:

“Do more” – ‘Do more’ has been a central tenet of recovery over recent years and has been underpinned by actions to increase capacity that has enabled us to do more through for example, workforce recruitment and training, increasing delivery opportunities through waiting list initiatives, utilising capacity available through our local independent sector providers and developing our estates. We will continually look for opportunities to “do more”.

“Do more, better” – ‘Do more, better’ describes how we aim to work efficiently, productively and proactively to achieve more and better patient experiences and outcomes. Improving efficiency and productivity has been central in our recovery, for example, our focus on ‘getting it right first time’ (GIRFT) including a focus on clinic templates, theatre utilisation, day case and outpatient procedure rates, scheduling and booking efficiencies; increasing throughput on lists, approaching bed utilisation flexibly; working with system partners to support flow and optimise benefits from urgent and emergency care and integrated care schemes, optimising demand management and ensuring patients are directed to the right place at the right time for the care and treatment they need, supporting patients to wait well, through perioperative initiatives, citizen facing digital enablers and waiting well apps and through various projects and programmes as well as a drive a reduction in health inequality and inequity.

“Do more, differently” – ‘Do more, differently’ brings into focus our longer-term ambitions and more radical strategic intentions, our exploration and implementation of new ways of working, our approach to and delivery of innovation. This includes (but is not limited to) our commitment to learning from elsewhere, developing and improving system-wide clinical pathways and models of care, providing care through community settings, and most recently engaging with system partners to plan for Neighbourhood models of care that alongside delivery, prioritise a prevention and earlier intervention approach.

In 2026/27 we will:

- Drive performance as per our operational plan, across elective care, cancer care and diagnostics
- Progress the alignment and integration of acute services
- Further develop and embed strengthened demand management practices
- Implement referral management changes and Single Point of Access (SPOA) in at least 10 specialities. Through the Single Point of Access model, specialists in secondary care will continue to provide advice that enables General Practice (and other referrers) to maintain care in the community and avoid referrals into secondary care unless needed.
- Drive forward digital development and transformation in key areas including DrDoctor, the NHS App and in areas such as Ambient Voice Technology.

- Deliver plans for existing and new estate
- Explore and plan for opportunities to deliver care outside of a hospital setting
- Work with system partners in the development of Neighbourhood Models of Care
- Continue addressing health inequalities with targeted interventions including building on success to date in improving ethnicity recording; rolling out learning about reducing missed appointments for global majority and IMD1 groups; and tackling tobacco dependency.

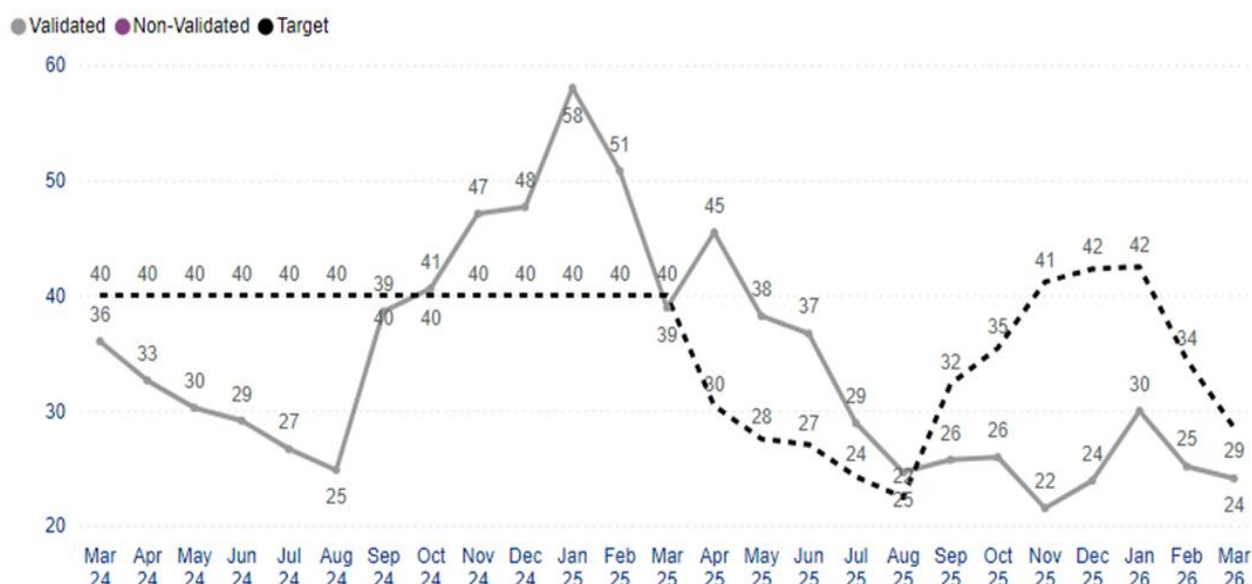
Urgent and Emergency Care

In 2025/26 BNSSG has been refreshing its five-year Strategic Plan for urgent and emergency care services, recognising changes to the urgent and emergency care landscape and population needs since the last strategy was published in 2018/19. In the intervening years several specific issues have arisen where agreement on the longer-term vision has been required to take steps forward with transforming existing services. These include:

- How best to deliver urgent and emergency care services for lower-acuity conditions, in the context of growing remote services such as 111 and 111 Online, seasonal overcrowding in A&E units, and high levels of growth in minor injuries units and urgent treatment centres.
- How best to deliver an integrated community ‘front door’ for urgent and emergency needs, building on the significant investments made to date in various services such as the Urgent Community Response teams, virtual wards, and the ‘Frailty-ACE’ remote multidisciplinary team used by GPs and the ambulance service. Joining these services together into a true ‘single point of access’ aims to deliver benefits to the quality of the wraparound response provided in the community as an alternative to hospital.

In 25/26, BNSSG remained at the forefront of systems tackling ambulance handover delays through the implementation of the Timely Handover Process to deal with surges in ambulance demand and maintain ‘flow’ through the hospital. The Timely Handover Process is a joint working arrangement between the ambulance service and hospitals that works towards delivering hospital handovers within 15 minutes, with working arrangements that ensure no handover takes longer than 45 minutes. This approach was implemented in the autumn of 2025 and led to BNSSG sustaining handover performance much better than the forecast plan.

Figure 3: BNSSG ambulance handover delays – average handover time (mins)

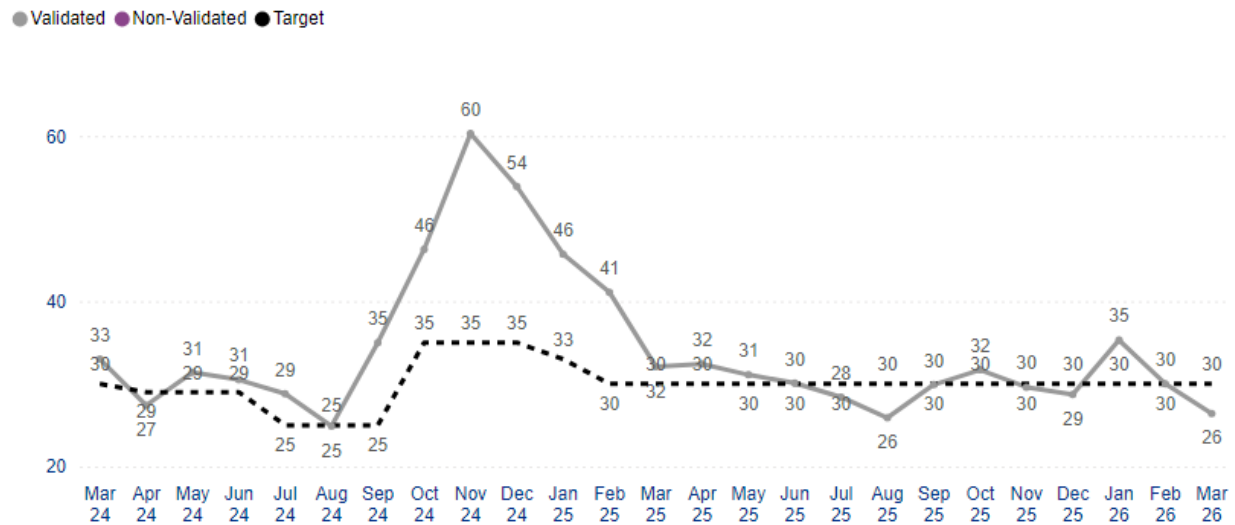


BNSSG has supported reducing the conveyance of patients to the Emergency Department (ED) and maximised the use of alternative care pathways, including through increased hear and treat processes, and the increased use of the Consultant Emergency Medicine Service (CEMS), where a Doctor from the Emergency Department works alongside a member of the Ambulance service to support advanced-decision making, diagnostics, treatments and clinic access that is currently only available through the ED, enhancing patient care and experience in the community. The Frailty-ACE, (assessment and coordination for emergency and urgent care) service also continues to be developed: 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.

In turn, this improvement in reducing handover delays impacted positively on our ambulance response times, with 'Category 2' responses seeing an average of 30 minutes over the year, a decrease from the 38.4 minutes achieved in 24/25 and achieving the national standard for 25/26 of 30 minutes.

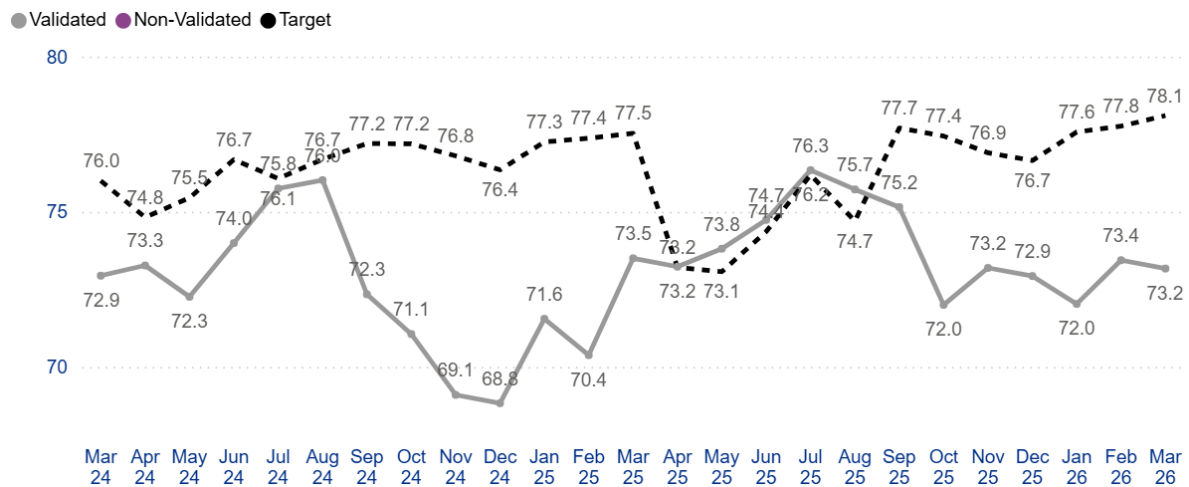
Figure 4: Category 2 ambulance average response times in BNSSG

Visualisation



Challenging winter demand for health and care services impacted flow within the hospitals, with BNSSG missing its 4 hour performance trajectory in 25/26 despite improvements seen in the first quarter of the year, finishing at an average of 74% against the national target of 78%.

Figure 5: BNSSG all-types A&E - percentage of patients waiting less than four hours



Mental Health, Learning Disabilities & Autism

Mental Health – Overview of Last Year and Looking Ahead to 2026/27

In 2025/26, we have continued to work collaboratively across the system,

and with people with lived experience, to progress delivery of our BNSSG All Age Mental Health and Wellbeing Strategy (2024–2029), and we have refreshed our priorities within the Population Health and Strategic Commissioning Plan 2026 to 2031. This has included a continued focus on strategic commissioning, strengthening neighbourhood and integrated care models, improving prevention and early intervention, and targeting action to reduce health inequalities.

Key progress this year includes strong delivery across all core mental health priorities, with achievement of plan in areas including IPS access, perinatal access, NHS Talking Therapies reliable recovery and improvement, inappropriate out of area placements, average length of stay, and dementia diagnosis rate. Areas of particular improvement this year include strong clinical outcomes in NHS Talking Therapies and a significant reduction in inappropriate out of area placements.

We have also rolled out personalised care planning more widely, recognising the importance of care that is shaped around people’s individual needs, goals and preferences, and of using patient reported outcome measures (PROMs) to better understand whether support is making a meaningful difference to people’s lives.

Alongside this, we continue to keep sight of the physical health of people with severe mental illness as an important priority, and in 2026/27 we will continue to develop more integrated care for mental and physical health to help reduce the greatest harm and tackle health inequalities, supported by the direction of the upcoming Modern Service Framework for SMI.

Mental Health – Performance in 2025/26 and Looking Ahead to 2026/27

The table below shows our performance against core NHS Operational Plan targets for mental health. Achievement against each measure is assessed as either Green, Yellow or Red with the reasons outlined.

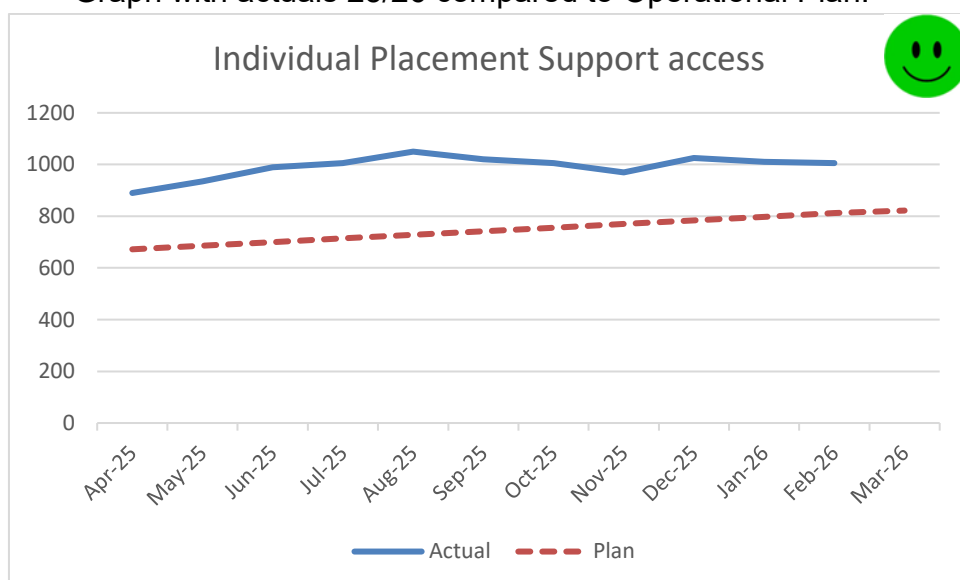
Smiley Rationale:				
	Measure	Assessment	Reason	
	IPS Access	Green	Plan achieved - consistently better than plan	
	Perinatal Service Access	Green	Plan achieved - consistently better than plan	
	TT Reliable Recovery Rate	Green	Plan achieved - consistently better than plan	
	TT Reliable Improvement Rate	Green	Plan achieved - consistently better than plan	
	Inappropriate OAP (BNSSG)	Green	Plan achieved	

	Avg LoS Adult Acute Beds	Green	Plan achieved	
	Dementia Diagnosis Rate	Green	Plan achieved, better than national standard	

Our performance against key areas for the year 2025/26 is set out in more detail below.

Individual Placement Support Access

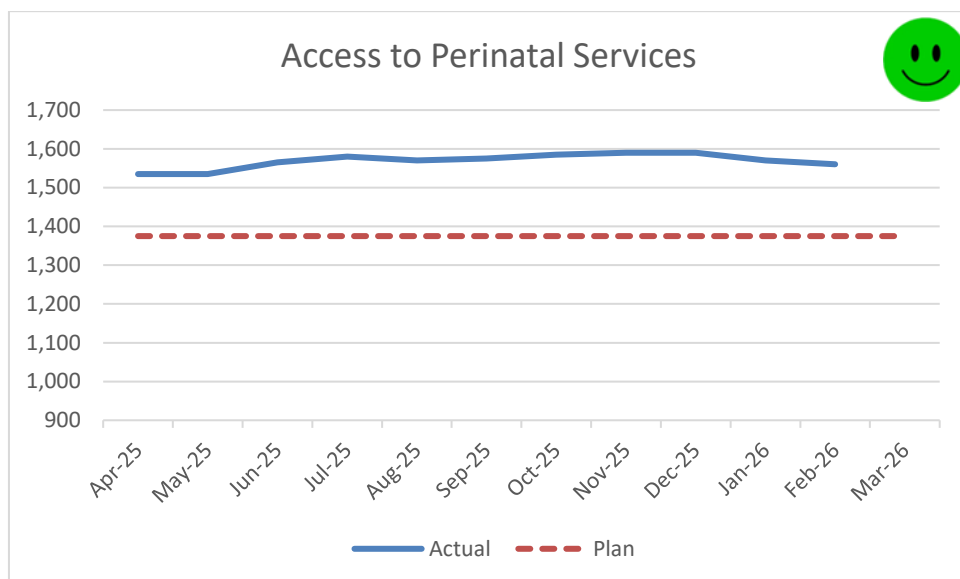
Graph with actuals 25/26 compared to Operational Plan:



Individual Placement and Support (IPS) helps people with severe mental illness find and keep paid employment, recognising the important link between good mental health, purpose, independence and financial security. Performance has remained strong during 2025/26, with BNSSG consistently achieving above plan for IPS access. In 2026/27, we will continue to build on this progress by working with partners to expand access to IPS support so that more local people can benefit from help to enter, return to and stay in work.

Perinatal Mental Health Access

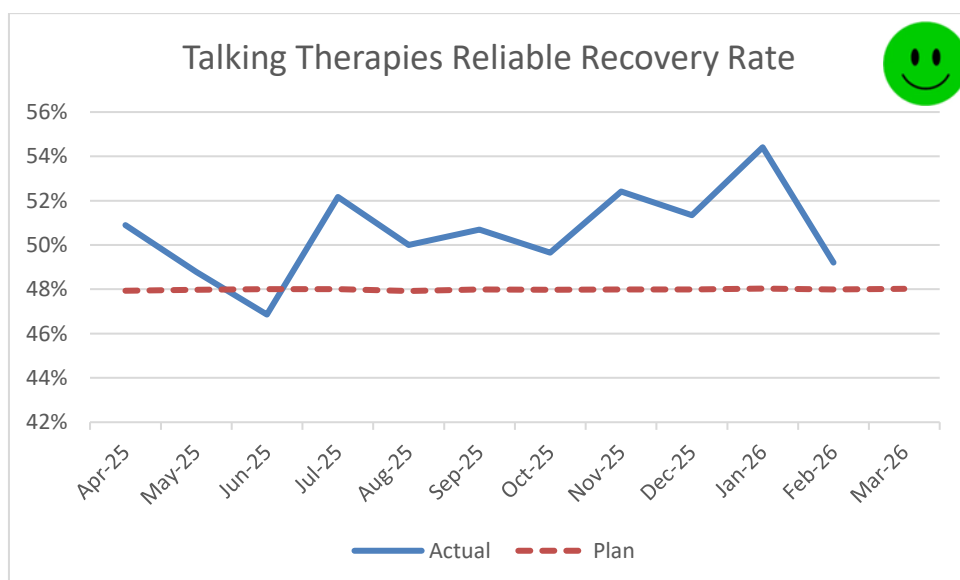
Graph with 25/26 actuals compared to Operational Plan:



Perinatal mental health support is important because good mental health during pregnancy and after birth has a significant impact on the wellbeing of parents, babies and families. Performance has remained strong during 2025/26, with BNSSG consistently achieving above plan for access to perinatal mental health services. In 2026/27, we will continue to work with partners to maintain this strong performance and support timely access to care for people who need specialist help during the perinatal period.

NHS Talking Therapies (for anxiety and depression) Reliable Recovery Rate

Graph with 25/26 actuals compared to Operational Plan:

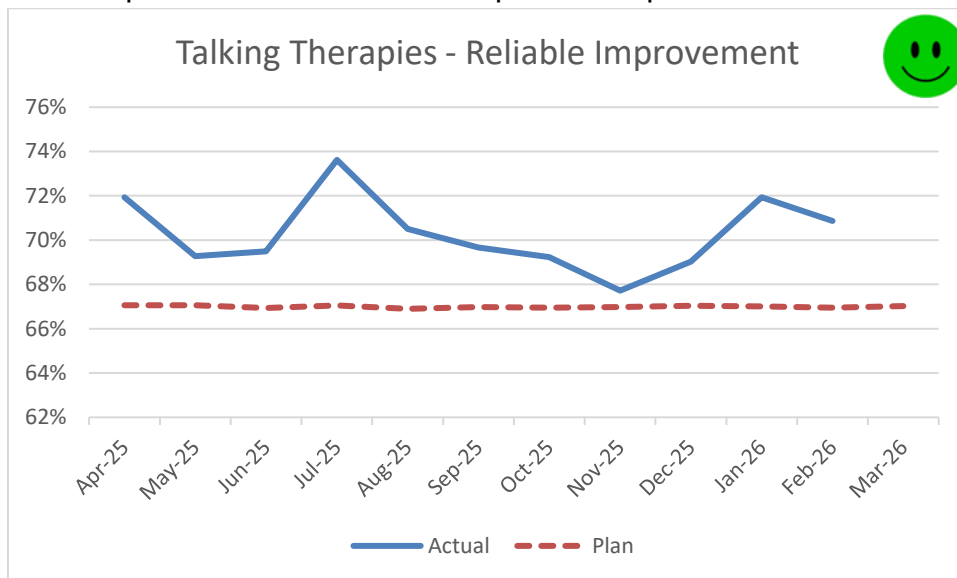


Reliable recovery in NHS Talking Therapies is an important measure because it shows that people have both recovered from symptoms of anxiety or depression and made a meaningful improvement in their mental health. Performance has remained strong during 2025/26, with BNSSG consistently achieving above plan, and local benchmarking indicates the service is performing well when compared with other areas. In 2026/27, we will continue to build on this through further investment in the service, helping to

maintain strong outcomes and support more local people to benefit from timely, effective treatment.

NHS Talking Therapies (for anxiety and depression) Reliable Improvement Rate

Graph with 25/26 actuals compared to Operational Plan:

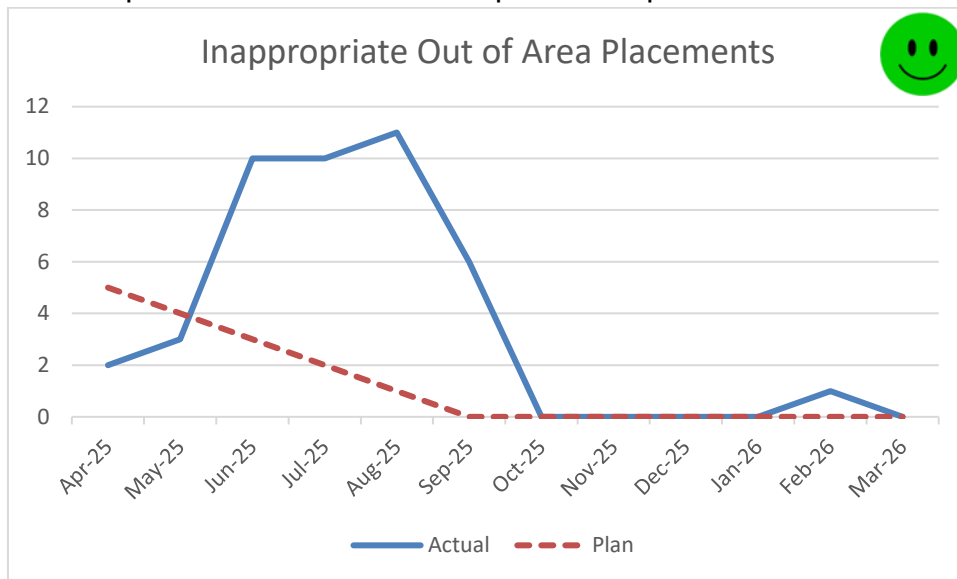


Reliable improvement in NHS Talking Therapies shows that people using the service have experienced a clear reduction in symptoms, even if they have not yet fully recovered. This makes it an important measure of whether treatment is helping people feel better and function better in daily life. Performance has remained strong during 2025/26, with BNSSG consistently achieving above plan, and benchmarking indicates the service is performing well compared with national expectations. In 2026/27, we will continue to build on this through ongoing investment in the service, helping to maintain good outcomes and support more local people to access effective help for

anxiety and depression.

Reduction and Elimination of Inappropriate Out of Area Placements

Graph with 25/26 actuals compared to Operational Plan:

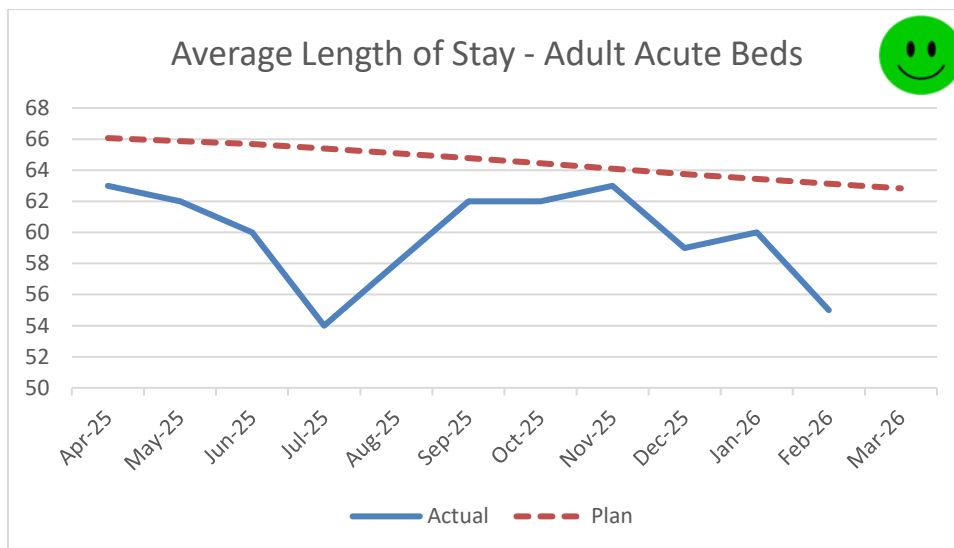


Reducing inappropriate out of area placements is important because it helps people receive care closer to home, family and local support networks, which can improve experience of care and support recovery. It also reduces disruption for carers and helps services work more effectively together around the person. Performance has been strong during 2025/26, with BNSSG achieving plan on inappropriate out of area placements. This has been supported through continued focus on local bed management, earlier discharge planning, community-based alternatives to admission and close partnership working across health and care services.

In 2026/27, we will continue to work with partners to sustain this progress and reduce the need for people to be placed out of area wherever possible. This will include maintaining a focus on timely discharge, strengthening community support and neighbourhood-based models, and continuing to improve local pathways so that more people can receive the right care in the right place, at the right time. Our aim is that in line with national policy, we will eliminate the use of inappropriate out of area placements by March 2028.

Average Length of Stay in Adult Acute Beds

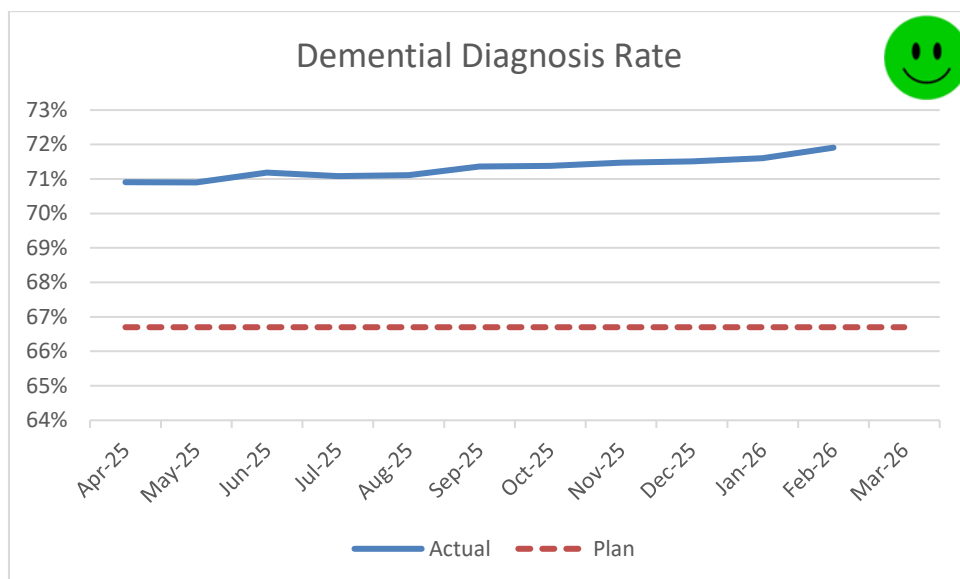
Graph with 25/26 actuals compared to Operational Plan:



Average length of stay in adult acute mental health beds improved during 2025/26 and achieved plan. Reducing length of stay is important because it helps people avoid spending longer than necessary in hospital and supports earlier return to home, family and community-based support when it is safe to do so. It also helps make sure inpatient beds are available for people who need them most. During the year, this has been supported through continued focus on discharge planning, improving flow through inpatient services and strengthening community alternatives and follow-up support. In 2026/27, we will continue to work with partners to build on this progress, with a focus on timely discharge, stronger community pathways and reducing avoidable delay in inpatient care.

Dementia Diagnosis Rate

Graph with actuals 25/26 compared to Operational Plan:



The Dementia Diagnosis Rate measures the proportion of people aged 65 and over who are estimated to have dementia and who have a recorded diagnosis. The national standard is 68%, and BNSSG has consistently exceeded this. This remains important to monitor because early diagnosis helps people access the care, treatment and support they need, and helps families and carers plan ahead. Although this target has a lower profile in current national planning than in previous years, we continue to track it locally as an important indicator of whether people are being identified and supported in a timely way.

Learning Disability and Autism – Overview of Last Year and Looking Ahead to 2026/27

In 2025/26, we have continued to work at a system level and in partnership with people with learning disabilities and autistic people. We have refreshed our priorities within the Population Health and Strategic Commissioning Plan 2026 to 2031. Our aim is for everyone with a learning disability and/or autism to live longer, healthier and happier lives. This means ensuring people are supported to have more choice, control and independence, while always being treated with dignity and respect. We believe it is important that these improvements are embedded through a rights-based approach, focused on citizenship and belonging. To support these aims, our key progress this year has been in service transformation to improve quality and reduce waiting times in our neurodiversity pathways, and in reducing avoidable admissions.

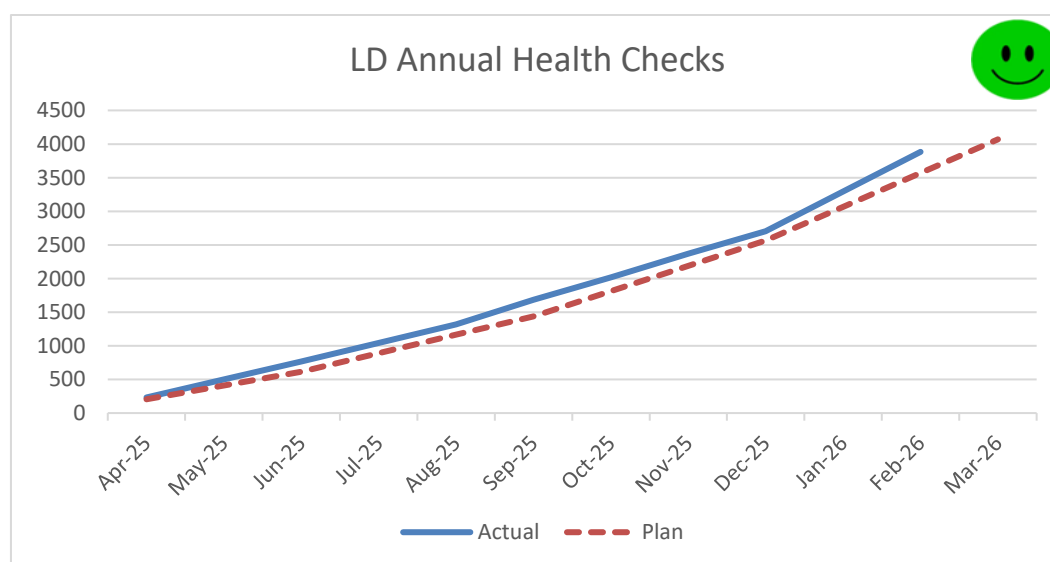
The table below shows our performance against core NHS Operational Plan targets for learning disability and autism. Achievement against each measure is assessed as either Green, Yellow or Red, with the reasons outlined.

Smiley Rationale:				
	Measure	Assessment	Reason	
	Learning Disability and Autism Annual Health Checks	Green	Plan Achieved	
	Reliance on inpatient care for adults with learning disabilities and autism	Red	Worse than 24/25 - plan not achieved	
	Reliance on inpatient care for children and young people with learning disabilities and autism	Green	Plan achieved	

Our performance against key areas for the year 2025/26 is set out in more detail below.

Learning Disability Annual Health Checks

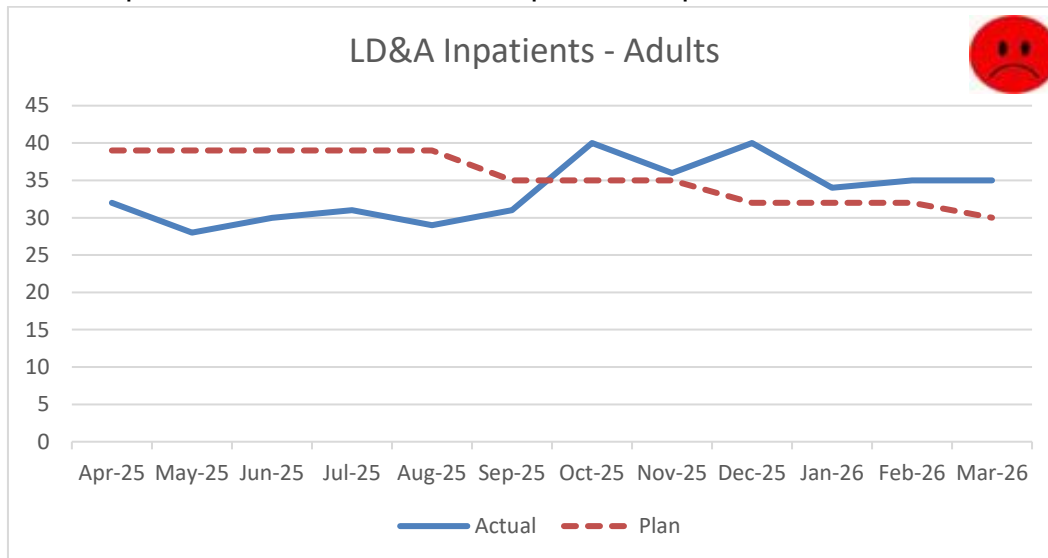
Graph with 2025/26 actuals compared to Operational Plan:



To support our aim of improving people's health, general practices keep a register of people with a learning disability and patients over 14 years of age are entitled to an annual health check (AHC). We met our national target and delivered above plan in every month. In 2026/27, this measure will expand to include health action plans.

Reliance on inpatient care for adults with learning disabilities and autism

Graph with 2025/26 actuals compared to Operational Plan:

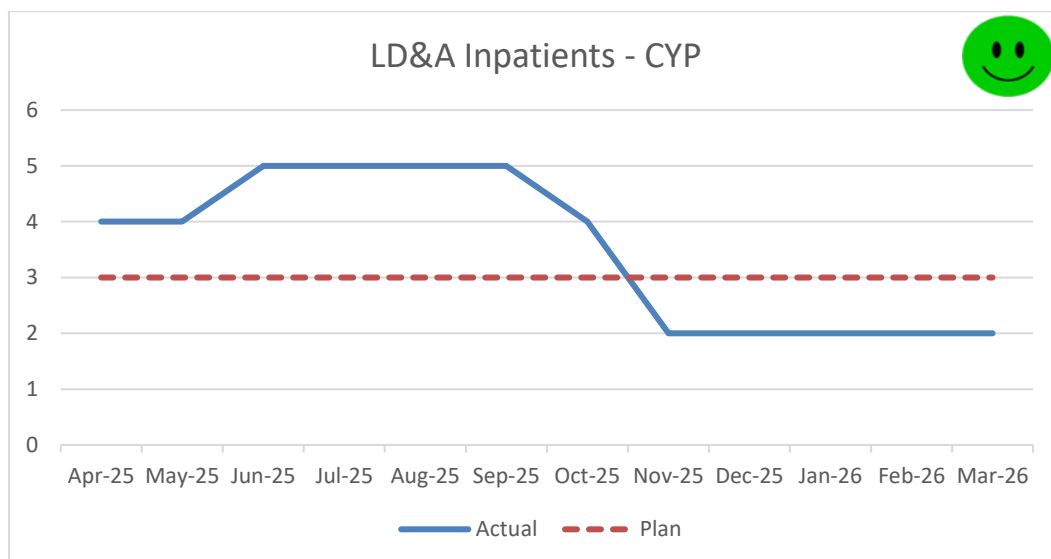


It is a national and local priority to reduce the reliance on inpatient care for adults with learning disabilities and/or autistic adults. Over the course of 2025/26, we did not meet the national target. We made good progress between April and September; however, during the year we saw an increasing number of adults with an autism diagnosis using mental health beds, which meant our performance improvement did not continue. As diagnosis rates continue to increase, we expect this to continue in 2026/27.

This will remain a priority area in 2026/27, and we are focused on supporting people with longer lengths of stay to be discharged back into the community, as well as preventing admissions of this type in the future.

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

Graph with 2025/26 actuals compared to Operational Plan:



In 2025/26, we met our performance target for children and young people using inpatient care, although it should be noted that, as the target is set at three admissions, the performance rate is very volatile. Admissions reduced in November, and we were able to maintain this position for the rest of the 2025/26 year.

This year we have invested in our keyworker team and are developing our Dynamic Support Register further to support greater admission avoidance in the future and help more children and young people remain in the community.

Voice and Influence

In 2025/26, we worked closely with people with lived experience and our parent carer forums across a number of programmes of work. This included the redesign of our strategic priorities and work on:

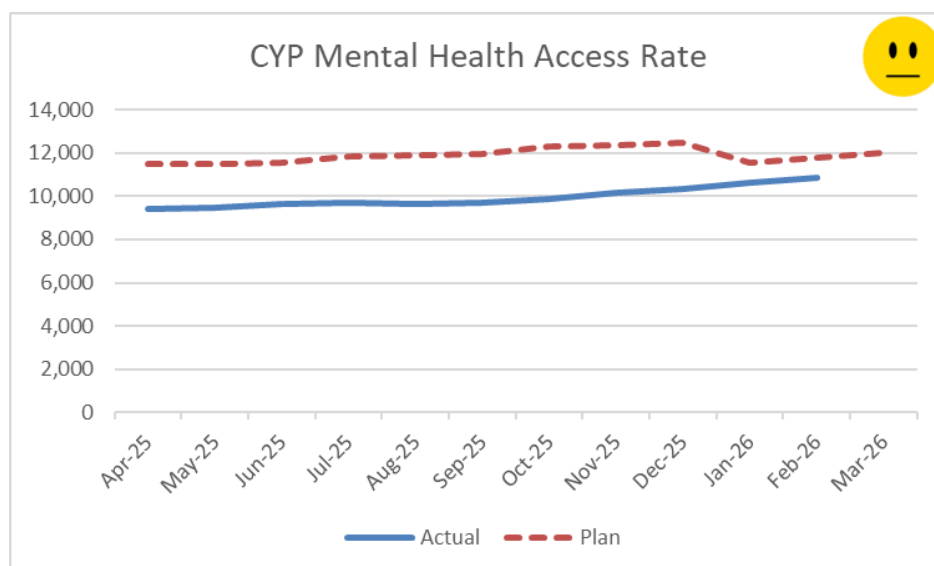
- The adult ADHD transformation project
- The children and young people (CYP) neurodiversity transformation project
- Our Care, Education and Treatment Review (CeTR) panels are largely made up of experts by experience.
- Our three parent carer forums provide engagement, insight and co-production to further develop support services for children and young people with special educational needs and disabilities.

25/26 Mental Health Expenditure

Financial Years	2024/25 £000	2025/26 £000
Mental Health Spend	202,052	233,545

ICB Programme Allocation	2,340,683	2,554,859
Mental Health Spend as a proportion of ICB Programme Allocation	8.63%	9.14%

Children and young people mental health access



Access to mental health support for children and young people continues to improve, with a sustained upward trend in the number of children and young people receiving support. However, BNSSG remains below the national access standard and improving timely access remains a system priority. Provider-led service improvement plans continue to drive performance and focus on improving productivity and reducing unwarranted variation.

Mental Health Support Teams (MHSTs) in schools continue to expand across BNSSG, increasing access to both individual and whole-school support. A consistent core MHST offer has been implemented, supported by

a communications campaign to improve awareness and increase appropriate referrals. Our expansion plan aims to achieve 77% MHST coverage by March 2027 and 100% coverage by December 2029, in line with national ambitions. The system-wide improvement plan continues for 2026/27 with renewed focus on productivity and efficiency, alongside an MHST transformation programme including the roll-out of self-referral and an integrated online and digital therapeutic offer to improve accessibility and acceptability for young people and their parents/carers. Work is also underway to resolve data variances between local providers and NHS England and to reduce unwarranted variation in access across BNSSG and for all groups of children, young people and their families.

Learning Disabilities Mortality Review (LeDeR)

LeDeR is a national service improvement programme commissioned by NHS England where the death of every adult with a learning disability and autistic people is reviewed.

LeDeR reviews the deaths of people with learning disabilities and autistic people in Bristol, North Somerset and South Gloucestershire. Everyone with a learning disability and/or diagnosis of autism aged 18 and over is eligible for a LeDeR review.

In Bristol, North Somerset and South Gloucestershire, recommendations following LeDeR reviews help us to make local improvements in the quality of health and social care for these groups of people. This may be by highlighting and sharing good practice or by demonstrating where improvements can be made to the care provided

Details of our programme can be found [here](#)

The seventh annual Learning from Lives and Deaths of people with a learning disability and/or autistic people (LeDeR) report will outline how Bristol, North Somerset and South Gloucestershire Integrated Care System (ICS) reviewed and learned from deaths occurring between April 2025 and March 2026. The BNSSG LeDeR annual report will be published later this year and will provide a comprehensive overview of activity across the reporting period. The LeDeR programme aims to reduce health inequalities, prevent premature mortality and improve the quality and safety of care.

Performance has continued to improve, with LeDeR reviews being completed in a timelier manner. This has supported the prompt sharing of learning and enabled quality improvement initiatives to progress more effectively. During the year, BNSSG ICS focused on improving understanding of deaths caused by aspiration pneumonia, with the aim of increasing uptake of the pneumococcal vaccine.

A detailed review of LeDeR cases involving aspiration pneumonia identified several key findings:

1. Most deaths occurred among individuals aged 50–69. Among younger people, particularly those in their 20s, deaths were more commonly associated with severe learning disabilities and genetic conditions. A higher proportion of deaths in younger age groups were also identified within global majority communities.
2. Many individuals had multiple co-morbidities and were subject to polypharmacy.
3. Carer burden was significant. Many carers had not received a carer's assessment, either because it was not offered or was declined. While individuals often received extensive multidisciplinary support, this was not always well co-ordinated or streamlined in a way that supported carers effectively.
4. Many people died in hospital. Reviews indicated that hospital admissions often occurred when individuals were already extremely unwell, limiting treatment options and resulting in death shortly after admission.

In 2026/27, the system will continue its focus on improving pneumococcal vaccine uptake among eligible people who have a learning disability. The Integrated Care Board (ICB) is also working with general practice to increase the number of people on the learning disability register who receive an annual health check. In addition, an audit of the quality of annual health checks will be undertaken.

Significant challenges remain, particularly due to organisational restructuring across BNSSG. However, the ICS continues to demonstrate a strong commitment to continuous improvement and to reducing health inequalities for people with learning disabilities and autistic people.

Community Services

Integrated Community Services

During 2025/26, Bristol, North Somerset and South Gloucestershire ICB continued to invest in integrated community services through the Better Care Fund, recognising their central role in supporting people to live independently and remain well at home. Across all three local authority areas, the focus was on strengthening joined-up working between NHS community services, local authorities and the voluntary, community and social enterprise sector to deliver more coordinated, preventative and person-centred care. This approach supported the reduction of avoidable hospital admissions and helped ensure timely and safe discharge from hospital.

Significant progress was made in developing integrated, place-based models of care that respond to local population needs. Better Care Fund investment enabled closer alignment of urgent community response, NHS@Home, intermediate care, reablement and community rehabilitation services, supported by multidisciplinary teams and shared decision-making. These arrangements improved access to rapid community-based support, expanded alternatives to hospital care and ensured that people received the right care, in the right place, at the right time.

Integrated community services also played a vital role in supporting system flow throughout 2024/25. Better Care Fund-funded services underpinned Delivery of Discharge to Assess pathways and step-down care, enabling health and social care partners to work together to manage demand and plan safe onward care. Alongside capacity, targeted service improvements strengthened assessment processes and enhanced collaboration between acute and community services, improving outcomes for people with frailty and reducing reliance on long-term residential and nursing care.

Delivery of integrated community services was supported by strong joint governance between the ICB and all three local authorities, aligned with Health and Wellbeing Board priorities and wider system objectives. Together, these actions demonstrate how integrated community services remain a core enabler of the ICB's ambition to deliver more coordinated, preventative and sustainable care closer to people's homes.

NHS Adult Community Services

During 2025/26, Sirona continued to deliver a wide range of community health services that play a critical role in supporting people to live independently, reducing pressure on acute services, and improving population health across the system.

Adult community services, including community nursing and rehabilitation, continued to support timely discharge from hospital and helped people manage long-term conditions closer to home. Sirona demonstrated a sustained focus on maintaining service continuity while responding to ongoing demand pressures, particularly for services supporting frail older people and those with complex needs. Progress against agreed improvement actions was routinely monitored through commissioner oversight.

Sirona's specialist community services, including musculoskeletal (MSK) pathways, physiotherapy and community-based outpatient services, supported earlier intervention and improved access to care outside of hospital settings. Work has continued throughout the year to align services

with integrated care pathways and to support system-wide transformation ambitions.

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

The all-age Funded Care team continues to assess individuals with complex care and support needs against the national all age continuing care and legal frameworks. This reflects individuals that can be high risk and high costs in the system and so a strong governed approach is needed.

This year the team have embedded revised governances and processes in the eligibility, review and commissioning process. The team continue to work with colleagues outside of our system to critique decision making to ensure an equitable approach is embedded in our work.

Continuing Health Care (CHC) Performance against national KPI's is improving and is near recovered. BNSSG has been identified as a high performer in relation to offering a Personal Health Budgets to individuals in receipt of NHS funded care. The ambition of the team to refine this further is high and as BNSSG migrate to a cluster model with Gloucestershire, further analysis will be undertaken to explore how we can continue to improve this offer to people.

Work is ongoing to identify how clinically trained staff are able to focus on elements of the service where they add most value. Using learning from the Calderdale framework, internal processes have been revised and continue to be tested to release clinical time for assessment and reviews.

Working with Local Authority colleagues, the ICB is testing how we undertake our shared responsibility for people eligible for S117 aftercare. S117 relates to individuals who have been admitted to hospital under the Mental Health Act and S117 aftercare is designed to support people to stay well in the community and avoid readmission. This work will continue in 26/27 with an aim to developing an agreed system-wide protocol to this cohort.

Children, young people and their families remain a priority for BNSSG, and the keyworker team have had a busy year. An expanding team they are working with families to support young children stay well in the community.

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

General Practice

In 25/26 the ICB has continued to work collaboratively with Avon Local Medical Committee (LMC), our GP Federation (One Care), the GP Collaborative Board and system partners to implement changes in response to GP Collective Action.

Further contract changes were introduced in October 2025 and the ICB has continued significant work to support practices in delivery of the contract as well as monitoring and providing assurance to NHSE.

The ICB has worked hard to continue to improve contract management, including processes and contract administration for example; partnership variations and national variations, Local Enhanced Services contractual arrangements, merger paperwork and boundary change paperwork.

25/26 has also seen a considerable amount of work for the ICB with procurement activity in terms of volume and ensuring the framework for procuring healthcare services is followed. This has led to a number of successful contract awards and mobilisations.

Our practices and PCNs have continued to work hard to improve access for our patients. The ICB has worked with PCNs to ensure they use their full Additional Roles Allocation to grow their workforce to support increased demand.

The ICB has supported all of our PCNs with 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 6.27% more appointments in 2025/26 compared to 2024/25 and above the Operational Plan target. This included:

- 40% of appointments same day, for those who are clinically appropriate, consistently maintained from previous years
- Percentage of GP appointments seen within 2 weeks remains around 80%, higher than the SW average of 77%
- Percentage of appointments delivered face to face remains consistently around 62% with an increase in online consultations

This increase in appointments reflects the demand in general practice rather than an increased workforce. Practices remain 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
- NHS app sign up has increased to 73% (from 62%) of the population with 41% having notifications on and 26% of messages now being sent through the NHS app. Estimated monthly savings are over £10,000 per month. NHS App sessions continue to be held by practices and community groups to support digital inclusion.
- Recruitment of 3 VCSE organisations to support digital inclusion (one for each locality)
- 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 continue to support delivering these improvements in access, resilience and quality across BNSSG. This intensive program looks 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. This work, alongside the ICB, has continued to support practice sustainability and a number of practices to achieve good CQC ratings, particularly where they have previously been rated requires improvement or inadequate.

The Training Hub continue to be vital in supporting recruitment and retention initiatives in general practice. Initiatives have been developed and implemented to support Practice and PCN Management Development and Strategic Workforce Planning Support.

The Newly Qualified GP and New to Practice Nurse Programme continues to be a success :

- Provided the CPD funding

- Supported 46 GPs, 15 Nurses, and 7 Nursing Associates in 25-26.
- Supported 15 members of staff working in permanent roles in practices in areas of deprivation to transition from training to independent practice and to develop fulfilling and sustainable careers, thus supporting the recruitment and retention of GPs and Nurses caring for underserved communities.

Community Pharmacy

The Pharmacy First service continues to be a success and expand, averaging 13,000 referrals a month. December reached the highest number of 15,587 referrals a month. BNSSG is the highest performing ICB in the country, with over 100,000 patients.

The extension of Pharmacy First Minor illness saw the most common conditions being Sore Throat, Ear problems, Skin, UTI, Cough. 2412 consultations took place from April 2025 to February 2026, with 2402 being face to face. 167 patients provided feedback with 99% strongly recommended and would use the service again.

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 (BP) checks and contraception services. The New Medicines Supply Service plus for hypertension pilot is now in place to increase medicines adherence in areas where patients are not reaching BP targets. 1102 consultations undertaken since September 25. In October community pharmacies also started to supply emergency hormonal contraception nationally commissioned.

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 saw 3 sites go live for minor ailments, This is being shown to enable more conditions to be completed by a Pharmacist rather than escalating to GP/111/UEC, supporting the system and improving the patient journey.

We have enabled capability in our digital system so referrals can be made in an efficient way which helps 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 and we are working with 111 to increase the number of referrals from 111 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.

Dentistry

A significant amount of work and progress has continued to improve access to NHS dental services for BNSSG and deliver the dental strategy. Working with stakeholders across local authorities, primary, community and secondary dental services, the Bristol Dental School and NHS England focusing on 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 has included work in the following areas:

Oral Health Improvement

First Dental Steps - This programme distributes oral health packs to every parent at their baby's 12-month health visitor check. The programme ensures health visitors have the necessary training, can offer advice and guidance to parents and are knowledgeable about referral criteria's and local pathways..

Supervised Toothbrushing (STB) - The purpose of the scheme is to enable children in early years education settings to brush their teeth with fluoride toothpaste each day they attend under supervision from staff. The STB provider supports each setting with the programme, provides toothbrushing packs to the students, gain consent from parents, provides staff training and quality assurance checks. They also support with engaging parents and provide off site advice and guidance. The scheme is aimed at settings in IMD 1-6 as well as additional vulnerable groups. The ICB is working closely with Local Authority to identify appropriate settings. At Month 9, there are 14,333 children brushing against target of 16,000 (on course to deliver 100%). With contributions from Local Authorities, we aim to expand this scheme to more schools and settings..

Increasing access

Stabilisation - We have 10 stabilisation providers (offering 21 sessions) across BNSSG; practices provide dedicated sessions to stabilise the oral health of patients without a dental home. The providers have been prioritised In IMD 1-5.

Children in Care – this pilot was launched in June 2024 across two high street dental practices, providing dedicated sessions for Children in Care. An evaluation of the service showed that as few as 39 children attended these sessions in 2024/25. Findings showed that a number of patients already had family practice or the distance was too far to travel. We have worked with Sirona to ensure that Health Visitors are informed of the service and referral routes. Paediatric Managed Clinical Network have developed a specification for Child Friendly Dental Practice; subject to approval, we aim to replace this service to encompass more vulnerable cohorts to ensure better utilisation of the slots. We aim to make this service open to Care Leavers

CASP – The purpose of the Cancer Action Support Service is to give Head And Neck Cancer patients a dental home for routine dentistry, preventative care and ongoing cancer surveillance. Following invites for expressions of interest, we will be selecting a dental practice to offer three sessions a week to this patient cohort.

Workforce

A workforce working group has been set up to look at data and understand workforce issues; membership includes Bristol Dental School and NHSE Workforce & Training Education.

The Golden Hello recruitment incentive scheme (offering new dentists £20,000 to stay in the area), has been relaunched; there are 8 handshakes across the area.

We have 11 dental foundation practices and have offered additional investment to maintain this vital training.

A careers event is planned with King's Trust to encourage young people to take up career in dentistry

Communications

A communications working group has been set up; key workstreams include messaging & promotion of urgent care appointments and setting up a newsletter with our providers.

Eye Care

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.

Our BNSSG Eye Care Delivery Board continues to meet monthly, working in partnership with Avon Local Optical Committee (LOC) along with primary and secondary care. This is helping us review current provision and strategically plan for and monitor delivery of prioritised areas including the following pathways:

- Cataract pre-referral checks
- Cataract Post-Operative
- Glaucoma

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

The Integrated Care Board (ICB) is accountable for delivering the statutory functions for safeguarding children under section 11 of the Children Act 2004 and the statutory functions for safeguarding adults under chapter 14 of the Care Act 2014. In addition to this, the ICB also has a duty to cooperate with and support the local authority who are corporate parents to the children in care under our local authorities. The statutory frameworks recognise that 'Safeguarding Is Everybody's Business' and the ICB is noted as a statutory partner within these. Therefore, the ICB is responsible for ensuring that safeguarding principles are embedded across the workforce and within all workstreams it has responsibility for, as well as having oversight across the whole health economy. All staff employed by the ICB also have a role in raising awareness of safeguarding concerns and connecting with the safeguarding team for advice when required. This is all underpinned in the [NHS England » Safeguarding children, young people and adults at risk in the NHS](#). The ICB works across three local authority areas who have all developed joint strategic needs assessments. Consequently, the joint forward plan does take into account the health and wellbeing needs of all children, adults, families and communities and highlights safeguarding priorities relevant for the population in which it serves. By contributing to the strategic plans of the safeguarding partnerships, using the Joint Strategic Needs Assessment and other safeguarding information and data will bring system partners together to improve the outcomes in population health. Particularly with the use of campaigns, to raise awareness of such safeguarding issues, we aim to prevent harm to children, young people, adults and communities.

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 and Care Leavers (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 2026 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 \(southglos.gov.uk\)](#)

The ICB Safeguarding Team have spent some dedicated in this financial year reviewing, updating and streamlining the suite of safeguarding policies. These have included separate Safeguarding Children, Safeguarding Adults, Children in care and Care Leaver policies, a Prevent Policy and a Mental Capacity Act and Deprivation of Liberty Safeguards Policy. Lastly, the team collaborated with the People Team to publish a Supporting Staff experiencing domestic abuse policy with a practice guide attached.

In addition to working internally, the team have continued to discharge the organisation's statutory safeguarding duties by proactively and positively engaging and contributing to all statutory safeguarding reviews and offering support to partnership work including audits, sub groups and practice guidance.

As an example, in Quarter 1 the ICB Safeguarding Team were involved in two Rapid Reviews; one of these related to the death of a baby who died following a teenage mother giving birth at home. The mother reported not knowing she was pregnant, however there were concerns during the panel meeting that this was a concealed pregnancy. A number of recommendations were supported as a result including the need to the Safeguarding Partnership to work with Public Health to promote the new sexual health service which had launched in the last year.

In Quarter 2, the ICB Safeguarding team supported a mock inspection focused on the Care Leaver Offer in North Somerset which was undertaken

by Mark Riddell, a National Implementation Advisor for Care Leavers. Insights and information was provided both from a strategic and operational perspective.

During Quarter 3 a Quality Assurance Audit in South Gloucestershire took place focused on repeated Self-Neglect referrals for adults. The headline findings from this audit were that multi agency professional's meetings should be used to identify clear pathways of escalation. Making Safeguarding Personal (MSP) and the voice of adults need to be clearer in assessments and referrals. In addition, it was also found that the use of mental capacity in assessments, advocacy service/IMCA consideration in multi disciplinary meetings as well as consideration of Carer stress was not always routinely considered. The ICB Safeguarding Team have taken a number of steps to share this learning with GP Practices through learning briefs, GP Link meetings, a bitesize webinar focussed on Mental Capacity Act which was very well attended and received extremely well.

During 2025-26, the ICB Safeguarding Team also commissioned, through the Research team, an evaluation of the Bristol Adult MASH in order to support next steps following a 12month pilot. The outcome of this evaluation was met with a positive response to the business case. AWP, as our commissioned mental health Trust, are now acting as the 'Health' representative in this process, working collaboratively with the other health partners. This project was also nominated under the 'Working in Partnership' category for the NHS Excellence Awards.

In addition to the above, 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 2025-26 for a whole day.

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 were reviewed in 2024-2025c and

further iterations were made for 2026-27.

As per SAAF guidance (updated in 2026) 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 BNSSG 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

Whilst children in care and care leavers feature within all aspects of the ICB Safeguarding Team work, there are some wider health promotion elements highlighted within statutory requirements that relate to the ICB duties as Corporate Parent and our role in promoting the health and wellbeing for children in care and care leavers.

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. Whilst many improvements have been made over the past year, some have sadly not been sustainable for a variety of reasons, so system partners continue to work together, looking not only to other areas for ways to address these challenges, but also exploring creative local options to sustainably achieve improvements for the future. It

is of note that many areas across the country also experience this challenge.

Specialist dental provision for children in care, and free prescriptions for care leavers remains a core part of the local health offer. The dental commissioning team have recently reviewed the provision and suggested improvements that will enhance the offer further and extend to include care leavers. In December 2025, the Government announced an offer for all care leavers to have free prescriptions, dental and eye care. Whilst no specifics for roll-out have been provided at this time, the ICB Safeguarding Team continue to be alert for any updates. System partners also continue to work 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.

Finally, substantial system work has begun over the past year to improve oversight and offer of timely support for children in care and care leavers who require additional healthcare relating to mental health and wellbeing. Initial areas of focus within this longer-term workplan have been aimed at understanding the needs of our children in our care who live out of area, alongside exploration of extending the health offer beyond 18 years to create a softer health transition into early adulthood.

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 Assurance 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 Control Management

Local leadership continues to be key in successful management of infection control. 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.

Pulmonary Tuberculosis (TB) There have been multiple outbreaks of TB

within BNSSG during 2025/26: Three (3) Haven staff were screened in July 2025 following an outbreak in an asylum hotel. A school screening event took place in September 2025 in the new term at Fishponds, with 40 individuals tested. Contract tracing commenced in September 2025 with prisoners, prison staff, healthcare staff working in the prison and Southmead staff following a death in custody at HMP Bristol. Contract tracing commenced in November 2025 following a symptomatic health care staff member having treatment administered with 15 staff at AWP Fromeside Ward receiving an invitation to screen.

During May 2025, BNSSG were an exemplar for the South West region at the National Tuberculosis Review England: TB Implementation Framework: and were successful with partner association colleagues in giving system feedback to Getting It Right First Time (GIRFT) colleagues.

Later during 2025, BNSSG TB Strategy Group initiated a TB find and treat task and finish group to explore the feasibility of a mobile community based mobile health unit (van) from UCLH London for a Bristol based screening event (chest x-ray) looking for active TB in the BNSSG population to minimise the risk of late diagnosis of TB to be held on the 24th & 25th February 2026. This was co-developed with system partner organisations. A post event debrief learning meeting is being organised for Q1 2026/27.

Invasive Pneumococcal Disease A *Streptococcus pneumoniae* cluster was reported at a South Gloucestershire care home in June 2025 and the GP/practice nursing staff vaccinated the residents on this occasion. Another cluster was reported in a care home setting in North Somerset in December 2025 following the unfortunate deaths of two (2) residents on separate floors within a 60 bedded home. Residents and high-risk staff were administered doses of a novel vaccine with support from the vaccination outreach team and antibiotics. A debrief is being planned in early 2026 for learning purposes.

Health Care Associated Infections (HCAI)

BNSSG HCAIs did not meet the BNSSG HCAI threshold levels for 2025/26. Between 1st April 2025 and 31st March 2026;

There were 336 cases of *Clostridioides difficile* Infection (CDI) assigned to the ICB. The NHS England set threshold is 292 cases. There were 348 cases reported in 2024/25. New infection continued to be the main categorisation. A systemwide CDI community-onset case review continued until the end of the period. A BNSSG CDI driver diagram is in place, with improvement initiatives ongoing such as bi-monthly COHA case learning meetings.

During the same period, there were 730 cases of *E. coli* bacteraemia cases

assigned to the ICB. The NHS England set threshold is 551 and the number of cases reported showed an increase in cases in comparison with the previous years (659 cases in 2024/25). The majority of the cases continued to be community onset. There were 208 cases of Klebsiella spp against an ICB threshold of 167 (184 cases in 2024/25). A systemwide Urinary Tract Infection working group continues to work across the system in the reduction of gram negative bacteraemia's including antibiotic stewardship for urinary tract infections, catheter care and hydration.

There were 32 cases of Methicillin Resistant Staphylococcus aureus (MRSA) bacteraemia cases assigned to the ICB meaning we did not meet the standard of zero. The number of cases reported showed a decrease in cases in comparison with the previous years'; 43 cases in 2024/25; an increase from previous years. A MRSA/Skin and Soft Tissue Infection (SSTI) task and finish group with sub-group formation has been created in early 2026 to focus on infection reduction strategies for the BNSSG population at risk.

There were 230 cases of Methicillin-Sensitive Staphylococcus aureus (MSSA) cases compared to 2024/25 with 217 cases reported cases. The ICB is collaborating with a regional improvement group.

There were 87 assigned cases of Pseudomonas Aeruginosa bacteraemia against an ICB threshold of 56 (65 cases in 2024/25).

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.

The Patient Safety Team continue to support system partners to embed the NHS Patient Safety Strategy NHS England » The NHS Patient Safety Strategy . The ICBs role in patient safety includes providing mechanisms for system-wide oversight of patient safety events, enabling cross-system risks and trends to be identified and understood. This includes fostering a just culture of kindness and civility, facilitating cross-system learning through patient safety networks and sharing best practice and coordinating responses to national safety concerns.

In this pivotal role the Patient Safety Team has consolidated system-wide patient safety governance to ensure risks and trends are clearly understood and that a collaborative, learning culture is consistently promoted. Key achievements include:

- Establishing a System Learning Panel, providing a structured forum to share learning across organisations within the BNSSG footprint. The panel aligns with the NHS Patient Safety Strategy and brings together themes and trends from patient safety incident investigations, Coroner Prevention of Future Death reports, Mental Health Homicides reviews, and national patient safety reviews. This supports a more holistic, system-level understanding of risk and learning.
- Working with system-wide Patient Safety Specialist to create a Cross-Organisational Memorandum of Understanding. This sets out shared principles for managing patient safety events that span more than one organisation and require collaborative working across providers. The approach supports the production of a more comprehensive account of events for patients, families and loved ones, and shared resources to support providers who may be new to aligning with PSIRF methodology.
- Collaborating with Primary Care colleagues to support the adoption of the NHS Primary Care Patient Safety Strategy in a proportionate, practical and meaningful way.
- Undertaking quality visits to a care home, dental practice and a mental health facility to gain assurance that services are safe and to agree any required improvements.
- Using the ICB Quality Management System escalation process, where appropriate, to respond to patient safety concerns
- Developing a BNSSG Patient Safety Incident Reporting Framework, with implementation currently paused pending confirmation of restructuring arrangements.

Patient Experience

During 2025/26, 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 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 25/26 the ICB received 925 contacts, 668 General Enquiries, 213 formal complaints, 10 Compliments and 34 MP/Councillor enquiries. In Q1 1 complaint to the Parliamentary and Health Service Ombudsman was outstanding from 2024/25

During quarter two of 25/26 the ICB received 1162 contacts, 760 General Enquiries, 328 formal complaints, 25 compliments and 51 MP/Councillor. 1 complaint were reported to the Parliamentary and Health Service Ombudsman.

During quarter three of 25/26 the ICB received 879 contacts, 525 General Enquiries, 287 formal complaints, 21 compliments and 46 MP/Councillor complaints. 1 complaint were reported to the Parliamentary and Health Service Ombudsman.

During quarter four of 25/26 the ICB received 903 contacts, 556 General Enquiries, 271 formal complaints, 15 compliments and 38 MP/Councillor complaints 0 complaints 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 experienced a significant increase in contacts regarding access to ADHD/Autism assessments along with access to weight loss treatments during 2025/26.
- 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

2024/25 marked a step-change in how the BNSSG system works with the VCSE sector, moving from engagement to embedded partnership, with tangible improvements in inclusion, investment and delivery.

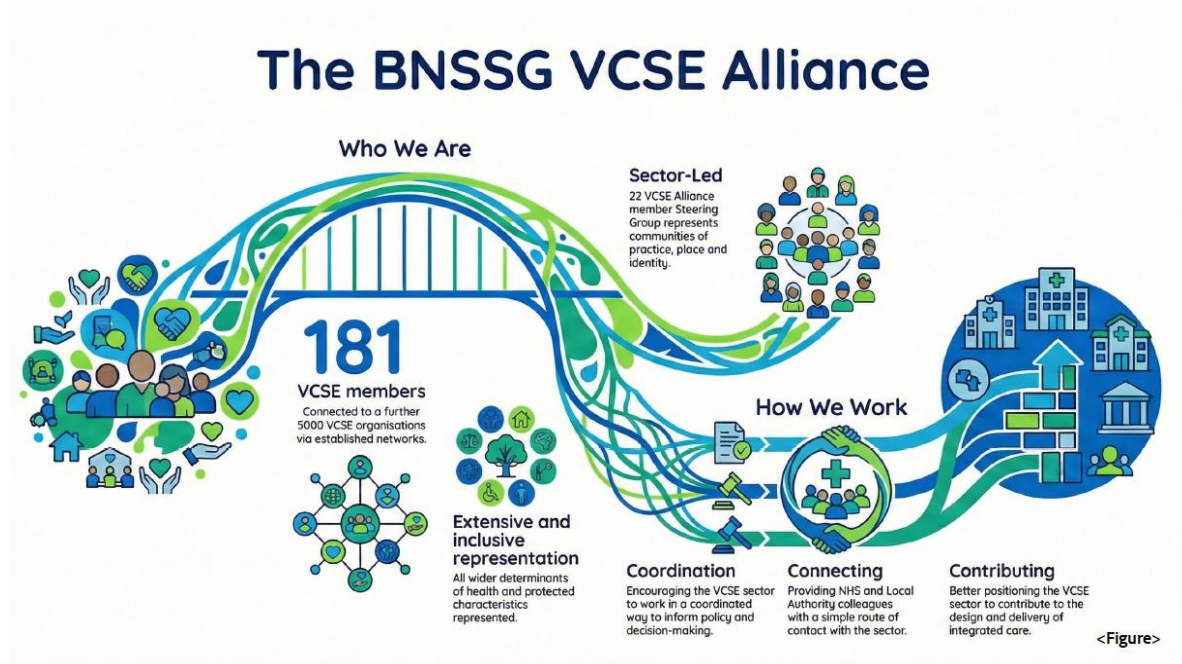
Our collaborative approach is underpinned by the BNSSG VCSE Vision, which establishes VCSE organisations as co-creators at the heart of system culture, planning, decision-making and delivery, supported by a clear framework for action to enable meaningful contribution to population health.

VCSE Vision: Our vision is a system where health creation and equity emerge from trusted, inclusive partnerships, where VCSE organisations are valued as co-creators of a healthier, fairer future and are at the heart of everything we do – from culture, planning and decision-making to delivery, learning, innovation and improvement.

Stronger partnerships and system integration

The VCSE Alliance has matured into core system infrastructure, enabling

coordinated leadership, wider engagement and active VCSE participation in governance, strategy and programme design. VCSE Ambassadors are increasingly embedded across the system, strengthening community voice and influence – providing diversity of thinking and community perspectives across BNSSG.



VCSE Brokerage – inclusive commissioning and innovation

The VCSE Brokerage Framework has demonstrated a new, inclusive and proportionate route to market, enabling diverse VCSE organisations—particularly smaller, community-led groups—to deliver neighbourhood-based health and wellbeing activity. Over £2.1m was invested across nine programmes.

- 177 VCSE organisations engaged and quality assured
- 94 proposals generated with 40 awards made
- 95% of awards issued as grants, enabling flexible, community delivery
- 65% of funded organisations new to ICB/NHS funding, significantly widening market access
- Strong reach into underserved communities, including hyperlocal organisations

The model has also improved system efficiency, combining multiple funding streams and reducing administrative burden for commissioners and providers.

Capacity building and market development

The Brokerage approach has strengthened VCSE capability and generated

valuable insight into market readiness, informing future strategic commissioning and targeted capacity-building support for the sector.

Culture change and community impact

There is clear evidence of growing trust, collaboration and co-production, with VCSE organisations increasingly recognised as equal partners. The system is adopting more proportionate, 'grant-first' approaches, enabling innovation and accessibility. VCSE-led activity is contributing to key priorities including health inequalities, mental health, employment and community wellbeing, with strong reach into underserved populations and increasing influence on neighbourhood health planning.

Through our work together, we are creating the means for diverse VCSE organisations to deliver in communities and neighbourhoods. The foundations are now in place for a more equitable, community-powered health and care system, with VCSE organisations playing a central role in tackling inequalities and improving outcomes.

Community and Public Engagement

Engagement and involvement are central to how the ICB develops priorities, improves services and demonstrates accountability to the communities we serve. Over the year, we have focused on inclusive, accessible approaches that value lived experience alongside clinical and operational expertise, and that support meaningful participation from people who are most affected by the decisions we take.

Below are a few examples of how we have engaged with patients, carers, partners, staff and wider stakeholders to shape our plans and commissioning intentions. We continue to use a blend of co-production, targeted outreach and structured feedback to ensure a breadth of perspectives.

Case studies

Children's community health services

During 2025–26, the ICB undertook an extensive programme of engagement to develop a shared vision and ambition for children's community health services. The approach prioritised co-production with children and young people and brought together lived experience, professional insight and system-wide evidence to shape future commissioning intentions. Engagement methods were designed to reach a diverse range of voices.

Children and young people were at the centre of the engagement, with a dedicated co-production steering group and seven engagement events delivered across the three local authority areas, involving 75 children and young people. This work was further complemented by:

- Targeted work delivered by 21 voluntary and community sector partners, engaging around 200 children and young people and over 150 parents,

families and carers. This specific element of our approach has been recognised as an example of best practice by the Royal College of Paediatrics and Child Health.

- Insight gathered by the BNSSG Parent Carer Forums through their annual health survey, which received feedback from more than 550 parents and carers of children and young people with special educational needs and disabilities.
- Insight from professionals working within and alongside children's community health services. A cross-sector survey engaged 101 professionals.

All engagement activity informed the development of a shared Theory of Change, which sets out the outcomes, behaviours and system conditions needed to translate the co-produced vision and ambitions into practice.

Summer and winter wellbeing: Seasonal 'Stay Well' behaviour change campaigns

Our seasonal 'Stay Well' behaviour change campaigns support people to take simple steps to maintain their health and wellbeing throughout the year, while also helping to manage demand on busy local services.

The campaigns are produced and promoted in partnership with local health, care, community and voluntary sector organisations and feature local people and places across Bristol, North Somerset and South Gloucestershire.

Stay Well This Summer

Our Stay Well This Summer campaign promoted sun safety and hydration, with a particular focus on more vulnerable older adults. We produced 'vox pop' social media videos with local people in Bristol -- including parents of young children, teenagers and people who work outdoors -- discussing how they stay safe in the sun. We also worked with a care home in South Gloucestershire to produce a social media video encouraging older adults and those who care for them, to stay hydrated. The video featured residents from the home and was one of our best performing social media assets that summer.



Stay Well This Winter

Winter brings a range of extra health challenges for vulnerable groups and our Stay Well This Winter campaign provided practical advice and guidance to help people protect themselves from illness and avoid hospital admissions. Priority behaviours promoted in the campaign included taking up vaccinations, staying active, eating well, tackling mental health worries and keeping warm at home.

Campaign content was designed to be authentic and relatable, in order to generate engagement and shares on social media, and featured real people from across BNSSG. As well as local health and care professionals, the campaign also featured professionals and volunteers at a local Citizens Advice office, Age UK and sporting charity Wesport.

Information was delivered through a range of accessible and engaging videos hosted on an online 'hub' on the Healthier Together website, together with links and signposting to local services.

The campaign was promoted on our social media channels and through on-site display materials and owned channels such as partner newsletters and websites. It also featured in local PR and this year, we again partnered with the Bristol Hippodrome to arrange a media photo call with the annual Panto cast and local community pharmacist Ade Williams MBE (see below).



Evaluation metrics for this year's campaign included:

- Over 1 million social media impressions (opportunities to see the campaign) across BNSSG
- 3,500 website hits
- Five media stories over the course of the campaign
- Promotion of the campaign toolkit across partner channels including waiting rooms, websites, newsletters and social media

'Feeling mixed up?': Improving access to mental health support for young people

During Autumn 2025 we launched a new campaign to improve mental health support access rates among local young people, focused on a new NHS service being made available in BNSSG (Northpoint/Silvercloud).

Silvercloud offers evidence-based programmes for low mood and anxiety grounded in cognitive behavioural therapy and complements our wider wellbeing support offer for children and young people. The 'Feeling mixed up' campaign aimed to raise awareness of the availability of Silvercloud and encourage young people to consider using it as a free, NHS service, accessible at any time, in confidence, and without requiring a formal diagnosis.

The campaign was delivered via highly targeted social media advertising and generated 900,000 opportunities to see and over 5,000 click-throughs to the service web site. It was also promoted in schools and education settings, in partnership with local authorities and multi-academy trusts.



Developing a new Neurodiversity Hub for Bristol, North Somerset and South Gloucestershire

During 2025/26, system partners approved the mobilisation of a new model of care for neurodivergent children and young people in the Bristol, North Somerset and South Gloucestershire area. This represents the culmination of several years of engagement, co-production and co-design with local parent carers, our parent carer forums, system partners and health, education and care stakeholders.

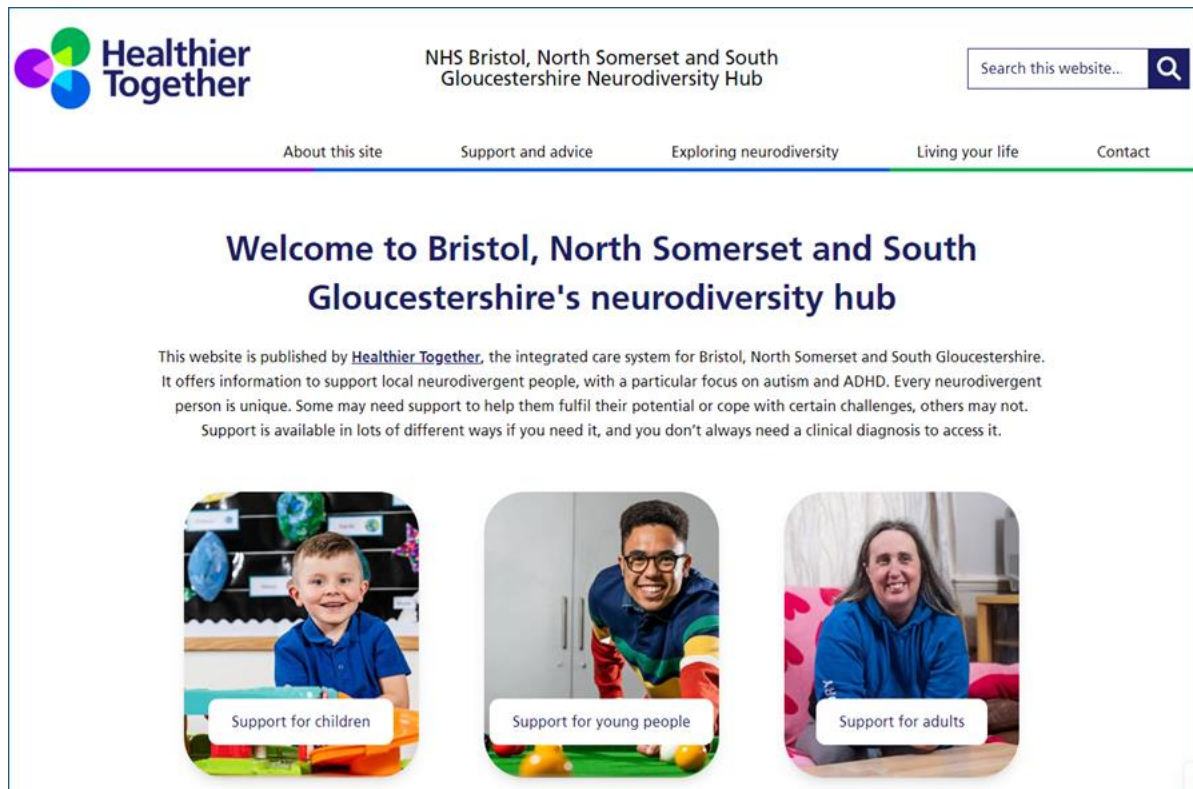
Encouraging access to universally available support and advice is a key element of the new model and to support this, we worked with the local partners to produce a new, neurodiversity information and advice hub for the BNSSG area.

The Neurodiversity Hub was developed at pace during autumn 2025 and launched during December as a standalone website maintained by the ICB's communications team on behalf of Healthier Together.

The Hub aims to promote greater understanding of neurodiversity, while

providing links to useful information, support and advice. It is suitable for parent carers, young people and adults, as well as professionals who work with people who are neurodivergent.

The Hub is designed to be a shared resource for our whole system, and we continue to work with local partners to add new links and resources as well as personal stories from local people with lived experience of neurodivergence.



Medicines Waste Campaign

In summer 2025 the ICB ran a campaign encouraging people to order only what they need, helping to cut medicines waste across Bristol, North Somerset and South Gloucestershire. Campaign materials were displayed in pharmacies and GP practices and wider health settings supported by paid advertising across social media, local publications and digital audio (podcasts, digital radio). A dedicated webpage also set out practical steps people can take to reduce medicines waste.

Analysis indicates a clear reduction in prescription orders during the campaign period, delivering estimated savings of around £150,000.

Urgent dental care promotion

During the year we have delivered communications activities to raise awareness of urgent dental care across Bristol, North Somerset and South Gloucestershire. This included promoting key messages about how to access urgent appointments through local NHS practices and NHS 111, following confirmation of additional urgent capacity in the area.

We shared information through a press release, stakeholder briefings and social media, helping ensure residents know how and where to seek care when experiencing dental pain or infection. This activity contributed to improved awareness of available urgent appointments and how to access them.

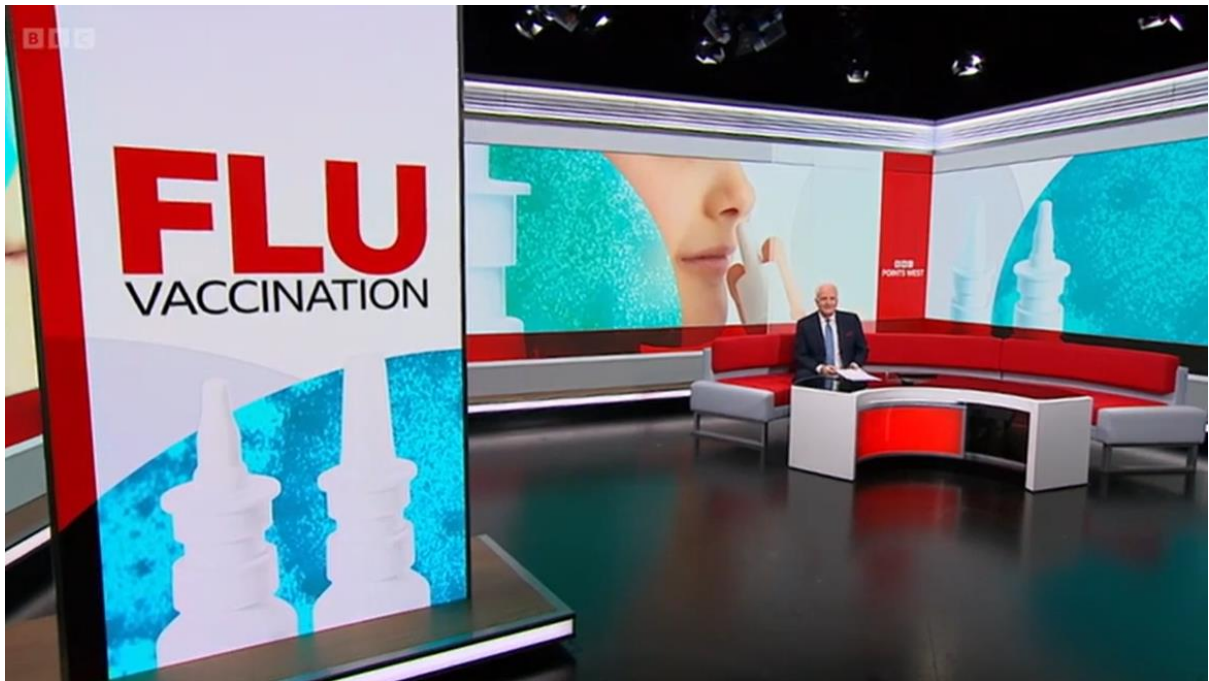
Flu vaccination outreach

Engaging with our varied communities and co-producing local materials was key to success in exceeding this year's national flu figures (54%) with over 350,000 individuals being flu vaccinated across BNSSG (60%).

Building on previous flu season learnings and putting inequality at the heart of our work meant involving more partners in different ways so we launched an innovative Community Paid Partnerships model which saw a dozen organisations sign up.

These ranged from a refugee women's group to a city farm, dementia charity, and two community radio stations. Taking imagery, languages and cultural norms into account these groups acted as our ambassadors for sharing flu messages. They reached right into the heart of their communities in many ways including Whatsapp messages to members, newsletters, posters and by hosting talks which led to pop-up vaccination clinics.

Our engagement extended further to local health organisations like Bristol Inner City's GP practices who engaged with patients directly and the local UKHSA team who produced a joint flu film and case study with us, also achieving regional TV news coverage.



Other examples of our flu engagement included a community flu film featuring well-known local faces which recorded over 33,000 views on YouTube and a young person's city charity which delivered 2,000 flu leaflets in different languages including Somali, Arabic and Bengali.



Get your flu vaccination this winter

Neurodiversity Transformation Programme and working with the Parent Carer Forums

Like many areas across the country, BNSSG has experienced a sustained increase in demand for autism and attention deficit hyperactivity disorder (ADHD) assessments. During 2025/26, we co-produced a Neurodiversity Transformation business case with our Parent Carer Forums, which has now been approved. Implementation is underway, with continued leadership and support from the three Parent Carer Forums in Bristol, North Somerset and South Gloucestershire, alongside education, health, local authority and VCSE partners. The programme is focused on strengthening earlier, needs-led support for children and young people, alongside recovery of assessment pathways.

BNSSG Vaccination Programmes

Overview:

The Bristol, North Somerset and South Gloucestershire (BNSSG) Integrated Vaccination Programme is currently funded and commissioned by NHS England (NHSE). The Programme is overseen by the BNSSG Strategic Immunisation Oversight Board (ISOB) consisting of a multi partnership collaborative. The purpose of ISOB is to have oversight of vaccination activity, risks, opportunities and plans across the BNSSG system for all Section 7A vaccination programmes, with focus on improving uptake coverage and reducing inequalities. Quarterly updates on activity, progress, issues and risks are reported to BNSSG ICB via the Outcomes, Quality and Performance (OPQ) Committee and the Local Authority Health Protection Committees.

The BNSSG Vaccination Clinical Delivery Group (VCDG) provides system coordination of the delivery of routine and seasonal vaccination management plans, to deliver national vaccination ambitions and support outbreak response.

BNSSG Maximising Access and Equality Vaccination Group (MAEV) is responsible for narrowing the vaccination gap by addressing inequalities in access, outcomes and experiences for all Section 7A vaccination programmes. The focus is on individuals, groups and communities where improvements in vaccinations are not keeping pace with the rest of the population, identified through MSOA data.

Across BNSSG, Section 7A vaccinations are commissioned to be delivered by multiple health partners including, Community Pharmacy (CP), Sirona School Aged Immunisation Service (SAIS) and Hospital Hubs. In addition, for the last five years, BNSSG has provided an outreach vaccination service that has been funded through NHSE's Covid19 vaccination access and inequalities (A&I) funding. The service is contracted until the end of August 2026, with North Bristol NHS Trust (NBT) holding the lead provider contract

currently.

Flu Autumn/Winter 2025-2026 update:

In 2025 NHSE highlighted that, in relation to the flu vaccine, increasing uptake in the children's cohorts will have the biggest impact on reducing the circulation of the flu virus, followed by those aged under 65 years who are in a clinical at-risk group. Furthermore, increasing the vaccination rates in frontline health and social care workers (FHSCW) may help improve staff absence levels and protect those they care for from flu. Therefore, there was a national focus in 2025 to at least maintain flu vaccination uptake in the 65 plus years and increasing uptake in:

- Children – all eligible ages
- Those aged under 65 years in a clinical at-risk group
- Frontline Health Care Workers

This approach aligned with our local BNSSG plans to maintain and improve uptake system wide improvement plans were developed using the NHSE KLOE submission to support this.

A clear BNSSG system communications strategy was developed and proved be key to supporting improvements in vaccination uptake. Key audiences were targeted directly by partnering with local organisations including voluntary groups, charities, and community interest companies as ambassadors, to cascade vaccination messages and signpost their members to trusted resources.

Health settings, including pharmacies and PCNs were encouraged to share flu messages in places of high footfall such as GP receptions where posters, leaflets and display screens will be used in various languages appropriate to the location.

A community partner initiative was launched for both flu and Covid-19 whereby local organisations applied for community grants to promote vaccination messages. More than a dozen organisations, from local charities to community radio stations and a city farm combined to share a series of trusted NHS vaccine messages with their thousands of members, in print, online and face to face. Many of the organisations hosted vaccine talks and pop-up vaccine clinics, ensuring vaccine messages and action resonated at the heart of our most at-risk and vulnerable communities.

Influenza (flu) vaccinations:

During 2025-2026, the hospital trusts continued to have vaccination hubs which focused on health care staff and inpatient vaccinations. These were based at Southmead Hospital (NBT), The Bristol Royal Infirmary and Weston Hospitals (UHBW) and Callington Road Hospital (AWP) and its associated sites. These teams have adapted their approach and offer vaccinations all over the hospitals with roving teams, to improve access for staff working on shift. Sirona also delivered vaccinations to their staff across a range of BNSSG venues and inpatient units.

Autumn/Winter 2025-2026 saw a national focus on frontline health and social care workers (FHSCW) vaccination uptake for flu, in line with the Joint Committee on Vaccination and Immunisations (JCVI) advice. As well as the hospital hub vaccination teams, the BNSSG Outreach Vaccination Service was utilised to attend and offer flu vaccinations to staff at some care homes in BNSSG to improve access for those social care staff that work long hours/shifts. These FHSCW's in hospitals and care homes/home care were not eligible for Covid19 vaccination in 2025 under the national programme. ([https://assets.publishing.service.gov.uk/media/69ba84f46b1db9df335fcb04/Green Book chapter Covid 14a 17 3 26.pdf](https://assets.publishing.service.gov.uk/media/69ba84f46b1db9df335fcb04/Green_Book_chapter_Covid_14a_17_3_26.pdf))

Each year, NHS England set uptake ambitions for seasonal flu uptake in certain cohorts. Uptake data was monitored throughout the 25/26 Flu season to ensure a proactive approach was taken and appropriate action or support considered in areas of lower uptake. We also compared the data to previous years to avoid complacency and continued to strive to improve the vaccination offer in BNSSG. The table below shows the flu vaccination uptake comparison from previous year/season along with the NHS England flu ambition targets for 2025/2026 flu season. Data from FDP on 10/03/26:

Cohort	BNSSG % uptake 01/09/25-31/03/26	BNSSG 2025/2026 ambitions	BNSSG % uptake 2024/2025 flu season	25/26 vs 24/25 change
2–3-Year-olds	52.82%	57.78%	49.88%	↑
65 Year & over	80.26%	81.0.%	80.53%	↓
Under 65 years at risk	66.34%	52.21%	62.74%	↑
Frontline healthcare workers	55.82%	55.75%	49.57%	↑
Primary schools	58.60%	63.19%	57.29%	↑

Secondary schools	49.47%	51.84%	46.11%	↑
Immunosuppressed	67.76%	N/A	54.05%	↑
Pregnancy	57.95%	N/A	34.78%	↑

The table below shows the overall flu vaccination uptake for the 2025-2026 season (data from FDP) on 10/03/26:

2025-2026 flu season uptake		2024-2025 uptake comparison
National uptake %	54.03%	50.31%
Southwest uptake %	62.74%	58.59%
BNSSG uptake %	60.06%	55.69%
Total BNSSG flu vaccination events	350,970	313,238

The 2025/26 flu season was characterised by an early start (compared to previous seasons), with significant activity driven by a highly mutated variant of influenza A(H3N2) known as subclade K. As a result, vaccination was crucial in helping to manage system pressures.

It is therefore positive to note the vaccination data showed an overall increase in the percentage of eligible people vaccinated in the BNSSG area during the 2025-26 season, with noticeable increases seen in the pregnancy, front line healthcare workers and 2 – 3-year-old cohorts compared to the previous year.

2025/2026 was the first flu season whereby Community Pharmacy could offer the free NHS Flu vaccinations to children aged 2 to 3 years old (born between 1st September 2021 and 31st August 2023). This provided

increased access to vaccination as an additional option to the existing GP vaccination offer, with an aim to improve uptake in this age group. Locally, the School Aged Immunisation Team (SAIT) provided an opportunistic offer of vaccination to 2- and 3-year-old siblings of school aged children in their community based catch-up clinics. The data above shows a significant increase which may be linked to effective cross system collaboration so there is hope this will continue.

Clinical at-risk groups were encouraged to come forward for vaccination through their GP practices, community pharmacies and also through work with local health charities and trusted community voices. Vaccination uptake among clinical at-risk groups increased in 2025/26; however, uptake varied by cohort. Uptake was highest in chronic heart disease and chronic kidney disease, and lowest in chronic liver disease and respiratory disease. These will be areas for ongoing focus in 2026/27. Community and outreach work also helped support a wider range of local communities in 2025/26, in particular the outreach team support to those people experiencing homelessness.

Our communications included a community-based film featuring many well-known local faces and organisations which gained 33,000 online views, along with regional BBC TV and radio coverage. We partnered with UKHSA to co-produce a flu case study film featuring a young person sharing their flu story and recommending those eligible to get vaccinated.

Learnings from the 2025/26 flu season will inform planning for the 2026/27 flu season.

Covid19 Vaccinations:

Covid19 vaccinations continue to be offered in Spring and Winter to the elderly and immunosuppressed populations, along with those in care homes. The data below shows BNSSG had a positive uptake for Covid19 vaccinations for Spring 2025 and Winter 2025/2026 when compared nationally and within the Southwest (data from FDP):

	Spring 2025	Winter 2025-2026
Eligible population (BNSSG)	119,634	120,001
Total vaccinations given (BNSSG)	75,012	81,197
BNSSG uptake percentage	62.70%	67.66% (3 rd in SW)
Southwest uptake percentage	62.64%	67.29% (1 st nationally)

National uptake percentage	53.05%	57.14%
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From Spring 2026, the seasonal Covid19 vaccination delivery will be commissioned at a GP/practice levels as opposed to Primary Care Network (PCN) level. Ambition uptake will be the same as Spring 25 uptake.

Measles Preparedness and Response:

From 1st January 2026, Varicella vaccination has been introduced into the routine childhood immunisation schedule using the combined Measles, Mumps and Rubella (MMRV) vaccine, with a change in scheduling alongside this.

The UK Health Security Agency (UKHSA) declared a national measles incident in March 2026 in response to large outbreak in London. UKHSA assessed the South-West region as being low risk for measles at this point but agreed with Bristol Public Health, in recognising our demographic and vaccination coverage similarities to places like London and Birmingham.

Measles presents an ongoing risk to BNSSG, particularly Bristol due to pockets of low MMR coverage. The majority of children receive their MMRV through their GP surgery but inequalities remain and there is a need to continue data driven targeted work to engage with communities, remove barriers to access and support confidence and understanding of MMRV vaccination. The SAIS provided vaccinations catch up offer through sixth forms, community clinics and the GP evergreen offer remains available to any adult or child who has missed their MMR/V.

The BNSSG Integrated Vaccination Programme, working with all relevant partners, have invested in a dedicated local campaign during 2025-26, building on previous learnings and insights on raising awareness on the MMRV changes and opportunities to access the vaccine. The communications and engagement plans have included:

- BCFM and Ujima community radio stations presented three separate radio shows focused on childhood immunisations. These featured three local GP's and a representative from Black Mothers Matter. The recordings were further promoted on social media
- GP and community influencers in Bristol Inner City (BIC) creating podcasts and advertising scripts
- Short films produced with a practice nurse, a GP and two new mums from different local communities

- Up to 70 bus side adverts on popular BNSSG routes continue
- 2 x digital billboards (including on the M32) along with postcode door drops planned for areas with lowest uptake of MMRV vaccinations
- A case study being explored with a Brislington nursery which experienced a measles outbreak last year
- Early years newsletter report by Bristol City Council aimed at those working with children (including nurseries and childminders)
- Digital screens and leaflets for GP surgeries, with posters sent to seven practices in the Bristol area in different languages depending on the local community needs

RSV Vaccination:

Starting in September 2024, the Government accepted the JvCI advise starting an RSV immunisation programme for older people and pregnant people, to protect infants. The link to the RSV Green Book, chapter 27a is here:

https://assets.publishing.service.gov.uk/media/69823003e8900d4c455f37d3/Green_Book_Chapter27a_RSV.pdf

RSV vaccinations continue to be offered in BNSSG by all GPs and in our hospital hub maternity services as a year-round vaccination offer. Nationally, the uptake (taken from FDP on 21/04/26) in maternity is 43% and BNSSG's uptake is 52%. For older adults' routine uptake, BNSSG is at 55%, while nationally the uptake is 49%. And for older adults catch up vaccination uptake, BNSSG continues to show higher uptake (75%) than national (70%).

Our acute trust hospitals have also set up vaccinations in their maternity departments to ensure vaccination was accessible for pregnant people attending maternity services and appointments. Alongside Covid19, flu and Pertussis vaccinations, the maternity services also offered Respiratory Syncytial Virus (RSV) vaccinations to pregnant people

Raising human papillomavirus (HPV) vaccine Awareness:

During January to March 2025, BNSSG Integrated Vaccination Programme were awarded short term funding from NHS England to improve 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.

Caafi Health's HPV Ambassadors are working with a range of community

groups, having discussions and raising awareness of HPV and its link to cancer. Further recruitment has been undertaken in North Somerset to replace one HPV Ambassador, and the others continue to work in BIC and South Bristol with communities including those of deprived socioeconomic areas, travelling communities, Romanian communities and those communities serving black and black African heritage. The Ambassadors have also linked with Sirona's SAIS team to help make contact with primary schools and been involved in the implementation and awareness of the new HPV Inform website.

In 2025, Sirona's SAIS team have been offering vaccinations in schools and been able to extend this to some sixth form's linked to secondary schools to offer catch up vaccinations for those who have missed appointments. This has also allowed them to check on other possible missed vaccinations.

The three BNSSG local authority teams have been working with students and young people at three local colleges. They have run workshops to raise awareness of HPV but also to listen to how young people may want to receive information. A report on the outcomes will be produced once all sessions have finished.

We also worked with our student health service teams, based at the two universities in BNSSG. Records for overseas students were updated, and additional vaccination clinics were stood up. Our Communications Lead worked with these teams to ensure a consistent message was shared, building on International HPV Awareness Day in March. Both Bristol universities engaged with this including posters on numerous sites, over 12,500 text messages direct to students, student newsletter reports, and university-owned social media posts.

Student health service teams will continued 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 due to engagement and Making Every Contact Count.

Jitsuvax Training:

Using the A&I funding from NHS England, the BNSSG integrated Vaccination Programme was able to put on three Jitsuvax Training sessions across BNSSG and invite staff from different partners to attend. This training supports clinical and non-clinical staff to have conversations regarding vaccinations and learn new skills on supportive and empathetic conversations techniques to allow views to be raised and discussed. We received overwhelming positive response to these courses and staff have reported putting new skills into practice during the winter season vaccination

programmes. This has been a very worthwhile project.

Summary:

During 2026-2026, our focus has continued to try to improve uptake in at risk population groups, including those people experiencing long term health conditions (inclusive of Core20Plus5 population groups). Focus also addresses the significant uptake disparities identified through MSOA level uptake data.

Our approach continues to be through collaborative partnership working with the local voluntary sector, our communities, Local Authorities, Public Health, General Practice (GP), CP's, hospital hubs and SAIS. 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

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 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

In 2025/26, Year 2 of the PINS project, a further 30 primary schools had a bespoke neurodiversity “whole school” support package so over the two-year PINS project, 75 primary schools across BNSSG benefitted this

targeted neurodiversity support. The national learning from the PINS initiative informed the recently announced SEND Reform plans.

Special Educational Needs and Disabilities (SEND)

South Gloucestershire local area was subject to an inspection by Ofsted and Care Quality Commission (CQC) from 14th to 18th July 2025 to determine the effectiveness of the local area partnership's arrangements for children and young people with special educational needs (SEND).

The inspection team's final report was published on 18 November. The report can be viewed using the following link:
(<https://files.ofsted.gov.uk/v1/file/50290649>)

The report highlights many strengths, and inspectors noted that arrangements have improved rapidly in recent years, leading to positive experiences for many children and young people. However, because this was not consistently the case across all categories of need and age groups, the overall outcome of the inspection was:

The local area partnership's arrangements lead to inconsistent experiences and outcomes for children and young people with special educational needs and/or disabilities (SEND). The local area partnership must work jointly to make improvements.

In particular, the inspection team made five recommendations for the local area partnership to consider as specific areas for improvement. The recommendations are:

- Leaders across the partnership should secure effective engagement with children and young people with SEND and their families consistently across the local area, including through stronger co-production at a strategic and operational level.
- Leaders across the partnership should develop further the work they have started to ensure children and young people can access the support they need when waiting on neurodevelopmental pathway.
- The local area partnership should establish a fully compliant dynamic support register, where all relevant children and young people up to the age of 25 are included and have a key worker when necessary.
- Leaders across the partnership should address the specialist sufficiency challenges, particularly in the breadth of SEMH provision, appropriate available AP, and range of post-16 opportunities, so that children and young people with SEMH needs secure improved outcomes.
- Leaders across the partnership should continue to improve the quality

and consistency of EHC plans to ensure that they consistently provide specific reference to appropriate health and social care provision that reflects children's needs and outcomes.

The local area partnership comprising South Gloucestershire Council and Bristol, North Somerset, and South Gloucestershire Integrated Care Board and all local providers of early years, education, children social care and health services in partnership with South Gloucestershire Parent and Carer Forum, are working together to deliver the local Strategic Action Plan, focused on addressing the findings and ensuring arrangements lead to consistent experiences and outcomes for children and young people with SEND.

Children and Young People

During 2025/26, 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.

The Children's HCIG works closely with other Health and Care Improvement groups recognising that children live in families and communities. The Local Maternity and Neonatal System now reports to the Children's HCIG, creating closer links between maternity and children's services, ensuring effective delivery of services and improvements to meet the needs of women and babies in our system.

An overwhelming theme from all sources is the requirement to focus on the needs of children, young people and families to promote future health and wellbeing in a seamless way across services, as well as reducing the need for a diagnosis before they can access the help and support required. This means partner organisations working in an integrated way to ensure that resources available across our health, social care, education, voluntary and other related sectors are targeted in the right way to ensure the best outcomes for children and young people. The children and young people Core20Plus5 further supports targeted action to address health inequalities goals for improvement in our system.

Maternity and Neonatal

We successfully recruited a full Maternity and Neonatal Voice Partnership (MNVP) Lead team consisting of a strategic lead, a community engagement lead, an acute trust lead and a neonatal lead. We are the only Local Maternity and Neonatal System in the South West that has recruited to the gold standard as set out in national guidance and has an MNVP that is more reflective of our local population.

The Local Maternity and Neonatology System is led by health and care leads from the key services across NHS and Local Authority partners, who report to the ICB as per national guidance

We are working with our business intelligence leads in both acute trusts supported by the Acute Provider Collaborative to develop a system wide maternity dashboard that will support identifying inequalities within our maternity outcomes.

The Local Maternity and Neonatal System is continuing to work alongside the Race and Health Observatory Learning and Action Network to reduce disparities in pre-term birth outcomes and experiences

Key Achievements and Focus Areas 2025/26

Maternity and Neonatal Outcomes

BNSSG continues to be recognised as one of the highest-performing maternity and neonatal systems in England. Both maternity providers, North Bristol NHS Trust (NBT) and University Hospitals Bristol and Weston NHS Foundation Trust (UHBW), have maintained their Care Quality Commission (CQC) ratings of 'Good', placing BNSSG amongst a small number of systems nationally where both providers hold this rating. This remains particularly significant in the context of continued national challenges across maternity services.

Both providers continue to demonstrate strong safety outcomes, with stillbirth rates remaining below the national average. The system has maintained a focus on learning, quality improvement and safety culture, ensuring that improvements are embedded and sustained across services.

Maternity and Neonatal Voice Partnership (MNVP)

During 2025/26, the BNSSG MNVP has continued to mature as an influential strategic partner within the Local Maternity and Neonatal System (LMNS). Building on the nationally aligned structure established in previous years, the MNVP has strengthened engagement with underserved communities and expanded its contribution to service design, quality improvement and equity initiatives.

A two-year strategic ambition framework was launched, focusing on reducing inequalities, improving experiences of care and increasing community representation. The MNVP has played a central role in co-production activities across the system and continues to be recognised regionally as an example of good practice.

Three Year Delivery Plan (TYDP)

2025/26 marked the final year of the NHS England Three Year Delivery Plan for Maternity and Neonatal Services. The LMNS has successfully transitioned from programme delivery to embedding sustainable improvements within business-as-usual arrangements.

Significant progress has been made in demonstrating the impact of key programmes through strengthened benefits realisation processes, ensuring improvements in safety, personalisation, equity and experience are measurable and sustainable beyond the lifespan of the national programme.

Maternity Incentive Scheme (MIS)

Both Trusts successfully achieved compliance with all ten safety actions within the Maternity Incentive Scheme for a third consecutive year. This achievement demonstrates the ongoing commitment of providers and system partners to maintaining high standards of maternity safety and governance.

The LMNS has continued to provide system oversight and assurance through regular review of evidence and monitoring against NHS Resolution requirements, supporting continuous improvement and organisational learning.

Saving Babies' Lives Care Bundle Version 3

Performance against the Saving Babies' Lives Care Bundle has continued to improve across both providers, with sustained high levels of compliance in all key elements. Particular progress has been achieved in the areas of foetal growth surveillance, pre-term birth prevention and smoking cessation interventions.

The LMNS has maintained robust oversight through audit and assurance processes, with a continued ambition to achieve full compliance and further improve outcomes for mothers and babies.

Equity and Equality Action Plan

The BNSSG Equity and Equality Action Plan has continued to drive system-wide action to address inequalities in maternity and neonatal outcomes.

During 2025/26, a comprehensive progress review demonstrated measurable improvements across a number of priority areas, supported by strengthened data reporting and targeted quality improvement initiatives.

An accessible public-facing version of the Action Plan and achievements report was developed in partnership with communications colleagues and the MNVP, helping to improve transparency, accountability and community engagement.

Reducing inequalities remains a core strategic priority for the LMNS and continues to underpin all improvement activity.

Race and Health Observatory Learning and Action Network

BNSSG successfully completed its participation in the Race and Health Observatory Learning and Action Network, one of only ten systems nationally selected to take part. The programme provided valuable insights into the experiences of Black women and families and highlighted opportunities to reduce inequities associated with pre-term birth and access to interventions.

Learning from the programme has informed local quality improvement initiatives, workforce development and anti-racist practice. The system has continued to support the delivery of Black Maternity Matters training and has embedded anti-racist approaches within maternity and neonatal improvement programmes.

The findings and achievements from the programme have been shared locally, regionally and nationally, contributing to wider learning across the NHS.

Maternal Medicine Network Development

During 2025/26, BNSSG has continued to play a leading role within the South West Maternal Medicine Network, strengthening pathways for women with complex medical conditions during pregnancy and the postnatal period. Collaborative working across providers has improved access to specialist advice, multidisciplinary care and equitable pathways across the region.

This work supports the wider ambition of reducing maternal morbidity and improving outcomes for women with pre-existing and pregnancy-related medical conditions.

Focus Areas for 2026/27

Whilst significant progress has been achieved, improving outcomes and experiences for underserved communities remains the overarching priority for the LMNS. Key areas of focus for 2026/27 include:

- Reducing inequalities in maternal and neonatal outcomes.
- Improving experiences of care for Black, Asian and underserved communities.
- Sustaining improvements delivered through the Three Year Delivery Plan.
- Strengthening personalised and trauma-informed care.
- Embedding anti-racist practice across maternity and neonatal services.
- Supporting workforce wellbeing, retention and culture.
- Delivering measurable benefits through the Equity and Equality Action Plan.
- Maintaining excellence in safety, quality and clinical outcomes across the system.

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 2025/26 to promote equality and reduce health inequalities.

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.

Progress on these objectives can be found in the Workforce section of this report

- **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.

In 2025-26 a CVD working group was set up to explore how we tackle inequalities in the treatment of Black African and Black Caribbean patients for hypertension by 2029. The group made a set of commissioning recommendations [Cardiovascular disease ICB Board paper](#) that were discussed at the ICB Board in December 2025.

- **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

Progress on this objective can be found in the Maternity section of this report.

- **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.

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 to:

- Continue to provide funding to the Locality Partnerships to use to reduce health inequalities in their area in response to their communities' needs
- Support general practice learning for supporting people with liver disease where there is a 16 year gap in the age of death from liver disease between those living in the most and least deprived areas of BNSSG.
- Provide poverty proofing training to staff working in providers

Collecting, analysing and publishing information on health inequalities

In November 2023 and November 2025, 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 2025-26 we published information based on the November 2023 requirements [Understanding healthcare inequalities in Bristol, North Somerset and South Gloucestershire - interim report](#). The reporting period was up to March 2025. This information was also shared with our system improvement groups to use to inform their plans and work during 2025-26.

The publication of the updated statement in November 2025 means that our progress on responding to it has been limited due to:

- Misalignment between the publication of NHSE's statement (November 2025), the period it covers (2025-26) and reporting deadlines (June 2025)
- The November 2025 statement being very different from the November 2023 statement which means that a large scale re-analysis and decisions about which indicators to select and which demographic groups to focus on are needed in order to make the work meaningful and inform the ICB's priorities. The changes to ICB structures have made it difficult to progress this work during 2025-26.

There is a commitment to use the latest statement to guide our commissioning work during 2026-27.

Workforce inequality is addressed on page 90

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 Strategic Commissioning Population Health 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 NHS England sets National Medicines Optimisation opportunities to enable ICBs to focus on 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 for a second year. The ICB has also made significant progress in the last 12 months in IV to oral antibiotics and best value direct-acting oral anticoagulants.

Primary Care Prescribing

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 patients.

In 2025/26, 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), weight management and heart failure. With continued growth forecast in other areas such as treatment for ADHD and Menopause. In 2025/26 growth has been broadly in line with forecast and the savings plan has been exceeded reflecting additional savings arising from patent expiries that occurred earlier than anticipated.

In 2025/26 approximately £161 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 £6.5 million, due to savings plans doing better and the loss of patent sooner than anticipated on apixaban (DOAC) and Dapagliflozin (SGLT2 inhibitor). Following an additional piece of work to switch patients to the most cost effective DOAC national data shows the ICB to be performing well with savings achieved.

There have been a range of medicines optimisation projects in primary care, aligning with system priorities that have included focussing on medicines safety, antimicrobial stewardship and reducing inappropriate antimicrobial prescribing in children; asthma project to promote and embed the updated NICE asthma guidelines aiming to improve asthma care and reduce asthma related hospital admissions; hypertension quality improvement project continuing work from 24/25 to improve hypertension management in general practice or chronic kidney disease (CKD) reviews to optimise treatment in CKD and reduce risk if acute kidney injury.

NICE and high cost drugs and devices

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 99% uptake of biosimilar and switch supporting the Southwest Region to be the fastest region in adopting biosimilar ustekinumab and resulting in significant savings.

Starting in December 2025 we have supported system colleagues and the ophthalmologists to implement the use of biosimilar aflibercept as a first-line, best value medicine for treating retinal conditions like wet AMD to reduce costs while maintaining clinical effectiveness. This work follows the NHS England (NHSE) ['Commissioning recommendations for medical retinal vascular medicines following the national procurement for anti-vascular endothelial growth factors \(VEGFs\) and intravitreal steroid implants'](#).

Regular biologic pathway and budget meetings continue with Gastroenterology, Rheumatology, Dermatology and Ophthalmology to support best use biologic, pathway development, horizon scanning and budget management throughout the year with the clinical teams. Updates to all biologic pathways have been undertaken in 25/26 to reflect best value biologic and new NICE Technology Appraisals (TA). Within this work the continued use of Blueteq, particularly within gastroenterology, has started to give rich data in the use of biologics within the pathway, showing first, second line and beyond choices and duration of treatment. We aim to work with the clinical team to use this data and link to outcomes to support biologic pathway updates.

In line with NICE and NHS England guidance we continue to support the adoption of hybrid closed loops in patients with type 1 diabetes in year 2 of rollout, working closely with our endocrinology colleagues through 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 have updated local guidance for diabetes devices to support best practice and cost-effective use and have developed a database of diabetes device orders to match to spend to provide assurance on choice and to inform budget setting.

We have continued to support the implementation of the weight management medicines in specialist weight management services (SWMS) and have implemented the NHS England (NHSE) funding variation to the NICE TA1026 for tirzepatide. From June 2025 adult patients could be assessed for eligibility to receive tirzepatide for managing overweight and obesity in primary care only in line with cohort 1 as commissioned by NHS England (NHSE). Since June 2025, BNSSG ICB offered a LES: Weight Management – tirzepatide prescribing and management in primary care, to provide payment to Practices to deliver tirzepatide to NHSE priority cohort 1 in year 1 alongside wrap-around care. The BNSSG Weight Management Group are working with all partners to support Practices with the implementation of priority cohort 2 in year 2 under the NHSE commissioning guidance, starting end June 2026.

Our annual horizon scanning for 26/27 highlights new biologics for use in Chronic Obstructive Airways Disease (COPD), expansion of access to tirzepatide for weight management and obesity and hybrid closed loops for patients with type 1 diabetes.

Medication Safety

The Medicines Safety Dashboard within general practice was developed to highlight key areas of medication-related risk. It enables practices to proactively identify, review and amend prescribing for patients at risk of

harm. Areas of focus included anticoagulant and antiplatelet medication as well as reviewing potentially nephrotoxic medications.

Overall, the work has contributed to reductions in preventable medication-related harms, potentially preventing hospital admissions and their associated costs as well as helping to embed medication safety as a core component of practice-level clinical governance.

In addition to the safety dashboard, the Eclipse RADAR tool is a risk stratification system that has been available to GP Practices in BNSSG for the last five years. The tool supports prescribers by identifying patients who may be at increased risk of harm from their medicines, enabling targeted clinical reviews to improve patient safety and outcomes.

The tool stratifies patients according to level of risk, with red alerts highlighting those at the highest risk of harm and requiring urgent clinical action or review. Use of the tool to prioritise and review red alerts was actively encouraged. In 2025/26, across BNSSG ICB, 98% of red alerts were reviewed, potentially preventing more than 8,500 incidents of patient harm or hospital admission. This activity is estimated to have avoided 2,556 hospital bed days, delivering annual cost savings of approximately £1.02 million

System-wide working groups continue to facilitate safer prescribing in areas such as anticoagulation, diabetes, prescribed drugs of dependence. A system-wide allergies working group which focuses on improving the accuracy, consistency, and visibility of allergy documentation across the BNSSG Integrated Care System (ICS) has been established. Supporting the requirements of the harm from incorrect recording of a penicillin allergy as a penicillamine allergy National Patient Safety Alert (NPSA).

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 has put in appropriate support and guidance to mitigate the impact on patients. E.g., co-codamol 30/500mg tablets and pancreatic enzyme replacement treatment (PERT).

Green Plan

The ambition to reduce the carbon impact of medicines and medical devices within the system continues with our system-wide medicines green plan. Work in 25/26 has focused on reducing the environmental impact of medicines waste with a successful public campaign encouraging patients to only order the medicines they need and dispose of unwanted medicines correctly. Going forward, there will be a focus on reducing overprescribing by supporting practices to undertake structured medication reviews in priority patients and looking to measure the carbon impact of this.

In addition to these projects, sustained efforts to reduce the carbon footprint

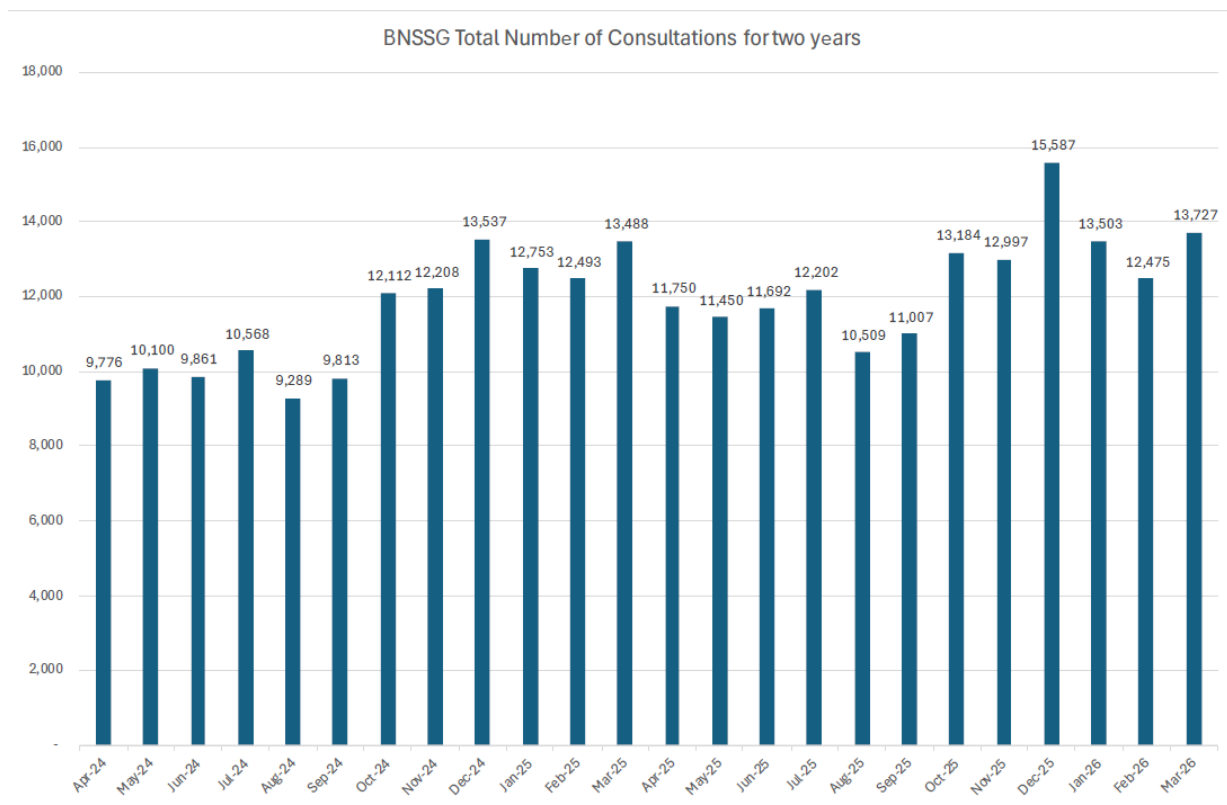
of inhaled anesthetic gases within the trusts have continued in line with the NHSE 2024 mandate and the medicines optimisation team has continued to reduce the environmental impact of inhaled therapies with the launch of 2025 asthma guidelines, supporting the use of DPI MART (Dry Powder Inhaler Maintenance and Reliever Therapy) first line for asthma.

Antimicrobial Stewardship

Safeguarding the efficacy of antimicrobials continues to be a high priority for the system a focus for 25/26 has been on the appropriate prescribing of antibiotics in children. Supporting the National Action Plan for Antimicrobial Resistance to reduce total antibiotic use in human populations and the NHS oversight framework. Optimising antibiotic prescribing in children where infections are frequently caused by viruses or are self-limiting is appropriate and ensures antibiotics will be available for use in the future. BNSSG remains the lowest prescribers of antibiotics for children aged 0-9 nationally and has seen a reduction in prescribing rate to below the 2020 baseline.

Pharmacy First

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.



Digital

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 efficiency. Medicines related digital projects and ambitions align with the wider BNSSG Strategy. In 2024/25 we were successful in obtaining phase three funding on a Technology for better care project from Health Foundation. During 25/26 we recruited a project team, worked with partners across the system and recruited over 100 patients to test different technologies to support with adherence to their medicines. Evaluation is underway and a focus in 26/27 will be, dependent on findings to take forward on a local and national front where applicable.

Research and innovation

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. We are the leading ICB for research activity in England.

Research Development

In 2025 BNSSG ICB was awarded £1.9m of Research Capability Funding (RCF) to invest in research development and supportive infrastructure. RCF supported 92 individuals across health, care and local university

organisations who are developing research in areas of priority for our population.

61 applications for external research grants (31 preliminary stage & 30 final stage) to fund innovative improvement projects have been submitted, which is a 45% increase on the previous year. Also, we have awarded 20 research development projects to local academic and health and care colleagues to develop new research grant applications in the near future.

We are proud to report that we have invested in and are actively supporting 12 early phase projects that have been initiated from research-naïve health and care delivery staff serving our most disadvantaged and under-represented communities, 3 are working with VCSE partners through the [Research Engagement Network](#) and 5 with [GPs at the Deep End](#).

Live Research Projects

BNSSG ICB supported 63 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, care homes and voluntary, community and social enterprise (VCSE).

Our portfolio of 38 externally funded research grants brought £48m 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 appointing a joint role with the University of Bristol, Dr Shoba Dawson, Associate Professor of Inclusive Research and Health and Care Practice. Shoba will work across the Bristol Medical School and ICB research to help raise standards for inclusive research practice and embed learning within the work of the ICB through the Population Health Improvement Directorate.

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 this year we have focused on supporting general practices introduce group consultations for long term conditions. Partnering with the Applied Research Collaboration West (ARC West) we have been able to ring fence a highly experienced general practice nurse to support 23 practices to introduce this evidenced method of positively

impacting the health of our population.

Leadership and governance across the ICS

The ICS Research and Innovation Steering Group (RISG) is provided by Bristol Health Partners (BHP) and Academic Health Science Centre (AHSC). The Steering Group formally aligns and integrates academic expertise in population and applied health research with the ICS priorities.

Collaborations between academia and ICS

As an Integrated Care System, BNSSG is performing very well in terms of research collaborations. As measured by NIHR investment, BNSSG is by far the most research active ICS in England.

We continue to build on our multidisciplinary collaborative research whereby research is designed and delivered by people in our communities along with people working in the health and care system and academics from our university partners. This approach, embodied by the BHP delivery vehicle of our 20+ Health Integration Teams, is delivered across all our research development activities

Secure Data Environments (SDE) for research

The South West SDE is an innovative and efficient approach to conducting research with millions of people's health and care records, while maximising privacy and security. The SDE is a secure platform for research and data analysis, being developed to the highest security standards. It will enable trusted, appropriately qualified professionals to safely access data, including routinely collected data from the NHS and local government, for approved projects. The South West SDE means we can all benefit from research using people's health and care records while providing strong safeguards that protect data security and privacy. It has the potential to revolutionise health research in the South West of England. The SDE design phase is complete and the build of the technology is underway.

Impact acceleration

Our Impact Accelerator Unit (IAU), is a partnership with the Universities of West of England and Bristol. The IAU will ensure evidence generated locally is embedded into practice as swiftly as possible, so that our population benefits from our local innovations. The IAU has appointed a full-time manager and is building a regional and national network of partner ICBs and Applied Research Collaborations (ARCs) who are looking to accelerate research in to practice. We have secured funding from ARC West to offer Knowledge Mobilisation Fellowships to ICS staff to provide them with time and support to embed research evidence into BNSSG.

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, ethnicity and disability 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.

Following the Government announcement that 50% reduction in running costs for the Department of Health and Social Care and NHS England will also extend to Integrated Care Boards including Bristol, North Somerset and South Gloucestershire ICB a significant amount of focus has been paid on supporting staff through organisational change. As well as our Employee Assistance Programme, which offers all staff support and guidance to support their overall health and wellbeing, we are also working with a local, black-led charity to ensure that culturally appropriate support is available for our staff racialised as Black and Brown.

Support from the Time to Talk Team has continued, run by our Mental Health First Aiders who are trained to help if you are experiencing feelings of anxiety or need mental health support. The Disability Staff Network have also offered peer support sessions on a fortnightly basis in recognition that anxiety levels inevitably run high because of fears and uncertainties about the future and possible job loss.

We have also introduced Equality & Diversity Representative (EDR) training for all staff to ensure that recruitment processes are fair and aim to reduce bias and preconceptions during the interview process, with a key focus on privilege and micro-aggressions and understanding of the Equality Act 2010. In addition to this, organisational change guidance has been released an Equality and Health Impact Assessment (EHIA) as well to ensure consistency in our monitoring and transparency of our data,

In line with the NHS Equality, Diversity and Inclusion (EDI) Improvement plan high impact actions, our executive team continue to all have specific and measurable EDI objectives to ensure that we create a culture that values and sustains a diverse workforce. Our senior leadership team have undertaken seminar sessions focused on anti-racism and are undertaking a leadership

focused anti-racism development programme delivered through Black Maternity Matters.

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 and Black History Month celebratory bring and share lunch to celebrate cultural heritage and identity. Our staff networks also provided support in ensuring diverse panels within our 'Shaping Our Future' organisational change programme.

While there is still work to do we saw significant improvements related to staff experience of those with protected characteristics between 2024 and 2025 staff survey results. These include:

- For those with a disability believing that their trust provides equal opportunities for career progression or promotion increased (49% to 57%).
- For colleagues racialised as black or brown, believing that trust provides equal opportunities for career progression or promotion increased (46.7% to 50%)
- For LGBTQ+ colleagues; not experienced discrimination from manager / team leader or other colleagues increased (77.3% to 95%)

The latest WRES information is published on our website [here](#).

The three aims of the public sector equality duty under the Equality Act 2010, being to:

- a) Eliminate unlawful discrimination, harassment, victimisation and any other conduct prohibited by the Act;
- b) Advance the equality of opportunity between people who share a protected characteristic and people who do not share it; and
- c) Foster good relations between people who share a protected characteristic and people who do not share it

ICS Workforce Inequity

ICS partners continued to work collaboratively throughout this year with

regular meetings of 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 (WRES) and workforce disability equality data (WDES) at a system level, as well as anti-racism and a focus on learning and development activity. A system wide Workforce EDI report was delivered to both People Committee to ensure awareness and accountability at senior levels.

The BNSSG ICB along with Avon and Wiltshire Mental Health Partnership and University Hospitals Bristol and Weston have joined the Best Practice Working Group for Trans & Non-Binary People in collaboration with local Charities from across the area and University of the West of England. This is to ensure learning, support and a collective message is taken when addressing inequalities for Trans and Non-Binary people.

The fourth iteration of the Bristol Race Data Product went live in December 2025, led by Bristol City Council with system input, this marked a significant milestone in our journey towards a more inclusive workforce. Capturing data from over 56,000 employees in a more disaggregated ethnicity format, the data represents 22% of Bristol's economically active population.

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.

Over the last 12 months, our work has focused on strengthening sustainable workforce pipelines across health and social care, with a particular emphasis on apprenticeships, T Levels, widening participation and employer and student readiness for development and embedding of careers pathways. Aligning to national directives such as the NHS 10 Year plan, the three shifts and wider NHS and Government skills and workforce initiatives to help stakeholders navigate and utilise these to support their workforce. We have led and supported system wide programmes to improve understanding, uptake and effective use of apprenticeships and wider skills programmes across HSC partners, including utilising workforce and wider demographic intelligence, delivering targeted stakeholder engagement to all areas of our community, including targeting postcodes of high deprivation and care leavers with outreach and engagement activity. We play an active and influential role in outreach and careers activity through our Cornerstone Employer, WECA Careers Hub, the CEC, and wider BNSSG HSC Ambassadors program, undertaking and coordinating outreach, supporting, and delivering webinars and practical guidance to address real world barriers to participation and workforce challenges.

We employ over 1,000 apprentices across the BNSSG footprint. Ranging from Level 2 (GCSE) to Level 7 (Post Graduate and Masters) and cover more than 70 professional pathways, including Advanced Practice, Nursing, Healthcare Scientist, Pharmacist, Support Workers, Senior Leadership, Solicitor and Business Administration. 76% of all apprentices are employed in clinical and clinical support worker roles. Outreach Ambassador program and our Careers events aimed at young people has had over 1000 engagements.

We have supported our HSC stakeholders understanding of the Education and Skills Landscape so that it can be utilised to build talent and development pipelines with the aim of growing our workforce for the future. Within T Level implementation, we have positioned industry placements as part of an integrated talent pipeline alongside apprenticeships, work experience, and early careers routes, and supporting employers to develop high quality, meaningful and scalable placement models aligned to service need rather than short term activity. We saw 75 new T level Health learners join orgs on industry placement across the ICS adding to the 55 already on programme bringing the total to 130 this year. We have also seen growth in engagement with non-clinical T levels such as those on Digital T level and Business learners being hosted across HSC organisations.

FE plays a crucial role in helping us attract a workforce that is representative of our communities, and we continue to build strong partnerships and collaborative workstreams in this area, to ensure our system workforce is representative and that we can help shape and influence the education and skills sector. We continue to have a key system leadership and influencing role locally and regionally and have shared our successes and best practice nationally.

This has included work across BNSSG ICS in the skills and widening participation space, initiatives with partners such as the King's Trust, WECA and our education providers as well as other Government departments such as DWP, where we are representing all ICS HSC employers and providing system perspectives through our networks across regional and national workforce forums.

We continue to translate complex policy change into actionable guidance for employers across our system, so that strategically we are aligned and can shape future direction of travel, particularly during a period of significant national reform affecting apprenticeship funding, leadership standards and skills and education policy and reform, so that we stay ahead of the curve.

Across all workstreams, our focus has been on evidence based decision making, equity of access, employer confidence, and long term workforce sustainability, ensuring that activity delivers tangible benefits for our system organisations, staff, learners, and the communities that they serve across the

ICS.

Organisations across BNSSG continue to progress implementation of the People Promise and Safe Learning Environment Charter, with a focus on embedding these principles through existing workforce, education, and culture programmes. Attention has been given through the newly established BNSSG Placements Group, which is reviewing learner experience, placement quality, and models of delivery, alongside identifying opportunities for continuous improvement across the system. This work is supporting a stronger focus on inclusive learning environments, psychological safety, compassionate leadership, and equitable access to high-quality placement experiences. In line with the People Promise commitment that we are compassionate and inclusive, and the equality expectations set out within the Safe Learning Environment Charter, partners have continued to strengthen oversight of learner experience, promote shared learning and support a consistent approach to addressing concerns, improving belonging and ensuring safe, supportive environments for learners and staff. This work provides an important foundation for further development in 2025/26 as these principles continue to be embedded across the system.

For our Acute and Avon & Wiltshire Mental Health trust (AWP), the staff survey results for the 10 people promise themes shows that we have made constant improvements over the last 5 years with the highest score in latest year and with our scores being above the benchmark median for at least the last 2 years. This gives us a clear opportunity to share approach across all our healthcare partners so these results can be replicated for all providers.

The staff survey also shows our ethnic minority staff that have experienced harassment, bullying or abuse from other staff is at the lowest levels in 2025 in the last 5 years and below the benchmark median. Our turnover is at the lowest levels experienced since the covid pandemic.

BNSSG is proud to have an award-winning team delivering Oliver McGowan Training to our NHS providers. Oliver's story is central to the training and is treated with care and respect. Trainers with lived experience deliver the content and 81% of the team have a learning disability and/or autism. The team have a strong sense of team identity and mutual support – our co-trainers refer to our team as a 'family' – and five of the team members have progressed into Facilitator/Supervisory roles or been seconded into roles with more responsibility.

We have delivered Tier 1 training to over 14,500 non-clinical staff this year which places us in the top 3 nationally. In addition, we have delivered Tier 2 training to 5357 clinical and patient facing staff, the highest achievement across the South West.

Our team is part of the national working group reviewing material for Tier 2

renewal training and BNSSG is one of five sites taking part in the national evaluation of Oliver McGowan Mandatory Training being undertaken by Leicestershire University. We are now developing a pilot to offer low-cost training spaces to providers out of scope of the NHS offer, eg Social Care, Councils hospices and private health companies. This is part of our long-term sustainability plan for the training, and we are honoured to work closely with Paula McGowan, Oliver's mother, to deliver her vision.

BNSSG continues to deliver WorkWell, having supported 1986 participants (105% of the target) over the initial 18-month Pilot which finished on the 31st March 2026. 94% of participants were satisfied or very satisfied with the services received, with 70% reporting that they were better able to manage their conditions and 70% felt more confident. 64% of participants during the pilot period reported that the support that they received helped them to remain in work.

The pilot allowed us to provide an additional £210,000 to the VCSE sector to extend current work and health provision while expanding capacity in the areas of need. BNSSG received an award for outstanding collaboration from the South-West Integrated Personalised Care Award 2026, and we are in the process of securing funding post Pilot stage for the continued delivery of the WorkWell Programme.

Bristol, North Somerset and South Gloucestershire Locality Partnerships

BNSSG's six Locality Partnerships have played a key role of how the system has delivered its ambitions for population health, prevention and neighbourhood-based care to this point. Bringing together partners from health, care, local government, the voluntary and community sector, and wider community infrastructure, Locality Partnerships provide the mechanism for understanding local need, shaping priorities at place, and translating system strategy into practical delivery with and for communities.

As the national health agenda increasingly focuses on shifting care closer to home, preventing ill health, and improving outcomes through more integrated neighbourhood working, Locality Partnerships have played a critical role in developing the conditions to deliver this locally.

The examples below illustrate just some of the ways Locality Partnerships have responded to population health data, local intelligence, and the voices of residents and partners to shape practical action at place. This work has generated important learning about what enables change locally, how partners can work together more effectively, and how services can be designed around communities. As the ICB moves through a period of change, this learning provides a valuable foundation for how we continue to deliver transformation, strengthen neighbourhood working, and support more

proactive, joined-up care in the future.

Community Mental Health

MINT services

Mental Health and Wellbeing Integrated Network Teams, known as MINTs, aim to put people and communities at the centre of mental health and wellbeing support. Across BNSSG, MINT is transforming community mental health services by bringing together new multidisciplinary teams to provide more holistic support for people whose needs are not met by general practice alone, but who do not require secondary care mental health support. These changes are intended to help people, wherever they live and whatever their background, to access high-quality, personalised care closer to home.

Locality Partnerships have continued to work closely with the MINT Mobilisation Team to support the continued development and rollout of MINT across BNSSG and the teams continue to support people across localities, providing an important foundation for more integrated, community-based mental health and wellbeing support.

As a relatively new service, MINT is being expanded gradually to ensure that capacity can be managed safely and that teams are able to establish themselves well within local systems. Initial referral routes have included the Primary Care Liaison Service and Bristol Mental Health Single Point of Access, and the programme is now moving into its next phase of rollout across general practices. As this broadens, we continue to support the development of relationships with primary care, community partners and wider local services, while working through the practical challenges that come with embedding a new model of care. A GP communications toolkit is also being developed to support this next phase, helping practices to understand the referral process, the role of MINT teams, and how the service can best support people with mental health and wellbeing needs in their communities.

Changes Bristol has been commissioned by Bristol Localities to provides free, accessible peer support for people experiencing mental health difficulties. Their two-hourly meetings are held both online and in community centres and halls across Bristol. Each session is facilitated by at least two trained Staff and Volunteer Peer Support Facilitators, who ensure that meetings are safe, supportive, and run in line with agreed ground rules.

Group attendance has remained stable year-on-year. The significant growth seen in previous years has now levelled into consistent engagement. On average:

- **146** people attend in-person groups each month
- **29** people attend our **online safe space** groups each month

Community Link Workers in Inner City and East Bristol Locality work with Nilaari to improve the mental health and wellbeing of people from Inner City and East Bristol's (ICE). This service supports the most marginalised populations, specifically the Somali, African-Caribbean and South Asian communities as these communities have been identified as those who experience the poorest access to mainstream services and have the least satisfactory experiences of engaging with the system resulting in worse outcomes

BNSSG Falls Prevention

The NHS England Neighbourhood Health Framework reinforces the need to redesign services so that support is provided earlier, deterioration is prevented, and unnecessary hospital use is reduced.

Falls place a significant burden on the local health and care system: across BNSSG, there were over 30,000 hospital admissions relating to falls in people aged over 80 in 2022, and national evidence estimates that falls cost the health and care system £4.4 billion each year.

The BNSSG Falls Prevention Strength and Balance Programme aims to reduce falls by addressing one of the most common and modifiable risk factors: declining strength and balance in older age. Falls are caused by multiple interacting factors, but this programme focuses on three practical components to better support people who are at risk of falling or who have already fallen.

1. **Community-based classes:** since February 2026 we have providers in place at each local authority area: Three Age UKs: Bristol; South Gloucestershire and Somerset leading the delivery of *Stay Strong and Steady* evidence-based strength and balance classes. Through this work we will increase VCSE sector capacity within each local authority area.
2. **Workforce development:** provide pump-prime training led by Later Life Training to train our local workforce to deliver evidence-based strength and balance approaches: OTAGO, FAME and REACT, and offer this consistently across funded VCSE delivery partners.
3. **Central information hub:** created a single point of access for people, patients and staff to find up-to-date information on local services, agreed evidence-based interventions, and practical ways to reduce falls risks at home on the Healthier Together [site](#).

National Neighbourhood Health Implementation Programme:

NHS England's Neighbourhood Plan (part of the 10-Year Health Plan) shifts care from hospital to local, community-based, and preventative care. Local teams - including GPs, nurses, and social care - will work together to provide coordinated support, aiming to treat people closer to home.

The NHS England/DHSC - NHS England National Neighbourhood Health Implementation Programme (NNHIP) is a large-scale programme that aims to accelerate delivery of the Neighbourhood model. It brings together doctors, nurses, and local organisations so they can work as a team and help people access health and wellbeing services better.

The core aim of the programme is to generate robust learning and evidence, using test-and-learn approaches to inform future commissioning and wider system transformation across BNSSG. South Bristol and Woodspring are two of 43 places in England participating in the Programme:

- In South Bristol is working with local healthcare staff, community partners and organisations to find the best ways to support people who have three or more long-term health conditions (Diabetes, Hypertension, Pain, Anxiety & Depression). Working with the 3 Primary Care Networks (PCN) each PCN has designed and will pilot a test and learn approach to address this cohort.
- Neighbourhood work is expected to address health inequalities and South Bristol includes areas of higher deprivation where access to care is more challenging and outcomes are significantly poorer (>15 years healthy life expectancy difference).
- In Woodspring their Complex Care Team (CCT) is a multidisciplinary, community-based model supporting older adults with frailty and multiple long-term conditions through proactive, anticipatory, and coordinated care delivered at home.
- It brings together NHS, social care and VCSE partners into a single integrated pathway, focused on "what matters to you", shared care planning, and reducing avoidable hospital admissions.
- The programme is delivering a set of coordinated "tests of change" including proactive identification of residents, non-clinical first contact and "what matters to you" conversations, shared care planning, strengthened VCSE and social prescribing support, use of digital/technology-enabled care, workforce training (e.g. motivational interviewing, team-of-teams), and embedding lived experience co-production with rapid feedback loops to drive continuous

improvement.

Inner City and East Bristol (ICE):

In 2024/25, the ICE Locality Partnership board allocated funding to 7 organisations to improve health inequalities through targeted projects across ICE that codesign and deliver within communities that need them most. Over the last year we have seen a huge amount of activity within these projects and an even bigger impact on the lives of those who have been involved. The organisations and projects include;

Black Mothers Matter have been supporting 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. They have continued their very successful campaign on raising awareness of issues identified including attending a Q&A on Black maternal health with Wes Streeting, contributed to the Baroness Amos' inquiry into maternity services, and presented at the BAPM Neonatal Conference. All of which increased awareness of Black maternal health issues and their projects in Inner City and East Bristol.

Fruit and Vegetables on Prescription Project launched by Caafi Health focuses 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. They target families living in poverty with children, on benefits, and those with long-term health conditions and from minority ethnic groups. Over the last year cohorts have received health checks, tailored nutrition guidance, recipes, weekly support and fruit and vegetable vouchers. The engagement has improved access to fresh produce, increased nutrition knowledge, and baseline data in place to monitor future outcomes. The emerging WhatsApp peer support group is an added benefit, helping to build motivation, connection and sustained engagement.

The BAME Dementia Support Project lead by the Chinese Community Wellbeing Society focuses on reducing the health inequalities gap within dementia services.

Over the last year of delivery, the project has provided communities with healthy ageing workshops, intervention activity sessions and carers support groups, supporting improved awareness of nutrition, brain health, stress management and practical support for unpaid carers. Outcomes from these well attended sessions include reduced isolation, stronger peer connections, and emerging evidence of improved trust, confidence and interaction between carers and people living with dementia.

Movement in Nature Wellbeing Alliance is delivered by Open Minds Active in partnership with Soultrail and ActiveBeing to support women's mental and physical wellbeing to bring opportunities for marginalised women to experience a range of nature-based activities. The project has delivered a range of inclusive physical activity and wellbeing programmes, including outdoor swims, nature walking, 1–2–1 support and confidence-building activities. Delivery is showing positive impact through sustained engagement with attendees, stronger referral pathways, reduced seasonal drop-off, and improved access to safe, supportive spaces for women of colour and isolated individuals, with participant feedback helping to shape future delivery.

Drop in and Reach out sessions are being ran for survivors of sexual violence and abuse by SARSAS. Positive outcomes from these sessions have been reported, with improvements in wellbeing, access to support and effective signposting all exceeding targets at 95%. Attendees also reported reduced isolation, increased connection, a stronger sense of community and gaining practical tools to support recovery. 75% felt the sessions aided their recovery and the reduction in likelihood of return visits to GP or mental health services is 48%.

Volunteering, Skills & Wellbeing Programme was launched by St Werburghs City Farm to provide practical courses, placements and activities for people experiencing mental health challenges or exclusion and marginalisation from the workplace. The project has delivered a varied programme of group activities and seasonal events, supporting volunteers to build routine, confidence, skills and social connections. Outcomes are strong, with 100% reporting a positive impact on wellbeing, 93% feeling less isolated, 81% feeling more connected to their community and 88% improving their mental health. Activities demonstrate a clear value in supporting mental wellbeing, reducing isolation, increasing physical activity and helping participants take positive next steps towards therapy, volunteering, training or work.

Gardening for Health is lead by the Wellspring Settlement to 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. Over the last year they have supported residents to improve local green spaces while building confidence, skills and community connection. Activities across Gaunts Ham, Wellspring Settlement, Strawberry Lane allotment, Redfield Educate School, Urban Park and Barton House have encouraged participation, peer support, volunteering, informal leadership and wider community stewardship

North and West Bristol

North and West Bristol Locality Partnership has committed funding to implement an **Emotionally Based School Avoidance (EBSA) Project**. Over the last year the lead provider, Southmead Development Trust has begun to support children and young people (CYP) and their families to improve wellbeing and school attendance. The project is now in mobilisation, with the EBSA Link Worker in post, referrals being received and live cases being supported. Early learning is already being implemented, including reviewing eligibility to identify children at an earlier stage, strengthening referral pathways, and developing broader support between schools, families and the Link Worker.

The North and West Bristol **Community Chronic Obstructive Pulmonary Disease (COPD) Project**, delivered through iCareiMove, focuses on improving wellbeing, supporting self-management and addressing health inequalities for people with COPD. Delivery will include 12 annual multi-agency information sessions, alongside the development of peer support networks and a locally co-designed COPD Passport. The programme will provide practical support around inhaler technique, smoking cessation, pulmonary rehabilitation, vaccinations, healthy homes advice, welfare support, mental health and carer support. The launch of the service of the first COPD Information Session at The Greenway Centre in Southmead was shared through BBC Radio Bristol, helping to raise awareness as the programme begins to roll out across the locality.

The **Healthy Aging Research Project (HARP)** is now progressing towards mobilisation, with Southmead Development Trust identified as the lead provider. The programme has been developed in response to local data and insight, which identified a cohort of people aged 50–70 with one or two long-term conditions, such as chronic pain, diabetes or COPD, who are experiencing higher levels of hospital use alongside wider wellbeing needs. The project will test whether community-based activities, designed with local people and delivered closer to home, can improve health and wellbeing, reduce escalation of need, and support people to stay well in their communities. Delivery is expected to begin over the summer of 2026 and will focus on strengthening links between health services, VCSE organisations and local residents. The programme will also make use of Helpful Locals as an asset directory, helping professionals, community organisations and residents to find local groups, activities and support more easily, while also identifying gaps in provision to inform future development.

South Bristol

Community Innovation Leads (CIL): The first Community Innovation Lead was recruited in 2023 in Swift Primary Care Network (PCN) to foster connections with voluntary and community sector (VCS) organisations and health and social care partners to build stronger, more connected and resilient communities. Over the following year it's success led to a second

role implemented within Connexus PCN.

Across Swift ([Swift PCN](#)) and Connexus ([Connexus PCN](#)), Community Innovation Leads have built strong relationships across health, care and community partners. They have worked closely with every GP surgery in the area and developed a wider network of community and primary care organisations across Bristol, creating opportunities to fill gaps in local provision and improve wellbeing in some of South Bristol's most economically deprived communities.

They have been supporting the development of the National Neighbourhood Health Implementation Programmes (NNHIP – see above) test and learn approaches and have been pivotal as part of the development of neighbourhood health conversations being led by ICB and Local Authorities. 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. Over the last few years they have developed relationships with over 1,000 new VCSE organisations and identified 116 funding sources for those organisations.

South Bristol Pre-diabetes Project

In Bristol, **37% of diabetes-related emergency admissions** come from the most deprived 20% of the city. South Bristol has some of the highest levels of deprivation in the country and with the impact of diabetes set to rise greatly over the next decade the locality partnership aims to take more preventative approach to helping people manage their health.

Over the past year, Heart of BS13, a trusted local organization, and a research partner from UWE lead a co-production process with residents, VCSE partners, and healthcare professionals to provide insight and practical recommendations for what is really needed to make an impact on lives. These findings show that clinical signposting alone is not enough for people diagnosed with pre-diabetes.

The workshops highlighted the need for:

- Person-centred guidance that reflects lived experience.
- Peer-led initiatives that build resilience and shared learning.
- Practical, holistic support to address barriers to lifestyle change.

The next stage in the project is to deliver a community-led model that provides consistent information and empower the individual by designing

and delivering a new South Bristol service to bridge the gap between diagnosis and sustainable lifestyle change, starting with a holistic 1:1 conversation that identifies barriers and creates a personalised pre-diabetes management plan that is supported by the community.

One Weston Locality:

Prevention of Osteoporosis, Falls & Fractures (PROFFs) service

Based out of Weston GP practices, this project uses an automated, digital screening process which enables detection of those adults at highest risk of falls and fracture without the need for clinician time.

A small multidisciplinary team, comprising an advanced physiotherapist, advanced pharmacist are then able to help those at highest risk by offering evidence-based preventative solutions.

The purpose of this project is to proactively identify older adults at highest risk of falling and fracturing in order to provide evidence-based interventions using a small multidisciplinary team to prevent falls and fragility fractures. Building on existing locality partnership work, these initiatives aim to provide more coordinated, preventative support that helps people remain independent and reduces avoidable hospital admissions.

The aims of this project is to;

- (1) provide cost-efficient screening of adults aged ≥ 65 years using an automated digital process to identify those at highest risk of falling and/or fracturing,
- (2) provide evidence-based interventions using a small non-medical team comprising an advanced pharmacist and physiotherapist to prevent falls and fragility fractures, and
- (3) promote health ageing by providing personalised lifestyle advice and signposting to local services.

Outcomes

- (a) A reduction of the number of adults falling, requiring emergency and A&E services
- (b) A reduction in the number of fragility fractures requiring A&E and orthopaedic services
- (c) A reduction in the number of hip fractures, hospital admissions and prolonged stays
- (d) A reduction in the number of people requiring social care after hip fracture

Progress has also included extending access to strength and balance provision and improving system coordination across partners delivering preventative services. While there is strong alignment across organisations, delivery continues to be constrained by workforce pressures and fragmentation in pathways. Current efforts are therefore focused on strengthening connectivity, embedding consistent approaches to proactive identification, and supporting more sustainable models of frailty care within the Weston locality.

Woodspring Locality

Children and Young People Social Prescribing

The Woodspring Children and Young People (CYP) Social Prescribing programme has been developed to provide early, community-based support for young people experiencing poor mental wellbeing, social isolation, and emotionally based school avoidance. Funded through the Health Inequalities Fund and delivered in partnership with North Somerset Family Hubs, the programme is currently funded through to March 2027.

The model is centred on a relational, community-based approach, offering personalised support to young people who do not meet thresholds for statutory services such as CAMHS. Delivery is led by social prescribers (link workers) embedded within Family Hubs, working alongside wider early help services to provide holistic, family-focused support.

Referrals are primarily received via GP practices, with a focus on young people aged 10–16. The service supports a range of needs, including anxiety, school non-attendance, SEND-related challenges, and low wellbeing. Interventions are flexible and tailored, including one-to-one engagement, family support, connections to community activities, and coordination with schools and partner services.

Since implementation, the programme has demonstrated strong demand and engagement, with high levels of participation and increasing referral volumes. Early outcomes show improved re-engagement with education, strengthened connections to community support, and increased confidence among young people and families.

Delivery has also highlighted key challenges, including higher-than-anticipated complexity of need, recruitment pressures, and initial delays in accessing integrated data systems. In response, the service has adapted its model to allow for more sustained engagement and to prioritise early intervention while maintaining flow through the service.

Looking ahead, there is a focus on consolidating the model, strengthening referral pathways and data integration, and aligning more closely with Family Hub, education and wider Starting Well priorities. The programme provides a scalable model for early intervention and community-based support, contributing to preventative approaches and reducing demand on specialist services

National Neighbourhood Health Implementation Programme (NNHIP)

Woodspring's Complex Care Team was designated as a Wave 1 site for NNHIP. Please see further details in NNHIP section at start of localities section (South Bristol also Wave 1 site)

North Somerset Localities (Both Weston and Woodspring localities)

Dementia

The North Somerset Dementia programme is focused on strengthening community-based support for people living with dementia and their carers, in line with the local Dementia Strategy and wider Ageing Well priorities. Through an agreement between BNSSG ICB and North Somerset Council, investment is supporting the development and expansion of services that improve access, enhance support, and foster greater community engagement.

A key area of delivery has been the establishment of co-produced Ageing Well Hubs across One Weston and Woodspring, providing accessible community spaces where voluntary and community sector partners can deliver support for people living with dementia, carers, and those with complex needs. This includes repurposing existing assets, such as the Tamar Court site, to create flexible, community-based provision. In parallel, work is underway to address identified gaps in respite care through the development of a dedicated day service, alongside exploring additional support such as transport and community-based access. Together, these initiatives aim to provide more coordinated, person-centred support while enabling people to remain connected and supported within their local communities.

Creative Health Arts Programme

The North Somerset Creative Health Arts programme represents a significant step in embedding creative, community-led approaches within local health and wellbeing systems. Through a successful Arts Council "Creative People and Places" bid, the programme secured £750,000 of external investment over three years from April 2025, alongside match funding from partners including BNSSG ICB.

The bid was developed through a strong cross-sector partnership including voluntary, community, cultural and statutory organisations. The process demonstrated shared leadership and collective ownership, with partners contributing expertise in governance, community engagement and bid development.

The programme is centred on a community-led model, with local residents—particularly those from communities experiencing the greatest need—forming panels to identify priorities and commission creative activity. This ensures that investment reflects what matters most to local people while supporting mental and physical wellbeing.

Aligned with locality priorities around prevention, reducing inequalities and strengthening community voice, the programme also provides an opportunity to build evidence on the role of creative activity in health outcomes.

Delivery will be coordinated by VANS as the lead organisation, with a dedicated programme team including a Programme Director and locality-based Producers. A wider consortium will provide strategic oversight.

In addition, partners have established a £50,000 'Community Chest' to fund small, place-based projects, supporting grassroots organisations and increasing access to creative opportunities for underserved communities.

Looking ahead, the programme will strengthen integration between creative, community and health partners, and support more preventative, community-driven approaches within locality and neighbourhood working

Children & Young People Wellbeing Fund

The North Somerset Children and Young People (CYP) Wellbeing Fund is a multi-partner initiative to improve mental health, healthy weight and overall wellbeing. It is funded through locality partnerships, North Somerset Council Public Health and Sirona Health & Care, with £250,000 committed over three years, including £150,000 in 2025/26.

The fund was developed through a collaborative, cross-system approach, with a focus on early intervention and reducing inequalities through community-based provision. Following a highly competitive process, seven VCSE organisations were selected to deliver services from April 2025.

Funded projects provide accessible, community-based support including peer-led mental health, creative and nature-based therapies, mentoring, and targeted provision for children and young people with additional needs or limited access to statutory services.

A structured approach to monitoring and evaluation is in place, including quarterly reviews, outcome data collection and case studies to capture impact and learning.

Due to funding reductions, Year 2 investment has decreased to £100,000. In response, partners and providers have agreed to continue delivery at approximately two-thirds of original funding levels.

Looking ahead, the programme will focus on sustaining effective provision, strengthening links with wider locality and Starting Well priorities, and identifying longer-term funding opportunities to support community-based prevention and early intervention.

Local Authority Research Practitioner

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.

Supporting Older People

“Improving Ageing in North Somerset” project, led by Voluntary Action North Somerset. This work is supported by new funding from the North Somerset Locality Partnerships and the Big Lottery Fund. In recognition of this ongoing work, North Somerset has now been approved as an official Age-Friendly Community. For full information see: [Improving Ageing — Voluntary Action North Somerset](#)

South Gloucestershire (SG)

In 25/26 the South Gloucestershire Locality Partnership committed Health Inequalities funding to sustain Health & Happiness Hubs projects:

- **Health & Happiness Hubs, SG wide** - Provided by Southern Brooks, the Hubs offer a 10-week programme of facilitated topics to explore self-care using practical and positive psychology approaches. Referrals are via General Practice and by self-referral via the Southern Brooks website ([Health and Happiness Hubs – Southern Brooks Community Partnerships](#)).

The aim is to help people value themselves, take responsibility for their wellbeing, and build supportive connections in their community, increasing happiness and resilience. Sessions are interactive and participatory, creating real peer support, and people are encouraged to make small, positive changes. Participants can attend reunions every 11 weeks to stay connected and motivated.

While mainly for people with long-term health conditions, the hubs also support people in social isolation, with low self-esteem and poor self-care.

A project to develop a Hubs Healthy Weight holistic support offer for people receiving or waiting for weight-loss medications is in the initiation phase.

Impact: People report feeling safe, having a better understanding of how to care for themselves, feeling valued and valuing self and increased connection to others. Many people have stayed in touch with each other and meet in the community, completely independently.

A total of 265 clients have attended and based on total responses across all 5 hubs, 89% of participants said they felt more motivated and empowered and 100% said they had benefitted from attending.

- **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. WARM won the Client Innovation Award at the National Citizens Advice Awards.

Impact: In 25/26 WARM supported 293 clients with over 2,700 issues. Each client was, on average, £2,039.40 better off because of WARM's support.

WARM has demonstrated the value of a holistic, person-centred approach – reducing pressure on other services, improving client wellbeing, and enabling individuals to resolve complex issues with confidence and dignity. WARM's low re-referral rates and consistently positive feedback reflect the lasting impact of the service.

Client testimonial:

"India didn't just help with housing and benefits; she helped emotionally too, far beyond her job description. I am autistic and have ADHD, and I struggle with phone calls, long messages, and expressing myself clearly. But India never made me feel like a burden. She spoke to me in office hours and outside them when emergencies happened. Hearing her voice on the other end of the phone was genuinely comforting. She's someone you can open to. She supported me through a lot more than she ever had to, and she did it with kindness, patience and understanding"

- **Health & Happiness Hubs (HHHs) Outreach Activities (4PCN Leg Club)** - The Leg Club provides community-based treatment, health promotion, education and ongoing care for people who are experiencing leg-related problems. It provides support from specially trained nursing staff to people on a walk-in basis, in a non-medical setting, while volunteers provide holistic care.

Impact: Faster wound healing and significantly lower recurrence rates coupled with improved wellbeing through a holistic approach that aims to enable communities to connect and build resilience.

The Leg Club has over 100 members registered and runs each week seeing 35-40 patients attend; some attendees are now healed but still attend for the social element.

- **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 aims to be the 'go to' individual for local information as well as create new opportunities for individuals and groups to help each other.

In 25/26 the South Gloucestershire Locality Partnership committed **Proactive Care funding** to sustain the:

- **DHI Pain Management Service:** Working across two PCNs (4PCN and Network4), helping people manage chronic pain and improve their wellbeing. The intervention approach is to work with clients over 3-4 contacts per client at spaced intervals over an 8-week period to facilitate engagement with the programme.

Impact: Participants have reported improvement of pain symptoms, increased general wellbeing, and activity levels which have led to fewer contacts with other healthcare services.

- **Physical Activity Link Workers:** Employed by Southern Brooks the PALWs service uses a person-centred approach to help individuals get more active in a supportive judgment-free way. Using a 'what matters to me' approach increases physical activity, builds confidence and emotional resilience, and connects people to their community. The PALWs are integrating with other services including the Health and Happiness Hubs where the PALWs deliver post-group local walks (x 3 sessions) and deliver one in-hub session for the physical activity topic. The PALWs are also integrated with the WorkWell West service.

Impact: Clients have increased general wellbeing and activity levels.

- **Dementia Hospital Discharge Service:** Funded via a shared investment model with the SGLP, South Gloucestershire Council and the Alzheimer's Society the service supports people living with dementia in South Gloucestershire by providing personalised preventative support to aid rehabilitation and reduce the chances of re-admission. The model delivered by the Alzheimer's Society is split across Secondary Care and in the community:
 - **Hospital:** A Dementia Adviser provides in hospital presence, attending daily board rounds on key wards to identify service users who will be suitable for support. The Dementia Adviser also works closely with the Transfer of Care team, Southern Brooks Link Workers and British Red Cross to support discharge
 - **Community Care:** A Dementia Adviser provides intense one-to-one support for people living with dementia for a period of 6 weeks following hospital discharge. This support includes a full care assessment, agreed Support Plan, and weekly contact via a blended approach of home visits and telephone support.

Impact: The service strengthens the integration of acute and community services for dementia so that they work together smoothly. This includes a focus on admission/re-admission avoidance and discharge planning.

Testimonials:

Cathy Daffada, Associate Director for Integrated Discharge, North Bristol Trust, Southmead Hospital

- o 'Early conversations with patients and their families have allowed us to work much more closely together to reduce the barriers to discharge that people often experience, and to help us secure a timely discharge from the hospital setting. Staff in the hub are able to raise any concerns they may have around appropriate support for people, while Alzheimer's Society and their team are able to signpost to appropriate services, whilst also providing education and training for the wider team'

Feedback from Dementia Practitioner in the ToCH at Southmead Hospital:

- o *'Having the two DAs not only helps with timely discharge but also gives our team confidence that community services will be in place and will be supportive. The DAs liaise with the right teams and organisations in the community to help avoid readmission. Their role has helped my team understand the community offer before there was little feedback once the person was discharged. The two DAs are the link to the community. If there is something wrong, they can follow it up, which helps reduce chances of readmission to hospital. Before, there may have been a good discharge plan but once the person was discharged there was no communication'*

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

The statutory Board is made up of elected Members and leaders from Bristol City Council, the NHS, Sirona and the VCSE sector. It is responsible for the Joint Local Health and Wellbeing Strategy, Joint Strategic Needs Assessment, Pharmaceutical Needs Assessment and for promoting and assuring health and care integration. In addition, the Bristol HWB leads action at place level on prevention and reducing inequalities.

Over the past year the Bristol Health and Wellbeing Board has received reports on Better Care Fund, Pharmaceutical Needs Assessment, Sirona Clinical Strategy, Age Friendly City, Multiple Disadvantage, Suicide Prevention Strategy, the health of refugees and asylum seekers, community cohesion, Healthwatch reports, Best Start in Life and the Drug and Alcohol Strategy.

During autumn 2025, two workshops were held with a wide range of partners to develop the initial Bristol Neighborhood's Wellbeing and Health Plan, setting out the vision, ambitions and high-level actions. The Plan was informed by data from the Bristol Joint Strategic Needs Assessment and built on the many existing assets in terms of people and place. In June 2026, following publication of the Neighbourhood Health Framework, further workshops were held at locality level to inform the next iteration of the Plan. These explored local refinement of neighbourhood footprints, community assets for co-location and outreach, and local design of Integrated Neighbourhood Teams.

The Bristol HWB is also a Board of the [One City Partnership](#), providing a platform to tackle the wider determinants of health and wellbeing. Over the last year the Board has held joint workshops with other One City Boards on creative health, active travel and a new Child Health Improvement Framework.

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, Cabinet Member for Homes and Health, since July 2023. Cllr Ho Marris represents North Somerset in the Integrated Care Partnership and was its chair during 2025/26.

Members of the Board include colleagues from the ICB, Locality Partnerships, UHBW (Weston General Hospital), Sirona, voluntary, community and social enterprise (VCSE) sector organisations, Town and Parish Councils, alongside Cabinet Members for North Somerset Council and the Directors of Healthy and Sustainable Communities, Children's Services, and Adults and Housing. Other invited guests attend for key topics as needed.

The Health and Wellbeing Board held three meetings during 2025/26. The Board has focused on a variety of topics, including maximising the potential for health benefit in the local plan, developing of the Joint Strategic Needs Assessment, working with Fire and Rescue, the Pharmaceutical Needs Assessment, the Better Care Fund, Improving Ageing, and shared investment opportunities for better wellbeing. A key theme has been developing our response to the NHS 10-year plan, including the opportunities presented by neighbourhood wellbeing and health.

The Board has monitored progress in delivery of the Joint Health and Wellbeing Strategy. 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.

Meeting papers for the Health and Wellbeing Board are shared via North Somerset Council's website: [Browse meetings - Health and Wellbeing Board | North Somerset Council](#)

South Gloucestershire Health and Wellbeing Board

South Gloucestershire's Health & Wellbeing Board (HWB) is chaired by Cllr John O'Neill, South Gloucestershire Council's Cabinet Member for Adults and Homes.

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 2025-26, at which representatives from the ICB South Gloucestershire Locality Partnership have supported and participated in Board discussions.

Board items included:

- Update on the South Gloucestershire Joint Strategic Needs Assessment (housed on the [Population Health Intelligence Portal](#)).
- Approval of the South Gloucestershire Pharmaceutical Needs Assessment.
- Ratification of the South Gloucestershire Better Care Fund Plan 2025-26.
- Updates on the NHS 10 Year Plan, Healthier Together 2040 and the BNSSG Population Health Plan.
- Discussions about Neighbourhood Health and agreement on how we develop the South Gloucestershire Neighbourhood Wellbeing and Health Plan in 2026.
- Input and updates on: dementia strategy consultation, sexual health services recommissioning, Age Friendly work, BNSSG Community Health and Wellbeing Fund, Giving Every Child the Best Start in Life (including the South Gloucestershire Best Start in Life Plan) and financial security and child poverty.

- Receipt of annual reports from the South Gloucestershire Health Protection Assurance Group, Learning Difficulties Partnership Board, and Drug and Alcohol Partnership.
- Receipt of Healthwatch reports.

The meeting papers can be viewed on the [South Gloucestershire Council Health and Wellbeing Board site](#).

In addition to the formal Board meetings, the Health and Wellbeing Board and ICB South Gloucestershire Locality Partnership held quarterly joint development sessions to explore and agree actions for the year one areas of focus in the [South Gloucestershire Joint Local Health and Wellbeing Strategy 2025-29](#).



In June 2025, partners explored place-based working and Neighbourhood Health. This area of focus provided the Board and Locality Partnership with an excellent starting point for developing plans for Neighbourhood Health (as set out in subsequent national policy).

In September 2025, the session focused on Healthy Weight and promoting the BNSSG 'Why Weight?' Healthy weight pledge.

In February 2026, the Board, Locality Partnership and wider partners working with children and young people, met to provide input into the [South Gloucestershire Best Start in Life Plan](#).

In March 2026, members came together with housing colleagues to build on learning from the housing development session in December 2024 and agree specific areas to take forward during 2026-27.

Finally, we have developed an annual survey to help us understand how the Board and constituent member organisations have developed ways of working in response to the South Gloucestershire Joint Local Health and Wellbeing Strategy 2025-29; and to help agree next steps and areas of focus for 2026-27. The results from the survey will be incorporated into the Board's Annual Report 2025-26, which will be published in July.

Environmental matters

The Bristol, North Somerset and South Gloucestershire ICS Green Plan can be found at [Healthier Together Integrated Care System Green Plan](#). We remain committed to delivering our Green Plan.

Our Chief Finance Officer, Matt Backler, 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 includes sustainability leads for organisations across the system.

ICS partners across the system have been working together on delivering our Green Plan with the aim to be a leader in delivering sustainable healthcare. A key piece of work this year was updating our Green Plan to be in line with new NHS England guidance. All Trust boards within our ICS approved the updates and we are currently in the process of formally publishing the update for public availability.

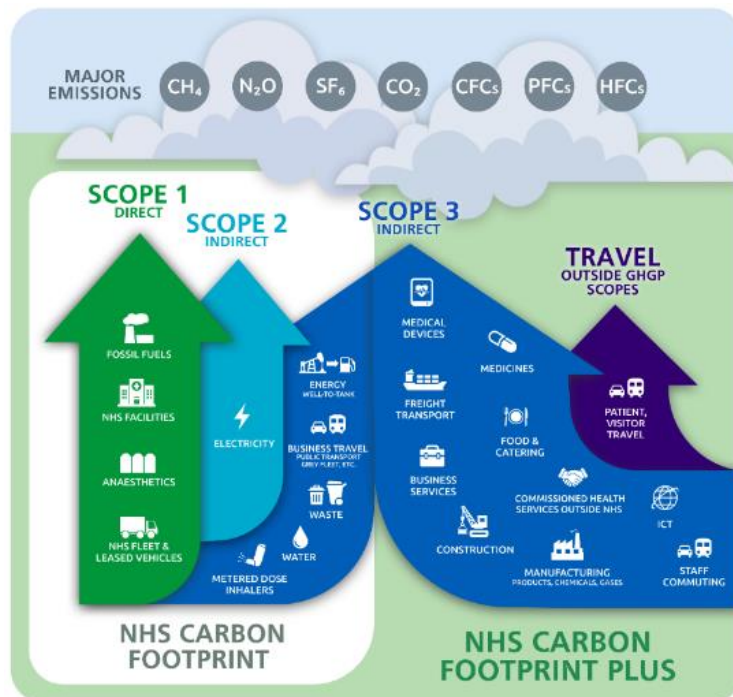
The refreshed Green Plan sets out three clear outcomes we are working towards:

1. Net zero carbon: We will reduce the impact of our services on the environment by achieving net zero carbon for emissions under our direct control by 2030.
2. Improve the environment: We will improve the overall environmental impact and sustainability of our services, creating a cleaner, safer, more ecologically resilient environment locally and globally, by reducing waste, improving air quality and restoring biodiversity.
3. Contribute to a BNSSG-wide movement: Our sustainability behaviours, actions and innovations as anchor institutions will support a cultural change amongst local citizens and businesses resulting in wider improvements in air quality, biodiversity, and the quality of the natural environment.

The ICS has also updated the delivery plan to drive implementation and monitor progress against the Green Plan commitments.

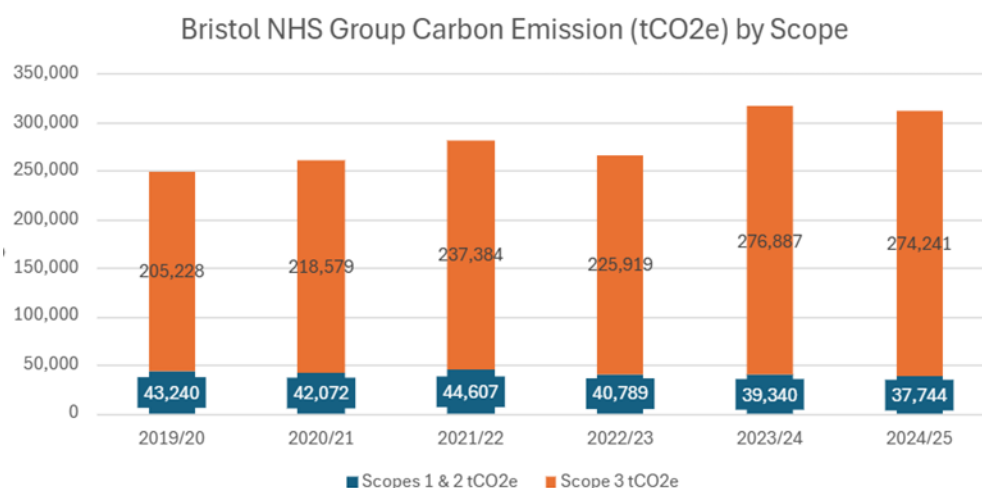
Green Plan Outcome 1 - Net Zero Carbon

The headline target in our Green Plan is achieving net zero greenhouse gas emissions by 2030. This total 'carbon footprint' can be broken up into direct emissions we control (scopes 1 + 2) and indirect emissions from our supply chain (scope 3) which is explained in the below graphic.



NHS Carbon Footprint and Carbon Footprint Plus

Annual data across all scopes is only available for University Hospitals Bristol & Weston NHS Foundation Trust (UHBW) and North Bristol NHS Trust (NBT). However most of our carbon footprint is associated with the acute sector so we are able to use this a representative of our system. The below graph shows the limited (1% reduction in last year) progress towards our net zero goal.



We continued investing in energy-efficiency projects across our hospitals and Avon & Wiltshire Mental Health Partnership (AWP), achieving a 4% reduction in direct emissions (scopes 1 and 2). However, most emissions still come from natural gas use, which remains our biggest barrier to decarbonisation until a major capital programme enables us to move away from gas-fired assets. This year, UHBW progressed plans for this transition and signed a Letter of Intent with Vattenfall, who are developing low-carbon district heating in Bristol.

We have a credible plan to decarbonise the emissions we directly control by 2030. For those we can only influence (NHS Carbon Footprint Plus), we achieved a 1% reduction but rely heavily on supply chains and wider society to decarbonise. As it became clear net zero by 2030 was unrealistic for scope 3, we updated our targets to a 50% reduction by 2030, 80% by 2036, and full decarbonisation by 2045, aligning with Bristol's One City programme and national NHS goals.

Recognising scope 3 as our largest and slowest-moving emissions area, we have prioritised accelerating progress. This has been supported by appointing a Joint Clinical Director for Green and Sustainable Healthcare and launching the Sustainable Healthcare Collaboration, our main programme for clinically led sustainability work.

Sustainable Healthcare Collaboration

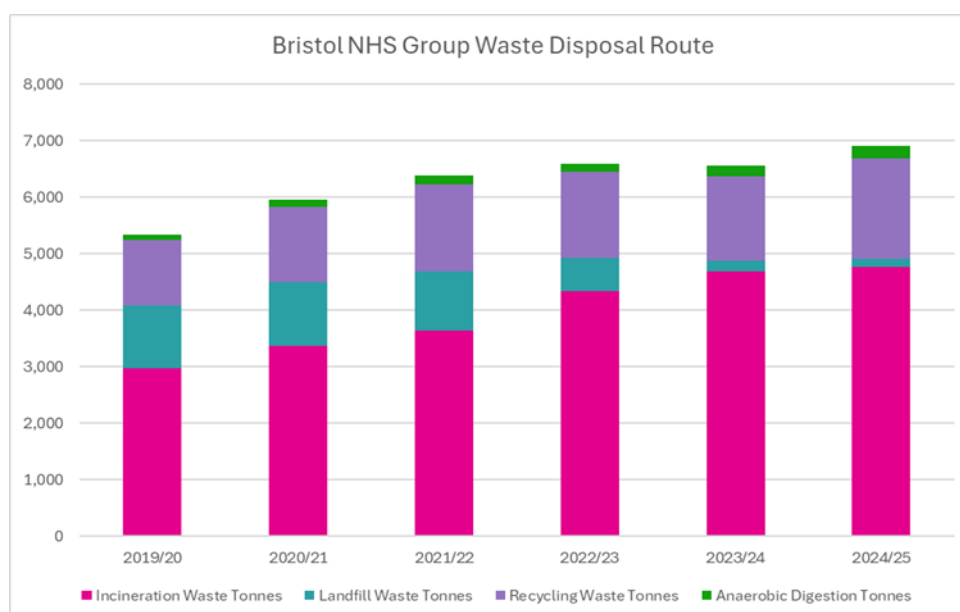
Sanjoy Shah was appointed as the Clinical Director for Green and Sustainable Healthcare across the Bristol NHS Group to drive forward and coordinate sustainability improvements. His roles both as a clinician and as a leader across the Group have been pivotal to accelerating change. Sanjoy created the Sustainable Healthcare Collaboration with the aim of centrally coordinating clinical sustainability projects to provide clear governance and encourage collaboration across the group.

The collaboration brings together high impact clinical specialities and key decision makers such as finance, procurement, quality improvement, and infection control to identify and unblock opportunities to transforming the way patient care is delivered so it does not harm the environment or deplete our limited resources. So far 140 opportunities have been identified and shared with hospital divisions to review.

Green Plan Outcome 2 - Improve the Environment

Waste

Another key target in our Green Plan is diverting 100% of our waste from landfill by 2025. We're very pleased to report this target was achieved on schedule. You can see from the graph below we still sent 96.3 tonnes to landfill in the start of the reporting year but had reduced to zero by the end of 2024.



Whilst this is a major milestone, we recognise there is still a long way to go in reducing our impact from waste. The above graph shows most of our total waste is currently being incinerated, and whilst we can capture energy from this process, it still has a high impact. There are three ways in which our waste is incinerated which are outlined in the table below. NHS England has a 20:20:60 clinical waste ratio target for these different incineration methods to move waste tonnages into lower impact categories.

Clinical Waste Segregation	High Temperature Incineration	Alternative Treatment	Offensive Waste
NHS England Target % Split	20	20	60
Bristol Group 2024/25 % Split	32	26	42

The table shows our progress against this target for the year and it shows that whilst we are close, we still have a way to go. Progress has improved over the year with data from March 2025 showing us being much closer to the target. We have implemented projects to increase segregation to stop waste from being over-treated and have also carried out bin composition audits for specific wards.

Restoring Biodiversity

Our Green Plan has a target of 30% of greenspace on our sites being improved and managed for wildlife and human wellbeing. To achieve this goal, we have integrated biodiversity questions into our sustainability impact assessments for business cases to understand the impacts our developments have on nature.

We've also appointed a grant funded Greenspace Coordinator who has been instrumental in improving the use of greenspace on our estate and delivering nature-based interventions for staff and patients' wellbeing.

Green Plan Outcome 3 - Creating Culture Change

This year we have shifted our staff engagement approach to focus on outcomes. Our approach to creating culture change across our services has also evolved from passive methods such as holding stalls in the NBT Atrium to visiting wards and labs through our Sustainability Audit Programme. Through this programme we have audited 21 departments across the Bristol NHS Group, gaining valuable insights to clinical pathways and curating department-specific action plans to improve. Our waste managers have enriched this programme by delivering compositional waste audits that occur over several days and provide detailed insights on product packaging as well as compliance with waste policies.

Events such as the Sustainable Healthcare Showcase and Allotment Gala aimed to celebrate, educate and empower staff. Through these events we engaged with hundreds of people from our Hospital Group, the wider NHS and local community.

Green Plan Progress

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.

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 System Executive Group at its meeting in January 2026. 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 update 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.

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 action 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.

We are really pleased with the progress made this year, but we recognise there is a long way to go to achieving the outcomes in our Green Plan. As we move into 2026/27 we have ambitious targets for delivering sustainable, resilient, and equitable healthcare. By focusing on systemic transformation, climate leadership, and community collaboration, BNSSG ICS aims not only to meet NHS net zero targets but also to improve the health and wellbeing of its population for generations to come. Our environmental and social sustainability work is aligned with the three strategic shifts the Government wants to make in health and care, which are all also crucial to reduce our carbon emissions.

- Sickness to prevention
- Analogue to digital
- Hospital to community

Maximising the opportunities to build a more sustainable healthcare through the three big shifts will achieve positive transformative change for health, health and care services, and the environment and is essential if we are going to maintain and improve patient care in the future.

Taskforce on Climate-related Financial Disclosures (TCFD)

The DHSC GAM set out 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.

The phased approach incorporates the disclosure requirements of the following 'pillars': Governance, Strategy, 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 organisation 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 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 has been updated during financial year 2025/26. The current Green Plan can be accessed here;

[Healthier Together Integrated Care System Green Plan](#)

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
- Clinical transformation
- Sustainable Waste

- Medicines
- Workforce and leadership

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.

Strategy Pillar

Physical and transition climate-related risks and opportunities need to be considered over the short, medium and long-term. It is proposed to achieve this by integration into the yearly operational planning process (short-term), Medium term 5-year integrated delivery plan and the NHS long term 10-year strategic plan timescales. The system annual operational planning includes assessment of contribution to the Green Plan, The ICS 5-year strategic commissioning plan is informed by the long-term ICS Healthier Together 2040 strategy. Across these timeframes, the degree of certainty and control over climate-related risks and opportunities decreases as the planning horizon extends.

Short term impacts (12-18 months) predominantly influence operational sustainability projects, compliance requirements and budget management. Regulatory changes may require investment to ensure compliance and changes to our operating instructions and processes. Lack of data accuracy and sensitivity impairs our ability to prioritise action and measure progress. Opportunities arise from resource-efficiency projects that reduce operating costs such as those delivered through clinical transformation projects. Access to funding and research also provides opportunities to better understand localised climate impacts. Key support areas affected include operations, supply chain, estates, procurement, fleet management and clinical services.

Medium term (18 months to 2035) impacts focus on strategic investment decisions, including decarbonising our energy use and planning for replacement of the CHP. Rising energy prices and potential carbon taxes create financial pressures that further incentivise investment in energy efficient and net zero technologies. Reputational risks may arise if the ICS does not meet its interim targets. Opportunities lie in embedding climate-related risk and opportunities into our decisions making processes. Medium

term impacts affect estates, finance, clinical services, strategy and governance.

Long term risks (to 2045 and net zero) increased frequency of extreme weather disruption including coastal flooding in Weston, infrastructure damage and escalating resilience costs. Failure to meet our net zero target may result in substantial financial liabilities linked to carbon offsets or carbon taxes. Long-term opportunities relate to the adoption of climate-resilient technologies and low carbon clinical pathways. These impacts affect estates, emergency planning, finance, supply chain, strategy, operations, clinical services, workforce and adaptation.

The ICS has not yet undertaken formal climate scenario analysis for a 2-degree warming pathway over short, medium and long-term horizons. However, preparatory work is underway. There are three impacts that we have prioritised;

1. The impact of heatwaves on demand for hospital services.
2. The impact of heatwaves on productivity.
3. Disruptions to our supply chain.

The Bristol NHS Group are part of a research study looking into the impact of heatwaves on Emergency Department admissions. Also in development is a study looking at the impact of heatwaves on Pathology. Both studies will look to quantify the current impact and apply it to scenario models under a 2-degree warming pathway.

This work is in the early stages but forms the basis of the Trusts looking at the medium to long term impact of climate change on its strategy, operations and finances.

Integration of climate-related risks into strategic and financial planning is developing. Whilst it is not yet systematically embedded, the use of Sustainable Impact Assessment process into business case development and decision making. The Assessment helps to quantify climate impacts. It focuses on mitigation actions but could be developed to include adaptation. Carbon budgeting is also being considered but data availability remains a limitation to the introduction of this

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.

Risks are identified using;

- Current and emerging regulatory requirements,
- Green Plan commitments,
- National NHS climate priorities,
- Previous evidence from operational impacts (e.g., increased cooling requirements during heatwaves),
- Local health priorities and
- Financial modelling of future energy and carbon related costs.

Long term risks carry greater uncertainty due to extended time horizons.

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 (essentially fossil fuel risk exposure). 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.

No mitigation measures are currently in place to address the increased risk of extreme weather events including the impact of heatwaves on staff productivity and service demands. The long-term time horizon that these risks cover do not complement current risk scoring mechanisms which leaves its priority in the face of more immediate pressures, low in comparison.

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 Green Plan contains a comprehensive set of environmental metrics to monitor performance, inform decision making and support compliance with NHS England reporting requirements. It outlines the interim and long-term targets for 5 years to 2030. All targets are absolute reduction targets. They are not science based but align with the wider NHS ambition for achieving net zero and reflect our local priorities and impacts. The Trust informally uses an internal carbon price through the completion of Sustainability Impact Assessments. This is not formally applied and is only used to influence decisions and change behaviour.

The Green Plan can be found here; [6.2 - ICS Green Plan Refresh - ICB Board July 2025](#)

The Trust's three main commitments are to;

1. Improve the environment: reduce air pollution and restore biodiversity.
2. Achieve net zero carbon:
 - a. Net zero for directly controlled emissions by 2030;
 - b. 50% reduction in influenced emissions by 2030;
 - c. 80% reduction in influenced emissions by 2036 and;
 - d. Net Zero for influenced emissions by 2045.
3. Drive a wider sustainability movement: inspire change across local communities and partners.

The baseline year for our carbon target is 2019/2020, representing a pre-pandemic operating position for comparison.

In 2025, ICS revised its net zero target for influenced emissions. The target date moved from 2030 to 2045. This decision aligns our target with the wider NHS net zero target. It also reflects the scale and complexity of scope 3 emissions.

Please refer to the ICS Green Plan for the specific measurable targets we are aiming to achieve under each Green Plan strategic commitment. The metrics are collected for regulatory compliance and NHS England reporting requirements. They also support the ICS in assessing and managing material climate-related risks. Metrics and performance have been reviewed by the Board and are publicly published in this document.

This data helps the ICS manage its climate-related risks in the following ways;

Risk Area	Metrics	Purpose
Local health risks	Air quality monitoring Travel and Transport	• Inform operational and financial decisions relating to fleet purchases and supply chain deliveries. • Health and safety risk for staff exposed to high levels of air pollution. • Health benefits of active travel.
Financial risks	Greenhouse gas emissions Waste Management	• Inform offset cost modelling for future financial exposure associated with residual emissions. • Inform fossil fuel financial exposure in supply chain • Assess the energy-cost risks and investments requirements for decarbonisation projects. • Budget planning for waste management and potential savings resulting from waste reduction and improved segregation activities.
Compliance and Reputation	All metrics and data	• NHS England reporting and compliance. • Demonstrate transparency and progress against our ICS Green Plan commitments.

The ICS aligns its reporting boundaries and accounting methodologies with those of NHS England and the GHG Protocol Corporate Standard.

Conversion factors are checked and updated each year where relevant.
Scope 2 emissions use location-based factors.

Consumption based data is used for energy, waste, water, owned fleet, grey fleet, business travel, anaesthetic gas and inhaler calculations.

Spend-based metrics are used for supply chain emissions including pharmaceuticals and medical equipment where consumption data is not currently available.

Travel and transport emissions are calculated via mileage claims, expenses claims or NHS England proxy formulas.

During 2025, the Trusts introduced a couple of changes to improve data accuracy:

- Inflation adjustments applied to supply-chain scope 3 emissions
- Correct reporting of waste sent for high temperature incineration and alternative treatment.

These changes have been made to all previous year's data including the baseline year to ensure their methodologies are comparable. Except for this, no other amendments have been made to the baseline year.

The carbon footprint includes scopes 1, 2 and 3 as described above. Annual data 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.

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 data in the table below shows our performance data for 2025/26. It also shows performance for the previous two financial years and the baseline year to allow for comparison.

Emissions Source	Unit	2019/20	2023/24	2024/25	2025/26
Scope 1	tCO ₂ e	13,354	10,887	9,369	TBC
Scope 2	tCO ₂ e	10,444	7,757	8,450	TBC
Scope 3	tCO ₂ e	70,405	121,347	121,534	TBC
Total	tCO₂e	94,203	139,991	139,353	TBC
Energy					
Gas consumption	kWh	45,472,381	38,847,710	34,074,385	TBC

Emissions Source	Unit	2019/20	2023/24	2024/25	2025/26
Oil Consumption	Litres	583,708	560,244	226,960	TBC
Electricity Consumption	kWh	40,860,494	37,459,751	40,812,725	TBC
Anaesthesia					
Anaesthesia	tCO2e	3,167	2,037	2,265	TBC
Supply Chain					
Purchased goods and services (including upstream transport and distribution)	tCO2e	44,326	97,686	97,370	TBC
Travel and Transport					
Trust owned Fleet	tCO2e	217	199	246	TBC
Business Travel Grey Fleet	tCO2e	132	235	98	TBC
Business Travel (Air, Rail)	tCO2e	116	199	59	TBC
Employee Commuting	tCO2e	4,304	4,705	4,893	TBC
Patient and Visitor	tCO2e	6,371	13,300	14,040	TBC
Waste					
Total Waste	Tonnes	2,970	3,032	3,119	TBC
Total Waste	tCO2e	843	865	829	TBC
Offensive Waste	tCO2e	64	151	175	TBC
High Temperature Incineration	tCO2e	256	348	301	TBC
Alternative Treatment Waste	tCO2e	333	183	192	TBC
General Waste for EfW	tCO2e	173	166	155	TBC

Emissions Source	Unit	2019/20	2023/24	2024/25	2025/26
Recycling	tCO2e	17	15	5	TBC
Anaerobic Digestion	tCO2e	1.06	0.84	0.86	TBC
Landfill	tCO2e	0.00	1.77	0.00	TBC
Offensive Waste	Tonnes	257	605	702	TBC
High Temperature Incineration	Tonnes	238	324	280	TBC
Alternative Treatment Waste	Tonnes	586	322	337	TBC
General Waste for EfW	Tonnes	1,005	963	904	TBC
Recycling	Tonnes	781	721	800	TBC
Anaerobic Digestion	Tonnes	104	94	97	TBC
Landfill	Tonnes	0	3	0	TBC
Water					
Water volume	m3	316,732	341,992	371,326	TBC
Waste water	m3	294,135	324,800	347,627	TBC
Water volume and wastewater	tCO2e	317	126	121	TBC

Current performance shows no significant reduction in total emissions, reflecting the dominance of Scope 3 emissions and limitations of spend based methodologies. We expect emission reductions to occur as structural decarbonisation measures are implemented and as data becomes more sensitive to the mitigation activities introduced..

Targets, commitments and key performance indicators set out in the Green Plan and delivery plan. The reporting on progress and actions to address performance are included in the green plan annual report to the ICB board.

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 and Social Care. 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 2025 to 31 March 2026.

Overview of 2025/26 financial framework

NHS financial arrangements for 2025/26 continued to support a system-based approach to planning and delivery. NHS England's revenue finance and contracting guidance for 2025/26¹ confirmed that systems would continue to be the key unit for financial planning purposes, with integrated care boards and partner trusts expected to work together to develop credible and realistic plans within the resources available. These arrangements continued to emphasise financial discipline, improved productivity, and local flexibility over the deployment of funding to meet the needs of local populations while living within allocated budgets.

For 2025/26, NHS England required systems and organisations to focus on improving access to timely care for patients, increasing productivity, reducing waste and delivering financial balance². System plans needed to be impact-assured and supported by realistic phasing of savings and efficiency delivery across the year.

The financial framework also continued to operate within the statutory duties established under the National Health Service Act 2006. As set out in national guidance, each ICB and its partner trusts were required to seek to achieve system financial balance and remain within revenue and capital resource use limits set by NHS England. In addition, ICBs continued to have their own statutory duty to maintain financial balance as individual organisations and to remain within their running cost allocation.

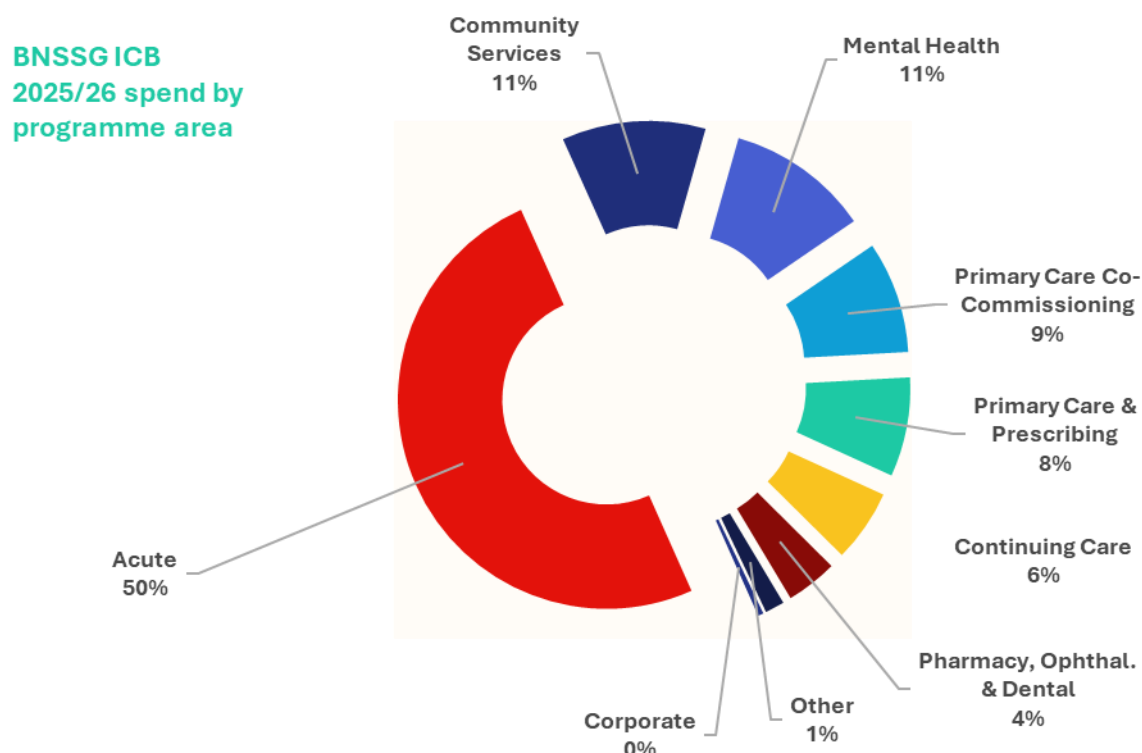
Our local health system produced an operational plan for 2025/26 which delivered a balanced net system financial position (and for each member organisation individually). Monthly finance

¹ [NHS England » Revenue finance and contracting guidance for 2025/26](#)

² [NHS England » 2025/26 priorities and operational planning guidance](#)

reports presented throughout 2025/26 have reported progress against these plans, with analysis of any variances.

The chart below sets out how the ICB planned to spend its revenue allocation for 2025/26:



Financial duties

During the financial period 1 April 2025 to 31 March 2026, 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 2025 to 31 March 2026.

Analysis of Financial Performance 1 April 2025 to 31 March 2026	Programme costs	Running Costs	Total
	£'000	£'000	£'000
Total net operating cost for the financial year	2,554,870	22,301	2,577,171
Final in year revenue resource limit	2,553,489	23,805	2,577,294
Surplus/(deficit) in year	-1,381	1,505	124

The table below sets out an analysis of how final expenditure compared to budget. This shows that, whilst the overall position was delivered within the planned control total, there were a number of over- and underspends across programme areas, with underspends in medicines management offsetting significant pressures in mental health and acute services.

Financial performance 1 April 2025 to 31 March 2026	Budget	Expenditure	Variance
Programme Area	£m	£m	£m
Acute	(1,322,672)	(1,325,143)	(2,471)
Mental Health	(241,220)	(247,605)	(6,386)
Community	(261,359)	(259,890)	1,469
Delegated Primary Care	(318,241)	(315,337)	2,904
Medicines Management	(167,708)	(161,846)	5,862
Primary Care	(38,988)	(39,005)	(17)
Funded Care	(140,732)	(141,108)	(377)
Children's	(53,795)	(55,096)	(1,301)
Support Costs	(15,607)	(16,669)	(1,062)
Reserves	6,833	6,829	(4)
Running Costs	(23,805)	(22,301)	1,505
BNSSG ICB Income/ (Expenditure)	(2,577,294)	(2,577,170)	124
<u>Provider Surplus/(Deficit)</u>			
AWP	-	1,672	1,672
NBT	-	4,941	4,941
UHBW	-	4,976	4,976
Provider (Surplus)/ Deficit	-	11,589	11,589
ICS Position	(2,577,294)	(2,565,581)	11,713

Included within the position above is delivery of the ICB's efficiency programme. The programme had a planned value of £49.8m and achieved full-year delivery of £51.7m, exceeding plan by £2.0m.

The provider surplus of £11.6m reflects a national reallocation of deficit support funding from trusts that did not meet the relevant pre-requisites to those that delivered a breakeven position

and submitted compliant 2026/27 plans. This provided additional cash support for the capital programmes of those organisations.

Capital resource is made available for long-term spend such as new buildings, equipment, and technology. We have been allocated £10.3m for capital which comprises:

- £2.3m core ICB capital relating to GP information and technology, Corporate Information Technology and for minor improvement grants in primary care
- £5.7m for the relocation and redevelopment of Well Road Surgery;
- £0.4m for initial scoping work at Broadmead Charlotte Keel Surgery;
- £0.6m for the redevelopment of the Thornbury Health Centre (residual balance on prior year investment of £16.2m); and
- £1.1m for the Central Weston development Centre (residual balance on prior year investment of £8.4m).

We have met our statutory duty not to exceed this resource for 2025/26, as demonstrated in the table below:

Analysis of Financial Performance 1 April 2025 to 31 March 2026	Total capital resource
	£'000
Total net capital cost for the financial year	10,148
Final in year capital resource limit	10,290
Under/(over) spend in year	142

Running Costs

NHS Bristol, North Somerset and South Gloucestershire ICB was funded a total of £17.0m for the period 1 April 2025 to 31 March 2026 to support headquarters and administration costs, together with an additional allocation of £6.8m to support transition costs associated with commissioning changes

Total expenditure (excluding transition costs) recorded against running costs for the period 1 April 2025 to 31 March 2026 was £17.5m, which was within the ICB's revenue administration resource limit as 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 business intelligence support, information technology and information governance support, procurement services support, care navigation services, GP IT services, and additional consultancy and project support. Following NHS England's announcement that CSUs will be

disestablished by December 2026, we are considering alternative arrangements for the provision of these services.

Financial governance

NHS Bristol, North Somerset and South Gloucestershire ICB's Finance 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 Finance 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 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 three non-executive members. Five meetings were held between 1 April 2025 and 31 March 2026, and considered: governance, risk management and internal control, internal audit, external audit, counter fraud and other assurance functions. Through the work of the Audit 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 2025 to 31 March 2026 are included in Appendix 1 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 2025 to 31 March 2026 is summarised below:

	2025-26 No.	2025-26 £'000	2024-25 No.	2024-25 £'000
Non-NHS Trade Payables				
Invoices paid in the period	30,523	910,666	31,747	857,922
Invoices paid within target	30,248	889,394	31,457	848,106
% paid within target	99.1%	97.7%	99.1%	98.9%
NHS Trade Payables				
Invoices paid in the period	1,206	1,477,119	1,265	1,324,977
Invoices paid within target	1,180	1,476,159	1,230	1,322,719
% paid within target	97.8%	100.0%	97.2%	99.8%

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 on page 189 of the remuneration and staff report, together with their pension entitlements and declarations of interest.

External Audit

KPMG LLP is the appointed external auditor for NHS Bristol, North Somerset and South Gloucestershire ICB for the accounting period 1 April 2025 to 31 March 2026. The total fees payable to KPMG UK LLP by the ICB for 2025/26 were £265,055 including VAT to cover the cost of the statutory audit, value for money audit requirements and associated services for the ICB.

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 147.

Operational Financial Planning 2026/27

For 2026/27, operational and financial planning is moving into a broader medium-term planning framework. NHS England has published a financial framework³ and allocations package covering 2026/27 to 2028/29, including the revenue finance and contracting guidance, capital guidance, ICB allocations and running cost allowances. This provides a longer planning horizon for integrated care boards and NHS trusts and supports the development of financially sustainable plans over the medium term.

Within this framework, systems are expected to align operational priorities, service transformation, productivity improvement and financial sustainability over the period 2026/27 to 2028/29. The planning framework places continued emphasis on affordability, efficient use of resources, and delivery of services within available allocations.

The 2026/27 planning regime also reflects a stronger emphasis on organisational accountability for financial performance. NHS England's finance business rules for 2026/27 indicate that both ICBs and NHS trusts are expected to deliver financially sustainable positions as individual organisations, alongside wider system sustainability.

In preparing our 2026/27 operational plan, we are taking account of the national medium-term planning framework and associated financial guidance. This includes consideration of service priorities, transformation requirements, workforce implications, productivity assumptions, capital affordability and running cost controls. Our planning is being developed through established governance arrangements, with formal oversight through the Finance Committee and Board.

The Bristol, North Somerset and South Gloucestershire system's 2026/27 planning assumptions are being reviewed through regular financial reporting and governance processes, including assessment of risks, mitigations and delivery against plan. As with previous years, the ICB will continue to seek to achieve its statutory financial duties while working collaboratively with system partners to support overall financial sustainability.

Going concern

Within our accounts, we are required to disclose that those charged with governance for NHS Bristol, North Somerset and South Gloucestershire ICB have considered the appropriateness of preparing the accounts on a going concern basis and, having regard to the information available, are satisfied that this remains appropriate. Where there are material uncertainties

³ [NHS England » Financial framework and allocations](#)

relating to events or conditions that may cast significant doubt on the ICB's ability to continue as a going concern, these are disclosed in the notes to the annual accounts.

In reaching its conclusion, the Board has considered the ICB's statutory functions, its approved financial framework and financial duties, its cash flow and liquidity arrangements, and the planning assumptions for 2026/27. The Board has also considered the wider financial governance arrangements in place, including regular reporting to the Finance Committee and Board, oversight of financial risks and mitigations, and the continuing development of operational and financial plans in line with national guidance.

The Board has additionally considered the planned changes to the ICB's organisational arrangements with Gloucestershire ICB. During 2025/26, a joint Board was appointed, and a common executive team was put in place across the two organisations. Consultation on the wider staffing structure remained in progress at the year end. From 1 April 2026, NHS Bristol, North Somerset and South Gloucestershire ICB and Gloucestershire ICB will operate under a common Board and executive arrangement as part of wider NHS requirements to reduce running costs and streamline management arrangements. There is also an intention for the two ICBs to merge from 1 April 2027, subject to the completion of the necessary statutory, regulatory and governance processes.

The Board has concluded that these changes represent a planned transition in organisational form and governance rather than any cessation of the ICB's activities. Throughout this period, the ICB is expected to continue to discharge its statutory functions, manage its resources, and prepare annual accounts in the normal course of business. Accordingly, the Board does not consider these organisational changes to create a material uncertainty in relation to the ICB's ability to continue as a going concern.

Having considered the going concern guidance, the ICB's financial reporting and governance arrangements, the approach to the development of operating plans for 2026/27, and the continued focus by the ICB and system partners on financial sustainability, the Board is satisfied that it remains appropriate to prepare the annual accounts on a going concern basis. The annual accounts have therefore been prepared on the basis that the organisation will continue in operational existence for the foreseeable future.

ACCOUNTABILITY REPORT

A handwritten signature in black ink, appearing to read 'SD', followed by a horizontal line.

SHANE DEVLIN

Accountable Officer

16 June 2026

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 2025 to 31 March 2026 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 policies 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 2025 and 31st March 2026. 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 25/26 there have been changes to our Constitution which were agreed by the Board and supported by NHSE, this included permission of a CEO to lead more than one ICB to support the development of clustering arrangements with Gloucestershire ICB.

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 Non Executive Directors (formerly known as Independent Non-Executive Members). Alison Moon has retained the role of Senior Independent Director (SID) during 25/26 to meet constitutional requirements.
- 8 Partner members

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
- Coastal, rural and urban communities represented by the CEOs of our three local authorities

From 1 September 2025, Jeff Farrar was appointed by NHS England as Cluster Chair. Shane Devlin was subsequently appointed as the CEO for both BNSSG and Gloucestershire ICBs. Following a period of consultation and a voluntary redundancy process a new Executive Team was appointed for the Cluster which will take effect from 1 April 2026.

From 1st April 2025 to 31st March 2026 voting Board members were as follows:

Name	Title	Tenure 2025/26	Attendance
Jeff Farrar	Chair of BNSSG Integrated Care Board	1 st April 2025 – present	Seventeen of Seventeen
John Cappock	Non-Executive Director, Chair of Audit and Risk Committee	1 st April 2025 – present	Seventeen of Seventeen
Jaya Chakrabarti	Non-Executive Director, Chair of People Committee	1 st April 2025 – present	Seventeen of Seventeen
Shane Devlin	Chief Executive Officer, BNSSG ICB	1 st April 2025 – present	Eleven of Eleven
Ellen Donovan	Non-Executive Director Chair Quality and Performance Committee and Chair of Remuneration Committee	1 st April 2025 – present	Thirteen of Seventeen

Dominic Hardisty	Chief Executive Officer, Avon and Wiltshire Mental Health Partnership NHS Trust	1 st April 2025 – present	Eleve of Seventeen
Nick Hibberd	Chief Executive, Bristol City Council	1 st April 2025 - present	Three of Seventeen
Maria Kane	Joint Chief Executive Officer, NHS North Bristol Trust and University Hospitals Bristol and Weston NHS Foundation Trust	1 st April 2025 – present	Thirteen of Seventeen
Jacob Lee	Clinical Chair, GP Collaborative Board	1 st April 2025 – present	Fifteen of Seventeen
John Martin	Chief Executive Officer, South Western Ambulance Service NHS Foundation Trust	1 st April 2025 – present	One of Seventeen
Joanne Medhurst	Chief Medical Officer, BNSSG ICB	1 st April 2025 – present	Thirteen of Seventeen
Alison Moon	Non-Executive Director, Chair Primary Care Committee	1 st April 2025 – present	Sixteen of Seventeen
Dave Perry	Chief Executive, South Gloucestershire Council	1 st April 2025 – present	Ten of Seventeen
Julie Sharma	Interim Chief Executive Officer, Sirona care & health	1 st April 2025 – 31 st December 2025	Thirteen of Fourteen
Jo Beer	Chief Executive Officer, Sirona care & health	1 st October 2025 – present	Six of Seven
Rosi Shepherd	Chief Nursing Officer, BNSSG ICB	1 st April 2025 – present	Twelve of Seventeen
Sarah Truelove	Chief Financial Officer and Deputy Chief Executive, BNSSG ICB	1 st April 2025 – 30 th July 2025	Six of Six
Matt Backler	Interim Chief Finance Officer, BNSSG ICB	1 st August 2025- present	Nine of Eleven
Jo Walker	Chief Executive Officer, North Somerset Council	1 st April 2025 – 31 st May 2025	Seven of Eleven
Mandy Bishop	Chief Executive Officer, North Somerset Council	1 st September 2025 – present	Six of Ten
Steve West	Non-Executive Director – Finance, Estates and Digital	1 st April 2025 – present	Fifteen of Seventeen

Participants regularly attending the ICB Board in 25/26 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
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
Richard Smale

Chief Executive, The Care Forum (providing Healthwatch perspective) (19 February 2025 – present)
Interim Director of System Coordination, NHS England South West (April 2025 – present)

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 the main, the Board meetings have been Chaired by Jeff Farrar, ICB Chair. However, in the latter part of the year, Alison Moon, Deputy Chair, has chaired meetings to increase the non-executive capacity required to support the organisational changes and clustering arrangements.

In 25/26, the Board met to discuss matters in seminars to support their work to serve our population. Seminars have included the following subject areas:

- The impacts of the proposed organisational changes and how staff are supported
- The design of a new ICB in line with the Model ICB Blueprint
- The learning from safeguarding reviews and associated developments.

Additionally, to support the development of cluster arrangements, the BNSSG Board met with the Gloucestershire ICB on 22 January 2026 at a session hosted by the Chair of both ICBs, Jeff Farrar.

The ICB Chair, 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 established nine committees including the Audit and Risk Committee. Committees' terms of reference can be found here [Governance Handbook](#). In 25/26, in response to the Publication of the Model ICB Blueprint, we added the Joint Transition Committee to govern the various aspect of the organisational changes and the cluster relationship with Gloucestershire ICB. In addition, to support our delivery of the delegated responsibility for Specialised Commissioning, our Board delegated responsibilities to the South West Joint Specialised Services Committee. This was established on 1 April 2025 and is managed by Somerset ICB. OUR Scheme of Reservation and Delegation identifies executives who are empowered to make decisions through this regional committee on behalf of the population we serve.

We provide more information about our committees, their membership and attendance details, in the Governance Statement on page 147.

Register of Interests

Details about the declared interests of ICB Board members and participants can be found at [ICB register of interests](#)

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 2025 to the 31st of March 2026, 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.

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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 2025 and 31 March 2026 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 operates in line with the good governance standards including the standards of behaviour published by the Committee on Standards in Public Life (1995) known as the Nolan Principles, Fit and Proper Person Test (FPPT) Framework in response to recommendations made by Tom Kark KC in his 2019 review of the FPPT (the Kark Review), and the seven key principles of the NHS Constitution. This includes the highest standards of propriety involving impartiality, integrity and objectivity in relation to the stewardship of public funds, the management of the organisation and the conduct of its business.

The ICB Board composition and attendance is described on page 140. 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](#) . In 25/26 the Board have agreed changes to the Board composition and the constitution. Due process has been followed and NHSE England have been engaged in and 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](#):

- 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 continues to involve the established the Independent Advisory Group to support the organisation's duties to address health inequalities. 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 Independent Advisory Group has also supported the Joint Transition Committee work to deliver organisational changes.

The following section identifies information about the remit of each committee, its membership and attendance. The Terms of Reference, which the committees keep under review, are listed in the [Governance Handbook](#).

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
Alison Moon	Non-Executive Director, ICB Board	Five of five

Anne Tutt	Non-Executive Director, UHBW	Two of three
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.

To support the clustering arrangements with Gloucestershire ICB, in addition to meeting as established by the Board, the BNSSG has met once 'in common' with the Gloucestershire ICB Remuneration Committee. Building on this arrangement, and to support the organisational changes, BNSSG ICB Board has established a Joint Remuneration committee with Gloucestershire ICB with a revised membership.

Committee membership and attendance are detailed in the table below:

BNSSG Remuneration Committee		
Name	Title	Attendance
Jaya Chakrabarti	Non-Executive Director, BNSSG Board	Four of Four
Ellen Donovan	Non-Executive Director ICB Chair of Remuneration Committee	Four of Four
Jeff Farrar	Chair ICB Board	Four of Four
Alison Moon	Non-Executive Director, BNSSG Board	Four of Four
Steve West	Non-Executive Director, BNSSG Board	Three of Four
Joint Remuneration Committee		
Name	Title	Attendance
Karen Clements	Non-executive Director, GICB	Four of Four
Jane Cummings	Non-executive Director, GICB	Four of Four
Ellen Donovan	Non-Executive Director ICB Chair of Remuneration Committee	Two of Four
Jeff Farrar	Chair ICB Board	Five of Five
Alison Moon	Non-Executive Director, BNSSG Board	Three of Four
Dominic Hardisty	Chief Executive, Avon and Wiltshire Mental Health Partnership Trust	One of One
Graham Russell	Chair, Gloucestershire Health and Care NHS Foundation Trust	One of One

Nick Hibberd	Chief Executive, Bristol City Council	One of One
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Please note that in December 2025, BNSSG ICB Board agreed terms of reference for its remuneration committee to become joint with Gloucestershire ICB. This accounts for the entries listed above.

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 2.

Name	Title	Attendance
Ellen Donovan	Non-Executive Director ICB; Chair of Outcomes, Performance and Quality Committee; Chair of Remuneration Committee.	Five of Five
Sue Balcombe	Non-Executive Director, UHBW (ENDED MARCH 2025)	One of Five
Hugh Evans	Executive Director, Adult & Communities, Bristol City Council	One of Five
Jacky Hayden	Non-Executive Director, Sirona care & health	Five of Five
Jacob Lee	GP Collaborative Board Chair	Two of Five
Jo Medhurst	Chief Medical Officer, ICB	Five of Five
Rosi Shepherd	Chief Nursing Officer, ICB	Four of Five
Sarah Weld	Director of Public Health, South Gloucestershire Council	Zero of five
Jeff Farrar	Chair, BNSSG ICB	Three of five
Alison Moon	Non-Executive Director, ICB	Five of five
David Jarrett	Chief Delivery Officer, ICB	Four of Five
Professor Sarah Purdy Group	Non- Executive and Vice Chair for NBT (replacement for Sue Balcombe at OQPC from April 2025)	Zero of five

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	Nine of twelve
Deborah El Sayed/ Seb Habibi	Director of Transformation and Chief Digital Information Officer, ICB	Twelve of twelve
Richard Gaunt	Non-Executive Director NBT	Ten of twelve
Christina Gray	Director of Public Health, Bristol City Council	Eight of twelve
Jo Medhurst	Chief Medical Officer, ICB	Eight of twelve
Amy Webb	Section 151 Officer, North Somerset Council <i>(attendance from March 2024)</i>	Four of twelve
Brian Stables	Non-Executive Director, AWP	Eleven of twelve
Martin Sykes	Non-Executive Director, UHBW	Zero of twelve
Rosi Shepherd	Chief Nursing Officer, ICB	One of twelve
Sarah Truelove/ Matt Backler	Chief Financial Officer, ICB	Eleven of twelve
Jeff Farrar		Four of Twelve
Nina Philippidis		Zero 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	Seven of Seven
Georgie Bigg	Healthwatch Bristol, North Somerset and South Gloucestershire	Two of six
Katrina Boutin	GP Collaborative Board Representative	Four of seven
Dr Barbara Brown	Chair, Sirona	One of five
Ellen Donovan	Non-Executive Director ICB Board	Six of Seven
Jeff Farrar	Chair ICB Board	Three of Seven
John Hopcroft	Avon Local Optical Committee	Four of seven
Matthew Jerreat	Clinical Chair of the Southwest Local Dental Network	Three of Seven
David Jarrett	Chief Delivery Officer, BNSSG ICB	Seven of Seven
Matt Lenny	Director of Public Health, North Somerset Council	Five of Seven
Dr Joanne Medhurst	Chief Medical Officer, BNSSG ICB	Four of Seven
Dr Shaba Nabi	Chair, Avon Local Medical Committee	Four of Seven
Sarah Purdy	Non-Executive Director, NBT	Four of Seven
Hayley Richards	Non Executive Director, Sirona	One of one
Rosi Shepherd	Chief Nursing Officer, ICB	Three of Seven

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	Five of five
Ellen Donovan	Non-Executive Director ICB	Four of five
Alison Moon	Non-Executive Director ICB	Four of five
Linda Kennedy	Non-Executive Director, UHBW	Five of five
Jo Hicks	Chief People Officer, BNSSG ICB	Five of five
Kelvin Blake	Non-Executive Director, ICB	Left in November 2025 as Jenny Lewis, Chief People and Culture Officer joined meetings. Two of five.
Rosi Shepherd	Chief Nursing Officer, BNSSG ICB	Two of five
Sonya Wallbank	Chief People Officer, Sirona	Left in 2025 Domini Harewood attends as CPO
Rebecca Helmsley	Chief People Officer, Sirona	Left in 2025 Domini Harewood attends as CPO
Jan Baptiste-Grant	Non- Executive Director, AWP	Three of five
Anil Patil	Non-Executive Director, Sirona	Zero of five
Tim Cooper	Non-Executive Director, Sirona	Not attended due to clashes but Domini Harewood has attended as his deputy for three of five
Lorraine Francis	Councillor for Eastville, BCC	Three of five
Bryony Campbell	Executive Director, Transformation and Strategy - One Care	Three of five

ICB People Committee		
Name	Title	Attendance
Jaya Chakrabarti	Non-Executive Director ICB	Five of five
Ellen Donovan	Non-Executive Director ICB	Three of five
Alison Moon	Non-Executive Director ICB	Four of five
Jeff Farrar	Chair	Four of five
Shane Devlin	Chief Executive	One of five
Jo Hicks	Chief People Officer	Five of five
Sarah Truelove	Deputy Chief Executive/Chief Finance Officer	One of five due to leaving the ICB in July 25. There was no replacement for Sarah.
Joanne Medhurst	Chief Medical Officer	One of five
Rosi Shepherd	Chief Nurse Officer	One of five
Deborah El-Sayed	Chief Transformation Officer	One of five due to leaving the ICB in December 25. There was no replacement for Sarah.
Dave Jarrett	Chief Delivery Officer	Four of five

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)	Six of six
Jo Medhurst	Chief Medical Officer BNSSG Integrated Care Board (ICB)	Five of six
Deborah El-Sayed	Chief Transformation and Digital Information Officer BNSSG Integrated Care Board (ICB)	Three of five
Rosi Shepherd	Chief Nursing Officer BNSSG Integrated Care Board (ICB)	Zero of six
Grace Burn	Public Contributor	Four of six
Samina Baig	Public Contributor	Two out four
Lucy Heard	Public Contributor	Four of six
Amanda Threlfall	Public Contributor	Three of six
Steve Nelson	Chief Executive Wesport	Four of six
Mark Graham	Chief Executive For All Healthy Living	Six of six
Kevin Peltonen-Messenger	Chief Executive of The Care Forum	One of six
Tracie Joliff	Chair ICB Independent Advisory Group on Race Equality	Three of six
Christina Gray	Director of Public Health Bristol City Council	Zero of six
Matt Lenny	Director of Public Health North Somerset Council	Three of six
Sarah Weld	Director of Public Health South Gloucestershire Council	Two of six
Katrina Boutin	Medical Director	Three of six

	General Practice Collaborative Board	
Richard Brown	Chief Officer Local Pharmaceutical Committee	One of six
Jen Bond	Deputy Director Communications and Engagement, BNSSG ICB	One of six
Philip Clatworthy	Consultant Stroke Neurologist and Honorary Senior Clinical Lecturer, North Bristol Trust (NBT)	One of six
Rebecca Dunn	Director of Business Development and Improvement, University Hospitals Bristol and Weston (UHBW)	One of six
Aisha Farooq	Non-Executive Director, BNSSG Integrated Care Board	One of six
Anne Gachango	Head of Equity and Health Inclusion Service, Sirona	Four of five
Sebastian Habibi	Acting Chief Digital and Transformation Officer, BNSSG ICB	One of one
Vivienne Harrison	Public Health Consultant Population Health, BNSSG ICB	Three of six
Joe Poole	Locality Partnership Director Bristol, BNSSG ICB	Three of six
Seema Srivastava	Executive Deputy Medical Director, University Hospitals Bristol and Weston (UHBW)	Three of six
Tim Keen	Associate Director of Strategy, North Bristol NHS Trust	Five of six
Adwoa Webber	Head of Quality and Clinical Excellence, BNSSG ICB	Five of six
Julie Northcott	Deputy Director of Public Health, Bristol City Council	One of six

Joint Transition Committee

The Joint Transition Committee was formed in September 2025 to provide oversight to the Board on the transition arrangements affecting BNSSG and Gloucestershire ICBs. The remit of the Committee is to manage the safe and coherent transition from the current BNSSG and Gloucestershire ICBs' state to the future ICBs' state, to make necessary decisions to enable this transition, and to assure the Boards that appropriate activities are being undertaken. The Committee will oversee and scrutinise arrangements for the transition of the ICBs into their future operating model, in line with national guidance. The Committee will also oversee the work of the ICBs' transition programme, including the development of the vision, organisational strategy, functions and responsibilities of the new ICB.

Name	Title	Attendance
Jeff Farrar	BNSSG and Gloucestershire Cluster Chair	Seven of Seven
Raz Akbar	Non-Executive Director and Audit Chair, South Western Ambulance Service NHS Foundation Trust	Seven of Seven
Matt Backler	Interim Chief Financial Officer, BNSSG ICB	Five of Seven
John Cappock	Non-Executive Director and Audit Chair, BNSSG ICB	Seven of Seven
Karen Clements	Non-Executive Director, Gloucestershire ICB	Seven of Seven
Tracey Cox	Director of People, Culture and Engagement, Gloucestershire ICB	Five of Seven
Jane Cummings	Non-Executive Director and Deputy Chair, Gloucestershire ICB	Seven of Seven
Shane Devlin	Chief Executive, BNSSG ICB	Seven of Seven
Jo Hicks	Chief People Officer, BNSSG ICB	Six of Seven
Cath Leech	Chief Financial Officer, Gloucestershire ICB	Six of Seven
Alison Moon	Non-Executive Director and Deputy Chair, BNSSG ICB	Seven of Seven

Jo Walker	Chief Executive, Gloucestershire County Council	Four of Seven
Tracie Jolliff	Chair ICB Independent Advisory Group on Race Equality	Five of Seven
Dr Joanne Medhurst	Chief Medical Officer, BNSSG ICB	Three of Four

ICB Decision Making Framework

BNSSG's 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.

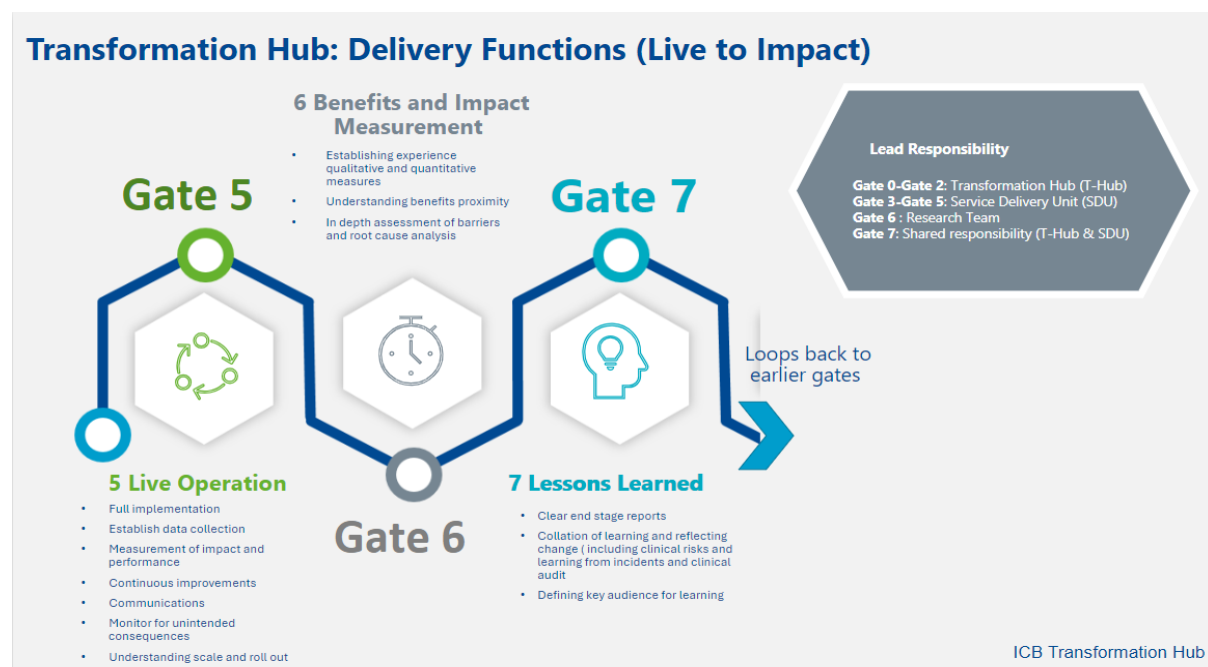
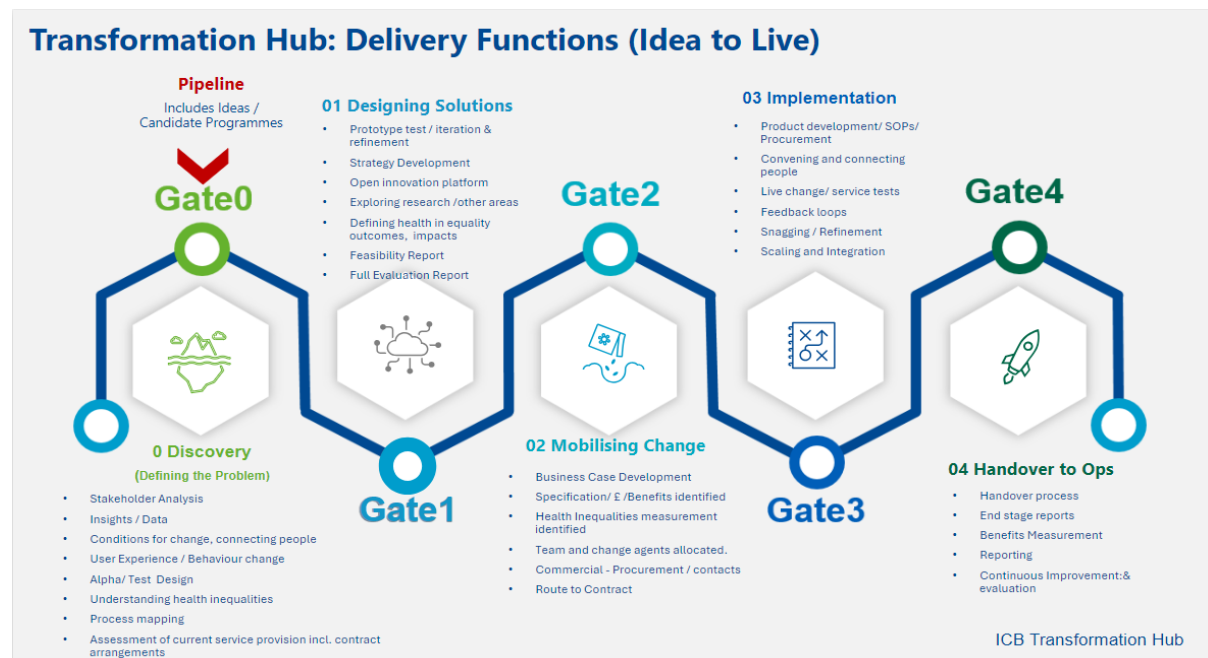
4. It is ICS partner organisations' responsibility to ensure that the right people with the appropriate delegated authority attend ICS Groups to agree and action the decisions.
5. If ICS partner representatives do not have delegated authority to agree and action ICS group decisions, they must escalate 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 continue to utilise 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 in 2025/26 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, and agendas for

committee meetings are driven by risk registers in line with the recommendations of internal audit. Updates from 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 for use during 2025 to support the delivery of obligations set out in the Planning Guidance for 25/26 by NHS England. As part of clustering arrangements there have been initial discussions about a harmonised risk appetite to support commissioning arrangements by a combined workforce.

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, 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 alongside the Corporate Risk Register.

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.

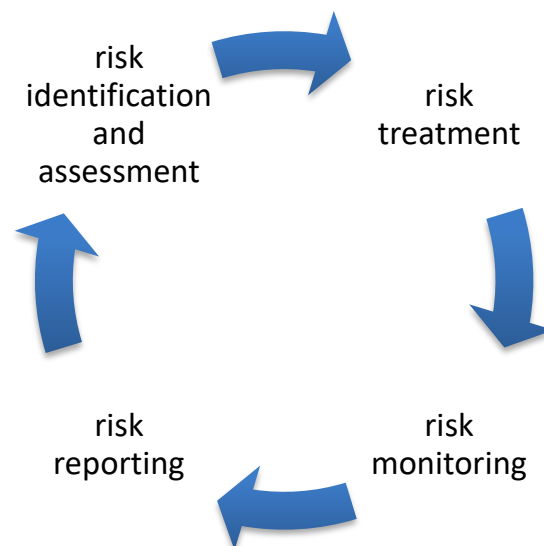
The ICB Board receives monthly reports on performance and quality, and finance providing timely, accurate data that supports the ICB Board in the assessment of risks, including risks to compliance with statutory obligations. The Board's regular review and interrogation of these reports and other ad hoc 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. Reminders to staff about the importance of training are issued through routine channels with key training courses identified as areas of focus each month.

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 25/26 are detailed at page 172 '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 25/26 To comply with the requirements of the Provider Selection Regime (PSR), the ICB published its compliance summary for the financial year 24/25 on its [website](#).

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:

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 25/26 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.
- Recognising the appointment of a new executive team to lead the clustering with Gloucestershire ICB, declaration of interest have been updated.

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 with suggestions for improvement made where necessary. No risks relating to the quality of data were highlighted between 1st April 2025 and 31st of March 2026.

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 24/25 the ICB submitted a compliant assessment to NHS England in June 2025. Our internal Auditors have independently reviewed our assessment of compliance, and continue to do so..

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.

The ICB has led on the implementation of the system wide Information Sharing Charter, to make information sharing easier and streamlined. The Charter covers sharing for broad purposes (like public health or service planning). If a project fits one of these purposes, no extra agreement is needed. Partners across the ICS have signed up to the Charter.

Our Information Governance team has supported activity on the Intelligence Centre and South West Secure Data Environment, ensuring data is available for system wide activities and research activities in line with the national programmes.

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.

BNSSG ICB is 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 2025, 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 267, and cover:

- NHS Shared Business Services for its provision of Finance and Accounting Services
- NHS Business Services Authority for its provision and maintenance of the Electronic Staff Record system
- NHS Business Services Authority for its Dental Payments Process system

- NHS Business Services Authority for its Prescription Payments Process system
- 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 Type II Service Auditor Report, covering Payroll and Non-Clinical Procurement services provided by the four NHS CSUs

There were no matters arising which were significant and an unqualified opinion has been given.

Our Internal Auditors have also worked with BDO, Gloucestershire's Internal Auditor, to support the transition to a clustered working arrangement between the two ICBs.

Control Issues

The following control issues were reported to NHS England in the January 2026 Governance Statement return. More detail information about performance is provided in the Performance section of the Annual Report on page 2.

Finance, Governance and Control – Finance and Procurement

1. The ongoing legal challenge following the completion of a Non-Emergency Patient Transport Service – Lot 1 (Haemodialysis Transport) & 2 (Planned Transport) legal challenge remains with an expected court hearing date – Nov 2026. Services continue to be delivered through actions taken during and after mobilisation including actions taken to place an urgent award with our NHS partners.

Numerous actions have been completed as previously mentioned including liaising with NHSE and HMT.

2. In addition, following the insolvency of the previous Non-Emergency Patient Transport Service provider the ICB has received a Provider Selection Regime Representation following the completion of the new Non-Emergency Patient Transport Service procurement for planned transport services.

To support the representation, the ICB has:

- Internally and independently reviewed all representations made and following that review decided to progress with contract award
- Following the representations made and the decisions taken by the ICB to progress to contract award, the ICB has supported / attended the NHSE National Panel following escalated representations made to the Independent Patient Choice and Procurement Panel (IPCPP).
- Expected outcome of the IPCPP review to be during January 2026

Quality and Performance – Children’s Services

Children and Young People (CYP) – not compliant with operating target for 2025/26

(please note this is inpatient <18yr target within the LDA programme, not CYP MH Access rates)

Performance against the target to reduce reliance on inpatient care for children and young people with learning disabilities and/or autism has not been compliant for most months between m1-m9. The target of having no more than three inpatients at any one time has remained challenging to achieve. Although discharges in M9 brought the position back into compliance, this reflects case variation rather than a sustained improvement trajectory. This has been discussed with NHSE in relation to next year’s target, and the baseline has been adjusted accordingly. Locally, the closure of Riverside Hospital, our General Adolescence Unit CYP Tier 4 unit, continues to be a constraint, and AWP are progressing work on future service options.

Mitigations in place: BNSSG ICB is prioritising the development of an all age digital Dynamic Support Register and the expansion of the keyworker function to strengthen support and improve performance in this area over 2025/26.

CYP long waits

BNSSG ICB is non-compliant with the national community 18 week waiting time metric. Long waits are affecting children’s bladder and bowel, Autism and ADHD services. Mitigating actions are underway to reduce children’s bladder and bowel waits to 18 weeks by end June 2026.

System support confirmed to implement new, needs-led neurodiversity model and backlog reduction. Subject to approval, waits for Autism and ADHD will reduce to

maximum 52 weeks by March 2029. Waits for children triaged with the most urgent needs will be maintained below 18 weeks.

CYP mental health access and 104 week waits

Access to children's mental health services in BNSSG remains below the national target. Improvement actions to increase access include:

- improved capture and reporting of contacts across providers
- continued focus on recruitment and retention
- implementation of a digital provider
- provider waiting list initiatives
- provider level improvement plans with supporting trajectories

BNSSG ICB is currently not meeting the national target of zero CYP mental health waits over 104 weeks but is forecasting compliance by the end of 2026/27. Significant data quality issue identified within AWP's reporting which will be resolved prior to April 2026 and which will remove a large number of referrals following a refresh of the MHSDS submission in February 2026. The remaining long waits are expected to be addressed during 2026/27 enabling the system to achieve compliance by year-end.

Quality and Performance – Adult Learning Disability and Autism – variance against operating target for 2025/26

Performance against the operating plan target to reduce reliance on inpatient care for autistic adults and adults with a learning disability has remained largely compliant through to M8. However, from M9 onward there was non compliance due to increased numbers of autistic adults being admitted to mainstream mental health beds.

Mitigations in place: Ongoing discussion with NHSE programme team about issue as pressure is likely to continue. Performance priorities for next year include a focus on reducing long lengths of stay, creating the opportunity to differentiate between short, appropriate admissions to mainstream beds and longer-term reliance on specialist inpatient provision. Housing step down has been developed to support six individuals with long length of stay admissions. We are supporting admission avoidance through

the development of an all-age digital dynamic support register. The ICB is also investing in the Kingfisher Unit, a specialist inpatient therapeutic unit designed to support short admissions and reduce complex individuals having very long inpatient spells.

Quality and Performance – Access to Service/Capacity

ASD / ADHD – significant system pressures requiring sustained transformation

Across both Children and Young People (CYP) and adult Autism (ASD) and ADHD pathways, demand for assessment has increased sharply, resulting in long waiting times, variation in diagnostic outcomes, and inconsistency between locally commissioned NHS services and national Right to Choose (RTC) providers. While RTC pathways offer additional choice and can reduce waits, they also create significant challenges, including limited demographic and outcome data, higher and inconsistent diagnosis conversion rates, variability in clinical pathways, and increased reliance on local services for ongoing post diagnostic support. These pressures have contributed to financial unsustainability and risk exacerbating existing inequalities, particularly for people from deprived communities, ethnic minority groups, females, and those facing digital or language barriers.

Mitigations in place: To support system stability, BNSSG ICB has introduced Indicative Activity Plans (IAPs) to ensure RTC activity remains within a financially sustainable envelope while protecting capacity required for service redesign. Priority is being placed on continuity of care for those already in treatment. Alongside this, a wide ranging transformation programme is underway, including the CYP Neurodiversity Transformation Programme, Adult ADHD pathway redesign, Partnerships for Inclusion in Neurodiversity in Schools (PINS), and planned redesign of the Adult Autism Service. These programmes aim to shift the system from a diagnosis led model to one focused on needs, strengthen early intervention, improve integration with mental health and community provision, and ensure more equitable and timely access. In parallel, work is underway to secure improved data from RTC providers and to strengthen system oversight through an Autism Partnership Board. Collectively, these actions aim to stabilise current pressures, reduce inequalities, and develop a sustainable, locally integrated model for future ASD and ADHD support.

Quality and Performance – Cancer

Performance position: Performance has not met 2025/26 operational plan YTD for 62 day cancer wait time standard at the ICB population level. Despite improvements since September, the latest performance position (November 2025) recorded 69.48% compared to plan target of 72.53%. Underperformance has been driven by one provider, and specifically a small number of high-volume tumour site services. Improvements have been recorded at this provider from 62% in September to 67% in November.

Mitigations: Performance is monitored at the Trust level and by the ICB led System Elective Recovery Operational Delivery Group, in addition to monthly meetings with the SW Region Cancer team and SWAG Cancer Alliance, who have each provided non-recurrent recovery support funding in Q3. A recovery action plan has been developed by the Trust, Days Matter actions have been implemented and the previously mentioned, non-recurrent recovery support funding is enabling the Trust to expedite and expand recovery actions. It is important to note, that some of the contributing challenges are a result of late receipt tertiary referrals, that are breached on receipt or close to, which impacts performance; and also recruitment issues and national shortages of staffing required for sustaining the capacity required to match demand in these services.

Quality and Performance – Accident and Emergency Services

Performance position: Current ED performance at end December was 72.93% against a target of 76.65% (footprint for the ICB). The ICB is maintaining performance and is holding its position within the SW ranked as 3/7.

Mitigations: The ICB continues to support all providers with flow and in particular through the discharge improvement programme focussing on P1 and faster flow, P2 capacity and LOS, P3 LOS including cycle times with LA colleagues. GIRFT has visited and support one of the Trusts on ED performance.

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 2025/26. 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.

Having previously put in place heightened surveillance arrangements to address concerns, during 25/26, the ICB was able to step down its level of oversight of AWP due to significant improvement in service quality and delivery by this important provider partner.

The Finance Review on page 130 describes how we have delivered efficiency, our central management costs and our approach to planning.

Commissioning of delegated specialised services

BNSSG ICB fulfilled its delegated responsibilities during 25/26 governed by a signed a delegation agreement (DA) with NHS England. In this reporting period the ICB took on delegated responsibility for Specialised Commissioning from NHS England.

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 25/26 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 2025⁴ to 31 March 2026 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.

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
Funded Care – All Age continuing Care	Reasonable Assurance
Financial Performance and Delivery	Reasonable Assurance
Financial Controls	Reasonable Assurance
Risk and Governance	Reasonable Assurance
Care Track Application	Reasonable Assurance
Procurement and Contract Management	Partial Assurance
Cyber Assessment Framework (CAF)-aligned Data Security and Protection Toolkit (DSPT) Independent Assessment	Low Risk Rating High Confidence Level
Care Track Process Mapping	Reasonable Assurance

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. A process for tracking completion of remedial activities has been implemented and commended by the Audit Committee.

No issues have been flagged by Internal Audit as significant control issues to be flagged as part of the Annual Governance Statement.

More detail on the Internal audit findings can be found in the Head of Internal Audit Opinion at page 267.

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 25/26 Month 9 return to NHS England in January 2026, no significant control issues have been identified during the year.



Shane Devlin

Accountable Officer

16 June 2026

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.

Last year, the ICB included all voting members of the ICB Board (including those employed outside the NHS, for example Council employees) within the definition of senior managers for the purposes of the Remuneration Report. However, only costs borne by the ICB were disclosed. This year, we have adopted the same approach, updated to reflect clustering arrangements.

Shane Devlin and Jeffrey Farrar were appointed cluster Chief Executive and cluster Chair during the year, and part of their salary was recharged to Gloucestershire ICB. Their remuneration disclosed is net of this recharge. All other cluster executives were appointed in January 2026, as set out in the Performance Overview. Cath Leech and Ananthakrishnan Raghuram were appointed from Gloucestershire ICB, but none of their costs were recharged to the ICB. Therefore, we have disclosed them as senior managers with £0 remuneration.

Remuneration Report

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 150.

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.

2025-26	Salary and allowances	Performance pay and bonuses
The percentage change from the previous financial year in respect of the highest paid director	(14)%	0%
The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole	5%	0%

2024-25	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 2025-26 for the fair pay disclosure is David Jarrett, Chief Delivery Officer and Deputy Chief Executive. The highest paid director in 2024-25 was Shane Devlin, ICB Chief Executive.

The fair pay disclosure is based on annualised salary at March 2026. Following Shane Devlin's appointment as ICB Cluster Chief Executive, 50% of his salary was recharged to Gloucestershire ICB from 1 October 2025. Therefore, his annualised salary at March 2026 is lower than his salary incurred by the ICB over the 12 months to 31 March 2026.

David Jarrett took on additional responsibilities as Deputy Chief Executive from 11 July 2025. Therefore, his annualised salary at March 2026 is higher than his salary incurred by the ICB over the 12 months to 31 March 2026.

Shane Devlin and David Jarrett did not receive performance pay in 2025-26 or in 2024-25.

The 5% increase in salary and allowances for employees of the entity as a whole is partly due to the Agenda for Change pay rise of 3.6% in 2025-26 and partly because the average salary cost for 2024-25 did not include the costs of four staff in error.

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 in the reporting period 1 April 2025 to 31 March 2026 was £175,000 - £180,000 (2024-25: £205,000 - £210,000). As set out above, this is based on the annualised salary at March 2026, and so is higher than the actual salary incurred in 2025-26 as set out below.

The relationship to the remuneration of the organisation's workforce for 2025-26 is disclosed in the below table.

Table 1

2025-26	25 th percentile pay ratio	Median pay ratio	75 th percentile pay ratio
Total remuneration (£)	£37,796	£47,810	£58,487
Salary component of total remuneration (£)	£37,796	£47,810	£58,487
Pay ratio information	4.70:1	3.71:1	3.04:1

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 2

2024-25	25 th percentile pay ratio	Median pay ratio	75 th 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

Pay ratio information for 2025-26 and 2024-25 is summarised below:

Table 3

Pay ratio information	25 th percentile pay ratio	Median pay ratio	75 th percentile pay ratio
2025-26	4.70:1	3.71:1	3.04:1
2024-25	5.68:1	4.49:1	3.67:1

During the reporting period 2025-26, no employees received remuneration in excess of the highest-paid director/member (2024-25: none).

Remuneration ranged from £14,554 to £177,579 during the year ended 31 March 2026 (£14,554 to £207,375 during the year ended 31 March 2025).

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.

Increases in remuneration at each percentile are driven by the 3.6% pay award in 2025-26. The reduction in the pay ratio is caused by the part recharge of Shane Devlin's salary to Gloucestershire ICB from October 2026, following his appointment as ICB Cluster Chief Executive.

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 2025-26.

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 4 Senior manager remuneration (including salary and pension entitlements) 2025-26 (SUBJECT TO AUDIT)

Name and Title	Note	2025-26					
		Salary	Expense payments (taxable)	Performance pay and bonuses	Long term performance pay and bonuses	All pension-related benefits	TOTAL
		(bands of £5,000)	(to nearest £100**)	(bands of £5,000)	(bands of £5,000)	(bands of £2,500)	(bands of £5,000)
		£000	£	£000	£000	£000	£000
Shane Devlin, Chief Executive Officer, BNSSG ICB ICB Cluster Chief Executive (from October 2025)	2	165-170	-	-	-	825-827.5	990-995
Sarah Truelove, Chief Financial Officer and Deputy Chief Executive (to July 2025)	3	50-55	-	-	-	-	50-55
Matt Backler, Interim Chief Finance Officer (from July 2025)	4	100-105	-	-	-	27.5-30	100-105
Deborah El-Sayed, Chief Transformation and Digital Information Officer (to January 2026)	5	110-115	-	-	-	55-57.5	170-175
Joanne Hicks, Chief People Officer, BNSSG ICB	6	150-155	100-200	-	-	37.5-40	190-195
David Jarrett, Chief Delivery Officer, BNSSG ICB	7	150-155	0-100	-	-	55-57.5	210-215
Joanne Medhurst, Chief Medical Officer, BNSSG ICB	8	155-160	-	-	-	740-742.5	895-900
Rosalind Shepherd, Chief Nursing Officer, BNSSG ICB	9	105-110	-	-	-	-	105-110
Ananthakrishnan Raghuram, ICB Cluster Chief Clinical Leadership and Delivery Officer – Medical (from 1 February 2026)	10	-	-	-	-	-	-

Name and Title	Note	2025-26					
		Salary	Expense payments (taxable)	Performance pay and bonuses	Long term performance pay and bonuses	All pension-related benefits	TOTAL
		(bands of £5,000)	(to nearest £100**)	(bands of £5,000)	(bands of £5,000)	(bands of £2,500)	(bands of £5,000)
		£000	£	£000	£000	£000	£000
Cath Leech, ICB Cluster Chief Finance and Corporate Services Officer (from 1 April 2026)	10	-	-	-	-	-	-
Non-Executives							
Jeffrey Farrar, Chair BNSSG ICB, Cluster Chair (from 1 September 2025)	11	45-50	200-300	-	-	-	45-50
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	100-200	-	-	-	15-20
Alison Moon, Non-Executive Member, Chair Primary Care Committee	12	15-20	-	-	-	-	15-20
Steve West, Non-Executive Member – Finance, Estates and Digital		15-20	-	-	-	-	15-20
Aishah Farooq Associate Non-Executive Member	13	-	-	-	-	-	-
Non-remunerated Senior Managers							
Dominic Hardisty,	13	-	-	-	-	-	-

Name and Title	Note	2025-26					
		Salary	Expense payments (taxable)	Performance pay and bonuses	Long term performance pay and bonuses	All pension-related benefits	TOTAL
		(bands of £5,000)	(to nearest £100**)	(bands of £5,000)	(bands of £5,000)	(bands of £2,500)	(bands of £5,000)
		£000	£	£000	£000	£000	£000
Chief Executive Officer, Avon and Wiltshire Mental Health Partnership NHS Trust							
Maria Kane, Joint Chief Executive Officer, North Bristol Trust and University Hospitals Bristol and Weston NHS Foundation Trust	13	-	-	-	-	-	-
Jacob Lee, Chair of the GP Collaborative Board	13	-	-	-	-	-	-
Nick Hibberd, Chief Executive, Bristol City Council	13	-	-	-	-	-	-
Mandy Bishop, Chief Executive Officer, North Somerset Council (from Aug 2025)	13	-	-	-	-	-	-
Jo Walker, Chief Executive Officer, North Somerset Council (to Aug 2025)	13	-	-	-	-	-	-
Dave Perry, Chief Executive, South Glos Council	13	-	-	-	-	-	-
Jo Beer, Chief Executive Officer, Sirona Care & Health (from Nov 25)	13	-	-	-	-	-	-
Julie Sharma, Interim Chief Executive Officer, Sirona Care & Health (to Oct 25)	13	-	-	-	-	-	-
John Martin	13	-	-	-	-	-	-

Name and Title	Note	2025-26					
		Salary	Expense payments (taxable)	Performance pay and bonuses	Long term performance pay and bonuses	All pension-related benefits	TOTAL
		(bands of £5,000)	(to nearest £100**)	(bands of £5,000)	(bands of £5,000)	(bands of £2,500)	(bands of £5,000)
		£000	£	£000	£000	£000	£000
Interim Chief Executive Officer, South Western Ambulance NHS Foundation Trust							
Rachel Pearce / Richard Smale Regional Director, NHSE	13	-	-	-	-	-	-
Kevin Peltonen-Messenger Chief Executive, The Care Forum	13, 14	-	-	-	-	-	-
Fiona Mackintosh VCSE Alliance representative	13, 14	-	-	-	-	-	-
Ruth Hughes Chief Executive Officer, One Care	13, 14	-	-	-	-	-	-

****Note:** Taxable expenses and benefits in kind are expressed to the nearest £100.

Table 5 Senior manager remuneration (including salary and pension entitlements) 2024-25 (SUBJECT TO AUDIT)

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	Expense payments (taxable)	Performance pay and bonuses	Long term performance pay and bonuses	All pension-related benefits	TOTAL
		(bands of £5,000)	(to nearest £100**)	(bands of £5,000)	(bands of £5,000)	(bands of £2,500)	(bands of £5,000)
		£000	£	£000	£000	£000	£000
Shane Devlin, Chief Executive Officer		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		145-150	-	-	-	20-22.5	165-170
Joanne Hicks, Chief People Officer		140-145	-	-	-	42.5-45	185-190
David Jarrett, Chief Delivery Officer		140-145	-	-	-	62.5-65	205-210
Joanne Medhurst, Chief Medical Officer		160-165	-	-	-	20-22.5	185-190
Rosalind Shepherd, Chief Nursing Officer	9	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

Name and Title	Note	2024-25					
		Salary	Expense payments (taxable)	Performance pay and bonuses	Long term performance pay and bonuses	All pension-related benefits	TOTAL
		(bands of £5,000)	(to nearest £100**)	(bands of £5,000)	(bands of £5,000)	(bands of £2,500)	(bands of £5,000)
		£000	£	£000	£000	£000	£000
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
Aishah Farooq Associate Non-Executive Member	13	-	-	-	-	-	-
Non-remunerated Senior Managers							
Dominic Hardisty, Chief Executive Officer, Avon and Wiltshire Mental Health Partnership NHS Trust	13	-	-	-	-	-	-
Jonathan Hayes, Chair of the GP Collaborative Board (to Nov 24)	13	-	-	-	-	-	-
Jacob Lee, Chair of the GP Collaborative Board (from Dec 24)	13	-	-	-	-	-	-
Maria Kane,	13	-	-	-	-	-	-

Name and Title	Note	2024-25					
		Salary	Expense payments (taxable)	Performance pay and bonuses	Long term performance pay and bonuses	All pension-related benefits	TOTAL
		(bands of £5,000)	(to nearest £100**)	(bands of £5,000)	(bands of £5,000)	(bands of £2,500)	(bands of £5,000)
		£000	£	£000	£000	£000	£000
Joint Chief Executive Officer, North Bristol Trust and University Hospitals Bristol and Weston NHS Foundation Trust (from Sep 24)							
Maria Kane, Chief Executive Officer, North Bristol Trust (to Aug 24)	13	-	-	-	-	-	-
Stuart Walker Interim Chief Executive Officer, University Hospitals Bristol and Weston NHS Foundation Trust (to Sep 24)	13	-	-	-	-	-	-
Nick Hibberd, (from Feb 25) Chief Executive, Bristol City Council	13	-	-	-	-	-	-
Hugh Evans, Executive Director for Adults & Communities, Bristol City Council (from Sep 24 to Jan 25)	13	-	-	-	-	-	-
Stephen Peacock, Chief Executive, Bristol City Council (to Aug 24)	13	-	-	-	-	-	-
Jo Walker, Chief Executive Officer, North Somerset Council	13	-	-	-	-	-	-
Dave Perry, Chief Executive, South Gloucestershire Council	13	-	-	-	-	-	-
Julie Sharma,	13	-	-	-	-	-	-

Name and Title	Note	2024-25					
		Salary	Expense payments (taxable)	Performance pay and bonuses	Long term performance pay and bonuses	All pension-related benefits	TOTAL
		(bands of £5,000)	(to nearest £100**)	(bands of £5,000)	(bands of £5,000)	(bands of £2,500)	(bands of £5,000)
		£000	£	£000	£000	£000	£000
Interim Chief Executive Officer, Sirona Care & Health (to Jul 23 & from Sep 24)							
Sue Porto Chief Executive, Sirona care & Health (from July 23 to Aug 24)	13	-	-	-	-	-	-
John Martin Interim Chief Executive Officer, South Western Ambulance Service NHS Foundation Trust	13	-	-	-	-	-	-
Mark Cooke Regional Director, NHSE	13, 14	-	-	-	-	-	-
Kevin Peltonen-Messenger Chief Executive, The Care Forum (from Feb 25)	13, 14	-	-	-	-	-	-
Vicky Marriott, Chief Officer, Healthwatch (to Jan 25)	13, 14	-	-	-	-	-	-
Fiona Mackintosh VCSE Alliance representative (from Jul 24)	13, 14	-	-	-	-	-	-
Chris Head VCSE Alliance representative (to Jul 24)	13, 14	-	-	-	-	-	-
Ruth Hughes Chief Executive Officer, One Care	13, 14	-	-	-	-	-	-

***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 2025-26 or in 2024-25.
2. Following his appointment as ICB Cluster Chief Executive, 50% of Shane Devlin's salary was recharged to Gloucestershire ICB from 1 October 2025. His total full year salary before the recharge was £225,000-£230,000.
3. Sarah Truelove left the ICB on 10 July 2025. Her full year equivalent salary is £180,000-£185,000
4. Matt Backler acted up as Interim Chief Finance Officer from 11 July 2025. His total full year salary was £135,000-£140,000.
5. Deborah El-Sayed left the ICB on 4 January 2026. Her full year equivalent salary is £150,000-£155,000.
6. Jo Hicks was appointed Chief Transformation, Organisational Development and People Officer for the BNSSG and Gloucestershire ICB Cluster from 1 February 2026. This did not result in any change to her remuneration.
7. David Jarrett was appointed Deputy CEO of BNSSG ICB from 11 July 2025. £5,508 of his salary relates to this additional responsibility. He was appointed Chief Strategic Commissioning Officer for the BNSSG and Gloucestershire ICB Cluster from 1 February 2026. This did not result in any change to his remuneration but does mean that his banded total remuneration is less than his fair pay disclosure remuneration, as the fair pay disclosure is based on annualised pay at March 2026.
8. Joanne Medhurst was appointed Chief Population Health Improvement Officer for BNSSG and Gloucestershire ICB Cluster from 1 February 2026. This did not result in any change to her remuneration.

9. Rosalind Shepherd was appointed Chief Clinical Leadership and Delivery Officer – Nursing for BNSSG and Gloucestershire ICB Cluster from 1 February 2026. This did not result in any change to her remuneration. She claimed partial retirement benefits during 2025-26 and 2024-25. She reduced her hours from 1 WTE to 0.7 WTE from January 2025.

10. Ananthakrishnan Raghuram was appointed ICB Cluster Chief Clinical Leadership and Delivery Officer – Medical from 1 February 2026. He did not receive any remuneration from the ICB for this position. Cath Leech was appointed ICB Cluster Chief Finance and Corporate Services Officer from 1 April 2026. She did not receive any remuneration from the ICB for this position.

11. Following his appointment as ICB Cluster Chair, 50% of Jeff Farrar's salary was recharged to Gloucestershire ICB from 1 September 2025. His total full year salary was £65,000-£70,000.

12. Alison Moon was appointed Deputy Chair of the ICB from 1 October 2025. £1,900 of her salary relates to this additional responsibility.

13. These are non-remunerated posts.

14. Board participants only.

15. 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 6 Pension benefits at 31 March 2026 (SUBJECT TO AUDIT)

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 2026 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2026 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2025	Real Increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2026	Employers Contribution to partnership pension
		£000	£000	£000	£000	£000	£000	£000	£000
Shane Devlin Chief Executive Officer, BNSSG ICB, ICB Cluster Chief Executive (from Oct 25)	2	45-47.5	177.5-180	55-60	175-180	177	1207	1415	-
Matt Backler, Chief Finance Officer (from Jul 25)	3	0-2.5	0-2.5	20-25	0-5	229	9	270	-
Deborah El-Sayed Chief Transformation and Digital Information Officer (to Jan 26)	4	2.5-5	0-2.5	50-55	120-125	1120	53	1227	-
Jo Hicks Chief People Officer		2.5-5	0-2.5	5-10	0-5	80	24	124	-
David Jarrett Chief Delivery Officer		2.5-5	0-2.5	55-60	135-140	1106	59	1202	-
Joanne Medhurst Chief Medical Officer	5	32.5-35	90-92.5	80-85	205-210	1164	-	210	-
Rosalind Shepherd Chief Nursing Officer	6	0-2.5	0-2.5	10-15	0-5	136	24	176	-

Table 7 Pension benefits at 31 March 2025 (SUBJECT TO AUDIT)

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	0-2.5	10-15	0-5	111	32	177	-
Deborah El-Sayed Chief Transformation and Digital Information Officer		0-2.5	0-2.5	45-50	120-125	1009	26	1120	-
Jo Hicks Chief People Officer		2.5-5	0-2.5	5-10	0-5	33	28	80	-
David Jarrett Chief Delivery Officer		2.5-5	2.5-5	50-55	130-135	960	64	1106	-
Joanne Medhurst Chief Medical Officer		0-2.5	0-2.5	45-50	115-120	1048	25	1164	-
Rosalind Shepherd Chief Nursing Officer	6	0-2.5	0-2.5	65-70	180-185	1745	-	136	-

Notes:

- 1 The ICB has no pension liabilities for Sarah Truelove, former Deputy Chief Executive and Jeffrey Farrar, ICB Chair. Neither of these employees are contributing to the NHS Pension Scheme
2. Following his appointment as ICB Cluster Chief Executive, 50% of Shane Devlin's salary was recharged to Gloucestershire ICB from 1 October 2025. His full pension benefits for the year have been disclosed in the tables above. The real increase in the Shane's cash equivalent transfer value (CETV) is significantly higher this year than last year. This is not the result of an unusual uplift in the value of benefits accrued during the year. Instead, the increase primarily reflects the transfer in of his pension benefits from the Northern Ireland pension scheme during the reporting period. This one-off transfer has the effect of increasing the reported CETV. However, it does not represent an additional award, enhancement, or change to his pension entitlement beyond the transferred value.
3. Matt Backler acted up as Interim Chief Finance Officer from 11 July 2025. His real increase in pension benefits has been calculated pro-rata.
4. Deborah El-Sayed left the ICB on 4 January 2026. Her real increase in pension benefits has been calculated pro-rata.
5. There is no real increase in cash equivalent transfer value for Joanne Medhurst as she claimed some of her pension in 2025/26.
6. Rosalind Shepherd claimed partial retirement benefits during 2025-26 and 2024-25. She reduced her hours from 1 WTE to 0.7 WTE from January 2025.
7. Non-remunerated senior managers do not receive pensionable pay.
8. Real increase in pension at pension age is calculated based on the increase between 1 April and 31 March, as adjusted for inflation.

9. 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 (SUBJECT TO AUDIT)

This statement is subject to audit by the External Auditors and is covered by the Audit Opinion issued on the ICB's Financial Statements.

No senior managers were made redundant during 2025-26 or in 2024-25.

No payments for compensation on early retirement were received by any senior managers in 2025-26 or in 2024-25.

Payments to past directors (SUBJECT TO AUDIT)

This statement is subject to audit by the External Auditors and is covered by the Audit Opinion issued on the ICB's Financial Statements.

Two directors left the ICB during 2025-26: Sarah Truelove and Deborah El-Sayed. All payments made to them in the year have been disclosed in the tables above. No payments were made to any other past directors during the year.

Staff Report

Number of senior managers

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 2025-26 (2024-25, 81).

Table 8 Senior Manager numbers 2025-26

Senior Managers (WTE)	Permanent			Other			Total		
	Female	Male	Total	Female	Male	Total	Female	Male	Total
Very Senior Manager	4	3	7	-	-	-	4	3	7
Band 9	5	2	7	1	-	1	6	2	8
Band 8D	4	6	10	-	-	-	4	6	10
Band 8C	14	8	22	-	-	-	14	8	22
Band 8B	23	11	34	-	-	-	23	11	34
Total	50	30	80	1	-	1	51	30	81

Table 9 Senior Manager numbers 2024-25

Senior Managers (WTE)	Permanent			Other			Total		
	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

Staff numbers and costs (SUBJECT TO AUDIT)

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 2025-26 were £33,818,257 (2024-25 £28,373,513). The breakdown by cost, contract type and category is set out in the table below.

Table 10 Staff costs 2025-26

	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	8,564	333	8,897	13,732	484	14,216	22,296	817	23,113
Social security costs	1,281	11	1,292	1,549	-	1,549	2,830	11	2,841
Employer contributions to the NHS Pension Scheme	3,290	-	3,290	1,611	-	1,611	4,901	-	4,901
-Apprenticeship Levy	95	-	95	-	-	-	95	-	95
Termination benefits	2,868	-	2,868	-	-	-	2,868	-	2,868
Gross employee benefits expenditure	16,098	344	16,442	16,892	484	17,376	32,990	828	33,818

Table 11 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

The total average number of staff was 416 in 2025-26 (2024-25, 416). The breakdown by staff category, contract type and sex is set out in the table below.

Table 12 Staff Numbers 2025-26

	Permanent			Other			Total		
Staff Category (WTE)	Female	Male	Total	Female	Male	Total	Female	Male	Total
Administrative and Clerical	177	61	238	4	5	9	181	66	247
Medical and Dental	3	1	4	1	-	1	4	1	5
Add Professional. Scientific and Technical	17	6	23	-	-	-	17	6	23
Nursing and Midwifery	54	5	59	-	-	-	54	5	59
Allied Health Professionals	-	-	-	-	-	-	-	-	-
Estates and ancillary	-	-	-	-	-	-	-	-	-
Senior Managers	50	31	81	1	-	1	51	31	82
Total	301	104	405	6	5	11	307	109	416

Table 13 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

Staff composition

There were 493 staff (headcount) in 2025-26 (2024-25, 494). The breakdown by sex, seniority and contract type is set out in the table below.

Table 14 Staff composition 2025-26

Senior Managers (headcount)	Permanent			Other			Total		
	Female	Male	Total	Female	Male	Total	Female	Male	Total
Members of the governing body	3	3	6	-	-	-	3	3	6
Directors	4	3	7	-	-	-	4	3	7
Band 9	5	2	7	1	-	1	6	2	8
Band 8D	4	6	10	-	-	-	4	6	10
Band 8C	15	8	23	-	-	-	15	8	23
Band 8B	27	12	39	-	-	-	27	12	39
Other employees	301	83	384	9	7	16	310	90	400
Total	359	117	476	10	7	17	369	124	493

Table 15 Staff composition 2024-25

Senior Managers (headcount)	Permanent			Other			Total		
	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

Sickness absence data

The ICB has a detailed and robust Managing 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.

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.

Staff sickness absence is recorded in the Electronic Staff Record (ESR). The ICB had an average number of full-time equivalent (FTE) members of staff of 408 over the period 1st January 2025 to 31st December 2025.

The full time equivalent possible working days available was 149,202. 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.

Table 16 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	409	5,529	149,202	2.3%	8

The figures above are provided by NHS Digital and can be found on the following website: <https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates>

ESR does not hold details of normal number of days worked by each employee. Data on days available and days recorded sick are based on a 365-day year.

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).

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 2025 to 31st March 2026, 30 members of staff joined the ICB, and 52 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 2025 to 31st March 2026 is 11.1% is based on a headcount of 54 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 91% of employees were retained during the period 1st April 2025 and 31st March 2026. The figures have been pulled from ESR but can also be located on the following website: <https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics>

Staff engagement percentages

In 2025, the ICB did not participate in the NHS National Staff Survey due to ongoing organisational change. However, recognising the continued importance of listening to staff and understanding their experiences during this period, the ICB undertook a locally

run staff survey. This approach enabled more frequent, timely and context-specific feedback, while maintaining alignment with several core NHS Staff Survey questions to support trend monitoring.

The local survey was conducted between November and December 2025 and achieved a response rate of 53%. The results present a broadly positive picture of staff experience, highlighting strong commitment, pride in teams, and improvements across several areas including trust, respect, and line management support. The findings also identify ongoing challenges linked to workload, wellbeing, and uncertainty associated with national change processes. The results have been shared across the ICB and key themes incorporated to support our change programmes and will feed into wider organisational development.

The ICB maintains staff engagement through a range of inclusive and regular forums and activities. This includes active staff networks for Disabled staff, LGBTQ+ staff and the EmPowered Network, which provide opportunities for connection, representation and feedback.

In 2025 the ICB hosted in-person all-staff events to bring colleagues together, support engagement and reinforce a shared organisational culture during a period of significant change.

Formal engagement and partnerships are maintained through the Inclusion Council and the Staff Partnership Forum, both of which meet on a bimonthly basis. Staff engagement is further supported through a variety of communication and listening routes, including weekly Have We Got News for You sessions with the Chief Executive, the Voice newsletter, line manager briefings, staff and HR drop-in sessions, all-staff away days and a locally run staff survey in place of participation in the NHS National Staff Survey during 2025.

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 to support staff and managers in ensuring employees can work comfortably and effectively. The guidance promotes open and supportive conversations to help identify barriers and agree appropriate reasonable adjustments, including access to external support such as Access to Work and Occupational Health.

The ICB is a Disability Confident employer, committed to inclusive and accessible recruitment, offering interviews to disabled applicants who meet the minimum criteria, providing reasonable adjustments, and supporting disabled staff in the workplace.

During this reporting year, the ICB has continued to review and update its workforce policies to reflect organisational change, legislative requirements and best practice. Key policy activity included the review of the Disclosure and Barring Service (DBS) Policy, Organisational Change Policy, and Pay Protection arrangements, alongside updates to a number of policies arising from the Employment Rights Bill. Staff and Trade Union representatives were actively engaged throughout this work through consultation via the Staff Partnership Forum and staff networks.

All staff policies continue to be developed and reviewed in partnership with staff and Trade Union representatives through the Staff Partnership Forum, ensuring that employee voice remains central to policy development. Policies are designed to support the recruitment and retention of a diverse workforce, promote fair and consistent treatment of staff, and meet the ICB's duty of care in relation to health, safety and wellbeing. Equality Impact Assessments are completed for all policies to ensure they do not disproportionately affect staff with protected characteristics under the Equality Act 2010, and workforce diversity is regularly monitored.

The ICB maintains a rolling timetable for policy reviews and will continue to update policies in line with this cycle and changes in employment legislation. Partnership working

through the Staff Partnership Forum remains a key mechanism for collaboration between staff representatives, Trade Unions and management.

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 2025 to 31st March 2026 was:

<i>Number of employees who were relevant union officials during the relevant period</i>	<i>Full-time equivalent employee number</i>
1	37.5 hours/1WTE

Percentage of time spent on facility time

During the reporting period, the ICB had one recognised Trade Union representative. No paid facility time was allocated or taken during the year, and therefore there was no cost to the organisation's pay bill.

<i>Percentage of time</i>	<i>Number of employees</i>
0%	1
1-50%	0
51%-99%	0
100%	0

Other employee matters

In March 2025, the ICB responded to a national requirement to reduce ICB running costs by 50%. This represented a significant organisational challenge and required a carefully managed approach to reshaping operating models, structures and ways of working, while continuing to support system priorities.

Key measures included entering into a formal clustering arrangement with Gloucestershire ICB to maximise efficiencies and reduce duplication, alongside the implementation of a voluntary redundancy scheme. These approaches are enabling the ICB to make progress towards cost reduction in a planned and controlled way, while seeking to minimise compulsory workforce impacts.

Throughout this period, the ICB remained focused on maintaining organisational stability and supporting staff through change, recognising that further requirements to support reduce costs are likely to continue to have implications for the workforce.

Expenditure on consultancy

Consultancy expenditure was £272,000 in 2025-26 (2024-25 £481,000), and this can be analysed as follows:

Table 17 Consultancy Expenditure

Consultancy Category	2025-26 £'000	2024-25 £'000
Finance	21	15
Human Resources, Training and Education	-	29
IT/IS	28	9
Organisation and Change Management	-	6
Procurement	7	-
Programmes and Project Management	120	3
Strategy	6	197
Technical	90	222
Total	272	481

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 17 Length of all highly paid off-payroll engagements

For all off-payroll engagements as at 31 March 2026 for more than £245* per day:

	Number
Number of existing engagements as of 31 March	3
for less than one year at the time of reporting	-
for between one and two years at the time of reporting	-
for between 2 and 3 years at the time of reporting	-
for between 3 and 4 years at the time of reporting	1
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 18 Off-payroll workers engaged at any point during the financial year

For all off-payroll engagements between 1 April 2025 to 31 March 2026, for more than £245⁽¹⁾ per day:

	Number
Number of temporary off-payroll workers engaged	6
No. not subject to off-payroll legislation ⁽²⁾	2
No. subject to off-payroll legislation and determined as in-scope of IR35 ⁽²⁾	4
No. subject to off-payroll legislation and determined as out of scope of IR35 ⁽²⁾	-
No. 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

Table 19 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 2025 to 31 March 2026:

	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 2025-26 (SUBJECT TO AUDIT)

This statement is subject to audit by the external auditors and is covered by the Audit Opinion issued on ICB's financial statements.

Table 20 Exit Packages 2025-26

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	1	3,546	-	-	1	3,546	-	-
£10,000 - £25,000	1	14,589	6	107,250	7	121,839	-	-
£25,001 - £50,000	-	-	5	189,936	5	189,936	-	-
£50,001 - £100,000	-	-	2	141,540	2	141,540	-	-
£100,001 - £150,000	-	-	-	-	-	-	-	-
£150,001 – £200,000	-	-	-	-	-	-	-	-
>£200,000	-	-	-	-	-	-	-	-
TOTALS	2	18,136	13	438,726	15	456,861	-	-
				Agrees to table 23 below				

Exit packages, including special (non-contractual) payments 2024-25 (SUBJECT TO AUDIT)

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				

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 2025-26

Table 22

	Agreements	Total Value of agreements
	Number	£000s
Voluntary redundancies including early retirement contractual costs	13	438,726
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	13	438,726

A – agrees to total in table 21

There were no voluntary redundancies in 2024-25.

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 but has opted to include disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges are included in the Financial Statements of this Accountability Report at page 223. An audit certificate and report is also included in this Annual Report at page 285.

ANNUAL ACCOUNTS

A handwritten signature in black ink, appearing to read 'Shane Devlin', with a long horizontal stroke extending to the right.

Shane Devlin

Accountable Officer

16 June 202

NHS Bristol, North Somerset and South Gloucestershire ICB
Accounts for the year ended 31 March 2026

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Statement of Comprehensive Net Expenditure for the year ended 31 March 2026

	Note	2025-26 £'000	2024-25 £'000
Income from sale of goods and services	3	(37,322)	(38,450)
Other operating income	3	(133)	-
Total operating income		(37,455)	(38,450)
Staff costs	4	33,818	28,374
Purchase of goods and services	5	2,560,584	2,360,461
Depreciation and impairment charges	5	444	391
Provision expense	5	2,850	(4,031)
Other operating expenditure	5	16,811	11,338
Total operating expenditure		2,614,507	2,396,533
Net Operating Expenditure		2,577,052	2,358,083
Finance expense	7	108	119
Comprehensive Net Expenditure for the year		2,577,160	2,358,202

The notes on pages 5 to 42 form part of this statement.

NHS Bristol, North Somerset and South Gloucestershire ICB
Accounts for the year ended 31 March 2026

Statement of Financial Position as at 31 March

	Note	2025-26 £'000	2024-25 £'000
Non-current assets			
Property, plant and equipment	8	434	600
Right-of-use Assets	9	2,224	2,502
Intangible Assets	10	166	-
Total non-current assets		2,824	3,102
Current assets			
Trade and other receivables	11	31,804	28,199
Cash and cash equivalents	12	339	377
Total current assets		32,143	28,576
Total assets		34,967	31,678
Current liabilities			
Trade and other payables	13	(165,771)	(141,655)
Lease liabilities	9	(312)	(298)
Provisions	14	(5,075)	(2,225)
Total current liabilities		(171,158)	(144,178)
Non-current liabilities			
Lease liabilities	9	(1,835)	(2,147)
Provisions	14	(204)	(204)
Total non-current liabilities		(2,039)	(2,351)
Total Assets less Total Liabilities		(138,230)	(114,851)
Financed by Taxpayers' Equity			
General fund		(138,230)	(114,851)
Total taxpayers' equity		(138,230)	(114,851)

The notes on pages 5 to 42 form part of this statement.

The financial statements on pages 1 to 41 were approved by the Audit and Risk Committee on 16 June 2026 with delegated authority from the Board and signed on its behalf by:



Chief Accountable Officer
Shane Devlin

NHS Bristol, North Somerset and South Gloucestershire ICB
Accounts for the year ended 31 March 2026

Statement of Changes In Taxpayers Equity for the year ended 31 March 2026

	Note	General fund reserves
Changes in taxpayers' equity for 2025-26		£'000
Balance at 1 April 2025		(114,851)
Changes in NHS Integrated Care Board taxpayers' equity for 2025-26		
Net recognised expenditure for the year		(2,577,160)
Net funding		2,553,781
Balance at 31 March 2026		(138,230)

	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 2023-24		
Net recognised expenditure for the year		(2,358,202)
Net funding		2,351,487
Balance at 31 March 2025		(114,851)

The notes on pages 5 to 42 form part of this statement.

NHS Bristol, North Somerset and South Gloucestershire ICB
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Statement of Cash Flows for the year ended 31 March 2026

	Note	2025-26 £'000	2024-25 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial period		(2,577,160)	(2,358,202)
Depreciation and amortisation	5	444	391
(Increase)/decrease in trade & other receivables	11	(3,604)	12,408
Increase in trade & other payables	13	23,949	589
Provisions utilised	14	-	(2,025)
Increase/(decrease) in provisions	14	2,850	(4,030)
Net Cash Inflow (Outflow) from Operating Activities		(2,553,521)	(2,350,869)
Cash Flows from Investing Activities			
Interest received		108	118
(Payments) for property, plant and equipment	8	-	(265)
Net Cash Inflow (Outflow) from Investing Activities		108	(147)
Net Cash Inflow (Outflow) before Financing		(2,553,413)	(2,351,016)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		2,553,781	2,351,487
Repayment of lease liabilities	9	(406)	(268)
Net Cash Inflow (Outflow) from Financing Activities		2,553,375	2,351,219
Net Increase (Decrease) in Cash & Cash Equivalents at 31 March		(38)	203
Cash & Cash Equivalents at the Beginning of the Financial Period		377	174
Cash & Cash Equivalents at the End of the Financial Year	12	339	377

The notes on pages 5 to 42 form part of this statement.

NHS Bristol, North Somerset and South Gloucestershire ICB

Accounts for the year ended 31 March 2026

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 2025-26 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. Bristol, North Somerset and South Gloucestershire ICB formally clustered with Gloucestershire ICB on 1 April 2026. There is an expectation that they will merge on 1 April 2027.

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 2026, 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 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. Further information is on page 38.

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 Research & Development income (R&D), 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 consider this to be a material estimate. 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.

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Accounts for the year ended 31 March 2026

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 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:

a) 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 2026, is based on valuation data as at 31 March 2024, updated to 31 March 2026 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

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Accounts for the year ended 31 March 2026

accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) 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.

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.

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.

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Accounts for the year ended 31 March 2026

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.

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).

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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 3.64% (2024-25: 4.03%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.
- medium-term rate of 4.22% (2024-25: 4.07%) 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 5.32% (2024-25: 4.81%) 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 5.07% (2024-25: 4.55%) 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

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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 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.

1.14.1 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.

1.14.2 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. The ICB has not elected to measure any financial assets/financial liabilities at fair value through profit and loss.

1.14.3 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. The ICB has not elected to measure any financial assets/financial liabilities at fair value through profit and loss.

1.14.4 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 or assets measured at fair value through other comprehensive income, 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

NHS Bristol, North Somerset and South Gloucestershire ICB

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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.

1.15 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.

1.15.1 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.

1.16 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.

1.17 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 2026. Resulting exchange gains and losses for either of these are recognised in the Integrated Care

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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.

1.18 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).

1.19 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.

1.20 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.

1.21 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.

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1.22 New and revised IFRS Standards in issue but not yet effective

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.

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2 Financial Performance

2.1 Financial duties

During the financial period 1 April 2025 to 31 March 2026, 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 2025 to 31 March 2026.

	2025-26		
	Target £'000	Performance £'000	Variance £'000
Expenditure not to exceed income	2,615,058	2,614,782	(277)
Capital resource use does not exceed the amount specified in Directions	309	166	(142)
Revenue resource use does not exceed the amount specified in Directions	2,577,294	2,577,160	(134)
Revenue administration resource use does not exceed the amount specified in Directions	23,814	22,301	(1,513)

A number of 2025-26 allocations were made close to or after the final cash drawn down deadline of 16 March 2026. As a result, £23.3m cash could not be drawn down in the year.

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3.1 Operating Income

	2025-26	2024-25
	Total	Total
	£'000	£'000
Income from sale of goods and services (contracts)		
Non-patient care services to other bodies - <i>note 1</i>	10,618	12,143
Prescription fees and charges	9,854	10,185
Dental fees and charges	15,130	13,795
Other contract income	1,720	2,327
Total income from sale of goods and services	37,322	38,450
Other operating income	133	-
Total Operating Income	37,455	38,450

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. £9.8m of this revenue figure relates to income for Research and Development from the Department of Health and Social Care (2024-25 £9.4m).

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3.2 Disaggregation of Income – Income from sale of goods and services (contracts)

	2025-26			
	Non-patient care services to other bodies £'000	Prescription fees and charges £'000	Dental fees and charges £'000	Other Contract income £'000
Source of Revenue				
NHS	552	-	-	1,720
Non NHS	10,066	9,854	15,130	-
Total	10,618	9,854	15,130	1,720

	2025-26			
	Non-patient care services to other bodies £'000	Prescription fees and charges £'000	Dental fees and charges £'000	Other Contract income £'000
Timing of Revenue				
Point in time	10,618	9,854	15,130	1,720
Over time	-	-	-	-
Total	10,618	9,854	15,130	1,720

	2024-25			
	Non-patient care services to other bodies £'000	Prescription fees and charges £'000	Dental fees and charges £'000	Other Contract income £'000
Source of Revenue				
NHS	151	-	-	889
Non NHS	11,992	10,185	13,795	1,438
Total	12,143	10,185	13,795	2,327

	2024-25			
	Non-patient care services to other bodies £'000	Prescription fees and charges £'000	Dental fees and charges £'000	Other Contract income £'000
Timing of Revenue				
Point in time	12,143	10,185	13,795	2,327
Over time	-	-	-	-
Total	12,143	10,185	13,795	2,327

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4. Employee benefits and staff numbers

4.1 Employee benefits

	2025-26		
	Permanent Employees	Other	Total
	£'000	£'000	£'000
Employee benefits			
Salaries and wages	22,296	817	23,113
Social security costs	2,830	11	2,841
Employer contributions to NHS Pension scheme	4,901	-	4,901
Apprenticeship levy	95	-	95
Termination benefits	2,868	-	2,868
Gross employee benefits expenditure	32,990	828	33,818

	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

There were no capitalised staff costs in 2025-26 or in 2024-25.

Pension costs include funding from NHSE relating to the change in employer's contribution rate.

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4.2 Average number of people employed

	Permanently employed Number	Other Number	Total Number
2025-26	405	11	416
2024-25	403	13	416

There were no whole-time equivalent people engaged on capital projects in 2025-26 or in 2024-25.

4.3 Staff annual leave accrual balances

	Permanent Staff £'000
Employee accrued benefits liability at 31 March 2026	207
Employee accrued benefits liability at 31 March 2025	177

The accrued benefits liability balance related to permanent staff only; no temporary or agency staff accrued annual leave benefits.

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4.4 Exit packages agreed in the financial year

2025-26						
	Compulsory redundancies		Other agreed departures		Total	
	No	£	No	£	No.	£
Less than £10,000	1	3,546	-	-	1	3,546
£10,001 to £25,000	1	14,589	6	107,250	7	121,839
£25,001 to £50,000	-	-	5	189,933	5	189,933
£50,001 to £100,000	-	-	2	141,540	2	141,540
£100,001 to £150,000	-	-	-	-	-	-
£150,001 to £200,000	-	-	-	-	-	-
Over £200,001	-	-	-	-	-	-
Total	2	18,135	13	438,723	15	456,858

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

The other agreed departures in 2025-26 all relate to voluntary redundancies.

There were no other agreed departures in 2024-25. There were no departures where special payments were made in 2025-26 or 2024-25. 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.

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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. (2024-25 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 2026 with summary global member and accounting data. In

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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. £222 NEST contributions were paid in year. The ICB recognises contributions payable under this scheme as an expense during the year that it was incurred.

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5. Operating Expenditure

	2025-26	2024-25
	Total	Total
	£'000	£'000
Purchase of goods and services		
Services from other ICBs and NHS England	8,458	11,369
Services from foundation trusts	702,738	636,625
Services from other NHS trusts	744,372	674,133
Services from other WGA bodies	1,841	1,637
Purchase of healthcare from non-NHS bodies	606,186	564,030
Purchase of social care	9,609	10,427
General dental & personal dental services	51,618	44,471
Prescribing costs	151,849	154,325
Pharmaceutical services	34,700	29,741
General ophthalmic services	8,747	8,458
GPMS/APMS and PCTMS	224,179	207,276
Supplies and services – clinical	4,415	4,118
Supplies and services – general	54	48
Consultancy services	271	455
Establishment	4,198	4,853
Transport	103	36
Premises	3,022	3,821
Audit fees - <i>notes 1,2</i>	265	258
Other non statutory audit expenditure		
· Internal audit services	-	-
· Other services	-	-
Other professional fees - <i>note 3</i>	2,366	2,676
Legal fees	1,069	1,086
Education, training and conferences	524	618
Total Purchase of goods and services	2,560,584	2,360,461
Depreciation and provisions expense		
Depreciation	444	391
Amortisation	-	-
Provisions expense	2,850	(4,031)
Total Depreciation provisions expense	3,294	(3,640)
Other Operating Expenditure		
Chair and Non-Executive Members	152	164
Grants to Other bodies - <i>note 4</i>	-	159
Research and development (excluding staff costs)	14,338	10,183
Expected credit loss on receivables	2,321	832
Other expenditure	-	-
Total Other Operating Expenditure	16,811	11,338
Total Operating Expenditure	2,580,689	2,368,159

5. Operating Expenditure (continued)

Notes

1. External audit liability is capped at £2m.
2. External audit fees in 2025-26 were £236 379, net of VAT. This includes an inflationary uplift of 2.83% and £15,500 relating to additional work related to ISFE2 and MHIS. In 2024-25, external audit fees were £215,000 in total, net of VAT. This comprised £194,400 core services, and £16,200 for the 2024-25 MHIS audit.
3. Internal Audit services are provided by an external provider RSM Risk Assurance Services LLP and fees in 2025-26 were £77,000 net of VAT (2024-25 £75,348 net of VAT). This is included in Other professional fees.
4. Grants to other bodies in 2024-25 reflected capital grants from NHSE to the community provider.
5. There is a new requirement in 2025/26 to disclose Mental Health Investment Standard (MHIS) spend. This information can be found in the note on page 42.

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6.1 Better Payment Practice Code

Measure of compliance	2025-26 No.	2025-26 £'000	2024-25 No.	2024-25 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the period	30,523	910,666	31,747	857,922
Total Non-NHS Trade Invoices paid within target	30,248	889,394	31,457	848,106
Percentage of Non-NHS Trade invoices paid within target	99%	98%	99%	99%
NHS Payables				
Total NHS Trade invoices paid in the period	1,206	1,477,119	1,265	1,324,977
Total NHS Trade invoices paid within target	1,180	1,476,159	1,230	1,322,719
Percentage of NHS Trade Invoices paid within target	98%	100%	97%	100%

6.2 The Late Payment of Commercial Debts (Interest) Act 1998

There were no payments made from claims under Late Payment of Commercial Debts (Interest) Act 1998 in 2025-26. 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.

7. Finance Costs

	2025-26 Total £'000	2024-25 Total £'000
Interest on lease liabilities	108	118
Interest on late payment of commercial debt	-	1
Total finance costs	108	119

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8. Property, plant and equipment

	2025-26 £'000	2024-25 £'000
Cost or Valuation opening balance at 1 April	979	830
Additions purchased	-	265
Disposals	-	(116)
Cost or Valuation closing balance at 31 March	979	979
Depreciation opening balance at 1 April	379	382
Disposals	-	(116)
Charged during the year	166	113
Depreciation closing balance at 31 March	545	379
Net Book Value closing balance at 31 March	434	600
Purchased	434	600
Total at 31 March	434	600
Asset financing:		
Owned	434	600
Total at 31 March	434	600

All property, plant and equipment held by the ICB at 31 March 2026 and 31 March 2025 relate to Information Technology assets.

8.1 Economic lives

	Minimum Life (years)	Maximum Life (Years)
Information technology	1	5

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9. Leases

9.1 Right-of-use assets

	2025-26 Buildings £'000	2024-25 Buildings £'000
Cost opening balance at 1 April	2,844	3,160
Additions	-	-
ROU dilapidation	-	204
Assets derecognised	-	(520)
Cost closing balance at 31 March	2,844	2,844
Depreciation opening balance at 1 April	342	584
Charged during the period	278	278
Derecognised	-	(520)
Depreciation closing balance at 31 March	620	342
Net Book Value closing balance at 31 March	2,224	2,502

All Right of Use Assets are leased from NHS Property Services, part of the DHSC group.

The derecognised lease relates to the ICB's former head office.

9.2 Lease liabilities

	2025-26 £'000	2024-25 £'000
Lease liabilities opening balance at 1 April	(2,445)	(2,595)
Additions	-	-
Interest expense relating to lease liabilities	(108)	(118)
Repayment of lease liabilities (capital and interest)	406	268
Lease liabilities closing balance at 31 March	(2,147)	(2,445)

All lease liabilities are with NHS Property Services, part of the DHSC group.

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9.3 Lease liabilities - Maturity analysis of undiscounted future lease payments

	2025-26 Obligations Leased from NHS Property Services £'000	2024-25 Obligations Leased from NHS Property Services £'000
Within one year	(407)	(406)
Between one and five	(1,343)	(1,473)
After five years	(779)	(1,056)
Total	(2,529)	(2,935)
Effect of discounting	382	490
Included in:		
Current lease liabilities	(312)	(298)
Non-current lease liabilities	(1,835)	(2,147)
Total	(2,529)	(2,445)

9.4 Amounts recognised in Statement of Comprehensive Net Expenditure

	SoCNE 2025-26 £'000	SoCNE 2024-25 £'000
Depreciation expense on right-of-use asset	278	278
Interest expense on lease liabilities	108	118

9.5 Amounts recognised in cashflow

	SOCF 2025-26 £'000	SOCF 2024-25 £'000
Total cash outflow on leases under IFRS 16	406	268

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10 Intangible non-current assets

	2025-26 Computer software: purchased £'000	2024-25 Computer software: purchased £'000
Cost or valuation opening balance	-	-
Additions	166	-
Cost or valuation closing balance	166	-
Amortisation opening balance	-	-
Charged during the period	-	-
Amortisation closing balance	-	-
Net Book Value closing balance	166	-
Purchased	166	-
Total at 31 March 2023	166	-

10.1 Economic Lives

	Minimum Life (Years)	Maximum Life (Years)
Computer software: purchased	2	5

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11. Trade and other receivables

	2025-26 Current £'000	2024-25 Current £'000
NHS receivables: Revenue	4,042	5,910
NHS prepayments	-	-
NHS accrued income	4,292	684
Non-NHS and Other WGA receivables: Revenue	7,109	6,549
Non-NHS and Other WGA prepayments	916	403
Non-NHS and Other WGA accrued income	8,783	4,319
Non-NHS and Other WGA Contract Receivable not yet invoiced/non-invoice	9,277	10,904
Expected credit loss allowance-receivables	(3,220)	(904)
VAT	604	324
Other receivables and accruals	1	10
Total Current trade & other receivables	31,804	28,199

The ICB had no non-current trade receivables at 31 March 2026 or at 31 March 2025.

The ICB had no prepaid pensions contributions at 31 March 2026 or at 31 March 2025.

11.1 Receivables past their due date but not impaired

	2025-26		2024-25	
	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
By three to six months	-	18	158	320
By more than six months	324	4,251	-	210
Total	324	4,269	246	1,562

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11.2 Loss allowance on asset classes

**Trade and other
receivables: Non DHSC
Group Bodies**

	2025-26	2024-25
	£'000	£'000
Allowance for credit losses opening balance	(904)	(73)
Lifetime expected credit losses on trade and other receivables-Stage 2	(2,321)	(833)
Amounts written off	5	2
Allowance for credit losses closing balance	(3,220)	(904)

The Integrated Care Board did not hold any collateral against receivables outstanding at 31 March 2026 or at 31 March 2025.

12. Cash and cash equivalents

	2025-26	2024-25
	Total	Total
	£'000	£'000
Opening balance	377	174
Net change in period	(38)	203
Closing balance	339	377
Made up of:		
Cash with the Government Banking Service	339	377
Cash in hand	-	-
Cash and cash equivalents as in statement of financial position	339	377

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13. Trade and other payables

	2025-26	2024-25
	Total	Total
	£'000	£'000
NHS payables: Revenue	3,682	3,851
NHS accruals	19,541	8,003
Non-NHS and Other WGA payables: Revenue	64,768	47,223
Non-NHS and Other WGA payables: Capital	167	-
Non-NHS and Other WGA accruals	72,721	79,381
Non-NHS and Other WGA deferred income	37	-
Social security costs	333	291
Tax	362	348
Payments on account	-	172
Other payables and accruals	4,160	2,386
Total Current Trade & Other Payables	165,771	141,655

The ICB had no non-current trade and other payables at 31 March 2026 or at 31 March 2025.

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 £2,167,717 outstanding pension contributions at 31 March 2026 (£1,998,701 as at 31 March 2025).

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14. Provisions

	2025-26			2024-25		
	Current	Non-current	Total	Current	Non-current	Total
	£'000	£'000	£'000	£'000	£'000	£'000
Current						
Redundancy	1,350	-	1,350	-	-	-
Legal claims	2,225	-	2,225	2,225	-	2,225
Other	1,500	204	1,704	-	204	204
Total	5,075	204	5,279	2,225	204	2,429

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.

	2025-26			
	Redundancy	Legal Claims	Other	Total
	£'000	£'000	£'000	£'000
Balance at 1 April 2025	-	2,225	204	2,429
Arising during the period	1,350	-	1,500	2,850
Utilised during the period	-	-	-	-
Reversed unused	-	-	-	-
Change in discount rate	-	-	-	-
Balance at 31 March 2026	1,350	2,225	1,704	5,279
Expected timing of cash flows:				
Within one year	1,350	2,225	1,500	5,075
Between one and five years	-	-	-	-
After five years	-	-	204	204
Balance at 31 March 2026	1,350	2,225	1,704	5,279

The Other provision opening balance relates to dilapidations associated with the ICB's Head Office.

The Other provision arising in the year relates to costs anticipated as a result of the GPIT service moving from the CSU to the ICB during 2026/27, following the closure of the CSU.

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	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

15. Financial instruments

15.1 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.

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15.1.1 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.

15.1.2 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.

15.1.3 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.

15.1.4 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.

15.1.5 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.

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15.2 Financial assets

	Financial Assets measured at amortised cost	
	2025-26	2024-25
	Total	Total
	£'000	£'000
Trade and other receivables with NHSE bodies	4,573	2,551
Trade and other receivables with other DHSC group bodies	3,761	4,400
Trade and other receivables with external bodies	25,170	21,425
Cash and cash equivalents	339	378
Bad debt reserve	(3,220)	(904)
Total closing balance	30,623	27,850

15.3 Financial liabilities

	Financial Liabilities measured at amortised cost	
	2025-26	2024-25
	Total	Total
	£'000	£'000
Trade and other payables with NHSE bodies	(374)	(2,383)
Trade and other payables with other DHSC group bodies	(22,849)	(9,839)
Trade and other payables with external bodies	(141,816)	(128,622)
Finance lease obligations	(2,147)	(2,445)
Total closing balance	(167,186)	(143,289)

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16. Operating segments

	2025-26	2024-25
	Commissioning Healthcare	Commissioning Healthcare
	£'000	£'000
Gross expenditure	2,614,615	2,396,652
Income	(37,455)	(38,450)
Net expenditure	2,577,160	2,358,202
Total assets	34,967	31,678
Total liabilities	(173,197)	(146,529)
Net assets	(138,230)	(114,851)

16.1 Reconciliation between Operating Segments and SoCNE

	2025-26	2024-25
	£'000	£'000
Total net expenditure reported for operating segments	2,577,160	2,358,202
Total net expenditure per the Statement of Comprehensive Net Expenditure	2,577,160	2,358,202

16.2 Reconciliation between Operating Segments and SoFP

	2025-26	2024-25
	£'000	£'000
Total assets reported for operating segments	34,967	31,678
Total assets per Statement of Financial Position	34,967	31,678

	2025-26	2024-25
	£'000	£'000
Total liabilities reported for operating segments	(173,197)	(146,529)
Total liabilities per Statement of Financial Position	(173,197)	(146,529)

NHS Bristol, North Somerset and South Gloucestershire ICB
Accounts for the year ended 31 March 2026

17. Related party transactions

17.1 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 2026 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 2026. The transactions with Bristol City Council, North Somerset Council and South Gloucestershire Council have a net spend of £150.5m and the main services this relates to are: Better Care Fund (£47.2m), Funded Nursing Care (£27.3m); and all groups of Complex Care clients (£76.0m).

	2025-26	2024-25	Movement
Local Authority	£m	£m	£m
Bristol City Council	52.0	46.3	5.6
North Somerset Council	66.6	62.2	4.4
South Gloucestershire Council	31.9	22.9	9.0
Total	150.5	131.5	19.0

17.2 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 (2024-25 with Avon & Wiltshire Mental Health Partnership Trust and Royal United Hospitals Bath NHSFT). The ICB had the transactions set out in the table below with these organisations.

	Avon & Wiltshire Mental Health Partnership Trust		Royal United Hospitals Bath NHSFT	
	2025-26	2024-25	2025-26	2024-25
	£'000	£'000	£'000	£'000
Expenditure	157,937	151,651	17,760	16,290
Income	80	1	-	-
Payables	3,668	393	1,275	305
Receivables	3,357	2,916	-	-

18. 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	2025-26	2024-25
	£'000	£'000
Funding provided to partnership budgets	46,203	41,131
Additional NHS contribution	1,369	1,340
ASC discharge funding	-	4,232
ICB funding to council for protection of adult social care	(22,224)	(21,384)
Expenditure from partnership arrangement	25,348	25,319

North Somerset Council	2025-26	2024-25
	£'000	£'000
Funding provided to partnership budgets	21,915	19,521
Additional NHS contribution	1,456	1,408
ASC discharge funding	-	2,059
ICB funding to council for protection of adult social care	(8,890)	(8,554)
Expenditure from partnership arrangement	14,481	14,434

South Gloucestershire Council	2025-26	2024-25
	£'000	£'000
Funding provided to partnership budgets	22,494	20,009
Additional NHS contribution	2,073	1,745
ASC discharge funding	-	2,201
ICB funding to council for protection of adult social care	(7,521)	(7,237)
Expenditure from partnership arrangement	17,046	16,718

NHS Bristol, North Somerset and South Gloucestershire ICB
Accounts for the year ended 31 March 2026

19. Losses and special payments

19.1 Losses

	Total Number of Cases 2025-26 £'000	Total Value of Cases 2025-26 £'000	Total Number of Cases 2024-25 £'000	Total Value of Cases 2024-25 £'000
Administrative write-offs	2	5	1	2
Fruitless payments	-	-	-	-
Store losses	-	-	-	-
Book Keeping Losses	-	-	-	-
Constructive loss	-	-	-	-
Cash losses	-	-	-	-
Claims abandoned	-	-	-	-
Total	2	5	1	2

19.2 Special payments

The ICB made no special payments in 2025-26 (2024-25: none).

20. Contingences

Contingent Liabilities

	2025-26 £'000	2024-25 £'000
Continuing Healthcare	-	18

The Continuing Healthcare contingent liability in 2024-25 related to continuing healthcare claims dating back to 2018. The uncertainty related to the eligibility of outstanding historic claims. Whilst possible, it was deemed unlikely these amounts would be reimbursed.

In 2025-26, the ICB has not included a contingent liability for continuing healthcare claims, due to immateriality.

NHS Bristol, North Somerset and South Gloucestershire ICB
Accounts for the year ended 31 March 2026

21. Mental Health Expenditure

	2025-26	2024-25
Minimum expenditure in mental health services to meet the Mental Health Investment Standard as notified by NHS England (£000)	228,912	201,552
Eligible mental health expenditure (£000)	233,545	202,052
Mental health expenditure above minimum investment required (£000)	4,633	500
Mental health expenditure as a proportion of total expenditure (%)	9	9

The ICB continues to meet the Mental Health Investment Standard, with actual eligible expenditure above the minimum investment required by NHS England. The eligible mental health expenditure is £233.545m in 2025/26, which is £4.633m above the minimum expenditure required by NHS England. The mental health expenditure represents 9.06% of the total ICB expenditure in 2025/26.

22. Events after the reporting period

There have been no events after the reporting period.

NHS BRISTOL, NORTH SOMERSET AND SOUTH GLOUCESTERSHIRE ICB

Annual internal audit report for the year ending 31 March 2026

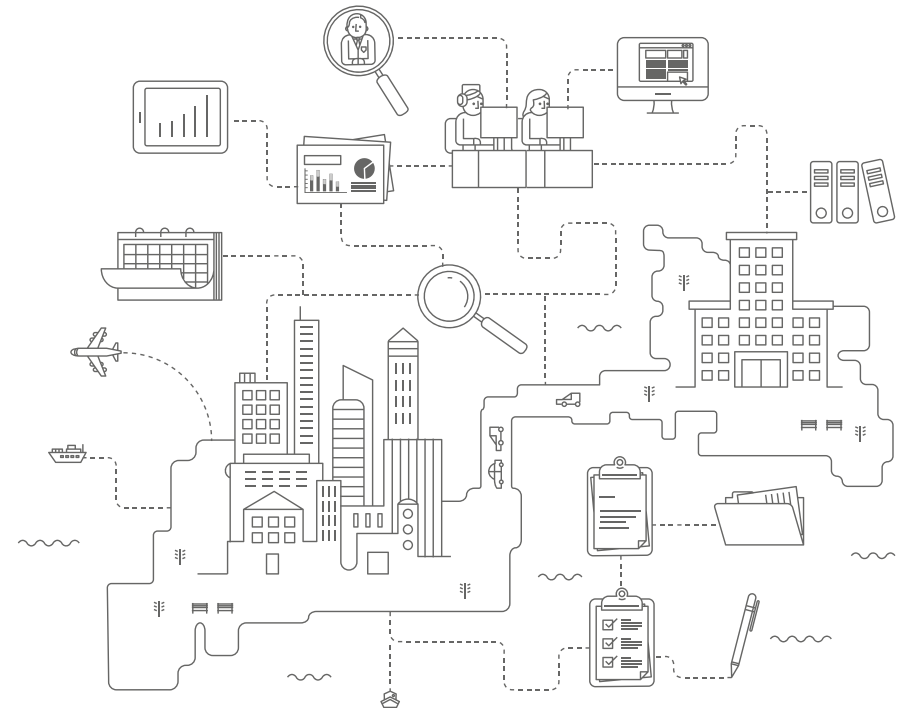
16 June 2026

This report is solely for the use of the persons to whom it is addressed.

To the fullest extent permitted by law, RSM UK Risk Assurance Services LLP will accept no responsibility or liability in respect of this report to any other party.

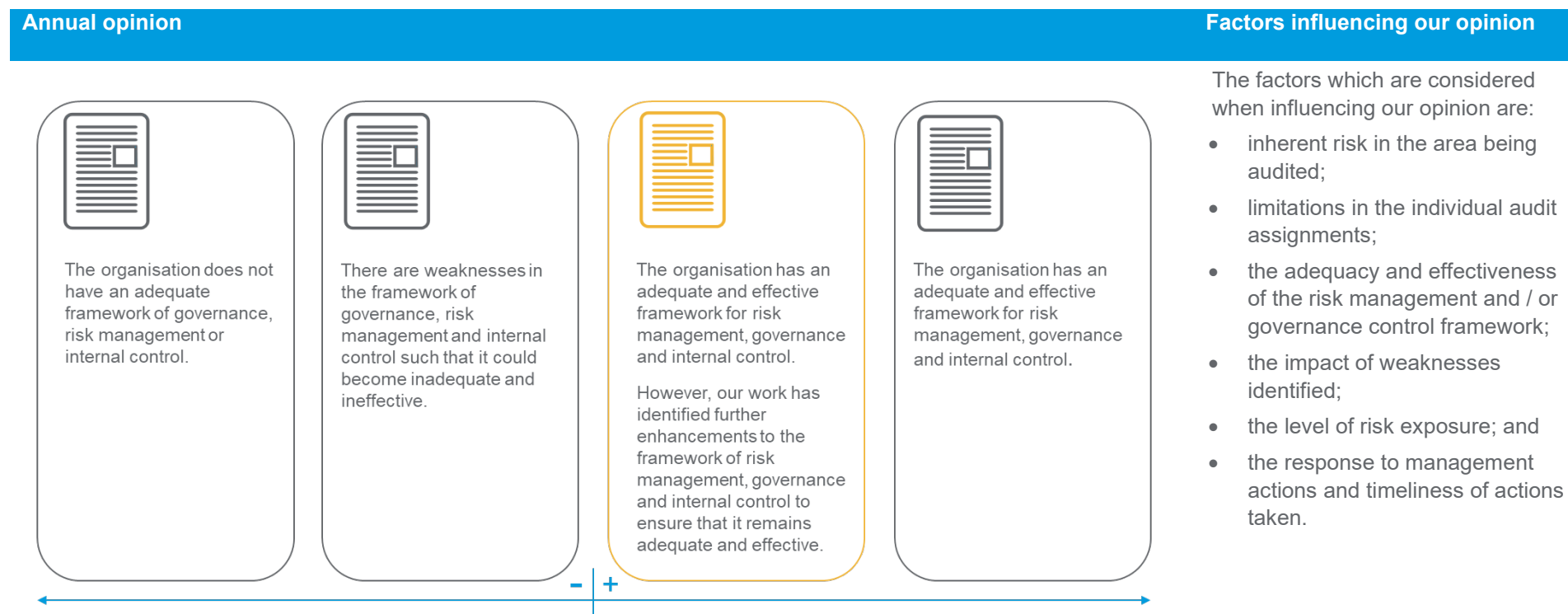
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THE ANNUAL INTERNAL AUDIT OPINION

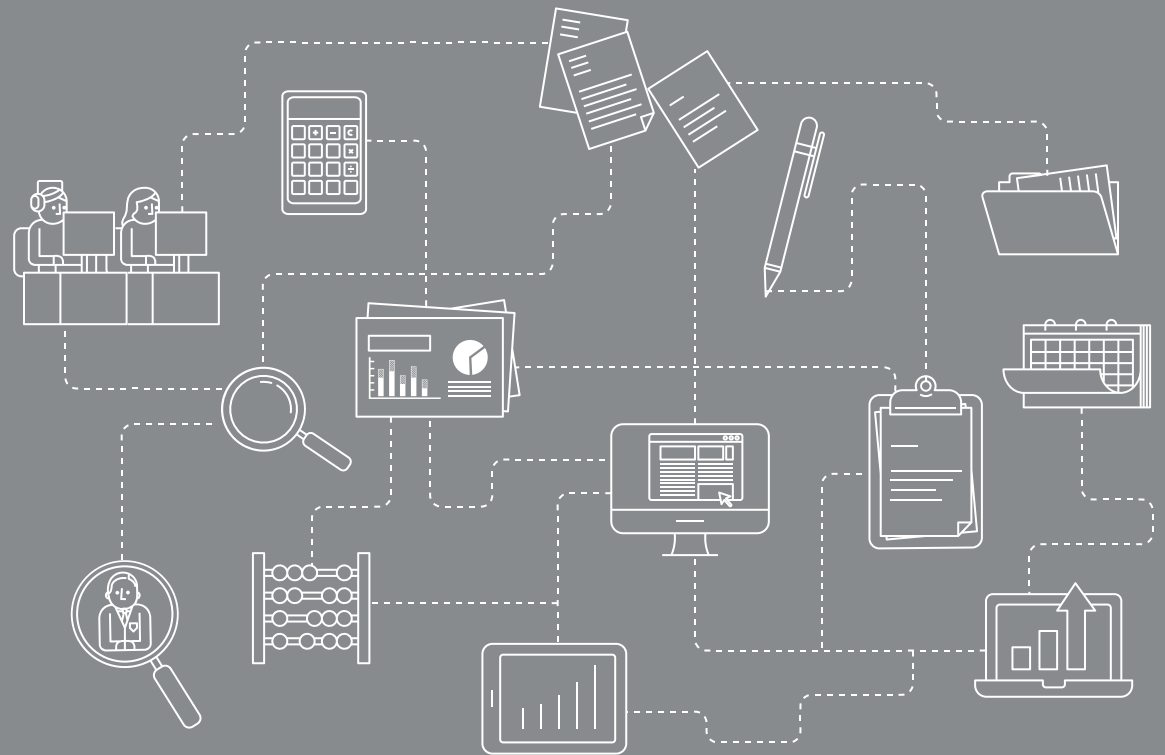
The annual internal audit opinion is based upon, and limited to, the work performed on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes. For the year ending 31 March 2026 the head of internal audit opinion for NHS Bristol, North Somerset and South Gloucestershire ICB is:



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

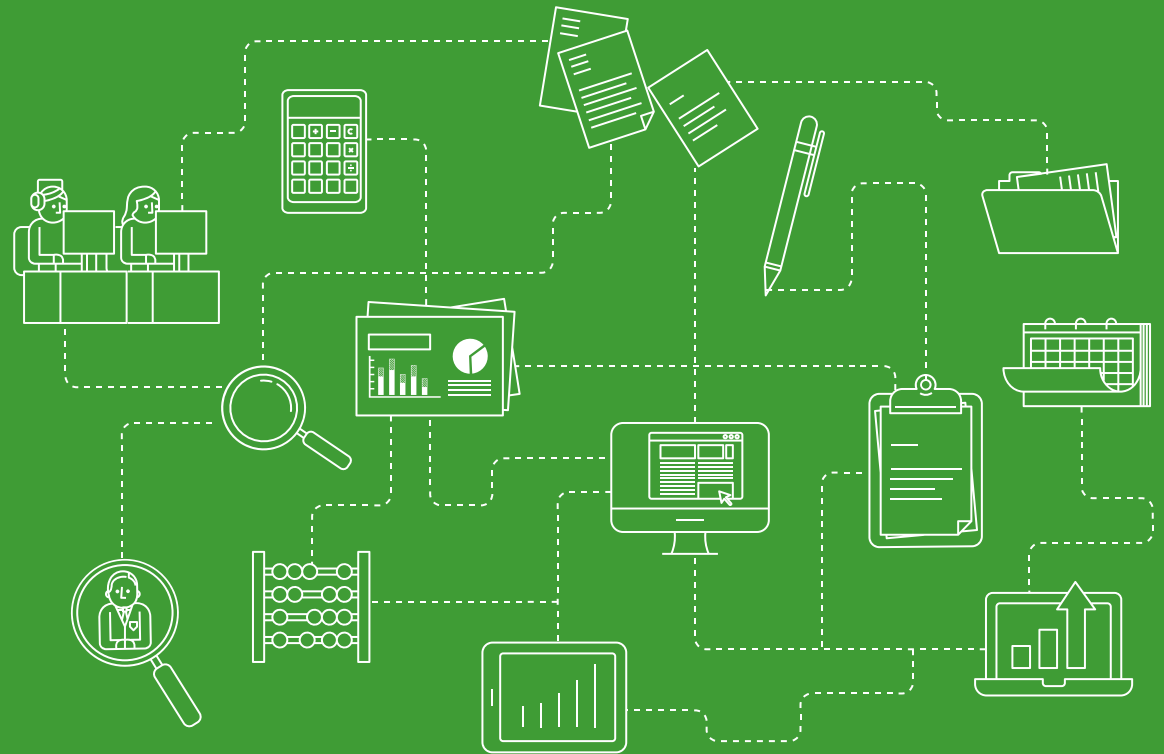
The formation of our opinion is achieved through a risk-based plan of work, agreed with management and approved by the audit committee, our opinion is subject to inherent limitations, as detailed below.



- 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 NHS 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 seven assignments as part of the 2025/26 internal audit plan. Of these, one provided a negative opinion (partial assurance) and five provided a positive assurance opinion (reasonable reasonable) and one related to the [Cyber Assessment Framework \(CAF\)-aligned Data Security and Protection Toolkit Independent Assessment Report \(7.25/26\)](#) and concluded with a **Low risk rating**; and a **High confidence level** in the veracity of the self-assessment.

The results of our work which resulted in a negative opinion are summarised below.

[Procurement and Contract Management \(3.25/26\)](#) – Partial Assurance

We concluded that the design of the ICB's control framework in this area was adequate overall. We confirmed that relevant policies and procedures had been updated to reflect the requirements of new legislation and the majority of processes we walked through were adequately designed.

However, our limited testing of controls and processes (due to competing pressures across the ICB) identified instances both of non-compliance with the ICB's processes, as well as concerns around data integrity. Additionally, as we were unable to undertake the planned all-staff survey on procurement knowledge and understanding, we were unable to comment on and confirm understanding and application of the legislation across the ICB – this also could not be properly demonstrated through our testing and identified instances of non-compliance. As a result of our actual testing completed and limited scope of work that we performed, we concluded with partial assurance. We agreed three medium and one low priority actions with management.

As at 16 June 2026, the three medium priority actions were not yet due.

The results of our positive assurance opinion audits are summarised below:

[Funded Care – All Age Continuing Care \(1.25/26\)](#) – Reasonable Assurance

The introduction of the Care Assurance Panel (CAP) in May 2024 represented a positive development in strengthening governance and oversight within the All Age Continuing Care commissioning process. The approved Commissioning Policy provided a framework for decision-making, with defined roles and responsibilities across key stakeholders. The CAP and Complex Case Panel (CCP) were supported by Terms of Reference and procedural documentation that offered clarity on expectations and actions required throughout the care pathway.

Our audit found that while the policy framework was sound, operational implementation presented challenges that impacted consistency, transparency, and assurance. Documentation processes, particularly around decision-making, case management, and panel governance, required strengthening to ensure alignment with policy updates and to support auditability.

CAP has contributed to improved scrutiny and oversight; however, its full potential is yet to be realised. Addressing documentation inconsistencies and embedding structured training and reporting mechanisms will be key to maximising its impact. Importantly, the absence of CAP-specific reporting within strategic oversight forums such as the Funded Delivery Group limits visibility and assurance over its operational effectiveness.

Overall, we conclude that the CAP process added value to the commissioning framework and provided a foundation for improved governance. From our qualitative review, we confirmed that overall, the introduction of CAP had a positive impact on the effectiveness of processes and added value.

With targeted enhancements to documentation, training, and performance oversight highlighted in this report, the process could deliver more value, greater consistency, accountability, and assurance across the All Age Continuing Care pathway.

Financial Performance and Delivery (2.25/26) – Reasonable Assurance

Through reviewing the design and operational effectiveness of BNSSG's financial performance and delivery control framework we found that the ICB had a framework in place to ensure that financial plans are developed and monitored appropriately. This was illustrated through the ICB delivering a surplus for 2024/25 and as of August 2025, the ICB reported a year-to-date and forecast breakeven position.

We confirmed that there had been consistent reporting to, and scrutiny of the ICB's financial performance by, the Finance, Estates and Digital Committee (FED) throughout 2025/26 to date. Additionally, further oversight was provided by the Board through reviewing the Financial Performance reports presented to FED, as well as FED minutes. The Financial Performance reports included detail on material underperformance and significant risks, with subsequent justifications and detail of required remedial work, such as the overspend with respect to Mental Health.

The ICB's efficiencies were broadly spread out to be met evenly across the year with £19.6m of efficiencies achieved at 31 August 2025, and the remaining £31.3m of efficiencies to be achieved across the remaining seven months of the year. However, due to the ongoing challenges and uncertainty facing the ICB, caution was advised and robust assurances were required moving forward to ensure these efficiencies remained achievable.

Management informed us that the impact of the planned 50% reduction in headcount was not included in the ICB's planning assumptions to date. The ICB continued to monitor the situation and was likely to begin consultation this year, which meant recognising cost of transition in the 2025/26 financial year with amounts of national funding available remaining unclear at the time of reporting.

Financial Controls (4.25/26) – Reasonable Assurance

Our review confirmed that the ICB completed a reconciliation process following the migration from ISFE1 to ISFE2, and that supporting controls such as training and internal and external oversight forums were in place and operating effectively. Data analytics testing also revealed that ISFE1 cost centres were mapped appropriately to a corresponding ISFE2 cost centre.

Wider issues outside of the ICB's control with the rollout and ongoing use of ISFE2 were well known nationally. Specifically, we noted that deficiencies within ISFE2 had caused several issues which the Financial Services team were required to manually work around at the time of our audit. For one of the workarounds, we raised an action to enable a more proactive approach to identifying invoices that are "stuck in the system" which had caused issues around timely payments to suppliers.

In line with the clustering arrangement with Gloucestershire ICB from 1 April 2026, we also noted that work was ongoing by the Finance team to work with Gloucestershire ICB colleagues to create a new accounts payable process, including aligning approval limits with the aim of improving the control environment.

Risk and Governance (5.25/26) – Reasonable Assurance

From reviewing the design and effectiveness of BNSSG's control framework we found that there were mature controls in place and clear oversight of risk management through the various governance forums such as the Audit and Risk Committee and System Executive Group. We reviewed a sample of directorates and the overarching Strategic Risk Register and found that risk registers were in place and predominately contained relevant detail.

However, further scrutiny of the risk registers, particularly the Directorate Risk Registers (DRRs), revealed inconsistencies in how the risk registers were populated. For example, the detail for controls, risk scoring and application of BNSSG's risk appetite varied among the three DRRs, highlighting that whilst risk management was taking place, risk registers and thereby the management of risks could be enhanced.

Our findings were of a similar theme to previous years whereby we confirmed that the ICB's frameworks and key controls for risk management were well designed. However, the identification of inconsistent application of housekeeping of specific aspects of DRRs undermined and weakened the foundations that the ICB's risk management arrangements were built on, ultimately, providing reduced assurance to the Board over the robustness of risk management activities across the organisation.

The areas of improvement noted and agreed actions within this report should be considered in the context of risk management arrangements and associated responsibilities potentially changing due to the clustering arrangement between BNSSG and Gloucestershire ICBs. In addition, the report should be read in the acknowledgement that the role of risk management in relation to ICS risk management may evolve in line with the changing remit and responsibilities of ICBs.

CareTrack Application (6.25/26) – Reasonable Assurance

We concluded that the ICB had established a foundation for the security and governance of its digital assets. Acacium Group, which operated CHS, holds ISO 27001 certification and Cyber Essentials Plus accreditation. ISO 27001 is the international standard for information security management, requiring organisations to establish, implement, and maintain an Information Security Management System (ISMS) that is independently audited and certified, demonstrating a systematic, risk-based approach to managing sensitive information. Cyber Essentials Plus is a UK government-backed certification that provides assurance through an independent technical audit of an organisation's core security controls, including firewalls, malware protection, access controls, secure configuration, and patch management, verifying their effective operation against common cyber threats.

These accreditations provided a level of assurance regarding the control environment within the provider organisation. In addition, Caretrack's procurement via the GOV.UK Digital Marketplace framework confirms that it underwent initial government standard security vetting and met baseline security requirements prior to adoption.

As Caretrack is managed by a third party, the ICB does not exercise direct technical control over the infrastructure, configuration, or security operations of the platform. In such arrangements, the ICB's primary control mechanism was effective supplier governance, including formal oversight, documented performance monitoring, and independent verification of key security controls.

Our review identified weaknesses in the design and operation of governance processes established to oversee CHS, the SaaS provider. Regular meetings with the SaaS vendor were not formally minuted, resulting in the absence of a documented audit trail of issues discussed, actions agreed, or remediation progress. This weakened accountability and reduced the ICB's ability to demonstrate structured oversight. The ICB was unable to obtain essential technical evidence from the provider to verify that critical security controls, including Multi Factor Authentication, Web Application Firewalls, and encryption standards, are active and appropriately configured. In the absence of verifiable evidence, assurance was based on provider representations rather than demonstrable proof.

We also noted that a significant service outage occurred in November 2025, during which the Caretrack platform was unavailable for an extended period of approximately sixty hours, with full functionality only restored several days later. This incident affected multiple services and users and required a complex restoration process following infrastructure and data corruption issues. While no data loss was reported, the duration and impact of the outage highlight the importance of robust resilience, recovery capability, and effective oversight of supplier controls.

Within the ICB's own internal operations, we identified that the user access lifecycle for Caretrack was entirely dependent on a single individual, representing a potential single point of failure. Regarding resilience, we noted a significant lack of alignment between recovery expectations and actual restoration performance, which presents a high risk to clinical safety during a prolonged system outage.

Taken together, the issue in third party governance, the absence of independently verifiable technical assurance, internal single points of dependency, and resilience misalignment resulted in a conclusion of reasonable assurance.

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 all of the findings reported by the internal audit service during 2025/26.



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 2026:

- the ICB had implemented three **High** and 21 **Medium** priority actions during 2024/25;
- two **Medium** actions from 2024/25 remained outstanding; and
- 11 **Medium** actions from 2025/26 were not yet due and would be monitored throughout 2026/27.



Working with other assurance providers

In forming our opinion, we have placed direct reliance on other assurance providers in line with the below:

We reviewed the service auditors report ISAE 3402 for NHS Shared Business Services for its provision of Finance and Accounting Services. Whilst exceptions were found, these were not significant and an unqualified opinion in this area was provided. We note from the report, where exceptions were found, management had put in place immediate actions and mitigations to improve compliance.

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 two control objectives where exceptions were identified in testing. These exceptions relate to changes to pension data only upon valid/authorised requests and payments only made following the validation of bank details. No management actions had been raised; however, management had provided responses to the exceptions and/or taken action to mitigate future recurrence of non-compliance. These exceptions are not considered sufficiently significant to impact on the ICB's Head of IA Opinion.

We reviewed the Type II Service Auditor Report, covering Payroll and Non-Clinical Procurement services provided by the four NHS CSUs for the period 1 April 2025 to 31 March 2026. One opinion was given for this report covering all four CSUs. No exceptions were noted.

We have also worked with BDO to support the transition to a clustered working arrangement between BNSSG and Gloucestershire ICB.

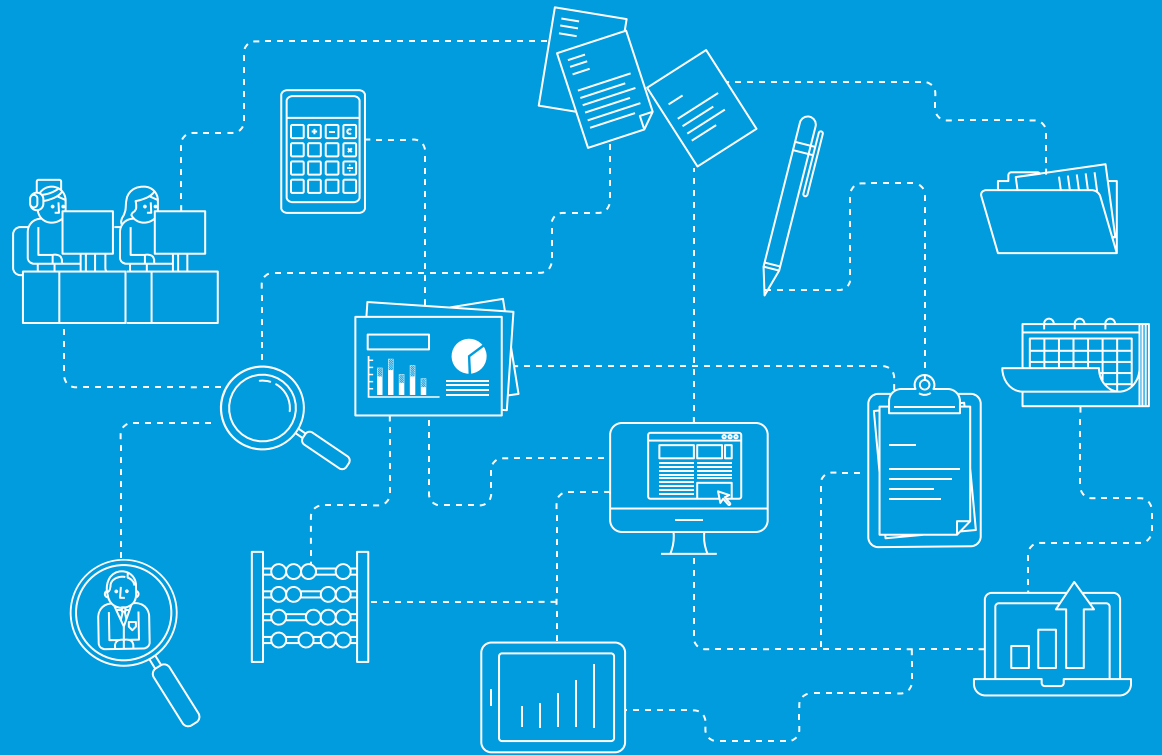


Topics judged relevant for consideration as part of the annual governance statement

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 report.

Our Performance

03



3.1 Wider value adding delivery

Area of work	How has this added value?
Briefings	We have issued a number of sector briefings during the year providing information on key developments, publications and guidance including: • our quarterly NHS Emerging Issues briefings' • Emerging Risk Radar; • Cyber Security Awareness briefing; • Fraud Awareness; • Procurement Regulations; and • Global Internal Audit Standards in the UK Public Sector.
Healthcare 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.
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 in supporting the CareTrack Application and DSPT work undertaken at the ICB in 2025/26. In addition, we have worked with colleagues at BDO to support the delivery of Part One of the ICB Transition work.
Regular liaison	We have met regularly with the Chief of Staff and Head of System Strategy & Planning to discuss progress with the plan, action tracking and to escalate any issues as required
Audit and Risk Committee	We contributed to the discussions at the Committee on various items on the agenda in order to ensure that the ICB benefits from wider input in further developing its governance arrangements.
Employment Rights Paper	We have shared a paper which explored the key amendments to the Employment Rights Bill. A further paper was shared which included the anticipated timeline and actions to be taken in accordance to this.
NHS Audit Chairs Forum	The ICB Audit Chair was invited to sessions of our NHS Audit Chairs Forum. We shared the papers highlighting key themes from our NHS Audit Chairs Forum. In these sessions, we looked at how ICBs, individual health bodies and ICSs should seek to understand and manage evolving technology risks, under the themes of digital transformation, AI, patient care and people. Other areas explored in these sessions have included workforce planning, people pressures and risks.
Failure to Prevent Fraud Briefing	We have circulated a paper around the government issued guidance on the new corporate offence of failure to prevent fraud (under s199 of the Economic Crime and Corporate Transparency Act). The paper highlighted the fraud prevention procedures required to be implemented by relevant organisations prior to the offence coming into force or risk an unlimited fine.

3.2 Conflicts of interest

RSM has not undertaken any work or activity during 2025/26 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 2025/26.

3.3 Conformance with internal auditing standards

RSM affirms that our internal audit services are designed to conform to the Global Internal Audit Standards in the UK Public Sector. Our next external quality assessment (EQA) will take place in 2026.

Under the Standards, internal audit services are required to have an EQA 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.

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

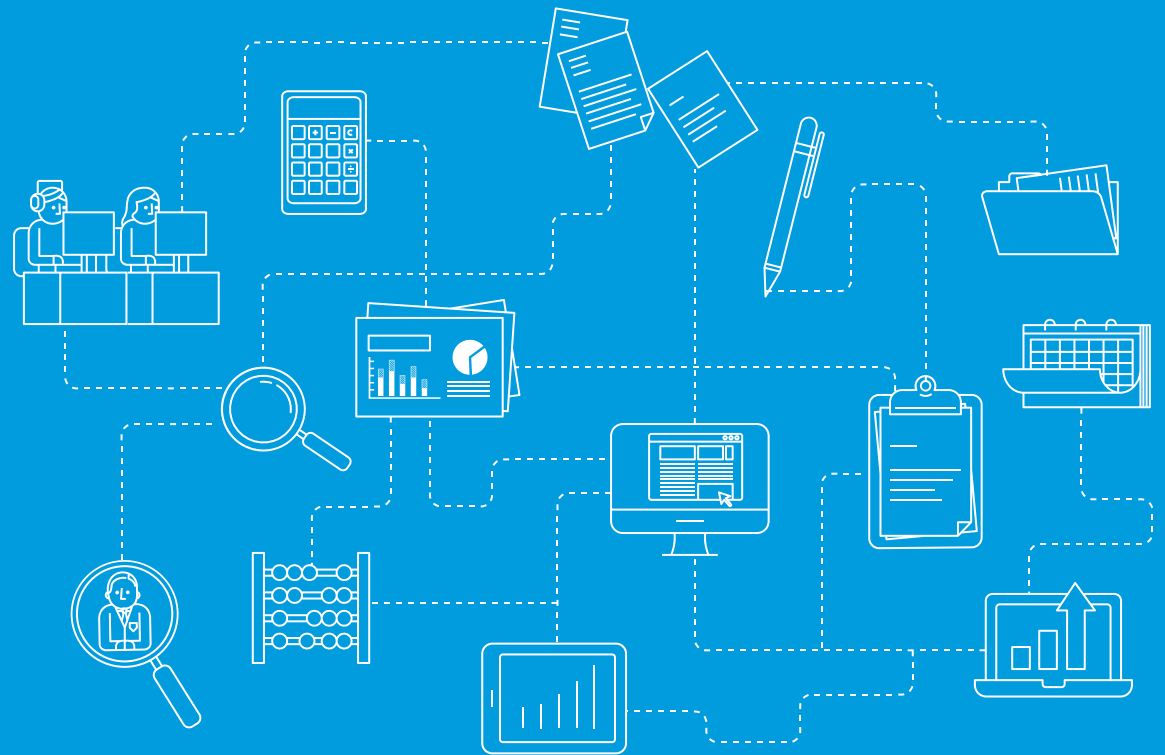
To ensure that RSM remains compliant with the Global Internal Audit Standards in the UK Public Sector we have a dedicated internal Quality Assurance Team who undertake a programme of reviews to ensure the quality of our audit assignments. This is applicable to all Heads of Internal Audit, where a sample 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 2025/26. 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	Opinion issued	Actions agreed		
			L	M	H
Funded Care - All Age Continuing Care	Rosi Shepherd	Reasonable Assurance	2	5	0
Financial Performance and Delivery	Matt Backler	Reasonable Assurance	1	0	0
Procurement and Contract Management	David Jarrett	Partial Assurance	1	3	0
Financial Controls	Matt Backler	Reasonable Assurance	0	1	0
Risk and Governance	Shane Devlin	Reasonable Assurance	1	4	0
Caretrack Application	Seb Habibi	Reasonable Assurance	3	6	0
Cyber Assessment Framework (CAF)-aligned Data Security and Protection Toolkit (DSPT)	Seb Habibi	Low Risk Rating High Confidence Level	2	0	0

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:



Minimal Assurance

Taking account of the issues identified, the board cannot take assurance that the controls upon which the organisation relies to manage this risk are suitably designed, consistently applied or effective.

Urgent action is needed to strengthen the control framework to manage the identified risk(s).



Partial Assurance

Taking account of the issues identified, the board can take partial assurance that the controls upon which the organisation relies to manage this risk are suitably designed, consistently applied or effective.

Action is needed to strengthen the control framework to manage the identified risk(s).



Reasonable Assurance

Taking account of the issues identified, the board can take reasonable assurance that the controls upon which the organisation relies to manage this risk are suitably designed, consistently applied and effective.

However, we have identified issues that need to be addressed in order to ensure that the control framework is effective in managing the identified risk(s).



Substantial Assurance

Taking account of the issues identified, the board can take substantial assurance that the controls upon which the organisation relies to manage this risk are suitably designed, consistently applied and effective.

- | +

FOR FURTHER INFORMATION CONTACT



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INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF THE BOARD OF NHS BRISTOL, NORTH SOMERSET AND SOUTH GLOUCESTERSHIRE INTEGRATED CARE BOARD

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

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 2026 which comprise the Statement of Comprehensive Net Expenditure, Statement of Financial Position, Statement of Changes in Taxpayers' Equity and Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the financial position of the ICB as at 31 March 2026 and of its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by NHS England with the consent of the Secretary of State on 23 April 2025 as being relevant to ICBs in England and included in the Department of Health and Social Care Group Accounting Manual 2025/26; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006 (as amended).

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the ICB in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Emphasis of matter – going concern

We draw attention to the disclosure made in note 1.1 to the financial statements which explains that on 1 April 2027 NHS Bristol, North Somerset and South Gloucestershire ICB will be dissolved and its services transferred to a newly formed successor organisation. Under the continuation of service principle, the financial statements of NHS Bristol, North Somerset and South Gloucestershire ICB have been prepared on a going concern basis because its services will continue to be provided by the successor public sector entity. Our opinion is not modified in this respect.

Going concern

The Accountable Officer of the ICB ("the Accountable Officer") has prepared the financial statements on the going concern basis, as they have not been informed by the relevant national body of the intention to either cease the ICB's services or dissolve the ICB without the transfer of its services to another public sector entity. They have also concluded that there are no material uncertainties that could have cast significant doubt over its ability to continue as a going concern for at least a year from the date of approval of the financial statements ("the going concern period").

In our evaluation of the Accountable Officer's conclusions, we considered the inherent risks associated with the continuity of services provided by the ICB over the going concern period.

Our conclusions based on this work:

- we consider that the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate; and
- we have not identified, and concur with the Accountable Officer's assessment that there is not, a material uncertainty related to events or conditions that, individually or collectively,

may cast significant doubt on the ICB's ability to continue as a going concern for the going concern period.

However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the above conclusions are not a guarantee that the ICB will continue in operation.

Fraud and breaches of laws and regulations – ability to detect

Identifying and responding to risks of material misstatement due to fraud

To identify risks of material misstatement due to fraud ("fraud risks") we assessed events or conditions that could indicate an incentive or pressure to commit fraud or provide an opportunity to commit fraud. Our risk assessment procedures included:

- Enquiring of management, the Audit Committee and internal audit and inspection of policy documentation as to the ICB's high-level policies and procedures to prevent and detect fraud including the internal audit function, and the ICB's channel for "whistleblowing", as well as whether they have knowledge of any actual, suspected, or alleged fraud.
- Reading Board and Audit Committee minutes.
- Using analytical procedures to identify any unusual or unexpected relationships.

We communicated identified fraud risks throughout the audit team and remained alert to any indications of fraud throughout the audit.

As required by auditing standards, we performed procedures to address the risk of management override of controls, in particular the risk that ICB management may be in a position to make inappropriate accounting entries.

On this audit we did not identify a fraud risk related to revenue recognition because of the nature of funding provided to the ICB, which is transferred from NHS England and recognised through the Statement of Changes in Taxpayers' Equity. We therefore assessed that there was limited opportunity for the ICB to manipulate the income that was reported.

We also identified a fraud risk related to expenditure recognition in response to the opportunity to alter the year end position. In line with the guidance set out in Practice Note 10 Audit of Financial Statements of Public Sector Bodies in the United Kingdom we also recognised a fraud risk related to non-pay expenditure recognition.

We performed procedures including:

- Identifying journal entries and other adjustments to test based on risk criteria and comparing the identified entries to supporting documentation. These included unexpected account pairings with cash and borrowings and post close journals.
- Assessing whether the judgements made in making accounting estimates are indicative of a potential bias
- Identifying journal entries and other adjustments to test based on risk criteria and comparing the identified entries to supporting documentation. These included unexpected account pairings with cash and borrowings and post close journals.
- For a selection of cash payments and purchase invoices in the period post 31 March 2026, verify that the expenditure had been recognised in the correct accounting period to which the expenditure related.

Identifying and responding to risks of material misstatement related to compliance with laws and regulations

We identified areas of laws and regulations that could reasonably be expected to have a material effect on the financial statements from our general sector experience and through discussion with the Board and other management (as required by auditing standards), and from inspection of the ICB's regulatory and legal correspondence and discussed with the directors and other management the policies and procedures regarding compliance with laws and regulations.

We communicated identified laws and regulations throughout our team and remained alert to any indications of non-compliance throughout the audit.

The potential effect of these laws and regulations on the financial statements varies considerably.

The ICB is subject to laws and regulations that directly affect the financial statements including the financial reporting aspects of NHS legislation. We assessed the extent of compliance with these laws and regulations as part of our procedures on the related financial statement items.

Whilst the ICB is subject to many other laws and regulations, we did not identify any others where the consequences of non-compliance alone could have a material effect on amounts or disclosures in the financial statements.

Context of the ability of the audit to detect fraud or breaches of law or regulation

Owing to the inherent limitations of an audit, there is an unavoidable risk that we may not have detected some material misstatements in the financial statements, even though we have properly planned and performed our audit in accordance with auditing standards. For example, the further removed non-compliance with laws and regulations is from the events and transactions reflected in the financial statements, the less likely the inherently limited procedures required by auditing standards would identify it.

In addition, as with any audit, there remained a higher risk of non-detection of fraud, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal controls. Our audit procedures are designed to detect material misstatement. We are not responsible for preventing non-compliance or fraud and cannot be expected to detect non-compliance with all laws and regulations.

Other information in the Annual Report

The Accountable Officer is responsible for the other information, which comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work:

- we have not identified material misstatements in the other information; and
- in our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

Remuneration and Staff Reports

In our opinion the parts of the Remuneration and Staff Reports subject to audit have been properly prepared, in all material respects, in accordance with the Department of Health and Social Care Group Accounting Manual 2025/26.

Accountable Officer's and Audit and Risk Committees responsibilities

As explained more fully in the statement set out on page 147, the Accountable Officer of the ICB is responsible for the preparation of financial statements that give a true and fair view. They are also responsible for such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; 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 either cease the services provided by the ICB or dissolve the ICB without the transfer of its services to another public sector entity.

The Audit and Risk Committee is responsible for overseeing the ICB's financial reporting process.

Auditor's responsibilities

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 our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities.

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

Opinion on regularity

The Accountable Officer is responsible for ensuring the regularity of expenditure and income.

We are required to report on the following matters under Section 21(4) and (5) of the Local Audit and Accountability Act 2014.

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 conform to the authorities which govern them.

Basis for opinion on regularity

We conducted our work on regularity in accordance with Statement of Recommended Practice - Practice Note 10: *Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2024)* issued by the FRC. We planned and performed procedures to obtain sufficient appropriate evidence to give an opinion over whether the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them. The procedures selected depend on our judgement, including the assessment of the risks of material irregular transactions. We are required to obtain sufficient appropriate evidence on which to base our opinion.

Report on 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 if we identify any significant weaknesses in the arrangements that have been made by the ICB to secure economy, efficiency and effectiveness in its use of resources.

We have nothing to report in this respect.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

As explained more fully in the statement set out on page 147, the Accountable Officer is responsible for ensuring that the ICB exercises its functions effectively, efficiently and economically. 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 are also not required to satisfy ourselves that the ICB has achieved value for money during the year.

We planned our work and undertook our review in accordance with the Code of Audit Practice and related statutory guidance, having regard to whether the ICB had proper arrangements in place to ensure financial sustainability, proper governance and to use information about costs and performance to improve the way it manages and delivers its services. Based on our risk assessment, we undertook such work as we considered necessary.

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice to report to you if:

- we issue a report in the public interest under section 24 and Schedule 7 of the Local Audit and Accountability Act 2014; or
- we make written recommendations to the ICB under Section 24 and Schedule 7 of the Local Audit and Accountability Act 2014; or
- we refer a matter to the Secretary of State and NHS England 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.

We have nothing to report in these respects.

THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

This report is made solely to the Members of the Board of NHS Bristol, North Somerset and South Gloucestershire Integrated Care Board, 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 Board of the ICB, as a body, 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 Members of the Board of the ICB, as a body, for our audit work, for this report or for the opinions we have formed.

DELAY IN CERTIFICATION OF COMPLETION OF THE AUDIT

As at the date of this audit report, we are unable to confirm that we have completed our work in respect of the ICB's accounts consolidation template for the year ended 31 March 2026 because we have not received confirmation from the NAO that the NAO's audit of the Department of Health and Social Care accounts is complete.

Until we have completed this work, we are unable to certify that we have completed the audit of NHS Bristol, North Somerset and South Gloucestershire Integrated Care Board for the year ended 31 March 2026 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the NAO Code of Audit Practice.

Jonathan Brown

Jonathan Brown

for and on behalf of KPMG LLP

Chartered Accountants

66 Queen Square

Bristol

BS1 4BE

18 June 2026