



**Bath and North East Somerset,
Swindon and Wiltshire**
Integrated Care Board

Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board

Annual Report

1 April 2024 – 31 March 2025

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PERFORMANCE REPORT

Sue Harriman

Accountable Officer

19 June 2025

(1.0) Performance overview

(1.01) Chief Executive Officer statement

I am delighted to present the Annual Report and Accounts for 2024/25.

This report charts our performance, outlines our achievements and describes the challenges we have faced over the past 12 months.

It has been an extraordinary year. Demand for NHS services has never been higher and there has been a renewed focus on the unique nature of our national health service from the new government.

In BSW, we have worked hard as a system to support services through challenging seasonal pressures, with the interests of the people and communities we serve at the heart of everything we do.

Our activity over the past year is based on our robust and ambitious planning that reflects the health and care needs of local people, the financial and operational challenges we face and the opportunities to do things differently – and better.

In 2024/25, we made significant headway in bringing to life the government's aims of moving from hospital care to community care, shifting from sickness to preventative care, and digitising the health service. Some of my personal highlights are set out below.

Connecting with our communities

The consultation on the 10-Year Plan, heralded as the biggest conversation on the future of the NHS in its 76-year history, was an unprecedented opportunity to find out what matters to people when it comes to health and care.

We have been proud to support that conversation in BSW, and the insights we have gathered are reflected in this report. They will inform service transformation and delivery in the months to come.

From sickness to prevention

During 2024/25, we have gone further to develop our understanding of the health needs of different communities and, in turn, what we as an organisation can do to actively address local health inequalities.

We have pushed forward innovative campaigns to support the prevention agenda, including outreach to our local communities to offer blood pressure advice as part of the [Know Your Numbers campaign](#) and through our own #StayWellBSW campaign, which helps our communities in looking after their own health.

Once again, we are ahead of the pack in our vaccination efforts. More than half a million vaccinations were delivered during winter 2024 thanks to the sterling work of our local teams who have gone above and beyond to protect the region's most vulnerable people.

Over recent years, we have achieved a high and more positive profile for the importance of mental health services, with initiatives such as the Parity of Esteem agenda helping to address inequalities within the health and care system. We know, however, that there is still more to do.

Our mental health strategy for 2025-2030 has been developed in partnership with clinicians and people with lived experience. It sets out a transformational roadmap that will ensure mental health and wellbeing has the same focus as physical health.

Initiatives such as outreach to the Wiltshire farming community at the Salisbury Livestock Market have resulted in people getting much-needed urgent medical care which they might not otherwise have sought. To me, that is the very essence of why we all come to work every day; so that we can make a genuine difference to people's lives.

From hospital to community

The Board's landmark decision to [appoint HCRG Care Group as the lead partner](#) for our community services portfolio from April 2025 marked the start of a new and innovative approach to commissioning and delivery of services in the community.

This move not only makes the 'left shift' set out in our Integrated Care Strategy a reality but also embraces the concept of 'neighbourhood health' and focusing squarely on the needs and experience of patients.

Local people can expect to receive more health and social care in or near their homes, in a more joined-up and streamlined way.

I'm also delighted that we have been able to invest in the facilities that house health and care services, with the [green light given for Trowbridge Integrated Care Centre](#) in November 2024.

Capital investment in bricks-and-mortar projects not always easy to come by. But, with a new [community endoscopy unit](#) currently under construction in Swindon, and new builds at our acute hospitals, we are breathing new life into the fabric of our NHS.

We now have a dedicated community diagnostic centre in each of our three main localities, with each site offering the type of vital investigative services, including X-rays, MRIs, CT scans and endoscopies, that would previously only have been available in hospital.

This supports the vision outlined in the government's Elective Care Reform Plan, which was published in January 2025, for reducing waiting times and helping people get diagnosed for potentially serious conditions, such as cancer, much sooner than before.

From analogue to digital

Our population's use of the NHS App continues to grow. In October, we hit more than 100,000 repeat prescriptions in a single month, as well as more than a million logins.

While we know that digital is not for everyone, this does show that people value the app and growth in usage is strong.

Looking ahead

We're acutely aware of the challenges that lay before us, particularly in terms of our performance in critical areas such as cancer waiting times and the four-hour target within our region's emergency departments.

Our financial position is also very challenging and, along with our partners, we have created and agreed a balanced plan that will require us to work collectively, as a system, to bring it to life.

The hard work of delivery has already begun, and with it comes opportunities to make pathways of care more efficient and effective for patients and staff alike, which we know will have a positive impact at the front line of health and care delivery.

More detail on what we're doing to address these issues is laid out further in this report, and I'm pleased that the effect of many of the transformative initiatives already in place are beginning to be felt.

The future form and function of ICBs

We are also responding to national proposals to make changes to integrated care board functions and geography, as part of a wider NHS reform programme to reduce management costs and focus more money on the front line.

All ICBs in England are being asked to significantly reduce running costs and shift to a more strategic role with different responsibilities for us and other parts of our health and care system.

It will help the NHS to deliver its absolute priorities for this year, bring down waiting lists, prepare for winter and continue to deliver high-quality patient care for our local population, while also laying the foundations to shift resources into prevention, wellbeing and care closer to people's homes.

ICBs, in the form we currently know, will look very different by the end of the 2025/26 financial year.

We will need to work on larger footprints, serving larger populations and take into account any new strategic local authority boundaries emerging from the local government reform process.

We are proposing to form a cluster in partnership with Dorset and Somerset ICBs, which will be subject to national agreement.

I am delighted that this proposal keeps BSW together, as well as giving us a good chance to meet the challenges set out in the blueprint for the ICBs of the future.

It also means we can partner with two ICBs who share our culture, values and ambitions to improve outcomes for our populations. We have much in common with both Somerset and Dorset, with high levels of rural deprivation and synergies around the way patients flow within our respective systems.

Celebrating our staff

None of the achievements outlined in this report would have been possible without the dedication of health and care staff working tirelessly across the BSW area. I speak on behalf of the ICB Board when I say a heartfelt thank you for their commitment and compassion.

The next year will bring change, but whatever the implications, our focus will never waver from our ambition to support the people and communities of BSW to live longer, happier and healthier lives.

Sue Harriman,

Chief Executive Officer,
Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board

(1.02) Our Executive Team

The ICB is led by an executive team of health and care professionals, all of whom have a wide-ranging knowledge of the NHS in Bath and North East Somerset, Swindon and Wiltshire, as well as its local partner organisations.

Led by Sue Harriman, Chief Executive Officer, the executive team is responsible for leading the ICB, and for supporting colleagues across all areas of the organisation to deliver effective health and care services to local people.

The full executive team for 2024/25 can be seen below:

- Sue Harriman, Chief Executive Officer
- Gill May, Chief Nurse
- Dr Amanda Webb, Chief Medical Officer
- Sarah Green, Chief People Officer
- Gary Heneage, Chief Finance Officer
- Rachael Backler, Chief Delivery Officer
- Laura Ambler, Director of Place – Bath and North East Somerset
- Gordon Muvuti, Director of Place – Swindon
- Caroline Holmes, Director of Place – Wiltshire (interim)
- Richard Collinge, Chief of Staff

(1.03) The role of the integrated care board

BSW ICB is a statutory body which brings together NHS organisations, along with local authorities and other partners, to work to improve population health and establish shared strategic priorities.

The ICB oversees how money is spent and makes sure that health services work well and are of high quality. It also ensures there is effective collaboration between hospital providers, primary care, local councils, hospices, voluntary, community, and social enterprise (VCSE) organisations and Healthwatch partners across all areas of Bath and North East Somerset, Swindon and Wiltshire.

As an ICB, we have strategic responsibility for overseeing healthcare strategies for the local health and care system.

A key focus of the ICB is to use its resources and powers to influence effective collaboration among partners, so that complex challenges specific to the local region can be addressed.

These challenges include, but are not limited to:

- Improving the health of children and young people
- Supporting people to stay well and independent
- Acting sooner to help people with preventable conditions
- Supporting people with long-term conditions or mental health issues
- Caring for the complex multiple needs of older people
- Getting the best from collective resources so people can access care quickly

We are also part of a wider integrated care system (ICS), known as BSW Together, which is one of 42 other similar systems in England.

As an ICS, BSW Together has four key purposes:

- Improve outcomes in population health and healthcare
- Tackle inequalities in outcomes
- Enhance experience, access, productivity and value-for-money
- Support broader social and economic development

More information on the ICB is detailed in its constitution, which is available to [read online](#).

(1.04) BSW ICB's core values

Our organisation's core values, which were developed with the help of our colleagues, are at the heart of all we do for local people and communities.

These values are represented by the following five characteristics:

- Caring
- Innovative
- Inclusive
- Accountable
- Collaborative

(1.05) The local population and their health

We serve a population of approximately 940,000 people, with our residents spread out across a large and varied area, which includes the densely populated town of Swindon in the north, Salisbury Plain to the south and the historic city of Bath to the west.

While the collective geography of Bath and North East Somerset, Swindon and Wiltshire is relatively less deprived than other parts of England, this is not the case for all communities.

People in more deprived areas do not live as long as those living elsewhere, and those in these communities are more likely to experience both physical and mental health issues.

The three main causes of mortality in BSW are cancer, cardiovascular disease and respiratory disease, with people in the more deprived areas more likely to have a poorer outcome if diagnosed with one or more of these conditions.

We know the main contributing factors for these diseases are smoking, being overweight, not getting enough physical activity and regularly consuming a high volume of alcohol.

As an integrated care system, our attention is focused on supporting those in high-risk groups to make better lifestyle choices, while also using our powers to make healthier decisions as easy and as accessible as possible.

(1.06) BSW System Vision

Our [BSW Integrated Care Strategy](#) sets out BSW Together's ambition as partners working across the health, social care and voluntary sectors to support people to live happier and healthier for longer.

Importantly, this is a strategy for us all, not just the NHS. We cannot help BSW residents to improve their health and wellbeing by working in silos. This can only be done so by working together.

Our Integrated Care Partnership vision is: "We listen and work effectively together to improve health and wellbeing and reduce inequalities."

We will deliver this vision by prioritising three clear strategic objectives:

- Focus on prevention and early intervention
- Fairer health and wellbeing outcomes
- Excellent health and care services

The strategy was informed by other existing strategies, such as the local authorities' Joint Local Health and Wellbeing Strategies.

The Health and Care Act 2022 requires ICBs to develop a Joint Forward Plan together with system partners.

In our system we call this the [BSW Implementation Plan](#). The purpose of the plan is to enable our local populations, partners and stakeholders to have a clear picture of the programmes that will be delivered in support of our partnership strategy.

The plan is a refresh of a previous version, and sets out how we and our partners will work together at both a system level and in our places, and how we expect to deliver our Integrated Care Strategy during 2026/27.

As part of this work, the ICB held discussions around reforming the way it oversees delivery of its collective priorities through its programmes.

The ICB engaged with CEOs and key stakeholders, including local Health and Wellbeing Boards, to seek feedback and opinions on a number of different areas, including how well the plan supported the delivery of the respective health and wellbeing strategies of each local authority.

(1.07) BSW Operational Plan

In December 2023, NHS England released its 2024/25 priorities and operational planning guidance, with associated technical guidance published in early January 2024.

The guidance outlined the metrics and outcomes that the BSW system was expected to achieve during the year and highlighted three key tasks:

- To recover core services and productivity
- To make progress in delivering the key ambitions of the NHS Long-Term Plan
- To continue transforming the NHS for the future

Collectively, strategic partners across the system worked to formulate the plan, which was submitted and approved by NHS England.

Further reporting and performance against the key priorities within the plan can be found later in this document.

(1.08) BSW Capital Plan

The BSW Joint Use of Capital Resources Plan outlines our intention to prioritise capital projects and schemes within the budget we have available.

As a system, we have been developing a comprehensive joined-up approach to capital and revenue planning, as well as investment, across the BSW infrastructure.

This is to ensure that BSW collectively makes best use of the capital that is available to us, while also making sure decisions on investment deliver maximum benefits for the local population.

The 2024/25 plan built on the successes that were achieved in the previous year, including how the funding enabled the system to meet both local and national strategic priorities.

While the system has a finite level of operational capital, the ICB was able to remain within its limit throughout 2024/25 and therefore met its statutory duty.

Some of the key schemes already under way include:

- **Community diagnostic centres**

There are three community diagnostic centres operating in BSW. One is at the Sulis Hospital in Bath, while the remaining two are respectively located at the West Swindon Health Centre and Central Health Clinic in Salisbury. The Swindon CDC provides a full range of imaging, endoscopy, and physiological measurement tests. The Central Health Clinic site provides more limited imaging, echocardiograms and ophthalmology

assessments. Over the two financial years of 2023/24 and 2024/25, the scheme received £16.5 million in central capital funding. All three CDCs were operational by April 2024, with the final services opening in March 2025.

- **Dyson Cancer Centre**

This purpose-built facility at the Royal United Hospital in Bath opened in May 2024, and brings together the majority of the RUH's cancer services, including research, under one roof. It provides oncology, chemotherapy and radiotherapy services and also has a 22-bed inpatient ward, along with a Macmillan Wellbeing Hub. The clinical imaging and diagnostics department are located at the new facility alongside the Medical Physics and Bioengineering team.

- **Electronic patient record**

In 2023/24, NHS England approved a shared electronic patient record system for use between the three acute hospitals in BSW. As part of the frontline digitisation programme, the EPR will ensure a baseline level of digital capability in all local organisations, which will ensure health and care staff have access to health-related information when and where it is needed. The EPR will enable BSW's new model of care and support new care designs, such as virtual wards and enhanced clinics. This will support improved clinical outcomes and efficiencies across the system. One example being the standardised ordering of hip replacements joints, which helps to ensure patients have similar outcomes regardless of which hospital they are treated in.

- **Integrated front door at the Great Western Hospital in Swindon**

The integrated front door project at the Great Western Hospital was part of the wider national expansion and reconfiguration of urgent and emergency care services, and was completed in the summer of 2024. The project included the construction of a new-build Emergency Department and the creation of a standalone Children's Emergency Unit. It also helped to promote a new system-wide approach to urgent and emergency care, with the overall aim of ensuring that patients requiring urgent care are seen promptly and by the most appropriate service.

- **Sulis Elective Orthopaedic Centre**

Construction of this two-theatre orthopaedic surgical hub at the Sulis Hospital in Bath began in the spring of 2024, and was made possible thanks to £25 million from the national Targeted Investment Funds and a further £20 million of local capital funding. The centre became operational in December 2024, and has so far supported more than 3,750 patients in receiving high-quality orthopaedic care away from the traditional hospital setting.

- **New inpatient unit for people with learning disabilities and autism**

A new regional facility to support people with learning disabilities and autism is currently under construction in Bristol. Once fully open, the Kingfisher unit will offer help and support to people whose complex needs mean they may have previously had to travel out of area for their treatment. The new unit will help to keep patients nearer to their home, and in turn closer to friends and family.

(1.09) Key Risks and Issues

During 2024/25, the highest scoring risks for the ICB were:

- **Insufficient capacity across urgent and emergency care and flow**

A continued shortfall in the system's ability to safely manage rising demand has resulted in prolonged periods of escalation, reduced hospital flow and poorer experiences for patients.

Mitigations and controls included:

- System demand and capacity modelling through the System Demand and Capacity Steering Group
- System-wide escalation plans
- Weekly UEC tactical urgent care meetings
- Monthly reporting on all elements of urgent care and flow to the Executive Management Team and ICB Board

- **Ambulance handover delays**

Continued ambulance handover delays at acute trusts, stemming from wider challenges with overall system flow, has led to a rise in poorer patient experiences and dented morale among both ambulance crews and hospital staff.

Mitigations and controls included:

- Provider escalation plans
- System demand and capacity modelling
- Weekly UEC Tactical urgent care meetings
- Waiting patients closely monitored and offered refreshments

- **Financial sustainability**

The wider integrated care system may not be able to deliver the agreed operating plan for 2024/25 or to produce a balanced financial plan for the system for 2025/26.

Mitigations and controls included:

- Regular meetings of local Directors of Finance
- A System Planning Group to develop the Operating Plan for 2024/25
- Establishment of a Financial Recovery Board
- The 'triple-lock' protocol on new investments over £50,000

- **Sufficiency of capital funding for the ICB and system**

The spend of finite capital resource must be focused on schemes that support the delivery of BSW system objectives and must not create revenue pressures which could add to the system's underlying deficit and ongoing savings requirement.

Mitigations and controls included:

- Capital assurance group in place
- Oversight via the ICB's Finance and Investment Committee
- BSW capital plan and capital prioritisation protocol

- **System-wide workforce and resilience**

A heavy reliance on temporary workforce, particularly agency workers, could result in fewer staff on hand to meet continued high demand.

Mitigations and controls included:

- Local risk management process for staffing, with a focus on hard to fill posts
- System-wide recruitment and retention initiatives, including international recruitment
- Development of plans to tackle staff absence, such as wellbeing initiatives
- A provider-led temporary staffing programme in partnership with NHS England
- An ICB-led, region-wide bank and agency usage programme, which has already proved successful

(1.10) Statement of Going Concern

At the time of preparing the financial statements, the Board was required to assess whether the ICB was a going concern, which relates to whether the organisation could continue to operate for the foreseeable future.

A parliamentary intervention would be required for the ICB to cease operating. In the event of such a situation, existing legislation states that the functions undertaken by the ICB would be transferred to an existing public sector entity or one that is newly created.

On 13 March 2025 the government announced NHS England and the Department for Health and Social Care will increasingly merge functions, ultimately leading to NHS England being fully integrated into the Department. The legal status of ICBs is currently unchanged.

Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated. If services will continue to be provided in the public sector the financial statements should be prepared on the going concern basis.

The ICB's accounts have therefore been drawn up at 31 March 2025, on a going concern basis.

(2.0) Performance Analysis

Between April 2024 and March 2025, the ICB focused on priorities shared by NHS England for operational planning, delivering the following three key tasks:

- To improve patient outcomes and experience, it is imperative that we:
 - Improve ambulance response and A&E waiting times
 - Reduce long elective waits
 - Improve performance against the core cancer and diagnostic standards
 - Make it easier for people to access community and primary care services, particularly general practice and dentistry
 - Improve access to mental health services so that more people receive the treatment they need
- To make progress in delivering the key ambitions of the NHS Long Term Plan
- To continue transforming the NHS for the future

This is a continuation of NHS England's ask that organisations recover national access standards, including the NHS constitutional measures, and prioritise the recovery of core services and productivity following the Covid-19 pandemic.

For example, in elective care, the NHS has focused on reducing waiting times for long waiters in a phased approach each year, and the focus this year has been on eliminating waits of more than 65 weeks and reducing people waiting longer than 52 weeks.

At the end of March 2025, six BSW patients were waiting longer than 78 weeks for elective treatment. The target for the removal of 65-week-waiters was extended to March 2025.

While plans were developed to deliver this target, there were some risks that could not be mitigated and, at the end of March 2025, there were 32 BSW patients waiting longer than 65 weeks for elective treatment.

Demand for urgent and emergency care remained high throughout 2024/25, with NHS 111, ambulance services and emergency departments experiencing significant pressure. Emergency departments, in particular, saw attendances increase dramatically.

BSW continued to run its System Coordination Centre and further developed the Care Co-ordination Hub so that local providers could work together to support patient access to safe high-quality care. The Care Co-ordination Hub enables providers to work together to manage the response to 999 calls and to ensure patients' needs are met by the most appropriate service.

Primary care demand has also been high, and the Primary Care Access Recovery Plan has supported BSW to work towards delivering its share of the national objective for an additional

50 million appointments.

BSW has also implemented the key deliverables of the government's NHS Dental Recovery and Reform Plan, which was issued in February 2024, to improve access to NHS dental services following the impact of the Covid-19 pandemic.

There is now a system-wide approach in place to develop initiatives and solutions to recover the delivery of these services. The system delivery groups bring together partners to recover and transform services, such as elective care and emergency care. The ICB has also worked with providers to maintain patient safety during times of increased pressure, and to ensure that longer waiting patients have been cared for safely and effectively.

NHS Oversight Framework

While the intention of NHS England was to refresh the [NHS Oversight Framework for 2022/23](#), this was postponed due to external national priorities. The ICB has therefore continued to use the 2022/23 version for 2024/25.

The framework describes NHS England's approach to oversight of integrated care boards and provider trusts. This framework focuses on the delivery of the priorities set out in NHS planning guidance, the NHS Long Term Plan and the NHS People Plan, as well as the shared local ambitions and priorities of individual systems.

The purpose of the NHS Oversight Framework is to:

- Ensure there is alignment of priorities across the NHS and its wider system partners
- Identify where ICBs and NHS providers can benefit from or require support
- Provide an objective basis for decisions about when and how NHS England will intervene

The [oversight metrics](#), updated from 2022/23 to align with the 2023/24 plan priorities, continue to be monitored by NHS England in 2024/25. These are applicable to integrated care boards, NHS trusts and foundation trusts, and support the wider implementation of the framework.

The metrics are used to indicate potential issues and prompt further investigation of support needs, while aligning with the five national themes of the NHS oversight framework:

- Quality of care, access and outcomes
- Preventing ill health and reducing inequalities
- People
- Finance and use of resources
- Leadership and capability

The ICB worked with partner organisations to agree the delivery and governance arrangements, and these were summarised in a memorandum of understanding between the

ICB and NHS England in the previous financial year.

The overall quarterly segmentation, driven by the areas of concern identified, determined the level and nature of support required throughout 2024/25, and enabled the system and NHS England to target support.

The ICB worked with partner organisations to review performance against the oversight themes. The system’s three acute trusts were reviewed individually, and other partners, including community providers and primary care, were reviewed as part of BSW overall.

NHS England and the ICB discussed the proposed segmentation, and any support required.

NHS England was responsible for making the final segmentation decision and taking any necessary formal enforcement action. A description of the segments can be found in the table below.

Support segments: Description and nature of support needs

Segment description			Scale and nature of support needs
	ICB	Trust	
1	<p>Consistently high performing across the six oversight themes.</p> <p>Capability and capacity required to deliver on the statutory and wider responsibilities of an ICB are well developed.</p>	<p>Consistently high performing across the five national oversight themes and playing an active leadership role in supporting and driving key local place-based and ICB priorities.</p>	<p>No specific support needs identified. Trusts encouraged to offer peer support.</p> <p>Systems are empowered to direct improvement resources to support places and organisations or invited to partner in the co-design of support packages for more challenged organisations.</p>
2	<p>On a development journey, but demonstrates many of the characteristics of an effective ICB.</p> <p>Plans that have the support of system partners are in place to address areas of challenge.</p>	<p>Plans that have the support of system partners in place to address areas of challenge.</p> <p>Targeted support may be required to address specific identified issues.</p>	<p>Flexible support delivered through peer support, clinical networks, the NHS England universal support offer, including Getting It Right First Time, Right Care, pathway redesign, NHS Retention Programme, or a bespoke support package via one of the regional improvement hubs.</p>
3	<p>Significant support needs against one or more of the six oversight themes.</p> <p>Significant gaps in the</p>	<p>Significant support needs against one or more of the five national oversight themes and in actual or suspected breach of the NHS provider licence, or</p>	<p>Bespoke mandated support, potentially through a regional improvement hub, which draws on system and national expertise as required.</p>

	capability and capacity required to deliver on the statutory and wider responsibilities of an ICB.	equivalent for NHS trusts.	
4	Very serious and complex issues, manifesting as critical quality or finance concerns that require intensive support.	In actual, or suspected breach, of the NHS provider licence, or equivalent for NHS trusts, with very serious, complex issues, manifesting as critical quality or finance concerns that require intensive support.	Mandated intensive support delivered through the Recovery Support Programme.

The results from the 2024/25 reviews saw no changes to the 2023/24 quarter four review with the ICB, along with Royal United Hospitals Bath NHS Foundation Trust and Salisbury NHS Foundation Trust, in segment three. Great Western Hospitals NHS Foundation Trust continued in segment two, with criteria set to support this position.

In March 2024, the ICB was placed into NHS England Tier 2 for urgent and emergency care. Due to the ongoing challenges that have continued, the ICB has been in receipt of Tier 2 support for all of 2024/25.

In April 2024, Royal United Hospitals Bath NHS Foundation Trust, Salisbury NHS Foundation Trust and Great Western Hospitals NHS Foundation Trust were placed in NHS England Tier 2 to support improving cancer and diagnostics performance. In October 2024, Salisbury NHS Foundation Trust and Great Western Hospitals NHS Foundation Trust met the criteria to exit this tier. However, Royal United Hospitals Bath NHS Foundation Trust continued to receive Tier 2 support until the end of 2024/25.

In November 2024, all of BSW, including the three trusts, entered shadow tiering for its performance against referral to treatment targets, namely for patients waiting longer than 65 weeks. BSW exited shadow tiering for RTT in February, albeit with regional oversight remaining in place.

Our partners commissioned by other systems – Avon and Wiltshire Mental Health Partnership NHS Trust and South West Ambulance Service NHS Foundation Trust – are in segment three.

The ICB has monitored the areas of concern noted for each organisation through its overall oversight arrangements.

2024/25	BSW ICB	GWH	RUH	SFT	AWP
Overall rating	3	2	3	3	3
Key areas of concern	• Elective (diagnostics)	• Finance (efficiency,	• Cancer (62-day backlog)	• Finance (efficiency,	• Workforce (leaver rate and

	<ul style="list-style-type: none"> •Mental health (children and young people access, CYP eating disorders, Talking Therapies and dementia) •Finance (efficiency, stability and agency spend) •Virtual wards •Urgent community response 	<ul style="list-style-type: none"> stability and agency spend • Elective (diagnostics) • Quality (Care Quality Commission rated maternity as requires improvement) • Cancer (62-day backlog) 	<ul style="list-style-type: none"> •Finance (efficiency, stability and agency spend) •Elective (diagnostics) 	<ul style="list-style-type: none"> stability and agency spend • Cancer (28-day faster diagnostic standard) 	<ul style="list-style-type: none"> senior leadership roles • Quality (Care Quality Commission provided an overall rating of requires improvement) • Agency spend
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Performance reporting and management

With the establishment of the ICB, there was a review of how reporting would be carried out under the new regulatory framework. This was refreshed in 2024/25 to include the updated operational plan deliverables and other emerging priorities.

The ICB integrated performance dashboard was further developed in 2024/25 to support the reporting of the key metrics from the NHS Oversight Framework and operational plan priorities.

This continued to allow the organisation to monitor delivery by the BSW system against the core NHS priorities with a single version of the truth, as well as making sure that assurance of safe high-quality services was provided.

Where possible, the ICB used nationally defined, reported and validated metrics.

Some of the key areas covered include:

- **Urgent care**
 - NHS 111, A&E, ambulance handovers and hospital discharge
- **Safe, high-quality care**
 - Patient safety, patient experience, infection prevention and control
- **Primary care**
 - Access activity and times for primary care, including dental
- **Community care**
 - Waiting lists, Hospital@Home, urgent care response and bed occupancy
- **Mental health**

- Access and treatment in community therapies for adults and children, dementia diagnosis rate
- **Learning disabilities, autism and neurodivergence**
 - Inpatients with learning disabilities and autism, annual health checks
- **Planned care**
 - Waiting times and activity for cancer treatment, diagnostics and elective care, outpatient activity and transformation metrics

BSW ICB has an agreed process to report against key workforce metrics for the three acute providers it is required to provide assurance on. This covers vacancies, turnover, sickness and temporary staff usage.

The ICB's performance and quality reports are a key part of the system assurance process, including reporting against the delivery of key metrics.

Where performance is not at the expected levels, or potential risks have been identified, escalation reporting includes an update on the operational delivery challenges and risks, actions to support improvement and expected recovery.

These are shared at the following meetings:

- System Planning and Delivery Executive
- System Recovery Board
- ICB Executive Management Meeting
- ICB Commissioning Committee
- ICB Quality and Outcomes Committee
- ICB Board

There is a range of more detailed and subject-specific reporting that goes to other key meetings, in which performance is reviewed, and recovery plans are discussed at both provider and system levels, including:

- Urgent Care Delivery Group
- Elective Care Delivery Group
- Mental Health Delivery Group
- Learning Disabilities, Autism and Neurodiversity Delivery Group
- Children and Young People Delivery Group
- Community Delivery Group

- Workforce Delivery Group
- Finance and Infrastructure Committee

Trusts in BSW also produce performance reports for internal meetings and public Board meetings, which provide detail on performance against local and national targets, including actions to improve performance and key risks and mitigations.

Delivery of national standards

One of the key pledges in the NHS Constitution is the right of everyone to access the care they need. There are a number of national standards that enable us to measure and compare access performance.

[The Handbook to the NHS Constitution](#) was last updated in October 2023.

Performance delivery of the national standards is supported by the quality team who work with providers to ensure patient safety is not compromised during times of increased pressure in emergency departments, and that waiting lists are managed in a way that maximises patient safety and clinical effectiveness.

This work is important for the safe management of people who are waiting for their first appointment, diagnosis, or treatment, as well as those experiencing delays in receiving emergency care.

Access to urgent and emergency care

The A&E four-hour target measures the time a patient spends in an emergency department from arrival to transfer, admission or discharge. These waiting times are often used as a barometer for overall performance of the health and care system. This is because A&E waiting times can be affected by changing activity and pressures in other areas, such as the ambulance service, primary care, community-based care and social services.

For example, patients cannot be admitted quickly from A&E if wards are full as a result of delays in transferring patients to other NHS services.

While the target in A&E is for 95 per cent of patients to wait no more than four hours, performance in recent years has been lower than this at both a local and national level, and NHS England has introduced stepped targets to support recovery.

In 2024/25, the year-end target was 78 per cent.

Provider data for A&E four-hour standard includes:

- Bath and North East Somerset – Royal United Hospitals Bath NHS Foundation Trust (RUH)
- Swindon – Great Western Hospitals NHS Foundation Trust (GWH)

- Wiltshire – Salisbury Foundation Trust (SFT)

National Standard	Period	Target	England	South West	BSW	BSW vs Eng	BSW vs SW
Percentage of patients admitted, transferred or discharged from A&E within four hours	Mar-25	78.0%	71.5%	75.5%	66.6%	R	R
Ambulance (average handover delays longer than 15 minutes)	Mar-25	25	-	-	70	Not available	Not available
No criteria to reside (NCTR) % occupancy	Mar-25 -	8.6%	-	-	20.0%	Not available	Not available
Ambulance response times in minutes (Category 2 mean)	Mar-25	00:30:00	00:28:34	00:37:00	00:42:00	R	R
Percentage of NHS111 calls answered within 60 seconds	Mar-25	95%	-	-	89.7%	Not available	Not available
Proportion of calls assessed by a clinician or clinical advisor	Mar-25	50%	58.3%	45%	63.7%	G	G

Ambulance call categories (Cats) were updated in 2017 by the ambulance response programme. The performance of category 2 is used as the key metric to measure to support delivery and improvement:

- Cat 1 – life threatening illnesses or injuries
- Cat 2 – emergency calls
- Cat 3 – urgent calls
- Cat 4 – less urgent calls (not reported)

Key for benchmarking ratings	Green	Amber	Red
vs Eng. (England) or SW (South West)	Better than Eng. or SW	Similar or within acceptable variance to Eng. or SW	Worse than Eng. or SW.

Compares BSW and ICB to England or South West result			Outside amber tolerance
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In 2024/25, urgent care performance continued to be challenging, with the system struggling to deliver the A&E four-hour planned performance throughout the year, which was reflective of what was happening elsewhere in the country.

Risks to the delivery of urgent care performance and system flow are listed in the key risks and issues section.

The BSW trusts all monitored their individual performance on an ongoing basis. Each trust identified contributing factors to individual performance and made recovery plans. The ICB convenes both tactical and strategic meetings, in which system partners can work together on delivering urgent care pathways, including patient flow.

Demand remained high for emergency services, with significant pressure affecting both ambulances and emergency departments. The Care Co-ordination Hub was fully established to enable providers to work together, as well as with the ICB, to manage less urgent 999 callers.

Ambulance response times for people with the most serious conditions were measured as a mean response time and at the 90th percentile, which measures delivery on the every-call-counts principle of the current standards.

Performance was outside of the national targets throughout all of 2024/25. The ongoing pressure in hospitals resulted in high levels of delayed ambulance handovers, which impacted the availability of ambulances for new calls.

Handover delays were a key risk for the ICB in 2024/25, and various mitigations and controls have since been put in place, with additional system-wide plans due to start in April 2025 to reduce the overall handover delays.

Due to the ongoing Think 111 campaign, the number of calls to NHS 111 remained high throughout 2024/25.

Although the number of calls answered within 60 seconds continued to improve across the year, performance was still below target. To improve services, including answering times, the 111 provider has been working through an improvement plan, with a focus on staff recruitment and retention.

Access to planned care

Referral to treatment access targets have remained the key measures of the NHS for planned care in 2024/25, with the aim to return to the 18-week referral to treatment standard and cancer waiting times detailed in the NHS Constitution.

Following the impact of the Covid-19 pandemic on waiting lists in recent years, ICBs were asked to focus on reducing longer waiters, in particular 65-week waiters in 2024/25.

National Standard	Period	Target	England	South West	BSW	BSW vs Eng	BSW vs SW
Patients waiting over 52 weeks for treatment	Mar-25	n/a	180,242	11,457	1,976	n/a	n/a
Patients waiting over 65 weeks for treatment	Mar-25	0	7,381	626	32	n/a	n/a
Patients waiting over 78 weeks for treatment	Mar-25	0	1,164	48	6	n/a	n/a
Patients waiting six weeks or more for Diagnostics	Mar-25	5.0%	18.4%	17.2%	17.5%	G	A
People with urgent GP referral being told of cancer diagnosis outcome within 28 days of referral (FDS)	Mar-25	77.0%	78.9%	79.3%	76.1%	A	A
People with decision to treatment for cancer within 31 day – combined standard	Mar-25	96.0%	91.4%	93.4%	89.9%	A	A
People with urgent GP referral having first definitive treatment for cancer within 62 days of referral - combined standard	Mar-25	70.0%	71.4%	74.7%	74.4%	G	A

Key for benchmarking ratings	Green	Amber	Red
vs Eng. (England) or SW (South West). Compares BSW and ICB to England or South West result.	Better than Eng. or SW	Similar or within acceptable variance to Eng. or SW	Worse than Eng. or SW. Outside amber tolerance

The BSW-wide patient waiting list grew from 103,880 patients in March 2024 to 106,625 patients in March 2025. However, for the same period, the number of people waiting more than 52 weeks reduced from 3,566 to 1,976.

The ICB, system partners and other providers have been working together to deliver the Elective Recovery Programme, which aims to reduce waiting times for patients, especially those who are classed as a long waiter, since 2022.

Key actions in 2024/25 included support from the regional team to identify and implement recovery actions, including system working to look for opportunities for transfers and mutual aid. The Elective Care Delivery Group brings together the ICB, BSW acute partners, and community and primary care to implement and monitor the recovery actions identified to improve delivery of elective care.

A very small number of 78-week waiters remained in 2024/25, and these patients have been managed on a case-by-case basis to support their choice and complex care pathways.

At the end of March 2025, there were 32 patients waiting longer than 65 weeks across all providers, including those out of area. Detailed planning to treat all patients that approach waiting 65 weeks has been continuous, with support from the NHS England regional team in the second half of the year.

However, to deliver this target, there are risks in some specific specialties that need to be mitigated.

Local diagnostic waiting times are better than the England average and near to overall South West performance in March 2025, with 17.5 per cent of patients waiting longer than the six-week standard. A recovery programme, working with the NHS England regional team, has been in place throughout the year, with BSW acute providers including improvement plans for challenged modalities.

While improvements have been seen in most diagnostic tests, work continues for non-obstructive ultrasound and endoscopy. The challenged performance for diagnostics has also had an impact on waiting lists, particularly those relating to cancer.

Significant improvements across 2024/25 have been seen in delivering the 28-day cancer standard, which involves patients being diagnosed within 28 days of referral, to meet the national target.

As of March 2025, BSW performance exceeds the national target and is above the England average, and near to overall South West performance for patients with urgent GP referral having first definitive treatment for cancer within 62 days of referral.

Patient choice

The ICB has a duty to enable patient choice with respect to aspects of health services provided to them. BSW has remained compliant with these regulations while work has continued to reduce waiting times and inequities relating to elective care.

In accordance with the NHS England requirements, the ICB has fulfilled the following actions in 2024/25:

- Having a named senior responsible officer for patient choice, and establishing a process for accrediting applications from new providers to offer patient choice services

- Ensuring that, where available and appropriate, patients are routinely offered five choices of potential providers through the ICB's two referral support centres
- Promoting the use of the NHS app and the Manage Your Referral option within the national Electronic Referral System, and providing guidance in letters and emails sent to patients when they are offered choice

The BSW referral services currently comprise of two services:

- BSW Referral Service
- SARUM Referral Service, which manages separately commissioned referrals for GP practices in South Wiltshire

The ICB has supported the rollout of auto conversion from advice and guidance to a referral, streamlining the process from advice to referral, and reducing the workload on both referrers and specialist services, while also enabling patient choice.

BSW referral services interface between GP practices and secondary care to help patients make informed choices about where to go for consultation and possible treatment.

The main objective of the services is to provide patients with a smooth journey from referrer to provider, and to ensure that the most appropriate choice of healthcare provider is always offered first.

Patient choice is promoted and publicised on the [ICB website](#).

Access to mental health

In recent years, national standards have been developed to enable the ICB to measure waiting times for many mental health services. This allows for understanding of the progress made in delivering timely access to mental health services.

Further nationally measured and monitored metrics are also included here.

The ICB works with local partners on the BSW delivery group to develop services, while keeping a focus on local outcomes.

National standard	Period	Target	England	South West	BSW	BSW vs Eng	BSW vs SW
Access to children and young people's mental health services (1 contact) rolling 12months	Mar-25	13,830	829,308	65,490	9,280	n/a	n/a
Estimated diagnosis rate for people with dementia	Mar-25	66.7%	65.6%	61.3%	61.6%	R	G

(Diagnoses as a percentage of prevalence)							
Inappropriate acute mental health out-of-area placements (beds)	Mar-25	0	401	35	<5	n/a	n/a
Severe mental illness (SMI) health checks	Dec-24	60.0%	59%	56%	56.0%	R	G
Specialist community perinatal mental health access (YTD)	Mar-25	985	63,784	6,290	1,130	n/a	n/a
Talking Therapies – Number of adults receiving a course of treatment (rolling 12 months)	Mar-25	9,651	667,143	58,260	5,235	n/a	n/a
Talking Therapies – reliable recovery rate (month actual)	Mar-25	48%	48.5%	50%	49%	G	A
Talking Therapies – reliable improvement rate (month actual)	Mar-25	67%	68.4%	70%	71%	G	G

Please note:

- Most mental health data published is rounded to the nearest five for absolute numbers.
- Mental health metrics with targets of absolute values are set nationally for each ICB. The targets shown are for BSW.

Key for benchmarking ratings	Green	Amber	Red
vs Eng. (England) or SW (South West) Compares BSW and ICB to England or South West result	Better than Eng. or SW	Similar or within acceptable variance to Eng. or SW	Worse than Eng. or SW. Outside amber tolerance

Access to children and young people’s mental health services is measured against an expected prevalence of need. The ICB has developed a range of services across a number of providers, such as online support services, one to one therapeutic interventions and group sessions.

The overall number of children and young people recorded as accessing our children and

young people’s mental health services is below the national expectation of population need, and focus has been on improving national reporting by the local providers. The focus has been on developing services including the Mental Health Support teams in Schools, Youth Worker pilots, Keyworkers, and other local support offers.

The ICB is not meeting the national standard for dementia diagnosis rates but is performing similarly to others in the South West. A recovery plan to expand workforce has been implemented with some success. The memory pathway and services are being reviewed with an aim of improving timely access to memory services.

Health checks for adults with Severe Mental Health Issues is at the same level as Region and below National but has improved in 2024/25 in line with the BSW operational plan.

Community talking therapies for adults has a nationally-set target for growth in course of treatment delivered, which is based on an estimated population need. The number of people who completed a course of treatment in 2024/25 is below the BSW planned target.

A full service review of the talking therapies service was undertaken in 2024/25 to identify the service development needed and BSW ICB are working with the provider within contractual levers to agree a recovery plan to meet the BSW target for 2024/25 and then the national target in 2025/26.

The recovery plan is progressing well with strong improvements across key areas evident i.e. access, waiting list reduction and the number of people completing a course of treatment.

The talking therapies reliable recovery rate has improved across 2024/25, meeting target in March 2025 and performing above national delivery.

The talking therapies reliable improvement rate has also met the target in 2024/25 and BSW’s performance is above both England and South West delivery.

The full service review and recovery plan will continue to support the recovery of both of the recovery rates in 2025/26.

Learning disabilities, autism and neurodivergence

The national focus on the reduction of inpatient numbers for people with a learning disability, autism or both, as well as those being treated for a mental health disorder, has continued in 2024/25.

The annual health checks for everyone aged 14 and over on the learning disability register are an important tool to reduce parity in physical health.

National Standard	Period	Target	England	South West	BSW	BSW vs Eng	BSW vs SW
Learning disability annual health checks (cumulative YTD)	Mar-25	75% (full year)	79.88%	75.95 %	75.82 %	A	A

Learning disability Inpatients per million (Adult)	Dec-24	30	43	-	34	G	n/a
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Please note:

- Numbers less than five cannot be reported as patients may become identifiable.
- Numbers for children and young people are suppressed and not reported as they are low.

Key for benchmarking ratings	Green	Amber	Red
vs Eng. (England) or SW (South West) Compares BSW and ICB to England or South West result.	Better than Eng. or SW	Similar or within acceptable variance to Eng. or SW	Worse than Eng. or SW. Outside amber tolerance

BSW did meet the overall target for ensuring people with learning disability aged 14 and over received an annual health check in 2045/25, and a number of actions were in place to improve availability and uptake of the health checks.

BSW is working towards reducing the number of learning disability inpatients to the national target in 2024/25, with the establishment of protocols to improve focus and support for discharges, including the creation of the BSW ICS Care, (Education) and Treatment Review Panel and weekly forums.

Where appropriate, discharge planning for individual inpatients is ongoing throughout their admission. There are increasing numbers of autistic inpatients which reflects the national trend, particularly around those who also have an eating disorder. Fewer admissions are seen for people with a learning disability.

(2.01) Mental health

	2024/25 (000s)	2023/24 (000s)
Mental health spend	£157,403	£145,219
ICB programme allocation	£2,175,937	£1,985,177
Mental health spend as a proportion of ICB programme allocation	7.2 per cent	7.3 per cent

In 2023/24, the ICB reported an outturn of £145,219 against the Mental Health Investment Standard (MHIS), which equated to 7.3 per cent of the ICB's programme allocation.

In 2024/25, the ICB is reporting £157,403 against the MHIS, which is 7.2 per cent of the ICB's programme allocation.

During this year, and supported by significant planning in 2023/24, the ICB has ratified its BSW ICB Mental Health Strategy 2025-2030. The strategy is founded on what people have told us is important to them, and provides a transformational roadmap for the next five years.

This important and significant milestone allows the ICB, and its partners to focus on priority areas, while also keeping an eye on emerging national policy, evidence and the ongoing conversation around the 10-Year Plan.

Following approval of the strategy, the ICB will work at pace with partners across the system to formalise the key year one deliverables through an implementation plan. Finalisation of the BSW ICB Mental Health Strategy is a milestone we are celebrating as a significant move forward in enabling us to make a step change towards our transformation priorities this year, and into the future.

During 2024/25, the ICB mental health programme has undertaken a competitive procurement for its third sector-led community mental health provision. This procurement was significant in scale and included services such as crisis house provision, crisis alternatives and primary mental health support services.

Moving into 2025/26, and as an outcome of the procurement, we will welcome new providers into our BSW ICB-commissioned landscape, and continue to support the mobilisation of the new services to ensure the support available to our population is accessible and of high quality.

We continue to strive to work with our commissioned providers to enable them to provide the very best support for individuals. However, one of the areas requiring improvement relates to Talking Therapies. Through utilising contractual levers, the ICB anticipates improvement at pace in areas including access, waiting times, courses or treatment, as well as improvement and recovery.

Close scrutiny of performance against national metrics will continue into 2025/26 to ensure improvements across both access and outcomes.

(2.02) Children and young people (CYP) safeguarding

BSW ICB, as a statutory safeguarding partner, is committed to working in collaboration with the police and local authorities to ensure the people across our area are safeguarded.

Safeguarding means protecting people's health, wellbeing and human rights, while enabling them to live free from harm, abuse and neglect. It is an integral part of providing high-quality healthcare. This is achieved through partnership working with all statutory and VCSE agencies across our area via the Safeguarding Partnership Boards, Domestic Abuse and Sexual Violence Boards, Community Safety Partnerships and the Health and Wellbeing Boards.

Effective safeguarding arrangements seek to prevent and protect individuals from harm or abuse, regardless of their circumstances. The ICB is working with partners to support strategic planning in the prevention and reduction of violence in our local communities.

Some of the key safeguarding partnerships within BSW are:

- BaNES – Bath and North East Somerset Community Safety and Safeguarding partnership (BCSSP)
- Swindon – Swindon Safeguarding Partnership (SSP)
- Wiltshire – Safeguarding Vulnerable Peoples Partnership (SVPP)

The ICB discharges its responsibilities in line with the statutory requirements of Section 11 Children Act 2004, Working Together to Safeguard Children (2023), the Mental Capacity Act 2005, the Care Act 2014 the Domestic Abuse Act 2021 and the Serious Violence Duty 2021.

Following the publication of Working Together to Safeguard Children (2023), BSW ICB has worked with safeguarding partners to strengthen how local multi-agency safeguarding arrangements protect children, including ICB-commissioned services. Accountability has also been strengthened by clarifying expectations for information-sharing, independent scrutiny, funding, and reporting.

The Safeguarding Accountability and Assurance Framework (SAAF) identifies core duties across the lifespan of safeguarding for individuals working in providers of NHS-funded care settings and NHS commissioning organisations.

BSW has complied with the NHS England Safeguarding Accountability and Assurance Framework by ensuring robust internal arrangements, and that organisations commissioned to provide healthcare services had systems in place to effectively safeguard children, children looked after, young people, and adults at risk.

The ICB continues to embed new duties and guidance from legislation across the health and care landscape.

Further demonstration of how the ICB has performed against statutory safeguarding duties is evidenced within the following annual reports for 2023/24:

- [Bath and North East Somerset, Swindon and Wiltshire ICB](#)
- [Bath and North East Somerset Community Safety and Safeguarding Partnership](#)

- [Swindon Safeguarding Partnership](#)
- [Safeguarding Vulnerable Peoples Partnership](#)

BSW ICB provides assurance to NHS England with quarterly reporting, and nationally via the safeguarding commissioning assurance tool (SCAT), which ensures NHS England oversight of this compliance to governance arrangements.

Our safeguarding team provide safeguarding leadership through expert safeguarding advice and expertise and engagement in sub-groups, audit processes and learning from significant incidents and statutory learning processes, such as Safeguarding Child Practice reviews, Domestic Homicide Reviews, Safeguarding Adult reviews and Child Death Overview Panel

The findings from these reviews reflect national learning and include neglect, self-neglect, professional curiosity and application of the Mental Capacity.

As safeguarding practice evolves, in line with changes to both statutory and legislative developments, we continue our ongoing system-wide work to focus on the under-ones, ensuring the voice of children, adults and their families are heard, intrafamilial sexual abuse, BSW-wide policy developments, support to acute trusts when caring for young people fit for discharge with no forward placement, the importance of understanding mental capacity, self-neglect, particularly with vulnerable adults and our response to the serious violence duty.

In 2024/25, we have continued to lead on developing practice, policy and procedure which safeguards unborns and under-ones across our system, with a focus on prevention and early intervention.

The delivery of the ICON programme is part of the BSW under-ones improvement plan work to reduce injury and harm to our most vulnerable population. Abusive head trauma in children under one accounts for 200 deaths in the UK a year and 24 out of every 100,000 hospital admissions.

The impact is significant and long lasting for families and for children who survive. There are also significant costs across health and social care to meet the lifelong care needs of these children.

Organisations are now working towards establishing ICON within their delivery of care, with the aim for the five contact points to be implemented by June 2025 and awareness for ICON conversations within children's wards, emergency departments, minor injury units and out-of-hours services. We have also worked with wider partners and have training progressing within police and social care, and have plans to extend this to early years partners and wider community resources.

Children Looked After and Care Experienced Young People

BSW ICB is committed to improving the health and wellbeing of children looked after and care experienced young people. BSW ICB works collaboratively across health systems, and with children and adults social care, to do this and to fulfil its statutory responsibilities for children looked after and care experienced young people.

As a corporate parent, the ICB's commitment to improving the health outcomes for children looked after and care experienced young people has been demonstrated this year with two new initiatives:

- **Implementing the children looked after dental pathway**

Initially commissioning three NHS dentists across BSW who will offer weekly sessions for children looked after who don't have a dental home. This will increase the number of children looked after, particularly unaccompanied asylum-seeking children, who can access dental care.

- **Providing annual pre-payment prescription certificate for care experienced young people**

This has been funded through the ICB inequalities fund, and was done in response to listening to care experienced young people who said they sometimes had to decide between paying bills or paying for prescriptions. This initiative will reduce health inequalities and improve the health of care experienced young people.

(2.03) Environmental matters

The Department of Health and Social Care Group Accounting Manual has adopted a phased approach to incorporating the recommended taskforce on climate-related financial disclosures, as part of its 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.

For 2024/25, the phased approach incorporates the disclosure requirements of the following pillars:

- Governance
- Risk management
- Metrics and targets.

These disclosures have not been provided as the ICB has not yet fully developed its approach and oversight framework for monitoring climate related issues.

We recognise the critical role of sustainable practices in healthcare and continue to work collaboratively with our health and care partners to ensure the health and care services we commission for our population, and the infrastructure enabling their delivery, are sustainable in the years that follow.

This section provides an update on the delivery of the BSW Green Plan (2022-25), highlights environmental sustainability achievements and provides an overview of ICB statistics in relation to travel and energy consumptions.

BSW Green Plan (2022-25) update

Since the publication of our [BSW Green Plan \(2022-25\)](#) in July 2022, health and care partners across the system have continued to work collaboratively to support delivery of our green commitments and the achievement of the long-term vision of [delivering a net zero NHS](#).

Aligned to the BSW Integrated Care System vision, the plan supports our ICS strategic priorities by improving the health and wellbeing outcomes of our population, so they can age well, and reducing health inequalities caused through poor environments.

Since the publication of the plan, the Greener BSW Group has achieved the following commitments:

Focus area	Commitment achieved	Period
Workforce and system leadership	<ul style="list-style-type: none"> - Staff have access to a sustainability/green peer network - - Staff are made aware of the relevant Green Plans (ICS/Trust) via training/ inductions/comms - 	2023/24
Estates and facilities	<ul style="list-style-type: none"> - Switch to 100 per cent renewable electricity suppliers 	2022/23
Medicines delivery	<ul style="list-style-type: none"> - NHS trusts to reduce use of desflurane in surgical procedures to less than five per cent 	2023/24
Travel and transport	<ul style="list-style-type: none"> - NHS trusts signed up to clean air hospital framework by March 2023 	2023/24
Supply chain and procurement	<ul style="list-style-type: none"> - All BSW partners will include 10 per cent social value weighting in all procurement tenders 	2024/25

Despite these achievements, we recognise there is still much work to be undertaken to achieve net zero. The Greener BSW group remains committed to working collaboratively to support sustainability within the system, and continues to meet monthly to progress our commitments.

The Greener BSW Group will also be focusing on refreshing its system plan in line with the NHS England guidance, which was published in February 2024.

Refreshing our system Green Plan will provide an opportunity for us to reassess our progress to date as a system, and set new commitments to support us on our journey to achieving net zero.

Postponement of ICB's Green Plan

In light of the uncertainty surrounding the future form and function of integrated care boards, which has been instigated by a change in policy brought forward by the government, a decision has been made to postpone the publication of the organisation's Green Plan until the final quarter of 2025/26.

While such a move had not been intended, especially with the draft plan containing many important initiatives designed to support not only the ICB, but also the wider health and care system in achieving its net zero target, doing so will allow the next iteration of the plan to be crafted once more is known about the future form of ICBs.

It is hoped that the updated version of the Green Plan, due to be published no later than the end of the 2025/26 financial year, will be much more meaningful, and more aligned to the ICB's new role within the new-look health and care system for Bath and North East Somerset, Swindon and Wiltshire.

BSW Clinical Sustainability Fellow

During 2024/25, BSW ICB benefitted from hosting and mentoring a Chief Sustainability Officer Clinical Fellow.

As part of this placement, clinical leadership training was provided alongside delivering sustainability initiatives in practice.

Our Clinical Sustainability Fellow supported the delivery of a range of sustainability projects across BSW during 2024.

These included:

- Providing three educational sustainability workshops for primary care networks (PCNs), with incentives to increase sign-up to the green impact for health toolkit
- Initiating a project to upscale the outpatient hypertension pathway for women during pregnancy across our acute settings, with funding obtained through the Chief Nursing Office for sustainability projects to reduce travel

Trowbridge Integrated Care Centre

In November 2024, the ICB commenced work to construct a state-of-the-art health and care facility in Trowbridge.

The £16 million Trowbridge Integrated Care Centre is being financially supported by the ICB, NHS England, NHS Property Services and Wiltshire Council, and is intended to replace the existing Trowbridge Community Hospital, which is reaching the end of its natural lifespan.

Like Devizes Health Centre, Trowbridge Integrated Care Centre is set to employ the latest green technology, such as solar panels and heat pumps, in order to be fully self-sufficient and net zero carbon.

The centre will also offer residents a wide range of health and wellbeing services under one roof.

Construction is anticipated to finish at the end of 2025, with the new centre then opening to patients in early 2026.

BSW ICB statistics

Mileage

The below table provides an overview of the number of miles claimed by ICB staff during the most recent period of April 2024 to February 2025.

The miles are categorised by petrol, diesel and zero emission vehicles and provide our estimated carbon footprint against each area.

Category	Unit	2022/23	2023/24	2024/25
Petrol	Miles	59860	83485	99,551
	tCO ² e**	16.4	22.0	26.4
Diesel	Miles	26175	39,727	37,739
	tCO ² e**	7.2	10.9	10.3
Zero emission	Miles	1,964	7,811	11,523
	tCO ² e**	0.2	0.7	0.9

Totals	2022/23	2023/24	2024/25*
Mileage	87,999	131,023	148,543
tCO ² e	23.6	33.6	37.5
Cost (£)	45,949	77,373	80,022

*Activity covers the period between April 2024 and February 2025.

**Carbon emissions calculated using the UK Government Conversion Factors for greenhouse gas reporting (2022, 2023 and 2024)

Other travel costs

Category	2022/23 costs (£)	2023/24 costs (£)	2024/25* costs (£)
Air	738	0	0
Bus	174	148	166
Taxi	527	598	375
Train	9,573	13,917	7,709
Total	11,011	14,252	8,609

*Activity covers the period of April 2024 – February 2025

Sustainable transport schemes

BSW ICB encourages all staff to consider sustainable transport, and offers colleagues a range of schemes to encourage this, including a cycle-to-work programme and an electric car lease offer.

During 2024/25*, 22 electric cars have been accessed by staff through the lease scheme, which is an increase of six cars on the previous year.

One bike was accessed via the cycle-to-work programme.

*Activity covers the period between April 2024 and February 2025.

Paper usage

The move to a paperless NHS can be supported by new ways of working, with ICB staff utilising digital technology to reduce the use of paper at office sites and continuing to recycle paper.

During this financial year*, the ICB purchased 76 boxes of A4 paper at a cost of £2,063. On average, one box of paper equates to five reams of 500 sheets.

It should be noted that A3 paper is no longer purchased.

*Activity covers the period between April 2024 and February 2025.

Energy, water and waste

The below table provides an overview of the ICB's energy, water and waste usage across its office sites.

Data relating to the remaining quarter of this financial year is not yet available.

The estimated carbon footprint is also included against each area.

Category	Unit	2021/22 (Q1 – 4)	2022/23 (Q1 – 4)	2023/24 (Q1 – 4)	2024/25* (Q1 – 3)
Electricity	KWh	268,807	340,439	293,791	67,687
	tCO ² e	62	66	61	14
	Cost (£)	33,946	52,098	76,942	21,084
Gas	KWh	302,823	347,432	284,694	162,434
	tCO ² e	55	63	50	29

	Cost (£)	10,372	16,901	22,338	12,557
Water	m3	740	1,654	2,401	3,549
	Cost (£)	2,176	4,821	7,069	10,452
Recovered waste	Kilograms	832	1,126	1,764	1,510
Recycled waste	Kilograms	679	1,415	3,087	1,765
Confidential waste	Kilograms	1,096	1,370	1,725	925
	Cost (£)	111	184	215	135

*Activity covers the period of Q1 to Q3 for 2024/25.

Electricity and gas figures include Southgate House, St Martins Hospital and Beacon House.

Water and waste figures also include Jenner House and the Pierre Simonet Building, in addition to those noted above.

(2.04) Improving quality

Quality governance

BSW ICB has an overarching statutory duty for quality. This is a duty to exercise its functions with a view to securing assurance and fostering continuous improvement in the quality of services for patients, as well as being committed to maintaining the highest standards of quality governance.

This approach ensures that patient safety, clinical effectiveness and patient experience are at the forefront of all healthcare delivery.

Quality Assurance Framework

In 2024/25, we continued to strengthen system oversight, assurance and improvement by developing a Quality Assurance Framework (QAF), which provided a structured approach to oversight and the continual improvement of the quality of care across all services.

This framework supported the ICB in delivering its duty for quality.

It set out our vision for quality across all commissioned services, the application of the National Quality Board (NQB) guidance, our governance arrangements and quality priorities.

Additionally, it set out the approach needed to drive quality improvement through the utilisation of our assurance processes. The framework included regular audits, performance reviews and feedback mechanisms to ensure continuous improvement across the wider integrated care system.

The framework will be refreshed annually to support ongoing quality improvement and the identification of any emerging themes across the BSW system.

The ICB's role in quality surveillance and assurance continues to evolve through ongoing collaboration with its provider organisations, and is supported by the BSW System Quality Group.

Achievements and improvements

In the past year, we have made significant strides in improving the quality of care.

Some of the ICB's key improvement projects for 2024/25 included:

- Improved use and consistency of the Emergency Department (ED) checklist across all three acute providers
- In collaboration with Health Innovation Network West of England, the rollout of the Prevention, Identification, Escalation, and Response (PIER) Framework and Martha's Law across all three acute providers

- An audit of the effectiveness of NHS England's Where Best Next campaign, which aims to improve the patient, carer and family voice in discharge planning
- The non-elective wound care improvement programme promoted safe care and improved the provision of wound care in the right place at the right time
- The rollout of the Patient Safety Incident Reporting Framework (PSIRF) in primary care, along with the development of a primary care PSIRF Community of Practice
- The rollout of a system-wide Patient Safety Partners Community of Practice
- Understanding outcomes and service user experience for women, babies and families

Patient safety priorities

Through the evaluation of local provider's patient safety response plans, the following key themes have been recognised and captured as system-wide safety priorities:

- Medicine safety
- Recognition and management of the deteriorating patient
- Pressure ulcer care
- Falls

Our safety priority themes will continue to evolve as greater insight is gathered.

Patient experience

Capturing people's experience of care is essential and integral to clinical effectiveness and safety through the following key components:

- Co-production as default for improvement
- Use of insight and feedback
- Keeping the improvement of care at the core of all priority work programmes

This approach to patient experience reflects the wider system's commitment to the ambition set out by the National Quality Board (NQB 2022), which states: "we want improving people's experiences to be as important as improving clinical outcomes and safety."

Clinical effectiveness

Clinical effectiveness is focused on providing evidence-based care that leads to positive outcomes for our population. It is informed by consistent and up-to-date training, guidelines and

evidence. All of which are designed to improve the health and wellbeing of a population and address inequalities through prevention, and by addressing the wider determinants of health, while being delivered in a way that enables continuous quality improvements based on research, evidence, benchmarking and clinical auditing.

We achieve these objectives through audits, surveys, compliance with NICE guidelines and collaboration with clinical networks. This comprehensive approach allows us to continually monitor and improve the quality of care provided.

The ICB is responsible for the commissioning and delivering of healthcare across its geographical footprint. Clinical effectiveness is a key aspect of that work and ensures that services are effective and meet the needs of the population.

The implementation of clinical guidelines can:

- Improve health outcomes for patients
- Reduce avoidable harm to patients
- Reduce variation in practice and improve the quality of clinical decisions
- Maximise value and avoid unnecessary interventions

There are 54 clinical policies in place across BSW, all of which have been developed collaboratively in conjunction with local experts across the system to facilitate the embedding of policy criteria within pathways.

The policies are implemented and monitored by the clinical policies team through a criteria-based access or prior approval process, which ensures the ICB is offering evidence-based interventions, with appropriate clinical thresholds.

This clinical effectiveness process frees up resources that can be used for clinical priorities across the system. In addition, we work closely with neighbouring ICBs to minimise any variation at borders, while understanding that local policies must reflect the local nuances of commissioning, service provision and resourcing.

Guidance adherence is crucial for identifying clinical effectiveness. Alongside the creation and maintenance of policies via the Clinical Policies Working Group, there is a robust process in place for supporting the adherence of policies.

The Prior Approval Process is in place to assess applications for such procedures against the clinical thresholds, with the aim being to reduce unwarranted variation and to ensure optimal clinical effectiveness and an appropriate clinical pathway for the patient.

Benchmark data is collated and any area of variance is identified and investigated by clinical experts.

Policies reviewed in 2024/25	
Heavy menstrual bleeding	Tongue tie
Blepharoplasty	Female genital surgery

Foot interventions	Ectropion
Chalazion	Circumcision
Breast reconstruction post breast cancer	Breast cosmetic
Policies in development	
Preservation of fertility	Standalone hysterectomy / gender dysphoria
Hernia repair	Shoulder replacement
Shoulder decompression	EFR policy – definition
Sativex	
Management of severe localized psoriasis outside of NICE in adults	

During 2025/26, we will:

- Continue to build on our successes and develop the clinical audit programme as a means for assessing quality of care and identifying areas for improvement
- Map the activity on a policy-by-point basis against inequalities data to ensure parity of access to services, while ensuring there is no widening of inequalities
- Continue to enhance the monitoring of patient outcomes via the use of Getting It Right First Time (GIRFT) and Model Hospital data, which in turn will be fed back to providers to ensure that healthcare is based upon the best available evidence

Delivering safe care

Patient Safety Incident Response Framework

The ICB has a responsibility to ensure the services it commissions are safe.

All healthcare organisations strive to ensure individuals are not harmed when receiving healthcare. However, it is acknowledged that a patient safety incident may occur, which then requires investigation and a clear process for sharing learning with patients, families and the wider health and care system.

In September 2022, the Patient Safety Incident Response Framework was published and marked the start of a transitional period, in which organisations began to move away from the Serious Incident Framework.

The Patient Safety Incident Response Framework sets out how the NHS should develop and maintain effective systems and processes for responding to patient safety incidents, for the

purposes of learning and improving patient safety.

There are four key principles to the Patient Safety Incident Response Framework, which are:

- Compassionate engagement and involvement of those affected by patient safety incidents
- Application of a range of system-based approaches to learn from patient safety incidents
- Considered and proportionate responses to patient safety incidents
- Supportive oversight focused on improving care and preventing future incidents

During 2024/25, the Patient Safety Specialists Community of Practice has worked collaboratively to support the implementation of the new Patient Safety Incident Response Framework among all expected providers.

The ICB has successfully collaborated in policy and plan development with commissioned providers and has effectively signed off provider policies and plans, as well as developing and verifying the ICB Patient Safety Incident Response policy.

A quarterly Community of Practice meeting has been established among BSW Patient Safety Partners, which offers a safe space to share feedback and gather views on the role.

The ICB has been working with system partners to implement relevant oversight groups and specific improvement activity to maximise learning and system improvement.

While many organisations across the country are at various stages with their implementation of PSIRF, those in BSW have progressed well, with the framework now embedded in practices.

Tools are being considered for the ICS, and a PSIRF maturity matrix workshop is due to be held in early 2025 to develop a maturity audit tool, which will help both the system, and its partners recognise the level of implementation.

BSW has participated in a series of national webinars to discuss the practical application of PSIRF in maternity settings, and these webinars, shaped by questions from the National Maternity Safety Forum, have been well received by local teams.

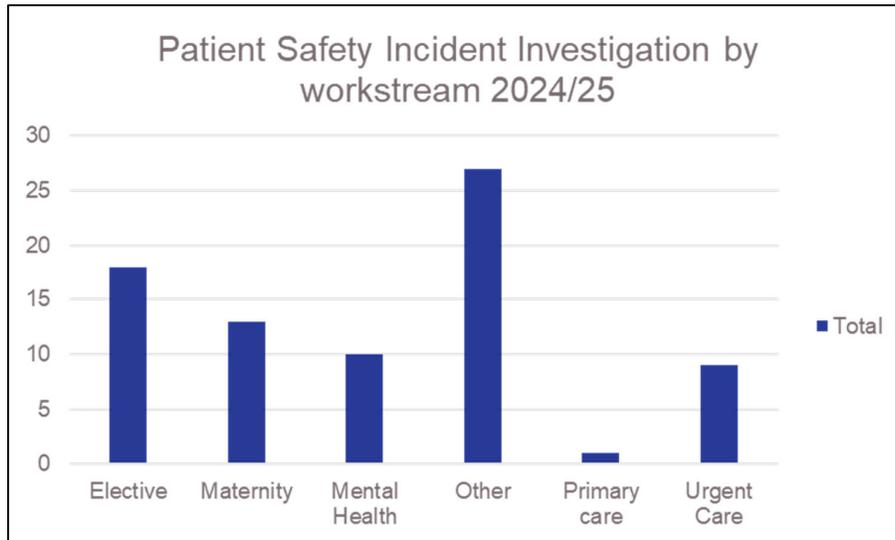
Patient safety incidents

Throughout 2024/25, BSW providers have been collaborating closely with their local risk management systems to ensure the seamless operation of the Learn from Patient Safety Events (LFPSE) functions.

Providers have been validating their data in preparation for the release of the national LFPSE dashboard in early 2025.

Providers have also continued to report Patient Safety Incident Investigations (PSIIs) to the Strategic Executive Information System (StEIS) as per NHS England National guidance.

A total of 78 PSIIs were reported between April 2024 and February 2025.



The graph above illustrates patient safety incident investigations categorised by workstream, as identified through ICS data.

The category of other encompasses various patient safety concerns that do not fit into the specified workstreams, but still remain crucial for overall safety and reporting.

Key learnings from Patient Safety Incident Investigations:

- **Medicine safety**

Ensuring medications are administered correctly and safely is crucial for reducing errors and preventing adverse drug reactions. The BSW Together Medicine and Safety Quality Group provides oversight and a collaborative approach to ensure learning is shared across the system.

- **Recognition and management of the deteriorating patient**

Early identification and intervention for patients whose condition is worsening can prevent serious complications and improve outcomes. This initiative has been prioritised under our Patient Safety Incident Reporting Framework, and we have commenced collaborative quality improvement work through the rollout of the Prevention, Identification, Escalation, and Response Framework.

- **Pressure ulcer care**

Preventing and treating pressure ulcers effectively can help to avoid prolonged hospital stays and additional health complications. Through the non-elective wound care improvement programme, we have promoted safe care and improved the provision of wound care in the right place at the right time.

- **Falls**

Implementing strategies to prevent falls can significantly reduce injuries and improve patient safety. The BSW Integrated Care Falls Collaborative supports a number of workstreams, including frailty and bone health.

Patient safety in primary care

Quality assurance in relation to primary care, pharmacy, optometry and dental services is supported through collaborative monitoring arrangements between the ICB's quality team and the quality and patient experience team based within the South West Collaborative Commissioning Hub.

Intelligence is triangulated across a range of data sources, including reported incidents, complaints, safeguarding alerts and learning from regulatory processes, such as inspections by the Care Quality Commission, the General Dental Council and the General Pharmaceutical Council.

The CQC is the independent regulator of health and adult social care in England, and is responsible for monitoring and inspecting.

There are currently four practices within BSW that are rated as requires improvement by the CQC, while 70 are rated as good and eight as outstanding.

No practices have been rated as inadequate.

The quality team has continued to work closely with practices in need of additional support to meet the required standards, with oversight of individual action plans to evidence improvement.

Links to quality improvement resources and contacts have been shared with all practices and are published on the quality team's GP Team Net page.

Mortality

The ICB has established a System Mortality Group to understand mortality across provider organisations, and to identify opportunities for shared learning and improvements in care quality.

The group meets monthly and brings together representatives from each of the acute trusts, mental health provider, local authorities and primary care to align how mortality is reviewed and to share good practice between partner organisations.

Throughout 2024/25, a broad perspective has been gained about the patterns of disease prevalence and current workstreams are in place to help tackle the challenges. Data sources are gathered for overview and analysis, which can support system-level understanding.

The Summary Hospital-level Mortality Indicator (SHMI) is one of these sources, and provides a report on mortality rates at trusts across the NHS in England.

Looking forward to 2025/26, the System Mortality Group is eager to pivot from a role centred on assurance to a role in which members are involved in identifying emerging trends and areas for improvement.

In this way, the group can have a more significant impact on the wider ICS.

Examples of specific workstreams which have reported into the SMG include:

- Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries Across the UK (MBRRACE-UK)
- Learning from Lives and Deaths – People with a Learning Disability and Autistic People (LeDeR)

Medical Examiner Service

In September 2024, the Medical Examiner Service was rolled out in BSW as part of a nationwide initiative.

The new service has been introduced to provide independent scrutiny of deaths and to ensure that bereaved families have a voice in the process. All deaths that occur in any healthcare setting, and not subject to a coroner's investigation, will now be reviewed by NHS Medical Examiners.

Infection prevention and control

The ICB is responsible for ensuring that systems and processes are in place to support the management, prevention and control of healthcare-associated infections.

It is the ICB's role to ensure appropriate governance structures are in place for infection prevention and control, and to support and monitor providers' contributions towards sustained improvement.

The ICB and its provider organisations work together to support quality improvement initiatives, which are aimed at delivering safer services and improved adoption of national policies.

The ICB sets, agrees, monitors and reviews surveillance data against nationally-set thresholds for specific organisms, as well as other locally-agreed indicators. The surveillance data, in combination with learning identified from post-infection reviews or root cause analysis of health care associated infection incidents, is used to inform key improvement areas and address potential risks.

Epidemiology data from the UK Health Security Agency Field Epidemiology Services (UKHSA FES) is also used by the ICB, its providers and local public health teams to scan for future risks.

During this reporting period, the ICB's infection prevention and control specialists continued to work collaboratively to support the wider system.

This was achieved by ensuring updates to national guidance were implemented and monitored at system level, including the review of risk assessments to ensure patient safety remained a priority.

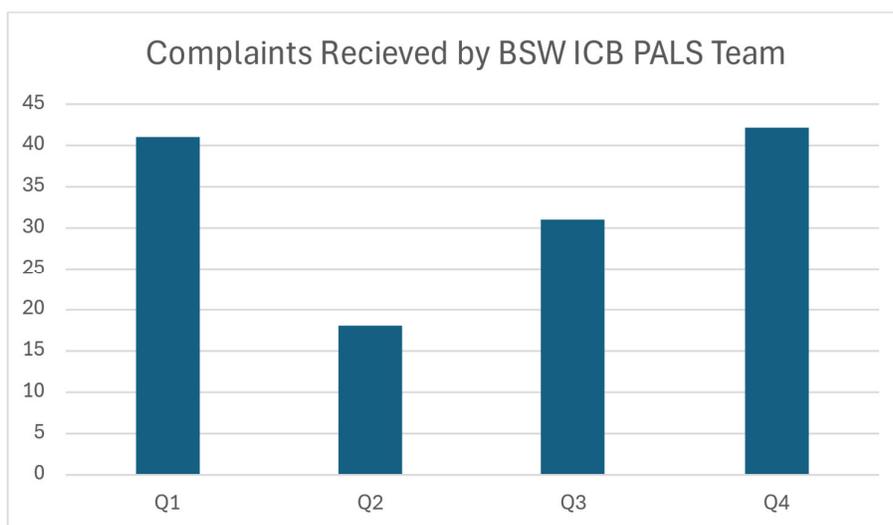
The approach to risk assessments and understanding patient outcomes has been a particular focus during the winter period, when outbreaks such as norovirus and respiratory infections impacted patient experience and flow.

The ICB's infection prevention and management collaborative has continued to work collectively throughout 2024/25.

Building on the work undertaken in the previous year, the collaborative has driven forward reduction plans and achieved a 0.5 per cent reduction in Clostridioides infections and a further four per cent reduction in Methicillin Sensitive Staphylococcus Sensitive (MSSA) bloodstream infections. It has also supported the prevention, management and response to communicable disease throughout 2024/25.

Complaints

Complaints, concerns and compliments are managed by the NHS South, Central and West Patient Advice and Complaints Team on behalf of the ICB.



The above table shows the total number of formal complaints received during the period between April 2024 and March 2025.

The top complaint themes identified across all commissioned provider services during 2024/25 were in relation to waiting times and quality of care given within acute hospital settings across BSW, together with access and waiting lists in mental health services.

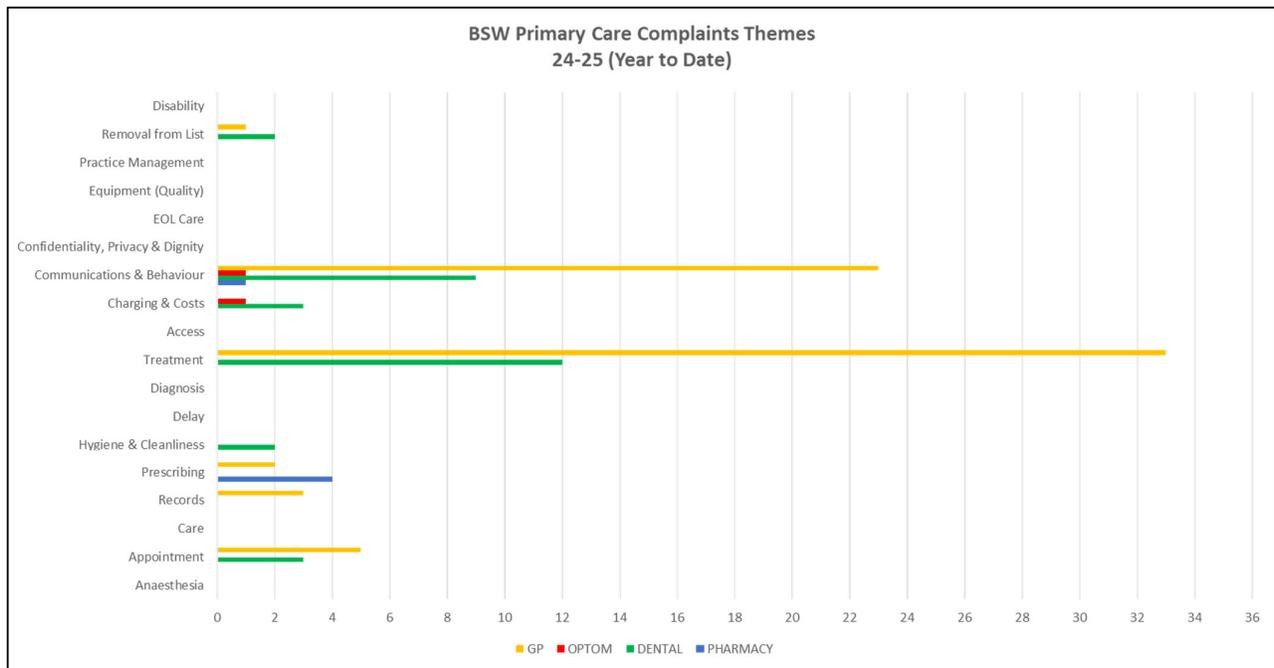
All learning from complaint themes is shared within the quality governance structure as per the BSW Quality Assurance Framework.

Complaints in primary care, pharmacy, optometry and dental

Formal complaints relating to primary care, pharmacy, optometry and dental services are managed by the South West Collaborative Commissioning Hub Patient Experience Team on behalf of the ICB.

Themes, trends, and learning are triangulated by the team and combined with wider sources of intelligence and data to support the system-wide approach of continuously improving care quality health outcomes.

Primary care and POD complaint themes



The total number of complaints received was 241. The two key themes were in relation to communication and treatment.

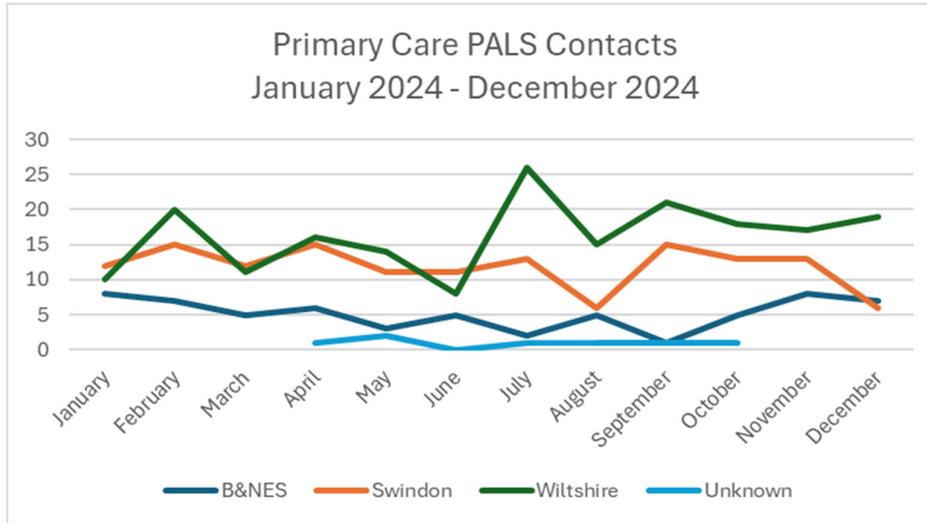
Themes and learning have been shared via both primary care and quality assurance governance structures.

Some of the other identified themes included:

- Access to NHS dentistry
- Cancellation of appointments
- Dental charges
- Treatment and clinical care
- Funding requests
- Removal from dental lists

- Waiting times in community pharmacies
- Access to community pharmacies out of hours

Concerns raised with PACT



The table above shows the number of concerns relating to primary care and POD that were made to PACT during the period between January 2024 and December 2024.

Overall, there were a total of 407 primary care and POD-related concerns.

Top theme	Action
Seasonal calls about Covid-19 booster vaccinations for housebound patients.	<p>PACT continued to work closely with the vaccine operational group.</p> <p>In repeat of the autumn programme, non-participating GP practices were asked to send a text to all housebound patients and carers assuring them of a visit by the end of the programme.</p>

Friends and Family Test

The Friends and Family Test is a tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience.

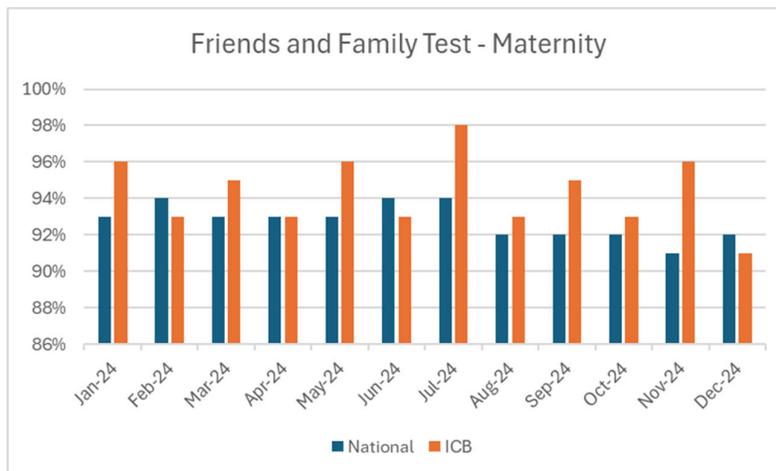
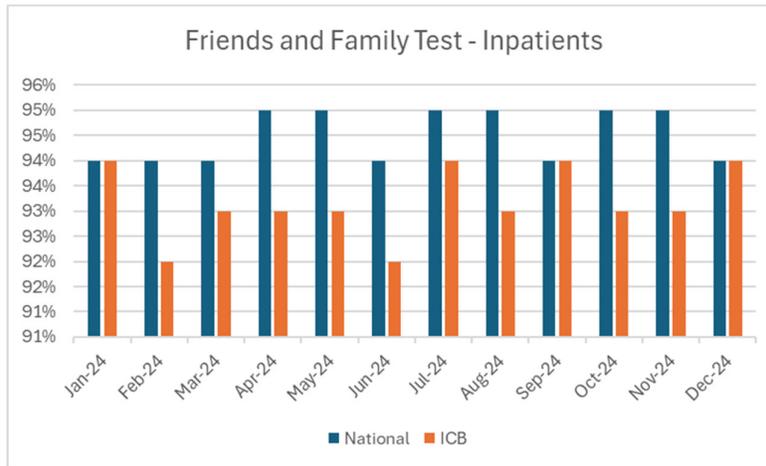
Listening to the views of patients and staff helps to identify what is working well and what can be improved.

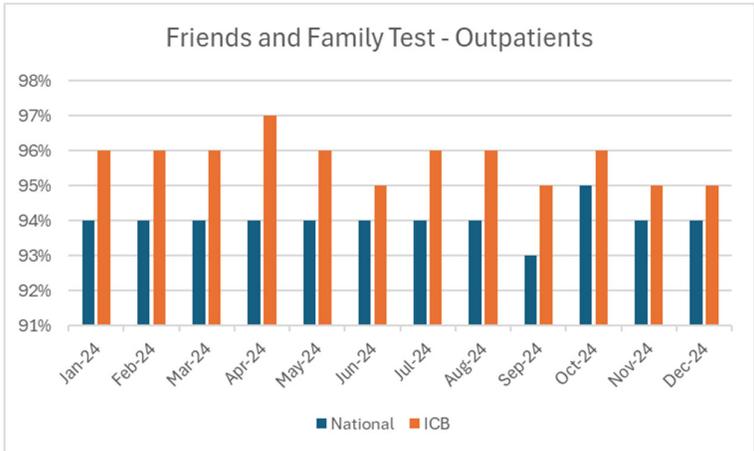
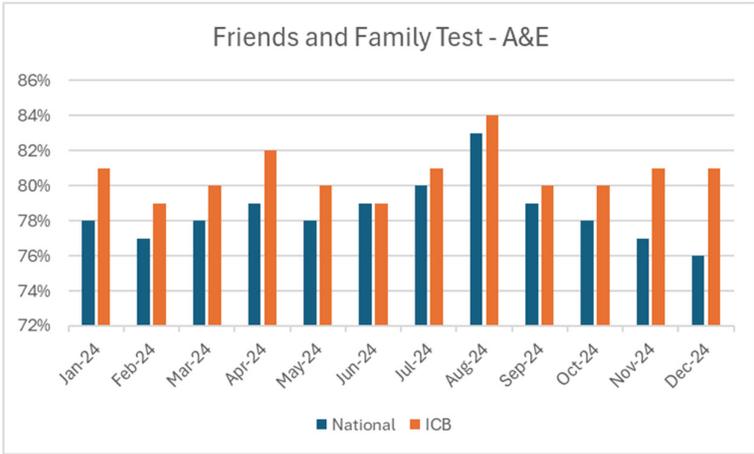
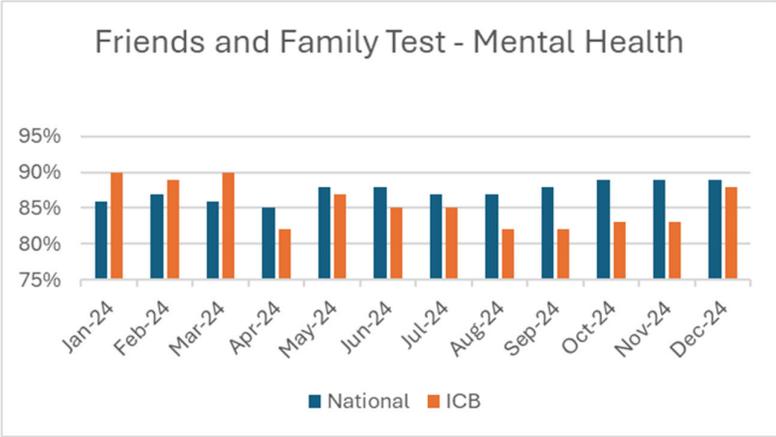
The Friends and Family Test is used by all providers within BSW.

The ICB is aligned to the national rates for all FFT responses with maternity, A&E and outpatients performing above the national rates. Throughout 2025/26, there will remain a focus on improving response rates within local inpatient areas.

The ICB is committed to responding to patient needs, and encourages a culture that proactively looks for feedback and uses people’s experiences of care to improve the commissioning of services.

The graphs below provide a summary of responses received by local providers and shows the percentage of respondents who would recommend the service to family or friends.





Continuing Healthcare

The ICB has a statutory duty to assess and fund the care provision of individuals eligible for Continuing Healthcare (CHC).

The National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care 2022 sets out the statutory responsibilities held by ICBs, and gives guidance on how this can be met using best practice while working in partnership with local authority colleagues.

During 2023/24, the ICB's delivery of CHC assessments against national targets was in a challenging position, with only 52 per cent of assessments completed within the 28-day national target.

In the first quarter of 2024/25, the ICB completed 56 per cent of assessments within the timeframe, with performance improving to 82 per cent for quarter two.

During 2024/25, both operational recovery and the transformation of CHC has continued with significant developments being achieved, some of which include:

- Implementation of a new end-to-end care management system which will enable operational efficiencies. The assessment process is completed within the system with partners and providers able to upload vital information to support the application. Payments to providers are made via the system which, in turn, has eliminated the need to raise invoices and has sped up the overall payment process.
- Implementation of technology and support for people in receipt of a Personal Health Budget to independently manage their health and care needs.
- Investment in a brokerage service to meet the needs of people with complex needs who require bespoke care provision.
- Achievement of meeting national standards for reporting to NHS England, which demonstrates compliance and, in turn, has eliminated delays in individuals being assessed for NHS Continuing Healthcare eligibility.

During 2025/26, the ICB will continue to build on the achievements of the previous year, and will review the service delivery operating model to maximise efficiencies.

A system-wide education offer that will provide health and social care-delivered training for our health providers, local authority partners and voluntary, community and social enterprises (VCSE) will also be developed.

Vaccination programme

Our delivery model has evolved to align with the National Vaccination Strategy, and incorporates a well-established Community Vaccination Hub that has been pivotal in improving the wider vaccination offer.

This model operates alongside a core offer from GP practices and community pharmacies.

The three local acute trusts, along with community trusts, continue to deliver vaccinations to their staff, long-stay inpatients and pregnant women.

Covid-19 and flu vaccination

Covid-19 and flu vaccinations have been consistently delivered across BSW through GP practices, community pharmacies, acute trusts and community trusts, with significant support from the Community Vaccination Hub.

The seasonal vaccination programmes prioritised the most vulnerable population in care homes and those who are housebound.

Flu vaccinations for two and three-year-olds were delivered early in the season to reduce the risk of transmission to more vulnerable relatives. Maternity services also offered flu vaccinations early in the season to help protect pregnant women and their babies.

GP practices were encouraged to maximise uptake among these cohorts.

Reducing inequalities

Working with local authority colleagues, there has been an increased focus on reducing inequalities regarding access to vaccinations.

Specific communities were identified, and invited to attend targeted clinics during the course of the programme, with vaccinations delivered through community partnerships.

Nursery-based clinics also have been introduced to further increase flu vaccination uptake among younger children.

Outbreak response and community engagement

The Community Vaccination Hub has supported various vaccination settings in response to outbreak situations, including families arriving as part of national resettlement schemes.

Some of the vaccination initiatives delivered in 2024/25 include:

- **Respiratory syncytial virus (RSV) project**

A new RSV vaccination programme for older adults and pregnant women was successfully implemented by GPs and maternity services within acute trusts.

- **Measles, mumps, and rubella (MMR) project**

In partnership with GP practices, this project focused on people aged between 17 and 30, with dedicated clinics established in areas with the lowest uptake.

- **Human papillomavirus (HPV) project**

This multi-faceted project was aimed at 16 to 25-year-olds, and included an innovative collaboration with community pharmacies that saw vaccines offered to this group, while sexual health providers offered the vaccines to gay and bisexual men up to the age of 45.

Maternity and neonatal quality and safety

The BSW Local Maternity and Neonatal System (LMNS) continues to support oversight of safety and quality outcomes and improvements within local maternity and neonatal services.

Perinatal quality and safety surveillance

The Local Maternity and Neonatal System brings together all key stakeholders including maternity and neonatal voices partners to work collaboratively in implementing the mandated and recommended changes that have been set out in the national three-year plan for maternity and neonatal services, as well as any other locally-identified actions.

This includes:

- Recommendations from national inquiry reports into maternity and neonatal services
- Parliamentary inquiries relating to maternity and neonatal services
- Maternity and newborn safety investigations
- National surveillance reports, including maternal deaths and perinatal mortality surveillance reports and enquiries

Focus on safety and quality of maternity and neonatal services

All maternity providers in BSW have continued to implement best practice care in line with NHS England's Saving Babies' Lives Care Bundle and the Clinical Negligence Scheme for Trust Maternity Incentive Scheme, both of which support safe outcomes for mothers and babies to reduce the risk of stillbirths, neonatal deaths and maternal deaths.

Assurance on progress with compliance is provided by the ICB and the Local Maternity and Neonatal System.

Learning from incidents is shared across the three local maternity and neonatal providers to support a proactive approach towards reducing adverse events in line with the NHS Patient Safety and Incident Response Framework (PSIRF).

The stillbirth and neonatal death rate in BSW is below the UK average.

Maternity and neonatal services have continued to focus on embedding improvements in outcomes for babies born prematurely by participating in the PERIPrem Optimisation Project, which supported by the West of England Health Innovation Network.

More premature babies in BSW are now receiving the 10 interventions that improve their neurological development and health, which contributes towards a healthy future life and reduces the potential of neurodevelopmental delay and physical health problems in later life.

Term babies are supported to stay with their parents when additional care is required after birth.

BSW's maternity and neonatal services are consistently meeting and exceeding the national target of fewer than five per cent of babies at term requiring additional care from a neonatal unit.

Listening to pregnant women and making improvements

The Local Maternity and Neonatal System has continued to listen to women and their families to make co-produced improvements to maternity and neonatal services.

This has included producing maternity hospital information folders for service users, providing information on antenatal parent preparation in different languages and creating a suite of maternity and neonatal videos, all of which are subtitled in 10 different languages.

The Local Maternity and Neonatal System is participating in the national pilot of the Maternity and Neonatal Independent Senior Advocate role, with provision of independent support to families who have experienced an adverse outcome during their pregnancy or birth.

This was as a recommendation from Independent Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust.

Improvements in service access and provision for members of the community who may be at increased risk of worse outcomes has been supported by the Maternity and Neonatal Voices Community Group. Engagement events took place throughout the year and were attended by families from a range of backgrounds, all of whom had experienced care as children themselves.

CQC maternity survey

The Care Quality Commission undertakes an annual experience survey of all women in England who have given birth in a single one-month period.

This was conducted in February 2024, with the results then published in November 2024.

Service users scored their experience, with the results then compared against all trusts that took part in the survey.

All three maternity providers had a higher response rate than the national average of 45 per cent.

While all three providers scored well on intrapartum care and antenatal care generally, opportunities for improvement were identified, specifically in relation to support for infant feeding and help at home during the first four weeks after birth.

All maternity services have co-produced actions for continued improvement during 2025/26.

Preventing ill health and reducing inequalities in healthcare outcomes

Maternity and neonatal services continue to progress with a variety of preventative programmes of work which contribute towards reducing ill health in pregnant women and babies, while also reducing inequalities in access to services and outcomes of care.

This included:

- Vaccinations, including the new RSV vaccine, being provided within maternity services
- Qualitative work to understand possible barriers to care for patients from Black, Asian and Minority Ethnic backgrounds
- Improving access to services through self-referral portals for maternity care, perinatal pelvic health care and maternal mental health. This has led to improved earlier booking from pregnant people, particularly those who from Black, Asian and Minority Ethnic backgrounds
- Implementation of a single maternity digital electronic record system across all three maternity providers, which will provide opportunity for enhanced equality and diversity monitoring
- Anti-racism training has been provided to more than 600 maternity and neonatal staff across BSW, with opportunities for system partner colleagues to attend. Maternity staff, including senior leaders, received specialist Black Maternity Matters training to support transformation and improve outcomes
- Continuing to focus on improving support for infant feeding through UNICEF's baby-friendly accreditation

Smoking in pregnancy

Smoking in pregnancy contributes towards a number of poor health outcomes, such as increased risk of stillbirths, neonatal deaths and low birthweight.

BSW has seen a continued reduction in the number of women who smoke during pregnancy. This is due to the provision of maternity smoke-free specialist teams, an increase in the participation of the NHS England Treating Tobacco Dependency programme and the recent provision of the national maternity incentive voucher scheme, which took place during quarters three and four of 2024/25.

Over the past seven years, the rate of women smoking at the time of birth has reduced from 10.8 per cent in 2017/18 to 6.6 per cent in 2023/24.

Early data from 2024/25 shows a continued reduction, with rates at approximately 5.5 per cent.

Reducing smoking in pregnant women also contributes to longer term health for the mother.

Maternal mental health

Local data has shown that service users who access maternal mental health services are normally symptom-free following their course of treatment, with feedback from patients being extremely positive.

This has contributed towards a reduction in the number of women experiencing severe mental illness.

Staff across a range of services, including military medical staff, health visiting and primary care staff, have reported improved knowledge of identification and referral criteria for maternal mental health, following training provided by the Outreach, Consultation, Education and Advocacy Network.

Perinatal pelvic health

The perinatal pelvic health services have received strong patient feedback, with 98 per cent of survey responses from patients indicating a positive experience. Early interventions not only support the ongoing work around preventing pelvic health problems, but also help to identify problems and secure access to specialist care in a timely way that can prevent incontinence.

(2.05) Our approach to meaningful engagement

Ensuring that the population of Bath and North East Somerset, Swindon and Wiltshire is able to have a say on the health and care provided in their region is so much more than a legal obligation.

Without the views, thoughts and opinions of those living in the local area, the ICB would struggle to develop and deliver services that truly reflect the bespoke needs of the very people being served.

We know that our public possesses a vast amount of unique knowledge and expertise on the local NHS, along with a real-world view of how services are delivered within our communities.

It is essential that we capture and reflect this rich insight when planning anything new or proposing a change to something already in existence.

Throughout 2024/25, we have strived to give our public as many opportunities as possible to have their voices heard, listened to and, most importantly, acted upon.

Our approach to meaningful engagement is that it should take place in every corner of our organisation, and that it should follow the 10 principles of good engagement outlined by NHS England:

- Ensure people and communities have an active role in decision-making and governance
- Involve people and communities at every stage and feed back to them about how it has influenced activities and decisions
- Understand your community's needs, experiences, ideas and aspirations for health and care, using engagement to find out if change is working
- Build relationships based on trust, especially with marginalised groups and those affected by inequalities
- Work with Healthwatch and the voluntary, community and social enterprise sector as key partners
- Provide clear and accessible public information
- Use community-centred approaches that empower people and communities, making connections to what works already
- Have a range of ways for people and communities to take part in health and care services
- Tackle system priorities and service reconfiguration in partnership with people and communities
- Learn from what works well and build on the assets of all health and care partners, such as existing networks, relationships and activity in local places

Examples of bespoke engagement

- **Listening to the views of local communities for the NHS 10-Year Plan**

During January and February 2025, BSW ICB held seven public engagement sessions with local people across Bath and North East Somerset, Swindon and Wiltshire to collect views for the forthcoming 10-Year Plan.

The ICB specifically looked to gather the views of seldom-heard groups to ensure a fair and representative collection of voices were listened to as part of the process.

Engagement sessions took place with more than 100 participants, including the Muslim community at Bath Mosque, the Black, Asian and Minority Ethnic community at the Bath Ethnic Minority Senior Citizens Association, the Roma, Gypsy and Traveller, Boater and homeless communities in Wiltshire and refugees and asylum seekers in Swindon.

Patient groups from Midsomer Norton, Radstock and Chippenham also took part in sessions, with representation from nearly 40 BSW-based VCSE organisations.

Feedback from all of these sessions, which helped to build and strengthen our relationships with local community groups, was recorded and passed on to NHS England for inclusion within the 10-Year Plan.

Further sessions will be planned once the plan has been published.

- **Raising awareness of hypertension and providing blood pressure clinics**

Using funding from NHS England to address rising level of high blood pressure across the South West, the ICB ran a series of outreach events during the summer of 2024.

These offered local people across BSW the opportunity to have a free blood pressure check and to find out how to reduce the risk of hypertension.

Events were held at Bath Rugby, a heritage railway station, a youth music festival and in the offices of Nationwide Building Society, which is a large local employer.

The events also provided the ICB with an opportunity to discuss health and care issues and with local people, and to gather feedback.

Staff from local pharmacies worked with the engagement team at the events to carry out blood pressure checks, while also offering information on hypertension and explaining how health and lifestyle changes can prevent the condition.

More than 160 checks were carried out and recipients were referred for further investigations with a local pharmacist if their readings were high.

As part of the same project, the ICB was able to gain an understanding of local attitudes towards blood pressure testing and knowledge of hypertension through an online survey which has been completed by more than 70 people.

The results of this survey have been circulated and will help to build our understanding of hypertension across BSW.

- **Understanding A&E attendances in BSW**

The ICB is working with Healthwatch on an ongoing engagement project to help understand the recent increase in walk-in attendances at local A&E departments.

The aim of the project is to gain an understanding of what is driving the increase and what can be done to help reduce demand over the next three years.

Findings will also be used to improve our understanding of population behaviours, and to use learnings to inform future public engagement campaigns.

An online survey has been completed by more than 820 participants, and has provided a detailed overview of the decision-making process made by people in BSW before attending A&E and the considerations given to alternative services, such as GP surgeries, minor injury units and NHS 111.

Working with Healthwatch, a number of face-to-face engagement sessions were held at A&E departments at the Great Western Hospital, the Royal United Hospital and Salisbury District Hospital to help broaden the reach of survey participants, particularly among those who may not have had the opportunity to participate online.

The project is still ongoing, with the final results due to be analysed and used to increase understanding of A&E demand, whether there are specific population or health inequalities contributing to the demand and identification of any commissioning gaps in services.

- **Supporting our rural and farming communities**

Between July and September 2024, the ICB took part in the Well Farmers for Wiltshire pilot scheme, which looked to address the distinct health and wellbeing challenges faced by the local farming community.

Bringing together 14 system partners, this neighbourhood collaborative delivered healthcare, prevention and support services on-site during a 12-week period.

The pilot engaged traditionally hard-to-reach rural populations, such as manual workers, who often face barriers due to geographical isolation, time constraints, and farming and livestock commitments.

Aside from the wide range of work to improve health and wellbeing among this group, through early cancer identification, referrals, blood pressure monitoring and mental health discussion, the pilot project achieved a huge amount in terms of continuous engagement with a seldom-heard rural population.

Engagement during the pilot achieved a number of significant successes including addressing negative opinions and mistrust of the NHS, addressing vaccine hesitance and building strong relationships.

The project also successfully secured funding for a Neighbourhood Collaboratives Engagement Lead, who will work to address health inequalities by fostering partnerships across health, social care, voluntary organisations and community groups.

A key component of the role is ensuring that the voices and perspectives of individuals with lived experience are integrated into the planning, decision-making and actions of the wider neighbourhood collaboratives.

By bringing this vital perspective to the forefront, the new role will ensure that interventions are not only designed for communities but also with them, making these initiatives more relevant, targeted and impactful.

Supporting regular engagement

The ICB is fully committed to holding meaningful conversations with local people on a regular basis, so that local communities can input into how services are developed and provided.

Our Your Health, Your Voice patient and public engagement forum meets on a regular basis and is chaired by the ICB's Place Director for Bath and North East Somerset.

This group has a strong and engaged membership, with attendee made up of interested members of the public, carers, people working in local voluntary organisations and representatives from Healthwatch groups.

Forum members play an important role in holding the ICB to account for how it involves local people in the design and commissioning of local health services.

Other engagement activities during 2024/25 included:

- Attendance at the Bath and North East Somerset Council Community Conversations drop-in session at St Andrews Church in Bath, meeting members of the local community to discuss access to services and collect views on vaccination
- Attendance at Alice Park Youth Festival to carry out engagement work with young people about access to health services and support from schools for emotional health and wellbeing
- Attendance at the Wiltshire Community Foundation (WCF) Connecting People Networking event, building important links with local VCSE organisations, which represent numerous community groups in BSW
- Support for Health Inequalities Grant Funding workstream, advising grant recipients in the VCSE sector on communications strategy and building important relationships for future engagement activities
- Online survey seeking the views of carers supporting those being cared for on virtual wards
- Our fortnightly engagement-focused newsletter is circulated to more than 170 people and offers a roundup of engagement opportunities, as well as news on local health and care engagement projects
- The ICB's Children, Young People and Learning Disability, Autism and Neurodiversity team carried out engagement with schools for the Partnership for Inclusion of

Neurodiversity in School (PINS) programme. This included questionnaires to help shape the service offer provided across 40 schools in BSW.

We continue to ensure that engagement is an integral part of supporting the development and delivery of services that serve our population.

This is embedded in our governance framework in a number of ways:

- Engagement is championed at Board level, with representation from the Non-Executive Director for Public and Community Engagement, who chairs the BSW ICB Engagement Committee
- Presenters at Board complete a section of their report titled Communications and Engagement Considerations, which outlines any communications and engagement work that needs to be planned
- Engagement and public involvement is a key function of the BSW ICB Commissioning Committee, which recognises the ICB's duties and responsibilities for involve the public in the development of services
- The ICB has representation at local health overview and scrutiny committees
- We hold fortnightly meetings with system partners to keep an up-to-date overview of engagement activities across BSW, and where we can align and work together

(2.06) Reducing health inequalities

The Health and Social Care Act 2022 describes the duties for reducing inequalities.

Each integrated care board must, in the exercise of its functions, have regard to the need to:

- Reduce inequalities between persons with respect to their ability to access health services
- Reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services, including the effectiveness of the services, the safety of the services and the quality of the experience undergone by patients.

During 2024/25, the ICB has achieved this in the following ways:

- **Strengthening the governance around reducing health inequalities**

In 2024/25, BSW enhanced governance efforts to reduce health inequalities. Notably, the Director of Public Health -chaired the Population Health Board, and health inequalities representatives attended every Quality Oversight Committee meeting to report on deep dives, which made health inequalities a standing agenda item.

Locality-based inequality groups were further developed in Wiltshire and Bath and North East Somerset. The Swindon inequalities group is still in development.

The Directors of Public Health from the three localities play a critical role in the development and oversight of the health inequalities work in BSW. Between them, as well as co-chairing the Population Health Board with the Chief Medical Officer, they also chair the Prevention Strategy Group and support the work of the Population Health Intelligence Team. They also report regularly to the Integrated Care Partnership Board on progress and the future of the health inequalities and prevention workstream.

- **Improving data to understand health inequalities**

During 2024, the available ICB analytical resource has largely been focused on supporting the hypertension programme as the major system priority. This has allowed delivery of meaningful analysis and, in turn, has supported the development of the hypertension business case.

In March 2025, the ICB responded to NHS England's statement on information relating to health inequalities. This response can be seen in full on the ICB's public-facing website at www.bsw.icb.nhs.uk/document/bsw-statement-on-health-inequalities.

There is now a team dedicated to population health intelligence, which sits within the wider ICB Strategic Intelligence team. Strategic Intelligence also includes staff in other teams who touch on population health work, including:

- **Modelling and Data Science:** Using advanced analytical techniques to help predict and gain insight from big data sets, such as predicting changes in our populations and the impact these changes might have

- **Analytical evaluation:** Helping to robustly evaluate the impact of change initiatives on our population
- **Data management:** Collecting, processing and linking all the data we have on our BSW population for analysis

- **Population Health Board initiatives**

The Population Health Board led deep dives into key delivery and transformation areas, with notable changes and improvements in approach.

At each Population Health Board meeting, a deep dive is conducted into transformation areas that focus on inequalities.

Over the past year, deep dives have focussed on:

- Mental health
- Neonatal and maternity services
- Learning disabilities, autism and neurodivergence
- Elective care
- Integrated community-based care

Recent developments offer opportunities to enhance the impact of deep dives:

- The BSW ICS Outcomes Framework will guide outcome-focused deep dives
- The Outcomes Framework Dashboard will highlight inequalities within specific outcomes
- Delivery groups are mapping transformation programmes and developing logic models, which will inform deep dives
- For the 2025/26 Implementation Plan, delivery groups will identify an inequalities priority area to provide additional focus

- **Adoption of Core20PLUS5 approach**

BSW adopted the national NHS England Core20PLUS5 approach to address healthcare inequalities at the system level for both adults and children.

This approach is now being embedded in the ICB delivery groups and has also been the framework for the 2025/26 BSW health inequalities grants programme.

- **Using additional funding to address specific identified health inequalities (2024/25)**

There are 35 projects currently in progress which have been supported by the 2024/25 health inequalities funding.

The ICB has been monitoring these on a quarterly basis, in partnership with local authority inequalities leads, and providing a quarterly summary report to the Population Health Board.

The process for quarterly monitoring has been developed in collaboration with the locality inequalities leads.

- **Using additional funding to address specific identified health inequalities (2025/26)**

The process for the 2025/26 health inequalities grants programme was conducted differently to the previous year's programme. To maintain a focus on health inequalities, the programme was aligned with the Core20PLUS5 framework.

A co-production approach was adopted, which saw stakeholders from Swindon and Wiltshire invited to identify challenges impacting the clinical priorities outlined in the framework.

Stakeholders participated in workshops to discuss these challenges and to agree on priority areas for a more targeted programme. After prioritising the issues, stakeholders collaborated on potential solutions, and the outcomes from these workshops informed the criteria for the 2025/26 programme.

The programme was launched in January, along with a webinar in February to support any queries about the application process.

A grants panel has been established for Swindon and Wiltshire to evaluate and select winning bids, with successful projects expected to commence in May.

Due to Bath and North East Somerset having delivered to programme and spend in 2024/25, there remains a smaller amount of funding available for the upcoming year.

A consistent approach has been taken with priorities identified by cross-sector partners as part of the Bath and North East Somerset Health Inequalities Locality Group.

An application process and grants panel, similar to that for Swindon and Wiltshire, is due to be launched in Bath and North East Somerset, with a closing date of May 2025.

- **Treating tobacco dependence**

The ICB has sustained its investment in the Treating Tobacco Dependence programme for the financial year 2024/25. In recent years, this programme has been successfully implemented in acute inpatient settings, including maternity, at the Royal United Hospital in Bath, the Great Western Hospital in Swindon and Salisbury District Hospital, as well as in mental health inpatient units provided by Avon and Wiltshire Mental Health Partnership NHS Trust.

The ICB leads a multiagency business group, which has supported the implementation of these services, ensuring they meet the standards required to be fully established. With most services across BSW now reaching this stage, the business group will shift its

focus to performance management and quality improvement. This includes addressing inequalities within the programme.

A recent stakeholder engagement workshop, hosted by the ICB and facilitated by the Health Innovation Network, identified opportunities to enhance the TTD pathways in all settings and address existing inequalities.

Given the higher prevalence of smoking among lower socio-economic groups and individuals with mental health conditions, any efforts to increase successful quit rates will contribute to reducing these inequalities.

However, since engagement with TTD services and successful quit attempts are lower in the lower socio-economic groups, the focus will be on increasing engagement in these areas.

- **Supporting the hypertension programme**

The ICS prioritised prevention and early intervention as one of its three core objectives, with cardiovascular disease identified as the foremost prevention priority. Within this area, hypertension has been selected as the focus due to its strong evidence base, significant population health impact and clear opportunity for system-wide improvement.

Hypertension is largely preventable and linked to modifiable risk factors, such as poor diet, obesity, smoking and inactivity. There is unmet local need, with anywhere between 85,000 and 125,000 people living with undiagnosed hypertension.

There is also a treatment gap, with around 46,000 people but not receiving care.

The ICB has taken a strategic commissioning approach to the hypertension programme, with the strategic intelligence team producing a hypertension population health management summary, which can identify population needs, variation and opportunity.

A case for change was developed which quantifies the gaps and defines what good looks like. A business case sets out commissioned interventions with measurable outcomes. Developed logic models describe coherent service models and provides the evaluation framework. Impact analysis quantifies potential health and system gains from increased case finding and optimised treatment.

Approximately £1.8 million of target investment was prioritised based on where the system could have the most measurable impact on outcomes and inequalities:

- General practice incentive
- An enabling Team to support general practice, which has been partially superseded by the ICB's involvement in the CLEAR programme and funding CLEAR transformation associates
- Optimising community pharmacy and enabling community pharmacy outreach
- Coproduced interventions with target population and facilitating blood pressure checks
- Providing blood pressure checks in dental practices

- NHS health checks for Core20plus populations
- Increasing health coaching capacity in primary care networks and local authority-commissioned services
- Community Development Fund to empower communities to actively participate in their own health improvement initiatives

Our aim over the next three years is to reduce the risk of hypertension by targeting smoking and obesity, which help approximately 38,000 more people to be diagnosed and a further 45,000 more to receive treatment. This should lead to around 600 fewer cardiovascular events and around 200 less deaths.

There was some activity and impact in 2024/25, with an increase of 2,265 people on the hypertension registers, and an increase of 1,955 people treated between June and December 2024.

However, the majority of the activity is expected to take place throughout 2025/26.

Contribution to Joint Health and Wellbeing Strategies

The ICB has continued to play an integral role in the development and delivery of the Joint Health and Wellbeing Strategies across Bath and North East Somerset, Swindon and Wiltshire.

Throughout 2024/25, the ICB has actively worked alongside local authority partners to embed shared priorities within system-wide planning and delivery, and to ensure alignment with the wider Integrated Care Strategy and Joint Forward Plan.

Building on the collaborative development of Joint Local Health and Wellbeing Strategies in 2023, the ICB has worked with each local authority to translate strategic commitments into action through jointly-developed and monitored delivery plans.

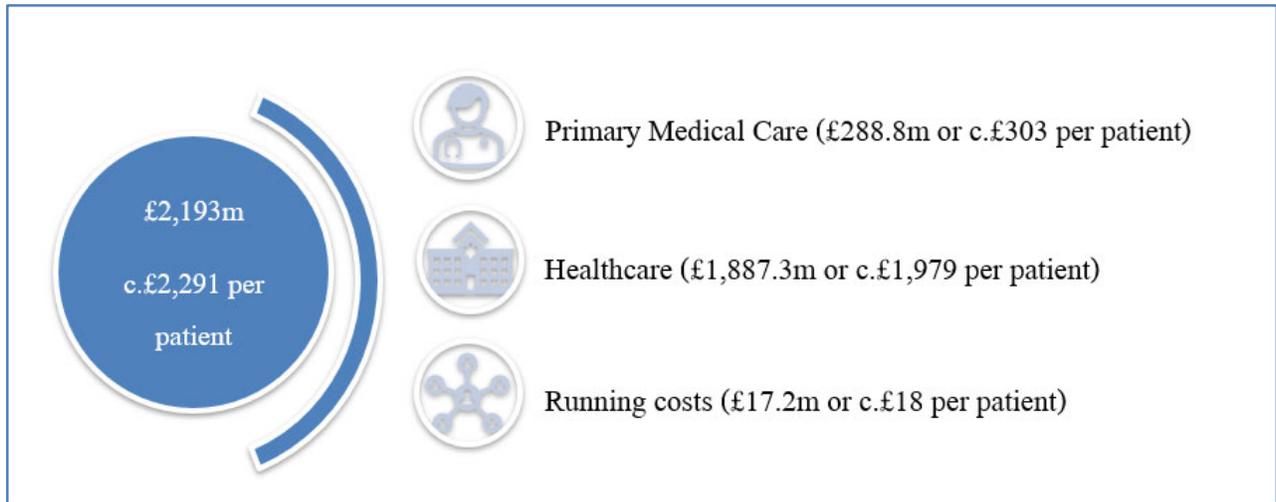
These delivery plans form the locality-specific contributions in the ICS Implementation Plan, which sets out how the system delivers against the Integrated Care Strategy.

To ensure meaningful progress and alignment, the ICB has:

- Actively participated in Health and Wellbeing Board discussions and strategy steering groups across all three local authority areas
- Supported the monitoring of joint delivery plans alongside local authority colleagues, using shared reporting mechanisms to track progress
- Contributed expertise and resources to key priority areas, including prevention and early intervention, tackling inequalities and ensuring fairer health and wellbeing outcomes
- Aligned joint efforts with locality-based transformation work, including each integrated care alliance's focus on key priorities in 2025/26, which included a strong focus on improving children's emotional health and wellbeing, preventing avoidable dental extractions in children from inequality groups, furthering the development of integrated neighbourhood teams and targeted support for young people not in education, training or employment

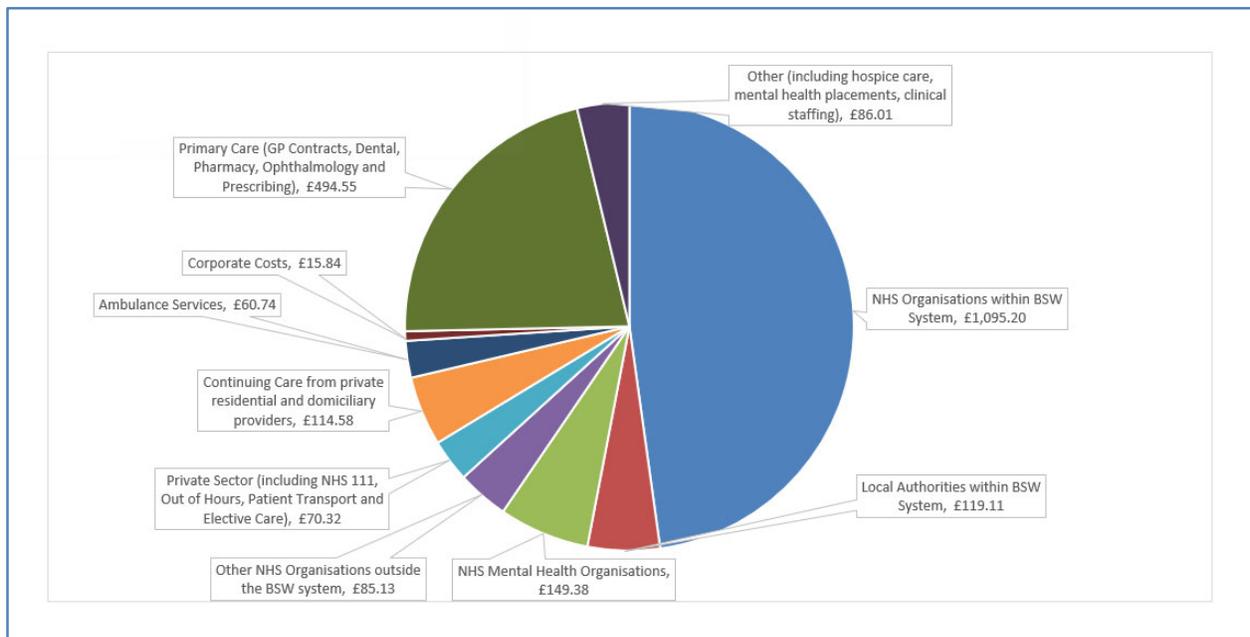
(2.07) Financial review

The funding that the has ICB received in 2024/25 is set out below:



Details of all payments of more than £25,000 are published under the transparency directive on the ICB website.

The funding that the ICB has received has been used to support services in the following areas:



The ICB has achieved or exceeded its financial performance targets as set by NHS England for the year.

An overall financial surplus has been delivered by the ICB as part of the mutual obligation that it shares with the three NHS provider organisations that it hosts to deliver the system financial plan.

The full year position has been supported by £30 million of national support funding, which was made available to all ICB systems.

The BSW system has remained within its fair share of national funding.

NHS England planning guidance for 2025/26 will again require the ICB and the three NHS provider organisations that it hosts to work together to deliver the organisational and system financial plan.

The system will receive £23 million of national support funding as part of its funding for 2025/26. The system has submitted a balanced financial plan for the year, but delivery is expected to be challenging due to the continued high demand for services and the current uncertainty surrounding the future of ICBs and the wider NHS.

Delivery of the financial plan for 2025/26 will require delivery actions being taken to address the high levels of NCTR patients within hospitals and non-elective demand, the successful implementation of the integrated community-based care contract and continued productivity improvements across all service areas.

As well as meeting all the statutory financial performance requirements as an ICB, the wider NHS system that the ICB forms part of has delivered its full year financial target to breakeven against the 2024/25 plans.

(2.08) Promoting and facilitating research

The ICB has a statutory responsibility to promote and facilitate research, closely linked to similar responsibilities with innovation.

Over the last year, the ICB has continued to work in partnership with the National Institute for Health and Care Research's Regional Research Delivery Network to support a BSW Research Hub.

This is accessible to all health and care researchers within BSW and particularly enables providers with little or no prior research experience to take initial steps towards establishing a sustainable research ability. This helps to achieve notably high recruitment numbers to studies in primary care too.

The ICB has led the creation of a System Research and Innovation Group, with a broad representation including well-established and aspiring research leads from providers across the system.

The group has co-created a draft system research and innovation strategy, which will provide an anchor, important shared milestones and a journey to achieve the system aspiration.

This draft will be going through appropriate governance and wider engagement shortly, and is viewed as a key enabler for aligning the system's agenda for the greatest benefit to our population.

As part of the recent whole organisational restructure, the ICB Executive Management Team established a lead research and innovation role to help take initiatives forward and to support research opportunities within the system.

The role has recently been recruited to from a choice of strong candidates. This will realise increased opportunity for the system to strengthen both commercial and non-commercial research to the benefit of our population in the year ahead, as well as start a self-sustaining model for the benefit of the whole system.

The ICB has continued the NHS England-funded Research Engagement Network project with an overall objective of increasing diversity in research participation to good effect.

This initiative has involved running community engagement events for raising awareness of research participation, joint work with RDN for marketing the recruitment of research champions, bespoke design of cultural competence training for research staff and enhanced awareness and tools for enabling inclusive research practice.

This network has grown considerably and the system strategy adoption would enable a sustainable model for the research network going forward as REN funding decreases.

One of the particular successes of REN in 2024/25 was the enhancement of relationships with research-active organisations in the system through the establishment of a research network.

The BSW Diversity in Health Research Network was set up in August 2024 and, as of March 2025, had grown to include 120 people from 35 different organisations, including health and care staff, researchers, academics, local authority partners, voluntary sector partners and community partners.

(2.09) Innovative use of technology

The ICB recognises the importance digital has in future transformation. It is a crucial element of plans to make the health service more efficient, safer and provide a better patient experience.

Key areas of progress over the past 12 months have been:

- **Artificial intelligence and automation**

Trialling AI solutions such as Microsoft Intelligence Recap and AI scribe solutions within primary care. Currently, a trial is taking place to use AI to capture and summarise GP consultations, which should free up GP time and enable better consultations.

It is expected that many of these AI-based solutions will become mainstream in the next 12 months, as we better understand the benefits and clinical safety.

Using Robotic Process Automation, administrative tasks that previously took thousands of hours to complete are now performed automatically by software that is designed to mimic the manual task.

- **Integrated care record**

The integrated care record takes a summary of information about an individual from all the BSW organisations involved in their care and presents it to a health and care professional to enable more informed decision-making.

This helps people to receive a safer, more efficient and more patient-orientated service.

More health and care professionals are now accessing the record than ever before, with usage nearly doubling in the last 12 months.

The ICR also provides a care planning solution for patients nearing the end of their lives, which includes the [ReSPECT](#) process. BSW is the first area in the country to make a digitised version of this form available via the National Record Locator Service, which means NHS organisations outside of BSW, including the ambulance service, can be informed about a patient's end-of-life wishes.

- **Remote monitoring**

Across BSW, patients who would have previously needed admitting to hospital are being cared for in the Hospital@Home service. Many of these patients are supported by technology that takes clinical observations, such as blood pressure, respiratory rate, oxygen saturation and temperature, and shares the results with clinical teams across BSW.

These patients can then be safely monitored from their own home, which prevents a hospital stay and reduces the number of visits clinical teams need to make.

- **Digitising social care**

Excellent progress has been made in our project to support the social care sector to move from paper to digital records, with more than 80 per cent of local social care providers now using digital records.

Digital records mean record keeping is more contemporaneous and means any deterioration in an individual's condition can potentially be spotted more quickly.

- **NHS App**

We have seen a doubling of repeat prescribing via the NHS App over the last year, with more than 100,000 repeat prescriptions issued via the NHS App each month.

Patients are now logging into the NHS App more than ever, with nearly one million local logins recorded in December 2024.

Increased usage of digital channels not only creates a better experience for those that can use digital but, more importantly, frees up resources to help those that cannot.

- **GP telephony**

New cloud-based telephony systems have been deployed to half of BSW GP practices in the last 12 months. This should help to reduce telephone wait times and increase patient satisfaction.

- **Community pharmacy prescribing**

The ICB has worked closely with community pharmacies to successfully deploy a digital solution that supports electronic prescribing. This technology helps to give an improved patient experience, while easing pressure on other services, such as GP surgeries and A&E.

The scheme is set to be expanded further in the coming year.

- **Future connectivity**

The ICB has been part of the NHS England Future Connectivity programme and has successfully trailed the use of Starlink's low earth orbit satellites to provide backup and mobile connectivity to GP practices.

Not only has this increased resilience, but has also allowed us to deliver healthcare from any location in a more agile way.

We have also started a significant full fibre connectivity upgrade programme across our GP practices to ensure each site has the connectivity required for the future.

- **Advanced analytics**

We have established teams with expertise in modelling, data science and evaluation to focusing on using more advanced analytical techniques to support with ICB and ICS decision-making.

The initial focus has been on supporting urgent care with forecasting and modelling to help project winter demand, and with developing robust evaluations of some of our major initiatives, including the Care Co-ordination Hub and Hospital@Home.

- **Cyber security**

The ICB has continued to promote the importance of good cyber security from Board level down, with increasing collaboration with partner organisations to further improve our defences in keeping patients' data safe and IT systems functioning.

(2.10) Anchor institution

The ICB has contributed to the ICS becoming an anchor system, which supports economic and social development through the following programmes:

- **Access to work and skills**

In 2024/25, the ICB was awarded leadership capacity funding from the Department for Work and Pension for developing a strategy for work and health integration.

The work intends to support workforce participation for people with health conditions who face barriers to good employment. The project has refined its focus to mental health conditions and musculoskeletal, with an active steering group that is linked to the emerging Connect to Work council teams and Get Britain Working policy.

The project plans to identify robust pathways of support for individuals who wish to maximise their income by starting, staying and succeeding in good employment.

The ICB continues to work with partners in maximizing apprenticeships, T Levels and skills for access to employment, with an emphasis on recruitment from within local communities.

This includes partnership working with further, higher education and Skills for Care for access to skills.

A Department for Education-funded project has provided numeracy skills for health and social care colleagues in Wiltshire that has led to the award of math qualifications, which in turn has enabled career development that would have otherwise been unavailable.

The completion of the care leaver project developed a toolkit and resources for employers to support young care leavers into employment with positive impact.

Increasingly, outreach initiatives are focused on working with system partners in supporting wider determinants of health as part of wider work to address health inequalities through access to education and work.

- **Increasing diversity of research participation**

The ICB has continued to lead system participation in the NHS England-funded Research Engagement Network (REN) programme.

In 2024/25, REN projects have included supporting several research engagement projects, such as with VCSE for working with people in under-served communities in Wiltshire and Swindon, and delivering diversity training to research-active staff.

A BSW Diversity in Health Research network has been successfully mobilised, with more than 120 people from 35 different organisations and sectors.

The network is sharing innovative solutions and valuing lived experiences for increasing diversity in research participation.

ACCOUNTABILITY REPORT

Sue Harriman

Accountable Officer

19 June 2025

(3.0) Accountability Report

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

It comprises three sections:

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

(3.01) Corporate governance report

The purpose of this report is to explain the composition and organisation of the ICB's governance structures, and how each supports the achievement of objectives.

Members Report

The ICB's constitution outlines how it will deliver its statutory duties, who its Board members are and how decisions will be made.

The ICB's Governance Handbook further explains how the organisation works, and includes the terms of reference of all the committees of the Board.

The ICB's Constitution, Governance Handbook, and other key corporate documents can be found on the [ICB website](#).

Member profiles

The ICB is a statutory body which brings together NHS organisations with local authorities, as well as other partners, to work to improve population health and establish shared strategic priorities.

Profiles of the ICB Board members can be found on the [ICB website](#).

Composition of the ICB Board

The Board is in place to ensure the ICB has the appropriate arrangements to discharge its functions effectively, efficiently and economically.

An ongoing role of the Board is to review the governance arrangements and ensure principles of good governance are adhered to.

The ICB's constitution, as determined by the Health and Care Act 2022, requires partner members to sit on the Board.

Each member of the Board has a responsibility to ensure that the ICB performs its duties in accordance with the terms of the constitution, with each member bringing a unique perspective that is informed by their individual expertise and experience.

The ICB's geographical area is coterminous with three local authorities, each of which are partner members of the Board. Also included are representatives from the voluntary, community and social enterprise sector, NHS trusts and primary care.

The membership of the Board between 1 April 2024 and 31 March 2025 was as follows:

Position on the ICB Board	Name
Chair	Stephanie Elsy
Chief Executive Officer	Sue Harriman
Chief Finance Officer	Gary Heneage
Chief Nurse	Gill May
Chief Medical Officer	Dr Amanda Webb
Non-Executive Director for Audit and Governance	Dr Claire Feehily
Non-Executive Director for Patient and Community Engagement	Julian Kirby
Non-Executive Director for Remuneration and People	Suzannah Power
Non-Executive Director for Finance – until October 2024 (position remained vacant until April 2025)	Paul Miller
Interim Non-Executive Director for Quality – until 31 March 2025	Alison Moon
NHS Trusts & NHS Foundation Trusts Partner Member – acute sector – from July 2024 (the position was vacant between March and June 2024)	Cara Charles-Barks
NHS Trusts and NHS Foundation Trusts Partner Member – mental health sector – until December 2024	Dominic Hardisty
NHS Trusts and NHS Foundation Trusts Partner Member – mental health sector – from February 2025 (the position was vacant during January 2025)	Alison Smith
Community Provider Partner Member	<vacant>
Local Authority Partner Member BaNES	Will Godfrey
Local Authority Partner Member Swindon – from July 2024 (the position was vacant September 2023 to June 2024)	Samantha Mowbray
Local Authority Partner Member Wiltshire – until August 2024	Terrence Herbert
Local Authority Partner Member Wiltshire – from October 2024	Lucy Townsend

Partner Member Voluntary Community and Social Enterprise (VCSE)	Pam Webb
Partner Member Primary Care	Dr Francis Campbell

When the ICB was established in 2022, there was a national expectation that ICBs would review their governance and partnership arrangements after year one of operations.

The ICB undertook a governance review during quarter three of the business year 2023/24, with the outcome and proposals discussed during Board development sessions, and presented to the ICB Board meeting in public for approval in September 2024.

Amendments to the governance arrangements are now reflected within this annual report.

NB: The ICB Public and Community Engagement Committee was formally disbanded in September 2024. Its last meeting was held in April 2024. The ICB Commissioning Committee was established in December 2024.

The Board has an ongoing programme of development, using its development sessions to collectively consider and define its way of working and focus against its roles and responsibilities, the skills set required within its membership, and to share knowledge and experience acquired from across the system, regionally and nationally.

This continues at an individual Board member level through the appraisal process.

When Board vacancies arise, the skills and requirements are taken into consideration to ensure a diverse and representational Board.

The NHS Leadership and Competency Framework, as published in February 2024, has been adopted and applied with Board members.

The publishing of the NHS Board Member Appraisal Framework is awaited at the date of writing this.

Committee(s), including Audit Committee

The Board is supported in its work by the mandated Audit Committee and Remuneration and People Committee.

The terms of reference for these mandatory committees are included in the ICB's Governance Handbook, which is available to view on the [ICB website](#).

The members of the Audit Committee for the reporting period were as follows:

BSW ICB Non-Executive Director (Audit and Governance)	Dr Claire Feehily
BSW ICB Non-Executive Director (Remuneration and People)	Suzannah Power
BSW ICB Non-Executive Director (Public and Community Engagement)	Julian Kirby

There is more information about the governance arrangements, including details and membership of all other ICB committees, in the governance statement below.

The Remuneration Report includes details of the membership of the Remuneration and People Committee.

Register of Interests

The ICB recognises that effective management of conflicts of interest is crucial to ensuring that patients, tax-payers, healthcare providers and Parliament are confident that all commissioning decisions are robust, fair, transparent and offer value for money.

In managing conflicts of interest, the ICB follows section 14Z30 of the Health and Social Care Act 2022, which sets out the minimum requirements of what must be done in terms of managing conflicts of interest.

The ICB's [Standards of Business Conduct Policy](#) complies with national guidance and sets out the expectations regarding standards of business conduct for the ICB, including the management of conflicts of interest.

The policy ensures that conflicts of interest are managed in a way that does not undermine the probity and accountability of the organisation. The policy also provides guidance to all staff and Board members on the receipt of gifts and hospitality.

The ICB regularly reviewed its register of Board member interests over this reporting period.

This register is published on the [ICB website](#).

Personal data-related incidents

Between April 2024 and March 2025, there were 103 breaches of personal data security reported by ICB colleagues.

Fifty-one of these have been attributed to acts or omissions by ICB colleagues.

Other organisations were wholly accountable for the remaining 52 identified incidents. This shows a marked improvement in the reporting culture of the ICB.

Of the 51 ICB incidents, the common themes were the accidental sharing of information about an identifiable data subject or sharing information with the wrong or additional recipients.

In most cases, the recipient was an ICB colleague or a trusted partner.

All ICB breaches were dealt with internally and, where appropriate, colleagues were directed to guidance and training materials.

The ICB has not had any data security incidents deemed to be Serious Untoward Incidents, or of a level that would require reporting to the Information Commissioner's Office.

The ICB has not received any enquiries from the ICO during this year.

Modern Slavery Act

The ICB fully supports the government's objectives to eradicate modern slavery and human trafficking.

The Slavery and Human Trafficking Statement for the period ending 31 March 2026 is published on [the ICB website](#).

Statement of Accountable Officer's Responsibilities

Under the National Health Service Act 2006 (as amended), NHS England has directed each ICB 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 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
- Prepare the accounts on a going concern basis
- 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 ICB shall have an Accountable Officer and that officer shall be appointed by NHS England.

NHS England has appointed the Chief Executive Officer to be the Accountable Officer of BSW 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 ICB and enables them to ensure that the accounts comply with the requirements of the Accounts Direction, and for safeguarding the 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 BSW ICBs' auditors are aware of that information.

So far as I am aware, there is no relevant audit information of which the auditors are unaware.

Sue Harriman

Accountable Officer

19 June 2025

(3.02) Governance statement

Introduction and context

BSW ICB is a body corporate established by NHS England on 1 July 2022 under the National Health Service Act 2006 (as amended).

The 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 required to arrange for the provision of certain health services to such extent as it considers necessary to meet the reasonable requirements of its population.

Between 1 April 2024 and 31 March 2025 the ICB 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 ICB's policies, aims and objectives, while 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 ICB's Accountable Officer Appointment Letter.

I am responsible for ensuring that the 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 Members Report summarises the composition of the Board from 1 April 2024 to 31 March 2025.

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.

Mandatory committees

- Audit Committee (see the Members' Report for the committee's membership)
- Remuneration and People Committee (see the Remuneration Report for details of the membership of the committee)

Non-mandatory committees

- Finance and Infrastructure Committee
- Quality and Outcomes Committee
- People Committee
- Public and Community Engagement Committee (disbanded September 2024)
- Commissioning Committee (established December 2024)

Committees' terms of reference are published on the [ICB website](#).

Audit Committee

The Audit Committee supports the Board and Accountable Officer by reviewing the comprehensiveness and reliability of assurances on governance, risk management, the control environment and the integrity of financial statements and the annual report.

The Audit Committee is accountable to the Board and provides an independent and objective view of the ICB's compliance with its statutory responsibilities.

Its terms of reference are included in the ICB's [Governance Handbook](#).

In summary, the Audit Committee is responsible for:

- Reviewing the establishment and maintenance of an effective system of integrated governance, continuous improvement processes, risk management and internal control, across the whole of the ICB's activities
- Ensuring there is an effective internal audit function that meets the Public Sector Internal Audit Standards, and provides appropriate independent assurance to the committee, the Accountable Officer and the Board
- Reviewing and monitoring the external auditors' independence and objectivity and the effectiveness of the audit process. In particular, the committee will review the work and findings of the external auditors and consider the implications and management's responses to their work

- Reviewing the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications for the governance of the organisation
- Ensuring the ICB has adequate arrangements in place for countering fraud, and reviewing the outcomes of work in this area
- Monitoring the integrity of the financial statements of the organisation
- Reviewing the effectiveness of the arrangements in place for allowing staff to raise concerns in confidence about possible improprieties in financial, clinical or safety matters, as well as ensuring that any such concerns are investigated proportionately and independently

The ICB has a Freedom to Speak up Policy in place, arrangements for allowing staff to raise concerns in confidence, and processes to investigate such concerns.

The Non-Executive Director for Public and Community Engagement is the ICB's Freedom to Speak Up Guardian, whose profile and contact details are published on the intranet.

The Audit Committee met six times during the reporting period.

Highlights of work undertaken during the period:

- Review of the Annual Report and Accounts for 2023/24
- Receipt and review of the internal audit reviews including community services procurement, primary care commissioning assurance framework, health inequalities data quality, care packages, and Data Security and Protection Toolkit
- Review of the ICB corporate registers and corporate documents
- Receipt and review of the Annual Emergency Preparedness Resilience and Response (EPRR) Assurance Report
- Receipt of the annual and six-month updates regarding ICS and ICB cyber security
- Receipt of six-month overview reporting against management consultancy and interim contractual arrangements.

The committee also regularly received reports from counter fraud and security management, and updates from the external auditors.

Remuneration and People Committee

The Remuneration and People Committee supports the ICB to exercise its functions in relation to the NHS Act 2006 by setting and adopting the ICB pay policy and

frameworks, and considering and approving executive remuneration and terms of employment.

This remit was expanded following the adoption of the ICB Governance Review recommendations in September 2024, to include assurance regarding ICB workforce matters, including organisational change processes.

Its terms of reference are included in the ICB's [Governance Handbook](#).

The Remuneration and People Committee met five times during the reporting period.

The Committee has overseen the assurance of the ICB people agenda from the final stages of major organisational change, NHS Staff Survey, remuneration and the Public Sector Equality Duties.

Finance and Infrastructure Committee

The Finance and Infrastructure Committee, previously the ICB Finance and Investment Committee, provides assurance to the ICB Board in relation to the financial management and sustainability of the ICB as a body corporate, the financial sustainability and achievement of agreed financial and productivity goals of NHS providers that operate in the ICB's area, and the effectiveness of the NHS in the BSW system to achieve financial sustainability of the system.

The committee's terms of reference are published in the ICB's [Governance Handbook](#).

In summary, the committee monitors the ICB's and system financial performance, supports the Board in ensuring financial management achieves value for money, efficiency and effectiveness in the use of resources, provides assurance that plans are effectively managed and outcomes are being delivered, reviews financial risks and sets the framework for the ICB's conduct of procurement, ensures estate, capital and digital plans support collaboration and increase productivity, and receives assurance of its implementation.

The Committee also seeks assurance on the arrangements for discharging the ICB's and BSW system's responsibilities in relation to the themes in the NHS Oversight Framework.

The Finance and Infrastructure Committee met 14 times during the reporting period and considered the financial performance, risks and position reports, the system-wide recovery programme, and the financial plan for 2025/26.

Quality and Outcomes Committee

The Quality and Outcomes Committee is responsible for providing assurance to the Board that the ICB is discharging its statutory duty and functions with a view to securing continuous improvement and innovation with respect to the quality, safety, outcomes and performance of commissioned services.

This includes reducing inequalities in access to and outcomes of health and care services, and reducing unwarranted variation in service provision.

The committee also provides assurance that the ICB has the right quality governance processes in place and that it is working effectively with providers of health services in its area to ensure the effectiveness, safety and good user experience of services.

The membership also includes a Director of Public Health from across BSW to bring public health advice and input into the ICB, committee and system.

The committee's terms of reference are published in the ICB's [Governance Handbook](#).

The Committee met six times during the reporting period, and considered the BSW Safeguarding Annual Report, patient safety and operational reports, BSW Equality Delivery System Report, and deep dives into elective care, health inequalities, and the integrated community-based care programme.

People Committee

The People Committee was in place to assure the Board on matters relating to the BSW health and care workforce, ICB staff and the BSW Academy, in line with the system's people strategies and plans, as well as the NHS People Functions.

The People Committee met once during this reporting period, and considered the work undertaken against the draft BSW People Plan, an update on Freedom to Speak Up activity, a high-level summary of the Project Evolve change process to meet the national requirement to reduce running costs by 30 per cent and the governance arrangements that were in place to support the recovery agenda.

The strategic workforce areas inclusive of risk and mitigations have continued to be managed as a core enabler through other committees such as finance, commissioning and quality.

At the time of writing, the position of a system-wide people committee is being considered.

Public and Community Engagement Committee

The Public and Community Engagement Committee disbanded in September 2024, following the ICB Governance Review and its recommendations.

The Public and Community Engagement Committee met once during the reporting period and considered the statutory requirements and expectations of public and community involvement and engagement under the Health and Care Act 2022, 14Z45 Public involvement and consultation by ICBs, the different models of engagement and the proposal to integrate the assurance remit regarding public engagement into other committees.

Commissioning Committee

The Commissioning Committee was established in December 2024 following the ICB Governance Review and implementation of the recommendations.

The Committee provides assurance to the Board that the ICB is delivering its functions in a way that secures the arrangement of health and care services for the BSW population, making commissioning decisions and providing oversight and assurance to the Board on the ICB's commissioning activities, and compliance with statutory duties and relevant regulation, guidance and policies.

The assurance remit regarding public engagement and involvement duties regarding service design, planning and change are also embedded within this committee, following the disbandment of the Public and Community Engagement Committee.

The detailed work to develop proposals is taking place in the context of the review and refresh of the ICB's stakeholder, public and community engagement and involvement approaches and arrangements.

This work will also address the statutory requirements under the Health and Care Act 2022 that the ICB has to meet with regards to public involvement in the planning or changes of commissioning arrangements.

The committee's terms of reference are published in the ICB's [Governance Handbook](#).

The membership includes a Director of Public Health from across BSW to bring public health advice and input into the ICB, committee and system.

The Commissioning Committee met twice during this reporting period, and considered the ICB's Commissioning Responsibilities and the Strategic Commissioning Framework for 2025/26, Specialised Commissioning Delegations from 1 April 2025, public engagement and the mobilisation of the community services contract.

Integrated Care Partnership

The Integrated Care Partnership is a statutory committee formed by the ICB, and brings together the NHS, local government, the VCSE sector and other partners to focus on prevention, wider social and economic factors that affect people's health and reducing health inequalities.

The ICP collectively developed, and continues to monitor, the achievement against the BSW Integrated Care Strategy for local health and care services, and acts as an advocate for innovation, new approaches and improvement to the way services are provided and run.

South West Ambulance Partnership Board

The South West agreed lead commissioning model governance arrangements saw the establishment of the Ambulance Partnership Board, which meets quarterly and is

attended by all South West ICB and South Western Ambulance Service NHS Foundation Trust Chief Executives.

The lead commissioner model is in place to enable joint commissioning of emergency ambulance services across the South West, and to manage the commissioning contract with the provider of emergency ambulance services.

The ICBs covered by these joint commissioning arrangements are:

- Bath and North East Somerset, Swindon and Wiltshire
- Bristol, North Somerset and South Gloucestershire
- Devon
- Dorset
- Gloucestershire
- Cornwall and Isles of Scilly
- Somerset

South West Joint Specialised Services Committee

Since April 2023, NHS England and the South West ICBs have come together as a statutory joint committee to collaboratively make decisions on the planning and delivery of the Joint Specialised Services, inclusive of the programme of services delivered by the Operational Delivery Networks and Specialised Mental Health, to improve health and care outcomes and reduce health inequalities.

Joint Committees are intended as a transitional mechanism prior to each ICB taking on full delegated commissioning responsibility.

The ICBs covered by these joint commissioning arrangements are:

- Bath and North East Somerset, Swindon and Wiltshire
- Bristol, North Somerset and South Gloucestershire
- Devon
- Dorset
- Gloucestershire
- Cornwall and Isles of Scilly
- Somerset

The South West Joint Specialised Services Committee has continued to work towards the planned delegation of commissioning responsibilities for a defined list of 175 specialised commissioned services to ICBs from 1 April 2025, with the principal commissioning model developed and agreed in support of this move forward.

The BSW ICB Board agreed to the delegation of specialised commissioning responsibilities from 1 April 2025 at its Board meeting held on 20 March 2025.

These new arrangements will now be implemented, and will be reflected in the Annual Report for 2025/26.

ICB Board

The Board has worked diligently to carry out its responsibilities as a statutory body.

The agendas and papers for those meetings held in public are available on the ICB's website in advance of the meeting, and act as a public record of the decisions taken and performance to date.

The ICB and its Board understand their public involvement duty and responsibility for listening to and engaging with its stakeholders and population when planning, developing and commissioning services for patients.

As set out in the ICB's constitution, the Board has statutory responsibility for ensuring the ICB has appropriate arrangements in place to exercise its functions effectively, efficiently and economically to achieve the four core purposes of the ICB, and to comply with the requirements of the National Health Service Act 2006 (as amended), and other supporting pieces of legislation applying to ICBs.

The Board is also responsible for approving the ICB's Annual Reports and Accounts, and ensuring good governance occurs and leading a culture of good governance throughout the ICB and wider system.

The ICB's [Scheme of Reservations and Delegations](#) sets out the Board's delegations of decision-making powers, authorities to Board committees and to individuals.

The Board met regularly throughout the reporting period to discharge its respective functions.

The business items covered included:

- BSW Equality Delivery System Report 2023/24
- BSW NHS ICS Operating and Financial Plan 2024/25
- BSW Implementation Plan (Joint Forward Plan) 2024/25
- BSW Primary and Community Care Delivery Plan
- NHS Equality, Diversity and Inclusion Improvement Plan

- BSW Winter Plan
- BSW All Age Mental Health Strategy
- ICB governance review and corporate documents
- Award of the integrated community-based care contract

The ICB Board knows of no information which would be relevant to the auditors for the purposes of their audit report, and of which the auditors are not aware. The ICB Board has taken all the steps it ought to have taken to ensure it was aware of any relevant audit information and to establish that BSW ICB's auditors are aware of that information.

Orange – as non-voter										
Total number of meetings 1 April 2024 to 31 March 2025:		6	6	5	1	6	14	1	2	
Position on the ICB Board	Name	ICB Board (Meetings held in public)	Audit Committee	Remuneration and People Committee	People Committee	Quality and Outcomes Committee	Finance and Infrastructure Committee	Public and Community Engagement Committee (until September 2024)	Commissioning Committee (from December 2024)	
ICB Chair	Stephanie Elsy	6	1	5		4	10		1	
Chief Executive / Accountable Officer	Sue Harriman	6	4	5		2 from 1.12.24	9		1	
Chief Finance Officer	Gary Heneage	5	6				14		2	
Chief Nurse	Gill May	6	3 until Sept '24			6		0	2	
Chief Medical Officer	Dr Amanda Webb	6				6	10			
BSW ICB NED for Public and Community Engagement	Julian Kirby	5	5	5	0	6	5 from Nov'24	1	2	
BSW ICB NED for Audit and Governance	Dr Claire Feehily	6	6							

Orange – as non-voter									
Total number of meetings 1 April 2024 to 31 March 2025:		6	6	5	1	6	14	1	2
Position on the ICB Board	Name	ICB Board (Meetings held in public)	Audit Committee	Remuneration and People Committee	People Committee	Quality and Outcomes Committee	Finance and Infrastructure Committee	Public and Community Engagement Committee (until September 2024)	Commissioning Committee (from December 2024)
BSW ICB NED for Finance – until October 2024 (position remained vacant until April 2025)	Paul Miller	1		3	1	3 until Oct '24	9 until Oct '24		
Interim BSW ICB NED for Quality – until 31 March 2025	Alison Moon	3		5		6	11		1
BSW ICB NED for Remuneration and People	Suzannah Power	6	6	5	1	2 from 1.12.24	7 until Nov'24		
Local Authority Partner Member – BaNES	Will Godfrey	4				1 until 1.12.24			0
Local Authority Partner Member – Swindon – from July 2024 (position was vacant September 2023 to June 2024)	Samantha Mowbray	3					2 from Dec '24		
Local Authority Partner Member – Wiltshire – until August 2024	Terence Herbert	2			0				
Local Authority Partner Member – Wiltshire – from October 2024	Lucy Townsend	2				1 from 1.12.24			
NHS Trusts and NHS Foundation Trusts Partner Member – mental health sector – until December 2024	Dominic Hardisty	0					1 until Nov '24		
NHS Trusts and NHS Foundation Trusts Partner Member – mental health sector – from February 2025 (position was vacant during January 2025)	Alison Smith	1							
Primary Medical Services Partner Member	Dr Francis Campbell	6				3 until 1.12.24		1	

Orange – as non-voter										
Total number of meetings 1 April 2024 to 31 March 2025:		6	6	5	1	6	14	1	2	
Position on the ICB Board	Name	ICB Board (Meetings held in public)	Audit Committee	Remuneration and People Committee	People Committee	Quality and Outcomes Committee	Finance and Infrastructure Committee	Public and Community Engagement Committee (until September 2024)	Commissioning Committee (from December 2024)	
Voluntary, Community and Social Enterprise Partner Member	Pam Webb	5			1			0	2	
NHS Trusts and NHS Foundation Trusts Partner Member – <i>from July 2024 (the position was vacant between March and June 2024)</i>	Cara Charles-Barks	4				3 from 1.9.24				
Community Provider Partner Member	<vacant for reporting period>									

To note: Committee terms of reference and membership were reviewed as part of the ICB Governance Review, with amendments implemented following Board approval in September 2024.

This table shows the attendance of those appointed Board members and does not reflect any deputy arrangements.

Provider selection regime – Required Reporting – Regulations 25 and 26

In relation to the period January 2024 to the end of March 2025, the ICB has directly awarded 36 contracts under Direct A, B and C of the Provider Selection Regime.

This excludes contracts where another ICB is the lead commissioner and responsible for procurement of the contract to which BSW ICB is a co-commissioner.

Direct Award A	Direct Award B	Direct Award C
3	16	17

The ICB has not set up or concluded any frameworks and has not entered into any contracts under the Provider Selection Regime.

The ICB has used the Urgent Contract Award process once.

Three new providers have been awarded contracts in this period. All under Direct Award B, having been accredited as Right To Choose providers. One of these providers is contracted by the ICB in another ICB geography for a different health facility where BSW ICB is a co-commissioner to that contract.

Three providers will cease to hold contracts from 31 March 2025.

All three of these providers were in scope of the procurement of the integrated community-based care (ICBC) contract which went live on 1 April 2025.

All of the services within the three providers will continue under this new contract (procured under Public Contract Regulations).

No representations were received in writing during standstill periods under Regulation 12(3).

Monitoring activity including management of conflicts of interests and decision-making is included in Contract Award Recommendation Reports as part of the ICB governance process.

The ICB is currently contract with 44 healthcare providers as lead commissioner and a further 10 as a co-commissioner.

There have been two requests for consideration received by the Independent Patient Choice and Procurement Panel. Both were in relation to the timely accreditation of Right To Choose applications.

Both of these were managed outside of the Panel and resolved as Direct Award B awards.

There have been no reviews undertaken by the Independent Patient Choice and Procurement Panel in relation to use of the Provider Selection Regime. There have been no occasions where the Independent Patient Choice and Procurement Panel has advised the ICB to re-run or go back to an earlier step in a provider selection process under the PSR.

UK Corporate Governance Code

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

Discharge of statutory functions

The 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 ICB 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.

Project Evolve, the internal programme of work that was undertaken during 2024, focused on redesigning the organisation and its structure to ensure the ICB was better aligned to its vision, mission and purpose.

Project Evolve concluded later in 2024, with directorates ensuring their structures provide the necessary capability and capacity to undertake all of the ICB's statutory duties.

Risk management arrangements and effectiveness

The ICB has a duty to assure itself that it has properly identified the risks that it faces, and that it has processes and controls in place to mitigate those risks and the impact they may have on the ICB's operations and ability to achieve its strategic objectives.

The ICB's Risk Management Framework recognises that the ICB's risk management requirements, as a corporate body, are complex because the ICB has system functions, and its performance and achievement of strategic and operational objectives is closely connected with the performance of NHS partner organisations.

System risks may also be risks that are relevant to, or affect, the ICB corporate body.

The ICB has had a Risk Management Framework in place since its establishment. This Risk Management Framework has been regularly reviewed, most recently by the Board in March 2025.

The framework is structured in two parts:

- Part one sets out the ICB's approach to risk, including risk appetite, and the Board Assurance Framework (BAF) and the ICB Risk Register as key components of the ICB's risk management framework
- Part two describes the ICB's risk management process, and colleagues' roles and responsibilities relating to risk management. Appendices contain explanation of commonly used terms and guidance to facilitate proactive risk management throughout the ICB. Further information and contact points on risk management are signposted throughout the document.

The Board is ultimately responsible for ensuring that an effective risk-aware culture is in place and that risk is effectively managed, recorded and reported.

This includes the process of risk escalation through the Board's assurance committees. This is an essential mechanism to ensure that senior managers, executives and Board members are aware of emerging risks and that prompt mitigating action is taken.

Capacity to handle risk

Risk refers to uncertainty, the possibility of incurring misfortune or loss, or missing opportunities.

This is measured in terms of the likelihood of something happening and the impact of the possible consequences on the ICB's ability to fulfil its aims and objectives, and its statutory functions and duties.

Risk management is the effective identification, analysis and response to risks in order to maximise the likelihood of successfully discharging the ICB's functions and achieving the ICB's strategic aims and objectives, while minimising the impact of any risk materialising.

The ICB's Board is responsible for the performance of the ICB and, as such, needs to be simultaneously entrepreneurial in driving the organisation forward while keeping it under prudent control. It needs to strike a balance between controls, assurance and strategy, risk-taking and delivery.

The Board determines the ICB's strategic objectives, strategic approach to risk, risk appetite, and identifies risks to the ICB's ability to achieve its strategic objectives.

The Board approves both the Board Assurance Framework (BAF) and the ICB's framework for risk management; the Board then regularly considers the Board Assurance Framework (BAF) and the ICB's Risk Register.

The Board also receives and responds to risk assurance reports and issues raised by the Audit Committee around risk, internal control and assurance.

The purpose of the BAF is to set out the risks to achieving the ICB's strategic objectives and the controls that management put in place to minimise the likelihood or effect of those risks materialising.

The BAF is built upon and around the ICB's agreed risk appetite for each strategic objective, and agreement regarding what is sufficient in terms of controls, and the assurances that the controls are operating effectively.

The Board defines the ICB's strategic objectives, and identifies, defines and assesses the risks to the ICB achieving these strategic objectives. The Board makes any decisions as to the inclusion or removal of risks on the BAF.

The Board's assurance committees regularly review the risks on the BAF. This is supported by the committees' review of risks on the ICB's Risk Register that relate to their respective remits.

The Chief Delivery Officer maintains the BAF on behalf of the Executive Group. The group reports the BAF regularly to the Board in full.

The BAF allows the ICB to determine where to focus resources to address identified risks. It is the role of the Board to focus on those risks and events which may compromise the achievement of strategic objectives and to support an organisational culture that allows the organisation to anticipate and respond appropriately to adverse events.

The Audit Committee scrutinises the ICB's risk management arrangements and processes, and their effectiveness via regular reviews of the ICB's Risk Register, Board Assurance

Framework and Risk Management Framework. It provides assurance to the Board that the ICB has in place appropriate mechanisms and processes to identify, manage and report risks, and on the effectiveness and adequacy of the ICB's arrangements for managing risks.

The Audit Committee of the ICB is responsible for commissioning internal audits to provide assurance to the Board on the robustness and effectiveness of risk management within the ICB.

A risk management audit for the ICB was undertaken by KPMG in quarter four, with the finding to be reported to the Audit Committee in May 2025. KPMG found that the overall rating for the ICB to be: "significant assurance with minor improvement opportunities."

The Board's assurance committees – Finance and Infrastructure, People, Quality and Outcomes, Public and Community Engagement, Commissioning – will regularly review risks with a score of 15 and above that fall within their remit and relate to the achievement of the ICB's operational objectives, plans and targets.

The purpose and focus of such reviews are to assure committees that risks are managed well, and committees may scrutinise the effectiveness of the risk management activities in place. Committees will not actively manage risks.

Each ICB Portfolio and Programme Board maintains records of the operational risks associated with the portfolio or programme's day-to-day operations. Portfolios and programmes regularly consider these risks and how they are managed, and identify those risks that should be escalated to the Senior Management Group (SMG) or the Executive Management Group for consideration.

The Executive Group regularly considers the ICB's risk register and the recommendations from the SMG. The Executive Group makes the ultimate decision as to the scoring and management of very high and extreme risks, and highlights to the Board and its assurance committees any risks that may have an impact on the ICB's strategic objectives.

The Chief Executive Officer is ultimately accountable for having in place appropriate mechanisms and processes to manage all risks relating to the operations of the organisation and leads on the strategic approach to risk, establishment and maintenance of risk management structures and processes in the ICB.

The Chief Executive Officer also ensures that the Board Assurance Framework is developed, reviewed and reported to appropriate committees and the Board, and that business continuity and disaster recovery plans are established and regularly tested and that risk transfer mechanisms are in place.

Executive Directors own their portfolio risk registers, and ensure that they are maintained, up-to-date and carry out monthly reviews. Each portfolio has nominated risk leads and deputy risk leads who coordinate the respective portfolio's risk management and risk reporting activities, and who are responsible for maintaining the portfolio's risk records, which cumulatively form the ICB's risk register.

ICB colleagues apply and implement the risk management process and actively identify risks, discuss and report it to line managers, team leads, and risk leads who will record the risks after scrutiny to ensure that risks are appropriately scored, described and have

appropriate risk treatment plans or mitigating actions in place. Risk leads regularly discuss the portfolio's respective risks with the portfolio's Executive Director.

The ICB has established a Senior Management Group (SMG) as an advisory group of the Executive Group. The SMG is a regular meeting of the ICB's senior managers, including nominated risk leads.

The SMG robustly reviews the ICB's risk register in the context of ICB and system performance and delivery, and articulates recommendations for the Executive Group regarding the management of high and extreme risks that have the potential of significantly impacting the ICB's operations and ICB's ability to achieve its strategic objectives.

The Associate Director of Governance, Compliance and Risk works regularly with portfolios, risk leads and teams to enable the successful implementation and application of the ICB's risk management framework and of tools and technologies to robustly record and monitor risks.

Training for risk leads, directorate and place teams and individuals have taken place throughout the year, and training needs analyses will support targeted provision of further relevant training.

All ICB colleagues can access, via the risk management intranet pages, the Risk Management Framework, advice, guidance, information and training slides, in order to carry out their respective responsibilities with regard to risk management.

The ICB is committed to maintaining a sound system of internal control, including risk management. By doing this, the organisation aims to ensure it can maintain a safe environment for patients, minimise financial loss to the organisation and demonstrate to the public that it is a safe, effective and efficient organisation.

Risk assessment

The Board reviews and agrees the ICB's risk appetite statement annually in light of the ICB's operating and risk environment.

Utilising performance data, its Equality and Quality Impact Assessment (EQIA) process, and intelligence, the ICB identifies and manages risks in light of the Board's agreed risk appetite.

Risk assessment and risk management are intrinsic parts of the ICB's operation.

The ICB's Risk Register is a live document, not a static record, and gives details of current controls, assurances and auditable actions for risk treatment.

It illustrates the operational and strategic risk profile of the ICB by reflecting the extent to which shorter term operational and longer-term strategic objectives are threatened by the uncertainty that risk presents. As such, the ICB's risk register informs the ICB's decision-making.

Reports to Executive Management Group, committees and Board describe relevant risks and mitigating actions, both to ensure that risk management is integral to any proposals or

reports brought to the Executive Management Group, committees and Board, and to provide assurance to these forums that appropriate mechanisms are in place to identify and appropriately manage risks.

The ICB actively deters risks through the adoption of robust counter fraud and security management methodology. The ICB has a contract with counter fraud specialists KPMG to provide counter fraud management and the ICB rated itself as green against the national standards for counter fraud and security management in 2024/25.

The highest scoring risks identified during the reporting period related to:

- Insufficient capacity across urgent and emergency care and flow leading to reduction in system flow
- Financial sustainability
- Hospital handover delays
- Industrial action
- System-wide workforce and resilience

Stakeholder engagement

Communication and consultation with appropriate stakeholders assist the understanding of the risks that the ICB faces, informs decision-making and explains the rationale and approaches to managing risk including the identification of particular actions.

Communication and consultation are designed into the ICB's approach to risk management, and bring together different functions across the ICB when considering risk to ensure that different views are appropriately considered. It also provides sufficient information and evidence to support oversight and decision making, building a sense of ownership and inclusion among those affected by risk.

The ICB holds quarterly System Quality Group meetings which include partner quality and safety leads and representatives of Healthwatch. The VCSE Alliance brings together the voices of the VCSE sector, engaging with voluntary and community groups and community members, building on existing networks, strengthening community partnerships and embedding the sector as partners in system level governance and decision-making arrangements.

Other sources of assurance

Internal Control Framework

A system of internal control is the set of processes and procedures in place in the BSW 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 ICB's systems have been in place for the year under review and up to date of approval of the annual report and accounts.

Annual audit of conflicts of interest management

There is no requirement to report on the internal audit of conflicts of interest via returns to NHS England, following the formal establishment of ICBs in July 2022.

While the Health and Care Act 2022 places responsibility on ICBs to manage conflicts of interest and publish their own conflicts of interest policy, which is referenced in the ICB's Governance Handbook, NHS England has provided updated national e-learning modules on managing conflicts of interest in the context of the ICB arrangements.

This has been included as mandatory training for BSW ICB colleagues and Board members.

Early in 2025, the Local Counter Fraud Specialist (LCFS) assessed the design and effectiveness of the ICB's counter fraud processes and controls over secondary employment.

This was reported through to the Audit Committee in March 2025. In the context of that audit, the effectiveness of the ICB's processes to identify and manage conflicts of interest was also assessed.

The audit resulted in an overall rating of "significant assurance with minor improvement opportunities."

The audit identified areas of good practice with regards to the ICB's management of conflicts of interest, and made a recommendation to further clarify the ICB's Standards of Business Conduct policy as to the consequences of not declaring secondary employment under the ICB's conflict of interest processes.

The ICB is taking this recommendation forward.

Data quality

The Board, in addition to its committees and sub-committees, receives information provided by the business intelligence team that is sourced from national mandatory returns, from local providers, and NHS Digital information.

This data is subject to data quality checks from providers prior to submission, from NHS Digital as part of the national collation process and from the ICB as part of its data management processes. Information is also sourced directly from local providers, and this is validated by the ICB business intelligence team, as well as against national information and guidance, wherever available.

The Board has recognised and adopted the NHS Insightful ICB Board guidance to assess the effectiveness of the information the ICB collects and uses, ensuring it is used to gain assurance with regards to the organisation meeting its statutory duties, to spot any early warning signs of quality, performance or financial issues across the system, to gain assurance that care provided across the system is continuously improving and services meet the population's current and future needs, and to consider whether the ICB's leadership, culture, systems and processes are getting the right results.

Information governance

The NHS Information Governance Framework sets out 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 and Protection Toolkit and the annual submission process provides assurances to the ICB, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively.

High importance is placed on ensuring there are robust information governance systems and processes to help protect patient, ICB colleague and corporate information. The ICB operated an information governance management framework in line with the Data Security and Protection Toolkit (DSPT), which is reviewed on an annual basis.

The ICB submitted a completed DSPT on 17 June 2024. The submission provided a status of standards met.

There is a suite of GDPR compliant information governance policies, and an Information Governance Handbook provides further information to ICB colleagues to ensure they are aware of their information governance roles and responsibilities.

The ICB had a trained Senior Information Risk Officer (SIRO), a trained Caldicott Guardian and a trained Data Protection Officer (DPO) in place throughout the year.

The ICB also benefited from trained Information Asset Owners (IAO) and Information Asset Administrators (IAA) across the organisation, and all ICB colleagues have been required to complete the national data security and awareness training on an annual basis.

The ICB actively promotes information governance through detailed intranet pages and briefings to ICB colleagues.

A reporting and investigation framework is utilised for information governance incidents and near misses with the ICB demonstrating a strong risk reporting culture. Incidents are

reviewed by South Central and West Commissioning Support Unit, which provides independence and information governance expertise.

The Information Governance Steering Group receives reports on all reported incidents, and provides oversight to their conclusion.

ICB colleagues understand the importance of privacy by design and complete data protection impact assessments (DPIA), often leading on these for the ICS. The legal sharing of information between ICS organisations to promote integration and patient care is supported by data sharing agreements.

Business-critical models

The ICB has an appropriate and proportionate approach to providing quality assurance of business-critical models.

This is in line with the recommendations of the 2013 Macpherson Report. The ICB's business-critical models primarily rely on activity and financial data sourced from national or provider data systems.

Reliance is placed on third party assurances, contracts and the ICB internal control environment. Outputs are also validated by NHS England through their assurance of the ICB.

Third party assurances

As a commissioning organisation, the ICB routinely contracts with third party providers to deliver healthcare services. These services are contracted using NHS standard contracts using national terms and conditions.

The ICB places reliance on these contracts to make sure that services remain effective, as well as on regular performance monitoring reports and meetings with providers.

The ICB also uses third party providers to deliver some of its back-office processes:

- It is nationally mandated for the ICB to use NHS Shared Business Services for the provision of back-office financial services. These services are provided under a contract between NHS England and NHS Shared Business services. The ICB places reliance on NHS England to manage this contract and report back on any control issues identified.
- The ICB sub-contracts the provision of several of its corporate services to the South Central and West Commissioning Support Unit. The ICB reviews the performance of this service level agreement each month.
- The ICB has pooled budget arrangements with its three local authorities for the provision of healthcare services. These arrangements are formalised through Section 75 agreements and performance is reviewed in-year by all partners.

Control issues

The ICB is set a range of operational and financial performance targets that it is expected to meet.

Further details on performance against these targets and any recovery plans are set out within the Performance Report.

The ICB has achieved all of its financial performance targets in 2024/25.

Review of economy, efficiency and effectiveness of the use of resources

The ICB has systems and processes in place for managing its resources effectively, efficiently and economically.

The Board has an overarching responsibility for ensuring that appropriate arrangements are in place and has delegated responsibility to the Finance and Infrastructure Committee, Commissioning Committee, Audit Committee and the Quality and Outcomes Committee.

The Chief Finance Officer has delegated responsibility to determine arrangements to ensure a sound system of financial control is in place. An annual internal audit programme is agreed by the Audit Committee to provide assurance.

The Audit Committee met regularly throughout the year to review and monitor the ICB's financial reporting and internal control principles, and to ensure the ICB's activities were managed in accordance with legislation and NHS regulation. Both internal and external auditors attend the committee.

The Finance and Infrastructure Committee met throughout the year to approve the financial plans, monitor financial performance, savings plans and overall use of resources. The committee also approves business cases and has oversight over procurement activities.

The Commissioning Committee has been introduced during the year and now also approves business cases.

The Quality and Outcomes Committee has monitored effectiveness of contracts and outcomes.

The Chief Finance Officer meets regularly with the ICB finance team to review monthly reporting. Regular meetings are also held between the ICB and the finance leads of system partner organisations.

As part of the annual audit, the ICB's external auditors are required to satisfy themselves that the ICB has made proper arrangements for securing economy, efficiency and effectiveness in the use of its resources.

The findings are reported to both the Audit Committee and the ICB Board.

The ICB's performance against its targets for the period are set out within the notes of the Financial Statements.

NHS England continued to assess the ICB using the NHS Oversight framework in 2024/25 as the expected new framework has been delayed to 2025/26. Further information on the NHS Oversight framework in 2024/25 can be found in the Performance Analysis Section of this report. With regards to quality of leadership, leadership is assessed against 3 areas but only one of these is measured at ICB level.

Proportion of staff in senior leadership roles who are from a) a BME background, b) are women or c) are disabled	
Female	78.60%
BME	6.30%
Disabled	4.80%

Delegation of ICB functions

Over this reporting period, the ICB has delegated its statutory function of the commissioning of ambulance services to Dorset ICB. This is aligned with the six other South West ICBs to enable joint commissioning of services for the South West region. BSW ICB's CEO is a member of the South West Ambulance Partnership Board, which is in place to have oversight of the regional ambulance provider performance and exercise its management of delegated functions as per the agreement in place.

The ICB also had a service level agreement in place with the Commissioning Support Unit (CSU) for the provision of a range of services, including procurement, human resources, health and safety support, Freedom of Information requests, and information governance.

The ICB has had a delegation and service level agreement with Somerset ICB for the provision of hub activities connected to the commissioning of pharmacy, ophthalmology and dental. Assurance in relation to these services is supported through collaborative monitoring arrangements between the ICB and the South West Collaborative Commissioning Hub. Regular meetings are held, including the Hub Customer Manager Board meetings (of which the CEO attends), and the South West Primary Care Operational Group, ensuring feedback on delegation, performance and risk is routinely considered.

Counter fraud arrangements

The ICB has a contract in place with a third party for the provision of counter fraud services.

This arrangement includes:

- An accredited counter fraud specialist team contracted to undertake counter fraud work proportionate to identified risks and to embed counter fraud measures in line with the NHS Counter Fraud Authority (NHSCFA) Strategy for 2023-2026 and the NHS Counter Fraud Authority's standards for commissioners, fraud, bribery and corruption

- The ICB Audit Committee receives a regular progress report and an annual report against each component of the NHSCFA requirements and the Government Functional Standard 013. The counter fraud specialist team regularly attend audit committee meetings. There is executive support and direction for a proportionate proactive work plan to address identified risks
- A member of the Board is proactively and demonstrably responsible for tackling fraud, bribery and corruption
- Appropriate action is taken in the event of any NHSCFA quality assurance recommendations and progress is overseen by the Audit Committee
- The ICB undertakes an annual assessment against its compliance with the standards and NHS requirements for counter fraud by submitting a Counter Fraud Functional Standard Return to the NHSCFA at the end of the year. The ICB's rating for the 2024/25 return was green overall.

Proactive reviews of systems, processes and controls by both internal audit and the counter fraud specialist team contribute to the identification of the risk of fraud, and recommendations are made to mitigate against the identified risks. The counter fraud specialist team have completed a bespoke fraud risk assessment for the ICB the current year.

Head of Internal Audit Opinion

Following completion of the planned audit work for the period 1 April 2024 to 31 March 2025 for the ICB, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the ICB's system of risk management, governance and internal control.

The Head of Internal Audit concluded that:

Overall opinion

Our overall opinion for the period 1 April 2024 to 31 March 2025 is that: "Significant assurance with minor improvement opportunities" can be given on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control.

Commentary

On the basis of our work outlined below, we have concluded that our overall opinion for the period 1 April 2024 to 31 March 2025 is that: "significant assurance with minor improvement opportunities" can be given on the overall adequacy and effectiveness of the ICB's framework of governance, risk management and control.

The range of individual assurances arising from contemporary core reviews of financial systems, governance, risk management and data quality.

Our plan includes core reviews of governance, risk, financial control and data quality.

There are robust controls over governance, risk management, finance and data quality.

This is evidenced by our 'significant assurance with minor improvement opportunities' ratings in these areas.

No core reviews have been given "partial assurance with improvements required" or "no assurance" ratings.

The range of individual opinions arising from risk-based audit assignments, contained within our risk-based plan that have been reported throughout the year.

In addition to core areas, we perform risk-based reviews.

These are areas that management has directed us towards as they have concerns or would like to seek external views and assurance.

We have given "significant assurance with minor improvement opportunities" for our review of secondary employment.

Two reviews were graded as "partial assurance with improvements required":

- **Care packages**

We raised one high priority finding relating to non-compliance with the completion of ongoing reviews of adult care packages. The ICB agreed an action to monitor compliance with three month and annual reviews for inclusion in Quality Assurance Performance and Planning Highlight Reports.

- **IEG4 Implementation**

We raised one high priority finding relating to limitations in data quality and the need to ensure responsibilities for maintaining data quality in the new system are clear.

This does not prevent us from issuing "significant assurance with minor improvements" overall as the ICB has agreed and is implementing the management actions raised as a result of our work to address the issues identified.

Additionally, we note that the ICB directed us towards an area which was known to be in development for our data quality review.

The implementation status of prior year actions raised from internal audit assignments

The ICB has implemented 11 recommendations raised in-year and has taken action to implement 17 historic recommendations.

No actions from the prior year are still outstanding.

This demonstrates the ICB's commitment to improving the control environment.

The following actions are high priority and remain outstanding at the date of this opinion:

- **Care packages**

There is a high priority action to monitor compliance with three-month and annual reviews for inclusion in Quality Assurance Performance and Planning Highlight Reports.

This was due on 31 March 2025 and has not yet been implemented.

An extended due date of 31 May 2025 has been agreed with management through the Executive Management Meeting.

Progress towards the completion of the action has been reported, with the EMM agreeing third party resource to continue to support service delivery in completing reviews and CHC assessments and a procurement exercise is under way.

- **IEG4 implementation**

There is a high priority action to identify clear responsibility for data governance and perform audits over data quality.

This action was raised in the final quarter and is not overdue at the date of our opinion.

We have therefore issued a: "significant assurance with minor improvement opportunities" opinion overall.

KPMG LLP
Chartered Accountants
London
31 March 2025

During the period, Internal Audit issued the following audit reports:

Area of audit	Level of assurance given
Health Inequalities Data Quality (May 2024)	Partial assurance with improvements required
Community Services Procurement – Part 1 (May 2024)	N/A – advisory review
Primary Care Commissioning Assurance Framework (May 2024)	Partial assurance with improvements required
Care Packages (September 2024)	Partial assurance with improvements required
Emergency Department Data Quality (December 2024)	Significant assurance with minor improvement opportunities
Secondary Employment (including Conflicts of Interest) (March 2025)	Significant assurance with minor improvement opportunities
Integrated Community Based Care - Transition Plan Governance and Risk Management (March 2025)	Significant assurance with minor improvement opportunities
Grip and Control Checklist (May 2025)	Significant assurance with minor improvement opportunities
Risk Management (May 2025)	Significant assurance with minor improvement opportunities
IEG4 Implementation (May 2025)	Partial assurance with improvements required

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 assurance 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 this review by:

- the Board
- Audit Committee
- Internal audit
- Other explicit review or assurance mechanisms

The conclusions of each were that there were no significant control issues.

The Governance Review also included the review of supporting corporate documents, policies and the Scheme of Reservation and Delegation (SoRD).

Conclusion

The factors described in this statement have given me assurance, and I am therefore satisfied that the ICB continues to operate effective and robust internal controls.

I can confirm that no significant internal control issues have been identified.

Sue Harriman

Accountable Officer

19 June 2025

(3.03) Remuneration and Staff Report

This section sets out the ICB’s remuneration policy for directors and senior managers, and how it has been implemented.

Remuneration Committee

The committee is accountable to the Board and sets the remuneration, fees and other allowances, including pension schemes, for the executive and other individuals who provide services to the ICB.

During the reporting period, its members were:

BSW ICB Non-Executive Director (Remuneration and People) – Chair	Suzannah Power
BSW ICB Non-Executive Director (Public and Community Engagement)	Julian Kirby
BSW ICB Non-Executive Director (Finance) – <i>until October 2024</i>	Paul Miller
Interim BSW ICB Non-Executive Director (Quality) – <i>until 31 March 2025</i>	Alison Moon
BSW ICB Chair	Stephanie Elsy

Percentage change in remuneration of highest paid director (AUDITED)

	Salary and allowances	Performance pay and bonuses
2024/25		
The percentage change from the previous financial year in respect of the highest paid director	7.4 per cent	0
The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole	7.6 per cent	0
2023/24		
The percentage change from the previous financial year in respect of the highest paid director	5.0 per cent	0
The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole	2.2 per cent	0

The percentage change in remuneration for the highest paid director reflects the pay award for 2024/25.

The percentage stated in the table above reflects the movement in the mid-point of the banded remuneration of the highest paid director.

The percentage change in remuneration for employees as a whole is driven by the following:

- Impact of NHS pay award
- Change in staff mix during the year as a result of a reorganisation of services provided
- Reduction in staff numbers

Pay ratio information (AUDITED)

Reporting bodies are required to disclose the relationship between the total remuneration of the highest-paid director 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 in BSW ICB in the reporting period 1 April 2024 to 31 March 2025 was £215,000 - £220,000.

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

2024/25	25 th percentile	Median pay ratio	75 th percentile pay ratio
Total remuneration (£)	£36,487	£48,544	£66,249
Salary component of total remuneration (£)	£36,483	£48,526	£66,246
Pay ratio information	6:1	4.5:1	3.3:1

2023/24	25 th percentile	Median pay ratio	75 th percentile pay ratio
Total remuneration (£)	£30,639	£45,996	£58,972
Salary component of total remuneration (£)	£30,639	£45,996	£58,972
Pay ratio information	6.6:1	4.4:1	3.4:1

During the reporting period 2024/25, no employees received remuneration in excess of the highest-paid director/member (2023/24: 0).

Remuneration ranged from £24,071 to £215,163 (£22,383 to £204,935), based on annualised, full-time equivalent remuneration of all staff, including temporary and agency staff.

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments.

It does not include employer pension contributions and the cash equivalent transfer value of pensions.

Policy on the remuneration of senior managers

The ICB executives are employed with terms and conditions including duration, notice periods and termination payments in accordance with existing Agenda for Change and very senior manager (VSM) arrangements, as well as the ICB Executive Pay Framework, which was released in February 2022.

Remuneration is designed to fairly reward each individual based on their contribution to the ICB's success, and takes into account the need to recruit, retain and motivate skilled and experienced professionals.

Remuneration must take into account considerations of equal pay, value for money in the use of public resources and the ICB's obligation to remain within its financial allocations.

Senior manager remuneration for executive directors is set through a process that is based on a consistent framework – the ICB Executive Pay Framework – and independent decision-making based on the framework and previous experience.

This ensures a fair and transparent process through bodies that are independent of the senior managers whose pay is being set.

No individual is involved in deciding his or her own remuneration.

NHS England published the ICB Executive Pay Framework in February 2022, which detailed the minimum and maximum operational salary ranges for all Board members. All appointment and salary data is to be reported annually moving forward to allow any equity issues to be identified.

One former CCG Director continued to be paid by the ICB during the reporting period.

The individual was, however, seconded to NHS England during this period and their salary was claimed back from NHS England. The individual left BSW ICB on 31 March 2025.

Amendments to VSM and Board member salaries are reviewed annually by the Remuneration Committee, which then provides assurance to the Board.

This is normally following the national guidance on VSM salaries as advised by the review pay bodies. Executive and senior manager performance is monitored through the ICB's formal appraisal process, which is based on organisational and individual objectives.

During the reporting period Executive Directors received a pay rise of five per cent in line with the recommendation made by the Senior Salaries Review Body for Very Senior Managers, which was applicable from 1 April 2024.

When considering and setting the remuneration of appointed members of the Board, the Remuneration Committee and the Board take into account available guidance, and comparative data from other ICBs and NHS organisations.

The ICB's constitution determines the composition of the Board, the ways in which members are appointed or elected and terms of office.

Remuneration of very senior managers

The ICB has taken robust steps to ensure the remuneration of all very senior managers is reasonable and appropriate for the roles being undertaken, as well as the conditions of the labour market and in line with the ICB Executive Pay Framework.

Recommendations made by the Senior Salaries Review Body (SSRB) for very senior managers has also been considered by the ICB Remuneration Committee and implemented where approved, specifically in relation to the cost of living pay increase of five per cent, which was applicable from 1 April 2024.

For any salary above £150,000, the ICB Remuneration Committee is to note and endorse the proposals and, where necessary, seek approval from NHS England and HM Treasury, in line with NHS England guidance.

Senior manager remuneration (including salary and pension entitlements)

2024/25

Senior manager remuneration (including salary and pension entitlements) 2024/25 (AUDITED)

Name	Title	Note	Salary (bands of £5,000) ⁶	Expense payments (taxable) to nearest £100 ³	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	Other (bands of £5,000) ⁵	Compensation for loss of office (bands of £5,000)	All pension-related benefits (bands of £2,500) ⁴	Total (bands of £5,000)
			£'000s	£s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
Suzanne Harriman	BSW ICB CEO		200 - 205	-	-	-	-	-	7.5 - 10	205 - 210
Dr Amanda Webb	ICB Medical Director		165 - 170	100	-	-	-	-	37.5 - 40	205 - 210
Gary Heneage	ICB Chief Finance Officer		160 - 165	-	-	-	-	-	45 - 47.5	210 - 215
Rachael Backler	ICB Chief Delivery Officer		155 - 160	-	-	-	-	-	42.5 - 45	195 - 200
Gillian May	ICB Chief Nurse		150 - 155	-	-	-	-	-	10 - 12.5	160 - 165
Gordon Muvuti	ICB Place Director		140 - 145	-	-	-	-	-	-	140 - 145
Sarah Green	ICB Chief People Officer		135 - 140	-	-	-	-	-	35 - 37.5	175 - 180
Laura Ambler	ICB Place Director		120 - 125	200	-	-	-	-	30 - 32.5	155 - 160
Caroline Holmes	ICB Place Director	1,8	70 - 75	100	-	-	-	-	15 - 17.5	90 - 95
Fiona Slevin-Brown	ICB Place Director	1,7	65 - 70	100	-	-	-	-	-	65 - 70
Stephanie Elsy	BSW Independent Chair	4	60 - 65	500	-	-	-	-	-	60 - 65
Dr Francis Campbell	Partner Member	10	35 - 40	-	-	-	-	-	27.5 - 30	60 - 65
Suzannah Power	Non-Executive Director (Remuneration & People)	4	15 - 20	-	-	-	-	-	-	15 - 20
Claire Feehily	Non-Executive Director Audit	4	15 - 20	100	-	-	-	-	-	15 - 20
Julian Kirby	Non-Executive Director Public & Community Engagement	4	15 - 20	-	-	-	-	-	-	15 - 20
Alison Moon	Non-Executive Director (Quality)	4	15 - 20	-	-	-	-	-	-	15 - 20
Paul Miller	Non-Executive Director (Finance)	4,9	5 - 10	100	-	-	-	-	-	5 - 10

Notes

- Where senior managers were in post for part of the financial year, salaries and figures relating to all pension related benefits have been calculated on a pro-rata basis to reflect the length of time in post.
- The salary figures shown for senior managers above include recharges out to, and recharges in from other NHS organisations.
- Taxable benefits refer to where senior managers are reimbursed for mileage at a rate above the 45p / mile tax free amount set by HMRC. This is in line with the Agenda for Change guidance on mileage payments.
- Non-Executive Directors are not eligible for membership of the NHS Pension Scheme so no figures are recorded for pension benefits. 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. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. The value does 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.
- Other relates to those senior managers in receipt of a relocation allowance or other non taxable expense. The banded figures disclosed relate to the amounts claimed under such arrangements.
- Salary includes any salary sacrifice arrangements under the ICBs lease car scheme.
- Fiona Slevin-Brown left the ICB Place Director role on the 30th September 2024
- On 2nd September, Caroline Holmes took on the role of ICB Place Director
- Paul Miller left the ICB at end of October 2024.
- Dr Francis Campbell holds a second remunerated position in the ICB as a clinical lead. The salary for this role is the band £5,000 - £7,500.
- The ICB Board includes attendees that are not considered senior managers and receive no remuneration. Please refer to note 22 of the accounts for further information.

2023/24 (AUDITED)

Name	Title	Note	Salary (bands of £5,000) 6	Expense payments (taxable) to nearest £100 3	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	Other (bands of £5,000) 5, 9	Compensation for loss of office (bands of £5,000)	All pension-related benefits (bands of £2,500) 4	Total (bands of £5,000)
			£'000s	£s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
Sue Harriman	Chief Executive Officer (ICB)	7	195 - 200	-	-	-	-	-	-	195 - 200
Gary Heneage	Chief Finance Officer		155 - 160	-	-	-	-	-	35 - 37.5	190 - 195
Gill May	Chief Nurse		145 - 150	300	-	-	-	-	-	145 - 150
Dr Amanda Webb	Chief Medical Officer		160 - 165	200	-	-	-	-	-	160 - 165
Laura Ambler	Director Of Place - Bath and North East Somerset		115 - 120	-	-	-	-	-	27.5 - 30	145 - 150
Rachael Backler	Director of Planning and Performance		150 - 155	-	-	-	-	-	22.5 - 25	170 - 175
Sarah Green	Acting Chief People Officer	1,12	5 - 10	-	-	-	-	-	2.5 - 5	10 - 15
Jane Moore	ICB Director of Equalities & Innovation	1,9	75 - 80	-	-	-	30 - 35	-	-	105 - 110
Fiona Slevin-Brown	Director of Place - Wiltshire		130 - 135	100	-	-	-	-	-	130 - 135
Richard Smale	Director of Strategy & Transformation	1,8	95 - 100	100	-	-	-	-	-	95 - 100
Jasvinder Sohal	Chief People Officer	1,10	105 - 110	100	-	-	-	-	-	105 - 110
Dr Francis Campbell	Partner Member Primary Care		35 - 40	-	-	-	-	-	-	35 - 40
Gordon Muvuti	Director of Place - Swindon	5	135 - 140	-	-	-	0 - 5	-	-	135 - 140
Allison Moon	Non-Executive Director for Quality & Performance	1,4	5 - 10	-	-	-	-	-	-	5 - 10
Stephanie Elsy	BSW Independent Chair	4	60 - 65	500	-	-	-	-	-	60 - 65
Dr Claire Feehily	Non-Executive Director for Audit	4	15 - 20	100	-	-	-	-	-	15 - 20
Julian Kirby	Non-Executive Director for Public and Community Engagement	4	15 - 20	100	-	-	-	-	-	15 - 20
Paul Miller	Non-Executive Director for Finance	4	15 - 20	200	-	-	-	-	-	15 - 20
Suzannah Power	Non-Executive Director for Remuneration and People	4	15 - 20	-	-	-	-	-	-	15 - 20
Professor Rory Shaw	Non-Executive Director for Quality & Performance	1,4,11	10 - 15	-	-	-	-	-	-	10 - 15

Notes

- Where senior managers were in post for part of the financial year, salaries and figures relating to all pension related benefits have been calculated on a pro-rata basis to reflect the length of time in post.
- The salary figures shown for senior managers above exclude recharges made to the BSW Sustainability & Transformation Partnership, but include recharges out to other NHS organisations.
- Taxable benefits refer to where senior managers are reimbursed for mileage at a rate above the 45p / mile tax free amount set by HMRC. This is in line with the Agenda for Change guidance on mileage payments.
- Non-Executive Directors are not eligible for membership of the NHS Pension Scheme so no figures are recorded for pension benefits.
- Other relates to those senior managers in receipt of a relocation allowance or other non taxable expense. The banded figures disclosed relate to the amounts claimed under such arrangements.
- Salary includes any salary sacrifice arrangements under the ICBs lease car scheme.
- The highest paid director/member on an annualised basis was Sue Harriman, who was contracted at 1 WTE. The annualised banded salary (excluding pension benefits and salary sacrifice arrangements) for this role was £200-205k.
- Richard Smale was employed in a senior manager role up to January 2024
- Jane Moore left the ICB during October 2023. A payment in lieu of notice was made equivalent to three months salary.
- Jasvinder Sohal left the ICB during February 2024.
- Professor Rory Shaw left the ICB during December 2023.
- On 26th February, Sarah Green took on the role of Acting Chief People Officer

Pension benefits

Pensions Disclosure - 2024-25 (AUDITED)

Name	Title	Note	Real increase in pension at retirement age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at retirement age at 31 March 2025 (Bands of £5,000)	Lump sum at retirement 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 stakeholder pension
			£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
Sue Harriman	BSW ICB CEO		0 - 2.5	0	60 - 65	145 - 150	1304	11	1428	0
Gary Heneage	ICB Chief Finance Officer		2.5 - 5	0	30 - 35	0	381	33	461	0
Gill May	ICB Chief Nurse	4	0 - 2.5	0	80 - 85	225 - 230	93	33	151	0
Dr Amanda Webb	ICB Medical Director		2.5 - 5	0	25 - 30	45 - 50	369	21	436	0
Laura Ambler	ICB Place Director		0 - 2.5	0	5 - 10	0	47	15	81	0
Rachael Backler	ICB Chief Delivery Officer		2.5 - 5	0	25 - 30	0	242	22	300	0
Fiona Slevin-Brown	ICB Place Director	1, 5	0	0	5 - 10	0	1258	0	124	0
Sarah Green	ICB Chief People Officer		2.5 - 5	0	20 - 25	20 - 25	342	30	412	0
Caroline Holmes	ICB Place Director	1	0 - 2.5	0	10 - 15	5 - 10	139	11	183	0
Dr Francis Campbell	Partner Member		0 - 2.5	0	15 - 20	35 - 40	236	14	269	0

Notes

1 Where senior managers were in post for part of the financial year, figures relating to real increases in pension, lump sum and CETV have been calculated on a pro-rata basis to reflect the length of time in post.

2 There is no lump sum for members of the 2008 and 2015 schemes, where this applies, nil is shown.

3 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 members 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.

The CETV values included in the table above have been prepared by NHS Pensions as at 31st March 2025.

Accrued pension benefits included in this table for any individual affected by the Public Service Pensions Remedy have been calculated based on their inclusion in the legacy scheme for the period between 1 April 2015 and 31 March 2022, following the McCloud judgment. The Public Service Pensions Remedy applies to individuals that were members, or eligible to be members, of a public service pension scheme on 31 March 2012 and were members of a public service pension scheme between 1 April 2015 and 31 March 2022. The basis for the calculation reflects the legal position that impacted members have been rolled back into the relevant legacy scheme for the remedy period and that this will apply unless the member actively exercises their entitlement on retirement to decide instead to receive benefits calculated under the terms of the Alpha scheme for the period from 1 April 2015 to 31 March 2022.

4 The Cash equivalent transfer values disclosed for Gill May relates to the 2015 Scheme only. The member is over the Normal Retirement Age in the existing schemes and therefore no CETV figures have been provided by NHS Pensions for those schemes.

5 The Cash equivalent transfer values disclosed for Fiona Slevin-Brown as at 1st April 2024 includes membership of existing (non 2015) schemes. The CETV at 31st March 2025 relates to the 2015 Scheme only.

6 CETV figures are calculated using the guidance on discount rates for calculating unfunded public service pension contribution rates that was extant at 31 March 2025.

7 As part of ongoing NHS Pension reforms, members of public service pensions may have their entitlement remedied, and their membership between 1 April 2015 and 31 March 2022 would be moved back into the 1995 to 2008 Scheme on 1 October 2023. Negative values are not disclosed in this table but are substituted with a zero. NHS Pensions has not confirmed which (if any) senior manager disclosed here is affected by this change.

8 Gordon Muvuti, chose not to be covered by the pension arrangements during the reporting year.

2023/24 (AUDITED)

Name ¹	Title	Real increase in pension at retirement age (bands of £2,500) £'000s	Real increase in pension lump sum at pension age (bands of £2,500) £'000s	Total accrued pension at retirement age at 31 March 2024 (Bands of £5,000) £'000s	Lump sum at retirement age related to accrued pension at 31 March 2024 (bands of £5,000) ² £'000s	Cash equivalent transfer value at 1 April 2023 £'000s	Real increase in Cash equivalent transfer value £'000s	Cash equivalent transfer value at 31 March 2024 ³ £'000s	Employers contribution to stakeholder pension £'000s
Sue Harriman	Chief Executive Officer (ICB)	0	45 - 47.5	55 - 60	140 - 145	1049	123	1304	0
Gary Heneage	Chief Finance Officer	2.5 - 5	0	25 - 30	0	262	72	381	0
Gill May ⁴	Chief Nurse	0 - 2.5	0	75 - 80	215 - 220	39	31	93	0
Dr Amanda Webb	Chief Medical Officer	0 - 2.5	5 - 7.5	20 - 25	40 - 45	253	68	369	0
Laura Ambler	Director Of Place - Bath and North East Somerset	0 - 2.5	0	0 - 5	0	14	15	47	0
Rachael Backler	Director of Planning and Performance	0 - 2.5	0	20 - 25	0	155	52	242	0
Sarah Green	Acting Chief People Officer	0 - 2.5	0 - 2.5	15 - 20	20 - 25	280	2	342	0
Jane Moore	ICB Director of Equalities & Innovation	0 - 2.5	0	85 - 90	0	1309	141	1593	0
Fiona Slevin-Brown	Director of Place - Wiltshire	0	25 - 27.5	50 - 55	145 - 150	1031	105	1258	0
Richard Smale	Director of Strategy & Transformation	0	30 - 32.5	50 - 55	135 - 140	930	159	1196	0
Jasvinder Sohal	Chief People Officer	0	0	0	0	70	0	0	0
Dr Francis Campbell	Partner Member Primary Care	0	0 - 2.5	10 - 15	35 - 40	173	42	236	0

Notes
¹ Where senior managers were in post for part of the financial year, figures relating to real increases in pension, lump sum and CETV have been calculated on a pro-rata basis to reflect the length of time in post.

² There is no lump sum for members of the 2008 and 2015 schemes, where this applies, nil is shown.

³ 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 members 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.

The 2023/24 values for accrued pension, lump sum and CETV have been calculated by NHS Pensions with no allowance for a potential adjustment arising from a legal case known as the McCloud judgement. This case concerned potential age discrimination over the way in which UK public sector pension schemes introduced a Career Average Related Earning benefit design in 2015 for all members excluding the oldest members who remained on a final salary design.

The CETV values included in the table above have been prepared by NHS Pensions as at 31st March 2024.

⁴ The Cash equivalent transfer values disclosed for Gill May relates to the 2015 Scheme only. The member is over the Normal Retirement Age in the existing schemes and therefore no CETV figures have been provided by NHS Pensions.

⁵ CETV figures are calculated using the guidance on discount rates for calculating unfunded public service pension contribution rates that was extant at 31 March 2024.

⁶ As part of ongoing NHS Pension reforms, members of public service pensions may have their entitlement remedied, and their membership between 1 April 2015 and 31 March 2022 would be moved back into the 1995 to 2008 Scheme on 1 October 2023. Negative values are not disclosed in this table but are substituted with a zero. NHS Pensions has not confirmed which (if any) senior manager disclosed here is affected by this change.

⁷ Gordon Muvuti, chose not to be covered by the pension arrangements during the reporting year

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

There were no such payments in the financial period.

Payments to past directors

No payments other than those otherwise stated in this report transpired in the financial period.

(3.04) Staff Report

Number of senior managers

The ICB has categorised members of the Board, and the senior leadership team, as being senior managers.

As of 31 March 2025, the number of senior managers were:

Agenda for Change band	Number of senior managers
Very senior managers (VSM)	9

The Board of the ICB has an independent Chair, and four non-executive directors who have non-Agenda for Change remuneration arrangements.

The Board carried a vacancy towards the end of this reporting period for a NED for Finance.

However, the role has been appointed to, with the individual not due to commence in role until April 2025.

Staff numbers and costs (AUDITED)

Staff costs	2024-25			2023-24		
	Permanent Employees £m	Other £m	Total £m	Permanent Employees £m	£m	Total £m
Employee Benefits						
Salaries and wages	20.5	0.6	21.1	21.5	0.6	22.1
Social security costs	2.4	-	2.4	2.3	-	2.3
Employer contributions to the NHS Pension Scheme	4.5	-	4.5	4.1	-	4.1
Apprenticeship Levy	0.1	-	0.1	0.1	-	0.1
Termination benefits	0.7	-	0.7	3.2	-	3.2
Employee benefits expenditure	28.2	0.6	28.8	31.2	0.6	31.8

The ICB paid £2.8 million in termination benefits during 2024/25.

However, this expense was accounted for as a provision in the 2023/24 accounts.

The balance of £0.7 million represents a provision raised in 2024/25 for agreed termination benefits that will be paid in 2025/26.

The average number of people employed by the ICB during the reporting period on a whole-time equivalent (WTE) basis was 369.70.

The permanent WTE average was 338.87, and the Other WTE average was 30.83.

Permanently employed	Other
338.87	30.83

Analysed as:	Permanent	Other
Scientific, therapeutic and technical staff	21.26	1.08
Admin and estates staff	255.85	23.21
Medical and dental staff	3.09	1.20
Nursing, midwifery and health visiting	58.67	5.34
Other healthcare	0	0

Staff composition

The table below shows the gender breakdown of staff working at the ICB as of 31 March 2025:

	Female headcount	Male headcount	Total
ICB Board Members	7	3	10
All other senior managers (excluding Board Members)	4	1	5
All other ICB staff	320	81	401
Total	331	85	416

The Board also includes members who are not remunerated. This includes four females and one male.

Sickness absence data

Overall, the rolling staff sickness absence figure for the 12-month period was 3 per cent. This was a reduction of 0.51 per cent from the previous 12-month period.

The overall rolling sickness absence figure is as a result of 1.01 per cent short-term sickness absence and 2.08 per cent long-term sickness absence.

Sickness absence for short-term and long-term has reduced in 2023/24, compared to 2022/23.

All sickness absence is managed in line with the ICB Sickness Management policy and colleagues are supported by their manager.

The Health and Safety Executive Stress Risk Assessment is also undertaken with colleagues, if appropriate. Sickness absence data is reported on a quarterly basis and action is taken to address any areas of concern.

As an organisation, the ICB recognises that organisational and systemic change is a growing feature, and this can cause feelings of uncertainty and unrest.

During the last 12-month period, the majority of the ICB has undergone significant change via the organisational change programme that has been carried out.

The peak of the change programme was April to August, and during this time it was acknowledged that sickness absence did increase to 4.31 per cent in May and 3.6 per cent in June 2024, the highest for the 12-month period.

Proactive steps have been taken, and continue to be taken, to support individuals experiencing episodes of sickness absence and their return to work.

A series of Sickness Management Support training sessions have been run within the ICB by the People Team, and the feedback has been extremely positive.

Managers have reported feeling more confident to support and manage colleagues who have experienced sickness absence or require reasonable adjustments.

A particular focus over the last year has been supporting colleagues who are experiencing cancer themselves or supporting family members, friends or colleagues who have been diagnosed and receiving treatment. A session has been offered to all colleagues run by Macmillan.

In addition to the focus on supporting colleagues being affected by cancer, resources have also been published regarding menopause following a very successful session in December 2023 by the See Her Thrive organisation. The resources include a menopause awareness toolkit, an employer guide to menopause and a wellness action plan.

In the coming year, the ICB is also commissioning external training regarding supporting colleagues who are neurodiverse and looking at any changes needed to enable neurodiverse colleagues to thrive.

Following the approval of the national sexual safety policy, training is also being taken forward to support sexual safety and anonymous reporting.

Staff turnover percentages

The overall average staff turnover percentage for the ICB for the 12-month reporting period based on the full-time equivalent was 2.65 per cent.

A number of colleagues took voluntary redundancy or were made redundant on compulsory terms during the reporting period.

The table below shows the turnover figures for each month during the reporting period.

The highest turnover for the 12-month period was recorded in June 2024.

Colleagues who were working within a service that was being decommissioned on 30 June 2024 were made redundant during May and June 2024 and some colleagues leaving under voluntary redundancy also left during this time.

	2024 / 04	2024 / 05	2024 / 06	2024 / 07	2024 / 08	2024 / 09	2024 / 10	2024 / 11	2024 / 12	2025 / 01	2025 / 02	2025 / 03
Turnover Rate (FTE)	4.9 5%	7.2 9%	7.96 %	1.28 %	1.30 %	1.37 %	1.34 %	0.78 %	0.82 %	1.69 %	0.50 %	2.48 %

Staff engagement percentages

The ICB participated in the national NHS Staff Survey between 7 October 2024 and 29 November 2024, and all eligible ICB colleagues were invited to take part.

A total of 404 colleagues were eligible to participate, and 296 colleagues completed the survey, which is a response rate of 73 per cent.

The survey reported on the seven elements of the People Promise, as well as two longstanding themes, staff engagement and morale.

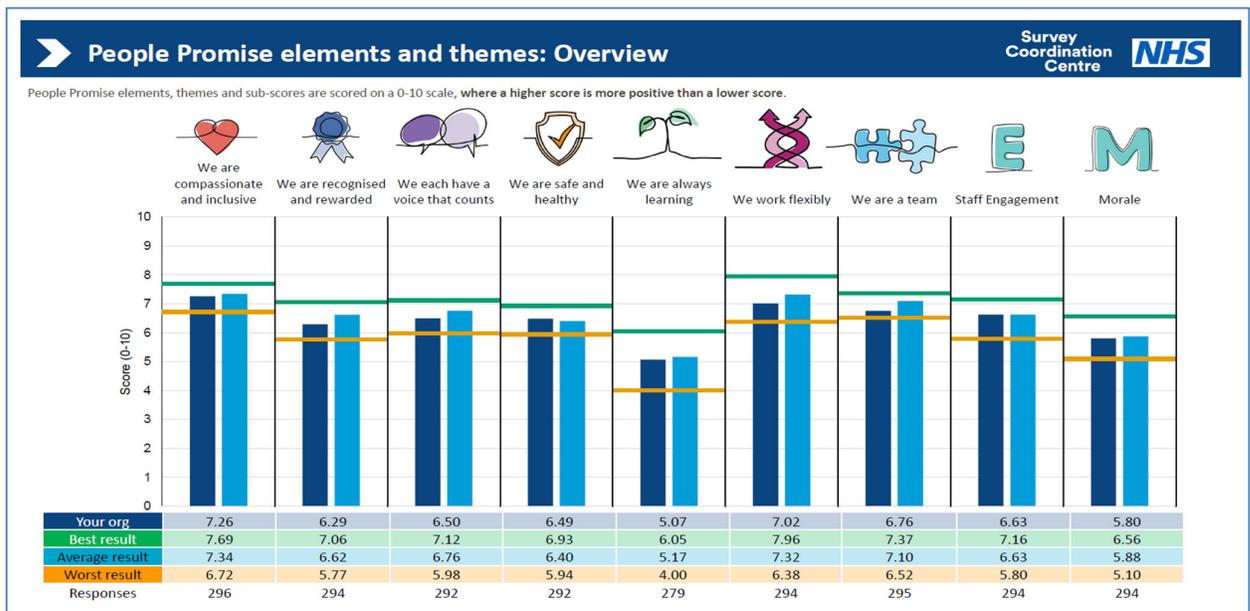
The survey consisted of a number of multiple-choice questions and two opportunities to provide free text responses.

The People Promise themes were:

- We are compassionate and inclusive
- We are recognised and rewarded
- We each have a voice that counts
- We are safe and healthy

- We are always learning
- We work flexibly
- We are a team
- Theme – Staff Engagement
- Theme – Morale

The infographic below details our highlights from the 2024 Staff Survey and how we performed against other ICBs.



Actions resulting from the 2024 Staff Survey include developing an engagement plan that allows feedback on key areas and how we can implement improvement particularly with a focus on:

- We have a voice
- We are recognised and rewarded

Health and wellbeing will remain a priority for the ICB, along with looking at initiatives which can best support colleagues.

The themes from the Staff Survey will underpin and support the planned OD cultural programme and endeavour to be responsive to the further changes facing the future of ICBs.

A breakdown of the Staff Survey results for each area within the ICB have been shared with the Executive Directors and senior leaders to share, discuss and develop an action plan within their teams and directorates.

The results have also been discussed at length with the Colleague Engagement Group, which represents staff from all directorates and meets monthly with the people team.

Staff policies

Over the course of 2024/25, the ICB has continued to review, update and develop policies to ensure compliance and alignment to the Agenda for Changes terms and conditions.

New policies have been created where required. In addition to legislative changes that have been implemented within the BSW ICB policy suite, standard user-friendly policies have been developed or are currently in development by NHS England for organisations to adopt and utilise.

As the standardised policies are released by NHS England, reviews of the ICB policies are taking place and, if appropriate, the policies are being updated based on information contained within the standardised policies.

Following any updates being made, the ICB policies are being reviewed and approved by the ICB Policy Steering Group (PSG) before final sign off by the BSW ICB Executive Team.

Any feedback provided by the PSG or the Executive Team has been discussed and incorporated where appropriate.

To summarise, there has been a thorough review of the following policies:

- Freedom to Speak Up Policy
- Retirement Policy
- Pay Protection Policy
- Ways of Working Policy
- Maternity/Paternity/Adoption and Parental Leave Policy.

This has been necessary to ensure that policies have been updated in line with recent legislative changes and also new guidance from NHS England.

All policies currently in operation are legally compliant and in line with Agenda for Change terms and conditions. The ICB does not have separate policies for disabled colleagues or colleagues with other protected characteristics, as the ICB has an integrated approach to delivering workforce equality.

All the HR policies pay due regard to the Equality Act 2010, and this is reflected in the policies and through training on specific HR policies. Equality Impact

Assessments have also been undertaken on the all the policies that have been reviewed.

The ICB's aim is to operate in a way that does 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, such as by making any reasonable adjustments that may be required on a case-by-case basis.

When applying any of the ICB's HR policies, the organisation will have due regard for the need to eliminate unlawful discrimination, promote equality of opportunity and provide good relations between people of diverse groups, in particular on the grounds of the characteristics protected by the Equality Act 2010.

Any employees who become disabled during their employment with the ICB will be supported by their line manager, HR, occupational health and the Staff Support service.

Where possible, reasonable adjustments will be made and training, if appropriate, provided to the individual's line manager and team members to ensure they are able to support the employee in the best way possible.

If appropriate, the ICB and occupational health will also work in conjunction with employees' GPs to ensure we are able to support individuals and make any reasonable adjustments.

The ICB will also work with Access to Work, if appropriate, to ensure the best possible support is provided. The ICB has a good relationship with Access to Work through supporting previous employees.

The ICB also has an inclusion charter – Everyone Counts – that was co-produced and details how it is committed to welcoming and embracing equality and diversity, and actively tackling discrimination in all its forms.

The ICB has submitted and published its Gender Pay Gap Report, Workforce Race Equality Report (WRES), Workforce Disability Equality Report (WDES) within its Annual Employer Equality, Diversity and Inclusion Report for 2023/24.

This report details the differences between the average and median hourly rate of pay for male and female employees, and includes an action plan to continue to narrow the gender pay gap.

Data has been collated and published within the report in relation to the WRES and WDES national indicators. The actions that are being taken are in line with the NHS EDI Improvement Plan and supports the NHS Long Term Workforce Plan by improving the culture of our workplaces and the experiences of our workforce, to boost staff retention and attract diverse new talent to the NHS.

Details of the improvement plan are contained with the Annual EDI report. The report can be found on the [ICB website](#).

The ICB had a mean gender pay gap of 22 per cent and a median pay gap of 23.5 per cent as of 31 March 2025. The mean gender pay gap has reduced by one per cent from March 2024 to March 2025, and the median pay gap has increased by 7.5 per cent.

The ICB has also committed to reporting on the ethnicity pay gap, and as of 31 March 2025, the mean ethnicity pay gap was 10.9 per cent, and the median pay gap was 7.8 per cent in favour of staff from an ethnic minority background, on average earning £4.33 more than white colleagues.

The mean ethnicity pay gap has reduced by 2.6 per cent and the median ethnicity pay gap by 8.7 per cent from March 2024 to March 2025.

The ICB has also committed to reporting on the disability and long-term condition pay gap within the ICB. As of 31 March 2025, the mean pay gap was £1.32 per hour and the median pay gap of £0 per hour between staff who declared they do not have a disability on ESR and those who did.

This indicates that staff who have declared a disability and those who don't consider themselves to have a disability are on an equal median pay rate of £24.82 per hour.

The ICB is committed, and aided through the national NHS Staff Survey, Gender Pay Gap data, WRES and WDES, to continue to improve diversity, remove barriers and increase inclusiveness of the workforce.

All of the data available through these valuable sources will help inform the organisational cultural programme.

Colleague Engagement Forum

The ICB has a proactive and committed Colleague Engagement Group, which meets on a regular basis, normally fortnightly, to discuss any issues that may impact ICB colleagues, any challenges on the horizon, and any feedback that representatives are receiving from their directorates.

Regular meetings are in place with the group to ensure effective communication and engagement of colleagues. The group has an important role in helping inform change and represent colleagues in the ICB, and the aim is that the group will continue to thrive and help build an organisation that listens to its colleagues and creates a sense of belonging.

The Colleague Engagement Group were paramount in the successful delivery of the organisational change programme in 2024 as strong foundations were in place to enable two-way communication and constructive feedback to be provided.

The ICB is an active member of the Social Partnership Forum and part of the NHS Confederation Social Partnership networks.

Trade Union Facility Time Reporting Requirements

The Trade Union (Facility Time Publication Requirements) Regulations 2017 requires the ICB to publish the following information:

The total number of relevant union officials employed by the ICB	0
Percentage of time spent on union facility time	0
Percentage of pay bill spend on union facility time	0
Paid trade union activities	0

Facility time is paid time-off for union representatives to carry out trade union activities.

The reporting requirements apply to all departments and a defined list of arm's length bodies within Statutory Instrument 328.

Other employee matters

BSW ICB is emerging from a year of significant challenges where it has faced considerable change with the completion of Project Evolve and its resulting 30 per cent reduction in running costs and redesign to improve its services.

In addition to this, the organisation also ran a voluntary redundancy programme and there was some decommissioning of services.

Throughout the last year, a number of support mechanisms were implemented including executive-led workshops, HR surgeries, a dedicated intranet information hub, increased colleague communications and varied methods for staff to provide feedback such as digital forms, one-to-ones and temperature check surveys.

Colleagues who were at risk of redundancy were also provided with career skills, advice and one-to-one career coaching.

It is recognised that it has been a time of uncertainty and anxiety for all of our colleagues, as we have worked to support them through this difficult transition.

It is hoped that as we all work to adapt to the organisational redesign, and new teams embed, that it will bring stability to better deliver our core purpose.

It is recognised that colleague engagement is a core area of focus and requires ongoing commitment and prioritisation so that we can create the right conditions where colleagues feel safe, supported, listened to and motivated.

Going forward, as part of the implementation stage, an organisational development programme will be designed with colleagues to help embed, sustain and support the collective BSW workforce.

The ICB has continued to work in an agile way and the estate of the ICB continues to be reviewed and monitored. Where possible, colleagues are provided with flexibility to work from home or a BSW office base.

The health and wellbeing of ICB colleagues continues to be a top priority.

Colleagues can access our mental health first aiders, occupational health services and self-referral counselling services. Data gathered through the quarterly pulse surveys, annual Staff Survey and sickness data is regularly analysed to inform the most appropriate support, education and signposting for colleagues and their line managers.

It has been recognised through analysis of the data that a number of colleagues are either experiencing and living with cancer themselves or supporting family members, friends or colleagues. As a result of this, external workshops were commissioned via Macmillan to offer support, advice and guidance during these difficult times.

The ICB wellbeing group continues to work to promote wellbeing activities, and its resources focus on a range of matters, including menopause, display screen equipment assessments, wellbeing checklists, stress risk assessments and flexible working.

As recently report by the Carer's Trust, our unpaid carers in the UK are suffering from increasing levels of exhaustion and more than two thirds reported that they are unable to get a respite from their caring role when needed.

Now, with more than 5.8 million unpaid carers in the UK, we are very aware some of our colleagues are also carrying out unpaid care work for family members and we want to support them in the workplace.

To that end, the ICB has also renewed its subscription with Carers UK, which provides a range of resources for carers to help manage work and their caring responsibilities, and we are also in the process of setting up a BSW ICB Carers Network this year and will be recommending the creation of a new standalone Carers Policy for the ICB.

The BSW ICB Annual Employer Equality, Diversity and Inclusion (EDI) Report 2023/24 details the ICB's commitment to implement the NHS EDI Improvement Plan, which supports the strategic EDI outcomes which are to:

- Address discrimination
- Increase accountability of all leaders
- Support the levelling-up agenda

- Make opportunities for progression equitable

Progress against the NHS EDI Improvement Plan will continue to be assessed and overseen through the Executive Management Meeting and People Committee.

It is acknowledged that the EDI agenda continues to be substantial and the ICB continues to be committed to improving in these areas.

The ICB coordinates the BSW ICS Equality, Diversity and Inclusion network which allows EDI leads from across all partners to draw on best practice and work collaboratively.

The ICB has also appointed a People and EDI Lead who started in March 2025 and will be proactively continuing to drive forward the EDI agenda.

Expenditure on consultancy

The ICB spent £0.3 million on consultancy services during 2024/25.

Off-payroll engagements

Table 1: Length of all highly paid off-payroll engagements

For all off-payroll engagements as of 31 March 2025, for more than £245* per day:

	Number
Number of existing engagements as of 31 March 2025	4
<i>Of which, the number that have existed:</i>	
for less than one year at the time of reporting	4
for between one and two years at the time of reporting	0
for between 2 and 3 years at the time of reporting	0
for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	0

*The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.

Table 2: Off-payroll workers engaged at any point during the financial year

For all off-payroll engagements between 1 April 2024 to 31 March 2025, for more than £245⁽¹⁾ per day:

	Number
No. of temporary off-payroll workers engaged between 1 April 2024 to 31 March 2025	7
<i>Of which:</i>	
No. not subject to off-payroll legislation ⁽²⁾	3
No. subject to off-payroll legislation and determined as in-scope of IR35 ⁽²⁾	0
No. subject to off-payroll legislation and determined as out of scope of IR35 ⁽²⁾	4
the number of engagements reassessed for compliance or assurance purposes during the year	0
Of which: no. of engagements that saw a change to IR35 status following review	0

(1) The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.

(2) A worker that provides their services through their own limited company or another type of intermediary to the client will be subject to off-payroll legislation and the Department must undertake an assessment to determine whether that worker is in-scope of Intermediaries legislation (IR35) or out-of-scope for tax purposes.

Table 3: Off-payroll engagements / senior official engagements

For any off-payroll engagements of Board members or senior officials with significant financial responsibility, between 1 April 2024 to 31 March 2025:

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during reporting period. ⁽¹⁾	0
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⁾	10

Exit packages, including special (non-contractual) payments (AUDITED)

Please refer to page 150, Note 4.3 of the financial statements.

(3.05) Parliamentary Accountability and Audit Report

The ICB is not required to produce a Parliamentary Accountability and Audit Report.

Disclosures on remote contingent liabilities, losses and special payments, gifts and fees and charges are included as notes in the Financial Statements of this report.

An audit certificate and report are also included in this Annual Report.

Financial statements and Audit Report

Audit opinion

Independent auditor's report to the members of the Governing Body of NHS Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board

Report on the audit of the financial statements

Opinion on financial statements

We have audited the financial statements of NHS Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board (the 'ICB') for the year ended 31 March 2025, which comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and Notes to the Financial Statements, including material accounting policy information. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards in conformity with the requirements of Schedule 1B of the National Health Service Act 2006, as amended by the Health and Care Act 2022 and interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2024-25.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the ICB as at 31 March 2025 and of its expenditure and income for the year then ended;
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2024-25; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006, as amended by the Health and Care Act 2022.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law, as required by the Code of Audit Practice (2024) ("the Code of Audit Practice") approved by the Comptroller and Auditor General. Our responsibilities under those standards are further described in the 'Auditor's responsibilities for the audit of the financial statements' section of our report. We are independent of the ICB in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

We are responsible for concluding on the appropriateness of the Accountable Officer's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the ICB's ability to continue as a going

concern. If we conclude that a material uncertainty exists, we are required to draw attention in our report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify the auditor's opinion. Our conclusions are based on the audit evidence obtained up to the date of our report. However, future events or conditions may cause the ICB to cease to continue as a going concern.

In our evaluation of the Accountable Officer's conclusions, and in accordance with the expectation set out within the Department of Health and Social Care Group Accounting Manual 2024-25 that the ICB's financial statements shall be prepared on a going concern basis, we considered the inherent risks associated with the continuation of services currently provided by the ICB. In doing so we have had regard to the guidance provided in Practice Note 10 Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2024) on the application of ISA (UK) 570 Going Concern to public sector entities. We assessed the reasonableness of the basis of preparation used by the ICB and the ICB's disclosures over the going concern period.

In auditing the financial statements, we have concluded that the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the ICB's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the Accountable Officer with respect to going concern are described in the relevant sections of this report.

Other information

The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. The Accountable Officer is responsible for the other information contained within the annual report. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements themselves. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office in November 2024 on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Governance Statement does not comply with the requirements of the Department of Health and Social Care Group Accounting Manual 2024-25 or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with the requirements of the Department of Health and Social Care Group Accounting Manual 2024-25; and
- based on the work undertaken in the course of the audit of the financial statements, the other information published together with the financial statements in the annual report for the period for which the financial statements are prepared is consistent with the financial statements.

Opinion on regularity of income and expenditure required by the Code of Audit Practice

In our opinion, in all material respects the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions in the financial statements conform to the authorities which govern them.

Matters on which we are required to report by exception

Under the Code of Audit Practice, we are required to report to you if:

- we issue a report in the public interest under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit; or
- we refer a matter to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the ICB, or an officer of the ICB, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we make a written recommendation to the ICB under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit.

We have nothing to report in respect of the above matters.

Responsibilities of the Accountable Officer

As explained more fully in the Statement of Accountable Officer's responsibilities, the Accountable Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions, for

being satisfied that they give a true and fair view, and for such internal control as the Accountable Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accountable Officer is responsible for assessing the ICB's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the ICB without the transfer of its services to another public sector entity.

The Accountable Officer is responsible for ensuring the regularity of expenditure and income in the financial statements.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists.

We are also responsible for giving an opinion on the regularity of expenditure and income in the financial statements in accordance with the Code of Audit Practice.

Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below:

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the ICB and determined that the most significant which are directly relevant to specific assertions in the financial statements are those related to the reporting frameworks (international accounting standards and the National Health Service Act 2006, as amended by the Health and Care Act 2022 and interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2024-25).
- We enquired of management and the audit committee, concerning the ICB's policies and procedures relating to:
 - the identification, evaluation and compliance with laws and regulations;
 - the detection and response to the risks of fraud; and
 - the establishment of internal controls to mitigate risks related to fraud or non-compliance with laws and regulations.
- We enquired of management, internal audit and the audit committee, whether they were aware of any instances of non-compliance with laws and

regulations or whether they had any knowledge of actual, suspected or alleged fraud.

- We assessed the susceptibility of the ICB's financial statements to material misstatement, including how fraud might occur, evaluating management's incentives and opportunities for manipulation of the financial statements. This included the evaluation of the risk of management override of control and cut-off risk in the ICB's non-block and non-NHS operating expenditure and its associated payables. We determined that the principal risks were in relation to:
 - journal entries outside the normal course of business
 - self-approved journal entries;
 - manipulation of expenditure recognition using journals close to and after year-end; and
 - deliberate manipulation of expenditure in order to meet agreed year end totals.
- Our audit procedures involved:
 - evaluation of the design effectiveness of controls that management has in place to prevent and detect fraud;
 - journal entry testing, with a focus on unusual and high-risk journals;
 - challenging assumptions and judgements made by management in its significant accounting estimates in respect of year-end expenditure accruals; and
 - assessing the extent of compliance with the relevant laws and regulations as part of our procedures on the related financial statement item.
- These audit procedures were designed to provide reasonable assurance that the financial statements were free from fraud or error. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error and detecting irregularities that result from fraud is inherently more difficult than detecting those that result from error, as fraud may involve collusion, deliberate concealment, forgery or intentional misrepresentations. Also, the further removed non-compliance with laws and regulations is from events and transactions reflected in the financial statements, the less likely we would become aware of it.
- We communicated relevant laws and regulations and potential fraud risks to all engagement team members, including management override of controls through fraudulent journal postings and deliberate manipulation of year-end expenditure. We remained alert to any indications of non-compliance with laws and regulations, including fraud, throughout the audit.
- The engagement partner's assessment of the appropriateness of the collective competence and capabilities of the engagement team included consideration of the engagement team's:
 - understanding of, and practical experience with audit engagements of a similar nature and complexity through appropriate training and participation
 - knowledge of the health sector and economy in which the ICB operates
 - understanding of the legal and regulatory requirements specific to the ICB including:
 - the provisions of the applicable legislation
 - NHS England's rules and related guidance
 - the applicable statutory provisions.
- In assessing the potential risks of material misstatement, we obtained an understanding of:

- The ICB's operations, including the nature of its other operating revenue and expenditure and its services and of its objectives and strategies to understand the classes of transactions, account balances, expected financial statement disclosures and business risks that may result in risks of material misstatement.
- The ICB's control environment, including the policies and procedures implemented by the ICB to ensure compliance with the requirements of the financial reporting framework.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Report on other legal and regulatory requirements – the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources

Matter on which we are required to report by exception – the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the ICB has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2025.

We have nothing to report in respect of the above matter.

Responsibilities of the Accountable Officer

As explained in the Governance Statement, the Accountable Officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the ICB's resources.

Auditor's responsibilities for the review of the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under Section 21(1)(c) of the Local Audit and Accountability Act 2014 to be satisfied that the ICB has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in November 2024. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the ICB plans and manages its resources to ensure it can continue to deliver its services;

- Governance: how the ICB ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness: how the ICB uses information about its costs and performance to improve the way it manages and delivers its services.

We have documented our understanding of the arrangements the ICB has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In undertaking our work, we have considered whether there is evidence to suggest that there are significant weaknesses in arrangements.

Report on other legal and regulatory requirements – Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate for NHS Bath and North East Somerset, Swindon And Wiltshire Integrated Care Board for the year ended 31 March 2025 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice until we have completed the work necessary in relation to the ICB's consolidation schedules, and we have confirmation from the National Audit Office that the audit of the NHS group consolidation is complete for the year ended 31 March 2025. We are satisfied that this work does not have a material effect on the financial statements for the year ended 31 March 2025.

Use of our report

This report is made solely to the members of the Governing Body of the ICB, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the members of the Governing Body of the ICB those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the ICB and the members of the Governing Body of the ICB as a body, for our audit work, for this report, or for the opinions we have formed.

Grace Hawkins, Key Audit Partner
for and on behalf of Grant Thornton UK LLP,
Local Auditor
Bristol

19 June 2025

ANNUAL ACCOUNTS

NHS BATH AND NORTH EAST SOMERSET, SWINDON AND WILTSHIRE ICB
ANNUAL ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2025.

Sue Harriman

Accountable Officer

19 June 2025

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**Statement of Comprehensive Net Expenditure for the year ended
31 March 2025**

	Note	2024-25 £m	2023-24 £m
Income from sale of goods and services	2	(30.6)	(41.6)
Other operating income	2	-	(0.1)
Total operating income		(30.6)	(41.7)
Staff costs	4	28.8	31.8
Purchase of goods and services	5	2,175.6	2,013.7
Depreciation and impairment charges	5	0.5	0.5
Provision expense	5	4.3	(3.9)
Other operating expenditure	5	6.3	0.8
Total operating expenditure		2,215.5	2,042.8
Net Operating Expenditure		2,184.9	2,001.1
Comprehensive Expenditure for the year		2,184.9	2,001.2

The notes on pages 149 to 152 form part of this statement.

**Statement of Financial Position as at
31 March 2025**

		2024-25	2023-24
	Note	£m	£m
Non-current assets:			
Property, plant and equipment		0.0	0.1
Right-of-use assets		0.7	1.5
Intangible assets		0.2	0.2
Total non-current assets		<u>1.0</u>	<u>1.8</u>
Current assets:			
Inventories	7	3.0	3.9
Trade and other receivables	8	13.3	40.1
Cash and cash equivalents	9	1.5	0.0
Total current assets		<u>17.8</u>	<u>44.0</u>
Total current assets		17.8	44.0
Total assets		<u>18.8</u>	<u>45.7</u>
Current liabilities			
Trade and other payables	10	(130.6)	(151.7)
Lease liabilities		(0.3)	(0.3)
Borrowings	11	-	(2.0)
Provisions	12	(9.1)	(7.8)
Total current liabilities		<u>(140.0)</u>	<u>(161.8)</u>
Non-Current Assets plus/less Net Current Assets/Liabilities		<u>(121.2)</u>	<u>(116.1)</u>
Non-current liabilities			
Lease liabilities		(0.5)	(1.2)
Total non-current liabilities		<u>(0.5)</u>	<u>(1.2)</u>
Assets less Liabilities		<u>(121.7)</u>	<u>(117.2)</u>
Financed by Taxpayers' Equity			
General fund		(121.7)	(117.2)
Total taxpayers' equity:		<u>(121.7)</u>	<u>(117.2)</u>

The notes on pages 152 to 157 form part of this statement

The financial statements on pages 141 to 162 were approved by the ICB Board on 19th June 2025 and signed on its behalf by:

Chief Executive Officer
Sue Harriman

Chief Finance Officer
Gary Heneage

Statement of Changes In Taxpayers' Equity for the year ended 31 March 2025

	General fund £m
Changes in taxpayers' equity for 2024-25	
Balance at 01 April 2024	(117.2)
Changes in taxpayers' equity for 2024-25	
Net operating expenditure for the financial year	<u>(2,184.9)</u>
Net Recognised NHS BSW ICB Expenditure for the Financial Year	(2,184.9)
Net funding	<u>2,180.5</u>
Balance at 31 March 2025	<u>(121.7)</u>

Statement of Changes In Taxpayers' Equity for the year ended 31 March 2024

	General fund £m
Balance at 01 April 2023	(120.3)
Changes in taxpayers' equity for 2023-24	
Net operating costs for the financial year	<u>(2,001.2)</u>
Net Recognised NHS BSW ICB Expenditure for the Financial Year	(2,001.2)
Net funding	<u>2,004.3</u>
Balance at 31 March 2024	<u>(117.2)</u>

**Statement of Cash Flows for the year ended
31 March 2025**

	2024-25	2023-24
Note	£m	£m
Cash Flows from Operating Activities		
Net operating expenditure for the financial year	(2,184.9)	(2,001.2)
Depreciation and amortisation	5	0.5
(Increase)/decrease in inventories	7	0.9
(Increase)/decrease in trade & other receivables	8	26.8
Increase/(decrease) in trade & other payables	10	(21.1)
Provisions utilised	12	(3.8)
Increase/(decrease) in provisions	12	5.0
Net Cash Inflow (Outflow) from Operating Activities	(2,176.6)	(2,003.6)
Cash Flows from Investing Activities		
(Payments) for intangible assets	(0.1)	(0.2)
Net Cash Inflow (Outflow) from Investing Activities	(0.1)	(0.2)
Net Cash Inflow (Outflow) before Financing	(2,176.7)	(2,003.8)
Cash Flows from Financing Activities		
Grant in Aid Funding Received	2,180.5	2,004.3
Repayment of lease liabilities	(0.3)	(0.4)
Net Cash Inflow (Outflow) from Financing Activities	2,180.2	2,003.9
Net Increase (Decrease) in Cash & Cash Equivalents	9	3.5
Cash & Cash Equivalents at the Beginning of the Financial Year	(2.0)	(2.1)
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year	1.5	(2.0)

The notes on pages 152 to 155 form part of this statement

Notes to the financial statements

1 Accounting Policies

NHS England has directed that the financial statements of Integrated Care Boards (ICBs) shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2023-24 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards 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

On 13 March 2025 the government announced NHS England and the Department for Health and Social Care will increasingly merge functions, ultimately leading to NHS England being fully integrated into the Department. The legal status of ICBs is currently unchanged.

Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated. If services will continue to be provided in the public sector the financial statements should be prepared on the going concern basis. The statement of financial position has therefore been drawn up at 31 March 2025, on a going concern basis.

1.2 Accounting Convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.3 Joint arrangements

Joint operations are arrangements in which the ICB has joint control with one or more other parties and has the rights to the assets, and obligations for the liabilities, relating to the arrangement. Where the ICB is a party to a joint operation, it recognises its share of the assets, liabilities, income and expenses in its own financial statements.

Joint ventures are arrangements in which the ICB would have joint control with one or more other parties, and where it has the rights to the net assets of the arrangement. Joint ventures are recognised as an investment and accounted for using the equity method.

1.4 Aligned/Pooled Budgets

The ICB has entered into separate joint arrangements with Bath and North East Somerset Council, Swindon Borough Council and Wiltshire Council in accordance with section 75 of the NHS Act 2006. Under these arrangements, funds are hosted by the local authorities.

The ICB accounts for its share of the assets, liabilities, income and expenditure in accordance with the respective Section 75 agreements. The ICB determines which party has control over the services being delivered in accordance with IFRS 11. Note 21 provides further details on the arrangements.

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 ICB.

1.6 Revenue

In the application of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows:

- As per paragraph 121 of the Standard, the ICB will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less,
- The ICB is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed
- The FReM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the ICB to reflect the aggregate effect of all contracts modified before the date of initial application.

The main source of funding for the ICBs is from NHS England. This is drawn down and credited to the general fund. Funding is recognised in the period in which it is received.

Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation.

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.

The value of the benefit received when the ICB accesses funds from the Government's apprenticeship service are recognised as income in accordance with IAS 20, Accounting for Government Grants. Where these funds are paid directly to an accredited training provider, non-cash income and a corresponding non-cash training expense are recognised, both equal to the cost of the training funded.

Notes to the financial statements

1.7 Employee Benefits

1.7.1 Short-term Employee Benefits

Salaries, wages and employment-related payments, including payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken.

The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.7.2 Retirement Benefit Costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the ICB commits itself to the retirement, regardless of the method of payment.

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

Employees not eligible to join the NHS Pension Scheme can be enrolled on an alternative defined contribution scheme (see Note 4.4). The costs of this scheme are recognised in the period in which service is received.

1.8 Other Expenses

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. 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 Grants Payable

Where grant funding is not intended to be directly related to activity undertaken by a grant recipient in a specific period, the ICB recognises the expenditure in the period in which the grant is paid. All other grants are accounted for on an accruals basis.

1.10 Inventories

Inventories are valued at the lower of cost and net realisable value, using the first-in first-out cost formula. This is considered to be a reasonable approximation of fair value due to the high turnover of stocks.

1.11 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 ICB's cash management.

1.12 Provisions

Provisions are recognised when the ICB has a present legal or constructive obligation as a result of a past event, it is probable that the ICB will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate as follows:

All general provisions are subject to four separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:

- A nominal short-term rate of 4.03% (2023-24: 4.26%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.
- A nominal medium-term rate of 4.07% (2023-24: 4.03%) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.
- A nominal long-term rate of 4.81% (2023-24: 4.72%) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.
- A nominal very long-term rate of 4.55% (2023-24: 4.40%) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

A restructuring provision is recognised when the ICB has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with on-going activities of the entity.

Notes to the financial statements

1.13 Clinical Negligence Costs

NHS Resolution operates a risk pooling scheme under which the ICB 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 ICB.

1.14 Non-clinical Risk Pooling

The ICB participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the ICB pays an annual contribution to 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.

1.15 Contingent liabilities and contingent assets

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 ICB, 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 and contingent assets are disclosed at their present value.

1.16 Financial Assets

Financial assets are recognised when the ICB 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.

The ICB only holds financial assets categorised as "Financial assets at amortised cost".

1.16.1 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.

1.16.2 Impairment of financial assets

For all financial assets measured at amortised cost, the ICB recognises a loss allowance representing the expected credit losses on the financial asset.

The ICB 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 month expected credit losses (stage 1).

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds and Exchequer Funds assets where repayment is ensured by primary legislation. The ICB 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 ICB 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.

1.17 Financial Liabilities

Financial liabilities are recognised on the statement of financial position when the ICB 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.

The ICB only holds financial liabilities categorised as "Other Financial Liabilities".

1.17.1 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.

Notes to the financial statements

1.18 Value Added Tax

Most of the activities of the ICB 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.

1.19 Foreign Currencies

The ICB's functional currency and presentational currency is pounds sterling. However, amounts are presented in the financial statements in millions of pounds unless expressly stated otherwise. During 2024/25, the ICB undertook some transactions in euros and US dollars. Transactions denominated in a foreign currency are translated into sterling at the spot 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. Resulting exchange gains and losses for either of these are recognised in the ICB's surplus/deficit in the period in which they arise.

1.20 Critical accounting judgements and key sources of estimation uncertainty

In the application of the ICB's accounting policies, management is required to make various judgements, estimates and assumptions. These are regularly reviewed. For 2024-25, the ICB has made no critical accounting judgements nor identified any areas of material estimation uncertainty.

1.21 New and revised IFRS Standards in issue but not yet effective

- IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2023. This Standard was adopted by the FReM in April 2025 but early adoption is not permitted. The ICB is currently reviewing its contracts to identify whether they include any insurance provisions. Nothing has been identified so far, so the current expectation is that this accounting standard would have minimum impact on the ICB's financial statements.
- 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. It is likely that this will have an impact on the ICB's financial statements although the impact is expected to be on the format and presentation of the accounts.
- 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 ICB does not have any subsidiaries, so at this stage, no impact on ICB financial statements is expected.

2 Other Operating Revenue

	2024-25 Total £m	2023-24 Total £m
Income from sale of goods and services (contracts)		
Non-patient care services to other bodies	7.0	19.4
Prescription fees and charges	11.0	10.4
Dental fees and charges	11.5	11.0
Other Contract income	1.1	0.8
Total Income from sale of goods and services	30.6	41.6
Other operating income		
Other non contract revenue	-	0.1
Total Other operating income	-	0.1
Total Operating Income	30.6	41.7

3 Disaggregation of Income - Income from sale of good and services (contracts)

	Non-patient care services to other bodies £m	Prescription fees and charges £m	Dental fees and charges £m	Other Contract income £m
Source of Revenue				
NHS	5.1	-	-	-
Non NHS	1.9	11.0	11.5	1.1
Total	7.0	11.0	11.5	1.1
Timing of Revenue				
Point in time	-	11.0	-	-
Over time	7.0	-	11.5	1.1
Total	7.0	11.0	11.5	1.1

4. Employee benefits and staff numbers

4.1.1 Employee benefits

2024-25	Total		
	Permanent Employees £m	Other £m	Total £m
Employee Benefits			
Salaries and wages	20.5	0.6	21.1
Social security costs	2.4	-	2.4
Employer Contributions to NHS Pension scheme	4.5	-	4.5
Apprenticeship Levy	0.1	-	0.1
Termination benefits	0.7	-	0.7
Gross employee benefits expenditure	28.2	0.6	28.8

The ICB paid £2.8m in termination benefits in 2024/25 (note 4.3). However, this expenditure was covered by a provision raised in 2023/24 which was released in this financial period.

2023-24	Total		
	Permanent Employees £m	Other £m	Total £m
Employee Benefits			
Salaries and wages	21.5	0.6	22.1
Social security costs	2.3	-	2.3
Employer Contributions to NHS Pension scheme	4.1	-	4.1
Apprenticeship Levy	0.1	-	0.1
Termination benefits	3.2	-	3.2
Gross employee benefits expenditure	31.2	0.6	31.8

4.2 Average number of people employed

	2024-25			2023-24		
	Permanently employed	Other	Total	Permanently employed	Other	Total
	Number	Number	Number	Number	Number	Number
Total	338.87	30.83	369.70	401.90	29.43	431.33

4.3 Exit packages agreed in the financial year

	2024-25 Compulsory redundancies		2024-25 Other agreed departures		2024-25 Total	
	Number	£	Number	£	Number	£
Less than £10,000	16	113,480	2	18,399	18	131,879
£10,000 to £25,000	19	293,270	7	130,466	26	423,736
£25,001 to £50,000	7	252,748	9	315,497	16	568,245
£50,001 to £100,000	3	158,316	8	614,749	11	773,065
£100,001 to £150,000	-	-	5	648,634	5	648,634
£150,001 to £200,000	1	160,000	1	157,628	2	317,628
Over £200,000	-	-	-	-	-	-
Total	46	977,814	32	1,885,373	78	2,863,187

	2023-24 Compulsory redundancies		2023-24 Other agreed departures		2023-24 Total	
	Number	£	Number	£	Number	£
Less than £10,000	7	32,863	2	5,513	9	38,376
£10,000 to £25,000	2	23,901	-	-	2	23,901
£25,001 to £50,000	-	-	1	30,125	1	30,125
£50,001 to £100,000	-	-	-	-	-	-
£100,001 to £150,000	-	-	-	-	-	-
£150,001 to £200,000	1	160,000	-	-	1	160,000
Over £200,000	-	-	-	-	-	-
Total	10	216,764	3	35,638	13	252,402

Analysis of Other Agreed Departures *

	2024-25		2023-24	
	Other agreed departures Number	£	Other agreed departures Number	£
Voluntary redundancies including early retirement contractual costs	32	1,771,708	-	-
Contractual payments in lieu of notice	21	113,665	3	35,638
Total	53	1,885,373	3	35,638

* 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 year. The expense associated with these departures may have been recognised in part or in full in a previous period. A provision for redundancy costs was included in the 2023/24 accounts.

Redundancy and other departure costs have been paid in accordance with the terms stipulated in contract of employments.

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.

4.4 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:

4.4.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2025, is based on valuation data as at 31 March 2023, updated to 31 March 2025 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

4.4.2 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.

4.4.3 Membership of other schemes

The ICB contributed to an alternative pension scheme during the period as a result of "auto enrolment" under the Pensions Act 2008. This pension is offered to staff who are not eligible to join the NHS Pension scheme. These staff are enrolled in a defined contribution pension scheme called "NEST". In the period, employee contributions were 5% and employer contributions 3%.

5. Operating expenses

	2024-25	2023-24
	Total	Total
	£m	£m
Purchase of goods and services		
Services from other ICBs and NHS England	3.2	3.7
Services from foundation trusts	1,112.6	1,021.3
Services from other NHS trusts	142.3	130.7
Services from Other WGA bodies	69.6	63.4
Purchase of healthcare from non-NHS bodies	327.2	305.1
Purchase of social care	40.1	37.9
General Dental services and personal dental services	43.0	36.4
Prescribing costs	165.1	159.6
Pharmaceutical services	32.8	29.7
General Ophthalmic services	17.8	16.9
GPMS/APMS and PCTMS	203.4	189.2
Supplies and services – clinical	4.1	4.5
Supplies and services – general	(0.3)	0.1
Consultancy services	0.3	1.0
Establishment	3.8	3.1
Transport	6.0	5.7
Premises	2.4	3.2
Audit fees	0.2	0.2
Other non statutory audit expenditure		
- Internal audit services	0.1	0.1
- Other services	0.0	0.1
Other professional fees	0.5	0.4
Legal fees	0.7	0.6
Education, training and conferences	0.7	0.7
Total Purchase of goods and services	<u>2,175.6</u>	<u>2,013.7</u>
Depreciation and impairment charges		
Depreciation	0.4	0.5
Amortisation	0.1	0.0
Total Depreciation and impairment charges	<u>0.5</u>	<u>0.5</u>
Provision expense		
Provisions	4.3	(3.9)
Total Provision expense	<u>4.3</u>	<u>(3.9)</u>
Other Operating Expenditure		
Chair and Non Executive Members	0.2	0.2
Grants to Other bodies	0.2	1.0
Expected credit loss on receivables	0.4	(2.4)
Inventories consumed	5.4	1.9
Other expenditure	0.1	0.1
Total Other Operating Expenditure	<u>6.3</u>	<u>0.8</u>
Total operating expenditure	<u>2,186.7</u>	<u>2,011.0</u>

The external audit fee for 2024/25 including unrecoverable VAT was £233,520. The external auditor has not yet completed a separate audit of the Mental Health Investment Standard (MHIS) for 2024/25 so an estimated cost of £44,400 including unrecoverable VAT has been recorded in this financial period. The agreement to undertake this work has not yet been finalised with the external auditor.

The external auditor's liability for external audit work carried out for the financial period 2024/25 is limited to £1,000,000.

6 Payment Compliance Reporting

6.1 Better Payment Practice Code

Measure of compliance	2024-25 Number	2024-25 £m	2023-24 Number	2023-24 £m
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	42,031	798.9	43,379	668.6
Total Non-NHS Trade Invoices paid within target	41,324	784.3	42,919	654.4
Percentage of Non-NHS Trade invoices paid within target	98.32%	98.18%	98.94%	97.88%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	1,355	1,308.0	1,517	1,140.4
Total NHS Trade Invoices Paid within target	1,342	1,306.5	1,491	1,140.2
Percentage of NHS Trade Invoices paid within target	99.04%	99.88%	98.29%	99.99%

6.2 The Late Payment of Commercial Debts (Interest) Act 1998

The ICB had no Late Payment of Commercial Debts (Interest) to report in 2024-25 or 2023-24

7 Inventories

	Loan Equipment £m	Total £m
Balance at 01 April 2024	3.9	3.9
Additions	4.5	4.5
Inventories recognised as an expense in the period	(5.4)	(5.4)
Balance at 31 March 2025	3.0	3.0
Balance at 01 April 2023	-	-
Additions	5.8	5.8
Inventories recognised as an expense in the period	(1.9)	(1.9)
Balance at 31 March 2024	3.9	3.9

8.1 Trade and other receivables

	Current 2024-25 £m	Current 2023-24 £m
NHS receivables: Revenue	2.8	4.3
NHS accrued income	2.3	15.6
Non-NHS and Other WGA receivables: Revenue	3.0	12.5
Non-NHS and Other WGA prepayments	1.2	3.4
Non-NHS and Other WGA accrued income	0.9	0.4
Non-NHS and Other WGA Contract Receivable not yet invoiced	4.7	5.2
Expected credit loss allowance-receivables	(2.0)	(1.6)
VAT	0.4	0.3
Total Trade & other receivables	13.3	40.1
Total current and non current	13.3	40.1

8.2 Receivables past their due date but not impaired

	2024-25 DHSC Group Bodies £m	2024-25 Non DHSC Group Bodies £m	2023-24 DHSC Group Bodies £m	2023-24 Non DHSC Group Bodies £m
By up to three months	0.6	0.9	3.0	-
By three to six months	-	0.0	-	-
By more than six months	(0.1)	1.3	-	-
Total	0.5	2.2	3.0	-

	Trade and other receivables - Non DHSC Group Bodies	Total
	£m	£m
8.3 Loss allowance on asset classes		
Balance at 01 April 2024	(1.6)	(1.6)
Lifetime expected credit losses on trade and other receivables	(0.4)	(0.4)
Total	(2.0)	(2.0)

9 Cash and cash equivalents

	2024-25 £m	2023-24 £m
Balance at 01 April 2024	(2.0)	(2.1)
Net change in year	3.5	0.1
Balance at 31 March 2025	1.5	(2.0)
Made up of:		
Cash with the Government Banking Service	1.5	0.0
Cash and cash equivalents as in statement of financial position	1.5	0.0
Bank overdraft: Government Banking Service	-	(2.0)
Total bank overdrafts	-	(2.0)
Balance at 31 March 2025	1.5	(2.0)

Please refer to Note 11 for further information regarding the "Bank Overdraft: Government Banking Service" balance in 2023-24.

10 Trade and other payables

	Current 2024-25 £m	Current 2023-24 £m
NHS payables: Revenue	4.5	16.3
NHS accruals	11.0	10.3
NHS deferred income	-	0.6
Non-NHS and Other WGA payables: Revenue	17.4	9.8
Non-NHS and Other WGA accruals	93.3	107.2
Non-NHS and Other WGA deferred income	0.7	0.4
Social security costs	0.3	0.3
Tax	0.3	0.3
Other payables and accruals	3.2	6.3
Total Trade & Other Payables	130.6	151.7
Total current and non-current	130.6	151.7

References to "WGA" relate to balances included in the Government's Whole of Government Accounts exercise.

Other payables includes £1.9m outstanding pension contributions at 31 March 2025.

11 Borrowings

The ICB had no borrowings at 31st March 2025 (In the previous financial year ending 31/03/2024; the ICB held a bank overdraft of £2.0m with the Government Banking Service)

12 Provisions

	Current 2024-25	Current 2023-24
	£m	£m
Restructuring	0.1	0.5
Redundancy	0.8	3.0
Continuing care	1.7	1.5
Other	6.5	2.9
Total	9.1	7.8
Total current and non-current	9.1	7.8

	Restructuring £m	Redundancy £m	Continuing Care £m	Other £m	Total £m
Balance at 01 April 2024	0.5	3.0	1.5	2.9	7.8
Arising during the year	-	0.7	0.8	6.5	8.1
Utilised during the year	-	(2.9)	(0.4)	(0.4)	(3.8)
Reversed unused	(0.4)	-	(0.1)	(2.5)	(3.0)
Balance at 31 March 2025	0.1	0.8	1.7	6.5	9.1
Expected timing of cash flows:					
Within one year	0.1	0.8	1.7	6.5	9.1
Balance at 31 March 2025	0.1	0.8	1.7	6.5	9.1

Redundancy and restructuring provisions have been recognised to reflect costs associated with organisational change.

Continuing Care - This category relates to those existing Continuing Healthcare retrospective applications which may demonstrate eligibility for Continuing Healthcare (CHC) that have not yet been agreed by the CHC panel and those identified funded nursing care cases which may demonstrate eligibility based upon the outcome of the nationally set application and review process.

Other provisions reflect contract indemnities, provisions for legal claims and undertakings associated with healthcare building developments in the BSW area.

Where appropriate a provision for legal claims may be calculated from the number of claims currently lodged with the NHS Resolution, and the probabilities provided by them.

There is a requirement for NHS bodies to note the value of provisions carried in the books of NHS Resolution in regard to ELS (Existing Liabilities Scheme) and CNST (Clinical Negligence Scheme for Trusts) claims as at 31 March 2025.

The provision for LTPS (Liabilities to Third Parties Scheme) claims is £2,832, and for CNST claims is £0. The provision is included in the category "Other".

13 Contingencies

	2024-25 £m	2023-24 £m
Contingent liabilities		
Continuing Healthcare	6.7	5.8
Net value of contingent liabilities	6.7	5.8

This represents an estimate of the cost that would be incurred if all outstanding claims for Continuing Healthcare and Funded Nursing Care were found to be eligible for funding.

14 Commitments

14.1 Capital commitments

The ICB had no capital commitments in 2024-25 or 2023-24.

14.2 Other financial commitments

	2024-25	2023-24
	£m	£m
In not more than one year	183.0	127.3
In more than one year but not more than five years	652.5	73.4
In more than five years	297.8	0.2
Total	<u>1,133.3</u>	<u>200.9</u>

The increase in the value of other financial commitments is largely due to the awarding of the new community services contract to HCRG Care Services Ltd. This came into operation from 1st April 2025.

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.

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 ICB 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 ICB in undertaking its activities.

Treasury management operations are carried out by the finance department, within parameters defined formally within the ICB's financial instructions and policies agreed by the ICB Board. Treasury activity is subject to review by the ICB and internal auditors.

15.1.1 Currency risk

The ICB is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The ICB has no overseas operations and therefore has low exposure to currency rate fluctuations.

15.1.2 Interest rate risk

When required the ICB receives capital resource from NHS England to fund capital expenditure. The ICB draws down cash to cover expenditure as the need arises, and generally does not need to borrow to finance its business. At the end of a reporting period, a technical overdraft may arise due to the timing of BACS payment runs. The ICB therefore has low exposure to interest rate fluctuations.

15.1.3 Credit risk

Because the majority of the ICB's revenue comes parliamentary funding, there is 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 ICB is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament. The ICB draws down cash to cover expenditure, as the need arises. The ICB is not, therefore, exposed to significant liquidity risks.

15.1.5 Financial Instruments

As the cash requirements of the ICB 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 ICB's expected purchase and usage requirements and therefore the ICB is exposed to little credit, liquidity or market risk.

15 Financial instruments cont'd

15.2 Financial assets

	Financial Assets measured at amortised cost 2024-25 £m	Total 2024-25 £m	Financial Assets measured at amortised cost 2023-24 £m	Total 2023-24 £m
Trade and other receivables with NHSE bodies	2.5	2.5	3.6	3.6
Trade and other receivables with other DHSC group bodies	2.5	2.5	20.0	20.0
Trade and other receivables with external bodies	8.6	8.6	14.3	14.3
Cash and cash equivalents	1.5	1.5	-	-
Total at 31 March 2025	15.1	15.1	37.9	37.9
			Total at 31 March 2024	

15.3 Financial liabilities

	Financial Liabilities measured at amortised cost 2024-25 £m	Total 2024-25 £m	Financial Liabilities measured at amortised cost 2023-24 £m	Total 2023-24 £m
Loans with external bodies	-	-	2	2
Trade and other payables with NHSE bodies	1.5	1.5	1.8	1.8
Trade and other payables with other DHSC group bodies	14.6	14.6	26.1	26.1
Trade and other payables with external bodies	113.3	113.3	123.6	123.6
Private Finance Initiative and finance lease obligations	0.7	0.7	-	-
Total at 31 March 2025	130.1	130.1	153.5	153.5
			Total at 31 March 2024	

16 Operating segments

	BSW Commissioning	Total
Gross expenditure £m	2,215.3	2,215.3
Income £m	(30.6)	(30.6)
Net expenditure £m	2,184.7	2,184.7
Total assets £m	18.7	18.7
Total liabilities £m	(140.3)	(140.3)
Net assets £m	(121.6)	(121.6)

17 Joint Arrangements

<u>BaNES Locality arrangement</u>	Total £m	Better Care Fund		Adult Services	Children's
		Better Care Fund £m	Community Equipment £m	(Learning Disabilities) £m	Services £m
Contribution					
Bath & North East Somerset Council	48.5	21.8	0.3	23.8	2.6
NHS Bath and North East Somerset, Swindon & Wiltshire ICB	55.6	47.2	0.6	7.3	0.5
Total Funding	104.1	69.0	0.9	31.1	3.1
Expenditure					
Bath & North East Somerset Council	56.6	21.8	0.3	28.9	5.6
NHS Bath and North East Somerset, Swindon & Wiltshire ICB	58.0	47.2	0.7	9.1	1.0
Total Expenditure	114.6	69.0	1.0	38.0	6.6
Net overspend/(underspend) as detailed below					
Bath & North East Somerset Council	8.1	-	-	5.1	3.0
NHS Bath and North East Somerset, Swindon & Wiltshire ICB	2.4	-	0.1	1.8	0.5
Total Overspend/(Underspend)	10.5	-	0.1	6.9	3.5

The Integrated Care Board has aligned budget arrangements with Bath & North East Somerset Council pursuant to Section 75 of the National Health Service Act 2006. The budgets are hosted by Bath & North East Somerset Council.

Any over/underspend on health services sit with the Integrated Care Board and over/underspends on social care services sit with the Local Authority. Over/underspends on The ICB has contributed £55.6m to the joint arrangements. These arrangements have overspent by £2.4m during 2024/25.

17. Joint arrangements cont'd

<u>Swindon Locality arrangement</u>	Total	Better Care Fund		Other Adult Services	Children's Services
		Better Care Fund	Community Equipment		
	£m	£m	£m	£m	£m
Contribution					
Swindon Borough Council	11.6	8.1	-	3.5	-
NHS Bath and North East Somerset, Swindon & Wiltshire ICB	24.0	18.7	0.7	2.0	2.6
Total Funding	35.6	26.8	0.7	5.5	2.6
Expenditure					
Swindon Borough Council	11.4	8.3	-	3.1	-
NHS Bath and North East Somerset, Swindon & Wiltshire ICB	24.2	19.1	0.9	1.6	2.6
Total Expenditure	35.6	27.4	0.9	4.7	2.6
Net overspend/(underspend) as detailed below					
Swindon Borough Council	(0.2)	0.2	-	(0.4)	-
NHS Bath and North East Somerset, Swindon & Wiltshire ICB	0.2	0.4	0.2	(0.4)	-
Total Overspend/(Underspend)	0.0	0.6	0.2	(0.8)	-

The Integrated Care Board has aligned budget arrangements with Swindon Borough Council pursuant to Section 75 of the National Health Service Act 2006. The budgets are hosted by Swindon Borough Council.

Any over/underspend on health services sit with the Integrated Care Board and over/underspends on social care services sit with the Local Authority. Over/underspends on community equipment are shared according to fixed percentages.

The net contribution by the ICB to the Joint Arrangement was £24m of which £0.2m was a net overspend.

17. Joint arrangements cont'd

<u>Wiltshire Locality arrangement</u>	Total £m	Better Care Fund	
		Better Care Fund £m	Community Equipment £m
Contribution			
Wiltshire Council	15.5	13.6	1.9
NHS Bath and North East Somerset, Swindon & Wiltshire ICB	42.4	39.6	2.8
Grant Funding	4.1	4.1	-
Total Funding	62.0	57.3	4.7
Expenditure			
Wiltshire Council	18.9	17.0	1.9
NHS Bath and North East Somerset, Swindon & Wiltshire ICB	42.4	39.6	2.8
Total Expenditure	61.3	56.6	4.7
Net overspend/(underspend) as detailed below			
Wiltshire Council	(0.7)	(0.7)	-
NHS Bath and North East Somerset, Swindon & Wiltshire ICB	-	-	-
Total Overspend/(Underspend)	(0.7)	(0.7)	-

The Integrated Care Board has aligned budget arrangements with Wiltshire Council pursuant to Section 75 of the National Health Service Act 2006. The budgets are hosted by Wiltshire Council.

Overspends and underspends on the Better Care Fund are managed by the Local Commissioning Board in accordance with the S75 agreement. If all remedial options to correct an overspend are exhausted, that the overspend will be recovered from the parties to the Fund in proportion to their respective financial contributions. Underspends are divided equally between the partners, unless a different arrangement is agreed by the Local Commissioning Board. The community equipment budgets are not pooled, and any overspend or underspend is attributed to the party that was responsible.

The final contribution by the ICB to the Joint Arrangement was £42.4m and the arrangement broke even.

18 Related party transactions

Details of related party transactions are as follows:

The Department of Health is regarded as a related party. During the period, NHS BSW ICB has had a significant number of material transactions with entities for which the Department of Health is regarded as the parent Department. The more significant transactions were with

- Great Western Hospitals NHSFT
- Royal United Hospitals Bath NHSFT
- Salisbury NHSFT
- South Western Ambulance NHSFT
- Oxford University Hospitals NHSFT
- Gloucestershire Hospitals NHSFT
- Avon and Wiltshire Partnership NHS Trust
- North Bristol NHS Trust
- NHS England
- NHS South Central and West CSU
- NHS Property Services

In addition, the ICB has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with Swindon Borough Council, Wiltshire Council and Bath and North East Somerset Council.

For this note, the ICB has considered all declarations of interest for Board Members. Related party transactions have been disclosed where they meet the criteria of having (i) control or joint control over the reporting entity, (ii) have significant influence over the reporting entity or (iii) are a member of the key management personnel. or (iv) where someone identified under (i), (ii) or (iii) controls or has significant influence over another entity.

Based on the above, the ICB considers Board members to be related parties.

The ICB has made payments under General Medical Contracts with GP practices for which some members of the ICB Board are partners of. These payments are to an organisation and not individuals. The ICB has also reimbursed practices for locum and related costs. The figures below reflect financial transactions between the ICB and GP practices and not between board members and the ICB. Details of payments made to GPs for their services to the ICB are included in the Remuneration report. The amounts disclosed below relate to the period 1st April 2024 to 31st March 2025.

The ICB has identified the following as related parties:

	Payments to Related Party £m	Receipts from Related Party £m	Amounts owed to Related Party £m	Amounts due from Related Party £m
Westrop Medical Practice - Dr Amanda Webb, ICB Medical Director is a GP at this practice.	7.85	0	0	0
Elm Tree Surgery - Dr Francis Campbell, ICB Partner Member is a partner in at this practice.	1.70	0	0	0

The following individuals are partner members of the ICB Board (but are not remunerated for their role):

- Cara Charles-Barks - ICB Partner Member - Acute Sector - Royal United Hospitals Bath NHS FT
- Dominic Hardisty - ICB Partner Member - Mental Health Sector - Avon and Wiltshire Mental Health Partnership (until December 2024)
- Alison Smith - ICB Partner Member - Mental Health Sector - Avon and Wiltshire Mental Health Partnership (from February 2025)
- Will Godfrey - ICB Partner Member - Local Authority - Bath and North East Somerset Council
- Terence Herbert - ICB Partner Member - Local Authority - Wiltshire Council (until August 2024)
- Lucy Townsend - ICB Partner Member - Local Authority - Wiltshire Council (from October 2024)
- Pam Webb - ICB Partner Member VCSE - Voluntary Action Swindon
- Samantha Mowbray - ICB Partner Member - Local Authority - Swindon Borough Council (from July 2024)

19 Events after the end of the reporting period

The accounts were authorised for issue by the Chief Finance Officer on 19th June 2025.

On 13 March 2025 the government announced NHS England and the Department for Health and Social Care will increasingly merge functions, ultimately leading to NHS England being fully integrated into the Department. The legal status of ICBs is currently unchanged but all have been tasked with significant reductions in their cost base. Discussions are ongoing on the impact of these and the impact of staffing reductions, together with the costs and approvals of any exit arrangements. All ICBs are currently being asked to implement any plans during quarter 3 of the 2025/26 financial year. NHS BSW ICB is currently exploring options with NHS Somerset ICB and NHS Dorset ICB, which may lead to a clustering arrangement.

20 Financial performance targets

NHS Integrated Care Boards have a number of financial duties under the NHS Act 2006 (as amended). The performance of NHS BSW ICB against these duties was as follows:

	2024-25 Target £m	2024-25 Performance £m	2023-24 Target £m	2023-24 Performance £m
Expenditure not to exceed income	2,224.0	2,215.5	2,033.4	2,043.3
Capital resource use does not exceed the amount specified in Directions	0.2	0.1	0.4	0.4
Revenue resource use does not exceed the amount specified in Directions	2,193.3	2,184.7	1,991.3	2,001.2
Revenue administration resource use does not exceed the amount specified in Directions	17.2	15.1	19.4	15.5

In 2024-25, the ICB has recorded a surplus of £8.6m - this reflects an underspend against the Revenue Resource Limit (RRL). This compares to 2023-24, when the ICB exceeded its RRL by £9.9m.

The ICB also underspent against its administration resource by £2.1m. In 2023-24, an underspend of £3.9m was reported. The ICB has spent £88k of its capital allocation of £169k. In 2023-24, the ICB fully spent its capital allocation.